THE UNIVERSITY OF HULL

A Social History of Paediatric Nursing 1920-1970

Being a Thesis for the Degree of PhD in the University of Hull

by

Michael Jeremy Jolley MA.,BN.,PGCEA.,RSCN.,RGN

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Contents

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To Susan, Alice and Catherine

'I left her and ... I often wake up in the night
and I can hear her'
(Participant AD)[1]

'If you can nurse a child,
perhaps you can nurse anyone'
(Participant D)[2]

[1] Participant AD (1964). Child age 4-5 years. Parent. Lincolnshire.
[2] Participant D (From 1967). Nurse. London, Bedfordshire.

Style notes

In this document, 'paediatric nursing' is used in preference to 'children's nursing' because the former term was generally used throughout the period upon which this material focuses.

Where the words 'medicine' and 'nursing' are used, historians may wish to read 'the medical profession' and 'the nursing profession' respectively.

The document uses modern language, much of it common to nursing and the social sciences. This is a legitimate approach (see Hendrick 1997)[3] and purposes to facilitate the appreciation of the historical content with paediatric nursing today.

Hendrick (1997)[4] argues that there is no well established histeriographical tradition which even broader studies on the social history of children can readily use as structure. This is an exploratory study in a relatively new area of historical investigation. The structure and content of this document necessarily reflects the youth of this area of study.

References are cited in name-date convention but also printed as numbered footnotes. The use of 'ibid' and 'op cit' is avoided. Minor references are cited with a number only and the full reference printed in the footnotes. A reference list and bibliography is included at the end of the document.

The identity of participants is hidden in order to comply with accepted standards of nursing and medical research ethics.

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[3] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[4] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

Abstract

This is a study concerning the social history of paediatric nursing between 1920 and 1970. Oral history data was collected from past nurses of children and from people who had been in hospital as children within the period in question. The study explores the professional orientation of nurses and their role within the micro-culture of the acute hospital, their relationship with doctors on the one hand and with the child and family on the other.

It is found that until the later years of the period 1920-1970, paediatric nursing was a regimented discipline, whose professional identity was intimately associated with that of medicine and with notions of 'science' and 'professionalism'. In practice, 'science' meant practicing the 'known way' as described in the literature of the time and which had been passed down by word of mouth and which could not be exposed to critique or review. 'Professionalism' meant being respectful and obedient to senior nurses and to doctors. This created a situation where nursing could not initiate change and as a result, failed to provide social and psychological care appropriate to the child and family. Nursing failed to question and develop its own practice and what changes did take place were the result of other agencies' manipulation of nursing for their own ends.

The nurse participants express a strong sense of value for their work history and are proud of what they achieved. Nursing is seen as a demanding and challenging occupation, to which the system of discipline and hierarchy presented most of the challenges. Nursing was an emotionally rewarding area of work, the nurse participants obtaining most satisfaction from being able to 'nurse the child better'. Nurses cared about the children but failed to realise that the emotional neutrality associated with their professionalism was interpreted by the children as a lack of affection.

It is found that the child participants tended to be traumatised by their hospital experiences. The cause of this trauma is found to be the way in which nurses practiced according to a scientific and professional paradigm. Unwittingly, this last resulted in the nurses being perceived by the child participants as lacking in affection or emotional

'care' for them as children. Many of the participants remain confused and troubled by this aspect of their experience.

By the end of the period 1920-1970 the system of discipline and hierarchy was being disassembled and nursing began to evaluate itself and subject itself to scientific scrutiny. At the same time, paediatric nursing did change to become more child and family orientated and it began to present a more 'human' face to the child patients and their families. These changes are identified with broader changes in society to which paediatric nursing did eventually become aligned.

Summary

This is a study concerning the social history of paediatric nursing between 1920 and 1970. Oral history data were collected from past paediatric nurses and from people who had been in hospital as children within the period in question. The focus of the study is the experience of paediatric nursing. The study explores the role of the nurse and the impact that the role had upon the child patients and the nurses themselves. The micro-culture of paediatric nursing is explored and an effort is made to analyse the degree to which paediatric nursing was influenced by events which were taking place in society during the period in question.

The methodology for such a study is inherently problematic, not least because of the paucity of material on and from sick children and their nurses within this period but even more widely in relation to the social history of children since 1800 (Hendrick 1997).[5] It follows that there is no well established histeriographical tradition on which to formulate a methodology and structure to this study. The study employs oral histories from past hospitalised children and from past nurses of children, an approach that is widely recognised as appropriate (see Hendrick 1997[6] and Porter 1985[7]).

Importantly, the nurses' role and indeed their core philosophy reflected what doctors expected of nurses. There was rarely any conflict between nurses and doctors. Nurses were happy to do what the doctors wanted, even when it affected the very nature of their role. This situation was facilitated by the positive value that doctors had for nurses and for nursing. Nurses felt privileged to be of assistance to doctors. Unfortunately, however, nursing's responsiveness to medicine meant that nursing did not develop its own unique body of knowledge and in this sense was never really a profession. Nursing did possess a unique 'care' philosophy which was often expressed

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[5] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[6] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[7] Porter, R. (1985). "The patient's view: doing medical history from below." Theory and Society **14**: 167-74.

in the literature. However, social factors such as the relationship with medicine were a more powerful influence. In addition, paediatric nursing was led, both locally and centrally by people who were not themselves paediatric nurses; this probably reduced the degree to which paediatric nursing was able to direct its own development. However, if this did limit the development of paediatric nursing, the nurse participants expressed no sense of frustration with it. The picture the nurse participants gave was largely one of remarkable harmony, especially with doctors but also with the system of discipline and hierarchy. The nurse participants were people who worked to avoid conflict. Knowing how to 'get along' with the other staff and to work in a team was an important attribute.

Paediatric nurses viewed their role as important and valuable but they regarded doctors as more senior people who deserved to be respected and supported. Nursing was seen as an important occupation but it was not as important or as 'clever' as medicine. It is notable that nurses should view another profession as more important than their own. Doctors were considered to be better educated and more intelligent. Doctors also took responsibility for treatment decisions whereas nurses practised a 'known way' which limited the degree to which they could be held responsible for what they did. It should be emphasised that a key nursing responsibility was to provide support for the doctor and that this was associated with a significant degree of loyalty. This loyalty, and the nurses' orientation to medicine meant that nursing was not really viewed as a profession, in that there was no sense of a responsibility to develop nursing practice. Nursing was a valued occupation but it was always in the shadow of medicine. Nurses were comfortable with this situation and did not seek to increase their level of responsibility.

On the whole, paediatric nursing was a skilled discipline but not one which was characterised by problem solving. What nurses did was determined partly by the doctors and partly by there being a 'known way' of nursing. Nursing was understood and documented. Students had to learn how to do nursing and were motivated to 'do the job properly'. Being a good nurse was to do the job properly. There was almost no sense of developing nursing practice. This would have meant criticising the 'known

way'. Nursing practice was described in textbooks and founded in history. In addition, the system of discipline and hierarchy encouraged obedience to the 'known way'.

Nursing was a comfortable discipline, nurses knew their place in the system, the institution looked after them as they in their turn looked after the patients. Both students and senior staff lived in the institution and spent their social as well as their professional time in it. This created a social group of nurses who enjoyed a significant sense of camaraderie. The social system within which nurses lived and worked reinforced the status quo and limited the degree to which change could take place. It should be emphasised that this produced no sense of frustration, rather, the nurse participants felt comfortable and protected. However, although nursing was 'comfortable' in a social sense, it still presented nurses with a significant challenge. The success with which the nurse participants dealt with this challenge is a source of considerable pride and value for what they achieved. The challenge was associated with becoming accepted as a member of the nursing team, of learning the range of skills which constituted nursing practice and coping with the sometimes aggressive system of discipline and hierarchy. The system of discipline and hierarchy probably appealed to people who could work within a controlled environment and where it was possible to work without having to question and problem solve. Senior staff were respected, but this respect was not gained in a professional sense. Senior staff were not respected for their achievements but simply because they were senior staff, the respect largely came with the job. The nurse participants valued the way in which senior staff were respected and see the lack of this respect today as a source of poor discipline in modern nursing.

It is argued here that nursing was influenced by changes in society. In the early 1920s paediatric nursing expressed romanticised views of its work with children. There was an emphasis on Christian values and of the value for what nurses did.[8] The emotional needs of the child appear to have been understood and nursing tried to provide children with the care that was designed to make them happy or less upset about their

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[8] See for example, Anonymous (1920). "Billiken." Nursing Mirror and Midwives Journal **31**(785): 23.

condition.[9] However, it is suggested that the increasing dominance of popular behaviourist psychology created a situation where nursing put less emphasis on the child's social and emotional needs.[10] At the same time, the state was intervening more in the lives of families and 'science' was seen as the only legitimate way of explaining human behaviour.[11] It is argued that notions of 'profession' and 'science' began to be seen as similar concepts and it began to be important to nursing that it should present a more cold, knowing and objective approach. This was an age when the professional knew better than the child or his or her parents and when parents were expected to follow the 'advice' of the professional.[12]

Perhaps unfortunately, ideas became classified as 'science' rather too easily. Nurses were not used to critically appraising printed material but were used to accepting printed material as fact. In addition, 'science' was about 'knowledge'. Nursing did not increase its questioning of practice during this period nor did it become a more problem solving discipline. In a sense, it was science with the thinking turned off. 'Science' also tended to produce uniformity because it would allow only one interpretation. This probably supported behaviourism which itself stressed the importance of regularity and uniformity.[13] Paediatric nursing seems to have become a somewhat harder discipline during this time,[14] certainly it is a time most clearly associated with reduced visiting opportunities for parents.[15] Parents began to be seen negatively, they were considered to upset their children by visiting them and to be ignorant while the professionals knew more about the care of sick children.[16] These notions probably built on existing fears of cross infection and of parents being

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[9] See for example, Anonymous (1920). "The care of the tuberculous child." Nursing Mirror and Midwives Journal **32**(818): 154-155. Anonymous (1920). "A Christmas incident in a nurse's life." Nursing Mirror and Midwives Journal **32**(820): 194. Anon (1920), Anonymous (1920). "In the children's ward." Nursing Mirror and Midwives Journal **32**(822): 228-229. Anonymous (1920). "A dying baby in a Brazilian home." Nursing Mirror and Midwives Journal **31**(792): 145.

[10] See Illingworth, R. S. (1956). "Young children in hospital." Nursing Times **03/02/1956**: 112-115.

[11] Darbyshire, P. (1999). "Nursing, art and science: revisiting the two cultures." International History of Nursing Journal **5**(3): 121-123.

[12] See Participant AD.

[13] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.

[14] See Illingworth, R. S. (1956). "Young children in hospital." Nursing Times **03/02/1956**: 112-115. Also see Robertson, J. (1956). "Letters." Nursing Times **24/02/1956**: 183.

[15] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal **6**(2): 44-51.

[16] See Duncombe, M. A. (1979). A brief history of the Association of British Paediatric Nurses 1938-1975. London, Association of British Paediatric Nurses.

responsible for much of the diseases seen in children (for example by practising poor hygiene).

It is suggested here that the merged notions of 'science' and 'professionalism' played down the importance of things that could not be measured. Emotions for example were seen as deleterious, even mischievous.[17] Nurses began to practice with a degree of emotional neutrality[18] and to argue against getting 'personally involved' with the children. Evidence is presented that the nurses did care and that they continued to be motivated to 'nurse the child better' and to 'do the job properly'. However, their emotional neutrality and the non-individualised care which was produced by the attempt to care for all the children in more or less the same way, confused the child participants. The child participants interpreted the emotional neutrality as lack of affection and this did result in psychological trauma which many of the child participants express in their oral histories. The child participants refer to being treated like inanimate objects and of being un-personed. The child participants felt alone, vulnerable, powerless and deserted. The child participants report a lack of bodily contact, no-one held their hand or comforted them. Crying was discouraged and ignored, the child participants recall crying for hours and days with no-one responding to them.

The child participants recall yearning for evidence of affection from the nurses and where such evidence was forthcoming it has become a treasured memory. It is as if the child participants needed to believe that the nurses had a sense of affection for them. Most of the child participants were separated from their families, often for a period of months. Very often, they were allowed to see their parents but not allowed to touch them. Some of the nursing practices seem to have been designed to be cruel, sweets brought in by the child's parents were not just a bag of calories, they were evidence of the parents continuing care and affection for the child. These sweets were usually 'confiscated' by the nurses, ostensibly so they could be shared 'equally' between all the children (however, no child participants recalled seeing their sweets again). Other

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[17] See Participant B.
[18] See Participant T (Child).

nursing practices appear to have been designed to cause emotional trauma, Participant B[19] (nurse) for example recalls:

'And then, if I get upset ignore me because it still upsets me [crying] [pause] then they were taken into theatre and guillotined[20]. Blood everywhere, and then the next poor child was brought onto that table [crying] [pause]. And the child that had had its Tonsils out with its big, red, plastic piny, rubber apron thing, blood running everywhere, going past that child [past the child about to have his or her operation] [crying] because the child that had been operated on was taken into the recovery area [crying] [pause] and I don't know [meaning I don't know why they could not have taken the returning child another way]. Yes there were sterilisers and things here [pointing] but why they couldn't have taken the child past that [crying] [pause] wall? And, it just went ... there was about thirteen at a time. Awful [emphasis]. If you were a recovery nurse, I mean I was a general nurse, probably second year, and there was like cloth hammocks and they used to carry these children from ... put them in the hammock and there were like lockers with a bowl of water and a sponge and you were expected to throw water at this kid's face and [crying] bring it round. As fast as possible, it was ... it was just a nightmare. It was a total nightmare and it could have been done so much nicer.'

Nursing was subject to a system of discipline which tightly regulated what nurses did and how they behaved. There was also an hierarchy which supported the system of discipline. The child participants were often frightened by the senior staff as they paraded through the ward, criticising the junior nurses.

Notwithstanding the above, the nurse participants' accounts show that they did care about the welfare of the children and did possess an affection for the children. However, the expectation that nurses should be 'professional' carried with it the view that nurses should be emotionally detached from their work. It follows that nurses began to see emotionality in children as undesirable. Nurses would fail to shield

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[19] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.
[20] Guillotined ... a method of dissecting the tonsils which involves a small 'guillotine' applied to the Pharyngeal Tonsils.

children from experiences that would frighten them and would fail to comfort them when they did become distressed. Some of the child participants are still traumatised by their hospital experience. These experiences have been lasting and un-repaired. Gifts presented to them while they were in hospital are often kept and treasured still, as if it is necessary for them to keep the evidence that their parents loved them during their time in hospital.

Hendrick (1984)[21] argues that children have been an oppressed group but have been different from other oppressed groups in that they have had no political organisation to struggle for their cause (see also Viner 2000)[22]. This present study not only shows that children were 'oppressed' but that parents were also powerless to protect their hospitalised children. Eventually, however, the lot of children in hospital did develop a political identity and organisations developed to support their cause.[23]

It is suggested that World War II was a turning point for the emotional neutrality and detachment practised by paediatric nurses. The mass evacuation of children taught Britons, by example, that children had an important emotional bond with their parents.[24] Increasingly, nursing began to be expected to present a more human and caring role. Hospitals began to experience pressure to increase visiting times. At the same time in wider society, uniformed human behaviour became associated with the Nazis and behaviourism began to lose ground to the much softer Freudianism (see Freud 1936)[25], the health care services came into the public domain and were seen to be owned by the people, people who began to express their views on what they wanted to get from the new NHS.

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[21] Hendrick, H. (1984). "The History of Childhood and Youth." Social History 9(1): 87-96.

[22] Viner, R. and J. Golden (2000). Children's experiences of illness. Medicine in the 20th Century. R. Cooter and J. Pickstone. Amsterdam: 575-588.

[23] See for example, an account of the influence of the National Association for the Welfare of Children in Hospital, in Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

[24] See Maunsell, M. (1940). "Seavacuation to Canada." Nursing Mirror **14/09/1940**: 554., and Armstrong, K. F. (1940). "Evacuation and epidemics." Nursing Times **20/01/1940**: 55., And the way in which views had changed by Editorial. (1945). "Our Children." Nursing Times **17/02/1945**: 107.

[25] Freud, S. (1936). Inhibitions, symptoms and anxiety. London, Hogarth Press.

The degree to which young nurses were willing to subject themselves to the system of discipline and hierarchy waned in the 1960s.[26] Concern had been building for some time about the conditions of service which were being blamed for the poor recruitment and retention figures that had always plagued paediatric nursing (Darbyshire 1988)[27]. Nursing gradually became less rigorously controlled. Significantly, however, nurses began to be encouraged to undertake professional development courses and to access the universities. Here they were encouraged to question and to expose their practice to analysis. It is suggested that questioning nurses eventually broke the back of the system of discipline and nursing was free to evaluate and develop its own area of work.

Most of the nurse participants express a desire to return to the system of discipline and hierarchy, characterised by the image of the hospital matron.[28] This study, however, illustrates the dangers inherent in taking such a course of action. The study shows that sick children need to know that they are positively regarded, they sometimes need comforting and they have emotional, social and psychological needs that should be met. The study shows that the child participants were individuals with individual needs which could not be met by a uniformed and generalised system of care. Most nurses worked hard for their child patients and were motivated toward their welfare and return to health. The last notwithstanding, the child patients were failed by a 'scientifically' rigid and emotionally neutral hospital environment when what they chiefly needed was emotional warmth, a common-sense understanding of their needs as children and access to their family.

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[26] Ward, M. (1964). "What has happened in four years?" Nursing Times 22/05/1964: 671.
[27] Darbyshire, P. (1988). "Looking to the past .. nurse recruitment." Nursing Times 84(19): 31-32.
[28] See Participant H (From 1958). Nurse. Yorkshire.

LITERATURE REVIEW

Chapter 1: preamble: setting the scene

This chapter provides a very brief background to paediatric nursing before and up to the beginning years of the period in question. It will be argued here that the background to paediatric nursing, from its inception in 1852 up until the 1920s was built upon a philosophy of what would now be called holistic care (Williamson 2001)[29]. Within this philosophical approach, the social, psychological, developmental and spiritual[30] needs of the child were considered essential elements of nursing care (see Viner and Golden 2000)[31]. It will be argued in subsequent chapters that from c. 1920s, the orientation to care discussed in this chapter would see a major re-orientation with the emphasis being on discipline, science and professionalism rather than on the holistic needs of the sick child and his or her family.

It should be understood that paediatric nursing confined its activities to children's hospitals and the care of sick children in general hospitals, a situation that is broadly the case today. Very few children's nurses worked in the community (private homes) (Great Ormond Street Hospital Archive 1926; Dingwall, Rafferty and Webster 1988; Mortimer 1997)[32] . Paediatric nurses tended not to be employed by the fever or orthopaedic hospitals (Recruitment advertisements 1920; Adams 1997; Currie 1997)[33]. Both Fever and Orthopaedic hospitals catered mostly for children at that time but did not tend to employ paediatric nurses.[34] [35] Rather, they offered shorter courses for

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[29] Williamson, L. (2001). "Entering into the spirit of nursing: holistic healers, past and present." International History of Nursing Journal **6**(1): 18-26.

[30] See for example, Derbyshire Children's Hospital Archive (1882). The children's hospital, Derby. Almanac 1882. Derby.

[31] Viner, R. and J. Golden (2000). Children's experiences of illness. Medicine in the 20th Century. R. Cooter and J. Pickstone. Amsterdam: 575-588.

[32] Great Ormond Street Hospital Archive (1926). Entry dated 07/01/1926. Nursing Committee Minutes. London. Dingwall, R., A. M. Rafferty and C. Webster (1988). An introduction to the social history of nursing. London, Routledge. Mortimer, B. (1997). Independent women: domiciliary nurses in mid-nineteenth century Edinburgh. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[33] Currie, R. (1997). "The rise and demise of fever nursing." International History of Nursing Journal **3**(1): 5-19. Adams, J. (1997). "From crippledom to orthopaedic nursing: Pyrford, Surrey 1908-1945." International History of Nursing Journal **2**(4): 23-37. Recruitment advertisements (1920). "Recruitment." Nursing Mirror and Midwives Journal **32**(810): x1.

[34] The word 'orthopaedic' = 'straight children'.

[35] Children's Orthopaedic Hospital - Marple - Cheshire (1945). "Appointments." Nursing Times **14/02/1945**: Supplement vi.

people too young to commence training in the general hospitals (Recruitment advertisements 1920).[36] [37] Furthermore, Lomax (1996)[38] points out that few children's hospitals took children over the age of fourteen years and most did not cater for sick neonates.[39] This meant that many 'children' were nursed in adult areas where paediatric nurses were very unlikely to be employed.

In the nineteenth century, nurses were essentially managed by non nurses. The Matron or Lady Superintendent was not a nurse in a modern sense of the word. Lomax (1996)[40] points out that the Matron was usually responsible for the domestic arrangements, including the cleaning of the wards and the preparation of food[41]. This, and the Matron's role in respect of domestic staff, catering etc. may account to some degree for nurses continuing role in relation to ward cleaning. There are times when ward cleaning seems to have been the main focus of the nurses' work. Certainly this element of their role must have limited the degree to which nurses could have focused on the development of a clinical role and a clinical area of expertise. The nurses' domestic role may also have achieved the effect of blurring their role and making it hard to pinpoint exactly what nurses did.

'Pre-history'; defining nursing and medicine

It is argued here that the 'history' of paediatric nursing is often confused with the development of paediatric medicine. However, between 1920 and 1970 a casual observer would have been very clear about the distinction between medicine and nursing. Overwhelmingly, doctors were men and nurses were women; doctors had been to university whereas nurses had only undergone an hospital training.[42]

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[36] Recruitment advertisements (1920). "Recruitment." Nursing Mirror and Midwives Journal 32(810): x1.

[37] Also see Anonymous (1920). "Invalid and crippled children: a joint two day conference." Nursing Mirror and Midwives Journal 32(818): 156.

[38] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[39] Neonate - a child under one month of age.

[40] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[41] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[42] Weir, R. I. (2000). "Medical and nursing education in the nineteenth century: comparisons and comments." International History of Nursing Journal 5(2): 42-7.

Nevertheless, it is only when one examines the role of the two disciplines and questions the existence or otherwise of an hierarchical relationship between the two, that an area of confusion appears.

The first English text on paediatric 'medicine'[43] (Phaire 1545)[44] reveals little if any mention of a discipline of medicine but rather entreats the reader to accept the universality of the practice of treating sick children. Phaire argues for the purpose of his book to be written in English, which could be understood by a greater number of people: he writes:

> *'How long wold they haue the people ignorant? Why grutche they phisyke to come forth in Englyshe? Woulde they haue no man to know but onely they? Or what make they them selues? Marchantes of our lyues and deathes, that wee shulde bye our health onely of theim, and at theyr prices, no good phisicion is of that mynde.' (p. 13)*

Furthermore, and as might be expected of a text written at that time, all the treatments involved substances that could be gathered from the environment. The medical regimens are very much those that could be followed by any carer of a sick child who could read and have access to plants, animals and charms. So it is argued here that there may be little point in trying to differentiate medicine from nursing, at least in the early years and before either discipline had become professionally organised.

It might be argued that Thomas Phaire's (1545)[45] book should be regarded as a medical text because the author was a 'doctor' ('studiouse in Philosophie & Phisicke', p. 65), no doubt medicine regards him as such (see Still 1931)[46]. It is of course likely that Thomas Phaire (1545, same reference) was writing to whoever was interested and to whoever might have the care of a sick child. His purpose was simply:

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[43] Still, G. F. (1931). The history of paediatrics: the progress of the study of disease of children up to the end of the XVIIIth century. London, Royal College of Paediatrics and Child Health.

[44] Phaire, T. (1545). The boke of chyldren. London, Reprinted by The Royal College of Child Health and Paediatrics in 1955.

[45] Phaire, T. (1545). The boke of chyldren. London, Reprinted by The Royal College of Child Health and Paediatrics in 1955.

[46] Still, G. F. (1931). The history of paediatrics: the progress of the study of disease of children up to the end of the XVIIIth century. London, Royal College of Paediatrics and Child Health.

'to doo theym good that haue moste nede, that is to saye, children: and to shewe the remedies that god hath created for the vse of man, to distribute in englyshe to them that are vnlearned, parte of the treasure that is in other languages ... and to communicate the fruite of my labours, to them that will gentilly and thankefully receyue them ..' (p. 13)

As the centuries progressed, there were clear attempts to draw the distinction between the male and 'science' dominated medicine and the female and relatively unlearned nursing. As early as 1771, Armstrong (1771, p. 7)[47] had tried to identify 'rules' to be observed in the nursing of sick children. These rules began to provide a scaffold for an understanding of the child and his or her reaction to illness. This guide, however, appears to be equally relevant to nursing as it must have been to medicine. In any case, it seems full of wisdom (p. 7):

'In order to be rightly informed what his real complaints are, you must apply to the parents or nurse ... another who perhaps is afraid of taking physic will answer, 'No' to every question that is put to him. A third will say, 'I don't know' if you should ask him fifty questions.'

Paediatric nursing also merges with other occupations. The care of the sick child employs many of the skills involved in caring for the well child. It is not surprising then that paediatric nursing, sometimes mixes imperceptibly with notions of 'mother-care', 'child-care' and parenting. The lack of clarity regarding what constitutes paediatric nursing, makes it difficult to identify it as a single historical phenomenon. It is well accepted for example that the reluctance to allow paediatric nurses onto the new Register of Nurses (1919 Nurses Act) was in part based on a fear of nannies and

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[47] Armstrong, G. (1771). An essay on the diseases most fatal to infants. To which are added rules to be observed in the nursing of sick children: with a particular view to those who are brought up by hand ..../. London, T. Cadell. Developed the first children's dispensary, possibly the first child only health care facility in Britain.

servants of children obtaining registration (see Arton 1992)[48]. Henry Burdett (1919, p. 174)[49] reported at the time that Sir Watson Cheyne (Standing Committee B) thought that the Register should only contain the names of 'fully trained nurses'[50] and not wet nurses and children's nurses *'who's only duty it is to push perambulators'*. Importantly, however, The Minister of Health, Dr Addison disagreed because he felt that those whose training was imperfect or incomplete should be admitted in recognition of their good work. So it was that paediatric nurses entered legitimised nursing, somewhat 'imperfect and incomplete' but present all the same.[51]

Armstrong (1771)[52] clearly considered nursing to be an important but simple activity, at the same time Armstrong voiced one of the first examples of competition between nursing and medicine. He argued (p. 2) '*that which regards the differences of infants, even with regard to medicine, has commonly been left to old women, nurses and midwives, so that it has been a common saying in this country, that the best doctor for a child, is an old woman'*. Perhaps from this point forward, medicine would be careful to keep nursing in its place.

1852- c.1920: nursing and the family[53]

It is argued here, that from the time when children's hospitals opened and first started to recruit children's nurses[54], there was an expectation that nursing would be holistically construed and that it would address the social, psychological, emotional

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[48] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[49] Burdett, H. (1919). "The Nurses' Registration (No. 2) Bill." Nursing and Midwives Journal 30(767): 174.

[50] Anonymous (1920). "Notes and queries." Nursing Mirror and Midwives Journal **32**(818): 166.

[51] Anonymous (1919). "Nurses' registration (no. 2) Bill: views of members of parliament and opinion of our readers." Nursing Mirror and Midwives Journal 30(766): 157.

[52] Armstrong, G. (1771). An essay on the diseases most fatal to infants. To which are added rules to be observed in the nursing of sick children: with a particular view to those who are brought up by hand ..../. London, T. Cadell. Developed the first Children's dispensary, possibly the first child only health care facility in Britain.

[53] 1852 is given here as the date the first children's hospital opened (The Hospital for Sick Children, Great Ormond Street. It is form this point that children's nurses were first recruited specifically to work with sick children.

[54] At this time, general (adult) hospitals had tended not to admit children and so did not seek to recruit children's nurses. See Abel-Smith, B. (1964). The hospitals 1800-1948: a study in social administration in England and Wales. London, Heinemann.

and spiritual needs of the sick child. Wood (1888)[55] aligned paediatric nursing as much with motherhood as with medicine. She argued that it was necessary to develop in the nurse, the instinct, self sacrifice and self forgetting of a mother. Wood argued that the children would (for a time) look to the nurse for a mother's care.

Even in the 1920's, nurses seem to have had little inhibition about revealing emotions in the professional press. Anon (1920)[56], makes clear her own distress at the death of a baby and the way in which she sought comfort from her religion. Nurses clearly valued the opportunity to save children from death and seem to have recognised the power of the human spirit as a treatment modality; Anon (1920)[57] for example, provides an account of a dying child who had a close friend in the same ward. The friend was allowed to sleep in the same bed as the dying child on their request.[58] Child nursing had significant moral value and was to be carried out with care and gentleness. In a popular home medical text Rotch (1925, p. 492)[59] states:

> *'... few know how to train and take care of children. It is a still more rare gift to know how to nurse them when sick ... When ... the nurse is weary and exhausted ... it is only by possessing peculiar qualifications that the nurse can maintain an even and unruffled disposition. While passing through these scenes, it is hard for the nurse to remember that sickness does not destroy the little loving heart, but only hides its affection for a short time'.*

It is perhaps interesting that Cunningham (1995)[60] labels the period between 1830 and 1920 as one of 'saving the children' (p. 134). Children were to be saved if possible, not for the state or for their soul but for the enjoyment of childhood. The 1920s was perhaps the last few years to see this romanticism, where children mattered because children were inherently good and brought goodness into the world.

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[55] Wood, C. (1888). "A training of nurses for sick children." Nursing Record **1**(36): 507-510.
[56] Anonymous (1920). "The sins of the fathers." Nursing Mirror and Midwives Journal **30**(779): 391.
[57] Anonymous (1920). "In the children's ward." Nursing Mirror and Midwives Journal **32**(822): 228-229.
[58] The 'dying child' lived, his life accounted for by the action of allowing his friend to stay with him through the night.
[59] Rotch, T. (1925). Care of children and their diseases. Virtue's Household Physician. H. Buffum, I. Warren, W. Thorndike, A. T. Lovering, A. E. Small, J. Heber-Smith, J. Dixon-Payne and C. P. Lyman. London, Virtue and Company Limited. **Two:** 483-509.
[60] Cunningham, H. (1995). Children and childhood in western society since 1500. London, Longman.

It should be noted, however, that this approach to nursing may have originated from what medicine wanted, or needed nursing to be. West (1854)[61] [62] had advised nurses to talk to the child gently and to avoid sudden movements. In this way, a child who is already ill can be made much worse by being upset (by some procedure), this causes the child to expend energy for which there may be no physiological reserves. West (1854)[63] provides some examples of how fearful procedures may be made even enjoyable by the way in which the nurse manages them. Here, the notions of fear, rest and psychological comfort are being argued. West (1854)[64] also seems to have laid the foundation for the basic practical aspects of nursing which would become known as 'basic nursing care'. The importance of rest is described. West is not advocating that the sick child should be made to rest (as in 'put on' bed rest[65]) but that exhaustion should be prevented. West argues that very sick children should be moved as little as possible, this argument is conceptually very close to that of 'minimal intervention' a more modern technique which ensures the sick child is disturbed as little as possible.

West (1854)[66] suggests that the nurse should soothe the child '*in every gentle way that a woman knows*' (p. 60). However, West does not argue that these skills are in some way indefinable, rather he goes on to give examples of the ways by which the sick child can be comforted. Some of the techniques advocated include singing to babies, wrapping the baby in a flannel wrapper, walking up and down with the baby in one's arms to 'hush it to sleep' (p. 60). West suggests that older children can be comforted by being read a story or a fairy tale (he even suggests one or two titles). West suggests that children should be told stories about nice things, that reflect the goodness and beauty of the world that God has created and to help the child to pray. West (same reference) argues that the nurse's role here is to give the child pleasure.

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[61] West, C. (1854). How to nurse sick children. London, Longman.
[62] Dr Charles West had opened The Hospital for Sick Children, Great Ormond Street, London, two years earlier. His writing was very influential because subsequent children's hospitals wished to emulate the success of the Great Ormond Street Hospital.
[63] West, C. (1854). How to nurse sick children. London, Longman.
[64] West, C. (1854). How to nurse sick children. London, Longman.
[65] 'Bed rest', a term which means that the patient was not allowed out of bed.
[66] West, C. (1854). How to nurse sick children. London, Longman.

Charles West did provide the template for children's hospitals across the U.K. (see Lomax 1996).[67] It is known, for example, that his list of 'rules' for The Hospital for Sick Children, Great Ormond Street were widely copied by the children's hospitals that opened after 1852. It is suggested here that he did identify his view of what nurses should do (their role) and in doing so, indicated what should be their core philosophical principles.

West (1854, same reference) suggests that the child should be comforted preferably by someone who the child knows and loves. He writes (p. 52) '*it is always desirable that a face which it knows and loves should be the first to catch it's eye on awaking*'. The care of parents does not figure very highly in West's account. However, the occasional mention does indicate that parents may have been an important part of the care situation. West (1854, p. 52) writes of the nurses' duty to maintain the spirits of the parents as well as the child. Interestingly, however, 35 years later, the 11th Annual Report of the Derbyshire Hospital for Sick Children would cite that the main benefit of the hospital was the removal of sick children from their squalid homes, though the respect for parents can still be discerned:[68]

> *'Not only are the children, unfortunately, suffering from physical and other ailments peculiar to childhood, treated in the most skilful and enlightened manner which modern science and experience can suggest, but by removal from their homes, often overcrowded and inconvenient, a burden is lifted from the family, although we are aware with what tenderness and solicitude sick children are invariably tended by the fond mother, and how hard it is to part with them even for a little while'.*

In 1869, at the Queen Elizabeth Hospital for Children, visiting seems to have been encouraged and Kosky (1992)[69] describes an account of 'Alice', a child with a brain tumour, who was visited by her mother every day after work. O'Neill (1989)[70]

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[67] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[68] See The Derbyshire Advertiser Dec 14th 1888.

[69] Kosky, J. (1992). Queen Elizabeth Hospital for Children: 125 years of achievement. London, The Hospitals for Sick Children.

[70] O'Neill, C. (1989). A picture of health: hospitals and nursing on old picture postcards. Oxford, Meadow Books.

provides postcards of children's wards c. 1910 where children seem clearly to have visitors. These postcards were sold to generate income and to encourage subscriptions. In doing so, it was necessary to present an image of unanimity with the child's mother. One picture of a child being comforted by a nurse bears the inscription 'must we turn mothers and children away?'.

Robinson (1972, same reference) notes that before WWI the Neonatal Surgeon James Nicholl, established accommodation for mothers. This accommodation, however, was being used for other purposes by the end of WWI. Indeed Nicholl was probably not representative of medical staff and Robinson (1972) points out that in 1910, one of the hospital physicians argues that *'by far the most common cause of illness in the hospital patient was the ignorance of the mother'* (p. 72).

Perhaps as a result of the Health Visitor movement, there were many small hospitals that had developed from infant welfare clinics, these had a much more co-operative philosophy toward parents. One such establishment was The 'Shoreditch Infant Welfare Centre' which included a 'ward for ailing babies' (Editorial 1920, p. 465)[71]. Mothers were '*encouraged to come and see their babies and when there, are taught many useful little points with regard to their care and feeding'* (p. 465). Similarly the Wandsworth Day Nursery actually employed the children's unmarried mothers who slept with their children at night. Burdett (1919)[72] reports that *'up to the present it has worked very well, and is doubtless of even more benefit to the girl herself than to the institution, since she is able to keep her baby near her and know that it is in safe and kindly hands'* (p. 43). Willes (1987, p. 3)[73] makes the anti DeMause (see DeMause 1974)[74] argument that *'parental love was clearly as strong as it is now, and the lack of it just as upsetting'* (see also Pollock 1983).[75]

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[71] Editorial (1920). "The Shoreditch Infant Welfare Centre." Nursing Mirror and Midwives Journal 30(783): 465.

[72] Burdett, H. (1919). "Tiny Toddler in a Jacobean House." Nursing Mirror and Midwives Journal 30(760): 43.

[73] Willes, G. (1997). Memories of childhood. London, The National Trust.

[74] DeMause, L. (1974). The evolution of childhood. The history of childhood: the evolution of parent child relationships as a factor in history. L. DeMause. London, Souvenir Press.

[75] Pollock, L. (1983). Forgotten children. Cambridge, Cambridge University Press.

Not all parents were considered to be 'good' and nurses would turn those away who appeared drunk or who frightened their child. Anonymous (1920)[76] describes how the nurses were pleased that a child (Billiken) died the night before he was due to be discharged home: *'Our heavy hearts were lightened with a great thankfulness, we knew that it was well with Billiken'* (p. 23).

Charles West had always been opposed to the admission of children under two years of age. He recognised that these children needed their parents (see Lomax 1996)[77]. However Lomax (1996, same reference) points out that this position was gradually eroded by doctors who were interested in the specific medical conditions affecting babies. Lomax (1996) also argues that the voluntary children's hospitals had to make the argument that sick children were better off in hospital than they would be at home, in order to generate the necessary income from voluntary contributions.[78] Lomax (1996, same reference) argues that in the 50 years following the establishment of The Hospital for Sick Children, Great Ormond Street, attitudes had changed from that of children being better off at home, to being better off in hospital. Lomax (1996, same reference) also argues that as early as 1854 The Hospital for Sick Children, Great Ormond Street became concerned about visitors, with the suggestion being made that 'visitor days' should be reduced from 4 days a week to 2 day per week, although this was not actioned at the time.[79]

Guthrie (1960, p. 58)[80] notes this (from The Hospital for Sick Children, London) regulation of the Royal Edinburgh Hospital for Children (c. 1920).

'It shall be the duty of every nurse, not merely to tend the children with gentle firmness and care, but also by all means to keep them cheerful and contented; and while impatience, ill-temper, or anger toward the patients will be followed by dismissal, the

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[76] Anonymous (1920). "Billiken." Nursing Mirror and Midwives Journal **31**(785): 23.

[77] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[78] Abel-Smith argues that the voluntary hospitals were always in financial difficulty. Abel-Smith, B. (1960). A history of the nursing profession. London, Heinemann.

[79] See also Medical Committee Minutes, The Hospital for Sick Children, Great Ormond Street, London, Entry for 20/04/1854 (cited in Lomax 1996).

[80] Guthrie, D. (1960). The Royal Edinburgh Hospital for Sick Children. Edinburgh, Churchill Livingstone.

inability generally to make children happy will of itself be regarded as a sufficient cause for not retaining a nurse in the service of the Hospital'.

In the 1880s, Miss Wood, in her articles about the training of children's nurses, advocated that children in hospital should be allowed to play (Wood 1888)[81]. Chapple (1996)[82] argues that although Miss Wood's Great Ormond Street wards were ordered, they were never tidy. Chapple (same reference p. 23) argues that '*it was generally felt that the toys and games were as big a part of treatment as the medicines.*' Chapple (same reference) points out that the garden at Great Ormond Street possessed a swing and a see-saw on which the children could go out and play. The psycho-social orientation of those early children's nurses is alluded to in Sister Leen Innes' (see Guthrie 1960, p. 18)[83] account of the way in which many children, in or out patients and with chronic conditions such as those cause by tuberculosis would become intimate friends of the staff.

It is clear, that at least in the years before c. 1920, children's need for emotional or psychological care was understood (see Lindsay 2001)[84]. Yapp (1915)[85] in her 'lectures to probationers' wrote at length of the provision of play, provision for ambulant children, developing an empathic understanding of child life and the provision of 'love and understanding' (p. 107):

'The successful children's nurse must have a real love for children, little children cannot be loved too much but they must be loved wisely. The nurse must possess sufficient imagination to enable her to put herself in her little charge's place. She must have a sympathetic understanding of child life, an abundant patience in dealing with children, and keen observation.' (p. 107).

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[81] Wood, C. (1888). "A training of nurses for sick children." Nursing Record 1(36): 507-510.
[82] Chapple, K. (1996). The history of children's nursing. Nursing. Hull, The University of Hull.
[83] Guthrie, D. (1960). The Royal Edinburgh Hospital for Sick Children. Edinburgh, Churchill Livingstone.
[84] Lindsay, B. (2001). "Visitors and children's hospitals, 1852-1948: a re-appraisal." Paediatric Nursing 13(4): 20-24.
[85] Yapp, C. S. (1915). Children's nursing: lectures to probationers. London, Poor Law Publications.

Yapp (1915, p. 8, same reference) was also clear about children's need for their own family:

'Probably most of you think that these children must be happier with us than they are in their own homes. Now, they are certainly in a healthier environment, but I am not at all sure that they are happier. However poor the house they have come from, it is their home, and that is what the ward can rarely be .... [at home] mother is there to caress and soothe when pains gnaw at one, and things are becoming more than one small person can bear alone.' ... 'There is a quality of happiness in these very homes which we cannot in the nature of things realise. The family of the working man are so closely drawn together that they instinctively cling to one another, and whenever there is self sacrifice, which is inevitable in their condition, there is the essence of love. It is in the power of every nurse to make these children feel that they are not "unwanted" and to see that at any rate they will never feel "un-mothered" in the wards of a poor law infirmary. No one with motherly instincts will ever allow a child to go to sleep unhappy. Children respond to loving tenderness (a very different quality to kindness) generously.'

An example of the holistic approach of the c. pre 1920s was the clear attempt to meet children's spiritual needs. Robinson (1972)[86] provides evidence of evening prayers and grace being said by the ward sister at Yorkhill in the 19th Century. In 1892 nurses are reported to have provided simple religious instruction.[87] This appears to have been common practice at the time and indicates that nurses did not confine their focus to the child's physical needs. Most of the sick children would have come from 'deserving poor' families and nurses probably accepted a responsibility to teach the children social skills. In this way they were providing parenting care and not just health care to the children.

In these years before c. 1920, comforting and cuddling children were common practices. In 1892, nurses at Yorkhill were reported as always being fond of children

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[86] Robinson, E. (1972). The Yorkhill story: the history of the Royal Hospital for Sick Children, Glasgow. Glasgow, The Board of Management for Yorkhill and Associated Hospitals.
[87] Yorkhill Hospitals Archive (1883-1891). Reports 1883-1891. Glasgow. **B2/3/1.**

and that in relation to a specific child who was dying in one of the wards … '*sometimes the night nurse would take him in her arms, and sitting by the fireside, would converse with the dying child'*. As noted above, unkindness to children was not tolerated and nurses were discharged for striking a child.[88]

O'Neill (1989)[89] provides photographs taken c.1900 of two female children in one bed, and a ward sister cuddling a boy (c. 7 years) in a bed next to a female adult patient. Other photographs show a smiling child playing on a rocking horse in 1904. Another photograph shows a chaplain whose role is stated to support the children, and also the nurses following the death of a child; indicating that such events were recognised as being distressing for the staff.

Before c.1920 there seems to have been no inhibition in the journals about the use of the word 'love' to describe nursing intervention. An article in 1919 (Anon 1919)[90] describes the nursing at The Children's Rest, Roehampton as characterised by loving care and happy surroundings. This country hospital also employed a school teacher, indicating that there was an appreciation that children had more than physical needs. In 1909, Barnes (1999, p. 32)[91] reports that Sir Henry Burdett wrote in the Pendlebury visitors book '*The children are happy and quiet throughout the hospital, an infallible sign of good nursing and excellent management'*. Barnes (same reference, p. 59) reports that when the Manchester Children's Hospital Convalescent Home was opened in 1897, the Matron was charged with maintaining '*the welfare and happiness of the inmates'*. Kosky (1992, p. 24)[92] makes a similar observation that nurses employed at the Queen Elizabeth Hospital for Children c. 1870 were required to *'attend the children with care and tenderness'*. By way of corroboration, Kosky (same reference, p. 140) provides evidence of children admitted to hospital (c. 1910) who positively evaluated their stay, using such terms as *'a second home'*. It is perhaps also

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[88] See Yorkhill Hospitals Archive (1916-1932). Nurses Register 1916-1932. Glasgow. **YH8/1/4.**

[89] O'Neill, C. (1989). A picture of health: hospitals and nursing on old picture postcards. Oxford, Meadow Books.

[90] Anonymous (1919). "The Children's Rest, Roehampton." Nursing Mirror and Midwives Journal 30(768): 195-6.

[91] Barnes, P. (1999). Royal Manchester Children's Hospital 'Pendlebury' 1829-1999. Leek, Churnet Valley Books.

[92] Kosky, J. (1992). Queen Elizabeth Hospital for Children: 125 years of achievement. London, The Hospitals for Sick Children.

noteworthy that at that time daily visiting from 2-4pm was allowed (such 'generous' visiting times would become unusual by 1930, see Bradley 2001)[93].

There seems to have been the notion that children were best placed in a stimulating environment within which they could express their imagination through play (see Anon 1919)[94]. The Nursing Mirror and Midwives Journal[95] was perhaps more romantic and less 'scientific' than its rival the 'Nursing Times'. In 1920, the journal published a tender account (Anon 1920)[96] of the death of an illegitimate baby whose care had in some way been limited by his illegitimacy. The author had clearly found this an emotionally challenging experience and ends the article with the biblical message (p. 391) '*Forbid them not, for of such is the Kingdom of Heaven*'.

It should be clear for the above, that paediatric nursing prior to c. 1920 was holistically construed. Nurses provided care that was characterised by its lack of focus on any one dimension of human need but which rather freely incorporated notions of psychological, social, physical and spiritual need.

Non individualised nursing from 1920

It should be understood that in this period from c.1920, parents and their sick children were separated by hospitalisation. Visiting times for parents were severely restricted and in some cases visiting was banned altogether. The fear of infection (Connell and Bradley 2000)[97] was usually blamed for the rules forbidding parents to visit their children. Infection could close wards and even the entire hospital. Infection could also increase mortality rates which might put the children's hospital in a bad light compared to the general hospitals. Later, the fear of cross infection became an excuse for keeping parents away but initially the fear of cross infection was real. Arton (1992)[98] reports

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[93] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

[94] Anonymous (1919). "How to amuse toddlers." Nursing Mirror and Midwives Journal 30(770): 243.

[95] By the 1920s this was a single journal.

[96] Anonymous (1919). "Our examination questions for nurses." Nursing Mirror and Midwives Journal 30(759): 12.

[97] Connell, J. and S. Bradley (2000). "Visiting children in hospital: a vision from the past." Paediatric Nursing 12(3): 32-35.

[98] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

that by 1932 the Westminster Infants Hospital did not allow parental visiting at all[99]. Once parents had largely been withdrawn from the ward arena, it must then have become clear that their occasional return upset the children. It seems that it was largely the nurses, rather than other staff who objected to parents visiting on these grounds. In 1935[100] and again in 1938, ward sisters of The Hospital for Sick Children, Great Ormond Street expressed their opposition to visiting by parents, arguing that it made the children more ill.[101] The sisters did not get their way, however, and six months later the House Committee enforced Sunday visiting against their will.[102] The sisters did not need to worry too much for at this time visiting was only allowed on one Sunday in each month and not at all in January, February and March.[103] Boal[104] looking back on the history of visiting remarked that the separation of parents and children 'must have been heartbreaking for [both] children and parents'.

Hargreaves (1987)[105] provides evidence that at Booth hall Hospital in the 1930s the whole family were brought in for the treatment of scabies. This probably does not indicate an orientation to holistic care but simply the need to eradicate the infestation from the whole family. In reality the visiting arrangements at Booth Hall were similar to those around the country. Visiting in the 1930s was for two hours on Saturday and Sunday and *'Many tears were shed, but were soon dried by the nurses who brought tea and gave a cuddle. in even the smallest eyes uniform must have meant security'* (see p. 12). Interestingly, 'visiting' often only meant the child's mother; fathers were not expected to visit in the afternoon and were only sometimes accommodated in the evenings.

Parents seem to have been treated as being in some way responsible for the illness. Much of childhood illness probably was caused by poverty and poor nutrition and

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[99] See House and Finance Committee, Westminster Infants Hospital, entry for 16/02/1932 (cited in Arton 1992).

[100] Great Ormond Street Hospital Archive (1935-1936). First Entry dated 1935. Nursing Committee Minute Book: Volume One. London.

[101] See Great Ormond Street Hospital Archive (1938). Entry dated 17/04/1938. House Committee Minutes. London.

[102] Great Ormond Street Hospital Archive (1938). Entry dated 13/10/1938. House Committee Minutes. London.

[103] Great Ormond Street Hospital Archive (1937). Entry dated 10/02/1937. Nursing Committee Minute Book: Volume Two 1937. London.

[104] Boal, L. (1982). One hundred years nursing. Yorkhill Hospitals Archive. Glasgow.

[105] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications..

there has probably always been a tendency to blame people for their own poverty. Underlying ideas in society at the time, may, however, provide some understanding of the way in which parents were treated. Hendrick (2003)[106] points out that at least from 1908 (The Children Act 1908) parents were not only seen to be liable for their child's accidents and unlawful acts but that delinquency and depravity were dealt with by the same courts. Hendrick (2003)[107] claims that it was the official policy that the root cause of the child's condition lay at home. Translated to the hospital environment, this makes parents largely responsible for their child's illness. A polarised social class differential between staff and family may well have provided support for the nature of this argument. What can at the very least be accepted, is that during the 20th century the family was forced to submit its authority over the child to the state and its agencies, one of which was health care. For the greater proportion of the population, both child and parents equally had to submit themselves to the will of doctors and nurses.

Conclusion

This chapter has provided a background to the history of paediatric nursing between 1920 and 1970. It has been argued that there was and perhaps still is some confusion regarding the occupational identity of paediatric nursing. It will be seen in later chapters that the development of the nursing role resulted in a peculiar and easily misunderstood relationship between paediatric nursing and medicine. Medicine needed nursing but it also needed to subjugate it so that Medicine could be seen as superior but while still being able to use nursing for its own ends.

From c.1920 nursing began to deliver care that was institutionalised, that is, the care was orientated more to the needs of nurses, doctors and the hospital institution than it was to the needs of the child patient. In addition, nursing care became orientated chiefly to the child's physical and medical needs with little if any emphasis on

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[106] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[107] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

psychological, developmental, social and spiritual needs. This resulted in part, on the exclusion of the child's family from the care situation and indeed from the clinical environment. It is this last perhaps, that characterises the period between c.1920 and c.1970 most clearly.

It can be seen in this brief overview that before c. 1920 paediatric nursing was based on holistic principles and focused on the developmental needs of the child and not solely on the needs of the nursing and medical services. It will be argued in later chapters that this position would undergo dramatic change with negative consequential effects on hospitalised children. It will further be argued that largely as a result of social pressure, paediatric nursing would return to its principles of origin in the years following World War II. The following chapters will describe, illustrate and explain that process and the important impact which it had on child patients and their nurses.

Chapter 2, professional servants

This chapter provides examples of the degree to which paediatric nursing was controlled. It will be seen that nurses belonged to a disciplined occupational group. Nurses clearly considered themselves to be professional (Boschma 1997)[108] and were indeed well regarded by the public (Hector 1976)[109]. This last notwithstanding, it will be argued that through most of the period between 1920 and 1970, paediatric nurses were treated in much the same way as were household servants and that this inhibited their professional growth.

Preamble

Nursing's origins in the household and institutional servants of the 19th Century is well documented (see Dingwall, Rafferty and Webster 1986[110] and Maggs 1983[111]). It will be argued below, however, that nurses continued to act like and be treated like servants well into the period between 1920 and 1970.

The relationship which nurses enjoyed with doctors will be discussed in the next chapter. Here, however, it will be argued that nurses possessed a servant-like relationship to both doctors and nurse managers who in their turn were strongly influenced by doctors. In a history of the development of nursing in France between 1880 and 1922 Schultheiss (2001)[112] found that (male) doctors at the time were still working for their own occupational closure, did not welcome women on their terrain and were active in defending 'medicine' from 'unqualified' practitioners. Schultheiss

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[108] Boschma, G. (1997). Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[109] Hector, W. (1976). The work of Mrs Bedford Fenwick and the rise of professional nursing. London, Royal College of Nursing.

[110] Dingwall, R., A. M. Rafferty and C. Webster (1988). An introduction to the social history of nursing. London, Routledge.

[111] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

[112] Schultheiss, K. (2001). Bodies and souls: politics and the professionalisation of nursing in France, 1880-1922, Harvard University Press.

argues that doctors deliberately defined nursing in altruistic terms and resisted the development of nursing's knowledge base. In this way, she argues, nurses were portrayed by doctors as the social and educational peers of patients in a deliberate attempt to ensure that nurses did not compete in terms of authority and control of the health care agenda. There was no room for two masters, one had to be master, the other servant. Schultheiss[113] makes the interesting argument that doctors introduced the concept of it being morally and socially 'wrong' for nurses to compete on the same grounds as doctors, an argument which had been made by Charles West in his text for nurses[114] (see also Vivian 1919, Pugh 1931 and Lindsay 2001).[115] This was very clever, but was only successful because the majority of nurses, and presumably women were prepared to accept the argument. It should be understood that it would not have been difficult for doctors to argue that female nurses were inherently inferior to them (see Olsen 1997)[116 117]. There is some evidence that by the beginning of the twentieth century even female teachers were regarded as intellectually inferior and less suitable for education that their male counterparts (see Gitlin 1996)[118]. Gitlin provides examples of female teachers being paid less than males and of female teacher students being expected to sit at the back of the class or even segregated and taught in separate buildings. In addition, it is likely, that doctors gained the support of hospital administrators because increasingly, nursing was becoming a large and potentially expensive occupational group. The lower the accepted standard of nursing's intelligence and education, the easier it was to pay them low wages. Lastly, Schultheiss[119] found that in France, doctors preferred secular nurses to those who

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[113] Schultheiss, K. (2001). Bodies and souls: politics and the professionalisation of nursing in France, 1880-1922, Harvard University Press.

[114] West, C. (1854). How to nurse sick children. London, Longman.

[115] Vivian, M. M. (1919). "Hospital etiquette." Nursing Mirror and Midwives Journal 30(761): 56-57. Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd. Lindsay, B. (2001). "An atmosphere of recognition and respect? Sick children's nurses and medical men 1880-1930." International History of Nursing Journal 6(1): 4-9.

[116] Olsen, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, R. Robinson and R. Elkan. London, Routledge.

[117] In much the same way, male and female nurses have argued, perhaps foolishly about their inherent worth and continue to do so. See Painton, J. F. (1994). "The outlook in male nursing." Creative Nursing 1(1): 22-24.

[118] Gitlin, A. (1996). "Gender and professionalisation: an institutional analysis of teacher education and unionism at the turn of the twentieth century." Teachers College Record 97(4): 588-625.

[119] Schultheiss, K. (2001). Bodies and souls: politics and the professionalisation of nursing in France, 1880-1922, Harvard University Press.

belonged to a religious order[120], the reason being that the latter would have had two masters and that would have weakened medicine's control over them. By the beginning of the twentieth century, medicine was a discipline that still had to prove itself, its control over the health care agenda was by no means assured (see Broman 1995)[121]. In order for that control to be acquired, medicine had to conquer and subjugate nursing.

The conquest of nursing by medicine, seems to have taken place on an international scale and to have applied to all the disciplines of nursing. Buhler-Wilkerson (2002)[122] found that doctors were afraid that the early community nurses in nineteenth century Baltimore would usurp their position and would begin to diagnose and prescribe for patients. Diagnosis and prescription lay at the shop floor of medical practice and it was these skills that were most at risk. Cherry (1996, p. 35)[123] quotes from Burdett's 'Official Nursing Directory' published in 1898 which noted that the nurse's position was '*subservient ... there to carry out orders ... not decide what methods of treatment is proper*'. Doctors did not have a monopoly on pharmacology, biochemistry or the manufacture of drugs, their unique perspective was diagnosis and prescription. It must have been all too easy for other disciplines, especially nursing to encroach there and centrally important to medicine that any such encroachment be prevented. Sandelowsi (2000)[124] argues that while medicine wanted nurses to be seen as ignorant, poorly educated but useful and kind people, it needed nurses to be able to make provisional (unofficial) diagnoses, to operate complex and dangerous machinery and to interpret the body's response to complex medical interventions. Nurses were with the patient all the time, doctors were not.

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[120] As in Germany, but unlike the situation in Britain, nursing in France had its background in the religious nursing orders.

[121] Broman, T. (1995). "Rethinking professionalisation: theory, practice, and professional ideology in eighteenth century Germany." Journal of Modern History 67(4): 835-873.

[122] Buhler-Wilkinson, K. (2002). No place like home: a history of nursing and home care in the United States. Baltimore, John Hopkins University Press.

[123] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[124] Sandelowski, M. (2000). Gender, technology and American nursing, University of North Carolina Press.

Gatlin (1996)[125] notes that the process of professionalisation is intimately associated with occupational conflict (see also Boosfield 1995)[126]. It will be seen below, that the 'servantisation' of nursing had a profound and largely negative effect on its ability to develop as a profession and on its ability to meet the social and psychological needs of sick children and their families.

The impact of Servant-hood in nursing

The system of discipline to which nurses were subjected is argued here to have been derived from that of the domestic servant from whose ranks nurses were originally recruited. Godden (1997)[127] argues that Florence Nightingale had to deal with the problem of how paid work could be seen as legitimate for middle class women. Nightingale achieved this, according to Godden (1997, p. 177)[128] by presenting the paid nurses as '*quasi religious, lady-like philanthropists*'. Long hours in particular, became seen as a symbol of dedication which elevated nurses from normal workers and nursing from a normal job. Unfortunately, this association with 'dedication' had the effect of engendering an atmosphere of obedience and conformity that would last for more than a century. In addition nurses were left with no defence against long hours, poor working conditions and exploitation by their employers. It can be seen that nurses were also exploited by their fellow workers, especially doctors. Rafferty (1996)[129] argues that hospital training for nursing achieved prominence over community training (home nursing, private nursing) because it provided an environment where discipline could be effectively taught (however, Maggs 1983[130] considers community nursing's lack of prominence to be an effect of the dominance of the general hospitals and the physicians who in practice managed them). Nurse leaders

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[125] Gitlin, A. (1996). "Gender and professionalisation: an institutional analysis of teacher education and unionism at the turn of the twentieth century." Teachers College Record 97(4): 588-625.

[126] Boosfield, B. (1995). "Conflict in decision making: do nurses have a role?" Paediatric Nursing 7(7): 21-23.

[127] Godden, J. (1997). "For the benefit of mankind": Nightingale's legacy and hours of work in Australian nursing, 1868-1939. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[128] Godden, J. (1997). "For the benefit of mankind": Nightingale's legacy and hours of work in Australian nursing, 1868-1939. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[129] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.

[130] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

such as Florence Nightingale had to deal with the problem that nurses were associated with the drinking classes. Alcohol was thought to make people physically and emotionally stronger and to protect them from disease and was often provided by employers, including doctors for this purpose. However, Rafferty (1996) suggests that doctors needed nurses to be sober and for this purpose, they and nurse leaders manufactured the nurses' morality. Furthermore, hospitals were organised in much the same way as the factories of the period and in such a way that both patients and nurses could be watched and their behaviour and performance monitored.[131] Rafferty (1996, p. 23) suggests that:

'The factory provided the organisational model for the development of the hospital and, by extension, the moral code for nurse training. Employers in factories conceived their task as one in which the habits, spirits and culture of a recalcitrant workforce had to be broken in order to mould labour .... defiance was to be replaced by unquestioning obedience.'

A popular text by Pugh (1931)[132] illustrates the way in which nursing was subjugated by medicine. This text advises that nurses should have the skills that doctors needed them to have (p. 3):

'To become a nurse, a woman must possess considerable intelligence, a good education, healthy physique, good manners, an even temper, a sympathetic temperament, and deft clever hands. To these she must add habits of observation, punctuality, obedience, cleanliness, a sense of proportion, and a capacity for and habit of accurate statement. Training can only strengthen these qualities and habits; it cannot produce them'.

Pugh (1931)[133] suggested that the nurse's first duty was obedience to the doctor (p. 5) and that the nurse should work in the way that he wants her to. In the same way, it was

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[131] For example, the 'Nightingale wards' introduced by Florence Nightingale, see Nightingale, F. (1860). Notes on nursing: what it is and what it is not. USA, D. Appleton and Co.

[132] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd. Published in earlier editions by HE Cuff and WTG Pugh.

[133] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

the nurse's duty to '*always do her utmost to promote her patient's faith in his medical attendant'* (p. 5). The nurse (p. 7):

> *'should learn to receive orders with deference and politeness. She should obey the written and unwritten laws of the hospital, respect its traditions, and so order her ways that no discredit should fall on it through want of thought on her part'.*

Whether the discipline of nursing originated from the domestic servant, factory floor or the public school (see Rafferty 1996) does not really matter. What matters is that those who employed nurses, employed them as disciplined workers, using templates with which they were already very familiar and which were designed to subjugate and control nurses for the benefit of the hospital institution and for medicine.[134] Early nurse leaders such as Florence Nightingale moulded nursing in such a way as to build on the female role as moral standard-bearer until eventually '*religion, convention and finally science endorsed the stratification of skills along class and gender lines'* (Rafferty 1996, p. 40)[135] trapping nurses into subordination. The most clear effect of this, however, is the way in which the service needs (medical and hygiene needs) of the hospital took precedence over the educational needs of both the individual probationers and their programmes of study. Baly (1987)[136] makes it clear that this last was the case even in the early days of the Nightingale school, a situation which Nightingale herself tried without success to remedy.

Examples of disciplined nursing

Arton (1992)[137] provides evidence of nurses being dismissed for wearing trousers while off duty in the local town (also see Editorial 1933[138]). The 'Nurses Register' at Yorkhill Hospitals[139] records the discharge of a nurse for not being a 'nice girl' and repeatedly staying up late at night. At Yorkhill, nurses were often discharged with

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[134] See Maggs, C. (1983). The origins of general nursing. London, Croom Helm.
[135] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.
[136] Baly, M. E. (1987). The Nightingale nurses. Nursing history, the state of the art. C. Maggs. London, Croom Helm.
[137] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[138] Editorial (1933). "Untitled." Nursing Times **08/07/1933**: 657.
[139] Yorkhill Hospitals Archive Nurses Register. Glasgow. **YH9/1/3.**

some regret. One nurse, for example, was discharged in 1919 for sleeping on duty, despite her being '*quite a nice girl really and was perfectly honest and upright*'[140]. On the other hand, some nurses survived their training at Yorkhill only to be described as '*... not a good nurse. She had to be constantly corrected*'[141]. Another nurse was discharged for failing an examination and '*had to leave. Was a nice girl and a good practical nurse*'.[142] There are many such records[143] of nurses being discharged at the regret of the matron. It appears that the rules had to be applied, even where this was against the matron's better judgement. The system of discipline was, in a sense, more powerful than the matron. The rules seem to have been implemented even against the better judgement of the matron who herself was subject to the system of discipline. Perhaps it is not surprising then that disobedience seems rarely to have been permitted at Yorkhill, this being the most common reason for dismissal.[144] [145] Nurses were expected to be committed to the aims of the institution even after they had been dismissed. Arton (1992)[146] provides the example of a nurse who was deemed unsuitable to work at the New Sussex Hospital with sick children but was nevertheless asked to 'stay on' until another nurse could be found (see Arton 1992, same reference).[147] Similarly, one nurse who reduced her hours to work part-time in order to look after her mother is recorded as paying for her replacement (see Arton 1992, same reference).[148]

Poor health was also considered to be a good reason for discharging a nurse, although nurses were sometimes taken back onto the staff if and when their health recovered. Boal (1982)[149] reports that illness was discouraged. At the Derbyshire Children's Hospital, even minor ailments had to be reported to the matron.[150] At The Hospital for Sick Children, Great Ormond Street in 1926 a nurse had to resign because she had

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[140] Yorkhill Hospitals Archive (1903). Nurses Register. Glasgow. **YH8/1/3**.
[141] Yorkhill Hospitals Archive (1903). Nurses Register. Glasgow. **YH8/1/3**.
[142] Yorkhill Hospitals Archive (1903). Nurses Register. Glasgow. **YH8/1/3**.
[143] Yorkhill Hospitals Archive (1916-1932). Nurses Register 1916-1932. YH8/1/4. Glasgow.
[144] Yorkhill Hospitals Archive Nurses Register. Glasgow. **YH9/1/3**.
[145] See also (Australia) Bashford, A. (1993). "Frances Gillam Holden and the Children's Hospital Dispute, 1887: Woman's Sphere, Feminism and Nursing." Women's History Review **2**(3): 319-330.
[146] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[147] House Committee (18/05/1925). HN12/12. New Sussex Hospital - Sussex,.
[148] House Committee (01/01/1926). New Sussex Hospital, Sussex. Brighton.
[149] Boal, L. (1982). One hundred years nursing. Yorkhill Hospitals Archive. Glasgow.
[150] Derbyshire Children's Hospital Archive (c. 1930). Nurse's Rulebook. Derby.

become a Typhoid carrier.[151] This did not seem to prompt the hospital to address this cause of staff loses, for in the same year the Nursing Committee refused to provide immunisations to its nurses.[152] Mental illness seems not to have been tolerated at all and in 1942 The Hospital for Sick Children, Great Ormond Street ruled that nurses were not allowed to complete their training if they had to be admitted to a mental hospital.[153] Recruitment advertisements often made it clear that candidates had to be strong and well.[154] Arton (1992)[155] points out that in many cases, paediatric nurses would have been able to stay at work if only they had been given more support. There does seem to have been very little practical, social and emotional help provided to nurses, especially considering their young age and the demands of the work.

Some nurses were discharged for reasons that do seem appropriate. An entry in the Yorkhill Nurses Register for 1924[156] reads:

1. 'Taken on at age 18 on 1st April 1924.
2. June 1924 Burnt a child for the first time.
3. 26th June 1924 Burnt a child for the second time
4. 30th June 1924 Was discharged for carelessness.'

However, there does seem to have been very little latitude with nurses who made clinical errors. In 1944 a sister at The Hospital for Sick Children, Great Ormond Street was asked to resign after administering an incorrect (although safe) dose of Chloral Hydrate.[157]

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[151] The Hospital for Sick Children Great Ormond Street Archive (03/06/1926). Nursing Committee Minutes. London.

[152] The Hospital for Sick Children Great Ormond Street Archive (02/12/1926). Nursing Committee Minutes. London.

[153] The Hospital for Sick Children Great Ormond Street Archive (08/12/1942). Nursing Committee Record Book Four. London.

[154] Recruitment advertisements (1920). "Recruitment." Nursing Mirror and Midwives Journal **32**(810): x1.

[155] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[156] Yorkhill Hospitals Archive (1916-1932). Nurses Register 1916-1932. YH8/1/4. Glasgow.

[157] Great Ormond Street Hospital Archive (1944). Entry dated 11/01/1944. Nursing Committee Minute Book Five: 1944. London.

Much of the discipline does appear to have been remarkably petty. Hargreaves (1987)[158] provides evidence from a nurse at Booth Hall Hospital concerning the strict routine around which the nurses were expected to work. Specific times of the day were given over to each duty. Many of these duties involved cleaning and polishing the ward. Hargreaves (1987, p.9 same reference) reports that there had to be exact distances between the beds and children had to be sat up looking neat and tidy, 'perfection' it is suggested was the 'required standard'. It is interesting that this ideal seems to have related mostly to the cleanliness of the ward and of the children rather than to the planning and delivery of disease related care to the child. Claydon (1991)[159] found that wards were expected to be kept meticulously clean, the bed wheels had to face the same direction and even the children's teddy bears had their prescribed place and position. This preoccupation with 'cleanliness' seems sometimes to have spilled over into notions of 'mental cleanliness' with Claydon (1991, same reference) reporting weekly sessions of exercises, compulsory for the nurses of Alder Hey children's hospital. This of course was a period when outdoor exercise was encouraged[160] but it is interesting that the sessions were compulsory, at least for the junior staff.

Hargreaves (1987)[161] provides the following examples of petty discipline from Booth Hall Hospital:

- The dismissal of two nurses, one for climbing the wall after 11pm and the other for letting her colleague into the nurses accommodation;
- In the nurses accommodation, lights had to be out at 11pm;
- At night the bathrooms were locked until 6am;
- Visitors were only occasionally allowed into the nurses home;
- It was not permitted to be late for breakfast before a morning shift.

A letter from a nurse working at Yorkhill between 1924 and 1928 indicates the conditions under which paediatric nurses had to work at that time.[162]

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[158] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.
[159] Claydon, R. (1991). The story of the Royal Liverpool Children's Hospital: Alder Hey and Myrtle Street. London, Image Publications.
[160] See Anonymous (1920). "Self governance." Nursing Mirror and Midwives Journal **31**(802): 313. and Editorial (1939). "Chailey Heritage Craft Schools." Nursing Times **01/07/1939**: 817-818.
[161] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.
[162] Edwards, G. (1980). Letter to Mrs Sacharine, 04/11/1980. Edwards, G. Glasgow.

'It was a grueling business, rules and regulations were very strict. Lights out at 10pm sharp no matter what you were doing ... Personal belongings were checked ... Sisters were strict and generally unfriendly. To be ill was a crime ... The food was poor and the off duty never made up until the day you had it, so it was impossible to keep in touch with your friends. Phone calls in or out were not allowed ... In spite of this we did get some fun, I suppose we ganged together against the monstrous establishment ... many a tear was shed and a resolve to leave but everyone suffered and so carried on.'

In 1951, A letter from 'Runabouts', a country branch of The Hospital for Sick Children, Great Ormond Street notes that nurses had to do the cooking on the cook's day off.[163] Brooke[164] provides an account of a nurse who worked at 'Runabouts' in the 1950s, which describes the long hours and amount of cleaning that was required of the nurses (including cleaning the children's shoes and washing the cot casters). However the account makes it clear that the camaraderie was 'great' and that no-one ever grumbled or felt exploited.

It is interesting that the system of discipline was by no means confined to on-duty periods. Boal (1982)[165] reports that she had to keep her room tidy and that personal possessions were inspected regularly. Nursing must have seemed a vocation to those who were subjected to this system of discipline 24 hours a day. It might seem that the hospitals were adopting a parental role where most of their students were under 21 years of age. However, older nurses were also subject, for example, to the strict rules of The Hospital for Sick Children, Great Ormond Street which even in 1945 was directing that nurses had to be in bed by 10pm.[166] In 1937, The Hospital for Sick Children, Great Ormond Street was allowing some post registration nurse students to live at home but it is clear that this applied to only a minority of mature students who in any case had to be resident in their parental home.[167] Williamson (1990)[168] notes

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[163] Great Ormond Street Hospital Archive (1951). Runabouts. Letter from Olive Nicolle. London.
[164] Brooke, H. (19/07/1998). Memories of runabouts. Great Ormond Street Hospital Archive, London.
[165] Boal, L. (1982). One hundred years nursing. Yorkhill Hospitals Archive. Glasgow.
[166] The Hospital for Sick Children Great Ormond Street Archive (13/02/1942). Nursing Committee Record Book Four. London.
[167] The Hospital for Sick Children Great Ormond Street Archive (13/02/1942). Nursing Committee Record Book Four. London.

that at the Southampton Children's Hospital after WWII, all nurses were still required to be resident.

Ward sisters were the key people in the nursing hierarchy and even the junior doctors were afraid of them and followed their instructions.[169] While the matron was seen (and feared) as the person with most power[170], it would have been difficult for her to make global changes to such things as visiting arrangements.[171] The matron's role was limited in a real sense to ensuring that what was done was done well (or was neat and orderly). Along with every other role in the hierarchy, the matron was not expected to be concerned with the initiation of change or the evaluation of practice. In practice, no-one was performing this role and as a consequence, nursing and society's expectation of what it should be, would eventually part company (see chapter 7).

It is not suggested here that rules were never broken but that nurses were afraid to be discovered breaking a rule. Claydon (1991)[172] provides an account of a nurse working at Alder Hey who claims to have regularly broken the curfew. She makes it clear, however, that this behaviour was generally not thought worth the risk. At Yorkhill, nurses were regularly discharged for disobedience.[173] Hargreaves (1987)[174] reports one nurse claiming that (page 28) '*We were scared of our senior nurses, and used to hide in the sluice when Matron or her assistants made their rounds*'.

Robinson (1972)[175] notes that at Yorkhill it was the nurses' responsibility to polish the floors until two charwomen were employed in 1904. Entries in the Nurses Register at

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[168] Williamson, D. A. J. (1990). Ninety years of service: a history of the Southampton Children's Hospital 1884-1974. Southampton, Published by author.

[169] Alder Hey Children's Hospital Archive (1987). Kathleen Inga Cawood: Matron of Alder Hey Children's Hospital 1948 -1965. Alder Hey Nurses League 25th Annual Reunion. Tolman, J. Liverpool.

[170] Edwards, G. (1980). Letter to Mrs Sacharine, 04/11/1980. Edwards, G. Glasgow.

[171] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

[172] Claydon, R. (1991). The story of the Royal Liverpool Children's Hospital: Alder Hey and Myrtle Street. London, Image Publications.

[173] Yorkhill Hospitals Archive (1903). Nurses Register. Glasgow. **YH8/1/3**.

[174] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.

[175] Robinson, E. (1972). The Yorkhill story: the history of the Royal Hospital for Sick Children, Glasgow. Glasgow, The Board of Management for Yorkhill and Associated Hospitals.

Yorkhill show that many nurses left because they were '*not strong enough*'.[176] Some nurses took one look at their first ward and left and many left within a few weeks of starting. One entry in 1923 reads '*Began duty on Ward 10, ran away*'.[177] However, as early as the 1920s Yorkhill nurses had a '*beautiful sitting room*' in which concerts and other social events took place.[178] Robinson (1972, same reference) notes that by the 1930s, nurses enjoyed the use of extensive accommodation, including a very large sitting room and recreation hall. The uniform had also become more comfortable with the removal of the stiff collar.

In the 1920s at Yorkhill, many nurses left before they had completed their training. Many of these cases show a history of repeated incidents of minor illness which may indicate that they were stressed.[179] Many nurses were also discharged for being '*not a good nurse*' but with no record of why they were not good nurses or what if anything had been done to help them improve.[180] The matron did not seem to have a role in counselling nurses. It seems clear from the number of paediatric nurses discharged from Yorkhill that many could have been helped to stay if more support had been offered them. Foulds[181] reports from her training in 1937 that only 10 of the 20 in her cohort completed their training. She argues this was '*such a waste*' and notes that all those who did not complete were from a '*sheltered home life*', indicating the arduous nature of the work. It is also possible, however, that these individuals found it too difficult to adapt to the life of a servant.

Nurses were uniformed from the beginning of their recruitment to the new children's hospitals in the mid nineteenth century, but domestic servants were also uniformed, the nurses' cap signalling membership of servant-hood rather than soldiering. It should also be considered that civilian nurses pre-existed the important contribution of Florence Nightingale, by at least several centuries[182]. In addition, the Salvation Army

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[176] Yorkhill Hospitals Archive (1903). Nurses Register. YH8/1/2. Glasgow.
[177] Yorkhill Hospitals Archive (1923). Nurses Register. YH8/1/3. Glasgow.
[178] Boal, L. (1982). One hundred years nursing. Yorkhill Hospitals Archive. Glasgow.
[179] Yorkhill Hospitals Archive (1916-1932). Nurses Register 1916-1932. YH8/1/4. Glasgow. Yorkhill Hospitals Archive (1903). Nurses Register. Glasgow. **YH8/1/3.**
[180] Yorkhill Hospitals Archive (1916-1932). Nurses Register 1916-1932. YH8/1/4. Glasgow.
[181] Foulds, J. (1980). "Letter." Journal of the Yorkhill Nurses' League.
[182] Still, G. F. (1931). The history of paediatrics: the progress of the study of disease of children up to the end of the XVIIIth century. London, Royal College of Paediatrics and Child Health. Points

was soon to provide a template for the use of an army model of organisation with its religious workers adopting military titles (see Walker 2001)[183]. This military model could have been adopted by those who fashioned the genesis of professional nursing, but it was not. It follows that it is necessary to look elsewhere for an understanding of the hierarchy and discipline which formed such a central theme in paediatric nursing between 1920 and 1970.

It should also be noted that household servants generally wore a uniform, not dissimilar from that worn by nurses. Pearson and others (2001)[184] suggest that the uniform was an outer symbol of professionalism which cause notions of discipline and hierarchy to take precedence over the development of nurses individual self esteem. Pearson and others (2001)[185] found that the colour white was used in both nurses' uniforms and in those worn by domestic servants to enable their masters to determine whether or not they were attending to their personal laundry and regular intervals. In the same way, hospital matrons would prioritise the task of ensuring that nurses maintained their uniforms in a clean and tidy state (see also Maggs 1981[186] Hart 1994[187] and Bartlett 1999[188]). Pearson and others (2001, p. 147) suggest:

'The remnants of this domestic influence may still be detected in the predominance of the colour white, which was worn by the servant class of the time to enable their masters and mistresses to detect whether or not they were carrying out their laundry at suitable intervals. The military influence remains in the epaulettes, capes, medals and badges of many contemporary uniforms that continue to mimic the military uniforms of the army officers of the time.'

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out that Aristotle described the work of 'nurses' approvingly in his text 'on the history of animals', Bk. Vii).

[183] Walker, P. J. (2001). Pulling the Devil's kingdom down; the Salvation Army in Victorian Britain. California, University of California Press.

[184] Pearson, A., H. Baker, K. Walsh and M. Fitzgerald (2001). "Contemporary nurses' uniforms: history and traditions." Journal of Nursing Management 9(2): 147.

[185] Pearson, A., H. Baker, K. Walsh and M. Fitzgerald (2001). "Contemporary nurses' uniforms: history and traditions." Journal of Nursing Management 9(2): 147.

[186] Maggs, C. J. (1981). "Control mechanisms and the "new nurses" 1881-1914." Nursing Times 77: 97-100.

