

UNIVERSITY OF SOUTHAMPTON

A Biographical Investigation of the Nightingale School  
for Midwives

By

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Doctor of Education

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ABSTRACT

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The thesis considers primary, contemporaneous documents and secondary sources concerning Florence Nightingale, her motives and experiences with the profession of midwifery. The thesis sets Nightingale within her family context and that of mid Victorian England, drawing on previous biographies, an autobiographical account (*Cassandra*), historical evidence and literature. The main events investigated take place following her return from the Crimean War and are focused on the work of Nightingale in relation to the profession of midwifery, childbirth, infection and maternal mortality, placing Nightingale in the English and European nineteenth century midwifery context and investigating the rationale for the commissioning of the Nightingale School for Midwives at King's College Hospital, London in 1862 followed by its subsequent closure five years later and the publication of *Notes on Lying-in Institutions* in 1871. The two events are linked, although the focus of the research is an investigation of evidence to substantiate Nightingale's reason for commissioning a training school for midwives. Evidence is ascertained through life documents including biographies, letters and other contemporaneous documents written by and to her or pertaining to the work, in particular, of the Nightingale Fund. These are reviewed using the biographical method and Nightingale's rationale is finally exposed within a complex web of personal and organisational inter-relationships.

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## GLOSSARY

**Accoucheur** - an obstetrician or midwife, one who is present at the bedside

**Direct Maternal Deaths** - deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from intervention, omissions, incorrect treatment or from a chain of events resulting from any of the above (ICD 9, cited in Lewis 2001, p. 7)

**Eclampsia** - (Toxaemia) a toxic condition of unknown cause, occurring in a pregnant or puerperal woman, characterised by high blood pressure, abnormal weight gain, protein in the urine and convulsions

**Erysipelas** - an acute streptococcal infectious disease of the skin, characterised by fever, headache, vomiting and purplish raised lesions

**Indirect Maternal Deaths** - deaths resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy (ICD 9, cited in Lewis 2001, p. 7)

**Late Maternal Deaths** - deaths occurring between 42 days and 1 year after termination of pregnancy, miscarriage or delivery that are due to direct or indirect maternal causes (ICD10, cited in Lewis 2001, p. 7)

**Lochia** - vaginal discharge of cellular debris, mucus and blood following childbirth

**Maternities** - the number of mothers delivered of registrable live births at any gestation or stillbirths of 24 weeks of gestation or later, i.e. these are the majority of women at risk of death from obstetric causes (Lewis 2001, p. 8)

**Metritis** - inflammation of the uterus

**Miasma** - pollution in the atmosphere, especially harmful vapours from decomposing organic matter

**Nosology** - the science of the classification of diseases

**Puerperal fever** - blood poisoning caused by infection contracted during childbirth

**Puerperium** - the period following childbirth, normally 6 weeks, during which the uterus returns to its pre-pregnant size and shape

**Pyaemia** - blood poisoning characterised by pus-forming micro-organisms in the blood

**Thromboembolism** - the obstruction of a blood vessel by a clot of coagulated blood that has become detached from its original site

## MID-VICTORIAN ENGLAND

*The progressive world is necessarily divided into two classes – those who take the best of what there is and enjoy it – those who wish for something better and try to create it.*

Florence Nightingale (1860) *Cassandra* (Poovey 1992, p. 209).

### Research Focus

The main claim to originality in this work is its concentration upon the education and training of midwives. Although mentioned by other authors, this aspect of Florence Nightingale's work has not received the detailed attention it deserves and warrants. In the light of the forgoing, an original synthesis of existing material on Florence Nightingale's life, time and practices is offered. The work is based on a consideration of primary manuscript sources and extensive secondary material, both integrated within a biographical methodology.

Florence Nightingale was born in Florence on 12<sup>th</sup> May 1820, the second daughter of William and Frances Nightingale. The family had two homes, one in Derbyshire and the other in Hampshire. However they had a fairly nomadic life style moving between homes, going to London for the season and taking extensive tours of Europe. The sisters were educated at home initially by a governess but later by their father (Cook 1913a, Woodham-Smith 1950). Their education went beyond that expected of young Victorian ladies and both girls were well accomplished in many fields. Florence was the more academic of the two sisters and grew close to her father during their study time together, although she found some of his teaching methods frustrating (Cook 1913a, Woodham-Smith 1950).

This thesis contextualises Nightingale's childhood and education, young adult life, spiritual life, her struggle for freedom, her life after the Crimean War and her involvement with hospitals, nursing, childbirth and maternal mortality. It therefore sets her within her family context and also that of mid-Victorian England. The thesis concentrates on the years after the Crimean War when Nightingale has returned to England as a heroine and commenced the secluded life style that she was to maintain until her death in 1910.

It was not until July 1856 – four months after the Declaration of Peace – that Miss Nightingale left Scutari for England. Her reputation was now enormous, and the enthusiasm of the public was unbounded. The royal approbation was expressed by the gift of a brooch, accompanied by a private letter. “You are, I know, well aware,” wrote Her Majesty, “of the highest sense I entertain of the Christian devotion which you have displayed during this great and bloody war, and I need hardly repeat to you how warm my admiration is for your services, which are fully equal to those of my dear and brave soldiers, whose sufferings you have had the *privilege* of alleviating in so merciful a manner. I am, however, anxious of marking my feelings in a manner which I trust will be agreeable to you, and therefore send you with this letter a brooch, the form and emblems of which commemorate your great and blessed work, and which I hope you will wear as a mark of the high approbation of your Sovereign! It will be a very great satisfaction to me,” Her Majesty added, “to make the acquaintance of one who has set so bright an example to our sex.” …

One of her very first steps was to take advantage of the invitation, which Queen Victoria had sent to her in the Crimea, together with the commemorative brooch. Within a few weeks of her return she visited Balmoral, and had several interviews with both the Queen and the Prince Consort.

(Strachey 1918, pp. 38, 43, letter also cited in Cook 1913a, p. 274)

In 1859 Nightingale wrote the first edition of *Notes on Nursing* which was published in December. The following year it was enlarged and rewritten and translated into Italian, German and French. In 1860 the Nightingale Training School for Nurses was established at St. Thomas’s Hospital in London. In the same year George Eliot wrote *The Mill on the Floss* and Wilkie Collins *The Woman in White*. Prince Albert, the Prince Consort, died of typhoid the following year (Mitchell 1988) and Nightingale wrote a cheap, popular edition called *Notes on Nursing for the Labouring Classes*. It was an abridged version of the 1860 edition but contained an added chapter entitled *Minding Baby* (Seymer 1947). It appears, by today’s standards, to be written in a very condescending manner. It is unlikely to have been read that way in 1861. Nightingale was asked to write the chapter by a School Headmaster to help him instruct the girls in his school. She may therefore have been attempting to write the text in a language that the schoolgirls would understand. This must have been quite difficult as she was taught Greek and Latin as a child and wrote very well (Skretkowicz 1992). Nightingale herself was pleased with this edition “I am told that the new Chapter *Minding Baby* in my *Notes on Nursing* is very successful. I think myself it is the best thing I have done” (MS 8998/53). In a letter to her mother on 21st April 1861 she writes:

...the new chapter on ‘Minding Baby’ - which I was ordered to write by a Schoolmaster of Peckham, Mr Shields, who had made my book a text book for his children and said that the girls went home and removed dung-heaps from before their parents doors and opened their parents windows at night, (to the great discomfiture of the latter) but that the ‘strongest motive’ was to tell the girls to do this for the sake of ‘Baby’ – and so I must write a chap. about ‘Minding Baby’

(MS 8999/10).

This chapter was clearly about caring for the baby, but not the newborn, more the growing baby. It advocated fresh air, warmth, cleanliness of body, clothes, bed, room and house, regular feeding with proper food, no shaking of its body, light and cheerfulness and proper clothes for bed and being up (Seymer 1947). This is linked more to Nightingale's interests in sanitary issues rather than maternal and infant care and mirrors her main text, which was also concerned with sanitary issues, hygiene and common sense with regard to nursing adults (Skretkowicz 1992). *Notes on Nursing* was concerned with nursing at home, not in hospital. Most of Nightingale's nursing experience was based in hospitals and mainly in Army hospitals. This would not make her an obvious authority for writing such a popular book. As a young adult Nightingale had contact with various nieces and nephews and visited the local villages around both her family homes in Embley and Lea Hurst (Skretkowicz 1992). This may have given her the knowledge required to write *Minding Baby*.

The thesis considers primary, contemporary documents and secondary sources concerning Nightingale, her motives and experiences with the profession of midwifery. The main episodes take place following her return from the Crimean War between 1859 and 1871 and are focused on two areas; the establishment of the Nightingale School for Midwives at King's College Hospital, London and its subsequent closure and the publication of *Notes on Lying-in Institutions* in 1871. The two events are linked, although the focus of the research is on investigating evidence to substantiate Nightingale's reason for establishing a training school for midwives. Evidence is ascertained through life documents including an ascribed autobiography (*Cassandra*), biographies, letters and other contemporaneous documents written by and to her or pertaining to the work in particular of the Nightingale Fund. Using the biographical method the personal writings and historical documents associated with Nightingale and the midwifery profession are reviewed, taking into consideration issues of the social context of mid Victorian England. The thesis is also set in English and European midwifery contexts, drawing on historical evidence and literature to highlight maternal mortality and puerperal fever, midwifery care, education and the struggle for registration. The documentary analysis indicates reasons for Nightingale's interest in midwifery and her rationale for establishing The Nightingale School for Midwives.

The Nightingale Fund was established from donations given by a grateful public for all the work Nightingale was undertaking during the Crimean War. Baly (1986) states that although the appeal was aimed at all classes of society, the majority of the money came from large individual

donations, mainly from the upper middle class. There were also an unusual number of donations from single women. The Fund was open for twenty months and collected £44,039 by the end of June 1856 when it was closed. The Fund organisers expected Nightingale to use the money to train nurses on her return to England (Baly 1986). Eventually, three years later, the establishment of the Nightingale Training School at St. Thomas's Hospital, London appears to have been thrust upon her, although she did have some enthusiasm for it. She kept a tight control on the Fund, even though there were Trustees. She appears to have managed the Nightingale School from afar, leaving the Matron, Mrs Wardroper to do the recruitment, selection and training of the 15 probationers for each cohort.

Baly (1986) suggests that Nightingale became interested in training midwives because she was aware of the high maternal death rate from puerperal infection in lying-in hospitals and felt that it could be prevented. Instead of using her sanitary knowledge to propose changes of practice in lying-in hospitals she decided to use part of the Nightingale Fund to train midwifery nurses. I can find no evidence to support Baly's (1986) assertion. However Nightingale set up a School to train midwifery nurses at King's College Hospital, London in 1862, although the places allocated were rarely filled. It closed in 1867. The evidence for its closure is complex and confusing. Many different people and organisations were involved and it is easy to see how the confusion has arisen and deepened over the intervening years.

Following the failure of her own midwifery training school Nightingale persistently blocked others attempts to start schools. Smith (1982) suggests that she would not sanction other courses firstly because some were too detailed and then because they were not. She wanted to set up a Government funded midwifery college along continental lines where educated women would be trained to undertake all cases. Smith (1982) further argues that had Nightingale supported a worthwhile training scheme then registration for midwives would have occurred much earlier than 1902 and the first Midwives Act. Nightingale came up against women who wanted to enter medicine and was opposed to this. She could not understand why women would want to imitate and emulate men. The moral right of women to undertake training as doctors, for example, did not interest her. She was of the opinion that women would make third rate doctors but first rate nurses and in her experience there was a shortage of first rate nurses, so women should train to be nurses (Baly 1986, Woodham-Smith 1950).

Nightingale appears to have undertaken extensive research into midwifery in other countries. In one of her letters she writes about the *sage femmes* in Paris and also about midwifery training in St Petersburg (Vicus & Nergaard 1989). She acquires some of her knowledge about European Midwifery training by sending out a questionnaire with 28 sections. The German response is still available (Baly 1986). The section in the thesis Midwifery in Europe is briefly illustrated to highlight the difference between midwives in Britain and Europe and the type of European midwife that Nightingale envisaged training for Britain.

Nightingale attempts to address the puerperal fever death rate following the closure of the King's College Hospital School. She publishes a survey of maternal mortality rates and states that it was safer to have a baby at home than in hospital (Nightingale 1871). She argues that improved sanitation, ventilation and less crowding could prevent maternal deaths. Baly (1986) and Smith (1982) suggest that the general hygiene rules Nightingale proposed helped to reduce the death rates in lying-in hospitals in the following years, even though some of her statistics were suspect and her reasoning wrong. The mortality figures and causes of death from the nineteenth century are critiqued and compared to those of the late twentieth century. Detail is given and critiqued particularly of Nightingale's statistics in *Notes on Lying-in Institutions* (1871) as well as the work of other statisticians and doctors and in particular White, Gordon, Holmes, Semmelweis and Lister. They were not only concerned with chronicling the causes and rates of death but of finding appropriate treatment and more importantly safe preventative measures. Nightingale published *Notes on Lying-in Institutions* in 1871 and the medical journal *Lancet* and the *British Medical Journal* reviewed it and on the whole were both expressing praise (Bishop & Goldie 1962). In the same year Charles Darwin published *Descent of Man* and George Eliot, a woman using a male pseudonym, published *Middlemarch*. Henry Morton Stanley and David Livingstone also met in 1871 at Lake Tanganyika (Mitchell 1988).

Midwifery care in the nineteenth century is also explored to demonstrate the context in which women were cared for during pregnancy, labour, delivery and the puerperium. It is surprising how forward thinking the medical men were in some instances with ideas that have since been supported by research evidence. The history of the education of the midwife is complex. Some of the doctors supported the education of the midwife whilst others fought hard against it because they saw educated midwives as a threat to their practice. By mid nineteenth century the daughters of professional men were being accepted for training as midwives. They had to attend lectures

and undertake examinations, which excluded those who were illiterate. They also had to pay for the training and were confined to normal cases when eventually in practice. Various medical acts restricted training and practice for midwives, particularly female midwives. However lobbying continued especially in the 1890s and almost yearly Bills were defeated in Parliament. Eventually in 1902 the first Midwives Act was passed, which empowered a Board to keep a roll of midwives and framed rules and regulations for training, examinations and practice.

### **A Victorian Kaleidoscope**

Queen Victoria was born on 24<sup>th</sup> May 1819 at Kensington Palace, London; one year before Florence Nightingale's birth. On 20<sup>th</sup> June 1837, Victoria succeeded to the throne and became Queen of the United Kingdom of Great Britain and Ireland and in 1876 Empress of India. Her reign lasted until her death on 22<sup>nd</sup> January 1901 following a short illness (Underwood 1980). Victoria's reign was the longest in English history during which many notable events occurred that mark the time as one of great achievement in British history. This thesis is concerned mainly with the mid-Victorian period defined by Best (1971) as 1851 to 1875. On 1<sup>st</sup> May 1851 Queen Victoria opened the Great Exhibition at the Crystal Palace. This was the start of the golden age of Victorianism and London was the focus of the world. The mid-Victorian era was one of industriousness, honesty, business efficiency and private enterprise culminating in material prosperity and progress both in farming and industry. The mood was buoyant and optimistic and some of the population prospered. However Thomson (1950) suggests that it is misleading to over-emphasise mid-Victorian materialism. Religion and humanitarianism were two other powerful forces inherent to mid-Victorian thought.

The most practised form of Christianity at this time could be considered evangelicism, with the stress on moral conduct as the proof of the righteous Christian. Bible reading in the home was popular and the goal was self-improvement. There was a strict observance of the Sabbath throughout all the varying non-conformist sects within England. The religious census of 1851 reported that of the ten million two hundred thousand people who attended a place of religious worship, five million three hundred thousand attended the Church of England, four hundred thousand attended the Roman Catholic Church and the remainder attended one of the main protestant dissenting churches. The census caused alarm at the time as it showed that over five and a quarter million people, especially in the working class, were non church attenders (Poovey 1992). The various church sects interpreted the data differently. The Anglicans were alarmed at

the strength of the Catholics and dissenters, the Catholics were delighted by the increase in their numbers and the dissenters were dismayed at the scarcity of urban ministries. The census demonstrated that the Church of England no longer represented the majority and that the faithful middle classes were threatened by the growing number of faithless poor. This was disturbing because of the link the middle classes made between godliness and morality (Poovey 1992). Various new movements were started around this time for example the Oxford Movement which was created through the writings of a group of Oriel College Oxford Fellows and emphasised ritual in the church. The Christian Socialists led by F. D. Maurice and Charles Kingsley concerned themselves with current social problems. They tried to Christianise education and supported better education for women, adult schools, and working men's colleges.

Charles Dickens wrote passionately about the social and moral evils of the time. He frequently gave readings of his work ensuring that it reached a wide audience. His novels contained satires and savage critiques on poor law institutions, Chancery, private schools and many other social problems highlighting the injustices in a way that the general public could identify. Through his writings he was able to stress the patience, good nature and good humour of the poor whilst creating both comic and sad characters. His novels painted a vivid picture of working class people whose poverty was the product of poor social conditions and the outcome of man's barbarity. However, often the "happy ending" was a result of Christian charity and good-natured benevolence. The *Daily News* wrote on 10<sup>th</sup> June 1870, the day after his death, "He was emphatically the novelist of his age. In his pictures of contemporary life posterity will read, more clearly than in contemporary records, the character of nineteenth century life" (cited in Ackroyd 1990, p. xiii).

Florence Nightingale was born into the gentry. She had a privileged upbringing and was educated at home with her older sister, Parthenope. Her neighbours included Lord Palmerston and Sidney Herbert. She moved in aristocratic circles which included going to London for the season. Her small world touched other less fortunate societies as she moved amongst the local villages engaging in philanthropic work during her teens.

The population of Britain at the 1851 census was about 20,817,000 and in 1861 23,817,000 (Best 1971). The 1851 census appeared to show that for the first time more people were living in urban

than rural domiciles. The largest of these urban areas was London; the largest city in the western world with over 3,000,000 people in inner London in 1871. People were leaving the country for the towns where employment was to be found because money was needed to feed the increasing population. In the 1850s Best (1971) states that Britain was the richest country in the world, even compared to other great European powers like France and Germany. The prosperity of the wealthiest of its subjects was all the more apparent compared with the many who appeared to remain in perpetual poverty.

Housing in the mid-Victorian era was wide ranging and Florence Nightingale lived in the best; the large house set in its own grounds in the country. Indeed the Nightingale family had two such homes, one in Hampshire and the other in Derbyshire. The summer was spent in Derbyshire at Lea Hurst and the rest of the year at Embley in Hampshire only leaving to spend the spring and autumn seasons in London residing in hotel suites (Woodham-Smith 1950). A detached villa in a private estate was the rich mid-Victorian town dweller's ideal residence, with a spacious garden around the house and gates with a gatekeeper to keep out undesirables. Best (1971) suggests that the respectability of the dwelling in the number and kind of rooms was important to the fashionable mid-Victorian. The villa, even without the private estate, became increasingly important for the better off Victorians. In the 1850s and 1860s the terrace house was standard for the middle, lower middle and the working class people who could afford a small house. The plainest terraces were for the poorest people, the worst being the back to back kind. Those with some external decoration; for example bay windows and porches or additional space such as attics were for the slightly better off. But on the whole "sameness and straightness" (Best 1971, p. 37) describes the streets, although there were huge regional variations.

The final place for the destitute to go was the workhouse. Mid-Victorian workhouses "were usually solid, symmetrical, hospital-like buildings" (Best 1971, p. 164). Some workhouses, mainly those in Lancashire, were humanely managed, with proper segregation for the sick and insane, schooling for the children and no separation of families. However this was not the case for the rest of the country, although some individual workhouses became exemplars for their school or hospital facilities. Many workhouses had cruel regimes which punished the inmates and separated the sexes and hence families. Often the inmates were neglected and given only the basic necessities, but the costs kept rising, partly because of the fraud attached to the running of the

institutions. Despite the workhouses and the associated Poor Law the problems of the poor and pauperism in the major cities of mid-Victorian Britain were not reducing.

