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. . . daß Krankenschwestern im Dienst so unbekümmert Zeit verschwenden. Im Gegenteil, sie müssen ein überaus hohes Maß verantwortungsvoller Arbeit leisten. Ihre Entlastung ist deshalb unerläßlich. Ein Weg dazu: gebrauchsfertige Lohmann-Mullkompressen und -tupfer. Hier können Sie Schwesternarbeit einsparen. Unsere Maschinen fertigen schneller und rationeller. Lohmann-Mullfertigerzeugnisse entlasten Krankenschwestern.

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NURSING AND ECONOMICS

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EDITORIAL – NURSING AND ECONOMICS

Susanne Kreutzer and Karen Nolte

Economic contexts have shaped the working conditions of nurses in various ways throughout history. Increasing marketisation in the healthcare sector has been noted and discussed since the 1960s, in particular in terms of the social and human costs for both nurses and patients. The articles in this special issue situate the marketisation of nursing in different social contexts, differentiate it from the principle of sound financial management in nursing, and thus contribute to the historicisation of the currently politically charged concept of marketisation. The articles focus on the transformation of nursing care in the second half of the 20th century and examine both the opportunities for nurses and the consequences that resulted from the adoption of market-oriented practices in the field of nursing.

The articles by Giordano Cotichelli and Susanne Kreutzer focus on the social upheavals of the 1950s and 1960s in Italy and West Germany. From the second half of the 1950s onwards, both countries experienced an enormous economic boom and the healthcare system was expanded. Cotichelli shows how nurses in Italy sought to take advantage of this situation – both in the context of trade union struggles to improve working conditions and pay, and in the context of efforts to develop the profession. Kreutzer uses the example of Christian sisterhoods to examine how the cost of nursing had to be recalculated in the course of the transformation processes. The introduction of a new time economy and the rise of professional administrators opened up nursing practice to business and administrative approaches. Nicole Kramer pursues an international comparative approach, linking the history of nursing with historical research on marketisation and neoliberalism. She analyses the early phase of privatisation of elderly and long-term care in the Federal Republic of Germany and Great Britain in the 1980s and 1990s and examines the economic ideas of the new care service and nursing home operators.

In the open section, two articles shed new light on the significance of Florence Nightingale. Carol Helmstadter uses the examples of four matrons to trace the enormous challenges faced by Nightingale's students as they attempted to anchor the basic principles of Nightingale Nursing in practice. The article deals with the resistance of hospital management and doctors as well as the motives and experiences of the four women, and discusses their failures, but also their successes. Christine Hallett's article is also dedicated to the transformation of the Nightingale system. She examines the difficulties involved in setting up the Indian Army Nursing Service and sheds light on the relationship between Catherine Grace Loch – the first Senior Lady Superintendent of the Indian Army Nursing Service – and her most important mentor, Florence Nightingale.

In the Lost and Found section, Mia Vrijens presents the diaries of district nurses that were written as part of a Dutch study project in the 1970s and are preserved in the archives of the Florence Nightingale Institute in the Netherlands. This study project was intended to contribute to the valorisation of district nursing by asking the women to document in their diaries the complexity of their work in this field, thereby providing evidence of their professionalism.

THE ECONOMICS OF CHRISTIAN NURSING. HOW THE COST OF NURSING CARE WAS RECALCULATED DURING WEST GERMANY'S SECULARISATION PROCESS

Susanne Kreutzer

Abstract

From the beginning, Christian sisterhoods have also been commercial enterprises that have had to constantly adapt to social changes in order to ensure their financial survival. In West Germany, the social upheavals from the second half of the 1950s onwards presented the communities with particular challenges. In view of the shortage of new recruits, the increasing importance of union-negotiated reductions in working hours and salary increases, the deployment of labour had to be reorganised and labour costs recalculated. A new time economy was introduced into nursing practice under the imperative of efficiency, as the logic of market economics reached the core area of nursing care. The withdrawal of the motherhouse-bound nurses also heralded the rise of professional administration, which in turn encouraged the application of business and administrative principles to nursing practice.

Keywords: economy, nursing, history, deaconess, secularisation, Germany

1 INTRODUCTION

Christian sisterhoods, with their understanding of nursing as a 'labour of love', dominated the nursing sector in West Germany until the 1960s. The understanding and practice of nursing in these communities and their transformation after 1945 have been well researched.[1] The fact that the sisterhoods were also commercial enterprises has not been studied much until now, in terms of nursing history.[2] The sisterhoods operated their own facilities, usually including a hospital of their own, which also served to train the nurses. These facilities had to be maintained and financed. The sisters' main areas of deployment were usually outside the motherhouse complex in other hospitals, parish nurse stations and social institutions. These assignments had to be organised and the specific conditions had to be negotiated with the operators of the outstations. Although the sisters themselves did not receive a salary, the motherhouses had to pay for the sisters' training and further education as well as their living expenses, including in the event of illness, invalidity and old age. All of this could only succeed if the sisterhoods ensured they had a solid economic basis and adapted it to the changing social conditions.

Christian sisterhoods faced a particular challenge in view of the social upheavals from the second half of the 1950s onwards. With the growing prosperity of West German society, a fundamental change set in that affected almost all areas of society and is described in terms such as secularisation, de-traditionalisation, liberalisation, democratisation and individualisation.[3]

[1] On Germany after 1945, see Gaida 2016; Kreutzer 2014; Müller 2023; on transnational history: Kreutzer/Nolte 2016.
[2] One of the few exceptions is Barbra Mann Wall's study on the entrepreneurial practice of Catholic sisterhoods in the USA between 1865 and 1925, which analyses the transfer of European sisterhoods to the market-oriented health system in the USA and the strategies with which they sought to assert themselves as entrepreneurs, see Mann Wall 2005. The existing studies on the situation in Germany refer to higher organisational levels – the Protestant Hospital Association or the Diakonie/Inner Mission or Caritas, see Henkelmann et al. 2012; Krey 2014; Schmuhl 2002.
[3] Frese/Paulus/Teppe 2005; Herbert 2002; Schildt 2007.

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The traditional model of nursing as a self-sacrificing 'labour of love' that would be 'rewarded in heaven' found itself increasingly at odds with the emerging consumer society. From the mid-1950s onwards, hardly any young women decided to join one of the Christian sisterhoods. At the same time, the number of 'secular' salaried staff was growing. During the 'long 1960s',[4] with the increasing influence of trade unions and under the pressure of a dramatically worsening nursing shortage, nursing was transformed into a women's profession regulated by labour law and collective agreements. These developments posed an immense challenge to the Christian sisterhoods. The fact that they had to react to social changes in their economic activities in order to ensure the survival of the institution was not new in itself; what was new was that principles of market economics were now also entering the core area of nursing care.

For the purposes of this article, it is important to make a distinction between the principle of sound financial management and marketisation. The sisterhoods had been committed to sound financial management ever since they were founded; after all, they wanted to survive financially as institutions. Economic behaviour – the economical, responsible use of resources – was undoubtedly part of the sisters' traditional self-image. Most of the women came from a farming or artisan background;[5] wastefulness was an alien concept to them. Marketisation means something different and refers to the process in which the principles of market economics, efficiency calculations and profit considerations expand into areas that previously followed different principles – ones determined by the actors themselves.[6] In the following study, two developments can be identified that can be attributed to this process of marketisation: the increasing presence of business management knowledge in the ranks of the providers and the emerging demand to organise nursing efficiently.[7]

Using the example of the Protestant deaconess motherhouse of the Henriettenstiftung in Hanover, this article examines the traditional economic setup of Christian sisterhoods. What economic reasoning guided the organisation of nursing? How did the Henriettenstiftung calculate the cost of its most valuable resource: the sisters' labour force? How did this calculation change with the secularisation of nursing, the growing importance of trade unions and the introduction of nursing as a salaried occupation? What consequences did these transformations have for the organisation and practice of nursing?

The article begins by outlining the traditional organisational and economic foundations of the Henriettenstiftung. It then sheds light on how the motherhouse came under pressure in the 1950s due to a lack of new recruits, union-negotiated reductions in working hours and salary increases, and how it reacted to this. The focus here is on the reorganisation of the workforce, the renegotiation of labour costs and the emergence of a new time economy in nursing under the imperative of efficiency. With the nursing crisis, which came to a dramatic head in the 1960s, the preservation of nurses' working capacity and protection against overwork also became guiding principles. In conclusion, it is shown that the withdrawal of the deaconesses had far-reaching consequences, not only for the financial basis of the Henriettenstiftung, but also for its administrative principles, which became increasingly market-oriented from the 1960s onwards. The article is based on two completed studies: one on the history of trade union policy in nursing and one on the history of Protestant nursing, using the example of the deaconess motherhouse of the Henriettenstiftung in Hanover.[8]

[4] While the year 1968 was long regarded as a profound turning point in West German history, more recent contemporary historical research emphasises the embedding of 1968 in a longer transformation phase – the so-called 'long 1960s', which began around 1958/1959 and lasted until 1973/74.
[5] Kreutzer 2014, p. 54.
[6] Graf 2019.
[7] Kramer 2019, p. 384.
[8] Kreutzer 2005; 2014. I would like to thank the Hans Böckler Foundation, Volkswagen Foundation, Robert Bosch Foundation and German Research Foundation for their financial support.

2 INITIAL SITUATION: ORGANISATIONAL AND ECONOMIC FOUNDATIONS OF THE MOTHER-HOUSE SYSTEM

The basic features of the deaconess motherhouse system, as it had developed in the 19th century, still applied after the Second World War. The motherhouse was the centre of the community and was where the Matron and the Principal Pastor were based. These two constituted the house management board that presided over the community. Although a full-time business manager was appointed for the first time in 1927, his influence remained limited.[9] Until the 1960s, it seems to have been inconceivable that he would have a seat on the house management board and be involved in managing the motherhouse.

In their capacity as members of the house management board, the Matron and Principal Pastor managed the motherhouse's own hospital in Hanover, which was traditionally designed primarily as a training hospital for the sisters. The sisterhood and hospital formed a single unit. Matron Florschütz – herself a trained nurse – resided on the first floor of the hospital. The costs for the motherhouse and hospital were not accounted for separately, but together. Until the early 1960s, nobody in the motherhouse had a precise idea of exactly how much the hospital cost or how it was financed. It was enough to know that the Henriettenstiftung was 'in the black'.

A deaconess, Sister Hildegard, was responsible for hospital administration and had been in this position since 1928. She was considered hard-working and dedicated, but also extremely headstrong. When she left this role in 1962, the Principal Pastor recalled:

The hospital administration is completely personalised to her and she didn't really let anyone else look into it. To keep the peace, we've let her get on with it so far, and our business manager [of the entire foundation, S.K.], Dr Mallau, has held back.[10]

The fact that Sister Hildegard's working style was tolerated until the early 1960s to keep the peace not only points to the strong position that the deaconesses still held at this time, but also indicates the extent to which consideration for personal relationships shaped organisational life.

This was not specific to Sister Hildegard. The deaconesses working in practical nursing roles also had a wide scope of action. Although the working hours were long and could be up to 70–80 hours per week, the tasks to be fulfilled during this time were poorly defined. The broad understanding of the nursing remit as caring for body and soul gave the sisters a great deal of autonomy in determining the needs of patients. It was within the nurses' genuine sphere of competence to decide how nursing care was to be organised in concrete terms.[11]

Some of the sisters worked in the motherhouse hospital, but the majority were sent to parishes, hospitals and social institutions outside the motherhouse. In 1951, the motherhouse provided nurses for a total of 235 outstations in Lower Saxony, Hamburg and Schleswig-Holstein.[12] The basic aim was to staff the nursing arms of these institutions exclusively with Henriettenstiftung nurses. These nurses were of two different types: deaconesses and independent nurses. The traditional deaconesses only worked for money on a limited basis – the sisters received board, lodging, pocket money and guaranteed lifelong care. Their actual wages, or 'heavenly rewards', were primarily of an immaterial nature. In religious terms,

[9] Mutterhaus-Diakonie 1960, p. 25.
[10] Principal Pastor Weber to Pastor Eichstädt, Protestant Deaconess Motherhouse Bremen, 8 Oct. 1962, Archive of the Henriettenstiftung, 2.03: Krankenhaus allgemeiner Schriftwechsel 1954 bis 1975.
[11] Kreutzer 2014, pp. 88–92, 176–182.
[12] Der gegenwärtige Stand der Arbeitsgebiete 1951, pp. 28–35.

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this included the prospect of eternal life, and in secular terms, the gratitude of the patients and their relatives. At the same time, the nurses were held in very high esteem due to their self-sacrificing work. Not least, the immaterial reward included the fact that the nurses were 'not like any other professional group' and thus were something special.

However, not all women were prepared to make this lifelong commitment. Even in the 19th century, the deaconess motherhouses were dependent on the cooperation of independent nurses. In 1939, these independent nurses were organised into a separate Association of Sisters in the Kaiserswerth Association (Verbandsschwesternschaft im Kaiserswerther Verband) with a uniform and brooch.[13] Unlike the deaconesses, the association sisters received a salary – albeit a small one – and were covered by social insurance. In this respect, their status was comparable to a gainful occupation. However, the other working conditions were very similar to those of the deaconesses. The association sisters were, of course, also single and were sent out by the motherhouse. In old age, however, the deaconesses were much better provided for than the association sisters. As late as 1955, the Federal Ministry of the Interior stated that the social situation of motherhouse-bound sisters in the event of premature incapacity to work or old age was considerably better than that of independent nurses.[14]

The provision of nurses was agreed in secondment contracts, which the Henriettenstiftung concluded with the outstations and which regulated the costs of the secondment. In addition to the provision of board and lodging, the operators of the outstations had to pay a lump sum to the deaconess motherhouse for each seconded sister. This station or posting allowance was by no means intended as remuneration for the labour of individual sisters. Instead, it was levied regardless of the work, age and status of the sisters. This principle of a uniform station allowance formed an important basis for the secondment principle. Only in this way was the Henriettenstiftung able to provide nurses without having to consider the impact on the level of the station allowance. Otherwise, there would have been regular conflicts with the operators of the outstations, for example when a less expensive deaconess was to be replaced by a more costly association sister.[15]

The station allowance was therefore conceived as a contribution to the motherhouse, with which the Henriettenstiftung financed the work of its organisation. This included, among other things, providing training and further education for the sisters, maintaining convalescent homes, as well as paying the salaries of the association sisters and pocket money and a pension scheme for the deaconesses. Even though each outstation paid a lump sum per sister, the amount was a matter for negotiation. For example, the Henriettenstiftung was prepared to reduce the rate for socially disadvantaged parishes, thereby ensuring social equalisation.

[13] Freytag 1998, pp. 54–55.
[14] Kreutzer 2005, p. 207.
[15] Financial provision for the association sisters, 1956, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.

3 1950s: THE MOTHERHOUSE SYSTEM UNDER PRESSURE

This traditional organisational and financing model came under massive pressure from the mid-1950s onwards as a shortage of new recruits set in. The growing influence of the trade unions also had far-reaching consequences for the Henriettenstiftung.

3.1 The Decline in the Number of Deaconesses and the Recalculation of Labour Costs and Labour Deployment

In the ten years from 1945, the number of deaconesses in the Henriettenstiftung fell from 673 to only 561.[16] Between 1958 and 1960, only two new students enrolled each year. In addition, the average age was shifting dramatically. In 1956, the Principal Pastor calculated that only 28 per cent of the deaconesses were under 50 years old, 50 per cent of the women had already reached the age of 50 to 65, and a quarter were living in retirement.[17] These declining membership figures were also evident in other deaconess motherhouses, not only in West Germany but also in East Germany.[18]

This development had serious consequences for the Henriettenstiftung's cost calculations. One critical point was the provision for deaconesses in retirement. Since the early 1930s, the motherhouse had endeavoured to ensure that as many deaconesses as possible were covered by the statutory pension scheme and the pension fund of the Kaiserswerth Association of German Deaconess Motherhouses – the umbrella organisation of deaconess communities.[19] Nevertheless, the motherhouse's calculation was crucially based on the fact that the younger deaconesses paid for the pensions of the sisters in retirement through their work. However, the 'intergenerational contract' that had been practised until this point broke down when the influx of young deaconesses dried up in the 1950s. Whereas, in 1933, there were eight active deaconesses providing for every retired sister, by 1957 this number had fallen to just 2.3, forcing the motherhouse to set aside more money for the deaconesses' retirement pensions.[20] This increased the labour costs that had to be charged to the outstations.

In addition, the Henriettenstiftung could no longer ignore the fact that it would hardly be able to maintain all its traditional areas of work in the long term. Smaller hospitals and parish nurse stations started to have their secondment contracts terminated because there were not enough nurses available. With the increasing prosperity of West German society and the expansion of the healthcare system, hospitals also began to modernise and expand their facilities. Already struggling to fill existing positions, the Henriettenstiftung was in general no longer able to meet the increased staffing requirements. It often saw no other option than to terminate secondment contracts. Between 1951 and 1960 alone, the number of outstations was reduced from 235 to 135.[21]

This gradual withdrawal from many areas of work turned out to be a long and difficult process. With each cancellation, the motherhouse lost its presence in the region and thus also its potential to recruit young people, since the young women generally became aware of the motherhouse diaconia and its significance through personal experience. The Henriettenstiftung was therefore keen to remain active across as much of the region as possible in order not to disappear from the everyday awareness of the Protestant population.[22]

[16] Helbig 1985, p. 103.
[17] Minutes of the proceedings of the Henriettenstiftung committee, 21 Feb. 1956, Archive of the Henriettenstiftung, S-9-3-1.
[18] Kaminsky 2012; Müller 2021.
[19] Circular letter from Principal Pastor Meyer to the sisters of the Henriettenstifung, 5 Feb. 1931, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Diakonissen-Versorgungsordnung.
[20] Principal Pastor Weber to the Regional Church Office Hanover, 30 Dec. 1957, Archive of the Henriettenstiftung, 1.11: Stationsgeld, Versorgung der Diakonissen und Verbandsschwestern, 1956–1971.
[21] Der gegenwärtige Stand der Arbeitsgebiete 1960, pp. 14–18.
[22] Müller analysed similar considerations at the deaconess motherhouse in Leipzig. In East Germany in particular, the missionary task of the parish nurse stations was especially important. The termination of secondment contracts with parish nurse stations was therefore extremely painful from the motherhouse's perspective. Müller 2021, pp. 62–63.

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The management boards of the outstations were usually equally keen to maintain the sisterhood. They had often been collaborating effectively for years with the Henriettenstiftung, which had taken over the entire organisation of the nursing side of their operations at comparatively low cost, thus relieving the outstations of a considerable amount of work and worry. The changeover to independent nurses threatened to be not only more cost-intensive, but also considerably more labour-intensive. In addition, many hospital directors feared for the good reputation of their institutions, which – as one head physician at Melle Hospital put it in 1960 – was "primarily based on the commitment and dedication of its nursing staff".[23] As long as 'secular' nurses were not recognised as equal, the withdrawal of the deaconess motherhouse threatened to be accompanied by a loss of reputation for the hospital. Many chief physicians also considered the "church orientation of the nurses"[24] to be an indispensable prerequisite for 'good' nursing care.

In order to avoid having to terminate further secondment contracts, from the mid-1950s onwards, the Henriettenstiftung gave up its claim to organise the entire nursing area and began to concentrate on certain activities.[25] The aim was now to fill key positions with deaconesses. Above all, these were the roles of head nurse, ward nurse and teaching nurse – nurses who played a key role in the training of junior staff. The motherhouse thus gradually withdrew from direct diaconal activities and shifted its work towards the targeted recruitment and training of the next generation of nurses.[26]

At the end of the 1950s, the motherhouse management was painfully aware that hardly any of this new generation would be future deaconesses. A similar downwards trend was also becoming apparent among the association sisters. At the end of 1955, the Henriettenstiftung counted 107 association sisters working as such, but five years later there were only 97. In the same period, the number of retired association sisters rose from 25 to 39.[27]

3.2 The Pressure of Trade Union Influences: The Impact of Reduced Working Hours and Salary Increases

The motherhouses were traditionally union-free spaces. The deaconesses were not employees and were therefore not subject to any labour law regulations. Even if the association sisters were sent to a public hospital via a secondment contract, they were not subject to the collective labour agreements negotiated by the trade union, but to the conditions set by the Henriettenstiftung. The motherhouses' dominance and special position under labour law therefore considerably limited the influence of the trade unions. When the Public Services, Transport and Traffic Union (Gewerkschaft Öffentliche Dienste, Transport und Verkehr, ÖTV), which was responsible for the nursing care sector, tried to persuade the umbrella organisations of the Protestant and Catholic motherhouses – Inner Mission and Caritas – to take part in collective bargaining negotiations in the early 1950s, it met with energetic resistance and failed. The Federal Ministry of Labour was also unwilling to support the trade union in its cause. Ultimately, there was also a lack of political will to enforce collective agreements against the interests of the powerful churches and welfare organisations.[28]

However, the autonomy claimed by the motherhouses in relation to trade union collective agreements dwindled from the mid-1950s onwards. With the decline in membership of the motherhouses,

[23] Dr Pook to Matron Florschütz, 23 Aug. 1960, Archive of the Henriettenstiftung, 1-09-61.
[24] Dr Dehlinger to Matron Florschütz, 9 Sep. 1960, Archive of the Henriettenstifung, 1-09-173 .
[25] Müller described this process at the Leipzig Deaconess Motherhouse in East Germany, Müller 2021, p. 59.
[26] Sister Auguste Schneider to Sister Martha Koch, 19 Mar. 1958, Archive of the Henriettenstiftung, 1-09-173; Principal Pastor Weber to Pastor Dr Pall, 4 Mar. 1958, Archive of the Henriettenstiftung, S-1-0326.
[27] Changes in the number of association sisters from the end of 1955 to December 1960, Archive of the Henriettenstiftung, S-5.
[28] Kreutzer 2005, pp. 152–154.

independent nurses gained in importance. The Henriettenstiftung was also increasingly reliant on independent nurses to supplement its workforce – initially mainly in the external hospitals. Not least, the serious shortage of nurses improved the trade union's negotiating position considerably.

From the mid-1950s, the ÖTV trade union began to influence the organisation of nursing in the motherhouse context. Although the collective agreements negotiated by the union only officially applied to public hospitals, they had a considerable indirect influence. The collectively agreed reductions in working hours and salary increases in the public sector were of particular importance.

In 1956, the ÖTV succeeded for the first time in reducing working hours in municipal hospitals to 56 hours per week. This was followed by further reductions to 51 hours in 1958 and 48 hours in 1960 for nurses across the entire public sector, which also became the benchmark for hospitals not covered by collective agreements.[29] If the Henriettenstiftung wanted to attract and retain independent nurses, it had to adapt its working conditions to those of the public sector. The traditional concept of 'total dedication' thus lost its relevance.

However, it was not only the competition for labour that motivated the Henriettenstiftung to rethink its understanding of service. In 1957, the Kaiserswerth Association of German Deaconess Motherhouses spoke out in favour of a reduction in weekly working hours in order to "protect our sisters' willingness to devote themselves from being abused and exploited."[30] The deaconess motherhouses also developed a keen self-interest in imposing binding limits on working hours, since they wanted to ensure that the Protestant sisters, with their high willingness to work, were not used as a buffer to cope with the nursing crisis. In 1957, the Henriettenstiftung stipulated a 54-hour working week in its employment contracts. In April 1957, it also introduced the 54-hour week in the motherhouse's own facilities.

This departure from 'total dedication' had far-reaching consequences for the use of labour, as working time now became a precious commodity that had to be used rationally. In 1957, the head of administration of the Annastift hospital in Hanover, where deaconesses from the Henriettenstiftung were working, stated in the journal *Die evangelische Krankenpflege* ("Protestant Nursing") that the management of the Annastift now had to seriously consider "the idea of rationalisation"[31] for the first time. The introduction of shorter working hours clearly showed "that the production reserves inherent in people working in hospitals must also be fully utilised."[32] This fundamentally changed the understanding of nursing. The nurse stopped being God's 'handmaiden' and became a factor of production. By removing nursing from its religious context and transferring it to the context of industrial production, the profession was opened up to the logic of economic cost-benefit calculations. Consequently, the head of administration intervened in the nurses' area of sovereignty in order to reorganise their work according to business efficiency criteria.

As rationalisation measures, the head of administration at Annastift suggested the use of technical aids, such as electric floor polishers, and the centralisation of routine functions, for example installing a central dishwashing machine. He also advocated a reorganisation of work processes on the wards with increased use of auxiliary staff.[33] His proposals were in line with the contemporary trend of countering staff shortages by rationalising care – for example, by introducing functional care.

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[29] Kreutzer 2005, p. 26.39
[30] Kaiserswerth Association of German Deaconess Motherhouses, Circular No. 2 to the boards of the motherhouses of the Kaiserswerth Association in the Federal Republic of Germany, 2 Feb. 1957, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Arbeitszeit Krankenpflegepersonal.
[31] Arnstorf 1957, p. 52.
[32] Arnstorf 1957, p. 53.
[33] Arnstorf 1957, pp. 53–55.

At the Henriettenstiftung, this switch to time-efficient work organisation was a lengthy process and began in the foundation's external hospitals, which became dependent on the employment of independent nurses earlier than the motherhouse hospital and had to accommodate their working time requests. In the motherhouse hospital, on the other hand, the ward nurses did not have to calculate the nurses' working hours and watch the clock to the same extent due to the large number of deaconesses working there. Here, the principle of rationing the use of manpower only became established in the 1960s.[34] In 1965, the Henriettenstiftung agreed on a catalogue of measures to reduce the workload of nursing staff, which established the rational use of working time as a new guideline. The aim was to avoid "unnecessary journeys and idle time" in day-to-day nursing care, for example by ensuring that "ancillary work" was not carried out in the evening but during idle times.[35] The rational use of working time therefore also meant a considerable intensification of work.

While reductions in working hours brought with them a new time economy, the wage increases negotiated by the trade union presented the Henriettenstiftung with new financial challenges. From 1954 onwards, the ÖTV was able to push through pay rises for nurses in the public sector at regular intervals.[36] The Working Group of German Sisterhoods (Arbeitsgemeinschaft deutscher Schwesternverbände) – the umbrella organisation of motherhouse-affiliated and "free" sisterhoods – also recognised that there was an urgent need to improve incomes in the nursing sector. In 1955, it complained that the nursing profession was losing much of its public image because the working and living conditions were far below the standard of other women's professions. The Working Group therefore campaigned for 'contemporary' remuneration.[37] Even if the very heterogeneous umbrella organisation was only able to agree on the vague goal of 'contemporary' remuneration, this demand reveals how far the criteria for evaluating nursing work had shifted by the mid-1950s. The traditional concept of 'heavenly reward' was no longer regarded as proof of extraordinary Christian dedication and thus as a special honour, but on the contrary as a sign of a lack of appreciation.

The salary rates negotiated by the ÖTV only applied to the public sector. However, as the Henriettenstiftung was increasingly unable to provide enough nurses to work at the outstations, it had to recruit more and more independent nurses. Better pay proved to be a particularly effective advertising tool. For this reason, non-public hospitals also began to pay salaries in line with the public sector. However, as a hospital in Goslar reported in 1954, this led to considerable differences in income of up to 30 per cent between independent nurses, who were paid according to the public sector rates, and association sisters, who received the Henriettenstiftung's salary rates.[38] If the Henriettenstiftung wanted to keep its association sisters as employees, it also had to significantly increase their income. From October 1954, the Henriettenstiftung therefore paid at least "payscale-like salaries".[39] It also increased the deaconesses' pocket money.[40] In other words, the outstations had to be asked to pay for this too.

3.3 Increase in Labour Costs and Negotiations on the Price of Nursing Care

The negotiations to increase salaries proved to be an extremely arduous endeavour. The financing modalities were anchored in the individual employment contracts. Every change had to be negotiated with the individual outstation, and with every pay rise in the public sector, the procedure started all

[34] Minutes of the committee meeting on 19 Nov. 1965, Archive of the Henriettenstiftung, 2.03: Krankenhaus allgemeiner Schriftwechsel 1954 bis 1975.
[35] Principal Pastor Weber, Matron Florschütz, Measures to relieve nurses at the Henriettenstiftung hospital, 22 Dec. 1965, Archive of the Henriettenstiftung, S-11-2-2.
[36] Kreutzer 2005, pp. 218–228.
[37] Kreutzer 2005, p. 221.
[38] Vereins-Krankenhaus Goslar to the house management board of the Henriettenstiftung, 9 Jul. 1954, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.
[39] Remuneration regulations for the Association and Johanniter Sisters, 9 Jun. 1955, Archive of the Henriettenstiftung, 4.05: Schwesternschulen 1955–1972.
[40] Minutes of the meeting of the Henriettenstiftung committee, 30 Sep. 1954, Archive of the Henriettenstifung, S-9-3-1.

over again. Negotiations with hospitals were relatively unproblematic, as they could generally look back on a long tradition of independent nurses in their facilities and therefore had a basic understanding of salary demands. Public hospitals, in particular, which also paid independent nurses in accordance with collective agreements negotiated by the trade union, will hardly have been surprised that the Henriettenstiftung followed suit with its salary demands.

The situation was different for many parish nurse stations. Home nursing care only became a compulsory service covered by health insurance companies in 1977.[41] Until then, parish nurse stations lacked a reliable financial basis, which meant that the increased funding for financially weaker parishes may indeed have posed a problem. From the point of view of the motherhouse, however, most operators of the outstations simply seemed to have failed to realise that the sisters' services were no longer available for next to nothing. In 1956, the Principal Pastor of the Henriettenstiftung complained bitterly in a letter to a fellow pastor:

When our motherhouses recently increased their outstation fees in order to be able to pay the association sisters a decent salary, a storm of indignation arose among many confreres, who were of the opinion that our association sisters could work for as little money as possible.[42]

The Christian concept of being 'rewarded in heaven', which the motherhouses had nurtured for decades, now proved to be a boomerang, so to speak.

In the second half of the 1950s, the impression grew that although the parish boards themselves were happy to benefit from the growing prosperity of West German society, they wanted to save money on the parish nurse station. This concern related not only to the association sisters, but also to the deaconesses. In 1957, the Principal Pastor emphasised that the motherhouse had taken on "the obligation to provide not only full care but also good care"[43] for the deaconesses. However, the standard for 'good' care changed fundamentally with the emergence of the consumer society in the 1950s. For example, the deaconesses no longer wanted to spend their holidays in the motherhouse's convalescent home – as had been the norm in the past – but wanted to go on their own holidays. This also increased the cost of maintaining the deaconesses in work.

In 1957, the motherhouse revised its employment contracts and stipulated that in future, the employment allowances were to be adjusted in line with the general increase in remuneration rates in the nursing sector. The motherhouse hoped in this way to avoid complicated negotiations with the individual outstations and at the same time wanted to make it clear that the motherhouse had "a claim to an increase"[44] that was not up for negotiation. In 1957, the Henriettenstiftung also joined forces with other deaconess motherhouses in the region to jointly communicate standardised outstation fee increases in the future. This was intended to prevent the operators of the outstations from playing the motherhouses off against each other.

This clear positioning obviously had an effect. In the 1960s, outstation fee increases were generally accepted as a matter of course. The severe shortage of nursing staff will also have contributed to this. The operators of the outstations will have been happy if nurses were available to work in their facilities at all.

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[41] Hackmann 2009, p. 198.
[42] Principal Pastor Weber to Pastor Kropatscheck, 7 Aug. 1956, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.
[43] Principal Pastor Weber to the Regional Church Office Hanover, 30 Dec. 1957, Archive of the Henriettenstiftung, 1.11: Stationsgeld, Versorgung der Diakonissen und Verbandsschwestern, 1956–1971.
[44] Principal Pastor Weber to the chairman of the Schneverdingen church council, Pastor Heyken, 11 May. 1957, Archive of the Henriettenstiftung, 1-09-229.

4 1960s – MANAGING THE LABOUR FORCE IN THE NURSING CRISIS

At the beginning of the 1960s, the shortage of nurses became even more acute. There was hardly a hospital that was not busy with expansion and extension measures. However, it was almost impossible to meet the additional demand for nurses and the motherhouse received increasingly alarming reports from the deaconesses, who were exhausted. "At the moment I just don't know what to do anymore," wrote Sister Auguste from Leer in 1961. "I constantly have to tell the sisters that I can't fulfil their holiday requests, it's almost overwhelming and takes so much energy."[45] The sister in charge of the Stadthagen hospital urgently requested that someone be sent to replace her because she could no longer bear the stress and "constant hardships of the sisters".[46] The motherhouse therefore had to think carefully about how it could protect the sisters from excessive workloads.

In order to reduce the workload in parish nursing, the Principal Pastor of the Henriettenstiftung appealed to the church councils to ensure that the parish nurses "are not so overburdened that they are no longer able to cope with the work and drop out."[47] In doing so, he reminded them of the outstations' own interest in maintaining the workforce of deaconesses. The local pastors also recognised that there had to be a limit to the sisters' willingness to serve. In 1960, the superintendent from Hamelin called on the parish nurses, *to take on only as much nursing care as they could be responsible for. You would also have to say no and consider that the Lord God has only given each of us a certain amount of strength.*[48]

Under the conditions of the nursing crisis, acting responsibly could now also mean saying 'no' in order to conserve one's strength – which was deliberately limited by God. The idea of conserving one's own strength was declared to be an expression of God's will – an argument that skilfully drew on the deaconesses' understanding of faith and in this respect must have found fertile ground. However, it is doubtful whether the women actually succeeded in practice in rejecting calls for help from parishioners in need.

In view of the steadily growing staff shortage, the Henriettenstiftung began to advocate more drastic measures in the mid-1960s and called on hospitals to reduce bed occupancy in their facilities. The hospitals were only to admit as many patients as could be cared for by nurses.[49] In an emergency, entire wards were also to be closed; a step that the Henriettenstiftung's own motherhouse hospital had to take in 1964.[50] This relieved the deaconesses working there of the constant conflict of having to find a balance between the legitimate interests of the patients and their own limits.

A paradigm shift came in the early 1960s when an attempt was made to tackle the excessive workload placed on deaconesses by means of salary policy. At this time, the Henriettenstiftung realised that external hospitals were starting to pay overtime to independent nurses who were not affiliated with the motherhouse. In January 1962, the head nurse at the district hospital in Leer reported that in order to "satisfy the independent nurses, overtime was being paid" and that there was immediately "renewed unrest among the association sisters",[51] for whom this had not previously been planned. The Matron of the Henriettenstiftung initially considered overtime pay to be absurd.[52] A sister who watched the clock

[45] Sister Auguste Schneider to Sister Martha Koch, 18 Aug. 1961, Archive of the Henriettenstiftung, 1-09-173.
[46] Sister Hinrika Schulz to Principal Pastor Weber, 17 Sep. 1960, Archive of the Henriettenstiftung, S-3-0282.
[47] Principal Pastor Weber to the church council of Hanover-Kirchrode, Pastor Meyer, 26 Jan. 1960, Archive of the Henriettenstiftung, S-1-0470.
[48] Superintendent Pellens to Matron Florschütz, 13 May 1960, Archive of the Henriettenstiftung, 1-09-100.
[49] Matron Florschütz to Dr med. Blattgerste, 15 Feb. 1964, Archive of the Henriettenstiftung, 1-09-239.
[50] Matron Florschütz to Chief District Director Nendel, 29 Apr. 1964, Archive of the Henriettenstiftung 1-09-239; Pastor Sturhan to the pastors in Schaumburg-Lippe, 6 Jul. 1964, Archive of the Henriettenstiftung, 1-09-239.
[51] Sister Auguste Schneider to Matron Florschütz, 6 Jan. 1962, Archive of the Henriettenstiftung, 1-09-173.
[52] Matron Florschütz to Sister Auguste Schneider, 10 Jan. 1962, Archive of the Henriettenstiftung, 1-09-173.

and carefully differentiated between working hours, free time and overtime was not compatible with the traditional understanding of nursing.

However, this position proved to be untenable. A blanket waiver of overtime pay threatened to provoke a wave of resignations from the association sisters, which the Henriettenstiftung could not afford. In addition, the motherhouse management was concerned that 'their' sisters would be used as a buffer when implementing the reduction of working hours for the independent nurses, and that the sisters would be burdened with too much work.

In view of this, the Henriettenstiftung also adopted the concept of overtime in the 1960s in order to protect the seconded sisters from unfair exploitation. In October 1962, the motherhouse launched a survey in the hospitals to find out what was happening with working hours. If the hospitals were not in a position to guarantee a 48-hour week or to compensate for overtime with time off, the Henriettenstiftung demanded that overtime be paid, including for the deaconesses. This initiative was ground-breaking, in that it required clearly limited working hours for deaconesses as well as association sisters.[53] This was intended to give hospitals a financial incentive not to make unlimited use of the working hours of the deaconesses, whose service was based on the principle of 'total dedication'.

However, the Henriettenstiftung's proposal met with resistance – not only from the hospital administrators, but also from the deaconesses themselves. The hospitals reported, among other things, that the 48-hour week did not apply to them, as it was a public service regulation to which they were not bound.[54] Others boycotted the practical implementation and explained that working hours were not recorded in everyday nursing and that they were therefore not in a position to provide proof of the nurses' working hours.

The Henriettenstiftung was also accused of betraying the principles of Christian charity. The head of administration at Leer Hospital stated that the deaconesses "neither ask for a 48-hour week nor claim compensation for overtime", but are happy to provide their services "as best they can, without paying attention to the time spent on them".[55] Already accustomed to such accusations, the business manager of the Henriettenstiftung calmly explained that this was precisely why the motherhouse had to ensure that the deaconesses' understanding of service did not lead to them being "overburdened in terms of labour and resources". In addition, "any extra work that deaconesses are happy to do must also benefit the care provided for the sisters in the motherhouse" and must "not lead to financial savings for the hospital administrations". In this respect, remuneration for overtime "also offers a certain degree of protection for deaconesses in hospitals that want to make savings at the expense of their sisters' labour and health."[56]

The deaconesses also boycotted the motherhouse's request. The deaconesses at New Bethlehem Hospital in Göttingen, for example, refused to adopt the concept of overtime and to record their working hours. They flatly declared that they would "not work overtime".[57] This meant that the motherhouse lacked a basis for calculation from the outset.

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[53] The administrative director stipulated 208 hours per month as the regular working hours of the deaconesses. Dr Mallau to Stadthagen Hospital, administrative director Martin, 3 Jan. 1963. Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.
[54] File note by Dr Mallau regarding a telephone conversation with Mr Kemna, Bethel Hospital, 4 Mar. 1963, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.
[55] Leer Hospital, Klaffke, to Dr Mallau, 15 Feb. 1963, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.
[56] Dr Mallau to Leer Hospital, Klaffke, 22 Apr. 1963, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.
[57] Neu-Bethlehem Hospital Foundation, Pastor Mensching, to Dr Mallau, 14 Jan. 1963 and Neu-Bethlehem Hospital Foundation, Pastor Mensching, to Dr Mallau, 14 Jan. 1963, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Schwesternbezüge.

In fact, not a single hospital reported working time records relating to individual nurses to the Henriettenstiftung. Insofar as the administrative directors were prepared to co-operate in this matter at all, they provided information on the average working hours in the hospital. The hospital in Hannoversch-Münden, for example, reported in 1963 that it adhered to a 51-hour working week, while the Protestant Hospital in Melle stated that it practised a 54-hour working week. The Henriettenstiftung then charged the hospital administrations the excess worked over and above the 48-hour week as a flat-rate overtime payment for all seconded sisters. This procedure did not provide for individual 'clock watching' or remuneration for actual work performed.

5 THE WITHDRAWAL OF THE DEACONESSES: FINANCIAL DEBACLE AND THE RISE OF BUSINESS AND ADMINISTRATIVE RATIONALES

From the 1960s onwards, the deaconesses slowly became a minority in their own organisation, not only at the outstations but also in the motherhouse in Hanover. This had far-reaching implications both in terms of hospital administration and the financial basis of the Henriettenstiftung.

At the beginning of the 1960s, the Henriettenstiftung began keeping separate accounts for the sisterhood and the hospital for the first time. It became clear that the hospital had previously been a subsidised enterprise and was by no means covering its costs. This was not surprising, as the daily rates paid by the social insurance organisations were significantly lower than the proven cost price for the hospitals until the early 1970s. In 1965, the cost shortfall for non-profit hospitals was estimated to be ten per cent.[58] For a long time this discrepancy went unnoticed at the Henriettenstiftung due to the mixed financing of the hospital and the motherhouse. Only when the accounts were separated did it become clear that the deaconesses had been generating significant profits through their work and had offset the losses of the hospital operations.[59] Not only did the deaconesses work at comparatively low cost, but they generally worked into old age, so that they provided the Henriettenstiftung with income well beyond the age of 65 and, at the same time, kept retirement expenditure relatively low.[60] On this basis, the Henriettenstiftung even managed to generate a surplus until the 1960s.[61]

This traditional model of internal financial reallocation was finally thrown off balance at the end of the 1960s when the motherhouse realised to its horror that the provisions for the deaconesses' pension scheme were far from sufficient.[62] From this perspective, the Henriettenstiftung had made its profits not least at the expense of the deaconesses' pension scheme. In making up for its longstanding omission, the motherhouse further increased the costs for the nursing sector, while at the same time the number of deaconesses in employment fell. Against this backdrop, the Henriettenstiftung found itself in the red for the first time in 1971.[63] A year later, the Henriettenstiftung stated that, in view of the age structure of the deaconesses, "the financing of measures from their work is coming to an end."[64]

[58] Schmuhl 2002, p. 194.
[59] Minutes of the Henriettenstiftung committee meetings, 28 Mar. 1961 and 13 Oct. 1964, Archive of the Henriettenstiftung, S-9-3-1.
[60] Annex by the Henriettenstiftung administration for the committee meeting, 2 Sep. 1947, Archive of the Henriettenstiftung, Wirtschaft und Versorgung, Protokolle Komitee.
[61] Minutes of the committee meeting, 28 Mar. 1961, Archive of the Henriettenstiftung, S-9-3-1.
[62] Business manager of the Henriettenstiftung, Brechtelsbauer, to Dr Werner Knüllig, Higher Regional Church Councillor, 1 May 1973, Archive of the Henriettenstiftung, S-9-3-4.
[63] Minutes of the Henriettenstiftung committee meeting, 27 Jul. 1971, Archive of the Henriettenstiftung, S-9-3-1.
[64] Minutes of the Henriettenstiftung committee meeting, 28 Jun. 1972, Archive of the Henriettenstiftung, S-9-3-2.
[65] Sister Hulda Weinrich to Principal Pastor Weber, 24 Jan. 1963, Archive of the Henriettenstiftung, 2.03: Krankenhaus allgemeiner Schriftwechsel 1954 bis 1975.