[187] Hart, C. (1994). Behind the mask: nurses, their unions and nursing policy. London, Bailliere Tindall.

[188] Bartlett, F. (1999). "Clean, white girls: assimilation and women's work." Hecate 25(1): 10-39.

Pearson and others (2001)[189] found a clear association with servant-hood:

'When Nightingale returned from the Crimea, Queen Victoria and certain of her ladies took considerable time (18 months) to devise a mode of dress which would distinguish the new 'lady' nurses of the Nightingale era from the 'Sairy Gamps' of the previous era. These lady nurses wore clothing, which ... differentiated in a discreet way, between nurses and real ladies. The distinguishing quality of the uniform introduced in 1866 was a hint of clothing worn by the upper echelons of domestic servants.' (p. 147).

The limitations set on nurses freedom of movement meant that for perhaps 3 years, nurses might not actually set foot outside the perimeter of the hospital, except during their holidays. It was not unusual for nurses to have to wear their uniforms even at formal dress dances to which family (but not boyfriends) were allowed. This again, paints a picture of institutionalised life, pinned together by a system of discipline and hierarchy, together making any case for change a pretty hopeless affair (see Castle 1987)[190].

Hulme (1996, p. 14)[191] provides a personal account of how hard was the work in the 1930s:

'We were (as students) full members of staff. Nurses were allocated bathroom duties. When one had graduated from bathroom duties, one was placed in charge of the kitchen duties, preparing special diets and baby feeds ... we were under a great deal of pressure and though we worked hard we also played and had fun.'

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[189] Pearson, A., H. Baker, K. Walsh and M. Fitzgerald (2001). "Contemporary nurses' uniforms: history and traditions." Journal of Nursing Management 9(2): 147.

[190] Castle, J. (1987). The development of professional nursing in New South Wales, Australia. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

[191] Hulme, O. (1996). Reflections of the past, in Journal of the Yorkhill Nurses' League. Yorkhill Hospitals Archive. Glasgow.

The effect on recruitment

Recruitment and retention at The Hospital for Sick Children, Great Ormond Street became a serious problem in the 1920s and 1930s (see Darbyshire 1988)[192]. The hospital reduced the age of entry to below that used by the general hospitals[193] but this seems to have had little effect, it being possible for nurses to leave the hospital when they became old enough to commence training in the general hospital of their choice. The other specialist hospitals, particularly the still child-focused orthopaedic hospitals also facilitated earlier entry to training or a separate course for those too young for the 'fully trained courses'.[194] By 1935, approximately 75% of probationers were leaving before the completion of the training. This resulted in a number of measures which included charging probationers £5 for leaving but also a reduction in the amount of cleaning and brass-rubbing required of the nurses and the employment of nannies to work with the less ill children.[195] There seems to have been little genuine attempt to address the cause of the poor retention figures.[196] [197] In practice, however, the Nursing Committee was probably unable to change the culture bound practices to which all hospitals subscribed. In the 1920s there seems only to have been a beginning awakening to the issue of conditions of service. It is perhaps notable that the GNC in 1920 decided to exclude nurses from the new 48 hour per week provisions (see Editorial 1920[198]). The new GNC of course did not employ nurses but perhaps it was afraid of falling out with those who did at such an early phase in the GNC's development. Gradually, the conditions of service would improve[199], mostly perhaps to improve the recruitment and retention figures.

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[192] Darbyshire, P. (1988). "Looking to the past .. nurse recruitment." Nursing Times 84(19): 31-32.

[193] Great Ormond Street Hospital Archive (1928). Entry dated 12/04/1928. Nursing Committee Minutes. London.

[194] Nursing Mirror and Midwives Journal (1920). "Recruitment advertisements." Nursing Mirror and Midwives Journal 32(810): xi.

[195] Great Ormond Street Hospital Archive (1935). Entry dated 12/06/1935. Nursing Committee Minute Book: Volume One. London.

[196] Great Ormond Street Hospital Archive (1935). Entry dated 12/06/1935. Nursing Committee Minute Book: Volume One. London.

[197] Great Ormond Street Hospital Archive (1935). Entry dated 13/11/1935. Nursing Committee Minute Book: Volume One. London.

[198] Anonymous (1920). "The General Nursing Council for England." Nursing Mirror and Midwives Journal 32(817): 139.

[199] Great Ormond Street Hospital Archive (1943). Entry dated 13/04/1943. Nursing Committee Record Book, Four, 1942. London. Great Ormond Street Hospital Archive (1941). Entry dated 25/08/1941. Nursing Committee Minute Book, Volume Three: 1939. London. Great Ormond Street Hospital Archive (1941). Entry dated 09/12/1941. Nursing Committee Minute Book, Volume Three: 1939. London.

The government gradually became concerned about the conditions of service for nurses. Nurse recruitment was a problem throughout this period and it was clear that improving the conditions of service would improve recruitment and retention (Darbyshire 1988)[200]. The government was probably influenced by sustained public concern about the conditions of service, concern which appears to have commenced after WWI (see Editorial 1919)[201] and seems to have reached a head by the 1940s. Children's hospitals had always experienced problems with recruitment, largely because recruits were persuaded by the argument that their career was best initiated in the general hospitals and because the 'SRN' was considered the only 'proper' registrable qualification (see Anonymous 1920[202], Arton 1992[203], Darbyshire 1988).

In the beginning of this period, both general and children's hospitals were charitable organisations and probably did not possess the funds to pay nurses reasonable and competitive salaries.[204] [205] However, it is interesting to contemplate whether they would have done even if they had been able to. The conflict of ideas about whether nurses should be recruited from the well educated or the servant classes was still raging and with clear implications for salary and conditions of service. Certainly, however, the children's hospitals seem not to have paid their nurses more than they thought they could get away with. Arton (1992)[206] provides evidence that despite not being able to recruit enough probationers, the Westminster Infant's Hospital paid their nurses significantly less than other hospitals in the area.[207] The vacancies being offered by the hospital were for junior staff and this at the same time that the Nurses

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[200] Darbyshire, P. (1988). "Looking to the past .. nurse recruitment." Nursing Times **84**(19): 31-32.
[201] Editorial (1919). "Untitled." Nursing Times **20/09/1919**.
[202] Anonymous (1920). "Notes and queries." Nursing Mirror and Midwives Journal **32**(815): 110.
[203] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[204] It is clear for example that the Westminster Infants Hospital had serious financial difficulties in the years around 1920 (see Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University. and Westminster Children's Hospital (1922). Entry for 10/12/1940. Management Committee Minutes. London..
[205] Ayers, G. (1971). England's first state hospitals and the Metropolitan Asylums Board 1867-1930. London, Wellcome Institute for the History of Medicine. Waterhouse, R. (1962). Children in hospital: a hundred years of child care in Birmingham. London, Hutchinson.
[206] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[207] See Westminster Infants Hospital (1919). Entry dated 7/5/1919. Management Committee Minutes. London.

Resettlement Committee of the Ministry of Labour were failing to find 900 posts for mostly senior, demobilised nurses (see Arton 1992). This was not an isolated situation, the Bristol Children's Hospital in 1920 was paying their porter the same salary as the matron, with ward sisters paid approximately half the matron's salary. In 1921, the College of Nursing suggested significant increases in salaries (see Editorial 1921)[208]. It should be remembered however that junior doctors were not remunerated well either (see Arton 1992). In this way it is possible that nurses' salaries were 'held down' by those of junior doctors who were themselves 'enjuvinated' by a system of medical hierarchy which exaggerated the role of the consultant and minimised other roles in the hierarchy. There can also be no doubt that the care provision was more basic than it is today[209] and this may have helped justify the poor remuneration.

The GNC tried to address the recruitment problem by proposing Central Preliminary Schools which would run over four years but enabling students to be taken directly from school before they had a chance to sample another occupation (see Editorial 1920[210]). Hospitals that could afford to choose (mainly the general hospitals) understandably chose to take older students. There does seem to have been a failure to realise that the conditions of service for nurses, especially perhaps those in training, were at odds with the changing social expectations of prospective recruits. It is possible, however, that the voluntary hospitals did appreciate that expectations regarding conditions of service were changing but simply could not afford to fund the necessary changes. Maggs (1987)[211] argues that the voluntary hospitals always did have difficulty keeping their finances in the black[212] and that nurses eventually delivered the death blow to the voluntary hospital system as their struggle for professionalisation caused escalating costs.

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[208] Editorial (1921). "Untitled." Nursing Times **15/01/1921**: 69.
[209] Nuffield Provincial Hospital's Trust (1948). Observations submitted to the Ministry of Health on the Ministry's Working Party's Report on the Recruitment and Training of nurses. Oxford, The University Press.
[210] Editorial (1920). "Untitled." British Journal of Nursing **25/09/1920**: 171.
[211] Maggs, C. J. (1987). Nursing history: the state of the art. London, Croom Helm. See chapter 11.
[212] See also Abel-Smith, B. (1960). A history of the nursing profession. London, Heinemann.

The positive side of servantship: improving living conditions

In 1932 the Lancet Commission concluded that the shortage of nurses was mainly due to nurses' conditions of service. In the same year, the GNC considered that the answer to the problem was to keep candidates at school until they were able to commence nurse training (see Arton 1992, same reference).[213] In 1935, the Joint Committee appointed by the Association of Municipal Corporations, and the County Council Association reported on ways to improve nurse recruitment. The report agreed with the main recommendations of the Lancet Commission although it also suggested that senior paediatric nursing posts should require the individual to be on the General Part of the Register, but that junior nurses could be RSCN. Nurses were not represented on the committee. Reporting in 1939, the Interdepartmental Committee, set up by the Ministry of Health and the Board of Education (Athlone Committee), recommended shorter hours and better conditions of service.[214] However, it did not look into the recruitment problems of the specialist hospitals (see Ministry of Health 1939)[215]. Note should be taken that nurses were not alone in having concern expressed about their conditions of service. In 1946 for example, the King Edward's Hospital Fund for London recommended better conditions for hospital domestic staff (King's Fund 1946),[216] perhaps the only other large group of health care workers who were associated with servant-hood.[217]

The notion that conditions of service were improving across British society and that the conditions of service of nurses needed to progress commensurably seems not to have been understood by either the hospitals or the GNC. Arton (1992)[218] provides a number of examples of the way in which nursing was falling behind the standards associated with semi professional occupations in Britain. Nurses died of communicable diseases, some of which were immunisable. Yet many hospitals did not provide

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[213] Public Record Office (1928-30). Council Minutes. DT5/6. London.
[214] Great Ormond Street Hospital Archive (1938). Entry dated 28/02/1939. Nursing Committee Minute Book, Volume Three: 1939. London.
[215] Ministry of Health (1939). Report of the Interdepartmental Committee on Nursing Services. London, Ministry of Health.
[216] King Edward's Hospital Fund for London (1946). Recommendations for the employment of domestic staff in hospitals. London, King's Fund.
[217] Hospital porters perhaps being the only other group.
[218] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

immunisation for their nurses.[219] Nurses were forced to leave work due to ill health without being provided with health care[220] and not even refunded their initial training fee which in 1933 for example was a significant amount of money (c. £60). It seems almost as if hospitals saw nurse recruits primarily as a source of cheap labour, rather than as a long term investment.

The Women's Employment Federation suggested in 1938 that conditions of service should be improved. It seems to have been recognised that the system of discipline was perpetuated in part by the nurses themselves and that to address this nurses would have to be exposed to less pedagogy. So it was that the Federation suggested that nurses should be expected to study the 'science' of hospital management.[221]

In 1948 the Nuffield Provincial Hospitals Trust submitted their observations to the Ministry of Health Working Party on the recruitment and training of nurses.[222] This made what would become a consistent set of recommendations for nursing and nurse training up to and including the debate about Project 2000 in the 1990s. Specifically, it was recommended that:

- there should be a thorough analysis of the work of qualified nurses;
- students in training should have full student status;
- students should not be regarded as employees subject to an outworn system of discipline;
- students should receive a grant and their course should be independent of the hospitals needs.

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[219] King Edward's Hospital Fund for London (1950). Memorandum on the supervision of nurses' health, second edition. London, King's Fund, Hutt, R. (1983). Sick children's nurses: A study for the Department of Health and Social Security of the career patterns of RSCNs. Lewis, Institute of Manpower Studies, University of Sussex, Hutt, R. (1984). "Issues and problems." Nursing Times 18(13): 51-52.

[220] Great Ormond Street Hospital Archive (1935). Entry dated 13/11/1935. Nursing Committee Minute Book: Volume One. London. Darbyshire, P. (1988). "Looking to the past .. nurse recruitment." Nursing Times 84(19): 31-32. Yorkhill Hospitals Archive (1980). Letter from Jane Foulds. Journal of the Yorkhill Nurses' League. Glasgow.

[221] See British Journal of Nursing, July 1938, p. 188

[222] See Yorkhill Hospitals Archive No title. YH8/3/8. Glasgow.

Five years earlier, however, the Hospital for Sick Children, Great Ormond Street, London had already agreed a positive response to the British Hospital Association Circular 107. The Nursing Committee seemed to be happy to acquiesce to the following improvements in nurses' conditions of service:[223]

- a grant would be available for the training of Sister Tutors;
- there would be a free uniform for nurses;
- there would be no fee for the Preliminary Training School;
- nurses with a diploma would receive a higher salary;
- nurses' salary would be incremented uniformly each April;
- there would be improvements to holiday and sick leave;
- nurses would not be allocated to night duty for more than 6 months.

At around this time (1942), the Hospital for Sick Children, Great Ormond Street also introduced the 'block system'[224] of training to facilitate nurses not having to attend lectures in their off duty time while still ensuring that ward activities were not disrupted.[225] It should be noted that the block system would have necessitated the recruitment of additional students.

Despite the above, Barnes (1999)[226] provides evidence that in the 1940s discipline was still regarded as tough and nurses still did much of the cleaning. At the Manchester Children's Hospital nurses were still doing some of the cooking, particularly of breakfasts. Williamson (1990)[227] notes that in the post WWII period nurses at the Southampton Children's Hospital were still spending much time cleaning and

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[223] Great Ormond Street Hospital Archive (1943). Entry dated 13/04/1943. Nursing Committee Record Book, Four, 1942. London.

[224] Where nurses received their theoretical training in 'blocks' of (usually) 2-6 weeks rather than interspersed through the working week. Essentially, this was an early 'modular' system which was associated with an increased emphasis on education in relation to service (practice).

[225] Great Ormond Street Hospital Archive (1941). Entries for 14/04/1941. Nursing Committee Record Book, Number Four: 1942. London.

[226] Barnes, P. (1999). Royal Manchester Children's Hospital 'Pendlebury' 1829-1999. Leek, Churnet Valley Books.

[227] Williamson, D. A. J. (1990). Ninety years of service: a history of the Southampton Children's Hospital 1884-1974. Southampton, Published by author.

polishing the ward and at the weekend when there were no domestic staff on duty, the nurses had to wash the nappies in a small laundry at the bottom of the garden.

Nurses salaries may have been low, but even in the 1920s, hospitals generally did provide reasonable levels of accommodation for nurses. Hargreaves (1987)[228] points out that when the new nurses' accommodation was built at Booth Hall Hospital in 1925, there were isolation bedrooms for sick nurses, a mechanical floor lift, recreation and sitting rooms, a lecture hall, study rooms, quiet, waiting and drying rooms. Later on a swimming pool became available. In addition to these facilities, the walls were lined with cork to reduce the problem of noise for sleeping night nurses.

It is hard to reconcile the conditions and system of discipline under which nurses had to live and work with the good quality of the accommodation and facilities. This seems an unusual model today and probably reflects the different expectations of the time. It indicates that the hospitals did care for their nurses and probably did see them as a valuable resource. The discipline and the ease with which nurses would find themselves released from service were probably things that no-one could control. However, hospitals could control the quality of accommodation and the life within the hospital.

At Yorkhill in 1940, nurses had a bedroom to themselves and the use of a communal sitting room, library, reading room, writing room, recreation room and a dining room.[229] The Yorkhill prospectus produced in the 1950s shows very plush looking accommodation and main lounge. Nurses had the use of a 'smoking room', a dining room equipped with tablecloths and the use of a visiting chiropodist who was said '*to be in regular attendance*'.[230]

By 1950, the conditions of service of nurses had improved markedly. In 1950, the King's Fund (King's Fund 1950)[231] recommended that there should be:

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[228] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.
[229] See Yorkhill Hospitals Archive (1940). Training school for nurses. YH8/3/2. Glasgow.
[230] See Yorkhill Hospitals Archive (1930). A syllabus of lectures and demonstrations for education and training of nurses for sick children. YH8/3/10 GNC (Scotland). Glasgow.
[231] King Edward's Hospital Fund for London (1950). Memorandum on the supervision of nurses' health, second edition. London, King's Fund.

1. a physician available to the nursing staff;
2. a requirement for a detailed medical certificate;
3. medical examination of all new candidates, including chest radiograph;
4. maintenance of nurses health records;
5. training in lifting and handling;
6. provision of foot care;
7. a sick bay for nurses;
8. properly conducted sick leave;
9. the provision of rest homes for nurses;
10. testing for tuberculosis;
11. immunisation;
12. good meals;
13. good accommodation;
14. facilities for recreation;
15. maximum duty our of 96 hours per fortnight;
16. age of entry no lower than 18 year.

In Great Ormond Street's 1967 'prospectus', Bendall (1967, p. 2)[232] writes:

'The Country Branch of 106 beds is situated in Tadworth Court, Tadworth , Surrey (20 miles from London). This fine Jacobean mansion, standing in 75 aches of lovely park-land, was acquired in 1927 as a recovery home. In 1932 one large pavilion for 40 children added and in 1936 a second pavilion was built, accommodating a further 42 children, as well as residence for the nursing staff. A third was opened in 1966 which allows the mansion to be used for the purposes of administration ...'

The following services were available to students at no cost:

- health service (some medical services were compulsory)
- chapel

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[232] Bendall, E. (1967). The Hospital for Sick Children: Great Ormond Street: Training School for Nurses. London, The Hospital for Sick Children, London.

- nurses' Social Committee (arranged social events)
- facilities at the residences included
    - library
    - dining rooms
    - lounge
    - chapel
    - telephone facilities
    - tennis courts
    - coach travel to work

Most of the Kings Fund (1950) recommendations (see above) were actually provided in the 1950s. Perhaps the 1950s were the easiest time for nurses who could get on with the institutional life. The institution was still there with its clear lines of authority, unambiguous roles and a supportive infrastructure. At the same time the conditions of service were improving, especially those related to accommodation and social life. Hargreaves (1987)[233] provides an account of a nurse from Booth Hall Hospital who reports very low pay (half that expected by manual labourers), but a very supportive social infrastructure. She was not allowed a key to the accommodation until she was 21 and '*Matron acted as our guardian'* (p. 27) ensuring she was in by 11pm. The nurse reports having big fires in the recreation room, sing-songs around the grand piano, a record player, fancy dance at Halloween and '*a superb Christmas Dinner served by Matron'* (p. 27). There was a separate dining room for the students, staff nurses and sisters but the food was good. She was wakened each morning by a night nurse and would be in trouble if she was not at breakfast on time. Claydon (1991)[234] provides an account from a nurse working at Alder Hey hospital who claims that conversation at meals times was almost exclusively confined to what was happening on the wards. This paints a picture of an almost 'family' life. However, it would be a mistake to consider the hospital staff as one big happy, mutually supporting family. A better comparison would be the way that servants were integrated into the life of the family which they served. They were there in the house, taking part to some extent in the life

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[233] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.
[234] Claydon, R. (1991). The story of the Royal Liverpool Children's Hospital: Alder Hey and Myrtle Street. London, Image Publications.

of the family and cared for and to some extent respected by the family, paid very little, expected to work long hours but provided with good accommodation in pleasant surroundings. Wrigley (1991)[235] claims of servants both now and in the past, that: '... *most are women, many are racial minorities, and all are oppressed.*' (p. 317)
In any case, no-one would suggest that these household servants were members of the family they served.

It is likely that the quality of the nurses' accommodation, related to the growing recognition that recruitment could be facilitated by the provision of such amenities as tennis courts and pleasant grounds. Although most paediatric hospitals were positioned in city centres, many hospitals possessed a country branch which often enjoyed much more comfortable surroundings. Prospective students might well have been rather choosy about where they were to spend three to four years and hospitals often tried to entice candidates by pointing out the advantages of their country branches (see Bendall 1967)[236].

Employment rights (or the lack of them) very much applied to student nurses because of course, they were employed by the hospital. It is perhaps surprising, however, that probationers would sometimes be made redundant if their employment no longer suited the hospital. Arton (1992)[237] for example, provides evidence of 2 probationers who were discharged when it was decided to replace them with more experienced nurses for private patients.[238] However, conditions of service had certainly come a long way since 1877 when the President of the Derbyshire Children's Hospital had noted how overcrowded it was (9 children).[239] One child had to sleep in the nurses' room and one in the Lady Superintendent's room, preventing the nurses getting proper rest.

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[235] Wrigley, J. (1991). "Feminists and domestic workers." Feminist Studies **17**(2): 317-330.
[236] Bendall, E. (1967). The Hospital for Sick Children: Great Ormond Street: Training School for Nurses. London, The Hospital for Sick Children, London.
[237] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[238] See New Sussex Hospital Archive (1922). HB12/10. House Committee Minutes. Brighton.
[239] Derbyshire Children's Hospital Archive (to 30th June 1878). First report of the Derbyshire Children's Hospital (to 30th June 1878). Derby.

The association between servants and nursing

It is argued here that there exits a close association between nurses' conditions of service and those of the household servants in the first half of the 20th century. Servants were subject to a system of discipline which extended into their 'private' time. Servants were also associated with tidiness, cleanliness and order. In a popular nursing text of the 1920s Millicent Ashdown (Ashdown 1927)[240] writes of the role of the professional nurse and she might have been writing about the role of an upper servant:

> *'A nurse must be punctual, good tempered, obedient and loyal to all rules as the foundation of her work. She must also be active, yet quiet and deft; methodical, reliable, careful, clean and neat; observant, intelligent and economical; possessed of self control, persevering gentleness, tact, sympathy, and common sense; careful to respect professional etiquette, remembering what is due to those in authority; courteous in manner and in attention to visitors and patients' friends (a duty that nurses in the pressure of their work are apt to overlook); careful to wear her uniform with spotless cleanliness, neatness and simplicity, with hair tidy, no jewelry, her general bearing that of military smartness; careful to be guarded in her behaviour towards doctors and students ... (p. 2) They must ever remember that discipline and obedience are the keynote to satisfactory and efficient work in life, for to rule well they must first learn to obey.'*

Servants were expected to know how to do things but not to problem solve or lead. In a sense, domestic servants belonged to and were even 'owned' by the family for which they worked. In this same sense, the above discussion shows that hospital managers and doctors felt that they could use nurses in whatever way was expedient to the institution.

The above is perhaps not surprising, as the early children's hospitals would have preferentially employed 'nurses' with a background in household servant-hood. It is

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[240] Ashdown, A. M. (1927). A complete system of nursing. London, Waverley Book Company Ltd.

interesting to consider, however, that Charles West[241] could have employed 'physician's assistants' to ensure that the child's treatment and observation were maintained in the absence of the physician but instead he chose to employ much more inexpensively, servants who would keep the wards clean and tidy but who could (like many household servants) administer treatments and carry out observations. This created an important effect and a discipline of paediatric nursing whose professional growth would be limited by the close management of servant-hood and the limited expectation of servants with regard to problem solving, independent practice and leadership.

It might have been anticipated that the registration of nurses and the 1919 Nurses' Act would have changed the working relationship of nurses with doctors and managers, however, there appears to be little evidence that the registration of children's nurses made any material difference to the servant-like nature of their work, perhaps because of the then continuing debate about the supplementary registers. Interestingly, however, Mcintosh (1998)[242] found a similar picture in a study of the effect of the registration of midwives in 1902. Specifically, Mcintosh (same reference) argues that:

> *'while regulation had a significant positive impact on the attitude of doctors toward midwives, the limits to their professional development were demonstrated by their lack of control over supervision, subordinate relationship to doctors, & inability to work in unison'.* (p. 403)

Rafferty (1996)[243] suggests that nurses have used their working proximity to doctors as a way of claiming a specialist knowledge and to appear as possessing expertise and intellectual skills. Ironically, this strategy seems to have backfired on nurses, Rafferty (1996)[244] argues that in imitating medicine nurses could not escape being compared with medicine with whom they were inevitably disadvantaged by class and by gender. There can be little doubt that medicine always needed nursing, as it probably does

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[241] Chiefly associated with the establishment of The Hospital for Sick Children, Great Ormond Street, London.

[242] Mcintosh, C. (1998). "Profession, skill or domestic duty? Midwifery in Sheffield, 1881-1936." Social History of Medicine **11**(3): 403-420.

[243] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.

[244] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.

today. Rafferty (1996, p. 183)[245] suggests that in this way doctors' support for nursing may *'have been strategic in so far as it was a means to doctors' as opposed to nurses' empowerment'* and that (p. 186) *'nursing is caught up in a contradiction in so far as it provides the necessary support for medicine to maintain its dominance, thereby perpetuating the subordination of nursing to medicine.'*

It is perhaps debatable whether paediatric nursing ever did shake off the shackles of its past. It will be seen, however, that by the time most people no longer employed servants, nursing was perceived to be asynchronous with the wider society and as a result, measures were taken to improve the conditions of service and gradually, in effect, begin the process of loosening nursing from its servant-hood past (see chapter 7).

Nurses as women

It is the case that most domestic servants were female, especially those who worked with children (see Schwarz 1999)[246]. Women's struggle for an equitable working relationship with men is well documented (see Coltrane 2000[247]) although Armstrong and Armstrong (1992)[248] suggest that the relationship between sex differences and the male and female professions is still poorly understood. Nevertheless, the association between 'women's work' and mechanisms of oppression have been asserted (see for example Bartlett 1999[249] and Wrigley 1991[250]). It is very likely that women's lack of equity with male hospital staff reinforced the subservient relationship associated at least initially, with servant-hood. As late as 1991, the New York Times reported that the health care professions in the United States were sexually segregated with 84% of

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[245] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.
[246] Schwarz, L. (1999). "English Servants and their employers during the eighteenth and nineteenth centuries." Economic History Review **52**(2): 236-256.
[247] Coltrane, S. (2000). "Research on household labor: modelling and measuring the social embeddedness of routine family work." Journal of marriage and family **62**(4): 1208-1234.
[248] Armstrong, P. and H. Armstrong (1992). "Sex and the professions in Canada." Journal of Canadian Studies **27**(1): 118.
[249] Bartlett, F. (1999). "Clean, white girls: assimilation and women's work." Hecate **25**(1): 10-39.
[250] Wrigley, J. (1991). "Feminists and domestic workers." Feminist Studies **17**(2): 317-330.

physicians being male and 97% of nurses being female[251]. Even within Medicine, men held a disproportionate number of senior posts and tended to earn more than female physicians[252]. Domestic servants and women had one more thing in common, they were both considered inferior, to their masters and to men. Specifically, by the early twentieth century, women were beginning to be regarded as less able than men, even in relation to the care of children. Liggins (2000)[253] for example, notes the increasing concern expressed in the late nineteenth century literature regarding poor motherhood. This may have paved the way for medicine to consider itself as possessing a duty to oversee nursing. The concern about women's ability to provide a healthy environment for their children[254] may well have become associated with the growing understanding of the association between un-cleanliness and disease. So perhaps it was, that nurses had to be clean but could not be trusted to be autonomous even in this field (see Bartlett 1999).[255]

Davies (1996)[256] argues that women were not so much deliberately excluded from professional life, but that there was in the past a general and routine assumption that women were to be included in ill-defined supportive roles. This then had the effect of highlighting the more focussed role that men enjoyed. This seems to have been the case in nursing and appears to have been an effect more powerful than the apparent professionalisation of nursing and in relation to which the registration of nurses seems to have had little if any effect.

Brooke (2001)[257] describes that way in which by the end of the 1950s, society had not only begun to adapt to the view that women could and should work but also that women's work was valuable, not least because it began to make a significant contribution to the prosperity of the family. Somewhat later and very gradually, men

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[251] However, it should be noted that in Britain more women than men are now training to be medics, see Lightbody, P., G. Siann, L. Tait and D. Walsh (1997). "A fulfilling career? Factors which influence women's choice of profession." Education Studies **23**(1): 25-37.

[252] See New York Times, September 10th, 1991.

[253] Liggins, E. (2000). "With a dead child in her lap: bad mothers and infant mortality in George Egerton's Discords." Literature and History **9**(2): 17-37.

[254] Note that there was some opposition to this view, see Scott, A. L. (1999). "Physical purity feminism and state medicine in late nineteenth century England." Women's History Review **8**(4): 625-653.

[255] Bartlett, F. (1999). "Clean, white girls: assimilation and women's work." Hecate **25**(1): 10-39.

[256] Davies, C. (1996). "The sociology of the professions." Sociology **30**(4): 661-678.

[257] Brooke, S. (2001). "Gender and working class identity in Britain during the 1950s." Journal of Social History **34**(4): 773.

began to enter paediatric nursing. The arguments made in this chapter should logically indicate that men would have changed the servant-like orientation of nursing. Isaacs and Poole (1996)[258] found that male nurses in Australia did indeed have a very different orientation to nursing, they considered themselves to be autonomous and in control and perceived nursing as a career and had aspirations for the future within nursing. Interestingly, they also felt that being men in a predominantly female discipline was an advantage for them in that it meant they would face less difficult competition for the senior posts to which they aspired. Clearly, the perception of female nurses has not changed very much from the period upon which the present study focuses. It also seems clear, that the subservient and controlled position of nursing did indeed have much to do with the fact that nurses were female.

Conclusion

This chapter has argued that paediatric nurses had a 'servant-like' orientation to their work. It should be understood, however, that paediatric nurses had a specific and unique role within the hospital and that their work did possess some of the characteristics of professional life. They did possess a unique body of knowledge (although much of what they did lay outside this body of knowledge and was work that non-nurses would have been able to do equally well). The nurses' work was not limited to specific hours of the day but flowed into their own private time. Nurses also possessed a code of conduct to which they had a high sense of allegiance.

Matched against the above was the nurses almost unquestioning obedience to the authority of their managers and to senior doctors. This last was particularly servant-like in character. Nursing was a disciplined workforce. No doubt nurses did think for themselves but it is the degree to which they did not question and evaluate what they did that is so remarkable. There was almost no sense of responsibility for qualitatively

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[258] Isaacs, D. and M. Poole (1996). "Being a man and becoming a nurse: three men's stories." Journal of Gender Studies 5(1): 39-47.

progressing their work, questioning accepted practices seems to have been regarded as almost morally wrong.

It should be noted that paediatric nurses were female and senior doctors were male. within the culture of the time this should have been expected to result in an hierarchical relationship between the two. However, matrons were female and nurses appear to have possessed the same sense of subservience in relation to this key position within the hospital. Nurses did sometimes break the rules and of course, as individuals they did think and they did reason and have views of their own. Nevertheless, this last is not the point; the point is that nurses did not go public with their views and almost never sought to openly confront the system of discipline and hierarchy that made them servants.

There was a positive side of the servantship of paediatric nursing. While nurses were poorly remunerated, at least by the 1950s many were able to enjoy well appointed accommodation, people employed to care for their physical and medical needs, libraries, sitting rooms, tennis courts and a whole range of facilities designed to make their lives comfortable. In fact this was part of the problem; life for paediatric nurses in these few decades was perhaps too comfortable. Their work was prescribed, its boundaries identified. In their private time they themselves were cared for and had little of the worries so characteristic of life outside an institution. The institutional nature of their lives and not just their work probably contributed to their servant-hood mentality. Maggs (1983)[259] suggests that the probationer who survived her training was likely to be a woman with sufficient commonsense to get along with and fall into line with her fellow nurses. She may have been 'niggled' (p. 109) by the etiquette but she would have liked the way that 'everything ran by clockwork'. In this way, Maggs (1983)[260] argues that the strict routine provided a sense of security to which her personality easily accommodated.

It is also likely that their institutional life, together with the unmarried status of nurses meant that as individuals they may have found it difficult to understand the

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[259] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.
[260] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

psychological and social needs of sick children and their families. Perhaps as individuals they would have had some understanding of these things but in any case their individuality was subsumed by their servant-hood, by their unquestioning obedience to their masters and by the system of discipline and hierarchy within which they were (if comfortably) trapped.

The following chapter will consider more closely the specific relationship that paediatric nurses had with doctors and will explore the aetiology and consequences of that relationship.

Chapter 3: doctors and nurses, the occupational position of paediatric nursing

Preamble

This chapter will look at the way in which paediatric nurses related to doctors and other members of staff. It will be argued that paediatric nursing possessed a core philosophy based on historical notions of holistic care. This underlying philosophy, however, was subject to the demands of the doctors who progressively put pressure on nurses to adopt a more treatment orientated role and one which was less holistically construed. In this way, paediatric nursing possessed a unique philosophical position on health care but which took second place to their accepted responsibility to support the doctor. The image consistently presented of nursing by the nursing press and by nurses themselves, was that of holistic care. However, this largely misrepresented the reality of nursing (see Long 1991)[261] which was more chiefly orientated to nursing's perceived obligations to medical and other staff.

Medical staff

Conceptually, the constructs of care and treatment are probably still confused. Davison (1943)[262] argues that medicine grew out of nursing. This perhaps rests on the notion that medicine is the scientific arm of caring for the sick and that nursing perhaps remained as the simple, non-scientific discipline of old. However, this might be expected to be medicine's view. Medicine's own lack of scientific effectiveness is noted by Porter (1997, p. 6)[263] who writes:

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[261] Long, T. (1991). "Toward a definition of children's nurses." Paediatric Nursing 3(9): 12-15.
[262] Davison, W. C. (1943). "Nursing as the foundation for Medicine." North Carolina Medical Journal **April 1943**: 141.
[263] Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.

'I say here, and I will say many times again, that the prominence of medicine has lain only in small measure in its ability to make the sick well. This always was true, and remains so today.'

It is interesting that texts on the history of particular hospitals and which were written within this period tend to have listings of consultants as well as 'key' figures such as hospital secretaries. Rarely do these texts cite the names of nurses[264], though occasionally Matrons are listed (see for example Ross[265]). It is clear that nurses tended to be considered as junior staff and consultant medics as senior staff. Nevertheless, there may always have been a gap between what was publicly reported of this relationship and its practice reality. In 1919, an examination guidance in the Nursing Mirror illustrates the degree of confusion about nursing's perceived relationship with medicine (see Anon 1919)[266]. The text (p. 12) gives guidance on a competition question:

'It is assumed that the nurse is working under a doctor, unless the contrary is stated. On the other hand it is no answer to a nursing question to say that "one would carry out the doctor's orders". All trained nurses do this as a matter of course, but they are certainly expected to know the way a particular case is nursed.'

In 1939, the Nursing Times publication of a 'model answer' to the State Final Question (General Paper) on the care of a child with Diphtheria gave no psychological or family care at all (see Anon 1939)[267]. No psychological care was discussed in Williamson (1939)[268], one in a series of 'interesting cases' published in the Nursing Times and despite this being about a baby who was resident in hospital for 10 months. Similarly,

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[264] For example, see Alder Hey Children's Hospital Archive (1964). Alder Hey Children's Hospital Souvenir Brochure 1914-1964. Ross, James. S. Liverpool.

[265] Ross, J. S. (1964). Alder Hey Children's Hospital Souvenir Brochure 1914-1964. Liverpool, Alder Hey Children's Hospital Archive.

[266] Anonymous (1919). "Our examination questions for nurses." Nursing Mirror and Midwives Journal **30**(759): 12.

[267] Anonymous (1939). "Model answers for state examination paper." Nursing Times **35**(1784): 868.

[268] Williamson, M. F. (1939). "Interesting cases series II: splenic anaemia treated by splenectomy,." Nursing Times **12/08/1939**: 1002-1003.

Whitehead (1939)[269], another in the 'interesting cases' group of articles provided no psychological care for a child with acute osteomyelitis.[270] James (1939),[271] however, in a case study of a child with pyloric stenosis[272], does document that the child's mother was 'instructed' to continue the feeds of Cow and Gate half cream milk, one of the very few references to parents. James (1939, same reference) also states that the prolonged hospitalisation required by the treatment was a disadvantage. There seems, however, to have been no notion that the mother might be trained to carry out treatments at home, or that a community nurse might have been able to do it. All of the articles in the 'interesting cases' series were written by general nursing students.

At The Hospital for Sick Children, Great Ormond Street, London, the Nursing Committee had not contained a single nurse, nurses were organised by people other than nurses and by a committee which also had responsibility for the hospital's domestic staff.[273] It is interesting, however, that there seems to have been little professional frustration associated with the nurses' role. In one of the very few early examples of frustration, the Matron of The Hospital for Sick Children, Great Ormond Street, asked the Committee in 1937 for permission to form a 'Nurses Representative Committee' which would enable nurses themselves to have their views heard, even although it would have no executive function.[274] This was allowed but the committee seems not to have been particularly well attended. It is also worth noting that the same minutes reflecting another matter, where the Matron was asked to confine her reports to social and domestic issues. Nursing seems not to have gained control of its own affairs by 1937, nor does it appear that it was particularly inclined to do so.

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[269] Whitehead, E. (1939). "Acute osteomyelitis." Nursing Times **26/08/1939**: 1060-1061.

[270] Acute Osteomyelitis .. infective inflammation a bone, without antibiotics, a protracted and life threatening condition.

[271] James, B. (1939). "Interesting cases series ix: pyloric stenosis." Nursing Times **30/09/1939**.

[272] Congenital Hypertrophic Pyloric Stenosis .. a condition where the pylorus of the stomach becomes enlarged at about 6 weeks of age, preventing the passage of food into the duodenum, resulting in projectile (forceful) vomiting.

[273] The Hospital for Sick Children Great Ormond Street Archive (1937). Entry dated 16/02/1938. Nursing Committee Minute Book: Volume Two: 1937. London.

[274] The Hospital for Sick Children Great Ormond Street Archive (1937). Nursing Committee Minute Book 3: Entry for 10/02/1937. London.

In 1949, Joyce Watson (Watson 1949)[275] suggested that the nurse '*must be prepared to combine the loving zeal of her predecessors with the scientific skill of modern nursing*' (p. 2). In this way, Watson may have been referring to nursing's core holistic care role and nursing's responsibility to doctors. Medicine was more likely to be seen as 'scientific' than was 'nursing'.

The choice of language in the May 1940 examination paper for Fever Nurses (most questions related to the care of children) clearly indicated who was in charge: '*For what purpose might a doctor order you to syringe an ear?*' (see Anon 1940[276] and Currie 1997)[277]. Watson (1949)[278] suggested that nurses were expected to do what the medical attendant told her to do. However, there were times, especially in urgent situations when this advice was to be disregarded. Even here it is argued, the matter should be referred to the doctor as soon as possible. It should be noted that nurses sometimes worked in situations where there were no doctors or at least doctors were not always available. Many of the country hospitals would only have had doctors visiting perhaps once a week. In this situation, there seems to have been an acceptance that nurses could work on their own. This is significant because it means that it was not the case that there was concern over whether nurses could work independently, many of them did so (see Waterhouse 1962[279], Lomax 1996[280]). Rather, the issue seems to have been that wherever there was a doctor, that doctor had the right to assume that the nurses would be available to him (or her).

It is likely that doctors used nurses to perform relatively simple interventions, and to undertake tasks that required a continuous presence, this is probably what doctors needed most. However, doctors sometimes seem to have been happy for nurses to

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[275] Watson, J. M. (1949). Aids to fevers for nurses. London, Bailliere, Tindall and Cox.
[276] Anonymous (1940). "Final examination for Fever Nursing (Scotland)." Nursing Times **25/05/1940**: 556.
[277] Currie, R. (1997). "The rise and demise of fever nursing." International History of Nursing Journal **3**(1): 5-19.
[278] Watson, J. M. (1949). Aids to fevers for nurses. London, Bailliere, Tindall and Cox.
[279] Waterhouse, R. (1962). Children in hospital: a hundred years of child care in Birmingham. London, Hutchinson.
[280] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

undertake quite complex interventions for them. Steppe (1997)[281] argues that as a result of the lack of professional independence from medicine (in Germany) the boundaries of professional development and the nursing role were limitless. In the same way, Robinson (1972)[282] reports that between 1923 and 1948, an out-patient Sister at Yorkhill routinely performed minor operations, often administering the anaesthetic herself. Hulme (1996)[283] and Hargreaves (1987)[284] report that in the 1930s and 1940s, nurses worked to protocols which were agreed with doctors and in this way were able to extend their practice beyond skills that were considered to be 'nursing'. While the skill base of nurses was increasing throughout this period , nurses did not on the whole ensure that they were fully responsible for what they did. It was still the doctor who determined what and when these advanced skills would be carried out (Lindsay 2001)[285]. In this way, it is suggested here that nurses were only responsible for performing the duty 'properly' and not for determining whether the execution of that skill was appropriate. In addition, nurses still performed a considerable amount of unskilled work, especially ward cleaning, often with the purpose of making the ward look clean for the doctors' round (Hargreaves 1987[286], Olsen 1997[287], Pugh 1931[288]).

It appears from the above that paediatric nursing was a sub-professional discipline, lacking responsibility for its own role within the hospital. However, in one way at least, paediatric nursing was a step ahead of its medical 'cousin'. Paediatric nursing was a specialised branch of 'nursing' and had been since 1852[289]. By 1928, the BPA[290]

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[281] Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Robinson, E. (1972). The Yorkhill story: the history of the Royal Hospital for Sick Children, Glasgow. Glasgow, The Board of Management for Yorkhill and Associated Hospitals.

[283] Hulme, O. (1996). Reflections of the past, in Journal of the Yorkhill Nurses' League. Yorkhill Hospitals Archive. Glasgow.

[284] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.

[285] Lindsay, B. (2001). "An atmosphere of recognition and respect? Sick children's nurses and medical men 1880-1930." International History of Nursing Journal 6(1): 4-9.

[286] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.

[287] Olsen, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, R. Robinson and R. Elkan. London, Routledge.

[288] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

[289] The date when the first children's hospital began to recruit nurses to work solely with sick children (Great Ormond Street Hospital for Sick Children, see Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[290] British Paediatric Association, now the Royal College of Paediatrics and Child Health.

had only 70 members and its organisation was little more than a gentleman's club (see Forfar, Jackson and Laurance 1989)[291], the whole membership being first and foremost, members of the Royal College of Physicians, an organisation with a clear 'adult' focus. The poor influence of paediatrics on general medicine is testified by the scant presence or absence of a paediatric disease section in many general medical textbooks such as the popular works by Frederick Price (Price 1946)[292] and John Conybeare (Conybeare 1949)[293]. Even by 1960, the BPA only possessed 350 members, all of whom still chiefly obtained their status from being members of the Royal College of Physicians (Forfar, Jackson and Laurance 1989)[294]. Only in the late 1990s did 'Paediatrics' finally break away from the Royal College of Physicians with the dissolution of the BPA and the establishment of the Royal College of Paediatrics and Child Health. Paediatric nursing on the other hand was an organisation which confined its activities to sick babies and children, it had 'specialised' 70 years in advance of medicine. This might have been expected to increase the degree of independence enjoyed by paediatric nursing but this seems not to have been the case. There were probably times when the nurse was more expert than the doctor but nurses seem to have been happy for doctors to continue to retain overall responsibility.

Williamson (1990, p. 40)[295] points out that by 1947 '*only a handful of doctors ... were specialising in childhood illness prior to WWII*'. Williamson also points out that even in the 1950s, obstetricians usually disallowed paediatricians from accessing special care baby units. Consequently, most paediatricians did not possess neonatal experience, but rather spent most of their time with the consequences of pulmonary T.B. and other common respiratory diseases (see Burgess 1988[296] but also Collis 1959[297]).

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[291] Forfar, J. O., A. D. M. Jackson and B. M. Laurance (1989). The British Paediatric Association 1928-1988. London, The Royal College of Child Health and Paediatrics.

[292] Price, F. W. (1946). A textbook of the practice of medicine. London, Oxford University Press. This 7th edition did have the paediatrician Alan Moncrieff as a contributor.

[293] Conybeare, J. (1949). Textbook of medicine. Edinburgh, E and S Livingstone Ltd.

[294] Forfar, J. O., A. D. M. Jackson and B. M. Laurance (1989). The British Paediatric Association 1928-1988. London, The Royal College of Child Health and Paediatrics.

[295] Williamson, D. A. J. (1990). Ninety years of service: a history of the Southampton Children's Hospital 1884-1974. Southampton, Published by author.

[296] Burgess, T. (1988). "No more potty rounds." Nursing Times 84(16): 69-71.

[297] Collis, W. R. F. (1959). Neonatal paediatrics. London, Heinemann. Note that this book was reviewed by a paediatric nurse, 'M.A.D.' who suggested it as a book for midwives. Nursing Times. 30th January 1959. p. 142.

It can be seen that for the greater part of the period in question, paediatric medicine was a small and somewhat vulnerable discipline. Nevertheless, doctors seem to have protected their superior position very carefully, providing lectures to nurses for example, but never allowing nurses to provide lectures to their students, even on matters such as dressing wounds where nurses may have been more knowledgeable (see Barnes 1999)[298]. In the same way, the provision of separate dining rooms (Yorkhill Hospitals Archive 1940)[299] for doctors, demonstrated that they were superior and helped to maintain the divide. Perhaps these artificial divisions were so rigidly enforced because medicine was vulnerable to the accusation that it could help most child patients only to a very limited degree[300] and that nurses quickly learned how to diagnose children and knew which treatments would be prescribed for the limited group of diseases with which the majority of children were admitted.

Medicine's hold on delivering lectures to nurses reached an all time high in 1936 when the GNC[301] decided that all sessions on anatomy should be delivered by anatomists (in practice this meant surgeons). The GNC might have been trying to ensure that sessions peripheral to nursing were delivered by those with appropriate qualifications. However, this would wrongly assume the possibility of no nurse tutor having completed a course in anatomy. The Hospital for Sick Children, Great Ormond Street, Nursing Committee expressed their disagreement with the GNC, considering that Nurse Tutors had proved themselves to be better teachers.[302] The point here, however, is that nursing's governing body had determined that at least one aspect of nursing should be considered the intellectual property of medicine. In addition, doctors were writing more books for nurses than nurses were themselves (consider for example Paterson and Forrest Smith 1940[303], Moncrieff 1941[304], Farrow 1956[305] Pugh 1931[306]

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[298] Barnes, P. (1999). Royal Manchester Children's Hospital 'Pendlebury' 1829-1999. Leek, Churnet Valley Books.

[299] Yorkhill Hospitals Archive (1940). Training school for nurses. YH8/3/2. Glasgow.

[300] Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.

[301] Great Ormond Street Hospital Archive (1936). Entry dated 25/03/1936. GNC circular 65 dated 14/03/1936. Nursing Committee Minute Book Volume One 1935-1936. London.

[302] Great Ormond Street Hospital Archive (1936). Entry dated 25/03/1936. GNC circular 65 dated 14/03/1936. Nursing Committee Minute Book Volume One 1935-1936. London.

[303] Patterson, D. and J. Forrest-Smith (1940). Modern methods of feeding in infancy and childhood. London, Constable and Co. Ltd.

and papers in the nursing press, for example Pearson 1940[307], Shaw 1945[308]). It should be noted, however, that paediatricians also considered themselves superior to some in their own profession, for example, doctors working within the school health and community services. Their rejection of the Court Report[309] as late as 1976 is perhaps an example of their isolationist or elitist position. In rejecting the Court Report, they (the BPA)[310] rejected the whole notion of an integrated child health provision (see Forfar and others 1989)[311]. Their wish to distance themselves from nursing, while accepting what services nursing had to offer, should be seen in relation to the within-profession struggle for elitism.

Cherry (1996, p. 27)[312] argues that the professionalisation of medicine in the 19th and 20th centuries '*involved the downgrading of other forms of healing* ...' and this seems to have been the case with doctors consistently being active in keeping nursing within its control and in its place. Maggs (1983) provides evidence of a degree of competition between nurses and general practitioners (but not the more prestigious general hospital physicians) in the years between 1881 and 1914. Maggs (1983)[313] suggests that this competition largely resulted in the abandonment of the system of lady probationers who paid for their own training, were often accommodated and trained separately and who were spared much of the menial work which fell to the ordinary probationers. The lady probationers were not liked, perhaps because they found it too easy to criticise the known way of nursing and that of medicine. Maggs (same reference) suggests that there were 'difficulties' (p. 146) in relation to their social position with doctors to whom they were equal and their professional position which was subordinate.

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[304] Moncrieff, A. (1930). A textbook for the nursing and diseases of sick children for nurses. London, HK Lewis and Co. Ltd..

[305] Farrow, R. (1956). The surgery of childhood for nurses. Edinburgh, Livingstone.

[306] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

[307] Pearson, W. (1940). "Respiratory diseases in children." Nursing Mirror **23/03/1940**: 611.

[308] Shaw, M. M. (1945). "Venereal disease in children." Nursing Times **5/5/1945**: 288-289.

[309] Court, S. D. M. (1976). Fit for the future: report of the Committee on Child Health Services. London, HMSO.

[310] British Paediatric Association, precursor to the Royal College of Paediatrics and Child Health

[311] Forfar, J. O., A. D. M. Jackson and B. M. Laurance (1989). The British Paediatric Association 1928-1988. London, The Royal College of Child Health and Paediatrics.

[312] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[313] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

The hierarchical relationship between doctors and nurses was probably strengthened by the social class difference between the two (Darbyshire 1987)[314]. In 1919, an article on hospital etiquette (Vivian 1919, p. 56)[315] suggests that everyone needed to know their place in the social order and that

' ... it is an accepted fact that the former (doctor) takes precedence over the latter (nurse) ... no doctor can be expected to recognise socially the nurse who is working for him, and she must wait for acknowledgement from him first'.

This position may indicate a change from Florence Nightingale's position (Nightingale 1860)[316] that there should always be a nurse in charge of nurses and indicate the growing dominance of medicine over other health care disciplines within this period (see Porter 1997)[317].

Nursing may have been the 'simple' relation of medicine, but medicine knew that its own work depended on skilled and reliable nurses. Arton (1992)[318] notes that in 1939, the BPA[319] met with the Minister of Health to place the argument that children should only be nursed by paediatric nurses (see also Editorial 1939)[320, 321]. Nurses were clearly valuable to doctors and the social divide between the two disciplines enabled doctors to use nurses without fear that they might one day usurp doctors own position in the health care hierarchy. This may have been important, not least because, as Porter

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[314] Darbyshire, P. (1987). "Nurses and doctors: the burden of history." Nursing Times **83**(4): 32-34.
[315] Vivian, M. M. (1919). "Hospital etiquette." Nursing Mirror and Midwives Journal **30**(761): 56-57.
[316] Nightingale, F. (1860). Notes on nursing: what it is and what it is not. USA, D. Appleton and Co.
[317] Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.
Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[319] British Paediatric Association, now the Royal College of Paediatrics and Child Health.
[320] Editorial (1939). "The paediatrician's plan and specialists for specialised nursing." Nursing Times **4/11/1939**: 1328-1329.
[321] Paediatricians seem largely to have supported the separate identity of paediatric nursing. However, there were paediatricians who saw the nursing of children as an essentially feminine role which could be performed by most suitable women. Pugh (1931) states for example, that the children's nurse 'must, by keen observation, be able to interpret the meaning of its different symptoms, without having them put into words as would be done by an older patient. These difficulties are in a measure overcome by that innate sympathy and liking which almost all women feel towards children, which help them to recognise a child's wants by its looks and inarticulate mutterings far more quickly than a man could.' Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

(1997)[322] argues, medicine only had a very tenuous hold on evidence with which to support its practice. Barnes (1999)[323] points out that paediatric medicine was not a particularly learned discipline. In Britain during the early and middle parts of this period paediatric medicine was a part time discipline, largely excluding participation in research and publication.

Nurses probably always did possess a degree of influence which was from time to time employed against the will of doctors. This influence was sometimes used to protect the position of nursing in the hierarchy but was sometimes used in the interest of children. In 1942, nurses succeeded in influencing the Nursing Committee at The Hospital for Sick Children, Great Ormond Street, London to prevent doctors treating children in the playroom. It had begun to be recognised that children needed a place where they could feel safe.[324] It is clear that doctors did not always get things their way. Nurses may not have possessed the professional credence enjoyed by medicine but they did sometimes know how to get what they wanted.

It should be understood that paediatric nurses did in practice work very closely with their medical colleagues and that there would only very rarely have been any disagreement between the two parties (see later chapters). It seems strange that two disciplines which purportedly shared the same locus should have disagreed so little, one would have expected the modalities of 'care' and 'treatment' to conflict sometimes.[325]

Although in most hospitals there existed a nursing or hospital committee which directed much of what nurses did. It was very unusual for there to have been a nurse

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[322] Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.

[323] Barnes, P. (1999). Royal Manchester Children's Hospital 'Pendlebury' 1829-1999. Leek, Churnet Valley Books.

[324] Great Ormond Street Hospital Archive (1945). Entry dated 12/06/1945. Nursing Committee Record Book Number Four: 1942. London.

[325] Olson (1997) found, however, that (in the USA) doctors operated quite separately from nurses and their records (between 1915 and 1937) showed little evidence of a dialogue between them. Doctors prescribed the treatment which the nurses carried out. Nurses were following orders and there may have been little need for dialogue. Olson, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

member of these committees (see Lomax 1996)[326]. At a wider level Paediatric nursing lacked a professional body of its own[327] and was dominated by the GNC[328] and College of Nursing which were staffed mainly by general nurses (see Arton 1992)[329] so that even at a national level paediatric nursing had no effective leadership.

At the Hospital for Sick Children, Great Ormond Street, London, the Nursing Committee seem also to have been responsible for key decisions in respect of nursing training. Certainly it was this committee which in 1939 allowed some nurses to re-sit their examination, this despite the fact that no nurses (nor the matron) sat on the committee (though it did have three members of the Medical Committee).[330] Only two years later, the same Nursing Committee would admonish a medic at Tadworth Court for trying to interfere in nursing affairs. The Committee made it clear that the medical officer was not responsible for nursing issues[331]. This, however, was no more than a 'blip' in a system of organisation which was trying to come to terms with a changing social climate and an increasingly aggressive discipline of medicine. Medicine would continue its struggle for health care supremacy, a struggle which was largely successful (see Porter 1997)[332].

Although from the beginning, doctors may not have existed in the same hierarchical arrangement as nurses, they nevertheless sought an increasing role in governing what

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[326] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[327] At the suggestion of Miss Lane, Matron of GOS, the Association of Sick Children's Nurses was founded on 11th June 1938. General nurses with 3 years children's experience could join as well as RSCNs and there was provision for probationer children's nurses to join as well (see Nursing Times 18/06/1938 pp 627-28). It soon began to be argued that general training was not sufficient for the nursing of sick children (see Nursing Times 9/7/1938, p. 710). However, the organisation (which would become the Association of British Paediatric Nurses) was not active until after WWII (Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.) and even then did not achieve the stature of other nursing organisations.

[328] General Nursing Council.

[329] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[330] Great Ormond Street Hospital Archive (1939). Entry dated 11/07/1939. Nursing Committee Minute Book: Volume Three. London.

[331] Great Ormond Street Hospital Archive (1941). Entry dated 14/01/1941. Nursing Committee Minute Book: Volume Three. London.

[332] Porter, R. (1997). Medicine: a history of healing, ancient traditions and modern practices. New York, Marlowe and Company.

nurses did (see Cherry 1996)[333]. They already prescribed treatment which the nurse then carried out and it was not long before they were attempting to determine other aspects of the nurses' role and responsibility. As early as 1854 Charles West[334] had decreed that while paediatric nurses were expected to perform to high standards, they had always to be subservient to the doctor. This same message was being presented to nurses at least as late as 1931 (see Pugh 1931)[335]. There can be little doubt that doctors thought they had control over everything that nurses did. Nurses too, were brought up to believe that that their role was to comply with the doctor as an adjunct to medicine (see Lindsay 2001)[336].

Barnes (1999)[337] records that by 1906 at the Royal Manchester Hospital, Pendlebury, a poster had been provided, presumably to remind paediatric nurses of the following rules:

- Children should be kept perfectly clean;
- No night binder allowed, clothing should be light, warm and loose;
- There should be as much fresh air as possible;
- No medicine should be given without doctor's orders;
- There should be given no 'soothing syrup' etc.;
- Children should be given regular meals in regular amounts;
- Breast milk should be the only food until 7 months;
- Sucking of dummies is harmful.

It is likely that the above was provided for and not by nurses.

It is accepted that by the period 1920-1970, doctors had succeeded in being perceived as linearly senior to nurses. The cost of university based medical education had helped to create an upper class medical profession characterised by conservative attitudes and

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[333] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[334] West, C. (1854). How to nurse sick children. London, Longman.

[335] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

[336] Lindsay, B. (2001). "An atmosphere of recognition and respect? Sick children's nurses and medical men 1880-1930." International History of Nursing Journal 6(1): 4-9.

[337] Barnes, P. (1999). Royal Manchester Children's Hospital 'Pendlebury' 1829-1999. Leek, Churnet Valley Books.

discrimination against women (see Cherry 1996)[338]. In 1923 a doctor was investigated following the death of a child who had been beaten by a doctor at the Down's Hospital for Children, Banstead (See Arton 1992)[339]. A nurse was implicated in that she had failed to report the incident, claiming that she understood she was not allowed to report a 'superior'. Interestingly, Bedford-Fenwick[340] appeared to play down the incident, supporting both the notion that reporting a senior would not be expected and that the abuse of children was not exceptional (see Anon 1923)[341]. Perhaps Bedford-Fenwick was trying to defend the nurse; it seems more likely, however, that she was defending the status-quo and the system of nurse-doctor hierarchy.

That nurses and doctors worked in a harmony of role can hardly be denied. Medicine needed nursing and if it did not view nursing with affection or respect, it does seem to have viewed it with a sense of proud ownership. Medicine's view of nurses is perhaps illustrated by a doctor writing in 1927 in the British Medical Journal and provided by Lindsay (2001, p. 7)[342] [343]

> *'A good modern nurse is wholly feminine, full of vitality, ordered in service, faithful and unweary in well doing, a fine responsive devoted instrument, willingly placed in the hands of medicine for the service of the sick. This is common knowledge.'*

Clearly, nurses were perceived to be simple, hardworking people whose role was to support doctors. A book review in 1930 criticised Moncrieff's (1930)[344] (doctor) 'Textbook on the nursing of diseases of children', suggested that the content was too complex for nurses.[345]

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[338] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[339] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[340] At this time, a member of the GNC. Bedford-Fenwick had initially trained in a children's hospital.

[341] Anonymous (1923). "News." British Journal of Nursing **04/09/1923**: 75-76.

[342] Lindsay, B. (2001). "An atmosphere of recognition and respect? Sick children's nurses and medical men 1880-1930." International History of Nursing Journal **6**(1): 4-9.

[343] See British Medical Journal 05/02/1927, p. 248.

[344] Moncrieff, A. (1930). A textbook for the nursing and diseases of sick children for nurses. London, HK Lewis and Co. Ltd.

[345] See British Medical Journal 1930, 1: 827.

It is interesting that formally, no single discipline was provided with the overall responsibility for the child patient. However, it was not long before doctors had assumed this responsibility. Cherry (1996, p. 27)[346] suggests that the professionalisation of medicine led directly to the 'accumulation of power over patients'. Nurses seem never to have challenged this claim to the throne. Certainly the patient was seen to be the responsibility of the doctor. This might not have been inevitable. It would seem sensible that the patient be seen to be the responsibility of the hospital which might then organise the increasing number of different professionals working under its roof. However, even the hospital institution seems to have bowed to the increasing authority and power of the doctor. As late as 1968, Paediatric Nurse Robottom (1968)[347] was to publish an article on the home nursing of a baby with toxoplasmosis, making it clear that she had acquired the doctor's permission before publishing. The child's case did not belong to the author or to the parents but to the doctor. Medicine had both manufactured and placed itself on the health care throne.

Dopson (1983)[348] reports that during World War Two, flirting with junior doctors at The Hospital for Sick Children, Glasgow, meant instant dismissal. However, this would not have been too much of a disincentive because nurses would not have been able to stay on the staff once they were married. A record on the 9th July 1940 from the Great Ormond Street hospital,[349] addresses the case of one nurse who was asked to leave when she announced her marriage to a doctor of the same institution. This was six months after the same hospital had agreed to allow married women to rejoin the staff.[350] This does indicate that there was a power differential between doctors and nurses which meant that marriage between them might interfere with discipline. This 'power differential' probably went deeper than the working relationship between medicine and nursing and may have related to the way in which (according to Kessler-

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[346] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[347] Robottom, B. M. (1968). "Home nursing of a baby with toxoplasmosis." Nursing Times 02/02/1968: 66.

[348] Dopson, L. (1983). "'Sick kids' 100 years on." Nursing Times 79(13): 8-9.

[349] Great Ormond Street Hospital Archive (1940). "Nursing Committee Minute Book record for 9th July 1940."

[350] Great Ormond Street Hospital Archive (1940). Entry dated 16/01/1940. Nursing Committee Minute Book Three. London.

Harris 2001)[351] the male right to earn a living was integral to the notions of male dignity, independence and self respect. This right to work depended in reality, on women remaining at home. Kessler-Harris (2001, same reference) makes the point, however, that this relationship caused the work of men to be seen as more important than the work of women. Women stayed at home because men 'had' to work. When, unusually, men and women worked together, it may have been necessary for the male role to be seen as superordinate. The non married status of nurses was perhaps first advocated by Florence Nightingale (Nightingale 1860)[352] who argued that married nurses would be more attached to their husbands than to their work. In addition, Brooke (2001)[353] argues that at least until the 1950s when a greater proportion of women sought employment, working women and social class were closely associated. This may have strengthened the already clear difference between the social class of doctors and nurses and in turn reinforced the notion that the work of the doctor was more important.

It is likely that nurses' subservience to medicine resulted in their role being aligned to that of medicine, rather than the role being able to develop along the lines of 'care' and 'holism' which might otherwise have been expected. The association between the role of paediatric nurses and that of doctors is illustrated in the way in which the nurses' role has changed with the changing prevalence of disease states. Burgess (1988)[354] argues that the conditions with which the children were admitted in the 1940s and 50s were very different from those seen today. The length of hospital stay was much longer. Burgess[355] points out that many of the diseases treated today, such as oesophageal atresia[356], were untreatable then. Instead wards were full of children with such diseases as pneumonia, gastro-enteritis, nephritis[357] and osteomyelitis[358]. Children were also admitted with the 'common' infectious diseases of childhood, such as

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[351] Kessler-Harris, A. (2001). In pursuit of equity: women, men, and the quest for economic citizenship in twentieth century America. Oxford, Oxford University Press.
[352] Nightingale, F. (1860). Notes on nursing: what it is and what it is not. USA, D. Appleton and Co.
[353] Brooke, S. (2001). "Gender and working class identity in Britain during the 1950s." Journal of Social History 34(4): 773.
[354] Burgess, T. (1988). "No more potty rounds." Nursing Times 84(16): 69-71.
[355] Burgess, T. (1988). "No more potty rounds." Nursing Times 84(16): 69-71.
[356] A congenital condition required surgery in the neonatal period.
[357] Inflammation of the kidney, resulting from a kidney or renal tract infection.
[358] Inflammation of a bone, caused by infection.

measles and scarlet fever. Tuberculosis was prevalent and involved very long periods of hospital treatment and a poor prognosis.

Hulme (1996)[359] makes the point that in the past there were fewer drugs and less medical intervention but instead a greater emphasis on good nursing care. However, the nature of 'good nursing care' and how it was different from the increasing complexity of medical intervention, needs to be explained. Hargreaves (1987)[360] suggests that before there were antibiotics, hot fomentations, cataplasma poultices, mustard baths, tepid sponges, cold compresses and ice bags were all used to fight infections while very few drugs were used. Hulme (1996)[361] suggests that it was accepted that patients got better by careful nursing and strict hygiene, as well as love, care and understanding. Anon (1919, p. 243)[362] placed emphasis on the nurses' role in keeping the nursery bright and cheerful, on the nurses' use of imagination, interaction and observation … *'study their characters, and as far as possible, with reason, let them do as they please and find themselves in their own way.'* The point here is that, as would be expected, the nursing role changed through the period 1920-1970. However, the nursing role changed to reflect the changing ways in which medicine was treating disease. Nursing was aligned to medicine and followed it.

It should be understood that nursing did not openly argue that its main role was as an adjunct to medicine. By the mid 1950s, the 'official line' (but not the practice one) was that nursing possessed a different goal to medicine. This is illustrated by a 'model answers' paper in the Nursing Times (see Anon 1956)[363]. The question asked about the care of a child with congenital dislocation of the hip and for the answer to be written from 'the nurses point of view' (p. 935). The model answer provided by Anon (1956) included encouraging the child's mother to retain 'close contact' with the child and an emphasis on positioning and skin care (nursing). Almost ten years later, Sharpe

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[359] Hulme, O. (1996). Reflections of the past, in Journal of the Yorkhill Nurses' League. Yorkhill Hospitals Archive. Glasgow.
[360] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.
[361] Hulme, O. (1996). Reflections of the past, in Journal of the Yorkhill Nurses' League. Yorkhill Hospitals Archive. Glasgow.
[362] Anonymous (1919). "How to amuse toddlers." Nursing Mirror and Midwives Journal 30(770): 243.
[363] Anonymous (1956). "Model answers to children's state paper." Nursing Times **21/09/1956**: 935-936.

(1964)[364] gave a rather negative evaluation of the text 'surgery of childhood for nurses' (Farrow and Forrest 1964)[365] because of its 'too medical orientation' (p. 502).

Those who led paediatric nursing never really developed a professional dialogue with medicine. It might for example, be expected that the ABPN [366] would have had formal, or at least routine contact with the BPA [367] and the British Association of Paediatric Surgeons. Duncombe (1979)[368] reports, however, that there were never any formal relations with these Medical organisations and that liaison for the most part only took place when the continuing existence of paediatric nursing as a speciality was under threat and when the medical organisations sought dialogue.

The above notwithstanding, the evidence is for a discipline of paediatric nursing subjugated to medicine. The GNC seems to have been more concerned about the quality or amount of medical care than it was about the degree of supervision available to students. In this way, students had to be provided with a learning environment that was medically stimulating. Arton (1992)[369] discusses the difficulty with which the Westminster Infants (later Children's) Hospital experienced in obtaining approval to train nurses because of the limited age group of its patients. The hospital had tried in 1929 to arrange a combined course with students gaining some of their experience at The Hospital for Sick Children, Great Ormond Street, London.[370] In 1927 GOS itself was refused permission to include its country hospital, Tadworth Court in the training circuit because of 'insufficient experience'.[371] Presumably, the GNC was referring to insufficient medical experience.[372]

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[364] Sharpe, M. (1964). "Book Review (Surgery of childhood for nurses)." Nursing Times **17/04/1964**: 502.

[365] Farrow, R. and D. Forrest (1964). Surgery of childhood for nurses. London, E&S Livingstone.

[366] Association of British Paediatric Nurses.

[367] British Paediatric Association, now the Royal College of Paediatrics and Child Health.

[368] Duncombe, M. A. (1979). A brief history of the Association of British Paediatric Nurses 1938-1975. London, Association of British Paediatric Nurses.

[369] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[370] Great Ormond Street Hospital Archive (1929). Entry dated 02/05/1929. Nursing Committee Minutes. London.

[371] Great Ormond Street Hospital Archive (1927). Entry dated 07/04/1927. Nursing Committee Minutes. London.

[372] Tadworth Court was eventually approved for training in 1938 (Great Ormond Street Hospital Archive (1938). Entry dated 09/03/1938. Nursing Committee Minute Book: Volume Two 1937. London.)

Other (non medical) staff

It is suggested here that the governing of paediatric nursing by general and non nurses resulted in the lack of occupational closure[373] and had the effect of damaging the growth of the discipline, chiefly by limiting its practice to domestic, unskilled work and by blurring its role. Discipline was needed to keep paediatric nurses in their place and prevent their professional growth. It should be remembered that this was a period in which the new discipline of medical paediatrics was being fashioned (see Forfar, Jackson and Laurance 1989)[374] and in which many of the para-medical disciplines such as radiography and physiotherapy were emerging from what had largely been a nursing role.

Paediatric nursing probably had a more intimate relationship with paediatricians than it had with surgeons and those medical staff who had a mainly adult focus. Nevertheless, Lindsay (2001)[375] argues that this positive relationship with paediatricians waned somewhat around the 1920s - 1930s with the latter valuing the 'fully trained nurse' (general nurse) more highly. Lindsay (same reference) points out that this was even the case in children's hospitals such as that at Sheffield where by 1929 all Staff Nurses were required to be 'fully trained'[376] (Recruitment advertisements 1920)[377]. It should be emphasised that through most of the period between 1920 and 1970, those doctors who worked with children did value the RSCN qualification. However, few others did at this time (see Arton 1992)[378] and it is not surprising that for a while the developing speciality of medical paediatrics did conform to the more widely held views about the 'specialist'[379] Parts of the Register.[380]

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[373] Meaning the degree to which a discipline can limit its practice to its own members.

[374] Forfar, J. O., A. D. M. Jackson and B. M. Laurance (1989). The British Paediatric Association 1928-1988. London, The Royal College of Child Health and Paediatrics.

[375] Lindsay, B. (2001). "An atmosphere of recognition and respect? Sick children's nurses and medical men 1880-1930." International History of Nursing Journal 6(1): 4-9.

[376] Fully trained, meaning on the General Part of the Professional Register (general nurses).

[377] Recruitment advertisements (1920). "Recruitment." Nursing Mirror and Midwives Journal 32(810): x1.

[378] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[379] Taken to mean paediatric, learning disability and mental health nursing.

[380] The pre-registration 'Parts' of the Professional Register were (as known today) mental health, learning disability and children's nursing. These were often known as specialist Parts, with Part 1

Maggs (1983, p. 26)[381] used the term 'occupational imperialism' to denote the way in which general nursing '*came to develop and maintain an occupational supremacy which has pervaded the profession ever since'*. This, he argues, came about because of the dominance of the general hospitals within which general nurses were trained and which were managed in practice by the medical elite. According to Maggs (1983), the key to this occupational imperialism is the way in which general nurses were able to claim that they could work not only in the prestigious general hospitals but also in the minority and more specialised hospitals, in this way displacing the incumbent specialists at least in terms of senior positions. They could do this because of their background in the more prestigious hospitals and because of the way in which nursing here was associated with the reforms of Florence Nightingale and were considered 'modern' and professionally superior. Rafferty (2000, p. 522)[382] appears to refer to this same phenomenon when she suggests that the discrimination against paediatric nursing and nurses and the relative power and influence of general nurses was reflected in a 'caste system':

> *'A 'caste' system existed in nursing according to which midwives, mental, male, fever and children's nurses were regarded as inferior due to their shorter training'*[383]

It should be understood that paediatric nursing did not possess its own management or professional structure. Nurses possessed very little professional freedom and senior nurses such as ward sisters and matrons were expected to be 'fully trained' (general nurses)[384] through most of this period.[385] There is some evidence that general nurse

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(general nursing) always referred to as 'general' and its registrants as 'general nurses' or 'fully trained'. There was never any objective reason to consider the general trained nurses as having undertaken a training that was in any sense more 'full', though it was of course, more general.

[381] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

[382] Rafferty, A. M. (2000). Nurses. Medicine in the twentieth century. R. Cooter and J. Pickstone. Amsterdam, Harwood Academic Publishers: 519-529.

[383] There are few examples of paediatric nurses objecting to the discrimination against them, but see 'An old experienced nurse and one of the children's nurses' (1920). "Children's nurses and uniform." Nursing Mirror and Midwives Journal **31**(787): 66.

[384] See Great Ormond Street Hospital (1941). "Vacancies." Nursing Times **01/02/1941**: Supplement vii. Nursing Mirror and Midwives Journal (1920). "Recruitment advertisements." Nursing Mirror and Midwives Journal **32**(810): xi. Booth Hall Hospital for Sick Children (1940). "Vacancies." Nursing Times **27/01/1940**: v. Bristol Royal Hospital for Sick Children (1939). "Vacancies."

managers didn't understand what an RSCN was or how best they could be employed, or at least they didn't know how to spell the name.[386] This meant that not only were paediatric nurses having to follow the will of doctors but their own core work was also determined by others.

Much of the published material on the care of sick children was being submitted by non paediatric nurses. The lack of occupational closure meant that virtually anyone could be expected to write about the care of sick children. The work of fever nurses[387] for example, focused heavily on the care of children with fevers but it seems to have been seen as perfectly acceptable for fever nurses to write about almost any aspect of the care of sick children. Bell (1940)[388] wrote a series of articles on the nursing of children with whooping cough and chicken pox. Welham (1940)[389], a midwife, published an article concerning the care of a child with a strangulated inguinal hernia.

The Nurses Act of 1943 brought about the Roll of Nurses (Enrolled Nurses), however, there were to be no enrolled nurses for paediatric nursing. It may be the case that children's nurses were considered to be junior enough with even most designated children's wards being led by a 'fully trained' (general) nurse (see Armstrong 1945)[390].

In 1945, the GNC published its draft proposed scheme for comprehensive training (Editorial 1945)[391]. This would, however, provide only 3 months experience in paediatric nursing within a four year course. Also in 1945, the GNC allowed general nurses who had held posts in children's hospitals for at least two years, to undertake the final examination in paediatric nursing. Interested nurses had to 'attend [some] lectures' and to provide a reference by a qualified children's nurse (see Anonymous

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Nursing Times **22/07/1939**. Great Ormond Street Hospital (1941). "Vacancies." Nursing Times **01/02/1941**: Supplement vii. Recruitment advertisements (1920). "Recruitment." Nursing Mirror and Midwives Journal **32**(810): x1.

[385] Bristol Royal Hospital for Sick Children and Women (1945). "Appointments." Nursing Times **03/03/1945**: Supplement v.

[386] Birkenhead and Wirral Children's Hospital (1941). "Appointments." Nursing Times **12/04/1941**: Supplement v. Here, the title 'RSCN' is spelt incorrectly.

[387] During most of this period, there was a separate 'Part' of the register for fever nurses.

[388] Bell, C. (1940). "Nursing infectious diseases in the home: whooping cough and chicken pox." Nursing Mirror **03/02/1940**: 425.

[389] Welham, W. E. (1940). "Operation for strangulated hernia on a 14 day old baby." Nursing Mirror **24/02/1940**: 507.

[390] Armstrong, K. F. (1945). "The second opportunity goes." Nursing Times **21/04/1945**: 251.

[391] Editorial. (1945). "Our Children." Nursing Times **17/02/1945**: 107.

1945)[392]. In a real sense, the General Nursing Council appears to have been a council for general nurses. The Nurses Bill of 1949 allowed the GNC to close the supplementary registers at the discretion of the Minister (it also allowed male nurses to enter the general register). The Bill was welcomed by the editor of the Nursing Times (see Editorial 1949).[393] The Nursing Times supported the 'occupational imperialism' of general nursing until post-registration courses replaced pre-registration courses (so that all paediatric nurses would also be general nurses). In the event, however, the threat to paediatric nursing never materialised and by the 1950s the supplementary registers had become 'Parts' of the main Register, an act which probably reinforced the status of paediatric nursing. It seems clear that the GNC had failed to get its way with the result that far from closing the children's register, its registration status was reinforced[394]. This was partly due to the House of Lords (and specifically Lord Shepherd) insisting at the report stage of the Bill that a paragraph be inserted to the effect that the GNC could not close the mental or children's supplementary registers without *'making such provision that would enable members of the public to ascertain whether a nurse had trained in these areas'* (see Editorial 1949)[395].

Gradually, pre-registration training for paediatric nurses abandoned the 3 year RSCN training in favour of the 'comprehensive' four year SRN/RSCN programme, approved initially as experimental schemes (see Editorial 1956).[396, 397] Initially, however, the Nursing Committee at The Hospital for Sick Children, Great Ormond Street, London had opposed the scheme, being concerned (rightly as it transpired) that if nurses obtained their general registration, they would choose to work in the general hospitals[398] and also that a comprehensive training scheme would mean the demise of the RSCN qualification, this being what the Nursing Reconstruction Committee (RCN)

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[392] Anonymous (1945). "News." Nursing Times **03/11/1945**: 726.
[393] Editorial (1949). "The Nurses' Bill." Nursing Times **23/04/1949**: 1088.
[394] Arton (1992) provides a full discussion of this. Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[395] Editorial (1949). "News, The House of Lords discuss nurse training." Nursing Times **02/07/1949**: 534.
[396] Editorial (1956). "Kings College Hospital and Belgrave Hospital for Children: combined four year training for general and sick children's nursing." Nursing Times **20/01/1956**: 50.
[397] Single RSCN training at The Hospital for Sick Children, Great Ormond Street, London was terminated in 1964, replaced by the 'comprehensive' SRN/RSCN programme (see Sharp, M. (1964). "A revolution in nurse education." Nursing Times **05/06/1942**: 714-715.).
[398] Great Ormond Street Hospital Archive (1942 and 1942). Nursing Committee Record Book Number Four, entries for 14/04/1941 and 09/06/1942. London.

wanted.[399] The children's hospitals were concerned that a combined training would fail to attract people with the 'special characteristics' required of children's nurses and that in the end, a combined training might herald the end of the 'special identity' of the children's hospitals.[400] Eventually and at the extreme displeasure of the College of Nursing[401], the recommendations of the Nursing Reconstruction Committee were never implemented[402]. Instead of the above, four year SRN/RSCN courses began to be approved by the GNC. However, this did not stop the discrimination against paediatric training. In 1959 the editor of the Nursing Times (Editorial 1959)[403] discusses a new comprehensive course at The Hospital for Sick Children, Great Ormond Street, London and the Middlesex hospital, heading the short news item as *'General training based at a children's hospital'* (see also Armstrong 1945)[404].