## Hospitals and Nursing

Florence Nightingale met the tenants on her father's land and tended the sick in the villages around. This could be viewed as philanthropic work, although it was usual for the land-owning family to care for their tenants and therefore her duty. However Nightingale appears to have had a deeper concern for sick people. In February 1845 she nursed William Shore Smith, aged fourteen, a young relative from her mother's side convalescing after measles, in August she nursed her grandmother and then her old nurse who subsequently died at Embley, with Nightingale by her side, and then in the autumn of that year she nursed in the village of Wellow and is said to have been present at two deathbeds and a difficult birth (Woodham-Smith 1950). Nightingale had already experienced a call from God at the age of sixteen in 1837, the year Victoria became queen, and knew that she was to nurse. Woodham-Smith (1950) records in some detail her struggles both within herself and within her family over her determination to train as a nurse in a hospital. Her mother, Fanny, in particular, was vehemently opposed to the idea. Mid-Victorian hospitals were no place for a young lady.

In 1845 hospitals, Woodham-Smith (1950) records were dirty and lacked sanitation, the smell being so overpowering that visitors were often given to nausea. The wards were overcrowded with minimal space between the beds such that no privacy was possible. The walls would run with moisture to such an extent that mould would grow and have to be regularly scraped and the walls lime washed. The patients tended to be the poorest folk who would enter hospital dirty and unkempt. Drunkenness and violence were common amongst the patients.

The unsanitary condition of hospitals was however only part of the objection of the Nightingale family. The other part concerned the notorious immorality of the unqualified nurses who "cared" for the patients. No respectable woman would normally want to work in a hospital. The nurses often slept on the wards in specially provided beds with the night nurse desperately trying to sleep on a busy and noisy ward during the day in the bed from which the day nurse had just risen. Often the nurses had no other home and lived, slept and ate on the hospital ward. Supervision

was rare and drunkenness and immoral conduct a regular occurrence. It was this association of hospitals and nurses to which the Nightingale family objected. For them it would be a disgrace for their daughter to work in a hospital. Nurses who worked in the villages were no better as characterised by Charles Dickens in *Martin Chuzzlewit* (1843) with the character of Mrs Sairey Gamp who was based on a real person and described by Dickens as a professional nurse. This description therefore contains some facts but also conveys the popular attitude of Victorians to the nurses at the time.

She was a fat old woman, this Mrs. Gamp, with a husky voice and a moist eye, which she had a remarkable power of turning up, and only showing the white of it. Having very little neck, it cost her some trouble to look over herself, if one may say so, at those to whom she talked. She wore a very rusty black gown, rather the worse for snuff, and a shawl and bonnet to correspond. In these dilapidated articles of dress she had, on principle, arrayed herself, time out of mind, on such occasions as the present; for this at once expressed a decent amount of veneration for the deceased, and invited the next of kin to present her with a fresher suit of weeds: an appeal so frequently successful, that the very fetch and ghost of Mrs. Gamp, bonnet and all, might be seen hanging up, any hour in the day, in at least a dozen of the second-hand clothes shops about Holborn. The face of Mrs Gamp – the nose in particular – was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits. Like most persons who have attained to great eminence in their profession, she took to hers very kindly; insomuch that, setting aside her natural predilections as a woman; she went to a lying-in or a laying-out with equal zest and relish.

(Dickens 1843, p. 313)

Nightingale eventually undertook some nurse training in the summer of 1851 at Kaiserswerth Institution, Germany, run by the Reverend Pastor Theodore Fliedner and his wife. So began Nightingale's long association with nursing and her life's work to relieve the poverty and misery in the world by doing God's work.

It is within this Victorian England "golden age" (Thomson 1950, p. 100) that the focus of this thesis concentrates on the work of Nightingale in relation to midwifery, childbirth and maternal mortality, placing Nightingale in the nineteenth century midwifery context and investigating the rationale for the commissioning of the Nightingale School for Midwives at King's College Hospital. Nightingale's involvement with midwifery is little referenced in both nursing and midwifery history books. Where it is mentioned, it is usually referred to in relation to the closure of the Midwifery School in 1867. Its establishment and particularly the reason for its founding are not covered in the main biographical and historical texts. This thesis illuminates the reason behind the founding of the midwifery school and also reviews the evidence for its closure.

## BIOGRAPHICAL METHODOLOGY

*I have taken effectual means that all my papers shall be destroyed after my death.*

Florence Nightingale, 25<sup>th</sup> June 1864. (BL, Add MSS45798, f. 243)

### The Biographical Method

Denzin (1989a p. 7) defines the biographical method as “the studied use and collection of life documents, … These documents will include autobiographies, diaries, letters, obituaries, life histories, life stories, personal experience stories, oral histories, and personal histories”. This list of documents could be extended to include images such as photographs and video film and voice recordings. This thesis on Florence Nightingale and her involvement with midwifery utilises life documents including a literary autobiography (*Cassandra*), biographies, letters and other papers written by and to her or pertaining to the work in which she was involved. It therefore conforms to Denzin’s definition of biographical method.

Denzin (1989a) defines biography “as a written account or history of the life of an individual. The art of writing such accounts” (p. 10). Biography is also defined as “a disciplined way of interpreting a person’s thought and action in the light of his or her past”, “the formative history of the individual’s life experience” (Berk cited in Cortazzi 1993, p. 14). A biography includes a selection of incidents from life, ordered and related to an outcome, so that sense can be made of the individual’s experience, with an understanding of how that outcome was realised. The major life incidents examined are those involving Nightingale and midwifery incorporating the establishment in 1862 of the Nightingale School for Midwives at King’s College Hospital, London, and its closure in 1867 and the publication of *Notes on Lying-in Institutions* in 1871. They are related to outcomes aimed at illuminating Nightingale’s experiences in relation to midwifery, particularly her reasons for becoming involved in training midwives.

The study of life histories is concerned with the interpretation of the narrative accounts of lives. The life being studied should be set in the economic, political, social and cultural context in which

it took place. Therefore some documentary evidence, both other research and evidence from contemporary documents, which support the findings of the interpreted life and set it in context, is essential to all biographies. Other evidence that may refute the findings as interpreted should also be included. This gives it authenticity in that each life is in reality part of a wider social and cultural setting which impinges on the life as it is lived. The biographical method involves continuous scrutiny of the interplay of family, primary group, community and socio-economic forces. To examine one without the others is to diminish the quality of the interpretation. However, it is reasonable to stress one single factor rather than another to reveal a particular pathway in a life (Erben 1998). "In order that the light of personality may shine through, facts must be manipulated; some must be brightened; others shaded; yet, in the process, they must never lose their integrity" (Woolf cited in Cameron 1992, p. 30). Nightingale and the life events in her relationship to midwifery are set in the social and cultural context of mid nineteenth century England. This context includes social class, housing and the place of women in society, as well as the more focused issues of hospitals and nursing, infection, childbirth and midwives.

Gittings (1978) suggests that the biographer must try and take part in the inward and spiritual life of the subject. He intimates that this is perhaps the biographer's most difficult task; to understand feelingly another person's religion and spiritual life from the past. Religion and spirituality were very important to Nightingale. One could argue that it was her driving force in that she was determined to respond to the will of God, although for many years she struggled inwardly as she did not know what she was called to do. Once she knew, she struggled further with her family to be able to fulfil her calling to nurse. Religion continued to be important to Nightingale in later life. She spent many years writing *Suggestions for Thought to the Searchers after Truth Among the Artisans of England*, a three volume exposition of her thoughts and understanding of religion and associated issues. This is not the focus of this thesis; however, Nightingale's spirituality is central to her life's work and is discussed as part of the setting in context and her earlier life in particular.

Gittings (1978) states that Lytton Strachey, who published *Eminent Victorians* in 1918, and included Nightingale as one of the eminent Victorians, brought to biography a humanistic and rationalising approach. Lytton Strachey defines biography as "the most delicate and humane of all the branches of the art of writing" (cited in Salwak 1996, p. ix, Edel 1957, p.1). Delicate because the biographer endeavours to re-establish life to the materials that remain following a life and humane because it is a civilising process. Later, biographers frequently became more

psychoanalytical after the publication of Freud's work at around the same time. Psychohistory, as it was termed, has fallen into disrepute, for as Stannard (1982) states, retrospective psychoanalysing cannot take place with a dead, inactive, non-participating subject. Elms (1994) suggests that psychobiography has a future. He defines psychobiography as "biography that makes substantial use of psychological theory and knowledge" (p. 4), although he too says that it has become an unfashionable word, with biographers preferring to use life history, narratology and psychological biography to describe their work. He concurs that it started with the psychoanalysts but now feels it is time to broaden the use of psychological knowledge in writing biographies. Psychology has much to offer biography, as does sociology, because the subject needs to be set within the social and cultural context of his/her time and interpretation, including psychological analysis, must be undertaken with this in mind. Gittings (1978) offers a different explanation to the awareness of psychoanalytical theory and suggests that it has made the biographer more honest; rather than delving more deeply into the motives of the subject, the biographer has become more self-analytical, questioning his/her own fitness for making certain judgements and the motives behind them. This self-analysis has enabled the biographer to be more aware of the unconscious in the subject and his/her idiosyncrasies and apparent contradictions. This would support the ideal that all biographies should include an autobiography because the cultural and social context of the biographer will impact on the interpretation that he/she brings to the subject's life.

As well as making use of the psychic, subconscious life of the subject, biographers have found medical evidence to be illuminating over the past years, especially since death certificates became a prime source of evidence. They can reveal previously unknown medical conditions in the subject and illnesses in his/her contemporaries that might explain the subject's behaviour at a particular time. Gittings (1978) suggests that the biographer should enquire into the treatment and medication the subject was receiving as this too could influence the subject's behaviour and the course of history for the subject and his/her contemporaries. This requires the biographer to interpret medical and scientific language and science itself, which is constantly changing in response to medical advances. When researching an historical subject this also includes understanding early and more imprecise medical terms. This is explored in the section on *Notes on Lying-in Institutions* (1871) where the terminology changes in the different reports referred to in the text. It is unfortunately still true, as is also demonstrated, but to a much lesser degree than in the nineteenth century. It is well known that on her return from the Crimean War Nightingale took to her bed and was rarely seen in public again. She conducted all her business from her home and visitors were expected to make an appointment and not arrive unannounced. Over the years

various theories have been expounded as to the reasons for this behaviour and the cause of her illness. This is discussed briefly when setting Nightingale within her own context as her work on midwifery and childbirth occurred in this period following her return from Scutari.

“The biographer must suffer, . . . not only the wrongs but all the experiences, triumphant or disastrous, of the subject whose life he attempts to recreate” (Gittings 1978, p. 58). This raises the issue of the biographer’s identification with his/her subject. The conscientious biographer needs to be continually aware of the degree of identification he/she has with the subject to get the balance right. Complete identification with an historical person is impossible and more a concern for those undertaking contemporary biographies. Some degree of detachment is as important as empathy to enable a disciplined interpretation. Now with the greater ease of travel the biographer can often visit places of significance to the subject, which can increase the identification and understanding and therefore aid interpretation. I have visited Embley, Nightingale’s Hampshire childhood home, which although it is now a boarding school, has maintained many of the original features in the main house, for example the secret door in the library, and has paintings and other original artefacts from the time it was her home. I was privileged to visit Lea Hurst, the family home in Derbyshire, which is now a nursing home. It too has kept some original features including the window ledge where Nightingale sat for her cousin Hilary to paint a watercolour. I have also visited Claydon House in Buckinghamshire, the Verney family home, where her sister lived following her marriage to Sir Harry Verney and which is now a National Trust House, incorporating a small museum of Crimean War artefacts, other Nightingale original paintings and her bedroom in the house. I have also walked around London looking at the sites of the properties where she once lived on her return from Scutari and undertaken research at the Florence Nightingale Museum. Finally I have visited her grave, which is the family grave in a small country village church, plain and unpretentious as one could picture Nightingale herself. These visits have given me a better understanding particularly of the social setting in which Nightingale lived and some of the distances she would have to travel for example to go from her London home to stay with her sister at Claydon House. I was excited particularly visiting Embley and going into the rooms that she went in as a child, where she had her lessons and sat and read with her father. The grounds also hold particular significance in Nightingale’s life and I have sat in the garden where she sat and contemplated and stood between the trees where she allegedly heard the voice of God.

All these skills – psychological, medical, economic, political, geographical, religious – are now part of the equipment of the modern biographer. All these arts and sciences may at any time be demanded by the biography of any subject, leaving out of account any special skills needed for the particular profession of the subject:...

(Gittings 1978, p. 63)

Erben (1996) describes the biographical method as an educative exercise because part of its purpose is “a development in the moral reasoning of the researcher” (p. 159). This conforms to Pearsall’s 1998 (p. 589) definition of educative, which includes giving “moral and social instruction”. Aspects of Nightingale’s work were educative in nature. She was a prolific writer and in 1859 wrote *Notes on Nursing: what it is and what it is not*, which was about nursing in the home. There were several subsequent editions including the 1861 version entitled *Notes on Nursing for the Labouring Classes* which contained the chapter *Minding Baby* written specifically as instruction for schoolgirls (MS8999/10). Also in 1860 she published *Suggestions for Thought to the Searchers after Truth Among the Artisans of England*. This was volume one of a three-volume treatise, which took over ten years to write and in which she explored religious philosophy, the law and moral right (Poovey 1992). Volume II contained long sections on women including *Cassandra*, which is thought to be autobiographical. Clearly Nightingale felt she had a duty to give “moral and social instruction” (Pearsall 1998, p. 589), to be educative, mainly to the working classes at home and abroad and to this end one could say her life’s work was focused. Central to this was her theology, which is expounded, in a muddled format (Poovey 1992), in *Suggestions for Thought to the Searchers after Truth Among the Artisans of England*.

## Hermeneutics

Hermeneutics is a noun defined as “the science of interpretation, especially of Scripture” (Treffry 1998, p. 723). It is taken from the Greek *hermeneutikos* - expert in interpretation. It is related to explaining or clarifying, of making the unclear clear. Chladenius (1710 – 1759) defines hermeneutics as “the art of attaining the perfect or complete understanding of utterances – whether they be speeches or writings” (Mueller – Vollmer 1986, p. 5). It was in the sixteenth century that hermeneutics first moved from relative obscurity to the centre of scholarly activity. It was pivotal to the debate concerning the authenticity of the text of the Bible of which there were various versions, including differing Catholic and Protestant ones. Coupled with this and essentially understood as the same problem, was the concern over the true meaning of the Bible’s message (Bauman 1978). In the early nineteenth century, the process of interpretation was subject to constant revision in an attempt to understand God.

Dilthey suggests that understanding has its origins in the process of human life itself. He argues that human beings, in their daily lives, find themselves in situations in which they have to understand what is happening around them so that they can react accordingly. Hence their actual behaviour represents their lived understanding and knowledge of their social and cultural environment (Mueller – Vollmer 1986). Dilthey argues that a person may only be understood by looking behind his/her actions and accessing his/her thoughts, feelings and desires; to grasp the meaning of the intention with which the person undertook the act. It is a process of deciphering both the obvious action and meaning but also the deeper, hidden meaning through which the significance of the overt action is revealed. Hence not only what a person did is known, but also the “motives, memories, value-judgements and purposes” that led him/her to do it (Erben 1993, p. 16). To interpret any human act the interpreter has to recreate the actor’s motives and intentions. This requires the development of an alliance in shared experience, a sensitive self-identification or insight with another person.

Hermeneutics also aims to get nearer the truth. Hermeneutic sciences aid the practice of communication and the endeavour of reaching agreement. Truth should be seen as the ultimate standard of belief for any agreed interpretation of meaning to be achieved. However truth, for both natural science and social science, can only be relative to the historical, cultural and social parameters of a given discussion. Hermeneutics will not guarantee the truth of intersubjective agreement, that negotiation reflects a true consensus concerning meanings (Bauman 1978). This can be directly reflected back to the role of hermeneutics in biographical studies in that it aims to interpret the narratives/discourses within the culture and context in which they are set. However true interpretation is never achieved. There is a hermeneutical circle where one interpretation influences the next but no end point or final interpretation can ever be attained because the interpreter brings his/her own bias, in the widest sense, to each succeeding interpretation.

Contemporary hermeneutics recognises that there is no single truth to be found through interpretation and no single method of interpretation. Meaning is constructed in that it is produced through acts of interpretation. Any scientific fact is only a fact within the context of a pre-existing body of knowledge which rests on previous interpretations which have led to previous understandings and so on. It is individual persons who interpret and each is framed in a history of personal circumstances, for example religion, gender and class. Therefore there cannot be one single objective truth that is the product of observation and interpretation (Steedman

1991). Indeed consensus among contemporary interpreters does not guarantee truth because the consensus is set within their historical tradition (Bauman 1978) and hence “there will always be a plurality of interpretation” (Tosh 1984, p. 125).

Florence Nightingale has been the subject of many biographies ever since she died, with the first one by Cook published, with the family’s consent, in 1913. However one may obtain differing views about the personality and life of Nightingale depending on which biography one reads. For example Smith’s (1982) opening sentence in chapter one (p. 11) reads “Florence Nightingale’s first chance to deploy her talent for manipulation came in August 1853”. In contrast Baly (1995, p. 111) commences her chapter nine with the following sentence “Florence Nightingale was literally a legend in her own day”. The difference between these two quotes is representative of the interpretations the authors made of the life of Florence Nightingale. There is undoubtedly some “truth” in both interpretations. The personal viewpoints and traditions of the authors combined with their interpretative skills sets each interpretation within its own historical tradition, despite their being only thirteen years between the two publications. Gender may also have a role in these particular interpretations. Researchers need to remember the concept that there is no one true interpretation and each interpretation has value in itself but is never the final interpretation.

The biographer may be as imaginative as he pleases – the more imaginative the better – in the way in which he brings together his materials, but he must not imagine the materials. He must read himself into the past; but he must also read that past into the present. He must judge the facts, but he must not sit in judgement. He must respect the dead – but he must tell the truth

(Edel 1957, p. 1).

The researcher can only use imagination to approximate an interpretation using empathy, sympathy, speculation and critical distance coupled with analytical integrity and supporting documentation (Erben 1996). A biographer must be able to feel what it is like to be the subject and yet, also be able to stand back to reduce bias and assess the truth about the subject and his/her personality (Cameron 1992).

## Language

Humans manifest their linguistic competence in speech acts that produce narratives; similarly their linguistic competence allows them to understand the narratives of others. Hence speech acts and acts of understanding closely conform to each other in that every act of speaking is the

converse of an act of understanding when the other must comprehend the thought that underpins a given narrative. Schleiermacher, an exponent of hermeneutics, believed that understanding a narrative, written or spoken, had two distinct aspects. The first concerned understanding the narrative in relation to the language in which it was written/spoken. The second concerned understanding the narrative as a part of the speaker's own personal history or life process (Mueller – Vollmer 1986).

These concepts align with biographical studies in that to understand a narrative requires the interpreter to have knowledge of prior events; understanding is referential to previous knowledge, experience and context. The interpreter should look deeper than the superficial language that describes the event to the factors that influence the subject's perspective on the event. This may, in turn, explain the subject's use of language leading to an even deeper interpretation of the event giving the "... detail, context, emotion and the webs of social relationships that join persons to one another.... (inserting) history into experience" (Denzin 1989b, p.83).