The withdrawal of the deaconesses from nursing care had serious consequences not only for the hospital's financial basis, but also for the way it was run. In 1962, Sister Hildegard gave up her role as head of hospital administration, opening up the possibility of reorganising the administrative work – with far-reaching consequences. In January 1963, Sister Hulda from the hospital admissions department complained bitterly that the business manager was beginning to interfere in her affairs and wanted to decide "where my auxiliaries should sit or what they should do". She explains energetically: "I don't think any ward nurse would put up with Dr Mallau telling her how and what her nurses have to do." The interventions of the business manager in the nursing area seemed all the more absurd to her as he "had no idea what was going on here."[65]

From today's perspective, the vehemence with which Sister Hulda sought to defend the internal logic of patient care against the interventions of business and administrative rationale is highly remarkable. A business manager who dared to intervene in nursing processes was, from the perspective of the deaconesses at the beginning of the 1960s, simply acting presumptuously. No other documents on the matter have survived. However, it can be assumed that this self-image eroded rapidly in the motherhouse hospital when the deaconesses left nursing.

The increase in the importance of business and administrative rationales continued in the 1970s, when the Henriettenstiftung reorganised its entire management structure. One of the main innovations was the inclusion of the business manager on the house management board from 1973 onwards[66] as the Henriettenstiftung took account of the growing importance of business management aspects in the organisation of patient care.[67] At the same time, it moved away from the traditional concept of the house management board as a 'parent couple' consisting of the Matron and the Principal Pastor. This step was logical insofar as the counterpart to the image of the parents – the 'daughters', i.e. the deaconesses – were also disappearing from the life of the Henriettenstiftung.

6 CONCLUSION

The economics of the traditional motherhouse did not follow a clear cost-benefit calculation or differentiated accounting systems. The secondment contracts were based on lump sums that did not take into account the number of working hours, or the age, qualifications or status of the nurses, and could be adjusted according to the outstation's ability to pay. The sisterhood and hospital were co-financed and even produced surpluses. However, until the early 1960s, it was not possible to trace exactly how these were generated. The deaconess responsible for the hospital administration apparently acted unsupervised. Peace in the community took priority. This economic practice was successful in that the Henriettenstiftung was 'in the black' and, from today's perspective, the sisters were able to carry out their work remarkably untroubled by financial considerations.

This form of economic activity was not able to withstand the upheavals of the 'long 1960s'. This was when it first became clear to what extent the healthcare system had been based on the low-cost labour of sisters – to the detriment of women's pensions, among other things. The cost of nursing work increased rapidly and the Henriettenstiftung had a hard time making it clear to the operators of the outstations

[66] Statutes of the Henriettenstiftung, 1 Apr. 1973, § 13, para. 3, Archive of the Henriettenstiftung, Schwesternarchiv, Handakten.
[67] Lange 2024, pp. 33–36, 133–146.
[68] Kühn 2003.
[69] Primc 2020.

that the nurses' work was no longer virtually free. In addition, the entire workforce had to be reorganised. In the 1960s, time-efficient organisation of work became established even in the motherhouse hospital. The withdrawal of the deaconesses also heralded the rise of professional administrators and opened up the nursing sector to business and administrative approaches.

This gave rise to an ethical conflict that has been discussed for quite some time in the context of marketisation processes: the increasing financialisation of professional nursing and ethical (as well as medical) decisions.[68] The prioritisation of economic interests over ethical principles of patient care is considered a key factor in the emergence of moral distress in nursing.[69] The knowledge of the historically high level of autonomy of Christian nursing in relation to administrative concerns reminds us that the current imbalance has grown historically and that there have been alternatives to the current self-image of nursing in the past. Even if a new edition of Christian sisterhoods is out of the question, historical perspectives offer an important opportunity to take a distanced look at the present.

BIBLIOGRAPHY

Archival Sources

Archive of the Henriettenstiftung

– Bestand Wirtschaft und Versorgung
– Schwesternarchiv
– Vorstandsarchiv

Printed Sources

Arnstorf, head of administration of the Annastift hospital: Bericht über die Durchführung der Arbeitszeitverkürzung im Annastift. In: Die evangelische Krankenpflege 7 (1957), 7, pp. 52–55.

Der gegenwärtige Stand der Arbeitsgebiete der Henriettenstiftung und die Namen der dort wirkenden Schwestern, Juli 1951. In: Blätter aus dem Henriettenstift (1951), 2/3, pp. 26–35.

Der gegenwärtige Stand der Arbeitsgebiete der Henriettenstiftung und die Namen der dort wirkenden Schwestern, August 1960. In: Blätter aus dem Henriettenstift (1960), 2/3, pp. 11–18.

Helbig, Wolfgang (ed.): … neue Wege, alte Ziele. 125 Jahre Henriettenstiftung in Hannover. Hanover 1985.

Mutterhaus-Diakonie im Umbruch der Zeit. Zur Hundertjahrfeier der Henriettenstiftung Hannover. Hanover 1960.

Rüther, Bernhard: "Spekulation in Nächstenliebe"? 2. Teil. In: Krankendienst 25 (1952), 11, pp. 281–285.

Secondary Literature

Frese, Matthias/Julia Paulus/Karl Teppe (ed.): Demokratisierung und gesellschaftlicher Aufbruch. Die sechziger Jahre als Wendezeit der Bundesrepublik. Paderborn et al. 2005.

Freytag, Günther: Unterwegs zur Eigenständigkeit. Von den "freien Hilfen" zur "Diakonischen Schwesternschaft", Gemeinschaft evangelischer Frauen und Männer im Kaiserswerther Verband deutscher Diakonissenmutterhäuser e. V. Gütersloh 1998.

Gaida, Ulrike: Diakonieschwestern. Leben und Arbeit in der SBZ und DDR. Frankfurt am Main 2016.

Graf, Rüdiger: Einleitung. Ökonomisierung als Schlagwort und Forschungsgegenstand. In: Graf, Rüdiger (ed.): Ökonomisierung. Debatten und Praktiken in der Zeitgeschichte. Göttingen 2019, pp. 9–25.

Hackmann, Mathilde: "Also früher war man als Schwester selbständig …" Veränderungen in der westdeutschen Gemeindekrankenpflege von 1950 bis in die 1980er Jahre. In: Thiekötter, Andrea et al. (ed.): Alltag in der Pflege – Wie machten sich Pflegende bemerkbar? Beiträge des 8. Internationalen Kongresses zur Geschichte der Pflege 2008. Frankfurt am Main 2009, pp. 191–207.

ENHE 6/2024 DOI:10.25974/enhe2024-2en

Henkelmann, Andreas et al.: Abschied von der konfessionellen Identität? Diakonie und Caritas in der Modernisierung des deutschen Sozialstaats seit den sechziger Jahren. Stuttgart 2012.

Herbert, Ulrich (ed.): Wandlungsprozesse in Westdeutschland. Belastung, Integration, Liberalisierung, 1945–1980. Göttingen 2002.

Kaminsky, Uwe: Die Personalkrise in der Diakonie in den 1950er/60er Jahren. Milieuauflösung und Professionalisierung. In: Henkelmann, Andreas et al. (ed.): Abschied von der konfessionellen Identität. Diakonie und Caritas in der Modernisierung des deutschen Sozialstaats seit den sechziger Jahren. Stuttgart 2012, pp. 18–43.

Kramer, Nicole: Der Wert der Pflege. Der Reiz der Ökonomisierung und der Wohlfahrtsmarkt der Möglichkeiten. In: Graf, Rüdiger (ed.): Ökonomisierung. Debatten und Praktiken in der Zeitgeschichte. Göttingen 2019, pp. 383–412.

Kreutzer, Susanne: Vom "Liebesdienst" zum modernen Frauenberuf. Die Reform der Krankenpflege nach 1945. Frankfurt am Main/New York 2005.

Kreutzer, Susanne: Arbeits- und Lebensalltag evangelischer Krankenpflege. Organisation, soziale Praxis und biographische Erfahrungen, 1945–1980. Göttingen 2014.

Kreutzer, Susanne/Karen Nolte: Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century. Stuttgart 2016.

Krey, Ursula (ed.): Von der inneren Mission in die Sozialindustrie? Gesellschaftliche Erfahrungsräume und diakonische Erwartungshorizonte im 19. und 20. Jahrhundert. Bielefeld 2014.

Kühn, Hagen: Ethische Probleme der Ökonomisierung von Krankenhausarbeit. In: Büssing, André/Jürgen Glaser (ed.): Dienstleistungsqualität und Qualität des Arbeitslebens im Krankenhaus. Göttingen et al. 2003, pp. 77–98.

Lange, Jette: The Nursing Process as a Strategy for a (De-)Professionalization in Nursing. A Critical Analysis of the Transformation of Nursing in Germany in the 1970s and 1980s. Göttingen 2024.

Mann Wall, Barbra: Unlikely Entrepreneurs. Catholic Sisters and the Hospital Marketplace, 1865–1925. Columbus 2005.

Müller, Fruzsina: Protestant Nursing in Crisis? The Shortage of Deaconesses in the GDR Using the Example of the Evangelisch-Lutherisches Diakonissenhaus Leipzig. In: European Journal for Nursing History and Ethics 3 (2021), pp. 44–71. DOI: 10.25974/enhe2021-7en.

Müller, Fruzsina: Das Leipziger Diakonissenhaus. Die Geschichte einer Schwesternschaft und ihres Krankenhauses. Leipzig 2023.

Primc, Nadia: Dealing with Scarcity of Resources in Nursing. The Scope and Limits of Individual Responsibility. In: European Journal for Nursing History and Ethics 2 (2020). DOI:10.25974/enhe2020-8en.

Schildt, Axel: Die Sozialgeschichte der Bundesrepublik Deutschland bis 1989/90. Munich 2007.

Schmuhl, Hans-Walter: Evangelische Krankenhäuser und die Herausforderung der Moderne. 75 Jahre Deutscher Evangelischer Krankenhausverband (1926–2001). Leipzig 2002.

NURSING LEADERSHIP DURING ITALY'S ECONOMIC MIRACLE (1950–1970)

Giordano Cotichelli

Abstract

Between the 1950s and 1970s, Italy experienced far-reaching social reforms, following economic improvements to living conditions and the country's industrial structure. The reforms were driven by the youth protests that swept across the entire Western world (May 1968 in France) and by the workers' struggles in Italy ("Hot Autumn"). In the nursing world, these changes foreshadowed significant transformations on three levels: a) Professional: the growth of leadership roles and positions that helped make the profession increasingly active and visible within Italian society; b) Unions: nurses played a key role in struggles to obtain better working conditions (wages, shifts, staffing levels) and supported the establishment of a universal public health system; c) Scientific: nurses became involved in experiments aimed at developing innovative care methods, particularly in psychiatric hospitals. These three levels often overlapped. The objective of this study is to elucidate the evolutionary trajectory of the transformations that occurred in the nursing profession during the aforementioned period.

Keywords: hospital, nurses, struggles, strikes, profession, Italy

1 INTRODUCTION

This paper examines the nursing profession during a particular moment in Italian history: the "boom" period of 1958–1963, known as the Italian economic miracle. It was the era of Fellini's *La Dolce Vita*, the Rome Olympics, the legendary Fiat 500, and the advent of television in every household. The refrigerator became the first status symbol desired by Italians, one of the many symbols of progress accompanying the country's journey out of the devastation of World War II, during which, once again, thousands of its citizens sought opportunities in wealthier economies through emigration. Many sectors of society were still in need of modernization, as they were tied both to the structure of the past fascist dictatorship and to the preceding liberal monarchic state. However, from the late 1950s onwards, various changes began to take shape. In the realm of healthcare services, a Ministry of Health was established for the first time in 1958. It took on issues that had previously fallen within the remit of the Ministry of the Interior and had often been dealt with institutionally as matters of public order.

The 1960s was a decade of events that significantly influenced and changed the face of the country. On the healthcare front, these years concluded with Law 132 of 1968, which aimed to reform the Italian healthcare system but actually only brought about some minor, yet significant, changes. These changes paved the way for the reform embodied in Law 833 of 1978.[1]

The period under investigation marks a turning point in Italy's history. Historian Paul Ginsborg[2] asserts that Italians were able to enjoy unprecedented widespread prosperity. The nursing profession played a significant role in this historiography at the professional, labor policy, and care levels. On a professional

[1] Among the main interventions of the law, the following are notable: a) Extension of hospital care to all citizens, both Italian and foreign. b) Transformation of hospitals into public entities. c) Obligation for the state to finance hospital debts. d) Regulation of medical management. e) Opening up the possibility of establishing training schools for personnel, including those for professional nurses and general nurses, starting with the provincial hospitals.

[2] Ginsborg 2006, p. 78.

level, we will consider the key figures involved in structuring a managerial class through the evolution of professional associations (Colleges of Professional Nurses, Health Care Assistants and Childminders)[3] and training (boarding schools). Many nurses began to contribute their knowledge in an institutional context and in scientific meetings. At the political and union level, there was a significant presence of nurses (both male and female) in job actions linked to contractual demands during this period, which was marked by prolonged strikes, demonstrations, protest marches, and, in some cases, the occupation of hospital wards or buildings. Finally, in a continuously evolving healthcare and work environment, changes also took place within the nursing profession itself on a purely scientific level. These changes were linked to technical and scientific progress and new models of care and assistance, with notable advances in the field of modern psychiatry.

Objectives

This study aims to elucidate the evolutionary trajectory of the transformations that occurred in the nursing profession in Italy between 1950 and 1970. In particular, it seeks to ascertain whether and to what extent the nursing profession began to assume a more prominent role during this period as a political, union, welfare, and professional resource within Italian society.

Methodology

Historical sources were examined in line with the teachings of the Italian historian Chabod.[4] This also included analyzing archival materials from the period (primary sources) and studying secondary sources derived from the available bibliography, especially conference and congress proceedings and the online archive of a contemporary newspaper, *L'Unità*.[5] The choice of reference material was made according to certain documentary priorities. This facilitated the historical reconstruction of events along a chronological axis, evaluated without considering specific political viewpoints. The source materials included articles on health policy, union struggles in hospitals, and writings related to events (e.g., conferences) concerning the nursing professions. The keywords used with the truncation technique were: *inferm** (nurses), *sanit** (healthcare), *ospedal** (hospital).

2 QUANTITATIVE RESULTS

Our analysis of the sources has enabled us to outline a picture of the events of the period and to highlight various forms of professional leadership along the three analytical axes. In the healthcare sector, this period saw the emergence of the professional nurse, although this role was not yet sufficiently representative in a care context dominated by general nurses, both male and female. This picture also reflects a limited male representation, since men were excluded by Law 1832/1925[6] from the boarding schools set up for the higher education of professional nurses – a form of gender segregation that contributed to a significant increase in the number of male general nurses, who often played leading roles in the struggles of the period. The chronicles of those years reveal the ongoing changes in healthcare, particularly in the field of psychiatry, where many past care practices were swept away by reformative actions led by both doctors and nurses.

[3] The National Professional Nurses, Health Care Assistants and Childminders College (Collegio Nazionale degli Infermieri Professionali, Assistenti Sanitari e Vigilatrici d'Infanzia – IPASVI) was the national body, encompassing the IPASVI provincial nursing colleges. For more than half a century, it united professionals and performed the functions that would subsequently become the remit of the professional association. Subsequently, from 2018 onwards, the provincial colleges underwent a transformation, becoming the Provincial Professional Orders, and are now collectively represented by the National Federation of Orders for Nursing Professions (Federazione Nazionale degli Ordini delle Professioni Infermieristiche – FNOPI).

[4] Chabod 1992, pp. 82–127.

[5] Despite *L'Unità* being a party publication – of the Italian Communist Party – this source was useful for gathering information on the movements of struggle, since it was also linked to the activities of the three most important trade union confederations of the time, particularly the Italian General Confederation of Labor (CGIL).

[6] The Royal Decree 1832 of 1925 was the first law in Italy to regulate the training of professional nurses by establishing boarding schools.

An analysis of the sources paints a comprehensive picture of the number of available hospital beds, the number of doctors, the number of professional nurses registered with the National Professional Nurses, Health Care Assistants and Childminders College (*Collegio Nazionale degli Infermieri Professionali, Assistenti Sanitari e Vigilatrici d'Infanzia* – IPASVI), and the number of general nurses over the course of the 1950s and 1960s. This overview aims to provide a comprehensive picture of the evolution of healthcare provision in Italy, both in organizational terms (hospital beds) and professional terms (healthcare personnel). Some minor quantitative discrepancies in the personnel numbers of the time were found while examining the sources, particularly between data collected by the Italian National Institute of Statistics (*Istituto Nazionale di Statistica* – ISTAT) and those presented at conferences and congresses and recorded in conference proceedings. However, these discrepancies do not significantly alter the overall historiographical representation.

Tables 1 and 2 below, derived from the ISTAT data,[7] along with the IPASVI[8] registration data, provide reference data for the healthcare landscape of the time:

Table 1: Availability of hospital beds, doctors and nursing staff 1956–1970 (our elaboration)

Year	Available hospital beds (ahb)	Doctors	Nurses	Registered IPASVI	Ratio ahb/ doctors	Ratio ahb/ nurses	Ratio nurses/ doctors
1956	393,720	23,237	45,102	23,720	16.9	8.7	1.9
1957	413,331	23,995	46,083	23,758	17.2	9.0	1.9
1958	425,706	24,975	48,484	23,509	17.0	8.8	1.9
1959	439,893	25,883	51,501	24,586	17.0	8.5	2.0
1960	450,539	27,034	54,939	25,408	16.7	8.2	2.0
1961	459,950	28,602	57,866	26,352	16.1	7.9	2.0
1962	472,314	30,082	61,322	27,393	15.7	7.7	2.0
1963	485,336	31,308	65,833	27,635	15.5	7.4	2.1
1964	493,563	32,840	69,132	28,159	15.0	7.1	2.1
1965	503,110	34,301	73,130	29,487	14.7	6.9	2.1
1966	515,607	35,730	77,131	30,207	14.4	6.7	2.2
1967	528,276	36,980	83,641	31,711	14.3	6.3	2.3
1968	542,834	38,281	90,423	33,045	14.2	6.0	2.4
1969	560,336	40,507	100,310	34,530	13.8	5.6	2.5
1970	568,459	43,414	114,608	37,259	13.1	5.0	2.6

[7] Istituto Nazionale di Statistica – ISTAT 1976, pp. 42–43.
[8] List of professionals enrolled in the National Federation of Nursing Professions (FNOPI) register. https://web.archive.org/web/20150402143659/http://www.ipasvi.it/chi-siamo/iscritti/gli-iscritti-dal-1956-ad-oggi.htm, accessed February 01, 2020.

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Table 2: Availability of hospital beds by hospital type and decadal average number of available beds and nursing staff for the period 1951–1970 (our elaboration)

Years	General hospitals (available beds)	Nurses	Nurses/beds	Psych. hospitals (available beds)	Nurses	Nurses/beds	Sanatorium hospitals (available beds)	Nurses	Nurses/beds	Private hospitals (available beds)	Nurses	Nurses/beds
1951–60	216,173	24,938	8.6	91,718	16,511	5.5	48,029	2,802	17.1	61,379	5,725	10.7
1961–70	289,949	47,195	6.1	94,814	21,123	4.4	40,652	2,768	14.6	87,564	8,254	10.6

The two tables illustrate the progressive growth in numbers of hospital beds and nursing staff over the years, highlighting differences between general hospitals and neuropsychiatric hospitals, sanatoriums, and private institutions. The rate of growth is closely linked to the type of patients treated and the economic policies followed. In facilities where patients require more attention due to acute clinical conditions or manifest psychological distress, the number of staff per bed is higher than in institutions specializing in chronic care, such as sanatoriums, or those influenced by different economic policies pursued by private institutions in the name of the market.

Compared to the European average, staffing levels in Italy are significantly lower overall. The availability of hospital beds varies from around 60% in private institutions to 90% in neuropsychiatric institutions. The calculation is then related to the total number of registered nurses, including both registered nurses and licensed practical nurses enrolled in the IPASVI Colleges, and shows that, before the reform of the boarding schools *(scuole convitto)* in 1971, nursing care was still largely supported by general nurses (or psychiatric nurses). As the number of staff increased, the ratio of general to registered nurses would reach nearly 2:1. This data suggests that the level and quality of care provided was minimal and performance-based, essentially focused on meeting the basic needs of patients. The quantitative data suggests that the quality of care was in need of radical transformation, starting with the professional identity of nurses, which would be affirmed primarily by registered nurses and the emerging professional frameworks.

3 CONFERENCES AND CONGRESSES: TESTING GROUNDS FOR A NEW PROFESSIONAL LEADERSHIP CLASS

After the pause imposed by World War II, the 1950s saw a resumption of the professionalization process for Italian nurses. The IPASVI Colleges and professional registers were established in 1954.[9] In 1956, the following numbers were recorded for schools associated with the IPASVI College: schools for professional nurses (48), for visiting health assistants (22), for child welfare supervisors (5), a higher education course for nursing school directors, two national courses for psychiatric specialization, two national courses for specialization in dietetics (for health assistants), and a national course for head nurses in teaching. Additionally, it was possible to set up various local courses for different healthcare specializations within this general framework.[10] The first draft of the Italian Code of Ethics for Nurses was drawn up in 1959 and came into effect the following year.

Public events began to follow one another in quick succession, highlighting the presence of a nursing body that, on the one hand, managed to create autonomous moments of collective debate on care issues and, on the other hand, was establishing itself as a professional reference point for public demonstrations. The Federation of IPASVI Colleges participated in the First International Health Exhibition in Rome in 1960, where it presented the newly adopted first version of the Code of Ethics. The following year, it was present at the Italia '61 exhibition in Turin to mark the centenary of national unity, and in 1963, on the occasion of National Nurses Day, a promotional campaign about the nursing profession was launched in secondary schools throughout the country.[11] A nursing presence was also noted at the 12th International Congress of Surgery (from May 15 to 18, 1960) and at the first two Congresses of Hospital History, held respectively from June 14 to 17, 1956, in Reggio Emilia, and five years later from June 7 to 9, 1961, in Turin and St. Vincent.[12]

On October 8, 1964,[13] the National Association of Professional Nurses, Visiting Health Assistants and Child Welfare Supervisors (*Consociazione Nazionale delle Infermiere Professionali e delle Assistenti Sanitarie Vigilatrici*)[14] organized a conference in Rome titled: "Our Country Needs Nurses. How to Solve the Problem?" This initiative was important for analyzing the state of healthcare, and showing the presence of one professional nurse for every 60 patients, given that there were 24,586 graduates (in 1959) for 422,000 hospital beds.[15] The conference was held in collaboration with the International Council of Nurses (ICN), thanks to the Director of the ICN's Social and Economic Division, Sheila Quinn, the Italian President Marina Caruana, the Director of the San Camillo Hospital in Rome, Mario Massani, and the President of National Maternity and Childhood Work, the Hon. Angela Gotelli. Attention was drawn to the low number of nurses graduating each year: just 1,500–1,600. To meet the country's healthcare needs, this figure would need to triple within a decade to achieve a ratio of one nurse for every 20 patients. It is also worth noting that in many Western countries, the nurse-to-doctor ratio was 4 to 1, while in Italy, there were just two nurses for every doctor.[16]

[9] Sironi/Ceconi/Di Mauro 1996, pp. 144–145.
[10] Marin 1957, p. 78; Cantarelli 2003, p. 11.
[11] Larghi/Perevelli 2008, p. 26.
[12] Cotichelli 2022, p. 56.
[13] E.b. 1964, p. 5.
[14] This association represents a continuation of the tradition of national nursing associations that originated with the National Italian Association of Nurses, which was established in 1919 and subsequently dissolved during the fascist regime. The association was established on March 1, 1946, and re-joined the ICN during the Stockholm Congress in 1949. In 1974, it underwent a further change of name to the National Association of Nurses and other Social and Health Workers, and subsequently in 1976 to the Italian Nurses Association, which is still in use today.
[15] Sironi/Ceconi/Di Mauro 1996, p. 142.
[16] E.b. 1964, p. 5.

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Serious issues also emerged during this period with regard to work shifts, which ranged from 50 to 54 hours per week – a heavier workload than was required in many factories, according to Prof. Massani. Career paths appeared ephemeral, with a salary range from 39,000 to 67,000 lire per month and pensions amounting to 20,000 lire.[17] The exodus towards other sectors was described as an endemic plague.[18]

The point at which a mature nursing world ready for managerial roles first made an appearance was the first IPASVI Congress held in Rome from May 31 to June 2, 1965. President Laura Sterbini Gaviglio opened the proceedings by recalling the many present difficulties, from contractual issues to those concerning training and professional recognition. She also emphasized the necessary evolution of post-basic specialized training to keep pace with technical and scientific progress and the differentiation of care provision, leading to the emergence of roles such as: a) residential nursing school director, b) psychiatric nurse assistant, c) operating room nurse, d) maritime nurse, e) hospital health assistant. An impassioned appeal was also made for the increasingly necessary establishment of Local Health Units, a system that would be reformed 13 years later.[19]

The principal of the school in Ivrea, Sister Emilia Lauriola,[20] speaking during the plenary session of the congress, raised the urgent need to reform the profession to meet the needs of modern healthcare and posed the following question:

What, then, keeps patients from affluent classes away from the hospital? [...] today, the functions of the professional nurse are more complex, and although for many she remains merely an order taker, she actually performs tasks of high responsibility in various fields.[21]

The principal recalled that this necessity had already been highlighted three years earlier during the National Conference of Hospital Medical Directors and Residential Nursing School Directors, held in Pietra Ligure in May 1962. She supported her words with data from a study by the International Labour Office,[22] showing the ratios of professional nurses to the population (per 10,000) as follows: 23 (Canada), 24.5 (Sweden), 25.6 (USA), 26.4 (Germany), 27.1 (New Zealand), 28.2 (Norway), 32.2 (Denmark), 31.5 (Ireland), 38.2 (Australia), 48.3 (UK). In Italy, it was 3.5.

It is worth noting that the congress took place one week after the approval of Presidential Decree no. 775 on May 24, 1965, which established the diploma for nursing care managers.[23] The first course would open that same year at the Hygiene Faculty of Sapienza University in Rome, followed by a course at the Catholic University (1969), also in Rome, and one at the University of Milan (1974). The first deputy director of the Rome school would be Italia Riccelli, who worked with Rosetta Brignone under the direction of the Director of the Institute of Hygiene. It should be noted that the Rome school was not the first training course for nursing managers in Italy. There had been similar schools in the past, but outside of direct academic control. For example, Sister Emilia Vinante[24] was instrumental in setting up courses from 1953 to 1965 at the Catholic University of Milan in collaboration with the Giuseppe Institute. A total of 56 nursing managers graduated from these courses.[25]

[17] A worker in the retail sector in 1964 in one of the major Italian industrial cities like Turin or Milan could earn 62,388 lire per month. ISTAT 1965, p. 68.
[18] With regard to the interest in nursing issues, it is pertinent to cite the report published by L'Unità on May 19, 1966, which states that the Italian radio and television broadcaster (RAI) included a segment on the 10th National Nurses Day in its television programme at 11:00 am. Programmi RAI: 11.00 X Giornata internazionale dell'Infermiere 1966, p. 12.
[19] Larghi/Peverelli 2008, pp. 24–25.
[20] Programmi RAI: 11.00 X Giornata internazionale dell'Infermiere 1966, p. 12.
[21] Lauriola 1965, pp. 32–42.
[22] International Labour Office 1960, p. 7; Vanzetta 2022 a.
[23] Dirigente assistenza infermieristica – DAI.
[24] Negri 2007, p. 29.
[25] Negri/Manzoni 2007, p. 132; Bezze/Manzoni/Di Mauro 2013, p. 80.

In the two years following the first IPASVI Congress, other significant events contributed to the profession's growth. On May 15, 1967, the official gazette announced the establishment of the Central Commission for Healthcare Professionals,[26] which included graduate nurses, specifically Sister Maria Laura De Cristoforo, Anna Platter, Giuseppina Postiglione, and Paola Zearo as full members, and Rosina Fracca and Laura Sterbini Gaviglio as deputy members designated by the National Federation of IPASVI. This was a token presence in a context dominated by doctors and male representatives.

The year 1967 is also notable for the European Agreement on the Instruction and Education of Nurses, signed in Strasbourg on October 25, which constituted a pivotal moment in the legal history of the nursing profession. Firstly, it established a uniformity of action among the participating countries regarding the selection of candidates, study programs, required internship hours, qualifications, and the minimum age required for admission. The IPASVI president at that time was Luciana Demanega Pallocchia.[27] And, secondly, the Federation's bulletin, *L'Infermiere*, began to publish more frequently on professional policy topics.[28]

In the same year, the Perugia Conference took place over three days, from June 16 to 18, 1967, with the participation of 256 people from various professional categories.[29] More than half of the attendees (137) were non-medical health professionals, in a general context where participants can be grouped into the following macro areas: nursing and midwifery professionals with 121 attendees (47%), medical professionals (doctors) with 97 attendees (38%), other health professionals with 16 attendees (6%), and another 22 attendees from various other professions and qualification backgrounds (9%). The majority of the nursing profession attendees were health visitor assistants (81).[30] Among the nurses, the presence of seven boarding school headmistresses (including one nun) and one deputy headmistress[31] is noteworthy. There were 87 boarding schools in operation at the time.[32] There were also five presidents of Provincial IPASVI Colleges among the delegates, out of 93 provinces. Two nurses from the Careggi Hospital boarding school in Florence were present, in addition to nine professional nurses and 12 male nurses, of whom six were general nurses, one was a psychiatric nurse, and three were union representatives.

The numbers essentially reveal very limited participation by the nursing profession, both in terms of professional nurses and general (or psychiatric) nurses. The conference proceedings, however, provide an overview of the topics discussed: the different nursing roles in services, their respective roles and functions, training issues, and healthcare challenges. The proceedings highlight the predominance of medical professionals, which a few years later would be referred to by the American sociologist Eliot Freidson[33] as medical dominance.

The contributions by non-medical health professionals in the conference proceedings are reduced to testimonies in the final communications section. Among these is the proposal put forward by Dr. Maria Antonia Modolo and Deputy Director Italia Riccelli regarding the education system, advocating for a reform plan starting from high school, with the creation of a technical institute with a biological focus. Nursing is also the focus of a report titled "Non-medical Health Personnel in Hospital Services", which is divided into two parts: a) "Functions and Training of Personnel" by Luigi Nuzzolillo, Director General of the Ministry of Health; and b) "Professional Nurses and General Nurses in Hospital Services", cura-

[26] Provided for by Article 17 of Legislative Decree No. 233 of September 13, 1946.
[27] A position he held until 1982. Vanzetta 2022 b.
[28] Vanzetta 2022 a.
[29] Seppilli 1968, p. 10.
[30] It should be noted that many of the health visitor assistants likely came from a nursing education background.
[31] Anna Maria Antici was the deputy headmistress in question. She worked at the boarding school in Perugia, while the others were: Maria Caruana from Naples, Andreina De Andreis from Turin, Rosa Dell'Antoglietta from Rome, Sister Angela Iacopini from Perugia, Giuseppina Menchini from Florence, Maria Rita Preite from Ferrara, and Italia Riccitelli from the Special School for Nursing Leadership in Rome.
[32] Modolo/Riccelli 1968, p. 215. In another account (Vianello 1973, p. 58), the total number rises to 96.
[33] Freidson 2002, p. 56.

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ted by Stelio Ferolla, National Secretary of the National Association of Hospital Assistants (*Associazione Nazionale Aiuti Assistenti Ospedalieri* – ANAAO) of Ferrara, and Mario Massani, Medical Director of San Camillo Hospital in Rome. Finally, Luigi Nuzzolillo's report[34] presents an interesting general overview of non-medical health personnel in service in Italy at May 31, 1967, showing 45,363 active personnel, including 41,491 nurses (professional and general), 2,000 midwives, 1,003 health visitors and child health inspectors, and 869 technicians, auxiliary professionals, and non-medical health personnel.

The simplicity of the numbers is striking. The table compiled by the ministry groups professionals into larger categories to provide a system-wide overview. The first group of 155 individuals consists of non-medical health personnel: biologists (74), chemists (54), physicists and nuclear physicists (15), sanitary engineers (5), and biostatisticians (7). The second group comprises 198 individuals: auxiliary professions, including psychologists (29), social workers (168), and health educators (1). The third group, referred to as the "technical" group, includes 516 rehabilitation professions: physiotherapists (210), occupational therapists (61), speech therapists (51), dietitians (134), and orthoptists (60). The group that includes health visitor assistants and child health inspectors, represented professionally along with nurses by IPASVI Colleges, totals 1,003 individuals, with 223 health visitor assistants and 780 child health inspectors. The number of midwives, with 2,000 employed in public hospitals, is almost double. The last group comprises nurses (41,491) and the table shows their secular or religious affiliation,[35] with the following breakdown: professional nurses 11,410 (secular 7,214 and religious 4,196) and general nurses 30,081 (secular 26,122 and religious 3,959). Table 3 shows how the numbers of non-medical personnel, including those in private institutions, grew from 1963 to 1967.[36]

Table 3: Chart of nursing staff growth from 1963 to 1967 (our elaboration)

Year	Registered Nurses/Head Nurses			General Nurses			All Nurses		
	Secular	*Religious*	*Total*	*Secular*	*Religious*	*Total*	*Secular*	*Religious*	*Total*
1963	14,080	9,719	23,799	32,696	2,362	35,058	46,776	12,081	58,857
1964	14,747	9,456	24,203	35,230	2,419	37,649	49,977	11,875	61,852
1965	15,814	9,425	25,239	37,848	2,410	40,258	53,662	11,835	65,497
1966	16,950	8,965	25,915	40,494	2,741	43,235	57,444	11,706	69,150
1967	17,990	8,838	26,828	44,754	2,767	47,521	62,744	11,605	74,349

The increase in nursing staff over this period was pronounced, with an overall growth rate of 26.3% (35.5% for general nurses and 12.7% for graduates). On the eve of Law 132/68, the five-year figures provide some indications of change, but still show limited growth in the number of graduate nurses, a key reference indicator for healthcare training. At the time, healthcare provision was not only hospital-centric and doctor-centric but also very limited, as hospitalization gradually became the only care and treatment option. Preventive healthcare and rehabilitation remained negligible in a healthcare context in

[34] Nuzzolillo 1968, p. 72

[35] The religious presence in healthcare, and in many other welfare sectors, in Italy was historically significant until the early 1980s. In terms of nursing, Church management of hospitals and care centers led to a Christian imprint on professional morality which, in quite a few cases, came into conflict with the scientific – secular – dimension of care and the profession itself. The numbers shown in the table also reveal a slow change in the professional composition, which was to play a role in nursing protagonism.

[36] ISTAT 1969, p. 61.

which nursing staff accounted for the vast majority of non-medical health personnel (91.4%). The Italian healthcare system at this time appears to have been based solely on performance, with a lack of broad objectives, and was likely inadequate and not equipped to respond to the complexity of social health needs accompanying the country's modernization.

The decade ends with another significant event: the second IPASVI Federation Congress, held from October 15 to 17, 1969, again in Rome. The participants and themes do not differ much from the event held two years earlier. Attention is drawn to the persistent issues of nursing staff shortages, made more evident by the ratio between nursing and medical staff, which, contrary to the European average, was heavily skewed in favor of the latter:[37] four doctors to one nurse in Italy compared with five nurses to one doctor in Sweden. In Italy, there were 22,000 nurses, of whom 14,500 were in public hospitals, whereas there should have been 71,500. The cited article, authored by Concetto Testai, emphasizes the serious professional situation for the representatives of the three professions grouped under IPASVI: "If specific bills are not prepared within the year, after consulting the relevant professional category, the necessary job action measures will be promoted".[38] This statement underscores the complexity of the many problems – problems related to the need to develop teamwork, a modern and decentralized health service, the admission of men to boarding schools (which could no longer be postponed), and the decision to lower the minimum age from 18 to 17 years in view of the low number of nurses (about 1,800) graduating each year from the 83 schools in existence at that time.

On the current website of the National Federation of Nursing Professions (FNOPI)[39] there is a section dedicated to images from that time, featuring photographs from the first two IPASVI Congresses and the Assembly of College Presidents that was held in Rome on March 2 and 3, 1968, as an intermediate event between the two congresses. The photos reflect a world in which the male component is absent on the nursing front but well represented among the institutional and medical delegates. The participants appear elegant in their poses and attire, reflecting their middle-class background – a status still linked to what the sociologist of professions, Amitai Etzioni,[40] calls a "semi-profession". Nonetheless, the documents produced and the events attended or organized clearly demonstrate a mature professional leadership class that has lived through the 1960s and is ready to face the anticipated changes. In this regard, a final significant event marking the end of the decade deserves a mention: The Florence Conference on Nursing Services in a New Framework of Health Structures was organized by the Tuscany Regional Hospital Association and took place on January 11–12, 1969.[41]

Several professional figures spoke at the congress, including Huguette Bachelot (France), Barbara N. Fawkes (UK), Marjorie Simpson (UK), and Maria Palmira Tito de Moraes (WHO). The main issues discussed concerned the evolution and structuring of the nursing profession, and the need for nurses to be represented in international institutions (WHO) and in research.

Italia Riccelli, also present on this occasion, recalled the activities of the DAI school in Rome, from which 14 nurses graduated in the 1965–1967 biennium and in which 19 candidates were enrolled for the 1967–1968 academic year. Nurse Livio Burroni addressed the importance of investment in education and healthcare professionalism to prevent care from becoming second-rate, as was often the case in the psychiatric field. There were also reports from Viviana Belloni, a unionist of the National Union of Professional Nurses, Assistant Visiting Nurses, and Child Welfare Supervisors[42] Romolo Rovere from

[37] Testai 1969, p. 2.
[38] Testai 1969, p. 2.
[39] History of the Bulletin in: https://www.infermiereonline.org/category/la-storia-della-rivista/.
[40] Etzioni 1969, p. 67.
[41] Amministrazione rete ospedaliera e territoriale – A.R.O.T. 1969.
[42] Little is known about the history and activities of this union, although the figure of Belloni herself appears in the available sources as a nurse and union activist of the time. Belloni 1971, p. 45.

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the Italian General Confederation of Labour (*Confederazione Generale Italiana del Lavoro* – CGIL), and Alessandro Zuini, who focused on contractual issues. The final items highlighted testimonies dealing with demands and protests, foreshadowing the continuation of mobilizations and union demands that had been taking place throughout the country for some time. These struggles involved all healthcare workers, from the chief physician to the lowest orderly.

4 THE BIRTH OF HOSPITAL WORKERS

The 1960s were characterized from the beginning by a progressive rise in social unrest. On the union front, worker participation in struggles increased by more than 70%, and strikes almost tripled compared to the preceding years. Between 1951 and 1960, 2,037,000 workers participated in job actions involving a total of 42,221,000 hours of strikes. In the following ten years, 3,508,000 workers were involved and there were 121,973,000 hours of strikes.[43] The labor disputes index rose from 92% in 1956 to 238% in 1962.[44] Workers participating in the struggles were not exclusively from the generation of forty-year-olds – those who had lived through the dramatic years of the fascist dictatorship, the war, the partisan struggle, and the difficult reconstruction phase – but also included many young people seeking to break free from old power structures. This rebellion stemmed partly from generational conflict but reached broader levels of politics and the world of work.

Historian Sergio Bologna,[45] borrowing an expression from German, speaks of a true *soziale Bewegung*, a protest movement with a strong demand for societal change. This drive inevitably affected the hospital world, caught between hierarchical medical corporatism and the rigid morality espoused by the religious staff, who were still prevalent. The hospital was also a world with a high percentage of unskilled healthcare workers, made up of auxiliaries, orderlies, and general nurses. This workforce represented the *machine à guérir* (healing machine) described by Foucault,[46] in which hospital managers were more concerned with performance in meeting health needs than with the quality of care provided, something that is closely linked to staff training and remuneration. It should also be remembered that in the 1960s, healthcare was still hospital-centric, and strongly influenced by a segregationist view, with hospitals divided by specialties. Here, the worst conditions were found in the hospitals for neuropsychiatric patients (asylums) and the sanatoriums for pulmonary tuberculosis patients. Then there were the hospitals in large cities, both public and private hospitals, and the "training" hospitals associated with university faculties. All these structures required very high management costs, which were kept in check through low wages and low staff numbers. Consequently, Italian hospitals were affected in a variety of ways by a wave of protests that grew throughout the decade.

An unsigned article dated October 26, 1960, highlights the disastrous situation of Italian hospitals, in terms of severe bed shortages, and provides a snapshot that varies from north to south. The following numbers of beds and doctors per 100,000 inhabitants were reported: 2.6 beds and 19.7 doctors (north), 2.4 beds and 27.1 doctors (center), 0.7 beds and 7.1 doctors (south), and 1 bed and 9.9 doctors (islands).[47] An article from November 3, 1962, provides some general data indicating the severity of the situation: 67,000 beds in private nursing homes were served by 3,598 doctors and 5,972 nurses, compared to 226,000 hospital beds (4 per 1,000 inhabitants), which was insufficient to meet the country's

[43] ISTAT 1976, p. 152.
[44] Colarizi 2019, p. 10.
[45] Bologna 2019, p. 9.
[46] Foucault et al. 1979, p. 87.
[47] La disastrosa situazione degli ospedali italiani 1960, p. 10.

needs.[48] At the end of the year, university staff went on strike demanding salary increases and improved staffing levels, and in protest at other contractual issues related to general poor working conditions, including various requirements (e.g., marriage clauses for women, under penalty of dismissal) and long shifts.[49]

In this context, strikes spread to affect all categories of health workers. From the archival sources cited, it is possible to outline the background, the contents of the protests, the participants, and the frequency of the disputes. In terms of participants, practically everyone was involved repeatedly, from doctors to technicians, nurses, and orderlies. Over the years, these healthcare workers would come to be grouped together under the generic label "hospital workers", a catch-all category of workers that ignored classes, differences and corporate barriers in order to demand profound changes in the healthcare world. Hospital workers would become the protagonists of the country's political chronicles. The struggles would affect both public and private structures. This was the case at the San Carlo and Buon Pastore hospitals in Rome, clinics linked to the Sovereign Order of Malta, essentially the last vestige of the charitable tradition of the Knights Hospitaller from medieval times, where, on August 15, 1962, workers started an indefinite "white strike", or work-to-rule action, to protest against the dismissal of 17 people, who had been fired as punishment for going on strike.[50]

Work-to-rule is one of the most commonly used tools in the hospital environment as it allows healthcare workers to exert pressure on companies, while at the same time ensuring that seriously ill patients receive the necessary assistance and care. This form of strike often receives solidarity from the patients themselves, who, especially if they are not too sick, often use the refusal of food as a protest tool. Patients at the San Camillo hospital in Rome went on a hunger strike in support of healthcare workers' struggles on November 11, 1962.[51] Similar protests also occurred on February 7, 1963, in various sanatoriums across the country, such as Forlanini, Ramazzini, and Buon Pastore in Rome, as well as at similar facilities in Milan, Como, Busto Arsizio, Palermo, Sondalo, and Naples.[52]

Many other struggles were recorded in different places at different times. At the Vito Fazi hospital in Lecce on October 1, 1966, staff protested against the non-payment of contractual dues.[53] On April 21, 1967, 7,000 employees of the Ospedali Riuniti in Rome protested for 36 hours.[54] Healthcare workers demanded salary increases, particularly in relation to the night allowance, which was supposed to increase from the 450 lire provided to 1,000 lire. On May 1, national union negotiations were initiated for 90,000 hospital workers.[55] An article dated April 30, 1968, regarding Rome's collective labor agreements highlighted the poor organization of work, which frequently forced staff to work double shifts of 14 or 16 hours straight, and in some cases, up to 24 hours.[56] These extreme situations were often related to an endemic indiscriminate use of overtime, and the denial of rest breaks, days off, or vacations. In some cases, overtime amounted to 200 additional hours per month, often uncompensated. The article paints an extremely poor picture, highlighting a chronic shortage of workers, with a nurse-to-patient ratio sometimes as low as one nurse per 60–70 patients, as was the case at Santo Spirito Hospital, where staff were even forced to cover three different wards simultaneously.