It is clear that the GNC, the RCN, Nursing Times and general nursing as a whole wanted the demise of paediatric nursing but that both the children's hospitals and the British Paediatric Association[405] wanted the RSCN qualification to be retained.[406] In the end the political pressure of the latter two organisations was to win the day and the RSCN qualification was retained. It is probably also the case, that placing the nursing register and ultimately the control of the nursing profession within statute (1919 Nurses Act) and in the hands of the government, seriously weakened the ability of the GNC and other agencies to effect change and that this played into the hands of the politically weak discipline of paediatric nursing.

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[399] Great Ormond Street Hospital Archive (1942). Entries for 10/10/1942 and 23/07/1942. Nursing Committee Record Book Number Four. London.

[400] Great Ormond Street Hospital Archive (1942). Entries for 10/10/1942 and 23/07/1942. Nursing Committee Record Book Number Four. London.

[401] Great Ormond Street Hospital Archive (1942). Entry dated 03/05/1943. Nursing Committee Record Book Number Four. London.

[402] Great Ormond Street Hospital Archive (1944). Entry dated 11/01/1944. Nursing Committee Minute Book Five: 1944. London.

[403] Editorial (1959). "General training based at a children's hospital." Nursing Times **04/12/1959**: 1221.

[404] Armstrong, K. F. (1945). "The wider basic training." Nursing Times **10/03/1945**.

[405] The BPA was the paediatricians professional body which became independent of the Royal College of Physicians in the 1990s after which it became known as the Royal College of Paediatrics and Child Health. Neither organisation represented paediatric surgeons.

[406] See British Paediatric Association (Royal College of Child Health and Paediatrics) (1945). Memorandum on the future of sick children's nursing. London, British Paediatric Association. Also see Great Ormond Street Hospital Archive (1945). Entry dated 12/06/1945. Nursing Committee Record Book Number Four: 1942. London.

The subjugation and political weakness of paediatric nursing through most of the period between 1920 and 1970 is more than clear. Paediatric nurses were not only subject to their medical 'peers' but the existence of their discipline was being challenged by general nursing. On the 'shop floor' this probably had the effect of limiting the influence of paediatric nurses and strengthening that of general nurses. It was perhaps general nursing, which chief among all the nursing disciplines championed the cause of 'professionalism' but which in practice was little more than a construct of servanthood to medicine.

Conclusion

It can be seen that the relationship between paediatric nurses and doctors was one that had been fashioned in history. Doctors were educated men and were therefore considered superior in the workplace to the less well educated female nurses. Davies (2000)[407] argues that doctors were taught to be independent and interventionist whereas nurses were taught to be passive and responsive. Steppe (1997, p. 12)[408] found that of nurses in Germany '*Serving, giving of oneself, self-sacrifice and obedience became the intrinsic values of middle-class women's nursing ... self-awareness and self-determination were declared to be inappropriate and irreconcilable with the "ideal" professional posture and stance.*' Davies (2000) suggests that that original relationship created an hospital culture which Davies, Salvage and Smith (1999)[409] argues continues even to this day.

It has been argued here that paediatric medicine and paediatric nursing possess an history and an orientation to practice that is probably a lot more intimate than either discipline cares to accept. The two disciplines are separately distinguished by nursing's unwillingness to accept a problem solving role and medicine's struggle for health care supremacy. This is a situation which was mirrored in most other European countries.

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[407] Davies, C. (2000). "Getting professionals to work together." British Medical Journal **320**: 1021-1022.
[408] Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[409] Davies, C., J. Salvage and R. Smith (1999). "Doctors and nurses: changing family values?" British Medical Journal **319**: 463-464.

Steppe (1997, p. 11)[410] reports of German nursing in the same period, that the development of nursing

'was supported by male medical doctors ... the price that women had to pay for the support of men was the subordination of nursing to the absolute domination of medicine and the accompanying surrender of any shred of independence'.

Medicine needed nursing, but it was (and perhaps remains) important to it that there should exist a significant divide between the two disciplines. Nursing was, by its nature and its history, the non-scientific branch of medicine. If medicine came too close, its own tenuous hold on science might be uncovered for what it was. At the same time, the reality of nursing's growing use of science and scientific principles might present some very uncomfortable competition. In the end, however, the failure of nursing to achieve an equivalent professional status to medicine may have been the result of the almost total female dominance of the discipline. As Maggs (1983 argues)[411] nursing was seeking professional status at a time when female occupations were not seen to be capable of meeting the criteria of professionalisation.[412]

It should not be considered that the relationship between medicine and nursing was that of captain and his sergeant, even though this might sometimes be indicated by the language of respect. In practice, the relationship was more collaborative, even accepting the hierarchical relationship between the two. This is partly because both disciplines did have a professional engagement with the same goal. They each exercised different skills but doctors and nurses were mutually dependent upon each other for the achievement of their stated goal. This was and perhaps remains a complex relationship that is easily misconstrued.

Paediatric nursing possessed no sense of allegiance to general nursing but it was controlled by it. General nurses successfully infiltrated paediatric clinical areas and

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[410] Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[411] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

[412] It is not argued here that paediatric nursing was seeking professional status as in 'autonomy' from Medicine but only that it was seeking a closer working relationship with Medicine.

usually succeeded in obtaining key positions within paediatric nursing. This occurred because of what Maggs (1983, p. 26)[413] referred to as the 'occupational imperialism' of general nursing which had widespread support from the nursing press, the GNC, nursing administration and of course, from general nurses themselves. The resulting lack of occupational closure had a seriously negative impact on paediatric nursing, causing it to lose control of its own sense of direction and future and making it appear as a less intellectual and less professionally developed occupational discipline.

It does appear that nursing was happy to take second place in a rapidly developing hierarchy of health care disciplines led by medicine. Questions remain to be asked about what impact this had on the nurses' relationship with the sick child and the child's family. In the same way, work is outstanding on the effect that this unusual working relationship had on the practice of paediatric nursing: in particular, the degree to which nursing's divided loyalty between holism (care) and its allegiance to medicine (and its other 'masters') had on its ability to provide sick children and their families with the intervention not provided by other health care workers. Specifically, questions still need to be asked about the relationship between the control of paediatric nursing by other occupational groups and the degree to which children and their parents received care that was orientated to their psychological, social, developmental and individual needs.

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[413] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

Conclusion to the literature review

This review of the literature has shown that paediatric nursing almost certainly performed a central function in terms of the care of the sick child. It is apparent, however, that paediatric nursing cannot be seen outside its interrelationship with medicine. Paediatric nurses worked for sick children but they also worked for their general nurse managers and their doctors. This was a sociologically rich and complex relationship which is easily misunderstood.

It is suggested here that paediatric nurses acted as servants to both their medical 'colleagues' and to their nurse managers. This relationship had its roots in nursing's background as a lower middle class discipline which had a female only workforce and which was institutionalised by the hospital regime. Paediatric nursing was not a profession even though its commitment to patients and its code of conduct does provide an image of professionalism. Nurses followed orders and subjugated themselves to others, particularly senior doctors and nurse managers. Undoubtedly nurses did think, reason and problem solve but only within the tight constraints of regimens and procedures and they did not make their analyses public or constructive in terms of the development of nursing practice. More importantly, nurses did not try to change the rules, rather they were happy to leave responsibility to others. In this way, nursing was a psychologically comfortable discipline. In all probability, nurses did 'care'[414] for their sick and vulnerable patients but the degree to which they cared was militated against by their perceived duty to doctors and managers. In this way, notions of 'care' and 'management' became confused.

The above is perhaps unfortunate because paediatric nursing commenced its life with a purely holistic orientation[415] and one which freely accounted for the sick child's psychological, social and spiritual needs. In this early period, however, medicine wanted and needed nursing to provide this simple, holistic 'care'. This would change

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[414] Meaning here 'have a sense of affection for'.
[415] See for example, Nightingale, F. (1886). Letter sent 09/03/1886. A. Hepworth, http://clendening.kumc.edu/dc/fn/2hpwrth1.html.

as medicine became a more technical discipline and doctors began to require more of nurses than the motherly care of their small charges. Because senior doctors were held in such respect by nurses, the former's changing requirements were met by nurses without question. Perhaps nurses even enjoyed the privilege of working more closely with such important people.

There can be little doubt that as Cherry (1996)[416] points out, the quality of medical provision suffered because of the lack of emphasis on social medicine. Nursing followed medicine instead of advocating for the child patient, in so doing it shared the narrow vision of medicine. Porter (1997)[417] argues that medicine's claims to both objectivity and its public interest orientation are also suspect, Cherry (1996[418]) suggests that it is only in this way that medicine's professional aims and the wider public health issues could ever have come into conflict, as they often did. The influence that medicine had upon nursing must be blamed for much that went wrong. Cherry (1996)[419] rightly points out that nursing continued to be subject to medical controls, non hospital work and specialist nursing were neglected because their focus was removed from medicine's core power base. Standards of health care did rise throughout this period but there was nevertheless a lack of investment in nursing and nurse training was abused and misused as a cheap source of labour as apposed to the investment in the future that is should have been. Cherry (1996)[420] suggests that the institutional life imposed on nurses was centred on the needs of doctors which resulted in care that was unsympathetic to the needs of patients. In addition, the developing nursing professionalism even failed to account appropriately for the needs of nursing and nurses themselves. Nurses may be blamed for the lack of humane care provided to children during this period,[421] for after all, that care should have been provided by nurses. However, it should be clear that doctors, for reasons ill or otherwise, provided

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[416] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[417] Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.

[418] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[419] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[420] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[421] See for example, Swanwick, M. (1983). "Platt in perspective." Nursing Times 79(2): 5-8.

the professional role model and manager role for nurses. Again, Cherry (1996, p. 38)[422] holds no punches in blaming doctors for much that went wrong. He argues that '*self enhancing and self-regulatory aspects of medical professionalism'* [resulted in the] 'interposition of nurses, loss of privacy, unsocial waking hours, waiting, noise and restrictions, all in the name of efficiency'. In addition, the doctor was portrayed as more valuable than the patient and axiomatically, the patient as less than valuable, less than important.

Paediatric nursing, however, did not simply exists as a relationship with others, as part of an hierarchy or as a factor in the struggle for medical dominance. Questions should be asked about the impact of nursing and the effect that this complex set of relationships had upon its practice with sick children and their families. These are broad areas of questioning that have largely gone unanswered, and even unquestioned until now. The research discussed in the following chapters will consider the impact that paediatric nurses had upon their child patients and specifically on the degree to which the nursing position in the hierarchy of health care effected their practice.

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[422] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

DESIGN AND METHODOLOGY

Chapter 4: study design and methodology

This is a study conducted between 1996 and 2001 and which focuses on the social history of British paediatric nursing between 1920 and 1970. The study employs oral histories of past child patients and past nurses. This material is supplemented by a literature search with data collected from hospital and other archives[423], an approach described by Clifford (1998)[424]. The study is primarily concerned with the common experiences of paediatric nursing and specifically on identifying the effect of paediatric nurses' servanthood and institutionalisation on sick children and their nurses.

Key themes were developed from the data and validated by the participants. The key themes were then content analysed to identify themes common to the participants. These key themes were then exposed to discussion.

Background

There exists little coherent work on the history of paediatric nursing in Britain for the first half of the twentieth century[425]. Examples that do exist are mostly either concerned with the history of a specific children's hospital[426] or are anecdotal accounts of individual's experiences of paediatric nursing,[427] or are quantitative, survey like

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[423] The following archives were searched: Alder Hey Children's Hospital, Liverpool; The Hospital for Sick Children, Great Ormond Street, London; Royal College of Nursing, Edinburgh; The Wellcome Library, London; Hospital for Sick Children, Derby; The Yorkhill Hospitals Archive, Glasgow.

[424] Clifford, C. (1998). "Capturing nursing memories." International History of Nursing Journal 3(4): 36-42.

[425] But see Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine. Lomax provides an account of the development of children's hospitals. Also see Duncombe, M. A. (1979). A brief history of the Association of British Paediatric Nurses 1938-1975. London, Association of British Paediatric Nurses. Duncombe provides a history of the Association of British Paediatric Nurses. Also see Saunders, D. (1982). Sick children's nursing. Nursing, midwifery and health visiting since 1900. P. Allan and M. Jolley. London, Faber and Faber.

[426] For example, Earl, E. (1996). Queen Mary's Hospital for Children. Knebworth, Able Publishing Services.

[427] For example, Totterdell, A. (1990). Five and a half times three: the short life and death of Joe Buffalo Stuart. London, Hamish Hamilton.

studies which usually fail to determine any long lasting effect of traumatic events in childhood (see for example Ventegodt 1999)[428]. Even looking at broader issues, Hendrick (1997)[429] remarks that there exists a paucity of material in relation to the social history of children since 1800, especially in relation to working class children. Hendrick (1997)[430] also notes that there is a particular lack of children's social history data covering the period from 1914 to the present day. This appears to be commensurate with the published history on paediatric nursing for which much seems to be known about the few decades following it's beginnings c. 1850 (see for example Lomax 1996[431]) but very little between c. 1920 and 1970. From about 1970, nursing had increased its academic status and as a result nurses were writing in professional journals, in addition, the period still exists in living memory. The period between 1920 and 1970 is not only much unknown but it is also particularly interesting because it is characterised by the separation of sick children from their parents[432 433 434 435 436]and by a system of 'care' which downplayed the child's emotional and social needs.[437 438] Considering this last, it is strangely perplexing that Hendrick (1997, p. 7)[439] should argue that *'there is a relative neglect by historians of nearly all the features of children's lives (especially their family lives) during the inter-war years and from 1945 onwards'*. In the same way and from a medical history perspective, Cherry

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[428] Ventegodt, S. (1999). "A prospective study on quality life and traumatic events in early life: a 30 year follow up." Child: Care, Health and Development **25**(3): 213-221.

[429] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[430] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[431] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[432] Ainsworth, M. D. (1962). The effect of maternal deprivation: a review of findings and controversy in the context of research strategy. Deprivation of maternal care. World Health Organisation. Geneva, World Health Organisation.

[433] Boorer, H. (1968). "Young children in brief separation." Nursing Times **19/07/1968**: 996.

[434] Bowlby, J. (1956). "The effect of mother child separation: a follow up study." British Journal of Medical Psychology **29**: 111.

[435] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

[436] Hall, D. J. and M. Stacey (1979). Beyond separation: further studies of children in hospital. London, Routledge and Kegan Paul.

[437] Mrazel, D. A. (1984). Effects of hospitalization on early child development. Continuities and discontinuities in development. R. N. Emde and R. J. Harmon. London, Plenum Press.

[438] Swanwick, M. (1983). "Platt in perspective." Nursing Times 79(2): 5-8.

[439] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

(1996)[440] argues that some aspects of medicine have been researched much more fully than have others. Paediatric medicine and nursing have sometimes been regarded as one of the 'Cinderella' disciplines that have been exposed to surprisingly little attention by medical researchers.

Rafferty et al (1997, p. 1)[441] argue that *'nursing history is becoming a robust and reflective area of scholarship from an internalist and triumphalist form of professional apologetics'*, even so, the history of paediatric nursing in the first two thirds of the twentieth century is still very much unmapped. Unravelling the history of this area of work is complicated by the fact that practitioners of the discipline have not been noted for professional publication (Brooks 2000)[442] and it will be argued that the discipline itself has for much of its existence been dominated by the more influential disciplines of medicine and general nursing (see Arton 1992)[443]. In addition, paediatric nursing in common with general nursing, practised its art and science (Darbyshire 1999)[444] with a minimal use of tools and so left little evidence of its varied activities (see Hall 1997)[445].

While mapping the history of paediatric nursing is complicated by the above, it is nevertheless worthy of study (Lait 2000 [446], Viner 2000 [447]). Paediatric nursing can be seen to be both reflective (and therefore informing) of changing social attitudes toward children and families and may in its turn have contributed to social change. The care of sick children probably continues to be an emotive and salient experience of a large proportion of the population. There can be no doubt that illness, trauma and the

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[440] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[441] Rafferty, A. M., J. Robinson and R. Elkan (1997). Introduction. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[442] Brooks, J. E. (2000). "Ghost of the past: capturing history and the history of nursing." International History of Nursing Journal 5(2): 36-41.

[443] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[444] Darbyshire, P. (1999). "Nursing, art and science: revisiting the two cultures." International History of Nursing Journal 5(3): 121-123.

[445] Hall, L. A. (1997). Nursing in the archives: archival sources for nursing history. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[446] Lait, M. E. (2000). "The place of nursing history in the undergraduate curriculum." Nurse Education Today **20**(5): 395-400.

[447] Viner, R. and J. Golden (2000). Children's experiences of illness. Medicine in the 20th Century. R. Cooter and J. Pickstone. Amsterdam: 575-588.

threatened or actual death of children are emotive and powerful experiences for those who live with and care for young people. In addition, the care of sick children exists on a concept base which lies near to the core defining principles of civilised society.[448] Gittins (1998)[449] presents evidence of the many ways in which the mapping of adult society cannot be complete without an understanding of childhood and the impact that it makes on the social world. Society is nothing without children. It is therefore axiomatic that any study of society must take account of children and the history of their care. Viner (2000, p. 576) [450] suggests that:

'It remains for historians to excavate the historical experiences of children's encounters with illness and suffering. And while this task has particular methodological and theoretical challenges, it can no longer be ignored. Such investigations promise to yield not only a deeper understanding of how children experience illness, but to enrich our knowledge of what Roy Porter called, "sufferers history" in which experience is primary, in which non-professionals are understood as the primary agents of care, and in which the intellectual agenda encompasses beliefs and conditions that medical historians have traditionally overlooked.'

Hendrick (1984, p. 88)[451] suggests of children that *'The inability to act politically on their own makes them almost invisible people, and this in turn lessens their attractiveness to historians who see them as passively experiencing economic, social and political change.'* And that (p. 96) *'Critical history ... needs to acknowledge ... that children and adolescents are active subjects within historical change, and that they live within generational, as well as social and political structures, in which power, authority and rights are a matter of continuous struggle.'* In a later work, Hendrick (1997)[452] argues that the omission of children from historical literature has

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[448] There are many texts which argue that professional nursing may have grown from societal concepts of care, see for example Donahue, M. P. (1996). Nursing: the finest art: an illustrated history. London, Mosby. Also see Ives, A. G. (1948). British Hospitals. London., Collins.

[449] Gittins, D. (1998). The child in question. London, MacMillan Press Ltd.

[450] Viner, R. and J. Golden (2000). Children's experiences of illness. Medicine in the 20th Century. R. Cooter and J. Pickstone. Amsterdam: 575-588.

[451] Hendrick, H. (1984). "The History of Childhood and Youth." Social History 9(1): 87-96.

[452] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

been purposeful and the result of ideology, attitudes and power struggles. In this way, he argues, the writing of the history of children will involve confronting the politics of age relations. In the same way, Porter (1985)[453] suggests that the history of the sufferer at the hands of medical men has remained obscured because medical historians have not been interested in, and have ignored historical patient accounts. As a result, Porter suggests that conventional medical history may be a '*major historical distortion'* (p. 175) and that (p. 175) '*In medicine's history, the initiatives have often come from, and power has frequently rested with, the sufferer, or with lay people in general, rather than with the individual physician or the medical profession at large'*. Hall (1997)[454] suggests that conventional methodologies in history should not block the way to lateral thinking, especially in relation to the use of non archival material. Porter (1985, p. 194)[455] warns that *'a people's history of health ... will show that sufferers are fertile in their resources ... as patients borrow the doctors' lines ... a peoples' history of suffering might restore to the history of Medicine its human face'*. If historical research has ignored children because of their apparent lack of political influence, so it may also be that children and perhaps children's nursing have not always been reflective of social policy. Certainly, it will be argued here that at least by the end of the second world war, children's nursing had become asynchronous with British society's perception of the social and emotional needs of children. Nurses and doctors seem to have been relatively free agents and to have created a micro-society, especially within the nation's hospitals. Rafferty et al (1997, p. 3)[456] go as far as to suggest that nursing existed as '*a cross class and cultural conduit into the lives and social spaces of groups otherwise beyond the reach of agents of social authority'*.

It is proposed here that paediatric nursing has been an human activity based upon the relationship between two or more people. Material evidence of this relationship is

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[453] Porter, R. (1985). "The patient's view: doing medical history from below." Theory and Society **14**: 167-74.

[454] Hall, L. A. (1997). Nursing in the archives: archival sources for nursing history. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[455] Porter, R. (1985). "The patient's view: doing medical history from below." Theory and Society **14**: 167-74.

[456] Rafferty, A. M., J. Robinson and R. Elkan (1997). Introduction. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

always likely to be lacking (Hall 1997[457], Foster and Sheppard 1980[458]) and is probably unrepresentative of the events and experiences which actually took place. The minutes of hospital committees and even the records of nurses themselves are unlikely to portray the richness of the human experiences which comprised the practice of paediatric nursing (see Callery and Luker 1996[459] and Summers 1987[460]). For this reason, the research discussed here focuses on the real life recollections of people who once played the role of paediatric nurse or patient.

It is no longer possible to obtain oral histories for paediatric nursing from before about 1920. Largely, the oral history of paediatric nursing prior to this time has already been lost. This, however, indicates the importance of pursuing the history of paediatric nursing in the twentieth century before even more of it becomes unobtainable.

Rationale

Whilst studies of the history of nursing have been conducted, no major work has been undertaken on the history of *paediatric* nursing in this country. Rafferty (2000, p. 520)[461] suggests there have been important differences between the reality of nursing and that portrayed by nursing leaders and managers:

> *'The aims, ambitions and strategies of the leadership [of nursing] are much better known than those of the clinical nurses and, least of all, patients.'*

Abdellah and Levine (1986)[462] argue that historical research in nursing exists as a neglected area and that it should receive a higher priority from nurse researchers.

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[457] Hall, L. A. (1997). Nursing in the archives: archival sources for nursing history. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[458] Foster, J. and J. Sheppard (1980). Archives and the history of nursing. Rewriting nursing history. C. Davies. London, Croom Helm.

[459] Callery, P. and K. Luker (1996). "The use of qualitative methods in the study of parents' experience of care on a children's surgical ward." Journal of Advanced Nursing **23**(2): 338-345.

[460] Summers, A. (1987). "Living memories." Nursing Times and Nursing Mirror **83**: 16-17.

[461] Rafferty, A. M. (2000). Nurses. Medicine in the twentieth century. R. Cooter and J. Pickstone. Amsterdam, Harwood Academic Publishers: 519-529.

[462] Abdellah, F. G. and E. Levine (1986). Better patient care through nursing research. New York, Macmillan.

Burns and Grove (1993 p. 77)[463] write '*There seems to have been no examination of historical patterns of nursing practice ... We have no clear picture of how nursing practice has changed over the years.*' Paediatric nursing has probably never yet told its own story.

The role of paediatric nurses has probably changed considerably since the time that the discipline began to be organised professionally[464]. Identifying what paediatric nursing existed as should help clarify what it is now and where its future could most usefully lie.

Paediatric nursing may have current opportunities. However, the size of its practice area has been diminishing since the middle of the 20th century when the toll of infectious diseases meant that child morbidity was higher than it is today. There is an argument for the development of a generic and multi-skilled nursing professional. In this way the existence of paediatric nursing at registration level may be being questioned. A greater understanding of the discipline's history might enable a more informed and rounded analysis of what the future of paediatric nursing should be.

Perhaps the purpose of historical research is the reconstruction of an aspect of history which is undertaken objectively and without bias. Such an enquiry should be critical and systematic and perhaps it is these two qualities of 'critical' and 'systematic' that qualify it as belonging to the scientific paradigm. The value of historical research lies, according to Hill and Kerber (1967)[465] in the ability to seek historical solutions to contemporary problems, to see contemporary trends in perspective, to see the effect of culture and of contemporary events and to re-evaluate assumptions made about the past. Notter (1972 p. 483)[466] argues that

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[463] Burns, N. and S. K. Grove (1993). The practice of nursing research: conduct, critique and utilisation. Philadelphia, WB Saunders Company.

[464] It is suggested that this began with the opening of the first children's hospital (The Hospital for Sick Children, Great Ormond Street) in 1852.

[465] Hill, J. E. and A. Kerber (1967). Models, methods and analytical procedures in educational research. Detroit, Wayne State University Press.

[466] Notter, L. E. (1972). "The case for historical research in nursing." Nursing Research **21**(6): 483.

'A major contribution of historical enquiry is in the development of a broader, more complete perspective to enhance our understanding of the present and our approach to the future.'

Specific focus

This study focuses on the following five domains of paediatric nursing. These domains orientated the direction of the oral histories to the subgroups of past child patients and past paediatric nurses. The domains were also used to categorise material collected from hospital and other archives:

- the nature of the relationship between paediatric nurse, child and members of the immediate family;
- the relationship of paediatric nurses' work to that of doctors, senior nurses and others;
- the practical nature of the work of the paediatric nurse, including what paediatric nurses did and their views on this in terms of the quality of their practice;
- the nature of decision-making and professional freedom enjoyed by paediatric nurses;
- the past child patient's recollection of the daily routine in hospital, what happened to them and the aspects of their stay that were most and least enjoyable.

There are two subgroups:

- paediatric nurses who worked between 1920 and 1970;
- adults who were once sick children nursed by paediatric nurses between 1920 and 1970.

List of Participants

Code	Nurse / Child	Period	Comment
A	Nurse	1956-1959	London
B	Child (5-6 years)	Child 1948-49 Nurse early 1960s	Yorkshire
C	Child (6years) Nurse	Child 1950s Nurse from 1959	South of England
D	Nurse	Started 1967	Wales
E	Nurse	c. 1939	London
F	Nurse	1950	Yorkshire
G	Nurse	From 1953	London
H	Nurse	From 1958	Yorkshire
I	Nurse	From 1954	Sussex and Nottinghamshire
J	Child (10 years) Nurse	1962	Scotland
K	Nurse	1968	The West Country and Sussex
L	Nurse	From 1953	London
M	Nurse	1945-1951	Essex
N	Nurse	From 1964	London, Scotland and Yorkshire
O	Nurse	From 1963	Yorkshire and Lincolnshire
P	Child (10 years)	1948	Lincolnshire
Q	Child (8 years)	1935	Yorkshire
R	Child (c. 10 years)	1950	Retained in confidence
S	Child (4 and 8 years)	1936	Lincolnshire
T	Child (4-5 years)	1934	Lincolnshire
U	Child (11 years)	1936	Lincolnshire
V	Child (5 years)	1940	Lincolnshire
W	Child (5-6 years)	1957	Yorkshire
X	Child (10 years)	1930	Lincolnshire
Y	Child (7 years)	1957	Yorkshire
Z	Child (8 years)	1953	Lancashire
AA	Child (5 years)	1965	Yorkshire
AB	Child (3-4 years)	1966	Cumbria
AC	Child (2 ½ and 5 years)	1965	Yorkshire
AD	Parent (child 4-5 years)	1964	Lincolnshire
AE	Nurses (group)	1950s	Yorkshire

Design and methodology

This study employs oral histories. The design follows that of a qualitative ethnographically driven explorative study (Starrin and Dahlgren 1997).[467] Yow (1994, p. x)[468] makes the point that '*the in-depth interview is a research methodology with standards of excellence and guidelines for achieving these*'. Yow (same reference) goes on to discuss the way in which oral interviews can be appropriately employed where there is '*an interest in how the respondents interpret (their) experience ..*' (p. 1). In this way the ethnographically founded oral history is not simply focused on reporting facts about culture but is rather orientated toward an interpretation of culture made through the analysis of the experience of individuals (see Darbyshire 1991)[469]. In advocating the use of oral histories, Hendrick (1997)[470] suggests that there has been little work so far within the study of the social history of children that has been derived from children themselves.

One of the main goals of an ethnographical approach is to shift the focus of power away from the researchers and to share it equally with the subject in a way which achieves a common respect and acknowledged validity. In this way, the subject's experiences are accepted as having an inherent validity, while at the same time, the goals of the research (stemming from the researcher) are accepted by the subject. Holloway and Wheeler (1996)[471] suggest the terms 'Trustworthiness' for qualitative research, rather than the quantitative concepts of 'reliability' and 'validity'. Yow (1994, p. 2)[472] considers the relationship between the researcher and the subject as sharing an equal part in the process of laying bare intra-personal truths. Such a study requires a co-operative intention to work toward the same or mutually acceptable goals. This co-operation overcomes some of the main problems with 'hard' but potentially invalid data from quantitative studies.

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[467] Starrin, B. and L. Dahlgren (1997). Along the path of discovery: qualitative methods and grounded theory. Sweden, Studentlitteratur.

[468] Yow, V. R. (1994). Recording oral history: a practical guide for social scientists. London, Sage Publications.

[469] Darbyshire, P. (1991). "Nursing reflections." Nursing times 87(36): 27-28.

[470] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[471] Holloway, I. and S. Wheeler (1996). Qualitative research for nurses. Oxford, Blackwell Science Ltd.

[472] Yow, V. R. (1994). Recording oral history: a practical guide for social scientists. London, Sage Publications.

It is clear that generalisability is not a goal of this kind of study. However, Yow (1994, p. 5)[473] argues that '*qualitative research does not involve manipulation of a few variables. Rather ... this kind of research is inductive, and a multiplicity of variables and their relationships are considered not in isolation but as being interrelated in the life context'*. Holloway and Wheeler (1996)[474] suggest the term 'transferability' for qualitative studies to describe the way in which qualitative research can still be made relevant to the wider population. In this way, qualitative studies do not claim representativeness but may still claim that the results infer a relationship with the wider population.

Qualitative studies enable a freedom for the subject to answer as he or she chooses and to attribute meanings to the experiences being discussed, qualities that can rarely be achieved with quantitative research. The subject may interject new topics and in this way new hypotheses can be formed 'on the hoof'. Strauss and Corbin (1990)[475] argue that the data collection and analysis are on-going and are therefore similar to the test-retest approach to establish reliability in quantitative research. It can be seen that this methodology seeks a quality and complexity of data which does not necessarily lend itself to quantitative analysis (see also Thompson and Perks 1993)[476].

Although the concepts of 'oral history' and 'ethnography' are close to that of 'grounded theory' (see Glaser and Strauss 1965[477], Strauss and Corbin 1997[478] and Strauss and Corbin 1999[479]) there is an important distinction to be made. Grounded theory demands the avoidance of preconceptions whereas some preconceived focus for the oral histories can sometimes be argued to be useful (Wiener and Wysmans

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[473] Yow, V. R. (1994). Recording oral history: a practical guide for social scientists. London, Sage Publications.
[474] Holloway, I. and S. Wheeler (1996). Qualitative research for nurses. Oxford, Blackwell Science Ltd.
[475] Strauss, A. and J. M. Corbin (1990). Basics of qualitative research: grounded theory, techniques and procedures. London, Sage Publications.
[476] Thompson, P. and R. Perks (1993). An introduction to the use of oral history in the history of medicine. London, The national life story collection (British Library).
[477] Glaser, B. and A. Strauss (1965). "The discovery of substantive theory: a basic strategy underlying qualitative research." American Behavioral Scientist 8(6): 5-12.
[478] Strauss, A. and J. M. Corbin (1997). Grounded theory in practice. London, Sage Publications.
[479] Strauss, A. and J. M. Corbin (1990). Basics of qualitative research: grounded theory, techniques and procedures. London, Sage Publications.

1990).[480] This study does employ a framework of concepts around which the data collection was modelled. The avoidance of such a framework may be appropriate for some studies but it is argued here that for the history of paediatric nursing to be initiated, some conceptual parameters are required. These delineators may be tested by the current research so that they can be modified for future explorations of this subject area.

Validity and reliability

Mouly (1978)[481] argues that there are some ways in which historical research is not characteristic of most forms of scientific study, especially where there is no ability to record direct observations of events. Rather, historical research depends on reports and other indirect observations which may be invalid, biased or simply untruthful. In this way, historical research maps out peoples' written or verbal reports of events, validity exists in the mapping of the report. There is sometimes no way of demonstrating the objective validity of the events themselves although an attempt may be made to substantiate data with that from other sources. However, this situation is much the same as any which employs an human interpretation of events. In this way, any study which involves the use of an interview or questionnaire can be argued to be historical and to share the qualities, limitations and perhaps advantages of an historical design. In the same way, the study of geology rests not on direct observation (of the ice age) but on present day evidence of events that took place in history. Geological data is not 'cut and dry' but may contain data that can lead to a misinterpretation of the past. Abdellah and Levine (1986 p. 204)[482] argue that historical research and the methodologies employed by the natural sciences are in fact similar in that they both '...*deal with discovery, verification, categorisation and interpretation of facts and events.*'

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[480] Wiener, C. L. and W. M. Wysmans (1990). Grounded theory in medical research: from theory to practice, Swets and Zeitlinger.

[481] Mouly, G. J. (1978). Educational research: the art and science of investigation. Boston, Allyn and Bacon.

[482] Abdellah, F. G. and E. Levine (1986). Better patient care through nursing research. New York, Macmillan.

The notion of internal and external validity have corollaries in historical research and have been referred to as internal and external 'criticism' (see Cohen and Manion 1989 p. 57)[483]. External criticism relates to the authenticity of the data while internal criticism relates to the accuracy of the data. Abdellah and Levine (1986 p. 204, same reference) make the point that '*Historical research must pass the same rigorous tests of validity and reliability as [do] other forms of research.*'

Holloway and Wheeler (1996)[484] suggest that research should be judged in terms of

- 'trustworthiness' - rather than 'reliability and validity';
- 'Dependability' - the research process follows accepted standards;
- 'Confirm ability' - the reader is able to assess the adequacy of the research process and judge whether the findings were derived directly from the data.

It is argued here that while quantitative research clearly has an important part to play in current research activities, there are ways in which it fails to provide the material required for further understanding of the history of nursing. In contrast, Higonet (1998)[485] has provided an account of the social history of childhood based wholly on paintings, photographs and other images of children. As Maggs (1983)[486] has shown the usefulness of novels in historical research, Porter (1985)[487] suggests that historians should use such intrapersonal materials as prayers, poems, folklore etc. and that in doing so *'there is no reason why the history of the sick should prove any more intractable than the history of the labouring classes .. or any other history "from below", in fact it should be easier'* (p. 183). Porter (1985)[488] suggests that the use of personal accounts would tell us more about the *'communal hearts and minds of the sick'* (p. 183). Personal experiences are important where research focuses on what people did, perceived and experienced. The social world is not so much about what happened, as why these events took place, their aetiology and their background. Social

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[483] Cohen, L. and L. Manion (1989). Research methods in education. London, Routledge.
[484] Holloway, I. and S. Wheeler (1996). Qualitative research for nurses. Oxford, Blackwell Science Ltd.
[485] Higonnet, A. (1998). Pictures of innocence, the history and crisis of ideal childhood. London, Thames and Hudson Ltd.
[486] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.
[487] Porter, R. (1985). "The patient's view: doing medical history from below." Theory and Society 14: 167-74.
[488] Porter, R. (1985). "The patient's view: doing medical history from below." Theory and Society 14: 167-74.

events are caused by people, not just their hands and their feet but their experiences, their values, their joys and their tragedies. No questionnaire nor diligent search of the archives can ever find or map these things. If the approach to this present study may seem a little foreign to traditional historians, it may be pertinent to consider the claim of Rafferty et al (1997)[489] who suggest that historical research into nursing needs to encourage a cross fertilisation of ideas between nursing, medicine, women's studies etc. and that *'as with the history of medicine, nursing has a hybrid histeriographical heritage, one that is porous and permeable to a matrix of influences'* (p. 2).

Ethical considerations

The study is considered to present no more than a 'minimal risk' as defined by the Royal College of Physicians (1990)[490]. The study is also designed to be compliant with the recommendations of the Royal College of Child Health and Paediatrics (1992)[491], Brearley S (1990)[492] and the Medical Research Council (1992)[493]. A review of the relevant ethical issues was undertaken by Jolley (1995)[494]. However, there is considered to be some risk in providing an expectation that people will communicate memories that may be emotionally charged. For this reason the following safeguards were employed:

- all subjects were told that while their co-operation with the study was welcomed, they did not need to be part of the study and that having agreed to be part of the study, they were free to decline further participation at any time. If participation or further participation was declined by the subject, the decision

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[489] Rafferty, A. M., J. Robinson and R. Elkan (1997). Introduction. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[490] Royal College of Nursing (1993). Ethics related to nursing research. London, Royal College of Nursing.

[491] British Paediatric Association (Royal College of Child Health and Paediatrics) (1992). Guidelines for the ethical conduct of medical research involving children. London, Royal College of Child Health and Paediatrics.

[492] Brearley, S. (1990). Patient participation: the literature. London, Royal College of Nursing.

[493] Medical Research Council (1992). Responsibility in investigations on human participants and material and on personal information. London, Medical Research Council.

[494] Jolley, M. J. (1995). "Forging the way ahead: obtaining consent for paediatric nursing research." Child Health **2**(5): 202-206.

to do so was not challenged by the researcher and no further attempt was made to ensure data collection from that subject within the life of the study;

- if the researcher considered that while the subject has not voiced or communicated a desire to decline further participation but that notwithstanding this last the subject appeared to wish the data collection to be terminated, any attempt to collect data from that subject was terminated by the researcher and was not recommenced within the life of the study;
- no person under the age of 18 years was included in the study;
- all subjects were given the opportunity of being provided with a summary of the research outcomes (see Royal College of Nursing 1993)[495];
- the data collection was not commenced until written approval had been obtained from the Local Research Ethics Committee (see appendix).

Recruitment and sampling

It is not intended that this study should be confined to a particular hospital or even a particular region of the country. This in any case would not have been possible, largely because of the traditional occupational and geographical mobility of nurses. In addition, it is widely recognised that paediatric nursing (and other key health care disciplines) possessed a nation-wide culture and professional orientation which meant that nurses could move to the opposite end of the country and work much as they had done before. Notions of 'paediatric nursing in East Anglia' and paediatric nursing in 'Hertfordshire' would have been, and are still alien to nurses and nursing. Paediatric nursing was and remains a national (even international) and not a regional entity. This last is testified by the ease by which nurses gained employment abroad. Indeed, nursing was used by people as a qualification with which they could travel. As a result, nursing was (and remains) a discipline characterised by a high degree of occupational mobility (see Hutt 1983).[496] This last notwithstanding, hospital archive data was collected at four geographically distant locations (Liverpool, Glasgow, Derby and

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[495] Royal College of Nursing (1993). Ethics related to nursing research. London, Royal College of Nursing.

[496] Hutt, R. (1983). Sick children's nurses: A study for the Department of Health and Social Security of the career patterns of RSCNs. Lewis, Institute of Manpower Studies, University of Sussex.

London). The records from each hospital archive demonstrate the expected degree of micro-cultural isomorphism.

Yow (1994, p. 8) quotes Renato Rosaldo clarifying the position with regard to determining sample size in studies such as this:

> *'Ethnographers begin research with a set of questions, revise them throughout the course of inquiry, and in the end emerge with different questions than they started with. One's surprise at the answer to a question, in other words, requires one to revise the question until a lessening surprise or diminishing returns indicate a stopping point.'*

The aim, however, is to produce an in-depth analysis, rather than to ensure generalisability in quantitative terms. This is a study of those nurses and past child patients who participated in the study. It is 'their' paediatric nursing that is made subject to analysis (see Darbyshire 1991)[497]. Subjects were recruited by advertising locally and nationally (see appendix for example copies of advertisements and letters to participants).

Data collection protocols

The interviews were focused (see below) but unstructured. The interview was protocoled as follows:

Paediatric nurses

- the nature of the relationship between them, the child patients and members of the child's immediate family;
- the relationship of their work to that of doctors, senior nurses and others;
- the practical nature of the their work, including what they did and their views on this in terms of the quality of their practice;
- the nature of decision-making and professional freedom enjoyed by them.

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[497] Darbyshire, P. (1991). "Nursing reflections." Nursing times **87**(36): 27-28.

Past child patients

- the nature of the relationship between them, paediatric nurses and members of their immediate family;
- the relationship of paediatric nurses' work to that of doctors, senior nurses and others;
- the practical nature of the work of the paediatric nurse, including what paediatric nurses did and their views on this in terms of the quality of their practice;
- the nature of decision-making and professional freedom enjoyed by paediatric nurses.
- their recollection of the daily routine in hospital, what happened to them and the aspects of their stay that were most and least enjoyable.

Terminal phase of the data collection

In this phase, the researcher thanked the participant for their help before summarising what appeared to the researcher to be the salient points of the discussion. This was to enable a 'running analysis' of the data to which the participant was encouraged to play an active part. This phase was also designed to engender a further clarification of the material discussed during the interview.

Review phase of the data collection

The participant was sent a copy of the transcribed interview and the key themes which were developed from the terminal phase (above) and by content analysis. The participant was asked to read both the transcript and the key themes, check them for accuracy and add any further material as he or she considered appropriate.

That is to check:

- the accuracy of the transcription and the key themes;
- the 'usefulness' of the key themes in summarising the main points of the transcript;
- the degree to which the transcription reflected the participant's experiences;

- whether, on reflection, any new material should be added to the account;
- whether, on reflection, any existing material should be removed or changed.

If the participant made changes to the transcript, a new version was sent to the participant and the process repeated. This process took place by post although the participant was encouraged to contact the researcher should he or she wish for a face to face meeting.

Analysis

The analysis employed concepts close to that of 'content analysis'. Content analysis normally considers recurrent themes or categories contained in individual accounts or oral histories. However, any type of consistency can be used as a template for analysis, including roles played by individuals and events in peoples' experience. Consistent in any content analysis is the attempt to find common meanings to shared experiences, such as the collective use of symbols and meanings or the discovery of significant classes or categories of meaning (see Mechelen 1992)[498]. Yow (1994)[499] argues that content analysis requires both a surrender to the ideas and experiences contained in the data and sufficient discipline to view the data in terms of the units of analysis and appropriate research questions within the constraints of what is pertinent to the study.

As outlined above, at the end of each 'interview', the researcher attempted to summarise the main issues that had been communicated by the participant. The participant was then encouraged to change or add to this summary. Following the creation of the transcript, 'key themes' were developed which were weighted toward the summary with which the participant had agreed. These 'key themes', together with the whole transcript were sent to the participant who was asked to comment on both the key themes and the accuracy of the transcript. During the progress of the data

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[498] Mechelen, I. V. (1992). Categories and concepts: theoretical views and inductive data analysis. London, Academic Press.

[499] Yow, V. R. (1994). Recording oral history: a practical guide for social scientists. London, Sage Publications.

collection, the key themes were reviewed in order to determine when data saturation had occurred. This was deemed to have taken place when no new key themes were identified from subsequent 'interviews'.

After completion of the data collection, the key themes were entered in the 'NUDIST' computer application.[500] This application facilitates the development of common meanings, which were then coded.

Coding

Key themes were derived from the codes using the qualitative analysis package, NUDIST. As subsequent data were processed, the codes were refined and placed into four main categories (see the table below). 'Discrimination' relates to the discrimination of paediatric nurses and paediatric nursing in relation to general nursing. The 'role of the nurse' relates to tasks, roles and values of paediatric nurses.

Main category codes

Discipline and Hierarchy	(D+H)
Children's Experience	(CE)
Discrimination	(D)
Role of the nurse	(R)

The table below, shows the number of times the codes were assigned to the Key Themes agreed with each participant. The use of the Key Themes in this way prevented the codes being applied more than once where the participant had repeated their description of an experience. It also allowed a further refinement of the Key Themes to ensure that the analysis remained focused. However, it should be understood that the coding only provided a guide for the analysis contained in the following chapters. In this way, 'lack of emotional care' was most often expressed by the child participants. This was then examined in terms of the narrative, for meanings,

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[500] Qualitative Solutions and Research PTY Ltd. PO Box 171, La Trobe University, Post Office, Victoria 3083, Australia.

values and focus. In this way, 'visiting' is frequently mentioned by both child and nurse participants, it will be seen however, that while 'visiting' was an experience common to both groups, the two groups had very different perceptions of the role that visiting had played. Codes derived from the Key Themes showing the number of times the codes were assigned for the 'child' and 'nurse' groups in descending order.

Please note that the terms used for the codes were generated from the participants' accounts and are used to reflect the terminology and meanings of the participants.

Child		Nurse	
Lack of emotional care (CE)	69	Leading and following (R)	66
Separation (CE)	55	Lack of emotional care (CE)	56
Visiting (CE)	48	Not explained (CE)	44
Uncared for by staff (CE)	39	Visiting (CE)	40
Felt cared for / loved (CE)	38	1919 Act and GNC (D)	37
Routinised care (D+H)	35	Meat and abuse (CE)	36
Important (CE)	31	Camaraderie positive (R)	34
Anxious / scared (CE)	25	Sad (CE)	32
Long term not adapted (CE)	25	Important (CE)	30
Skills and jobs (R)	24	Felt cared for / loved (CE)	28
Discipline and hierarchy (D+H)	23	General and children's hospitals (R)	27
Emotional care (CE)	21	Nursing and medicine (R)	20
Independent thinking (D+H)	21	Happy (CE)	19
Meat and abuse (CE)	20	Uncared for by staff (CE)	16
Sad (CE)	18	Training supervised methodological (R)	15
Not explained (CE)	16	Poor physical care (D)	13
Nursing and medicine (R)	16	Pro paeds nurses (D)	13
Happy (CE)	8	Political discrimination (D)	12
Nurses busy (R)	7	Community nursing (R)	9
Pleasure and value (R)	7	Conditions of service (D+H)	8
Long term adapted (CE)	6	Interesting / exciting (CE)	6
Bored (CE)	5	Play / non routine care (D+H)	6
General nurses (D)	4	Training (R)	6

Interesting / exciting (CE)	3		Bored (CE)	5
Play / non routine care (D+H)	3		Routinised care (D+H)	5
Camaraderie other children (CE)	2		Separation (CE)	5
Conditions of service (D+H)	1		Training academically undemanding (R)	5
Examples (D)	1		Training academically difficult (R)	4
Females and males (D+H)	1		Females and males (D+H)	3
Focus of nursing (R)	1		Independent thinking (D+H)	3
Modes of organisation (R)	1		Nurses busy (R)	3
1919 Act and GNC (D)	0		Examples (D)	2
Camaraderie positive (R)	0		Focus of nursing (R)	2
Children unwanted (D)	0		Long term not adapted (CE)	2
Community nursing (R)	0		Modes of organisation (R)	2
Explained (CE)	0		Pleasure and value (R)	2
General and children's hospitals (R)	0		Responsibility high (R)	2
Hospital institution (R)	0		Training effective (R)	2
Leading and following (R)	0		Children unwanted (D)	1
Occupational closure (R)	0		Emotional care (CE)	1
Political discrimination (D)	0		Hospital institution (R)	1
Poor physical care (D)	0		Long term adapted (CE)	1
Pro paeds nurses (D)	0		Occupational closure (R)	1
Responsibility high (R)	0		Skills and jobs (R)	1
Training (R)	0		Training ineffective (R)	1
Training academically difficult (R)	0		Anxious / scared (CE)	0
Training academically undemanding (R)	0		Camaraderie other children (CE)	0
Training effective (R)	0		Discipline and hierarchy (D+H)	0
Training ineffective (R)	0		Explained (CE)	0
Training supervised methodological (R)	0		General nurses (D)	0

Critique of the design and methodology

It is one thing to develop a methodologically robust design for the here and now but another to develop one for times past. In two principal ways, the design presented here

could at least in theory be improved. The first would be to employ participants who were associated; past child patients and nurses who had shared experiences. However, this approach seems hardly possible. This last notwithstanding, it would clearly be desirable not only to identify past patients and past nurses who had a shared experience (nurses who had nursed the child patients) but that those participants be randomly selected. It should be clear, however, that such a design is almost certainly impossible to achieve. Furthermore, this present study's research goal remains limited in that it properly seeks only to identify the experiences of those people who have acquiesced to participate and it follows that they may not be representative of child patients and paediatric nurses of the past. However, these participants existed, they worked, lived and experienced and were part of the society that is represented by the calendar years of 1920-1970. This is their study, a study of them. The robust validity of this study lies in the truth that each of the participants did exist, lived, experienced and in 1999 and 2000 looked back on that experience.

Only a superficial attempt has been made here to defend the use of oral histories within nursing history research. Rather, it is argued here that the use of oral histories has now become a legitimate approach to historical research and no longer needs to be defended. Brooks (2000, p. 41)[501] puts the matter clearly;

> *'If the point of history is to try to establish some sort of understanding, surely it can only be done by interpretation, which is how much of the understanding of the here and now is achieved. It is not how it is which matters most, but how it appears to me.'*

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[501] Brooks, J. E. (2000). "Ghost of the past: capturing history and the history of nursing." International History of Nursing Journal 5(2): 36-41.

RESULTS

Chapter 5: participants' accounts

Introduction

This chapter will consider the following areas as they are reflective of the participants' accounts of paediatric nursing:

- Professional freedom and decision-making, the degree to which change in nursing was within the control of nursing;
- Generalised care and the lack of individualised care;
- The system of discipline and hierarchy; nursing's relationship with Medicine;
- The impact of emotional neutrality;
- Parents and separation;
- The long term effects of the participants' experience;
- Accounts of violence.

Professional freedom and decision-making

The system of discipline meant that there were known ways of doing almost everything. Participant C[502] argues that *'everything was done properly and by the book'* and that it was possible to 'do things properly'. Participant C argues that there would have been no point in questioning practice because the nurses knew it was as good as it could be, she argues:

> *'... we went by the textbooks. If for example a person comes in with appendicitis and they had to go to theatre. We would do the observations, we took their history, they were premeded, we went with them to theatre and in the anaesthetist's room they were anaesthetised. We went in to the theatre with them and then we brought them back into the anaesthetic room, we brought them round, then we took them back to the ward and*

[502] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.

we looked after them in the ward. That's how it was in the textbooks and we did it. You wouldn't deviate from that because it was what worked fine and the patient was recovered as a result of it. So you know we never questioned how anything could be done differently because everything was right.'

This appears to be supported by Participant P (child)[503] who presents a picture of the hierarchy with the nurse at the bottom of the hierarchy not thinking for herself but doing what she was told and having little if any professional freedom. Participant P[504] argues:

'They were following a routine, I'm not sure they thought for themselves at all ... they were dealing with an illness in the way that they had been told to be dealing with it.'

Participant E[505] suggests that decisions regarding what nursing needed to be done and the rules and regulations by which nursing was ordered were largely out of her control and were devised by other people. Participant I[506] goes one important step further and argues that independent thinking was actively discouraged. It is one thing to claim that all was known and understood, but quite another to accept that this meant active thinking was not necessary. Perhaps everything was thought to be known and understood, but Participant I's[507] observation indicates otherwise, and that in reality, the extent to which everything was known and understood took second place to the needs of the institution, to the institution's need for order and the fear that freedom of thought, even if directed toward addressing the child patients' needs, could destroy the social order. It is also interesting that Participant K[508], working in the late 1960s, has much the same recollections as Participant E[509] and Participant I and emphasises that nurses who did challenge were encouraged to change their ways.

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[503] Participant P (1948). Age 10 years. Child. Lincolnshire.
[504] Participant P (1948). Age 10 years. Child. Lincolnshire.
[505] Participant E (1930s-1940s). Nurse. London.
[506] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.
[507] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.
[508] Participant K (From 1968). Nurse. West Country and Sussex.
[509] Participant E (1930s-1940s). Nurse. London.

Participant V[510] (child) argued that the existence of the hierarchy limited the degree to which nurses could understand the needs of the children and the degree to which they could think independently. However, Participant V seems to have had difficulty reconciling the obvious control that more senior nurses had with the notion of independent thought. She argues that the staff nurses were in control and responsible for such things as the linen store and crockery. It is possible that nurses did have a good deal of responsibility and were responsible for relatively important matters. However, this does not mean that they enjoyed a degree of professional freedom and were able to employ decision-making and analysis.

'Well I'm pretty sure that the staff nurse was the person who had a lot of responsibility because ... I one day accidentally let an egg cup slip off my tray. I know it was the staff nurse then who was talking to another nurse and it was obvious that she was very responsible for equipment and stuff like that. And she was saying rather ruefully, it might well be difficult to match up this particular children's set. And also I seem to remember when it was a matter of getting out clean linen and so on from a linen cupboard, I think she was very much involved in that, so I think she was fairly autonomous. But obviously every grade was answerable to the grade above them.'

(Participant V (child))

Participant AA[511] (child) argued that nurses were probably not problem solving and professional people, however the nurses are described as kind and helpful and people who clearly tried to make her hospital experience a positive one. Nevertheless, there seems to have been no attempt whatsoever to address Participant AA's social and psychological problems. The nurses' role seems to have been to 'do things' and what they did they seem to have done well. In this case, however, what was required was an individual assessment and planning based on analysis of the child's behaviour and social situation. This last seems not to have taken place at all. Participant AA[512] reports that before being admitted to hospital she had enjoyed a good relationship with her mother but that this relationship changed very negatively as a result of her hospitalisation.

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[510] Participant V (1940). Age 5 years. Child. Lincolnshire.
[511] Participant AA (1965). Age 5 years. Child. Yorkshire.
[512] Participant AA (1965). Age 5 years. Child. Yorkshire.

It is possible that in the above case, the nurses did not understand the child's problem. However, Participant AB[513] (child) found that even when the staff were informed of the problem they did not modify their care, probably because the rules prevented them from doing so:

'I was really upset because they put me in a cot. I think they had a cut off age that if you were five or under or whatever it was, then you went in a cot. I hadn't been in a cot for ages and I was really affronted by this.'

'So nobody asked you or your mother whether a cot was an appropriate thing?'

'I think my mum asked about it when they were putting me in a cot and they said to her 'if they are under a certain age, then they get a cot', my mother said [protesting] 'well she hasn't been in a cot for 18 months'. It upset me because I was sort of like closed in, in this thing. Also it was really difficult because ... the kids that were in the beds had over-bed tables to eat from and with me they gave me a tray on my lap. When you are a little person, trying to balance a tray on your lap when you are in a cot is really a bit awkward. I wasn't amused by that.'

Nursing was only one discipline with a responsibility for providing care to children. It follows that it might be expected that medicine for example might have provided the problem solving which nursing lacked. However, this seems not to have been the case. Participant Y[514] (child) continues to be affected by the separation she experienced while in hospital with Tuberculosis. Touching her parents was not allowed for fear of transferring the disease, this despite the then knowledge that the child would not have been infective and that pulmonary TB is passed by airborne bacteria.[515]

The isolation needs of infectious patients must be something that is subject to knowledge and scientific scrutiny, yet it is clear that the treatment in this case was based not on medical science but on culture and social norms. Nurses were sub-

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[513] Participant AB (1966). Age 3-4 years. Child. Cumbria.
[514] Participant Y (1957). Age 7 years. Child. Yorkshire.
[515] See Behrman, R. E. (1992). Nelson textbook of paediatrics. London, Saunders.

professional in that they failed to imagine ways of achieving their aims more efficiently. However, there is no sign in the above case that medicine offered anything to the analysis. It is perhaps too easy to blame nurses for the lack of individualised care and evaluation of care. However, nurses were not the only people who worked in the hospitals, it has been argued that both nurses and doctors accepted that what nurses had to do was to follow the treatment regimen laid down by the doctor. In this way, nurses were the observable face of medicine. If what nurses provided was unthinking, then it is axiomatic that the medical impetus for what nurses did was unthinking too. Parents too were parties to the scenarios discussed here. Participant AD[516] makes the commonly accepted argument that nurses were powerless. However, she also points out that parents too were disenfranchised and that despite their trauma, were no more able to change the system than were the nurses. Participant AD makes it clear that parents did not approve of the rules to which they were subject. Even despite this, they were in no way able to change those rules. Nurses had to obey orders, they were not in control of what they did, this is understood. What is not so readily understood is that no other party was in control, not the children, not their parents, not their doctors. Nobody was in control. The system itself perpetuated itself.

The child participants provide a common consensus concerning the inflexibility of the nursing provision. Participant W[517] (child) argues that this inflexibility sometimes worked against the interest of the child patients. The nurses worked to a routine from which they did not on the whole waver. Participant W (child) provides evidence that nurses were sometimes more inflexible than was actually necessary within the system of rules by for example failing to provide the child with a bed-pan in between toileting times.

Reference has been made above, to the fact that the child participants sometimes found it difficult to reconcile the level of responsibility with the amount and level of judgement and analysis performed by nurses. In the same way, some of the child participants recognised that junior nurses did not think for themselves but argued that the senior nurses did their thinking for them. It is argued here that this is a response to

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[516] Participant AD (1964). Child age 4-5 years. Parent. Lincolnshire.
[517]Participant W (1957). Age 5-6 years. Child. Yorkshire.

the intuitive position that 'someone somewhere must have been thinking'. In a way this makes some sense, especially when one considers that the junior nurses were almost certainly students. However, it is argued here that the system of discipline subsumed everyone, even the medical staff. Participant Q[518] (child) argues that only the matron made any decisions. However, it could not have been possible for one single, non ward-based person to make all the clinical nursing decisions which would have been necessary. In any case, even where the matron could have made minor adaptations to the rules, these would then be enforced across the board and the individual clinical as well as psychological and social needs of children would still not have been addressed.

Participant Z[519] (child) also argues that the senior nurses were able to make decisions. This, it is argued here, was chiefly because the doctors were not on site during the day and that this meant that nurses had to make clinical decisions in their absence. While accepting Participant Z's perception, it is argued here that she is referring to the degree of 'responsibility' possessed by nurses (which this present text does not seek to refute). Nurses were responsible, they really did have the lives of the sick children in their hands; the children's welfare did depend on the nurses' skill and learning. Nurses had status in society, chiefly perhaps because of this degree of responsibility. It is argued here, however, that responsibility does not necessarily equal decision-making and professional freedom.

Participant U[520] (child) argues that nurses were free to make decisions within the system of discipline. He argues that the nurses could not break the rules but that the rules still allowed for decision-making. To an extent this is undoubtedly the case; nurses would be able to determine whether to offer a child water or some other liquid, determine how they applied a nappy and determine what lifting technique they would use to move an older child. The question, however, is to what extent this level of freedom related to the individual needs of the child patients. Much evidence is provided later that children did not feel their needs were being met and that the factors constraining the nurses' practice were an important reason for deficiencies in care. In

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[518] Participant Q (1934). Age 8 years. Child. Yorkshire.
[519] Participant Z (1953). Age 8 years. Child. Lancashire.
[520] Participant U (1936). Age 11 years. Child. Lincolnshire.

this way, the system of discipline had the effect of deflecting the nurses' decision-making away from what was important and onto the relatively trivial aspects of care.

Participant R[521] (child) puts the above clearly, arguing that nurses were only concerned with physical care, with completing their tasks and following orders. She argues that nurses did not think for themselves and were not frustrated by any perceived deficiency in the care provided as long as they were seen to be performing their duties. In common with many of the child participants, Participant R considers that the nurses were dominated by senior staff and by the hospital routine while at the same time influenced by a culture which stressed the importance of emotional control. These nurses may have had some clinical freedom but not in a domain that was salient to the children. For Participant R (child), it just would not have mattered whether the nurse used her judgement to apply one sort of dressing or another but a cuddle and a kind word might have made a real difference to her experience then, and perhaps later. The system of discipline forced nurses to focus on the observable manifestations of 'nursing' and therefore to ignore aspects of care that were inherently more valuable. Participant R (child) reports:

'Umm, I can think of one or two possibilities. One we have already briefly covered, that that wasn't part of their remit, was it? I mean I don't think that in the 1950's people were as concerned about the human psyche and the damage you can do to it as we are now. Umm, you soldiered on and got on with it. I think that's got something to do with it that it wasn't part of how to care for the child patient. But the other thing I think was the general rigidity of the whole hospital structure. I mean I can certainly remember the almost adulation with the Matron who was like God almighty arriving with wings flapping. And when you got to consultants arriving, dear Lord, Gabriel himself had descended. And I think something like this did actually have something to do with it. There were the consultants and what-have-you at the top and then the Matron and then these poor nurses. And I can definitely remember the mad flapping round little corners and tidying lockers and all the rest of it whenever one of these great personalities arrived ... I mean if you start picking up a sobbing child and giving it a cuddle, umm bearing in mind the sort of regime they were living in; what would

[521] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).

happen when the consultant walked in, my God the bedspread was creased or something and you hadn't lined up the orange juice correctly. Maybe it just wasn't part of it at all.'

It has not been argued here that nurses always obeyed the rules, only that they sought not to be found out and that the rules did on the whole prevent nurses addressing the most important aspects of care and responding to each child's individual needs. Participant X[522] (child) recalls being given a more palatable meal despite this necessitating her being hidden while she ate it so that no-one would see. While amusing and while indicating that at least some nurses did defy the rules, it should be understood that this was an exceptional incident in relation to this child's diet. Hiding the odd child away at lunch time was unlikely to have addressed the problem that the hospital diet did not meet this child's needs.

Nurse participants seem on the whole to agree with the child participants about the degree to which nursing was a thinking discipline. Participant A[523] (nurse) reports that much of the role (between 1956 and 1959) was basic and non technical, she reports *'how very undemanding it was really, the whole thing, of any intellectual process'*. Participant A quotes a consultant at The Hospital for Sick Children, Great Ormond Street, London who apparently claimed that the hospital turned out second class nurses but first class cleaners. Participant B[524] (c. 1948) reports that the staff in one particular children's hospital were routinised, nursing to them was a job rather than a profession and in no way did they consider it possible to plan to change or improve what had become a well established job. Participant B suggests that from her experience nurses couldn't change anything and that *'in those days you did exactly as you were told'*. Sisters were very powerful and it was only possible to perform nursing intervention as they wished it to be done. Participant J[525], working decades later in c.1962 made much the same comment, that student nurses possessed no degree of decision-making and

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[522] Participant X (1930). Age 10 years. Child. Lincolnshire.
[523] Participant A (1956-1959). Nurse. London.
[524] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.
[525] Participant J (From 1962). Child 10 years. Nurse. Scotland.

that staff nurses had to work within known and accepted methods of practice, this necessarily limiting their freedom to make decisions.

Participant K[526] argued that some practices did seem strange at the time but that it was not normal practice to question decisions made by the Sister and it was easy to assume that the Sister knew best. Participant K argues that this made nursing a rather unchallenging profession with the system of hierarchy allowing for little problem solving and decision-making. Decisions which had to be made about nursing intervention could only, in Participant K's experience, be made by consulting the senior doctors. This would change in her experience, but at the time nurses who did challenge were *'treated very harshly'*. Participant K worked quite late in the period in question (1968) and it is interesting that independent thinking was still poorly developed at that time, at least in Participant K's experience. However, signs of the demise of the system of discipline seem already to have been present with Participant K reporting that there was really no hierarchy at that time. She reports that no-one had an hierarchically derived role and students could do whatever they had been seen as being capable of doing. In this way, once for example, a student had been seen to perform a particular dressing satisfactorily, she would then be encouraged to perform the task on her own. To an extent this had always been the case, the difference here is that no highly defined set of roles was assigned to students or to any grade of nurse. This would have allowed nursing to develop in a way that it is argued here could not have been possible a few years earlier. Participant K also reports that later in her career, questioning of existing practice began to be encouraged and there was a discernible attempt to develop nursing practice. This occurred in Participant K's experience as a direct result of senior nurses undertaking the Diploma in Nursing programme[527]. Participant K also attributes the legitimacy of seeking to improve practice to the fact that she and her colleagues were working in a medical teaching hospital. It is possible that medicine was also becoming rather less bound to its own regulatory and culture-tied system of practice and that the two disciplines created a

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[526] Participant K (From 1968). Nurse. West Country and Sussex.

[527] This programme was run (or validated) by universities and had an academic orientation which encouraged questioning and analysis.

synergism which may not have been so apparent in hospitals that did not take part in medical training (also see Participant H[528]).

It should be understood that nursing was to change and it did become more problem solving toward the end of the period in question. Participant R[529] argues that initially (1950s) medicine was a significantly more intellectual discipline; later, doctors came to respect nurses' opinions in relation to problem solving and not just in terms of their observational skills. Participant R argues that the greater availability of academic courses began to have an effect on senior nurses in terms of their willingness to develop practice. Such courses also led to an increased respect for those nurses who had embarked on them and that they could be seen to be better nurses. Participant R agrees that, eventually, academic study became perceived as a legitimate activity, assisted to a significant degree by some well published research in the early 1970s which received major funding from the Ministry of Health and which was overseen by the Royal College of Nursing.[530] These changes must have presented a significant personal challenge to nurses who were comfortable working within the system of discipline and hierarchy. Others, such as Participant H, were to enjoy the new challenges and embrace the move to individualised care.

It is clear that most of the participants valued the system of discipline which preceded today's nursing. The participants felt comfortable in an arena where they knew what was expected of them and resources, intervention and even visiting were equitably allocated to the sick children. However, the negative implications of this scenario are also clear, that it failed to allow intelligent thought to be applied to the problems, psychological and otherwise with which sick children presented. Nevertheless, any analysis of this era of nursing must account for the fact that those nurses involved tend still to value that system of discipline and hierarchy, even where they would now

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[528] Participant H (From 1958). Nurse. Yorkshire.
[529] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).
[530] A series of 27 research studies, published from 1970 (the first of which was McFarlane, J. K. (1970). The proper study of the nurse. London, Royal College of Nursing.). The studies were funded in 1966 by the Ministry of Health (see McFarlane 1970). In the same series were: Hawthorne, P. J. (1974). Nurse, I want my mummy. London, Royal College of Nursing. Birch, J. (1975). To nurse or not to nurse: an investigation into the causes of withdrawal during nurse training. London, Royal College of Nursing. Lamond, N. (1974). Becoming a nurse: the registered nurses' view of general student nurse education. London, Royal College of Nursing.

modify it; they maintain that its value is self evident. Participant I[531] argues for a balance. She suggests that nurses should be exposed to academic study and accepts the consequences of this on the organisation of nursing. However she also suggests that this should not take place at the expense of good practice experience. Participant I considers her training in the 1950s to have been both sound and valuable, whereas current nurse education is criticised for failing to provide good quality practice experience, there being a lack of respect and discipline and a concomitant paucity of good role models. In common with most of the nurse participants, Participant I ascribes the core of this problem to too much informality leading to a lack of respect for senior staff. In this way, without this respect, juniors do not learn from seniors but must reinvent nursing knowledge with each succeeding generation.

Nurses were not at all unthinking but they did little problem solving. They had responsibility but did not, nor did they strive for autonomy of practice. Doctors made most of the key decisions and nurses were happy for that to happen.

Nursing's Relationship with Medicine

Participant G[532] remarks that nursing was not medicine, but that nursing was largely non technical and intended to help treat the child by delivering the treatments prescribed by the doctor. The common goal, however, probably engendered a degree of mutual respect and an almost professional relationship. Participant H[533] remarks on this relationship, suggesting that from her experience it was more collaborative in general hospitals where general nurses were more likely to be employed. She suggests that paediatric nurses were more submissive, partly because the more adult orientated general hospitals required nurses to exercise a degree of assertiveness in order to advocate for the child patient. Participant H argues that general nurses were more active than paediatric nurses in bringing about change, with the latter being more

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[531] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.
[532] Participant G (From 1953). Nurse. London.
[533] Participant H (From 1958). Nurse. Yorkshire.

insular and resistant to change. She criticises paediatric nurses as being the body of people who should have led the process of change.

Participant L[534] elaborates on the nature of the collaboration between nurses and doctors, emphasising the way in which the goal of cure, or amelioration of symptoms was shared. Participant L takes this argument further, suggesting that nurses and doctors worked as a team, although with the doctor being the senior partner or the team leader. This describes a semi-professional organisation rather than one in which nurses simply did what they were told. Participant D[535] argues that the doctors were the senior partners, nurses were the junior partners and were valued for their skills and their experience. However, Participant D makes it clear that nurses were not valued for their minds and that the ultimate responsibility lay clearly with the doctor. In practice, this process probably developed over time and may have been different in different areas, probably depending on the personalities involved in particular cases. However, it can be seen that the system of discipline and hierarchy did become moderated and was gradually replaced by a semi-professional model of co-operation. However, this model was still based on a shared goal with that of medicine. The degree that the goal was shared between nursing and medicine is perhaps illustrated by Participant D's failure to recollect a single occasion when the nurse and doctor members of the 'team' disagreed about a child's treatment or care. This shared goal meant that paediatric nursing could not wholly break away from its ordered and rule bound past. To do this, it would need to clarify a perspective on health care that was unique and un-shared with medicine and to accept sole responsibility for the resulting area of practice. This never happened, despite Participant L suggesting that doctors led the 'team' because they were more knowledgeable than nurses. Today she claims that senior nurses often have more knowledge than do doctors.

In practice, nurses worked very co-operatively with doctors. If this had not been the case, one would have expected a degree of professional rivalry or frustration with the way that resources were used for one discipline or the other. Participant D does not remember senior nurses and doctors disagreeing about a child's treatment or care and

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[534] Participant L (From 1953). Nurse. London.
[535] Participant D (From 1967). Nurse. London, Bedfordshire.

she argued that there was a benefit in working together for the same goal as medicine, whereas the parallel orientation of today can be dysfunctional.[536] In 1967, the medical and nursing goal was in the same dimension. The goal for both nurse and doctor was to make the child better. This is not to say that nurses and doctors did the same job, both Participants G[537] and D make it very clear that the role of the paediatric nurse was circumscribed and different from that of the doctor (see also Participant E)[538]. What is argued here, is that between 1920 and 1970, the 'orientation' and goal of the two disciplines was more or less identical. The shared goal was to make the child better and nurse participants refer to 'nursing the child better'. Participant L[539] (1953) puts the matter clearly:

'If I were to ask you what was the purpose of the nursing that you did, is there ... did you have a goal in mind, something that you were always working towards?'

'Well to get them better sounds a bit too [pause]. I suppose, to help them recover, that's if they were able to recover [pause] in the best way possible I suppose.'

'Right, so it was to help them get better?'

'Yes, or, if they weren't going to get better, to sort of try and relieve ... to make them as comfortable as possible, to relieve their symptoms as much as possible. Some children were so bad that perhaps they were prone to bed sores and things like that, so general nursing care so even if they weren't going to get better they could be kept as comfortable as possible.'

'So the main goal was to help them get better and to make them comfortable?'

'Oh yes, definitely, yes.'

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[536] Here, the participant is suggesting that today, nurses and doctors do have a separate goal with regard to 'care' and 'treatment'.
[537] Participant G (From 1953). Nurse. London.
[538] Participant E (1930s-1940s). Nurse. London.
[539] Participant L (From 1953). Nurse. London.

Here perhaps lies the confusion. Was the goal of paediatric nursing (shared with medicine) to treat the children, or to comfort them during their illness? It should be clear, however, that doctors and nurses had different jobs to do while working toward the common goal. Doctors diagnosed the condition and prescribed the treatment, nurses carried out the treatment and perhaps secondarily tried to make the child comfortable and ameliorate the effects of the disease and its treatment. The nurses' emphasis on the child's treatment which directly related to the nursing goal, necessitated an hierarchical relationship with the doctors because it was the doctors who were seen as responsible for deciding what to do. In any case, delivering the child's treatment was a cognitively simple task, perhaps more complex than that which parents could reasonably be asked to do, but much more simple than the task of diagnosing and determining treatment. Participant C[540] suggests that doctors provided an important function and that nurses could not have fulfilled their own role without doctors and that nurses '... *went by what the [senior] doctors instructed'*.

It is also clear from the participants' accounts that they tended to find medicine interesting. One would perhaps have expected the participants to have been 'interested' in nursing but this seems not to have been the case. The nurse participants were stimulated by medical knowledge and by working closely with doctors. Participant L[541] states that it was the medical conditions of the children which made the work interesting (see also Participant E)[542]. It was perhaps this shared interest in 'medicine' that allowed the goal to be shared and for the two professions to work so closely together, with each respecting the other. Nevertheless, Participant L makes it clear that doctors knew more and were therefore the senior partners.

Participant G[543] notes that treatments were not changed without authority from the doctor. Participant M's[544] experience corroborates the above, paediatricians prescribed the treatment and nurses carried it out. However, the doctors respected nurses and would listen to their advice. Participant M recalls that nurses possessed a sense of loyalty to the doctors and that they in turn respected the nurses' advice. Participant M

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[540] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.
[541] Participant L (From 1953). Nurse. London.
[542] Participant E (1930s-1940s). Nurse. London.
[543] Participant G (From 1953). Nurse. London.
[544] Participant M (1945-1951). Nurse. Essex.

recalls that doctors were *'friendly, co-operative and courteous'*. This close association between nursing and medicine indicates their shared goal, which was the (successful) treatment of the patient.

By 1956, Participant A[545] was witnessing a fundamental change in the relationship between medicine and nursing. Participant A recalls that the two professions became much more closely aligned and doctors, whilst still being seen as ultimately responsible for clinical decisions, came to respect the reasoned opinions of nurses. It should be understood, however, that Participant A worked in one of the largest children's hospitals. Participant K's[546] experience in a more provincial and perhaps more typical hospital was quite different. Participant K, even as late as 1968, found that the ward sister's role was mainly to ensure that the consultant's 'round' proceeded smoothly. In this way, the sister's role was directly orientated to ensuring that the ward conditions allowed the doctors to get on with their work uninhibited. This would have meant that the holistic needs of children were not considered a priority. Even by the late 1960s, most children admitted to hospital would have experienced a nursing service which was orientated to supporting doctors rather than meeting the holistic needs of children. Participant K, recalls that this loyalty to doctors resulted in a nursing service that was not problem-solving or decision-making and where nurses who did challenge the 'system' would still be treated harshly.

Many of the social divisions would disappear by the end of this period as skills began to require knowledge and problem solving. Claydon (1991)[547] refers to the rapid development of medical specialities after WWII and the way in which ground breaking technology tended to bring nurses and doctors closer together. Claydon (1991, p. 50) reports one cardiac surgeon who recalled:

> *'There was a feeling of closeness and of working as part of a team. The involvement was personal and the support and loyalty of the nursing staff is remembered many years later by the consultant team as one of the great mainstays of that time.'*

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[545] Participant A (1956-1959). Nurse. London.
[546] Participant K (From 1968). Nurse. West Country and Sussex.
[547] Claydon, R. (1991). The story of the Royal Liverpool Children's Hospital: Alder Hey and Myrtle Street. London, Image Publications.

It is clear that by the 1960s nurses were becoming both more academically orientated and more aligned to medicine. Many of the nurse participants (see for example Participant J) note that the advances in modern medicine could not have taken place without the allegiance of nursing to the common cause.

Participant J alludes to the nurses' psyche, suggesting that they may have wished to avoid conflict. Many of the nurse participants stated that they did not like interpersonal conflict and that they deliberately steered away from conflict (see Participants D[548] and J)[549]. This attitude may have cemented the relationship between medicine and nursing.

Participant K[550] makes it clear that by the late 1960s paediatricians had changed, and that they tended to be *'... paternal, Grandfatherly [and] approachable'*, and orientated to the individual needs of the sick child and his or her family. It seems likely that nurses in these areas followed the direction of the consultant and in this way their own orientation did change. Participant K suggests that questioning did eventually become accepted and that this was a result of nurses undertaking academic courses in nursing, such as the Diploma in Nursing[551]. Still, however, Participant K found that the medical teaching hospitals alone, provided an environment where nurses were expected to problem solve and work more closely with doctors.

It should be understood that paediatric medicine was also developing at this time and was perhaps becoming more problem solving and academic. Even here, paediatric nursing seems to have followed, probably to the good, but followed all the same. Participant H[552] observes that even today there are some paediatric nurses who too readily follow the doctor's wishes ... *'there is still this degree of yes doctor no doctor'*.

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[548] Participant D (From 1967). Nurse. London, Bedfordshire.
[549] Participant J (From 1962). Child 10 years. Nurse. Scotland.
[550] Participant K (From 1968). Nurse. West Country and Sussex.
[551] At this time a post registration course.
[552] Participant H (From 1958). Nurse. Yorkshire.

The degree to which nurses and doctors worked collaboratively probably increased toward the latter end of the period in question. Participant N[553] observes that the liaison was chiefly between senior nurses and senior doctors. Doctors were still the senior partner but they were dependent upon skilled application of treatment and skilled observation. Nurses did not initiate treatment but they had to understand it. Their role was to ensure the success of the treatment and their goal was successful treatment. In this way, the nurses' role became closer to that of the doctor. However, the doctor's role had not moved. Participant N makes the point that while nurses were undertaking more of what was once the doctor's role, doctors did not undertake what had been the nurses' role (see also Participant E)[554]. In this way, traditional nursing skills and the traditional caring role was being lost at the expense of the medicalisation of nursing. Nursing became more skilled, more knowledgeable but at the eventual loss of their own unique body of knowledge, focused as it once was on the means to ensure a patient's comfort and understood by the patient as 'care'.

Interestingly, Lindsay (2001)[555] suggests that doctors were beginning to feel threatened by nurses' increasing knowledge, especially that related to premature babies, a field which was experiencing rapid development. Participant D[556] suggests that while nurses didn't verbalise concepts of child psychology etc., nursing was still much more holistic than was medicine. Even here, however, Participant D continues to regard medical knowledge as more useful and more focused on the goal of making the child better. Participant D welcomes modern examples of training where nurses and doctors are educated together.