Nineteenth century written English language is very different to twenty first century written English language. Part of the interpretation of Nightingale's relationship with midwifery needs to focus on the language she and other correspondents used in their dialogues and writings. Both understanding the English language as it was written and understanding and interpreting the language in its social and political context is important. Social status and gender were also important in prescribing language conventions in the nineteenth century. An example of this can be found in Nightingale's 1871 *Notes on Lying-in Institutions*. On several occasions in the text Nightingale uses the phrase "told off" (pp. vii, 71, 97, 98). "Tell off" we would understand and interpret to day as "to reprimand; scold" (Collins 1998, p. 1575). The dictionary suggests that this is an informal use of the words and gives a second definition "to count and dismiss" (Collins 1998, p. 1575). Roget's Thesaurus (1962) also gives synonyms for "tell off" as "command, detail" (p. 481). These definitions would conform to the sense in which Nightingale would have used "told off" in her text for two reasons. Firstly that this formal definition of the words would have been more common parlance in the nineteenth century, than the informal definition of the words which is understood today. Secondly the formal definition has a military flavour, which would be in keeping with Nightingale's personal experience with the army and War Office, and with the way nursing and midwifery training was organised at the time, with discreet levels of authority.

Nightingale utilises the phrase in *Notes on Lying-in Institutions* (1871) in the following ways:

“A midwife was told off to attend her,...” (p. vii)

“It is true that any sort of building may be leased or bought and altered, or added to, and told off as a training school;...” (p. 71)

“For this one pupil would be told off for each four wards or beds,...” (p. 97)

“Through all this organisation, however, as far as possible, each pupil is told off to be in charge of a mother and infant from beginning to end.” (p. 98).

By substituting “told off” with “command or detail” or other synonyms from Roget’s Thesaurus (1962, p. 481) the sense of Nightingale’s text becomes clearer to the twenty first century reader:

“A midwife was *detailed* to attend her,...” (p. vii)

“It is true that any sort of building may be leased or bought and altered, or added to, and *commissioned* as a training school;...” (p. 71)

“For this one pupil would be *ordered* for each four wards or beds,...” (p. 97)

“Through all this organisation, however, as far as possible, each pupil is *commanded* to be in charge of a mother and infant from beginning to end.” (p. 98).

Today we would probably tone it down even more by asking pupils to go to certain wards for example, but at the same time expecting them to go, and therefore in essence ordering rather than asking them to go. So the sense of the interpretation has not changed over the years but rather the formal use of the phrase has fallen into disuse as other words and phrases have become more popular parlance.

## Time

Time is the one constant and common factor of all lives. Usher (1998) suggests that lived time involves the interlacing of past, present and future. In lived time the past and future are always present. How people understand themselves is a product of how they understood themselves in

the past and their anticipation of future possibilities. “Our self understanding is an unfolding into a future which is enfolded in a past, itself unfolding into a future” (Usher 1998, p. 22,). In narrative stories people include their past and future when recounting the present. As they remember more or different parts of their past, so the story changes to integrate the new knowledge, which will then influence the way they see and narrate the future.

Baly (1991, p. 5) states that over sixty or so years Nightingale “changed her mind many times”. One could even use her sayings to support opposing ideas (Baly 1991). For example on the one hand Nightingale claimed that working class girls without much education, but with the right motivation, made the best nurses and on the other hand only the educated would rise to the post of superintendent. These, of course, are not necessarily opposing views in nursing and are part of a still ongoing debate on whether the nursing profession should be all graduate on the one hand or widening the entry gate on the other. The changes in Nightingale’s views may be explained through the long passage of time during which she was active. Mid nineteenth century England was a time of great change in hospitals, medicine, industry and women’s education and these will have influenced her changing views over time. She was able to integrate new knowledge from her past and present into her future predictions. This may have given the impression that she kept changing her mind.

### **Researcher Bias**

“...the biographer brings all of his or her own personality, understandings, and experience to the task of creating a view of the individual under study” (Smith 1994, p. 292). These biases are an inherent part of the biographer’s own life and culture and should be acknowledged in any biographical account. These will include the social location of the biographer within a society and the assumptions of that society that are shared by the biographer. Each person chooses, to some degree, which social influences modify his/her individual persona, however this will represent his/her social location, society and time (Nock 1992, p. 34). The subjective bias of the biographer can enhance the interpretation. The biographer’s own concept of the focus of study gives him/her some insight when interpreting the story from a personal and shared knowing and experience perspective.

A researcher needs to be confident that the final outcomes are not mere artefacts of one particular method. Triangulation is a strategy to “overcome the intrinsic bias that comes from single methods, single observer and single theory studies” (Denzin 1970, cited in Patton 1990, p. 464). A biographical researcher needs to utilise more than one source of data in order to validate the findings. I review Nightingale’s own writings, both published and letters, correspondence to Nightingale and other contemporary documents, for example, the reports from the Nightingale Fund, as well as more recent commentaries on her work.

All historical researchers need to be selective in their choice of the “facts” and in the use and creation of theory and interpretative frameworks. Value-neutrality is not possible and which facts are selected depends, mainly, upon the researcher’s questions (Purvis 1994). The researcher may choose to limit the document search to one type of document i.e. letters, to a specific time period, to the material that is easily obtainable or to that which only corroborates his/her view/bias of the focus of study. “It is not the mass and variety of evidence which counts, but its quality, reliability, and relevance to the subject” (Gittings 1978, p. 71). It is also important to acknowledge the limitations of the documentary review in a thesis as well as highlighting the evidence the documents provide to substantiate or refute the argument.

A biographer needs to think about the subject and his/her situation and through critical judgement and reflective practices choose the starting and endings points for the biography. This then is a subjective decision, although based on critical reflection. The biographer may choose to start with the subject’s birth or recount an episode of the subject’s life which encompasses the reason for undertaking the biography; the event or “epiphany” that changed the person into a hero or heroine (Smith 1994). This freedom to choose where to begin and end the biography should be seen as a methodological advantage because it brings a unique interpretation to the data of the subject’s life. Whilst this thesis concentrates on the period 1859 to 1871 and Nightingale’s relationship to midwifery, her earlier life is briefly related, to set her in context with herself as well as her social and cultural situation.

When a biographer is researching one event through the accounts of several people there is an argument that suggests that he/she can distinguish the difference between accurate accounts and those that are inaccurate or irrelevant. This argument is based on the assumption that any social

event has one “true” meaning. The converse argument suggests that a social activity is a “repository” of multiple meanings. The same event can be described in a variety of ways to emphasise different features, which could be said to be “true” for the person relating them. The researcher is not in a position to decide which version is more objective or accurate because he/she will have his/her own interpretation of the event having reviewed all the accounts. The researcher should try to construct various separate versions of what actually happened from the differing accounts and examine the ways in which the accounts are organised through the study of discourse rather than the study of the actual words (Wooffitt 1993). This is particularly important when researching an historical figure like Nightingale. The accounts of events could differ considerably depending on which version is reviewed including, personal contemporaneous and reflective accounts, political accounts and third party accounts.

Reflexivity is an attempt to record openly and honestly the subjective experiences of doing research. The researcher reflects upon, critically examines and explores analytically the nature of the research process (Maynard 1994). In historical biographical research this enables a researcher’s own consciousness to provide insight into the lives of the subjects in the past, and vice versa. However, the researcher needs to be aware of the dangers of projecting current ideals and values back into the past. For example, by writing about and respecting the differences between the women in the historical research and women of today and also acknowledging the mutual bonds between all women throughout time, a researcher can write a more refined history of the subjects, whilst acknowledging his/her own position (Purvis 1994). This is also relevant for this thesis in that Nightingale is set in the social and cultural context of mid-Victorian England and an endeavour is made not to credit her and her peers with labels more suited to twenty first century women. Although it is arguable that there are some mutual female bonds that span across the centuries, which indeed may outweigh the differences.

In biographical research, the researcher’s biography is important and relevant to the research process. “Both the researcher and those people in the research carry with them a history, a sense of themselves and the importance of their experience” (May 1993, p. 14). A researcher may choose to undertake biographical research for some personal interest/reason whether it is historical or contemporary research. This underlying reason could be the source of researcher bias. However this bias may also give the researcher insight into the life of the person being

investigated which in turn could influence the interpretation of the life events. Hence the autobiography of the researcher is a necessary part of the research process.

My reasons for undertaking this thesis are inter-related. I was a practising midwife responsible for the education and training of student midwives until September 2000 when the Non-Medical Education and Training contract ended. In May 1998, after I had learned that the contract was to end, six of my student nurses were chosen to escort the Florence Nightingale lamp down the aisle of Westminster Abbey at the annual Memorial Service to commemorate her birth. Thus began my relationship with Florence Nightingale, a local woman, buried in the family grave at East Wellow, whose life and work was spent trying to improve the standard of life for ordinary people through nursing and midwifery care and management.

### **Historical Research**

History is an enterprise whose purpose is to study events not accessible to observation. These events are studied inferentially, arguing from the point of accessible evidence for the events. It is an attempt to answer questions about past human actions by the interpretation of evidence to teach us what man has done and thus what man is (Collingwood 1946). This explanation of history conforms well to the biographical methodology of this thesis utilised to answer questions concerning Florence Nightingale and her past actions in relation to midwifery by the interpretation of evidence to learn about what she did and what kind of person she was.

Historical biography relies particularly on documentary evidence like most other historical research. Written evidence has survived in a larger amount than any other source for Western history (Tosh 1984). However, the researcher may also have available personal artefacts and oral sources, either contemporary or through the oral tradition of passing on history. Written sources are usually exact regarding time, place and authorship, and they disclose the thoughts and actions of individuals in a way other sources do not. They may have been written for many different purposes, information, propaganda, personal communication, private reflection or creative writing, all of which can be useful to the researcher (Tosh 1984). They can also, of course, lie or be unintentionally misleading. The researcher may well find a source that appears not to support previous interpretations and is therefore initially rejected. He/she needs to remember that it is not

how it was written, but the meaning attributed to the source at the time of writing, that is important. This calls for high critical abilities in the researcher. The resonance or purpose is more important than the statement itself.

Collingwood (1946) states that to ask what a statement might mean, rather than copying it out from the best sources, is critical history, through which the researcher draws his/her own conclusions based on the evidence available. However, Tosh (1984) is critical of Collingwood saying that any interpretation that the researcher makes of an event is influenced by knowledge of what happened next and therefore “we can never recapture the authentic flavour of a historical moment” (p. 121). This hindsight can therefore be viewed as an obstacle or an asset to the researcher. In scientific history the researcher asks a series of questions which he/she expects can be answered from the actual evidence available. Anything is evidence that enables the researcher to answer the question that he/she is currently asking. Critical history can lead into scientific history and it is this pathway that this thesis aims to follow. It copies statements of facts, interprets the meaning of those facts as they were written in mid nineteenth century English and then asks questions of those facts, the answers to which are expected to come from the evidence available for this thesis.

Although researchers must refer to the work of their predecessors, it is important that, where possible, they refer back to the original primary sources and re-interpret them. Primary sources themselves vary in their authorship and contemporaneous nature. A written source may be scribed by an actor or eyewitness to an event or written as a result of hearsay. Both may be inaccurate, muddled and intended to mislead or completely exact. “The actions of an individual can only be fully understood in the light of his or her emotional make-up, temperament and prejudices” (Tosh 1984, p. 73). It must also be remembered that an individual of a given age, sex and status plays a particular role within the social and cultural context in which he/she lives (Gottschalk *et al* 1945). Hence the written source will also be only what the author wants to commit to paper, which may not be what researchers are interested in today. Researchers need to scrutinise the source for its reliability and establish its bias, as no source is ever neutral. They may well derive the same conclusion as their predecessors, however it is important to attempt to see sources in a new light and for researchers to create their own interpretation. Inevitably they will be influenced by the work of their predecessors either negatively or positively.

By using a secondary source a researcher can obtain information about how the author viewed the historical event being described at his/her period in history. For example in 1913 Sir Edward Cook was commissioned by Nightingale's surviving relatives to write her biography. He acknowledges using many primary sources lent to him by the family and the manuscript was proof read by Mrs Vaughan Nash who gave Cook "valuable information, corrections, suggestions and criticisms" (Cook 1913, p. viii). This biography was written three years after Nightingale's death in a manner in which the family wanted her to be remembered and that was contemporaneous with the writing style of that time period. Hence it tells the reader not only about the life of Florence Nightingale but also the commemorative biographical style of the early twentieth century. Primary sources; records and personal correspondence are used to uncover Nightingale's relationship with midwifery. Reference is also made to other biographers, particularly in setting Nightingale in both the mid nineteenth century context and her earlier life and work.

Having found primary documentary sources the researcher first needs to determine if they are genuine. Gottschalk *et al* (1945) put forward four rules to indicate why one set of documents might be given preference over another, assuming that the documents are authentic. Firstly, the closer the document was written to the events it describes the better, as reliability is inversely proportional to the time lapse between event and recollection. Secondly, the more earnest the author's intention to make a bare record, the more dependable the document as an historical source, although all documents contain some bias. Thirdly, the greater the confidential nature of the document the less embellished its contents are likely to be. Finally, the greater the expertness of the author in the event he/she is reporting the more reliable his/her account. These rules would appear to be appropriate for all written documents.

The researcher needs to confirm that the author, date and place of writing are as they seem. Having established this he/she then needs to start the interpretation of the document, initially possibly having to translate it from an archaic form of language, without losing the original meaning. Having translated the document the researcher needs to determine the reliability of the evidence. It needs to be set in the historical context in which it was written and in the conditions under which it was written, for example, is it a first hand contemporaneous account of an event or a forgery and what were the intentions and prejudices of the writer regardless of the format (diary, letter, official record) of the written evidence. "..., biography is indispensable to the

understanding of motive and intention" (Tosh 1984, p. 73). No forms of writing ever convey the bare truth. "As Strachey suggests and Popper confirms, totally objective knowledge or reporting does not exist" (Nadel 1984). Hence the historical researcher is often equally interested in those documents that are overtly prejudiced and contain factually incorrect evidence. The bias itself is likely to be significant in reconstructing the past.

The researcher also needs to be cognisant of missing evidence, for example; evidence that is purposefully removed by someone to hide an event. It is important that the researcher seeks out all available and varied sources to enable him/her to have the best chance of revealing the actual events, given all the constraints cited above. In reality though this is often a selection of sources as the number of potential sources has increased so much that a researcher cannot in actuality review them all. The primary sources available are an incomplete record, partly because so much has disappeared by accident or design and partly because much that happened in the past left no material trace to be used as a source, for example; the thoughts and assumptions of historical characters. The sources available are tainted by the intentions of their authors and by their confinement within the assumptions of the people in that time and place. Historical records only record those facts thought to be important enough to record at the time (Tosh 1984). "...the nature of the materials available ... affect the nature of each biography's truth" (Cameron 1992, p. 28). However, critical reflection on the sources allows the researcher to scrutinise the meaning in the documents for bias and then use this as a basis for inference. This enables the researcher to make allowances for both the deliberate and the subconscious distortions of the author.

This thesis utilises, in particular, personal letters and official contemporaneous Minute Books in an attempt to capture as much evidence as possible and cross reference the official records between the different organisations involved with the personal communications between the main individuals during the commissioning and closure of the Nightingale School for Midwives.

## FLORENCE NIGHTINGALE

*Mrs Nightingale says with tears in her eyes (alluding to Andersen's Fairy Tales), that they are ducks, and have hatched a wild swan.*

Cook (1913a, p.139).

### Introduction

This chapter endeavours to give a brief history of the life of Florence Nightingale up until 1871 when she published *Notes on Lying-in Institutions*. It explores her childhood, youth and early adulthood, but omits her exploits during the Crimean War, recommencing on her return. The Crimean War is not illuminated because it is the main focus of many biographies and this thesis endeavours to investigate Nightingale's experiences related to midwifery, following her return. The writings of Cook (1913a&b) and Woodham-Smith (1950) give greater biographical detail of Nightingale's life and Small (1998) documents an alternative view of Nightingale's Crimean experiences and how it affected her life afterwards. Appendix 1 offers a Time-Line, which summarises Nightingale's life in comparison to other events occurring at the time. Some of Nightingale's biographers are critiqued in a further attempt to understand her through the various interpretations placed on her life and personality over the years. Cook (1913a&b), especially and Woodham-Smith (1950) have been consulted in the composition of this contextual biography. This is supplemented with other sources to emphasise or discredit a point.

William Edward Shore changed his surname in 1815 to Nightingale on succeeding to the property in Derbyshire, of Peter Nightingale, his mother's uncle. In 1818 William married Frances Smith of Parndon Hall, Essex and they travelled extensively in Europe. They had two daughters, both born in Italy. Frances Parthenope was born in Naples in 1819. Parthenope is Greek for the name of her birthplace, and she was usually referred to by that name or some derivative. Florence was the younger daughter, born in the city of that name on 12<sup>th</sup> May 1820 in the Villa Colombaia (Cook 1913a). Both sides of the family were exceptionally long lived. In the immediate family Mr Nightingale lived to be 80, his wife 92, Parthenope 75 and Florence 90 years of age, despite living the last fifty three years of her life infirm and reclusive.

Although Parthenope and Florence were the only children of William and Frances Nightingale they had a large extended family of aunts, uncles and cousins. Cook (1913a) states that the Nightingale's homes were often visited by relations, with a succession of babies and christenings, illnesses and lessons, in which the young Florence took an active interest. Like many young girls Florence was also given to playing nurses and bandaging dolls which Parthenope had broken. She also gave first aid to animals, like Cap a shepherd's collie that was found with a broken leg near Embley (Cook 1913a).

### **Childhood and Education**

Their father educated the Nightingale sisters at home, although Cook (1913a) and Woodham-Smith (1950) make reference to Miss Christie, the first governess, to whom Florence became greatly attached. Cook (1913a) suggests that Florence was a “sensitive, and a somewhat morbid child” (p. 11) who was self-absorbed, shy and introspective. Mr Nightingale was educated at Edinburgh, and Trinity, Cambridge. He was a Unitarian and held the view that women should be educated. The girls' education encompassed those skills which one would expect young ladies of society to acquire, for example, geography, reading, writing, literature, needlework and music. Their wider curriculum included modern languages, constitutional history, Roman, German, Italian and Turkish history, Latin, Greek and mathematics. At sixteen Florence and her sister were reading Homer with Mr Nightingale (Cook 1913a). Part of their education consisted of their father reading aloud to them in the library at Embley each day. Parthenope used to draw or sew whilst being read to, but Florence found this boring and deeply resented the use of her time in this way (Cook 1913a, Woodham-Smith 1950). In *Cassandra* she remembered this experience and wrote “Everybody reads aloud out of their own book or newspaper – or, every five minutes, something is said. And what is it to be ‘read aloud to’? The most miserable exercise of the human intellect” (Nightingale 1860, cited in Poovey 1992, p. 213). This demonstrates Nightingale's passion over relatively minor issues, in the minds of others, and her eagerness to be engaged in meaningful tasks whilst managing her own time. On the whole though, Florence flourished in her studies and became closer to her father. Some of this wider education proved useful to her in later life. In conversations with abbots and monks, whilst on her travels, she found Latin was the only common language. Equally statistics became a tool which Nightingale used to support her case in many reports she wrote on her return from the Crimean War. Indeed, some people regard Nightingale as a great statistician, instead of the founder of modern nursing (Kopf 1916, Nuttal 1983).