The situation in Roman hospitals was as dramatic as it was representative of many other conditions in the country. At San Camillo, 250–270 healthcare workers were required to work double shifts. At San Giovanni, where there were 800 available beds, 1,600 patients were admitted for 1,200 healthcare

[48] Tedeschi 1962, p. 3.
[49] Le infermiere che si sposano minacciate di licenziamento 1960, p. 8.
[50] Due ospedali in sciopero 1962, p. 4.
[51] San Camillo, sciopero della fame di 75 ricoverati 1962, p. 4.
[52] Manifestano i tbc davanti alla Camera 1963, p. 5.
[53] In agitazione il personale dell'ospedale "Vito Fazi" di Lecce 1966, p. 18.
[54] Ospedali: hanno preferito il caos pur di non trattare con i lavoratori 1967, p. 6.
[55] Trattative avviate per medici ed ospedalieri 1967, p. 2.
[56] N. c. 1968, p. 6.

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workers, with a theoretical presence of 400 people per shift, although this was lower in practice because of a lack of replacements in the event of absences due to vacations, illnesses, rest breaks, and permissions for time off (often denied), resulting in a nurse-to-patient ratio of one to five. Contractual precariousness was also widespread among hospital staff.

In several cases of prolonged strikes in hospitals, especially those in the capital and in large-scale institutions, the military was drafted in – or threatened to be drafted in – to fulfill basic assistance tasks (e.g., food preparation and distribution). One such case involved the Divina Provvidenza clinic in Rome, where, in the autumn of 1963, a prolonged series of strikes led to the use of army personnel, in this case the grenadiers stationed in the capital.[57]

On April 11, 1967,[58] a chart was published comparing the distribution of financial resources in Italy (40 million inhabitants), a country with a mutual healthcare system, and the United Kingdom (52 million inhabitants), which has a public healthcare system (the National Health Service or NHS). In the latter, the total expenditure amounted to 1,247 billion lire, split between 1,099 billion for hospital spending and 148 billion for pharmaceutical spending. The situation in Italy was very different, with a total expenditure of just 400 billion lire, of which 100 billion was for hospital spending and 300 billion for pharmaceutical spending.

Very often, the body against which strikes were directed was the Italian Federation of Regional Hospital Associations (FIARO), the representative body of the various healthcare administrations. The three main trade union confederations (CGIL, CISL, and UIL)[59] all called for a series of strikes of at least 48 hours each in 1967. Agitation by hospital workers had created a heated climate that would not calm down on its own – a situation recognized on May 31, 1967, by the Minister of Health himself, the socialist Luigi Mariotti, who would go on to promote the aforementioned Law 132 of 1968. He recognized the seriousness of the shortage of nursing staff, which he estimated to be 30,000 workers (this was in fact a serious underestimate).[60] The protests continued over the following weeks. In June, even the 1,300 nurses of the mutual organization ENPAS[61] joined the struggle.[62] In July, there were work stoppages in private clinics in Cagliari.[63] In August, there were demonstrations by tuberculosis nurses from the Valle Fiorita and Santa Lucia clinics in Torrevecchia (Rome), who earned 37,000 lire per month for twelve-hour shifts with a ratio of one nurse to every 40 patients.[64] In the same period, a letter drafted by a group of professional nurses from Reggio Emilia was published in the newspaper L'Unità, raising the perennial issues of work shifts, low salaries, staff shortages, and the demand for a different qualification for graduate nurses.[65]

The strikes continued until September 27, 1967, when FIARO met at Palazzo Chigi with Prime Minister Aldo Moro to obtain funding from the State.[66] The requested amount was 80 billion lire. Pressure on the government was linked to the union's threat of a new season of strikes by healthcare workers and the risk of having to make patients pay for treatments and hospitalizations starting from October 30.[67] The mutual insurance companies owed hospitals 238 billion lire and pharmacies 200 billion lire.

On November 19, 1967, the press reported serious organizational conditions in the 27 private clinics in Rome, including the two psychiatric clinics of Santa Maria della Pietà and Ceccano.[68] In December,

[57] I granatieri in manicomio, in sostituzione degli infermieri in sciopero 1963, p. 4.
[58] Un confronto illuminante 1967, p. 2.
[59] CISL: Confederazione Italiana Sindacati dei Lavoratori; UIL: Unione Italiana del Lavoro.
[60] Nessuna delega al governo per il personale sanitario 1967, p. 2.
[61] ENPAS (Ente nazionale di previdenza e assistenza) for state employees created in 1942 and liquidated with reform law 833 of 1978.
[62] Tre giorni di lotta negli ambulatori ENPAS 1967, p. 4.
[63] 14 ore in corsia per 20.000 lire al mese 1967, p. 4.
[64] Mille lire al giorno per 12 ore di lavoro 1967, p. 6.
[65] Le ragioni della carenza di infermiere professionali 1967, p. 4.
[66] La FIARO a Moro: "Vogliamo 80 miliardi" 1967, p. 2.
[67] Medici ospedalieri ancora in sciopero 1967, p. 2.
[68] Conca 1967, p. 7.

the unions announced new strike days, just before the Christmas holidays.[69] It was in this climate full of tensions and ferment that the first regional conference of the National Nurses Association took place in Rome on December 17, 1967, where the problems that had not yet found a solution were raised again.[70]

5 THE STRUGGLES OF '68

Social conflict was heightened in the last two years of the decade, fueled in part by student protests that originated on US campuses, especially in Berkeley, and spread to the Sorbonne in Paris, and to Berlin, Prague, and many other European capitals. France would be the country most affected by the protests, which were initially youth-led, before becoming a workers' movement. This was May '68, a period of civil unrest characterized by slogans that were both immediate and impactful and would continue to resonate for years: *"La beauté est dans la rue", "Nous irons jusqu'au bout", "Salaires légers, chars lourds", "Grève illimitée"*.[71] Among the many demands were those related to the protection of public health and the healthcare workers themselves. Already, two years earlier, in the spring, there had been a massive demonstration by nurses in front of the Hotel de Ville in the French capital, concluding with a final speech. Now, the protest extended to hospitals. Among the many pieces of evidence available are some posters from that time with texts such as: *"En médecine comme partout, plus de grand patron"; "Les travailleurs de santé pour l'hôpital nouveau"; "Dénonçons la psychiatrie policière!!"*.[72]

The heightened social tensions in other parts of Europe were mirrored in the Italian protests defending the right to health. The year 1967 ended with numerous disputes against FIARO, which resumed in February 1968, when a national indefinite strike took place, with the participation of 120,000 hospital workers, who were joined by doctors.[73] FIARO met with the parties after five days of struggle.[74] The fights against disciplinary measures taken by hierarchical hospitals and corporate management that were intolerant of change also continued. This was the case at the Policlinico of Rome, where, on May 15, 1968, a strike was called in response to disciplinary measures taken against two members of the internal union committee.[75]

The agitations continued throughout June and July in the capital.[76] In the end, it would be possible to address the serious staff shortages by hiring two hundred nurses and various other healthcare workers, thanks to the intervention of the management of the Ospedali Riuniti hospital. The last hospital strike is recorded at San Giovanni Hospital on July 9, 1968.[77] The long wave of protests would continue into 1969, involving both the main industrial centers and the most remote agricultural areas of the country, with an increase in social conflicts, particularly in the last months of the year, so much so that this period would go down in history as Italy's "Hot Autumn."

In the healthcare sector, the struggles at the Policlinico were particularly notable and would continue from spring to autumn. Worth mentioning in this context is the important protest march by university workers on May 1, 1969, which began with banners bearing the words: "Workers united against the power of the barons," "Get the barons out of the university," "50% of university staff are

[69] Lottano i medici e gli infermieri 1967, p. 6.
[70] La piccola cronaca 1967, p. 16.
[71] "Beauty is on the streets", "We will keep going to the end", "Light wages, heavy tanks", "Unlimited strike".
[72] "In medicine, as everywhere, no more big bosses"; "Health workers for the new hospital"; "Denounce police psychiatry!!" The posters cited can be found on the following sites (accessed February 01, 2024): https://sante.lefigaro.fr/article/mai-68-la-revolution-sur-les-bancs-de-la-mede-cine;https://www.bridgemanimages.com/it/noartistknown/poster-france-may-1968-les-travailleurs-de-sante-pour-l-hopital-nouveau-serigraph/screen-printing/asset/3663820; Rubiera 2018, p. 1.
[73] Gli ospedali resteranno senza medici e infermieri 1968, p. 5.
[74] In lotta anche gli psichiatri degli ospedali 1968, p. 5.
[75] Policlinico senza infermieri 1968, p. 6.
[76] La paralisi negli ospedali 1968, p. 6.
[77] San Giovanni: scioperano anche gli infermieri 1968, p. 6.

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excluded from mutual benefits."[78] As mentioned earlier, the reaction from the administration was often very heavy-handed, resulting in disciplinary measures that led in many cases to dismissals. This happened, for example, in Palermo,[79] where 106 employees of the civic hospital were reported for union agitation on July 6, 1969,[80] and 46 nurses were reported in similar circumstances in December of that same year.[81] The justification was usually the same: abandonment of public service. On several occasions, the struggles escalated to encompass the occupation of hospitals, such as the Colle Cesarano Psychiatric Clinic near Rome, where protests of various kinds led to the occupation of the hospital in September 1969.[82] This form of protest was also repeated at the psychiatric hospital of Santa Maria della Pietà, which was occupied for six hours on May 14, 1969,[83] and at the offices of the provincial administration (the body responsible for psychiatric asylums) in Sassari on May 29, 1969.[84]

Over the course of the decade, there would be much news coverage of protests and struggles within the mental hospital universe, revealing a context in which nursing found itself caught between two poles: the role of simple guardian, and the role of assistance professional – one who has tried, since the time of Jean Baptiste Pussin,[85] to respond in a scientific and ethical way to the needs of internees. However, the psychiatric dimension of care and assistance would also see important experiments and changes that would further incentivize the reform of both the asylum system and the Italian healthcare system.

6 THE SITUATION OF PSYCHIATRIC HOSPITALS IN ITALY

Psychiatric hospitals have always been a setting where two poles clash: They are a place of internment, often worse than a prison, and, at the same time fertile soil for the emergence of innovative and progressive movements and tension. The conditions in psychiatric asylums in Italy at the beginning of the second half of the 20th century were characterized by profound backwardness. During the fascist dictatorship, the number of hospitalized patients had increased, partly because the asylums were used as a structure for the repression of political dissent. ISTAT data shows that the population of psychiatric asylums rose from 36,845 hospitalized individuals (113/100,000) in 1902 to 61,697 (134/100,000) in 1946.[86] At the start of the 1960s, the rate of psychiatric hospitalization was still very high.

In 1965, there were approximately 170,715 patients in 92 institutions, despite only 96,869 beds being available[87] – an unsustainable situation that began to give rise to increasingly urgent demands. One of the protagonists of the change would be Franco Basaglia who, as director (from 1961 onwards) of the psychiatric hospital in Gorizia, introduced innovative therapeutic, support, and relational methods.[88] Basaglia was inspired by the ideas that a group of psychiatrists had been promoting in France since 1952, disseminated through the pages of the magazine *L'Esprit*,[89] and by the experiments carried out in the United Kingdom by Maxwell Jones.[90] Basaglia would have the opportunity to affirm:

[78] In corteo dal Policlinico alla P.I. 1969, p. 12.
[79] In Sicily, healthcare was an opportunity for malfeasance and clientelism. Poor conditions and speculation of all kinds dominated. The food was often poor. Many healthcare institutions were controlled by private individuals. Of the 234 healthcare institutions in Sicily, at least 130 were private: Catania 21 public and 44 private, Syracuse 7 public and 12 private, Messina 17 and 17, Palermo 38 public and 33 private.
[80] Denunciati oltre 100 dipendenti all'ospedale civico 1969, p. 4.
[81] Palermo, 46 infermieri denunciati per uno sciopero 1969, p. 2.
[82] Muti 1969, p. 4.
[83] Occupato per sei ore Santa Maria della Pietà 1969, p. 6.
[84] Lorelli 1969, p. 2.
[85] Jean Baptiste Pussin was a French nurse who worked with the psychiatrist Philippe Pinel in France between the 18th and 19th centuries. Pinel is considered one of the founders of a modern psychiatry tailored to the needs of patients, Cotichelli 2010.
[86] Cotichelli 2010, pp. 295–310.
[87] Ferrario 2001, p. 498.
[88] The first law to reform psychiatric care – 180/78 – would be called, not surprisingly, "Basaglia's Law".
[89] Basaglia 1997.
[90] Jones 1987.

A mentally ill person enters the asylum as a person to become a thing. The patient, first of all, is a person and as such must be considered and treated [...]. We are here to forget that we are psychiatrists and to remember that we are people.[91]

In 1964, a nurse, Eraldo Fruttini, arrived at the provincial asylum of Gorizia. He was a member of the working group of the Psychiatric Clinic of Perugia, which also included the Provincial President and the Provincial Health Assessor. The purpose of the trip was to observe the work of Basaglia, who had long been advancing innovative approaches in the relationship between healthcare personnel and people with mental distress, minimizing the use of coercive and repressive methods and providing care and assistance with a primary focus on the individual, their space, and their freedom. Participation and relationship were at the center of a new way of understanding the asylum, defined a few years earlier by the Canadian sociologist Erving Goffman as an example of the total institution.[92] Basaglia[93] would overturn the way the issues were interpreted, exposing them in various writings, including a book with a decidedly provocative title *L'Instituzione Negata* ("The Denial of the Institution"), and another with an even more significant title: *Morire di Classe* ("Dying of Class")[94]. The latter is a photo reportage of the living conditions of patients in Italian asylums, emphasizing the close link between mental distress and socioeconomic conditions.

The argument was therefore that the therapies of the past, based on social isolation, coercion, corporal punishment, restraint, and straitjackets, which were considered shock therapies aimed at restoring mental balance, should no longer be used. Such therapies were often unscientific and, in some cases, amounted to outright torture. They included malaria therapy (inducing fever through malaria infection), electroshock therapy, insulin therapy, cardiazol shock therapy, water therapy (hot or cold showers), purges, acetylcholine therapy, and psychiatric surgery (lobotomy).[95] The advancement of new pharmacological protocols would lead to a redefinition of the three main axes of nursing care developed up to that point: technical (administration of therapies), social (guardian function), and organizational (long working shifts). In the latter case, Eraldo Fruttini would emerge as a key figure. Shortly after his visit to Gorizia, he was called by Basaglia himself and appointed as chief inspector with the task of reorganizing nursing work in the Friulian asylum. Fruttini developed an eight-hour shift, with four working days and two rest days, which led to a better management of workloads (previously, as mentioned, shifts could last up to 24 hours). This innovation reduced absenteeism due to illness from 20–25% to a more realistic 0.6%.

Fruttini's organizational decisions involved increasing staff numbers and redefining several contractual and administrative terms – something that the Provincial Administration of Gorizia, the body responsible for managing the asylum, initially refused, only to sign off the changes following a 10-day total strike. Among the changes achieved was the addition of another 20 nurses.[96] Fruttini continued to be a close collaborator of Basaglia, accompanying him to many conferences throughout the country and collaborating on many projects.[97] The analysis by the English historian John Foot includes some photographs of these activities, and one of these, showing a meeting of the Gorizia working group, includes Fruttini, the only nurse among a group of doctors.[98]

[91] www.mariotommasini.it, accessed January 02, 2024.
[92] Goffman 2010.
[93] Basaglia 2013.
[94] Basaglia/Ongaro 1969.
[95] De Giacomo 1972.
[96] Basaglia 1997.
[97] Addio al braccio destro di Basaglia. Scelse i turni 4-2 per gli infermieri 2019. The article is based on the reminiscences of another nurse – Livio Bianchini – who worked in the field of psychiatric care in Gorizia. He was a friend of Fruttini, and involved in politics as a municipal councilor.
[98] Foot 2014.

Eraldo Fruttini would not be the only nurse to strive to improve the care provided in asylums. Also notable is the nurse Enzo Quai, who was hired at a very young age by Basaglia himself in 1962. Quai immediately embarked on a path of growth and training, together with the patients themselves, to develop an innovative approach to care relationships. His work highlights the generational divide. In Italy's booming economy, new generations of both doctors and nurses were seeking security and growth. These professionals were different from their longer-serving colleagues, particularly those who had worked in the asylums of during the fascist era and who had often witnessed political detentions and abuses. Some of them had been active in resistance movements, but many others had been accomplices of the fascist hierarchies. Quai complains that the old nurses, many of whom still adhered to a past vision of care, instructed him to do a simple job of controlling patients, using restraint and sedation, including severe methods, especially on the most agitated patients:

There were 20 to 30 patients. They walked up and down, chatted among themselves, smoked like chimneys. The old nurses left me there, ordering me: "Never talk to them, they're dangerous [...] Always stand with your back to the wall."[99]

This attitude is what Basaglia was working against, and Enzo Quai would find himself, as mentioned, growing day by day as a nurse in a relationship of mutual respect and trust with the patients, following the experimental lines of the director.

Basaglia gave me orders that were completely different:

Stay with the patients, talk to them, sit down, have a dialogue, try to understand the problems [...]. I began to find meaning. Those, to me, were people. [No more] straitjackets, electroshock, beds with cages that almost reached the ceiling [...] aluminum bowls and a spoon as the only utensils, bare tables without tablecloths [...] shoes without laces [...] dark gray uniforms like those of a prisoner [...] the 650 hospitalized prisoners, men with shaved heads.[100]

Quai recounts how, along with him, other young nurses would invent various activities every day to involve the patients.[101] Even a simple walk in the hospital grounds or, better yet, outside the hospital, was considered a good opportunity to build better care and assistance. And the nurses themselves, as experimenters, would diligently document the activities undertaken each day and discuss them with the medical team. The change was almost total. The patients no longer wore uniforms like detainees, but clothes worthy of the name that matched their tastes. Aluminum trays were removed, and meals were consumed with utensils on tablecloths.

Slowly, fences and cages of all kinds were removed. Freedom took hold, and more and more patients participated in meetings where everything was discussed, and decisions were made. The motto was "Let's help each other heal." In this regard, a local newspaper – *Il Picchio* – edited by the patients proved to be a very fruitful experience. It was first published in August 1962 and continued until 1966, involving patients and healthcare staff in an experience previously unheard of in Italian psychiatry.[102]

Another significant event was the meeting between the healthcare staff and patients of Gorizia and the nurses and administrators of the psychiatric hospital of Colorno (PR), which took place on December 20, 1966, in an open and participatory forum, where the participants shared experiments and hopes, methods, and innovations. A detailed account of the event can be found in Basaglia's book: *Che cos'è la psichiatria?* ("What is Psychiatry?").[103]

[99] Sartori 1996, p. 14.
[100] Sartori 1996, p. 14.
[101] Ritratti Enzo Quai 2019, p. 1.
[102] Foot 2014.
[103] Basaglia 1997.

The staff of the Colorno hospital would have plenty of material to reflect on and start working from, to the point that, after just over two years, they would occupy their own hospital for 35 days, starting on February 2, 1969. Everyone was united by a common feeling, by a desire for change that saw doctors, patients, nurses, and determined family members come together to denounce the poor conditions in the asylum. Indeed, many patients there were still classified according to old schemas based on degrees of disorder (calm, agitated, epileptic), while the hospital was understaffed, and the building was dilapidated.[104] Outside the hospital, banners appeared with slogans such as: "Asylum occupied", "The rich son is exhausted, the poor son is crazy".[105] It should be noted that the occupation began with a permanent assembly made up of days of meetings between patients, nurses, doctors, medical students, and family members, and this assembly was a feature throughout the occupation.[106] The struggle ended for various reasons, including the actions of some nurses who had not participated in the occupation and were more concerned about lost work hours and pay. As often happens, the actions and thinking of some innovators keen to see an evolution of nursing care towards social equity faced resistance not only from the system but also from internal and corporate forces. This situation was linked to a subordinate status that was difficult to eradicate.

In 1968, Basaglia moved to Trieste, where he initiated his small-scale psychiatric revolution. The strikes that were sweeping the entire country would serve as a driving force for change and union demands in many other places, including in Collegno,[107] Nocera Superiore,[108] Rome (Santa Maria della Pietà), and in the aforementioned Colorno. In Colorno, testimony has survived from another nurse, Pino Zerbini.[109] After the struggles, Basaglia's reform would arrive here too through the doctor himself, who was appointed director of the Colorno psychiatric hospital from 1970 to 1971. In this case as well, nurses would be engaged in both new care approaches and in union struggles to assert their rights and those of the patients.

Zerbini, who, like Quai, started working at the asylum at a young age, was a thirty-year-old nurse who found himself supporting the struggles of the patients against what he has described as "a place of suffering, a morbid and fictional place",[110] where nurses were in a ratio of 1 to 20 – at best – and doctors just 4 per 1,200 patients.

For me, the patients were people, just like us, not numbers. I remember once I even broke the rules. I was very close to Master R., an inmate of great artistic and cultural depth, who unfortunately suffered from nervous exhaustion and mood swings. His father had died, and I absolutely wanted to take him to the funeral, even though it was prohibited by the regulations in force. I asked the doctors and the director, who were against it. So I got angry and said, "But if it were your father, and you were inmates?". I received no response, and I decided to take R. to the funeral. Everything went well, and upon my return, my superiors, despite knowing about my breach of the rules, pretended nothing had happened and did not file a report.[111]

Zerbini's words reflect a human and professional protagonism that, as we have seen, was expressed in various ways within the world of Italian nursing care in the decade under review, for which it is now possible to outline a comprehensive framework.

[104] Dalmasso 2005, p. 164.
[105] Quando i matti occuparono il manicomio di Colorno 2021, p. 1.
[106] G. m. 1969, p. 2.
[107] Anche a Collegno "porte aperte" nel manicomio 1969, p. 3. The experimentation was always recorded by doctors, nurses, patients and students.
[108] Here, healthcare reforms would also be launched at the Materdomini psychiatric hospital with the elimination of restraints, the structuring of periodic meetings/assemblies between staff and patients and the creation of an open ward. Conflicts were present from the beginning and were eventually swept aside with the dismissal of the director, Prof. Sergio Piro. Also in this case, nurses, doctors and patients formed a common front against the management's decisions, threatening a hunger strike by patients and agitation by health workers. Piemontese 1969 a; 1969 b.
[109] Capriglio 2020, p. 1.
[110] Capriglio 2020, p. 1.
[111] Capriglio 2020, p. 1.

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7 CONCLUSION

A review of the historical sources from the period in question has enabled us to respond in the affirmative to the research question, demonstrating the prominent role of nursing in Italian society at all levels. The 1960s were characterized by a wind of transformation that would continue to blow for at least another 15 years. It arose from the demands for modernization of a society that, at the beginning of the 20th century, was characterized by strong disparities and social inequalities, largely produced by an ancient stratification that still clung to customs linked to medieval society and its agricultural world. The end of the liberal state, the fascist dictatorship, the war, and the slow and difficult reconstruction acted as catalysts for the demands for equality and modernity.

Workers' and union struggles, the mobilization of the intellectual class, and new technical and scientific paradigms assisted this path towards progress at all levels, although success was not always guaranteed. In this process, nurses also became protagonists. The simple "shop floor workers" of the health factory joined healthcare managers in a catch-all category of hospital workers, who would succeed in making themselves heard, and would find solidarity from patients and the families of the sick.

The face of psychiatric asylums began to change rapidly. Already at the dawn of the 1970s, Law 431/1968 changed psychiatric care. Psychiatric admission no longer entailed a criminal record, but had to be voluntary and made in relation to a specific diagnostic path. Mental health centers were launched as part of an innovative, multiprofessional and interdisciplinary "territorialization" approach – moving healthcare out of hospitals and into the community. Nursing education would move towards the introduction of further changes, such as admitting men to boarding schools, following the reform initiated by Law 124 of 1971, and increasing the duration of nurse training itself from two to three years. On the threshold of healthcare reform, in 1977, professional frameworks and the nursing body itself would launch the second, updated edition of the 1960 code of ethics, ready to face the imminent challenges posed by the advent of the Italian National Health Service.

Obviously, not everything would progress automatically. During the 1970s, there would still be struggles and mobilizations, hospital occupations, and care experiments,[112] but all this would be thanks to the commitment put in place in the 1960s and the protagonism of men and women who became the standard bearers of a social ethics that had to navigate the corridors and clinics of everyday healthcare in order to return to the community with the power of modern science and collective participation. Through their protagonism, nurses proved themselves to be fully-fledged professionals and therefore representatives of a scientific doctrine that is closely linked to the evolution of the reality in which they live. In addition to assuming the role of protagonists within their own professional sphere, the nurses also serve as a social indicator of the broader historical trajectory of humanity. This quality is intrinsic to the very nature of caregiving, and is not merely an element of the profession, but rather a key to understanding the passage of time and the evolution of narratives.

[112] Cotichelli 2019, pp. 171–183.

Bibliography

Printed Sources

Amministrazione rete ospedaliera e territoriale – A.R.O.T. (ed.): I servizi infermieristici in un nuovo assetto delle strutture sanitarie. Florence 1969.

Basaglia, Franco/Franca Ongaro: Morire di classe, la condizione manicomiale fotografata da Carla Cerati e Gianni Berego. Torino 1969.

Belloni, Viviana: Federazione Nazionale e Collegi Professionali delle I.P. – A.S.V. – V.I. Rome 1971.

Comitato dei Ministri per il Mezzogiorno e per le zone depresse del Centro-Nord (ed.): Relazione sull'attuazione del piano di coordinamento degli interventi pubblici nel Mezzogiorno e sui provvedimenti per le aree depresse del Centro-nord. Rome 1969, pp. 155–177.

De Giacomo, Umberto: Manuale per infermieri psichiatrici. Rome 1972.

Etzioni, Amitai: The Semi-Professions and Their Organization. Teachers, Nurses, Social Workers. New York 1969.

Foucault, Michel/Blandine Barret-Kriegel/François Béguin/Anne Thalamy/Bruno Fortier: Les machines à guérir: aux origines de l'hôpital moderne. Liège 1979.

Freidson, Eliot: La dominanza medica. La base sociale della malattia e delle istituzioni sanitarie. Milan 2002 (american original edition: 1970).

Gazzetta Ufficiale della Repubblica Italiana (ed.): Indice mensile 1–31 agosto. Rome 1967, pp. 4332–4333.

Goffman, Erving: Asylums. Le totali: i meccanismi dell'esclusione e della violenza. Torino 2010 (american original edition: 1961).

International Labour Office: Employment and Condition of Work of Nurses. Geneva 1960.

Istituto Nazionale di Statistica – ISTAT: Annuario Statistico Italiano. Rome 1965.

Istituto Nazionale di Statistica – ISTAT: Annuario Statistico Italiano. Rome 1969.

Istituto Nazionale di Statistica – ISTAT: Statistiche storiche d'Italia, 1861–1975. Rome 1976.

Jervis, Giovanni: Manuale critico di psichiatria. Milan 1974.

Jones, Maxwell: Il processo di cambiamento. Nascita e trasformazione di una comunità terapeutica. Milan 1987.

Lauriola, Emilia: Evoluzione delle professioni sanitarie ausiliarie in rapporto alle strutture sanitario-assistenziali del nostro paese. Quaderni FIRO. Rome 1965.

Marin, Anita: Il ruolo dell'infermiera nell'organizzazione di sanità pubblica. In: Bollettino di Informazioni (1957), Anno X, 5–6, pp. 67–78.

Modolo, Maria Antonia/Itala Riccelli: Problemi e proposte relative alla preparazione del personale infermieristico e delle A.S.V. In: Seppilli, Alessandro (ed.): Il personale sanitario non medico nella programmazione sanitaria. Assisi 1968, pp. 195–220.

ENHE 6/2024 DOI: 10.25974/enhe2024-3en

Nuzzolillo, Luigi: Funzioni e Preparazione del Personale. In: Seppilli, Alessandro (ed.): Il personale sanitario non medico nella programmazione sanitaria. Atti del Convegno organizzato dall'Istituto di Igiene dell'Università di Perugia, sotto gli auspici del Ministero della Sanità; Tipografia Porziuncola. Assisi 1968, pp. 63–87.

Seppilli, Alessandro (ed.): Il personale sanitario non medico nella programmazione sanitaria. Assisi 1968.

Vianello, Mino: Contributo alla critica della teoria classica dell'organizzazione. Milane 1973.

Online Archival Sources

14 ore in corsia per 20.000 lire al mese. In: L'Unità (1967), July 12, p. 4. https://archivio.unita.news/assets/main/1967/07/12/page_004.pdf, accessed January 02, 2024.

Anche a Collegno "porte aperte" nel manicomio. In: L'Unità (1969), April 09, p. 3. https://archivio.unita.news/assets/main/1969/04/09/page_003.pdf, accessed January 02, 2024.

Archivio de L'Unità. https://archivio.unita.news/, accessed January 02, 2024.

Artiglieria per sostituire il personale del manicomio in sciopero. In: L'Unità (1963), November 09, p. 04. https://archivio.unita.news/assets/main/1963/11/09/page_004.pdf, accessed January 02, 2024.

Conca, Taddeo: Il ritmo convulso della città. In: L'Unità (1967), November 19, p. 7. https://archivio.unita.news/assets/main/1967/11/19/page_007.pdf, accessed January 02, 2024.

Denunciati oltre 100 dipendenti all'ospedale civico. In: L'Unità (1969), July 06, p. 4. https://archivio.unita.news/assets/main/1969/07/06/page_004.pdf, accessed January 02, 2024.

Due ospedali in sciopero. In: L'Unità (1962), August 15, p. 4. https://archivio.unita.news/assets/main/1962/08/15/page_004.pdf, accessed January 02, 2024.

E. b.: Una infermiera ogni 60 malati. La paurosa carenza e stata denunciata in un convegno tenutosi ieri al Ridotto dell'Eliseo. In: L'Unità (1964), October 09, p. 5. https://archivio.unita.news/assets/main/1964/10/09/page_005.pdf, accessed January 02, 2024.

Gli ospedali resteranno senza medici e infermieri. In: L'Unità (1968), February 11, p. 5. https://archivio.unita.news/assets/main/1968/02/11/page_005.pdf, accessed January 02, 2024.

G. m.: Fare dei manicomi strumenti di cura, non segregazione. In: L'Unità (1969), February 02, p. 2. https://archivio.unita.news/assets/main/1969/02/03/page_002.pdf, accessed January 02, 2024.

I granatieri in manicomio, in sostituzione degli infermieri in sciopero. In: L'Unità (1963), November 09, p. 4. https://archivio.unita.news/assets/main/1963/11/09/page_004.pdf, accessed January 02, 2024.

In agitazione il personale dell'ospedale "Vito Fazi" di Lecce. In: L'Unità (1966), October 02, p. 18. https://archivio.unita.news/assets/main/1966/10/02/page_018.pdf, accessed January 02, 2024.

In corteo dal Policlinico alla P.I. In: L'Unità (1969), May 01, p. 12. https://archivio.unita.news/assets/main/1969/05/01/page_012.pdf, accessed January 02, 2024.

In lotta anche gli psichiatri degli ospedali. In: L'Unità (1968), February 15, p. 5. https://archivio.unita.news/assets/main/1968/02/15/page_005.pdf, accessed January 02, 2024.

La disastrosa situazione degli ospedali italiani. In: L'Unità (1960), October 22, p. 10. https://archivio.unita.news/assets/main/1960/10/26/page_010.pdf, accessed January 02, 2024.

La FIARO a Moro: "Vogliamo 80 miliardi". In: L'Unità (1967), September 27, p. 2. https://archivio.unita.news/assets/main/1967/09/27/page_002.pdf, accessed January 02, 2024.

La paralisi negli ospedali. In: L'Unità (1968), June 18, p. 6. https://archivio.unita.news/assets/main/1968/06/18/page_006.pdf, accessed January 02, 2024.

La piccola cronaca. In: L'Unità (1967), December 17, p. 16. https://archivio.unita.news/assets/main/1967/12/17/page_016.pdf, accessed January 02, 2024.

Le infermiere che si sposano minacciate di licenziamento. In: L'Unità (1960), October 18, p. 8. https://archivio.unita.news/assets/main/1960/10/18/page_008.pdf, accessed January 02, 2024.

Le ragioni della carenza di infermiere professionali. In: L'Unità (1967), August 2, p. 4. https://archivio.unita.news/assets/main/1967/08/02/page_004.pdf, accessed January 02, 2024.

Lorelli, Salvatore: Occupano la provincia infermieri psichiatrici. In: L'Unità (1969), May 29, p. 2. https://archivio.unita.news/assets/main/1969/05/29/page_002.pdf, accessed January 02, 2024.

Lottano i medici e gli infermieri. In: L'Unità (1967), December 15, p. 6. https://archivio.unita.news/assets/main/1967/12/15/page_006.pdf, accessed January 02, 2024.

Manifestano i tbc davanti alla Camera. In: L'Unità (1963), February 7, p. 5. https://archivio.unita.news/assets/main/1963/02/07/page_005.pdf, accessed January 02, 2024.

Medici ospedalieri ancora in sciopero. In: L'Unità (1967), October 30, p. 2. https://archivio.unita.news/assets/main/1967/10/30/page_002.pdf, accessed January 02, 2024.

Mille lire al giorno per 12 ore di lavoro. In: L'Unità (1967), August 1, p. 6. https://archivio.unita.news/assets/main/1967/08/01/page_006.pdf, accessed January 02, 2024.

Muti, Marcello: Colle Cesarano, lotta di tipo nuovo dei 93 operai. In: L'Unità (1969), September 8, p. 2. https://archivio.unita.news/assets/main/1969/09/08/page_004.pdf, accessed January 02, 2024.

N. c.: Ecco la realtà degli ospedali. In: L'Unità (1968), April 30, p. 6. https://archivio.unita.news/assets/main/1968/04/30/page_006.pdf, accessed January 02, 2024.

Nessuna delega al governo per il personale sanitario. In: L'Unità (1967), May 31, p. 2. https://archivio.unita.news/assets/main/1967/05/31/page_002.pdf, accessed January 02, 2024.

Occupato per sei ore Santa Maria della Pietà. In: L'Unità (1969), May 14, p. 6. https://archivio.unita.news/assets/main/1969/05/14/page_006.pdf, accessed January 02, 2024.

Ospedali: hanno preferito il caos pur di non trattare con lavoratori. In: L'Unità (1967), April 21, p. 6. https://archivio.unita.news/assets/main/1967/04/21/page_006 .pdf, accessed January 02, 2024.

Palermo, 46 infermieri denunciati per uno sciopero. In: L'Unità (1969), December 18, p. 2. https://archivio.unita.news/assets/main/1969/12/18/page_002.pdf, accessed January 02, 2024.

Piemontese, Felice: Rivogliono la camicia di forza perché i matti li contestano. In: L'Unità (1969 a) February 23, p. 5. https://archivio.unita.news/assets/main/1969/02/26/page_004.pdf, accessed January 02, 2024.

ENHE 6/2024 DOI: 10.25974/enhe2024-3en

Piemontese, Felice: Prima viene il profitto poi la salute malato. In: L'Unità (1969 b), February 26, p. 4. https://archivio.unita.news/assets/main/1969/02/26/page_004.pdf, accessed January 02, 2024.

Policlinico senza infermieri. In: L'Unità (1968), May 15, p. 6. https://archivio.unita.news/assets/main/1968/05/15/page_006.pdf, accessed January 02, 2024.

Programmi RAI: 11.00 X Giornata internazionale dell'Infermiere. In: L'Unità (1966), May 19, p. 12. https://archivio.unita.news/assets/main/1966/05/19/page_012.pdf, accessed January 02, 2024.

San Camillo, sciopero della fame di 75 ricoverati. In: L'Unità (1962), November 11, p. 4. https://archivio.unita.news/assets/main/1962/08/15/page_004.pdf, accessed January 02, 2024.

San Giovanni: scioperano anche gli infermieri. In: L'Unità (1968), July 9, p. 6. https://archivio.unita.news/assets/main/1968/07/09/page_006.pdf, accessed January 02, 2024.

Sartori, Michele: L'infermiere della rivoluzione. In: L'Unità (1996), December 8, p. 14. https://archivio.unita.news/assets/main/1996/12/08/page_024.pdf, accessed January 02, 2024.

Tedeschi, Rubens: Le malattie: un affare per le Case di cura. In: L'Unità (1962), November 03, p. 3. https://archivio.unita.news/assets/main/1962/11/03/page_003.pdf, accessed January 08, 2024.

Testai, Concetto: In Italia mancano piu di 200 mila infermiere. In: L'Unità (1969), October 20, p. 2. https://archivio.unita.news/assets/main/1969/10/20/page_002.pdf, accessed January 02, 2024.

Trattative avviate per medici ed ospedalieri. In: L'Unità (1967) May 01, p. 2. https://archivio.unita.news/assets/main/1967/05/01/page_002.pdf, accessed January 02, 2024.

Tre giorni di lotta negli ambulatori ENPAS. In: L'Unità (1967) June 14, p. 4. https://archivio.unita.news/assets/main/1967/06/14/page_004.pdf, accessed January 02, 2024.

Un confronto illuminante. In: L'Unità (1967) April 11, p. 2. https://archivio.unita.news/assets/main/1967/04/11/page_002.pdf, accessed January 02, 2024.

Secondary Literature

Addio al braccio destro di Basaglia. Scelse i turni 4-2 per gli infermieri. In: Il Piccolo (2019), November 20, p. 1. https://ilpiccolo.gelocal.it/trieste/cronaca/2019/11/20/news/addio-al-braccio-destro-di-basaglia-scelse-i-turni-4-2-per-gli-infermieri-1.37926979, accessed January 02, 2024.

Basaglia, Franco: Che cos'è la psichiatria? Milan 1997.

Basaglia, Franco: L'istituzione negata. Milan 2013.

Bezze, Sabrina/Edoardo Manzoni/Stefania Di Mauro: Il contributo allo sviluppo della professione infermieristica delle congregazioni religiose del XIX secolo. In: Professioni Infermieristiche 66 (2013), 2, pp. 75–84.

Bologna, Sergio: Il lungo autunno. Le lotte operaie degli anni '70. Milan 2019.

Cantarelli, Marisa: Il modello delle prestazioni infermieristiche. Milan 2003.

BIBLIOGRAPHY

Capriglio, Marco: L'ospedale psichiatrico nelle parole di un ex infermiere. In: The Wise magazine (2020), September 05, p. 1. https://www.thewisemagazine.it/2020/09/05/ospedale-psichiatrico-ex-infermiere/, accessed January 02, 2024.

Chabod, Federico: Lezioni di Metodo storico. Bari 1992.

Colarizi, Simona: Un paese in movimento: L'Italia negli anni Sessanta e Settanta. Bari 2019.

Cotichelli, Giordano: L'infirmier psychiatrique en Italie: de gardien à professionnel du territoire. In: Revue Sociologie santé (2010), 32, pp. 295–310.

Cotichelli, Giordano: Infermieri e Movimento del '77. In: Guzzo Domenico (ed.): Da non garantiti a precari. Il Movimento del '77 e la crisi del lavoro nell'Italia post-fordista. Milan 2019, pp. 171–183.

Cotichelli, Giordano: Storiografia della professione infermieristica in Italia (1945–2020). Milan 2022.

Dalmasso, Sergio: Il sessantotto e la psichiatria. In: Cassata, Francesco/Massimo Moraglio (ed.): Manicomio, società e politica. Pisa 2005.

Ferrario, Paolo: Politica dei servizi sociali. Rome 2001.

Foot, John: La "Repubblica dei matti": Franco Basaglia e la psichiatria radicale in Italia, 1961–1978. Milan 2014.

Ginsborg, Paul: Storia d'Italia dal dopoguerra a oggi. Torino 2006.

Larghi, Giuseppina/Antonella Peverelli: Ri...visti, rubrica storica. In: Rivista Agorà dell'IPASVI (2008), 38, pp. 21–26.

Negri, Marina: Suor Emilia Vinante, Direttrice di Scuola Infermiere a Milano. In: Journal of Medicine and the Person (2007), 2, pp. 28–30.

Negri, Marina/Edoardo Manzoni: Il Corso per aspiranti direttrici per scuole infermiere, Milano: cronaca di una scoperta storica. In: Professioni Infermieristiche 60 (2007), 3, pp.131–138.

Quando i matti occuparono il manicomio di Colorno. In: Viaggiatori ignoranti (2021), May 25, p. 1. https://www.viaggiatoriignoranti.it/2021/05/quando-i-matti-occuparono-il-manicomio-di-colorno.html, accessed January 02, 2024.

Rubiera, Claudia Lorenzo: Mai 68: la revolution de la psychiatrie. In: The Conversation (2018), May 16, p. 1. https://theconversation.com/mai-68-la-revolution-de-la-psychiatrie-96734, accessed January 02, 2024.

Sironi, Cecilia/Fanny Ceconi/Stefania Di Mauro: L'Associazione regionale Lombardia infermiere/i: 50 anni di storia. Falconara M.ma 1996.

ENHE 6/2024 DOI: 10.25974/enhe2024-3en

Websites

Chi era Basaglia, https://www.mariotommasini.it/services/il-manicomio-di-colorno/, accessed January 02, 2024.

Gli iscritti dal 1956 a oggi, https://web.archive.org/web/20150402143659/http:/www.ipasvi.it/chi-siamo/iscritti/gli-iscritti-dal-1956-ad-oggi.htm, accessed January 04, 2024.

La storia della rivista, sezione dedicata. In: L'Infermiere organo ufficiale della Federazione Nazionale Ordini delle Professioni Infermieristiche, https://www.infermiereonline.org/category/la-storia-della-rivista/, accessed January 04, 2024.

Poster of May '68 a, https://sante.lefigaro.fr/article/mai-68-la-revolution-sur-les-bancs-de-la-medecine, accessed January 02, 2024.

Poster of May '68 b, https://www.bridgemanimages.com/it/noartistknown/poster-france-may-1968-les-travailleurs-de-sante-pour-l-hopital-nouveau-serigraph/screen-printing/asset/3663820, accessed January 02, 2024.

Ritratti Enzo Quai. In: Radiofragola (2019), p. 1, https://www.radiofragola.com/ritratti-enzo-quai/, accessed January 02, 2024.

Vanzetta, Marina: 1965, il cambio di passo. In: L'Infermiere organo ufficiale della Federazione Nazionale Ordini delle Professioni Infermieristiche (2022 a), June 21, https://www.infermiereonline.org/2022/06/21/1965-il-cambio-di-passo/, accessed January 02, 2024.