It can be seen that the nurses relationship with doctors was remarkably cooperative. The goal was one that was shared, not only as being the successful treatment of the child but as being whatever the doctor wanted it to be. There is no evidence of nurses seeking an independence from doctors and this is the case even where nurses may have been more knowledgeable than at least the junior doctors.

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[553] Participant N (From 1964). Nurse. London, Scotland and Yorkshire.
[554] Participant E (1930s-1940s). Nurse. London.
[555] Lindsay, B. (2001). "An atmosphere of recognition and respect? Sick children's nurses and medical men 1880-1930." International History of Nursing Journal 6(1): 4-9.
[556] Participant D (From 1967). Nurse. London, Bedfordshire.

The lack of individualised care[557]

Nurses were often busy and generalised care may have been the only way in which they could cope with the workload. In any case, accounting for children's individual differences would have increased the workload. Generalised care meant that each nurse would have known what to do and when to do it and the repetitive nature of the work would have meant that they became skilled at the tasks and able to perform them efficiently. However, the children's psychological and perhaps social and spiritual needs were not so amenable to routine and consequently tended to be ignored. Participant V[558] (child) was asked whether the lack of psychological care was due to the nurses' lack of understanding, she replied to the contrary

'I think that they had probably just not thought it through because it was just so much the prevailing culture at the time and that this was the way things were ... and they were there to look after children and make their bodies well ...'

It is perhaps hard to appreciate the extent of the hospital that was managed and run by nurses. Barnes (1999)[559] details how nurses conducted all the sterilisation, from cotton wool balls and syringes to theatre instruments. Nurses were in one way or another responsible for cooking and even late in this period still prepared meals for babies and infants (see Participant G[560]). In his way, nurses had more to do than attend to the child patients' individual needs. It is also likely that those needs that were 'individual' were perceived as 'wants' not needs, a need was a human characteristic and so could not relate to individual differences.

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[557] Individualised care, meaning that the system of care delivered to patients takes account and is orientated to their individual clinical and other holistic needs. Opposite to 'generalised care' where an effort is made to provide the same care to all the patients and which is often highly routinised but emphasises the qualities of parity and high procedural standards.

[558] Participant V (1940). Age 5 years. Child. Lincolnshire.

[559] Barnes, P. (1999). Royal Manchester Children's Hospital 'Pendlebury' 1829-1999. Leek, Churnet Valley Books.

[560] Participant G (From 1953). Nurse. London.

Participant K[561] recalls with regret not being able to comfort children because that was seen as wasting time, she recalls the children crying themselves to sleep. The lack of individual care did not just mean that the child's worries and anxieties failed to be addressed but also that children were exposed to unnecessary psychological trauma. Participant AB[562] (child) was exposed to the sights and sounds of the operating theatre reception area where this experience could easily have been made less frightening. Unfortunately, the child's physical and medical care was also not addressed as care sometimes became subsumed by the needs of the institution (see Participant W[563] (child)). At this point the generalised care had become associated with the institutionalisation of nurses and medical staff with the result that care was delivered outside the interest of the child. The effects of institutionalisation, where both nurses and doctors worked first for the interest of the hospital and only second for the sick child, were mostly negative. Participant B's[564] account of children being rushed through theatre, several at a time, with speed being the priority is a salutary example of the needs of the institution coming before the needs of the child. Reading Participant B's account it is doubtful whether she has yet come to terms with her memories and her experience.

Most of the Participants report the nurses being busy and associate this with the routine nature of the work (see for example Participant R[565] and P[566]). Participant T[567] recalls:

'I can't remember anybody sitting by my bedside, everything seemed to be [pause] so straight, so erect, so blue and white [pause]. I probably didn't know the word at the time but 'starch', you know everything, nothing was unruffled, everything was so upright and clean and straight and so proper I suppose. But the one bit of kindness was [Name] but I really think I was just another patient [to her].'

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[561] Participant K (From 1968). Nurse. West Country and Sussex.
[562] Participant AB (1966). Age 3-4 years. Child. Cumbria.
[563] Participant W (1957). Age 5-6 years. Child. Yorkshire.
[564] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.
[565] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).
[566] Participant P (1948). Age 10 years. Child. Lincolnshire.
[567] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

The nurse participants were able to describe the routine in significant detail (see Participant F[568]). It is interesting that to this day, they remember such detail as at what time of the day and in what order the nappies were disinfected or when the steriliser had to be emptied and when the ward lights were dimmed to herald the beginning of the night. Some of the nurse participants defended the generalised care, arguing that it was the only way to get all the work done. Participant G[569] also suggests that routine care was possible because the needs of the children were similar with each particular ward being orientated to a particular range of medical conditions and was necessary in order to co-operate successfully with non nursing staff. However, Participant G's[570] account indicates that the identified needs of the child were limited to their physical condition and that this allowed the child's care to be organised around the needs of other staff. Participant H[571] recalls children still dressed in a hospital 'uniform' in the late 1950s. It should be understood that it was not just the organisation of work which was routinised, but each procedure was done in a particular way and in a particular order. Participant P[572] recalls that the bed-bath was the height of routine, there being a particular way of carrying out the procedure.

An apparently insignificant ritual, that of taking any food and sweets provided by parents and distributing them to all the children (though this last didn't always happen) was perceived by many of the child participants as particularly cruel (see Participant X)[573]. This activity was carried out in an attempt to treat all the children equally. The sweets were meant to be shared out amongst all the children (see Claydon 1991[574], Kosky 1992[575]). Not only did they seem never to receive even a part of their gift, but the gift was seen as something that belonged to them and that was a demonstration of their parents' love for them, taken away by the nurses. Some of the child participants seem still to be affronted by this act of 'theft' even today. Their sweets were stolen, but the impact of the misdemeanour chiefly relates to the theft of their parent's love and

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[568] Participant F (From 1950). Nurse. Yorkshire.
[569] Participant G (From 1953). Nurse. London.
[570] Participant G (From 1953). Nurse. London.
[571] Participant H (From 1958). Nurse. Yorkshire.
[572] Participant P (1948). Age 10 years. Child. Lincolnshire.
[573] Participant X (1930). Age 10 years. Child. Lincolnshire.
[574] Claydon, R. (1991). The story of the Royal Liverpool Children's Hospital: Alder Hey and Myrtle Street. London, Image Publications.
[575] Kosky, J. (1992). Queen Elizabeth Hospital for Children: 125 years of achievement. London, The Hospitals for Sick Children.

the loss of trust in the nurses. In practice, it seems to have been well understood that many children did not see their sweets again, Participant AA[576] (child) recalls:

'I remember having a small milky way bar and my mother said "hide it in your locker because they'll take it off you". So I had to secretly hide this Milky Way and eat it before they had time to tidy my locker up. That was strange.'

It would be some time before 'case assignment'[577] was widely accepted. Working in the 1950s, Participant L[578] suggests that while patient allocation was employed, there were still some tasks that were organised centrally. By the 1960s routinised care seems to have become a little more relaxed. Participant AA[579] (child), admitted c. 1965 for example, reports:

'I could have my favourite drink, whatever I wanted ... and they would get it for me ...They asked me "how often would you like a bath?", "every night, if I could have one". We only had one once a week at home...'

In the same way, Participant K[580] argues that by the end of the 1960s, the more child focused staff would adapt the rules to the child's particular needs. Working in a children's hospital in the late 1960s, Participant D[581] claims that care was always holistic[582] and was by that time not task orientated.

Photographs of wards in the period 1920-1970 often look regimented. However, these pictures were often taken for the hospital to sell as postcards, presenting an image of professional order (see O'Neil 1989[583] and O'Neil 1991[584]). Photographs taken by

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[576] Participant AA (1965). Age 5 years. Child. Yorkshire.

[577] Case assignment, a system of semi-individualised care where nurses were allocated patients rather than generalised tasks (baths, observations). Even where case-assignment (sometimes called 'patient allocation') did take place it seldom operated for all three shifts in the 24 hour period.

[578] Participant L (From 1953). Nurse. London.

[579] Participant AA (1965). Age 5 years. Child. Yorkshire.

[580] Participant K (From 1968). Nurse. West Country and Sussex.

[581] Participant D (From 1967). Nurse. London, Bedfordshire.

[582] Holistic .. strictly meaning accounting for the psychological and social needs of the patient but here meaning that care was delivered in a flexible manner.

[583] O'Neill, C. (1989). A picture of health: hospitals and nursing on old picture postcards. Oxford, Meadow Books.

nurses themselves often portray a much more informal order (see below). Nurses did often deliver care in their own time, so, for example, they might have taken the children out for a walk. During these times their care was probably more individualised.

Photograph 1: Nurses c. 1930, source, Participant T[585]

It can be seen that through most of the period 1920-1970, generalised care was the system of nursing organisation to which most children would have been exposed. It has also been seen that generalised care went 'hand in hand' with an acceptance of a known way of practicing and known standards of practice. Into this arena were admitted all kinds of children with needs that were often multi-factorial and complex.

The system of discipline and hierarchy

By 1920-1930 senior nurses managed a system that was no longer orientated to the specific or individual needs of each child patient and their family. Participant T[586] (child) reported being scared to move in bed, in case he disordered the clean lines of

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[584] O'Neill, C. (1991). More pictures of health: hospitals and nursing on old picture postcards. Oxford, Meadow Books.

[585] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

[586] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

his bed linen. Participant S[587] remembered being told off for getting out of his bed to look out of the window. The participant recalled that the following day he was given an injection the effect of which was to prevent him from standing. Participant P[588] (child) recalls:

'The matron was definitely in charge and then after her everybody kowtowed to the doctor and I never remember ... the doctor speaking to me and nor did he to anyone as far as I know. You were spoken to through the sister and she told the nurse what to do. And the nurses did the menial tasks like pull the covers back or whatever and the sister was there to communicate with the doctor. So it was very much a pecking order. And I didn't like that at all.'

It is interesting that the system of discipline does seem to have involved children. This may have been exacerbated by the fact that children in this period were often kept in bed for the length of their stay in hospital. This meant that they could not run about and it was more difficult for them to play. Being forced to keep still could easily be confused with discipline and even punishment. Participant T (child) seems to link the lack of play with discipline, making it clear that he did not even remember quiet play and reading. Play seems not only to be associated with the release from discipline but the lack of it seems to be associated with discipline and perhaps even punishment. It is doubtful whether the nurses would have seen it this way and whether they understood the powerful difference that enabling simple play would have made. Early evidence of 'play' in the nursing literature appears in 1940 (Anon 1940)[589], with an article encouraging nurses to facilitate play in order to amuse sick children. Participant T (child) recalls '*But as far as I remember I can never remember us being out of bed .. I can only remember being sat in bed and the beds being immaculate and not a wrinkle or a crease'*. Children could be in fear of the trappings of the system of discipline as Participant T (child)[590] recalls:

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[587] Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.
[588] Participant P (1948). Age 10 years. Child. Lincolnshire.
[589] Anonymous (1940). "Amusing the sick child in bed: practical suggestions for nurses who have care of sick children in hospital or at home." Nursing Mirror **16/03/1940**: 595.
[590] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

'When the matron did her rounds, you know she would come down the centre of the ward ... with her entourage and cape flowing and everybody was in fear and I really mean fear [emphasis] the nurses as well. I can see the old battle-axe now, coming down and criticising this, that and another ...I can remember being in fear of the matron, I was in fear of everything really. You were nearly in fear of [pause] moving off your bed or moving in bed really because everything had to be kept ... like that board [pointing], so straight. You know, I can't remember much laughing ...I don't know why I'm like this [cries] [pause] ...'

Again, Participant T (child) emphasises the degree to which the children were frightened by the system of discipline:

'I would call her the Queen of Sheba now, with people either side of her, trailing behind her of course, and her blue cape and ... God, here come God and everybody trembled you know, including the kids, including the kids, they were ohh matron. And I think you thought everyone was like that. I think you were more frightened. I think you were frightened to do anything. I think you were frightened to talk or play, no, no chance.'

Participant L[591] recalls that the more treatments the children were having, the more interaction they received. She recalls little in the way of play or recreation for the children although nurses would sometimes use their days off to take the children walks outside the hospital.

Many of the Participants associated the interpersonal environment and discipline with that of the armed forces. Interestingly, however, there is often a direct association with the lack of emotion and lack of respect for children and nurses as individuals. Perhaps these last did not necessarily have to go side by side with a desire for common standards and good practice. However, the 'military' discipline and lack of emotional 'care' does seem to have gone hand in hand. Participant V[592] put it like this:

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[591] Participant L (From 1953). Nurse. London.
[592] Participant V (1940). Age 5 years. Child. Lincolnshire.

'They were very much under the thumb of the sisters, you know, the younger nurses. It was very militaristic in that way, you know, and the fact that everyone had surnames ... even the nurses between themselves ... used often to use their surnames. You know, it would be '[surname]' and so on, rather than [forename] or [forename] and so on. And it was very much like the Army I think, the sisters were rather like sergeants ... and the way that they all lined up and the way that it was so important for everything to be spick and span ... for the nurses to be well groomed and so on. And they would be reprimanded if there was anything slightly out of place.'

Children, then as now, were sometimes subjected to procedures that were frightening and painful. It is within this perspective that the emotional neutrality of nurses should be viewed. Participant K[593] provides some insight into the way in which nursing procedures were associated with fear:

'Did anybody explain to the children what was going to happen to them?'

'[pause] I don't remember anybody explaining. But they were quite young children, they were generally, ... at an age when they wouldn't understand. They [continuing immediately] use to have their eye lashes cut off which is something that we don't do now. I remember them putting Vaseline on and they used little sharp scissors. To do that to children. That was dreadful. Very frightening to have to do [pause] thinking about [pause] [pause] I [pause] ... It sounds dreadful doesn't it. I feel ashamed to admit I was there [laugh] It's like saying you were in the concentration camps, it's the same sort of feeling when you look back on it.'

However, it was not just that nurses had to do frightening things to children, but that they did not appear to understand how frightening the procedures were. The nurses' emotional neutrality, however, is easily interpreted as lack of empathy. Participant K alludes to this below:

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[593] Participant K (From 1968). Nurse. West Country and Sussex.

'Admission days, they were terrible [pause]. The children weren't the most popular patients and as the new nurse on the ward, as the most junior, you were given the children, because no-one else wanted them. [pause] As somebody (this is in my first year), as somebody of eighteen with very little experience [smile] with children, it was quite frightening really, because you didn't really know what to do for these poor children, you could see that they were unhappy, but if you spent too much time trying to comfort them you were called away because 'you've got more important things to do nurse'. Just very ... rigid, unkind, well uncaring perhaps not unkind, I don't think they were deliberately cruel. It was just a culture at that time.'

Perhaps the above is an example of the way in which children's emotional needs were recognised, at least by junior staff but where the culture of the time did not allow for those needs to be recognised or met. In any case, providing frightened and distressed children with emotional comfort was clearly not seen to be part of the nurses' role. It is possible to see Participant K struggling to make sense of her experience as she tries to reconcile notions of 'nursing care' with what she actually experienced.

While most of the child participants report that they were frightened by the system of discipline, some were more in awe of it without being frightened, very few enjoyed it, however Participant V[594] (child) reports:

'... I was very self sufficient and I was impressed by the order of the ward and I took my colour from the attitude of the staff and I suppose that we all had to sit up and keep quiet and only speak to Matron if she spoke to us ... it was very much a matter of knowing your place and knuckling down and doing what the grown ups wanted.'

Perhaps some children found the system of discipline reassuring and safe, although it is clear that most did not. Perhaps to some older children it would have been an adventure of limited duration, while younger children would not know how long the experience would last. Participants sometimes linked the discipline with notions of the job being done well, often arguing that standards of care and cleanliness have fallen in

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[594] Participant V (1940). Age 5 years. Child. Lincolnshire.

the modern NHS. Participants Q[595] (child) and U[596] (child) argued that while the nursing hierarchy was too extreme it was also strict and that caused standards to be higher than they are today. The participants felt sorry for the junior nurses because they had to work hard and were at the bottom of the hierarchy but they emphasised that the system of discipline is too lax today. Participant Z[597] (child) commented that the system of hierarchy simply meant that senior nurses were respected by the children in a manner that seemed to her to be normal.

Hospitals did appear to vary in the degree to which children were exposed to the system of discipline. Participant AA[598] (child) reported that while there was discipline, the nurses were still kind and pleasant, both attributes that appear missing in some of the participants' experience. However, Participant AA (child) was admitted rather late in this period (1965). It is quite possible that by 1965, at least in some hospitals the system of discipline had become less severe.

It is interesting that most of the nurse participants had difficulty reconciling the psychological trauma to which children were exposed and their own (usually) positive view of their professional past. Some (see Participant H[599]) argued that while nursing was a strict discipline, there was a softness underneath and that nurses did care about the children. These participants tended to support the system of discipline and were disparaging about the situation today, many arguing that a middle way needed to be found (see for example Participant H). It is interesting that the modern use of first names and familiarity is most often condemned, with participants arguing that this leads to a lack of respect. The avoidance of first names seems, however, to be associated with the emotional neutrality which appears to have been so injurious to children. Participant C[600] considers the uniform to be important, the lack of one being the chief reason that she chose to leave Health Visiting.[601]

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[595] Participant Q (1934). Age 8 years. Child. Yorkshire.
[596] Participant U (1936). Age 11 years. Child. Lincolnshire.
[597] Participant Z (1953). Age 8 years. Child. Lancashire.
[598] Participant AA (1965). Age 5 years. Child. Yorkshire.
[599] Participant H (From 1958). Nurse. Yorkshire.
[600] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.
[601] Mann's (1994) autobiography illustrates the way in which the author moved through her career, from one hospital to another in search of a better uniform. Mann finished her nursing career in the

Participant C's account employs a number of themes which together form an image of emotional neutrality and institutionalisation which Goffman (1961)[602] first described as characterising mental health institutions; these include:

- even where rules were unfair, they were fair in the sense that they applied to everyone;
- 'you were told to do it and you did it', unquestioning obedience;
- rules were considered to be appropriate because they were in the interest of the majority;
- there was a strong sense of hierarchy with fear of those in higher positions and communication possible only between adjacent levels in the hierarchy;
- the uniform was an important symbol of the hierarchy.

It does seem that paediatric nursing was an institutionalised discipline (see Goffman 1961, same reference). This perhaps largely accounts for its failure to acknowledge the individuality of both children and nurses and the emphasis on emotional neutrality. In a real sense the nurses could not provide humane care because they had dehumanised themselves. Perhaps they still 'cared' for the children but their practice did not always demonstrate this. They may have cared, but they did not practice 'care'. In this way it can be seen that the system of discipline was not just that, but part of a much deeper institutionalisation which applied to the children every bit as much as the nurses.

Arton (1992)[603] claims that matrons and senior nurses enjoyed the power which they held over the junior nurses. Arton (1992 p. 167, same reference) cites this as the main reason for the continuation of petty discipline and what he calls the 'institutionalisation of nurses'. Participant B[604] seems to support this, reporting that *'everything was regimented'*, that the sisters and not the tutors provided the role model for the students and staff, that the staff feared the sisters and that the sisters were '*horrible people*'.

Queen Alexandra's Royal Naval Nursing Service. Mann, J. (1994). Four years hard. London, New Millennium.

[602] Goffman, E. (1962). Asylums: Essays on the social situation of mental patients and other inmates. Garden City - New York, Doubleday and Co.

[603] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[604] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.

Participant B describes the paediatric ward sisters as '*witches ... as hard as nails'* and as people who enjoyed demoralising their staff and who were responsible for the bad things that happened to children. The hierarchical system meant that junior nurses and students were disempowered, '*in those days you did just exactly as you were told'* (Participant B). Participant Q[605] (child) claims that student nurses had a hard time because they had to work hard and were at the bottom of the hierarchy. The nurse participants generally agree about the 'disenfranchisement' of junior nurses, especially in the early years of this period. Participant E[606] (1930s and 1940s) for example provides a clear account of decisions about what needed to be done being devised by others and being largely out of her control.

Junior doctors would also fear the ward sister. This can be partially explained by the liaison which took place between the sister and the consultant (see Participant I)[607]. The ward sister certainly had a daily audience with the consultant and would understand his or her preferred ways of working better than would the junior doctor whose place on the ward would have been temporary.

It is clear from the transcripts that hospitals and wards differed in the degree to which they were friendly and in other respects, the atmosphere being set largely by the ward sister. Participant I reports that while psychological (emotional) care tended to be lacking in the 1950s, this depended very much on the orientation of the ward sister. She argues that the ward sister's role was central in that she had considerable freedom in terms of the atmosphere of the ward '*she was very much the role model and you replicated her style'*. Participant I argues that the most important way in which the ward sisters differed was in the degree to which they were 'human'. Accepting this means that to a degree, some sisters were regarded as something less than 'human'. Perhaps this relates to the degree of emotional neutrality as much as it does to the degree to which they would instil fear into their subordinates. Perhaps also, while nurses would have been aware of their fear of the ward sister, her attributes of emotional neutrality and detachment may have been more obvious to the children. In

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[605] Participant Q (1934). Age 8 years. Child. Yorkshire.
[606] Participant E (1930s-1940s). Nurse. London.
[607] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.

such circumstances it is unfortunate that her attributes were replicated by the other staff.

Participants do provide some evidence of professional respect based on the achievement of the nurses. However, this seems to have been relatively limited. Senior nurses were respected because of their place in the hierarchy and not because of what they had achieved.

If the model was not a professional one, based on professional achievement, it was nevertheless simple and easily assimilated. Participant G[608] supports the hierarchical system in place in the 1950s by suggesting that there was mutual respect and that while there was no familiarity, the relationship was nevertheless friendly. There is evidence (Participant B)[609], however, that it was not always 'friendly' and was sometimes based on fear. If it was not friendly, it was probably 'comfortable'. Participant G argues that it was a system in which everyone knew their place with each place being associated with a different range of tasks. In this way the hierarchy must have made life simple and the various roles divided and unambiguous.

Participant L[610] reports her continuing support for the system of hierarchy and discipline and relates this to one ward which had a friendly social atmosphere where junior nurses were hierarchically positioned only slightly higher than the children. In Participant L's case, discipline of children is reported to have been mainly handled using communication skills and diplomacy. Here too, however, there was, according to Participant L, a strong sense of hierarchy and of respect for senior students and nurses. The respect for senior nurses is seen as something that is sadly missing from nursing today. In common with many other nurse participants, Participant L reports that the system of hierarchy and discipline meant that you '*knew where you were and what you had to do*'.

The role of the paediatric nurse does appear to have been relatively comfortable and secure with each nurse protected by the hierarchy and responsible only for the work

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[608] Participant G (From 1953). Nurse. London.
[609] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.
[610] Participant L (From 1953). Nurse. London.

allocated to them rather than the outcome of the nursing intervention as a whole. However, this limited responsibility must also have made it difficult for the nurses to address overall patient outcomes and the holistic needs of the children. Even if it had been accepted that (for example) visiting arrangements might be improved, the limited focus of the nurses' responsibility would have made it difficult for them at any point in the hierarchy to address these more global issues. In this way, junior nurses were responsible for keeping patients and the ward clean and tidy; sisters were responsible for ensuring the prescribed treatment was carried out and that the interface with other departments worked smoothly (that food was ordered appropriately); the matron was responsible for the observable evidence of tidiness and order. Global issues such as visiting arrangements were thus nobody's responsibility and the system of hierarchy meant that new issues could not easily become incorporated into the hierarchical roles. Thus while the organisational system was tidy, secure and comfortable, it resulted in a resistance to evaluation and change. It follows that while the goal of both individual nurses and of the system was good quality care with everything being 'done properly', the result was that care failed to account for both the individual needs of sick children and more global issues. As society moved inexorably on, paediatric nursing became disjoined and eventually in conflict with the society to which it was once in comfortable harmony (see Participant N)[611].

If the hierarchical model was simple, it was also seen to be fair in that it applied to everyone equally. Both nurses and children were subjected to rules which in each case applied to each member equally and without exception. Participant C[612] makes the point that this equity made it easier to accept the petty rules, even when on an individual basis they might not have seemed fair. The nurses were in it together in more or less full acceptance of their own disenfranchisement. It is suggested here that this is clear evidence of institutionalisation which must also have tended to perpetuate the hierarchical system. Again, however, the notion of equity also applied to the children; Participant C argues that liberal visiting regulations today are inherently unfair because parents do not visit each child for the same amount of time per day. It follows she argues, that visiting times should be determined by the hospital and not by

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[611] Participant N (From 1964). Nurse. London, Scotland and Yorkshire.
[612] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.

parents and that limiting visiting to an hour a day had the important advantage that all the children were being treated on an equal basis.

It is perhaps inevitable that the system of hierarchy and discipline acted to limit the decision-making potential of paediatric nurses. Participant J[613] argues that the staff nurses' decision-making powers were limited by the way in which there were known and accepted way of doing things. Participant AD[614] also reports that paediatric nurses simply had to obey orders and they were not in control of what they did and did not do and the matron monitored what they did to ensure that it was done to a suitable standard. She makes the point that even senior staff would not have been able to change the system. To some extent, Participant AD blames parents for not making a stand and insisting on staying with their child. Parents, she recalls, accepted the rules despite disapproving of them and being traumatised by the experience of separation. Perhaps parents were also frightened by the system of discipline and hierarchy but it is also likely that the culture of the time did not permit a stand against authority. In this way and probably to some extent, no single part of the system could exercise control over it. Like Goffman's (1962)[615] 'institution', the system had become self perpetuating and propelled by perpetual motion, nobody controlled it. In the end it would take external forces, mainly social and cultural in origin, to impact upon the systems which controlled paediatric nursing.

The impact of emotional neutrality

Few child participants report unkindness or cruelty. However, they do report nurses being emotionally 'neutral' or cold (Participant AC (child))[616]. For children to be cared for by emotionally cold (but perhaps still caring) people is perhaps unusual in our culture. It is suggested here that some children survived this emotional coldness better than others. The emotional neutrality or coldness also seemed to be associated with the

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[613] Participant J (From 1962). Child 10 years. Nurse. Scotland.
[614] Participant AD (1964). Child age 4-5 years. Parent. Lincolnshire.
[615] Goffman, E. (1962). Asylums: Essays on the social situation of mental patients and other inmates. Garden City - New York, Doubleday and Co.
[616] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.

nurses' preoccupation with physical, rather than psychological care. Participant R[617] (child) reported that the nurses were only concerned with physical care and with completing their tasks and following orders, as they were influenced by a culture which stressed the importance of emotional control. It appears to be the case that those who suffered most from separation anxiety also found it most difficult to cope with the emotional coldness of the staff. Participant R (child) reports:

'So, I think what was most frightening of all was the fact that my mother wasn't there and that there didn't appear to me to be any one human there at all other than me, really ... the only feeling that I have is of cold ... totally ... they were into bodies, not feelings .'

Participant P[618] (child), a patient in the late 1940s recalls that the nurses did not talk to her unless necessary and she described this as 'awful'. The nurses were also only concerned about getting their work done and were not concerned about her as a person:

'I'll give you an instance. The most awful thing that happened to me in that hospital was that it started to become dusk one night and no lights on anywhere. We are talking November now and I desperately wanted a bed-pan. Somebody had brought me a bowl of fruit and children don't realise that you shouldn't eat too many grapes do they [laughter]. And nobody washed them, in an isolation hospital they just came out of the bag. And I wanted a bedpan and I shouted for a bed-pan and no-body came, no-body came. The man that afternoon had not sung 'bless this house' and so, where was he? And I went hysterical, I screamed, no-body came, eventually somebody came and they had been for tea. Into a little building which wasn't actually part of our building, maybe a couple of strides away but it wasn't part of our building. And when they eventually found me distressed, I obviously said, 'why did no-one come'. 'We had gone for tea'. I don't know whether that explains anything to you?'

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[617] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).
[618] Participant P (1948). Age 10 years. Child. Lincolnshire.

Later, however, she was transferred to another ward where she was given a uniform and asked to help distribute bed pans and hot drinks. At the time she viewed this positively as the only 'human' interface she had had with the nurses. On reflection, however, she wonder whether the nurses simply saw her as a useful assistant. She was also involved in the care of a man inside an iron lung with whom she developed a friendship but who, to her continuing distress, eventually died. The participant indicates that she was 'un-personed' by the lack of psychological care. She enjoyed dressing up as a nurse because it made her feel that she 'belonged' and was therefore a person. The lack of bodily contact increased the feeling of being 'un-personed':

'Nurses could come in. The man in the iron lung, his parents came in gowned from head to foot with a mask on. But no-one was allowed to come and see me. So you never had any bodily contact.'

Some participants' only bodily contact was when they were held down for a procedure or (rarely) smacked: when asked *'you don't remember any physical contact?'* Participant AA[619] replied:

'No, I don't remember, no. The smack was probably the only physical contact.'

Participant O[620] suggested that the older nurses in general hospitals in the 1960s tended to regard children as little adults and regard quiet behaviour as good behaviour. However, she maintains that children were always regarded as people and that all the nurses cared about them and worked to make them better. However, Participant R[621] (child) admitted to a general hospital in1950 describing her experience as one of fear, related to powerlessness and vulnerability in the face of an environment that was cold and inhuman. Participant R perceives the nurses as not understanding and not wanting to understand the child's feelings. Staff treated the participant as a passive receptacle for treatments and they were not interested in the participant's views and feelings:

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[619] Participant AA (1965). Age 5 years. Child. Yorkshire.
[620] Participant O (From 1963). Nurse. Yorkshire and Lincolnshire.
[621] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).

'If you want me to actually choose one thing, I think it was the powerlessness. I wasn't anything. I had no-one on my side to protect me, I was just there to be done to. Yes, I think that was it, the powerlessness ... So all I have thoughts on now is ... that they didn't really care. I think that they were getting on with their jobs. The fact that we were kids who (there must have been others who were as unhappy as I was). I don't think they cared a hoot what our feelings were, they were into bodies, not feelings ... I was completely and utterly isolated. It's like sticking a naked child in a pen with a load of farmyard chickens. You've got nothing to protect yourself with at all ... I, and I still do this. I was afraid of anybody who approached me because I never knew what they were going to do ... It didn't really matter where you were, there wasn't a place of safety that I recall. And whenever anyone approached me I was wary of what they were going to do. No one ever told you what they were going to do, it just happened. And I've still got that, I mean my dentist is one of my best friends. I know my optician socially. I know some of the doctors through [daughter's] friends. But wherever, they are I'm watching their hands, particularly if I've gone for new spectacles or something. I'm watching all the time to see what they are picking up and what he's doing. It's ludicrous but it's because I remember that ...I remember that they would discuss me, the nurse and the doctor usually, as if I was deaf. By this time I was ten years old and I knew what was going on. And things were discussed simply as if I were either dead or deaf ... And I remember the consultant saying to the nurse that the plaster could be taken off and I asked what was the plaster for. And was told to mind my own business" it's totally not anything to do with you."'

Along with being 'un-personed', the participants also express feelings of abandonment. Participant P[622] (child) puts it like this:

'I had been abandoned and I couldn't get out of bed. Was the place going to burn down, what was going to happen to it. Imagine children's minds. They've got wonderful imaginations haven't they? ... O, for a child to be totally abandoned, no parents, not even another human being as far as I knew ...'

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[622] Participant P (1948). Age 10 years. Child. Lincolnshire.

Participant S[623] (child), also admitted to a general hospital remembers crying a lot but not a single occasion when the nurses comforted him, his crying being consistently ignored. Participant S (child) recalls the nurses as being 'busy' rather than unkind but yet they did not interact with him unless they were undertaking a procedure. Participant S (child) had a favourite magazine (Tiny Tots) and through this had recently joined the 'Ovaltinies' but feared that he would not be able to take home the magazines and that they would be left unread in the hospital because the nurses wouldn't read them to him.[624] Similarly, Participant T[625] (child), admitted in 1934, recalls:

> *'... I can't remember any kindness being shown to me, nothing, no holding hands or sitting and talking to you or mention of your parents or anything like that.'*

Sometimes the lack of psychological care caused the child participant unnecessary fear. Participant V[626] (child) recalls:

> *'... and then we zoomed off ... into this little room, with the masked and gowned figures looking down at me, and they didn't sort of say, tell me what was going to happen. I wasn't prepared for this, and suddenly I thought I was being suffocated because there was this thing put over my nose and mouth and I was really terrified. I tried to get away ... and then I was gone.'*

Participant K[627], working on an adult ward (taking ENT children) in the late 1960s reports being unable to comfort children because this was seen as wasting time, consequently, children cried themselves to sleep. The staff were unaware of children's psychological needs but in addition to this the children were considered a nuisance because they cried. She reports:

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[623] Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.
[624] It being common practice to disallow the taking home of personal possessions because of the fear of cross infection.
[625] Participant T (1934). Age 4-5 years. Child. Lincolnshire.
[626] Participant V (1940). Age 5 years. Child. Lincolnshire.
[627] Participant K (From 1968). Nurse. West Country and Sussex.

'It just sounds so barbaric to think that you were actually involved in it and didn't realise it was very good at the time'.

Participant L[628] noted that the more treatments the child received, the more interaction they got. Sometimes, however, nurses would interact socially with the children but were expected to do this in their own time.

Typically, the child participants still cannot understand why there was so little psychological care. Participant V thought that it might have been because she was a self confident child:

'[They] probably thought "Oh, she's all right, quite a grown up little girl for her age" and they probably didn't realise how distressed I was really ... I tried to hide it because I didn't want them to think I was a baby.'

... and that the nurses did care really but that the culture of the day preventing the nurses expressing emotion:

'They did love us in their way but they didn't have a very touchy feely way of showing love in those days.'

Participant Y[629] (child), admitted in 1957 provided a similar perspective but added that it was probably felt that all parties had to 'get on with it' and that emotionality was not therefore useful. This last may relate to behaviourist notions which played down the usefulness of emotion. Perhaps too, the nurses may have felt that they were having a hard time and if they had to cope, why shouldn't the children have to do the same.

Participant AB[630] (child), admitted in 1966 to a general hospital considers that the nurses wrongly thought that she was too young to engage in conversation. Participant AB found that the staff would tell her off and criticise her but the staff offered no

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[628] Participant L (From 1953). Nurse. London.
[629] Participant Y (1957). Age 7 years. Child. Yorkshire.
[630] Participant AB (1966). Age 3-4 years. Child. Cumbria.

kindness and did not play with her or help her to adjust to her experiences. In the same way, there was no attempt to make distressing procedures less distressing and care was not modified to the participant's developmental needs. Participant Y (child), admitted to a children's infectious disease hospital[631] in 1957 also found that the nurses did not understand her developmental level. Participant W[632] (child) told her parents that the nurses had informed her that she was going to die. Probably a casual threat to entice the child to eat her rice pudding but one which failed to account for the way young children can take adult comments literally and seriously.

Participant V[633] (child, c.1940) did find some covert kindness:

'There was one young nurse called nurse [Name], I think she was quite a junior really, she was very nice, she was the only person who seemed to some how twig that I was very much missing home, because she said she missed home too. I think she had quite a large family in Yorkshire and she did come and talk to me and take time to ask me about my brothers and sisters and my parents, so I think she probably did understand. I got the feeling that she did understand that it was an ordeal. But it wasn't openly stated by any of the staff because as I said in those days the idea was that ... I mean they did actually seem to think officially that it was better for children to be separated from their parents while they sort of settled down to the hospital routine. Seems weird now but ...'

It should be noted that most of the child participants report evidence of kindness and that the nurses especially were motivated to see the children recover from their illness (see child Participants V[634], AA[635], Q[636], U[637], Z[638] and X[639]). It is possible that some participants have confused 'professionalism' and 'dedication' with 'affection'

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[631] These hospitals were unlikely to have employed paediatric nurses.
[632] Participant W (1957). Age 5-6 years. Child. Yorkshire.
[633] Participant V (1940). Age 5 years. Child. Lincolnshire.
[634] Participant V (1940). Age 5 years. Child. Lincolnshire.
[635] Participant AA (1965). Age 5 years. Child. Yorkshire.
[636] Participant Q (1934). Age 8 years. Child. Yorkshire.
[637] Participant U (1936). Age 11 years. Child. Lincolnshire.
[638] Participant Z (1953). Age 8 years. Child. Lancashire.
[639] Participant X (1930). Age 10 years. Child. Lincolnshire.

but the end result was the same, that the child participants did experience 'care' and seem to have conceptualised this on the same continuum as the affection for which they yearned. The nurses had the child's welfare at heart. The nurse participants also refer to this 'care', if in a number of different ways. Some refer to the energy expended on trying to provide the kind of intervention that children, as children, specifically needed (Participant A)[640]. Some refer to kindly personalities among the senior staff who were respected for the sort of people they were (Participant K)[641]. Some refer to a hidden 'softness' under a harder, professional exterior (Participant H)[642]. Some refer to 'hard', institutionalised nurses but who still regarded the children as people, who cared about them and who worked hard to make them better (Participant O)[643]. Other nurse participants openly used the word 'love' to describe their relationship with the child patients (Participant D)[644]: '*I find them very easy to love and to care for*'.

Unfortunately, it is also clear that some of the child participants were unable to find evidence of 'care'. Participant S[645] (child) fails to recall a single example of kindness though questions whether the nurses were too 'busy' to be kind. Nevertheless, the memory, still vivid today of crying that was deliberately ignored must indicate a 'lack of care' for the welfare of the child. Some child participants (Participant P[646] (child)) were influenced most by the lack of 'affection' that characterised the behaviourist approach of the day. Some of these child participants remain confused and troubled about why they were not cuddled when upset, why they were 'abandoned' in hospital and why they were 'attacked' and hurt:

'...And then I remember this [pause] piece of cotton wool with a hole in, I think it went over my mouth and my nose. [pause] And then [pause] I remember this spray, spraying something in my face [pause] and I remember kicking and screaming [pause] terrible. [pause] [cries] I remember [pause], Sister [Name], I think she was a theatre assistant and I remember her holding my legs down [pause] I remember her getting

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[640] Participant A (1956-1959). Nurse. London.
[641] Participant K (From 1968). Nurse. West Country and Sussex.
[642] Participant H (From 1958). Nurse. Yorkshire.
[643] Participant O (From 1963). Nurse. Yorkshire and Lincolnshire.
[644] Participant D (From 1967). Nurse. London, Bedfordshire.
[645] Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.
[646] Participant P (1948). Age 10 years. Child. Lincolnshire.

hold of my legs and holding them down [emphasis]. I don't remember anymore, but it was terrible. [pause] Those things don't happen anymore do they [question] [cries].'
(Participant T)[647]

Other child participants (Participant AB[648], Y[649] (child)) recall an emotional neutrality where there was little or no overt unkindness but neither was there any overt kindness. An important outcome of this behaviourist approach was that there was no attempt to help the child patients deal with traumatic events such as injections. Similarly, the nurses' emotional neutrality had the effect of limiting the degree to which the nurses tried to understand the child as a person, and even to understand the child's developmental level and degree of understanding (see Participant W[650] (child)). This led directly to failures of communication between the nurses and the children. It also led to a 'cold' interpersonal atmosphere (see Participant AC[651] (child)) which probably most affected more psychologically vulnerable children and which in other cases was interpreted as a lack of 'care' and a lack of concern for the welfare of the child. The child participants seem to be referring to a lack of 'affection'. They are confused by the fact that the nurses did 'care' for them (provided intervention) but showed little or no affection. It should be noted, however, that where the nurse participants mentioned lack of care, this was usually related to children admitted to areas orientated chiefly toward the adult patient (Participant K)[652], where the needs of children seem largely to have been ignored or misunderstood.

As late as 1965, Participant AA[653] (child) found that nurses did not provide the psychological care which she recognised that she needed. The nurses, however, were kind and flexible in their approach to the participant and they did try to make her stay as pleasant as possible, it was just that psychological care and play were not on their agenda. Even in the 1930s some participants did experience emotional care and

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[647] Participant T (1934). Age 4-5 years. Child. Lincolnshire.
[648] Participant AB (1966). Age 3-4 years. Child. Cumbria.
[649] Participant Y (1957). Age 7 years. Child. Yorkshire.
[650] Participant W (1957). Age 5-6 years. Child. Yorkshire.
[651] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.
[652] Participant K (From 1968). Nurse. West Country and Sussex.
[653] Participant AA (1965). Age 5 years. Child. Yorkshire.

recognised the difference that this had made to their experience. Participant Q[654] (child), admitted to a children's hospital, for example did miss her mother but coped with this largely because the nurses were compassionate and because she never felt alone. She found that the nurses tolerated her sometimes errant behaviour and that they understood her feelings and would comfort her when she was upset. Similarly, Participant U[655] (child), admitted to a general hospital has very positive memories of being in hospital in 1936. He argues that nurses were more kind than nurses are today because nursing used to be a vocation and people became nurses because they wanted to help people. Participant U (child) did find that the nurses understood him as a child and appreciated his emotional needs. However, Participant U (child) was probably an emotionally robust child who remembers the hospital experience as an exciting adventure which inspired him to want more such adventures away from home. In any case, his experiences of a general hospital are unusually positive. Participant Z[656] (child) found that although the staff nurses and sister did not provide psychological care, the student nurses did and were like 'big sisters' to them. The students probably spent more time with the child patients in the course of their ward work but they may also have had less opportunity to be indoctrinated into the emotional detachment which seemed to characterise the qualified staff.[657]

It appears that the participants' experience was made much more positive where they were able to develop a relationship with even one of the nurses, or where emotional care was provided even in limited quantities (see Participant AA (child))[658]. Participants were helped even when the emotional contact was probably more imagination than reality (see Participant T (child))[659]. In the same way, even a small amount of family involvement would demonstrate to the child that they had not been abandoned and therefore had a very positive effect (see Participant AA (child)). Even an occasional cuddle by a nurse or a demonstration that they knew and cared about

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[654] Participant Q (1934). Age 8 years. Child. Yorkshire.
[655] Participant U (1936). Age 11 years. Child. Lincolnshire.
[656] Participant Z (1953). Age 8 years. Child. Lancashire.
[657] Participant Z seems to have been admitted to a long term hospital which may not have been typical of either acute general or children's hospitals. In any case it is unlikely to have been staffed by paediatric nurses.
[658] Participant AA (1965). Age 5 years. Child. Yorkshire.
[659] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

how the child was feeling would result in the child feeling cared about. The child participants yearned for a simple demonstration of affection from time to time.

For the young child to be expected to live without those who had always cared for him or her was both frightening and unnatural. Participant V continues knowingly:

'... we were a very affectionate, close knit family and I knew they all cared about me. And you know, the idea that ... I had never been sent away on holiday on my own, the nearest thing to being separated was being sent to stay with my Grandmother in Scunthorpe when she was staying there and I mean, I was very close to her because she had lived next door to us for years. When in my earliest memories she was living next door. So I had never been with complete strangers, alone before. And it was at night that it was worst because in the daytime I could keep myself amused but at night when I was supposed to be asleep, as I say the first week I was lying there covering my head up and crying as quietly as I could. But I didn't want the nurses to know because there was very much the idea that you had to be a big girl and be brave and all that sort of thing, you know. And it was also the beginning of the war and this was another thing that made people feel they had to be brave and all do their bit and so on.'

Here, one is reminded of Yapp (1915, p. 107)[660] quoted earlier in this section:

'No one with motherly instincts will ever allow a child to go to sleep unhappy. Children respond to loving tenderness (a very different quality to kindness) generously.'

It is perhaps not surprising that the child participants varied in the degree to which they needed to feel an affectional bond with someone. They probably also varied in the way in which they interpreted affectionate behaviour. Intervention was sometimes interpreted as affection. Nurses were doing things for the children, providing them with food and drink and ensuring that they were physically comfortable. Nurses were also closely observing the children and would recognise and try to meet specific needs

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[660] Yapp, C. S. (1915). Children's nursing: lectures to probationers. London, Poor Law Publications.

as they arose (See Participant X (child))[661]. Those few children who were able to interpret nursing procedures as affection were probably more emotionally robust than the others. Participant AC[662] (child) suggested that while the interpersonal atmosphere was 'cold', she was able to cope with this but she recognised that more emotionally sensitive children might not have done.

Interestingly, some of the nurse participants had also been in hospital as children, most of these participants acknowledge that what they learned from the experience has been useful in their adult practice. Participant J[663] makes it clear that as a child patient she found that signs of friendship from the nurses pleased her and unfriendly behaviour made her unhappy. 'Little things' such as a smile meant a great deal to her and she is conscious of learning the importance of such things:

'Well there was a couple of the nurses, I probably hero worshipped them, I thought they were great and I wanted to be them. And I still remember at night, I couldn't sleep and you know they came to the central desk to have the report in the middle of the night, and one of them winked at me and smiled at me and I was absolutely over the moon. Just little things. And then another little incident which was absolutely opposite of that, I had had an anaesthetic and I was in a side ward and I wanted to be sick and I shouted and shouted and shouted and nobody came and I was sick all over the place and then they came ... somebody came and told me off and that really stuck in my brain. And I can still see her face now and I was trying to say 'well I did call' [as if upset] [laugh]. And those little incidents helped me as a nurse to know that little things matter. Not just big things.' (Participant J)

Any sign of emotional affection from the nurses or from home was important to the child participants. They clung to any sign that they were still cared about and still loved and that people still wanted to protect them. Participant Q's[664] (child) separation

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[661] Participant X (1930). Age 10 years. Child. Lincolnshire.
[662] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.
[663] Participant J (From 1962). Child 10 years. Nurse. Scotland.
[664] Participant Q (1934). Age 8 years. Child. Yorkshire.

was made much more bearable because she found the nurses to be compassionate and they were always there when she needed them.

Perhaps in much the same way, the child participants experienced empathy and were troubled when they witnessed the suffering of others. Participant T[665] (child)) reports:

'... [pause]because [gets upset] I don't know what happened to him [pause] because [gets upset] I think one of them ... was called [name], I think. He had his leg off, he'd only got a stone in it or something ...'

When the child participants were upset, they would often hide their feelings from the nurses. Participant V (child)) reports:

'... as I say, the first week I was lying there covering my head and crying as quietly as I could. But I didn't want the nurses to know because there was very much the idea that you had to be a big girl and be brave and all that sort of thing.'

The way in which the child participants hid their feelings from the nurses probably meant that they could not have received support from them. However, the child participants did sometimes give and receive support from the other children on the ward. Participant V (child) reports:

'On this night, it just happened that I was probably the only child on the ward who didn't sleep very well or was often awake in the small hours. It was all done quite discretely, it was all very quiet. I just saw that ... there were screens around this bed with a light inside and there were a lot of staff comings and goings. The people came, the Mother came and other people as well, I suppose the Father or whoever. I just know that when it was just beginning to get light in the morning, they went away, you know the light went out and the Mother was being supported, there were staff and the Mother was obviously very upset. I didn't really understand that she had died at that stage, it was later on in the morning when two porters came with a trolley, the screens were still round this cubicle. They came and they wheeled the trolley away and there

[665] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

was obviously the shape of this little girl under a blanket, completely covered up, including the head covered up and these two men were just talking quite loudly and casually about ordinary things, obviously to make it seem normal and just when they were getting to the door, one of the suddenly remembered and went back to the cubicle and brought this cage this away, which had been keeping the bed clothes off the little girl's legs. And so they were gone. And that was when the children all began to speculate about what had happened. And there was all this talk and this boy up near the door saying that he thought she's gone to an open air hospital. And some thinking she had gone home and this little boy, [Name], who's bed foot was opposite mine, being absolutely sure that she was dead. He said she ... he said 'that girl is dead'. And it was because her face was covered up. He said that people who were alive never had their faces covered up. So then I believed it, because I had been arguing with him, I didn't really believe that she was dead. And I knew what dead was because of pets who had died at home and been buried. So that was rather a shock but I think ... I don't think I dwelt on it, put it like that because there was so much happening in hospital all the time that I wouldn't say that it really frightened me. It made me sad, it sort of opened my eyes and I thought after all, we are not definitely all going to get well.'

In this way, children were exposed to sights and experiences that would have challenged many adults. Yet the child patients could only seek explanation and solace amongst themselves, as they did so, they generated fears about their own possible mortality which in most cases would have been unfounded and unnecessary. Many of the child participants expressed an ignorance of what was going on at the time and the way in which this ignorance generated unnecessary fears. Participant P[666] (child) recalls the concern about red blankets in the ambulance and their association with blood; a child with decubitus ulceration[667] and fears about how she might have come by her sores; fears about her own enforced immobility and who would protect her if there was a fire: *'imagine children's imaginations, they've got wonderful imaginations haven't they?'* Participant AA[668] (child) recalls that she didn't know how long she was going to be in hospital but that furthermore, there was essentially no communication

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[666] Participant P (1948). Age 10 years. Child. Lincolnshire.
[667] Bed sores.
[668] Participant AA (1965). Age 5 years. Child. Yorkshire.

between the nurses and her parents, so that they didn't know either. Despite the fact that Participant AA had been admitted with what would have been regarded then as a psychological problem, upon discharge, her parents were given no information regarding her treatment in hospital or advice on what to do at home. Children were discharged when they were well. She was well and so there was nothing that needed to be communicated with the parents. It was common for the child participants to be ignorant about how long they would be in hospital. Participant AB[669] (child) makes the point that not knowing how long one would be in hospital increased the feeling of abandonment and separation from one's family. The nurses and (at least the) junior doctors probably did not know themselves how long children would be in hospital. Nevertheless, they probably knew whether it would be 2-3 days or 2-3 months.

Participant B[670] seems also to find it difficult to come to terms were her early nursing experience. She reports that the induction of anaesthesia failed to respect the child's dignity and feelings and the children were given an anaesthetic that was too 'light' causing them to routinely begin to regain consciousness in the middle of the operation. She reports that the important variable was the speed with which the children were processed in theatre, the child's feelings counted for nothing. Participant B considers that she remains traumatised by her theatre experience, *'it was a total nightmare and it could have been so much nicer ... it was like an abattoir'*. The central point in Participant B's experience is that the staff deliberately fashioned procedures in order to distress children and to exert power over them. In the same way, the child participants recall being treated like 'meat', Participant B recalls that 'children were just articles to do your work with'.

It is common among the child participants for them to refer to themselves as 'meat', meaning that they were not regarded as human. Sometimes the participant uses the terms 'cold' and 'inhuman' (see Participant R[671]). The staff did not communicate with them about what was going to happen, did not reassure them (that perhaps nothing was

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[669] Participant AB (1966). Age 3-4 years. Child. Cumbria.
[670] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.
[671] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).

going to happen to them) and conducted procedures without discussing it first with the child. Participant T[672] (child) puts this very clearly:

'Well there was nobody there to ... I might have just been a lump of meat, you know ... And I was terrified of what they were going to do. [pause] Of course at that age you have no control do you and you don't know do you.'

Parents and separation

It is not surprising that issues of child-parent separation figure highly in the participants' accounts. Perhaps what is surprising is the degree to which the situation (even accepting the existing hospital culture of the time) appears to have been caused to be worse than it needed to be.

It was quite usual for parents to be allowed to come to the ward door to look at their child from the window but not to be allowed in (see Participant M[673 674] and Participant Y[675]). Sometimes the child could see, but not touch their relatives but sometimes a one way mirror prevented this (Participant C[676 677]). Participant S[678] (child), admitted to a general hospital in 1936 reports the frustration of being able to see his mother but not get close to her and the loneliness that resulted from this separation. The child and family must have yearned to touch and cuddle each other. To allow such close contact but to then deny touching must have been very difficult for the people concerned. Participant P[679] (child), admitted to an isolation hospital, also reports the negative effect of seeing her mother once a week but missing the bodily contact with her. Despite the fact that in Participant P's case, the parents had to stand outside, a bell

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[672] Participant T (1934). Age 4-5 years. Child. Lincolnshire.
[673] Participant M (1945-1951). Nurse. Essex.
[674] A general hospital.
[675] Participant Y (1957). Age 7 years. Child. Yorkshire.
[676] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.
[677] A general hospital.
[678] Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.
[679] Participant P (1948). Age 10 years. Child. Lincolnshire.

would be rung at the beginning and end of visiting time *'and it seemed very important that you [they] went on the dot of the bell'*.

Especially for young children, the hospital often seemed a long way from home, Participant S[680] (child) recalls the length of the ambulance journey and the knowledge that it meant he was being taken to a distant place, even if in reality the hospital was only a few miles away. Participant AB[681], similarly makes it clear that as a child, she had no idea how long she would have to stay in hospital. Participant Y[682] (child) recalls that she was too young to understand time and feared that her mother would forget about her and leave her in hospital. This increased the feeling of abandonment and loneliness at a time when no visiting at all was allowed. Participant S's prevailing memory is one of being alone. Interestingly, the lack of emotional care, not only meant that children were considered as less than human, but also that they perceived the nurses as less than human too. In this way, the hospital was a microcosm full of people, in which human beings failed to recognise each other as people. Participant P (child) admitted in 1948, indicates that she was 'un-personed' by the lack of emotional care.

Participant P[683] notes that the staff in one isolation hospital, sometimes left the ward unmanned and this was understood to indicate a lack of care and a lack of interest in the welfare of the child. Participant P was never comforted when she was distressed and felt abandoned by the staff. This feeling of abandonment still affects Participant P's feelings and behaviour today. She comments *'Oh for a child to be abandoned, no parents, not even another human being as far as I knew'*.

The separation from parents is still remembered with some distress by most of the child participants. Participant T[684] (child) recalls:

> *'And from what I can recollect I was in a month and the thing that really [pause] one of the things was that I never saw my parents, I never saw them while I was in.*

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[680] Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.
[681] Participant AB (1966). Age 3-4 years. Child. Cumbria.
[682] Participant Y (1957). Age 7 years. Child. Yorkshire.
[683] Participant P (1948). Age 10 years. Child. Lincolnshire.
[684] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

Everybody was strangers ... I wanted somebody there. I missed my mother [pause] I missed my mother ... But the kicking and screaming and holding me down, probably if I had had somebody to hold my hand. Like you do a cat, you know, like you stroke a cat to calm it down ... In fact, I think it was that that upset me the other day, thinking of you coming .... I seem to remember [pause] that I didn't actually see my parents, but I got to know they had been, would they have been able to look through a black screen?'

Participant T found some humaneness in the hospital chapel:

'[pause] [pause] As a child, difficult to say. [pause]. What amazes me is how I remember being in hospital [age c. 4 years] and yet I can't remember anything when I was six, seven, you know. But I remember being in hospital and how ... a terrible time it was and so alone and so isolated and afraid I think is the right word, when you look back [pause] I also remember [pause] the first time I heard the word God and I seem to remember, in fact I know we had a church service on the Sunday and I seem to remember we got a card, I look back and I think we got one every Sunday and I've looked for those cards and I can't find them. I suppose looking back that had some effect on me, for the better, that church. .... probably relief from the hospital.'

Interestingly, even when daily visiting was allowed, child participants still felt that the separation was by far the worst aspects of their stay in hospital, and this even when their family was supportive and proactive (see Participant W (child))[685]. Some of the nurse participants remain opposed to the liberal visiting arrangements of today (see Participant G[686] and C[687]). Participant O[688] argues that nurses resisted greater parental access because they were concerned about the increase in workload that it might cause.[689] Children were upset after the visiting period ended and this was unpleasant for the nurses and added to their feeling that visiting was not helpful. Participant L[690]

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[685] Participant W (1957). Age 5-6 years. Child. Yorkshire.
[686] Participant G (From 1953). Nurse. London.
[687] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.
[688] Participant O (From 1963). Nurse. Yorkshire and Lincolnshire.
[689] In the event, increased parental access almost certainly reduced the workload of the paediatric nurse. Participant L broadly defends the visiting regulations of the past but does not see them as relevant to today because of the current shortage of nurses.
[690] Participant L (From 1953). Nurse. London.

plays down the way in which children were upset after visiting time and instead emphasises that otherwise the children coped well because of the camaraderie with other children. However, evidence has been presented here that the child participants' behaviour may not have reflected the emotional turmoil that was being experienced. Participant R[691] (child) recalls that her behaviour might well not have signalled to the staff or her parents that she was as upset as she undoubtedly was:

'I think I can remember my parents go out of the door as they visited me ... and went but I don't remember being in floods of tears or anything as they went. I just sat there like a good girl and watched them go. Perhaps I was told to do that, I don't know.'

Participant R (child) also found that she could not share with her parents the humiliating and degrading hospital experiences. In this way her parents never found out about some of the most negative experiences.

Participant C[692] remains opposed to liberal visiting believing that children are robust and gain in maturity from being separated and also through the camaraderie with other children. It is clear, however, that this was not the case with most of the child participants. Even, however, where the child participants perceived themselves as coping with the separation, they recognise the lack of contact with the parents as the most negative aspect of their hospitalisation (see Participant X)[693]. Participant V[694] (child) remembers her mother's visits vividly but although she missed her parents, seems to have coped perfectly well with the absence. Even here, however, the effect of separation during illness is clear:

'... the main thing that was distressing was finding out that I wasn't allowed to see my parents for a whole week, which seemed like forever, that was really terrible because I'd never been separated from them before and I was ... very much the youngest member of my family, I was very much cosseted by my mother and grandmother as you

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[691] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).
[692] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.
[693] Participant X (1930). Age 10 years. Child. Lincolnshire.
[694] Participant V (1940). Age 5 years. Child. Lincolnshire.

can imagine, my father as well I suppose, and my eldest sister was protective towards me, so finding myself alone without these people did seem very frightening.'

Perhaps if the staff had made it clear that they understood the child's feelings and 'homesickness' the child patients might have taken some solace from this. However, as most of the child participants note (see especially Participant V[695] (child)), such recognition of psychological need was rarely if ever forthcoming.

Participant AA[696] (child) illustrates the emotional significance of a jigsaw she received from her parents, the giving of which demonstrated to her their love.

'I remember having a jigsaw, I can't remember my parents visiting much but it was a long way from [Town of domicile], we lived at [Town] and we had a small guest house and they maybe couldn't get there and perhaps they weren't advised to go, you know I don't know what they told you in those days. I remember, they bought me an 'Old King Cole' jigsaw, it was four pieces with the rhyme of Old King Cole, you know it followed it through. Anyway I don't know what happened to it. I never took it home. I remember on the way home I said 'I've forgotten my jigsaw' and they said 'never mind it doesn't matter.''

It was not of course the jigsaw that mattered to the participant but the fact that her parents had given it to her. It was a symbol of their love, inadvertently left behind, her unknowing parents response was 'never mind it doesn't matter.', they had their daughter back, what did the jigsaw matter? It mattered. It reflected their love. It 'didn't matter' meant that during all the time the child had been in hospital, their love hadn't mattered. In common with many of the child participants, Participant AC[697] (child) still possesses the Teddy Bear she was given by her parents whilst in hospital. It remains one of her most treasured possessions.

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[695] Participant V (1940). Age 5 years. Child. Lincolnshire.
[696] Participant AA (1965). Age 5 years. Child. Yorkshire.
[697] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.

Sadly, this present study identifies some very severe treatment of parents. Participant AC (child) recalls that her parents were told that they could only visit on the child's operation day, after surgery. They were not allowed to visit at any other time. This resulted in them seeing their child in a semi conscious state which would have caused them significant anxiety. This sight would have stayed with the parents for the rest of the admission during which they were not allowed to visit. This must have been a deliberate attempt to cause parents anxiety. This practice, in 1965, may have been adopted as a retaliation against increasing pressure to allow free visiting, as if 'if they want to visit, let them see things at their worst'.

Some nurse participants appear to recognise that the separation imposed on parents and children was wrong. Participant K[698], working in c. 1968 reports:

> *'And some of the things that happened were just so dreadful, you know, some of the things that were in all the research. Things that shouldn't have happened. Children were dragged screaming from their Mothers, taken away to be examined, no communication with parents, parents sent away, no visiting ... No [pause] care as to what sort of people were around them [children], who was handling them and ... and it's with hindsight that you can see, it's all [pause].'*

Participant B[699] (c. 1948) considers that children were forcibly removed from the parents in a manner which was not necessary and which was designed to distress both parties, Participant B continues:

> *'And so this Toddler that by now was distraught, sobbing, I went to pick him up, because he was just, he was just left on the cot to break his heart and sob, so I went to pick him up and just as I did, he was like a little monkey, his arms around me, and [laugh] I can still see him today, his little fingers ... I'm going to get upset again [crying] hanging up to me. [crying] [pause] [pause] it was awful [crying] [pause]. And so [crying] the good children's nurse came and put a harness on him and fastened him down [emphasis] [pause] and sob, sob, sob [meaning the child] it was awful. I*

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[698] Participant K (From 1968). Nurse. West Country and Sussex.
[699] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.

think, one of the worst things and he was just left to get on with it [pause]. And I don't know why, I don't know why, I don't know why, I don't know why [emphasis].'

Participant B felt that the children's nurses wanted to exert power over children, parents and other nurses and that this partially explained their lack of 'human' care. However, another view is expressed by Participant H[700] worked in the period past 1970 as a nurse tutor, teaching experienced General Nurses who wished to become paediatric nurses.[701] She reports that the experienced ward sisters of paediatric wards often expressed anti-parent views and that they wanted to 'mother' the children themselves.

Participant M[702] values the greater influence parents now have and to some extent sees the lack of parental involvement as a negative aspect of her own nursing. However, she feels that this is balanced by the fact that 'her' nurses had more time to get to know the children and that their care to some extent replaced that normally provided by parents. The longer patient stay and the quieter, less hurried environment and the more civilised nature of the interaction between different types of staff had an important effect on the nurses' ability to provide care that the children (as children) needed. Participant M feels that parents were excluded from care because nurses did not understand the child's psychological and social needs.

Participant L[703] remains broadly in favour of parental visiting but only as long as the parents do not get in the way of the nurses' treatments. She makes the salutary but probably valid point that parents are more useful today because of the shortage of nurses.

It is clear that parents also suffered from not being able to visit their children in hospital. Participant W[704] (child) reports:

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[700] Participant H (From 1958). Nurse. Yorkshire.

[701] In this period, the ward sister of a children's ward was required by the English National Board for Nursing, Midwifery and Health Visiting, to be on Part 8 (RSCN) of the Register. Thus many general nurse sisters had to undergo a shortened training to become RSCN. It is suggested here that many of these people entered the course under duress.

[702] Participant M (1945-1951). Nurse. Essex.

[703] Participant L (From 1953). Nurse. London.

[704] Participant W (1957). Age 5-6 years. Child. Yorkshire.

'I was admitted in 1957. I was diagnosed with TB in my hip. My first recollection is being taken up to the ward, my mother putting me on the bed and being told 'say goodbye to your mummy' and her walking down the corridor and me screaming. My mum never turned round. I later found out that if she had turned round she would have come back, picked me up and taken me out.'

It has been noted (above) that when parents did visit, they were often not allowed to hold or cuddle their child.

'The mother's dare not pick them out of the cot and cuddle them. That was the thing that really upset me, that I could not get out of bed and sit on mum's knee or granddad's knee or aunt and uncle's knee.' (Participant W (child)).

Participant Y[705] (child), admitted in the 1960s found that the nurses failed to understand her needs as a child for contact with her parents. Participant Y's mother also suffered from the separation and the fact that while monthly visiting was enabled, it was still not possible for her to touch her child. She reports:

'But the big thing was, we weren't allowed any visitors and I only saw my mum ... once a month at a gate. We used to come from the wards, walk down, the nurses used to bring us and we used to see the visitors at a gate, they weren't allowed to come in ... I remember once talking to my mum about it years and years later. I was, you know, an adult. And I said 'Oh mum it must have been really hard for you having my dad in [hospital] and me out at [another hospital]'. And she just broke down in tears and I think it was the first time ever in all those years, let it out. And she was really, really upset about it all and how hard it had been for her having a husband in one place, a daughter in another and never getting to see us.'

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[705] Participant Y (1957). Age 7 years. Child. Yorkshire.

Participant AD[706] (Parent) recalls the night when she was separated from her child:

'... and she was very upset because she didn't know what had happened and we didn't know the extent of her injuries and they took her away, I'm not sure whether they took her into the ward or not. But they took her one way, we had to go into this room, they wanted to know her details and I thought they could have got them from my husband and I could have gone with her but no, we both had to be there ... And then we went back to her and they were taking her up for x-rays. Now that was about the only thing she can remember is going in this dark room and the nurse, or whoever it was, telling me I had to go outside, which you have to when you're x-rayed. But she was screaming for me. And she said just lately, that she was being punished for coming up the village when she shouldn't have done. Anyway they x-rayed her and they told her what had happened. And they said, 'now you go home now and ring up about midnight' (because we had to sign that she could have an anaesthetic). And [child's name] was crying for me [painfully], but they wouldn't let us .... The last thing I remember was that they were cutting her Wellingtons off. I left her and ... I often wake up in the night and I can hear her.'

When Participant AD did visit her child she found that it took a considerable journey from her home to do so, a task which would have been much easier if the visiting regulations had been more relaxed. The process of visiting was demeaning, requiring checking in and waiting in poor accommodation. The visiting restrictions are seen as petty and cruel. Participant AD recognised her fortune in possessing a child who could be given to understand the visiting regulation but she did also recognise that parents of younger children had a more difficult time. Participant AD argues reasonably that her child was traumatised unnecessarily by the inflexible visiting regulations and that the effect of that experience continues to this day. Participant AD reports:

'She's grown up and married now but she still is [pause]. They went away to live in Scotland after she was married because of work or that, but she never really settled, she wanted to come back home. She lives at [a village near the maternal home] now

[706] Participant AD (1964). Child age 4-5 years. Parent. Lincolnshire.

so she hasn't far to come. But she never wanted to go from home. And I always say it's part of it, you know. But she did cling for a long time which was understandable, I thought. In fact I was going to take us when we went back to the hospital after you know, when she had to go for a check up, she went very reluctantly, I had to keep telling her, you know 'we won't be stopping, you'll be coming out and we'll be bringing you back up' [emphasis] but I suppose to her, a five year old, she would think 'well I went once before and I was in all that time', it must have done something to all the children, not just her but to all the children. There was a little boy I think, he would be about 18 months old and he had been badly scolded and he had to be on his stomach I think and Oh, he used to cry all the time. I know his mother went to see him but it must have been dreadful when she left him at that age [emphasis]. My daughter, I use to tell her, 'two o'clock, you keep an eye on the clock' I think she learned to tell the time there [laugh]. But this little boy, you couldn't tell him, you know 'I'm coming back tomorrow'. And the poor little thing was in pain, an awful lot of pain, As I say, it wasn't just my daughter .... Them poor nurses, after we'd all gone, they must have taken some settling, it can't have been easy for them.'

Even as late as the 1960s, Participant AB's[707] (child) mother was unable to visit at all. Her distress was exacerbated when, upon collecting her child from hospital, she found that the child had not been washed and that her hair had not been attended to. This is the only account of the lack of physical care amongst the participants. However, the account may indicate the beginning of a changing emphasis in nursing. It also indicates that parents would have understood the physical and other needs of their children and yet had to withdraw completely from the care arena and from the child. This must have been a frustrating and distressing experience.

Siblings were usually completely barred from visiting their ill brother or sister in hospital. This occurred to the extent that siblings would sometimes not see each other for years. In Participant W's[708] (child) case, she did not see her brother for two years and this separation is considered to have affected their relationship permanently and to

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[707] Participant AB (1966). Age 3-4 years. Child. Cumbria.
[708] Participant W (1957). Age 5-6 years. Child. Yorkshire.

this day. Grandparents too were often denied the level of access permitted of parents. Grandparents could usually visit but the fact that the number of visitors was usually limited to two, meant in practice that Grandparents tended to be excluded (see Participant AC[709] (child)). Participant AC's account also indicates that the visiting arrangements sometimes caused conflict between parents and grandparents as both vied for the chance to visit the child.

Many of the accounts of children being separated from their families indicate the presence of grief. Although their parents had not died, in a real sense the children had lost their parents and their wider family (see Bowlby 1953)[710].

Participants O[711] and I[712] argue that changes took place because of the way in which parents expected more say in what happened to their child as a result of WWII and the new NHS. Parents had more time to spend with their children and so were more likely to resist efforts to be separated from them. They argue that older nurses resisted the move to family orientated care. The older nurses, tending to be unmarried and living in hospital accommodation were more socially isolated and this was the chief reason for them failing to understand the emotional needs of family members (see Participant O and Bradley 2001[713]). In line with a number of the nurse participants, Participant O considers that she gained valuable experience from the separation of her own sibling in hospital and the way that this experience traumatised the whole family. Both younger nurses and younger doctors came from a new post war British culture which stressed freedom, ownership of society and social integration.

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[709] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.
[710] Bowlby, J. (1953). Child care and the growth of love. Harmondsworth, Penguin.
[711] Participant O (From 1963). Nurse. Yorkshire and Lincolnshire.
[712] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.
[713] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

Long term effects of the hospital experience

At least some of the child participants found that their relationship with their parents changed after their discharge home, a few needed treatment for their resulting psychopathology (see Participant J)[714]. In each of these examples, the relationship change which took place proved to be permanent. Participant R[715] (child) perceives the change to be due to the powerlessness of her parents during the hospitalisation period. This was probably made worse by medical staff criticising her mother in front of the child:

*'In a sense she was almost as negated as I was really. I mean her presence comforted me because it was my mother, like a puppy nuzzles up to its mother dog, but her ability to control the situation was actual no better than mine was and I think because I felt degraded and humiliated about things that happened to me and the way I was treated I couldn't tell my mother. Umm it quite amazes me actually, I keep referring .. and I almost resent it because I have no right to compare myself with the Kosovans or holocaust victims because I .. But it makes me wonder why they were able to talk about their experiences because I never could. By hanging on to them and not talking about them, and this is the first time in forty five years I ever have told anybody [with emphasis] umm, you preserve your dignity. If only you know, you still have your dignity. I could never discuss it with anyone close to me or with any member of my own family. It's a sort of protective shell. It didn't happen and therefore ... I didn't communicate any of that to my mother. I mean she knew I wasn't happy ... but she didn't know how I really felt about it. It damaged the relationship ... because she lost the powerfulness that my mother had. She was no more powerful than I was when it actually came to the crunch ... And it seems to me in some ways that I had more power than she did. Because somewhere along the line I ask [in his /her diary] her to go and see Dr ***** privately to ask if I can go home. But it's me that makes her do that, she doesn't do it. And that was a shift of the balance of power between mother and child that we had never had before. It turned the world upside down, I don't think I was ever*

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[714] Participant J (From 1962). Child 10 years. Nurse. Scotland.
[715] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).

quite the same again. And I also saw how other people perceived my mother ... But I distinctly remember at one point, my mother must have been called into the hospital I think because the consultant was actually there [with emphasis] ... Umm but I remember while my mother was there the doctor asking me what I usually ate for breakfast. And I said 'rock cakes'. Why I said 'rock cakes' I don't know. We certainly didn't have bacon and eggs or anything like that once in my whole life. We usually had toast or something like that we certainly didn't have the egg and the sausage line. But I must have had rock cakes for breakfast at sometime in my childhood because that was my answer 'rock cakes and toast'. Umm, and this was in the ward and he turned on my mother and said 'you have no idea how to bring up a child, how can you feed her rubbish like that?' In front of all the children that I knew on the ward and everybody else who was there. And my mother. And I thought, I mean now I would have thought it was very bad mannered and would probably clip him round the ear. But at the time I just thought he's hurt her and it's not her fault, she doesn't know any better. But it also did belittle her because here was the big, big man who was a doctor, telling my mother she didn't know how to bring me up. And I had to believe him slightly didn't I because he was the authority figure. I found that quite incredible, I can't imagine anyone doing that now. Totally amazing.'

Other child participants did suffer separation anxiety but did eventually come to terms with their experience and re-establish 'normal' relations with their parents (see Participant AB[716] (child)).

For most of the child and nurse participants, their experiences remain salient and are often treasured. For the child participants, the hospital experience often continues to have an impact on their daily lives. Participant S[717] (child) initially denied that the experience continued to affect him and recollected that he easily settled down once discharged home. However, he claims to find himself thinking about the time in hospital from time to time, despite the experience occurring in his early childhood some 65-70 years ago. It is perhaps also interesting that the participant had never told

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[716] Participant AB (1966). Age 3-4 years. Child. Cumbria.
[717] Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.

anyone about the experience of hospital, until he participated in this study. It was a common finding that the child participants would claim that they often found themselves thinking about their hospital experience, this, even when as in Participant Q's[718] (child) case the experience had been mainly very positive:

' ... sometimes, something flashes across your mind and you think ... and when I go past [Name] Hospital, I think 'where has the balcony gone'? They've taken that down , you can see where it was but ... No, no really, I mean I have no lasting resentment of it'

'No, was it an important .. of all the experiences you have had, is it one of those that you put in the 'well this was something' box?'

'Yea [with emphasis].'

'Did it affect the sort of person you became after that?'

'I don't think so, I was always horrible I guess [laugh].'

'[Laugh], in what way were you horrible [laugh]?'

'O well when I came back from [place] my family said I was horrible [laugh].'

'You were just assertive really, had a mind of your own?'

'Well yes. Yes unfortunately [laugh] it's not always good is it?'

Not all of the child participants were able to easily adapt to being at home again after discharge. Participant T[719] (child) recalls being referred to as a 'delicate child' despite only having been in hospital for the removal of an abscess. He reports:

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[718] Participant Q (1934). Age 8 years. Child. Yorkshire.
[719] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

'... I remember sitting on [Teacher's] knee and I think the rest of the class didn't like it and I didn't like it either. It was one of those things. I always blame the hospital for it you know, probably unwisely looking back. I think it was, it seemed like a lifetime to me, it was a lifetime and the fact that ... your parents weren't there, you would use the word 'trauma' now wouldn't you ... It seemed to put me back and I seemed to be a long, long time getting over it, a very long time. In fact, I didn't think I ever did get over it and by today's performance , I don't think I have [pause].'

The one nurse who had shown Participant T (child) some kindness became befriended by the participant. In time, the participant would help her with her financial problems and her accommodation in old age. Finally, Participant T (child) would settle her affairs on death and arrange for some of her estate to be paid to the local children's ward. In a real sense, Participant T's hospital experience would never leave him.

Participant W's[720] (child) account also illustrates the way in which kindness and unkindness are remembered more vividly and continue to carry importance for the individual (see also Participant AC[721] (child)). Participant W's account also illustrates the way in which the hospital experience tended to make the child participants more protective towards their own family and those for whom they cared:

' ... and I could see my mum walking and she used to promise she would wave and she never did. Her head was down all the time, so whether she was upset, she said in later years that she was, she didn't like having to leave me. [pause] that does stick in your mind. And I have never left mine, well my son has only been in once when he broke his wrist and I went with him to theatre and back to the ward and I was going to stay with him until he (well he was 15) and he said 'go home, please go home' [laugh] so I did but I didn't like it. I didn't like having to leave him. I think even now, he's 25, if he rang and said he was going into hospital, I would probably be there like a shot, much to his disgust. But I suppose that's much to your maternal instincts plus what happened to me.'

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[720] Participant W (1957). Age 5-6 years. Child. Yorkshire.
[721] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.

It is interesting that for a number of the child participants, the hospital experience was their first childhood memory. Participant T (child) recalls:

'What amazes me is how I remember being in hospital [aged c. 4] and yet I can't remember anything when I was six, seven, you know. But I remember being in hospital and how [pause] a terrible time it was and so alone and so isolated and afraid ...'

Participant AC (child) was able to give a detailed description of her hospital experience despite the fact that she was only two and a half years old at the time, this being her earliest childhood memory.

In the same way, Participant AB[722] (child) recalls:

'I can remember going into hospital quite clearly and it is one of the first things that I can remember, so I know that I wasn't very old. I was really upset because they put me in a cot. I think they had a cut off age that if you were five or under or whatever it was, then you went in a cot. I hadn't been in a cot for ages and I was really affronted by this.'

In Participant AB's (child) case, the significance of her childhood experience is illustrated by her reaction when she started her own nurse training and unwittingly returned to the ward where she had been a patient years earlier:

'I was 18 and I just walked into this room and just froze, I didn't know, I think I maybe knew that, that was the ward I had been on, I don't think it had changed, it was still children's ENT. But I hadn't been told that that was the room I had been in and I just walked in and just froze in the door.'

As has been noted, the continuing importance of the hospital experience is evidenced by the way in which most of the child participants still possess gifts that they were given whilst in hospital. On questioning, most of the participants didn't seem to know why they had held onto these gifts in preference to the many others they had received

[722] Participant AB (1966). Age 3-4 years. Child. Cumbria.

during their childhood. It is clear that there continues to exist something about their hospital experience that is important to them. However, most of the child participants are not clear exactly why the experience, or the kept gift is so meaningful to them. Participant V[723] (child) intellectualises her experience:

'... My mother sent me a comic and postcards, I've still got a postcard she sent me ... it was extremely, I look back on it as extremely interesting, extremely educational experience ... and that I had never been away from home at all. It was a very interesting experience. So, I think that it was so interesting and unusual that it has remained so very a vivid compartment of my life ... But I wouldn't say that I dwell on my hospital experience more than other experiences. But I do value it, I think it was extremely valuable and useful really.'

Participant AA's[724] (child) forgotten jigsaw (page 152), remains an important memory. It is likely that a combination of the near absence of visiting and the parents' failure to understand the significance of the gift may well have been responsible for a breakdown in the relationship between the participant and her parents, which exists to this day:

'I think perhaps it ruined my relationship with my mother through perhaps being separated, she obviously didn't stay with me. My mother and I can't stand each other, we just put up with each other now. And apparently it all happened since then. But that's not actually being in hospital as such, the physical things that are going on around you but the after effects I think had quite serious consequences.'

'And this is because you were separated ...'

'Perhaps, I don't know. Apparently I was okay with her and then I went in hospital and after that it all went down hill. And I was an atrocious teenager but that's a separate issue I suppose.'