Her education also included travel on the continent. In September 1837 Mr Nightingale took his family to Europe, whilst extensive alterations were undertaken at Embley (Cook 1913a). The family did not return to England until April 1839. Eighteen months travelling in Europe as a teenager gave Florence the finishing touches to a grand education. The Nightingales journeyed through France and Italy mixing with foreign society and sightseeing. They visited many places of interest including Chartres, Blois, Tours, Nantes, Bordeaux, Biarritz, Carcassonne, Nîmes, Avignon, Toulon, the Riviera and Nice. They then spent a month in Genoa and two months in Florence before going on to the Italian lakes and Switzerland. Whilst in Geneva Nightingale became particularly interested in the political struggle for Italian freedom. She had the rare opportunity to hear about the conflict first hand from various Italian refugees and Sismondi the historian. She also mixed with the best of foreign society and attended a lively round of picnics, concerts, operas, soirees and balls. In October 1838 the family reached Paris (Cook 1913a). They stayed there over the 1838 – 39 winter and Florence and Parthenope were introduced to the last of the *salons*. This was centred on Mary Clarke, who was half Irish and half Scots by descent, but educated and resident in France (Cook 1913a). She gathered around her the best intellectual minds in Paris and Florence and her sister became drawn into that scene and established a lifelong friendship with Mary Clarke, later Madame Mohl. Nightingale's extensive education enabled her to converse knowledgeably in the *salon*. The social scene across Europe helped to dispel her childhood shyness and transform her into an eligible, confident young woman.

### **Young Adult Life**

Florence Nightingale had a privileged upbringing in a gentry family. The family had two homes; one at Lea Hurst in Derbyshire and the other at Embley, Hampshire. The neighbours in Hampshire included the Palmers at Broadlands, Romsey and the Herberts at Wilton, Salisbury. The family spent the summer at Lea Hurst, some time staying in an hotel in London for the season and the rest of the year at Embley. The sisters had been groomed for a life in society and for several years they both participated and blossomed in the company of like-minded aristocratic individuals. They were not known as particular beauties, but they were both expected to make successful marriages. In the meantime though they were required to undertake the social rounds within the family and community in which they lived and socialised. Nightingale wrote passionately in a section of *Suggestions for Thought to the Searchers after Truth Among the Artisans of England* entitled *Cassandra* on the life style of the upper middle class single daughter. She wrote “Why have women passion, intellect, moral activity – these three – and a place in society where no one of the three can be exercised?” (1860, cited in Poovey 1992, p. 205). Nightingale began to

feel trapped by the life of a young Victorian woman. She found it boring to spend hours engaged in trivial household duties and social visiting and was too restless to indulge in reading and drawing like her sister. She wanted to be busy helping others, but could never find the time to do so in a constructive manner. “Women are never supposed to have any occupation of sufficient importance not to be interrupted, . . .” (Nightingale 1860, cited in Poovey 1992, p. 211). “Women never have half an hour in all their lives (excepting before or after anybody is up in the house) that they can call their own, without fear of offending or of hurting someone” (Nightingale 1860, cited in Poovey 1992, p. 213). Clearly, this is a topic about which Nightingale had passion. Parthenope and her mother could not understand or appreciate Florence’s view and her unwillingness to engage in requisite duties was an issue on which much heated debate occurred in the Nightingale household.

The only times she enjoyed these domestic duties were when she was called upon to help because someone was ill and needed nursing or the household needed managing in someone’s absence. She nursed her paternal grandmother, her old nurse, a young cousin William Shore Smith and various villagers around the family estates. Her young adulthood, on the whole though, was unhappy. She spent much time day dreaming and in a depressive state because she was not free to live the kind of life she wanted. The continual changing of homes from Lea Hurst to London to Embley also meant that she had no fixed routine, something which she developed in her own life in later years.

### **Her Spiritual Life**

Nightingale records in an autobiographical fragment written in 1867 (Cook 1913a, Woodham-Smith 1950) that she was called to God’s service on 7<sup>th</sup> February 1837, aged 16 years, at Embley, although as yet, she was unsure as to the form that service might take. She spent the next fourteen years struggling before she was able to take up her service. The first seven years she struggled internally to understand what she was called to do. When she was sure it was to nurse the sick then she spent the next seven years in family conflict trying to convince them that this was what she wanted to do with her life and to obtain their support and blessing (Woodham-Smith 1950). During this time she became more morose, frustrated, depressed and yet more determined towards her life of vocation and action.

The Nightingale family was initially Unitarian. The central tenet of the faith, which was formed in England in the eighteenth century, was that God is One. It denies the separate deity of Christ and the doctrine of the Trinity and takes reason, conscience and character as the criteria of belief and practice (Treffry 1998, Underwood 1980). The mainstream of English Unitarianism grew out of Calvinist Puritanism. By the nineteenth century the English Unitarians were a small group, however, they were powerful in parliament, local government, the professions and social reform. Around 1840 a crisis arose among English Unitarians and James Martineau challenged Joseph Priestley's view of Unitarian Christianity. He believed in a faith based on intuition rather than on argument and the Bible. He opposed the name Unitarian, preferring Presbyterian and wanted cognisance within a liberal national church. Partly as a result of Unitarian endeavours, penal laws enacted against nonconformity were repealed and many Unitarians achieved prominence in commerce and public life. The second half of the nineteenth century was a period of church building, large congregations and social idealism for Unitarians (Underwood 1980). It is easy to understand why the Nightingale family was initially of this faith.

However, Mrs Nightingale and her two daughters conformed in practice to the Anglican Church. Mrs Nightingale considered the Established Church more appropriate for the gentry than Unitarianism, although the family was strongly influenced by the political liberalism and humanitarianism with which Unitarians were associated (Poovey 1992). Religion was very important for Nightingale. She felt called by God to do some special task, although for years she was unsure what that task might be. During that time she became very despondent and searched for a way forward. She was impatient and chastised herself for her own lack of confidence in God's timing (Cook 1913a). She desperately wanted to put her religious beliefs into action; she wanted to do everything for the love of God. She worked through her own religious beliefs, which determined that she must work to relieve the poverty and misery in the world by doing His work. Her salvation would be in her work. She believed that humans contributed to the realisation of God's laws through work designed to develop the individual's capabilities but which also enhanced society as a whole. Nightingale assigned a spiritual and ethical importance to work that explains why she felt that the life of an upper class daughter was wasted. The daughter's opportunity to do God's work was blighted by the societal conventions by which she lived (Poovey 1992). Cook (1913a) suggests that when Nightingale returned from the Crimean War she hid from publicity so as not to taint her work for God with any worldliness. Nightingale was intensely religious and this could be true. A follow on argument might suggest that if Cook is correct in his assumption, then she missed an opportunity to evangelise according to her beliefs. Nightingale spent many years writing a three volume treatise called *Suggestions for Thought to the*

*Searchers after Truth Among the Artisans of England*, which expounds her religious beliefs. It was developed largely before Nightingale went to Scutari in 1854, although it was only published privately in 1860 and contains Nightingale's confirmed beliefs on religious ideas (Poovey 1992).

Nightingale had a tolerant mind for any faith that promulgated good works and an impatience for those that did not (Cook 1913a, Palmer 1977). Nightingale was therefore in favour of the Roman Catholic Church because of its view on good deeds and in the summer of 1852 she had conversations with Cardinal Manning regarding converting to Catholicism. She wanted to become a Catholic and enter a religious order because she believed that there she could pursue her calling. However Manning read extracts from *Suggestions for Thought to the Searchers after Truth Among the Artisans of England* and decided that she was not in the necessary state of mind for admission into the Catholic Church (Woodham-Smith 1950). The Church of England offered no alternative form of service for women.

The Church of England has for men bishoprics, archbishoprics, and a little work (good men make a great deal for themselves). She has for women – what? ... Luther gave us 'faith', justification by faith, as he calls it; and the Church of Rome gives us 'works'. But the Church of England gives us neither faith nor works. She tells us neither what to believe nor what to do.

(Nightingale 1860, cited in Poovey 1992, p. 88).

### **Her Struggle for Freedom**

From February 1837 Nightingale was searching for exactly what was her "Call" and then how to escape from her family in order to fulfil it and yet, as a dutiful daughter, she wanted their blessing as well. She strove hard to comply with the duties expected of her. She felt that as her sister was content to stay at home her parents might allow her to have a life of activity outside. She had many intellectual pursuits, which kept her busy. She was an avid reader who copied out passages that were of particular interest or annotated books in the margins. As she waited all these years her conviction regarding her "Call" grew stronger and she more determined. In 1844, seven years after the "Call", she realised that her vocation was in hospitals amongst the sick. At this point she did not realise it would be in nursing, she thought it would be doing charitable work (Woodham-Smith 1950). So began her struggle with her family.

Initially she mentioned nothing to her family and privately tried to work through how to confront them with her desire. Her life at home was miserable; she had fallen out with one of her cousins, her sister continually criticised her and there was the dull routine that she disliked. In 1845 she had two episodes of nursing; her grandmother Shore and her old nurse, Mrs Gale. She began to realise that her vocation was to nurse, but she needed to learn how to properly. Her plan was to ask her family to allow her to go to Salisbury Infirmary for three months to learn. The head physician, Dr Fowler was a friend of the family. In December 1845, at the age of 25 years Nightingale proposed the idea, whilst the Fowlers were staying at Embley. Needless to say an almighty argument ensued and her mother and sister had hysterics. Her mother, in particular, was concerned about the obscenities she might hear in a hospital whilst mixing with the other nurses and the shame she would bring on her family (Baly 1995, Woodham-Smith 1950). No concern appears to have been shown about Florence being in such an unhealthy environment. Her father went to London to escape from the row. Boyd (1982) suggests, and it is argued here, that through his silence her father conspired in her defeat. Nightingale sank into a depression. In a letter to her cousin Hilary on 11<sup>th</sup> December 1845 she says, “no advantage that I see comes of my living on” (cited in Cook 1913a, p. 44). Cook (1913a) suggests that Nightingale’s persistence in wanting to nurse in hospitals needs to be seen as courageous, given the weight of the moral and social objections against her doing so by many different people within and outside her family. Mr Nightingale, who wanted to do what was best for his daughter, made enquiries amongst friends and acquaintances about hospital nursing. Whilst some replies were supportive, the majority held the conventional view that a refined gentlewoman might find herself in unpleasant surroundings should she join the nursing profession (Cook 1913a). Smith (1982) states that the evidence for Nightingale’s conflicts with her mother and sister was derived from Nightingale’s own writings and cannot be corroborated. He suggests that her family realised that they had a brilliant but obstinate daughter and that at every crisis they were supportive. Nevertheless this sympathy wore thin on occasions, but in general they were exceptional at discerning and handling Nightingale’s irritating egotism. Smith (1982) also suggests that her mother’s remarks indicate that neither parent was interested in his/her daughter’s passions. Her father eventually supported her financially and this, it is argued, demonstrates his interest in her desires. His inaction on earlier occasions highlights his fear of family conflict.

In 1846 Nightingale found some happiness whilst visiting the sick around Lea Hurst over the late summer. 1847 was a year of social activity in London and then in the autumn she went to Rome for the winter. She travelled with Mr and Mrs Bracebridge, family friends, to try and recover some of her health in order to pursue her vocation on return. Her family hoped that her travels would

divert attention from her vocation and return her to them as a dutiful daughter content with the life that she had been given. Nightingale enjoyed Rome immensely; she learned much and met many interesting people. She indulged in the ruins and sights and took copies and drawings and wrote long descriptive letters home. Whilst in Rome she also found time to visit some of the Roman sisterhoods and talk to them about their work. She found a young orphan girl and paid for her education at the school and orphanage of the Dames du Sacre Coeur. She became good friends with the Madre Santa Coloma whose talk and spiritual experiences made a great impression on Nightingale (Cook 1913a, Woodham-Smith 1950).

It was in Rome too that she first met Mr and Mrs Sidney Herbert who were friends of Mr and Mrs Bracebridge. She became friends with Mr and Mrs Herbert and she and Mr Herbert formed a working relationship later in her career. She returned home in the summer of 1848, perhaps even more encouraged, and accompanied Mrs Herbert who was establishing a Convalescent Home. Life at home soon returned to its normal routine and travelling had not had the desired effect hoped for by her family. In the autumn of 1848, a year of revolution in Europe, there was a plan for Florence to accompany her mother and sister to Frankfurt and she was to have the opportunity of visiting Kaiserswerth, an Institution for Deaconesses. However, disturbances broke out in Frankfurt and the plan was abandoned. Nightingale found some consolation in inspecting hospitals and working in Ragged schools in London. In the autumn of 1849 another foreign tour was suggested.

This time she went with Mr and Mrs Bracebridge to Egypt. Parthenope hoped that Egyptology would absorb her sister and she would develop a life of learned pleasure. Nightingale thoroughly enjoyed Egypt and again sent detailed letters home describing her exploits. Baly (1991) suggests that despite the battles with her family, Nightingale was devoted to them as shown by the long, descriptive letters that she wrote, particularly to her father, during her life. Boyd (1982) suggests that Nightingale's long letters to her father were affectionate and even-keyed. However, Nightingale could not face the ambivalence she felt towards him because of his inability to confront and support her passions on one hand and yet her love and desire for approval from him on the other. Boyd (1982) further suggests that Nightingale, rather than acknowledge her anger towards her father, turned it on herself, sentencing herself to a life of self-destruction. Whilst it is not unreasonable to suggest that a person can hold a grudge for life which can interfere negatively with the whole of that lived life, Boyd appears to suggest Nightingale turned

her anger on herself consciously. Her strength of character and determination would suggest otherwise, although Cook (1913a) states that Nightingale was “humble, even to the verge of morbid abasement, in thought” (p. 427). This would support Boyd (1982) and the depressive nature she demonstrated, particularly in her early adulthood, but not Boyd’s view that it was a conscious inward turning of anger, rather a result of Victorian socialisation and Nightingale’s desire for parental approval.

In April 1850 the party moved onto Athens where Mr Bracebridge owned a property. Again she became involved in the tourist way of life, but also took an interest in the politics. Britain and Greece were involved in the “Pacifico Crisis” (Cook 1913a) at the time. By the end of June the party were on their way home via Germany. On 31<sup>st</sup> July Nightingale reached Kaiserswerth where she stayed for two weeks with the pastor and his wife studying the Institution. She wrote a manuscript about the Institution at Kaiserswerth, which was published anonymously soon after Nightingale returned from her travels (Cook 1913a). She arrived home fired with enthusiasm and determined to dedicate her life to the service of the sick. Once again her travels had not had the effect that her family wanted.

Nightingale was a well educated young woman from a gentry family who was expected to make a good marriage and develop the role of hostess to her husband. As a young adult she had revelled in the London season, she loved dancing and being the centre of attention, but realised that this lifestyle was not complementary to her desire to work with the poor and sick and as she matured she regarded the desire to shine in society as one of her temptations to be overcome (Boyd 1982, Woodham-Smith 1950). Her family, acknowledged her literary gift, encouraged her to write and would have supported Nightingale in developing a literary career at home. But Nightingale felt it was not a gift to be cultivated but rather a temptation to be subdued (Cook 1913a). Another temptation for Nightingale, which also had to be subdued, was marriage. Over the years Nightingale had several proposals of marriage. The most persistent of her admirers was Richard Monckton-Milnes. He first met Nightingale in the summer of 1842 at a dinner party given by the Palmers at Broadlands. He visited Embley several times that summer and was falling in love with her. But the feelings were not mutual. However, Monckton-Milnes continued to be a regular visitor to Embley for several years. He asked her to marry him on several occasions and eventually in 1849 would wait no longer for a definitive answer. Nightingale refused him and he became engaged to Miss Annabel Crewe in 1851 (Woodham-Smith 1950). Nightingale was very

fond of Monckton-Milnes but refused him for the sake of her calling, which at that point in time she had no idea how it would ever be fulfilled. She desperately tried to rationalise her reasons for rejecting him and concluded that whilst she could be satisfied spending a life time with him combining their different powers for some great cause, she could not be satisfied in making society and arranging domestic things with him (Woodham-Smith 1950). Nightingale refused proposals of marriage in order to fulfil her vocation. If she had married she would never be able to follow her calling, but by remaining single there was still a chance, however slim (Cook 1913a).

Nightingale was not opposed to marriage and felt it was a happy state for many couples as they pursued God's work with companionship and sympathy (Cook 1913a). However, she also felt that some women were destined for the single life, according to how God had marked out their vocation. Cook (1913a) proposes that Nightingale wanted to strive for a better life for women. Nightingale suggests in some of her writing that socially well positioned Victorian girls only had the choice of suitors who liked their parents. Cook is not convinced by this argument but concurs that the restriction on women's employability limited their choice of partner and further suggests that many chose marriage as an escape from home. In later life Nightingale campaigned for women's rights in a quiet way. Of particular concern to her was the need to change the law concerning married women and their right to possess property. She also became a member of the London National Society for Women's Suffrage in 1868 and in 1871 her name was added to the general committee. However she had many years of long debate with John Stuart Mill over women's issues before finally agreeing to add her name to the fight for the vote for women. She felt that other social issues were of greater importance and should be taken through parliament before women's suffrage (Woodham-Smith 1950).

In 1851 Nightingale continued in her life of misery at home with her parents and sister. She loved her family but they could not understand her yearning to work with the sick and she could not submit to their desire that she adopt the conventional Victorian lady role. She was depressed to the point of wanting to die, to escape from the turmoil of the unsatisfying routine that was her life. Her sister was again in poor health and a visit to Carlsbad was proposed. Nightingale insisted on going with her mother and sister and spending the time that they would be at Carlsbad and on subsequent travels at Kaiserswerth. She arrived in early July and stayed as an inmate of the Institution until early October (Cook 1913a, Woodham-Smith 1950). The objections that her family had previously shown had gone. They felt unable to object too strongly when Nightingale

had the support of friends like the Bracebridges and the Herberts. Nightingale was ecstatic there, despite the strict regime.

Kaiserswerth is a small town on the Rhine, near Dusseldorf. It has a twelfth century church in which are preserved the bones of an Irish saint who came to Germany to spread the Gospel in 710. The young Pastor Theodor Fliedner established an order of deaconesses there in thanks for the work of St Suitbertus. In 1823-24 he travelled to Holland and England in search of funds for his parish which had been ruined by the failure of a silk mill. On his return he founded the Rhenish-Westphalian Prison Association in 1826. Shortly afterwards he met Frederike Munster a woman who had devoted herself to reformatory work. They were married and in 1833 opened a small refuge in the Pastor's summer house for a single discharged prisoner. Three years later, also on a modest scale, they added first an infant school and then a hospital for training volunteer nurses as deaconesses. The Fliedner's encouraged help and self help and their institution played a part in the emancipation of women by developing the idea of a sisterhood in which unmarried women could work within the support of a spiritual community. During the rest of the century the institution grew and daughter houses were founded all over Germany and in other countries in the Middle East. It is said to be the founding organisation for all deaconess institutions (Cook 1913a). Nightingale was very impressed at the small beginning of Pastor Fliedner's institution and yet how it grew in strength and size. This was a model she admired. She did not like the idea of large collections of money and publicity at the opening of an institution. At the time of Nightingale's second visit the institutions comprised of a 100 bed hospital, an infant school, a 12 inmate penitentiary, an orphan asylum and a normal school for training schoolmistresses (Cook 1913a, Woodham-Smith 1950). There were 116 deaconesses of which 22 were still on probation. The pastor was personally involved in the instruction, weekly discussing with the deaconesses any difficulties they may have and how they might be overcome. Topics included the education of the young, the ministration of the sick, the art of district nursing and the work of rescue and reformation. She was also impressed that many of the deaconesses were peasant women (Cook 1913a, Woodham-Smith 1950, Baly 1995). She found a better life for women and room for the exercise of "morally active" powers. Here she found that "that the service of man" was organised as "the service of God" (Cook 1913a, p. 111). This conforms to her ideal of working for salvation.

Nightingale slept in the orphan asylum and worked with the children and in the hospital and was even present at operations including an amputation (Cook 1913a, Woodham-Smith 1950). She noted that there was no hospital smell, as present in English hospitals and male patients were attended to by male nurses so as not to embarrass the sisters by having them do anything for a man beyond that which a sister would do for a brother (Woodham-Smith 1950). Nightingale was not enamoured by the nurse training at Kaiserswerth and refuted the idea that she had received her nurse training there. It fell far below the standards that she set for the Nightingale School at St Thomas's in 1860. However she did find peace, devotion and religious instruction and it is that which particularly remains in her memory as she recounts in old age.