Vanzetta, Marina: Non solo notizie, 1966–1970. In: L'Infermiere organo ufficiale della Federazione Nazionale Ordini delle Professioni Infermieristiche (2022 b) June 29, https://www.infermiereonline.org/2022/06/29/non-solo-notizie-1966-1970/, accessed January 03, 2024.

AT THE HEART OF NEOLIBERALISM. THE PRIVATISATION OF LONG-TERM CARE FOR OLDER PEOPLE AND THE EVERYDAY HISTORY OF ECONOMIC POLICY IDEAS IN THE FEDERAL REPUBLIC OF GERMANY AND GREAT BRITAIN

Nicole Kramer

Abstract

The 1980s and 1990s saw significant growth in the private sector for long-term care for older people in both Great Britain and Germany. Until then, care policy in both countries had tended to be incidental to welfare state expansion. Among those involved in this privatisation boom were professional carers and nurses who were looking for new career paths. This article examines this early phase of the privatisation of care for older people and asks questions about the economic ideas espoused by the new care service and home operators, who reflected on the market and the opportunities it offered them as entrepreneurs. They advocated ideas based on a harmonious relationship between the market and morality. The aim is to link historical healthcare research and the history of marketisation.

Keywords: Long-term care, old age, welfare state, neoliberalism, welfare market, nurses, privatisation

1 INTRODUCTION

The history of the ideas of neoliberalism has already filled several books and researchers have studied core networks such as the Mont Pelerin Society and key players from academia and politics. But is it enough to trace the thinking of the elites in times of democratic rule and a market economy? Were large sections of the population and their attitudes not relevant to the economic paradigm shift? This is the starting point for the following article. The focus is on a group of actors who are particularly relevant to the topic: carers who became self-employed in the 1980s and 1990s and opened care services or care homes. Care is a large and multifaceted field. Here I will be dealing mainly with the professional area, i.e. care of elderly and disabled people provided by people employed to perform this role. This is the area where privatisation has had a particular impact and where the actions of individual carers can be well understood. However, there are major overlaps with nursing care, which will be included in the argumentation, where relevant.

In the 1980s and 1990s, the marketisation of care was progressing rapidly, as can be seen in the growth of the private sector, among other things. These two decades therefore form the main focus of the study. Various processes are summarised under the term "marketisation", but it is important to distinguish between them for the purposes of analysis. They include the strengthening of market

mechanisms, the adoption of practices from business administration and management, the growth in the proportion of private commercial providers and the increasing activity of listed companies. All of these processes have changed the conditions for carers and those in need of care in very different ways. In the following, the focus will be on the privatisation of care, i.e. the increase in privately run homes and outpatient care services.

Geographically, the focus of the study is on the Federal Republic of Germany and Great Britain – two countries that form a classic pair for comparison in the history of social policy, above all because they are regarded as representatives of different welfare models.[1]

In a direct comparison, however, the similarities are striking. The welfare state flourished in both countries, although care policy only played a subordinate role in the post-war boom years. In Great Britain and Germany, the state, the market, the third sector and the family worked together to cover the risk of long-term care, with the balance shifting repeatedly over the decades. These similarities form the basis for a comparison of variations, which highlights the development of the privatisation of care for older people that is visible in different countries and promoted by international organisations, and makes national characteristics visible. The aim is not so much to simply identify the differences, but to explain them and gain insights into the interrelationships of privatisation. In other words, the comparative method is to be used analytically, using differences in the country setting with regard to the traditions of care and the structure of healthcare provision to examine the significance of different development conditions.[2]

While Great Britain is regarded as a country in which neoliberal ideas led to early and comprehensive social policy reforms under Margret Thatcher's government, political decision-makers in the Federal Republic of Germany are said to have taken a more moderate stance towards marketisation and privatisation ideas.[3] However, the growth of the private sector took place over a similar period, which raises questions about the influencing factors.

The article is divided into four parts. The first part traces the marketisation of social policy and the implementation of neoliberalism as a social order. The second part outlines the structure of care for older people in Great Britain and West Germany after 1945, showing how it developed from an add-on to poverty policy in times of boom to a social policy field in its own right. The impetus for change in nursing care did not only come from policymakers. Changes in the nursing professions must also be taken into account. The third part examines the privatisation spurts of the 1980s and 1990s in more detail, highlighting the differences between countries in terms of the nature and speed of this development. Finally, the article focuses on the experiences and interpretations of professional carers who embarked on the path to independence. Did they see themselves as economic actors? How did they perceive the market and care as a business? What ideas and values did they refer to in their professional and economic activities?

This article aims to contribute to linking the contemporary historical debate on the marketisation of social policy[4] with the history of nursing[5]. Carers thus become visible as economic actors whose actions were guided by political and economic ideas. The research on marketisation and neoliberalism is extended beyond the previous scope of investigation, i.e. in addition to the political elites and

[1] Hockerts 2010, p. 15.
[2] On the various functions of the comparison, see Kaelble 2012.
[3] Süß 2022, p. 213.
[4] On marketisation as a topic of contemporary history, see Graf 2019, pp. 10-11.
[5] For some time now, the history of nursing has been turning to everyday life and practices, Nolte, 2012, pp. 121-122.

experts, groups are examined who, as actors, shaped the everyday life and practices of the market – in this case specifically the care market. Such an approach serves to promote the study of neoliberalism as a programme of action.

2 THE MARKETISATION OF SOCIAL POLICY

Privatisation and marketisation since the 1970s is usually told as a story of transnational networks of experts in which economists such as Milton Friedman and Friedrich August von Hayek set the tone. Particular attention is also paid to the activities of international organisations such as the World Bank and the OECD, whose representatives promoted the denationalisation of social and economic policy. The history of ideas approach leads back to the 1930s, when experts, many of them from the discipline of economics, met in Paris in 1938 to attempt a reformulation of liberalism. They felt that this was urgently needed in view of developments such as the rise of communism, Italian fascism and National Socialism. However, they also observed the spread of Keynesian doctrines in the USA,[6] particularly the New Deal programme, with concern. Ultimately, they saw the autonomy of the individual, a fundamental demand of liberalism, threatened by state control and intervention. The 1930s are considered the birth of neoliberalism and were followed by a long evolution phase, in which the teachings surrounding the self-regulating powers of the market were limited to a small circle of experts. The Mont Pelerin Society, founded in 1947, created an important forum for networking during this period, which can be seen in conferences and correspondence between its members.[7]

An individual, materialistic view of humanity and the belief in the regulating and equalising power of the market were at the heart of neoliberalism, although it took very different forms and is difficult to grasp. It is not until the 1970s that we can speak of a breakthrough for neoliberalism, with the oil price shock and the subsequent economic crisis creating a situation in which the proponents of this school of thought found themselves heard. They increasingly shaped the discussions and actions of international organisations such as the OECD and the World Bank.

The neoliberal influence was particularly evident in the field of old age pensions. Since the early 1980s, more and more countries have cut state pension benefits or at least refrained from expanding them further. Instead, they embarked on a path that favoured the spread of private pension products. This policy contributed significantly to the growth of the capital and financial markets. Behind the move by international organisations and national governments towards the (partial) privatisation of pensions were representatives of the financial services industry, who used it to boost their own business.[8]

Neoliberal ideas were already popularised in the 1980s. A central figure was Milton Friedman, who was awarded the Nobel Prize for Economics in 1976. In an eight-part television series entitled "Free to choose", the economist conveyed his views on market mechanisms to television viewers. In order to appeal to as broad a section of the population as possible and to illustrate Friedman's theoretical concepts, the series presented real markets and participants. An important group included small entrepreneurs and the self-employed, who were often just starting to build up their business. The series used scene selection and Friedman's comments to promote the superiority of the market and problematise state regulation.[9]

[6] Keynesianism is an economic theory named after the British economist John Maynard Keynes. After experiencing the Great Depression, he assumed that economic slumps would occur regularly. In order to ensure full employment and enable economic growth, he believed that the state had a duty to stimulate general economic demand through state intervention in times of economic downturns.
[7] Ther 2016.
[8] Hockerts 2011, pp. 276-277 and Leimgruber 2012, pp. 36-37.
[9] Brandes 2015, pp. 531-532. A book was also written based on the television series.

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The series was shown in Great Britain and in the Federal Republic of Germany. Moreover, both German and British experts can be found in the neoliberal circles depicted. However, the two countries differ in terms of the timing, speed and extent of their privatisation and marketisation policies. Alongside the USA and Chile, Great Britain is regarded as a pioneer. Even at the time, Thatcherism was referred to as a combination of conservative moral concepts and neoliberal ideas. The leader of the Conservative Party and Prime Minister from 1979, Margaret Thatcher shaped this world view through speeches, articles and interviews. At the centre of this was the self-reliant individual, who should be guaranteed freedom of choice as a right, but who also had a duty to perform. She believed in the power of the market to shape society, enabling individuals to work according to their abilities and ideas. The free play of market forces equalised individual interests and at the same time served the welfare of the nation.[10] The state had a responsibility to promote free enterprise and a broad distribution of private property in the sense of a property-owning democracy. Accordingly, property was seen as the key to social security and democratic participation.[11]

In the Federal Republic of Germany in the 1980s, such approaches to neoliberal thinking were initially barely able to assert themselves at the level of political decision-makers. The CDU, the equivalent of Thatcher's Tory party, was dominated by a group centred around Helmut Kohl, whose members had promoted a change in economic policy in the 1970s, but were not proposing a withdrawal of the state and continued to assume that the market would be clearly restricted in terms of social policy. However, there were some dissenting voices. They came not only from politicians, such as the Free Democratic Party (FDP),[12] but also from media representatives. The business section of the *Frankfurter Allgemeine Zeitung (FAZ)*, one of Germany's major daily newspapers with a more liberal bias, clearly criticised the economic policy of Helmut Kohl's government. The journalists had pinned their hopes on the change of government for a neoliberal turnaround. However, the members of the *FA*Z economics department were quickly disappointed when it came to reducing public debt and privatising state-owned companies.[13] Even if there were no political decisions in the direction of market liberalisation, a look at the *FAZ*'s economics department shows how neoliberal thinking was spreading. From the end of the 1980s, the German Social Democratic Party (SPD) also underwent a more subtle shift towards a market-oriented programme. Step by step, the Keynesian understanding of the state was clearly being called into question. In the 1990s, the SPD thus laid the foundations for the subsequent Agenda 2010,[14] which was not a sudden change in policy, but a set of reforms that had emerged gradually during the party's years in opposition.[15]

The extent to which Great Britain and the Federal Republic of Germany had converged in terms of market-liberal thinking is demonstrated by the Schröder-Blair paper. This was a document intended to reposition social democracy. The authors deliberately leave the content vague, partly through frequent use of the nominal style. The paper invokes personal responsibility, entrepreneurial spirit and the self-regulating power of the market and makes use of neoliberal doctrines.[16] In particular, reforms such as Hartz IV,[17] which entailed severe cuts to unemployment benefits and increased the pressure on the unemployed to take up work, led to a transformation from a prevention-based welfare state to an activation-based welfare state in the Federal Republic of Germany, as in many other European countries.

[10] Geppert 2002, pp. 123-125.
[11] Francis 2012, pp. 288-289.
[12] The Free Democratic Party (FDP) was founded in 1948. It has been involved in many governments in the Federal Republic of Germany as a smaller partner in various coalitions. The party has liberal social and economic tendencies, with the latter dominating party policy in recent decades.
[13] Kutzner 2019, pp. 284-285.
[14] Agenda 2010 was a labour market and social reform programme developed by the SPD under Gerhard Schröder in 2003 and implemented in the following years. Its effects are controversial. On the one hand, it led to a reduction in unemployment figures and an economic up turn. On the other hand, the welfare state was severely and fundamentally curtailed, e.g. in the area of unemployment insurance.
[15] Nawrat 2012.
[16] Blair/Schröder et al. 1999.
[17] The name Hartz IV refers to the fact that the law was based on a proposal by a working group headed by Peter Hartz, a former manager at Volkswagen (VW).

Looking at the level of international expert circles and organisations as well as political elites, there are clear differences in terms of the timing and pace of market liberalisation.

When the focus is shifted towards the implementation of social policy, e.g. in the form of care services, a different picture emerges. The privatisation and marketisation of care for older people, which has been observed in both countries since the 1980s, has been surprisingly similar. Before describing this historical development in more detail, the following section outlines the development of care policy after 1945.

3 CARE FOR OLDER PEOPLE IN THE POST-WAR BOOM

The European welfare states of the post-war period were primarily focussed on gainful employment, so benefits for those in need of long-term care were not a political priority. Nonetheless, this period saw important reforms that affected the provision of long-term care. In particular, the reorganisation of poverty policy and healthcare had an impact on those in need of long-term care. However, the restructuring of the European welfare states did not only bring improvements for those in need of care; the mixed consequences were particularly evident in Britain.

The expansion of the welfare state, which was initiated by the economist William Beveridge's plan, had a lasting impact on care policy. Two laws in particular affected the risk of care dependency. Firstly, the National Assistance Act 1948 stipulated that local authorities were responsible for the provision of home nursing services and residential care for people in need of long-term care.[18] On the other hand, the introduction of the National Health Service (NHS) in 1946 was of great significance, as it meant that, for the first time, all Britons had access to free healthcare, both in acute cases and for ongoing nursing care.[19] With regard to older people in need of care, there was therefore an overlap of competences. According to sociologists Paul Bridgen and Jane Lewis, this is the reason for the structural neglect of this population group.[20] The institutions of the National Health Service, especially hospitals, but also the local authorities, have tried to limit the care of people in need of long-term care as much as possible. In hospitals, as in the NHS as a whole, there was strong pressure from the outset to keep costs down. This was because the National Health Service took up a considerable part of the state budget, which attracted attention and criticism. Limiting care for those in need of long-term care, whose longer stays consumed resources, seemed to be an effective way of reducing costs. However, the fact that those in need of ongoing care were the target of cost-cutting efforts was primarily due to the fact that the vast majority of carers, just like doctors, had traditionally disadvantaged this patient group.

In the old British healthcare system which existed before 1946, the charitable hospitals funded by trusts had completely rejected the care of patients in need of long-term care. This mentality persisted in the new NHS, partly because the same decision-makers sat on hospital boards.[21] In addition, geriatrics was not held in high regard by doctors and nurses. Reducing the average length of inpatient stays as much as possible was seen as a criterion for success among doctors. This could not be realised in the case of people in need of long-term care. Most nurses and doctors chose specialisations oth-

[18] National Assistance Act, 1948.
[19] Bridgen/Lewis 1999, p. 11; National Health Service Act, 1946.
[20] Bridgen/Lewis 1999; this is the main thesis of the work.
[21] Gorsky 2013, p. 601.

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er than geriatrics when they could. The few who did work in this area rarely did so of their own free will, but because there were no other paths open to them due to poor references or because they belonged to socially disadvantaged groups.[22] Of course, there were also counterexamples, such as Marjorie Warren, who worked as a doctor at Middlesex Hospital and in this capacity worked towards the admission of older people in need of care from the poorhouses. With her writings on the special care needs of older people and the possibilities of rehabilitation, she contributed to the establishment of geriatrics as a sub-discipline.[23] She was a pioneer and also one of the few exceptions.

In the 1950s and 1960s, the view that hospitals should primarily treat acute cases with the prospect of recovery, or at least improvement, became increasingly prevalent in politics. The more hospitals limited services for the chronically ill, the greater the pressure on the local authorities. They were reluctant to expand their services for those in need of long-term care because they feared this would send a signal that they were taking on tasks that they were not prepared to shoulder, at least not without suitable funding guarantees.[24]

The expansion of outpatient care was rather hesitant. Charitable organisations had already begun to set up support services for older people in the final phase of the Second World War, such as "Meals on Wheels". Such formats were expanded to include others in the post-war period. From the 1960s onwards, local authorities became more involved in this area, but it was not until the 1970s that there was a significant increase in spending. There were visiting services and private carers could be temporarily replaced. However, there were hardly any full-time outpatient care services in the post-war decades.[25]

The situation of elderly care in post-war Britain therefore has two important characteristics. Firstly, those in need of long-term care tended to be sidelined during the expansion of the welfare state. Care risk protection was not at the centre of the reforms and the expansion of the NHS had mixed consequences. Rising healthcare costs fuelled austerity debates and the treatment of those in need of long-term care came under fire for driving up costs. The more representatives of the public sector tried to limit its commitment to older and disabled people, the more they involved other stakeholders, initially mainly those from the non-profit sector. Outpatient care services were intended to reduce the number of older people who needed to be admitted to hospitals or care homes.[26]

A look at the Federal Republic of Germany initially reveals many similarities, even though the welfare state social security system functioned very differently. In the post-war period, the signs were in favour of continuity. Attempts to fundamentally restructure social security failed in the mid-1950s. The welfare state was expanded within the framework of the traditional insurance system. Elderly people in need of care were initially covered by post-war legislation, such as the Emergency Aid Act and the Equalisation of Burdens Act.[27] This enabled old people's and nursing homes, among others, to receive funding to modernise and expand their services. The reform of welfare had far-reaching significance. The need for care for older people was a central aspect in the debates that led to the introduction of the Federal Social Assistance Act (BSHG) in 1961. This is particularly evident in Paragraph 75 BSHG, which explicitly refers to assistance for older people, which contributed to the spread of this term. Welfare experts regarded it as a particular sign of the law's progressiveness, as it regulated the

[22] Bornat/Raghuram/Henry 2010, p. 63.
[23] St. John/Hogan 2010, pp. 22-23.
[24] Bridgen/Lewis 1999, pp. 59-65.
[25] Means/Smith 1998, pp. 92-95, 232-234; Bridgen/Lewis 1999, p. 71.
[26] Boucher 1957, p. 54.
[27] Hughes 1999, pp. 194-195.

provision of personal assistance for the first time, i.e. social services that were intended to counteract social exclusion and enable participation.[28] However, the provisions that had the greatest impact, such as Sections 68 and 69 of the BSHG, were those that offered the prospect of cash and non-cash benefits in a more traditional and tried-and-tested manner. The ground-breaking aspect of the BSHG was that, in addition to the basic amounts, which corresponded most closely to the previous welfare legislation as assistance for maintenance, "assistance in special circumstances" could be awarded as additional benefits.[29] Just a few years after the reform came into force, the extent of the need for care in old age became clear. Almost half of the financial volume allocated to "assistance in special circumstances" went to people in need of care. The number of people, who were 65 years and older receiving this benefit quadrupled between 1963 and 1989.[30] The individual entitlement to benefits in the event of a need for care and simultaneous destitution was a lever for keeping the issue on the political agenda.

However, the situation regarding care for older people did not change purely because social policymakers were including the need for care in welfare legislation more frequently than before. Significant impetus also came from the care sector itself. In the early years of the Federal Republic of Germany, care underwent profound changes that were shaped by crisis. In particular, the providers of nursing care that were linked to religious orders of sisters and deaconesses, faced massive recruitment problems. The willingness of women to join a religious community and submit to its rules declined significantly. In addition, not only was the number of available carers decreasing, but the number of hours they were available to work were also declining. Although change was rather slow in this regard, the demands for a reduction in working hours were gaining ground in the care sector at this time. While 70 to 80-hour weeks were still common in the early 1950s, it was possible to set working hours at 54 or 60 hours in 1956, which was admittedly still high in view of the fact that the German Trade Union Confederation was calling for a 40-hour week.[31]

The high demand for carers contributed to the development of care for older people as a separate field of nursing. The first regionally organised training courses at the end of the 1950s were aimed, among other things, at attracting women to the nursing profession. Almost all of the participants in the first six-month courses, which took place in North Rhine-Westphalia, had already completed vocational training. They included factory workers, sales assistants and housekeepers, who used the courses as an opportunity to retrain. The average age was 41.[32] The early days of nursing training were characterised by contradictory views – some that devalued the profession and some that sought to enhance its status. The training was to be moderate in terms of duration and requirements, in order to keep it accessible to women looking for an alternative job or those who wanted to re-enter the world of work after bringing up a family. Nursing care for older people was thus modelled on a slimmed-down nursing training course. However, school principals also recognised in geriatric nursing the opportunity to uphold traditional nursing skills, especially those that required social and communicative tasks. They saw little room for these in general nursing, which was becoming increasingly mechanised and medicalised.[33]

The shortage of nursing staff was ultimately also a stumbling block for new developments, particularly for the expansion of home care services. The number of community nurses fell noticeably in the 1950s and 1960s. Initially, the impetus to expand home care, which was provided by the Social Assistance Act,

[28] Föcking 2007, pp. 331-337.
[29] See Weller 1963, pp. 270-274.
[30] See Statistisches Bundesamt: Wirtschaft und Statistik 1965, vol. 9, Wiesbaden 1965, pp. 617-618.
[31] Kreutzer 2018, pp. 127-128, 132 for more details.
[32] Heumer/Kühn 2010, pp. 46–48.
[33] Heumer/Kühn 2010 p. 45–46.

for example, had little effect. It was not until the 1970s that a counter-trend emerged with the establishment of inter-agency social care centres. They partly filled the gaps left by the community nurses.[34]

As far as better protection against the risk of long-term care is concerned, the results for the first three decades after the Second World War are mixed in both West Germany and Great Britain. Those in need of long-term care were not really the focus of the reforms introduced during the heyday of the welfare state. They were explicitly considered when poverty policy was restructured. In the Public Assistance Act and in social welfare there were regulations that related specifically to care for older people. However, this group did not benefit much, if at all, from the expansion of health insurance and the National Health Service. In Great Britain, there is even evidence of a clear marginalisation of those in need of long-term care.

The post-war period was certainly not a golden age for nursing care. Staff shortages, a lack of social recognition and a growing workload due to the demographic age structure were challenges back then that still characterise the situation today. What was the impact of the privatisation and marketisation of care that emerged in the 1980s?

4 THE BOOM IN PRIVATE COMMERCIAL CARE IN THE 1980S AND 1990S

Private commercial providers have existed in both countries from the very beginning. In his pioneering study in 1962, the British sociologist Peter Townsend stated that 9% of care homes were in private hands. The vast majority, however, were in the hands of public organisations.[35] In addition to the private commercial sector for inpatients, there were also freelance nurses, the number of whom cannot be determined. A significant proportion of trained nurses became self-employed after graduating. For one London hospital at the end of the 19th century, it is recorded that 30-40% of each training cohort went into self-employment. For the first half of the 20th century, there is also evidence that freelance work offered opportunities, e.g. more flexible working hours, which were particularly attractive to nurses with young children.[36]

By 1981, the picture was already different, with the private sector now accounting for a good 19% of the total, slightly more than the non-profit sector. However, the growth boom was not to follow until the next few years, and by 1993 the situation had almost reversed. 59% of the approximately 224,000 care home places in 1993 were provided by the private sector, while the public sector only provided just under 26%.[37]

The main reason for this rapid growth was the austerity measures taken by the government, which cut its allocations to local authorities, forcing them to close and sell their own care homes.

The Department of Health and Social Security (DHSS) in London changed access to asset-based welfare benefits. From 1979 onwards, anyone who decided to move into a private or charitable home

[34] Riege 1978, p. 205.
[35] Townsend 1962, p. 187.
[36] Hawkins 2010, pp. 173-175; Hargreaves 2022.
[37] Office of Population Censuses and Surveys (OPCS) 1988, p. 41; OPCS 1993, p. 46.

could apply for funds – provided their own income was not sufficient to pay the monthly fees. The responsible authorities only checked the economic need. However, there was no assessment of whether care in a home was necessary. While there were only around 11,000 recipients of this form of support in 1979, about ten years later the number had risen to around 280,000.[38]

Just how unplanned the resulting wave of privatisation was, becomes clear when we look at how people in need of care came to receive DHSS services. The idea of making DHSS pots available to residents in non-state care homes was first conceived when representatives of the non-profit sector started demanding support to make up for their financial losses from social welfare funds. Since the local authority budgets, from which they had previously received large grants, had been cut, their existence had been in jeopardy.[39] Initially, these were case-by-case decisions; it was not until 1983 that the DHSS formalised this regulation and it happened very quietly, without the wider public noticing. This paved the way for "privatisation by default" or "back-door privatisation".[40]

However, the rising number of applications also meant rising costs. Within seven years, there had been a considerable increase, from £6 million to £280 million.[41] Costs continued to rise despite the DHSS's efforts to cap benefits. In the early 1990s, annual expenditure finally totalled £2.6 billion.[42]

The Federal Republic of Germany also saw a surge in privatisation. Germany, like Great Britain, has always had a private commercial sector, which is particularly visible in the form of care homes. In 1969, it accounted for 9% of care home places.[43] The sector grew steadily but slowly. The real dynamic of privatisation began to unfold in home care in the 1980s. Exact figures are not available until the end of the 1990s. When an Infratest study provided concrete figures in 1998, it showed that 43% of the approximately 11,600 outpatient services were run commercially. For a long time, the wave of privatisation was mainly attributed to care insurance.[44]

Long-term care insurance was introduced in 1995. It was part of the German social insurance tradition, but introduced innovations with the partial "casco" principle. Long-term care insurance added a fifth pillar to the German social insurance system. It is regarded as a "market creation law",[45] as the regulations it contains favour the activities of private-sector providers of long-term care insurance and care services.[46] It also reinforced the trend towards privatisation, although this was already clearly visible before 1995. A study published by the Kuratorium Deutsche Altershilfe in 1985 presented evidence of a boom in the establishment of "small commercial, freelance and alternative private care services".[47] Reports in daily newspapers and specialist journals about individual operators and their history provide further evidence. Finally, it should be noted that around 66% of the services counted in 1998 (no differentiation by operator group is included here) had already started operations before 1993, and 39% before 1989.[48]

A German-German variant of privatisation was ultimately linked to reunification. In the German Democratic Republic (GDR), there had been a state-run community nursing system. After reunification, many of these community nurses chose to become self-employed and opened their own nursing services. An initial study for the Brandenburg region in 1994 described this phenomenon and spoke of a "trend

[38] Hansard, 1990, col. 1028.
[39] Player/Pollock 2001, p. 234.
[40] Phillips/Vincent 1986, p. 159. Estrin/Pérotin 1988, p. 13.
[41] Hansard 1986, col. 318.
[42] Laing and Buisson 1994.
[43] Cf. Bericht der Bundesregierung 1969.
[44] See Igl 2007 for details on long-term care insurance.
[45] Hockerts 2012, p. 76.
[46] Hockerts 2012, p. 76.
[47] Hartmann 1985 The Kuratorium Deutsche Altershilfe was founded in 1962 to promote support structures for older people. It finances model projects on a limited scale and acts as an expert advisory organisation for state actors. The KDA also addresses social service providers for older people in order to network them
[48] Schneekloth/Müller 1999, pp. 89-91.

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towards a renaissance of the GDR community nurse". The contacts and reputation they had built up among the local population and with local doctors helped them to make a new start.[49]

The privatisation push in home care in East Germany was already clearly evident in the statistics at the end of the 1990s. On average, private care services had a share of 43.6%, based on the number of people cared for per provider. The national average was lower at 35.6 %; the average for the western German federal states (excluding city states) was only 31.2%.[50] This development can be described as very rapid when one considers that the privatisation push in eastern Germany took place in less than ten years.

Looking at East Germany, it is already clear which group was of great importance for privatisation: the trained nursing staff. This also applied to developments in West Germany and Britain in the 1980s. An initial study of the operators of private nursing homes in Great Britain came to the conclusion that 50% of the new care entrepreneurs had training in nursing. A follow-up study carried out by social and nursing scientists in the mid-1990s also found that a large proportion of nursing home operators, namely 40%, were former employees of the National Health Service.[51]

Trained nurses and geriatric nurses were also one of the largest groups among the private-sector care service providers that began operating in West Germany in the 1980s and 1990s.

What motivated the carers to give up paid employment and take on the role of small entrepreneurs? What ideas about the market and privatisation did they hold and what experiences did they have?

5 CARE AS A BUSINESS: IDEAS AND EXPERIENCES

It is difficult to trace the ideas and experiences of those who decided to open a care home or set up a care service as actors in the private sector. Sources are scarce. Various categories of documents contain clues, although the situation in the two countries under investigation differs. For Great Britain, there are a number of sociological studies that focus on small-scale care home operators and bring them to life through quotes from qualitative interviews. In Germany, on the other hand, only a few such studies can be found. Here, it is mainly articles and letters from readers in specialist journals and articles in daily newspapers that provide information about care home operators.

A number of written submissions are available for England. These arose when the then Labour government convened a commission of enquiry in 1997, the Royal Commission on Long Term Care for the Elderly, which was primarily intended to discuss the issue of financing care for the elderly. In order to evaluate the situation of care for older people, the commission issued a public call for submissions.[52] Among the more than 2,000 responses received by the commission were numerous letters from private care providers. In Germany, the websites of care service providers proved to be a treasure trove. Those providers that can look back on a longer company history talk about their history in "History" or "About us" sections on their websites. Operators explain their motivation and provide insights into how they see themselves as entrepreneurs.

[49] Schmidt 1994, p. 66.
[50] In the city states, particularly Hamburg and (West) Berlin, the proportion of private providers has always been higher. If the number of care services is taken as a basis, the proportion of commercial providers was higher. Accordingly, the national average was 50.9% private (58% in the eastern German states excluding Berlin), 47.2% non-profit and 2% public. See Statistisches Bundesamt 2002, p. 5-6.
[51] Andrews/Kendall 2000, p. 903.
[52] With respect to old age 1999.

In both countries, and in almost all of the document categories mentioned, the question of why carers took up private-sector work plays an important role. For Britain, a study carried out in the early 1990s in the county of Devon in the south-west of the country provides some indications. For the nurses who had previously worked in NHS organisations, a number of findings stand out. For example, none of them cited the situation of the health service, which was the subject of public criticism, as a reason for deciding to open a care home. Moreover, the path into geriatrics was anything but obvious for the nurses, as the work took them into a field that, as noted above, was not held in high regard within the NHS. People in need of long-term care were one of the groups that had been increasingly marginalised within NHS facilities. So what prompted them to make this switch? Among the answers, those citing higher pay and a desire to continue care work under better conditions ranked highly. However, the desire to "be your own boss" came top of the list by a long way.[53] The change from being an employee to running their own business was the decisive motivation for many. The market policy, which played a major role in the political debate during the years of the Thatcher government, resonated here on a small scale. In short, nurses who opened commercial care homes and transformed themselves from NHS employees into entrepreneurs could count themselves part of the "free enterprise" system that Thatcher celebrated in numerous speeches and interviews as a driver of innovation and prosperity.[54] The statements of the newly minted care home operators, like the texts of political elites, are part of a discourse on free market forces and their social organising function.

The same trend of nurses and carers becoming entrepreneurs can also be found in the Federal Republic of Germany, and the available sources provide even deeper insights. Although there are no survey studies from this period, articles and letters to the editor repeatedly appeared in specialist journals and daily newspapers, focussing on the new care entrepreneurs and their path to self-employment and business start-ups.

As early as 1981, the trade journal *Altenpflege* reported on a private nursing and geriatric care service from Nuremberg, a novelty according to the article, which the editors took as an opportunity to discuss the privatisation of nursing care with readers. The article, in which Jürgen Nitsch, who had completed an industrial apprenticeship before spending four years in the German Armed Forces working in the medical service and nursing, talked about his career, took up more than two pages. He ventured into self-employment in 1979, describing his motivation as the "urge to work independently and freely [...] as well as the desire to help overcome the anonymity of hospitals and nursing homes". [55]

The two themes that are reflected in Jürgen Nitsch's statement, as reproduced in the magazine Altenpflege, reappear in many sources on private commercial care services. It is striking how the step into self-employment is associated with freedom.

In Jürgen Nitsch's case, the aim was to be as independent as possible while pursuing nursing as a profession, even though he did not have the relevant specialist qualification. Another nurse, from North Rhine-Westphalia, left to escape the nursing shortage in hospitals. A geriatric nurse from Hildesheim, who appeared in *Altenpflege* in 1990, stated that she wanted to escape the high time pressure in the nursing home and a "permanently gruelling job".[56] At the time of publication, the then 29-year-old had only been working independently for two years on a small scale, with just two employees. Her care service was one of those that would go on to establish itself permanently. On the 20th anniversary of

[53] Andrews/Kendall 2000, p. 903.
[54] Cf. e.g. interview with Margaret Thatcher 1983.
[55] Private Alten- und Krankenpflege 1981, pp. 326-328.
[56] Hahn 1990, pp. 630-631.

her business, she was employing 17 people, who completed their visits in 11 company-owned cars that had been sprayed pink.[57] Other sources, such as surveys and interviews, also document the establishment of a business as an opportunity and a gain in autonomy.[58]

At times when there were political calls for the "humanisation of work", i.e. a more humane organisation of working life, such arguments fell on fertile ground.[59] Although such discussions tended to centre on industrial work, an effect on other areas of work cannot be ruled out. In addition, from the 1970s onwards, an increasingly political and militant understanding of the profession emerged among carers, which can be seen in the founding of the Federal Association for Elderly Care in 1974 and the growing commitment of the Public Services, Transport and Traffic Union (ÖTV) in the years in which there were political debates about staffing ratios. The first highlight of this development was the warning strike by carers in May 1989.[60] Poor working conditions in the care sector and the need to improve the situation were a hot topic in the media and politics. A survey of participants attending seminars organised by a private training institute on the basics of home care revealed that they expected better earning opportunities, more professional independence and more freedom to shape their own care work.[61]

The newly qualified care service providers expressed an optimistic interpretation of the market, which, although having less of a theoretical basis, was essentially very similar to the views of the neoliberal thinkers.[62] The market gave them freedom and opportunities. They presented themselves as a kind of homo economicus, shaping their own biographies as market players.

A particular historical manifestation of the autonomy narrative occurred at the time of reunification, when many former community nurses did not join the ranks of the social welfare centres as planned, preferring to set up their own nursing services. Sabine Ettinghausen from Halle was one of them. She had been a parish nurse in the south of Halle for years before setting up her own business after reunification.[63] Initially, she was a one-woman business, travelling by bicycle as she had done in the GDR era. It was only three years after setting up her own business that she took on employees and swapped her bike for a car. Looking back on the company's 20th anniversary, another nursing service founder stated that she had set up her own business in order to "rescue the working model of the community nurse from GDR times by bringing it into the new system".[64] Of course, the reference to the legacy of the community nurses can also be understood as a deliberate advertising strategy, as the community nurses, just like the polyclinics and the Volkssolidarität, a welfare organisation for the elderly, were among the more positive experiences that many East German citizens remembered with regard to the care system of the GDR.[65]

However, it cannot be denied that former community nurses were extremely complimentary about their former work. The high degree of independence and wide range of medical and nursing activities for different population groups (pregnant women, people with disabilities, elderly people) demanded a lot from them, but also gave them scope to manage their own work. Community nurses had held an important intermediary position, as they had been the point of contact for the sick, medical staff and

[57] Vom Berge 2009.
[58] Zawada 1989, pp. 65-66; also Schuermann 2016, pp. 88-89. Schuermann's study refers to care services that mostly started in the 2000s, but very similar patterns of argumentation can be found in the interviews she conducted.
[59] Müller 2019, p. 80.
[60] Wiede 2022, p. 56.
[61] Zawada 1989, pp. 65-66.
[62] For the optimistic market idea, see Wirsching 2019, p. 39-40.
[63] See Färber 2017, p. 14 .
[64] Gitter 2012, p. 9.
[65] Volkssolidarität was initially founded in 1945 and later became a mass organisation in the GDR, specialising in the provision of social services, particularly for older people. After reunification, Volkssolidarität continued to exist as a charitable organisation, with its area of operation mainly extending to East Germany.

health authorities.[66] They saw many of the advantages of their previous work as being preserved by setting up their own nursing business rather than being employed in a social care centre. The market therefore offered them the opportunity to preserve a piece of the GDR, so to speak.

In addition to the interpretation of the market as a space of freedom, there is a second aspect that overlaps with neoliberal doctrines, which postulated a close relationship between the market and morality.

The statements made by care service providers, who brought this argument to life, read very similarly. After all, they had not only found their own happiness on the market, but had also done something for the well-being of others, namely for those in need of care. Like Nitsch, many care service providers argued that they were providing a service to elderly people in need of care and were helping to humanise care. This can be read in an article in the *FAZ* newspaper from 1989, which reported on a nurse who had set up his own business in the 1980s. The costs for his outpatient care services were lower than the costs in a nursing home. He was more dependent on the "satisfaction of the people he cared for and their relatives" than employed colleagues from public and non-profit organisations.[67] A care service provider found even clearer words in a letter to the editor in 1994, which was directed against an article that had denounced grievances in private commercial outpatient care. The letter to the editor criticised the article in the *FAZ* as being overly general. He admitted that there were individual "black sheep", but emphasised that they not only violated moral codes, but also rational market behaviour.

> "Of course, in addition to patient care, there is also an economic aspect at play. Nevertheless, it is probably a law of the market economy that providers who pay too much attention to the financial side of a company end up in the headlines because nobody is prepared to pay well for poor service."[68]

In statements such as these, the market is construed as a force of order with the ability to produce or even favour moral action.

It was necessary to point out that private commercial activity could serve the welfare of those in need of care, because until then the media had mainly reported on private commercial care when there had been grievances. This early reporting was characterised by the fact that the incidents were not regarded as individual cases, but were presented as a structural problem of private commercial providers. The authors saw the desire to make a profit from the need for care as immoral per se.[69]

However, a contrary interpretation emerged with the newspaper reports about the private care service providers. Their commercial basis, and thus the market, allowed them to deliver care according to humanitarian standards. This narrative is even more prominent on the websites of care services than in the newspaper articles mentioned above.

There are few examples as explicit as that of Christine Kern's nursing service in Emmendingen in Baden-Württemberg. In 1992, the trained nurse decided to open a nursing service that grew rapidly. In a website first published in 2008, she describes the beginnings in detail. She presents herself as a carer who wanted to improve her working conditions, as an entrepreneur who was aware of the logic of the market, and as an agent of customer-oriented and therefore humane care:

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[66] Strupeit 2008, p. 172; Schmiedhofer/Brandner/Kuhlmey 2017, p. 458.
[67] "Sometimes the carer becomes the caretaker" 1989, p. 41.
[68] Weinhart 1994, p. 5.
[69] "Gegen private Altenheime" 1972.

> One of Christine Kern's convictions is also that work is more than just a means to an end – work must be the purpose of life, the quality of work is also a big part of quality of life!
>
> With these basic motivations, Christine Kern gave up her management position in a large hospital in order to find fulfilment and put her ideas into practice autonomously, which was hardly possible in systems such as her previous working environment. In doing so, she was also willing to give up a high level of security: relinquishing a senior position in the civil service to face a market that was still in its infancy: **the care market...** [...]
>
> "Understanding care as a service that is subject to the laws of the free market economy was a clear understanding of our own work from the outset and one of the requirements for future employees.[70]

Of course, these statements must be understood as an advertising strategy, among other things.[71] But even as such, they are examples of the discourse on the social benefits of the free market. The websites demonstrate how well the argument of the free market as a haven of freedom and a harmonious social order fits the logic of private commercial care services. Is it possible to trace the reception of Friedman and Hayek's theories here? This cannot be proven with the available sources. However, it is clear that many of the basic assumptions of neoliberal thinkers corresponded to real-world explanatory patterns. In this case, it was a question of attributing meaning to the decisions of a minority of professional carers to become commercially active and thus to leave familiar paths. Freedom in their own work and the well-being of those in need of care as clients were central motives for this creation of meaning. They implicitly referenced neoliberal market ideas and reinforced them at the same time.

The wave of care company start-ups also produced less optimistic stories. However, these received far less publicity. Of course, there were no websites for the significant number of care homes and care services that were forced to close again after only a short time. They were also not mentioned in the local newspapers, unlike those that managed to stay on the market. Failure left far fewer traces in the sources.

6 CONCLUSION

What new insights into the privatisation of care for older people have been gained by linking historical research on marketisation with the history of care? Three points should be noted in conclusion:

1. The comparison of the Federal Republic of Germany and Britain initially raises the question of why the privatisation waves were very similar in terms of time period and dynamics, despite the very different structures in the two countries. Different welfare state models and, above all, major differences in the reception of neoliberal doctrines by social policy decision-makers would have suggested otherwise. Financial incentives for privatisation, as they existed – albeit unintentionally – in Britain, were absent in the Federal Republic of Germany. In both countries, however, there was a well-educated group of care professionals who became supporters of privatisation.

[70] http://www.pflegedienste-kern.de/index.php?geschichte, last accessed on 6 August 2008. On 31 October 2022, Christine Kern discontinued her home care service.
[71] See also e.g. https://pflegedienst-kramer.de and https://bsb-pflegedienst.de/, last accessed on 1 June 2024.

2. This leads to the next point: historians who have devoted themselves to marketisation as a contemporary historical process have enriched our knowledge of the expansion of the network of neoliberal thinkers and also clarified the circulation of their teachings. With the history of care, completely different actors are now coming into view and, with their history, new approaches to explaining marketisation are emerging. In their studies on the network of neoliberal economists, Daniel Stedman Jones and other scholars have emphasised that, despite the transnational networking that took place in politics and business, it was anything but inevitable that their teachings would prevail.[72] He sees the economic crises of the 1970s as the main, contingent factor that contributed to the breakthrough of neoliberalism. It was only then that the teachings of Hayek, Friedman and others increasingly found an audience. However, the growth of private commercial care is characterised less by the crises of the 1970s than by the heyday of the European welfare states, which saw an increase in well-trained workers in the social and medical services sector. Many of them found themselves in a kind of personal crisis because they saw the demands of democratic welfare states disregarded in terms of their own working and living conditions and those of the people entrusted to their care. The market offered them opportunities. To reduce these to material benefits alone and thus to reduce the actors to a kind of homo economicus would be misguided. The spread of neoliberalism had political as well as financial and economic causes.

3. It is also possible to gain new insights in the other direction. Research on marketisation, which sheds light on concepts of order as a new history of ideas, offers new perspectives for the history of nursing. Nursing professionals were not only actors in care and knowledge of medicine, but also carriers of ideas. They were actors in a professional world, but also political contributors who helped to shape the transformation of the welfare state in the final third of the 20th century. Their influence was admittedly much smaller than that of economists who wrote and popularised doctrines, and of politicians who incorporated them into their programmes. However, in order to explain the privatisation of care, it is necessary to consider this group of individuals with their ideas about the market and the role of companies, because they set the tone. In doing so, we can grasp fragments of an everyday history of neoliberalism.

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[72] Stedman Jones 2012, pp. 215-216.

Bibliography

Primary sources

Blair, Tony/Gerhard Schröder et al.: "Der Weg nach vorne für Europas Sozialdemokraten". In: "Der Weg nach vorne für Europas Sozialdemokraten" Zeitschrift Blätter für deutsche und internationale Politik, No. 7, 1999, pp. 887–896.

Berge, Moritz vom: Stadtteilzeitung Hildesheim West, No. 199, October 2009.