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[723] Participant V (1940). Age 5 years. Child. Lincolnshire.
[724] Participant AA (1965). Age 5 years. Child. Yorkshire.

Participant AC[725] (child) still keeps the two Teddy Bears she was given whilst in hospital in her bedroom:

'... and he brought me a teddy bear, I still have the teddy bear ...'

'Did you keep your other teddy bears?'

'Funnily enough the Auntie and Uncle who took us to the fair, it was him that brought the teddy, the only other thing that I've got that I kept is the tiny tears doll that they brought me for the Christmas I was five. One of its legs falls off because my sister and I had a fight over it. But yes they are sat on the picture rail in my bedroom.'

'Have you a view on why you've kept the bear?'

'Possible because of the link with my Auntie and Uncle who I was very close to. Probably I was closer to them than to my parents, God this sounds like a counseling session [laugh].'

'Sorry about this [laugh].'

It may be that Participant AC (child) keeps the bears because of the association with her Aunt and Uncle. Nevertheless, it is also possible that they remind the participant of their love whilst she was separated from her family and when the demonstration of care and affection was an unusual event. Keeping the bears in her possession may indicate that it is still important to the participant that she was cared for during the time she was in hospital but that a physical reminder of that care is necessary for her to believe it. As with so many of the child participants, this may be evidence that the participant has still to achieve 'closure' and may not yet have come to terms with her childhood experience in hospital.

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[725] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.

Participant Z[726] (child) was separated from her family for several years. When she returned briefly at the age of 12 years she found that she had little in common with them and even spoke with a different accent. Participant Z (child) was never again to be reunited with her family but on release from her hospital school would choose not to return home. It is interesting that Participants AE[727] report that children who had been in hospital for as little as a month would turn back to the nurses when they saw their mother at the ward door. This, contrary to the 'conventional' history of paediatric nursing (see Swanwick 1983)[728] indicates that nurses did recognise the dangers of separating children from their parents, perhaps long before being described by Bowlby and his colleagues at the Tavistock Institute (see Bowlby 1953[729], Bowlby 1951[730], Bowlby 1956[731], Bowlby, Robertson and Rosenbluth 1967[732]).

Child participants sometimes found that parents were suddenly much less powerful than they had been before admission (Participant R[733] (child)). This was sometimes exacerbated by the child not feeling able to talk to his or her parents about aspects of treatment that were perceived as humiliating or degrading. This resulted in a divide between the child and parents which was often never breached by time. Occasionally, the distancing of the child's parents made it necessary for the child to 'stand up for him or herself', this usually developed alongside a fear of being alone and a perception that no-one could be trusted (see Participant R).

'I have told you about my desire to be in control and to assert myself. I also have an urge to protect in the same way that I wanted somebody to protect me. Among other things I do teach, I teach junior school children. I've got a sort of fight to the death, mother hen syndrome. If anybody hurt them I would probably kill them. Because nobody did that for me and I can't bear to see kids that are vulnerable. And the other

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[726] Participant Z (1953). Age 8 years. Child. Lancashire.
[727] Participant AE (1950s). Nurses. Yorkshire.
[728] Swanwick, M. (1983). "Platt in perspective." Nursing Times 79(2): 5-8. The conventional history of paediatric nursing places the work of Bowlby as being central in a re-enlightenment of the social and psychological needs of children.
[729] Bowlby, J. (1953). Child care and the growth of love. Harmondsworth, Penguin.
[730] Bowlby, J. (1951). Maternal care and mental health. Geneva, World Health Organisation.
[731] Bowlby, J. (1956). "The effect of mother child separation: a follow up study." British Journal of Medical Psychology 29: 111.
[732] Bowlby, J., J. Robertson and D. Rosenbluth (1967). A two year old goes to hospital. The psychoanalytic study of the child. New York, International Universities Press Inc. 7.
[733] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).

thing is that I trust very few people. I have loads and loads of friends and acquaintances. I have about two close friends who I would tell anything to and that is about it, I don't trust anybody. I really, really don't.'

'And you feel that this comes from your hospital experience?'

'I know it does yes. Because I was betrayed again and again by people that I thought I could trust. I mean in some cases they were doing their job but they weren't doing it properly. They weren't doing it as they should with a sick child. In some ways they were doing what they had to do but there are ways of doing it. And I didn't trust them anymore because I never knew what they were going to do to me. Some of the things weren't very nice at all . They had to be done, I appreciate that, I know that. But there are ways of doing it, they could have made it so, so much more easy. They didn't do that.'

I have a terrible fear of waking up alone. I sleep very late sometimes because I work funny hours. My family, if they leave the house before I'm awake, always leave a note by the bed 'gone to school, gone to work'. Because if I wake and the house is silent I'm literally terrified for a little while. And I think that comes from waking up and mother wasn't there, waking up alone, petrified. I have a permanent vision of the windows of the hospital. I think it must have been [Hospital] because our home wasn't all that far from [Hospital]. And I think my mother had said 'if you look through the window you can almost see home'. And I can still see the shape of those blasted windows. They were long ones with a bar across the top. And that is just an abiding memory of desperate loneliness, desperate loneliness. Which is another reason why I have an obsession about keeping in touch with people. I can't say goodbye to anybody. My own stepdaughter went to India for a year, last week with VSO and she was supposed to ring us from the departure lounge before the plane took off and I couldn't take the call I had to get someone else to take and give my apologies. I can't say goodbye to people and I must have the longest Christmas list in the world. And I send them to people I have known in my past, I can't let go of people. Because it's like my mother, they'll disappear and I'll be left on my own again. So I have to keep the treads together. It's part of my control freak. Outside it looks all confident. You know it's like the swan all

very smooth but paddling like hell underneath. That's me, I've got a very protective shell but underneath there is a kid who is terrified. It is still there [with emphasis]. Always be there.'

It is not suggested here that the child participants suffer from any degree of psychopathology as a result of their hospital experience. It is suggested, however, that in many cases, the child participants continue to fail to understand their experiences. In particular, they fail to understand why they seem not to have been loved and received affection whilst they were in hospital. Sometimes the child participants openly expressed a lack of understanding for the apparent lack of love and care, sometimes the participants seem to cling onto the briefest example of affection or tangible evidence in the shape of a gift received at that time. It is suggested here that this last does illustrate a lack of closure or failure to 'come to terms' with the hospital experience. As a result, the experiences continue to have an effect on their daily lives.

The child participants often recalled that after their discharge home, everything carried on as usual although several child participants recall having some difficulty settling down again at home (see Participant C[734]). However, it was often apparent that the hospital experience had never really been resolved (Participant P[735] (child)) or that the hospital experience remained an important event in the 'child's' life (Participant V[736] (child)). Occasionally, a child participant found that some good had come of the hospital admission, in most of these cases, the experience is seen as either 'maturing' or that it resulted in a strengthening of relationships within the family (Participant W[737] (child)).

For some of the child participants, a major life event would cause them to relive their hospital experience. When Participant P's (child) husband died suddenly it brought back fears of abandonment and memories of her childhood admission to hospital:

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[734] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.
[735] Participant P (1948). Age 10 years. Child. Lincolnshire.
[736] Participant V (1940). Age 5 years. Child. Lincolnshire.
[737] Participant W (1957). Age 5-6 years. Child. Yorkshire.

'And the doctor, once again, I was always led to believe that when it was bad news you sat someone down somewhere. And I stood up you see, when the doctor got out of the ambulance and he just walked up me and said 'I'm sorry, your husband is dead'. And I just stood there and looked up at the house and thought I would run away. I could see my parents and they are both dead. Then I thought, you can't, you've got two children, you can't run away. They don't live with me, they didn't live with me and then I suddenly thought, do you realise that you have suddenly become the head of the family .. all alone. I didn't go to bed that night but the first night I went to bed I relived that ... abandoned. As I say, no one can have a heart attack and abandon their wife, you know what I am saying.'

Participant T[738] (child) was admitted to hospital recently for a minor operation on his hand but had to be discharged again to receive professional support so that he could go through with the operation. His fear of being held down for the anaesthetic almost prevented him having the surgery he needed.

One participant (Participant Y[739] (child)) developed what appears to be an aversion to the signs and symptoms associated with her childhood hospital admission (Tuberculosis). She is now conscious of a fear of being thin which she associates with disease and death. She has since come to recognise that her over-weight 'problem' is due to her early childhood experience of being in hospital with T.B. and the associated fear of becoming thin.

Parents too were traumatised by their child's admission and the separation and concern that ensued. Participant AD[740] continues to feel strongly that both her and her child were traumatised unnecessarily by the admission to hospital and that the effect of that trauma is still very real today. Participant AD recalls:

''I left her and ... I often wake up in the night and I can hear her''

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[738] Participant T (1934). Age 4-5 years. Child. Lincolnshire.
[739] Participant Y (1957). Age 7 years. Child. Yorkshire.
[740] Participant AD (1964). Child age 4-5 years. Parent. Lincolnshire.

The long term effects of the experience of nursing (nurses)

The nurse participants also tended to portray a set of experiences which they clearly cherished or at least saw as valuable. Participant L's[741] account for example, clearly portrays a work history that remains personally salient and valuable:

'You seem to have enjoyed the time you were nursing children ...'

'Oh yes, definitely [emphatically] ...'

Participant D[742] reported that the experience of being a student nurse did shape the sort of person she eventually became. An important component of this was the way in which her care of seriously ill and dying children taught her to value good health and life itself. Participant D still finds herself thinking about her early nursing experience and especially the time when she was a student paediatric nurse:

'The experiences that you had at that time, do you think they shaped what you became as a person?'

'Yes [emphasis]. Oh, yes.'

'And in what way?'

'Well, I may be going off the point here but half of the children in that hospital seemed to be there for one or other reason or another connected with the fact that they had some form of Spina Bifida[743] or Hydrocephalus[744] because that was the huge bulk of children with that problem then because they were able to be treated. The Spitz-Holter valve[745] had been recently invented and surgery was growing apace. And so you

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[741] Participant L (From 1953). Nurse. London.
[742] Participant D (From 1967). Nurse. London, Bedfordshire.
[743] Myelomeningocele (usually), a congenital abnormality of the spinal cord, causing dysfunction (usually) affecting the muscles of the leg and bladder.
[744] Hydrocephalus .. sometimes loosely referred to as 'water on the brain' and meaning a pathological dilatation of one or more ventricles with Cerebro-spinal fluid, resulting in compression and eventual dysfunction of the cerebral cortex. H. often occurs with Spina Bifida.
[745] The first valve device which when implanted in the ventricular system, reduced the intraventricular pressure to normal and so counteracted the effect of the hydrocephalus on the brain.

couldn't not be aware of children who were grossly handicapped which made one very conscious of .. if you weren't yourself, you know good fortune.'

'So you saw children in difficult situations and that somehow had an impact on you.'

'Yes, it made you aware constantly that good health is inestimable good luck really and good fortune.'

'Do you still find yourself remembering those times?'

'Very much [emphasis]. Yes, yes. Well they are kind of the background.'

'And it is a positive memory on the whole?'

'Yes.' ....

'So you regret nothing?'

'That sounds a very arrogant thing to say put like that. I'm not saying that I haven't got any regrets. I'm sure I could have been a better student and a better nurse and all the rest of it. I'm not saying that. I'm only saying that I would make the same decision. I don't ... professionally, if I had my chance all over again, I would still train to be a children's nurse. I would still expect to put a lot in and get a lot out.'

Similarly and in common with most of the other nurse participants, Participant J[746] reports:

'Yes. Yes, I can remember a lot of the children, even though it is a long time ago.'

'So these were probably valuable experiences, in that you still remember them now.'

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[746] Participant J (From 1962). Child 10 years. Nurse. Scotland.

'Yes.'

'Does that period, do you think that it contributed to the sort of person you are now?'

'Yes. Definitely.'

'Can you tell me in what way?'

'I think everything you do in life has an effect, not only on yourself but on your family. Not only on the family but on the wider ... I think you have a duty to do your best with what you're given.'

'So it was a significant experience?'

'Yes. '

As already noted, not all of the nurse participants view their past as positive, some seem to have much the same difficulty in coming to terms with their past as do the child participants. For Participant B[747], the experience of working in theatre as a student continues to be upsetting, *'it was a total nightmare and it could have been so much nicer ... it was like an abattoir'*. Participant B feels sure that the experience has traumatised her.

The above provides evidence that both the child and nurse participants continue to be affected by their experiences of hospital life. The experiences remain salient and are considered to be an important contributor to what each person (participant) has become. The experiences have played a part in the shaping of their personalities.

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[747] Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.

Violence

Abuse is unexpected because through much of this period the hospital institutions depended upon voluntary contributions[748] and so would not have wanted stories of violence or unkind treatment to receive public attention. In the 1920s and 1930s and before WWII, however, it would not be altogether surprising if some sick children had been treated more harshly than would be considered necessary today. In the 19th Century for example, it was common practice for a tonsillectomy to be performed without the use of anaesthetic (see Ashby and Wright 1899)[749].

Twistington-Higgins (1952)[750] points out that at least in the early days, nurses would be dismissed for hitting a child. However, it was perhaps the way that painful treatments were used that causes the most concern. Some of the child participants recall being held down during the induction of anaesthesia[751] or other treatments. In many cases this was done without preparing the child for what was going to happen and without seeking the child's co-operation. Participant S[752] (child) considers being held down for induction of anaesthesia to have been 'barbaric'.

Privacy seems not to have been considered through most of this period. Adult patients would have been screened off while they had treatments performed. The lack of privacy caused embarrassment but it also meant that children could see painful procedures being carried out on other children. This last frightened them, partly because it made them wonder whether the same thing would be done to them. Participant T[753] (child) recalls:

' ... But this other lad, they took something out of his back, I don't know but I don't know whether I'm imagining it or not but I can nearly see it now and they didn't draw the curtains and if they did I can see it.'

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[748] Abel-Smith, B. (1960). A history of the nursing profession. London, Heinemann.
[749] Ashby, H. and G. A. Wright (1899). The diseases of children, medical and surgical. London, Longmans.
[750] Twistington-Higgins, T. (1952). Great Ormond Street 1852-1952. London, Odhams Press.
[751] Induction of anaesthesia ... the initial stage of anaesthesia when unconsciousness is produced.
[752] Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.
[753] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

So they took something out of his back in the ward area where you were?

'Yes. [pause] Whether I'm imagining it or whether it was something they were putting in or ... some tool or something, I mean I was only young, but I remember the blood [pause] and of course I remember looking and wondering what they were doing you know.'

Parents too were sometimes subjected to unnecessary trauma and note has already been made of two examples of this (see Participant AC[754] and Participant R[755]). Participant AD[756], a parent of a child admitted to hospital remains critical of the systems in place at the time. She remains aggrieved at the separation that took place and she regards it as cruel. Participant AD continues to regard her child and herself as being unnecessarily traumatised by the hospital admission, trauma that has never been resolved:

'But it wasn't easy and I'm pleased it's better than it was. Not quite five and suddenly leaving you and going away, and not there next morning and she would still be in shock and woozy after the anaesthetic, and mum wasn't there [exclamation]. Must have been awful [emphasis] for her, for any child. When you think, wasn't it cruel [emphasis]. So I am pleased it changed. It wanted changing. It was wrong for parents to allow it to happen, leaving her in this state, but we didn't [as in didn't seek to change the system]. Not just me, all of us, we used to come out and say 'oh crikey, can you hear mine', 'oh mine's still crying', you know as we were going down the corridor we could still hear them. We should have said 'right, let's go back and tell them we are stopping' but [pause] you didn't. I think they would nowadays.'

Some of the participants remember being smacked by the nurses. In each case the perpetrator was probably a nursing auxiliary (see Participant AA[757]). The smack was

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[754] Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.
[755] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).
[756] Participant AD (1964). Child age 4-5 years. Parent. Lincolnshire.
[757] Participant AA (1965). Age 5 years. Child. Yorkshire.

probably born out the frustration of trying to get work done when children were being less than co-operative. In each case, the smack seems to have hurt psychologically rather than physically and it tends to be remembered vividly by the participants. For Participant W[758] (child) the smack was probably culturally acceptable at the time although still inappropriate for the situation. Nevertheless, the smack remains as a particularly significant and negative memory for Participant W.

Sadly, a small number of the child participants were subjected to more direct forms of abuse. Participant V[759] (child) recalls the junior sister performing 'deep cleaning' of the umbilicus. The umbilicus is sensitive if it exposed to pressure, resulting in pain. Participant V's condition was not related to her umbilicus although she had had abdominal surgery which would have made such a procedure more painful.

' ... the only thing that I really remember as a frightening experience was that sister who was fond of probing about in children's navels. That really was frightening. I just felt that there was really something very funny about it although I couldn't put my finger on why it was funny and I just thought that was what they did in hospitals ... Well there is that thing about the navel, that is a really horrible memory. It seems so sort of bizarre and melodramatic and perhaps it seems worse to me than it really was. It was just the feeling that this lady was somehow enjoying hurting me, although she wasn't unkind in any other way. And she wasn't the sister that the nurses resented. So I think it was just one particular peculiarity that she had, she probably didn't even realise how weird it was, you know. As I think I have probably said, probably now she would get counselling or something ... for this little aberration. I'm sure she wouldn't have harmed a child deliberately. She probably just thought she was being extra hygienic you know.'

But you don't think so?

'Well, I don't know, I mean these are the memories of a very young child, I've never experienced any [pause] anything like it at all. I mean the idea that any grown up

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[758] Participant W (1957). Age 5-6 years. Child. Yorkshire.
[759] Participant V (1940). Age 5 years. Child. Lincolnshire.

might want to hurt me in any way and in such a weird way ... But this was [pause] I had never had any experience of something weird and ... I mean what I now look back on is a rather weird sort of psychological twist in someone's character.'

In other respects, as far as you remember, she behaved normally ?

'Absolutely yes, I mean she was very .. both the sisters were strict, I mean sisters were strict but with the staff as well but that was the only thing that actually hurt me. It was the way I was sort of ... well it wasn't agony but it was very, very unpleasant and I can well remember wriggling about, sort of squirming about ... I can remember her, and the nurses sort of standing around, because she always used to say at that particular time, that she would take over to do that bit. So they must have known, those girls must have realised that there was something weird, a wee bit funny I would have thought.'

Was she visible to the other nurses?

'Oh absolutely, this wasn't done behind curtains or behind closed doors or anything like that. It would just be odd times during the day, perhaps on a quiet afternoon, she would say 'we'll do a couple of blanket baths now' you know there would be nurses doing it, but to do this particular process, this navel business and they would see, they would just have a moment's rest you know, just waiting to take over and finish the blanket bath. I can well remember how I used to squirm and say 'oh no, please, no sister', and she would be tickling me with one hand and still sort of doing this navel digging with the other, it was horrible. My navel was very sensitive and maybe it was because a bit more sensitive because I had just had that surgery near it recently, not very nice. But I don't know, I don't feel any resentment now looking back. I don't suppose she realised quite how awful it was. Of course she should have restrained herself, if she ... I mean, presumably anything that was going to hurt a child, presumably they should have stopped. Oh, I don't know.'

So your perception of that was that basically it was wrong, that this was something that shouldn't have happened.

'I just had a funny feeling that somehow, she ... as I say she was very lively and high spirited at that particular time, it always seemed to bring her very much to life, these operations, cleansing navels. I did rather ... I had a sort of feeling that somehow it had something to do with ... the fact that she was so high spirited at that time seemed to have something to do with this process but obviously I couldn't really explain it or understand it. And for all I knew that was what they did in hospitals, I'd never been in a hospital before.'

It was not uncommon in this period for babies with congenital abnormalities to be killed. This was, it appears, carried out, out of a feeling that it was the kindest thing to do. Participant C[760] discusses the 'treatment' of babies with Myelomeningocele (Spina Bifida):[761]

'Only one had movement in their legs. Only one survived.'

Were they being treated at that time, or ...

No, no, no, no, just gave them tender loving care and boiled water. The bigger babies survived for weeks but the little ones only days. No, nothing could be done for them, they couldn't be repaired surgically. Things are different now ... And the doctors were very good, they talked to them [to the parents] saying 'there is nothing we can do, there is no hope', it's hard but it was accepted.'

Participant J[762] has similar experiences of children 'being allowed to die'.

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[760] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.

[761] Spina Bifida can affect any level of the spinal cord, below which the muscles are usually paralysed. Sometimes, unusually, the baby does have use of his or her legs and the bladder functions normally, meaning that walking (if with aids) and micturition will occur normally.

[762] Participant J (From 1962). Child 10 years. Nurse. Scotland.

'Fallot's Tetralogy[763]*, they could just about manage to help that. Anything a bit more complicated, they used to come to us and died. They were ... towards the end, they were doing an awful lot more than they were doing at the beginning. They became a little bit more ... when we used to get babies in, in the beginning nobody actually said what the policy was, one baby was anencephaly*[764]*, hardly any head at all. And they just put a wee bonnet on it and they put it in an incubator and you weren't to feed it, so there was no drips, no nothing and they got a bottle but it couldn't feed anyway and you had to make ... I think it was for the parents, you just made a pretence of trying to feed it but you weren't really feeding it ... and they just let it die, things like that, sort of badly deformed babies, they didn't do anything [emphasis] for them. And in fact the doctor would come along and 'oh just give me a minute' and a wee huddle of doctors would just come in and they would come out, within about an hour, you'd find the baby was dead. And it was ... nothing was actually said and it was just understood that possibly, they gave it something, not exactly a lot but a bit more medication or something and there wasn't a fuss about it. It was just accepted. But I think if anything like that happened now, somebody would say 'I saw doctor so-and-so, he went in at such and such a time', and a big case would be made.'*

It seems ironic that perhaps paediatric nursing's earliest history rests with the 'killing nurses' and 'church-yard luck' of the 19th Century and earlier (see Hardyment 1995)[765]. In the scientific age and at the end of the 20th Century, the 'killing nurses' were still at work. Just as in the 19th Century and earlier, they were working at the fringe of the law and determining themselves, on the basis of degree of handicap, who should live and who should die. Nurses worked to help children recover health, but they were in command and parents had no say in what happened to their child, they were not even involved in decisions about whether their child's life should be terminated. This all happened in a 'Western' and 'civilised' country where laws existing to prohibit the killing of children.

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[763] A serious congenital heart abnormality which at this time was being treated with a good degree of success.

[764] Literally 'without head', a condition where major parts of the brain are missing and which remains incompatible with life.

[765] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

Participant R[766] (child) appears to have been sexually assaulted by one of the female nurses, her account is particularly traumatic:

'... I am fairly sure that I was abused when I was in hospital. I can't say this specifically because I don't know what she did. But it was a nurse. It was certainly at [hospital] ... And that probably left the greatest wound on me of the lot. I am married now and we had kids and things are all hunky-dory. But my first marriage I was actually married for twelve years and the marriage was never consummated because I just couldn't and it dates back to that. I don't know who she was, I really don't but I hope she had a miserable life. That was awful. I don't know what she actually .. well I do know what she actually did but I don't know entirely what she did. But the thing that is associated with it most and that made the wound was because she drew all the curtains around the cubicle and I thought this was quite dinky, because I had never seen curtains drawn before probably. I don't know but I thought it was splendid. And I said 'O, it's a little house'. And she said 'yes it is, it's a little play house. We can play together, can't we'. Well that was the first time anybody had showed any kindness. How wonderful, somebody wanting to play, we'd got a little house. She said 'yes we can, we'll play mummies and daddies', she said. The rest I'll leave to your imagination. And it isn't what she did that is the problem, it's the violation of the trust. If it had just been some child heaved into the hedges and raped by somebody .. that's dreadful but the trust hasn't been betrayed because there wasn't any. But I trusted her and I thought we were going to play. And I have never ever forgiven her for that. I really really can't. That was the most cruel thing of all. We had a kid who was desperately unhappy and very ill I might add. But if you're going to damage a child don't do it in an atmosphere of trust, just do it in anger anyway. That is the abiding thing that I recall.'

The participants' accounts offer few examples of violence or what would now be called abuse. What examples there are probably indicate a key deficiency of the system of discipline and hierarchy, professionalism and emotional neutrality. Such a culture

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[766] Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).

inevitably leads on to the perception of child patients as something less than human and this in turn to their human degradation and abuse. Such things did not characterise paediatric nursing but do indicate the direction in which the culture of paediatric nursing may have been travelling.

Conclusion

In detail, the child participants refer to being treated as inanimate objects, whose opinions and feelings were immaterial and ignored. Even parents were ignored and in much the same way. Children were there to 'be done to', their physical recovery was important, but their minds and their souls could be ignored and were sometimes abused. The child participants refer to a lack of bodily contact, of being un-personed and of being deserted and alone, powerless and vulnerable. Some of the child participants recall crying for long periods of time while being ignored by the nurses. Crying was an undesirable behaviour, to be extinguished by ignoring it.

For the child participants, these experiences seem to have exacerbated the separation from their family. The hospital staff even seemed to use this key negative experience to turn the screw on their child patients, children and parents were allowed to see but not touch their loved ones. Children were told that their parents had visited and were left to work out why their parents had apparently chosen not to come and see them. Parents had to watch their children through a one way mirror or through a window, or from the hospital gates. An analysis of the risk of cross infection would have determined this practice to have been without support. The child participants yearned for evidence of love and affection, yet even here the nurses created harm. When parents gave their children sweets they were 'stolen' by the nurses. The sweets represented their parents love and were evidence of their continuing affection for the child, yet even this was removed as if it were nothing more than a bag of unnecessary calories. Nursing pretended to be superior to mother care because it employed science. In reality, this was nothing but a confidence trick which hid practices that were unnecessarily cruel.

Nurses did know that these practices were causing harm. Participant T[767] (child) put it well when he claimed:

' ... probably if I had had somebody to hold my hand. Like you do a cat, you know, like you stroke a cat to calm it down.'

Like most of us, Participant T (child) possesses a degree of empathy, a degree of shared understanding, even with his cat. However, his experience was that even this degree of empathy did not exist amongst the nurses.

In the minds of the child participants, emotional neutrality was associated with a lack of empathy and a lack of empathy in its turn with cruelty. At least for some child and nurse participants, the hospital ward seems to have been perceived as a place without empathy or kindness.

It is important to note that there are here, examples of individual nurses who continued to practice emotional and psychological care. Some of the child participants were exposed to a degree of kindness and 'care' made all the more significant when the prevailing culture is taken into account.

The experiences presented in this study appear so much more important because of their lasting nature. The experiences of both nurses and children, those experiences that were good and were bad, tend to be valued and treasured. The evidence of this personal significance is that participants tend to find themselves thinking about their hospital experiences. Those that had bad experiences had usually not told anyone about those experiences until this present study facilitated them to do so. Child participants clearly clung emotionally to the things that had been good, to evidence of the parents' love for them and evidence that the nurses did really care for them. Today, their parents' gifts sit on bedroom shelves as if it is still necessary to be reassured that their parents really did love them when they were in hospital. Child participants characteristically fear desertion and loneliness and cling to the relationships with their

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[767] Participant T (1934). Age 4-5 years. Child. Lincolnshire.

family and with others. They fear 'goodbyes' and 'letting go' and expend energy in keeping in touch with the people they love. The child participants' relationship with their parents was sometimes damaged by their separation and hospital experience; the effect tended to be permanent. These are important effects and are commensurate with the experiences of those who have been traumatised by war and abuse. These children were admitted to an hospital, a place of hospitality, a place of treatment and of care. Their parents had faith in the health care system of the day and faith in nurses to do their best for their child. This was a trust that was violated in the name of professionalism, science and an overly energetic respect for senior staff.

The child participants were exposed to unnecessary trauma via hospital policies and accepted procedures. Examples put forward by individual child participants indicate that these practices were not necessary and that they could and should have been avoided.

Sadly, there is evidence presented here that some of the child participants were physically and even sexually abused. It is suggested here that this is merely a natural development of emotional neutrality and with it the trivialisation of 'love' and 'affection'. This last is associated here with professionalism, idolisation of senior staff, submission to authority and the acceptance of science as synonymous with the 'known way'. It is into this arena that sick children were admitted and in which some of the child participants suffered, as they suffer still.

It is clear that paediatric nursing did fail to accommodate the psychological, social and individual needs of children. Furthermore, it is argued that this failure resulted directly from the adoption of the scientific paradigm as it was understood at the time, and the concomitant abandonment of nursing's historical perspective on 'care'. It should be perfectly clear, however, that nursing did not exist alone; Medicine is also criticised here, especially because it was the lead health care discipline and because it claimed to practice 'science'.

This chapter has identified a number of key issues relating to the effect that nursing's system of discipline had on the child and nurse participants. It frightened most of the

child participants and significantly exacerbated the negative experience of being in hospital. Nursing's flawed attempt to be 'scientific' and 'professional' resulted in children experiencing nurses as 'emotionally neutral'. Sadly, this was interpreted by children as the nurses not having affection for them. To young children especially, this was very negative; children need affection, they need to be positively regarded and know that they are liked[768]. Generalised care embraced the 'scientific' approach to children and emphasised the need to be objective and unemotional when addressing child care issues. This emotional neutrality contributed to the child participants' fear, anxiety and sense of abandonment, the feeling that no-one cared for them.

The 'science' in nursing was flawed because it had nothing to do with a methodological approach to discovering new approaches to care but instead with accepting the status quo as it existed in the literature.

Castle (1987, p. 9)[769] found (Australia) that '*The living-in requirement meant a thorough integration of working and non-working life making ward discipline and the protocol of rank automatic responses for most trainees*'. In Britain and within this period the entire hospital staff and not just the nurses were institutionalised, their lives intertwined with the hospital institution and this in turn created a situation where no-one at any level could initiate change, especially in relation to practices that affected more than one ward. The rules had to be obeyed by both doctor and matron. The 'known way' and emphasis on ensuring the job was done well, rather than 'done better' largely prevented the development of analysis and evaluation, even in the most senior and experienced staff. No one person was responsible for the development of practice and it would have required the dissolution of the system of discipline, hierarchy and institutionalisation for this to change.

The system of discipline and hierarchy was synergistic with the institutionalisation of the hospital staff and created a profession which was attractive to those who enjoyed exercising power over junior staff or who were prepared to subject themselves to the will of others rather than to think for themselves. Senior nurses were respected by

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[768] Illingworth, R. S. (1956). "Young children in hospital." Nursing Times **03/02/1956**: 112-115.

[769] Castle, J. (1987). The development of professional nursing in New South Wales, Australia. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

junior nurses. However, they were respected for their place in the hierarchy and not for their professional achievements. The nurse participants placed emphasis on this 'respect', the lack of it being blamed for much of the perceived deficiencies in modern nursing. The positioning of 'respect' on the hierarchy rather than on professional achievement meant, however, that 'respect' strengthened the system of discipline, hierarchy and institutionalisation and in so doing depreciated notions of change, evaluation and research. The nurse participants tended to value this system where there was a known, prescribed and learned way to paediatric nursing practice and to the life of a nurse. It was a physically hard but socially and cognitively comfortable occupation and one in which the nurse participants felt secure and supported.

Institutionalisation and the system of discipline and hierarchy depended upon there being a known way of practising paediatric nursing. This probably worked well for physical care but could not be applied to the child's individual emotional, spiritual and social needs. These could simply not be prescribed because they were subject to individual differences. It follows that care could not be individualised. In any case, this would have been against the perceived notions of science and professionalism which with the prevailing doctrine of behaviourism and the concomitant social events of eugenics (see Grier 1998 and later chapters)[770] and an increasing state intervention in the lives of families, promoted and required uniformity. The result was that the child participants felt that while their bodies were cared for, their other needs were largely ignored by both the system and the individual nurses. What the child participants needed most was to know that the staff had a sense of affection for them as individuals and to receive comforting and reassuring words and physical contact when they were unhappy and upset. They yearned for affection. Instead they were met with emotional neutrality which they interpreted as the nurses not caring about them as people and of being treated as sub-human beings or even inanimate objects.

It should be understood that the nurses probably did care about the children and there can be no doubt that the nurse participants did. This last notwithstanding, the child participants did interpret nursing as lacking in 'human care' when human care was

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[770] Grier, J. (1998). "Eugenics and birth control: contraceptive provision in North Wales 1918-1939." Social History of Medicine 11(3): 443-458.

what they most needed. Some of the child participants dealt with this better than others, possibly those with a more robust psychological constitution, those older rather than younger and those who were used to being cared for by people outside their immediate family. It is clear, however, that some of the child participants have yet to come to terms with their experience and are still traumatised by it.

Some of the nurse participants regret the passing of the system of discipline and hierarchy. However, almost all of the child participants see modern paediatric nursing practice as a significant improvement. Those child participants who may still be traumatised by their experience seem to obtain considerable solace from the knowledge that children's services now appear to meet the individual psychological and social needs of present day children.

Two principle questions derive from this data. How could it be that such a culture of nursing developed from the holistically driven nursing of the late 19th century and early 20th century. Secondly, what societal events caused the eventual breakdown of this powerful health care culture to result in paediatric nursing adopting a family centred, holistically driven and individualised care focussed provision? It is these questions that are addressed in the following two chapters.

DISCUSSION OF RESULTS

Chapter 6: factors influencing the acceptance of non-individual care

Introduction

Bradley (2001, p. 45)[771] argues of paediatric nursing that *'It is a matter of concern, both to historians and makers of current policy, as to why change took so long to become accepted and established in practice. It is also an area which until recently has remained virtually undisturbed from an historical perspective.'* It is hard to understand how the nurse, parent and childhood experiences illustrated in the previous chapter could have taken place within what was demonstrably an atmosphere of care. This chapter will try to identify possible causes for the lack of psychological, social and emotional care provided to hospitalised children between 1920 and 1970 as evidenced in the previous chapter.

In this chapter, it will be argued that within the early part of the period in question (1920-1970), paediatric nursing began to adopt the professional behaviours of doctors and in so doing embraced the notion of 'science' and 'professionalism'. Rafferty et al (1997)[772] for example, suggest that history has been used to justify the 'scientific' (p. 3) basis of nursing values, claims to professionalism, the independence of nursing from medicine and the pursuit of autonomy.[773] During the first half of the twentieth century, improving social conditions were probably responsible for an impressive range of medical developments. These developments benefited the Medical profession which increasingly began to look 'scientific' (see Porter 1997)[774]. It will be argued here that three prevailing social constructs facilitated this process as the notion of 'science' continued to dominate professional life. It will be argued that increasing state and professional intervention in the business of families were founded on what were

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[771] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

[772] Rafferty, A. M., J. Robinson and R. Elkan (1997). Introduction. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[773] It will not be argued here, that paediatric nursing sought independence from Medicine or doctors.

[774] Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.

considered to be scientific principles, principles which separated these activities from what families could do for themselves. Maxwell (1997)[775] goes as far as to suggest that child care and welfare should be considered as essential components of what Rafferty et al (1997, p. 8)[776] refer to as 'the wider goals of social regulation'. It is suggested here, that the dominance of behaviourism[777], state intervention (Davies 2000)[778] and the eugenics movement[779] [780] acted in synergy to create an environment which stressed the importance of 'science' and the superordinate knowledge of professionals but where children's individual and holistic needs were trivialised and went unmet. In the same way, the influence of parents was decreased and professionals were seen to have legitimate authority over the child. This was a migration from the situation prior to 1900 when the family was the principle institution of influence (Hendrick 1994)[781]. Hendrick (1994, p. 20)[782] suggests that:

> *'.. since the early 1900s, war, welfare, a changing social fabric and psycho-analysis and medicine, have profoundly affected the ways in which childhood has been 'put together'.'*

It is suggested here that as the influence of parents declined, the child increasingly became subject to the will of professional doctors and nurses. In this way, Hendrick (1994, p. 2)[783] argues that '*Much of the history of social policy ... is in fact the history of the imposition of adult will upon children's bodies.*'[784]

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[775] Maxwell, J. (1997). Children and state intervention: developing a coherent historical perspective. Nursing history and the politics of welfare. A.-M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[776] Rafferty, A. M., J. Robinson and R. Elkan (1997). Introduction. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[777] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.

[778] Davies, R. (2000). "Children's nursing: achievements in child health over the first half of the 20th century." British Journal of Nursing 9(1): 28-32.

[779] Galton, F. (1905). Eugenics, its definition, scope and aims. London, Sociological Society of London.

[780] Grier, J. (1998). "Eugenics and birth control: contraceptive provision in North Wales 1918-1939." Social History of Medicine **11**(3): 443-458.

[781] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

[782] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

[783] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

[784] See Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge. for a full account of the changing social construction of children and childhood from the 19th century to the later 20th century. See also Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press. p. 2.

Nurses may not have studied developmental psychology, but psychological concepts became ingrained throughout society as for example in notions of 'regular habits' and the harmfulness of emotions (behaviourism).[785] The eugenics movement argued that parents should not be free to determine how handicapped children should be cared for and accommodated but that such decisions should be left to experts and to the state.[786] These societal constructs occurred at the same time as increasing state intervention in what had been the province of the family.[787] These three societal constructs had in common an argument that they were based on 'science'. It will be argued that perversely, science meant that things were 'factual' and therefore not open to criticism and evaluation.[788] Science also meant that the three societal constructs were perceived as being objective and unemotional. This lack of emotion (or emotional neutrality) began to characterise paediatric nursing as nurses themselves began to embrace their relationship with doctors and the latter's 'professionalism' and subscription to 'science'.[789] In addition, the notion of 'profession' to which nursing had purported to ascribe in 1919[790] (Nurses Act 1919) became confused with that of 'science', probably because the former was believed to require the latter. 'Science' also meant that procedures based on 'known evidence' had to be applied uniformly, what was right for one was right for all. In this way, nursing began to adopt what became known as 'generalised care', meaning that procedures were applied equally to all patients, irrespective of their individual needs. In this way, the individual needs of children went unrecognised and unmet while at the same time, some of the global needs of children, for example, their need for affection also went unmet because of the perceived deleterious nature of emotion.

In accepting the paradigms of 'science' and 'professionalism', paediatric nursing lost control of its understanding of the holistic or emotional needs of children. This

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[785] See Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[786] Farrall, L. A. (1985). The origins and growth of the English eugenics movement 1865-1925. London, Garland.

[787] Maxwell, J. (1997). Children and state intervention: developing a coherent historical perspective. Nursing history and the politics of welfare. A.-M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[788] Darbyshire, P. (1999). "Nursing, art and science: revisiting the two cultures." International History of Nursing Journal 5(3): 121-123.

[789] See for example, participants A,P,R,T,V and X.

[790] See Nurses Act 1919 which set up a national register of 'qualified' nurses.

'unlearning', however, was facilitated by the then prevalent[791] psychological principles of behaviourism and the 'science' which was seen to provide the foundations for behaviourism. It was not so much that paediatric nurses failed to understand normal child psychology as that in their striving to adopt 'science', they came to accept behaviourism with its lack of emphasis on emotional needs.[792]

It will be argued that the effect of these societal constructs decreased from WWII, largely as a result of the rejection of anything that characterised the Nazis, including the eugenics movement and 'blind obedience' to authority. Also, however, the mass evacuation of children and other causes of child-parent separation had raised the perceived importance of emotional bonds and the degree to which children were seen to need the affection of their own family (see Davies 2000)[793]. This eventually led to the provision of more individualised care which was also more orientated to holism and the wider needs of the family.

Science and professionalism

Early in the 1920-1970 period Anon (1920)[794], makes clear her distress at the death of a baby and the way in which she sought comfort from her religion. Nurses clearly valued the opportunity to save children from death and seem to have recognised the power of the human spirit as a treatment modality.

It is perhaps interesting that Cunningham (1995)[795] labels the period between 1830 and 1920 as one of 'saving the children' (p. 134). Children were to be saved if possible, not for the state or for their soul but for the enjoyment of childhood. The 1920s was perhaps the last few years to see this romanticism, where children mattered because

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[791] See Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[792] Hendrick (1994) argues that in medical and school services, there had been a focus on children's bodies (at the expense of their minds) since the end of the 19th century. Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

[793] Davies, R. (2000). "Children's nursing: achievements in child health over the first half of the 20th century." British Journal of Nursing 9(1): 28-32.

[794] Anonymous (1920). "The sins of the fathers." Nursing Mirror and Midwives Journal **30**(779): 391.

[795] Cunningham, H. (1995). Children and childhood in western society since 1500. London, Longman.

children were inherently good and brought goodness into the world. Nurses were not just working for individuals (though they were doing this) but the more children they 'saved' by the grace of God, the better would be the world.[796]

Hendrick (1997)[797] points out that in the nineteenth century, the child had been economically valuable but that by 1900 this had largely ceased to be the case and the child, across the social classes, had become an emotional asset which '*belonged to a world of cosy domesticity, school and play*'. Hendrick (2003) argues that initially, confusion existed between the romantic, Victorian image of the child and the equally prevalent evangelical image (the child is wicked and needs punishment). These conflicting ideologies continued to cause confusion in social policy for some decades. Hendrick (1997)[798] suggests that by 1900 society was shaping children into its ideal mould (in relation to school, justice and welfare). Hendrick (1997, p. 10)[799] notes that between 1880 and 1920 children's issues had become part of most public policy issues of the day, partly out of concern for the health and future of the nation and race '*with children holding the key to both*' (p. 11). It can be seen, however, that the evangelical view fitted more comfortably with the notion of nursing and medical 'science', with increasing state intervention and with eugenics. Hendrick (1997, p. 14)[800] argues that by the outbreak of WWI '*childhood was in large measure, legally, legislatively, socially, medically, psychologically, educationally and politically institutionalised*'.

Hendrick (2003)[801] suggests that from the 1880s there was an increasing focus on children's minds. However, Hendrick notes that by the inter-war period most of the early work was being dismissed as unscientific and foolishly orientated toward emotions which in themselves had no 'scientific' value. This is not to say that the 'mind' had fallen from fashion but only that it was being scientifically construed. In

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[796] See West, C. (1854). How to nurse sick children. London, Longman.
[797] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.
[798] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.
[799] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.
[800] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.
[801] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

effect this simply meant that it was being categorised into identities that were measurable. So it was that children were categorised as (for example) 'nervous', 'delicate' etc. 'Hygiene' (both mental and physical) was also emphasised with mental hygiene being seen in very similar terms as its physical counterpart. In a rather modern sense, the child's mind and body were one but only the 'bits' that were measurable and subject to categorisation were given credence. Interestingly, Hendrick (2003)[802] also provides evidence that at least by 1940 children's health was being seen as separate and different from adult health. 'Science' had resulted in the study of children and had become legitimate.

Freidson (1970)[803] provides a contemporary definition of the sociological concept of 'profession', defining it as where an occupational group possesses a stable set of ethical values which are used to guide practice and where there is a stated sense of importance in education, attitudes, values and ethics. These qualities are seen to be more important than the circumstances in which they are being tested. In this way the 'profession' sees itself as a group with a unique body of knowledge and with a high degree of autonomy to practice as it sees fit. Freidson (1970)[804] argued that this set of qualities tended to cause the professions to fail to understand both the members' and the subjects' (patients) individual characteristics and needs. In other words the individual nature of both (in this case) nurse and child patient were subsumed by the orientation and needs of the professional group. While acknowledging that nursing had failed to achieve 'autonomy' (but that in other respects nursing did possess the qualities of professional life), Woods (1987)[805] argued that the professional tended to act in the same way no matter what was required by the individual client (patient). It is therefore with some irony that the professional nurse emerging from the c. 1920s possessing a degree of automatic behaviour but yet failed to develop (and perhaps never really sought to develop) autonomy.

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[802] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[803] Freidson, E. (1970). Professional dominance: the social structure of medical care. New York, Atherton Press.

[804] Freidson, E. (1970). Professional dominance: the social structure of medical care. New York, Atherton Press.

[805] Woods, C. Q. (1987). From individual dedication to social activism: historical development of nursing professionalism. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

Woods (1987)[806] shows how, from the c. 1920, medicine successfully extended its social prestige and occupational power within health care. According to Woods (same reference) this had the effect of drawing more clearly, the lines of superior / subordinate lines of relationship between medicine and nursing. Although in the early years and in many ways, nursing had been the equal of medicine, at least in terms of usefulness, nurses were nevertheless socially subordinate to doctors. Nursing was probably also plagued by its social stereotype as unscientific but saintly, this last being derived from Florence Nightingale's model of nursing which while emphasising notions of autonomy had not provided nursing with the means to achieve it.

For medicine, professional prestige derived largely from its hold on science and its growing reputation for a scientific approach to its work. Porter (1997) [807] describes how from the beginning of the twentieth century, Medicine increasingly adopted the paradigm of 'science'. Nurses, working in close proximity to doctors and whose 'professional' status had been improved by the 1919 Nurses Act, may have confused the concepts of 'science' with those of 'professionalism'. The concept of 'professionalism' may in turn have been confused with those of the servant's 'loyalty', 'obedience' and 'order'.[808]

The increasing orientation to 'science' and 'professionalism' probably served to build on the belief that parents were fundamentally unscientific and ignorant, this in turn would have built on existing fears of infection (Connell and Bradley 2000).[809] A text published in 1949 highlighted the effect that cross infection would have on a hospital, it often being necessary to close wards to new admissions and visitors or move the patients elsewhere (Pearce 1949)[810]. The Watsonian view was that the child's mother

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[806] Woods, C. Q. (1987). From individual dedication to social activism: historical development of nursing professionalism. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

[807] Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.

[808] Ashdown proposes a 'system of nursing' which in effect involved nurses being methodical, doing one task at a time, completing one task before they start another (with special emphasis on clearing and cleaning up after themselves). Ashdown, A. M. (1927). A complete system of nursing. London, Waverley Book Company Ltd.

[809] Connell, J. and S. Bradley (2000). "Visiting children in hospital: a vision from the past." Paediatric Nursing 12(3): 32-35.

[810] Pearce, E. (1949). A general textbook of nursing. London, Faber and Faber.

might not be wholly good for the child (Watson 1928)[811] This compounded upon the view that child care should be organised on scientifically derived principles to which the average mother would not be familiar. Watson (1928)[812] argued that children should be modelled on the American way of life with a high regard for self reliance and emotional adjustment (a concept close to that of 'emotional neutrality' used here). Watson emphasised the dangers of maternal tenderness as hypochondria, invalidism, nest habits and dependence (see Hendrick 1997)[813]. It is perhaps not surprising that paediatric nurses of this era appeared to advocate, or at least accept the principles laid down by King (1913)[814] and Pritchard (1907)[815] of good hygiene, nutrition, fresh air, regularity and consistency, the usefulness of absent parents and an approach to the child that was a little cold, certainly firm but nevertheless focussed on the child's recovery from illness. Hendrick (1997) suggests that both Truby King's (King 1913)[816] and the behaviourist approach of Watson (1928)[817] were not new methods in themselves but were repackaged using scientific terminology, in this way they were sold to the public in the name of science.

Pugh's (1931)[818] popular text on practical nursing illustrates the way in which repetitive work patterns were 'packaged' as scientific when in reality they represented opposing qualities to a search for better and more informed practice. Pugh (1931)[819] writes that (p. 6):

> *'Nurses should endeavor to do their work in the same routine, and at the same time each day. This is what we mean by "method" ... Nurses will find that the best method includes the habit of cleaning up as they go, putting away everything when they have done with it, clean, neat, and everything in its proper place.'*

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[811] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.
[812] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.
[813] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.
[814] King, F. T. (1913). Feeding and care of baby. London, Macmillan.
[815] Pritchard E (1907), Infant education, Marylebone Health Society, London.
[816] King, F. T. (1913). Feeding and care of baby. London, Macmillan.
[817] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.
[818] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.
[819] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

Similarly, Millicent Ashdown (Ashdown 1927, p. 2-3)[820] makes a direct association between cleanliness (and the associated notions of discipline and obedience) and science:

'They [nurses] must always remember that discipline and obedience are the keynote to satisfactory and efficient work in life, for to rule well they must first learn to obey ... the importance of this [cleanliness] is emphasised when one realises that practically all the triumphs of modern surgery have been achieved through the adoption of a scientific system of cleanliness'.

This approach ensured, that as medical science did develop, nursing was available to support it. Steppe (1997)[821] describes how, as nursing (Germany) became aligned to medicine, it was forced to become skilled in the natural sciences, at the same time, the religious nursing orders lost influence as they increasingly became seen as unscientific. The popular image of the professional nurse is perhaps still one of a somewhat cold and un-emotional being. This emotional 'distancing' from the child patient seems easily linked to the prevailing doctrine of behaviourism. Perhaps the major implication of behaviourism was that emotion and physical closeness were considered harmful.[822], [823] It is not then surprising that paediatric nursing became characterised by emotional neutrality, along with task orientated and generalised care[824].

The behaviourist notion of 'regular habits' (especially for sleeping and eating) may have reinforced the perceived need for nursing to be organised by rules and regulations. Behaviourism made this easy because the same rules could be applied to every patient and exceptions would have been seen as unscientific and emotional. This does seem to be more or less what paediatric nursing accepted as a philosophical

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[820] Ashdown, A. M. (1927). A complete system of nursing. London, Waverley Book Company Ltd.
[821] Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[822] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.
[823] Skinner, B. F. (1948). Walden two. New York, Macmillan.
[824] 'Task orientation' is a system of nurse organisation where the tasks rather than the patients are divided up between the available nurses. The system leads to 'generalised' care where the needs of the individual patient come second place to the tasks that require to be done.

position.[825] [826] So too, the professional nurse may have been seen to possess the knowledge and training with which mothers were ignorant: nurses knew best. A Nursing Times competition in 1939 for student nurses led to the publication of a paper by Eyre (1939)[827] on 'post basic meningitis treated by M&B 693'[828], a care study which included detailed medical observations but no psycho-social care.

Olsen (1997)[829], studied the degree to which 'care' featured in nurse training (USA) and found that the word 'care' was used only in association with 'manage', 'control' and 'handle' and that these terms meant using a degree of coercion or force. 'Care' also had to be visible or tangible and one could 'care' for a floor by cleaning it. Words associated with 'care' at the time, such as nurture, comfort etc. were also rarely if ever used. The nursing goal was to produce neat, well finished work. Olsen (1997)[830] suggests that this was largely a product of the female role where both males (doctors) and females (nurses) were exercising control and authority. Control and authority were not concepts with which females were comfortable and for this reason they were put in terms of 'care' more closely associated with the female role. Olsen (1997)[831] argues that nursing has never been associated with 'caring' but rather with patient and ward management (see also Darbyshire 1994[832], Darbyshire 1987[833]). Olsen (1977)[834] points out that words similar to 'nursing' such as 'nurturing', 'soothing', 'comforting' have not been used in nursing, whereas words associated with management (such as

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[825] Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

[826] Ashdown, A. M. (1927). A complete system of nursing. London, Waverley Book Company Ltd.

[827] Eyre, J. G. (1939). "Posterior basic meningitis treated with M&B 693." Nursing Times **01/07/1939**: 812-814.

[828] An early Sulphonamide, used as an antimicrobial agent, especially for serious bacterial infections.

[829] Olson, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[830] Olson, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[831] Olsen, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, R. Robinson and R. Elkan. London, Routledge.

[832] Darbyshire, P. (1994). "Understanding caring through arts and humanities: a medical / nursing humanities approach to promoting experiences of thinking and learning." Journal of Advanced Nursing **19**(5): 856-863.

[833] Darbyshire, P. (1987). "Bring back the 'Care Bear': the caring aspect of nursing." Nursing Times **83**(26): 60.

[834] Olsen, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, R. Robinson and R. Elkan. London, Routledge.

manage, control and handling) have (see Lindsay 2000)[835] [836]. In this way nurses were actually controlling and administrating but calling that process 'nursing' and 'care'. This may help to explain why a discipline which ostensibly was focused on caring, used a work model associated so closely with discipline and regimentation (see Darbyshire 1990)[837].

Similarly Greenhalgh and Vanhanen (1998)[838] found that physical manifestations of 'care' were valued more highly by nurses than emotive notions of care. It can also be seen, that the way in which notions of 'care' came in practice to be manifested as 'control' mirrored the way in which child welfare and health initiatives were used to create the perfect, uniform family. Hendrick (1997)[839] suggests that the welfare regime was staffed by professionals who ostensibly had a caring role but whose role in practice was to exert control over both children and parents. In practice, nurses seem to have been playing out their role in much the same way (in this respect) as other health professionals who had a duty to mould the child and family into the perfect social unit.[840] The public image of the nurse as a caring person may have caused a degree of confusion among the hospitalised children and their families when in reality nurses were seen to be exhibiting more masculine qualities. Rafferty (1996)[841] argues that society never did value 'caring' and that nurses have been handicapped by their association with this virtue. It is possible that nurses were trying to move away from or intellectualise their widely understood responsibility for 'care'. 'Care' also suggests a focus on the patients 'feeling' states as much as on their bodies and this redirection of the term may explain why social and emotional care did not characterise this period.

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[835] Lindsay, B. (2000). Who cares? The morphology of 'caring in children's hospitals, 1852-1950, with special reference to Jenny Lind Hospital for Sick Children, Norwich. Ipswich, University of East Anglia.

[836] Note should be taken, however, that emotive terms for nursing were widely used in the nursing press prior to c. 1920 (see chapters 2 and 3).

[837] Darbyshire, P. (1990). "The heart of the matter: human caring." Nursing Times **86**(47): 63-64.

[838] Greenhalgh, J., L. Vanhanen and H. Kyngas (1998). "Nurse caring behaviours." Journal of Advanced Nursing **27**(5): 927-32.

[839] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[840] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[841] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.

Hendrick (1994)[842] suggests that a healthy body was considered to be indicative of a healthy mind, in this way nurses may have considered that by focussing their attention on the child's body, his or her mind was being catered for too. However, Hendrick (1994)[843] also argues that children were not only seen as victims but as a threat to society by virtue of their victimhood, Hendrick (1994[844], 2003[845]) suggests that in this way '*depravity and deprivation were one*' (p. 10). The notion of the child as 'threat' fitted easily into pre-existing notions of Darwinism (a threat to the integrity of the species or society) and 'original sin' which by its nature might infest others and corrupt society. In this way, neglected and delinquent children were not only considered as one (because they both threatened social order) but throughout much of the 19th and 20th centuries were treated as one by the state (see Hendrick 2003)[846]. Maxwell (1997)[847] maps the way in which social policy changed in relation to the changing notion of children as problem individuals and later, as potential victims. The existence of these prevailing ideas on children and childhood may have made it easier for nurses to act in a way that was sometimes contrary to the emotional needs of the child. What was done to the child was what was thought to be good for the child but the child was not always expected to see it that way. The negative nature of the child as discussed by Hendrick (1994)[848] made is possible to be cruel to be kind. A decade earlier, Hendrick (1984, p. 96)[849] had argued that '*Critical history ... needs to acknowledge ... that children and adolescents are active subjects within historical change, and that they live within generational, as well as social and political structures, in which power, authority and rights are a matter of continuous struggle.*' It is clear from this present study, however, that not only were sick children oppressed but so too were their parents. In terms of health care provision, children and

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[842] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.
[843] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.
[844] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.
[845] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.
[846] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.
[847] Maxwell, J. (1997). Children and state intervention: developing a coherent historical perspective. Nursing history and the politics of welfare. A.-M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[848] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.
[849] Hendrick, H. (1984). "The History of Childhood and Youth." Social History 9(1): 87-96.

adolescents have probably never been active in this country and parents did not seek influence until the early 1960s (next chapter)[850].

Boschma (1997)[851] suggests that nursing's traditional holistically orientated stance shifted when during the 19th and 20th centuries, medicine adopted a more scientific orientation. This orientation required the organisational skills of nursing, to facilitate, for example, the implementation of infection control and asepsis. As medicine became more complex, nurses were required to know more about the natural sciences and to organise themselves in ever more sophisticated ways. Boschma (1997)[852] argues that this process acted to diminish the degree of psycho-social care that could be delivered and instead orientated the nursing model toward body and disease orientated care. Brandon (1986)[853] argued that 'science' in nursing brought the loss of the patient as a person. It is argued that paediatric nursing largely abandoned the construct of 'care', at least as one that included holistic and individual principles. It is argued that the adoption of 'science' caused nursing to focus on the observable and measurable manifestations of child behaviour with the consequent lack of emphasis on the child's emotional and developmental needs and on the needs of the child's family. This is not to say, as commonly argued (see Young 1992)[854] that paediatric nurses did not understand the child's psychological needs but that paediatric nurses focused on the prevailing behaviourist understanding of child psychology, perhaps because this had become more closely associated with 'science'. The evidence contained in the transcripts suggest that this course of action had serious and damaging consequences for child patients and their families. Rafferty (2000, p. 528)[855] refers to the ideological conflict between 'science' and 'care' and suggests that this conflict continues today:

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[850] Refers to the activity of the National Association for the Welfare of Children in Hospital.

[851] Boschma, G. (1997). Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[852] Boschma, G. (1997). Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[853] Brandon, S. (1986). Children in Hospital. London, National Association for the Welfare of Children in Hospital.

[854] Young, J. (1992). "Changing attitudes towards families of hospitalised children from 1935 to 1975: a case study." Journal of Advanced Nursing **17**: 1422-1429.

[855] Rafferty, A. M. (2000). Nurses. Medicine in the twentieth century. R. Cooter and J. Pickstone. Amsterdam, Harwood Academic Publishers: 519-529.

'At the end of the 20th century nurses in industrialised countries are caught is a web of contradictions. As emotional labourers in the vineyard of health care they titrate the tension between the ideology of intimacy advocated by nurse leaders and the increasingly impersonal nature of services occasioned by the intensification of care'.

The above suggests that there has not been so much a 'development' from science to care (from care to science) but rather that there has been a continuing dichotomy produced by conflict between the practice of nursing and the way in which nurse leaders have wanted it to be marketed. Rafferty (2000, p, 519)[856] claims that *'nursing reinvents itself when the political and ideological tide turns'* but also that (p. 525):

'... the possibility that emotional care was incorporated within the physical signalled a contradiction in care that remained an enduring part of the nursing work ethic'.

Rafferty (2000, p. 528)[857] suggests that even by the end of the 20th century, nursing was still caught in '*a web of contradictions*'. Rafferty (same reference) argues that when the Nursing Process failed to work efficiently because of gaps in practice knowledge, nursing leaders used it as a tool to ensure accountability rather than to initiate new research. Rafferty (same reference, p. 528) also suggests that modern terms which try to reconcile the science-care dichotomy do little but achieve '*the ultimate contradiction*'.

The influence of 'science' and 'professionalism is seen here to have had an essentially negative effect on both paediatric nursing and child patients. It is suggested here that this influence lay not in a struggle for autonomy with regard to Medicine but with a wish to become aligned to Medicine and to be seen as the doctor's junior partner. In pursuance of this goal, 'care' was re-construed as scientifically derived in the same way as was much of the non-scientific work of doctors. This effort was assisted by the embracement of behaviourism as a 'scientific' approach to the management of children

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[856] Rafferty, A. M. (2000). Nurses. Medicine in the twentieth century. R. Cooter and J. Pickstone. Amsterdam, Harwood Academic Publishers: 519-529.

[857] Rafferty, A. M. (2000). Nurses. Medicine in the twentieth century. R. Cooter and J. Pickstone. Amsterdam, Harwood Academic Publishers: 519-529.

and to the increasing legitimacy with which the state intervened in the affairs of the family, doing so in most cases via the established professions.

Eugenics movement and state intervention

Rafferty (1996)[858] argues that historians have tended to downplay the role of welfare policy in explaining reform in nursing. Rafferty (1996)[859] illustrates the way in which changes in nursing have largely come about as a result of conflict between government policies and the desires of nursing leaders. Welshman (1997)[860] suggests that eugenics shaped the social changes in the early 20th century, especially those changes related to reformers seeking to increase the fitness of the nation in respect of social hygiene. This (c. 1930) was also the era of state intervention (see Rafferty 1996[861]), born in part out of the fear of insufficient human material to feed the increasing military threat from Germany. Maxwell (1997, p. 236)[862] defines state intervention in this respect as being '*defended by claiming a moral right to protect innocent children from various kinds of ill-treatment and inadequate or poor upbringing ... intervention is also justified because of the state's interest in children as future citizens*'. State intervention was probably more prominent in Germany than in any other European country during the 1930s and early 1940s and the regime there may well have influenced attitudes here. National socialism embraced both notions of state intervention and eugenics and created a situation where the Christian tradition which focussed on the needs of the individual was sacrificed in favour of the needs of the state (see Steppe 1997).[863] Steppe (1997)[864] suggests that state intervention in the Nazi years (Germany) increased the status of nursing and tended to unify nursing under one umbrella organisation and

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[858] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.
[859] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.
[860] Welshman, J. (1997). "Eugenics and Public Health in Britain, 1900-40: Scenes from Provincial Life." Urban History **24**(1): 56-75.
[861] Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.
[862] Maxwell, J. (1997). Children and state intervention: developing a coherent historical perspective. Nursing history and the politics of welfare. A.-M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[863] Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[864] Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

to provide uniform standards. However, the professional ethic of servitude and obedience, especially to doctors remained.

The relative poor health of the mass of children attending the new state education system probably gave credence to the eugenics movement (see Farrall 1985)[865]. For a while at least, children may have been viewed as a potential resource, to be nurtured surely, but not for their own sake. Mansell and Hibberd (1998)[866] illustrate the way in which nurses in Canada supported the Canadian eugenics legislation which was aimed they suggested, at '*an available means for racial improvement'* (p. 4). Mansell and Hibberd (1998, p. 4, same reference) argue that the period between 1920 and 1940 '*represent a time in nursing history when the nurses duty to care was complicated by the attitudes and values of the society in which she existed'*.

The eugenics movement and the key eugenics arguments can be seen as part of the impact of 'science' upon British society and specifically on nursing. Welshman (1997)[867] for example, provides evidence of the way in which eugenics ideas were proposed in both scientific and medical terms. Welshman (same reference) also provides evidence that at least in one English city, eugenics was an accepted ideology amongst some senior medical staff. Welshman (1997)[868] suggests that eugenics succeeded in 'penetrating' (p. 56) intellectual life and provides evidence of the degree to which eugenics ideas and actions were prevalent amongst the well educated and middle classes, including doctors and medical officers. He also provides evidence that these individuals were successful in making some changes to public health policy (see p. 67) but that the eugenics movement never succeeded in wholly controlling public health policy. The degree to which doctors were concerned with eugenics issues is probably related to their professionalisation during this period, a period in medical history characterised by an overextension of medical focus in an attempt to subsume

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[865] Farrall, L. A. (1985). The origins and growth of the English eugenics movement 1865-1925. London, Garland.

[866] Mansell, D. and J. Hibberd (1998). "Forcible sterilisation in Canada, 1920-1940." International History of Nursing Journal 3(4): 4-11.

[867] Welshman, J. (1997). "Eugenics and Public Health in Britain, 1900-40: Scenes from Provincial Life." Urban History 24(1): 56-75.

[868] Welshman, J. (1997). "Eugenics and Public Health in Britain, 1900-40: Scenes from Provincial Life." Urban History 24(1): 56-75.

and dominate other health care disciplines. Cherry (1996, p. 39)[869] suggests for example that '*doctors were prominent in interpreting a range of issues including race, poverty, criminality, hereditary illness, alcoholism and sexual behaviour, the whole welded into alarmist speculations concerning national degeneration. Eugenicist outlooks often underpinned [their work]*'.

Hendrick (2003)[870] makes the point that the concepts of 'Darwinism' and 'eugenics' were always intermixed. The first was concerned with defining the species and the second with protecting it. The influence of eugenics demonstrates the way in which children were considered to be belonging to and import for the continuing health of the nation. This in no way indicates that children were seen to be important for their own sake. The accepted importance of children (but not for their own sake) is clearly demonstrated by such events as the founding of the NSPCC (between 1881 and 1884) and by the 1908 Children Act, both of which were designed to protect children from cruelty and neglect. Hendrick (2003)[871] points out, however, even the NSPCC placed little emphasis on addressing assault, preferring instead to focus on dealing with neglect. The NSPCC did not want to criticise the 'family' (see Hendrick 2003)[872].

Children's nursing seems to have reflected these ideas in the way that nursing practice was not about the needs of the individual child, nor was it focussed on what either the child or the child's family wished or wanted. Rather, nursing practice was focussed on the needs of many, of the whole ward, of the nurses themselves and of society. It is also worth noting that the proponents of eugenics and hospital nurses had one more thing in common, they both directed their attention almost wholly at the working classes. It was the 'lower' social classes that were seen as a threat to social order and the health of the nation and it was this section of society which became subject to the greatest degree of state intervention (see Hendrick 2003)[873]. State intervention in what had traditionally been the province of the family can be seen developing from the later

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[869] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[870] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[871] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[872] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[873] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

19th century with the 1870 Education Act (compulsory schooling) and the 1908 Punishment of Incest Act of which Hendrick (2003, p. 40)[874] writes, it '*was an attempt to legislate a public and private morality*'. Large educational institutions began to be set up under the Poor Laws from about 1850, a model which seems largely to have been copied by the many emerging voluntary 'rescue' societies which were established around the same time.[875] Excepting the NSPCC, most of these societies did little work with the family as a whole and most sought to permanently separate the child from the family. Barnardo had said '*they [children] were better off without parents ... they are my chief difficulty everywhere; so are relatives ... because I have to take from a very low class*' (quoted in Hendrick 2003, p. 45)[876].

Other examples of increasing state intervention include the Infant Welfare Movement (c. 1860s, later to be gradually 'nationalised' by being incorporated into the social services system), Health Visitors[877], Notification of Births Act 1907 (made compulsory 1915), 1902 Midwives Act, 1907 Education (administrative provisions) Act (provided LEAs with a responsibility for children's health and welfare and not just their education), 1915 Notification of Births Act and the 1918 Maternity and Child Welfare Act[878].

The effect of the eugenics movements can be seen in Adams' (1997)[879] account of how Pyrford Orthopaedic Hospital was threatened during the early part of the twentieth century by the public attitude against crippled children. In the end this hospital did indeed terminate its work with children and focused instead on admitting adult

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[874] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[875] For example; Dr Barnardo's 1870, National Children's Home 1869, Church of England Waifs and Strays Society 1881, Catholic Crusade of Rescue 1899.

[876] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[877] Health Visitors started in 1862 as the Ladies Sanitary Reform Association (later Ladies Health Society). The first paid HV, according to (Hendrick 2003) was seen in Huddersfield in 1905.

[878] This consolidated Health Visiting and the maternity and child welfare provision which had been variably provided by charities and local authorities. It also made provision of school milk and food, medical services for young children, the training of midwives and the provision of midwives for women in labour. The provisions of this Act were eventually replaced by the 1946 National Health Service Act.

[879] Adams, J. (1997). "From crippledom to orthopaedic nursing: Pyrford, Surrey 1908-1945." International History of Nursing Journal 2(4): 23-37.

patients. An early child developmentalist, Nixon (1920)[880] described child development but only that of physical development, arguing that growth is more active in the Spring and that new-born babies have only rudimentary senses of sight, hearing and smell. The link here with the animal world and with the scientific notion of generalisability is clear.

Hendrick (2003)[881] argues that the positive Montessori approach to the 'treatment' of handicapped children was not seen in Britain effectively until the late 20th century because of the influence of the eugenics movement which of course argued for the segregation and sterilisation of most handicapped children. The fear of sexual promiscuity among mentally handicapped children probably encouraged the social segregation of these children and led to the lack of positive 'treatment' in favour of their institutionalisation.

Sir Francis Galton's (1905)[882] notions on eugenics may have influenced both the state and individuals to focus on children and their potential contribution to society. One of the messages of eugenics was that children were too valuable to be left to the whims of parenthood and that the state should therefore assume control of the care of children. The implementation of this philosophy appears to have been chiefly targeted on the lower social classes. It was this social group to whom the state provided health education and care fifty years before the introduction of the NHS[883]. Welshman (1997)[884] suggests that on the whole, it was the poor, poorly housed and destitute who were the target of eugenics attention.

Both Skinner (1948)[885] and Watson (1928)[886] wrote against the institution of the family, in favour of institutions that could be run by the state and in line with

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[880] Nixon, J. A. (1920). "The physical and mental development of infants." Nursing Mirror and Midwives Journal **31**(784): 8.

[881] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[882] Galton, F. (1905). Eugenics, its definition, scope and aims. London, Sociological Society of London.

[883] However, Hardyment (1995) discusses the 'baby clubs' intended for the educated and professional classes and which required a subscription. Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[884] Welshman, J. (1997). "Eugenics and Public Health in Britain, 1900-40: Scenes from Provincial Life." Urban History **24**(1): 56-75.

[885] Skinner, B. F. (1948). Walden two. New York, Macmillan.

[886] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.

'scientific' thought. The family had become 'unscientific'. It was clearly easier to argue that working class and poorly educated families were 'unscientific'. In this way, it is possible that the embracement of 'science' had started to alienate paediatric nursing, not only from the child's emotional and individual 'needs', but also from the child's family who provided for most of those needs.

Before Nazism and the second world war, the philanthropic work that had started in the nineteenth century continued into the twentieth. However, an increasing amount of this work began to fall under the responsibility of state provision. Cunningham (1995)[887] argues that there was increasing discontent with the philanthropic movement because its provision was inconsistent across geographic areas. There needed to be more 'uniformity' (science) and the state was the obvious choice to ensure this. It is suggested here that the increasingly uniform approach probably led in part to a reduction in emphasis toward the idiosyncratic emotions of 'care' and 'affection'.

The development of special schools in the first half of the 20th century can be seen as another way in which the state obtained control in what had been the affairs of the family. Hendrick (2003)[888] points out that *'offenders, neglected and the victims of offences were brought together with a common sense of treatment seen to be in their interest'* (p. 118)[889]. Importantly, for this present discussion, Hendrick (2003) points out that children sent to special schools were always from the working class. In much the same way, children admitted to hospital through much of the 20th century would have been from a lower social class than the hospital doctors. Here, they were subject to 'doctors orders' and 'hospital regulations' and a system of control and hierarchy that was firmly and deliberately outside the control of the family.

The impact of the eugenics movement had declined by the end of WWII (see next chapter), probably as a reaction against Nazi Germany. However, it would be surprising if some of the ideas core to eugenics would simply disappear. The Education Act 1944, made it a duty for every LEA to set up a Child Guidance Clinic,

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[887] Cunningham, H. (1995). Children and childhood in western society since 1500. London, Longman.
[888] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.
[889] Approved schools were established by the 1933 Children and Young Person's Act.

the need for which had been demonstrated by the experience of the mass evacuation (see next chapter). At this time, however, Hendrick (2003, p. 110)[890] argues that the Child guidance clinics were '*bounded by political considerations, the most prominent of which was a kind of citizenship ... it was about teaching people self discipline and communal responsibility in pursuit of a democratic consensus*'. In the same way, Maxwell (1997)[891] illustrates the way in which child health and child welfare policy was focussed on (p. 230) the '*monitoring and regulation of parenting in order to ensure the appropriate socialisation of children*' with the goal being to produce good citizens. Cherry (1996)[892] also suggests that the Child Welfare Movement was stimulated by the prevailing interest in national efficiency by fears of social degeneration (eugenics).

It is suggested here that the eugenics movement probably did have an impact on the way in which paediatric nursing developed in the first half of the 20th century. Notions of eugenics were widely accepted both within society and by nursing and existed as a validation of state intervention in the affairs of the family and in the downgrading of the family as a legitimate controlling agent in relation to the management of the sick child. In this way, notions of eugenics might not have been stated explicitly within nursing but were nevertheless part of nursing's attempt to be the junior partner of Medicine and which resulted in nurses seeking and obtaining control of the sick child from what had previously and perhaps properly been the domain of the family.

Behaviourism

Urwin and Sharland (1992)[893] note that it was Frederick Truby King's visit in 1917 from new Zealand which inspired the establishment of the influential 'Mothercraft

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[890] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[891] Maxwell, J. (1997). Children and state intervention: developing a coherent historical perspective. Nursing history and the politics of welfare. A.-M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[892] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

[893] Urwin, C. and E. Sharland (1992). From bodies to minds in childcare literature: advice to parents in inter-war Britain. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

School' in Highgate. The school began training health visitors and nursery nurses and produced 'The Mothercraft Manual' (Liddiard 1924)[894] which it is claimed, remained influential for the next 30 years (Urwin and Sharland p. 177, same reference) The Mothercraft Manual emphasised feeding techniques and measures of basic hygiene which Truby King had successfully employed in New Zealand to reduce the incidence of gastro-enteritis in babies. The Mothercraft Manual had been modelled on King's own book (King 1913)[895]. In neither work was there any mention of babies' emotional needs. The emphasis was on a regimentation of care which involved regular feeding, fresh air and cold baths. Urwin and Sharland (1992, same reference) argue that the behaviourist regimentation and discipline of the recommendations were related to the fear of social disorder in a period where mass unemployment could have produced social unrest. So it was perhaps that King (1913, same reference) associated regular defaecation with social order and the malleability and brittleness of the infant's nervous system with the friable nature of the current social order. Perhaps it can be seen that the increasing use of behaviourist principles, state intervention and the construct of 'science' may have become very closely associated in the minds of paediatric nurses who may have wished to become more 'professional' and 'scientific' themselves.

Viner (2000)[896] argues that Medicine did not get involved in the psychology of children until the 1920s, when behaviourism and the child guidance movement gained in popularity. However, the 'psychology' to which Viner (same reference) alludes should not be thought to relate to the child's feelings, thoughts and fears and as such this argument is probably misleading. John Watson published the 'Psychological Care of the Infant and Child' in 1928 (Watson 1928).[897] As might be expected, the Watsonian approach to child rearing played down the importance of affection. Watson (1928, same reference) argued that the child's mother should deliberately spend a large part of the day away from her children so that they did not grow to be too emotionally

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[894] Liddiard, M. (1924). Mothercraft manual. London, Churchill.
[895] King, F. T. (1913). Feeding and care of baby. London, Macmillan.
[896] Viner, R. and J. Golden (2000). Children's experiences of illness. Medicine in the 20th Century. R. Cooter and J. Pickstone. Amsterdam: 575-588.
[897] Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.

dependent upon her. Urwin and Sharland (1992)[898] argue that in Britain, Watson's arguments were largely accepted, especially as they appeared to build on the 'regularity' arguments emphasised by King (1913)[899]. Other popular books, including 'Common sense in the Nursery' (Frankenberg 1922)[900] shared the emphasis on physical health and regularity. It is important to note that the message was sold within the remit of modern 'science'. The theories were claimed to have been scientifically tested. Unfortunately perhaps, sufficient scientific rigour had not always been employed thoroughly to test the theories being proposed and that 'science' was sometimes confused with 'measurable'. It is possible that to paediatric nursing (and perhaps medicine), a discipline new to 'science', the mere fact that material was published gave it sufficient scientific credence.

The open air schools, which were still popular, existed as an illustration of the focus on physical health (see Ayers 1971)[901] and may have had little to do with the child's psychological needs. This emphasis on the child's physical needs should not be regarded as evidence of a lack of value for childhood. Far from it, the middle years of the twentieth century saw a renewed interest in the study of children and childhood. This is evidenced in the focus of behaviourism and psychoanalysis on childhood and in the several institutions which were established for the study of children.[902].

Bradley (2001) argues that nurses were probably influenced by the prevailing behaviourist doctrine. In itself, this doctrine was associated with the notion that children from good homes tolerated hospital well. It followed that those children who did not cope well with hospital must have come from bad or psychologically disorganised homes. This relieved the hospital staff of any responsibility for the child's distressed behaviour, reinforced the view that the hospital policies were right and would help the child learn better ways and further served to hide the real truth from the

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[898] Urwin, C. and E. Sharland (1992). From bodies to minds in childcare literature: advice to parents in inter-war Britain. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

[899] King, F. T. (1913). Feeding and care of baby. London, Macmillan.

[900] Frankenburg, C. (1922). Common sense in the nursery. London, Cape.

[901] Ayers, G. (1971). England's first state hospitals and the Metropolitan Asylums Board 1867-1930. London, Wellcome Institute for the History of Medicine.

[902] For example the 'British Child Study Association' founded in 1894 (its journal was the 'Paidologist'); the 'Childhood Society' and the 'Parents National Education Union'.

nurses, that it was the hospital policies themselves that were causing distress (see also Robertson 1970)[903].

Hardyment (1995)[904] makes the point that the new mapping of child development and the resulting 'milestones' of development (Gessell 1926[905], 1929[906], 1945[907]) placed a new stress on parents who for perhaps the first time could easily relate their own child's abilities with the 'average'. This understanding of 'normal' development also existed as a way in which doctors and nurses could demonstrate their superior knowledge over parents. Hardyment (1995, same reference) points out that vitamins were discovered in the period. This must have reinforced the notion that science was needed to inform mothers even of such basic things as the child's diet. Of course, this new area of concern would also provide the newly emerging paediatricians with employment. For years to come, the paediatric clinic room would be discernible from the others by the presence of an 'assessment box' containing a few selected 'toys' to help identify children's stage of development. Learned paediatricians would spend many hours counting the number of wooden blocks each child could place one on top of the other, carefully mapping each achievement on the child's development chart with the child's parents (and nurses) doubtless looking on in awe of the intellectual powers being played out in front of them.

Conclusion

This chapter has considered the changes which it is proposed here took place c. 1920, specifically in relation to a move from an emotional and holistic orientation to the care of sick children to one which was focussed on a closer collaboration with doctors and

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[903] Robertson, J. (1970). Young children in hospital (2nd edition). London, Tavistock Publications.
[904] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.
[905] Gessell, A. (1926). The mental growth of the pre-school child: A psychological outline of normal development from birth to the sixth year including a system of developmental diagnosis. New York, MacMillan.
[906] Gessell, A. and H. Thompson (1929). "Learning and growth in identical twins: an experimental study by the method of co-twin control." Genetic Psychology Monographs 6: 1-123.
[907] Gessell, A. (1945). The embryology of behaviour. New York, Harper and Row.

therefore with generalised and institutionalised care. An attempt has been made to explain the lack of individualised care identified in the participants accounts.