She wrote home, as usual, long, descriptive letters telling her family of the work in which she was involved and the religious instruction she was receiving. The regime was fairly harsh with four small meals a day and bare essentials only but Nightingale wrote "I find the deepest interest in everything here, and am so well in body and mind. This is Life. Now I know what it is to live and to love life, and really I should be sorry now to leave life" (Cook 1913a, p. 112). Nightingale's spirits had finally risen, but she still longed for approval from her family for the path she had chosen to take. They felt unable to give her the sympathy she desired, despite or because they loved her. She in turn could not bring herself to do anything that they would have considered unworthy of someone they loved. Her mother was particularly concerned about what their friends would say concerning Nightingale's sojourn to Kaiserswerth. Nightingale herself was not concerned and felt that the opinion of those who mattered would support her visit. Hence, although Nightingale could be said to have made progress towards achieving her goal, the battle was not yet won. Cook (1913a) suggests that she returned home more serene, calm and patient, as her letters demonstrate, although no less determined to take her life into her own hands and follow her own path.

It was around this time in the early to mid 1850s that Nightingale concentrated on writing, not novels as she had abandoned a literary career, but books on religion by way of instructing others on her religion of practical service. *Suggestions for Thought to the Searchers after Truth Among the Artisans of England* was largely developed before 1854 and enlarged again in 1856, although it was not printed privately until 1860 (Poovey 1992). Part of this book is entitled *Cassandra* and in it Nightingale describes the life of Victorian gentlewomen. Cassandra was the daughter of the King of Troy who was taught the art of prophecy by Apollo because he wanted to gain her love.

Having promised to give her love she then refused him and so Apollo deprived her prophecy of the power to persuade. The prophecy for which she is most remembered is that of foretelling the presence of the armed force inside the Wooden Horse. The Trojans did not believe her and were defeated. Nightingale appears not to reveal why she entitled this section *Cassandra*. It is not unreasonable to speculate that she thought of herself in a similar position, in not having the power to persuade her family to agree to her following her calling to nurse.

Nightingale was now 32 years old and past the age her parents would expect her to marry. Her father's sister, Aunt Mai, became her ally and together they sought to work out a compromise with the family. Nightingale was to spend part of the year with the family and part pursuing her own activities. This worked well for a time, but Nightingale wanted more. She had the support of her father who was prepared to give her an allowance to enable her to run a mission but her mother stubbornly refused and it was her opposition that had to be finally overcome. Cook (1913a) states that her mother would have been happy for Nightingale to pursue a mission like Mrs Fry, if there was a Mr Fry equivalent around to protect her. Finally Aunt Mai attained Mrs Nightingale's agreement that at a future specified age Nightingale should be free to pursue her mission without a husband. However Cook (1913a) notes that Nightingale still wanted to train to be able to run such a philanthropic institution.

Nightingale negotiated a trip to Paris to visit the Catholic Sisters of Charity. She was to be accompanied to Paris by her cousin, Miss Hilary Bonham Carter and Lady Augusta Bruce, nevertheless her mother initially managed to thwart the trip, which finally took place in February 1853 (Cook 1913a). Part way through the trip she was suddenly recalled to England by the illness and death of her grandmother. In April 1853 Mrs Herbert wrote that through Lady Canning she had heard of a post as Superintendent at the Institution for the Care of Sick Gentlewomen in Distressed Circumstances. It had got into difficulties and was looking for someone to supervise a move of premises and reorganisation. Mrs Herbert suggested Nightingale and Lady Canning sent Nightingale the post details. On 18<sup>th</sup> April she had an interview and Lady Canning wrote to Mrs Herbert of her delight in Miss Nightingale's quiet, sensible manner. Needless to say her mother and sister repeated previous scenes of crying, hysterics and rage and Mr Nightingale retreated away from the female members of his family. However, he made one positive step and granted his younger daughter a £500 a year allowance. Meanwhile Nightingale negotiated her position with the Institution's Committee. This did not go smoothly, but by the end of April it was

complete. She was to receive no remuneration and pay for the services of a matron herself, but in return to have complete control of the management of the Institution and its finances (Cook 1913a, Smith 1982, Woodham-Smith 1950). Whilst new premises were found Nightingale returned to Paris to complete her training with the Sisters of Charity. However, after two weeks she contracted measles and left the convent to stay with M. Mohl. During July and August she supervised the alterations to the new premises and then on 12<sup>th</sup> August 1853 took up residence at 1 Harley Street. She resided there until October 1854. She also had rooms in Pall Mall where she used to see friends and went on Sunday mornings so as not to scandalise the patients in Harley Street by being known not to go to church, as would have been expected by someone of her position and status. Managing the Institution and accountable to a formidable Committee did not seem to perturb Nightingale. She had her friends on the Committee including Lady Canning and Mrs Herbert but did not always get her own way without considerable negotiation. It was hard work. She continued to write long detailed letters home, particularly to her father. She was happy and had found her vocation. Smith (1982) however, suggests that this post was less successful than Cook (1913) and Woodham-Smith (1950) state. His rationale was the debts she incurred with all the changes she made, for example, relinquishing the local grocer in preference to Fortnum and Mason. Her mother and sister continued to be less than happy and expected Nightingale to spend all her off duty time with them in London. But Nightingale chose to leave her family and devote herself entirely to her calling. She was of the opinion that if she spent time with her family she would continually have to justify her actions. Having gained her freedom Nightingale did not want to risk the possibility of losing it (Cook 1913a).

After a year or so at Harley Street Nightingale became restless and was looking to move to King's College Hospital as Superintendent of Nurses. However, in 1854 the British went to war in the Crimea and news of the terrible scenes there were sent back to England on 13<sup>th</sup> October by the war correspondent William Howard Russell. On 21<sup>st</sup> October Nightingale and her party set sail for Constantinople.

### **On Return from the Crimean War**

Nightingale returned to England on 5<sup>th</sup> August 1856. She spent a few hours with the Bermondsey Nuns resting, and reached Lea Hurst on 7<sup>th</sup> August. Cook (1913a) suggests that Nightingale's return from the Crimean War signalled not the "summit of her attainment or the fulfilment of her life. Rather it was a starting point" (p. 305). This is supported in that Nightingale lived for a

further fifty four years following her return and was active in work for the majority of those years. Her sight started to fail in 1887 and she noted in 1895 that her memory was deteriorating (Cook 1913a). Nightingale was thirty six years old on her return from the Crimean War and her contribution to the improvement of living conditions for differing populations at home and abroad was only just beginning. Nightingale was praised for the effect the nursing by women during the war had had in raising the status of women and opening a new profession to them, one of public usefulness. Nightingale was aware of the endeavours of herself and her nurses and determining a better way of life for women was a mission close to her heart, as detailed in *Cassandra* (Nightingale 1860).

Nightingale now wanted to utilise her reputation and experience to further her ideals. She had gone to the Crimean War as “Superintendent of the Female Nursing Establishment of the English General Military Hospitals in Turkey” and yet whilst there had utilised her administrative skills, in particular, to manage the supplies and stores of the hospitals. She did not force her ideas on the medical doctors but bided her time and would not let her nurses work in the wards until the doctors eventually asked for her help. Now returned to England, as a woman, Nightingale would have to use men to achieve her desired results by getting them involved. She used the power of her prestige to ensure the reforms she wanted were achieved by people in positions of social and political leadership, including the Queen (Palmer 1977). Her first task was to improve the medical administration of the army. She was also conscious of the fact that whilst the war had advertised the usefulness of women as nurses, it had not raised the status of nursing as Nightingale had envisaged and therefore more work needed to be undertaken in this area (Cook 1913a). Initially though she needed rest and recuperation at Lea Hurst to recover her strength and composure.

Nightingale was very much affected by her experiences in Scutari and set about analysing the death rates and causes of death. Cook (1913a) states that Nightingale realised that the great majority of soldiers need not have died. She devised a statistical diagram, the coxcomb, to demonstrate the causes and rates of death during the war years. It showed that most of the British soldiers had died of sickness rather than of wounds and other causes and that the death rate was higher in the first year of the war, before the Sanitary Commissioners arrived in March 1855 to improve the hygiene in the camps and hospitals. Her statistical work earned great respect, which

was recognised in 1858 with her election as a member of the Statistical Society. The coxcomb was appended to various reports as well as being privately printed and distributed.

Although the enormous death rate during the Crimean War has never been in dispute its cause has been. The Government blamed it on the effects of starvation and exposure on the front line; however, Small (1998) discovered some inconsistencies in published accounts and noted that Nightingale made different claims in private. Small (1998) undertook extensive research, including previously unused letters, from a wide variety of sources. His focus was the reason for Nightingale's physical and mental collapse on her return from the Crimean War and the change of direction in her work following this.

By reviewing the chronology of events through letters and public accounts, Small (1998) demonstrates that the Army's ill-treatment of the soldiers in the trenches including inadequate food, overwork and lack of shelter was not the cause of the death of eighteen thousand soldiers, as the Government had expected. Using statistical techniques Nightingale and Dr William Farr demonstrated that it was the unsanitary conditions, particularly overcrowding, in the hospitals that caused the soldiers' deaths. In Nightingale's hospital at Scutari five thousand men died in the winter of 1854/5. Her hospital had the highest death rate amongst all the war hospitals. Small (1998) concludes that Nightingale's education and logic had led her to the realisation that her ignorance and arrogance had led to the death of thousands of ordinary English men and that she spent the rest of her life trying to compensate for that blunder. It was this revelation, Small claims, which caused Nightingale's collapse and influenced her work in public health in the following years. Small (1998) concludes that Nightingale may have preserved her records so that history might remember how "through her ignorance and arrogance, she let that army die" (Small 1998, p. 203).

Small (1998) criticises previous biographers, including Cook (1913a&b) and Woodham-Smith (1950) for their treatment of Nightingale, saying that they have ignored some of the evidence and therefore come to the wrong conclusions. Equally, Small (1998) speculates as to the probable cause or outcome of various events, albeit using the evidence, but going into the realms of conjecture. This debate highlights the difficulties in interpreting past events from historical documentary evidence, whether the evidence is official, factual documents or personal

correspondence. Cook's biography of 1913 was the first and in many ways most comprehensive Nightingale life story. Although Cook had access to many privately held papers, he also had to satisfy the family wishes with regard to the content of the biography, given that Nightingale had only died three years before publication. He therefore could have intentionally omitted any contentious issues, although his biography does not portray Nightingale as a paragon of virtue. Woodham-Smith (1950) relied heavily on Cook (1913) as a source and therefore took many of his points as facts, without further corroboration. Small (1998) had access to more original data, given that over time additional documents have come to light. If the assumption is made that the raw data collected at the time is correct then Small had the opportunity to check and further analyse the data using computer technology. This may have enabled him to reach the same private conclusion as Nightingale and thus support his claim that Cook (1913) ignores some of the evidence.

In contrast to Small (1998), Brook (1990) writes convincingly that Nightingale suffered "burn out" (p. 25) from long hours and over work in Scutari. She supports this with an extract from a letter written by Nightingale's Aunt Mai, describing Nightingale's working day and contemporary medical evidence of the signs and symptoms of burn out. Brook (1990) further suggests that the burn out was compounded, on return to England, by Post Traumatic Stress Disorder. She proposes that the invalid life style that Nightingale adopted shortly after her return was her coping mechanism. She isolated herself from her family, exaggerating her symptoms whenever they suggested visiting. She also surrounded herself with people who shared her passion for improving the health of the army and could support her emotionally. By requiring visitors to make appointments she structured her life to give her more time for her work, which in itself was a positive outlet for her stress. As time passed, Brook (1990) states that the lifestyle Nightingale adopted to relieve her stress was reinforced and became learned behaviour and so it continued for the rest of her life.

We will never know why Nightingale became a reclusive invalid on her return from the Crimean War. It was customary for nineteenth century upper class women to be seen as frail and delicate. Elizabeth Barrett Browning (1806 – 61) poet and critic was another upper class women who became an invalid during her life. Societal expectations would have supported the invalid role that Nightingale adopted, particularly following her harrowing experiences. This prolonged and controversial self indulgent lifestyle as an invalid is ironic, given her earlier determination to break

free of the demands imposed on her by her class as detailed in *Cassandra* (Nightingale 1860). Nonetheless both Small (1998) and Brook (1990) make well researched claims for the cause of Nightingale's invalidity. It is possible that the two rationales are intertwined and that Nightingale had Post Traumatic Stress Disorder following burn out in Scutari and complicated by the discovery that Nightingale's own war hospital had the highest death rate from sickness among the soldiers and that therefore ultimately she was responsible for their deaths.

In today's era of "evidenced based practice" it is interesting to read in a letter Nightingale wrote to Sidney Herbert after the war that he must have documentary evidence to support the statements which the doctors were making to the Royal Commission of which he was Chair (Small 1998). Nightingale wrote her own confidential report, *Notes affecting the Health, Efficiency, and Hospital Administration of the British Army* (1858), which she sent as her evidence to the Royal Commission established to review the health of the Army. She hoped that they would print it as part of the public report (August 1857). Her report was never published, although the following year she sent privately published copies to various influential people. Some of these reports eventually found their way into libraries, which is why the evidence is now available. Following the public release of the Report of the Royal Commission in February 1858, Nightingale threw herself into the next challenge of improving the barracks of the soldiers and the quality of their life when not at war. In 1857, despite failing health, Nightingale offered to go to India, if she could be of any help during the mutiny there. She was also involved in lengthy discussions over the design of a new military hospital at Netley, Hampshire in 1858.

Over the first five years, following her return to England, Nightingale was heavily involved in matters relating to the health of the army both during peace and war times and at home and abroad. Her own health was poor and she spent most of her time in various hotels or apartments in London, close to working colleagues. She confined herself to her home and accepted visitors only by appointment. She gave her full concentration to the reports she wrote and the development of her sanitary and statistical work. This was the beginning of her most productive writing period. Some of the major publications Nightingale produced are listed in Appendix 2. Between 1857 and 1901 Nightingale published most years and more than one paper. She was also a prolific correspondent, which is why biographers can utilise so much original material, despite the fact that at one point she asked for all her papers to be destroyed, and then changed her mind. Nightingale kept copies of most of the letters she wrote and made comments in margins on texts.

Despite her self imposed personal isolation from the world she appeared to like to work with people in that she had many callers, mainly those associated with her project at the time. She also wanted support and recognition or perhaps approval for her work because she sent many of her papers to others for comment, for example, *Suggestions for Thought to the Searchers after Truth Among the Artisans of England*, was reviewed by Dr Sutherland, Richard Monckton Milnes, John Stuart Mill, Benjamin Jowett and Sir John McNeill (Woodham-Smith 1950). This need for others opinions, even if she didn't take their advice, is reminiscent of the need she felt as a young woman for approval from her family (Smith 1982) for her desire to undertake nurse training. This could be a trait peculiar to Victorian or indeed women in general, a need to be liked and seen to exhibit the correct behaviour. It is suggested however that it is a human trait, a need to conform to society's rules of the time.

Nightingale's headstrong character propelled her through these post war years. She could be described as a workaholic who forsook society for the pursuance of her own goals. Her influence amongst politicians and others in authority seems difficult to comprehend.

Miss Nightingale, who was in favour of female suffrage, would hardly have gained more influence by the possession of a vote. But then very few women, and not many men, have the opportunities, the industry, the mental grasp, and the strength of will which in combination were the secret of "the Nightingale power."

(Cook 1913a, p. 332)

1861 was a watershed year for Nightingale in that Sidney Herbert, her friend, supporter and co-worker died. Cook (1913a) and Woodham-Smith (1950) suggest Nightingale drove him to his death by her constant pressure to complete the current project. She would not believe he was in ill health and could not understand how his illness could prevent him from continuing the work they were jointly undertaking. She had given up social life and travelling, everyone came to her. Cook (1913a) suggests that she had forgotten the strain that these activities can put on a life and that this gave rise to her incomprehension of the severity of Herbert's illness. Nightingale mourned him as a friend and as a co-author.

## Hospitals and Nursing

In between reforming military hospitals and involvement in sanitary issues in England, Nightingale became involved in her main passion of nursing and training nurses. In 1858 *Notes on Hospitals* was read at Liverpool to the National Association for the Promotion of Social Science and then printed in 1859, with a second edition the same year and a third edition in 1863 (Cook 1913b).

Nightingale's most famous writing *Notes on Nursing: What it is and what it is not* was first published in December 1859 at the price of five shillings. It sold very quickly, 15,000 copies within a month of publication. A new edition, revised and enlarged, was published in 1860. In 1861 it was rewritten as *Notes on Nursing for the Labouring Classes* and sold bound in limp red cloth for seven pennies. It was an abridgement of the previous book, with a supplementary chapter entitled *Minding Baby* and was reprinted in 1865, 1868, 1876, 1883, 1885, 1888, 1890, 1894, and 1898 (Cook 1913a). It is not the intention of this thesis to elaborate further on these texts, simply to note their publication.

The nineteenth century produced three famous persons in this country who contributed more than any of their contemporaries to the relief of human suffering in disease: Simpson, the introducer of chloroform; Lister, the inventor of antiseptic surgery; and Florence Nightingale, the founder of modern nursing.

(Cook 1913a, p. 439)

This statement was seen in the last decade of the twentieth century, in particular, as contentious. Many nurses felt that Nightingale did not deserve the accolade because she was rather a manager, administrator, sanitary advisor, hospital architect, military advisor and statistician. They claimed that she did not nurse in Scutari, but rather administered the hospital. The founding of the training school at St Thomas's Hospital in 1860 also did not qualify her for the title as suggested by Cook because others had founded training institutions before. However Cook (1913a) presses his point stating that Nightingale was not the founder of nursing but the founder of modern nursing as a "distinct and trained calling" (p. 440) on a large scale, "...because she made public opinion perceive, and act upon the perception, that nursing was an art, and must be raised to the status of a trained profession" (Cook 1913a, p. 445).

The Nightingale Fund was started on 29<sup>th</sup> November 1855, (Woodham-Smith 1950), whilst the Crimean War was still raging in the east, by a grateful public for the work Nightingale was

undertaking there. The Fund was eventually closed with around £45,000 collected. Nightingale procrastinated regarding use of the Fund for several years, but in 1859 became interested in opening a training school for nurses. The path to the successful opening was not smooth. Various negotiations took place between hospital sites and potential staff. Nightingale was in poor health and could not take an active role in the organisation of the school. Nevertheless on 24<sup>th</sup> June 1860 the Nightingale School opened with fifteen pupils. They were not admitted without a certificate of good character. The probationers were to have a year's training and to live in a nurse's home, an idea originated by Nightingale (Woodham-Smith 1950). Detailed descriptions of the inauguration and organisation of the Nightingale Training School for Nurses are documented in Cook (1913a&b) and Woodham-Smith (1950).

In January 1862 Nightingale commenced a school for the training of midwifery nurses at King's College Hospital. The school closed five years later and is the subject of another chapter. In the first half of the 1860s Nightingale also became involved with India. There was a high mortality among the British Army in India and Nightingale was determined to help in any way she could. She determined to obtain a Royal Commission for India along the lines of the 1857 Commission after the Crimean War. Lord Stanley approved the Commission and it commenced its work in 1859 and reported in 1863. Nightingale and Dr William Farr worked tirelessly gathering statistics, undertaking postal surveys in India and analysing the data. She was a formidable woman when it came to making sure the intended persons understood her point of view and accepted her analysis and recommendations, none more so than in her Indian campaign, although Nightingale never went to India at anytime in her life. Following the publication of the Report Nightingale worked to ensure the recommendations were enforced (Cook 1913b).