Bericht der Bundesregierung an den Deutschen Bundestag über die Erfahrungen in der Ausführung des § 38 Satz 1 Nr. 10 und Satz 2 der Gewerbeordnung (Altenheime), Bundestagsdrucksache 5/4122 dated 21 April 1969.

Boucher, C.A.: A (1957). Survey of Services Available to the Chronic Sick and Elderly 1954-1955. Ministry of Health: Reports on Public Health and Medical Subjects No 98, 1957.

Hahn, Marita: "Diese Aufgabe erfüllt mich". Die junge Unternehmerin versorgt elf Senioren zu Hause. In: Altenpflege 11 (1990), pp. 630–631.

Färber, Detlef: "Da zu sein, lindert Leid". Sabine Ettingshausen. Vor 25 Jahren gründete sie als Gemeindeschwester einen der ersten Pflegedienste Halles. Inzwischen zählt er zu den größten. In: Mitteldeutsche Zeitung 4 August 2017, p. 14.

Gitter, Danny: Als Gemeindeschwester plötzlich Unternehmerin. Monika Winkler gründete vor 20 Jahren den ersten privaten Kranken- und Altenpflegedienst in Dessau. In: Mitteldeutsche Zeitung 28 February 2012, p. 9.

"Manchmal wird der Pfleger zum Hausmeister. Wie sich Freiberufler um Patienten kümmern", In: FAZ, 20 March 1989, p. 41.

Ulf Weinhart to FAZ editor. In: Frankfurter Allgemeine Sonntagszeitung, 17 July 1994, No. 28, p. 5.

"Gegen private Altenheime". In: Frankfurter Rundschau, 27 May 1971, PA VII/176 B I.

Hansard, House of Commons, Renee Short, 9 July 1986, col. 318.

Hansard, House of Commons, Gillian Shephard, 24 January 1990, col. 1028.

Hartmann, Helmut: Neue Erscheinungsformen privater Pflegedienste und Pflegestellen für ältere Menschen. Cologne 1985.

Klee, Ernst: Geschäfte mit Alten, in: ZEIT, 27 October 1972.

Laing and Buisson, Care of Elderly People Market Survey, London 1994.

Office of Population Censuses and Surveys (OPCS), Population trends No. 52 (1988), pp. 41.

OPCS, Population trends No. 73 (1993), pp. 46.

Private Alten- und Krankenpflege, in: Altenpflege, September 1981, pp. 326-328.

Statistisches Bundesamt: Pflegestatistik 1999. 3. Bericht: Ambulante Pflegedienste. Wiesbaden 2002.

With respect to old age: a report by the Royal Commission on Long Term Care. London 1999.

Internet sources

Interview with Margaret Thatcher in The Sunday Times 22 February 1983, Margaret Thatcher Foundation, URL: https://www.margaretthatcher.org/document/105088.

National Health Service Act, 1946, URL: https://www.legislation.gov.uk/ukpga/1946/81/pdfs/ukpga_19460081_en.pdf.

National Assistance Act, 1948, URL: https://www.legislation.gov.uk/ukpga/Geo6/11-12/29/enacted.

http://www.pflegedienste-kern.de/index.php?geschichte, 6 August 2008, Internet Archive wayback machine.

https://pflegedienst-kramer.de oder https://bsb-pflegedienst.de/ (zuletzt gesehen am 01.06.2024).

Secondary literature

Andrews, Gavin J./ Sally A.Kendall: Dreams that Lie in Tatters: The Changing Fortunes of Nurses who Left the British NHS to Own and Run Residential Homes for Elderly People. In: Journal of Advanced Nursing 31 (2000), 4, pp. 900-908. DOI: 10.1046/j.1365-2648.2000.01359.x

Bornat, Joanna/Parvati Raghuram/Leroi Henry: Oral History Voicing Differences: South Asian Doctors and Migration Narratives. In: Economic and Political Weekly 49 (2014), pp. 60–66. http://www.jstor.org/stable/24479741.

Brandes, Sören: "Free to Choose". Die Popularisierung des Neoliberalismus in Milton Friedmans Fernsehserie (1980/90). In: Zeithistorische Forschungen/Studies in Contemporary History, online edition, 12 (2015), DOI: https://doi.org/10.14765/zzf.dok-1434

Bridgen, Paul/Jane Lewis: Elderly People and the Boundary between Health and Social Care 1946-91: Whose Responsibility? Research Report. Nuffield Trust. London 1999.

Estrin, Saul/Virginie Pérotin: Privatisation by Default: Old Age Homes in Britain and France, Welfare State Programme Research Note No. 11, 1988.

Föcking, Friederike: Fürsorge im Wirtschaftsboom. Die Entstehung des Bundessozialhilfegesetzes von 1961. Munich 2007.

Geppert, Dominik: Thatchers konservative Revolution. Der Richtungswandel der britischen Tories 1975–1979. Munich 2002.

Gorsky, Martin: "To Regulate and Confirm Inequality"? A Regional History of Geriatric Hospitals under the English National Health Service, c. 1948-c. 1975. In: Ageing and Society 33 (2012), pp. 598–625. DOI: https://doi.org/10.1017/S0144686X12000098

ENHE 6/2024 DOI:10.25974/enhe2024-4en

Graf, Rüdiger: Einleitung. Ökonomisierung als Schlagwort und Forschungsgegenstand. In: Graf, Rüdiger (Ed.): Ökonomisierung. Debatten und Praktiken in der Zeitgeschichte. Göttingen 2019, pp. 9–25.

Hargreaves, Janet: "In the Nursing Homes, Nurses Really Nurse": Nursing in Private Nursing Homes in 1930s Britain. In: The UKAHN Bulletin 10 (2022), https://bulletin.ukahn.org/in-the-nursing-homes-nurses-really-nurse-nursing-in-private-nursing-homes-in-1930s-britain-1/editorial-team-2022#janet-hargreaves.

Hawkins, Sue: Nursing and Women's Labour in the Nineteenth Century: The Quest for Independence. Abingdon 2010.

Hockerts, Hans Günter: Abschied von der dynamischen Rente: Über den Einzug der Demographie und der Finanzindustrie in die Politik der Alterssicherung. In: Becker, Ulrich/Hans Günter Hockerts/Klaus Tenfelde (Ed.): Sozialstaat Deutschland. Geschichte und Gegenwart. Bonn 2010, pp. 257–286.

Hockerts, Hans Günter: Vom Wohlfahrtsstaat zum Wohlfahrtsmarkt. Privatisierungstendenzen im deutschen Sozialstaat. In: Norbert Frei/Dietmar Süß (Ed.), Privatisierung: Idee und Praxis seit den 1970er Jahren. Göttingen 2012, pp. 70–87.

Hockerts, Hans Günter: Einführung. In: Hockerts, Hans Günter/Winfried Süß (Ed.): Soziale Ungleichheit im Sozialstaat. Die Bundesrepublik Deutschland und Großbritannien im Vergleich. Munich 2020, pp. 9–18.

Hughes, Michael L.: Shouldering the Burdens of Defeat: West Germany and the Reconstruction of Social Justice. Chapel Hill 1999.

Igl, Gerhard: Die Entstehung der sozialen Pflegeversicherung und ihre Konsequenzen. In: Ritter, Gerhard A. (Ed.) Geschichte der Sozialpolitik, Vol. 11: Bundesrepublik Deutschland 1989-1994. Sozialpolitik im Zeichen der Vereinigung, Baden-Baden 2007, pp. 694–717.

John, Philip D. St./David B. Hogan: The Relevance of Marjory Warren's Writings Today. In: The Gerontologist 54 (2014), pp. 21–29, https://doi.org/10.1093/geront/gnt053

Kreutzer, Susanne: Abschied vom zölibatären Berufsbild? Gewerkschaftspolitik in der Pflege nach 1945. In: Hähner-Rombach, Sylvelyn/Pierre Pfütsch (Ed.): Gesundheitsberufen nach 1945: Ein Lehr- und Studienbuch. Frankfurt a.M. 2018, pp. 120–145.

Kühn, Cornelia/Mechthilde Heumer: Die Entstehung und Entwicklung der Altenpflegeausbildung: historische Rekonstruktion des Zeitraums 1950 bis 1994 in Nordrhein-Westfalen. Hamburg 2010.

Kutzner, Maximilian: Marktwirtschaft schreiben. Das Wirtschaftsressort der Frankfurter Allgemeinen Zeitung 1949 bis 1992. Tübingen 2019.

Leimgruber, Matthieu: The Historical Roots of a Diffusion Process: The Three-Pillar Doctrine and European Pension Debates, 1972–1994. In: Global Social Policy 12 (2012), pp. 24–44.

Francis, Matthew: "A Crusade to Enfranchise the Many": Thatcherism and the 'Property-Owning Democracy'. In: Twentieth Century British History 23 (2012), pp. 275–297, https://doi.org/10.1093/tcbh/hwr032.

Means, Robin/Randall Smith: From Poor Law to Community Care. The Development of Welfare Services for Elderly People 1939-1971. Bristol 1998.

Müller, Stefan: "Das Forschungs- und Aktionsprogramm „Humanisierung des Arbeitslebens" (1974-1989). In: Kleinöder, Nina/ Stefan Müller/ Karsten Uhl (Ed.): "Humanisierung der Arbeit". Aufbrüche und Konflikte in der rationalisierten Arbeitswelt des 20. Jahrhunderts. Bielefeld 2019, pp. 59–97.

Muthesius, Hans: Der Deutsche Verein, das Bundessozialhilfegesetz und das Gesetz für Jugendwohlfahrt. In: Deutscher Verein für Öffentliche und Private Fürsorge (Ed.): Fürsorge im Spannungsfeld der Generationen. Gesamtbericht über den Deutschen Fürsorgetag 1961 in Mannheim. Cologne 1962, pp. 452–460.

Nawrat, Sebastian: Agenda 2010 – ein Überraschungscoup? Kontinuität und Wandel in den wirtschafts- und sozialpolitischen Programmdebatten der SPD seit 1982. Bonn 2012.

Nolte, Karen: Einführung: Pflegegeschichte – Fragestellungen und Perspektiven. In: Medizinhistorisches Journal 47 (2012), pp. 15–28.

Phillips, David R./John A. Vincent: Private Residential Accommodation for the Elderly: Geographical Aspects of Developments in Devon. In: Transactions of the Institute of British Geographers 11 (1986), pp. 155–173.

Player, Stewart/Allyson M. Pollock: Long-Term Care: From Public Responsibility to Private Good. In: Critical Social Policy 21 (2001) 2, pp. 231–255.

Raghuram, Parvati/ Leroi Henry/Joanna Bornat: Difference and Distinction?: Non-Migrant and Migrant Networks. In: Sociology 44 (2010), pp. 623–641. https://doi.org/10.1177/0038038510369360

Riege, Fritz: Leistungsfähige Sozialstationen – Gebot der Stunde. In: Sozialer Fortschritt 27 (1978), pp. 204–210.

Schmidt, Roland: Gewerbliche Altenpflege in Ostdeutschland. Nischenexistenz und Wachstumsrisiken – dargestellt am Beispiel Brandenburgs. In: Schmidt, Roland (Ed.): Heime und Pflegeheime in Brandenburg. Materialien zur Entwicklung einer Altenhilfestruktur in einem neuen Bundesland III. Berlin 1994, pp. 60–70.

Schmiedhofer, Martina H./Susanne Brandner/Adelheid Kuhlmey: Delegation ärztlicher Leistungen an nichtärztliche Fachkräfte. Der Versorgungsansatz agneszwei in Brandenburg – eine qualitative Akzeptanzanalyse. In: Gesundheitswesen 79 (2017), 6, pp. 453–460.

Schneekloth, Ulrich/Udo Müller: Wirkungen der Pflegeversicherung. Forschungsprojekt im Auftrag des Bundesministeriums für Gesundheit. Baden-Baden 1999, pp. 89–91.

Schürmann, Lena: Unternehmerische Akteure auf Wohlfahrtsmärkten: private ambulante Pflegedienste im Spannungsfeld zwischen Fürsorge und Wettbewerb. In: AIS-Studien 9 (2016), pp. 75-95. https://doi.org/10.21241/ssoar.64833

St John, Philip D./David B. Hogan: The relevance of Marjory Warren's Writings Today. In: Gerontologist 54 (2014), 1, pp. 21–29.

Stedman Jones, Daniel: Masters of the Universe. Hayek, Friedman, and the Birth of Neoliberal Politics. Princeton/Oxford 2012.

ENHE 6/2024 DOI:10.25974/enhe2024-4en

Strupeit, Steve: Präventive und gesundheitsförderliche Aufgaben und Maßnahmen durch Gemeindeschwestern in der ehemaligen DDR – ein Rückblick. In: Pflege & Gesellschaft 13 (2008), 2, pp. 159–173.

Süß, Winfried: Umbau am "Modell Deutschland". Sozialer Wandel, ökonomische Krise und wohlfahrtsstaatliche Reformpolitik in der Bundesrepublik "nach dem Boom". In: Journal of Modern European History 9 (2011), 2, pp. 215-240. https://doi.org/10.17104/1611-8944_2011_2_215

Philipp Ther: Neoliberalismus, Version: 1.0, in: Docupedia-Zeitgeschichte, 5 July 2016 http://docupedia.de/zg/ther_neoliberalismus_v1_de_2016, DOI: http://dx.doi.org/10.14765/zzf.dok.2.647.v1.

Weller, Arnold: Sozialhilfe für alte Menschen wirksam gestalten! In: Sozialer Fortschritt 12 (1963), 12, pp. 270–274.

Wiede, Wiebke: Der ÖTV und die Altenpflege seit den 1970er Jahren. Stagnation in einer Wachstumsbranche [Hans-Böckler-Stiftung, Study 476]. Düsseldorf 2022.

Wirsching, Andreas: Gehören Markt und Moral zusammen? Über ein historisches Dilemma des Liberalismus. In: Brechtken, Magnus et al. (Ed.): Demokratie und Gesellschaft. Historische Studien zur Moderne. Göttingen 2019, pp. 127–144.

Wirsching, Andreas: "Neoliberalismus" als wirtschaftspolitisches Ordnungsmodell? Die Bundesrepublik Deutschland in den 1980er Jahren. In: Plumpe, Werner/ Joachim Scholtyseck (Ed.): Der Staat und die Ordnung der Wirtschaft. Vom Kaiserreich bis zur Berliner Republik. Erträge des Theodor-Heuss-Kolloquiums vom 28. bis 30. Oktober 2010 in Stuttgart-Hohenheim. Stuttgart 2012, pp. 139–150.

Zawada, Ursula: Freiberufliche Krankenpflege – Kreativer Neuanfang oder Flucht aus den Institutionen? Düsseldorf 1989.

SPREADING NIGHTINGALE NURSING. A SLOW AND TORTUOUS PROCESS

Carol Helmstadter

Abstract

This article studies four matrons who tried to introduce Nightingale nursing into their hospitals: Angélique Lucille Pringle at the Royal Edinburgh Infirmary 1874–1887, Maria Machin at the Montreal General Hospital 1875–1878, Emily Aston at the Eastern Hospital 1887–1889, and Flora Masson at the Radcliffe Infirmary 1891–1896. Contrary to popular belief, Nightingale nursing did not spread rapidly around the globe. Although many early nursing reformers called their training schools Nightingale schools, few understood Nightingale's basically religious approach to nurse training. Some Nightingale matrons simply ran the nursing service in the old way but these four matrons did try to introduce some or all of Nightingale's principles. The article studies the opposition from hospital governors and doctors with whom they had to deal, the motivations of the four matrons and the progress they made.

Keywords: Nightingale training, Nightingale principles, Lucille Pringle, Maria Machin, Emily Aston, Flora Masson

1 INTRODUCTION

Florence Nightingale's devoted efforts to improve nursing have dominated the history of nursing to the point that the term "Nightingale nursing" has become a synonym for nursing reforms, whether they have anything to do with her or not.[1] This is partly because she made enormous contributions to the new nursing, and partly because early nursing leaders were anxious to disassociate themselves from the old nurses, who almost all belonged to the lowest level of society and lacked Victorian respectability. Nursing reformers preferred associating with the elevated social status Nightingale enjoyed. They renamed the position of hospital matron "lady superintendent" to differentiate themselves from the old lower middle-class matrons, while many who knew nothing about Nightingale's principles adopted her name for their training schools. Two of the earliest historians of nursing, Nutting and Dock, who never had any contact with Nightingale and were not aware of her vision for trained nursing, provide an excellent example. Once refined ladies took the lead teaching Nightingale principles, they claimed, nursing became a profession and trained nursing spread immediately and almost magically around the world.[2] Nightingale's fame did spread almost magically around the world and gave a level of respectability to the new nursing, but few nursing reformers were familiar with Nightingale principles. For those who understood her aims, nursing reform was a very slow, tortuous process. Despite the ongoing interest in Nightingale herself, few historians have studied the reforms in the early years. Apart from Monica Baly's Florence Nightingale and the Nursing Legacy and Judith Moore's A Zeal for Responsibility, both published in the 1980s, and Helmstadter and Godden's Nursing Before Nightingale, published in 2011, there are no major works on early nursing reforms.

[1] Helmstadter/Godden 2011, pp. 169–170.
[2] Dock/Nutting 1920, p. 73.

This article fills that gap in the historiography of nursing by studying the lengthy and often painful advance of nursing. I examine the experiences of four Nightingale-trained matrons who worked from 1874 to 1896. The matrons are Lucille Pringle at the Royal Edinburgh Infirmary 1874–1887, Maria Machin at the Montreal General Hospital 1875–1878, Emily Aston at the Eastern Hospital in Homerton in northeast London, 1887–1890, and Flora Masson at the Radcliffe Infirmary in Oxford 1891–1896. Although the four hospitals differed in mission, setting and funding sources, the opposition the new lady superintendents met was similar and arose in part from the class structure and gendered beliefs of their era. Other factors intervened as well. Trained nursing was markedly more expensive than the old nursing system and placed a strain on hospital budgets at a time when revenues were restricted. Equally important, many hospital governors continued to think of nurses as maids-of-all-work, as they had been in the old nursing system, rather than as women who, in the new era of medicalized hospitals, needed special education and a high degree of competence. All four matrons were very competent nurses and good teachers but three gave up the struggle and resigned. This article also demonstrates the terrible toll the work took on the matrons, and how those with religious commitment like Nightingale, Pringle and Machin tended to survive longer than those without.

What was the new trained nursing and what were the Nightingale principles which these matrons, worked so hard to introduce? In part, major medical advances determined Nightingale's principles: doctors demanded clinical knowledge, assessment skills and professional judgement.[3] Nightingale appreciated that nurses had to have these abilities to succeed in their own practice as well as to meet medical men's needs but she insisted on another aspect: nursing should be a spiritual commitment. Woman's mission, a powerful nineteenth century social construct, prescribed that ladies should not enter the public sphere because they were physically and intellectually inferior to men and therefore not able to handle the responsibilities involved in public institutions such as business and government or, in the case of the new matrons, public hospitals. However, woman's mission also posited that ladies were above all motherly,[4] and by motherly Victorians meant ladies were more religious, caring, self-sacrificing, and compassionate than men. Nightingale accepted this definition of motherliness and thought it made women ideally qualified to be nurses. As her most successful protégée, Lucille Pringle wrote, "motherliness of nature" is "the most precious attribute of a nurse."[5] Nightingale postulated three principles for good nursing. First was this natural, or motherly, component. Second was "the intellectual (or professional) motive, the desire & perpetual effort to do the thing as well as it can be done[6] – to nurse or to teach up to the ideal." Third, and most important for Nightingale, was the religious motive.[7]

Current critics of Nightingale usually take no account of the centrality of religion in her work. A good example is Sarah DiGregorio, who accuses Nightingale of establishing the racism and class bias which has troubled the development of modern nursing. She believes she placed the social values of her era over appropriate nursing care. DiGregorio seems unaware of Nightingale's religious dedication to helping those who were less fortunate.[8] On the other hand, Lynn McDonald, the foremost Nightingale scholar today, emphasizes that religion was the driving force in all of Nightingale's work.[9] Today it is generally accepted that the Nightingale School at St. Thomas's Hospital was the first secular training school.[10] It was secular in the sense that it was not a sisterhood and in the nineteenth century sense that

[3] Helmstadter/Godden 2011, pp. 4–8.
[4] Crawford et al. 2020, pp. 2–7, 47–49.
[5] Pringle 1880, pp. 1049–1050.
[6] All underlinings are original.
[7] Florence Nightingale to Caroline Stephen, [May 1869], British Library (BL), 47802, fols 22–30.
[8] DiGregorio 2023, pp. 5, 39–40, 48–50, 54–55.
[9] McDonald 2022, p. 7.
[10] Baly 1997, p. 216.

it was non-denominational. But because of Nightingale's religious commitment it was not secular in the twenty-first century sense of having no connection with religion. There were so many "disappointments, such sickenings of the heart, such contradictions" in founding a new service, she said, that she did not believe anyone could succeed "except by feeling that he or she was called to the work by God [...] that he or she is a fellow-worker with God." Nurses must have this sense of "serving God & man," she wrote, "Without the higher motive we Nurses can do nothing."[11]

Ideally, Nightingale also wanted nurses to dedicate their whole lives to nursing, eschewing marriage. However, she did not achieve this goal. By the 1890s, as British society became less spiritually oriented and more options for women's work opened, she had to acknowledge that very few women entering nursing did so as a religious vocation.[12] Pringle and Machin accepted Nightingale's more spiritual view of nursing but the two matrons who came from the next generation, Aston and Masson, did not.

2 LUCILLE PRINGLE

Angélique Lucille Pringle (1846–1920) was the earliest of the four matrons and is generally recognized as the most successful nineteenth century matron the Nightingale School produced. The school she established at the Edinburgh Infirmary adhered more closely to Nightingale's ideal than did the school at St. Thomas's, as Monica Baly so ably demonstrated.[13] Ironically, the Nightingale School was one of the two last training schools in the 12 London teaching hospitals to hire a matron who was a trained nurse and was the first school to use the probationers as cheap replacements for staff nurses. In 1868 Nightingale published an article, "Una and the Lion," which described Agnes Jones, a Nightingale-trained matron of the Liverpool Workhouse Infirmary, who died there of typhus at the age of 33. Nightingale portrayed her as a Christian martyr who devoted herself to Christ's poor and laid down her life for them.[14] "Una and the Lion" inspired Pringle to go into nursing, entering training at the exceptionally young age of 22 in 1868. She proved an exceptional nurse and an enormous success with probationers, staff nurses, the other sisters and Nightingale. Probationers complained that few of the other sisters had taught them anything but Pringle taught them a great deal. She actually "showed us how to do things herself," one working-class probationer explained.[15]

The lady probationers were equally impressed. Rachel Williams was considering leaving training after her first seven months because she was so disgusted with the atmosphere in the school. She found it a godless place where there was no spirit "except getting through the work at the least cost and the most credit to oneself, nothing but the most servile servant service." But when she was transferred to Pringle's wards everything was different. Pringle raised the tone of everyone – surgeons, dressers, patients and probationers. "Everything was done unto God," Williams reported. She saw Pringle as a real power but, although she exercised it so well, Williams thought authority was a real cross to her.[16]

Like Nightingale, Pringle used diplomacy and feminine tact when dealing with opposition. She had an excellent political sense: one of her key principles was to avoid inciting opposition from the doctors. "A woman [...] is certainly wanting in herself," she wrote, "who cannot soon win round patients and [medical] students and doctors to gracious and delicate ways." She was also extremely pragmatic. Horrible

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[11] Florence Nightingale to Caroline Stephen, [May 1869], BL, 47802, fols 22–30.
[12] Crossland to Florence Nightingale, 18 June 1894, BL, 47741, fols 143–144.
[13] Baly 1987, pp. 33–59.
[14] McDonald 2004, pp. 278–280, 290–301.
[15] Nightingale notes, 16 February, 2 May, 11 June 1873, BL, 47762, fols 13, 54, 64.
[16] Nightingale notes, 5, 31 May 1873, BL, 47747, fols 1–2, 3, 8.

working conditions in hospitals made them attract mainly "shiftless people who could not do better for themselves, or clever people hindered by some flaw of character." Pringle firmly believed that nurses, "severely tried by their manual work for the patients while their intelligence, observation, judgement, and temper are under a continuous strain," should never have to do the rough heavy cleaning demanded of them.[17]

In November 1872 the Nightingale Fund sent Elizabeth Barclay as matron, Pringle as assistant matron, and seven Nightingale staff nurses to the Royal Edinburgh Infirmary to introduce Nightingale nursing. Pringle did not want to go to Edinburgh; she only agreed to go so she could be near her mother who was dying of ovarian cancer.[18] Barclay soon proved incompetent and was forced to resign, while Pringle had done so well the governors appointed her interim matron and eventually matron. "Miss Pringle knows how to manage," a lady probationer reported. "One feels the Highest Presence with her as she goes about the Hospital," but, she later added, "she looks very tired."[19] Pringle's constant exhaustion was typical of all the successful lady superintendents. The responsibility for such a major operation as a nursing staff in a large academic hospital was a harrowing job. A society which assumed women lacked managerial and business abilities made it worse, for many hospital governors strongly resisted giving lady superintendents the authority they needed to run an efficient service.

Nursing had been a minor concern for management committees in the past and continued to be so for many governors in Edinburgh. However, in 1872 the governors appointed a professional administrator, C. H. Fasson, a retired military surgeon general[20] who, as a surgeon, appreciated the enormous difference which good nursing made in medical outcomes. He became a strong and consistent supporter of Pringle. Shortly after their new building opened in 1879, a new Committee of Managers made up new rules without knowing what the new nursing involved and without consulting Pringle. She managed to get the rules changed.[21] When the Board agreed to do away with bonuses and instead pay the nurses a higher salary and then did just the opposite, keeping the bonuses and lowering the nurses' wages, Pringle convinced them to reverse the policy. She also persuaded the governors to make major improvements in the living conditions of the ward assistants. Attracting lady probationers was the most difficult task for all matrons, as we will see with Flora Masson, but Pringle had no problem recruiting them,[22] and she worked steadily at turning her probationers into pupils rather than simply using them as cheap replacements for staff nurses.

Nevertheless, despite her outstanding successes throughout her stay in Edinburgh, Pringle found the work so difficult that she continuously asked Nightingale's permission to resign. When her mother died three months after she arrived in Edinburgh,[23] Pringle immediately told Nightingale she wanted to leave; she felt unequal to the terrible responsibilities she had to shoulder. Fasson and the Management Committee convinced her to stay until Christmas but, she told Nightingale, "I wish to consider it settled that I leave at Christmas."[24] In 1880 she told Nightingale, "I have held this post under protest," and furthermore, she did not like living in Edinburgh. "Do I have your sanction to leave?" she asked. Nightingale told her it was her duty to stay although she agonized over whether she had the right to tell her so.[25] That sanction did not come. Pringle's health began to show signs of the tremendous strain under which she worked. In January 1884 she again told Nightingale she was waiting to be relieved of her charge. She had come to Edinburgh on condition that it was for only three months and now she had been in Scotland ten years.

[17] Pringle 1880, pp. 1049–1050.
[18] Florence Nightingale to Bonham-Carter, [27 October] 1872, London Metropolitan Archives (LMA), H01/ST/NC1/72/37, fol. 12.
[19] Nightingale note, 30 May 1877, BL, 47762, fol. 246.
[20] McDonald 2009 a, p. 305.
[21] Lucille Pringle to Florence Nightingale, 1 May 1880, BL, 47734, fols 116–119.
[22] Lucille Pringle to Florence Nightingale, 15 January 1882, BL, 47734, fols 152–159.
[23] Florence Nightingale to Rachel Williams, 17 January 1874, Florence Nightingale Museum (FNM), FNM/LMA/H01/ST/NC3/SU180/74/15.
[24] Lucille Pringle to Florence Nightingale, 23 April, 15 May 1874, BL, 47734, fols 16–21.
[25] Lucille Pringle to Florence Nightingale, 29 June 1880, BL, 47734, fols 125–128.

At last, she had the nursing running smoothly, the governors completely trusted the nurses and all the doctors were finally pleasant to them.[26] She was now so ill that she had to take over two months sick leave. Nightingale again refused to sanction her resignation and she again agreed to continue until her "earthly Chief" (the Nightingale nurses often called Nightingale Mother Chief) approved it.[27]

Nightingale did not want the Nightingale Fund to lose such an important hospital as the Royal Infirmary and viewed the terrible strain on Pringle as constituting a kind of living Christian martyrdom. As well, in the class-bound and deferential society of Victorian England, Nightingale used her social position to enforce her wishes on her matrons. Although not an aristocrat, Nightingale moved in the top levels of aristocratic society and would invite matrons to her family's homes or to her own home in London to encourage them.

Nightingale saw Pringle frequently and she found it a great privilege and honor to be invited to the homes of such socially élite people. "To the end of my life I shall look back on it as a privilege most singular,"[28] Pringle wrote after her first visit. "If I had not seen you I think I must have sent in my resignation at the end of this month if it had not been for my visit to you."[29] she effused after another. Pringle finally gained Nightingale's approval in 1887, when Sarah Wardroper retired and she succeeded her as matron of St. Thomas's.

3 MARIA MACHIN

Maria Machin (1843–1904) entered the Nightingale School in March 1873 at the age of 31. She was a Canadian who, as a teenager, had helped her mother teach in her school for young ladies.[30] Then she and her two sisters ran a school in Quebec City[31] and in 1869 Maria became principal of an Anglican seminary for young ladies in Ottawa.[32] She made a deep impression on Nightingale. "Of altogether superior education," she wrote, "the highest character and most spiritual tone and purpose, excepting Agnes Jones." Nightingale judged her "chastened in spirit: of masculine determination and education: experienced in life and its trials: unflinching in resolution to carry out God's work: [...] fitted to exercise the highest influence over women."[33] In short, Machin fulfilled Nightingale's requirements for a good nurse. It is also noteworthy that although Nightingale's education, like Machin's, was one which few men expected ladies to have, she described Machin's education and commitment as masculine attributes.

Because of her extensive teaching experience, Nightingale quickly made Machin Home Sister, the nurse in charge of the Nurses Home and teaching the probationers. The prayer, asking the Holy Spirit to "incite us to dedicate ourselves and our work daily to God"[34] that Machin wrote and said every evening with the probationers, illustrates her religious approach to nursing. The probationers said she took immense pains with them and was so patient. She had "such grace and dignity" and told them to tell her when anything was the matter with them. She spoke as kindly as a mother to them, and, like Pringle, she taught them so much.[35]

Machin's experienced, sympathetic, kind and systematic approach made her an enormous success. Unfortunately for St. Thomas's, before she had completed her first few months as Home Sister, the

[26] Lucille Pringle to Florence Nightingale, 16 January 1884, BL, 47734, fols 186–191.
[27] Lucille Pringle to Florence Nightingale, 23 July, 10 December 1884, BL, 47734, fols 205–210, 214–217.
[28] Lucille Pringle to Florence Nightingale, 14 September 1874, BL, 47734, fols 23–26.
[29] Lucille Pringle to Florence Nightingale, 14 September 1874, BL, fols 23–26, 1 March 1876, fols 44–47.
[30] Eastern Township Gazette (1856).
[31] Quebec Mercury (1866), 24 August; Quebec Directory (1866/67), pp. 236–237.
[32] Ottawa Times (1869); Quebec Directory (1866/67), pp. 236–237.
[33] Maria Machin, Probationers Records, LMA/H1/ST/NTS/C4/2, p. 65.
[34] Maria Machin, Note, July 1874, BL, 47745, fol. 32.
[35] Nightingale Notes, 16, 18, 20 May 1874, BL, 47762, fols 118, 120, 123.

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governors of the Montreal General Hospital asked her to introduce Nightingale nursing there and she agreed to go. Founded in 1822, the Montreal General was the teaching hospital for McGill University and received almost all its funding from subscriptions and donations. Its board of governors did not include the medical staff; rather the doctors formed a Medical Board which the governors sometimes consulted, though they frequently rejected the medical staff's recommendations. Since at least 1866 the Medical Board had been pushing the Committee of Management to engage a better class of nurse. The governors made real efforts to attract more able women, improving their housing and increasing wages but without any noticeable improvement in the standard of nursing.[36] Then, hard pressed by the Medical Board, the Committee came round to introducing Nightingale nurses and in 1874 the Board finally approved the idea. They appreciated it would be more expensive but thought the added expense would be worthwhile.[37]

The 139-bed hospital building dated from the 1820s and had many structural problems. It also desperately needed more beds because the medical staff routinely admitted more than 139 patients. The Committee was considering demolishing one of the hospital's two wings and replacing it with a new state-of-the-art 100-bed building similar to St. Thomas's in London. In August 1874 the governors completed renovations in the second wing and, rather than demolishing the first wing, decided to enlarge its wards and introduce better heating and ventilation. The Board was badly divided between those who wanted to have an impressive hospital building and those who wanted to spend the money on patient care. They noted that hospital expenses were increasing because they were treating more patients, but nevertheless continued to mull over building the proposed 100-bed hospital. In April 1875, six months before Machin and her nurses arrived, the Board of Governors bought property contiguous to their existing land for the modern hospital some wanted to build.[38]

Machin, lady nurse Helen Blower, and three staff nurses started work on 4 October 1875. Four weeks later, the governors reported that the new Lady Superintendent and her nurses had surpassed their most sanguine expectations.[39] So successful was Machin that, after only four months, the governors placed the whole hospital administration in her hands, asking her to carry through every reform, not simply nursing reforms. She had no wish to be sole manager of the hospital and found the range of her duties far too extensive, but she dutifully worked closely with Peter Redpath, President of the Board of Governors, making numerous changes.[40] She hired cleaning women so she could remove the cleaning duties from the nurses, allowing them to concentrate on patient care and making the hospital more hygienic and presentable; she added six more nurses, improving the nurse-patient ratio from 1:18 on days to 1:9½.[41] The doctors were delighted with the superior patient care and with the way the Nightingale nurses understood their cases.[42]

The Nightingale Fund Council eventually sent six more staff nurses. Blower and four staff nurses proved excellent but of the other five staff nurses, one died in a typhoid fever epidemic and another absconded to get married without giving notice. Two were so unsatisfactory that Machin dismissed them and she did not renew the contract of the fifth.[43] She took the failure of her nurses as her own failure although she tried not to take it personally but rather as something God allowed either for her own good or for his glory.[44] Machin and her Nightingale nurses had been training the Canadian nurses clinically from the time they arrived and, by June 1877, Machin considered three or four to be good, reliable nurses.[45]

[36] Committee of Management, 1866–1874, McGill University Archives, Montreal General Hospital Archives (MGH), passim.
[37] Committee of Management, 11 November 1874, MGH.
[38] Committee of Management, 28 April 1875, MGH.
[39] Committee of Management, 31 October 1875, MGH.
[40] Maria Machin to Florence Nightingale, 16 February 1876, BL, 47745, fols 66–67.
[41] Committee of Management, 8 October 1877, MGH.
[42] Maria Machin to Florence Nightingale, 16 October 1875, BL, 47745, fols 63–65.
[43] Godden/Helmstadter 2004, pp. 169–170.
[44] Maria Machin to Florence Nightingale, 11 May 1877, BL, 47745, fols 77–81.
[45] Maria Machin to Florence Nightingale, 29 June 1877, BL, 47745, fols 83–86.

The governors, however, were pushing for a formal training school. A school meant much more work for Machin when her duties were already onerous but in June 1876 she agreed to start one with six probationers. Indicating how little they understood of what trained nursing meant, some governors thought six far too few and a year ridiculously long for training, while others wanted a training school because it would provide them with good nurses if someone in their family were ill.

But, as in most hospitals, the principal reason the governors were so eager to establish training schools was because they diminished the cost of trained nursing[46] which was so much more expensive. Formerly, women with no nursing experience whatsoever started as staff nurses at full salary but when they could be called probationers, they were paid at a very much lower rate. Machin and her Nightingale nurses were training Canadian nurses clinically but they were staff nurses and being paid at staff nurse, not probationer, rates. Furthermore, Machin and Blower were being paid more than the hospital had ever paid a matron or a nurse, and the Nightingale staff nurses were being paid more than the Canadian staff nurses.[47] Machin's nursing service was indeed more expensive. Unfortunately, Machin never began her school because severe typhoid and diphtheria epidemics left her so short-staffed.

In October 1876 the Committee began repeatedly pressing both Machin and the Medical Board to cut back on their expenses. Machin responded by laying off the housekeeper and added her extensive duties to her own.[48] The Great Agricultural Depression 1873–96 had pushed the whole province of Quebec into a severe economic depression and the governors were having difficulty balancing the budget. The hospital had run with a balanced budget, and sometimes with a significant surplus until 1874, the year before the Nightingale nurses arrived, when expenditures began far outrunning income.

Table I. Hospital Expenditures and Revenue 1870–1877

Year	Total Revenue	Total Expenditure
1870	$ 20,741.83	$ 19,727.42
1871	$ 25,812.58	$ 25,489.71
1872	$ 34,383.62	$ 22,897.68
1873	$ 38,557.39	$ 31,270.79
1874	$ 35,846.46	$ 45,013.27
1875	$ 44,333.36	$ 59,224.53
1876	$ 39,186.60	$ 45,616.59
1877	$ 41,721.13	$ 52,084.29

Source: Committee of Management: Report of Retrenchment Sub-Committee, 24 September 1877, MGH.

In May 1877 the Management Committee appointed a Sub-Committee for Retrenchment with Vice-President of the Board Charles Alexander as its chair.[49] Normally, Redpath chaired the Management Committee but he was frequently away in England. On 30 June 1877 he left for one of his lengthy stays there[50]

[46] Maria Machin to Bonham-Carter, 16 June 1876, LMA/H01/ST/NC18/36.
[47] Committee of Management, 26 July 1875, 29 May 1876, MGH.
[48] Committee of Management, 27 November 1876, 5, 12 February 1877, MGH.
[49] Committee of Management, 21 May 1877, MGH.
[50] Maria Machin to Florence Nightingale, 29 June 1877, BL, 47745, fols 83–86.

and would not return until late October. As Vice-President, Alexander then took over the chair. Andrew Robertson, the Treasurer, who was a strong supporter of Machin, was out of town on business at the same time.[51] Alexander was a poorly educated first-generation immigrant who had made a small fortune in the catering business. He did not accept the somewhat more advanced status of women in the colonies[52] and objected strenuously to Machin's assumption of so much authority. She considered him a drag to progress and wished he would resign.[53] He was strongly supported by fellow board member Charles Brydges, also a poorly educated first-generation immigrant who objected vigorously to the way Machin exercised so much authority. Machin described him as a "great railway man" who was "clear, polished and plausible but lacking in integrity."[54] She had previously noted and been astonished at the painful changes in Alexander and some of his colleagues when Redpath was away.[55] Once Redpath and Robertson were both away, Alexander and Brydges made their move. They initiated a virulent press campaign against Machin and the Committee and began objecting to everything she did without their express approval. For example, they took her to task for granting Blower leave without first obtaining their authorization. Machin diplomatically replied that this had been her practice for two years, but now that she knew the governors wished to authorize leaves, she would seek their approval first.[56] She obviously severely underestimated Alexander's perseverance and ability to sway the Committee when Redpath and Robertson were away. Likewise, she overestimated the strength of Redpath's support.

In September 1877 Machin and Blower, who acted unofficially as assistant matron, thought the hospital was running better in every department than it ever had. As well, they finally had an excellent team of four Nightingale staff nurses.[57] It was just at this point that the Retrenchment Sub-Committee released its report, which recommended firing Machin and some of her nurses, resuming the old, much cheaper system of nursing with a housekeeper as matron, and fewer nurses and cleaning staff. Nurses and patients were again to help with the cleaning. The report accused Machin of being the main cause of the hospital's large deficit because she had increased her staff and, equally important, had not established a training school.

The Board of Governors approved and immediately adopted the committee's recommendations, ordering them to proceed directly.[58] The Medical Board objected unanimously and forcefully. They strongly deprecated an untrained matron and declared the current number of nurses barely adequate. Without the nurses' assistance, they said, doctors "would be powerless for good." To indicate their willingness to retrench, they suggested cutting their own salaries in half, which was done later.[59] But the doctors were powerless because they had no representative on the Management Committee or Board.

Machin was stunned. The governors had never objected to the increases in her staff, she told Nightingale. If she resigned, she said, Blower would go with her, as would the four Nightingale staff nurses, who did not want to stay under another matron, especially the kind the committee wanted.[60] Nightingale of course urged Machin to remain. "We do serve not a committee but the Lord," she wrote, "I cannot fancy you remaining: but endure: at least a little longer."[61]

The Management Committee and Board of Governors had not informed Redpath, who was then in London, of their decision to implement the Retrenchment Committee's recommendations. It was not

[51] Maria Machin to Florence Nightingale, 19 October 1877, BL, fols 97–101.
[52] http://www.biographi.ca/en/bio/alexander_charles_13E.html, accessed January 22, 2024.
[53] Maria Machin to Florence Nightingale, 11 May 1877, BL, 47745, fols 78–81.
[54] Maria Machin to Florence Nightingale, 5 November 1877, BL, 47745, fols 102–104.
[55] Maria Machin to Florence Nightingale, 15 January 1877, BL, 47745, fols 75–77.
[56] Committee of Management: 23, 30 July 1877, MGH.
[57] Maria Machin to Florence Nightingale, 19 September 1877, BL, 47745, fols 91–95.
[58] Committee of Management: 24, 26, 28 September 1877, MGH.
[59] Medical Board, 8, 15 October 1877, 6 May 1878, MGH.
[60] Maria Machin to Florence Nightingale, 19 September 1877, BL, 47745, fols 91–95.
[61] Florence Nightingale to Maria Machin, 22 October 1977, University of Toronto Archives, MS Collection 229, fol. 12.

until October that he learned of the major changes from Henry Bonham-Carter, the Secretary of the Nightingale Fund. Redpath's surprising response to this unexpected news was that he had many other pressing engagements and could do nothing about it.[62] Machin reported that his "luke-warm and undecided conduct" throughout Brydges' persecution of her "excited surprise even among his intimate friends."[63]

By contrast, Robertson was furious when he returned to Montreal, and immediately began fighting the retrenchment measures which dealt with the nursing. He could not imagine that friends of the hospital would be willing to revert to the old system of an untrained superintendent of nurses. Many governors who were not on the Board had approached him as soon as he returned, declaring they would withdraw their support from the hospital if Machin and her trained nurses were dismissed. Robertson very much regretted having been away when the new budget was drawn up, and especially regretted that, contrary to proper procedure, the Sub-Committee had not submitted the budget to him as Treasurer before presenting it to the Committee and the Board.