The transcripts demonstrate that an ignorance of child psychology and sociology was not the cause of the lack of individualised care. Nurses were mostly young women who would not have forgotten their own needs as children and the social needs of their siblings. It is suggested here that when they had the opportunity, nurses did provide individualised care but that on the whole they were prevented from doing so by the requirement to act 'professionally', the key characteristic of this approach was not a lack of care but an outward projection of emotional neutrality, a uniform approach to their work (goaled to achieve parity so that all the children received the same quality of care) and an inattention to emotionality exhibited by children and parents.

The 'professionalism' referred to above, was confused with objectivity and science, notions of which originated both from the culture in Britain at the time and in the way that medicine and nurse managers had sold notions of cleanliness and smartness of appearance as belonging to the construct of 'profession'. Clearly, it would have been possible for nursing to develop as a profession without it having to embrace science (consider the legal profession or the Christian priesthood[908]) but nursing's close association with medicine and the emphasis on social conformity within both behaviourism and eugenics, both popular social constructs of the time, forbade such an approach. Furthermore, it was in the interest of nursing managers and senior doctors to portray basic ward and personal cleanliness as 'professional' and 'medical science' because it was so very useful that nurses should do this work.

Parents were excluded from the child's care and had little or no influence within the hospital ward. For the most part, they were not even kept informed about their child's welfare and were not allowed to see, communicate with or embrace their ill, suffering and sometimes dying child. Their emotions and needs as people were often ignored. The child became subject to the will of 'professionals' who had the interest of the child's physical welfare at heart but with whom they had no emotional bond. This,

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[908] See for example, Ramsey, M. (1972). The Christian priest today. London, SPCK.

Hendrick (2003)[909] argues is typical of the societal position of children throughout history but it is suggested here that within nursing it is characteristic only of the period between c. 1920 and c. 1970. In this chapter it has been argued that the exclusion of parents and their enforced separation occurred in part because of the socially legitimised intervention of professionals in the core business of families (the care of children) and in the name of the state. It has been seen that the eugenics movement did influence medical thinking and practice[910] and can be considered to be the logical extension of state intervention but which failed to reach its potential largely because of the social impact of the Second World War.[911] It can be seen that parents were excluded because:

1. their emotional 'support' (for the child) was not valued
2. it was accepted that nurses possessed all the knowledge that was required to care for the sick child because nurses were 'professionals' which meant that they understood medical science and were objective and unemotional

Of course nursing was a disciplined organisation whose servantship has already been described. The entry of parents into the system would have broken the system of discipline and hierarchy. Parents could not have been controlled were their views to have been permitted to be heard and had they been allowed to petition for the individual needs of their own children. Largely for this reason it was important to keep parents away from the clinical area. Eventually parents did ensure that their views were heard and this did play an important role in the dissolution of generalised care.[912]

Lastly, it is important to consider what 'science' nursing had adopted. This was medical science, nursing as a discipline does not appear to have possessed its own research base. Nursing did have a body of knowledge and it did take much learning to acquire the necessary knowledge and skills to work as a qualified nurse. However, nursing knowledge was not characterised by research and analysis. In fact, the opposite

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[909] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[910] Welshman, J. (1997). "Eugenics and Public Health in Britain, 1900-40: Scenes from Provincial Life." Urban History **24**(1): 56-75.

[911] See chapter 7.

[912] See chapter 7.

was the case. There was a known way to do everything and it was considered wrong to criticise that known way.[913] Science was what was written in books and what was learned in the training school. There was no attempt to develop or critique nursing practice and no-one at any level, either nurse or doctor was responsible for the development of nursing practice. In this way, not even the matron, whose role it was to ensure consistent standards, could initiate change. This was a situation where nursing was perhaps too 'comfortable' a discipline. If nursing was not a 9-5 job it was an occupation with defined parameters and without the responsibility and accountability that is and was associated with professional life.

It is proposed here, that paediatric nursing in the yeas following 1920 reflected the wider British culture of the day. In this way, nursing was influenced by notions of eugenics, behaviourism, state intervention in the affairs of the family and the increasing impact of 'science' and 'professionalism'. In other words, nursing adapted to the changing nature of British culture. These influences impacted strongly on nursing largely because of the latter's association with medicine and its desire for greater social influence. This association which was to characterise nursing was at least at an organisational level to mutually benefit both disciplines. Nevertheless, it has been demonstrated here that this association and the cultural influences which strengthened that relationship acted against the interest of the sick child and his or her family. This negative effect was actuated because paediatric nursing's client group was comprised of pre-socialised individuals who were subject first to forces controlling their human development as individuals and only remotely to human society.

It is proposed here that the factors identified above account for the lack of individualised care which so characterises the participants' accounts of paediatric nursing between 1920 and 1970. The next chapter will explore how, toward the end of the period 1920-1970, generalised care did eventually become replaced by a more holistically and family orientated focus on individualised care. This change, would in time radically alter the nature of paediatric nursing.

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[913] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.

Chapter 7: the return to holistic care

This chapter will consider the factors which eventually began to return paediatric nursing to a philosophy of holistic and individualised care. It will be argued that there were four main factors which worked synergistically to effect this change. It should be understood, however, that before the end of the period in question (to 1970) these factors were only beginning to have an effect on paediatric nursing. It will be argued that change did eventually take place[914] and that the beginning of the process of change can be discerned and was initiated prior to 1970.

The four factors are claimed to be:

- The move to academic nursing and the way in which nurses began to be encouraged to think and to question, this had the effect that questioning practice became 'allowed';
- The demise of the matron. The government led restructuring of nursing in the 1970s removed the 'symbol' of authority and spread responsibility among several individuals;
- Men and women, the effect of the introduction of men and also of married women in nursing;
- The social experience of World War II and the mass evacuation of children and the gradual dissolution of behaviourism as a framework for the upbringing and management of children.

These four factors in turn resulted in pressure being aimed directly at paediatric nursing, pressure that is, for paediatric nursing to orientate itself to the individual and holistic needs of sick children, including those needs related to the family and to separation. These challenges to paediatric nursing's key philosophical orientation came

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[914] Bowden, V. R. (2000). "Pediatric nursing practice: keeping pace with technological advances." MCN: American Journal of Maternal/Child Nursing **25**(6): 318-21.

chiefly from the nursing press, the GNC, the government, NAWCH and from psychologists.

Social change

The effect of academic nursing

There can be no doubt that nursing was always something that was associated with a long period of learning. However, it has been argued that this learning was about coming to understand a known way, it was not about developing new knowledge or of challenging accepted ways. This tradition of learning the known way probably did have an effect on the intransigence shown by paediatric nurses as they came under increasing pressure to provide more humane, social and family orientated care to sick children.[915] Robertson's (1970)[916] very influential view was that it was this unacademic and non child focussed training that led to paediatric nurses being less than responsive to the new post WWII ideas on hospitalised children's emotional and social needs (see also Bradley 2001).[917] However, it will be argued here, that this was only one factor in the very slow acceptance of family centred care nursing.[918]

Perhaps one of the first pieces of evidence that nursing was slowly becoming a more academic discipline was in 1927 when a nurse at the Hospital for Sick Children, Great Ormond Street, placed a request to attend a London conference at the hospital's expense. The Nursing Committee seems to have been thoroughly taken aback by this request, denied it but agreed that 'events be watched'.[919] They must have been surprised by the speed with which nursing was progressing for by 1935 they were to record that one of their senior nurses had obtained the Diploma of Nursing from the

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[915] See Duncombe, M. A. (1979). A brief history of the Association of British Paediatric Nurses 1938-1975. London, Association of British Paediatric Nurses.

[916] Robertson, J. (1970). Young children in hospital (2nd edition). London, Tavistock Publications.

[917] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

[918] For evidence of the slow development of family centred and individualised care approaches, see Hawthorne, P. J. (1974). Nurse, I want my mummy. London, Royal College of Nursing.

[919] Great Ormond Street Hospital Archive (1927). Entry dated 03/02/1927. Nursing Committee Minutes. London.

University of London.[920] By 1941, the same committee was to agree to provide grants for nurses to do the Sister Tutor course on condition that the nurses continued to work for the hospital after the completion of the period of study.[921]

Most of the nurses' transcripts show a positive regard for the system of discipline in force between 1920 and 1970 and a concomitant poor regard for the lack of discipline today (see for example Participant C)[922]. Note has already been made about the way the system of discipline was based upon the premise that there was a known way of doing things (see Participant C) which was described in published material (see for example Houghton 1942[923]). Participant C argues that it would have been pointless to challenge existing practices because they had been tried and tested and were known to work. Participant C still values the way in which it was possible to '*do things properly*', she argues that there would have been little point in considering a change in practice because if junior nurses had considered such a thing, she was sure the staff nurses and sisters would already have thought about it. Participant C notes that she had little difficulty complying with the rules, for example those relating to 'lights out' because they were appropriate, the work was hard and staff did need a good night sleep. It is clear that at least some nurses were happy to exist in the tight system of discipline and hierarchy that was nursing. It is likely that most students who entered nursing and decided to stay would have done so with their eyes open. The discipline in nursing was well known and understood. In this way nursing may well have attracted people who were happy to have been told what to do and to place their own thoughts in subservience to those of the institution. It is clear how the introduction of an expectation to challenge existing practice would have disintegrated the system of discipline which was intimately bonded with the notion that there was a known way of doing almost everything. Participant I[924] argues that at least in the 1950s independent thinking was actively discouraged for staff below ward sister level.

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[920] See Great Ormond Street Hospital Archive (1935-1936). "Nursing Committee Minute Book: Volume One 1935-1936, entry dated 11/10/1935."

[921] Great Ormond Street Hospital Archive (14/04/1941). Nursing Committee Record Book Four. London: This entry was in relation to the 'British Hospital Association Draft Memorandum (No. 54) on nursing policy for consideration in area committees'.

[922] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.

[923] Houghton, M. (1942). Aids to Tray and trolley setting. London, Bailliere and Cox.

[924] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.

There are some early examples of nurses criticising the system of discipline, although such examples are uncommon it is interesting that such criticism existed. An anonymous[925] article in the Nursing Mirror and Midwives Journal (Anon 1920)[926] makes the point that the Scout movement encouraged children to develop a sense of self discipline and to make their own rules and regulations. The author argued that if this was appropriate for children then so it was so for the recruits to nursing and that (p. 313) '*Modern educationalists have long realised that blind, enforced obedience is a poor substitute for the ready and willing co-operation given by those in sympathy with the necessary rules of life'*. However, the androgogical[927] 'education' as opposed to pedagogical 'training' had yet to receive universal acceptance[928]. This does indicate, however, that the increasing emphasis on academic development in nursing would eventually impact upon the system of discipline by encouraging the evaluation of practice.

The social changes in the 1920s may have encouraged some nurses to seek more professional freedom. Arton (1992)[929] provides rare evidence of a probationer causing unrest at the Westminster Infants Hospital by trying to change the hours of work and the duties of nurses. There is no evidence that paediatric nurses who embarked upon such a course of action were in any way successful and certainly, the Infants Hospital probationer found herself without a job.[930]

Participant J[931] (1950s) notes that there was very little writing to be done within her role. It should be understood that nursing had to operate a 3 shift per day system and therefore had to pass information on to following shifts. It is hard to understand how nurses could have operated efficiently without providing written information to the shift of nurses coming after them. Surely it was necessary to present their thoughts and feelings about the child patients problems, even if not their analysis of the presenting

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[925] Anonymous publication was very common at this time.
[926] Anonymous (1920). "Self governance." Nursing Mirror and Midwives Journal **31**(802): 313.
[927] Literally meaning the teaching of adults and in practice meaning 'education' as opposed to 'training'.
[928] In nursing terminology, training is conceptually aligned to pedagogy and education to androgogy.
[929] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[930] See Management Committee Minutes, Westminster Infants (Children's) Hospital archive, Entry dated 05/01/1921. Cited in Arton (1992).
[931] Participant J (From 1962). Child 10 years. Nurse. Scotland.

problems. Nevertheless it is clear that this did not happen. Perhaps the lack of written notes is the clearest indication of the lack of decision-making, problem solving and analysis. The system of discipline, hierarchy and known ways of doing things meant that any nurse arriving on the scene would know what to do, this, to the extent that she needed no clear, written record of the previous nurses' intervention. While such a scenario probably could result in known, understood and established standards of care, it is easy to see how that care could never be either analytical or individualised.

It is interesting too that the 1920s saw the advent of professional debate in the nursing press. An example of this can be found in Anon (1920)[932] where a 'maternity nurse of 18 years experience' challenges Miss Ashton's article on infant feeding and responds to a number of earlier letters supporting Miss Ashton. Miss Ashton was the Matron of Booth Hall Infirmary for Children and had published a book on the subject of infant feeding. It should be understood, however, that this kind of professional debate does not seem to reappear until the 1980s.

Lomax (1996, p. 64)[933] argues that training was '.... *instituted as a way of maintaining staff consistency'*, and as such soon became a powerful tool used to preserve the system of discipline and hierarchy. It is perhaps ironic then, that the system of preparing students to become qualified paediatric nurses was probably the strength behind the system of discipline and the cause of its eventual demise. As the culture of adult education moved gradually from pedagogy to androgogy,[934] students were encouraged to think for themselves and to evaluate existing practice. This gradually replaced the pedagogical emphasis on learning how things are done (see Walsh and Ford 1989)[935] although Walsh and Ford (1989)[936] argue that this traditional pedagogy of practice never completely disappeared. Discipline depended on there being one way of doing things, a known way, a proper way, with every paediatric nurse ritually performing each task in the same way. Questioning and evaluation resulted in the

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[932] 'Maternity nurse of eighteen years experience' (1920). "The feeding of infants and children." Nursing Mirror and Midwives Journal **31**(805): 371.

[933] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

[934] Androgogy, meaning 'education' as opposed to 'training'.

[935] Walsh, M. and P. Ford (1989). "We always do it this way: rituals in nursing in the surgical area examined in the light of research based evidence." Nursing Times and Nursing Mirror **85**: 26-35.

[936] Walsh, M. and P. Ford (1989). Nursing rituals, research and rational actions. London, Heinemann.

gradual acceptance that there was not just one way to achieve a goal. Once that had been accepted it became inevitable that the variable of 'individual patient' would be entered into the problem solving formula. This variable would prove to be indeterminable by anyone but the nurse undertaking the task and in this way the task methodology could not be prescribed.

The Syllabus of Training published by the GNC and the GNC (Scotland) shows a clear and unambiguous development from pedagogy to androgogy and from physical tasks to the psychology and sociology of the child patient. The 1930 Syllabus 'of lectures and demonstrations for the education and training of nurses for sick children'[937] contains a list of content (the level of learning not identified) relating to:

- Anatomy and physiology
- Hygiene and dietetics
- The theory and practice of nursing
- Dietetics and cooking
- Bacteriology
- Medical nursing
- Surgical nursing

Theory and practice of nursing included basic nursing skills such as bed-bathing and administration of medicines but also included ethics and etiquette, personal hygiene and uniform. The latter were probably included to ensure the nurses' compliance with the system of discipline. Interestingly, however, Boal[938] reports that the above syllabus did not reflect the amount of cleaning she had to do. Boal also comments that there was no introductory period of study, she was expected to start on the wards on her first day.

It should be understood that the government were consistently opposed to the idea that nursing should be the well educated discipline so desired by the new GNC (see Arton

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[937] Yorkhill Hospitals Archive (1930). A syllabus of lectures and demonstrations for education and training of nurses for sick children. GNC (Scotland). Glasgow.
[938] Boal, L. (1982). One hundred years nursing. Yorkhill Hospitals Archive. Glasgow.

1992)[939]. It has already been argued that Medicine wanted paediatric nursing to remain as a disciplined body. Nursing provided a body of inexpensive 'helpers' much needed by the growing and diversifying profession of medicine. Clearly, medicine took an active interest in nursing and nurse training, an interest which caused one of its members to criticise the complexity and academic level of the RSCN final examination for 1927 (see Arton 1992). Medicine had much to fear from the academic development of paediatric nursing for such development might have encouraged its professional independence from medicine.

Chapple (1996)[940] notes that the term 'student nurse' began to be used in the 1930s. This term was probably intended to carry the notion that nurses in training were students rather than apprentices, even though this would not in reality be the case until the end of the twentieth century. At the same time (Chapple 1996), courses began to be arranged which involved separate periods of practice and study, although still with the emphasis on practice. These changes may appear minor, but they probably reflected the beginning of a concern that nursing should be seen to possess a legitimate training. Doctors had enjoyed a university based education almost from the beginning of their professional organisation but by this time some paramedical disciplines were also moving their courses into universities and nursing may have begun to feel left out of this movement.

Lomax (1996)[941] argues that as training became more academically orientated, it became necessary to recruit teachers rather than use existing staff to deliver lectures. This meant that a new senior grade of staff was introduced and one which was not based on the wards where the individual would have been influenced by the system of discipline. Lomax (1996, same reference) notes a degree of conflict between these nurse educators and the doctors and administrators. This conflict may indicate a degree

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[939] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.
[940] Chapple, K. (1996). The history of children's nursing. Nursing. Hull, The University of Hull.
[941] Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

of independent thinking which in time would rub off onto the students and begin to break apart the system of discipline (see also Weir 1988)[942].

It should be noted that university based courses in general nursing had existed throughout most of the twentieth century. However, these tended to be associated with nurse teacher training and later with pre-registration undergraduate studies leading to a baccalaureate degree and general nurse registration. The list below identifies some of the main developments:

Early developments in university and college based education for (general) nurses

1918	Sister Tutor Course commenced in 1918: Kings College for Women (to become Kings College of Household and Social Science).
1919	Princess Christian College for the Training of Children's Nurses (Manchester) opened. provided an 8 month course of theory followed by practical experience in a hospital during which time the students remained the responsibility of the college.
1920	Fund started to establish a Chair in nursing so that a degree in nursing could be enabled.
1921	First university course for nurses: University of Leeds: Diploma in Nursing.
1925	College of Nursing approved by the Ministry of Health to run a Health Visitor training course.
1926	Diploma in Nursing: University of London.
1930	Midwife Teachers Course established at the college of nursing (at the request of the Central Midwives Board).
1939	Nurse Teachers Course at the College of Nursing.
1941	The College of Nursing establishes courses for nurses working in war-time nurseries.
1943	Nine month course in Health Visiting and District Nursing run by the College of Nursing.
1944	One year, full time course for hospital matrons (College of Nursing).
1946	Tutor Course, reorganised along the lines of the University of London, Sister Tutor Diploma.

Interestingly, there was at least one college which, independently of any hospital, trained children's nurses (The Princess Christian College for the Training of Children's Nurses, which opened in 1919). However, such establishments seem to have made

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[942] Weir, R. I. (1988). "Gladys Carter: an advocate for higher education for nurses." International History of Nursing Journal 4(2): 22-27.

little impact on paediatric nursing and seem to have had a short lifetime (see Arton 1992).[943] [944]

General nursing publications began to appear quite early after the introduction of the children's hospitals in Britain.[945] Sir Henry Burdett founded The Nursing Mirror and Midwives Journal which was perhaps the first British nursing journal and later founded (and edited) 'The Hospital' in 1888. These journals sometimes contained material relevant to paediatric nursing but it would be another hundred years before a British paediatric nursing journal would be founded.[946] On the whole, very few books which were written for paediatric nurses were published until the 1970s. However, some that were published include Yapp (1915)[947], Ashton (1920)[948], Jeans and Rand (1936)[949], Mitchell, Upham and Wallinger (1940)[950], Paterson and Forrest-Smith (1940)[951], Latham and Heckel (1968)[952] and Broadribb (1968)[953], most of these were written by doctors. Psychology textbooks designed for nurses began to be published from about 1940. The degree to which paediatric nurses and doctors were aligned to the same goal is perhaps illustrated by the number of texts published by a nurse / doctor team, consider for example, Lyson and Wallinger (1959)[954]. These texts were written for nurses, no such nurse / medicine author created a text for medics. Early examples of clinical paediatric articles include 'Sister Tutor' (1926)[955] and 'Sister Louise' (1940)[956]. Before the mid 1940s, most clinical paediatric articles were written by non

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[943] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[944] Also see Editorial (1919). Nursing Times **18/08/1919**: 836.

[945] The Hospital for Sick Children, Great Ormond Street, London was founded in 1852.

[946] Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University., claims that Burke, A. M. (1919). "Incontinence (of urine) in children at night." British Journal of Nursing **18/01/1919**: 42.. is the first clinical paediatric nursing article to be published in Britain.

[947] Yapp, C. S. (1915). Children's nursing: lectures to probationers. London, Poor Law Publications.

[948] Ashton, E. (1920). The feeding of infants and young children. London, Scientific Press Ltd.

[949] Jeans, P. C. and W. Rand (1936). The Lippincott Essentials of Paediatrics for Nurses. London, Lippincott., Originally an US text published in Britain for the first time in 1936.

[950] Mitchell, A. G., E. F. Upham and E. M. Wallinger (1940). Pediatrics and pediatric nursing. USA, WB Saunders and Co. Ltd.

[951] Patterson, D. and J. Forrest-Smith (1940). Modern methods of feeding in infancy and childhood. London, Constable and Co. Ltd.

[952] Latham and Heckel (1968). Paediatric nursing. London, Henry Kimpton.

[953] Broadribb, V. (1968). Foundations of paediatric nursing. London, Pitman Medical.

[954] Lyson, R. A. and E. M. Wallinger (1959). Nursing of Children. USA, Saunders.

[955] Anonymous ('Sister Tutor at The Hospital for Sick Children, G. O. S., London') (1926). "The nursing care of poliomyelitis." Nursing Times **18/12/1926**: 1168.

[956] Sister Louise (1940). "Restoration of the Larynx." Nursing Mirror **04/05/1940**: 125.

paediatric nurses; examples include Williamson (1939)[957], Whitehead (1939)[958] and James (1939)[959].

From the mid 1940s more paediatric articles were written by paediatric nurses and more articles were published on psychology and personality. See for example: Mackenzie (1945)[960], Sharp (1950)[961], Sharp (1950)[962], Hunter (1950)[963], Anon (1964)[964] and Robottom (1968)[965]. The nursing press published a good many articles on child health issues and on child psychology. However, the nursing press had been largely ignoring paediatric nurses until this time and seems to have encouraged non paediatric nurses to publish. Certainly there were very few articles written by paediatric nurses until this period. As soon as post registration RSCN courses became the accepted way of becoming a paediatric nurse, the press seems to have been much more welcoming of paediatric nurses seeking to publish. It seems to have been perfectly reasonable for a general nurse to do a post registration course in paediatric nursing, but not for Part 8 of the Register to be used as a sole qualification. It may be, however, that single qualification paediatric nurses did not seek to publish and that the general nursing qualification in some way gave nurses the confidence to publish, so that when they undertook the post registration RSCN course, they then started to write about paediatric nursing.

It is interesting that the articles written by non-paediatric nurses (which before the end of the 1940s included most such articles), comprised very little or no psychological care and tended to present the view that only qualified nurses could undertake the care required by the sick children. Also, most articles were written by general nursing students with very few articles written by any grade of paediatric nurse.

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[957] Williamson, M. F. (1939). "Interesting cases series II: splenic anaemia treated by splenectomy,." Nursing Times **12/08/1939**: 1002-1003.
[958] Whitehead, E. (1939). "Acute osteomyelitis." Nursing Times **26/08/1939**: 1060-1061.
[959] James, B. (1939). "Interesting cases series ix: pyloric stenosis." Nursing Times **30/09/1939**.
[960] Mackenzie, N. (1945). "Temperament and personality." Nursing Times **12/05/1945**: 302-303.
[961] Sharp, J. (1950). "Nursing by case assignment." Nursing Times **07/01/1950**: 4-5.
[962] Sharp, J. (1950). "Increased visiting for children." Nursing Times **11/02/1950**: 152.
[963] Hunter, M. (1950). "Malrotation of the midgut complicated by volvulus." Nursing Times **18/03/1950**(287).
[964] Anonymous (1964). "Removal of tonsils and adenoids." Nursing Times **31/07/1964**: 993-996.
[965] Robottom, B. M. (1968). "Home nursing of a baby with toxoplasmosis." Nursing Times **02/02/1968**: 66.

Note should be taken that the first successful paediatric medical journal (Archives of Diseases of Childhood) was first published in 1926 (see Forfar, Jackson and Laurance (1989)[966]. Forfar, Jackson and Laurance (1989, same reference) make the point that paediatric medicine was little more than an emerging discipline at this time. In this way it should perhaps not be expected that paediatric nurses should have been publishing much before this time. However, note should also be taken that the first paediatric nursing journal was not published until the late 1980s ('Paediatric Nursing').

It is clear that the requirement for technical skills also increased during this period. One of the first examples of the development of technical nursing is that of Sister Jane Turnbull, successor to 'Sister Laura' at Yorkhill[967]. Sister Turnbull is known to have performed minor operations in the Out-Patient Department at Yorkhill, administering the anaesthetic herself between 1923 and 1948 (see Robinson 1972)[968]. Nevertheless, Participant G[969] argues that nursing was largely non technical (c. 1950s) and that this, and not the goal of nursing differentiated it from medicine. It follows that as the amount and degree of technical nursing increased, it would tend to do so in respect of that shared goal. In this way, technical nursing was closely aligned to medical knowledge and medical skills. This new alignment of nursing and the more problem solving medicine, may well have served to increase the amount and depth of problem solving in nursing. Financial recognition of this additional value came to the X-Ray Sister of the Westminster Infants (Children's) Hospital between 1930 and 1949 who was paid more than the Assistant Matron for her skills.[970]

Hulme (1996)[971] provides evidence that nurses working early in this period were using protocols agreed with doctors at a time when most doctors only came into the hospital in the evening. As already noted, this indicates that at least some nurses were working

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[966] Forfar, J. O., A. D. M. Jackson and B. M. Laurance (1989). The British Paediatric Association 1928-1988. London, The Royal College of Child Health and Paediatrics.

[967] Baby food was marketed in Sister Laura's name in 1911. See Dopson, L. (1983). "'Sick kids' 100 years on." Nursing Times 79(13): 8-9.

[968] Robinson, E. (1972). The Yorkhill story: the history of the Royal Hospital for Sick Children, Glasgow. Glasgow, The Board of Management for Yorkhill and Associated Hospitals.

[969] Participant G (From 1953). Nurse. London.

[970] See Wages Book 1930-1949, WCH(A) 311, Westminster Infants (Children's) Hospital, London. Cited by Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

[971] Hulme, O. (1996). Reflections of the past, in Journal of the Yorkhill Nurses' League. Yorkhill Hospitals Archive. Glasgow.

with a degree of professional freedom. Participant L[972] regrets the passing of the system of discipline and the simple skills with which it was associated. She argues that although nurses are now seen as knowing more, nurses then (1950s) had to know how to do a great many things that are now automated. Any one of these skills could be seen as simple and not requiring of learning and academic study. This last notwithstanding, Participant L argues that nurses needed to know a great many of such skills which collectively did amount to significant learning. It follows that while technology has increased at least the perception of nurses' skill and knowledge, this has been achieved only by sacrificing what was already there, together with the respect and prestige associated with those now redundant skills. Participant L argues that a key difference between then and now is that nurses did not need academic skills then, and one did not need to be 'clever' to be a nurse. The knowledge and skill required less problem solving and analysis and it was made up of many hundreds of what alone were simple skills but which collectively amounted to a skill base which did take years to learn; most or all of these skills being necessary for one to do the job of a nurse. In this way one had to be the right sort of person to make it as a nurse, and many did not make it. In this way, paediatric nursing has changed but in Participant L's experience has not necessarily improved. Nurses were respected then and the system of hierarchy and discipline strengthened the degree to which nurses were respected and respected themselves. This respect for nursing was such that even in the 1960s, nursing was successful in recruiting candidates from public and grammar schools, at least into the well known and London hospitals (see Participant N)[973], this despite nursing being understood as relatively unacademic and there being many other opportunities for women at that time. It is argued here that this respect for nursing helped to maintain it as a cohesive and robust discipline and one that was able to survive largely unchanged, through some of the most socially turbulent decades of the twentieth century.

It is possible that in the most well known children's hospitals, the traditional recruitment of relatively well educated candidates may have enabled nursing to adopt a more academic and problem solving approach to its development. Participant O[974] considers that nursing became more academic, partly because schools of nursing

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[972] Participant L (From 1953). Nurse. London.
[973] Participant N (From 1964). Nurse. London, Scotland and Yorkshire.
[974] Participant O (From 1963). Nurse. Yorkshire and Lincolnshire.

increased their academic entry requirements and that this also gradually decreased the class difference between nurses and doctors (Darbyshire 1987)[975]. It is likely that this facilitated the move to a more academic basis for nursing, something that would have been quite difficult to achieve otherwise.

It is clear that nursing was beginning to be a more technical field than had once been the case (see RCN 1964, p. 10)[976]. Advances in medicine meant that technology was gradually taking the place of clinical skills. More technical tasks that had once been the strict province of medicine were being handed to nurses. It was becoming necessary that nurse education prepared nurses for these technical roles.

By 1970, the Joint Board of Clinical Nursing Studies (JBCNS)[977] had been established by the Secretary of State for Social Services. This body would set up and approve a wide range of post basic courses for qualified nurses. Further study for nurses had become legitimate. Only three years later, the Royal College of Nursing would be broadly supporting plans to establish colleges of nursing which would begin to remove initial nurse education from the control of practice managers and the NHS.[978]

It is clear that nursing between 1920 and 1970 presented an image of 'professionalism' which was dependant in part upon an academic background. Initially, nursing seemed to acquire both these standards by its simple proximity to doctors. By the end of the period in question, nursing in the United States was beginning to argue its independence from medicine (see Boschma 1997).[979] Nurse leaders in the US, such as Virginia Henderson[980] began to argue not only for the use of the scientific method in

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[975] Darbyshire, P. (1987). "Nurses and doctors: the burden of history." Nursing Times 83(4): 32-34.

[976] Royal College of Nursing (1964). First report on a special committee on nurse education; a reform of nursing education. London, RCN.

[977] Atkins, H. (1972). Joint Board of Clinical Nursing Studies: first report. London, Joint Board of Clinical Nursing Studies.

[978] RCN (1973). RCN comment on the Report of the Committee on Nursing. London, Royal College of Nursing.

[979] Boschma, G. (1997). Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[980] McCormick, P. (1996). "A tribute to Virginia Henderson: Virginia Avenel Henderson - the mother of modern nursing - dies at age 98." Psychiatric Care 3(Supplement 1): 47.

nursing (the 'nursing process')[981] but for a model of care based on psycho-social research. The approach appeared far more holistically driven than the disease and body system orientated medical approach. This initiative would gain ground in Britain too but not until perhaps a decade later. The initiative probably did give added credence to the adoption of a more holistically driven model of care and to a greater emphasis on psycho-social care. The effect of these changes were probably not clearly felt in this country until the late 1970s. However, this initiative might not have been successful at all had there not already existed a groundswell of feeling that the hospital environment had become too hard and too orientated to the child's physical condition. Additionally, this initiative demonstrated that nursing was not always a passive recipient of social and medical change and that the increasing emphasis on academic nursing did play a part in the return to holistic care to which nursing would eventually submit.

It is suggested here, that whatever the reasons for nursing's increasing academic orientation, the effect was to empower junior nurses to criticise and evaluate care. This in turn destroyed the principle of there being a 'known way' of doing everything. It was upon this 'known way' that discipline and the associated uniformity (and generalised care) depended. Once junior nurses began to evaluate care, the job-based respect for senior nurses evaporated and the system of discipline and hierarchy fell apart.

The demise of the Matron

While some nurse participants welcomed the greater family involvement in care which has come to characterise modern paediatric nursing, it is interesting that no single participant wholly welcomed the loss of the system of discipline and hierarchy. Most suggested a middle way, returning to some of the discipline of the past and embodied by the notion of a 'matron'.

Some of the nurse participants (see Participant J)[982] blame the dissolution of the system of discipline on the removal of the matron role which came about as part of the Salmon

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[981] The 'nursing process' is an individualised problem solving approach to nursing where care is planned according to an individual Assessment, Goal identification, Implementation and Evaluation.

[982] Participant J (From 1962). Child 10 years. Nurse. Scotland.

restructuring of nurse management (DHSS 1965)[983]. This structure provided a line management system which ranged from nursing officer with responsibility for a small number of wards, to posts which extended to the regional health authorities and beyond. Consequently, responsibility seemed to be distributed among the line of managers and not possessed wholly by any one senior nurse within the hospital (see Baly 1995)[984]. Participant C[985] put the concern thus:

'Yes, I might be old fashioned but I prefer the nursing when we had a Matron and Matron assisted the hospital secretary. Yes, that was all, there wasn't all these managers and different people as they are now. Before Salmon[986] came in it was better, when Salmon started grading people, nursing wasn't the same.'

Participant J[987] suggests that there was an advantage in there always being someone who was clearly in charge. In this way, the Salmon restructuring spread managerial responsibility across several posts and in addition would have meant that each nurse only had daily contact with his or her immediate superior. Before Salmon, the daily appearance of the most senior nurse in the hospital probably did have more impact.

Most of the nurse participants associate the role of the matron with the preservation of more basic aspects of care, such as keeping the ward clean and tidy. There are no examples in this data of the matron being associated with technical care or with the extending role of the nurse. It follows that the demise of the matron is associated with a reduction in the quality of more basic but nevertheless fundamental aspects of care. Participant J[988] makes this point and in common with several other nurse participants, claims that the problem became exacerbated by increasingly poor staffing levels which, with the development of technical care, meant that basic care slipped down the list of priorities.

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[983] Department of Health and Social Security (1965). The committee on senior nursing staff (The Salmon Report). London, HMSO.
[984] Baly, M. E. (1995). Nursing and social change. London, Routledge.
[985] Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.
[986] Began to be implemented c. 1976.
[987] Participant J (From 1962). Child 10 years. Nurse. Scotland.
[988] Participant J (From 1962). Child 10 years. Nurse. Scotland.

However, the demise of the matron cannot be solely responsible for the dissolution of the system of discipline. What does not come across in these accounts is why the nurses were not self motivating in respect to discipline. Florence Nightingale (Nightingale 1860)[989] had argued that a good manager could leave the ward and still be sure that the care would be practised as she had determined. The notion that nursing was undisciplined seems untenable as in other important ways nursing retained a professional orientation. Participant I[990] for example recalls paediatric nursing as a service which ran into and over the nurses' private time. She recalls that the needs of the children came before any private arrangements the nurse might have made. This is illustrated by the fact that nurses had to ask permission before leaving the ward at the end of their shift and that there was no guarantee that this permission would be given. The Nurses' Rule-book (c. 1930) of the Derbyshire Children's Hospital directed that split shifts[991] were preferable to full days off so that the ward could be adequately covered.[992] In 1927, the Hospital for Sick Children, Great Ormond Street decreed that leave of one day per month and half a day per week was dependent upon the 'necessary work of the word'.[993] Participant I recalls that it was in this respect that nurses were said to be 'dedicated' to their work and to the sick children who came before the nurses own private and personal needs. It is argued here, however, that these principles did not so much relate to professionalism but to servanthood. It is suggested here that paediatric nursing, freed from its bondage of hierarchy and discipline, developed a range of very different goals and priorities. These were priorities that would lead to a more family and individually focused provision of care but perhaps at the expense of uniform but good standards of basic, physical care.

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[989] Nightingale, F. (1860). Notes on nursing: what it is and what it is not. USA, D. Appleton and Co. For an 'in-print' publication see Nightingale, F. (1969). Notes on nursing, what it is and what it is not. New York, Dover Publications Inc. (first published in the UK in 1859).

[990] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.

[991] 'Split shifts', where the complement of off duty was taken in half days.

[992] Derbyshire Children's Hospital Archive (c. 1930). Nurse's Rulebook. Derby.

[993] The Hospital for Sick Children Great Ormond Street Archive (1927). Entry dated 03/03/1927. Nursing Committee Minutes. London.

Marriage, women and men

Baer (1997 p. 256)[994] argues that '*Nurses are the prototypically invisible women whose minds, hearts and glands have shaped a huge industry, yet who are ignored equally by traditionally male power brokers and new feminist status builders*'. It could be argued here that the feminist movement had an impact on the return to holistic and psycho-social care but to do that would be misleading. In fact there is little evidence either of female nurses being empowered in a feminist sense, or of there being a feminist movement to bring about more 'human' care to child patients and their families (but see Bashford 2000, Australia)[995]. Female nurses may have acquired traditionally male orientated roles in the hospitals, although probably not in the period in question and if they did they seem to have had little if any influence on the development of holistic or psycho-social care. Baer (1997)[996] argues that while feminism achieved a number of successes in the late twentieth century, it actually delayed the development of women in nursing and in other traditionally female roles. She argues that it did so by resting its case on the argument that women were equal to men, that is that they could do the jobs that were traditionally considered to be male territory. It follows logically from this position that women in traditional female roles were inevitably less able than other women. The problem for women is put succinctly by Baer (1997)[997] as how to value 'women's work' and yet at the same time demand that not all women should be expected to do it.

It does appear somewhat strange that nursing seems from its inception to have merged the roles of servant and lady (see Brooks 2001)[998]. Maggs (1978)[999] illustrates some of the arguments which went to sustain this unusual amalgamation of roles. There were initially two classes of nurses, those paid and from what Maggs (1978[2])[1000] considers to be the lower middle classes, and those who were unpaid and were largely upper

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[994] Baer, E. D. (1997). Women and the politics of career development: the case of nursing. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[995] Bashford, A. (2000). "Domestic Scientists: Modernity, Gender, and the Negotiation of Science in Australian Nursing, 1880-1910." Journal of Women's History **12**(2): 127-146.
[996] Baer, E. D. (1997). Women and the politics of career development: the case of nursing. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[997] Baer, E. D. (1997). Women and the politics of career development: the case of nursing. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.
[998] Brooks, J. (2001). "Structured by class, bound by gender." International History of Nursing Journal 6(2): 13-21.
[999] Maggs, C. J. (1978). "Towards a social history of nursing -1." Nursing Times 74(14): 53-56.
[1000] Maggs, C. J. (1978). "Towards a social history of nursing - 2." Nursing Times 74(15): 57-58.

middle class. There can be no doubt that the first group overtook the second in terms of numbers.

Participant O[1001] (c. 1963) argues that the London hospitals continued to recruit upper middle class students because of a preference for candidates from upper social groups. Participant O however considered that these nurses offered little to nursing as they tended to marry early and leave nursing. What unites both groups is that they were both used to 'women's work' (see Simonton 2001)[1002] either conducting this work themselves or seeing that other women did it. The nature of the work was uniquely female and would have been socially familiar to upper and lower social class females. Perhaps this focus on 'women's work' helped to initiate and maintain the paediatric nurses' role on cleanliness and order.

The exclusion of married women from the work-base was a well understood social and cultural phenomenon. However, it is one which had a major impact upon the female-only discipline of paediatric nursing. It had the effect of creating a membership of two classes of people, the first were young, unmarried females, many of whom would leave nursing in order to marry and who had no experience of caring for their own children. The second group were older, unmarried women who had (more or less) chosen to stay unmarried and to stay within nursing. As a result, the membership of paediatric nursing, had little or no experience of living with children and no experience at all of bringing up their own children. They were without the experience of the emotional bond between parent and child and had no experience of guiding a child through the normal stresses of childhood.

It should be understood that the exclusion of married women from paediatric nursing was not just a social norm but was often formally prescribed. The regulations of the Hospital for Sick Children, Great Ormond Street in 1935 required that the matron be unmarried[1003]. The Hospital for Sick Children, Great Ormond Street would be a little flexible for example by allowing a recently married nurse to work for a further 3

[1001] Participant O (From 1963). Nurse. Yorkshire and Lincolnshire.

[1002] Simonton, D. (2001). "Nursing history as women's history." International History of Nursing Journal 6(1): 35-47.

[1003] Great Ormond Street Hospital Archive (1935). Entry dated 17/04/1935. Nursing Committee Minute Book: Volume One 1935-1936. London.

months so that she could meet her pension requirements.[1004] By 1939, the hospital had allowed two married nurses to rejoin the staff,[1005] and in 1940, the retention of married women was formally approved.[1006] Four years later, hospitals around the country received a circular from the Ministry of Labour asking them to retain women after marriage.[1007] However, it would be some time before sexual equality reached the nursing profession. At the Hospital for Sick Children, Great Ormond Street, for example, nurses in training were not allowed to finish their training if they got married.[1008]

Hargreaves (1987, p. 28)[1009] found that even in the 1950s '*very very few nurses were married before they finished their training, the idea was frowned upon*'. In 1959, the editor of the Nursing Times made special note that the author of one of the articles was married and working as a hospital school teacher (see Gray 1959)[1010]. From the end of WWII it was beginning to be accepted that nurses should be allowed to marry. Hargreaves (1987, same reference) provides one of the earliest examples of a married paediatric nurse in Nurse Hubbart who married the assistant hospital secretary and worked after WWII at Booth Hall Children's Hospital until 1975. Presumably, she had the benefit of influence. By the 1960s the nursing press was encouraging the notion of married nurses. From this time the Nursing Mirror regularly published nurses' wedding pictures (See Editorial 1968)[1011], presumably to emphasise that married nurses could work.

Participant J[1012] recalls that there were cultural and personal expectations that she would leave work once married and that in practice she had little choice. Participant

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[1004] Great Ormond Street Hospital Archive (1937). Entry dated 14/04/1937. Nursing Committee Minute Book: Volume Two 1937. London.

[1005] Great Ormond Street Hospital Archive (1939). Entry dated 02/10/1939. Nursing Committee Minute Book: Volume Three 1939. London.

[1006] Great Ormond Street Hospital Archive (1940). Entry dated 16/01/1940. Nursing Committee Minute Book Three. London.

[1007] See Great Ormond Street Hospital Archive (1944). Entry dated 11/07/1944. Nursing Committee Record Book Four, 1942. London.

[1008] See Great Ormond Street Hospital Archive (1944). Entry dated 15/08/1944. Nursing Committee Record Book Four, 1942. London.

[1009] Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.

[1010] Gray, W. (1959). "Teacher in a children's ward." Nursing Times **27/03/1959**: 373-374.

[1011] Editorial (1968). "Weddings." Nursing Mirror **09/02/1968**: 48-49.

[1012] Participant J (From 1962). Child 10 years. Nurse. Scotland.

I[1013] suggests that marriage was seen as leaving nursing, though it was (1950s) sometimes possible to get a less responsible job. Even where nurses did this they were criticised for wasting the time that had been put into their training. Participant I reports that getting married was a bad thing to do because nurses were meant to be dedicated to their work and that meant there was no room for private life and no room for marriage.

Brown (2000)[1014] provides evidence that nursing had been a predominantly female occupation but that Florence Nightingale, responding to the changing social construction of masculinity and femininity succeeded in feminising nursing further. This probably had the effect of confining the development of nursing and delaying the introduction of male nurses. However, while the feminist initiative may have had little effect on nursing, the introduction of male nursing may have done. Brown (2000)[1015] provides evidence that male nurses may have been partly responsible for the shift from institutionalised and hierarchical nursing and toward patient centred and individualised approaches to care. It is possible that the entry of male paediatric nurses also contributed to the dissolution of the system of discipline (see Brown 2000[1016], Darbyshire 1986[1017]). The first male nurse to train for Part 8 of the Register appears to have been accepted for training in 1952 at the Royal Hospital for Sick Children, Glasgow.[1018] However, male children's nurses remained very few in number through to 1970.[1019] Participant N[1020] reports that there were no male paediatric students or qualified nurses at the Hospital for Sick Children, Great Ormond Street while she was

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[1013] Participant I (From 1954). Nurse. Sussex and Nottinghamshire.

[1014] Brown, B. (2000). "Men in nursing: ambivalence in care, gender and masculinity." International History of Nursing Journal 5(5): 4-13.

[1015] Brown, B. (2000). "Men in nursing: ambivalence in care, gender and masculinity." International History of Nursing Journal 5(5): 4-13.

[1016] Brown, B. (2000). "Men in nursing: ambivalence in care, gender and masculinity." International History of Nursing Journal 5(5): 4-13.

[1017] Darbyshire, P. (1986). "The unfairer sex." Senior Nurse 5(5-6): 44-45.

[1018] See Yorkhill Hospitals Archive (1952). Letter to Miss Clarkson, Matron from the GNC (Scotland), 12/05/1952. YH8/8/1 GNC (Scotland). Glasgow.

[1019] Miles, I. (1986). "The emergence of sick children's nursing Part 1: sick children's nursing before the turn of the century." Nurse Education Today 6: 82-87., points out that in 1985, there were 25 post-registration courses (53 weeks) and 11 171 week courses (combines RGN/RSCN courses) in England and Northern Ireland. Miles (same reference) points out that in Scotland, the three year RSCN course had been maintained. According to Miles (same reference) between 1981 and 1982, there were 645 female admissions to the Register for Sick Children's Nurses, and 15 male admissions. In the same period, there were 10733 female and 582 male admissions to the general Part of the Register (General Nursing Council 1981-82).

[1020] Participant N (From 1964). Nurse. London, Scotland and Yorkshire.

there c. 1964. Interestingly, however, Participant N remarks '*I don't know what they would have found them to do*' and argued that the nursing administration would not have been able to cope with them. Participant N's account indicates that the system of discipline was focused on female nurses who did not have experience of managing men. Ward sisters usually lived in hospital accommodation and were almost always unmarried. It has also been pointed out that the system of discipline was particularly inflexible and in this way may simply not have been able to cope with male nurses. Undoubtedly, male nurses would have brought a different orientation to paediatric nursing and might themselves have found it difficult to adapt to the system of discipline in force. Participant N's comment '*I don't know what they would have found them to do*' appears to suggest that the integration of males into the system of hierarchy and discipline was almost inconceivable and the resulting friction inevitable.

Men of course did eventually begin to play a bigger part in paediatric nursing (Darbyshire 1986)[1021] and while outside the period being considered here, may well have played a part in the dissolution of the system of discipline; certainly, they must have presented something of a challenge to the existing ward sisters (see Brown 2000).[1022] It should be noted that British culture did not fully accommodate females managing males and that such an arrangement would have been much more of a challenge than would be the case today. Furthermore, Goffman's (1961)[1023] main thesis was that institutions and institutionalisation depended on the rules being consistently applied. Many of the rules simply could not be applied to male nurses, especially those relating to uniforms, accommodation and working with older and female children.

The effect of World War II and the mass evacuation of children

Baly (1995, p. 1)[1024] argued that '*Nursing has developed as a response to changing social needs. As the structure of society alters, so new demands for health care arise*

[1021] Darbyshire, P. (1986). "The unfairer sex." Senior Nurse **5**(5-6): 44-45.
[1022] Brown, B. (2000). "Men in nursing: ambivalence in care, gender and masculinity." International History of Nursing Journal **5**(5): 4-13.
[1023] Goffman, E. (1962). Asylums: Essays on the social situation of mental patients and other inmates. Garden City - New York, Doubleday and Co.
[1024] Baly, M. E. (1995). Nursing and social change. London, Routledge.

...' and that (p. 168) '*When it comes to change, war is the sorcerers apprentice, and once released from the peacetime pot the genii are reluctant to return ...*'. Nursing histories have often cited WWII as a change agent for paediatric nursing[1025] but the way in which WWII caused changed seems to have been given only superficial treatment in the literature.

Macnicol (1986)[1026] argues that WWII was a major force behind social change. Macnicol (1986) points out that in 1939, less than half the population spent at least one night away from their home but that in the course of the war 60 million people changed their address (pop. 38m). The first evacuation (September 1939) caused 826,959 unaccompanied schoolchildren, 523,670 mothers with pre-school children, 12,705 pregnant women and 173,000 others to be re-located. Macnicol (1986, p. 6) reports that:

> *'Evacuees frequently began their journey early in the morning at a railway station thronged with crowds of forlorn and confused children, clutching suitcase and gas mask. Exact destinations were kept secret, and rail journeys would be long and slow - with the result that many of the children, already traumatised by separation from their families, arrived at their destinations, tired, frightened and lonely* .. [Evacuation was] (p. 7) *'the most crucial life event experienced by the civilian population. At a stroke, family ties were disrupted: children found themselves, at an appallingly early age, having to stand on their own two feet in a strange and hostile environment; parents were suddenly deprived of their offspring.'*

Urwin and Sharland (1992)[1027] argue that the Second World War brought with it the bugle cry for democracy, a claimed characteristic of British life that was not shared by

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[1025] See for example Saunders, D. (1982). Sick children's nursing. Nursing, midwifery and health visiting since 1900. P. Allan and M. Jolley. London, Faber and Faber.

[1026] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester: 3-31.

[1027] Urwin, C. and E. Sharland (1992). From bodies to minds in childcare literature: advice to parents in inter-war Britain. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

the German or Russian social order. Hendrick (1997, p. 31)[1028] suggests that in the atmosphere of WWII '*habit training and rigid timetables for children (behaviourism) came to be associated with Prussianism and totalitarianism'*. However, the new understanding that Britons possessed democracy (they must sometimes have wondered what it was) took some time to be incorporated into the management strategies to which children were exposed. It is suggested here that the mass evacuation of children during the Second World War is evidence of the then traditional behaviourist and state interventionist thinking. Bowlby, Winnicott and Miller (1939)[1029] did speak out to the editor of the British Medical Journal against the evacuation on the grounds of their research into separation anxiety. Throughout the Second World War, a co-author of the 1939 letter, Donald Winnicott broadcast to wartime mothers about the importance of early 'stimulation' and the mother-child relationship. It should be understood, that the mass evacuation of children, as Hendrick (2003)[1030] points out, reflected a difference between theory and practice rather than an ignorance of theory. Hendrick (2003)[1031] suggests that the 1948 Children Act would eventually signal an understanding of this theory practice divide.[1032] Hendrick (2003)[1033] notes that the beginning of WWII, saw the number of child guidance clinics reduced because of manpower shortages but that from that point on, the number of clinics increased in a response to the number of evacuated children who were identified to have psychological problems.

Hendrick (1994)[1034] suggests that the mass evacuation of children caused nearly 900,000 children to present with psychological problems and that some of these problems were of such severity that 15-20,000 could not be found a placement. Hendrick argues that (p. 6):

[1028] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[1029] Bowlby, J., D. Winnicott and E. Miller (1939). "Letter to the Editor." British Medical Journal **16/12/1939.**

[1030] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[1031] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[1032] The 1948 Children Act established Local Authority Children's Departments which had partial responsibility for young offenders. The Act also gave new emphasis to the use of boarding-out as opposed to residential homes, the restoration of children in care to their families and a greater emphasis on adoption.

[1033] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[1034] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

'... it was the evidence produced of mental disorientation and emotional turmoil (both of which were felt to have serious social consequences), caused in part by separation of the children from their parents (mothers), that proved to be one of the formative influences on early post-war childcare policy'

Macnicol (1986)[1035] provides evidence that children appeared to cope well with the blitz etc. as long as they were in the company of their parents (their mother). However, distress resulted when children were separated from their parents. Plans for the evacuation had been commenced earlier in the 1930s[1036] but mostly by male, middle class individuals with a military background (Macnicol 1986)[1037]. Of course, it has never been argued that all the evacuees suffered from the experience. Hendrick (1997)[1038] makes it clear that many of the evacuated children recalled an interpersonal environment that was characterised by kindness and even love.

Welshman (1999)[1039] provides evidence from the 'Our Towns' report of 1943[1040], that the mass evacuation of children may have had less impact on child social policy than has previously been assumed. Titmuss' (1950)[1041] widely influential work on the evacuation had suggested that it had had a dramatic effect on social policy regarding children. Welshman (1998)[1042] suggests that the traditional belief of social historians is that the evacuation and the blitz caused changes in social policy even during WWII but that this view is now widely contested (see Macnicol 1986)[1043]. It should be understood, however, that these arguments centre almost entirely on the physical

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[1035] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester: 3-31.

[1036] The Report on the Committee on Evacuation (Anderson Report) was published in 1938.

[1037] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester: 3-31.

[1038] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[1039] Welshman, J. (1999). "Evacuation, Hygiene, and Social Policy: The Our Towns Report of 1943." Historical Journal 42(3): 781-807.

[1040] Our towns: a close up, published by the Women's Group on Public Welfare in 1943.

[1041] Titmuss, R. (1950). Problems of social policy. London, Longmans.

[1042] Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History 9(1): 28-53.

[1043] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester: 3-31.

condition of the evacuee children and on the possible effect that the recognition and concern over this had on social policy. Conversely, it is only argued here that evacuation may have had an effect on the way that children began to be seen as having emotional and psychological needs (see Cleary and others)[1044]. It should be understood that much of the social history in this area is concerned with the physical state of the evacuees and the provision before, during and after the war of school meals, school milk and school medical services etc. This area of work does not easily relate to the growing understanding that children possessed social, psychological and emotional needs as proposed for example, by Bowlby (1951).[1045] Welshman (1998)[1046] does point out that there was increasing concern about the physical manifestations of emotional ill-health such as nocturnal enuresis and anti-social behaviour. It is not surprising that the child's emotional and social needs should have reached public consciousness in this practical way. The effect, however, was to encourage the opening of more child guidance clinics and in general to legitimise the study of child psychology. Macnicol (1986)[1047] points to the evidence of the evacuation causing long lasting psychological effects which had begun to be realised at the time. Welshman (1998)[1048] notes the growing interest in child psychology and of Bowlby's assertion about the effects of mother-child separation. Hendrick (1997)[1049] suggests that in this way, the evacuation had the effect of centring attention away from children's sometime antisocial behaviour and how they could become more socially pliable toward the notion of 'mothering' and their needs as children. In this way and in time, the notion that children had important social and emotional needs would become legitimate among both academics and health professionals. In much the same way, Hendrick (1997)[1050] argues that the single most important effect of the evacuation was

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[1044] Cleary, J., P. Gray, P. H. Rowlandson, C. P. Q. Sainsbury and M. M. Davies (1986). "Parental involvement in the lives of children in hospital." Archives of Diseases in Childhood **61**: 779-787.

[1045] Bowlby, J. (1951). Maternal care and mental health. Geneva, World Health Organisation.

[1046] Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History 9(1): 28-53.

[1047] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester: 3-31.

[1048] Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History 9(1): 28-53.

[1049] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[1050] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

to cause the 'family' to be integrated in post war child welfare policies. In this way the value of the family was rediscovered.

Interestingly, Welshman (1999)[1051] notes that the Our Town's report is partly critical of parents for the physical state with which many of the evacuees arrived at their placement. However, this is not atypical of the attitudes toward parents within medicine and nursing at the time at the time[1052] and probably illustrates the way in which evacuation served to reinforce social stereotypes (see Welshman 1999)[1053].

Macnicol (1986)[1054] suggests that in respect of the well understood and poor conditions of the evacuee children, the evacuation did little more than serving to reinforce the existing middle class opinion that *'the bulk of the problems were caused by an incorrigible underclass of personally inadequate "cultural orphans" for whom a Welfare State could do little'* (p. 27). In much the same way, Macnicol (1986, p. 3)[1055] suggests that both the post war health and education policy reforms (included the NHS) succeeded in '*consolidating the power of an elite of consultants'* and provided secondary education in a manner that further supported social class differentiation.

Welshman (1998)[1056] provides evidence that there was widespread concern about the state of and behaviour of evacuees (including mothers) and which were probably caused by a mismatch of class, religion etc. It has been seen that nursing attitudes were also generally anti-parent in the early years of the evacuation but that they had changed by the end of the war. While there seemed to be an effort on the part of politicians to criticise parents (mothers) for the state of their children, on the whole it was the

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[1051] Welshman, J. (1999). "Evacuation, Hygiene, and Social Policy: The Our Towns Report of 1943." Historical Journal **42**(3): 781-807.

[1052] See for example Anonymous (1949). "Visiting children in hospital." Nursing Times **01/10/1949**: 824. Anonymous (1949). "State Examination Questions (February 1949): Final examination for sick children's nurses." Nursing Times **19/03/1949**: 232. Armstrong, K. F. (1940). "Evacuation and epidemics." Nursing Times **20/01/1940**: 55. Robertson, J. (1962). Hospitals and children: a parents' eye view. London, Victor Gollancz. Young, J. (1992). "Changing attitudes towards families of hospitalised children from 1935 to 1975: a case study." Journal of Advanced Nursing **17**: 1422-1429.

[1053] Welshman, J. (1999). "Evacuation, Hygiene, and Social Policy: The Our Towns Report of 1943." Historical Journal **42**(3): 781-807.

[1054] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester**:** 3-31.

[1055] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester**:** 3-31.

[1056] Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History 9(1): 28-53.

interwar school medical service and the related social policy that was criticised. Welshman (1998)[1057] argues that generally, there was an increase in awareness of the need for better housing, school meals and medical and nursing care than had been provided in the interwar years. Welshman (1999)[1058] does argue that much of the concern regarding evacuation was being voiced by women and women's organisations such as the National Federation of Women's Institutes. Children's nurses were themselves women and were led and managed by women. It is therefore possible that nurses were more heavily influenced by the concern regarding evacuation than were more male dominated disciplines. It is not being argued here that the mass evacuation of children directly caused a change of heart toward the social and psychological needs of children but that it was one social event that contributed to a change in society's attitudes to children and their needs which did eventually occur and which did eventually cause a change in the practice of children's nursing. Welshman (1998)[1059] does argue that the effect of the evacuation may have been overstated by historians but that despite this, it is clear that the mass evacuation of children did have a discernable effect on social policy toward children *'... the evacuation led to a fundamental sea-change in opinion that was consolidated in policy reforms'* (Welshman 1998, p. 53)[1060]. In an evaluation of Titmuss' (1950)[1061] work, Macnicol (1986) concurs that evacuation did dominate social policy during and after the war and that it *'aroused the consciousness of the nation'* (p. 8). Macnicol (1986)[1062] makes the point that evacuation succeeded in creating a wide debate on the issues generated by the mass evacuation of children. In this way, it matters little what direct effect the evacuation had on child policy, what is important is that the widespread social experience of child evacuation resulted in a *'revolution in attitude'* (p. 9) toward the social and emotional needs of children.

[1057] Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History 9(1): 28-53.

[1058] Welshman, J. (1999). "Evacuation, Hygiene, and Social Policy: The Our Towns Report of 1943." Historical Journal 42(3): 781-807.

[1059] Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History 9(1): 28-53.

[1060] Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History 9(1): 28-53.

[1061] Titmuss, R. (1950). Problems of social policy. London, Longmans.

[1062] Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester: 3-31.

It is perhaps ironic that it was the very model of eugenics and state intervention; Nazi Germany, which caused British nursing to re-orientate itself toward the family, personal freedom and democracy. Politicians argued that Germany and what it stood for were evil, Britain was painted as different and as a result eugenics and state control would retreat as the allied forces advanced to conquer the Nazis.

Hardyment (1995) argues [1063] that by WWII the family had changed its function from one of rearing a new generation of canon fodder and obedient citizens, to one which focused on the needs and happiness of the members of the family. In the same way, Hendrick (1994)[1064] suggests that British society after 1945 was not only characterised by a sense of democracy and social progress but of faith in the institution of the family. It is likely that the disciplined paediatric nursing took some time to adapt to these societal changes. Nevertheless, important changes were taking place in the way that the mother-child role and 'science' itself was socially construed. 'Science' could no longer be construed as published and therefore un-challengeable facts, it had become clear that scientific disciplines had an obligation to validate scientific theories and that state policies could be wrong and errors could be made in applying research.

WWII seems to have been a turning point in the provision of care, perhaps mostly because of the influence of the mass evacuation of children. It is likely that the eugenics movements became aligned in people's minds to Nazism. It is interesting that at the beginning of the war, Armstrong (1940)[1065] criticises mothers for not fully co-operating with the evacuation of their children and an editorial (1940)[1066] in the Nursing Times criticises mothers who allowed their children to return home for the Christmas holidays, many of whom then failed to return to their evacuation placement.[1067] Hendrick (2003, p. 124-125)[1068] argues that '*The evacuation process*

[1063] See Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[1064] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

[1065] Armstrong, K. F. (1940). "Evacuation and epidemics." Nursing Times **20/01/1940**: 55.

[1066] Editorial (1940). Nursing Times **20/01/1940**.

[1067] Hendrick (2003) and Macnicol (1986) point out that by early 1940, 80% of the evacuees had returned to the cities although the Blitz caused many to go back to their evacuee placements. Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press. Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester: 3-31.

was one of those rare moments when prejudice, mainly shaped and articulated by sections of the rural and small-town middle class, unveils itself unashamedly ... officials gave very little thought to children's feelings on being separated from their parents and friends, and on having to come to terms with their new living environments'. However, by the end of the war, there was increasing concern about the welfare of evacuees and an emphasis on children's need for their parents. Certainly, an increasing number of psychological articles appeared in the nursing press, most of which presented a more Freudian perspective than had been the case before the war (see Wallace 1939[1069], Wright 1940[1070], Mills[1071] 1940, Mackenzie 1945[1072]). It is clear that the nursing journals wanted to see a greater input from psychology. Book reviews began to include psychology textbooks, including that of Muse (1940).[1073] [1074] Wallace (1939)[1075] wrote that nurses should gain the child's confidence, talk with the child about his or her evacuation problems (by now recognised as being the source of much psychological trauma) and that crying and tantrums were a 'normal' part of expressing oneself as a child. Mechanic (1964)[1076] discusses the way in which an understanding of mother's health beliefs can influence their use of health care. This illustrates an attempt to understand and to work with parents even where their health behaviour may be in conflict with those of health care professionals. Mills (1940 p. 104)[1077] presented an unambiguously Freudian interpretation of the stages of child development and of the effects of wartime separation, showing that behaviourism had begun to lose ground. She argues for example:

[1068] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[1069] Wallace, H. (1939). "Night terrors and bedwetting." Nursing Mirror **21/10/1939**: 67.

[1070] Wright, M. (1940). "Psychological problems of the war as they affect the nurse: conversion hysteria." Nursing Mirror **24/02/1940**: 511.

[1071] Hermia Mills was a psychotherapist as the Tavistock Clinic, London. See Mills, H. (1940). "Psychological problems of wartime." Nursing Times **27/01/1940**: 90-91. Mills, H. (1940). "Psychological problems of wartime." Nursing Times **03/02/1940**: 114. Mills, H. (1940). "Psychological problems of wartime." Nursing Times **06/04/1940**: 360-361.

[1072] Mackenzie, N. (1945). "Temperament, character and personality 1: the instincts and emotions,." Nursing Times **14/04/1945**: 139-238.

[1073] Muse, M. B. (1940). A textbook of psychology. London, WB Saunders.

[1074] Reviewed positively in Nursing Times, 08/06/1940, p. 606.

[1075] Wallace, H. (1939). "Night terrors and bedwetting." Nursing Mirror **21/10/1939**: 67.

[1076] Mechanic, D. (1964). "The influence of mothers on children's health attitudes and behavior." Pediatrics **33**: 444.

[1077] Mills, H. (1940). "Psychological problems of wartime." Nursing Times **27/01/1940**: 90-91.

'The results of this experiment [evacuation] no one knows. Some kinds of neurosis will undoubtedly be caused by it, and quite certainly others will be cured. A sudden external upheaval with the need for a great, united effort jerks may people out of their dreams, makes them sensible of reality and forces them to live their lives, it may be, to fight for them'.

The post war years saw what amounts to an intense period of redressing the behaviourist and family exclusion principles of the past. Dame Myra Curtis (Curtis Report 1946)[1078] suggested that *'the whole attitude of society to the treatment of children has been moving toward a gentler and more sympathetic approach'.*[1079] The 1948 Children Act placed new emphasis on the continuing role of the family and on improving adoption and provided for improved registration and supervision of residential homes. John Bowlby was made director of Child Guidance at the Tavistock Clinic and according to Hendrick (2003)[1080], the childcare services responded to Bowlby's work on maternal deprivation (see Bowlby 1951).[1081] The 1945 Family Allowances Act, 1946 National Health Service Act, 1946 National Insurance Act and the 1948 National Assistance Act can all be seen as evidence of the state supporting the family, in part to prevent the need for child-family separation either because of ill health or poverty. The family was still seen as a causative agent in child ill health (as well as youth crime etc.) but now the state was working with the family instead of against it or excluding it. Hendrick (2003)[1082] suggests that following the bitterness of the economic depression and WWII there was an aspiration to create a '*better life for the community as a whole'* (p. 138) and as part of this there was an increasing acceptance of the need for the provision of 'personal care' (p. 139) for children which would reflect the work of the psychoanalytical psychologists.

[1078] Led to the 1948 Children Act.

[1079] Quoted from Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press. p. 133.

[1080] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

[1081] Bowlby, J. (1951). Maternal care and mental health. Geneva, World Health Organisation.

[1082] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

It is argued here, that the above created an atmosphere of change which began to put pressure on nursing to adopt a more holistic, individualised and family centred service to sick children. Where this did not happen, as was the cause at least initially, nursing grew out of synchronisation with wider society. This inevitably led to an increasingly strong, unrelenting and focussed pressure on paediatric nursing to provide the kind of service that society was increasingly demanding.

The demise of behaviourism and the 'science' of parenting

The discipline of Psychology has struggled and probably continues to struggle to find a common approach to the analysis of human behaviour. As Mackintosh (1997)[1083] notes, this has led to a number of psychological sub-disciplines which have adopted a unique perspective on the focus of the discipline as a whole. It is also not surprising that through the passage of time, one paradigm succeeds another in academic popularity (see Mackintosh 1997).[1084] Litt (2000)[1085], while also describing Psychology as a 'discordant discipline' (p. 14) argues that behaviourism rose in popularity from 1900 but that around 1950 a new and more holistically orientated paradigm became increasing accepted by both academics and those involved in psychological practice (see Boschma 1994)[1086].

Urwin and Sharland (1992)[1087] discuss the way that through the 1920s, the child guidance movement began to look at problems such as truancy and bed-wetting from a more or less psychoanalytical perspective. This Freudian perspective (see Freud 1936[1088], Freud and Freud 1991[1089]) had little in common with the prevailing behaviourist explanation of child behaviour and instead focused on individual child experiences. Prior to the establishment of the Child Guidance Council in 1927, a

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[1083] Mackintosh, N. J. (1997). "Has the Wheel Turned Full Circle? Fifty Years of Learning Theory, 1946-1996." Quarterly Journal of Experimental Psychology **Section A 50**(4): 879.

[1084] Mackintosh, N. J. (1997). "Has the Wheel Turned Full Circle? Fifty Years of Learning Theory, 1946-1996." Quarterly Journal of Experimental Psychology **Section A 50**(4): 879.

[1085] Litt, S. (2000). "Gestalt therapy and humanistic Psychology." Positive Health **53**: 14-16.

[1086] Boschma, G. (1994). "The meaning of holism in nursing: historical shifts in holistic nursing ideas." Public Health Nursing **11**(5): 324-30.

[1087] Urwin, C. and E. Sharland (1992). From bodies to minds in childcare literature: advice to parents in inter-war Britain. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

[1088] Freud, S. (1936). Inhibitions, symptoms and anxiety. London, Hogarth Press.

[1089] Freud, S. and A. Freud (1991). Essentials of psychoanalysis. Harmondsworth, Penguin.

number of clinics had opened for the psychological treatment of children with psychological problems. These included that set up in 1920 by Hugh Crichton-Miller which was to become the Tavistock Clinic. Margaret Lowenfeld, a paediatrician, also opened a clinic for nervous and difficult children.[1090] These clinics employed a psychological approach which aimed to understand children's behaviour, rather than simply to change the behaviour (see Hendrick 1997)[1091]. Early precursors to this anti behaviourist movement included Susan Isaacs'[1092] 'nursery years' in 1929 which attempted to help parents understand their child's behaviour, Klein (1935)[1093] which emphasised that emotion was natural and beneficial and Aldrich and Aldrich (1939)[1094] who wrote of the individuality and humanness of babies and children. The inter-war years were to see a gradual decline in behaviourist influence and a greater focus on the child's mind as opposed to his or her body which Hendrick (1997)[1095] ascribes partly to the Aldrich's publication (see also Hendrick 1994)[1096] [1097], even if this had little effect on the popular understanding of behaviourist principles as 'science'.

It should not be considered, however, that the inter-war period brought about a major change in nursing practice, it did not. While the 'mood' was changing toward a less behaviourist and regimented approach to the care of children, popular texts of the time would still demonstrate the influence of the previous years' orientation to behaviourism. Bowley (1948)[1098] rejects the limited focus of behaviourism, emphasises the need to study the child's emotional as well as physical development[1099]

[1090] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[1091] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[1092] Isaacs sometimes published under the pseudonym 'Ursula Wise'.

[1093] Klein, M. (1935). Weaning. On the upbringing of children. J. Rickman. London, Kegan Paul.

[1094] Aldrich, C. A. and M. M. Aldrich (1939). Understand your baby. London, Black.

[1095] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

[1096] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

[1097] Hendrick (1994) suggests as evidence, the increase in the number of organisations which were orientated to the study or welfare of the child's mind, including the National Institute of Child Psychology (1931), The Children's Clinic for the Treatment and Study of Nervous and Delicate Children (1928), the Tavistock Clinic (1920) and the Child Guidance Council (1927). Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

[1098] Bowley, A. H. (1948). The natural development of the child: a guide for parents, teachers, students and others. Edinburgh, E and S Livingstone Ltd.

[1099] See p. xiv for example, 'a child's hopes and fears, his loves and hates, his delights and disappointments are a primary concern to his parents, and they should be of importance to his teacher'.

and yet still advises against discussion of the child's fears (war time fears) with him or her and suggests that the child's stress should be 'ignored' (p. 155) in favour of avoiding comment and ensuring the provision of regular food and sufficient sleep, these are clearly behaviourist notions. Hendrick (1997)[1100] writes of the '*atmosphere of regimentation and increased state control of many aspects of life'* (p. 30) and claims that the new focus on the mind, described by Hendrick (1994)[1101] still categorised the child's mind mechanistically, as if it were composed of physical and measurable entities (oversensitive, well adjusted, delicate etc.); this Hendrick (1994)[1102] sees as the 'medicalisation' (p. 4) of the mind. It would be some time before the mind would be seen as a fluid, free and even democratic entity. Both Hendrick (1994)[1103] and Hardyment (1995)[1104] notes the publication of Illingworth's 'The Normal Child' in 1953[1105] (see also Illingworth and Illingworth 1954 which provides a wholly non-behaviourist approach to child development)[1106]. 'The Normal Child', however, was not so much a mapping exercise of what was to be expected in children, but was rather an illustration of the significant 'range' of normal indices in children's behaviour and growth. In his preface to this first edition, Illingworth argues for the existence of this 'range' of normal and states '*it is almost impossible to define the normal'* (p. viii).

It is possible that the increasing number of women entering both psychology and paediatric medicine may have had an impact on the direction of study and research into child care. Certainly, a more 'human' message was being sold to mothers in the inter-war years. This is not to say that behaviourism was forgotten. However, Dr Spock (Spock 1947)[1107] did argue that emotions and what comes naturally were a good

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[1100] Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.
[1101] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.
[1102] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.
[1103] Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.
[1104] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.
[1105] Illingworth, R. S. (1953). The normal child. London, Longman.
[1106] Illingworth, R. S. and C. M. Illingworth (1954). Babies and young children. London, J and A Churchill Ltd.
[1107] Spock, B. (1947). Avoiding behavior problems. Washington, United States of America Departments of State and Public Institutions: Children's Bureau.

starting point for developing a theory of child management. This in turn may have renewed the notion that 'mother knows best' (a mid nineteenth century concept)[1108].

Hardyment (1995)[1109] argues that parenting texts had, by the publication of the Aldrichs' book (Aldrich and Aldrich 1939)[1110 1111] adopted a thesis of enjoying one's baby rather than training him or her to perform to particular standards of behaviour. Hardyment (1995, p. 214-219) summarises the main themes for this period as 'fun is important, all babies are different', 'babies need warmth and cuddling', 'babies know best' (e.g. when they need feeding), mothers' and babies' experience was important. This was a thesis categorically opposed to that of behaviourism. By 1945, the nursing press seems to have unambiguously rejected the behaviourist approach to child care, accepting instead the softer Freudian approach.[1112]

It is clear that there was an increasing amount of non and anti-behaviourist psychological work in the middle years of the 20th century. This work emphasised the interdependency of the mind and body (Hendrick 2003)[1113], and both the complexity of and need to understand the mind of the child. This probably had the effect of not only countering the behaviourist tradition but also its over-simplistic approach to the child. In attempting to understand the child, the Freudian approach needed the family and in this way, the gradual rejection of behaviourism in favour of a more psychoanalytical framework had the effect of re-introducing the family as team members (see Hendrick 2003). Hospitals may have been slow to follow this anti-behaviourist movement but their progress in this respect was probably inevitable and was made so in any case by the effect of WWII and the many parents and professionals who were affected by it.

[1108] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[1109] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[1110] Aldrich, C. A. and M. M. Aldrich (1939). Understand your baby. London, Black.

[1111] Hardyment (1995) Argues that this text was the inspiration for Spock's first edition in 1945 (see Spock 1969). Spock, B. (1969). Common sense book of baby and child care. London, Duell Sloan.

[1112] See for example Mackenzie, N. (1945). "Temperament and personality." Nursing Times **12/05/1945**: 302-303.

[1113] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

Pressures focussed directly on paediatric nursing

Pressure from child study (psychology) orientated organisations

The war had taught Britons that emotions of and for children were valuable, it had taken the loss of many loved children to teach the British of the importance of these emotions. The war and the mass evacuation of children had affected almost every citizen in one way or another. The cold behaviourism had quickly lost its grasp on child care. The uniformity and discipline associated both with behaviourism and the eugenics movement would no longer be tolerated. Freudian psychology was of course not new in the 1940s, the Tavistock Institute had opened in 1920 (see Editorial 1949)[1114], but it is suggested here that the Freudian emphasis on emotions and understanding the mind was what people now wanted. Winnicott (1949)[1115] for example describes how the cause of a child's nightmares had been understood by using the child's drawings. The article provided an example of the way in which practitioners could come to understand what was going on in the mind of a child.

Behaviourism had treated people, especially children, like simple animals, regarding emotions as a mere nuisance. Now children were precious and family life became firmly locked inside the Englishman's castle where there could be no room for the authoritative professional. Hardyment (1995)[1116] argues that between 1946 and 1981, parents were positively advised to ignore behaviourism and to do what they found came naturally and to enjoy their baby. Hardyment (1995) suggests that the defeat of fascism meant that the British needed a free world form of parenting and that this allowed the doctrines of Piaget[1117] and Freud[1118] to become popular. The professionals accepted the position and while still arguing that the 'doctor knows best', emphasised a

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[1114] Editorial (1949). "The Institute of Medical psychology." Nursing Times **29/01/1949**: 98.
[1115] Winnicott, D. W. (1949). "A child's nightmare: explaining a simple psychological problem." Nursing Times **05/03/1949**: 187.
[1116] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.
[1117] See for example, Piaget, J. (1932). The moral judgement of the child. London, Routledge and Keegan Paul. Also see Piaget, J. (1952). The origins of intelligence. New York, Harcourt Brace.
[1118] Freud, S. (1936). Inhibitions, symptoms and anxiety. London, Hogarth Press.

relaxed attitude and that if there was a 'normal' child, the range of normal was very great (see Illingworth 1953[1119] and Illingworth and Illingworth 1954[1120]).

Also by this time, parents were being addressed directly (Central Council for Education 1960)[1121] by a small number of non medical organisations such as the Tavistock Institute which produced a leaflet for parents, advising them that:

- the child would find everything new and strange;
- parents should tell the child the truth and make it clear that hospitals had nothing to do with punishment;
- parents should tell the child about the hospital;
- parents should make it clear that they would not be there all the time but that they would visit as often as they could;
- the child should take with them a favourite toy;
- it was normal for the child to cry when parents left, this crying would not be harmful;
- on return home, the child's behaviour might be different and that parents should be patient.

It should not be thought that the new emphasis on Freudian psychology impacted immediately on paediatric nursing. In fact, by 1949, hospital librarians having accepted the newly understood psychological trauma of separation and hospitalisation complained that nurses would not let librarians into the children's wards (See Guild of Hospital Librarians 1949)[1122]. Nurses were still concerned about the transmission of infection (Connell and Bradley 2000)[1123], or rather that rules related to the same should be followed[1124]. The Guild of Hospital Librarians made fun of this, questioned whether it was the books or the librarians who were infectious and suggested that the children's psychological welfare was every bit as important as the erroneous belief that books could transmit germs. Individual paediatric nurses might have accepted the new

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[1119] Illingworth, R. S. (1953). The normal child. London, Longman.

[1120] Illingworth, R. S. and C. M. Illingworth (1954). Babies and young children. London, J and A Churchill Ltd.

[1121] Central Council for Education (1960). Coming into hospital. London, Tavistock Institute. Derbyshire Children's Hospital Archive L58/30m/4.56/L. Main archive. Derby.

[1122] Guild of Hospital Librarians (1949). "Letters." Nursing Times **24/12/1949**: 1142.

[1123] Connell, J. and S. Bradley (2000). "Visiting children in hospital: a vision from the past." Paediatric Nursing **12**(3): 32-35.

[1124] Some diseases could be spread by 'fomites' e.g. books but in reality most children's infectious diseases were probably spread by close contact with an infected person and by droplets (airborne). In reality, the use of books in a children's ward, even where the books were shared, would not increase the incidence of cross infection.

approach to children but they had still to practice within their system of discipline and hierarchy which was inflexible and largely outside the control of even the senior nurses. The system of discipline and hierarchy was making paediatric nursing seem un-academic because it couldn't adapt to changing social expectations. The 'science' or 'professionalism' of nursing was being challenged, paediatric nursing had become asynchronous with society, perhaps for the first time in its history.