In the latter part of the 1860s and into the early 1870s Nightingale became more involved with reforms in workhouse nursing. In May 1865 twelve Nightingale trained nurses started work at the Liverpool Infirmary. Mr William Rathbone, a philanthropist in Liverpool worked with Nightingale to introduce district nursing among the poor in the city (Cook 1913b). Nightingale also became involved with various other causes over the years asserting her influence on those in authority whom she knew and trusted.

In 1871 she published *Notes on Lying-in Institutions* having worked since the closure of the King's College Hospital lying-in ward (Cook 1913b) with Dr Sutherland to collect and analyse maternal mortality statistics from around the country and from Europe. She discovered that the death rate in all lying-in wards was much greater than that of home deliveries. She determined that these deaths could be prevented and in the latter part of the book includes descriptions and diagrams of wards that she designed. She also describes the ideal institution for the training of midwives and calls for "midwifery as a career for educated women" (Nightingale 1871).

No doubt her position in life as a gentlewoman of independent means had much to do with the influence she was able to bring to bear on a succession of politicians in different governments over several decades in the nineteenth century. She was certainly a woman of immense conviction and persuasion who was single minded on each and every project she undertook. Her broad education had equipped her to research thoroughly, record in detail and think laterally, to work closely with others and to shut out friends and family who were not likeminded and could be seen as distractions to her various goals. Her health was poor for the majority of her life, but how much of that was genuine illness and how much the female frailty so common in the Victorian age is difficult to say. She certainly was able to use her health to her advantage on several occasions, including keeping away from her own close relatives with whom she had had such a difficult relationship in her early years.

Florence Nightingale was by no means a Plaster Saint. She was a woman of strong passions - not over-given to praise, not quick to forgive; somewhat prone to be censorious, not apt to forget. She was not only a gentle angel of compassion; she was more of a logician than a sentimentalist; she knew that to do good works requires a hard head as well as a soft heart... She weighed every consideration; she sought much competent advice; but when once her decision was taken, she was resolute and masterful - not lightly turned from her course, impatient of delay, not very tolerant of opposition.

(Cook 1913b, p. 424 & 425)

This description by Cook appears to me a just summary of the woman as depicted in the documentary evidence available from the nineteenth century. Nightingale is portrayed as having a severe nature, with little tolerance or understanding for friends or family who did not hold her point of view. Cook (1913a) describes the young Nightingale as a rebel and Baly (1991) sees her as a radical, influenced by the liberal views of her family. Lytton Strachey in his *Eminent Victorians* (1918) describes Nightingale as being possessed by a Demon. His book is considered a selective, artistic biography, but even so there is undoubtedly some truth in it. Yet Cook (1913b) also suggests that she was full of compassion; pity for the sick, devotion to the common soldier, sympathy for the common Indian people and that this compassion was her prime motive. If he is

correct, then for me somehow the compassion gets lost in the forcefulness of her character and her determination to be seen to be right all the time. Queen Victoria and the Price Consort found her modest, (Cook 1913b), which in their presence she probably was because of her education as a gentlewoman and because of her deep religious belief in doing good works. She was also prone to depression and suicidal as a young woman (Cook 1913a). This could have given others the impression that she was quiet and reserved, except those with whom she worked closely following her return from Scutari, who would have found her single minded and driven to achieve success and improve the standard of life for all those for whom she felt compassion.

## MIDWIVES, MIDWIFERY AND CHILDBIRTH IN THE NINETEENTH CENTURY

*...there is a large amount of preventable mortality in midwifery practice,..., as a general rule, the mortality is far, far greater in lying-in hospitals than among women lying-in at home.*

Florence Nightingale (1871, p. 3)

### Introduction

The havoc created by the Industrial Revolution and the vast movements of people from rural areas into towns coincided with a population explosion, which must have strained resources, especially in the industrialised areas. Many people moved from the poverty of the rural areas to the towns in search of work, which they found, but the overcrowded housing and unsanitary conditions in which they frequently lived often meant that they were still impoverished of many home essentials like bedding and furniture (Towler and Bramall 1986). This is the environment into which babies were born and from which many of the midwives must have come themselves. The women were so poor that they would often return to work two or three weeks after confinement, because they needed the money. They would leave their babies, often drugged with opiates, either alone or in the care of girls or older women, so that the babies would sleep and not cry in hunger whilst their mothers were away at work.

By the 1851 Census there were over a quarter of a million more women than men in the 20 - 40 age group, hence many women remained single and had to earn their living through employment, along with widows and deserted wives. Donnison (1988) suggests that estimates of between a quarter and a third of women working are likely to be conservative, given the present general under-recording of women's part-time work. Employment for lower-class women tended to be in domestic service, factories or in the needle trades, which paid particularly badly. Middle class women and aspiring lower class women opted for the role of governess. Donnison (1988) suggests that low pay was part of the lot of the governess who was also often slighted by the other servants and the family and bullied by the children. Governess' frequently led very lonely existences and many found themselves in the workhouse at the end of their working life. It was this group of unsupported gentlewomen; for example, governess' and philanthropic Victorians

who began the various women's movements to improve the position of all women. In 1848, F. D. Maurice and Charles Kingsley, established Queen's College for Women in Harley Street, in 1855 the campaign for the rights of married women to own property commenced and 1859 saw the founding of a Society for Promoting the Employment of Women. Various philanthropic organisations, founded and run by women for the improvement of the status of women at a village level were also inaugurated.

There were also those women who were not in employment or were unemployable and, following the 1834 Poor Law (Amendment) Act, were confined to large Union Workhouses. Each workhouse had its own Infirmary where part-time Workhouse Medical Officers gained experience in midwifery to benefit them in their private practice. It may be assumed that the midwives were recruited from the able-bodied inmates, like the nurses (Dean and Bolton 1980). Infant mortality was defined in 1997 as "deaths at ages under one year" (Lewis 1998, p. xxiii). The infant mortality rate was 150 per 1000 live births (Registrar General's figures) and the maternal mortality rate was 4.75 per 1000 registered births between 1855 and 1864 (Donnison 1988). By comparison in 1997 the infant mortality rate was 5.7 per 1000 live births (Lewis 1998, p. 131).

## **Maternal Mortality**

Maternal deaths are defined as "deaths of women while pregnant or within 42 days of delivery, miscarriage or termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (International Classification of Diseases, Injuries and Causes of Death – ninth revision (ICD9) cited in Lewis 2001, p.7). Two figures were given for the maternal death rate between 1994 and 1996, 9.9 per 100,000 maternities, which was the same as the triennial period 1991 to 1993 and 12.2 per 100,000 maternities. This second figure is to become the new bench mark; a new computer program, run by the Office for National Statistics, used for the 1994 – 1996 figures, identified an additional "67 deaths not otherwise known to the Enquiry" (Lewis 1998, p. 3), which previously would have passed unrecognised. In the report covering 1997 to 1999 it identified an extra 40 deaths (Lewis 2001) including 2 who died of sepsis. The combined overall maternal mortality rate (Direct and Indirect deaths) for the triennial period 1997 to 1999 is 11.4 per 100,000 maternities, a slight decrease from the previous triennium (Lewis 2001). Dr Farr in 1881 tried to do something similar about hidden maternal deaths. He organised the distribution of letters of inquiry to be sent out to all doctors who had written death certificates in which the causes of death were

incompletely stated asking for further details (Loudon 1992). 1,200 letters were sent out, this being only a small proportion of the incomplete certificates. 330 additional maternal deaths were discovered of which 80% were deaths due to puerperal sepsis. These deaths represented an additional 8% to the total maternal mortality and an additional 12% of deaths due to puerperal fever (Loudon 1992). Loudon (1992) suggests that maternal mortality before 1880 was therefore likely to have been under-recorded to at least the same amount. However, there is evidence in the Registrar General's Report of 1898 that these inaccuracies in recording maternal death continued and some 10% of hidden maternal deaths were reassigned to puerperal causes. Loudon (1992) also notes that the largest number of deaths where the causes stated in the registers were most unsatisfactory was for deaths under the age of one year, which raises issues regarding the infant mortality rates quoted above. It is supported here that if in the late twentieth century a computer program can identify an additional 67 maternal deaths, then the figures quoted for the nineteenth century are likely to be very inaccurate, under recorded and wrongly certified.

Whilst accepting that the definitions used in the mid nineteenth century for infant and maternal mortality will have been different and varied, the comparison serves to highlight the enormity of the death rate in nineteenth century England and that mothers, in particular, still die as a consequence of pregnancy and childbirth at the end of the twentieth century. The Victorian woman, either rich or poor, spent most of her adult life either pregnant or recovering from one birth in preparation for the next pregnancy. This was particularly so for the middle and upper class women who did not have to go out to work and were expected to provide the heir of the family. Also being a wet nurse for a wealthy family would delay the next conception for a poor mother; whilst the wealthy mother had no such contraceptive protection from breast feeding. This repeated childbearing had medical repercussions on the woman's general health and longevity. For the vast majority of women in England now this repeated childbearing is not part of adult life and hence women's life expectancy and general health has improved. In 1871 Florence Nightingale wrote *Notes on Lying-in Institutions* and stated that "a death in childbed is almost a subject for an inquest" (p. 74). The public may be reassured to know that the above quoted Office for National Statistics figures are taken from 2 volumes *Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the UK 1994 - 96 and 1997 - 1999*. Maternal death in the UK is investigated in detail and reported every three years in the expectation that lessons will be learned from these women's deaths such that the avoidable factors can be evaded in future maternities. The first report of a national enquiry into maternal deaths in England and Wales was published in 1915 by the Local Government Board, whose responsibilities included public health

(Macfarlane 2001). The first triennial Report for England was published in 1952 (Lewis 2001), the other countries of the UK joined in the reporting process later.

It was not until 1843 – 4 in the seventh annual report of the Registrar General that deaths in childbirth were even included in the published lists of causes of death. In that report Dr Farr published his nosology and childbirth deaths were split into two categories. Deaths from puerperal fever were in the list of zymotic (infective) diseases and deaths from childbirth were further split into two with deaths from abortions as a secondary category. In the reports of 1847 and 1858 the classification was modified but deaths from puerperal fever were still separated from deaths in childbirth. This system was followed in some European countries, for example Belgium, and signals the significance that deaths from puerperal fever was given in the annual reports. The deaths in childbirth were later described as “accidents of childbirth” (Loudon 1992, p. 525) and included all other deaths. Later still there were “deaths in pregnancy” (Loudon 1992, p. 525) as well as deaths in childbirth which included all deaths except the most common ones of puerperal sepsis, haemorrhage and toxæmia. In the early reports of the Registrar General for England and Wales puerperal fever was first listed as metria, then puerperal fever and by the end of the nineteenth century puerperal septicaemia and puerperal sepsis (Loudon 1992). Clearly, over the years, there is a continuing issue of terms and classifications being inconsistent and therefore the examination of the statistics for comparative purposes should be undertaken judiciously. In 1911 this changed when Britain adopted the nomenclature of the International Classification of Diseases (ICD). This classification is still used in the twenty first century as can be seen above in the definition of maternal mortality taken from ICD9. In the triennial reports 1994 – 96 and 1997 - 1999 (Lewis 1998 and 2001) it is termed genital tract sepsis and puerperal sepsis is a sub-grouping under the main heading. However, there are sub definitions of Direct deaths, Indirect deaths and Late deaths and these are peculiar to the UK reports. This makes detailed international comparisons problematic, beyond the ICD codes.

It needs to be remembered that women also died in childbirth from causes other than puerperal sepsis, although this was recorded separately to the other deaths in childbirth. Loudon (1992) suggests that “the incidence and death rate from abortion began to rise in the second half of the nineteenth century” (p. 109). Abortion, including all types of miscarriage, is an outcome of pregnancy and therefore should be included in maternal mortality figures. It was not until 1931, when England and Wales had adopted ICD4, that deaths due to septic abortion were published

separately (Loudon 1992). Many doctors in the early part of the twentieth century did not want, particularly criminal abortions, included as this would unnecessarily inflate the figures and scare respectable women who were only interested in the risks for normal wanted pregnancies. As a result of this it is possible that deaths from criminal abortion were attributed to non-abortion causes, so inflating these figures. However Loudon (1992) disagrees and is of the opinion that mis-reporting abortion deaths was only part of the problem. An overstatement of the true number of abortions and an embellishment of the fatality rate of illegal abortions also played a part.

Women also died from toxæmia and eclampsia. In 1843 John Lever collected data from colleagues and demonstrated that 26.5% of women who had eclamptic fits died as a result (Loudon 1992). By the mid 1930s there was no improvement on Lever's statistics with the mortality rate of eclampsia around 25 – 30%. Again there is a difficulty when reviewing the statistics of differences in definition and classification between countries. Haemorrhage was another major cause of maternal mortality and this could be antepartum, intrapartum or postpartum haemorrhage. Antepartum haemorrhage could not be prevented or treated in the nineteenth century and if it was catastrophic then both the mother and baby died. Postpartum haemorrhage could usually be prevented by waiting patiently for separation and descent of the placenta. Data from the Edinburgh Maternity Hospital for the years 1844 – 6 show that postpartum haemorrhage was twice as common as antepartum haemorrhage, but that the majority of women survived (Loudon 1992). The classification of the type or timing of the haemorrhage was fairly detailed, although not all institutions or countries used the same classification system. Loudon (1992) has calculated the incidence of haemorrhage from the Edinburgh Maternity Hospital data as 473 per 10,000 or 4.7%. He attributes the reducing maternal mortality rate from haemorrhage between 1900 and 1935 to improvements in maternal care, especially the management of the third stage of labour, to the 1902 Midwives Act and the regulated training of midwives.

Finally it needs to be remembered that women died in pregnancy and childbirth from associated illnesses and from being generally unhealthy. Rickets was common in the nineteenth century owing to the pollution, poor diet and lack of sunlight that those working in the factories in the cities received. Poor women were particularly at risk of the rachitic contracted pelvis. This means that the baby cannot be delivered vaginally because the baby's head is too big to pass through the

mis-shaped maternal pelvis. There were several alternative methods of delivery, most of them fatal to either mother or child or both. They included craniotomy, embryotomy, early induction of labour and caesarean section. However, Loudon (1992) suggests that contracted pelvis in nineteenth century childbearing women was uncommon, with only a 1% incidence and hence did not account for a large number of maternal deaths.

In the late twentieth century the causes of maternal death are similar, but the rates are very much reduced and the major cause is no longer puerperal sepsis.

Cause (Direct)	Number of cases 1994 - 1996	Number of cases 1997 - 1999	Rate per million maternities 1994 – 1996	Rate per million maternities 1997 - 1999
Thrombosis + Thrombo-embolism	48	35	21.8	16.5
Hypertensive diseases of pregnancy	20	15	9.1	7.1
Haemorrhage	12	7	5.5	3.3
Amniotic fluid embolism	17	8	7.7	3.8
Ectopic pregnancy	12	13		
Spontaneous miscarriage	2 {	2 {	6.8	8.0
Legal termination	1 {	2 {		
Sepsis	16	14	6.4	6.6
Genital tract trauma	5	2	2.3	1.0
Other	2	5	0.9	2.3
Anaesthetic	1	3	0.5	1.4
Total	136	106		
Indirect causes				
Cardiac	39	35	17.7	16.5
Psychiatric	9	15	4.1	7.1
Other indirect	86	75	39.1	35.3
Indirect malignancies	—	11	—	5.1
Total	134	136	121.9	114.0

Table 1 showing the number of maternal deaths by cause and rate per million maternities in the UK 1994 – 96, 1997 - 1999 (derived from Lewis, 1998, p. 7 – 8, and Lewis, 2001, p. 28).

The major cause in 1994 – 1996 was thromboembolism which caused 36% of all direct maternal deaths. Whilst thromboembolism, hypertensive diseases, amniotic fluid embolism, early pregnancy causes and sepsis form the top five causes of maternal deaths and were responsible for 85% of all direct maternal deaths in the triennium 1994 – 1996 (Lewis, 1998). There was an increase in the maternal mortality rate from sepsis to 6.6 in 1997 - 1999 from 6.4 in 1994 – 1996 and from 3.9 per million maternities in the 1991 – 1993 triennium. The majority of the deaths in 1994 - 96 were from puerperal sepsis with only two women dying from sepsis following a caesarean section. Following the introduction and use of guidelines developed in part as a result of findings and recommendations of previous reports the number of deaths from sepsis following caesarean section has remained low. However the pattern of the causes of death from sepsis in the triennium 1997 – 1999 changed with a significant increase in the incidence of fatal antenatal infections in both early and late pregnancies. There was only one case of sepsis before delivery in 1994 – 1996 (Lewis 2001).

Sepsis, including deaths in early pregnancy following miscarriage and ectopic pregnancy, is the third leading cause of Direct deaths. Unlike the other leading causes of Direct deaths, the rate of maternal deaths from sepsis is slowly increasing. In this triennium the rate was 8.0 per million maternities a rise from 6.8 per million maternities in the last Report.

(Lewis 2001, p. 31)

The 1998 Report states “Puerperal sepsis is not a disease of the past, and GPs and midwives must be aware of the signs and be prepared to institute treatment and referral of any recently delivered woman with a fever and/or offensive vaginal discharge” (Lewis p. 76).

Subcategory	Deaths 1994 - 1996	Deaths 1997 - 1999
Early pregnancy <sup>a</sup>	2 <sup>b</sup>	6
Puerperal Sepsis	11	2 + 2 late
Sepsis after surgical procedures	3	1
Sepsis before or during labour	1	7
Total	17 (including abortions)	18
Rate per million maternities	7.3 (including abortions)	8.4

Table 2 showing the breakdown of maternal deaths from genital tract sepsis per million maternities; UK 1994 – 1996 and 1997 – 1999 (derived from Lewis 2001, p. 122).

<sup>a</sup> including deaths following miscarriage, ectopic and other causes

<sup>b</sup> in 1994 – 1996 these deaths included in early pregnancy deaths

As can be seen from the tables, subcategories for grouping deaths, even within the genital tract sepsis group, have changed between the last two Reports. This makes any comparisons difficult without detailed scrutiny of the figures in both individual reports and on initial reading of the figures may suggest that different figures for the same subcategory are being used. How much more difficult it must have been to compare the same categories over time in the nineteenth century, when the definitions were changing even more rapidly.

Chapter 7, Genital sepsis pages 76 to 83, in the 1994 - 1996 Report (Lewis 1998), makes grim reading as each case is summarised following the enquiry. Part of the aim is to identify substandard care, in that some of these women may not have died had the care been better. In the deaths from sepsis substandard care occurred in five of the cases. In other words 11 women or 68.75% of the women who died of sepsis between 1994 and 1996 died despite good medical and midwifery care (Lewis 1998). In the 1997 – 1999 triennium of the 14 maternal deaths from sepsis, 6 had a major factor of substandard care and 1 a minor, i.e. in 50% of the cases reviewed the women may not have died had the care been better (Lewis 2001).

“There have been recent reports suggesting an increase in the number of cases of serious invasive streptococcal infection, with and without shock, suggesting spread of a more virulent clone. The course of these infections is dramatically rapid...” (Lewis 1998, p. 83). The first key recommendation in the 2001 Report for genital tract sepsis states that “The onset of life threatening sepsis at any stage of pregnancy can be insidious and all doctors and midwives must be aware of the symptoms and signs and be prepared to institute immediate treatment to avoid serious consequences” (Lewis 2001). Sepsis as a cause of death in childbirth is still very real and doctors and midwives clearly have to be even more vigilant and proactive in diagnosis and treatment if the death rate from sepsis is not to continue to rise as we enter the twenty first century.