He forced the Committee to appoint a new Retrenchment Sub-Committee, which he himself chaired. He demonstrated that the first Sub-Committee did not understand his annual statements and, furthermore, had no idea of accounting principles. For example, they tripled the hospital's salary expenses by merging the salaries of the construction workers who were doing the renovations with those of the hospital's staff. The hospital's large debt, Robertson showed, was primarily due to the extensive renovations and the land purchase. He and the new Sub-Committee submitted an accurate financial statement and a realistic budget, balancing it by closing beds.[64]

"The battle is over," Machin wrote Nightingale following the Board meeting on 14 November when the governors reinstated her. Robertson proved himself a noble friend and one of the few men who could handle Brydges and still preserve the peace.[65] Unfortunately, the battle was not over. Alexander was deeply humiliated and resigned but Brydges did not. Determined to force Machin out of office, he kept the vicious press campaign going in full swing. Machin did endure longer – seven months – but by the end of October, the governors had laid off most of the housemaids and scrubbing women, heavily burdening the nurses, who had to help with the cleaning.[66] In December, Machin was so thin and run down that she had to take ten sick days. The hospital atmosphere was so toxic that it was extremely difficult to keep the nursing running smoothly.[67]

In February 1878, an anonymous and untruthful eight-page pamphlet, believed to be written by a governor or at his order, was published and widely circulated. It claimed the governors had dismissed Machin because of her ignorant and imperious conduct to the hospital's officers and employees, her direct opposition to the Committee and her malicious persecution of employees. She had totally failed to place nursing on a proper footing and never lost an opportunity of libeling the characters of the officers, employees, and other persons who refused to sanction her Jesuitical system.[68]

Machin asked the Committee to investigate the pamphlet's accusations and publicly refute them. On Brydges' motion, the Committee responded "that statements made in an anonymous pamphlet do not deserve the trouble of an enquiry and that the only proper course to pursue is to treat them with

[62] Redpath to Bonham-Carter, 9 October 1877; Bonham-Carter to Redpath, 16 October 1877, LMA/H01/ST/NC18/13/35–36.
[63] Maria Machin to Bonham-Carter, 1 September [1878], LMA/H01/ST/NC18/13/10.
[64] Robertson 1877, pp. 1–16, 18–20, 24, 28–29.
[65] Maria Machin to Florence Nightingale, 5, 16 November 1877, BL, 47745, fols 102–104.
[66] Committee of Management, 29 October 1877, MGH.
[67] Blower to Florence Nightingale, 30 December 1877, BL, 45804, fols 277–278.
[68] The Suppressed Report and the Lady Superintendent, LMA/H01/ST/NC15/34/1, pp. 1–6.

perfect silence." There was a clause in Machin's contract stating that both the Board and the Lady Superintendent had the right to terminate the contract giving three months' notice[69] and she knew Brydges would invoke it at the first opportunity, so when the Board refused to refute the pamphlet she could see no point in continuing. The governors made every effort to retain Blower and the Nightingale staff nurses but they all stood firmly with Machin and, giving three months' notice, resigned as of 30 June 1978.[70]

Redpath then sent Bonham-Carter an even more astonishing letter. None of the nurses had any cause of complaint against the hospital, he said, yet they were putting it in an embarrassing position. If they stayed, they would be paid what they would receive elsewhere. In other words, the hospital would pay them at the lower Canadian staff nurse rate. Redpath wanted the Nightingale Fund to put pressure on the nurses to stay. Bonham-Carter, who was by no means always sympathetic with the nurses, replied that Machin was "extremely justified" in resigning and the staff nurses were free to make their own decisions.[71] The opposition Machin had to deal with was extremely personal and unethical and sadly showed how easily hospital governors could be misled by dishonest members. However, her religious commitment to advancing nursing compelled her to struggle on until it was obvious, even to Nightingale, that her position was untenable.

4 EMILY ASTON

The third and fourth matrons, Emily Aston and Flora Masson, were conventionally religious but did not take up nursing as a call from God. They were more interested in Nightingale's second basic principle, professionalism. Aston (1851–1914) entered training in 1875 at the age of 24. She got off to a bad start when Home Sister Mary Crossland told Nightingale that she was a spoilt child who was smart but thin-skinned.[72] She nevertheless had a successful career as a probationer and was soon made a sister. At first, Nightingale considered her the best sister in the hospital[73] but by 1881 she no longer looked on her favorably because she considered her a "New Woman," or "new man" as she sarcastically called the women who, starting in the 1870s, began pushing for more independence and the same education and career opportunities as men. New Women aroused opposition among the more conservative public, including Nightingale, who thought them especially lacking in the supposed self-sacrificing devotion of motherhood. For example, she thought Nurse Kent was a sweet little nurse when she worked under a different sister but under Aston's influence, "she put on the 'new man' of Miss Aston," and was "vulgarly self-asserting & a harsh & not truthful critic. Kent was a princely Nurse," Nightingale said, "her reports on methods were almost perfect" but Aston had "lowered her morally rather than raising her."[74]

In 1887 Aston was appointed matron of the Eastern Hospital in Homerton. She was an experienced matron for, after several years as a sister at St. Thomas's, she had served three years as matron of the Government Civil Hospital in Colombo, Ceylon (Sri Lanka). It had been a difficult position because colonial society expressed the standard opposition to ladies in positions of authority. Even more difficult, the Ceylonese considered nursing menial and degrading work, so parents would not allow their daughters to enter training. As a result, Aston had to draw most of her probationers from the

[69] Committee of Management, 14 November 1877.
[70] Committee of Management, 8 April, 13 June 1878, MGH.
[71] Redpath to Bonham-Carter, 25 April 1878, Bonham-Carter's response, 16 March 1878, LMA/H01/ST/NC18/13/4.
[72] Nightingale note, December 1875, BL, 47738, fol. 18.
[73] McDonald 2009 a, p. 173; 2009 b, p. 325.
[74] Florence Nightingale to Crossland, 1881, BL, 47747, fol. 163.

Church of England orphan asylum. These girls were very young, "dreadfully apathetic" in her view, and lacked the energy and necessary physical strength to do the work. Worse still, they were not interested in nursing. Adjusting to the colonial situation, Aston hired ward assistants to do most of the nursing care.[75] She tried to make the young girls understand that, even if they were not required to do the actual nursing, they were required to see that the ward assistants did their work conscientiously.[76] After three years in Colombo, Aston returned to St. Thomas's as a sister before going to the Eastern Hospital.

The Eastern, or Homerton Hospital, as it was also called, was not one of the prestigious teaching hospitals but rather one of the new, recently built, publicly funded Metropolitan Asylum Board (MAB) hospitals, often called Poor Law hospitals because the MAB incorporated the old Poor Law infirmaries. These infirmaries were basically chronic care institutions, where the work was much less exciting and interesting than the work in cutting-edge teaching hospitals like the Edinburgh Infirmary. They were notorious for using their inmates as nurses, resulting in very poor care.

The chronic care aspect also meant the doctors did not require the highly skilled nurses on whom doctors in the more academic hospitals were dependent, so Aston was the only one of the four matrons who was not required to establish a training school. However, Nightingale was especially anxious to see improved nursing in the MAB hospitals and was urging some of her candidates for matronships to consider them. She had not kept in touch with Aston as she did with her favorite nurses but when she learned that she was working in a Poor Law infirmary, she invited her to visit her. What Aston told her about the nursing at Homerton was not encouraging.

Things went reasonably well until 1889, when a new medical superintendent, Dr. Collie, was appointed. An older man, almost ready to retire,[77] he immediately took charge of the nursing. This was not surprising because, under the old nursing system, doctors were in charge of the nursing in their wards and treated their sisters as personal servants.[78] Collie treated Aston as a traditional old-fashioned housekeeper matron – in charge of the laundry, linen, cleanliness of the wards and discipline of the nurses, but in no way involved in or responsible for nursing care. He did not allow her to give classes, and even if she saw a nurse mismanaging a patient, she could not instruct the nurse. Of the 103 women the hospital employed, none of the staff nurses were trained and only seven of the 32 charge nurses had some training. Collie promoted ward maids in their teens to nurse and from nurse to charge nurse; one of the young women whom he made charge nurse was only 16 years old. He said he preferred the very young people because they were more biddable.[79]

Aston thought the nursing staff badly needed discipline and training while Nightingale was appalled that the nurses were receiving no moral instruction. "The only living beings who can be called Moralizers to the Nurses are 2 Roman Catholic Sisters of Charity who visit in the Wards,"[80] she wrote. Aston desperately wanted to resign but, as with all her matrons who were having difficult times, Nightingale strongly pressured her to stay. She was the only lady matron in the whole Poor Law system in 1889 and Nightingale could not bear letting the Nightingale Fund lose its foothold there. "I steadily impressed upon her that she must not resign," Nightingale said, "but that [...] she must by tact & temper, work out the salvation of these poor little sick brats, and finally gain the power which she must have to fulfil the responsibility."[81]

[75] Emily Aston to Crossland, 25 August 1884, BL, 47738, fols 340–341.
[76] Emily Aston to Wardroper, 27 August 1884, BL, 47733, fol. 190.
[77] Emily Aston to Florence Nightingale, 8 December 1890, BL, 45810, fols 124–129.
[78] Nightingale note, 11 March 1878, BL, 47761, fols 13–15.
[79] Florence Nightingale to Maude Stanley, 30 December 1889, BL 47758, fols 195–196, 200.
[80] Florence Nightingale to Maude Stanley, 30 December 1889, BL 47758, fol. 204.
[81] Florence Nightingale to Maude Stanley, 30 December 1889, BL 47758, fol. 196.

Unfortunately, Nightingale thought Aston lacked the necessary tact and temper.[82] She may have had a point, for Aston was not deferential and, as a New Woman, sometimes stood up for herself rather than always deferring to Collie.

Collie insisted that Aston consult him about what went into her weekly report to the Management Committee, then write it out and bring it to him for his approval before she could submit it. She considered this humiliating but complied. On Christmas Day she organized a party for the children and brought a piano into one of the wards. One of the nurses, Nurse Barnes, asked if the nurses could dance. Aston replied that the party was for the children, not for the entertainment of the nurses, and she thought the children would not find the dancing amusing. Barnes then summoned Collie to the ward, who informed Aston he had told the nurses they could dance and they should do so. Aston explained she wished he had told her so beforehand so that she would not have been put in the difficult position of giving counter orders, but he held firm. Feeling that Collie's public ignoring of her authority could only lead to the destruction of any trace of influence she had ever had, Aston resigned.[83] Nightingale was thoroughly disgusted, declaring that Aston had been given greater powers than any other matron but "had thrown them all away by personal antagonism," letting her personal feelings take precedence over advancing nursing.[84]

Nightingale was not being fair. She knew Collie did not give Aston any of the power she needed to fulfil the responsibility. Nightingale had been placed in humiliating positions in the Crimean War hospitals, where she had struggled tenaciously and ultimately successfully against Sir John Hall, the principal medical officer of the field army. Her main support in the government came from Sidney Herbert but, when the Aberdeen government fell on 30 January 1855, he was out of office for the remaining 14 of the 18 months the British were in the war. In the new Palmerston government, Benjamin Hawes, Under Secretary of the War Department, was opposed to Nightingale, as were many of his civil servants. It was not until two weeks before the peace treaty was signed on 30 March 1856, a month after the fighting had officially stopped, that Lord Panmure, the Secretary for War, issued a General Order confirming Nightingale's position as head of the army nursing service.[85] She described her support from the War Department as "feeble and treacherous." She was always expecting it to say, "Could we not shelve Miss N.? We dare say she does a great deal of good. But she quarrels with the authorities & we can't have that."[86]

Nightingale wanted her nurses to persist as tenaciously as she had. However, she failed to appreciate that she had many advantages which they lacked. First, after the first two or three months of the Crimean War, she had the strong support of public opinion; by contrast, Aston was totally unknown to the public. Second, Nightingale spent more than half of her time during the war in Turkey, hundreds of miles away from Hall in the Crimea, and she won the backing of most of the doctors in Scutari; Aston had to work closely with Collie every day. Then Nightingale reported directly to the War Office while the Army Medical Department was a civilian department, so Hall did not have the direct contact with the ministry which half-heartedly supported Nightingale. Finally, and most important, Nightingale moved in the top levels of society and, as Sidney Herbert pointed out when he recruited her in 1854, her knowledge of administration was important but far more important was her rank in society, which gave her advantages which no one else had.[87] In the deferential society of Victorian Britain, Nightingale's social status was indeed

[82] Florence Nightingale to Maude Stanley, 30 December 1889, BL 47758, fol. 205. [83] Emily Aston to Florence Nightingale, 6 Jan 1890, BL 45809, fols 254–259.
[84] Florence Nightingale to Crossland, [c. 11 January 1890], BL, 47739, fol. 183.
[85] Bostridge 2008, pp. 290–293.
[86] Florence Nightingale to Samuel Smith, 6 March 1856, BL, 45792, fols 17–18.
[87] Cook 1913 (Vol. I), p. 153.

paramount, especially compared to that of medical men, whose social status had risen significantly but was nevertheless far below that of Nightingale.

Aston was a middle-class lady but she certainly did not move in aristocratic circles. She felt that Collie was set against her from the beginning and he enjoyed the support of his Board and the chairman in particular. As she wrote later, from a similar situation as matron of the Gibraltar Colonial Hospital, "It is almost impossible to work reforms unsupported."[88] She was justified in believing that, despite her efforts to cooperate with Collie, nursing at the Eastern Hospital could not be improved while he was there.[89] However, Collie was close to retirement age, and if Pringle or Machin with their religious commitment had been in Aston's place, they would probably have patiently "endured" until he retired.

5 FLORA MASSON

Flora Masson (1856–1937) entered the Nightingale Training School in July 1886 at the age of 28. Her father was the professor of English literature at the University of Edinburgh (there is only one full professor in each department of British universities) and her mother was a suffrage campaigner. Before entering training, together with her mother and sister, Flora had been active in the local suffrage campaigns. Later she became a writer.[90] Despite Masson's work in the women's movement, Nightingale did not consider her a New Woman. She thinks she is radical, Nightingale said, but she was really "a gentlewoman lady of high education." She found her rather aristocratic, although a bit stiff at first, but noted that "she always managed her nurses and people very well and was exceedingly clever."[91] Masson served very successfully as a sister at St. Thomas's and in 1891 was appointed matron of the Radcliffe Infirmary, Oxford University's teaching hospital.

Founded in 1770, the Radcliffe was poorly endowed and, when Masson arrived, was in the midst of a fundraising campaign to improve its outdated buildings. It was a teaching hospital but not a cutting-edge hospital where skilled nursing was essential for successful medical practice – Masson said that one year of clinical experience at St. Thomas's was worth two at the Radcliffe.[92] Unlike the Montreal General, doctors did sit on the board of governors. On arrival, Masson thought the whole hospital overstaffed and the nurses' sleeping quarters unsatisfactory, but she felt optimistic because she expected some trained nurses from St. Thomas's and there were two excellent sisters who had been at the Radcliffe for some years.[93] Throughout her stay at the Radcliffe she constantly sought advice from Nightingale, who, as with all her favorite pupils, corresponded with her and invited her to her family's homes. Like the other matrons, Masson was in awe of Nightingale, partly as a national heroine but largely because of her social status. She considered it bold even to write to her without getting Nightingale's special permission first[94] and, like Pringle, was effusively grateful to her for actually deigning to see her in person.[95]

Masson identified the hospital's small endowment and its probationer system as major problems. The probationers were young ladies who came for one year and paid for their training, thus providing a small source of income for the hospital. Masson considered them singularly childish and undisciplined, "very dilettantish and lukewarm." She thought their clinical work poor and their manner of dressing positively amusing: "some in outdoor uniforms with flying veils, others including the sisters in blouses and sunhats

[88] Emily Aston to Florence Nightingale, 8 December 1890, 8 October 1891, BL, 45810, fols 124–129.
[89] Emily Aston to Florence Nightingale, 11 April 1890, BL, 45810, fols 318–320.
[90] https://www.scottishwomenwritersontheweb.net/writers-a-to-z/rosaline-masson; https://www.doi-org.myaccess.library.utoronto.ca10.1093/ref:odnb/34924, accessed May 3, 2024.
[91] Nightingale notes, [c. August 1891], BL, 47750, fols 21–22.
[92] Florence Nightingale to Bonham-Carter, 8 August 1893, BL, 47725, fols 103–104.
[93] Flora Masson to Florence Nightingale, 26 September 1891, 7 February 1892, BL, 47750, fols 26–45, 51–52.
[94] Flora Masson to Florence Nightingale, 15 July 1891, 13 March 1892, BL, 47750, fols 13, 61.
[95] Flora Masson to Florence Nightingale, 1 December 1894, BL, 47750, fols 183–184.

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with wreaths of flowers and other personal adornments." A third problem was that, with no housekeeper, Masson was spending most of her time weighing food and giving out all the drugs, laundry and dressings.[96] She herself had to inspect every sheet before the nurses could change them.[97] She needed a housekeeper and thought the Committee would agree but was afraid to ask for one because the governors were offering such a low salary that no competent person would apply. Equally important, there was no space in the hospital to accommodate a housekeeper.[98] This was a standard problem in all the teaching hospitals. They had been designed when medical and surgical activity was minimal and hence needed few nurses. Hospitals now required much larger nursing staffs but had been built with no space to house them.[99]

Masson felt the whole staff, and especially the lady probationers, severely lacked discipline and immediately set about introducing stricter regulations. A year after her arrival, a probationer complained to the Management Committee about her.[100] It was to be the first of many complaints against Masson, every single one of which, on investigation, was found to have no factual basis. She believed her insistence on better discipline triggered the complaints from the lady probationers who, she thought, did little work and whom she deprecatingly referred to as "the girl-nurses."

Unusually for a teaching hospital at the time, the Radcliffe had a Nursing Committee which had five members. Without speaking to Masson first, this committee also complained to the Management Committee about her.[101] By 1892 she had three (working-class) staff nurses from St. Thomas's. They worked well but were not popular with the medical staff.[102] The doctors enjoyed the company of the young lady nurses and complained that the nurses Masson appointed were not as young or smart.[103] Since they did not do much pioneer work or research, they could get along reasonably well without highly skilled nurses. Masson said they wanted "pretty and glib attenders on the staff" and a matron who did not interfere with the nursing.[104]

The Rev. J. Frank Bright, the Treasurer to whom Masson reported, told her the complaints against her did not hold water but he believed she was too strict and the staff did not like her. Masson replied that she did not expect or even wish to be liked in that way. However, she could see that Bright preferred the "happy-go-lucky tone" of the lady probationers and the old "easy-going ways" to her more disciplined approach. She was especially disapproving of the unchaperoned hospital dances, which she wanted Bright to abolish. He thought that would be too harsh but did agree to have them chaperoned.[105]

By 1893 the hospital had expanded from the 80–100 beds when Masson first arrived to 116–126, and, with a staff of 70 women, she still had no housekeeper or assistant matron. She was also finding the lack of support from the governors and doctors harassing and told Nightingale she was considering resigning. Nightingale responded immediately, as always advising against it. When Masson heard that House Physician Dalgleish was telling the servants that he was going to complain to the Committee about her, she summoned him to meet with her. She told him she "always spoke to and not of people" to which he replied that he didn't care what her feelings were.[106] Again she considered resigning: if Dalgleish did not resign, she felt she would have to. At this point, she was in crisis mode, no longer writing Nightingale for

[96] Flora Masson to Florence Nightingale, 24 September, 28 November, 6 December [1891], 7 February 1892, BL, 47750, fols 36–52.
[97] Flora Masson to Florence Nightingale, 22 February 1893, BL, 47750, fols 78–83.
[98] Flora Masson to Florence Nightingale, 19 May [1892], 9 March 1893, BL, 47750, fols 67–70, 84.
[99] Helmstadter 2021, pp. 137–157.
[100] 5 October 1892, Oxfordshire Health Archives, Radcliffe Infirmary Archives (RI), RI/CM C1/19.
[101] Nightingale notes, 3 August 1893, BL, 47750, fol. 114.
[102] Flora Masson to Florence Nightingale, 13 March, 19 May [1892], BL, 47750, fols 61, 67–70.
[103] Flora Masson to Florence Nightingale, 2 August 1894, BL, 47750, fols 178–179.
[104] Flora Masson to Florence Nightingale, [14] January 1894, BL, 47750, fols 143–146.
[105] Flora Masson to Florence Nightingale, 22 February 1892, 20 February 1893, BL, 47750, fols 55–58, 74–77.
[106] Flora Masson to Florence Nightingale, [23 July 1893], 8 July, 4 August 1893, BL, 47750, fols 88–99, 110–112.

advice but sending numerous telegrams. Nightingale was highly distressed; she was afraid Masson did not pay enough attention to what she called "the thin-skinned-ness of the Medicos."[107] Bonham-Carter had some sympathy with Bright and thought Masson's manner might be part of the difficulty.[108] However, in the end it was Dalgleish who had to resign.[109]

Yet another crisis came when Mr. Symonds, the House Surgeon, made a scene about the nursing in the operating room. This time it was Masson who complained to the Committee and Symonds had to apologize. However, seven months later, Symonds refused Masson's recommendation for theater nurse, and the Committee assigned him the "nurse in pink with fair hair" he asked for. Masson tried to explain to the governors why she should make the appointments unilaterally, but they simply could not understand what she was talking about. The following October, the new House Surgeon, Mr. Gowring, complained about the nursing in the children's ward. It was another crisis for Masson but the governors again supported her, following which House Physician Boyd as well as Gowring resigned in protest.[110]

In July 1895 Masson was once more in a crisis state. A few months previously, keeping it secret from Masson, Dr. Collier, one of the visiting physicians who sat on the Management Committee, established an executive nursing committee. Like Alexander and Brydges, who waited until Redpath and Robertson were out of town, Collier waited to set up his committee until he knew that Masson's two main supporters, Lord Dillon, who had replaced Bright as Treasurer, and Mrs. Green, would be away. This committee then took evidence from sisters who did not support Masson and published a very unfavorable report. Masson only heard about it indirectly and was absolutely enraged. As with Dalgleish, she demanded that Collier come to see her. She told him this was not a course of action any superintendent of nursing would tolerate: when the nursing was involved, he had to consult her first. She then wrote a letter of protest to the Committee[111] which she sent to Nightingale for her approval. Nightingale considered it too belligerent. She had told Masson that she could not give her any advice until Masson told her more about the Treasurer's view of things and that she considered it unwise to act in a hostile way. A kitten of mine, she told Masson, taught me one of the secrets of life. The kitten said, "Stand your ground & kiss your enemy's nose."[112]

This was indeed Nightingale's approach when dealing with opposition: she always found out as much information as possible about the situation, then took up her position and stood her ground. However, while not giving ground, she was always extremely gracious and courteous, and sometimes positively flattering. On this occasion Nightingale advised Masson to leave her defense in Dillon's hands. Then if he was not successful, even Nightingale supposed Dillon, governors who supported Masson, and Masson herself would have to resign. Dillon did prevail and Masson did not send her belligerent letter or resign[113] but it was obvious that she had completely lost the confidence of the doctors and was rapidly losing the support of the lay governors.

Despite her heavy housekeeping burdens, in February 1892 Masson managed to begin laying the foundations for a real training school. She introduced a second class of probationer, women who would serve two years with no pay before getting their certificates, and she arranged for doctors' lectures for sisters and nurses. She hoped to gradually do away with the paid staff nurses and replace them with the non-paying probationers. She also wanted to do away with all paying probationers, but the Committee said it could not afford that.

[107] Florence Nightingale to Bonham-Carter, 24 July 1893, BL, 47725, fol. 80.
[108] Bonham-Carter to Florence Nightingale, 5 August 1893, BL, 47725, fols 96–98.
[109] Committee of Management, 2 August 1893, RI/C1/19.
[110] Committee of Management, 3, 17 October 1894, RI/1/C1/20.
[111] Flora Masson to Florence Nightingale, 17 July, 25 September [1895], BL, 47750, fols 201–205.
[112] Florence Nightingale to Flora Masson, no date, University of Leeds Archives, BC MS Letters 1 Flora Masson/Nightingale.
[113] Flora Masson to Florence Nightingale, 27 July [1895], BL, 47750, fols 204–205.

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What she thought she needed more than anything else to attract lady probationers was a modern nurses' home. When the Committee raised the premium for lady probationers to £28, Masson told them they were deterring applicants. If the young ladies could afford £28, she said, they usually chose better nursing schools where the standard premium was only a few pounds more. With its dreadful quarters for probationers, the Radcliffe simply could not compete with these schools.[114]

On 4 November 1896 Masson reported on the first full year of her new training system. It had not been a success. Of 203 applications, only 29 women were serious enough to fill out the application form. Of the 20 whom Masson accepted, she dismissed six as inadequate and one had to withdraw because of poor health, so only 13 remained.[115] She had to hire four nurses paid at full salary to bring the staff up to full strength.[116] She explained she had not designed her staffing plan to make money but rather to get what she called "good material." Furthermore, she felt she was understaffed. She and her committee ideally wanted 42 nurses but now she could barely house 38 because there was only accommodation for 37.[117]

The Committee was not impressed and, on 18 November, voted eight to four to discontinue Masson's nursing system and revert to the old system of all paying probationers with only one year of training. Masson was reduced to a mere housekeeper and caterer and felt she must resign, which she did on 16 December 1896. Lord Dillon had already resigned because he also believed the old one-year, all paying probationer system did not provide adequate training.[118] If Dillon fully supported Masson, Mrs. Green did not. She believed Masson was partly at fault. Nightingale was not as hard on Masson as she had been on Aston but felt, quite reasonably, that she had not handled the situation well. She was at a loss to "know what can be done between an 'angry' woman [Masson] & a maniac man like Symonds."[119] Masson unrealistically acted as if she had the authority she believed she should have but clearly did not have. This may have been partly because she was a gentlewoman of high social standing and expected the doctors to respect that. However, she clearly was unwilling to make the compromises Pringle, Machin and Aston had, and she made no effort to cultivate support from either the governors, doctors or lady probationers.

6 CONCLUSION

Working with governors who considered nursing the lowest form of domestic service, and who did not want to see women in positions of authority, placed these four matrons in intensely harrowing positions. Pringle's success came from her extraordinary competencies, the steadfast support of Fasson, her deferential and diplomatic approach, and Nightingale's refusal to sanction her continuously sought resignation. Nightingale succeeded in keeping Pringle at her post but, for all her influence and social status, failed with the other three matrons. In fact, she reluctantly agreed that two of the three really had no choice but to resign.

Machin was as deferential and diplomatic as Pringle and, unlike Pringle, gained complete authority over her nursing service almost immediately. Paradoxically, it was her success that incited the ferocious enmity of Alexander and Brydges. She became the victim of a divided and indecisive Committee, a weak

[114] Committee of Management, 23 March 1892, RI/C1/19; Flora Masson to Florence Nightingale, 22 February 1892, 3 August, 21 December 1893, 19 October 1895, BL, 47750, fols 55–58, 114, 121–193, 220–221.
[115] Committee of Management, 4 November 1896, RI/1/C1/20.
[116] Committee of Management, 15 April, 7 October 1896, RI/1/C1/20.
[117] Committee of Management, 4 November 1896, RI/1/C1/20.
[118] Committee of Management, 18 November, 2 December 1896, RI/1/C1/20.
[119] Florence Nightingale to Bonham-Carter, 3, 15 December 1896, BL, 47728, fols 1, 15–16.

president, and the personal animus of two unethical governors. Aston and Masson belonged to a different, more secular generation and, as New Women, were less deferential and willing to work within the woman's mission structure. Masson never considered Pringle's principle of avoiding opposition from the doctors and her confrontational approach and disdain of the lady probationers made her lose the support of doctors, governors and her nurses. It also made her an easier target for the unethical behavior of Collier and his colleagues. Aston was more flexible and willing to make compromises but when Collie reduced her to an old-fashioned housekeeper matron, she was not willing to spend ten years cultivating doctors' support as Pringle had done.

Finance played no role in Aston's case. She was not to start a training school, and in fact was not even allowed to give classes. It was a minor factor in Machin's case where the Committee's vacillating and conflicting financial policies were the major cause of the hospital's deficit. Although her nursing service was decidedly more expensive in a time of financial restraint, she achieved tremendous improvements. At the Radcliffe, finance was more important. Unlike Machin's highly successful nursing service, Masson's unsuccessful system did not justify the added expense. Still, in all three cases where the matrons resigned, it was their demand for authority in the hospital administration which underlay the governors' dissatisfaction.

It was very difficult to make major changes in established administrative cultures. The four matrons were relatively young women – in their early thirties, with Pringle in her twenties when she started – and most governors were older, conservative men who believed it ill-advised to delegate authority to ladies, while Alexander and Brydges found it positively outrageous. In general, by the 1890s, doctors in the leading hospitals strongly supported trained nursing because they were so dependent on skilled nursing, but most lay governors remained opposed to giving matrons the authority they needed to function effectively. The less religiously inclined Aston and Masson wanted just as genuinely to advance nursing but, without the strong spiritual commitment of Nightingale, Pringle and Machin, they lacked the determination to struggle on in the face of so many defeats. They were not willing to accept the compromises, or what Nightingale termed disappointments, heartbreaks and contradictions, which were necessary to succeed in an environment which denied the capabilities of women. Although she failed to make nursing a religious vocation, Nightingale's privileged social position and her status as a national heroine helped her advance nursing reform and the standing of women. The three matrons who failed did not enjoy those advantages but we should acknowledge their valiant and pioneer efforts in the same cause.

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BIBLIOGRAPHY

Archival Sources

British Library, Nightingale Collection

Florence Nightingale Museum

London Metropolitan Archives, St. Thomas's Hospital

McGill University Archives, Montreal General Hospital

Oxfordshire Health Archives, Radcliffe Infirmary

University of Leeds Archives, Masson Collection

University of Toronto Archives, Nightingale Collection

Primary Sources

Cherrier and Kirwin's Ottawa Directory for 1872/73.

Eastern Township Gazette [Quebec] (1856).

Ottawa Times (1869–1872).

Pringle, A. L.: Nurses and Doctors. In: Edinburgh Medical Journal (1880), May.

Quebec Directory (1866/67).

Quebec Mercury (1866).

Robertson, Andrew: Letter on Hospital Expenditures Addressed to Peter Redpath, Esq., President of Montreal General Hospital. Montreal 1877.

Secondary Literature

Baly, Monica E.: The Nightingale Nurses. The Myth and the Reality. In: Maggs, Christopher: Nursing History. The State of the Art. London 1987.

Baly, Monica E.: Florence Nightingale and the Nursing Legacy, 2nd ed. London/Whurr 1997.

Bostridge, Mark: Florence Nightingale. The Making of an Icon. New York 2008.

Cook, Sir Edward: The Life of Florence Nightingale, 2 vols. London 1913.

Crawford, Paul/Anna Greenwood/Richard Bates/Jonathan Memel: Florence Nightingale at Home. Cham 2020.

DiGregorio, Sarah: Taking Care. The Story of Nursing and Its Power to Change the World. New York 2023.

Dock, Lavinia/Adelaide Nutting: A Short History of Nursing. New York 1920.

BIBLIOGRAPHY

Godden, Judith/Carol Helmstadter: Woman's Mission and Professional Knowledge. In: Social History of Medicine 17 (2004), 2, pp. 169–170.

Helmstadter, Carol: The Nursing of the All Saints Sisters. In: Nursing History Review 29 (2021), pp. 137–157.

Helmstadter, Carol/Judith Godden: Nursing Before Nightingale 1815–1899. Farnham 2011.

McDonald, Lynn (ed.): Florence Nightingale on Public Health Care. Waterloo, ON, 2004.

McDonald, Lynn (ed.): Florence Nightingale. Extending Nursing. Waterloo, ON, 2009 a.

McDonald, Lynn (ed.): Florence Nightingale. The Nightingale School. Waterloo, ON, 2009 b.

McDonald, Lynn: Florence Nightingale and the Medical Men. Working Together for Health Care Reform. Montreal 2022.

Moore, Judith: A Zeal for Responsibility. The Struggle for Professional Nursing in Victorian Britain 1868–1883. Athens 1988.

DiGregorio, Sarah: Taking Care. The Story of Nursing and Its Power to Change the World. New York 2023.

Dock, Lavinia/Adelaide Nutting: A Short History of Nursing. New York 1920.

Godden, Judith/Carol Helmstadter: Woman's Mission and Professional Knowledge. In: Social History of Medicine 17 (2004), 2, pp. 169–170.

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ENIGMAS OF IMPERIAL NURSING: FLORENCE NIGHTINGALE, CATHARINE GRACE LOCH AND THE INDIAN ARMY NURSING SERVICE

Christine E. Hallett

Abstract

Professional nurse, Catharine Grace Loch made a significant contribution to the development of the Indian Army Medical Services in the late nineteenth century. With the notable exception of George and Lourdusamy (2023), historians have almost entirely overlooked her work. This article addresses our lack of understanding of her project in India, focussing on her genteel struggle with the imperialist military medical establishment of her day and drawing out several themes: Loch's understanding of the nature of nursing and the need for fully-trained women to deliver it; the significance of Florence Nightingale's mentorship and the enigmatic ways in which both women decoded the imperialist mentalities of their age in order to make use of Anglo-Indian networks and patronage; and the personal costs of Loch's sustained efforts to implement a form of nursing that harmonised with her professional values. The main primary sources for the study are Loch's letters to her mentor, Florence Nightingale, her correspondence with her sisters (which was subsequently developed into a *Memoir*), and her articles in professional nursing journals.

I argue that Loch successfully navigated the complex terrain of late-nineteenth and early-twentieth-century Indian military medicine. Nursing care was delivered by teams composed of lady-nurses, who she herself managed; military orderlies, over whom she had no control and little influence; and so-called 'native' orderlies, who suffered prejudice and sometimes outright abuse from doctors, orderlies and patients, and who, in consequence, withdrew psychologically and emotionally from the delivery of care. These complexities are analysed within the paper, which concludes that Loch's work had a profound and positive influence on the tortuous history of late-nineteenth-century British India, but that these gains were won at the cost of Loch's own health.

Keywords: Catharine Grace Loch; imperial nursing; colonial nursing; Indian Nursing Service; Indian Medical Service; professional nursing values

1 INTRODUCTION

"Skilled and tender nursing is a boon which all are quick to recognize, but perhaps nowhere are its benefits more clearly to be appreciated than in India," wrote Field Marshal Earl Roberts in 1905.[1] He had been asked to compose a preface to the posthumously published *Memoir* of Catharine Grace Loch, the first Senior Lady Superintendent of the Indian Army Nursing Service.[2] Roberts' somewhat bland description of nursing as a 'boon' conceals both the complexities of running a military nursing service in India, and the wider philanthropic and medical work that operated under the often patronising, but sometimes highly effective, imperial matriarchies of British vicereines, wealthy ladies and

[1] Loch 1905, p.vi.
[2] The Indian Army Nursing Service became the Queen Alexandra's Military Nursing Service for India in 1903. See: Piggott 1975, pp. 26–27; Light, Sue, Scarlet Finders. Website available at: http://www.scarletfinders.co.uk/8.html

professional nurses. This paper focuses on the difficulties encountered by Loch in establishing the Indian Army Nursing Service, and on the relationship between Loch herself, as the executor of military nursing in India, and her most prominent mentor, Florence Nightingale.

The paper highlights the complex synergies between the ideas of iconic nurse leader, Nightingale, and late-nineteenth-century nursing superintendent, Loch. It draws out a number of themes examining the two women's shared understanding of the nature of nursing and the need for fully trained women to deliver it. It also explores the ways in which their work was refracted through the lenses of their professional, gendered and imperial sensibilities, noting their attitudes to both patients and fellow-workers, and acknowledging their use of Anglo-Indian networks and patronage. Ultimately, the paper concludes that, although the behind-the-scenes (or perhaps 'behind-the-screens') work of nurses had a profound influence on the tortuous history of military medical care in late-nineteenth-century British India, the right to perform that work was hard won. The creation of nursing 'teams' in military hospital wards, consisting of female nurses, male military orderlies, and 'native' workers, was complicated by the social, gendered and imperialist attitudes and prejudices of both male doctors and female nurses.

In referring to 'enigmas' of imperial nursing, I am drawing upon the idea that, whilst they could often be overt – or even forthright – the communications of those British ladies who sought to advance the cause of imperial nursing projects often had a hidden or secretive quality. In their correspondence and other writings, Nightingale and Loch hid their messages of angst and resolve behind communications that drew so heavily upon the conventional social codes and mores of their time that their writings could be seen as encoded. The gritty realities of the challenges they faced were often veiled behind words of deference and polite courtesy.

2 BACKGROUND TO THE STUDY

Whilst gender and imperialism form a significant element of the context in which this article is set, they should not be read as the main focus of the work, which is, essentially, nursing practice and organisation and the ways in which they could be supported and undermined. Nevertheless, even though it takes neither an overtly gendered, nor an overtly post-colonial stance, this work is heavily influenced by existing research within both fields. The gendered nature of nineteenth-century nursing is inescapable, and yet it has received little attention from women's historians within the Anglo-American academic world. Historians of nursing from Susan McGann to Carol Helmstadter and Judith Godden have focussed on the politics behind the emergence of the profession in the nineteenth century without paying overt attention to gender politics.[3] Some women's historians – notably Martha Vicinus, Judith Moore and Sue Hawkins – have given prominence to gender and social class in their analyses.[4] Others who have deliberately foregrounded gender have tended to focus on Canadian or U.S., rather than on British or colonial nursing.[5] In the late twentieth century, Juliet Piggott was commissioned by the British Army to write the first 'official history' of the Queen Alexandra's Royal Army Nursing Corps (QARANC) (including its forerunners the Queen Alexandra's Imperial Military Nursing Service (QAIMNS) and the

[3] McGann 1992; Helmstadter/Godden 2011.
[4] Vicinus 1985; Moore 1988; Hawkins 2010.
[5] Reverby 1987; Lynaugh/Brush 1996; McPherson 1996; Nelson 2001.

Indian Army Nursing Service). As might be expected, her work is largely celebratory in tone and views the development of the QARANC as a linear process characterised by slow but steady progress.[6] Writing several years later in the 1980s, Anne Summers brought a more critical perspective to her work, yet the main purpose behind her study of the development of military nursing was to understand how women's direct involvement in warfare made the First World War more likely. Hence, her work focussed more on women's political consciousness than on their nursing identities or perspectives.[7]

Although imperialism is not the main focus of this paper, it forms an essential component of its context. Florence Nightingale and Catharine Grace Loch were both steeped in the imperialist attitudes of their time. Although both were sympathetic towards the subjects of Empire, neither was able to move beyond the essentially paternalistic attitude to social reform in India, or the assumption that only British superiority and expertise could effect that reform.

The focus of historians' writings on the British Empire has changed over time. From largely laudatory accounts which perpetuated the view that the empire was a civilising force, to searing critiques of the brutality shown by British soldiers and politicians towards their imperial subjects, largescale overviews, in which India takes a prominent place, have abounded in the last three decades.[8] The process through which British attitudes to empire have changed has accelerated in the last ten years as a result of a greater consciousness of current prejudices and inequalities.

Historian Lawrence James commented at the end of the twentieth century on the power of British imperial mythology, which, almost invariably, highlighted the stoicism and military discipline of the British troops. From Clive's legendary victory at Arcot in 1751 to the Siege of Lucknow during the so-called 'Indian Mutiny' of 1857-8, fable after fable unfolded during the first hundred years of British imperial incursion and conquest, to create a multi-layered narrative of British prowess – a narrative that was laced with a sense of British exceptionalism.[9] Over the last 30 years, these narratives have been gradually broken down and rewritten, as historians have become increasingly critical of British imperial propaganda. At the same time, histories of India have increasingly come to be written from the perspectives of the empire's Indian subjects, rather than those of its British rulers.[10] By 2022, Caroline Elkins could argue that even the apparently benevolent attitude to empire that was espoused by genuinely concerned liberals such as Florence Nightingale cloaked a succession of "chimeras" which "took fresh breath from a potent ideology of liberal imperialism."[11]

The self-delusion of British empire-builders was expressed in a particularly invidious form by Rudyard Kipling's declaration that the empire was "the white man's burden".[12] But even if one agreed with this characterisation of empire, an inescapable (yet never-voiced) question remained: where did women stand within this burdensome landscape? Governing India was viewed as an intrinsically masculine pursuit; one, moreover, which required either political skills (and women were barred from politics) or military prowess (and women were not permitted to bear arms). Iris Macfarlane's evocative account of three generations of women within her own family illustrates how women's lives could be both desolate and powerless;[13] yet it also demonstrates how closely they shared their fathers', husbands' and brothers' attitudes to imperial subjects. These were almost invariably seen as 'other', in ways rather similar to those identified by Edward Said as 'Orientalism'.[14] Very few studies of women in the British colonies

[6] Piggott was only able to devote two pages to the inauguration of the Indian Army Nursing Service in what is a brief history of British military nursing: Piggott 1975. pp. 26–27. See also: Hay 1953.
[7] Summers 2000.
[8] Porter 2004; Thompson 2014.
[9] James 1998, p. 25. For a further critique of imperial mythology, see: Burton 2015.
[10] See, for example, the work of Amartya Sen: Sen 1999; Sen 2006; Sen 2021.
[11] Elkins 2022, p. 8.
[12] Rudyard Kipling's poem 'The White Man's Burden' was first published in The Times newspaper on February 4, 1899.
[13] Macfarlane 2006.
[14] Said 1978.

have focussed on nursing. A small body of work by Anne Marie Rafferty and colleagues forms a notable exception, focussing on the work of nurses in promoting a particularly British form of 'hygiene' in a number of colonies.[15]

3 METHODOLOGY

This study explores the relationship between the iconic Florence Nightingale and the largely unknown Catharine Grace Loch. Although it considers the writings of both women, it leans heavily on Loch's side of their ongoing conversation: the letters she wrote to Nightingale. This focus on Loch is, in part, pragmatic. Whilst her letters were preserved as part of the British Library's Nightingale Collections, Nightingale's replies appear, frustratingly, to have been lost.[16] The study has, therefore, been obliged to read 'between the lines' of Loch's correspondence to attain a glimpse of Nightingale's mentorship style and a sense of the synchronicities within the thinking of the two women. Further insights into the peculiarly female imperial project of which each was a part have been gained through Nightingale's writings on nursing in India (available in McDonald's Collected *Works of Florence Nightingale*) and articles published by Loch in the professional nursing journals of the day. Insights into Nightingale's work have been gained from a close reading of letters to recipients other than Loch. These display a remarkable consistency in approach and content and are revealing both of Nightingale's mentorship style and of her attitudes to the boundaries of nursing practice.

The most valuable primary source for the purposes of this article was the *Memoir* of Catharine Grace Loch.[17] A remarkable text, the *Memoir* consists of Loch's own personal letters, which were incorporated into a lightly edited published book by Alexander Frederick Bradshaw – the Principle Medical Officer with whom Loch served in India. The letters were given to Bradshaw by two of Loch's sisters in 1905, following her death. The book is redolent of the respect and deferential affection which Lady Superintendent and Principal Medical Officer felt for each other during a time when the nursing profession was edging its way carefully into the British military medical services. It is clear from Loch's letters that Bradshaw was a key enabler of her work in India. Yet, she was also clearly not happy with all of his decisions, and it is notable that Bradshaw does not flinch from including materials in the book which are critical of his own actions. A number of Loch's published articles were also, helpfully, included by Bradshaw, as appendices to what is a superbly comprehensive overview of Loch's work in India. Bradshaw clearly had great respect for Loch. Nevertheless, his work as editor was undoubtedly influenced both by his position in the hierarchy of the health service in India and by his gendered perspective.