It has been seen, that by the 1950s, even some paediatricians were becoming critical of paediatric nurses tardiness in applying the new understanding of children's psychological and social needs. Illingworth (1956)[1125] argued that paediatric nurses had become hardened to human suffering , that they did not feel for the child or recognise the reasons for their behaviour. Illingworth (1956) tried to persuade nurses that crying for one's mother is normal and that this expression of love is normal and not naughty (see also Illingworth and Illingworth 1954[1126] , where the Illingworths provide a comprehensive account of the growing child's need for parental affection and individualised care). Illingworth (1956) argued that parents should be resident, there should be toys and that nurses should cuddle and 'love' the children and be honest with them. Robertson (1956)[1127 1128] responded, praising Illingworth and suggesting that children commonly experienced lasting psychological trauma as a result of their hospitalisation, agreeing that nurses were insensitive to the needs of sick children and that their training needed to be improved. It should be understood, however, that what Illingworth was proposing would have meant a very significant change to the way in which paediatric nurses worked. The emphasis on physical and observable tasks and the emotional neutrality of professionalism was deeply ingrained in their micro-culture and inherently antagonistic to the new perspective. In any case, for nurses to accept change, they would have to accept the principle of practice evaluation and research, and that was still a way off. It can be seen that nurses could

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[1125] Illingworth, R. S. (1956). "Young children in hospital." Nursing Times **03/02/1956**: 112-115.

[1126] Illingworth, R. S. and C. M. Illingworth (1954). Babies and young children. London, J and A Churchill Ltd.

[1127] Robertson, J. (1956). "Letters." Nursing Times **24/02/1956**: 183.

[1128] James Robertson worked in the Tavistock Institute and would produce the film 'A two year old goes to hospital' which demonstrated the psychological effects of hospitalisation. This film is still available from Concord Video and Film Council Ltd. 201 Felixstowe Rd, Ipswich, IP3 9BJ.

not have accepted the new perspective on children without completely revising their role, their purpose and their orientation.

It was to be psychologists who would persuade the government that change in the health care disciplines was needed. The story of the way this happened has been told elsewhere,[1129] it is sufficient here to note that that pressure resulted in the production of what would become known as the Platt Report (Ministry of Health 1959).[1130] In relation to the development of individualised and holistic care, this report was perhaps to have the most significant impact on paediatric nursing.

Pressure from the government

Hendrick (1994) cites the 1950s as a period when the notion of children as a threat to society began to wane to be replaced by '*children as victims*' and a concomitant social and moral concern about the welfare of children. It is interesting then, that the 1950s and 1960s should be a period when nursing came under increasing pressure from the government to provide a more humane and child family focussed service.[1131]

By 1956, 10% of hospitals still did not allow daily visiting (usually allowing weekly visiting) and 28 hospitals still did not allow visiting at all (Ministry of Health 1956)[1132]. The Ministry of Health was clearly concerned about this and asked hospitals to re-examine their visiting policy and to allow unrestricted visiting (see also Anon 1959)[1133]. The circular stressed that there was no reason to ban visiting because of surgery or infectious disease and that children should be allowed to visit their parents in hospital. Perhaps in order to counter an argument of any 'scientific' nature, the circular points to Illingworth and Holt (1955)[1134] advising those learnéd in the science of nursing that the article *'should convince all those nurses who are still in doubt that*

[1129] Swanwick, M. (1983). "Platt in perspective." Nursing Times **79**(2): 5-8.
[1130] Ministry of Health (1959). The report of the committee on the welfare of children in hospital (the Platt Report). London, HMSO.
[1131] See for example, Ministry of Health (1959). The report of the committee on the welfare of children in hospital (the Platt Report). London, HMSO.
[1132] See also Editorial (1956). "Visiting children in hospital." Nursing Times **03/02/1956**: 109.
[1133] Anonymous (1959). "News." Nursing Times **20/02/1959**: News pages.
[1134] Illingworth, R. S. and R. S. Holt (1955). "Children in hospital: some observations of their reactions with special reference to daily visiting." The Lancet **17/12/1955**: 1257-1262.

the welfare of the sick children in their care is seriously hindered if parents are not permitted to visit their child daily' (p. 109). As if to press home the argument, Illingworth himself wrote in the same publication of the need of children to be visited, strongly criticising nurses as unfeeling and hardened to human suffering (Illingworth 1956)[1135]. It did seem necessary to prove 'scientific' evidence for the nurses and doctors to believe in separation anxiety and the benefits of visiting. To service this need, Vaughan (1957)[1136] published a 'scientific' study on the introduction of visiting in order to determine what effect it had.

The Ministry of Health had recognised that hospitals were not providing the kind of 'human care' and parental involvement that was being demanded by parents, psychologists and other professional groups. By 1959 the Platt Report[1137] had been published, based mostly on submissions from psychologists, especially John Bowlby and the Robertsons. The report emphasised that :

- the emotional care of children was important;
- the potentially damaging effect of separation should be considered;
- children should only be admitted when home care was not possible;
- paediatric out-patients departments should be established;
- day care and day surgery should be encouraged;
- children should not be admitted to adults wards;
- the physical environment should be cheerful;
- it was desirability for children to be nursed with other children of the same age;
- the sister in charge should be RSCN;
- 'patient allocation'[1138] should be used;
- the paediatrician should have over-all concern for all the children admitted to hospital;
- nursery nurses could help with children under 5 years;
- children should receive psychological preparation for admission;
- there should be facilities for play;
- there should be facilities for the education of children;
- parents should be encouraged to visit freely;
- parents should stay with children under 5 years;
- parents should play a part in the child's care;
- financial help should be available for parents to visit;
- nurses, doctors and ancillary staff should be trained in the emotional needs of children.

[1135] Illingworth, R. S. (1956). "Young children in hospital." Nursing Times **03/02/1956**: 112-115.
[1136] Vaughan, G. F. (1957). "Children in hospital." The Lancet 1: 1117-1120.
[1137] Ministry of Health (1959). The report of the committee on the welfare of children in hospital (the Platt Report). London, HMSO.
[1138] 'Patient allocation' a system of individualised patient care.

Interestingly, there was only one RSCN on the committee which produced the above report (Miss MW Janes). However, if paediatric nursing was less than keen to change its practice in line with the Platt Report[1139], the Nursing Times seemed more than willing to align itself with the key recommendations. The editor pointed out that the pictures of children illustrating the article had all been published in the Nursing Times before, indicating perhaps that they had been right all along to put emphasis on the holistic needs of sick children.[1140] Within a month of the Platt Report being published in the Nursing Times an article by a ward teacher discussed how her role complied with the Report (see Gray 1959)[1141].

In 1962, the Scottish Home and Health Department (See Dunlop 1962)[1142] positioned that the 'new' NHS had changed the accepted view on visiting because people now considered the hospital to be their property and the increasing ownership of cars etc. had made visiting easier. Interestingly, the report talks of 'changing times' and the need for hospitals to keep up with changing expectations (p. 6). For children, the report suggested 'open visiting' between 10am and 7pm because this had proved 'very successful' (p. 9) where it had been implemented. The report went further, however, indicating that parents should take a part in their child's care. The report considered those children whose parents could not visit and suggested the setting up of a system of voluntary helpers. The report is clearly a response to the Platt Report (Ministry of Health 1959)[1143] and the report recommended that Scottish hospitals follow its advice.

In the post war years nursing was subjected to a sustained and increasingly intense attack on its traditional non family orientated philosophy. Bradley (2001)[1144] points out that the Care of Children Committee in 1946 criticised the lack of emotional care in

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[1139] See Robertson, J. (1970). Young children in hospital (2nd edition). London, Tavistock Publications. See page 131.
[1140] Editorial (1959). "Children in hospital." Nursing Times **13/02/1959**: 185 and 197-200.
[1141] Gray, W. (1959). "Teacher in a children's ward." Nursing Times **27/03/1959**: 373-374.
[1142] Dunlop, J. (1962). Visiting patients in hospital. Edinburgh, Scottish Home and Health Department.
[1143] Ministry of Health (1956). Visiting children in hospital: Circular HM(56)6. London, HMSO.
[1144] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

long stay hospitals and the Ministry of Health in 1952 reported negatively that only 300 out of 1300 hospitals allowed daily visiting of children. There was criticism that some hospitals allowed visiting only when the children were asleep or that parents could only see their children through a window. It is clear however, that nursing was slow to change[1145] and this despite the 'Platt Report'[1146] in 1959 and a succession of Ministry of Health circulars in the 1960s encouraging a more humane and sensitive provision of care for sick children. These last included material on the employment of nursery nurses[1147], the use (non use) of restrainers[1148], the promotion of unrestricted visiting[1149], the discouragement of putting children on adult wards[1150] and that children should be nursed by paediatric nurses[1151].

The government in 1971 would write to every acute hospital, reiterating the key recommendations of the Platt report[1152] and requiring each hospital to write back to the Ministry of Health on their progress (Ministry of Health 1971)[1153]. At around the same time (c. 1970) The National Nursing Staff Committee (NHS)[1154] published a guide to staff appraisal for nurses, where skills of developing good relationship with patients, relatives and visitors and also of developing new ideas and methods of care were emphasised. It is likely that on the whole, neither what was being claimed of paediatric nursing nor the content of nursing journals reflected the slow progress paediatric nursing was making toward the provision of more holistic care. However, the government appear to have been aware of this and applied relentless pressure on hospital boards to modernise their approach to the child's individual and holistic needs.

[1145] Connell, J. and S. Bradley (2000). "Visiting children in hospital: a vision from the past." Paediatric Nursing **12**(3): 32-5.

[1146] Ministry of Health (1959). The report of the committee on the welfare of children in hospital (the Platt Report). London, HMSO.

[1147] Ministry of Health (1960). HM (61) 83: Employment of nursery nurses in hospital. London, Ministry of Health.

[1148] Ministry of Health (1966). HM (66) 11: The use of restrainers. London, Ministry of Health.

[1149] Ministry of Health (1966). HM (66) 18: Unrestricted visiting. London, Ministry of Health.

[1150] Ministry of Health (1967). HM (67) 50: Children nursed on adult wards. London, Ministry of Health.

[1151] Ministry of Health (1969). HM (69) 4: Children in hospital. London, Ministry of Health.

[1152] Contained in the document attached to H.M.(71)22 - Welsh Office (1971). Hospital facilities for children: annex to H.M.(71)22. London, Department of Health and Social Security.

[1153] Ministry of Health (1971). The welfare of children in hospital, HM(71)22. London, HMSO.

[1154] Graham-Bryce, I. (c. 1970). Staff appraisal in the hospital nursing service: explanatory notes. London, National Staff Nursing Committee.

Pressure from NAWCH[1155] and resistance by the ABPN[1156]

Bradley (2001)[1157] reports that the Association of British Paediatric Nurses (ABPN) was consistently apposed to the introduction of open and daily visiting. The ABPN was established as the Association of Sick Children's Hospital Nurses in 1938 by a group of London sisters and matrons. Bradley (2001)[1158] claims the ABPN to have been an active organisation in relation to professional matters (although, Bradley provides little evidence of this).[1159] It is clear, however, that in the 1950s and 1960s the ABPN seems to have come to represent the traditionalist position, even to submit an anti parent visiting paper to the Platt Committee. Robertson (1970, p. 131)[1160] wrote of this submission that it *'... has an archaic quality that reflects narrow concerns and un-insightful attitudes of the kind that were common twenty years earlier, when emotional upsets in children were complacently attributed to faults in the child's family rather than to the effects of illness and hospitalisation.'*

The ABPN (Duncombe 1979)[1161] would eventually admit that it had failed children in the struggle to provide more humane care to children in hospital. The National Association for the Welfare of Children in Hospital (NAWCH)[1162] was much more active and much more influential. NAWCH was probably instituted as a response to Robertson's films 'A two year old goes to hospital'[1163] and 'Going to hospital with mother'.[1164] Robertson also wrote an article in the Observer (see Bradley 2001)[1165] encouraging parents to write to him about their hospital experiences. These last were

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[1155] National Association for the Welfare of Children in Hospital, now Action for Sick Children.
[1156] Association of British Paediatric Nurses.
[1157] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.
[1158] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.
[1159] The organisation seems to have declined during the 1980s, though it does still exist as an organisation (see http://www.abpn.org.uk/).
[1160] Robertson, J. (1970). Young children in hospital (2nd edition). London, Tavistock Publications.
[1161] Duncombe, M. A. (1979). A brief history of the Association of British Paediatric Nurses 1938-1975. London, Association of British Paediatric Nurses.
[1162] Formally Mother Care for Children in Hospital and presently Action for Sick Children.
[1163] Robertson, J. (1958). A two year old goes to hospital. London, Tavistock Clinic.
[1164] Robertson, J. (1958). Going to hospital with mother. London, Tavistock Clinic.
[1165] Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal 6(2): 44-51.

eventually published by Robertson in 1962.[1166] In the same year as Robertson's article in the Observer, a group of mothers in Battersea wrote to the Guardian and elicited a large number of responses from like minded people. NAWCH grew very quickly, both in size and in political influence. Bradley (2001) reports that by 1963 the organisation had 2,200 members in 40 groups and that by 1968 it had 4000 members in 58 groups. The success of NAWCH probably lies both in the perceived legitimacy of the debate which Robertson had initiated and in the fact that it lobbied high ranking ministers. It should also be recognised that the organisation provided ordinary parents with a means to speak out against their forced separation from their own sick children. It is perhaps appropriate to quote again here from Porter 1985 (p. 195)[1167] *'but a people's history of health ... will show that sufferers are fertile in their resources ... as patients borrow the doctors' lines ... a peoples' history of suffering might restore to the history of Medicine its human face'.*

It is likely, however, that the charitable principles of the health service, based as they were on a background of eugenics, behaviourism and an associated professional authority were now failing to work because the resourceful and educated middle classes increasingly used its services. It has been argued here that nursing was eventually forced to provide a more child and family-centred approach to care as a result of societal changes rather than within-profession dynamics. However, while broadly agreeing with this sentiment, Cherry (1996, p. 8)[1168] suggests that not all the developments in medicine and nursing came about by changes in social policy but that many important changes occurred via '*grass roots, self help approaches'*, local, collective action by private individuals. The influence of NAWCH upon paediatric nursing is surely an example of this, though it has been noted that the system of discipline and hierarchy prevented any such movement within nursing itself. Cherry (1996, p. 10)[1169] also makes the point that in this period, while patients (adult and child) were largely subjected to the will of the doctor '*some were better placed to*

[1166] Robertson, J. (1962). Hospitals and children: a parents' eye view. London, Victor Gollancz.
[1167] Porter, R. (1985). "The patient's view: doing medical history from below." Theory and Society **14**: 167-74.
[1168] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.
[1169] Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

complain, articulate and record their experiences'. It must be the case, however, that society provided the right atmosphere for NAWCH to publicly complain about doctors and nurses. By the 1960s, the time was right for change.[1170]

Pressure from the GNC

By 1949, the effect of the war years were already clear. The State Examination Paper (February 1949) was asking students '*In what ways may a child be affected by being removed from his mother during illness?*' (see Anon 1949, p. 232)[1171]. Perhaps this statement (question) alone shows that it was not the work of John Bowlby and the Robertsons which initiated the concern over generalised care and separation but that such concerns were already 'in the air', largely, it is suggested here, as a result of the nation's experience of World War Two. However, it would be a long time before hospital policy adopted a friendlier approach to visitors. Indeed, another question in the same examination paper alludes to the real feelings of the question setter: '*Discuss the problem of visitors to a children's ward'*. Clearly, visitors were a 'problem' still. Six months later, however, an anonymous writer in the Nursing Times advised readers that hospitals should allow visiting by parents if only by appointment and that children could suffer psychological problems when separated from their parents (Anon 1949)[1172].

The children's nursing state paper in September 1956 (see Anon 1956)[1173] asked for care to be described '*from the nurses point of view'* and consequently the model answer emphasised the need for the mother to maintain close contact with the child. The model answer focused on the nurses' role in teaching the mother how to care for

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[1170] NAWCH continued to be active and was especially so in the 1980s. This is illustrated by the publication in association with the department of health and the British Paediatric Association of a number of studies including: National Association for the Welfare of Children in Hospital (1987). The child alone, a report on the unaccompanied child in hospital. London, NAWCH. Also National Association for the Welfare of Children in Hospital (1986). Where are the children. London, NAWCH. Also see Thornes, R. (1986). Access, accommodation and facilities for parents: a resurvey of the wards that caused concern in 1982. London, National Association for the Welfare of Children in Hospital.

[1171] Anonymous (1939). "State Examination Questions (February 1949): Final examination for sick children's nurses." Nursing Times **19/03/1939**: 232.

[1172] Anonymous (1949). "Visiting children in hospital." Nursing Times **01/10/1949**: 824.

[1173] Anonymous (1956). "Model answers to children's state paper." Nursing Times **21/09/1956**: 935-936.

her sick child (Congenital Dislocation of the Hip)[1174]. Nursing's official orientation was now the psychological, social and physical comfort of the patient. By 1973, the GNC (Scotland) was recommending a syllabus for paediatric nursing which employed '*an approach and attitude to the child's relatives and other visitors*' as a principle of paediatric nursing.[1175]

The GNC was no more in control of the system of discipline and hierarchy than was anyone else but they were also not subject to it. This (along with the nursing journals) created a gulf between what was being suggested should be practised and what was actually being practised. A Part 8 [1176] state final question paper in 1956 asks the student to write about the care required when a mother and child is admitted and about how the student would interpret a child's behaviour. The GNC, however, may not have been quite up-to-speed in terms of changing social expectations regarding the care of children, one question asks '*What might lead you to suspect that a three year old boy in your care is a Mongolian idiot?*'[1177] [1178] However, things had moved on a little, the proposed new syllabus of training published in 1945 had contained no psychology or sociology at all.[1179]

By the mid 1960s there were clear messages from the GNC (Scotland) that paediatric nursing was about holistic care. The syllabus for sick children's nursing in 1964[1180] contained a reasonably large section on child psychology, psychological development, and on communication with the child's family, it stated that (p. 1):

> *'The training of the sick children 's nurse is demanding, full of interest and encompasses a very vulnerable age range .... The aim of the training in this special*

[1174] A congenital condition where the child is born with a dislocated hip. Treatment involved hospital admission for a number of weeks during which the baby would be suspended by the legs from a semicircular frame and later put in to an hip spica (plaster cast involving the pelvis area and thighs.

[1175] Yorkhill Hospitals Archive (1973). Syllabuses for nursing. YH8/3/6 GNC (Scotland). Glasgow.

[1176] Part 8, the Part of the Professional Register for paediatric nurses.

[1177] The term 'idiot' was once socially acceptable, denoting a specific IQ range, 'Mongolian Idiot' refers the congenital condition of 'Down's Syndrome'.

[1178] Anonymous (1956). "State examination questions for sick children's nursing." Nursing Times **16/11/1956**: 1176-1177.

[1179] See Great Ormond Street Hospital Archive (1945). Entry dated 12/06/1945. Nursing Committee Record Book Number Four: 1942. London.

[1180] Yorkhill Hospitals Archive (c. 1964). Syllabus for sick children's nursing and record of practical instruction and experience. YH8/3/5, GNC (Scotland). Glasgow.

sphere is to develop skill in nursing care of the whole child and to acquire a full understanding of the emotional and physical needs of the sick child in an environment where the parents cannot always be present'.

However, the practice skill section had no entry relating to psychological care or to parents, perhaps because these were not considered skills.[1181] By 1969, the GNC's syllabus contained a section on '*human behaviour in relation to illness'* which included preparing children for the effects of hospitalisation, visiting of children and effects of emotional states on medical conditions.[1182]

It appears clear, that the GNC (and GNC Scotland) were somewhat awkwardly following what they saw as the changing expectations of society. The GNC was not initiating change or imagining a new way forward. In reality, the changes in question setting and curriculum development produced little more than a theory-practice gap. Nevertheless, the above does demonstrate that cultural changes in society were being appreciated by the GNC. Had nurses in practice been able to sway with the wind as easily as the GNC there would probably never have been a desynchrony between nursing and society's expectations for the care of the sick child.

Pressure from the nursing press

At the beginning of WWII, nurses were still seen as knowing what was best for sick children and it was considered reasonable to criticise parents especially for their lack of knowledge. Charnell (1940)[1183] criticises a mother (who nevertheless gets her way) for refusing to allow her child to go to a seaside convalescent home ('*the mother was very stubborn about this'* (p. 40)).

[1181] See also Derbyshire Children's Hospital Archive (c. 1960). Record of practical instruction and experience for the certificate of nursing sick children. GNC. Derby. This is a much thinner document which only includes practical tasks.

[1182] Alder Hey Children's Hospital Archive (1969). Syllabus of subjects for examination and record of practical instruction and experience for the certificate of the nursing of sick children. General Nursing Council. Liverpool.

[1183] Charnell, E. (1940). "A case of cerebro-spinal meningitis." Nursing Times **13/01/1940**: 38-40.

The separation of children from their families was not of course confined to hospitals. The evacuation of children to Canada during WWII had been reported quite positively in the nursing press (see Maunsell 1940)[1184]. Hendrick (2003)[1185] suggests that '*the evacuation process was one of those moments when prejudice, mainly shaped and articulated by sections of the rural and small town middle class, unveils itself unashamedly*'. Officials (p, 125) '*gave little thought to children's feelings on being separated from their parents and friends, and on having to come to terms with their new living environments.*' The scale of the evacuation is illustrated by the fact that in the first week of the evacuation, (1939), 829,959 unaccompanied children and 523,670 mothers with pre-school children (and others) were evacuated (Hendrick 2003)[1186]. Also in 1940, the Nursing Times criticised those mothers who had allowed their evacuee children to come home for Christmas (see Armstrong 1940)[1187], though in the same journal there was some concern over evacuation (see Mills 1940)[1188]. Hendrick (2003) notes that by 1940, 80% of the evacuees had returned home.

As already noted, by the end of the war, the editor of the Nursing Times was referring to *'the urgent question of the welfare of those unfortunate children who, through war circumstances or other reasons, are deprived of the natural background of home life.'* (Editorial 1945)[1189]. By the end of the WWII there is a clear change of direction in the nursing press. By Christmas 1949 Wenger (1949)[1190] argued that nurses should make visitors welcome because the patients need their family, and visitors have '*a tremendous part to play in the recovery of the patient*' (p. 1097). A news item in the Nursing Times of the same year (Anon 1949[3])[1191] tells of a local storm over a nurse who had helped care for her own child in hospital. This was clearly an unusual event as the nurse in question had felt it necessary to wear her uniform.

[1184] Maunsell, M. (1940). "Seavacuation to Canada." Nursing Mirror **14/09/1940**: 554.
[1185] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press. p. 124
[1186] Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press. p. 124
[1187] Armstrong, K. F. (1940). "Evacuation and epidemics." Nursing Times **20/01/1940**: 55.
[1188] Mills, H. (1940). "Psychological problems of wartime." Nursing Times **27/01/1940**: 90-91.
[1189] Editorial. (1945). "Our Children." Nursing Times **17/02/1945**: 107.
[1190] Wenger, M. N. (1949). "Welcome at Christmas." Nursing Times **17/12/1949**: 1097.
[1191] Anonymous (1949). "News." Nursing Times **24/12/1949**: 1132.

In the post war period there was also a concern for the separation of children in long term care institutions (see Bowley 1950)[1192]. This concern wasn't directly related to children in hospital but would nevertheless add to the general concern. The 'model answer' (Anon 1950)[1193] to the State Final Examination paper of May 1950 indicates however that little more than lip service was being given to the issue of visiting. A question on the care of a child admitted for surgery was answered by sending away all the relatives except the child's mother. The mother was reassured but greater stress was laid upon ensuring she took her son's clothes home.

During the few years of WWII the nursing press seems to have accepted the child's emotional need for his or her family and rejected the notion that professional care is necessarily superior to that provided by the child's own family. A news item in the Nursing Times reads (Editorial 1945, p. 107)[1194]:

> *'Two incidents have recently brought up again the urgent question of the welfare of those unfortunate children who, through war circumstances or other reasons, are deprived of the natural background of home life ... there is no real substitute for a home and the real solution of the problem can only be to establish such conditions as will make it possible for all parentless children to be receive in normal homes .... it is welcome news that a Government commission of inquiry is to be set up to explore the facts and possibilities of improvement'.*

(Refers to a case where a child was punished too harshly in the opinion of the writer).

Convinced of the need for change and for lack of good practice examples in this country, the Nursing Times went to New York to review a nursery where children were helped to come to terms with their fears. The article emphasises that these were normal fears of childhood and in so doing was arguing that normal childhood was different from normal adulthood and that children needed to be understood as children

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[1192] Bowley, A. H. (1950). "The child without parents." Nursing Times **08/04/1950**: 364.
[1193] Anonymous (1950). "Model answers to state final paper." Nursing Times **06/05/1950**: 466.
[1194] Editorial. (1945). "Our Children." Nursing Times **17/02/1945**: 107.

(see Editorial 1945[2])[1195]. The editorial headed 'brave new world' may have meant to signify what the editor hoped would be a new world for British children. Articles also began to appear which focused solely on the child's normal emotional and psychological development rather than on the care of the child's physical condition (see Mackenzie 1945)[1196]. The Nursing Times also carried a series of articles on adult psychology, which while not relating to children would still have indicated the perceived importance of psychology and the psychological needs of children (see Mackenzie 1945)[1197].

It is clear that psychologists, with their new found avenue through the nursing journals, had a message for the GNC [1198] and those responsible for nurse education. Mackenzie (1945[2], p. 838)[1199] in an article on 'teaching normal psychology to the student nurse' illustrates a sister comforting a child and argues:

'The Sister at the Hospital for Sick Children, Great Ormond Street, is dealing with the relief of illness: she is also dealing with a human being for which a 'grounding' in the nature of a genius human is an asset'.

Doubtless, The Hospital for Sick Children, Great Ormond Street was illustrated to influence other hospitals to follow this new emphasis on care. A significant body of work was being assembled in relation to both 'separation anxiety'[1200] and 'maternal deprivation'[1201] which would have had a validating influence on those psychologists

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[1195] Editorial (1945). "Brave new world: psychological training at West Side Day Nursery, New York." Nursing Times **31/03/1945**.

[1196] Mackenzie, N. (1945). "Temperament, character and personality 1: the instincts and emotions,." Nursing Times **14/04/1945**: 139-238.

[1197] Mackenzie, N. (1945). "Temperament, character and personality 1: the instincts and emotions,." Nursing Times **14/04/1945**: 139-238. Mackenzie, N. (1945). "Temperament and personality." Nursing Times **12/05/1945**: 302-303. Mackenzie, N. (1945). "The teaching of normal psychology to the student nurse." Nursing Times **15/12/1945**: 838-839. Mackenzie, N. (1945). "Temperament, character and personality: the personality of the sister." Nursing Times **26/05/1945**: 340-341.

[1198] General Nursing Council, responsible for setting nursing examinations.

[1199] Mackenzie, N. (1945). "The teaching of normal psychology to the student nurse." Nursing Times **15/12/1945**: 838-839.

[1200] For example, Bowlby's seminal work, Bowlby, J. (1973). Attachment and loss, Volume II: separation anxiety and anger. New York, Basic books.

[1201] Ainsworth, M. D. (1962). The effect of maternal deprivation: a review of findings and controversy in the context of research strategy. Deprivation of maternal care. World Health Organisation. Geneva, World Health Organisation.

who sought to influence the health care professions. In this way, children were being portrayed as different from adults but they were also human beings who demanded study and understanding. They were not 'just children' but important members of society and important in their own right, and worth the effort. Perhaps importantly, psychologists and paediatricians were publishing articles together,[1202] this probably had the effect of revealing the psychology literature to nurses and doctors who would otherwise not sought access to it. Similarly, concern about the effect of hospitalisation on children reached the more prestigious medical journals [1203], this would have helped to make it a legitimate area of concern for both doctors and nurses. Certainly, the number of articles on the psycho-social needs of hospitalised children in the more 'readable' medical journals increased.[1204]

It is likely that the institutionalisation of nursing had become recognised as leading to a situation where many nurses had little understanding of normal child development. In 1956, the Nursing Times published a 'camera talks' article showing pictures illustrating normal stages in development. Perhaps the editor felt that paediatric nurses would not be interested enough to read a more in-depth account of the subject. Not surprisingly, the nursing times responded very favourably to the Platt Report (Ministry of Health 1959)[1205] and suggested that '*This far-sighted, practical and persuasive report is essential reading for every ward sister today and should be part of every student nurses' preparation'* (see Editorial 1959)[1206].

In 1956, the Whittington Hospital published two booklets, one for mothers and one for student nurses, both of which encouraged visiting (see 'M.A.D' 1956)[1207]. In much the same way, articles designed to introduce general students to the specific needs of

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[1202] Bowlby, J., D. Winnicott and E. Miller (1939). "Letter to the Editor." British Medical Journal **16/12/1939**.

[1203] MacCarthy, D., M. Lindsay and I. Morris (1962). "Children in hospital with mother." The Lancet **24/03/1962**: 603-608.

[1204] See for example, Schaffer, H. R. and W. M. Callender (1959). "Psychological effects of hospitalization in infancy." Pediatrics **October 1959**: 528-539. Also see Vernon, D. T. A., J. L. Schulman and J. M. Foley (1966). "Changes in children's behaviour after hospitalization." American Journal of Diseases of the Child **111**: 581.

[1205] Ministry of Health (1959). The report of the committee on the welfare of children in hospital (the Platt Report). London, HMSO.

[1206] Editorial (1959). "Children in hospital." Nursing Times **13/02/1959**: 185 and 197-200.

[1207] "M.A.D." (1956). "Book reviews." Nursing Times **03/08/1956**: 134.

children began to appear in the nursing press (see Netherwood 1967)[1208]. Further encouragement came in Duncombe (1956)[1209 1210] who, after a tour of children's services in Holland reported that the Dutch employed the same mistaken arguments to defend the lack of visiting as were used by British nurses. In the same year the regular writer on psychological matters, MacCarthy (1959)[1211] presented a study claiming to illustrate the child's needs for visiting parents.

Stoke Mandeville Hospital seems to have allowed parents to visit daily since the early 1950s. Morris (1959)[1212], a ward sister at the hospital, seems keen to make it known that the 'new way' was what she had been practising all along. In doing so she countered the argument against visiting (mostly that parents would bring in infection and would upset their child).

Even by 1968 it is clear that hospitals were still failing to allow parents to visit and the proponents of the pro-visiting lobby had turned their attention on trying to persuade parents to complain. Commenting on a film on the effects of short term separation, Boorer (1968, p. 996)[1213] reports:

> *'I cannot believe that the law would uphold a hospital's right to refuse reasonable access of relatives to patients, and I think there are very few consultants who would stick rigidly to the non visiting policies if these were challenged by parents, therefore it surely cannot be much longer before the educational effects of films such as these bring about greater sensitivity to the needs and rights of little children and those who help them at times of crisis.'*

Mothers' worries and concerns were now considered to be entirely normal and mothers were reassured so. An increasing literature began to focus on the needs of parents in

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[1208] Netherwood, W. A. (1967). "Children in hospital." Nursing Mirror **22/12/1967**: 290-291.
[1209] Duncombe, M. A. (1956). "Paediatric study tour of Holland." Nursing Times **10/08/1956**: 772-773.
[1210] MA Duncombe was at the time, the Lady Superintendent of the Evelina Children's Hospital (now part of Guy's Hospital, London).
[1211] MacCarthy, D. (1959). "The practical aspects." Nursing Times **20/02/1959**: 89.
[1212] Morris, I. (1959). "A ward sister's eight years experience." Nursing Times **20/02/1959**: 56.
[1213] Boorer, H. (1968). "Young children in brief separation." Nursing Times **19/07/1968**: 996.

hospital (see for example Merrow and Johnson 1968[1214], Meadow 1969[1215] , Robertson 1962[1216] and Morgan 1969[1217]). Moller (1968) portrays an image of a 'difficult mum' but in a positive way. The mother is portrayed as understanding best what were her child's needs, and her concerns are presented as legitimate.

Even up to (and following) the end of the 1960s, concern was still being expressed at the number of hospitals which restricted visiting. In 1964, the editor of the Nursing Times asked Mr Anthony Barber, the then Minister of Health how many hospitals still restricted visiting. His reply was that 240 of the 900 hospitals still did so and that he would be asking them to provide a rationale for their policies (see Anon 1964[2]). In the same year, the organisation 'Mother Care for Children in Hospital'[1218] argued that there were still too many restrictions imposed by hospitals on the visiting of sick children (see Salford 1964[1219]). Later on a similar complaint was published (see Kirwin 1964[1220]).

The pressure on paediatric nursing to change was relentless and the nursing press continued with its emphasis on the holistic needs of children (Guildford 1956)[1221] and even extended the discussion to the needs of adolescents, most of whom were still being excluded from the children's hospitals and children's wards (see Guildford 1956)[1222]. Indeed, it was not just paediatric nursing which was being urged to change its ways, Midwifery too began to be expected to appreciate the emotional needs of expectant mothers (see Craig 1964)[1223].

By the late 1960s, the subject of play was being discussed in the literature, not merely as a way of occupying children but as a therapeutic tool to help children adjust

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[1214] Merrow, D. I. and B. S. Johnson (1968). "Perception of the mother's role with her hospitalised child." Nursing Research 17(2): 155-156.
[1215] Meadow, S. R. (1969). "The captive mother." Archives of Diseases in Childhood 44: 362-367.
[1216] Robertson, J. (1962). Hospitals and children: a parents' eye view. London, Victor Gollancz.
[1217] Morgan, B. D. (1969). "Mothers in hospital." The Lancet 2(425): 38-39.
[1218] NAWCH, now called 'Action for Sick Children'.
[1219] Salford, N. (1964). "Letters." Nursing Times 17/04/1964: 509.
[1220] Kirwin, W. B. (1964). "Letters." Nursing Times 05/06/1964: 734.
[1221] Guildford, R. (1956). "Problems of adjustment." Nursing Times 20/04/1956: 450.
[1222] Guildford, R. (1956). "Needs of childhood and adolescence." Nursing Times 13/04/956: 405.
[1223] Craig, A. (1964). "Emotional needs of expectant mothers." Nursing Times 10/01/1964: 43.

psychologically to their illness and hospital experiences (see Chaloner 1968[1224] and Noble 1967[1225], Noble 1964[1226]). Clinical articles (such as Kuenssberg and Kuenssberg 1964[1227] and Anon 1964[1228]) which focused on psychological care also became more common. The gradual disassembling of the system of discipline and hierarchy and the increasing emphasis on play and that children should be happy in hospital began to create in people's minds (if not yet in practice) an image of the hospital environment that was even a fun place to be. As it did so, it probably began to attract a different kind of neophyte paediatric nurse – one who wanted to nurse children for the pleasure of being with children (see Hutt 1983).[1229]

What is clear from this discussion, is that paediatric nursing did not change from the grass roots up, but was instead, forced to change by agencies outside the profession. There seems to have been a propaganda machine in operation, one which lasted for so many years that paediatric nurses (especially those new to the profession) must have come to believe it. Perhaps by teaching a generation of nursing students that paediatric nursing was all about psychological care, it did in time become so.

Conclusion

One of the key outcomes of this study is the postulation of a possible cause for paediatric nursing to have become more holistically orientated and family centred in the years leading up to 1970. It is important to know whether nursing initiated this change, whether from the shop floor or from higher management, or whether change came from elsewhere. The source of change indicates the degree to which nursing was self initiating and whether it was caught in the ebb and flow of wider social forces. There are other reasons for wishing to know the source of this important change,

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[1224] Chaloner, L. (1968). "Play in hospital." Nursing Mirror **12/04/1968**: 23-24.
[1225] Noble, E. (1967). Play and the sick child. London, Faber and Faber.
[1226] Noble, E. (1964). "The value of play for young children in hospital." Nursing Times **18/12/1964**: 1671-1673.
[1227] Kuenssberg, C. V. and E. C. Kuenssberg (1964). "When Bruce goes to hospital." Nursing Times **29/05/1964**: 349.
[1228] Anonymous (1964). "Removal of tonsils and adenoids." Nursing Times **31/07/1964**: 993-996.
[1229] Hutt, R. (1983). Sick children's nurses: A study for the Department of Health and Social Security of the career patterns of RSCNs. Lewis, Institute of Manpower Studies, University of Sussex.

reasons that are clearly expressed in one way or another by the child participants. Chief among these is the durability or otherwise of the changes that did eventually take place, how genuine were (are) these changes to more individualised and family centred care, what is the likelihood that new social forces will result in paediatric nursing once again practicing generalised and non child centred care?

For those wishing to be reassured that paediatric nursing has changed permanently there is good news and bad news. The bad news is that paediatric nursing was not self initiating and that it did not choose to give up generalised and non-family-centred care. It was forced to do so and was indeed 'dragged kicking and screaming' from its entrenched and institutionalised position.

Much stress here, has been made on the servantisation of nursing and on its desire to be seen as professional (meaning here subordinate but 'similar to' medicine) but not autonomous from medicine. In the end, nursing's servantisation had much to do with its inability to initiate change. Whether this servantisation has changed today is debatable but outside the scope of this study. It should be understood that medicine bears at least part of the blame, if not the greater responsibility for the negative aspects of paediatric hospital care demonstrated in this study. It should also be understood that medicine was forced to change just as was nursing and did so at the same time. In this way, the changes described here did in no way result in friction between paediatric nursing and medicine, both disciplines grew through these changes together.

The important changes that did take place in the delivery of paediatric nursing came about after it had become asynchronous with wider society. WWII had changed society, which did turn its back on the cold and unemotional behaviourist approach to child management. Experience of the war, the reaction against Nazi Germany, the new-found sense of democracy and a sense of ownership of the new NHS must have impacted strongly against the institutionalised sub-culture of nursing. By the 1960s society was becoming more liberal, especially for young women. This last is evidenced perhaps most strongly, not by what women in nursing did but by the fact that men began to be prepared to enter what had traditionally been a strongly female occupational province.

It is important here to unseat a myth that has become central to the conventional history of paediatric nursing. The change to individualised and family-centred care had nothing at all to do with paediatric nursing being re-educated in the ways of Bowlby, child developmental psychology and 'normal' childhood. Young, female nurses had always known about children. These nurses were not much older than children themselves and as has been seen here, experienced some of the same traumas especially with regard to exposure to discipline and homesickness. What nurses needed to know to understand the needs of children did not and still do not require learning from books. The frustration and anguish experienced by some of the nurse participants demonstrates that an understanding of sick children's needs as children were perfectly well understood.

Even despite the above, nursing could not change itself. It was unable to adapt because of its own freely acquired servanthood to medicine and its Goffman-like institutionalisation. It was forced to change by outside pressure that was unrelenting. In the end, this pressure was aimed directly at paediatric nursing, not only from child psychologists but from those with social influence who had only to convince a society and a government that was already primed by wider social changes to receive the message.

However, it should be remembered that what was seen as paediatric nursing was in many ways not paediatric nursing at all but was a nursing discipline firmly led by general nursing and general nurses. To an important degree, this did change once the within-nursing agencies, especially the GNC and the nursing press (but not so much general nurses themselves) had become satisfied with the post-registration only position of paediatric nursing. It is probably the case, that from this point paediatric nursing was more in control of its own destiny. It can be determined, that from the 1980s both junior and senior paediatric nurses were expected to be RSCN and did become so.

More hope derives from the fact that paediatric nursing really did change. A new discipline was created by neophytes entering a changing profession from a changed

society with views about what changes they were personally going to make. Academic nursing had had an effect almost from the beginning but now its union with the 1960s recruits to nursing was symbiotic. Antagonism to academic nursing had probably derived from nursing's institutionalisation and as that rapidly disintegrated in the 1960s and 1970s it became acceptable and then expected that nursing practices be made subject to criticism and research.

Perhaps strangely, there is nothing here to suggest that paediatric nursing changed in respect of its relationship with medicine or in it's lack of desire for autonomy from medicine. In this way the institutionalisation of nursing did disintegrate and for the reasons identified above but there was never the same pressure applied to nursing's relationship with medicine. For this reason, it should not be considered that paediatric nursing found its freedom in these changes, it did not and there is no evidence, at least to c.1970 that it was seeking freedom from medicine. To view paediatric nursing as even beginning to become an autonomous discipline in this period is quite untenable. It is perhaps more accurate to view medicine and nursing as having once shared a common history (Still 1931)[1230] and as still doing so even at the end of this period.

[1230] Still, G. F. (1931). The history of paediatrics: the progress of the study of disease of children up to the end of the XVIIIth century. London, Royal College of Paediatrics and Child Health.

Overall conclusion

This study has considered paediatric nursing from a cultural and social perspective. The study has identified the way in which paediatric nursing's changing social identity impacted upon its client group. Paediatric nursing is seen as a servantised discipline which from c. 1920 developed a close but subordinate relationship with medicine while at the same time being strongly influenced and controlled by general nursing. The impact of this last and that of wider British culture before WWII is seen as being essentially negative as witnessed by both child and nurse participants. Nursing failed to account for their individual needs and exposed them to an emotional neutrality which both damaged and confused the participants.

Before c.1920, paediatric nursing appears to have been orientated to the holistic and emotional needs of sick children and their families. This orientation reflected that of wider society for which 'science' was one, but not the only way of construing reality. Certainly, the beginnings of paediatric nursing appear to have been founded by Charles West at the Hospital for Sick Children, Great Ormond Street whose notion of nursing, if not indeed of medicine was one constructed out of holism, developmental and individual need.

At the beginning of the period 1920-1970, British society was influenced by increasing state intervention[1231] which was reflected in health and social care policy[1232] and which in itself was influenced by the eugenics movement[1233] and the popular psychology of the time (behaviourism). Women had a largely secondary and subservient position in the workplace.[1234] It is widely understood that notions of democracy, to the extent they existed were subsumed by an acceptance of each person's place in society and

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[1231] Maxwell, J. (1997). Children and state intervention: developing a coherent historical perspective. Nursing history and the politics of welfare. A.-M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[1232] For example (Germany) see Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

[1233] For example, see Grier, J. (1998). "Eugenics and birth control: contraceptive provision in North Wales 1918-1939." Social History of Medicine **11**(3): 443-458.

[1234] Bartlett, F. (1999). "Clean, white girls: assimilation and women's work." Hecate **25**(1): 10-39.

there were important differences between the working and middle classes, especially in relation to the authority of one over the other. It was in this way that professional nurses and doctors were able to exert a high degree of control over child patients, largely to the exclusion of parents.[1235]

The transcripts illustrate the changes that took place from c.1920. Nursing became orientated to principles of generalised care, parity of provision and medical science. It has been argued that this was largely the result of changes in society and culture which gave increasing credence to notions of eugenics, state control and the authority of state agencies such as that of medical provision. People were more or less forced to follow doctor's orders, certainly children were and their parents were morally bound to submit themselves to the wishes of their child's doctor. Doctors were gaining social authority and were seen as experts of childhood conditions and diseases. The family was the poor, ignorant and at times irrelevant party in the decision making process. They had little say in what medical provision was proposed for their child. Children had no say at all.

Paediatric nursing with its largely non-academic and emotive past was ill-equipped to provide scientifically orientated care. Nevertheless, nursing did become seen as a 'professional' and science orientated discipline. It achieved this last by acquiring a closer working relationship with medicine. It is doubtful whether nursing's move in this respect was consciously motivated but it came about at the same time as advances in medicine created the need for a servantised discipline of trained, reliable and conscientious people, ready to provide a service to doctors, even putting their own work in the background.

The principle effect of this last was the provision of non-individualised, generalised, parity focussed care and the greater institutionalisation of nursing. Paediatric nursing became more orientated to the hospital institution, led as it was by senior doctors than it was to the child patient. Behaviourism demonstrated synergy with eugenics principles and the increasing state intervention in what had been the province of the

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[1235] See for example, Anonymous (1949). "Visiting children in hospital." Nursing Times 01/10/1949: 824.

family. It was these influences to which nursing became subject. The transcripts illustrate the effect that this had on the participants as child patients and nurses. As nurses they were institutionalised and made subject to a system of discipline and hierarchy that would not be tolerated today and which caused the exclusion of analysis and reflection. The child participants were nursed with emotional neutrality and with generalised care; unknown to their nurses this confused and traumatised the child participants as it does so still. Contrary to the conventional history of paediatric nursing, the child participants did not suffer most from forced separation from their parents (though they did suffer from this). In fact they suffered most from being cared for by nurses who's emotional neutrality, falsely masquerading as professionalism and scientific objectivity was interpreted by them as a lack of affection. To them as children, this mattered. As one child participant knowingly testified, what was lacking was nothing more than what anyone would do to calm down a troubled cat, to stroke the cat, to cuddle the child, a wink, a smile, a demonstration of human empathy. There are clearly lessons to be learned from this in relation to the nursing of children today and in any age. Careful note should be taken that paediatric nursing existed within a micro-culture of health care and that the 'mistakes' referred to above almost certainly applied to other health care disciplines and especially to medicine.

By the end of the period 1920-1970 nursing was beginning to return to its holistic and individual care roots. This circle of events is acknowledged by Saunders (1982, p. 143)[1236] *'Paediatric nursing has changed fundamentally in the last 30 years. Most of the changes are radical but some are revolutionary; the circle has turned fully and, ironically, we have returned to some of the ideas, ideals and attitudes of a century ago.'*

It has been argued, that the return to individualised care had a multi-factorial and purely social aetiology. It is not the case that individualised care and a concern for the holistic needs of the child and family came about as a result of either (inductive) nursing research or of the (deductive) acceptance of the psychological studies of

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[1236] Saunders, D. (1982). Sick children's nursing. Nursing, midwifery and health visiting since 1900. P. Allan and M. Jolley. London, Faber and Faber.

Bowlby[1237], Robertson[1238] and the Tavistock Institute[1239]. Nor is it the case that these important changes were primarily the result of government influence in the shape of the Platt Report[1240] or of the influence of NAWCH[1241]. It is argued here that had the social events discussed in this chapter, especially World War II not taken place, the work of the Tavistock Institute and NAWCH would not have been given the necessary credence, either by government or by the disciplines of medicine and nursing. Of course Bowlby, Platt and NAWCH are important factors in the history of paediatric nursing but they did not initiate change, they were responses to far more important and powerful changes that were already taking place in society.

British society changed in the years leading up to 1970 in a number of important ways. It is argued here that although nursing resisted these changes[1242], it eventually capitulated and adapted to the changing social expectations for the kind of service it should deliver to sick children and their families. In particular, nursing eventually acquiesced to the demand for individualised care and a more holistically orientated provision of care that went beyond the limitations of medicine's focus on physical pathology.[1243]

It is possible to see social changes affecting paediatric nursing before World War II, particularly in terms of the position of married women[1244], the 'institution' of the hospital (institutionalisation of nursing)[1245] and the beginning impact of academic

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[1237] See Bowlby, J. (1956). "The effect of mother child separation: a follow up study." British Journal of Medical Psychology 29: 111.

[1238] Bowlby, J., J. Robertson and D. Rosenbluth (1967). A two year old goes to hospital. The psychoanalytic study of the child. New York, International Universities Press Inc. 7.

[1239] Referred to here as the conventional history of paediatric nursing, for a typical account of this approach see, Swanwick, M. (1983). "Platt in perspective." Nursing Times 79(2): 5-8.

[1240] Ministry of Health (1959). The report of the committee on the welfare of children in hospital (the Platt Report). London, HMSO.

[1241] Siddle, J. (1991). "A voice for children NAWCH -- the National Association for the Welfare of Children in Hospital." British Journal of Theatre Nursing 1(6): 4-5.

[1242] Duncombe, M. A. (1979). A brief history of the Association of British Paediatric Nurses 1938-1975. London, Association of British Paediatric Nurses.

[1243] See for example, National Association for the Welfare of Children in Hospital (1988). Parents staying overnight in hospital with their children. London, NAWCH (Action for Sick Children). Also, for example, Swanwick, M. (1983). "Platt in perspective." Nursing Times 79(2): 5-8.

[1244] See for example, Great Ormond Street Hospital Archive (1939). Entry dated 02/10/1939. Nursing Committee Minute Book: Volume Three 1939. London.

[1245] Nuffield Provincial Hospital's Trust (1948). Observations submitted to the Ministry of Health on the Ministry's Working Party's Report on the Recruitment and Training of nurses. Oxford, The University Press.

nursing.[1246] However, the above mostly had an affect after World War II. In practice, the social experiences of World War II had a synergistic effect on the social changes that were already beginning to take place and impacting on nursing. It is proposed here that the experience of separation and evacuation associated with World War II and the general mood against state authority which resulted from the conflict with Nazi Germany created significant disquiet about both the control that health care professionals exerted on the family and on the prevailing psychological doctrine of behaviourism. Put simply, the family became a precious possession (see Hardyment 1995) [1247] and ordinary people were no longer willing to give up responsibility for their loved ones.

Paediatric nursing's re-orientation to family centred care and to individualised care was not the result of Bowlby's[1248] work alone, or of the re-educating of paediatric nurses supposedly ignorant in developmental psychology and sociology.[1249] The changes which did take place were the result of social changes which stemmed from World War II, namely the demise of behaviourism and the reduced authority of health care professionals. It was these influences which resulted in society demanding a more humane nursing provision for children.

Furthermore, society became more 'open' and 'liberal', nurses were encouraged to participate in academic programmes of study. This resulted in nurses questioning the 'known way' of unquestioned practice. This alone might have been successful in breaking the back of the system of hierarchy and discipline (see Goffman 1962)[1250]. In addition, however, male nurses began to be recruited and it is likely that the female matrons who had ruled nursing so effectively up to that point, were simply unable to do the same with male nurses.[1251] In any case, the matron's days were numbered by

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[1246] Great Ormond Street Hospital Archive (1935). Entry dated 11/10/1935. Nursing Committee Minute Book: Volume One 1935-1936. London.

[1247] Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

[1248] See Bowlby, J. (1953). Child care and the growth of love. Harmondsworth, Penguin.

[1249] See for example, Swanwick, M. (1983). "Platt in perspective." Nursing Times 79(2): 5-8.

[1250] Goffman, E. (1962). Asylums: Essays on the social situation of mental patients and other inmates. Garden City - New York, Doubleday and Co.

[1251] Damrosch, S. P., P. A. Sullivan and L. L. Haldeman (1987). "How nurses get their way: power strategies in nursing." Journal of Professional Nursing 3(5): 284-90.

the Salmon Report[1252] and her role and responsibilities would be diffused among several managers, limiting the effectiveness with which authority could be wielded upon the increasingly married, less institutionalised and more academically motivated nurses. If the changes to paediatric nursing had been chiefly the result of Bowlby's work as is so often testified in conventional accounts of the history of paediatric nursing[1253], McCarthy (1981)[1254] would not have found it necessary, some 20 years later to be encouraging paediatric nurses to accept those very changes and modify their practice.

Maggs (1987)[1255] has argued persuasively, that the history of nursing is that of a struggle for professionalisation and autonomy from medicine. Yet Maggs (1987)[1256] also deals with the conundrum of how it was that developing professionalisation and independence gave way to subservience, dependency and exploitation. This present study shows that the struggle for professional autonomy played a minor part in the history of paediatric nursing. The truth is that paediatric nursing as a whole has never wanted to be separate from medicine nor has it wanted to break away from its subservient relationship with doctors. Woods (1987)[1257] suggests that much of what nurses have written regarding professionalism existed as little more than fiction. There is no evidence here that paediatric nursing even attempted to change its relationship with medicine (see Herdman 2001[1258]). To some extent it is likely that medicine, also being liberated from the social constraints of the past accepted family centred and more individualised care in much the same way as did nursing (though this goes beyond the remit of this present study). Certainly, there appears to have been no conflict between nursing and medicine in relation to the provision of more individualised and family centred care. It is clear that in the early days medicine resisted these changes much as did nursing. Medicine and nursing seem to have experienced even this together.

[1252] Department of Health and Social Security (1965). The committee on senior nursing staff (The Salmon Report). London, HMSO.
[1253] Swanwick, M. (1983). "Platt in perspective." Nursing Times 79(2): 5-8.
[1254] MacCarthy, D. (1981). "The under fives in hospital: a report on the emotional well-being of children aged 0-5 years in hospital." Nursing Times 22/07/1981(Supplement): 1-8.
[1255] Maggs, C. J. (1987). Nursing history: the state of the art. London, Croom Helm.
[1256] Maggs, C. J. (1987). Nursing history: the state of the art. London, Croom Helm.
[1257] Woods, C. Q. (1987). From individual dedication to social activism: historical development of nursing professionalism. Nursing history, the state of the art. C. Maggs. London, Croom Helm.
[1258] Herdman, E. A. (2001). "The illusion of progress in nursing." Nursing Philosophy 2(1): 4.

There is little if any evidence here for the 'struggle' for autonomy which Maggs (see Maggs 1983[1259] and Maggs 1987[1260]) suggests is the very identity of the history of nursing. On the contrary, in the years between 1920 and 1970 there was no nursing struggle for autonomy, only a deeply engrained desire to be accepted by and to serve the needs of doctors. This involved adopting their professional codes and their ethics but not in seeking autonomy from them. It should be understood, however, that the effect on patients and their families was just as if paediatric nursing was trying to professionalise. As Wood (1987)[1261] argues, the nurses' keen sense of professionalism (but as we now understand, 'their sense of wanting to be accepted by and serve doctors') had more effect on patients than all the good intentions, skills and care of individual nurses.

Individual nurses did care for their child patients, they cared not just for their bodies but for their child patients as people, as valuable, vulnerable children and as individuals. The effect of this care, however, was subsumed, even suffocated by the nurses' doctor-focussed professionalism which was perceived by the child patients as emotional neutrality. In most cases, this was probably the opposite of what human qualities were actually confronting them. The 'truth' here is not important, the 'effect' was caused by how that truth (that nurses did care) was perceived so negatively by the child patients. In this important sense, care is not care unless it is perceived and witnessed as such.

The research discussed here has important implications for the understanding of paediatric nursing. The study provides an explanation of how it came to be that in the period between 1920 and 1970 nursing seemed to act against the interests of child patients and their families. This study has implications for modern nursing where the lessons of the past are easily forgotten, especially when they were perhaps never fully understood in the first place. The reinvention of the 'modern' matron may be an innocent triviality but it could be more than that. An understanding of the history of

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[1259] Maggs, C. (1983). The origins of general nursing. London, Croom Helm.
[1260] Maggs, C. J. (1987). Nursing history: the state of the art. London, Croom Helm.
[1261] Woods, C. Q. (1987). From individual dedication to social activism: historical development of nursing professionalism. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

paediatric nursing is still very much a limited and superficial thing but the more it is understood the less likely is it that mistakes of the past will be lived anew. This study has identified the harm that was done when good people tried to do their best for sick children. The depth of this harm is concerning. However, even more concerning is the way in which the situation was improved, as it was improved, by what were little more than chance events in wider 20th century society.

References

Abdellah, F. G. and E. Levine (1986). Better patient care through nursing research. New York, Macmillan.

Abel-Smith, B. (1960). A history of the nursing profession. London, Heinemann.

Abel-Smith, B. (1964). The hospitals 1800-1948: a study in social administration in England and Wales. London, Heinemann.

Adams, J. (1997). "From crippledom to orthopaedic nursing: Pyrford, Surrey 1908-1945." International History of Nursing Journal 2(4): 23-37.

Ainsworth, M. D. (1962). The effect of maternal deprivation: a review of findings and controversy in the context of research strategy. Deprivation of maternal care. World Health Organisation. Geneva, World Health Organisation.

Alder Hey Children's Hospital Archive (1964). Alder Hey Children's Hospital Souvenir Brochure 1914-1964. Ross, James. S. Liverpool.

Alder Hey Children's Hospital Archive (1969). Syllabus of subjects for examination and record of practical instruction and experience for the certificate of the nursing of sick children. General Nursing Council. Liverpool.

Alder Hey Children's Hospital Archive (1987). Kathleen Inga Cawood: Matron of Alder Hey Children's Hospital 1948 -1965. Alder Hey Nurses League 25th Annual Reunion. Tolman, J. Liverpool.

Aldrich, C. A. and M. M. Aldrich (1939). Understand your baby. London, Black.

'An old experienced nurse and one of the children's nurses' (1920). "Children's nurses and uniform." Nursing Mirror and Midwives Journal 31(787): 66.

Anonymous (1919). "The Children's Rest, Roehampton." Nursing Mirror and Midwives Journal 30(768): 195-6.

Anonymous (1919). "How to amuse toddlers." Nursing Mirror and Midwives Journal 30(770): 243.

Anonymous (1919). "Nurses' registration (no. 2) Bill: views of members of parliament and opinion of our readers." Nursing Mirror and Midwives Journal 30(766): 157.

Anonymous (1919). "Our examination questions for nurses." Nursing Mirror and Midwives Journal 30(759): 12.

Anonymous (1920). "Billiken." Nursing Mirror and Midwives Journal 31(785): 23.

Anonymous (1920). "The care of the tuberculous child." Nursing Mirror and Midwives Journal **32**(818): 154-155.

Anonymous (1920). "A Christmas incident in a nurse's life." Nursing Mirror and Midwives Journal **32**(820): 194.

Anonymous (1920). "A dying baby in a Brazilian home." Nursing Mirror and Midwives Journal **31**(792): 145.

Anonymous (1920). "The General Nursing Council for England." Nursing Mirror and Midwives Journal **32**(817): 139.

Anonymous (1920). "In the children's ward." Nursing Mirror and Midwives Journal **32**(822): 228-229.

Anonymous (1920). "Invalid and crippled children: a joint two day conference." Nursing Mirror and Midwives Journal **32**(818): 156.

Anonymous (1920). "Notes and queries." Nursing Mirror and Midwives Journal **32**(815): 110.

Anonymous (1920). "Notes and queries." Nursing Mirror and Midwives Journal **32**(818): 166.

Anonymous (1920). "Self governance." Nursing Mirror and Midwives Journal **31**(802): 313.

Anonymous (1920). "The sins of the fathers." Nursing Mirror and Midwives Journal **30**(779): 391.

Anonymous (1923). "News." British Journal of Nursing **04/09/1923**: 75-76.

Anonymous (1939). "Model answers for state examination paper." Nursing Times **35**(1784): 868.

Anonymous (1939). "State Examination Questions (February 1949): Final examination for sick children's nurses." Nursing Times **19/03/1939**: 232.

Anonymous (1940). "Amusing the sick child in bed: practical suggestions for nurses who have care of sick children in hospital or at home." Nursing Mirror **16/03/1940**: 595.

Anonymous (1940). "Final examination for Fever Nursing (Scotland)." Nursing Times **25/05/1940**: 556.

Anonymous (1945). "News." Nursing Times **03/11/1945**: 726.

Anonymous (1949). "News." Nursing Times **24/12/1949**: 1132.

Anonymous (1949). "State Examination Questions (February 1949): Final examination for sick children's nurses." Nursing Times **19/03/1949**: 232.

Anonymous (1949). "Visiting children in hospital." Nursing Times **01/10/1949**: 824.

Anonymous (1950). "Model answers to state final paper." Nursing Times **06/05/1950**: 466.

Anonymous (1956). "Model answers to children's state paper." Nursing Times **21/09/1956**: 935-936.

Anonymous (1956). "State examination questions for sick children's nursing." Nursing Times **16/11/1956**: 1176-1177.

Anonymous (1959). "News." Nursing Times **20/02/1959**: News pages.

Anonymous (1964). "Removal of tonsils and adenoids." Nursing Times **31/07/1964**: 993-996.

Anonymous ('Sister Tutor at The Hospital for Sick Children, G. O. S., London') (1926). "The nursing care of poliomyelitis." Nursing Times **18/12/1926**: 1168.

Armstrong, G. (1771). An essay on the diseases most fatal to infants. To which are added rules to be observed in the nursing of sick children: with a particular view to those who are brought up by hand ..../. London, T. Cadell.

Armstrong, K. F. (1940). "Evacuation and epidemics." Nursing Times **20/01/1940**: 55.

Armstrong, K. F. (1945). "The second opportunity goes." Nursing Times **21/04/1945**: 251.

Armstrong, K. F. (1945). "The wider basic training." Nursing Times **10/03/1945**.

Armstrong, P. and H. Armstrong (1992). "Sex and the professions in Canada." Journal of Canadian Studies **27**(1): 118.

Arton, M. E. (1992). The development of sick children's nursing, 1919-1939. History. Bath, Bath University.

Ashby, H. and G. A. Wright (1899). The diseases of children, medical and surgical. London, Longmans.

Ashdown, A. M. (1927). A complete system of nursing. London, Waverley Book Company Ltd.

Ashton, E. (1920). The feeding of infants and young children. London, Scientific Press Ltd.

Atkins, H. (1972). Joint Board of Clinical Nursing Studies: first report. London, Joint Board of Clinical Nursing Studies.

Ayers, G. (1971). England's first state hospitals and the Metropolitan Asylums Board 1867-1930. London, Wellcome Institute for the History of Medicine.

Baer, E. D. (1997). Women and the politics of career development: the case of nursing. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Baly, M. E. (1987). The Nightingale nurses. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

Baly, M. E. (1995). Nursing and social change. London, Routledge.

Barnes, P. (1999). Royal Manchester Children's Hospital 'Pendlebury' 1829-1999. Leek, Churnet Valley Books.

Bartlett, F. (1999). "Clean, white girls: assimilation and women's work." Hecate **25**(1): 10-39.

Bashford, A. (1993). "Frances Gillam Holden and the Children's Hospital Dispute, 1887: Woman's Sphere, Feminism and Nursing." Women's History Review **2**(3): 319-330.

Bashford, A. (2000). "Domestic Scientists: Modernity, Gender, and the Negotiation of Science in Australian Nursing, 1880-1910." Journal of Women's History **12**(2): 127-146.

Behrman, R. E. (1992). Nelson textbook of paediatrics. London, Saunders.

Bell, C. (1940). "Nursing infectious diseases in the home: whooping cough and chicken pox." Nursing Mirror **03/02/1940**: 425.

Bendall, E. (1967). The Hospital for Sick Children: Great Ormond Street: Training School for Nurses. London, The Hospital for Sick Children, London.

Birch, J. (1975). To nurse or not to nurse: an investigation into the causes of withdrawal during nurse training. London, Royal College of Nursing.

Birkenhead and Wirral Children's Hospital (1941). "Appointments." Nursing Times **12/04/1941**: Supplement v.

Boal, L. (1982). One hundred years nursing. Yorkhill Hospitals Archive. Glasgow.

Boorer, H. (1968). "Young children in brief separation." Nursing Times **19/07/1968**: 996.

Boosfield, B. (1995). "Conflict in decision making: do nurses have a role?" Paediatric Nursing **7**(7): 21-23.

Booth Hall Hospital for Sick Children (1940). "Vacancies." Nursing Times **27/01/1940**: v.

Boschma, G. (1994). "The meaning of holism in nursing: historical shifts in holistic nursing ideas." Public Health Nursing **11**(5): 324-30.

Boschma, G. (1997). Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Bowden, V. R. (2000). "Pediatric nursing practice: keeping pace with technological advances." MCN: American Journal of Maternal/Child Nursing **25**(6): 318-21.

Bowlby, J. (1951). Maternal care and mental health. Geneva, World Health Organisation.

Bowlby, J. (1953). Child care and the growth of love. Harmondsworth, Penguin.

Bowlby, J. (1956). "The effect of mother child separation: a follow up study." British Journal of Medical Psychology **29**: 111.

Bowlby, J. (1973). Attachment and loss, Volume II: separation anxiety and anger. New York, Basic books.

Bowlby, J., J. Robertson and D. Rosenbluth (1967). A two year old goes to hospital. The psychoanalytic study of the child. New York, International Universities Press Inc. **7**.

Bowlby, J., D. Winnicott and E. Miller (1939). "Letter to the Editor." British Medical Journal **16/12/1939**.

Bowley, A. H. (1948). The natural development of the child: a guide for parents, teachers, students and others. Edinburgh, E and S Livingstone Ltd.

Bowley, A. H. (1950). "The child without parents." Nursing Times **08/04/1950**: 364.

Bradley, S. (2001). "Suffer the little children: the influence of nurses and parents in the evolution of open visiting in children's wards 1940-1970." International History of Nursing Journal **6**(2): 44-51.

Brandon, S. (1986). Children in Hospital. London, National Association for the Welfare of Children in Hospital.

Brearley, S. (1990). Patient participation: the literature. London, Royal College of Nursing.

Bristol Royal Hospital for Sick Children (1939). "Vacancies." Nursing Times **22/07/1939**.

Bristol Royal Hospital for Sick Children and Women (1945). "Appointments." Nursing Times **03/03/1945**: Supplement v.

British Paediatric Association (Royal College of Child Health and Paediatrics) (1945). Memorandum on the future of sick children's nursing. London, British Paediatric Association.

British Paediatric Association (Royal College of Child Health and Paediatrics) (1992). Guidelines for the ethical conduct of medical research involving children. London, Royal College of Child Health and Paediatrics.

Broadribb, V. (1968). Foundations of paediatric nursing. London, Pitman Medical.

Broman, T. (1995). "Rethinking professionalisation: theory, practice, and professional ideology in eighteenth century Germany." Journal of Modern History **67**(4): 835-873.

Brooke, H. (19/07/1998). Memories of runabouts. Great Ormond Street Hospital Archive, London.

Brooke, S. (2001). "Gender and working class identity in Britain during the 1950s." Journal of Social History **34**(4): 773.

Brooks, J. (2001). "Structured by class, bound by gender." International History of Nursing Journal **6**(2): 13-21.

Brooks, J. E. (2000). "Ghost of the past: capturing history and the history of nursing." International History of Nursing Journal **5**(2): 36-41.

Brown, B. (2000). "Men in nursing: ambivalence in care, gender and masculinity." International History of Nursing Journal **5**(5): 4-13.

Buhler-Wilkinson, K. (2002). No place like home: a history of nursing and home care in the United States. Baltimore, John Hopkins University Press.

Burdett, H. (1919). "The Nurses' Registration (No. 2) Bill." Nursing and Midwives Journal **30**(767): 174.

Burdett, H. (1919). "Tiny Toddler in a Jacobean House." Nursing Mirror and Midwives Journal **30**(760): 43.

Burgess, T. (1988). "No more potty rounds." Nursing Times **84**(16): 69-71.

Burke, A. M. (1919). "Incontinence (of urine) in children at night." British Journal of Nursing **18/01/1919**: 42.

Burns, N. and S. K. Grove (1993). The practice of nursing research: conduct, critique and utilisation. Philadelphia, WB Saunders Company.

Callery, P. and K. Luker (1996). "The use of qualitative methods in the study of parents' experience of care on a children's surgical ward." Journal of Advanced Nursing **23**(2): 338-345.

Castle, J. (1987). The development of professional nursing in New South Wales, Australia. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

Central Council for Education (1960). Coming into hospital. London, Tavistock Institute.

Chaloner, L. (1968). "Play in hospital." Nursing Mirror **12/04/1968**: 23-24.

Chapple, K. (1996). The history of children's nursing. Nursing. Hull, The University of Hull.

Charnell, E. (1940). "A case of cerebro-spinal meningitis." Nursing Times **13/01/1940**: 38-40.

Cherry, S. (1996). Medical services and the hospitals in Britain 1860-1939. Cambridge, Cambridge University Press.

Children's Orthopaedic Hospital - Marple - Cheshire (1945). "Appointments." Nursing Times **14/02/1945**: Supplement vi.

Claydon, R. (1991). The story of the Royal Liverpool Children's Hospital: Alder Hey and Myrtle Street. London, Image Publications.

Cleary, J., P. Gray, P. H. Rowlandson, C. P. Q. Sainsbury and M. M. Davies (1986). "Parental involvement in the lives of children in hospital." Archives of Diseases in Childhood **61**: 779-787.

Clifford, C. (1998). "Capturing nursing memories." International History of Nursing Journal **3**(4): 36-42.

Cohen, L. and L. Manion (1989). Research methods in education. London, Routledge.

Collis, W. R. F. (1959). Neonatal paediatrics. London, Heinemann.

Coltrane, S. (2000). "Research on household labor: modelling and measuring the social embeddedness of routine family work." Journal of marriage and family **62**(4): 1208-1234.

Connell, J. and S. Bradley (2000). "Visiting children in hospital: a vision from the past." Paediatric Nursing **12**(3): 32-35.

Connell, J. and S. Bradley (2000). "Visiting children in hospital: a vision from the past." Paediatric Nursing **12**(3): 32-5.

Conybeare, J. (1949). Textbook of medicine. Edinburgh, E and S Livingstone Ltd.

Court, S. D. M. (1976). Fit for the future: report of the Committee on Child Health Services. London, HMSO.

Craig, A. (1964). "Emotional needs of expectant mothers." Nursing Times **10/01/1964**: 43.

Cunningham, H. (1995). Children and childhood in western society since 1500. London, Longman.

Currie, R. (1997). "The rise and demise of fever nursing." International History of Nursing Journal **3**(1): 5-19.

Damrosch, S. P., P. A. Sullivan and L. L. Haldeman (1987). "How nurses get their way: power strategies in nursing." Journal of Professional Nursing **3**(5): 284-90.

Darbyshire, P. (1986). "The unfairer sex." Senior Nurse **5**(5-6): 44-45.

Darbyshire, P. (1987). "Bring back the 'Care Bear': the caring aspect of nursing." Nursing Times **83**(26): 60.

Darbyshire, P. (1987). "Nurses and doctors: the burden of history." Nursing Times **83**(4): 32-34.

Darbyshire, P. (1988). "Looking to the past .. nurse recruitment." Nursing Times **84**(19): 31-32.

Darbyshire, P. (1990). "The heart of the matter: human caring." Nursing Times **86**(47): 63-64.

Darbyshire, P. (1991). "Nursing reflections." Nursing times **87**(36): 27-28.

Darbyshire, P. (1994). "Understanding caring through arts and humanities: a medical / nursing humanities approach to promoting experiences of thinking and learning." Journal of Advanced Nursing **19**(5): 856-863.

Darbyshire, P. (1999). "Nursing, art and science: revisiting the two cultures." International History of Nursing Journal **5**(3): 121-123.

Davies, C. (1996). "The sociology of the professions." Sociology **30**(4): 661-678.

Davies, C. (2000). "Getting professionals to work together." British Medical Journal **320**: 1021-1022.

Davies, C., J. Salvage and R. Smith (1999). "Doctors and nurses: changing family values?" British Medical Journal **319**: 463-464.

Davies, R. (2000). "Children's nursing: achievements in child health over the first half of the 20th century." British Journal of Nursing **9**(1): 28-32.

Davison, W. C. (1943). "Nursing as the foundation for Medicine." North Carolina Medical Journal **April 1943**: 141.

DeMause, L. (1974). The evolution of childhood. The history of childhood: the evolution of parent child relationships as a factor in history. L. DeMause. London, Souvenir Press.

Department of Health and Social Security (1965). The committee on senior nursing staff (The Salmon Report). London, HMSO.

Derbyshire Children's Hospital Archive L58/30m/4.56/L. Main archive. Derby.

Derbyshire Children's Hospital Archive (1882). The children's hospital, Derby. Almanac 1882. Derby.

Derbyshire Children's Hospital Archive (c. 1930). Nurse's Rulebook. Derby.

Derbyshire Children's Hospital Archive (c. 1960). Record of practical instruction and experience for the certificate of nursing sick children. GNC. Derby.

Derbyshire Children's Hospital Archive (to 30th June 1878). First report of the Derbyshire Children's Hospital (to 30th June 1878). Derby.

Dingwall, R., A. M. Rafferty and C. Webster (1988). An introduction to the social history of nursing. London, Routledge.

Donahue, M. P. (1996). Nursing: the finest art: an illustrated history. London, Mosby.

Dopson, L. (1983). "'Sick kids' 100 years on." Nursing Times **79**(13): 8-9.

Duncombe, M. A. (1956). "Paediatric study tour of Holland." Nursing Times **10/08/1956**: 772-773.

Duncombe, M. A. (1979). A brief history of the Association of British Paediatric Nurses 1938-1975. London, Association of British Paediatric Nurses.

Dunlop, J. (1962). Visiting patients in hospital. Edinburgh, Scottish Home and Health Department.

Earl, E. (1996). Queen Mary's Hospital for Children. Knebworth, Able Publishing Services.

Editorial (1919). Nursing Times **18/08/1919**: 836.

Editorial (1919). "Untitled." Nursing Times **20/09/1919**.

Editorial (1920). "The Shoreditch Infant Welfare Centre." Nursing Mirror and Midwives Journal **30**(783): 465.

Editorial (1920). "Untitled." British Journal of Nursing **25/09/1920**: 171.

Editorial (1921). "Untitled." Nursing Times **15/01/1921**: 69.

Editorial (1933). "Untitled." Nursing Times **08/07/1933**: 657.

Editorial (1939). "Chailey Heritage Craft Schools." Nursing Times **01/07/1939**: 817-818.

Editorial (1939). "The paediatrician's plan and specialists for specialised nursing." Nursing Times **4/11/1939**: 1328-1329.

Editorial (1940). Nursing Times **20/01/1940**.

Editorial (1945). "Brave new world: psychological training at West Side Day Nursery, New York." Nursing Times **31/03/1945**.

Editorial (1949). "The Institute of Medical psychology." Nursing Times **29/01/1949**: 98.

Editorial (1949). "News, The House of Lords discuss nurse training." Nursing Times **02/07/1949**: 534.

Editorial (1949). "The Nurses' Bill." Nursing Times **23/04/1949**: 1088.

Editorial (1956). "Kings College Hospital and Belgrave Hospital for Children: combined four year training for general and sick children's nursing." Nursing Times **20/01/1956**: 50.

Editorial (1956). "Visiting children in hospital." Nursing Times **03/02/1956**: 109.

Editorial (1959). "Children in hospital." Nursing Times **13/02/1959**: 185 and 197-200.

Editorial (1959). "General training based at a children's hospital." Nursing Times **04/12/1959**: 1221.

Editorial (1968). "Weddings." Nursing Mirror **09/02/1968**: 48-49.

Editorial. (1945). "Our Children." Nursing Times **17/02/1945**: 107.

Edwards, G. (1980). Letter to Mrs Sacharine, 04/11/1980. Edwards, G. Glasgow.

Eyre, J. G. (1939). "Posterior basic meningitis treated with M&B 693." Nursing Times **01/07/1939**: 812-814.

Farrall, L. A. (1985). The origins and growth of the English eugenics movement 1865-1925. London, Garland.

Farrow, R. (1956). The surgery of childhood for nurses. Edinburgh, Livingstone.

Farrow, R. and D. Forrest (1964). Surgery of childhood for nurses. London, E&S Livingstone.

Forfar, J. O., A. D. M. Jackson and B. M. Laurance (1989). The British Paediatric Association 1928-1988. London, The Royal College of Child Health and Paediatrics.

Foster, J. and J. Sheppard (1980). Archives and the history of nursing. Rewriting nursing history. C. Davies. London, Croom Helm.

Foulds, J. (1980). "Letter." Journal of the Yorkhill Nurses' League.

Frankenburg, C. (1922). Common sense in the nursery. London, Cape.

Freidson, E. (1970). Professional dominance: the social structure of medical care. New York, Atherton Press.

Freud, S. (1936). Inhibitions, symptoms and anxiety. London, Hogarth Press.

Freud, S. and A. Freud (1991). Essentials of psychoanalysis. Harmondsworth, Penguin.

Galton, F. (1905). Eugenics, its definition, scope and aims. London, Sociological Society of London.

Gessell, A. (1926). The mental growth of the pre-school child: A psychological outline of normal development from birth to the sixth year including a system of developmental diagnosis. New York, MacMillan.

Gessell, A. (1945). The embryology of behaviour. New York, Harper and Row.

Gessell, A. and H. Thompson (1929). "Learning and growth in identical twins: an experimental study by the method of co-twin control." Genetic Psychology Monographs **6**: 1-123.

Gitlin, A. (1996). "Gender and professionalisation: an institutional analysis of teacher education and unionism at the turn of the twentieth century." Teachers College Record **97**(4): 588-625.

Gittins, D. (1998). The child in question. London, MacMillan Press Ltd.

Glaser, B. and A. Strauss (1965). "The discovery of substantive theory: a basic strategy underlying qualitative research." American Behavioral Scientist **8**(6): 5-12.

Godden, J. (1997). "For the benefit of mankind": Nightingale's legacy and hours of work in Australian nursing, 1868-1939. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Goffman, E. (1962). Asylums: Essays on the social situation of mental patients and other inmates. Garden City - New York, Doubleday and Co.

Graham-Bryce, I. (c. 1970). Staff appraisal in the hospital nursing service: explanatory notes. London, National Staff Nursing Committee.

Gray, W. (1959). "Teacher in a children's ward." Nursing Times **27/03/1959**: 373-374.

Great Ormond Street Hospital (1941). "Vacancies." Nursing Times **01/02/1941**: Supplement vii.

Great Ormond Street Hospital Archive (14/04/1941). Nursing Committee Record Book Four. London: This entry was in relation to the 'British Hospital Association Draft Memorandum (No. 54) on nursing policy for consideration in area committees'.

Great Ormond Street Hospital Archive (1926). Entry dated 07/01/1926. Nursing Committee Minutes. London.

Great Ormond Street Hospital Archive (1927). Entry dated 03/02/1927. Nursing Committee Minutes. London.

Great Ormond Street Hospital Archive (1927). Entry dated 07/04/1927. Nursing Committee Minutes. London.