### **Early Nineteenth Century Midwifery**

Early in the century there was a decline in the need for female midwives owing to the establishment of lying-in hospitals, the regulation of men-midwives, medical advances and the seizing of control of childbirth by male doctors. There was also training for monthly nurses who

appeared to supersede the need for the female midwife. The training of monthly nurses commenced in 1824 at the British Lying-in Hospital (Towler and Bramall 1986). The monthly nurse often attended a woman in labour for the doctor-accoucheur, so that he didn't personally have to be there throughout the labour. Then she would stay and care for the mother and baby during the lying-in period (Loudon 1992, Towler and Bramall 1986). However, monthly nurses were not highly thought of by the public. A description of a monthly nurse by Leigh Hunt in 1846 (cited in Towler and Bramall 1986) seems to echo Charles Dickens' portrait of Mrs Gamp. Nevertheless the poor could often only afford the untrained midwife who would deliver the baby and then visit for a week and help with the housework. The trained midwife would deliver the baby but would not spend so much time helping the mother in the home (Loudon 1992) and was more expensive.

One of the main reasons for the threat to midwives was the attitude of the majority of doctors who saw the untrained midwife as incompetent and dangerous to society and the educated and trained midwife as potential competition. "There was no shortage of birth-attendants in the nineteenth century" (Loudon 1992, p. 178). However all over the country midwives delivered the majority of babies at home, particularly those of the lower social classes, without medical assistance. These poor families could not afford to buy the services of a doctor and so were at the mercy of the local midwife; an educated woman or more in the genre of Sairey Gamp. The village midwife therefore often had to attend women with poor health from heavy physical work and repeated childbearing. They may also have had pelvis distorted by rickets, tuberculosis or anaemia in addition to complications of pregnancy. The midwife often had to go out at night alone. She was likely to be exposed to crude language and manners and bawdy humour, from those under the influence of alcohol. Respectable gentlewomen would not want to be associated with this occupation.

Determining the number of midwives in the country was a spurious calculation. The first national census was in 1801, but it was not until 1841 that individuals' occupations were recorded. The 1841 census return showed that in England and Wales there were just over 700 midwives. By 1851 this figure had risen to 2,204 and by 1881 a further rise had taken place to 2,600 (Loudon 1992). Dr Aveling in his evidence to the Select Committee on Midwives Registration in 1892 put the number of midwives in England and Wales between 10,000 and 15,000 (Loudon 1992). The difficulty in determining whether the census data or Dr Aveling's figures are nearer the reality is

complicated. Some midwives worked full time in the job, but others combined it with nursing or field labour and many who just undertook the occasional delivery were often known as the nurse and were more likely to put that title as their occupation on the census form than midwife. The census data and indeed that of other notable persons of the time are therefore likely to be unreliable in determining the actual number of women who conducted deliveries during the nineteenth century.

In the early part of the nineteenth century the threat to female midwives from men-midwives/apothecaries/surgeons was decisive. In 1813 the Society of Apothecaries failed to get a bill passed through Parliament for the examination and regulation of female midwives (Arthure 1973, Aveling 1872). Dr Aveling (1872) quotes an extract from the *Transactions of the Associated Apothecaries and Surgeon-Apothecaries of England and Wales* in his book *English Midwives* but this only relates to the female midwife and her license and practice. Aveling (1872) suggests that the Committee of the House of Commons “incurred a grave responsibility” (p. 155) in rejecting this part of the Bill. He felt that although it did not include any mention of teaching of midwives it would have anticipated some measures that Parliament would have to consider in the future. The Society of Apothecaries persuaded the College of Surgeons to propose that only men-midwives who held their diploma should be allowed to practise midwifery. This, of course, included the majority of apothecaries and therefore increased their opportunities to practise midwifery. However Aveling (1872) states that throughout the nineteenth century there was a prejudice against men-midwives that was “fostered by ignorance and jealousy” (p. 156). Aveling (1872) also quotes Dr Samuel Merriman who wrote a reply to another enquirer about the art of midwifery as practised by medical practitioners. Merriman was of the opinion that the question of employing male accoucheurs was virtually settled and men were preferred because “they have been proved to possess greater skill, greater judgement, greater mildness, greater patience, and greater decorum” (p. 157). He continues that if men had not possessed these attributes then women would not have been employing them. Aveling (1872) also quotes Dr Merriman’s reply to Dr Kingslake from 1816 citing declining maternal and infant mortality statistics over two twenty five year periods as another good reason for the engagement of male accoucheurs. Men-midwives became acceptable to women, providing they could afford their fees. However Loudon (1992) is of the opinion that the middle classes liked to be attended by well trained middle class women for their lying-in. Towler and Bramall (1986) state that even in rural communities the man-midwife or accoucheur had an established presence. Female midwives tended to be relegated to a more domestic and nursing role.

Some midwives received instruction in the lying-in hospitals and either remained in practice there, working under the supervision of the men-midwives, or worked in the community either independently or linked to the hospital (Donnison 1988, Towler and Bramall 1986). Many of the lying-in hospitals were charitable organisations and therefore dependent on funding for continuous operation. At Queen Charlotte's Hospital, London nurses and medical students received midwifery instruction from 1809. It was not until 1851 that a three month training period was introduced for midwives. They had practical teaching from the sisters and lectures from the doctors, received a diploma and were entitled to act as qualified midwives if, at the end of their training, they passed an examination (Adams 1984 cited in Towler and Bramall 1986). However the majority of midwives, outside London and the main cities, were unqualified having received no formal instruction at any time. Only a few of the Poor Law Institutions, which were large enough to provide training, agreed to do so, for example Liverpool and Kensington. Many of the Poor Law Guardians considered it unnecessary. Some midwives learned their skills in a form of apprenticeship, accompanying an experienced midwife. Sometimes it was a family business where the daughter learned from the mother (Loudon 1992). Many of them had not even had any formal general education. Towler and Bramall (1986) suggest that the skill of these local midwives varied from capable and experienced to dangerous even by the standards of mid nineteenth century England.

### **Puerperal Fever**

Puerperal fever is an illness which results from infection of the uterus during or after delivery. Very occasionally it occurred before delivery as a result of premature rupture of the membranes surrounding the foetus, or because of the intrauterine death of the foetus, or both. But the vast majority of cases which occurred in the past began in the first or second week of the postnatal period. Typically, the uterus was infected during delivery, but the disease only became evident after a latent period, sometimes as short as one or two days, but usually four or five and sometimes longer.

(Loudon 1992 p. 53)

In the nineteenth century it was generally considered safer for a mother to give birth at home rather than in one of the lying-in hospitals because of the fear of puerperal fever. Indeed Dr Farr made such a comment in his 1867 Report. Lying-in hospitals had been built originally to accommodate poor women in large open wards and as a result many of them died. Dr Farr believed that the wards should be converted into small units for one or two women or closed, given that the majority of babies were born at home. Nightingale (1871) supports this view in her *Notes on Lying-in Institutions* where she gives a breakdown of the Registrar-General's 1867 Annual Report. There was an overall death rate of 5.1 per 1000 from all cases including 1.4 per 1000 for

puerperal diseases for women delivered at home. In Birmingham the Lying-in hospital was closed and an out-door midwifery system instigated. The maternal mortality rate dropped. Dr Farr commented in his 1876 Report that if all mothers had received the standard of care given by the out-door charities then the maternal mortality rate would have fallen by 65% and 2,600 women would not have died (Donnison 1988). Statistics did not exist for the practice of midwives alone, but they existed for midwives practising in out-door charities, who worked under the oversight of the Medical Officer. A number of these charities showed a maternal mortality rate of less than half the national figure. Donnison (1988) states that midwives in private practice and lone practice medical practitioners claimed similar low figures. However many midwives and medical practitioners fell below this standard as Dr Farr pointed out in his 1876 Report as Registrar General (Donnison 1988). The question of the closure of maternity wards in nineteenth century Britain occurred, not just because of the rising puerperal fever death rates but also because of the rising costs of the hospital maternity services, partly because of the inefficient administration of the hospitals. Similar discussions have taken place in the late twentieth century regarding the closure of small maternity units, which serve a local population, but are expensive to run and do not have emergency services available on site (Paterson 1990, Young 1989).

The eminent Edinburgh obstetrician James Matthews Duncan challenged both the maternal mortality figure, saying it was too low and the out-door charity midwifery system. He said that their figures must be wrong. He could not comprehend how poor women in slum conditions attended by unqualified midwives could survive childbirth, whilst wealthy women attended in salubrious conditions by trained accoucheurs were at a higher risk of death. However Dr Braxton-Hicks a Physician-Accoucheur at Guy's Hospital in London thought Duncan's estimate of a maternal mortality rate of 8 per 1000 high. He based his opinion on the out-door practices attached to Guy's Hospital, which had a mortality rate of 2.5 per 1000 (Donnison 1988). Nightingale (1871) also challenges Duncan's mortality rate and, accepting that the figure was as correct as the Registrar-General's, asks whether the fate of women "in the hands of educated accoucheurs" (p. 10) was that one in every 128 must die. She suggests that these figures stress the need to collect accurate statistics. Nightingale ends this section of *Notes on Lying-in Institutions* with figures from a Mr Rigden's private practice in Canterbury over a thirty year period. He had a total mortality rate of 2.17 per 1000 of which less than 1 per 1000 was due to puerperal fever. Clearly whether you lived or died in childbirth depended greatly on where you lived and who was your doctor or midwife. Nightingale (1871) also used the statistics of Dr Le Fort. He demonstrated that of women delivered at home in Edinburgh, London, Paris, Leipzig, Berlin, Munich,

Griefswald, Stettin and St Petersburg there was an overall death rate of 4.7 per 1000, which is similar to the Registrar-General's figure of 5.1 per 1000 for women delivered at home.

In Britain the main puerperal fever epidemics occurred in London in 1860 and 1861, although according to Towler and Bramall (1986) these never reached the death rate of the European hospitals. In 1867 Baly (1986) cites a death rate of 35 per 1000, or 1 in 29 as not unusual for a lying-in hospital and further concurs with Smith (1982) that the maternal death rate of 1 in 29 was a poor reason for Nightingale to close the training school at King's College Hospital, London, in 1867 when at the same time the death rate was 44 per 1000 at Guy's Hospital. In *Notes on Lying-in Institutions* Nightingale (1871) writes a section on deaths in Lying-in hospitals. She compares rates in military hospitals (8.8 per 1000) with those in Liverpool workhouses (9.06 per 1000), London workhouses (9.8 per 1000), City of London Lying-in Institution (10.9 per 1000), British Lying-in Institution (14.3 per 1000) and Queen Charlotte's Lying-in Hospital (25.3 per 1000). The death rates have been calculated over several years figures, but not the same years, so like is not compared with like. The figures quoted for the Rotunda Hospital, Dublin, for example, show a death rate of 26 per 1000 between 1857 and 1861 but a death rate of 14.5 per 1000 if the figures are extrapolated between 1828 and 1861. These were all deaths not just puerperal fever deaths.

In Britain and Europe the maternal mortality rate was far higher in lying-in institutions and hospitals than home. The exceptions to this were the rates in English workhouse infirmaries which also had lower rates. Births, annually, were less frequent in the workhouses and therefore Nightingale suggests conditions were more similar to homes than lying-in institutions (Loudon 1992). However most babies were still born at home, with in-patient deliveries just a small part of the total births. The average number of live births in England and Wales in the 1880s was 890,000 of which 31,700 were voluntary hospital or workhouse infirmary deliveries and 36,000 out-patient deliveries (Loudon 1992). Loudon (1992) suggests that the majority of deaths from puerperal fever therefore occurred after normal deliveries at home. Loudon (1992) suggests that the proportion of total deaths from puerperal fever which occurred in lying-in hospitals in the second half of the nineteenth century was less than 30 per 1000. One of the main problems in considering these figures is that the comparison is not considering figures derived over the same years or even from the same size samples or populations. This raises issues of statistical significance in the figures for different groups (hospitals, towns, rural communities and countries), which could well show a range of variation in number of deaths but on comparison are not

statistically significant at the 95% level (Loudon 1992). The annual values of maternal mortality are only practical if populations and the number of births are very large. When comparing differences between counties and small towns one needs several years of births to accumulate big enough numbers for mortality rates to be significant. Swings in figures over a time series will appear greater if the number of maternal deaths is small. Issues of statistical significance need to be kept in mind particularly when comparing figures and graphs from the nineteenth century, when maternal mortality rates from individual lying-in institutions were often compared with those of whole countries (Loudon 1992), for example Nightingale (1871) in *Notes on Lying-in Institutions*.

Nightingale (1871) quotes 12 Parisian hospitals between 1861 and 1863 as having a death rate of between 70.3 and 95.1 per 1000 deliveries. Nightingale (1871) also uses Dr Le Fort's data again. He gathered figures from 58 lying-in institutions across Europe ranging over one to 63 years, which again demonstrates that like is not compared with like. The deaths rates from all causes ranged per 1000 deliveries from 0 over four years to 140 over four years. Nightingale (1871) acknowledges that in some of the hospitals the rates vary in different groups of years. She therefore appears to be recognising that she is not comparing like figures, but still calculates an overall death rate in Europe of 34 per 1000, which she also acknowledges was higher than the rate when the midwifery training school was closed at King's College Hospital. Loudon (1992) states that in 1874, the worst year for puerperal fever deaths since death registration began in 1837, 3,108 deaths or 52% were registered as being due to puerperal fever. This figure is likely to be an underestimate. In 1885 a New York doctor estimated that 75% of deaths in childbed resulted from puerperal fever and given the doctors' unwillingness to acknowledge its presence he suggested a mortality rate of 40 per 1000 in private practice (Wertz and Wertz 1977). This is cognate to the death rates in England and Europe.

In 1893 Robert Boxall was Assistant Obstetrician to the Middlesex Hospital and under took a survey of maternal mortality from 1847 to 1892. He compared the deaths rates for all causes and those for puerperal fever. He noted that in a year when there was a high incidence of puerperal fever there was also a higher incidence of deaths from other causes. He suggested that if women died and there were two possible causes of death, for example, the woman had had a postpartum haemorrhage but had then developed an infection and died, many of the doctors would cite the haemorrhage as the cause of death because of the disgrace associated with deaths from puerperal

fever. Boxall also noted that the 1874 peak was obvious not only for England and Wales as a whole but also for the individual provinces and London. Loudon (1992) has taken this analysis further and has shown that there were also peaks in the puerperal fever death rate in Scotland, Sweden, Paris, Amsterdam, Belgium, Norway and Massachusetts between 1873 and 1875.

In *Notes on Lying-in Institutions* Nightingale (1871) gathers together vast amounts of English and European statistics on maternal mortality in the nineteenth century. It makes fascinating yet sobering reading as the detail of just how many women used to die in childbirth emerges from the pages. Reading the text, which Nightingale wrote, gave me another view of the woman whom I had previously only read about or read her letters. The detail and dedication she obviously showed in researching the issues demonstrates the passion with which she undertook the task “under circumstances of all but overwhelming business and illness” (Nightingale 1871, p. x) and her consummate understanding of the issues involved. *Notes on Lying-in Institutions* commences with a short preface regarding the deaths and closure of the Kings College Hospital Midwifery School. She includes a table listing all the dates and deaths. In the year of the closure, 1867, the death rate was 1 in 13.8 or 72 per 1000 and of the nine deaths, eight died of puerperal fever and one of pyaemia (an interesting distinction). Part of Nightingale’s reason for writing *Notes on Lying-in Institutions* centres on her concern regarding the training of midwifery nurses. She felt very strongly that the pupils should have experience caring for women at home and hospital confinements, but she was concerned about the maternal death rate in hospitals and any connection the pupils may have with it.

Later in *Notes on Lying-in Institutions* Nightingale (1871) turns her attention to the causes of deaths in lying-in institutions. She states that puerperal fever is the principal cause of death and that it occurs across Europe in varying climates, although she says that it is less frequent in the summer, when due to the hot temperature more windows are open which facilitates ventilation. Nightingale was very keen on fresh air and ventilation as can be seen in some of her other work, particularly in designing hospitals. Dr Le Fort wrote about the communicability of puerperal fever and as Nightingale read his work she would most likely have been aware of the major theories of the spread of disease at that time. Nightingale was aware that there appeared to be some fatal connection between students first visiting surgical patients or the post mortem theatre then women on the lying-in ward. However she does not mention the work of Semmelweis and placed emphasis on miasmatic influences. Nightingale had tried to ensure that precautions were taken at

King's College Hospital to minimise the risk from the students, but enquiries at the time of the high death rate found that the rules had been broken and a post mortem theatre was "almost under the ward windows" (Nightingale 1871, p. 26). Nightingale (1871) explores the effects of the numbers of women brought together in buildings constructed and managed for the purpose of lying-in as a risk and comes to the conclusion that lying-in hospitals and lying-in wards in general hospitals, such as those at King's College Hospital should be closed. This supports Nightingale's belief in the need for fresh air, ventilation and cleanliness and the airborne nature of the spread of putrescence. It also confirms her strong belief in home delivery. Whilst acknowledging the potential for inaccuracy in Dr Le Fort's data she writes "for every two women who would die if delivered at home, fifteen must die if delivered in lying-in hospitals" (p. 68).

Following on from Nightingale's interest in buildings and designing hospitals she is convinced that training schools should not be converted buildings but purpose built and as safe for lying-in women as if they had been delivered at home. Nightingale (1871) concludes *Notes on Lying-in Institutions* with her own design for a lying-in institution and training school, including such details as number of beds to a ward, number of wards to a floor, amount of space per bed, number of windows to a bed, healthy walls, ceilings and floors, healthy and well lit delivery ward, the scullery, lavatory, ventilation, furniture, bedding, linen, water supply, drainage, washing, medical officer's room, waiting room, segregation ward, kitchen and site (p. 74 – 86). The detail is quite remarkable. It is indicative of the amount of research she undertook into the subject, her belief in herself and her belief that she was right despite the fact that there were still several theories regarding the aetiology of infection and her views on it were not eventually the correct ones. Nightingale also wrote about the management of the lying-in institution and it included moving the women three times during their stay with seven or eight hours in the delivery ward, then five or six days in the lying-in ward and finally nine or ten days in the convalescent ward (p. 93). However Nightingale suggests that the mattress and blankets of any bed in the delivery ward should not be used for more than three or four cases in succession without undergoing a process of disinfection (p. 94). This sort of suggestion clearly demonstrates her lack of knowledge and/or understanding which can be attributed to the discovery and dissemination of scientific knowledge at the time.

During labour the cervix, vagina and perineum may be lacerated or torn, whilst the inner surface of the uterus is an open wound following the delivery of the placenta and membranes. Being

warm and wet, it is an ideal breeding ground for bacteria. On rare occasions the genitalia's own bacteria may be harmful, but most infectious bacteria enter from outside via unclean hands or instruments. Some bacteria, for example beta haemolytic streptococcus, group A are so virulent that they can be transmitted on clothes from one woman to another and between homes. Infection can take hold quickly in these typical conditions and cause widespread inflammation of the pelvic and abdominal cavities, septicaemia and death within days (Loudon 1992). Some doctors were very concerned about this childbed fever and tried to introduce prophylactic regimens to control the spread of infection. Dr Charles White of Manchester recommended as early as 1763 "fresh air, strict attention to cleanliness of patients, attendants and their environment, adequate ventilation, postural drainage and early rising after delivery" (Towler and Bramall 1986, p. 154). Wertz and Wertz (1977) state that Charles White believed that the fever was caused by self poisoning from vaginal fluids that were not permitted to drain properly when confining the women to bed. Loudon (1992) suggests that Charles White was sure that any outbreak of puerperal fever was due to the putridity of the atmosphere, a common view at the time, and hence the need for fresh air and cleanliness. Either way, under his regimen the puerperal death rate in Manchester dropped.