As part of the study of the relationship between Nightingale and Loch, I have drawn upon correspondence between Nightingale and other senior nurses she mentored. Her approach to those nurse-reformers of whom she approved appears to have been remarkably consistent, with an emphasis on the composition of encouraging letters which advise the recipient to act with strength and determination, and yet also with diplomacy.

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[15] Rafferty/Solano 2007, pp. 147–54; Howell/Rafferty/Wall et al. 2013. pp. 338–341. See also: Sweet 2015.
[16] Vallee/ McDonald 2007, p. 786.
[17] Loch 1905.

4 MATRIARCHS OF EMPIRE

Anna Davin was one of the earliest women's historians to identify the key characteristics of ideal imperial British womanhood. The perfect role for a British woman, she observed, was that of mother: producer and nurturer of new civil servants and soldiers who would govern and protect the empire.[18] But there was also a place for 'matriarchs' who were not necessarily biological mothers: indeed, for a few such as teachers and nurses, it was essential to be neither married nor a mother. Nightingale and Loch both appear to have fitted admirably into this nurturing matriarchal niche. In an article for the *Nursing Record*, Loch declared that:

> What is needed [for the Indian Army Nursing Service] are gentlewomen in every sense of the word. In the social sense first of all, for something more than a hard-working Nurse is required to be able to maintain her position in working with and nursing the British soldier, and those who have not an unquestionable social position are not suited either for the work or the society into which they are admitted when they join the Service: they will be out of their element, and it will be hard on both them and their colleagues. Secondly, we require gentlewomen who are devoted first and foremost to their work – who care for nursing for its own sake and for their patients' sakes, and who are content to live quietly and unostentatiously, without parading their independence or craving for gaiety and excitement.[19]

In referring to women of higher social class who would devote themselves to their work and behave with decorum, Loch was describing characteristics possessed both by herself and by her mentor, Florence Nightingale. In the late nineteenth century, the British social elite, to which both women belonged, viewed the administration and support of the Empire as one of its primary 'missions': a duty that could only be discharged by those whose social background and disciplined upbringing were regarded within their own circles as impeccable. The prerequisites of imperial service, then, were gentility (a quality that was almost invariably associated with an upper- or middle-class upbringing), physical strength and devotion to service. Historians Preethi Mariam George and John Bosco Lourdusamy have argued that "British Victorian middle-class 'ladies' in India served a performative function as representatives of the 'civilised' culture of the British colonisers."[20]

Loch was far from being Nightingale's first protégé; the latter appears to have been willing to support any nurse-reformer who possessed the 'right' qualities, and was particularly devoted to nurses who had trained at the school she herself founded at St Thomas's Hospital: women such as Angelique Pringle and Rachel Williams, to whom she gave the respective nicknames, 'Little Sister' and 'Goddess Baby'.[21] Her affection for these acolytes is clear in her letters, as is their loyalty and devotion to her. Yet, she was willing to offer support and mentorship to any senior nurse who clearly promoted and forwarded her project for reformed nursing, and Catharine Grace Loch appears to have represented everything she wished to see in a senior nurse: gentility, devotion to service and a determination to advance her profession.

[18] Davin 1978, pp. 9–65.
[19] Loch, June 4, 1896.
[20] George/Lourdusamy 2023, p. 351, p. 353.
[21] Bostridge 2008, p. 457.

5 FLORENCE NIGHTINGALE'S ENCOUNTERS WITH IMPERIAL MILITARY NURSING

Florence Nightingale's interest in India began soon after the Indian Mutiny in 1857 with her work on the Indian Army Hospital Corps, but expanded to encompass a wide range of issues, including village sanitation, the protection of ryots (Indian peasants, or tenant-farmers), and the health of Indian women.[22] Her correspondence on these subjects was voluminous and much of it was conducted with men of power such as viceroys, members of parliament and prominent public health officials. Her collaborations with powerful ladies, such as Hariot, Lady Dufferin and Nora, Lady Roberts, have often been overlooked,[23] whilst her support for professional nurses, such as Loch, has been omitted almost entirely from the historical record.[24]

Nightingale's mentorship of Loch opens a window into a particularly female imperialist mindset of the late nineteenth century, because the writings of both women reveal their drives, aspirations and frustrations. Nightingale's mentorship style appears to have consisted of a complex process of: firstly, choosing who to support – focussing her attention on those who shared her values and pursued work she considered worthy, relevant, and within her own sphere of influence; second, offering warm encouragement for any actions she considered likely to expand her own projects; and third, placing clear boundaries around her involvement, in part to conserve her own energy during a time when she was experiencing chronic debilitating illness.[25] It may seem a little obtuse to study Nightingale's mentorship style almost entirely through the lens of letters written *to* rather than *by* her, but this serves the purpose of exploring the impact of her work on one particularly energetic nurse-reformer. It also helps reveal the significance of Loch's own work – a significance which has, hitherto, been largely neglected. The often lamenting, and sometimes tortured tone of Loch's letters enables an understanding of the fierce resistance and exhausting barriers that were placed in the paths of nurse-reformers during this period: ranging from the apathy of senior military officials, through opposition of medical officers, to the vagaries of the Indian culture and climate.

Nightingale's history is well known; it has frequently been transmuted into complex mythologies which have soaked up the aspirations and fears of successive generations. Most biographies, whether hagiographical or analytical,[26] agree that, at the age of 17, Nightingale experienced what she interpreted as a 'call to service' which came directly from God. After years of searching, researching, and battling the prejudices of her upper-class family and its encompassing 'society', she gained experience of the nursing care provided by a Protestant religious sisterhood in Germany and of a Catholic order of nurses in France. She then, in 1853 and 1854, led and managed a small hospital in London: The Institute for Gentlewomen During Illness. It seemed fortuitous that, soon after she had taken on this leadership role, a close family friend, Sidney Herbert, who was, at that time, British Secretary of State at War, was searching for someone who could lead an experimental team of nurses to the Crimea, where British soldiers were dying in their thousands, not only from war wounds, but also (and more frequently) from enteric diseases such as dysentery, typhoid and cholera. Nightingale was chosen to lead a group of 38 British and Irish nurses to the Black Sea and Bosphorus in November 1854. Here, she established small enclaves of what she viewed as 'professional nursing' in hospitals in Turkey and on the Crimean Peninsula.[27]

[22] Gourlay 2016, pp. 1–20; Vallee/McDonald 2006, pp. 1–22; Vallee/McDonald 2007, pp.1–17.
[23] It is ironic that the only secondary sources which give any insight into the work of Nora, Lady Roberts are those that focus primarily on her husband. See, for example, Atwood 2015.
[24] The work of Vallee and McDonald is an obvious exception: Vallee/McDonald 2006, pp. 730–36; p. 786.
[25] On Nightingale's mentorship of nurse-leaders as a strategy for spreading her own version of reformed nursing, see McDonald 2009, passim.
[26] The more laudatory biographies include: Cook 1913; Woodham-Smith 1972; Huxley 1975. Probably the most measured and well-re searched biography is: Bostridge 2008. See also: Nelson/Rafferty 2010.
[27] Helmstadter 2019.

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The enormity of Nightingale's task in developing a cadre of female military nurses in the Crimea cannot be overstated. She faced numerous barriers in placing professional nurses into the highly masculine environment of the military hospital, and in asserting their distinct expertise and authority. The most significant of these were the opposing claims of medical authority versus that claimed by the nascent nursing profession, and the clinical complexities that arose when female nurses worked alongside male medical orderlies, who took official orders only from doctors. The melding of the distinct (and very different) approaches and priorities of surgeons, nurses and orderlies created a parallel hierarchical system that was very complex. But, in one sense, this was exactly what Nightingale wanted. Her project for nursing (both civilian and military) was to interpolate a cadre of highly efficient women of impeccable moral character into the harsh and somewhat undisciplined environment of the hospital ward. It was inevitable that some male medical authority figures would oppose this move, and that conflict was likely to ensue.

Other difficulties encountered by Nightingale (and by the medical services generally) in the Crimea related to the servicing and supply of an imperial army that was so far from home. Her battles with the 'Commissariat' are legendary.[28] But her greatest frustrations arose out of medical and political interference in the choosing of 'her' nurses. When a second contingent of nurses was sent to the Crimea in November 1854 without her consent, she almost resigned.[29] This personal experience of being unable to control events for which she was held responsible undoubtedly contributed to her sympathy for her protégé, Catharine Grace Loch, who encountered similar difficulties in India.

Following a visit to Balaklava, Nightingale contracted a 'Crimean fever' (identified subsequently as brucellosis) which recurred throughout her life and reduced her to a housebound state from 1858 onwards. Refusing to be constrained by her situation, Nightingale used her reclusiveness as a means to focus on the work for which she had felt inspired since her teenage years.[30]

By means of voluminous correspondence and occasional meetings with people she viewed as influential or significant at her house in South Street, London, Nightingale pursued her many goals, all of which were focussed on enhancing the health and wellbeing of the British people, including its imperial subjects. The health of the British soldier, and the wellbeing of the Indian population were probably her two most favoured projects.[31] Twenty-first-century historians might well interpret the twinning of these aspirations as intrinsically self-defeating: surely bolstering the British Army merely served to strengthen the instrument that acted as the primary means of oppressing, disempowering, and ultimately contributing to misery and poverty in India? Whether we interpret this as an innocent blind spot of imperial womanhood, or an intrinsically immoral self-delusion, neither Nightingale herself, nor philanthropic women in India such as Lady Roberts or Lady Dufferin, would have sensed any irony in the directions taken by their work. They focussed, in all sincerity, on alleviating suffering and enabling all people (whether British or colonial subjects) to live fuller lives.

Historian Jharna Gourlay emphasises the way in which Nightingale's interest developed from a concern with the health of the British Army in India to a focus on health and sanitation for the entire Indian population. She argues that Nightingale's "empathy for Indians was in sharp contrast with the imperialistic and colonial attitudes of the period."[32] But she also reveals Nightingale's cleverness in appealing to the imperialist vested interests of her time, by, for example, pointing out that the health of the British in India could not be improved without a complete overhaul of the entire sanitary system,

[28] Helmstadter 2019.
[29] Helmstadter 2019.
[30] Young 1995, S.1697–1700; McDonald 2010.
[31] Vallee/McDonald 2006, pp. 1–22; Vallee/McDonald 2007, pp.1–17.
[32] Gourlay 2016, p.1. See also: Crawford/Greenwood/Bates et al. 2020, p.184; pp.192–193, p.196.

from the provision of good drainage, fresh air and clean water to a recognition of the need for social and political justice for Indian people.[33] Paul Crawford and his colleagues elaborate on Nightingale's mode of 'working from home', at first, in the late-1850s, from the Burlington Hotel and then later (and for most of the rest of her life) from No. 10 South Street in Mayfair, London. They argue that she not only overcame, but made use of her status as a chronic invalid to give herself the seclusion required to complete her work as effectively as possible. They argue that her "unique brand of bedroom imperialism" was, indeed, highly effective,[34] enabling her to more fully understand and empathise with the situation of the Indian people, even though she was "never able to totally break free of the notion that educated British citizens had a tacit right to offer tutelage over how India should be run."[35]

Nightingale's attention appears to have been drawn to the nursing care of British troops in India during the so-called 'Indian Mutiny' of 1857. The Royal Commission of the Army in India and the Bengal Sanitary Commission (appointed respectively in 1859 and 1864) sought her advice, but in 1867 her plan for the introduction of professional female nurses into Indian military hospitals was rejected.[36] It was not until the 1880s that the combined efforts of Lord and Lady Roberts enabled the foundation of the Indian Army Nursing Service under the command of two lady superintendents (Catharine Grace Loch in Rawalpindi, and Miss Oxley in Bangalore). Overall command of the service soon devolved upon Loch.[37]

6 CATHARINE GRACE LOCH'S WORK IN INDIA

Nightingale's partner and protégé in providing professional nursing care to British soldiers in India, Catharine Grace Loch, was different from her mentor in a number of ways. She belonged to a newer generation of British nurses who aspired to a type of professionalism of which Nightingale disapproved. She had trained at The Royal Hants County Hospital in Winchester (1879-80), and then worked as a ward sister at St Bartholomew's Hospital in the City of London (1882-88).[38] Here, she appears to have become imbued with the values of two famous 'Bart's' matrons: campaigner for nurse registration, Ethel Gordon Fenwick, and reformer of nurse education, Isla Stewart. Loch saw nursing as less a moral and spiritual vocation, than a professional and technical science, although the differences between her perspective and that of Nightingale should not be overstated, and these differences are never mentioned in a correspondence which is always impeccably courteous and deferential on Loch's part. Indeed, Loch appears to have placed Nightingale on a pedestal: her letters have an apologetic tone; they express gratitude, concern about taking up Nightingale's time and energy, and a sense of the honour paid by Nightingale in reading them. In a letter home to her sisters, which was later incorporated into her posthumous *Memoir*, Loch wrote:

> Jan 28 [1889] – I have just been writing a long letter to Miss Nightingale in answer to one of hers. She does write such charming letters full of encouragement and also lots of questions about our work. When she wrote last it was immediately after receiving all the doctors' reports, etc., also several private and official letters to the India Office, which had all been sent to her to see, so you see she is very well up in all that goes on.[39]

[33] Gourlay 2016, pp. 14–15.
[34] Crawford/Greenwood/Bates et al. 2020, p.185.
[35] Crawford/Greenwood/Bates et al. 2020, p.199.
[36] Rana 2022, pp. 209–216, pp. 210–212. On Nightingale's fascination with India and her work for the Royal Commission. See also: Godden 2010, p. 60.
[37] Rana 2022, pp. 209–216, p. 212.
[38] Anonymous, Loch, Catherine Grace; Pioneering Nurses. Archives of King's College, London. Website available at: https://kingscollections.org/nurses/j-l/loch-catherine-grace. Accessed March 2023.
[39] Loch 1905, p. 36.

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In 1888, Loch, clearly an impressive character, who exuded both a 'ladylike' persona and a steely sense of determination, was offered the arduous task of jointly heading the newly founded Indian Army Nursing Service.[40] Her letters indicate that she received a rare invitation to visit Nightingale in her home on South Street before taking up her mission.[41] This personal visit marks out Loch as one of Nightingale's most favoured mentees.

Loch departed Britain in February 1888, along with another Lady Superintendent, Miss Oxley, and eight nursing sisters who were to be deployed throughout the four 'Circles' or commands of Rawal Pindi, Meerut, Bangalore and Poona.[42] They arrived at one of the largest Indian military stations, in Rawal Pindi, on 21 March. This was to be Loch's posting as Lady Superintendent, and her first letter to Nightingale from the Station Hospital, reveals her ambivalence towards the military medical officers of the British Army. On the one hand, she comments on the courtesy and kindness of individual officers, and clearly feels that their intentions are good:

> The medical officer in charge of this hospital is Brigade Surgeon Walsh, Surgeon Genl. [sic] Bradshaw is the P.M.O. [Principal Medical Officer]. These are both most thoughtful and kind in everything that they have arranged for us and they are most anxious that we should succeed in every way. Indeed, I think we are exceedingly fortunate to begin our career in this country under Medical Officers who are so favourably inclined to the new scheme and so ready to help and support us in our work.[43]

Nevertheless, she lamented what she saw as a lack of insight which was shared by all medical officers in India, revealing a belief (clearly shared by Nightingale) that only a trained professional (female) nurse could understand the true nature of nursing work. Men – however senior, experienced and intelligent – could never grasp the real nature of the contribution to be made by an expert nurse:

> There is a vast amount to be done before the nursing arrangements can be rendered anything like efficient and it seems to me that the medical officers have no notion, no conception in any way what is required for sick people. There are so many things I long to see altered, many of which would certainly be considered out of my province even to suggest, so it will only be by very slow degrees, if ever, that we will be able to make improvements.[44]

One of the striking features of this passage is the juxtaposition of an inherent confidence that she, Loch, knew what was best for military patients, with the frustration of her powerlessness – which was both gendered (she was a woman) and professional (though a highly-trained nurse, she was seen as inferior in both knowledge and ability to a 'medical man'). Loch's *Memoir*, which was published post-humously in 1905, was edited by Bradshaw, who clearly had huge respect for Loch. In his 'Note by the Editor' he commented that "by her administrative ability, strikingly sound and tactful common sense, and by her decisive and level-headed judgement in complex and trying circumstances, she had obtained the high esteem of the medical authorities with whom she was brought into communication."[45]

Nightingale would, undoubtedly, have approved both of Loch's ladylike diplomacy towards her medical colleagues and of her mentee's insights into the need to overcome the medical profession's entrenched and obstructive attitudes to female nursing. In 1872 Nightingale herself had written to U.S. physician, Gill Wylie:

[40] Loch's fellow Superintendent was a 'Miss Oxley', but it appears that Loch took over as the sole 'senior nurse' and leader of the service soon after their arrival. Loch 1905. 'Note by the Editor'.
[41] Loch, Letter dated 24 January 1888.
[42] George/Lourdusamy 2023, pp. 347–64, p. 351, p. 353.
[43] Loch, Letter dated 12 April 1888.
[44] Loch, Letter dated 12 April 1888.
[45] Loch 1905, p.xii.

> Nurses are not 'medical men'... The whole organization of discipline to which the nurses must be subjected is for the sole purpose of enabling the nurses to carry out intelligently and faithfully such orders and such duties as constitute the whole practice of nursing... And for this very purpose, that is, in order that they may be competent to execute medical directions – to be nurses and not doctors, they must be, for discipline and internal management, entirely under a woman, a trained superintendent, whose whole business is to see that the nursing duties are performed according to this standard.[46]

Loch's leadership of a small (yet growing) and scattered nursing service required her to travel throughout India. In 1895, she described a "tour of official inspection" in which she had visited members of her nursing team in "Mian Mir [sic], Quetta, Umballa, Peshawar and Cherat."[47] She also undertook numerous, intrepid, tourist expeditions during her periods of leave. By the time her tenure ended in 1902, Loch had established a nursing service throughout India.

7 THE BRITISH SOLDIER-PATIENT: A MILITARY ASSET

The work of Catharine Grace Loch in India was viewed by the British establishment – both political and military – as vital. Britain, a small, divided nation in the North Atlantic, had by the 1880s, conquered vast areas of territory throughout the known world: an empire that was both a source of great wealth and prestige and a potential drain on the expertise and energies of the British people. The British soldier was coming to be regarded by all as a necessary resource of that small, complex nation, although the campaign to recognise his needs and pay attention to his health was still in its infancy. Any gains during the latter half of the nineteenth century had been hard won by Nightingale's campaigning efforts after the Crimean War.

The British officer, who was always drawn from a higher social class than his rank-and-file counterparts, was a prized asset: one the nation could not afford to lose cheaply to either disease or injury.[48] The Crimean War had already demonstrated what a mistake it was to take soldiers' lives for granted. Yet, in spite of Nightingale's best efforts, the British military was slow to learn the lessons of the Crimea.

Officers and men, along with civil servants, engineers, and other male 'specialists' were shipped in their thousands to British imperial territories, and the vast sub-continent of India received more than its share of 'ex-patriot' Britons, many of whom remained for most of their lives, serving colonial governments and imperial armies (the elite sending their children back alone to British boarding schools to acquire a 'properly British' education).[49]

When Loch and her fellow Lady Superintendent, Miss Oxley, landed in Rawal Pindi, they took only a small cadre of eight professional nurses with them: a tiny team on whose shoulders the founding of a large and effective service would rest. Arriving at the Station Hospital, they found that all serious cases had been brought to the one base from outlying districts, and had been placed in the fever ward to be under the care of the professional nurses. There were also other, 'scattered cases' who were considered serious enough to require their care, including "an officer convalescing from Typhoid [sic],

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[46] Nightingale, Florence, Letter to Gill Wylie dated 18 September 1872, in: McDonald 2009, pp. 501–502.
[47] Loch, May 18, 1895.
[48] On the ways in which imperialism fuelled a militaristic mentality, see: Dawson 1994; Paris 2000.
[49] Macfarlane 2006.

and absolutely insane in the verandah" [sic].[50] It was made clear to the nurses that they were to have 'nothing to do' with less sick cases – undoubtedly because it was seen as improper for nurses to come into contact with recovering men. Their ministrations were reserved for those who were 'in extremis': unconscious or delirious, and, significantly, incapable of flirtation. Loch's nurses often cared for men who were very acutely ill; they had to contend, for example, with frequent epidemics of cholera, a disease which caused such severe ill health that only expert nursing care could hope to save sufferers, who were usually prostrate with dehydration and debility.[51] Among the other serious illnesses they encountered were dysentery, rheumatism, malaria, enteric fever, influenza and pneumonia.[52]

By 1893, Catharine Grace Loch was becoming a recognised expert in the care of patients with severe infections, ranging from the enteric diseases common amongst soldiers in all climates to more acute and life-threatening diseases such as malaria and yellow fever. In an article commissioned for the *Nursing Record* by editor Ethel Gordon Fenwick, Loch commented on how difficult it was to be one of the nurses who remained on the "burning, fiery, intense heat" of the plains of the Punjab whilst the majority of troops and nurses retreated to the foothills of the Himalayas to continue their work "seven or eight thousand feet above the oven-like plains."[53] At the base in Rawal Pindi, fevers were rife and the condition of the patients was always worse during the hot season. Loch's dangerous work on the plains of British India was reminiscent of Nightingale's 1855 visit to the Crimean Peninsula (during which she contracted the illness that would keep her housebound much of her life). This tendency to put one's own health and wellbeing at risk to support the soldiers who were, themselves, seen to be a bulwark of British imperial strength, undoubtedly served as an important bond between the two women.

8 THE BRITISH MILITARY ORDERLY: A MALLEABLE YET SCARCE AND BRITTLE INSTRUMENT

George and Lourdusamy have commented that "the newly introduced nursing sisters of the INS were required not only to care for the patients, but also to train the orderlies in nursing and to supervise their work,"[54] adding that "this can be counted among the few scenarios in the nineteenth and in the early-twentieth centuries where women were in charge of instructing men."[55] The professional nurses would have seen this as an entirely appropriate aspect of their role. Yet they encountered difficulties. They found that, not only were most of the male assistants who were assigned to help them worse than incapable, but also, the entire system into which nurses and orderlies had been placed was faulty: there were no clear lines of command. As George and Lourdusamy have commented, "the inadequate delineation of responsibility in the military medical system, and the refusal of the government to grant a nominal rank to the sisters undermined the authority and position of the sisters in relation to the orderlies and the assistant surgeons."[56]

In her first letter to Nightingale, Loch declared, "There is no hospital orderly corps at all. Men volunteer for hospital service out of the ranks, chiefly I think because they get more liberty."[57] Prior to the arrival of the female nurses, all care had been given by these 'orderlies' under the direction of apothecaries

[50] Loch, Letter dated 12 April 1888.
[51] There are numerous references in Loch's Memoir to cholera epidemics. See, for example: Loch 1905, p. 101, pp.124–125.
[52] George/Lourdusamy 2023, pp. 347–64, p. 354.
[53] Loch, October 7, 1893.
[54] George/Lourdusamy 2023, pp. 347–64, p. 352.
[55] George/Lourdusamy 2023, pp. 347–64, p. 356.
[56] George/Lourdusamy 2023, pp. 347–64, p. 357.
[57] Loch, Letter dated 12 April 1888.

(trained medical men placed under the command of medical officers); but the system was marred by two serious problems: the apothecaries did not seem to care whether the orderlies worked or not; and the orderlies were members of the fighting force, with no nursing training, who were only ever assigned to ward duty for short periods. As Loch lamented: "They know nothing of nursing. They are not to be depended on either to feed a patient or to keep his bed dry, even when left to watch him. They sleep soundly at night, and we are told they must not have the work rendered irksome to them or they will throw it up and return to their barracks."[58] In the fever ward, Loch speculated, the orderlies "got thro' the work by the simple plan of not doing it."[59] She added that on some wards the bad cases were being cared for only by their convalescent fellow patients, offering the example of one 'poor fellow' who was found "hugging a large packet of Dovers Powders marked 'every four hours'. He has severe pleurisy and dysentery, and he was left to take care of himself."[60]

Not all military orderlies were uncaring. Loch commented that, "of course, there are some men a great deal better than this – men who seem really anxious to learn, and who have already picked up very quickly much that the sisters have taught them – but there is no certainty of keeping them. If this regiment were moved tomorrow they would have to go too."[61]

Nightingale would almost certainly have understood the feelings of helplessness experienced by Loch. Indeed, it is clear from Loch's subsequent letters that Nightingale must have responded sympathetically to her feelings of anxiety and pressure. Over 30 years earlier in the Scutari Barracks Hospital, Nightingale had found herself working under very similar circumstances. She may well have found it disheartening to discover how little progress had been made in the training and deployment of military orderlies since the publication of her reports on the need for reform in the late 1850s and early 1860s.[62]

Loch and her fellow nurses responded to what they considered to be a crisis in care at the Rawal Pindi Station Hospital by "[throwing] themselves heart and soul into the work". They had "been able, as the number of sick [was] comparably small, to do a great deal of personal work, and to show the orderlies actually how to turn, wash the patients etc."[63] But Loch knew that her team was too small to perform all the care themselves in the long term:

> I feel that this will do only very temporary good, from the shifting nature of the arrangements, and that in the unhealthy season when the wards are crowded, as each sister has charge of a much larger number of beds, that it will be almost impossible for her to keep the orderlies up to their work. If only we could persuade the authorities to start a regular organised orderly corps, we may succeed.[64]

The supply of orderlies appears to have worsened rather than improved during Loch's first ten years in office.[65] In 1898, she wrote home to her sisters:

> We have lost fourteen men in ten or twelve days and several more will certainly die; and as the regiments have changed again we have changed our orderlies – only for the thirteenth time in ten months – and of course the new ones know nothing at all… I was altogether in such despair, that I wrote yesterday a private and confidential appeal to the adjutant of the Dragoon regiment here. I knew that they have several certificated men whom we have trained in former years, if they

[58] Loch, Letter dated 12 April 1888.
[59] Loch, Letter dated 12 April 1888.
[60] Loch, Letter dated 12 April 1888.
[61] Loch, Letter dated 12 April 1888.
[62] Nightingale 1858. Passim, on the Propositions as to General Hospitals, see pp. 218–234. On the compiling of this report, see: Bostridge 2008, pp. 316–23. Nightingale offered significant advice and direct help in the drawing up of two reports on army sanitation: Royal Commission, Report 1858; Royal Commission, Report 1863.
[63] Loch, Letter dated 12 April 1888.
[64] Loch, Letter dated 12 April 1888.
[65] See, for example, the account in a paper written by Loch for The Nursing Record: Loch, November 18, 1893.

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> would only consent to send them, and I knew that the S.M.O. had been applying for them, and that as usual everything was full of red tape delays and mutual jealousies between the medical, the military, and the station staff offices and nothing was happening, so I wrote. Capt. B., the adjutant, came this morning to see me and is going to send up four good men to-night, who will be I hope a backbone for us to depend upon, so I feel encouraged. But I do not know whether the S.M.O. will be down on me for having ventured to interfere![66]

This story illustrates the deep frustration that was so frequently felt by Loch in being unable to assemble teams of workers who would possess the skills necessary for the efficient running of a hospital. The fundamental problem for the nurses was the 'itinerant nature' of the medical teams, and George and Lourdusamy have commented that "the dynamics of work in a military hospital in India was such that mutual trust and confidence could not be cultivated easily. This resulted in a system where the expertise of a nursing sister was not adequately validated."[67]

The problems associated with a constant turnover of male nursing staff was exacerbated by lack of cooperation from medical officers. In a letter home to her sisters, Loch commented that "one is always at the mercy of the individual medical officers who happen to be in a given place at a given time."[68] It is clear that, with greater support from these fellow professionals, many of her difficulties could have been overcome with much greater ease, and less stress upon herself. In a letter dated 4 November 1901, Loch gives way to a long treatise on the shortcomings of junior doctors. Her letter has many of the qualities of a rant but is, nevertheless, controlled and thoughtful:

> Sometimes they [the medical officers at the Station Hospital] are sensible, broad-minded and friendly, but sometimes even at this time of day they are quite the reverse, and it is maddening to have a bumptious boy just come out to the country, trying experiments and treating the patients on lines which one has seen tried over and over again without success, and which one knows he will utterly give up and try to forget in a year or two, and looking upon us as though we were mere probationers… This is what makes it so trying out here.[69]

It is clear that, although Loch felt well supported by senior medical officers, the gendered and professional power relations between late-nineteenth-century doctors and nurses meant that she and her fellow nurses were helpless to intervene when poor treatment or bad care was provided by medics and orderlies.

9 THE 'NATIVE ORDERLY': A DOUBTFUL AND DANGEROUS IMPERIAL RESOURCE

The Station Hospital at Rawal Pindi, like all large military hospitals in India, relied heavily on a small army of native servants and 'coolies'.[70] In an article for the *Nursing Record*, Loch described the scene in a typical ward in the early 1890s:

[66] Loch 1905, p. 235. See also: Loch, October 7, 1893.
[67] George/Lourdusamy 2023, pp. 347–64, pp. 352–53.
[68] Loch 1905, p. 289.
[69] Loch 1905, p. 290.
[70] On the creation of the Native Army Hospital Corps, see: Vallee/McDonald 2007, p.173.

> Imagine a long narrow one-storied building surrounded by deep verandahs [sic], which forms one wing of the hospital. Outside there are blinding glare and pitiless scorching heat; inside darkness and (comparative) coolness... The doorways are filled up with closely fitting thick mats of cuscus grass called 'tatties', which are kept wet by troops of little boys perpetually throwing water over them, and the very rapid evaporation transforms the oven-like blast into a cool damp air as it blows through and pervades the place with a pungent sweet smell. In spite of all precautions, however, it is difficult to keep the temperature of the ward much below 100 degrees, and I have known it 104 degrees for days together. A small punkah hangs over every bed; these punkahs are attached to a large heavy frame which swings from the rafters, and this is pulled sleepily to and fro, day and night, by a half-naked coolie who squats on his haunches in the very middle of the floor.[71]

Loch clearly saw such menial tasks as appropriate for 'native' workers. She had commented in her earliest letter to Florence Nightingale on what she saw as the capacity of the native workers on the wards at the Station Hospital: "There are a number of coolies and sweepers who do the cleaning and all the menial work, but they are wretchedly dirty fellows and quite incapable of any nursing." [72]

She later adjusted her perspective in response to a query from Nightingale:

> It was wrong if I gave you to understand that there is no native hospital orderly corps. I think that I did not realize at first that the tribes of coolies, ward servants, sweepers, etc. about the hospital do belong to a regularly organized corps, and are enlisted as part of the Bengal Army, but they are quite hopeless as nurses. According to the army regulations, they are supposed to receive training, and they are supposed to be able to pass an exam in simple dressings, poultices and bandaging, etc., before they can be promoted to a higher grade. This looks very well on paper! But practically it is of very little use. They are dirty, idle, untruthful, dishonest! They will steal the patients' food off their locker if they are too ill to look after it.[73]

Loch was clearly unimpressed by what she saw as the character deficiencies of the 'native orderlies', and it is clear from this quotation that she had a tendency to assume that they were exactly alike – an assumption she did not make with the British orderlies. Nevertheless, there is one sense in which she saw the orderlies as being distinct from each other: in terms of their skill set. She believed that each orderly could only learn to do one task well:

> It is true these Indians are often skillful with their hands, and they can be taught to do any one thing very nicely, but then each man does only one thing, and when that thing has to be done the right man has to be hunted up and told to do it, which is far more tedious than doing it oneself. In addition to this, the soldiers do not like being touched by them. They despise them utterly, abuse them and treat them very badly, which does not promote good service and altogether prevents any satisfactory relation between them as nurse and patient.[74]

The failure of patients to allow themselves to be nursed by Indian orderlies undoubtedly impacted on the capacity of those orderlies to learn to perform nursing work well. Given the importance of understanding and emotional connection in building nurse-patient relationships, the racism shown by some British patients towards Indian orderlies is likely to have been a serious barrier to care.

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[71] Loch, October 7, 1893. The temperatures in this quotation are given in Fahrenheit.
[72] Loch, Letter dated 12 April 1888.
[73] Loch, Letter dated 12 June 1888.
[74] Loch, Letter dated 12 June 1888.

Loch herself never expresses overt racism in her letters to Nightingale or in the letters and papers later collected for her *Memoir*. Yet it is very clear that she is a product of her upbringing as an English middle-class 'lady' operating in a highly militaristic environment at the height of Empire. Many of her letters home describe historic scenes in various parts of India, with frequent reference to events suchas the 'Mutiny' or works such as those by Rudyard Kipling.[75] On a visit to Mandalay in 1895, she writes:

> I think Mandalay is rather a sad place. It is barely ten years since we turned out Theebaw and his queen and established ourselves in possession, and though the natives appear to be perfectly cheerful and satisfied and no doubt are really much better off, still many of the public buildings are falling into disrepair and look neglected and miserable.[76]

What seemed to Loch herself – and no doubt to her readers – to be perfectly normal comments on one particular corner of the British Empire are likely to evoke discomfort and censure from a twenty-first-century readership. The casualness of the reference to 'turning out' the previous ruler and establishing the British 'in possession' is a little jarring, despite the genuine sympathy which also appears to be expressed by Loch.

By 1896, Loch was describing the "native ward servants of various grades" as a "regular Hospital Corps", but she was still bemoaning the fact that "they do the cleaning and ward work, but are absolutely useless from a nursing point of view. They are nearly all a very low class of men and poorly paid, and they never do more work than they are absolutely obliged. The soldiers do not like them and would often bully them if they dared… and the ward boys retaliate by being as idle and provoking as in their turn they dare to be."[77]

10 THE IMPERIAL (AND IMPERIOUS) PROFESSIONAL NURSE: THE LYNCHPIN OF CARE

In her first letter to Nightingale from India, Loch commented that only another senior female nurse could really understand the problems she was facing:

> It has been a great comfort to me to write all this out to you, for I feel that you understand the right bearings of all these things and that you will be able to judge how things really are out here. I should be afraid to write so fully to anyone else. It is very likely that coming from a place like Barts where the nursing arrangements and general discipline have been worked up to a pitch of perfection, that we are more scandalised than is necessary at the general promiscuousness in the manner in which the subordinates here carry out their instructions – but I hope we shall not grow too particular ourselves.[78]

One of Loch's major concerns was her own lack of control over the appointment of nurses to the service – a concern which had long been reflected in Nightingale's own writings.[79] In a letter home to her sisters dated 5 February 1892, Loch deplores some of the choices made by the "gentlemen at

[76] Loch 1905, p.182.
[77] Loch, September 12, 1896.
[78] Loch, Letter dated 12 April 1888.
[79] See, for example, Nightingale's letter to Gill Wylie, quoted earlier in this paper: Nightingale, Florence, Letter to Gill Wylie dated 18 September 1872, in: McDonald 2009, pp. 501–502.
[80] Loch 1905, pp. 95–96.

the India Office", adding that they "know nothing about selecting or rejecting candidates; how should they?"[80] Her own wish (which seems to have remained unfulfilled) was that nurse leader and reformer Ethel Gordon Fenwick should be involved in the selection of staff. Loch's faith in Fenwick is interesting, given that Fenwick was viewed with mistrust by Florence Nightingale. Her capacity for drawing upon the support and counsel of nurse-leaders of different perspectives and persuasions provides suggestive evidence for her diplomatic skills.

Nightingale's approach to promoting a better understanding of nursing among powerful medical men had always been a careful and diplomatic one. She avoided controversy, and her tendency towards diplomacy was admired and shared by her acolytes. In 1880, during the so-called 'Guy's Hospital dispute', Nightingale's supporter, Angelique Pringle (at that time matron of the Edinburgh Royal Infirmary) had written to her deploring the actions of openly assertive nurses such as Margaret Lonsdale, declaring, "That was not the silent and patient way of our Chief."[81] Loch appears to have taken a very careful stance in her relationships with senior medical men in India, perhaps realising that open dispute with them would hinder rather than advance her work. Yet, the tensions created by this need for diplomacy appear to have taken their toll on her emotional wellbeing.

In October 1897, plans were drawn up for a new Base Hospital in Rawal Pindi to support British forces sent to suppress an uprising on the North West Frontier. Due to a shortage of staff and illness among her nurses, Loch found it difficult to staff the new hospital. Having expressed her concerns to the Principal Medical Officer, she was horrified to find that he was planning to advertise for 'temporary nurses'. Writing home, she exclaimed:

> I cannot think what kind of creatures he would find. I know that all sorts of funny people have been volunteering and clamouring to be allowed to nurse on active service, so no doubt he would find people in petticoats calling themselves trained nurses; but we all went crazy at the idea, and I flew up to Murree at a moment's notice to see the P.M.O. of the Punjab Command.[82]

The P.M.O. of the Punjab Command was Loch's ally, Alexander Bradshaw. Gaining his immediate support, Loch wrote a letter to the Commander-in-Chief at Simla, but volunteer nurses had already been posted to various army hospitals. Loch takes up the story in her letter:

> The only orders that have reached us here were that a certain Miss P. and a Miss D., temporarily appointed nurses, were ordered to the Punjab… Miss P. turned up promptly, and to my dismay she is very dark and about nineteen years old, with as only training two months in a zenana hospital and has never in her life seen a male patient! We are furious naturally. However it is so bad that my spirits rose immediately and I have positively refused to allow her to go into the wards at all, and I have written officially to say so and to request that she may be sent back at once.[83]

Loch's determination not to allow 'Miss P.' to nurse appears to have produced a deadlock, during which the unwanted volunteer remained at the Station Hospital for several weeks. Loch commented that she felt "sorry for the girl", who had clearly volunteered out of ignorance and could not be held to blame for the actions of the army high command. The situation worsened when large numbers of troops suffering from "a virulent and fatal form of dysentery" were brought to the hospitals in Rawal Pindi. Meanwhile, Loch received "the biggest wigging I ever received in my life" in response to her first letter,

[81] Pringle, Letter dated 1880.
[82] Loch 1905, pp. 211–212.
[83] Loch 1905, pp. 212.

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and was waiting to see what her refusal to appoint Miss P. would bring. There was no hint, though, that she would 'back down'. At this point, her letters begin to reveal how disheartened she was becoming:

> It is a tiresome sort of life this; everything that may or may not happen depends on something else that also may or may not occur, or on somebody who cannot be got at or who cannot be counted on, but always does what I do not expect or leaves undone what I do expect. At present we are extremely short-handed both here and at Nowshera, from various causes such as more work and sick Sisters... The last of the wretched men from Tochi Field Force are coming in – about 250 more I believe – and they are awful; they nearly all die, and nothing does them any good.[84]

It is likely that Florence Nightingale saw in Loch's struggles with military bureaucracy in India something akin to her own battles with the 'Commissariat' during the Crimean War. Her sympathy was clearly aroused by Loch's struggles. In 1894, Loch returned to England on leave, and once again visited Nightingale in her house on South Street. Soon afterwards, she wrote a letter of thanks which suggests that she felt that the question of whether the Indian Army Nursing Service would succeed or fail was still an open one:

> I wanted to thank you very much for the lovely flowers which I recd [sic] from you... I was so much delighted with them for there is no place so absolutely lacking in flowers as a country home in the winter - when there are none in the garden - and it was so kind of you to think of them. Thank you also very much for letting me come to see you. I am very glad indeed to have had the privilege of doing so and of talking to you about a few of our experiences and difficulties in India. I often wonder very much how matters will turn out in the end. Whether eventually they will materially increase the number of nurses in the service and whether, if they do, a more regular and general system of nursing and training in the military hosps [sic] will be gradually established, or whether they will remain as they are at present, only a few doing it scattered here and there.[85]

Loch and Nightingale appear to have shared the view that a hospital ward staffed by female nurses rather than male orderlies would always be a healthier, better-organised place. Both women had experience of civilian nursing in which female nurses performed all the nursing care (with the help of probationers). And both had been shocked by their first experiences of military hospitals, in which they believed that patients were badly neglected by both medical men and military orderlies. They appear to have shared the view that male military hospital orderlies were necessary to perform the work of lifting and handling patients, pitching hospital tents and performing other heavy work such as hauling water and digging drainage ditches. They were also, however, united in their view that fully trained female nurses should be in charge of all the nursing care on a given hospital ward – and that there was a need for a much higher ratio of nurses to orderlies, in order to ensure that the former could properly train and supervise the latter, as well as providing the more intricate care themselves. It was clearly of considerable comfort to Loch that a social icon such as Nightingale should share her concerns – and, indeed, demonstrate enough sympathy to send flowers.

[84] Loch 1905, pp. 218–219.
[85] Loch, Letter dated 1 February 1894. I am indebted to Lynn McDonald for sending me a legible transcript of this letter.

11 CONCLUSION: 'A BRAVE SOLDIER WITH A LARGE HEART AND BRAIN'[86]

Much of the stress and strain experienced by Loch can be attributed, whether directly or indirectly, to the failure of senior British medical officers to share her vision for military nursing, or to provide the resources she needed. As George and Lourdusamy have commented, "[the] Lady Superintendent [in India] was accorded a semblance of power – but no real authority."[87] The support of Alexander Bradshaw notwithstanding, Loch frequently found (and explained in her candid letters home) that senior officers were incapable of listening to, or taking advice from, a woman. The endemic gendered and racial prejudices in Indian military hospitals, which dictated that, whilst nurses would be treated with deference as ladies, and orderlies (both British and Indian) would be accorded their own 'lines of command', both groups would be left to flounder in a system that had become archaic, disorganised and often uncaring. Both Loch and Bradshaw agreed that the system needed a complete overhaul, but, although reform was slowly emerging during Loch's term of office, it was not in place until the outbreak of the First World War, ten years after her death. Medical ignorance of nursing expertise and a wilful refusal to recognise nursing authority were not, however, the most destructive elements of Loch's situation. At no point during her tenure – or for several decades after it – did the British Government in India assign adequate resources to the Indian Army Nursing Service. Even after the reforms of 1903, through which the service was renamed the Queen Alexandra's Military Nursing Service for India and Loch was given the title 'Chief Lady Superintendent', staffing levels remained inadequate, and "the government continually showed an attitude of neglect towards the nursing service."[88]

Florence Nightingale's mentorship of Catharine Grace Loch clearly had an important and supportive influence on her younger colleague. Consistent with her mentorships of her own former St Thomas's probationers, Nightingale assumed a fellow feeling with Loch. Much of the understanding between them appears to have been born out of the similarities in their social class backgrounds and reforming projects. Loch's letters frequently contain thanks to Nightingale for so thoroughly understanding the position in which she found herself in India.