Great Ormond Street Hospital Archive (1928). Entry dated 12/04/1928. Nursing Committee Minutes. London.

Great Ormond Street Hospital Archive (1929). Entry dated 02/05/1929. Nursing Committee Minutes. London.

Great Ormond Street Hospital Archive (1935). Entry dated 11/10/1935. Nursing Committee Minute Book: Volume One 1935-1936. London.

Great Ormond Street Hospital Archive (1935). Entry dated 12/06/1935. Nursing Committee Minute Book: Volume One. London.

Great Ormond Street Hospital Archive (1935). Entry dated 13/11/1935. Nursing Committee Minute Book: Volume One. London.

Great Ormond Street Hospital Archive (1935). Entry dated 17/04/1935. Nursing Committee Minute Book: Volume One 1935-1936. London.

Great Ormond Street Hospital Archive (1935-1936). First Entry dated 1935. Nursing Committee Minute Book: Volume One. London.

Great Ormond Street Hospital Archive (1935-1936). "Nursing Committee Minute Book: Volume One 1935-1936, entry dated 11/10/1935."

Great Ormond Street Hospital Archive (1936). Entry dated 25/03/1936. GNC circular 65 dated 14/03/1936. Nursing Committee Minute Book Volume One 1935-1936. London.

Great Ormond Street Hospital Archive (1937). Entry dated 10/02/1937. Nursing Committee Minute Book: Volume Two 1937. London.

Great Ormond Street Hospital Archive (1937). Entry dated 14/04/1937. Nursing Committee Minute Book: Volume Two 1937. London.

Great Ormond Street Hospital Archive (1938). Entry dated 09/03/1938. Nursing Committee Minute Book: Volume Two 1937. London.

Great Ormond Street Hospital Archive (1938). Entry dated 13/10/1938. House Committee Minutes. London.

Great Ormond Street Hospital Archive (1938). Entry dated 17/04/1938. House Committee Minutes. London.

Great Ormond Street Hospital Archive (1938). Entry dated 28/02/1939. Nursing Committee Minute Book, Volume Three: 1939. London.

Great Ormond Street Hospital Archive (1939). Entry dated 02/10/1939. Nursing Committee Minute Book: Volume Three 1939. London.

Great Ormond Street Hospital Archive (1939). Entry dated 11/07/1939. Nursing Committee Minute Book: Volume Three. London.

Great Ormond Street Hospital Archive (1940). Entry dated 16/01/1940. Nursing Committee Minute Book Three. London.

Great Ormond Street Hospital Archive (1940). "Nursing Committee Minute Book record for 9th July 1940."

Great Ormond Street Hospital Archive (1941). Entries for 14/04/1941. Nursing Committee Record Book, Number Four: 1942. London.

Great Ormond Street Hospital Archive (1941). Entry dated 09/12/1941. Nursing Committee Minute Book, Volume Three: 1939. London.

Great Ormond Street Hospital Archive (1941). Entry dated 14/01/1941. Nursing Committee Minute Book: Volume Three. London.

Great Ormond Street Hospital Archive (1941). Entry dated 25/08/1941. Nursing Committee Minute Book, Volume Three: 1939. London.

Great Ormond Street Hospital Archive (1942). Entries for 10/10/1942 and 23/07/1942. Nursing Committee Record Book Number Four. London.

Great Ormond Street Hospital Archive (1942). Entry dated 03/05/1943. Nursing Committee Record Book Number Four. London.

Great Ormond Street Hospital Archive (1942 and 1942). Nursing Committee Record Book Number Four, entries for 14/04/1941 and 09/06/1942. London.

Great Ormond Street Hospital Archive (1943). Entry dated 13/04/1943. Nursing Committee Record Book, Four, 1942. London.

Great Ormond Street Hospital Archive (1944). Entry dated 11/01/1944. Nursing Committee Minute Book Five: 1944. London.

Great Ormond Street Hospital Archive (1944). Entry dated 11/07/1944. Nursing Committee Record Book Four, 1942. London.

Great Ormond Street Hospital Archive (1944). Entry dated 15/08/1944. Nursing Committee Record Book Four, 1942. London.

Great Ormond Street Hospital Archive (1945). Entry dated 12/06/1945. Nursing Committee Record Book Number Four: 1942. London.

Great Ormond Street Hospital Archive (1951). Runabouts. Letter from Olive Nicolle. London.

Greenhalgh, J., L. Vanhanen and H. Kyngas (1998). "Nurse caring behaviours." Journal of Advanced Nursing **27**(5): 927-32.

Grier, J. (1998). "Eugenics and birth control: contraceptive provision in North Wales 1918-1939." Social History of Medicine **11**(3): 443-458.

Guild of Hospital Librarians (1949). "Letters." Nursing Times **24/12/1949**: 1142.

Guildford, R. (1956). "Needs of childhood and adolescence." Nursing Times **13/04/956**: 405.

Guildford, R. (1956). "Problems of adjustment." Nursing Times **20/04/1956**: 450.

Guthrie, D. (1960). The Royal Edinburgh Hospital for Sick Children. Edinburgh, Churchill Livingstone.

Hall, D. J. and M. Stacey (1979). Beyond separation: further studies of children in hospital. London, Routledge and Kegan Paul.

Hall, L. A. (1997). Nursing in the archives: archival sources for nursing history. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Hardyment, C. (1995). Perfect parents: baby care advice, past and present. Oxford, Oxford University Press.

Hargreaves, R. (1987). The story of Booth Hall Hospital. Bolton, Ross Anderson Publications.

Hart, C. (1994). Behind the mask: nurses, their unions and nursing policy. London, Bailliere Tindall.

Hawthorne, P. J. (1974). Nurse, I want my mummy. London, Royal College of Nursing.

Hector, W. (1976). The work of Mrs Bedford Fenwick and the rise of professional nursing. London, Royal College of Nursing.

Hendrick, H. (1984). "The History of Childhood and Youth." Social History 9(1): 87-96.

Hendrick, H. (1994). Child welfare: England 1872-1989. London, Routledge.

Hendrick, H. (1997). Children, Childhood and English Society, 1880-1990. Cambridge, Cambridge University Press.

Hendrick, H. (2003). Child welfare: historical dimensions, contemporary debate. Bristol, The Policy Press.

Herdman, E. A. (2001). "The illusion of progress in nursing." Nursing Philosophy **2**(1): 4.

Higonnet, A. (1998). Pictures of innocence, the history and crisis of ideal childhood. London, Thames and Hudson Ltd.

Hill, J. E. and A. Kerber (1967). Models, methods and analytical procedures in educational research. Detroit, Wayne State University Press.

Holloway, I. and S. Wheeler (1996). Qualitative research for nurses. Oxford, Blackwell Science Ltd.

Houghton, M. (1942). Aids to Tray and trolley setting. London, Bailliere and Cox.

House Committee (01/01/1926). New Sussex Hospital, Sussex. Brighton.

House Committee (18/05/1925). HN12/12. New Sussex Hospital - Sussex,.

Hulme, O. (1996). Reflections of the past, in Journal of the Yorkhill Nurses' League. Yorkhill Hospitals Archive. Glasgow.

Hunter, M. (1950). "Malrotation of the midgut complicated by volvulus." Nursing Times **18/03/1950**(287).

Hutt, R. (1983). Sick children's nurses: A study for the Department of Health and Social Security of the career patterns of RSCNs. Lewis, Institute of Manpower Studies, University of Sussex.

Hutt, R. (1984). "Issues and problems." Nursing Times **18**(13): 51-52.

Illingworth, R. S. (1953). The normal child. London, Longman.

Illingworth, R. S. (1956). "Young children in hospital." Nursing Times **03/02/1956**: 112-115.

Illingworth, R. S. and R. S. Holt (1955). "Children in hospital: some observations of their reactions with special reference to daily visiting." The Lancet **17/12/1955**: 1257-1262.

Illingworth, R. S. and C. M. Illingworth (1954). Babies and young children. London, J and A Churchill Ltd.

Isaacs, D. and M. Poole (1996). "Being a man and becoming a nurse: three men's stories." Journal of Gender Studies **5**(1): 39-47.

Ives, A. G. (1948). British Hospitals. London., Collins.

James, B. (1939). "Interesting cases series ix: pyloric stenosis." Nursing Times **30/09/1939**.

Jeans, P. C. and W. Rand (1936). The Lippincott Essentials of Paediatrics for Nurses. London, Lippincott.

Jolley, M. J. (1995). "Forging the way ahead: obtaining consent for paediatric nursing research." Child Health **2**(5): 202-206.

Kessler-Harris, A. (2001). In pursuit of equity: women, men, and the quest for economic citizenship in twentieth century America. Oxford, Oxford University Press.

King Edward's Hospital Fund for London (1946). Recommendations for the employment of domestic staff in hospitals. London, King's Fund.

King Edward's Hospital Fund for London (1950). Memorandum on the supervision of nurses' health, second edition. London, King's Fund.

King, F. T. (1913). Feeding and care of baby. London, Macmillan.

Kirwin, W. B. (1964). "Letters." Nursing Times **05/06/1964**: 734.

Klein, M. (1935). Weaning. On the upbringing of children. J. Rickman. London, Kegan Paul.

Kosky, J. (1992). Queen Elizabeth Hospital for Children: 125 years of achievement. London, The Hospitals for Sick Children.

Kuenssberg, C. V. and E. C. Kuenssberg (1964). "When Bruce goes to hospital." Nursing Times **29/05/1964**: 349.

Lait, M. E. (2000). "The place of nursing history in the undergraduate curriculum." Nurse Education Today **20**(5): 395-400.

Lamond, N. (1974). Becoming a nurse: the registered nurses' view of general student nurse education. London, Royal College of Nursing.

Latham and Heckel (1968). Paediatric nursing. London, Henry Kimpton.

Liddiard, M. (1924). Mothercraft manual. London, Churchill.

Liggins, E. (2000). "With a dead child in her lap: bad mothers and infant mortality in George Egerton's Discords." Literature and History **9**(2): 17-37.

Lightbody, P., G. Siann, L. Tait and D. Walsh (1997). "A fulfilling career? Factors which influence women's choice of profession." Education Studies **23**(1): 25-37.

Lindsay, B. (2000). Who cares? The morphology of 'caring in children's hospitals, 1852-1950, with special reference to Jenny Lind Hospital for Sick Children, Norwich. Ipswich, University of East Anglia.

Lindsay, B. (2001). "An atmosphere of recognition and respect? Sick children's nurses and medical men 1880-1930." International History of Nursing Journal **6**(1): 4-9.

Lindsay, B. (2001). "Visitors and children's hospitals, 1852-1948: a re-appraisal." Paediatric Nursing **13**(4): 20-24.

Litt, S. (2000). "Gestalt therapy and humanistic Psychology." Positive Health **53**: 14-16.

Lomax, E. M. R. (1996). Small and special: the development of hospitals for children in Victorian Britain. London, Wellcome Institute for the History of Medicine.

Long, T. (1991). "Toward a definition of children's nurses." Paediatric Nursing **3**(9): 12-15.

Lyson, R. A. and E. M. Wallinger (1959). Nursing of Children. USA, Saunders.

"M.A.D." (1956). "Book reviews." Nursing Times **03/08/1956**: 134.

MacCarthy, D. (1959). "The practical aspects." Nursing Times **20/02/1959**: 89.

MacCarthy, D. (1981). "The under fives in hospital: a report on the emotional well-being of children aged 0-5 years in hospital." Nursing Times **22/07/1981**(Supplement): 1-8.

MacCarthy, D., M. Lindsay and I. Morris (1962). "Children in hospital with mother." The Lancet **24/03/1962**: 603-608.

Mackenzie, N. (1945). "The teaching of normal psychology to the student nurse." Nursing Times **15/12/1945**: 838-839.

Mackenzie, N. (1945). "Temperament and personality." Nursing Times **12/05/1945**: 302-303.

Mackenzie, N. (1945). "Temperament, character and personality 1: the instincts and emotions,." Nursing Times **14/04/1945**: 139-238.

Mackenzie, N. (1945). "Temperament, character and personality: the personality of the sister." Nursing Times **26/05/1945**: 340-341.

Mackintosh, N. J. (1997). "Has the Wheel Turned Full Circle? Fifty Years of Learning Theory, 1946-1996." Quarterly Journal of Experimental Psychology **Section A 50**(4): 879.

Macnicol, J. (1986). The evacuation of schoolchildren. War and social change: British society in the Second World War. H. Smith. Manchester**:** 3-31.

Maggs, C. (1983). The origins of general nursing. London, Croom Helm.

Maggs, C. J. (1978). "Towards a social history of nursing -1." Nursing Times **74**(14): 53-56.

Maggs, C. J. (1978). "Towards a social history of nursing - 2." Nursing Times **74**(15): 57-58.

Maggs, C. J. (1981). "Control mechanisms and the "new nurses" 1881-1914." Nursing Times **77**: 97-100.

Maggs, C. J. (1987). Nursing history: the state of the art. London, Croom Helm.

Mann, J. (1994). Four years hard. London, New Millennium.

Mansell, D. and J. Hibberd (1998). "Forcible sterilisation in Canada, 1920-1940." International History of Nursing Journal **3**(4): 4-11.

'Maternity nurse of eighteen years experience' (1920). "The feeding of infants and children." Nursing Mirror and Midwives Journal **31**(805): 371.

Maunsell, M. (1940). "Seavacuation to Canada." Nursing Mirror **14/09/1940**: 554.

Maxwell, J. (1997). Children and state intervention: developing a coherent historical perspective. Nursing history and the politics of welfare. A.-M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

McCormick, P. (1996). "A tribute to Virginia Henderson: Virginia Avenel Henderson - the mother of modern nursing - dies at age 98." Psychiatric Care **3**(Supplement 1): 47.

McFarlane, J. K. (1970). The proper study of the nurse. London, Royal College of Nursing.

Mcintosh, C. (1998). "Profession, skill or domestic duty? Midwifery in Sheffield, 1881-1936." Social History of Medicine **11**(3): 403-420.

Meadow, S. R. (1969). "The captive mother." Archives of Diseases in Childhood **44**: 362-367.

Mechanic, D. (1964). "The influence of mothers on children's health attitudes and behavior." Pediatrics **33**: 444.

Mechelen, I. V. (1992). Categories and concepts: theoretical views and inductive data analysis. London, Academic Press.

Medical Research Council (1992). Responsibility in investigations on human participants and material and on personal information. London, Medical Research Council.

Merrow, D. I. and B. S. Johnson (1968). "Perception of the mother's role with her hospitalised child." Nursing Research **17**(2): 155-156.

Miles, I. (1986). "The emergence of sick children's nursing Part 1: sick children's nursing before the turn of the century." Nurse Education Today **6**: 82-87.

Mills, H. (1940). "Psychological problems of wartime." Nursing Times **27/01/1940**: 90-91.

Mills, H. (1940). "Psychological problems of wartime." Nursing Times **03/02/1940**: 114.

Mills, H. (1940). "Psychological problems of wartime." Nursing Times **06/04/1940**: 360-361.

Ministry of Health (1939). Report of the Interdepartmental Committee on Nursing Services. London, Ministry of Health.

Ministry of Health (1956). Visiting children in hospital: Circular HM(56)6. London, HMSO.

Ministry of Health (1959). The report of the committee on the welfare of children in hospital (the Platt Report). London, HMSO.

Ministry of Health (1960). HM (61) 83: Employment of nursery nurses in hospital. London, Ministry of Health.

Ministry of Health (1966). HM (66) 11: The use of restrainers. London, Ministry of Health.

Ministry of Health (1966). HM (66) 18: Unrestricted visiting. London, Ministry of Health.

Ministry of Health (1967). HM (67) 50: Children nursed on adult wards. London, Ministry of Health.

Ministry of Health (1969). HM (69) 4: Children in hospital. London, Ministry of Health.

Ministry of Health (1971). The welfare of children in hospital, HM(71)22. London, HMSO.

Mitchell, A. G., E. F. Upham and E. M. Wallinger (1940). Pediatrics and pediatric nursing. USA, WB Saunders and Co. Ltd.

Moncrieff, A. (1930). A textbook for the nursing and diseases of sick children for nurses. London, HK Lewis and Co. Ltd.

Morgan, B. D. (1969). "Mothers in hospital." The Lancet **2**(425): 38-39.

Morris, I. (1959). "A ward sister's eight years experience." Nursing Times **20/02/1959**: 56.

Mortimer, B. (1997). Independent women: domiciliary nurses in mid-nineteenth century Edinburgh. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Mouly, G. J. (1978). Educational research: the art and science of investigation. Boston, Allyn and Bacon.

Mrazel, D. A. (1984). Effects of hospitalization on early child development. Continuities and discontinuities in development. R. N. Emde and R. J. Harmon. London, Plenum Press.

Muse, M. B. (1940). A textbook of psychology. London, WB Saunders.

National Association for the Welfare of Children in Hospital (1986). Where are the children. London, NAWCH.

National Association for the Welfare of Children in Hospital (1987). The child alone, a report on the unaccompanied child in hospital. London, NAWCH.

National Association for the Welfare of Children in Hospital (1988). Parents staying overnight in hospital with their children. London, NAWCH (Action for Sick Children).

Netherwood, W. A. (1967). "Children in hospital." Nursing Mirror **22/12/1967**: 290-291.

New Sussex Hospital Archive (1922). HB12/10. House Committee Minutes. Brighton.

Nightingale, F. (1860). Notes on nursing: what it is and what it is not. USA, D. Appleton and Co.

Nightingale, F. (1886). Letter sent 09/03/1886. A. Hepworth, http://clendening.kumc.edu/dc/fn/2hpwrth1.html.

Nightingale, F. (1969). Notes on nursing, what it is and what it is not. New York, Dover Publications Inc. (first published in the UK in 1859).

Nixon, J. A. (1920). "The physical and mental development of infants." Nursing Mirror and Midwives Journal **31**(784): 8.

Noble, E. (1964). "The value of play for young children in hospital." Nursing Times **18/12/1964**: 1671-1673.

Noble, E. (1967). Play and the sick child. London, Faber and Faber.

Notter, L. E. (1972). "The case for historical research in nursing." Nursing Research **21**(6): 483.

Nuffield Provincial Hospital's Trust (1948). Observations submitted to the Ministry of Health on the Ministry's Working Party's Report on the Recruitment and Training of nurses. Oxford, The University Press.

Nursing Mirror and Midwives Journal (1920). "Recruitment advertisements." Nursing Mirror and Midwives Journal **32**(810): xi.

Olsen, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, R. Robinson and R. Elkan. London, Routledge.

Olson, T. (1997). Ordered to care?: professionalisation, gender and the language of training, 1915-37. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

O'Neill, C. (1989). A picture of health: hospitals and nursing on old picture postcards. Oxford, Meadow Books.

O'Neill, C. (1991). More pictures of health: hospitals and nursing on old picture postcards. Oxford, Meadow Books.

Painton, J. F. (1994). "The outlook in male nursing." Creative Nursing 1(1): 22-24.

Participant A (1956-1959). Nurse. London.

Participant AA (1965). Age 5 years. Child. Yorkshire.

Participant AB (1966). Age 3-4 years. Child. Cumbria.

Participant AC (1965). Age 2 1/2 and 5 years. Child. Yorkshire.

Participant AD (1964). Child age 4-5 years. Parent. Lincolnshire.

Participant AE (1950s). Nurses. Yorkshire.

Participant B (Child 1948-9, Nurse 1960s). 5-6 years (child). Nurse and Child. Yorkshire.

Participant C (Child 1950s, Nurse from 1959). Child 6 years. Nurse and Child. South of England.

Participant D (From 1967). Nurse. London, Bedfordshire.

Participant E (1930s-1940s). Nurse. London.

Participant F (From 1950). Nurse. Yorkshire.

Participant G (From 1953). Nurse. London.

Participant H (From 1958). Nurse. Yorkshire.

Participant I (From 1954). Nurse. Sussex and Nottinghamshire.

Participant J (From 1962). Child 10 years. Nurse. Scotland.

Participant K (From 1968). Nurse. West Country and Sussex.

Participant L (From 1953). Nurse. London.

Participant M (1945-1951). Nurse. Essex.

Participant N (From 1964). Nurse. London, Scotland and Yorkshire.

Participant O (From 1963). Nurse. Yorkshire and Lincolnshire.

Participant P (1948). Age 10 years. Child. Lincolnshire.

Participant Q (1934). Age 8 years. Child. Yorkshire.

Participant R (1950). Age 10 years. Child. (Place of treatment retained in confidence).

Participant S (1936). Age 4 and 6 years. Child. Lincolnshire.

Participant T (1934). Age 4-5 years. Child. Lincolnshire.

Participant U (1936). Age 11 years. Child. Lincolnshire.

Participant V (1940). Age 5 years. Child. Lincolnshire.

Participant W (1957). Age 5-6 years. Child. Yorkshire.

Participant X (1930). Age 10 years. Child. Lincolnshire.

Participant Y (1957). Age 7 years. Child. Yorkshire.

Participant Z (1953). Age 8 years. Child. Lancashire.

Patterson, D. and J. Forrest-Smith (1940). Modern methods of feeding in infancy and childhood. London, Constable and Co. Ltd.

Pearce, E. (1949). A general textbook of nursing. London, Faber and Faber.

Pearson, A., H. Baker, K. Walsh and M. Fitzgerald (2001). "Contemporary nurses' uniforms: history and traditions." Journal of Nursing Management 9(2): 147.

Pearson, W. (1940). "Respiratory diseases in children." Nursing Mirror **23/03/1940**: 611.

Phaire, T. (1545). The boke of chyldren. London, Reprinted by The Royal College of Child Health and Paediatrics in 1955.

Piaget, J. (1932). The moral judgement of the child. London, Routledge and Keegan Paul.

Piaget, J. (1952). The origins of intelligence. New York, Harcourt Brace.

Pollock, L. (1983). Forgotten children. Cambridge, Cambridge University Press.

Porter, R. (1985). "The patient's view: doing medical history from below." Theory and Society **14**: 167-74.

Porter, R. (1997). The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London, Harper Collins.

Porter, R. (1997). Medicine: a history of healing, ancient traditions and modern practices. New York, Marlowe and Company.

Price, F. W. (1946). A textbook of the practice of medicine. London, Oxford University Press.

Public Record Office (1928-30). Council Minutes. DT5/6. London.

Pugh, G. W. T. (1931). Practical nursing including hygiene and dietetics. London, William Blackwood and Sons Ltd.

Rafferty, A. M. (1996). The politics of nursing knowledge. London, Routledge.

Rafferty, A. M. (2000). Nurses. Medicine in the twentieth century. R. Cooter and J. Pickstone. Amsterdam, Harwood Academic Publishers: 519-529.

Rafferty, A. M., J. Robinson and R. Elkan (1997). Introduction. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Ramsey, M. (1972). The Christian priest today. London, SPCK.

RCN (1973). RCN comment on the Report of the Committee on Nursing. London, Royal College of Nursing.

Recruitment advertisements (1920). "Recruitment." Nursing Mirror and Midwives Journal **32**(810): x1.

Robertson, J. (1956). "Letters." Nursing Times **24/02/1956**: 183.

Robertson, J. (1958). Going to hospital with mother. London, Tavistock Clinic.

Robertson, J. (1958). A two year old goes to hospital. London, Tavistock Clinic.

Robertson, J. (1962). Hospitals and children: a parents' eye view. London, Victor Gollancz.

Robertson, J. (1970). Young children in hospital (2nd edition). London, Tavistock Publications.

Robinson, E. (1972). The Yorkhill story: the history of the Royal Hospital for Sick Children, Glasgow. Glasgow, The Board of Management for Yorkhill and Associated Hospitals.

Robottom, B. M. (1968). "Home nursing of a baby with toxoplasmosis." Nursing Times **02/02/1968**: 66.

Ross, J. S. (1964). Alder Hey Children's Hospital Souvenir Brochure 1914-1964. Liverpool, Alder Hey Children's Hospital Archive.

Rotch, T. (1925). Care of children and their diseases. Virtue's Household Physician. H. Buffum, I. Warren, W. Thorndike, A. T. Lovering, A. E. Small, J. Heber-Smith, J. Dixon-Payne and C. P. Lyman. London, Virtue and Company Limited. **Two:** 483-509.

Royal College of Nursing (1964). First report on a special committee on nurse education; a reform of nursing education. London, RCN.

Royal College of Nursing (1993). Ethics related to nursing research. London, Royal College of Nursing.

Salford, N. (1964). "Letters." Nursing Times **17/04/1964**: 509.

Sandelowski, M. (2000). Gender, technology and American nursing, University of North Carolina Press.

Saunders, D. (1982). Sick children's nursing. Nursing, midwifery and health visiting since 1900. P. Allan and M. Jolley. London, Faber and Faber.

Schaffer, H. R. and W. M. Callender (1959). "Psychological effects of hospitalization in infancy." Pediatrics **October 1959**: 528-539.

Schultheiss, K. (2001). Bodies and souls: politics and the professionalisation of nursing in France, 1880-1922, Harvard University Press.

Schwarz, L. (1999). "English Servants and their employers during the eighteenth and nineteenth centuries." Economic History Review **52**(2): 236-256.

Scott, A. L. (1999). "Physical purity feminism and state medicine in late nineteenth century England." Women's History Review 8(4): 625-653.

Sharp, J. (1950). "Increased visiting for children." Nursing Times **11/02/1950**: 152.

Sharp, J. (1950). "Nursing by case assignment." Nursing Times **07/01/1950**: 4-5.

Sharp, M. (1964). "A revolution in nurse education." Nursing Times **05/06/1942**: 714-715.

Sharpe, M. (1964). "Book Review (Surgery of childhood for nurses)." Nursing Times **17/04/1964**: 502.

Shaw, M. M. (1945). "Venereal disease in children." Nursing Times **5/5/1945**: 288-289.

Siddle, J. (1991). "A voice for children NAWCH -- the National Association for the Welfare of Children in Hospital." British Journal of Theatre Nursing **1**(6): 4-5.

Simonton, D. (2001). "Nursing history as women's history." International History of Nursing Journal 6(1): 35-47.

Sister Louise (1940). "Restoration of the Larynx." Nursing Mirror **04/05/1940**: 125.

Skinner, B. F. (1948). Walden two. New York, Macmillan.

Spock, B. (1947). Avoiding behavior problems. Washington, United States of America Departments of State and Public Institutions: Children's Bureau.

Spock, B. (1969). Common sense book of baby and child care. London, Duell Sloan.

Starrin, B. and L. Dahlgren (1997). Along the path of discovery: qualitative methods and grounded theory. Sweden, Studentlitteratur.

Steppe, H. (1997). Nursing under totalitarianism regimes: the case for national socialism. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Still, G. F. (1931). The history of paediatrics: the progress of the study of disease of children up to the end of the XVIIIth century. London, Royal College of Paediatrics and Child Health.

Strauss, A. and J. M. Corbin (1990). Basics of qualitative research: grounded theory, techniques and procedures. London, Sage Publications.

Strauss, A. and J. M. Corbin (1997). Grounded theory in practice. London, Sage Publications.

Summers, A. (1987). "Living memories." Nursing Times and Nursing Mirror **83**: 16-17.

Swanwick, M. (1983). "Platt in perspective." Nursing Times **79**(2): 5-8.

The Hospital for Sick Children Great Ormond Street Archive (02/12/1926). Nursing Committee Minutes. London.

The Hospital for Sick Children Great Ormond Street Archive (03/06/1926). Nursing Committee Minutes. London.

The Hospital for Sick Children Great Ormond Street Archive (08/12/1942). Nursing Committee Record Book Four. London.

The Hospital for Sick Children Great Ormond Street Archive (13/02/1942). Nursing Committee Record Book Four. London.

The Hospital for Sick Children Great Ormond Street Archive (1927). Entry dated 03/03/1927. Nursing Committee Minutes. London.

The Hospital for Sick Children Great Ormond Street Archive (1937). Entry dated 16/02/1938. Nursing Committee Minute Book: Volume Two: 1937. London.

The Hospital for Sick Children Great Ormond Street Archive (1937). Nursing Committee Minute Book 3: Entry for 10/02/1937. London.

Thompson, P. and R. Perks (1993). An introduction to the use of oral history in the history of medicine. London, The national life story collection (British Library).

Thornes, R. (1986). Access, accommodation and facilities for parents: a resurvey of the wards that caused concern in 1982. London, National Association for the Welfare of Children in Hospital.

Titmuss, R. (1950). Problems of social policy. London, Longmans.

Totterdell, A. (1990). Five and a half times three: the short life and death of Joe Buffalo Stuart. London, Hamish Hamilton.

Twistington-Higgins, T. (1952). Great Ormond Street 1852-1952. London, Odhams Press.

Urwin, C. and E. Sharland (1992). From bodies to minds in childcare literature: advice to parents in inter-war Britain. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

Vaughan, G. F. (1957). "Children in hospital." The Lancet **1**: 1117-1120.

Ventegodt, S. (1999). "A prospective study on quality life and traumatic events in early life: a 30 year follow up." Child: Care, Health and Development **25**(3): 213-221.

Vernon, D. T. A., J. L. Schulman and J. M. Foley (1966). "Changes in children's behaviour after hospitalization." American Journal of Diseases of the Child **111**: 581.

Viner, R. and J. Golden (2000). Children's experiences of illness. Medicine in the 20th Century. R. Cooter and J. Pickstone. Amsterdam: 575-588.

Vivian, M. M. (1919). "Hospital etiquette." Nursing Mirror and Midwives Journal **30**(761): 56-57.

Walker, P. J. (2001). Pulling the Devil's kingdom down; the Salvation Army in Victorian Britain. California, University of California Press.

Wallace, H. (1939). "Night terrors and bedwetting." Nursing Mirror **21/10/1939**: 67.

Walsh, M. and P. Ford (1989). Nursing rituals, research and rational actions. London, Heinemann.

Walsh, M. and P. Ford (1989). "We always do it this way: rituals in nursing in the surgical area examined in the light of research based evidence." Nursing Times and Nursing Mirror **85**: 26-35.

Ward, M. (1964). "What has happened in four years?" Nursing Times **22/05/1964**: 671.

Waterhouse, R. (1962). Children in hospital: a hundred years of child care in Birmingham. London, Hutchinson.

Watson, J. B. (1928). Psychological care of the infant and child. London, Allen and Unwin.

Watson, J. M. (1949). Aids to fevers for nurses. London, Bailliere, Tindall and Cox.

Weir, R. I. (1988). "Gladys Carter: an advocate for higher education for nurses." International History of Nursing Journal **4**(2): 22-27.

Weir, R. I. (2000). "Medical and nursing education in the nineteenth century: comparisons and comments." International History of Nursing Journal **5**(2): 42-7.

Welham, W. E. (1940). "Operation for strangulated hernia on a 14 day old baby." Nursing Mirror **24/02/1940**: 507.

Welsh Office (1971). Hospital facilities for children: annex to H.M.(71)22. London, Department of Health and Social Security.

Welshman, J. (1997). "Eugenics and Public Health in Britain, 1900-40: Scenes from Provincial Life." Urban History **24**(1): 56-75.

Welshman, J. (1998). "Evacuation and Social Policy During the Second World War: Myth and Reality." Twentieth Century British History **9**(1): 28-53.

Welshman, J. (1999). "Evacuation, Hygiene, and Social Policy: The Our Towns Report of 1943." Historical Journal **42**(3): 781-807.

Wenger, M. N. (1949). "Welcome at Christmas." Nursing Times **17/12/1949**: 1097.

West, C. (1854). How to nurse sick children. London, Longman.

Westminster Children's Hospital (1922). Entry for 10/12/1940. Management Committee Minutes. London.

Westminster Infants Hospital (1919). Entry dated 7/5/1919. Management Committee Minutes. London.

Whitehead, E. (1939). "Acute osteomyelitis." Nursing Times **26/08/1939**: 1060-1061.

Wiener, C. L. and W. M. Wysmans (1990). Grounded theory in medical research: from theory to practice, Swets and Zeitlinger.

Willes, G. (1997). Memories of childhood. London, The National Trust.

Williamson, D. A. J. (1990). Ninety years of service: a history of the Southampton Children's Hospital 1884-1974. Southampton, Published by author.

Williamson, L. (2001). "Entering into the spirit of nursing: holistic healers, past and present." International History of Nursing Journal **6**(1): 18-26.

Williamson, M. F. (1939). "Interesting cases series II: splenic anaemia treated by splenectomy,." Nursing Times **12/08/1939**: 1002-1003.

Winnicott, D. W. (1949). "A child's nightmare: explaining a simple psychological problem." Nursing Times **05/03/1949**: 187.

Wood, C. (1888). "A training of nurses for sick children." Nursing Record **1**(36): 507-510.

Woods, C. Q. (1987). From individual dedication to social activism: historical development of nursing professionalism. Nursing history, the state of the art. C. Maggs. London, Croom Helm.

Wright, M. (1940). "Psychological problems of the war as they affect the nurse: conversion hysteria." Nursing Mirror **24/02/1940**: 511.

Wrigley, J. (1991). "Feminists and domestic workers." Feminist Studies **17**(2): 317-330.

Yapp, C. S. (1915). Children's nursing: lectures to probationers. London, Poor Law Publications.

Yorkhill Hospitals Archive No title. YH8/3/8. Glasgow.

Yorkhill Hospitals Archive Nurses Register. Glasgow. **YH9/1/3**.

Yorkhill Hospitals Archive (1883-1891). Reports 1883-1891. Glasgow. **B2/3/1**.

Yorkhill Hospitals Archive (1903). Nurses Register. Glasgow. **YH8/1/3**.

Yorkhill Hospitals Archive (1903). Nurses Register. YH8/1/2. Glasgow.

Yorkhill Hospitals Archive (1916-1932). Nurses Register 1916-1932. Glasgow. **YH8/1/4**.

Yorkhill Hospitals Archive (1916-1932). Nurses Register 1916-1932. YH8/1/4. Glasgow.

Yorkhill Hospitals Archive (1923). Nurses Register. YH8/1/3. Glasgow.

Yorkhill Hospitals Archive (1930). A syllabus of lectures and demonstrations for education and training of nurses for sick children. YH8/3/10 GNC (Scotland). Glasgow.

Yorkhill Hospitals Archive (1930). A syllabus of lectures and demonstrations for education and training of nurses for sick children. GNC (Scotland). Glasgow.

Yorkhill Hospitals Archive (1940). Training school for nurses. YH8/3/2. Glasgow.

Yorkhill Hospitals Archive (1952). Letter to Miss Clarkson, Matron from the GNC (Scotland), 12/05/1952. YH8/8/1 GNC (Scotland). Glasgow.

Yorkhill Hospitals Archive (1973). Syllabuses for nursing. YH8/3/6 GNC (Scotland). Glasgow.

Yorkhill Hospitals Archive (1980). Letter from Jane Foulds. Journal of the Yorkhill Nurses' League. Glasgow.

Yorkhill Hospitals Archive (c. 1964). Syllabus for sick children's nursing and record of practical instruction and experience. YH8/3/5, GNC (Scotland). Glasgow.

Young, J. (1992). "Changing attitudes towards families of hospitalised children from 1935 to 1975: a case study." Journal of Advanced Nursing **17**: 1422-1429.

Yow, V. R. (1994). Recording oral history: a practical guide for social scientists. London, Sage Publications.

Bibliography

"O.G." (1940). "Book reviews." Nursing Times **08/06/1940**: 606.

Ackerknecht, E. (1982). Short history of medicine. Baltimore, John Hopkins University Press.

Alder Hey Children's Hospital Archive (1985). The Royal Liverpool Children's Hospital Myrtle Street Branch. Anonymous. Liverpool.

Alderson, J. (1983). A brief outline of the history and progress of cholera at Hull. Hull, Malet Lambert High School, Hull.

Allan, P. and M. Jolley (1982). Nursing, Midwifery and Health Visiting since 1900. London, Faber and Faber.

Allan, H. (1997). "Reflexivity: a comment on feminist ethnography... including commentary by Maggs C." NT Research **2**(6): 455-468.

Allen, P. and M. Jolley (1982). Nursing, Midwifery and Health Visiting since 1900. London, Faber and Faber.

Anderson, M. (1995). Approaches to the history of the western family 1500-1914. Cambridge, Cambridge University Press.

Anderson, J. (1995). Children in Art. London, Bracken Books.

Anonymous (1919). "A seaside hospital for tuberculous children." Nursing Mirror and Midwives Journal **30**(760): 37.

Anonymous (1919). "Appointments." Nursing Mirror and Midwives Journal **30**(762): 88.

Anonymous (1919). "The Register of the College of Nursing." Nursing Mirror and Midwives Journal **30**(764): 121.

Anonymous (1919). "Nurses' Registration Bill." Nursing Mirror and Midwives Journal **30**(765): 139.

Anonymous (1919). "Surgical home for boys, Banstead." Nursing Mirror and Midwives Journal **30**(770): 245.

Anonymous (1920). "The Cripples Hospital at Alton." Nursing Mirror and Midwives Journal **30**(775): 320.

Anonymous (1920). "The Queen's Hospital for Children, Bethnal Green." Nursing Mirror and Midwives Journal **30**(778): 376.

Anonymous (1920). "An asphyxiated baby." Nursing Mirror and Midwives Journal **30**(780): 410.

Anonymous (1920). "A new matron at Great Ormond Street Hospital." Nursing Mirror and Midwives Journal **30**(782): 441.

Anonymous (1920). "Appointments." Nursing Mirror and Midwives Journal **30**(783): 470.

Anonymous (1920). "Death of Mrs Humphy Ward." Nursing Mirror and Midwives Journal **31**(784): 1.

Anonymous (1920). "The foundling hospital." Nursing Mirror and Midwives Journal **31**(785): 33.

Anonymous (1920). "Princess Mary's gift to the children's hospital." Nursing Mirror and Midwives Journal **32**(811): 21.

Anonymous (1920). "Appointments." Nursing Mirror and Midwives Journal **32**(818): 165.

Anonymous (1920). "How the Alexandra children went into the country." Nursing Mirror and Midwives Journal **32**(819): 177.

Anonymous (1920). "Advertisement." Nursing Mirror and Midwives Journal **32**(820): iv.

Anonymous (1920). "A new matron from Great Ormond Street Hospital." Nursing Mirror and Midwives Journal **30**(782): 441.

Anonymous (1949). "For the student nurse: final examination in sick children's nursing." Nursing Times **22/12/1945**: 854.

Antrobus, S. and A. Kitson (1999). "Nursing leadership: influencing and shaping health policy and nursing practice." Journal of Advanced Nursing **29**(3): 746-754.

Arendell, T. (2000). "Conceiving and investigating motherhood: the decade's scholarship." Journal of Marriage and Family **62**(4): 1192-1208.

Aries, P. (1962). Centuries of Childhood. London, Cape.

Armstrong, G. (1777). An account of the diseases most incident to children, from their birth till the age of puberty; with a successful method of treating them. To which is added, An essay on nursing, also a general account of the Dispensary for the Infant Poor, from its first institution in 1769 to the present time. London, T. Cadell.

Armstrong, K. F. (1939). "The Royal College of Nursing." Nursing Times **35**(1784): 841.

Arton, M. E. (1982). "Children first and always: the story of nurse training at the hospital for sick children." Nursing Times **06/10/1982**: 1687-1688.

Arton, M. E. (1985). "A separate identity." Nursing Times **81**(17): 50.

Arton, M. E. (1996). "The caretaker General Nursing Council and sick children's nursing 1920-1923." Bulletin of the History of Nursing **2**(1): 5.

Ashton, E. (1920). "The feeding of infants and young children." Nursing Mirror and Midwives Journal **31**(804): 348.

Association of British Paediatric Nurses (1984). Sick children's nursing: the way forward. London, Nurse Teacher Group, ABPN.

Aston, M. (1977). Always with children. Pittsburgh, Dorrance Publishing Co. Inc.

Astruc, J. (1746). A general and compleat treatise on all the disease incident to children, from their birth to the age of fifteen with particular instruction to tender mothers prudent midwives and careful nurses. The whole made familiar to every capacity., Joh.

Atherton, T. (1993). "Child-care nursing: the faltering steps." Nursing Standard 7(21): 50-51.

Atkinson, B. A. (1981). "Paediatrics Past." Nursing Times **77**(50): ABPN 1-2.

Ballin, A. (1902). From cradle to school, a book for mothers. London, Constable.

Baly, M. E. (1980). Nursing and social change. London, Heinemann Medical.

Barlow, S., H. Lewer and A. Tucker (1985). "Children are different." Nursing Times **81**(17): 51-54.

Barlow, S. and M. Swanwick (1994). "Supplementary benefits." Paediatric Nursing 6(3): 16-17.

Bartrip, P. W. J. (1990). Mirror of medicine: history of the British Medical Journal. Oxford, Oxford University Press.

Bates, S. M. (1971). Practical paediatric nursing. Oxford, Blackwell Scientific Publications.

Beattie, J. (1990). "The future of paediatric nursing." Nursing 4(16): 29-31.

Bendall, E. R. D. and E. A. Raybould (1969). A history of the General Nursing Council for England and Wales. London, H.K. Lewis and Co. Ltd.

Besser, F. S. (1977). "Great Ormond Street Anniversary." Nursing Mirror **144**(6): 60-63.

Bett, W. R. (1940). A short history of nursing. London, Faber.

Binet, A. and T. Simon (1905). "New methods for the diagnosis of the intellectual levels of subnormals." Annals of Psychology **11**(191): 444-459.

Birkenhead and Wirral Children's Hospital (1941). "Appointments." Nursing Times **12/04/1941**: Supplement v.

Blackman, R. J. (1920). The care of children. London, The Scientific Press Ltd.

Booth Hall Hospital for Sick Children (1956). "Appointments." Nursing Times **24/08/1956**: Supplement xxv.

Bourdillon, H. (1988). Women as healers: a history of women and medicine. Cambridge, Cambridge University Press.

Bowman, G. (1967). The lamp and the book: the story of the RCN 1916-1966. London, The Queen Anne Press Ltd.

Brimblecombe, F. S. W., M. P. M. Richards and N. R. C. Roberton (1978). Separation in special care baby units. London, Spastics International Medical Publications.

British Paediatric Association and the British Association of Paediatric Surgeons (1980). Children's wards and their nurse staffing in the UK 1980. London, BPA.

Brockington, C. F. (1966). A short history of public health. London, Churchill.

Brooke, H. (1997). Medicine women. London, Harper Collins.

Brown, M. (1940). "The health visitor and the community." Nursing Mirror **06/04/1940**: 21.

Bryder, L. (1992). Buttercup, clover and daisies. In the name of the child: health and welfare. R. Cooter. London, Routledge.

Buchan, W. (1769). Domestic medicine. Edinburgh, Balfour, Auld and Smellie.

Buchan, W. (1803). Advice to mothers on the subject of their own health and the means of promoting the health, strength and beauty of their offspring. London, Cadell and Davis.

Buchanan, M. (1983). "The sick child." Nursing Times 79(8): 66-69.

Bull, T. (1837). Hints to mothers. London, Longman.

Bull, T. (1840). Maternal management of children in health and disease. London, Longman.

Bullough, V. L. and B. Bullough (1979). The care of the sick: the emergence of modern nursing. London, Croom Helm.

Burdett, H. (1920). "Death of Mrs Humphry Ward." Nursing Mirror and Midwives Journal **31**(784): 1.

Burdett, H. (1920). "Hospital for sick children." Nursing Mirror and Midwives Journal **30**(771): 257.

Burdett, H. (1920). "the Cripples Hospital at Alton." Nursing Mirror and Midwives Journal **30**(775): 320.

Burdett, H. (1920). "The Queen's Hospital for Children, Bethnal Green." Nursing Mirror and Midwives Journal **30**(778): 376.

Burling, K. A. (1969). "Emotional responses of hospitalised children: results of a pulse monitor study." Clinical Pediatrics **8**(11): 641-646.

Burnby, J. G. L. (1983). A study of the English apothecary from 1660-1760. London, Wellcome Institute.

Burr, S. (1987). "Paediatric nursing: past, present and future." Journal of the Royal Society for Health **107**(4): 155-156 and 158.

Burr, S. (1991). "The wider view (greater integration between hospital and community services for children)." Paediatric Nursing **3**(5): 9-10.

Buxbaum, E. (1951). Your child makes sense, a guidebook for parents. London, Allen and Unwin.

Bynum, W. F. (1993). Companion encyclopaedia of the history of medicine. London, Routledge.

Bynum, W. F. (1994). Science and the practice of medicine in the nineteenth century. Cambridge, Cambridge University Press.

Cadogan, W. (1748). Essay on the nursing and management of children. London, John Knapton.

Calder, J. M. (1963). The story of nursing. London, Methuan.

Callery, P. and L. Smith (1991). "A study of role negotiation between nurses and the parents of hospitalised children." Journal of Advanced Nursing **16**: 772-781.

Campbell, S. and P. Summersgill (1993). "Keeping it in the family." Child Health **1**(1): 17-20.

Campling, S. (1966). Foundations of the welfare state. Edinburgh, Addison Wesley Longman Ltd.

Campling, S. and J. Allsop (1995). Health policy and the NHS. New York, Longman.

Carpenter, S. (1980). "Observations of mothers living in on a paediatric ward." Journal of maternal and child health **5**(10): 368-373.

Cartwright, F. F. (1977). A social history of medicine. London, Longman.

Cassatt, M. (1995). Paintings. London, Leopard Books.

Cassedy, J. H. (1992). Medicine in America, a short history. Baltimore, John Hopkins University Press.

Chavasse, P. H. (1839). Advice to mothers. London, Longman.

Chavasse, P. H. (1869). Counsel to mothers. London, Churchill.

Cleverley, J. and D. C. Phillips (1986). Visions of childhood, influential models from Locke to Spock. New York, Teachers College Press.

Clothier, C. (1994). The independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven hospital during the period February to April 1991. London, HMSO.

Cohn, V. (1981). "Sister Kenny's Fierce Fight for Better Polio Care." Smithsonian **12**(8): 180-200.

Combe, A. (1840). Treatise on the physiological and moral management of infancy. Edinburgh, Maclachlan.

Connor, B. (1977). "Recollections of speciality nursing in war-time Lancashire." International History of Nursing Journal 3(1): 69-78.

Consumer Association (1980). Children in hospital. London, Consumer Association.

Cooter, R. (1992). In the name of the child: health and welfare, 1880-1940. London, Routledge.

Cooter, R. (1993). Surgery and society in peace and war: orthopaedics and the organisation of modern medicine, 1880-1948. London, Macmillan Press.

Cope, Z. (1961). Six disciplines of Florence Nightingale. London, Pitman.

Council, G. N. (1969). Syllabus for subjects for examination and record of practical instruction and experience for the certificate of the nursing of sick children. London, GNC.

Court, D. and A. Jackson (1972). Paediatrics in the seventies: developing the child health services. London, Nuffield Provincial Hospitals Trust and Oxford University Press.

Coyne, I. T. (1995). "Parental participation in care: a critical review of the literature." Journal of Advanced Nursing **21**: 716-722.

Coyne, I. T. (1996). "Parent participation: a concept analysis." Journal of Advanced Nursing **23**(4): 733-740.

Creighton, C., D. F. C. Eversley, E. A. Underwood and L. Ovenall (1965). A history of epidemics in Britain. London, Cass.

Crosby, T. L. (1986). The Impact of Civilian Evacuation in the Second World War. Wolfeboro, N.H., Croom Helm.

Cule, J. (1986). Child care through the centuries: an historical survey from papers given at the Tenth British Congress on the History of Medicine. London, STS Publishers.

Cule, J. (1997). The history of medicine. Medicine, a history of healing: ancient traditions to modern practices. R. Porter. New York, Marlow and Company.

Cunningham, H. (1991). The children of the poor: representations of childhood since the seventeenth century. Oxford.

Dainton, C. (1961). The story of England's hospitals. London, Museum Press Ltd.

Dally, A. (1997). Medicine in the sixteenth to nineteenth centuries. Medicine, a history of healing: ancient traditions to modern practices. R. Porter. New York, Marlowe and Company.

Darbyshire, P. (1993). "Parents, nurses and paediatric nursing: a critical review." Journal of Advanced Nursing **18**(11): 1670-1680.

Darbyshire, P. (1994). Living with a sick child in hospital: an experience of parents and nurses. London, Chapman and Hall.

Davies, C. (1980). Rewriting nursing history. London, Croom Helm.

Davin, A. (1996). Growing up poor: home, school and street life in London 1870-1914. London, Rivers Oram Press.

Davis, A. B. (1981). Medicine and its technology: an introduction to the history of medical instrumentation. London, Greenwood Press.

Department of Education and Science (1978). Special educational needs: report of the Warnock Committee on the inquiry into the education of handicapped children and young people. London, HMSO.

Derbyshire Children's Hospital Archive (1888). Eleventh Annual Report of the Derbyshire hospital for sick children, north Street, Duffield Road, Derby 1888. Annual Reports. Derby.

Dickens, C. (1984). A Christmas carol. Harmondsworth, Penguin.

Dietz, L. D. (1963). History and modern nursing. Philadelphia, F.A. Davis Co.

Dock, L. L. and I. I. Stewart (1938). A short history of nursing from the earliest times to the present day. New York, Putman GP.

Dolan, J. A. (1963). Goodnow's history of nursing. Philadephia, W.B. Saunders Company.

Donaldson, P. (1990). Yes matron, history of nurses and nursing at the Royal Victoria Hospital, Belfast. Belfast, White Row Press.

Donnison, J. (1988). Midwives and medical men: a history for the struggle for the control of childbirth. London, New Barnett Historical Publications.

Dopson, L., E. Parker, C. Maggs, P. Nuttall and S. Kirby (1998). "Reflections on the life of Monica Baly." International History of Nursing Journal 4(2): 41-45.

Douglas, J. B. W. (1975). "Early hospital admission and later disturbance of behaviour and learning." Developmental Medical Child Neurology **17**: 456-480.

Drummond, W. B. (1901). The child, his nature and nurture. London, Dent.

Duncombe, M. A. (1951). "Daily visiting in children's wards." Nursing Times **47**: 587-588.

Duncombe, M. A. and B. Weller (1969). Paediatric nursing. London, Bailliere Tindall and Casell.

Edgeworth, M. and R. Lovell (1789). Essays on practical education. London, Johnson.

Editorial (1919). "A mother's devotion." Nursing Mirror and Midwives Journal **30**(760): 47.

Editorial (1920). "The home for blind babies at Chorley Wood." Nursing Mirror and Midwives Journal **31**(793): 163.

Editorial (1920). "Lord Mayor Trelor Cripples Hospital." Nursing Mirror and Midwives Journal **31**(793): 168.

Editorial (1920). "The Leaslow Hospital for Crippled Children." Nursing Mirror and Midwives Journal **21**(808): 417.

Editorial (1920). "A convalescent home for children." Nursing Mirror and Midwives Journal **31**(805): 366.

Editorial (1940). "Picture editorial." Nursing Times **23/03/1940**: 308-309.

Editorial (1949). "The Institute of Medical psychology." Nursing Times **29/01/1949**: 98.

Ellis, S. (1843). The mothers of England, their influence and their responsibility. London.

English National Board (1992). A survey to identify progress made towards meeting the requirements of ENB circular 1998/53/RMHLV - supervision of students gaining nursing experience in children's wards. London, ENB.

Erikson, E. H. (1968). Identity, youth in crisis. New York, Norton.

Evans, P. (1970). "A hundred years of children's hospitals: the centenary of the Evelina Hospital for Sick Children." Proceedings of the Royal Society of Medicine **63**: 44-46.

Evans, P. (1989). "Paediatrics at Kings College Hospital 50 years ago." Archives of Diseases in Childhood **64**: 1329-1331.

Fagermoen, M. S. (1995). "The meaning of nurses' work: a descriptive study of values fundamental to professional identity in nursing." University Of Rhode Island **318**.

Fairfax-Lucy, A. (1983). The mistress of charlecote. London, Victor Gollancz.

Fleetwood, J. F. (1983). History of medicine in Ireland. Ireland, Skelling Press.

Ford, J. (1945). "Signs of illness in children." Nursing Times **01/12/1945**: 790-791.

Ford, J. M. T. (1987). A medical student at St. Thomas' Hospital, 1801-1802. London, Wellcome Institute for the History of Medicine.

Forsberg, R. (1985). Means test kid. Beverley, Hutton Press Ltd.

Fradd, E. (1990). "Setting up a community paediatric service." Senior Nurse **10**(7): 4-7.

Fradd, E. (1992). "The evolution of the RSCN." Journal of Clinical Nursing **1**: 309-314.

Franklyn, A. W. (1964). Children's hospitals. The evolution of hospitals in Britain. F. Poynter. London, Pitman Medical.

Frazer, W. M. (1950). A history of English public health, 1834-1939. London, Bailliere and Cox.

Friedlander, W. J. (1992). Golden wand of medicine: history of the Caduceus symbol in medicine. London, Greenwood Press.

Gegson, J. (1992). "The child branch: a view from the front." Paediatric Nursing **4**(4): 6-7.

General Nursing Council (1975). Teachers of Nursing, 1975. London, GNC.

Glasper, A. (1993). "Back to the future: innovatory trends in paediatric nursing." Child Health **1**(3): 93-96.

Glasper, A. (1995). "The value of children's nursing in the third millennium." British Journal of Nursing **4**(1): 27-30.

Glasper, E. A. and I. Charles-Edwards (2002). "The child first and always: the registered children's nurse over 150 years Part one." Paediatric Nursing **14**(4): 38-42.

Glavin, E. J. (1940). "Calling male nurses." Nursing Times **30/03/1940**: 344.

Glen, S. A. (1982). "Hospital admission through the parents' eyes." Nursing Times **78**: 1321-1323.

Golden, J. (1996). Social history of wet nursing in America: from breast to bottle. Cambridge, Cambridge University Press.

Goodnow, M. (1953). Nursing history. Philadelphia, Saunders.

Gough, P. (1994). "Widening the gate." Paediatric Nursing **6**(10): 6.

Great Ormond Street Hospital Archive (1927). Entry dated 02/06/1927. Nursing Committee Minutes. London.

Great Ormond Street Hospital Archive (1936). Entry dated 14/10/1936. Nursing Committee Minute Book Volume One 1935-1936. London.

Great Ormond Street Hospital Archive (1940). Entry dated 11/06/1940. Nursing Committee Minute Book, Volume Three: 1939. London.

Great Ormond Street Hospital Archive (1942). Entries dated 13/07/1942. Nursing Committee Record Book, Number Four: 1942. London.

Grell, P. P. (1993). Medicine and the reformation. London, Routledge.

Griffin, G. J., J. K. Griffin and D. M. Jenson (1973). History and trends of professional nursing. Saint Louise, Mosby.

Guillemin, J. H. and L. L. Holstrom (1986). Mixed blessings: intensive care for newborns. Oxford, Oxford University Press.

Haller, J. A., J. L. Talbert and R. H. Dombro (1967). The hospitalized child and his family. Baltimore, John Hopkins Press.

Hallum, P. (1991). Gavin. This is our child. A. Cooper and V. Harpin. Oxford, Oxford University Press.

Hardy, G. and W. Rathbone (1981). William Rathbone and the early history of district nursing. Ormskirk, Hesketh.

Hardyment, C. (1984). Dream babies. Oxford, Oxford University Press.

Harland, M. (1886). Common sense in the nursery. Glasgow, Morison.

Harris, P. J. (1980). "Children in hospital (part 1)." Nursing Times 77: 1744-1746.

Harris, P. J. (1980). "Children in hospital (part 2)." Nursing Times 77: 1803-1804.

Harris, P. J. (1980). "Children in hospital (part 3)." Nursing Times 77: 1849-1850.

Harris, P. J. (1980). "Children in hospital (part 4)." Nursing Times 77: 1893-1894.

Harris, P. J. (1980). "Children in hospital (part 5)." Nursing Times 77: 1936-1937.

Harvey, S. and A. Hales-Took (1972). Play in hospital. London, Faber and Faber.

Hay, I. (1953). One hundred years of army nursing: the story of the British Army Nursing Service from the time of Florence Nightingale to the present day. London, Cassell.

Hayes, V. and J. E. Knox (1983). "Reducing hospital related stress in parents of children with cancer." The Canadian Nurse 79(10): 24-28.

Hayes, J. S. and J. Vessey (2000). "Back to the Future? A New Millennium in Pediatric Nursing Research." Pediatric Nursing **26**(1): 91.

Health, A. C. a. t. D. o. (1993). Children first: a study of hospital services. London, HMSO.

Hector, W. (1970). Mrs Bedford Fenwick. London, Royal College of Nursing.

Hendrick, H. (1992). Child labour, medical capital, and the school medical service c. 1890-1918. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

Heywood-Jones, I. (1981). "The largest family in the world." Nursing Times **77**(41): 513-518.

Hill, L. (1918). "Infant mortality and garden cities." Child **9**: 489.

Hocking, J. (1992). "Don't ask me I'm only the client (children are being sent to adult psychiatric wards)." Social Work Today **23**: 13.

Hogg, C. (1994). Setting standards for children undergoing surgery. London, Action for Sick children.

Holt, L. M. (1894). Care and feeding of children. New York, Appleton.

Honigsbaum, F. (1979). Division in British medicine: history of the separation of general practice from hospital care, 1911-1968. London, J. Kingsley Publishers.

Houghton, M. and M. Whittow (1965). Aids to practical nursing. London, Bailliere Tindall and Cox.

Hudson, J. A. (1968). Images of nurses perspectives from history, art and literature. Pennsylvania, University of Pennsylvania.

Hutt, R. (1984). "Issues and problems." Nursing Times **18**(13): 51-52.

Jackson, Q. M. (1952). A handbook of paediatrics for nurses in general training. London, H.K. Lewis and Co. Ltd.

Jackson, Q. M. (1998). "Oldchurch County Hospital, Romford." International History of Nursing Journal **3**(3): 55-56.

James, A., C. Jenks and A. Prout (1998). Theorizing childhood. Cambridge, Polity Press.

Jamieson, E. M. and M. F. Sewall (1949). Trends in nursing history. Philadelphia, W.B. Saunders Co.

Jenks, C. (1996). Childhood. London, Routledge.

Jenson, D. M., J. F. Spalding and E. L. Cady (1959). History and trends of professional nursing. Saint Louise, Mosby.

Jolly, J. (1981). The other side of paediatrics: a guide to the everyday care of sick children. London, MacMillan Education Ltd.

Jones, O. V. (1984). Progress in medicine: history of the Caernarfon and Anglesey Infirmary, 1809-1948. Wales, Gomer Press.

Kelsey, A. (2002). "Health care for all children: the beginnings of school nursing 1904-1908." International History of Nursing Journal 7(1): 4-11.

Kennedy, D. A. (1940). The care and nursing of the infant (for Infant Welfare Workers and Nursery Nurses). Heinemann, London.

Keown, J. (1988). Abortion, doctors and the law, some aspects of the legal regulations of abortion in England from 1803 to 1932. Cambridge, Cambridge University Press.

Kerr, J. (1919). "Tuberculosis and schools." Child **10**: 149-150.

Kimpton, D. (1990). A special child in the family: living with your sick or disabled child. London, Sheldon Press.

Kinnaird, J. (1960). Matrons and nurses. The Royal Edinburgh Hospital for Sick Children. D. Guthrie. Edinburgh, Churchill Livingstone.

Kiple, K. (1997). Plague, pox and pestilence: disease in history. London, Phoenix Illustrated.

LaBerge, A. F. (1991). "Mothers and Infants, Nurses and Nursing: Alfred Donne and the Medicalization of Child Care in Nineteenth-Century France." Journal of the History of Medicine and Allied Sciences 46(1): 20-43.

Lawrence, C. (1995). "A partnership in care (the role of the nurse in integrating care for the child and family)." Practice Nursing 6(14): 16-18.

Lawrence, S. C. (1996). Charitable knowledge: hospital pupils and practitioners in eighteenth century London. Cambridge, Cambridge University Press.

Leach, M. M. (1956). Paediatrics for the general hospital nurse. London, Faber and Faber.

Lederer, S. E. (1992). Orphans as guinea pigs. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

Lederer, S. E. (1995). Subjected to science: human experimentation in America before the Second World War. Baltimore, John Hopkins University Press.

Lee, S. (1995). Medicine and public health. London, Longman.

Locke, J. (1996). Some thoughts concerning education and of the conduct of the understanding. Cambridge, Hackett.

Love, H. (1998). The Royal Belfast Hospital for Sick Children. Belfast, Blackstaff Press.

Lyons, A. S. and M. Keiner (1987). The dark ages. Medicine: an illustrated history. A. S. Lyons and R. J. Petrocelli II. New York, HN Abrams inc.

Lyons, A. S. and R. J. Petrocelli II (1987). Medicine: an illustrated history. New York, HN Abrams Inc.

MacCarthy, M. (1985). A nineteenth century childhood. London, Constable.

MacDonald, I. (1939). "Letter." Nursing Times **01/07/1939**: 820-821.

Mackintosh, C. (1997). "A historical study of men in nursing." Journal of Advanced Nursing **26**(2): 232.

Maggs, C. J. (1981). "The register of nurses in the Scottish Poor Law service, 1885-1919." Nursing Times **77**: 129-132.

Maggs, C. J. (1984). "A new history of nursing: the world is your oyster... the turn of the century... part 4." Nursing Times **80**(47): 49-51.

Maggs, C. J. (1984). "A new history of nursing: changing perspectives... part 1." Nursing Times **80**(38): 28-31.

Maggs, C. J. (1984). "A new history of nursing: made, not born... part 2." Nursing Times **80**(38): 31-34.

Maggs, C. J. (1985). "A new history of nursing: the state of the art." Nursing Times **81**(33): 36-37.

Maggs, C. J. (1987). "The unquiet revolution." Nursing Times **83**(47): 28-29.

Maggs, C. J. (1987). Nursing history: the state of the art. London, Croom Helm.

Maggs, C. J. and F. Rapport (1995). "Oral history and content analysis using Ethnograph." International History of Nursing Journal **1**(2): 29-38.

Maggs, C. J. (1996). "Editorial... Nursing, Women's History and the Politics of Welfare Conference held at the University of Nottingham, England." International History of Nursing Journal **2**(1): 3-4.

Maggs, C. J. (1996). "Towards a history of nursing... version of a lecture delivered to the Diploma in Medical History Course, Royal Society of Apothecaries, London, 1996." International History of Nursing Journal **1**(4): 88-92.

Maggs, C. J. (1996). "A history of nursing: a history of caring?" Journal of Advanced Nursing **23**(3): 630-635.

Maggs, C. J. (1998). "The Royal National Pension Fund for Nurses: a noble contribution." International History of Nursing Journal 3(3): 61-62.

Maggs, C. J. (1998). "The Royal National Pension Fund for Nurses: a noble contribution." International History of Nursing Journal 3(3): 61-62.

Manchester Children's Hospital (Pendlebury) (1920). "Advertisement." Nursing Mirror and Midwives Journal 32(812): v.

Mangan, P. (1993). "A dream ticket?" Nursing Times 89(29): 26-27.

Marks, S. (1997). The legacy of the history of nursing for post-apartheid South Africa. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

McGann, S. (1992). The battle of the nurses. London, Scutari Press.

Medical Research Council (1991). The ethical conduct of research on children. London, MRC.

Miles, I. (1985). "A new history of nursing: a suitable case for treatment, sick children's nursing." Nursing Times 81(18): 48-50.

Miles, I. (1986). "The emergence of sick children's nursing Part 1: sick children's nursing before the turn of the century." Nurse Education Today 6: 82-87.

Miles, I. (1986). "The emergence of sick children's nursing, part 2." Nurse Education Today 6: 133-138.

Moller, L. (1968). "The difficult mum." Nursing Mirror 05/04/1968: 41-42.

Moss, W. (1794). An essay on the management, nursing and diseases of children from the birth, and on the treatment and disease of pregnant and lying in women, with remarks on the domestic practice of medicine. London, C. Boult.

Mrs Sumner (1909). Nursery training: a book for nurses. London, Warren and Sons.

Murphy, G. (1990). "Promoting child health." Paediatric Nursing 2(2): 21-22.

Mussen, P. H., J. J. Conger and J. Kagan (1963). Child development and personality. New York, Harper and Row.

Neill, C. A. (1995). Developing heart: history of pediatric cardiology. London, Kluwer Academic Publishers.

Nelson, J. (1753). An essay on the government of children under three general heads, viz. health, manners, and education by James Nelson, apothecary, just as the twig is bent the tree's inclined. London, Pope.

Newby, M. (1987). Sick children's hospital nursing in nineteenth century Britain. Bath, Bath History Inc.

Newman, M. (1991). "The focus of the discipline of nursing." Advances in Nursing Service 14(1): 1-6.

Newsom, J. and E. Newsom (1963). Infant care in an urban community. London, Allen and Unwin.

O'Neill, R. (1996). The art of Victorian childhood. Bristol, Parragon.

Oswin, M. (1971). The empty hours. London, Allen Lane.

Oswin, M. (1978). Children living in long stay hospitals. London, Heinemann Medical Books Ltd.

Paget, J. (1874). Letter. The Times. London: 10.

Palmer, S. (1993). "Care of sick children by parents: a meaningful role." Journal of Advanced Nursing 18: 185-191.

Parker, E. and J. Colson (1995). "Equity and discrimination." Paediatric Nursing 7(1): 10-12.

Patterson, D. (1930). Sick children, diagnosis and treatment. London, Cassell and Company Ltd.

Patterson, D. and J. Forrest-Smith (1940). Modern methods of feeding in infancy and childhood. London, Constable and Co. Ltd.

Pavey, A. E. (1959). The story of the growth of nursing. London, Faber.

Pearce, P. and B. Fairfax-Lucy (1995). The children of charlecote. London, Gollancz Children's Paperbacks.

Pickstone, J. V. (1985). Medicine and Industrial Society: a history of hospital development in Manchester and its region, 1752-1946. Manchester, Manchester University Press.

Plank, E. (1964). Working with children in hospital. London, Tavistock.

Porter, R. (1992). "The poverty of professionalism: a critical analysis of strategies for the occupational advancement of nursing." Journal of Advanced Nursing 17(6): 720-726.

Porter, R. (1996). Medicine. Cambridge, Cambridge University Press.

Poynter, F. (1964). Evolution of hospitals in Britain. London, Pitman Medical.

Price, F. W. (1946). A textbook of the practice of medicine. London, Oxford University Press.

Price, J. (1984). Miss Nightingale's vision of a nursing profession: an interim report of the Third Winifred Raphael Memorial Lecture. London, Royal College of Nursing.

Price, S. (1992). "The child branch." Paediatric Nursing 4(2): 6-8.

Price, S. (1993). "Children's nursing, lessons from the past." Nursing Standard 7(50): 31-35.

Prince, J. (1983). The third Winifred Rapael Memorial Lecture: Miss Nightingale's vision of a nursing profession, an interim report. London, Royal College of Nursing.

Pringle, M. K. (1975). The needs of children. London, Hutchinson.

Quinton, D. and M. Rutter (1976). "Early hospital admissions and later disturbances of behaviour." Developmental Medical Child Neurology **18**: 447-459.

Rafferty, A. M., N. Allcock and J. Lathlean (1996). "The theory/practice 'gap': taking issue with the issue." Journal of Advanced Nursing **23**(4): 685.

Rafferty, A. M., J. Robinson and R. Elkan (1997). Introduction. Nursing history and the politics of welfare. A. M. Rafferty, J. Robinson and R. Elkan. London, Routledge.

Rafferty, A. M. (2000). Nurses. Medicine in the twentieth century. R. Cooter and J. Pickstone. Amsterdam, Harwood Academic Publishers: 519-529.

Ramsey, W. R. (1920). Care and feeding of infants and children. Philadelphia, Lippincott Company.

Rayner, C. (1959). "Letters." Nursing Times **15/05/1959**: Letters page.

Robertson, J. (1958). Young children in hospital. London, Tavistock Publications.

Robertson, P. (1974). Home as a nest: middle class children in nineteenth century Europe. The history of childhood: the evolution of parent child relationships as a factor in history. L. DeMause. London, Souvenir Press.

Rosenberg, C. E. (1974). Explaining epidemics and other studies in the history of medicine. Cambridge, Cambridge University Press.

Rosser, C. and C. C. Harris (1965). The family and social change. London, Routledge and Kegan Paul.

Rothman, D. (1971). "Documents in search of a historian: towards a history of children and youth in America." Journal of Interdisciplinary History **2**: 369.

Rousseau, J. J. (1762). Emile, ou l'education. Amsterdam and London, T. Bechet.

Royal College of Nursing (1942). Nursing Reconstruction Committee Report (Horder). London, RCN.

Royal College of Physicians of London (1964). A history of the Royal College of Physicians of London. Oxford, Clarendon.

Rutty, J. E. (1998). "The nature of philosophy of science, theory and knowledge relating to nursing and professionalism." Journal of Advanced Nursing **28**(2): 243-251.

Sacharin, R. M. and M. H. S. Hunter (1964). Paediatric nursing procedures. Edinburgh, Livingstone.

Sackett, D. L. and W. M. C. Rosenberg (1995). "On the need for evidence based medicine." Journal of Public Health Medicine **17**(3): 330-334.

Sainsbury, C. P. Q. (1986). "Care by parents of the children in hospital." Archives of Diseases in Childhood **61**(6): 612-615.

Save the children fund (1989). Hospital, a deprived environment for children? The case for hospital playschemes. London, StCF.

Saxton, J. (1981). "Paediatric nursing: an historical view." Nursing Times (Spotlight on Children) **77**(50): 4-7 (ABPN).

Seidler, E. (1989). A historical survey of children's hospitals. The hospital history. L. Granshaw and R. Porter. London, Routledge.

Seymer, L. R. (1932). A general history of nursing. London, Faber and Faber.

Shahar, S. (1990). Childhood in the middle ages. London, Routledge.

Shannon, F. T., D. M. Fergusson and M. E. Dimmond (1984). "Early hospital admissions and subsequent behaviour problems in 6 year olds." Archives of Diseases in Childhood **59**: 815-819.

Sharkey, P. W. (1993). Philosophical examination of the history and values of western medicine. Canada, E Mellen Press.

Shaw, M. (1989). "Paediatric care then and now." Nursing Standard **47**(3): 35-37.

Sheppard, J. (1991). Guide to the contemporary medical archives centre of the Wellcome Institute for the History of Medicine. London, Wellcome Institute.

Shorter, E. (1990). Women's bodies: a social history of women's encounter with health, ill-health and medicine. USA, Transaction Publishers.

Shrand, H. (1964). "Home care scheme for sick children." Nursing Times **28/08/1964**: 1113-1116.

Sigerist, H. E. (1987). A history of medicine. Oxford, Oxford University Press.

Singer, C. J. and E. A. Underwood (1962). A short history of medicine. Oxford, Clarendon.

Smith, H. (1772). Letters to married women on nursing and the management of children (cited in Hardyment 1995). London, C and G Kearsley.

Smith, E. A. (1967). "Lack of progress." Nursing Mirror **10/11/1967**: 151.

Society of Registered Male Nurses (1945). "For male nurses." Nursing Times **12/05/1945**: 312.

Spitz, R. (1945). "Hospitalism." Psychoanalytic Study of the Child **1**: 53-74.

Steedman, C. (1992). Bodies, figures and physiology. In the name of the child: health and welfare, 1880-1940. R. Cooter. London, Routledge.

Stewart, I. M. and A. L. Austin (1962). A history of nursing from ancient to modern times, a world view. New York, G.P. Putman.

Stickweh, R. (1997). "Professions in modern society." International Review of Sociology 7(1): 95-13.

Stocks, M. (1960). A hundred years of district nursing. London, Allen and Unwin.

Stone, L. (1990). The family, sex and marriage in England 1500-1800. Harmondsworth, Penguin.

Stoppard, M. (1977). Mariam Stoppard's book of baby care. London, Weidenfeld and Nicholson.

Storey, G. O. (1992). History of physical medicine: story of the British Association of Rheumatology and Rehabilitation. London, Royal Society of Medicine.

Sully, J. (1895). Studies of childhood. London, Longman.

Sweet, S. J. and I. J. Norman (1995). "The nurse-doctor relationship: a selective literature review." Journal of Advanced Nursing **22**(1): 165-70.

Taylor, J. (1997). "The Ladies Committee of the Woman's Hospital, Castlegate, Nottingham 1880-1900." International History of Nursing Journal **2**(4): 38-47.

Underwood, M. (1784). A treatise on the diseases of children, with directions for the management of infants from the birth; especially such as are brought up by hand, London.

United Nations (1989). Conventions on the rights of the child. Geneva, United Nations.

Verbov, J. (1999). "Letter." The Lancet **354**: 1214.

Wattie, N. (1949). "The effect of recent legislation on the health of mothers and children." Nursing Times **27/08/1949**: 715.

Webb, N., D. Hull and R. Madely (1985). "Care by parents in hospital." British Medical Journal **291**(20): 176-177.

Weindling, P. (1992). From isolation to therapy: children's hospitals and diphtheria in fin de siecle Paris, London and Berlin. In the name of the child: health and welfare 1880-1940. R. Cooter. London, Routledge.

Wellcome Institute for the History of Medicine (1664). Children's diseases both outward and inward. From the time of their birth to fourteen years of age. With their natures, causes, signs presages and cures. The resolutions of many profitable questions concerning children, and of nurses. Staresmare, J. London.

Wellcome Institute for the History of Medicine (1992). Medical theory, surgical practices: studies in the history of surgery. London, Wellcome Institute.

Which? (1980). Children in hospital: campaign report. London, Which?

White, R. (1978). Social change and the development of the nursing profession: a study of the poor law nursing service 1848-1948. London, Henry Kimpton.

Whiting, R. (1994). "Meeting needs: RSCNs in the community." Paediatric Nursing 6(1): 9-11.

Woods, R. (1995). The population in Britain in the nineteenth century. Cambridge, Cambridge University Press.

Young, D. G. and E. J. Martin (1979). Young and Weller's baby surgery. Aylesbury, HM and M Publishers.

Zelizer, V. A. (1985). Pricing the priceless child: the changing value of children. New York, Basic books.

Archival sources

Alder Hey Hospital, Liverpool

Alder Hey Nurses' League, Alder Hey hospital library, Liverpool.

Ross JS (1964), Alder Hey Children's Hospital souvenir brochure 1914-1964, Alder Hey Children's Hospital library, Liverpool.

Derby Children's Hospital

Almanac (1882), The Children's Hospital, Derby.

Anon (1878), First report (to 30th June 1878) of the Derbyshire Hospital for Sick Children, Derby, Derbyshire children's hospital archive, Derby.

Children's Hospital photographs 1877-1949 (1949), Derbyshire Hospital for Sick Children archive, Derby.

Coming into Hospital, Published by the Tavistock Institute (Central Council for Education), Reference L58/30m/4,56/L, Derbyshire Hospital for Sick Children archive, Derby.

Eleventh annual report of the Derbyshire Hospital for Sick Children (1888), Derbyshire Hospital for Sick Children archive, Derby.

First Report (to 30th June 1878) of the Derbyshire Hospital for Sick Children, Derbyshire Hospital for Sick Children archive, Derby.

Some extracts from the Nurses' Rulebook (circa 1930), Derbyshire Hospital for Sick Children archive, Derby.

The Hospitals for Sick Children, Great Ormond Street, London

Brooke Helen (1942), Letter entitled 'Memories at 'runabouts' at Chipping Norton, Great Ormond Street Hospital archive, London.

Nursing Committee Minutes 1926, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Minutes 1927, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Minutes 1928, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Minutes 1929, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Minute Book: Volume One 1935-1936, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Minute Book: Volume Two 1937, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Minute Book: Volume Three 1939, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Record Book: Number Four 1942, Great Ormond Street Hospital for Sick Children archive, London.

Nursing Committee Record Book: Number Five 1944, Great Ormond Street Hospital for Sick Children archive, London.

Record of practical instruction and experience of nursing sick children (1960), The Hospital for Sick Children, Great Ormond Street archive, London.

Yorkhill Hospitals, Glasgow

A syllabus of lectures and demonstrations for education and training of nurses for sick children, GNC, London, Reference YH8/3/1, Yorkhill Hospitals Archive, Liverpool.

General Nursing Council for Scotland (1964), Syllabuses for the Roll of Nurses and record of practical instruction and experience, Reference YH8/3/4, Yorkhill Hospitals archive, Glasgow.

General Nursing Council for Scotland (1973), Syllabuses for nursing, Reference YH8/3/6, Yorkhill Hospitals archive, Glasgow.

Journal of the Yorkhill Nurses' League, Yorkhill Hospitals archive, Glasgow.

Ledger (1881), Reference HB2/4/1, Yorkhill Hospitals Archive, Glasgow.

Letter to Miss Clarkson (Matron) (1852), Reference YH8/8/1, Yorkhill Hospitals Archive, Glasgow.

Nurses Register (1883), Reference YH8/1/1, Yorkhill Hospitals Archive, Glasgow.

Nurses Register (1903), Reference YH8/1/2, Yorkhill Hospitals Archive, Glasgow.

Nurses Register (1921), Reference YH8/1/4, Yorkhill Hospitals Archive, Glasgow.

Nurses' timetable, 1888, Reference YH8/4/1, Yorkhill Hospitals archive, Glasgow.

Reports 1883-1891, Royal Hospital for Sick Children, Glasgow, Reference B2/3/1, Yorkhill Hospitals archive, Glasgow.

Training school for nurses, Royal Hospital for Sick Children, Glasgow, Reference YH8/3/10, Yorkhill Hospitals archive, Glasgow.

Training school for nurses, 1940, Royal Hospital for Sick Children, Glasgow, Reference YH8/3/2, Yorkhill Hospitals archive, Glasgow.