Ultimately, Loch's story is a sad one. She suffered a stroke in 1901 at the age of 47, whilst on active service in India. It is difficult to avoid the conclusion that Loch's work contributed significantly to the breakdown of her health. Her Memoir resonates with a sense that she found herself living a life of strife and difficulty which could only be overcome by a determined and persistent struggle. A letter written home to her sisters in May 1901 addressed a question: "Alice asks, Why do I not come home?" She answers by observing that she must work for five years before she can draw the pension that military service entitles her to, and adds that she feels she cannot let her team of nursing sisters down. They will be "short-handed" all summer and would "feel very sick" if she left.[89] Seven months after writing of her need to stay, Loch became seriously ill. Her close friend and fellow-nurse, Miss. R.A. Betty, wrote to Loch's sister: "Dec 18 – I am writing to you this mail as I grieve to say that dear Cathy is unable to do so...She had a stroke on Friday morning." [90]

In February 1902, having made a partial recovery, Loch returned home to England, and was invited to join the 'Ladies Board' of the India Office – the panel which selected nurses for service in India. For

[86] Sister M.E. Barker, Dalhousie, India, Letter of Appreciation, cited in: Loch 1905, p. 306.
[87] George/Lourdusamy 2023, pp. 347–364. p. 351, p. 356. [88] George/Lourdusamy 2023, pp. 347–64, p.351, p.353.
[89] Loch 1905, p. 284.
[90] Loch 1905, p. 294–295.

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years she harboured a desire to return to 'active service', but a trip to Gibraltar and Tangier convinced her that she would be unable to cope with the extreme weather conditions in India. She wrote to Miss Betty:

> The die is cast! I had to go to the India Office to the Medical Board and it is settled. They were all very nice and kind; however, it is all over and done and nothing makes any difference. It has come so suddenly at the last that I sit most of the time quite a blank...It is horrid to arrive home decrepit, and it is the one thing that from the beginning I had hoped to avoid. Oh! It is very sad, and I have nothing now to do except remember and think over the past delights and glories.[91]

Catharine Grace Loch died on 1 July 1904 at the age of 50. Her physician expressed the belief that "the primary cause of the illness which proved fatal was excessive mental strain acting on a constitution enfeebled by long residence in India."[92]

Florence Nightingale outlived her protégé by six years. Both women had fallen ill whilst working overseas caring for soldiers of the British Army, and both had returned home to England somehow 'broken' by their pioneering work. Loch's illness has never been subjected to the same scrutiny as that of Nightingale,[93] and remains mysterious. It was, nevertheless closely linked by her contemporaries both to the strain caused by overwork, and to conditions in the military hospitals in India.

Loch's tenure as Lady Superintendent of the Indian Army Nursing Service illustrates the enigmatic nature of imperial nursing in the late nineteenth century. In the person of Loch, that nature was a co-mingling of fiery determination, a desire for adventure, unconscious prejudice, deep compassion, and an icily self-composed gentility; or to put it more simply, as M. E. Barker, one of her nursing team in India, declared: she was nothing less than "a brave soldier with a large heart and brain."[94]

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[91] Loch 1905, p. 302.
[92] Loch 1905, p. 304.
[93] Young 1995, pp. 1697–1700.
[94] Sister M.E. Barker, Dalhousie, India, Letter of Appreciation, cited in: Loch 1905, p. 306.

Bibliography

Sources

Hay, Ian: One Hundred Years of Army Nursing. London, Cassell and Company Limited 1953.

Piggott, Juliet: Famous Regiments: Queen Alexandra's Royal Army Nursing Corps. London, Leo Cooper, Ltd. 1975.

Light, Sue: Scarlet Finders. Website available at: http://www.scarletfinders.co.uk/8.html

Loch, Catherine Grace, to Florence Nightingale: Letter dated 24 January 1888. ADD 45808, Nightingale Papers, Vol LXX; Film No: SCH. No. 82416. The British Library, London, UK.

Loch, Catherine Grace, to Florence Nightingale: Letter dated 12 April 1888. ADD 45808, Nightingale Papers, Vol LXX; Film No: SCH. No. 82416. The British Library, London, UK.

Loch, Catherine Grace, to Florence Nightingale: Letter dated 12 June 1888. ADD 45808, Nightingale Papers, Vol LXX; Film No: SCH. No. 82416. The British Library, London, UK.

Loch, Catharine Grace: Our Indian Letter: A Military Hospital in the Hot Weather. In: The Nursing Record, October 7, 1893.

Loch, Catharine Grace: The Indian Army Nursing Service: Candidates. In: The Nursing Record and Hospital World, November18, 1893.

Loch, Catherine Grace, to Florence Nightingale: Letter dated 1 February 1894. ADD 45808, Nightingale Papers, Vol LXX; Film No: SCH. No. 82416.

Loch, Catharine Grace: A Tour of Official Inspection. In: The Nursing Record, May 18, 1895.

Loch, Catharine Grace: The Indian Army Nursing Service, being a paper read at the Nursing Conference, London, June 4, 1896. In: The Nursing Record, September 12, 1896.

Loch, Catharine Grace: A Memoir. Edited by Bradshaw, A.F. London, Henry Frowde, 1905.

Loch, Catherine Grace: Pioneering Nurses. Archives of King's College, London. Website available at: https://kingscollections.org/nurses/j-l/loch-catherine-grace. Accessed March 2023.

Nightingale, Florence: Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army Founded Chiefly on the Experience of the Late War. London, Harrison and Sons, 1858.

Pringle, Angelique, to Florence Nightingale: Letter dated 1880. ADD 14, Nightingale Papers, Vol 47734; 14 [Viewed in the original].

Royal Commission: Report of the Commissioners Appointed to Inquire into the Regulations Affecting the Sanitary Condition of the Army, The Organization of Military Hospitals, and the Treatment of the Sick and Wounded. London, H.M.S.O, 1858.

Royal Commission: Report of the Commissioners on the Sanitary State of the Army in India. London, H.M.S.O, 1863.

Woodham-Smith, Cecil: Florence Nightingale, 1820–1910. London, Book Club Associates, 1972, first published 1915.

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Literature

Atwood, Rodney: The Life of Field Marshal Lord Roberts. London 2015.

Bostridge, Mark: Florence Nightingale: The Woman and Her Legend. London 2008.

Burton, Antoinette: The Trouble with Empire: Challenges to Modern British Imperialism. Oxford 2015.

Cook, Sir Edward Tyas: The Life of Florence Nightingale. London 1913.

Crawford, Paul/Anna Greenwood/Richard Bates/ Jonathan Memel: Florence Nightingale at Home. Cham 2020.

Davin, Anna: Imperialism and Motherhood. In: History Workshop 5 (1978), pp. 9–65.

Dawson, Graham: Soldier Heroes: British Adventure, Empire and the Imagining of Masculinity. London 1994.

Elkins, Caroline: Legacy of Violence: A History of the British Empire. London 2022.

George, Preethi Mariam and Lourdusamy, John Bosco: Trained Army Nurses in Colonial India: Early Experiences and Challenges. In: Medical History, 67 (2023), 4, pp. 347–64.

Gourlay, Jharna: Florence Nightingale and the Health of the Raj. Oxford 2016 (first published 2004).

Hawkins, Sue: Nursing and Women's Labour in the Nineteenth Century. London/New York 2010.

Helmstadter, Carol: Beyond Nightingale: Nursing in the Crimean War. Manchester 2019.

Helmstadter, Carol and Godden, Judith: Nursing Before Nightingale, 1815-1899. London 2011.

Howell, J, Rafferty, A. M. Wall, R; Snaith, A.: Nursing the tropics: nurses as agents of imperial hygiene. In: Journal of Public Health, 35 (2013), 2, pp. 338–41.

Huxley, Elspeth: Florence Nightingale. London 1975.

James, Lawrence, Raj: The Making and Unmaking of British India. London 1998.

Lynaugh, Joan and Brush, Barbara: American Nursing. From Hospitals to Health Systems. Malden/ Massachusetts 1996.

Macfarlane, Iris: Daughters of the Empire. A Memoir of Life and Times in the British Raj. Oxford 2006.

McDonald, Lynn (ed.): Florence Nightingale: Extending Nursing. Waterloo/Ontario 2009.

McDonald, Lynn: Florence Nightingale at First Hand. London 2010.

McGann, Susan: The Battle of the Nurses. London 1992.

McPherson, Kathryn: Bedside Matters: The Transformation of Canadian Nursing, 1900-1990. Toronto 1996.

Moore, Judith: A Zeal for Responsibility: The Struggle for Professional Nursing in Victorian England, 1868–1883. Athens/London 1988.

Nelson, Sioban: Say Little, Do Much: Nursing, Nuns and Hospitals in the Nineteenth Century. Philadelphia 2001.

Nelson, Sioban/Anne Marie Rafferty: Notes on Nightingale: The Influence and Legacy of a Nursing Icon. Ithaca 2010.

Paris, Matthew: Warrior Nation: Images of War in British Popular Culture 1850–2000. London 2000.

Porter, B.: The Absent-Minded Imperialists: Empire, Society and Culture in Britain. Oxford 2004.

Rafferty, Anne Marie/Diana Solano: The Rise and Demise of the Colonial Nursing Service: British nurses in the Colonies, 1896-1966. In: Nursing History Review, 15 (2007), 1, pp. 147–54.

Rana, Rajkumar: A Brief History of the Beginning of Military Nursing Service in Colonial India During Late Nineteenth Century. In: Anudhyan An International Journal of Social Sciences 7 (2022), 1, pp. 209–216.

Reverby, Susan: Ordered to Care: The Dilemma of American Nursing, 1850–1945. Cambridge 1987.

Said, Edward W.: Orientalism. New York 1978.

Sen, Amartya: Development as Freedom. New York 1999.

Sen, Amartya: The Argumentative Indian: Writings on Indian History, Culture and Identity. London 2006.

Sen, Amartya: Illusions of Empire: Amartya Sen on What British Rule Really Did for India. In: The Guardian 29 (2021), June.

Summers, Anne: Angels and Citizens: British Women as Military Nurses, 1854–1914. Newbury 2000 (first published 1988).

Sweet, Helen/Sue Hawkins (eds.): Colonial Caring: A History of Colonial and Post-Colonial Nursing. Manchester 2015.

Thompson, Andrew: Writing Imperial Histories. Manchester 2014.

Vallee, Gerard/Lynn McDonald (eds.): Florence Nightingale on Health in India. Waterloo/Ontario 2006.

Vallee, Gerard and McDonald, Lynn (eds.): Florence Nightingale on Social Change in India. Waterloo/Ontario 2007.

Vicinus, Martha: Independent Women: Work and Community for Single Women, 1850–1920. London 1985.

Young, D.A.B.: Florence Nightingale's Fever. In: British Medical Journal 311 (1995), pp. 1697–1700.

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DIARIES OF DISTRICT NURSES IN THE NETHERLANDS FROM THE 1970s

Mia Vrijens

Abstract

In 1970 the Nederlandse Bond van Wijkverpleegsters (Dutch Association of District Nurses) decided to start a study project to counter the dominant image of district nurses, which was too much about washing patients and taking care of babies. They believed this image prevented them from being invited to sit on various boards and committees. The study project requested district nurses to keep diaries about their work, focusing specifically on the importance of the highly complex care they delivered in order to demonstrate their professionalism.

Fifteen of those diaries were found in the archive of the Museum for Nursing History FNI (Florence Nightingale Institute), the Dutch knowledge center and virtual museum on the history of nursing and care, in fall 2022. This find opened up a totally new perspective on district nursing in the 1970s but also provided new insights: Some work-related issues were already present 50 years ago and had not changed in the ensuing years.

Keywords: nursing history, district nursing, diary, 1970s, the Netherlands

1 DISTRICT NURSING DIARIES

In 1970 the Dutch Association of District Nurses (Nederlandse Bond van Wijkverpleegsters) initiated a study project which invited district nurses to keep work diaries to counter the general image of district nurses. They believed that the overall image of district nurses in the Netherlands was too much about washing patients and taking care of babies. The association and its members assumed that this image prevented them from being invited to sit on various boards and committees. The solicited work diaries were intended to demonstrate specifically the district nurses' professionalism in performing tasks of highly complex care.

During fall 2022, the archive of the Museum for Nursing History FNI (Florence Nightingale Institute), the Dutch knowledge center and virtual museum on the history of nursing and care, found 15 of those diaries in its collection. Up until that moment these diaries were unknown to the FNI. The diaries provide a new perspective on district nursing in general but also new insights, revealing that some work-related issues were already present back in the 1970s and had not changed in 50 years.

This find is important for further research for three reasons: First of all, the diaries could be used as a starting point for the current oral history project that the FNI is conducting. Retired Dutch district nurses could respond to the descriptions and say whether they agree/disagree and explain how they see themselves in relation to their work. Second, the (brief) descriptions of daily life routine in the

various districts provide insights into the differences between urban and rural areas, between areas with an elderly population and those with predominantly young families, and regarding relationships in the early 1970s in the Netherlands. For example, they demonstrate how loneliness and individualism are not merely a current-day issue but existed back then too. They also show changes in society, where a single mother was commented on, and the working class was dominated by men. Third, and this is the main argument of this article, is that these diaries or weekly journals show two contradictory aspects of the image of district nursing in the Netherlands. On the one hand, the district nurses do not want society to see them as only washing patients and caring for babies. On the other hand, when referring to their tasks, they mention washing patients and taking care of babies without context, which means it still appears as though these tasks dominate their weekly routine. In this regard, the district nurses who wrote the diaries were less aware that they themselves were portraying the dominant image.

The details in the descriptions of work tasks performed during the day do present an image of an all-round professional because the nurses mention their great knowledge of complex care but also the societal tasks involved in preventing the deterioration of personal circumstances, such as housing, a lack of a social support network, or even domestic violence. It is understandable that the association wanted to portray and convey this professional image to the public, but did they succeed through this diary project? One could argue that they did, but one could also argue that they did not. This is the question at the center of our research: Were the diaries beneficial in helping to change the image of district nurses in the Netherlands?

In this article, the various descriptions of work tasks are analyzed by looking at the differences between the areas where the district nurses worked and how these various tasks are described, and assessing whether they actually perpetuate the image the association was trying to counteract. The overall history of district nursing in the Netherlands is described in Section 2, followed by an explanation of the diaries' context in Section 3. Section 4 analyzes the content of the diaries, while Section 5 deals with relevance and research after the find, before Section 6 presents a conclusion.

2 THE HISTORY OF DISTRICT NURSING IN THE NETHERLANDS

District nursing in the Netherlands is a system of private nursing and health care offered outside of hospital care. Although it is similar in its structure and education program to that of other countries, one major difference, which makes the district nursing system in the Netherlands unique, is that historically it is organized along denominational lines. Religious and non-religious groups in the Netherlands, such as Protestant, Catholic and non-denominational groups, organized their own public health care support systems and membership through separate district nursing organizations.

During the 19th century, access to the health care system of the Netherlands meant access through financial means. Both for the 'haves' and 'have nots', access to the health care system was predominantly a matter of money. Affluent people could afford to pay for private care by women who would

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take care of the sick, comfort both the patient and their family, and offer companionship. Less affluent people with no resources were not able to hire private care and were left at the mercy of charity care, which was first and foremost offered by churches or religious organizations.[1] As health care was still organized around care and not cure at the beginning of the 1800s, this health care was limited to the final stages of diseases and did not encompass prevention or healing until the Epidemic Diseases Act of 1872.[2]

As was the case in the rest of Northwestern Europe, industrialization had a tremendous effect on cities in the Netherlands in the 19th century. As factories attracted people from the countryside, families searching for work inundated the cities. These cities, most of which still had medieval street layouts, sometimes still with walls marking the original city boundaries, were not able to cope with this influx of people. Housing situations deteriorated quickly. A lack of running water, proper sewer systems and overcrowded houses led to a situation in which infectious disease such as smallpox, cholera and tuberculosis could flourish and spread easily.[3] Public health was at stake and in the Noord-Holland region (Hilversum and the surrounding area) Dr. Penn, a physician and infectious disease inspector, set up an organization in 1875 which would mark the start of the district nursing system in the Netherlands.[4] The goal of this 'cross organization' *(kruisvereniging)* was to start prevention work to fight the spread of epidemic diseases. The name White Cross (Witte Kruis) was inspired by the Red Cross organization that assisted the injured during armed conflicts.[5]

Women were hired to visit poor neighborhoods for prevention work and to instruct families on how to improve their health. After only a few years, the White Cross started its training program for nurses, which marks the beginning of education for district nurses. As the White Cross organization spread and founded local organizations in the urban parts of the Netherlands, it was copied from 1900 onwards in other parts of the Netherlands as well, and new organizational structures arose. These newcomers, the Green Cross (Groene Kruis), Orange Green (Oranje-Groen) Cross and White Yellow (Wit-Gele) Cross, would merge into one organization by the end of the 1970s.[6] Although each group's denomination – Protestant in the case of Orange Green and Catholic in the case of White Yellow – was mentioned in their nurse contracting policies, the tasks performed by the district nurses were the same everywhere and were regularly described as care from cradle to grave. In general, the main tasks were considered to be: care of patients at home, care of mother and child, fight against tuberculosis, and mental health care. However, mental health care tended to be considered one of the tasks of the denominational cross organizations.[7]

District nurses in the Netherlands mostly lived in the district in which they worked. It was not very common for men to work as (district) nurses.[8] Work contracts stopped when nurses got married,[9] and training was facilitated through the various district organizations themselves until an official nursing education program was launched in 1972, which included 'district nursing' as one of its fields of specialization. In the early 1970s, there were approximately 1,500 cross organizations, and their membership comprised over half of the Dutch population.[10]

[1] Daalen/Gijswijt-Hofstra 1998, p. 127.
[2] Rensman/van den Schoor 2013, pp. 10-12.
[3] Jamin/ Carbo/ Michon 1999, p. 11.
[4] Jamin/ Carbo/ Michon 1999, p 15.
[5] Jamin/ Carbo/ Michon 1999, p 14.
[6] Jamin/Carbo/Michon 1999, p. 164.
[7] Huige 2011, p. 143.
[8] Daalen/Gijswijt-Hofstra 1998, p. 125.
[9] Until the Handelingsonbekwaam ('Incapacity') Act was abolished in 1956, married women were legally barred from working. After the abolishment of this act, women were no longer restricted officially, but socially it still took a while for married women in the Netherlands to take on jobs.
[10] Jamin/Carbo/Michon 1999, p. 167.

3 THE CONTEXT OF THE DIARIES

Strong images dominate the descriptions of the work of district nurses in the Netherlands up until today. Images like the support stocking and bicycle are still dominant, and weighing babies and washing patients are frequently mentioned when summarizing tasks. As the district nurses themselves were aware of and frustrated by this dominant image, they decided to address it during a study day in 1969. The Dutch Association of District Nurses noted "that district nurses were not invited for meetings about public health care and that even school nurses were invited instead of them". They thought this had to do with the fact that "the district nurses are only known for caring for babies and washing patients and not for the highly complex health care tasks they performed".[11]

In the following year, 1970, a study project set out to obtain more clarity about the professional identity of district nurses.[12] Its goal was to investigate how the work of the district nurses was perceived in society and to describe and keep track of tasks performed to enforce an image of professionalism. Thereafter, the Dutch Association of District Nurses asked all regional circles to collect examples of the health care issues encountered in daily practice by keeping work diaries.

Like any other museum depot, the FNI depot is used to store not only objects, but also various archives, in particular of nursing organizations and representation boards connected to nursing history. Mostly, these archives contain minutes of meetings, agendas, letters and reports. Amongst the usual files of policy papers, minutes and reports, these diaries are exceptional. The format, typed A4 sheets of plain paper, is easily overlooked since there is nothing to distinguish them from any other report, policy paper or minutes. No other files similar to or connected to these diaries have been found in the FNI depot since this find.

In total, the find consists of 15 diaries, 164 pages of A4, mostly typed, with only one diary being handwritten. The paper copies of all 15 diaries look the same, so they are not even the original ones but most likely xeroxed on the same machine. The accompanying letter offers 15 diaries but also mentions that more will be sent in the future. In an accompanying file there is a two-page document reflecting on the progress of the study project towards its goal of gathering information and documenting the work of the district nurses to debunk the idea that they only take care of babies and wash patients. It discusses how to proceed and motivate some of the circles to hand in diaries.

The length of the diaries varies between three and 29 pages each. This has to do with the fact that some district nurses tend to write in an anecdotal style, while others enumerate tasks. The diaries mostly cover two weeks in the summer of 1970 or 1971, specifically in July/August. It is likely that this was a most convenient period of the year to keep diaries due to the Dutch summer holiday season – a time when additional administrative chores, such as writing diaries, could be completed. The diaries underline the degree of autonomy enjoyed by the district nurses when faced with regulatory pressure. One author sighs that one week was already too much, and that she does not have the courage to continue writing the diary for another week.[13] Another notes on Thursday August 20: "necessary day off".[14]

Diary number 12 is the only one that is handwritten and the copy is not very bright, making it hard to read. Diaries number 3 and 5 are identical, but not direct copies. The layout is different and some

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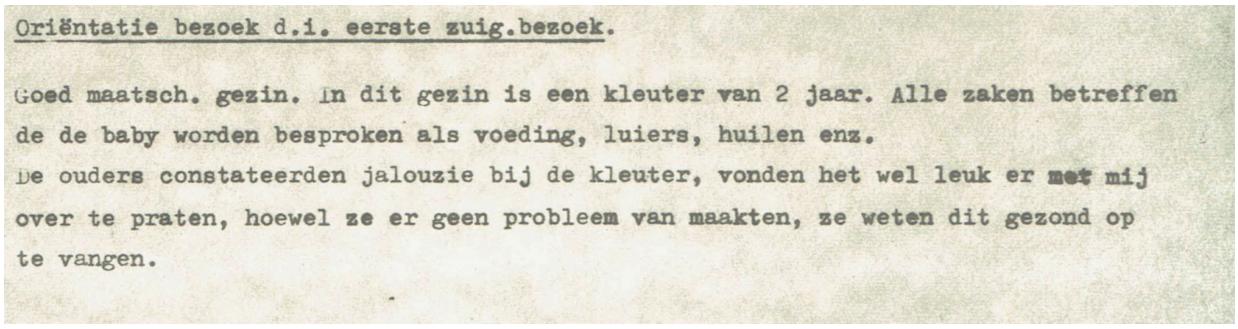
[11] Verslag bijeenkomst studieprojecten dagboeken van Ned. Bond Wijkverpleegsters, 15 May 1971, pp. 1–2, p. 2.
[12] Verslag bijeenkomst studieprojecten dagboeken van Ned. Bond Wijkverpleegsters, 15 May 1971, pp. 1–2, p. 1.
[13] Diary no. 15 of 15 (1970–1971).
[14] Diary no. 4 of 15 (1970–1971).

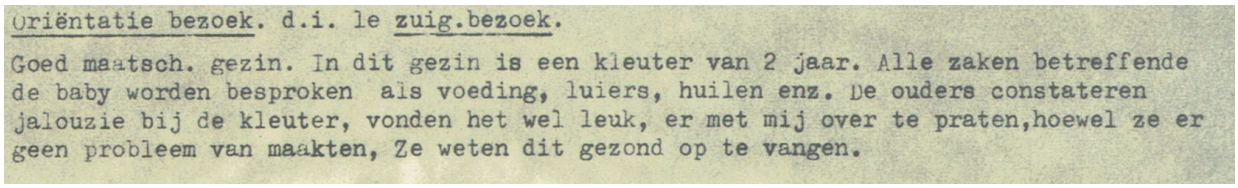
typos are corrected but content-wise both documents are completely identical. The file accompanying the find explains that original diaries would be typed at the head office, so one diary was typed up twice, maybe by accident, since no other reason was found (compare the similarity of photos of diaries 3 and 5).

After the find, the files were scanned and stored as PDF files for research purposes only. They are not filed publicly because some of the documents contain personal information. The numbering of the diaries (1 to 15) was done by the FNI and refers to the order of the find. It therefore ignores the fact that diaries 3 and 5, as mentioned above, are identical.

Photos of diaries 3 and 5


Oriëntatie bezoek d.i. eerste zuig.bezoek.

Goed maatsch. gezin. In dit gezin is een kleuter van 2 jaar. Alle zaken betreffen de de baby worden besproken als voeding, luiers, huilen enz.
De ouders constateerden jalouzie bij de kleuter, vonden het wel leuk er met mij over te praten, hoewel ze er geen probleem van maakten, ze weten dit gezond op te vangen.


Oriëntatie bezoek. d.i. le zuig.bezoek.
Goed maatsch. gezin. In dit gezin is een kleuter van 2 jaar. Alle zaken betreffende de baby worden besproken als voeding, luiers, huilen enz. De ouders constateren jalouzie bij de kleuter, vonden het wel leuk, er met mij over te praten,hoewel ze er geen probleem van maakten, Ze weten dit gezond op te vangen.

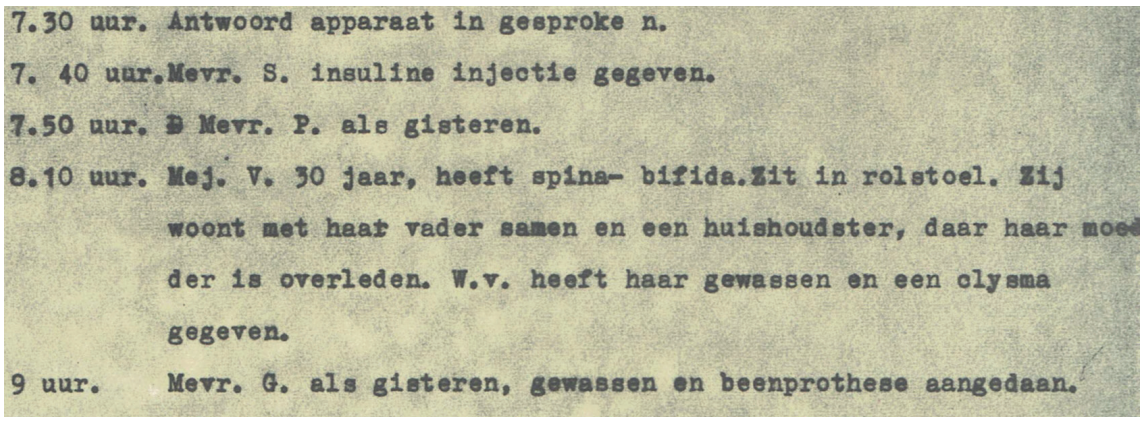
Good social family. In this family, there is a toddler of 2 years old. All matters concerning the baby are discussed such as feeding, diapers, crying, etc. The parents observed jealousy in the toddler, found it nice to talk to me about it, although they didn't make a problem out of it, they know how to handle this healthily. (Text translation by ChatGPT)

4 THE CONTENT OF THE DIARIES

Although the diaries were solicited and written while the nurses were going about their daily practice, apparently no further instructions were given on how to write them as they appear to vary strongly both in style and content. The anecdotal, descriptive ones give insights into the tasks performed, sometimes adding brief, opinion-style reflections on the (home) situation of the patient. These short personal notes reflect the moods of patients and the mood of the district nurse involved, for example whether they were agitated, irritated, tired or relieved. Most comments suggest either physical

reactions (tired) or mental reactions (agitated) to situations encountered by the district nurses. The business-style ones include hardly any personal comments or reflections on the task performed (example diary 7). One possible explanation is that the district nurses were used to writing patient records in a professional way with limited options for reflection on their own emotional state of mind.

Diary 7



7.30 uur. Antwoord apparaat in gesproke n.
7. 40 uur. Mevr. S. insuline injectie gegeven.
7.50 uur. Mevr. P. als gisteren.
8.10 uur. Mej. V. 30 jaar, heeft spina- bifida. Zit in rolstoel. Zij woont met haar vader samen en een huishoudster, daar haar moeder is overleden. W.v. heeft haar gewassen en een clysma gegeven.
9 uur. Mevr. G. als gisteren, gewassen en beenprothese aangedaan.

7.30 am The answering machine message was recorded

7.40 am Administered an insulin injection to Ms. S

7.50 am Ms. P. as yesterday.

8.10 am Ms. V, 30 years old, has spina bifida. She is in a wheelchair. She lives with her father and a housekeeper since her mother passed away. The district nurse has bathed her and administered an enema.

9 am Ms. G, as yesterday, was washed and her leg prosthesis put on.

(Text translation by ChatGPT)

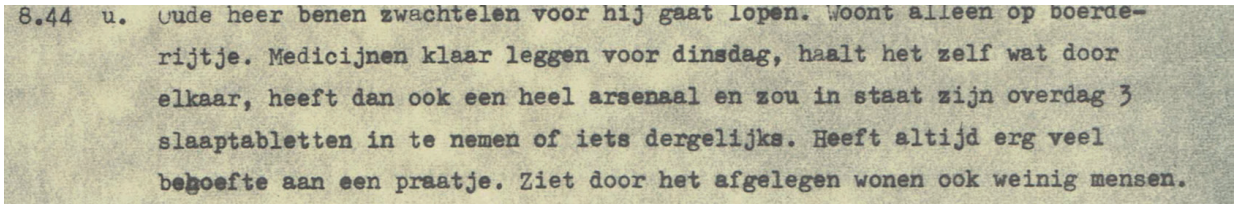
Locations cannot be distinguished unless they are explicitly mentioned. In one of the diaries (diary 1), names of small villages in the border region of Friesland/Groningen are explicitly mentioned as well as the names of the patients or streets, so this diary would be affected by privacy issues. Other diaries only explicitly mention the province, but the specific areas or villages are not made public. Some diaries mention names but the districts are impossible to identify.

Some diaries include time records (e.g. diary 7). From these records it is clear that all the nurses have an early start (working days started around 7.30/7.45 am) and rather long days, with some tasks in the evenings and/or on weekends. They mention lunch breaks of 1–1.5 hours. Looking closely at the descriptions of the lunch breaks, however, we find frequent mentions of other related tasks being performed during them. These include administrative tasks like telephone calls and (membership) administration.

Some explicit details provide an indication of the demographics or socioeconomic situation of the district in question. For example, diaries that describe districts with more elderly people living in farmhouses indicate that these are located in rural areas. Contrasting with these are diaries written by district nurses who provide care to (young) mothers and their babies. Fathers are only mentioned as being at work, or absent in the case of a single mother or a 'shotgun' marriage. In rare occasions, diaries mention disturbing situations, like a father having recently been released from prison or a mother who cannot handle the new situation raising a baby on her own, and in which the district nurse is worried about the safety of little children but also of the mother herself.

In the (brief) comments about family and baby care, all the diaries give an indication of the district nurses' opinion of the home situation. It becomes very clear that these differences in demographics require different care tasks to tackle health care issues. Rural locations with farmhouses can be inferred when a diary mentions elderly people with a grown-up single child still living at home, and this is different to a city-like description of a mother alone with a new-born child in a flat. Some of the problems mentioned in relation to the situations of elderly people, like loneliness, lack of support from family and staying at home, are surprisingly identical to the health care topics being discussed in the Netherlands at the moment (example diary 8).

Diary 8


8.44 u. Oude heer benen zwachtelen voor hij gaat lopen. Woont alleen op boerderijtje. Medicijnen klaar leggen voor dinsdag, haalt het zelf wat door elkaar, heeft dan ook een heel arsenaal en zou in staat zijn overdag 3 slaaptabletten in te nemen of iets dergelijks. Heeft altijd erg veel behoefte aan een praatje. Ziet door het afgelegen wonen ook weinig mensen.

8.44 am The elderly gentleman's legs are bandaged before he starts walking. He lives alone on a small farm. Set out medications for Tuesday; he mixes them up a bit himself, so he has quite an arsenal and might be able to take three sleeping pills or something similar during the day. He always craves conversation. Due to his remote living situation, he also sees few people. (Text translation by ChatGPT)

A few specific notes can be made. Firstly, descriptions of means of transport and distances are found in hardly any of the diaries. In diary 8, driving is explicitly mentioned in time slots of a few minutes, and diary 13 mentions beginning the day with starting the car engine. Secondly, the diaries sometimes mention handling objects like instruments, but not in a descriptive way, merely as a tool. Thirdly, none of the diaries mentions the religious denomination of the organization or specifies the background of the district organization. A first conclusion that can be drawn is that working for an organization was not material to the professional identity of district nurses. Fourthly, all diaries still use the word patients and not clients, which is more common nowadays.

5 AFTER THE FIND – FURTHER RESEARCH AND RELEVANCE

The two-page file accompanying the diaries refers to a meeting on 15 May 1971 during which the project's progress was discussed. The aim of the study project was to analyze the data of ten diaries per province: 10x11=110 diaries of unknown length. By the time of the study day in May 1971, only 25 diaries had been handed in and this number was considered too small. The 15 diaries of this find, dated summer 1970 and 1971, can only represent a part of the total of 25 diaries collected earlier and mentioned in May 1971. Responses from several regional boards show that, in some regions, opinions of the project were quite negative – they did not see the relevance of this locally collected material and would have preferred a more national, overarching approach. As there was no majority opinion and some regions had a positive view of the project, the document concludes that they would like to put out a new call to hand in diaries. Additionally, the meeting decided to organize a national conference to elaborate the project's findings in a follow-up project in January (1972 presumably).

The offer letter accompanying the diaries is the most confusing part of the whole find. It is very unclear who sent the diaries to whom. From the village of Schiedam, this batch of 15 diaries (and a promise: there are five more to be sent later) was sent to Amsterdam, to a nurse working at the Cultural Information and Service Center Amsterdam (CISCA). It is not clear whether CISCA was at that moment connected in some sort of way to the Dutch Association of District Nurses because there are records showing that this Nurses' association ceased to exist in 1974. So it is very likely that no formal conclusions were drawn by the end of the study project. It is unclear whether this has to do with the merging of the association, or whether there were simply too few files to analyze, or a lack of manpower to finalize the project. Additionally, it is impossible to tell whether the other five promised diaries were ever sent.

When examining the diaries' content, one thing stands out: It is clear that the district nurses are required to be highly flexible and their view on societal issues is tremendously thorough, but it is less clear whether they provide highly complex care. The purpose of logging the tasks performed was to demonstrate the professionalism of district nursing as a profession. This is achieved through descriptions of the variety of the nurses' tasks and responsibilities in a vast range of health care-related areas. However, although the diaries reflect the breadth of the tasks, they are less clear on the high degree of complexity, as these references mostly relate to diabetes injections, washing patients and bandaging the legs of elderly people. It is unclear why the medical and technical tasks are not made more explicit. One explanation might be that the medical and technical aspects are either subject to privacy restrictions, or that it is taken for granted that the readers will be peers and will know that if someone needs treatment X or Y, certain medical and therefore technical tasks will automatically be performed. Another possible but very simplistic conclusion could also be that the district nurses had an inflated sense of the complexity of their tasks.

Analyzing the 14 diaries does not give a straightforward answer and leaves us with an ethical question: Were the district nurses actually performing highly complex care tasks? One of the remarks in diary 2 is quite explicit on this point. The patient is suffering from a hernia and keeps lying in bed although the doctor's prescription is to exercise. The district nurse who discovers this situation manages to

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convince the patient to exercise and this quickly improves the recovery process. The interesting part is that the district nurse needs to 'convince the patient' and demonstrate her expertise. This reflection on the work and its implications shows that the district nurse was a professional. While performing the task of 'washing the patient', the aspect of full care and recovery is addressed properly, with the nurse taking an overall view of the situation, whether it be the circumstances of the patient's living conditions, e.g. hygiene, or the social dimension, which could support or limit a full recovery.

As the anecdotal accounts do not describe the tasks performed in full and leave out the complexity involved, this raises the following (ethical) question: Were nurses not able to address this aspect properly on paper, or was the care not complex? To illustrate, one could assume that even if a patient was too ill or wounded to be touched by anyone besides a professional, the general task performed could be summarized as washing the patient. This would still not fully describe all the implications involved, such as ensuring that bandages covering the wound were replaced properly, and would not detail any additional steps that had to be taken to be able to wash the patient.

Additionally, the high degree of complexity of the work of district nurses is fully reflected in the diversity and social aspects of the work they did to support the patients socially and watch over them. There are several mentions of combining a personal coffee break with having coffee with the patient. The nurses' sensorial approach – being professional 'eyes and ears', and not merely automatons – is something that should not be ignored. The administrative workload and the extra work mentioned, for example in connection with contacting a housing corporation or municipality, are not tasks that demonstrate medical skills, but could be considered care-related soft skills that unofficially form part of a district nurses' job description. The invisibility of those skills has to do with writing for peers in which it is taken for granted that those tasks were done, but maybe also with modesty when working autonomously, as district nurses mostly did. The doctor or hospital colleagues do not see the full complexity of the district nurses' work directly themselves, and perhaps take it too much for granted, so that district nurses do need a sense of their own worth to fight for their existence. However, it is not clear whether the diaries were successful at this level.

Physically, the diaries are not the original documents (as they have been typed up and photocopied) but, in terms of content, the documents are original, simply because no other documents of this kind are known to exist. District nurses did write ego documents like letters and postcards or photo albums and shared them with the FNI. The diaries found here, however, are unique since they were written during the same period, which makes them comparable, although individual details like wording differ. There are in total 14 different districts to compare. The importance and use of this find as a historical source lies in the fact that (technical) descriptions of work are only known through protocols and hardly any descriptions of practical day-to-day routines have been documented, meaning they were unknown up until this find.

These lost & found objects are valuable historical sources of the history and ethics of nursing care and add to the research in three ways. Firstly, the documents add a historical point of view, giving insights into the position of district nurses in Dutch society in the early 1970s by showing how they organized themselves and came up with this study project. Secondly, the diaries give quite a thorough insight into the technical aspects of the workload and the varied tasks involved, whether medical and

technical tasks, or the social aspects of the work. Although the entries are limited and do not always provide full details, it is clear that the district nurses in the early 1970s really did work as 'all-round' district nurses, and this emphasizes their ability to move quickly from one situation to another, which is different from work in a hospital, where one is assigned to one ward with e.g. a cardiological focus. Lastly, the brief reflections on the work, especially the situations encountered by the district nurses in the various households and the tasks performed, provide an insight into their views regarding the ethics of the work of public health in general and nursing care in particular.

6 A LAST FIND: THE FULL CONTEXT

After this article was submitted to ENHE, another discovery was made, which completes the context of the diaries. No additional diaries were found, but when checking the monthly magazine of the Dutch Association of District Nursing for details of the study day in 1969, it became clear that this was the first time the association had organized a themed day and it was new to all the participants. They were invited to reflect on the work and professional identity of district nursing in the Netherlands. As no formal conclusion was drawn concerning the professional identity and work of district nurses due to the variety of opinions, a decision was taken to start a study project involving diaries. The study project was initiated in 1970 but it lingered on. There are reports that not enough diaries had been sent in and that the board kept requesting more and emphasizing their importance.

When checking the magazines published between November 1969 (the study day) and November 1974, when the association merged with other district nursing organizations and the magazine ceased to exist, it becomes clear that up until May 1973, the diaries and the project are mentioned in the reports of the board on an irregular basis. It also becomes clear that the total number should be 45 separate diaries handed in. According to the reports, the diary project was delayed due to the typing process, and administrative support provided by the secretary of the board was limited because of illness and delayed for a year.

In May 1973, the typing and analyzing process was completed and the study committee intended to discuss it further. After that report, there are no further comments until September 1974, when one of the nurses involved in the study committee mentions that it is such a shame and waste of effort that nothing has been done with the diaries. The board decides to put it on the agenda for their closing and dissolution meeting and a final account is found in the magazine of November 1974. This mentions that there were 'about 40 diaries' and that the decision had been taken to send some of them to a district nursing education program to have a student write a report on the outcomes. As the education programs were being restructured, the diaries were sent back, and no report was made.

After a new review, the board notes that the diaries do not mention the restructuring of local cross organizations in the health centers and notes that this could provide interesting additional input for discussion by new committees involved in the restructuring and regionalization of district nursing. The board invites the district nurses to participate in these committees, saying the diaries could most

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probably be used as source material for those groups.[15] One of the explanations for the 15 diaries in the find could be that they were the ones that were sent to the education program for a report, hence the accompanying letter of April 1973, and were then sent back to the association. However, this is not yet definite and, up until today, summer 2024, the other 25–30 diaries mentioned have still not been traced.

7 CONCLUSION

The diaries are a very valuable find, although unfortunately not a complete one, since not all of the diaries mentioned have been rediscovered and there are some unanswered questions, which might never be solved. However, the existence of these diaries is already relevant and gives voice to the 'lack of understanding' or 'lack of involvement' of district nurses in the public debate. As mentioned, district nurses were not automatically invited to official meetings to which other (nursing) professionals were invited, indicating the outsider position which they held and continue in some sort of way to hold to this day. Working (and living) in the various districts, the district nurses are the first to observe and report societal changes and their effect on public health situations and standards.

The diaries reflect the day-to-day work at the time, which is sometimes comparable to the work of district nurses today and sometimes different. There are similarities that reflect the fact that the position of district nursing in general is still taken for granted. These hard-working professional women (and men nowadays) are the eyes and ears of society because they are the only ones entering the homes of people from all sectors of society on a regular basis. The situations they encountered in the 1970s are comparable to the situations encountered today and reflect societal issues like the loneliness of elderly patients, insecure mothers with babies alone at home, the workload and the administrative burden.

The importance of this find for the Museum for Nursing History FNI (Florence Nightingale Institute) collection is high. The diaries give a snapshot of a period in the early 1970s before the advent of material changes (the use of disposable materials) and societal changes (women going out to work). This article demonstrates that the work of the district nurses in participating in the study project and writing down their experiences will be saved for future research purposes.

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[15] Bondsnieuws November 1969 until November 1974 (monthly journal of the Dutch Association of District Nursing)

BIBLIOGRAPHY

Archival Sources

Archive of the Museum for Nursing History FNI (Florence Nightingale Institute)

Bondsnieuws, Orgaan van de Ned Bond van Wijkverpleegsters (Amsterdam, November 1969 until November 1974) (monthly journal of the Dutch Association of District Nursing)

Diaries of the Identity of District Nurses project filed under numbers 1 to 15 (1970–1971)

Verslag bijeenkomst studieprojecten dagboeken van Ned. Bond Wijkverpleegsters, 15 May 1971

Secondary Literature

Allen, Davina: The Invisible Work of Nurses: Hospitals, Organisation and Healthcare. Routledge Advances in Health and Social Policy. Abingdon, Oxfordshire 2016.

Daalen, Rineke van/Marijke Gijswijt-Hofstra (eds.): Gezond En Wel: Vrouwen En de Zorg Voor Gezondheid in de Twintigste Eeuw. Amsterdam 1998.

Fealy, Gerard M.: "The Good Nurse": Visions and Values in Images of the Nurse. In: Journal of Advanced Nursing 46 (2004), 6, pp. 649–656. https://doi.org/10.1111/j.1365-2648.2004.03056.x

Hallam, Julia: Nursing the Image: Media, Culture and Professional Identity. London 2012. https://doi.org/10.4324/9780203136027

Huige, Jan J.C.: Van kruiswerk tot thuiszorg: de moeizame strijd voor erkenning van een boeiende maar complexe werksoort in de periode 1946–1990. Bunnik 2011.

Jamin, Hervé/Christa Carbo/Yolande Michon: 125 jaar thuiszorg: oude tradities en nieuwe ambities: 1875–2000. Baarn 1999.

Rafferty, Anne Marie: The Politics of Nursing Knowledge. London/New York 1996.

Rensman, Eva/Leonie van den Schoor: Zuster over de vloer: thuiszorg, toen en nu. Bunnik 2013.

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