Alexander Gordon studied medicine in Aberdeen and Edinburgh, served as a naval surgeon for five years and spent nine months in London studying midwifery. He then returned to Aberdeen in 1786. In December 1789 there was a severe outbreak of puerperal fever in Aberdeen which lasted for over two years. At first it was not recognised, but then Gordon realised that he had seen it in London. He kept accurate and specific notes and was able to observe that it was confined to the practice of a few midwives. He was able to predict the next case simply by knowing which midwife had delivered the woman. From these observations he was able to provide evidence that puerperal fever was a contagious disease which could be carried by the birth attendant from one woman to another, including himself. This was one of the first studies of maternal mortality (Macfarlane 2001). Gordon also demonstrated that it was closely related to erysipelas. He therefore anticipated the findings of Holmes and Semmelweis by more than half a century, but he believed that the cure was early and heavy bleeding and purging. This treatment was not popular in Aberdeen and women refused to be delivered by him. He was eventually recalled to the navy, but was invalidated out with pulmonary tuberculosis and died aged 47. In the nineteenth century Gordon's work was mainly used to refute the idea that bleeding was the only treatment, his work on contagion was rarely mentioned. It was however part of the growing body of evidence that demonstrated the contagious nature of puerperal fever (Loudon 1992). By the 1840s it was generally understood that the disease could be carried from one case to another, but that the

possibility could usually be avoided by a complete change of clothes and thorough washing (Loudon 1992).

In 1843 an American, Dr Oliver Wendell Holmes published the conclusions of a study he had undertaken of the deaths of women following home deliveries and doctors following autopsies. He concluded that some doctors were carrying a contagion from home to home, possibly from autopsy material from women who had died of the fever. He determined that if a doctor conducted such an autopsy he should clean himself and his clothes thoroughly and should not undertake any deliveries for some weeks should a case occur in his practice (Rhodes 1995, Wertz and Wertz 1977). The article was published again in 1855 under the title of *Puerperal Fever as a Private Pestilence* (Loudon 1992, Rhodes 1995) and this time it reached a wider audience. His main argument was that puerperal fever is so contagious as to be carried from patient to patient by doctors and nurses. Professor Meigs objected to Holmes suggestion that a gentleman's clean hands could carry this infection and cited the case of Dr Simpson in Edinburgh who had had women die of puerperal fever. Holmes replied that as Dr Simpson was both a gentleman and as a gentleman's hands were clean it just proved his point that some doctors carried the infection (Rhodes 1995, Wertz and Wertz 1977). Meigs denied that puerperal fever was a contagious disease until his death and was ridiculed for his personal attacks on Holmes. Ironically Meigs admired Gordon for his advocacy of heavy bleeding in the treatment of puerperal fever and Meigs continued using venesection whilst others were abandoning it (Loudon 1992).

In 1846 Ignaz Philipp Semmelweis was appointed to the large Vienna Maternity Hospital. It was a prestigious obstetric training hospital with around 8,000 patients a year. He observed that in the ward where medical students attended deliveries the maternal mortality was 437% more than in the ward where midwives attended the women (459 deaths to 105 deaths). The medical students would attend post mortem examinations and then go to the labour wards and perform vaginal examinations with their bare unwashed hands. For teaching purposes each woman had to undergo several examinations, it was also considered good practice (Loudon 1992). The Viennese women were aware of this disparity and would often leave admission to hospital until the last minute so that they would be taken to the midwives ward (Rhodes 1995). Semmelweis also observed that those women who delivered on the hospital steps or the corridors did not die and concluded that this was because the staff did not touch them (Wertz and Wertz 1977). The mortality from puerperal fever was often as high as 99 per 1,000. When a medical colleague died,

having cut his finger at an autopsy, with similar symptoms to puerperal fever, Semmelweis determined that decomposed matter caused the disease and required all birth attendants to wash their hands in a chloride of lime solution before attending the women. In 1848 45 women died from 3,556 deliveries on the medical students' ward, a death rate of 12.7 per 1000 and a comparable number died on the midwives ward (Loudon 1992, Rhodes 1995, Wertz and Wertz 1977). Wertz and Wertz (1977) suggest that the death rate was this high because Semmelweis did not realise that the bed sheets should be changed between women bed occupants. However he did correctly deduce that puerperal fever was caused by the transmission of putrid particles acquired from living organisms by doctors examining women internally. Loudon (1992) suggests that Semmelweis' achievements need to be put in perspective in that he certainly reduced the death rate in the Vienna Maternity Hospital dramatically, but that the mortality rate was still higher than in England and Wales (5.1 per 1000 in 1867). This seems a little unfair to Semmelweis, given the inaccuracy of maternal mortality statistics at the time, which Loudon comments on. Loudon (1992) further proposes that were it not for the prestigious nature of the Vienna Maternity Hospital there would have been convincing justification for closing it. Semmelweis' treatise *The Aetiology, Concept and Prophylaxis of Childbed Fever* was not published until 1861 and Loudon (1992) states that there is no evidence that Semmelweis knew of the work of Holmes, Gordon or any of the other authors who had published earlier in the century. Nightingale (1871) was aware, through the writings of Dr Le Fort, of the findings on the two wards in Vienna and recounts them in *Notes on Lying-in Institutions*. Nevertheless there is room to doubt that she either knew or understood all that had happened in Vienna, in that her conclusion is to reaffirm the separation of medical and midwifery students' education and instruction.

Despite washing hands and changing clothes some doctors continued to transmit the infection because they were chronic carriers of bacteria, for example, in the nasal passages. Dr. Rutter, a pupil of Dr Meigs in Philadelphia, had ninety five cases in four years; eighteen of whom died, despite his sanitary practices. After the first forty five cases Dr. Rutter left the city for ten days, burned his clothes, shaved his head, beard and moustache, cut and cleaned his nails and bathed. His next patient died of puerperal fever (Loudon 1992, Wertz and Wertz 1977). Hence prevention was not completely successful because the cause and treatment were still unknown.

Several speculative theories of causes for the fever were advanced. Carl Braun, Professor of Obstetrics in Vienna did not accept Semmelweis' cause of the fever and blamed the weather for

the epidemics. Semmelweis compared meteorological records with the incidence of the fever to show that this was not true (Rhodes 1995). Holmes thought that puerperal fever was an infectious skin disease. Others believed that it was specific to parturient women and resulted from some morbidity of their condition like putrefaction of retained products of conception. Causes were thought to include putrid air, tight stays, difficult labours and overcrowding in hospitals (Loudon 1992). Others thought it was autogenic i.e. from causes within the woman and others thought it heterogenic; from causes outside the woman, for example Semmelweis. Some European doctors and indeed Nightingale believed in the miasma theory according to which bad air or some other environmental influence carried the disease to some but not all women. English and Scottish doctors tended to favour the contagion theory of the transmission of disease between people, although they didn't know what was transmitted. Some American doctors, having observed changes in the blood chemistry of pregnant women argued for a spontaneous rise of the fever in the blood, but they could not account for why the fever arose in some women and not others. According to Wertz and Wertz (1977) in 1877 the president of the American Gynaecological Society blamed puerperal fever on the woman's moral and mental condition. He particularly mentioned the unmarried mother driven from her home and seeking the lying-in asylum who would be anxious over her and her baby's future and weak from cold and hunger. There is some truth in that these women would no doubt be more likely to die from infection, because of their general poor state of health, if they caught it in the first place. Queen Charlotte's Hospital also tried to use the same rationale for its high maternal mortality rate. It claimed that its policy of admitting unmarried mothers was the reason for its high maternal mortality rate. However, the proportion of unmarried mothers delivered in workhouse infirmaries was even higher and yet their mortality rates were much lower (Loudon 1992).

Some, of course, thought it was a contagious disease, but this was not considered important as the large majority of sporadic cases occurred with home deliveries (Loudon 1992). Semmelweis persisted with his theory of contagion and insisted that in every case there had to be absorption of decaying matter. He failed to provide any evidence for all cases including the sporadic cases in home deliveries, the epidemics, and the cases that appeared to follow certain medical practitioners or midwives. His insistence on a single theory of spread of infection lost him credibility and he died aged 47 a "disappointed man" (Loudon 1992, p.70).

Although other bacteria could cause death from puerperal fever the vast majority were, and are, caused by beta haemolytic streptococcus Group A. Although the bacterial cause of puerperal fever was first demonstrated in 1864 when the presence of bacteria in the vaginal discharge of infected women was discovered, only a few medical scientists were prepared to accept the germ theory. In 1879 Louis Pasteur demonstrated that the microbial chains he first described in 1860 and called streptococci were puerperal fever's major cause by cultivating them in the laboratory from cases of puerperal fever (Loudon 1992).

Joseph Lister, a Professor of Surgery in Glasgow, described the principles of antisepsis in 1867 with the use of antiseptics in surgery. He used carbolic acid or phenol to dress compound fractures where the skin was broken and published a series of papers in the *Lancet* (Rhodes 1995). Doctors were slow to transcribe these for use in childbirth, to prevent infection, particularly in hospitals. In 1877 Lister moved to King's College Hospital in London. By that time there was no major use of antiseptics in midwifery. In 1878 the governors of the General Lying-in Hospital in Lambeth recorded a very high maternal mortality rate and closed the hospital for a thorough cleaning and repair. At the same time they appointed Lister as Consulting Surgeon to the hospital. He introduced his antiseptic principles. The maternity wards re-opened in 1880 with only one death from puerperal fever and the following year there were no deaths (Rhodes 1995). This was important as the General Lying-in Hospital was a major venue for training midwives who then practised all over the world taking the knowledge and practice of antisepsis with them (Rhodes 1995). Loudon (1992) suggests that the only significant change in obstetric practice across Europe and the United States of America at that time was the introduction of antisepsis. He also states that there was a corresponding drop in the deaths from erysipelas during this time and that the common factor was Streptococcus pyogenes. Antisepsis would not have had an effect on the erysipelas death rate and therefore Loudon (1992) suggests that there may also have been a corresponding fall in the virulence of the streptococcus at this time. He further proposes that the fall was less dramatic in Britain than in Europe and surmises that this was because of "the low standard of antiseptic practice in home deliveries in Britain" (p. 239). The puerperal fever incidence declined, but there was still room for error. Wertz and Wertz (1977) cite the example of the Boston Lying-in Hospital in 1883 which used to douche women's vulvas with carbolic acid, without disinfecting the syringe or washing hands between women. Hence the hospital had another outbreak of puerperal fever. Venesection was popular until the 1870s when surgical methods then became fashionable. The infected uterine cavity was irrigated with douches or treated with packs containing iodine, carbolic acid, mercurochrome or other antiseptics. Intramuscular or intravenous injections of normal saline, formalin or aqueous solutions of silver

were also administered as treatment. Curettage and hysterectomy were considered treatments for puerperal fever in the late nineteenth century. Many of the treatment regimes were fatal in themselves. Negligence in antiseptic practices and changes in the virulence of the streptococcus made puerperal fever a continuing problem well into the twentieth century, until sulphonamides and penicillin became available for treatment (Loudon 1992).

### **Obstetric and Midwifery Practices**

The nineteenth century saw the first use of chloroform for childbirth by James Young Simpson (Rhodes 1995). Chloroform was most widely used after Queen Victoria chose to have it administered for the birth of Prince Leopold in 1853 and again for the birth of Princess Beatrice in 1857 (Rhodes 1995). However it was more than likely only administered to the richer women in their home confinements, as they were the only ones who could afford it. James Young Simpson was also the first to use chloroform for a Caesarean section delivery. Caesarean section was usually the last resort in the nineteenth century and was practiced very infrequently, even with the advent of anaesthesia. The outcome was usually fatal for both mother and baby.

Nineteenth century antenatal care was limited. Mothers were advised to have a daily rest in a quiet cool room (Smith 1979). As the pregnancy advances Churchill, (1872) an eminent doctor who wrote *A Manual for Midwives and Monthly Nurses*, suggests that “Stays should be altered entirely, the front bone or steel should either be removed or exchanged for one much slighter” (cited in Baker 1985, p. 34). Vaginal examinations were also performed antenatally after the administration of an opiate and using two ungloved fingers lubricated with lard (Smith 1979). The mother was placed in the left lateral position and the oiled finger was passed under the bedclothes, to maintain the mother’s modesty and prevent her from catching cold “which in childbirth is a very serious thing indeed” (Churchill 1872 cited in Baker 1985, p.34). Catheterisation was performed in the supine position but still with the midwife passing the catheter under the bedclothes and feeling for the urethra with her hands (Churchill 1872 cited in Baker 1985). Pregnancy was not to be considered as a diseased state but “rather as a natural condition which needs little more than common sense in the majority of instances to conduct it to a happy termination” (Churchill 1872 cited in Baker 1985, p.34).

Churchill (1872) also describes the equipment the midwife would need for the delivery including, “a quiet bedchamber, a bed without or half a roof, a hair mattress, castor oil, a sheepskin, binders, strong pins, scissors and a sufficient supply of bed linen and napkins” (cited in Baker 1985, p.34). The prevailing belief amongst doctors was that interference with the physiological processes of labour was unnecessary. In the first stage of labour mothers were advised to be up and about. Some nourishment was permitted; thin gruel, arrowroot, sago, whey or weak tea but no alcohol (Ryan 1841 cited in Towler and Bramall 1986, Churchill 1872 cited in Baker 1985). This was sensible advise, although the doctors at the time did not know it, as an intravenous infusion of alcohol was used in part of the twentieth century to slow down and hopefully stop premature labour and delivery (Enkin, Keirse and Chalmers 1989). Various studies were also undertaken in the latter part of the twentieth century on feeding in labour. For many years doctors would not allow women to eat during labour for fear of aspiration pneumonia, following an anaesthetic. More recently studies have suggested that a light diet is acceptable in early labour, if wanted by the woman (Enkin, Keirse and Chalmers 1989, Michael, Reilly and Caunt 1991).

Most women at this time were delivered in bed. Liquor of opium was prescribed for the relief of pain (Ryan 1841 cited in Towler and Bramall 1986), although most women were encouraged to bear labour courageously and cry out, using a sheet fastened to the bedpost to pull on (Churchill 1872 cited in Baker 1985). Midwives were keen to get the women out of bed within the first twenty four hours to help drain the lochia, but the literal lying-in period was at least fourteen days. Women were advised to remain horizontal and only to sit up on the 5<sup>th</sup> or 6<sup>th</sup> day if they felt able and the more fragile patients were discouraged from doing so until much later. “Cases of sudden death have repeatedly occurred from patients sitting up too soon” (Churchill 1872 cited in Baker 1985, p.34). Churchill (1872) is adamant that the mother should not get out of bed at all at least until the eighth day following delivery and then warmly dressed and only for one hour (cited in Baker 1985). Nightingale (1871) states that the average number of days in the lying-in ward at King’s College Hospital was sixteen. None were allowed to leave before fourteen days and up to twenty one days were permitted in ordinary cases. Gruel, beef tea, whey milk and bread and milk were the diet for the first four or five days, then the mother could progress to chicken or veal broth or a chop with a glass of wine or water until eventually she would return to her normal diet (Churchill 1872 cited in Baker 1985, Thompson 1945). Camomile tea was taken for spasmodic after-pains. Camomile was also used externally to alleviate discomfort from small lacerations (Towler and Bramall 1986). Churchill (1872) also suggests the midwife reads to the mother to “calm and compose her mind” (cited in Baker 1985, p.34).

Leeches, blood letting, laxatives, refrigerants, strong opiates and regimes aimed at reducing inflammation were all used in the treatment of puerperal fever (Towler and Bramall 1986). The application of eight to ten leeches was also advocated by Churchill (1872) for badly inflamed breasts, but those that were just hard and painful could be rubbed gently with a little warm oil to give relief (cited in Baker 1985). In the twenty first century the treatment would be to put the baby to the breast, if the mother was breast feeding, or to leave well alone and prescribe paracetamol for pain relief, if she was bottle feeding (Enkin, Keirse and Chalmers 1989, Inch and Fisher 1995).

### **Late Nineteenth Century Midwifery**

In the latter half of the nineteenth century more changes occurred regarding the status and education of female midwives. Nightingale became involved when in 1862 she started the School at Kings College Hospital, London to train midwifery nurses. This will be expounded later in a subsequent chapter. Nightingale also wrote in 1871 *Notes on Lying-in Institutions and a Scheme for Training Midwives*, which indicated her commitment to raising the standard of midwifery practice, despite the failure of her own training school.

By mid century, educated women, the daughters of professional men, were being accepted for training as midwives in hospitals around the country. The midwives had to attend lectures and examinations, which presupposed an entry requirement of literacy. These trained midwives were often given the responsibility for normal deliveries, as is the case now (Towler and Bramall 1986). Training also incurred a cost and therefore it also presupposed an ability to pay the training fee, which was beyond most poor and unqualified midwives. In the late 1880s three infirmaries took pupil midwives for a fee of £10 for a three month course, including board and lodging. Even this sum was way beyond the means of the class of women Dr Aveling, from the London Obstetrical Society, wanted to encourage to train to serve the poor. Also at this time unqualified midwives could practice and often charge the same fee as certified midwives and so there was little incentive to gain a formal qualification (Donnison 1988). The London Lying-in hospitals charged £30-£50 fees, a cost only the wealthiest women could afford (Donnison 1988).

In 1858 the Medical Act established a system of registration for practitioners who held a single qualification in medicine or surgery. However, in practice, the majority held both, but not a qualification in midwifery (Loudon 1992). This in effect granted the continued practice of midwifery by men, not qualified in the area, and it did not require future practitioners to study midwifery either. However the Medical Act 1886 redressed this and required a qualification in medicine, surgery and midwifery before registration as a doctor. Midwifery was established as a legitimate discipline for doctors to practise. Midwives could now rely on calling doctors, who had at least some training, when there was an emergency (Loudon 1992, Rhodes 1995). However it did not make illegal midwifery practice by unqualified persons or other branches of medicine (Donnison 1988, Rhodes 1995). There was no mention of female midwives in these Acts (Towler and Bramall 1986).

In 1858 a group of obstetricians founded the London Obstetrical Society. They were mainly concerned with the reduction in maternal mortality. At the inaugural meeting Dr. Routh called for the compulsory education of midwives (Arthure 1973). They tried on several occasions to call for this and the exclusion from practice of untrained midwives, but failed to convince the Government that it was essential. A second attempt through a Parliamentary Bill in 1870 followed a survey in 1869 which was instigated by Dr Farr, (Rhodes 1995, Towler and Bramall 1986). The investigation found that few midwives were trained or had received proper instruction, many were incompetent and ignorant and that many births still occurred without a midwife in attendance, particularly in the villages. Although in London there were women practising midwifery who had received instruction and were fairly competent in normal cases, they could not manage the obstetric emergencies (Arthure 1973, Aveling 1872, Rhodes 1995, Towler and Bramall 1986).

In September 1865, Elizabeth Garrett, the daughter of a Norfolk merchant passed the examination of the Society of Apothecaries. She had been denied access to a recognised medical school and therefore paid for private tuition. The Society of Apothecaries initially refused to examine her, however since the Apothecaries Act 1815 mentioned persons, not men specifically, women could not be excluded from its examinations. The Society continued to refuse until threatened with legal action by Elizabeth's father. It then sought to amend its regulations to prevent other women taking its examinations. Miss Garrett became a successful practitioner to a wide class spectrum of clientele (Donnison 1988).

Women also tried to gain recognition for themselves as midwives. In 1873 the Ladies Obstetrical College was established to educate lady-midwives. They wanted to get an amendment to the Medical Acts so that women could gain a registrable diploma to practise midwifery with a defined professional status. In 1875 some members tried unsuccessfully to gain a licence in midwifery from the Royal College of Surgeons, who had in 1872 "gained powers to examine persons" (Towler and Bramall 1986, p. 162). The women prepared themselves for the examination, attending the required number of lectures and having conducted twenty labours; (Arthure 1973) but they were not as fortunate as Miss Garrett and the Board of Examiners resigned in protest. They were supported in their decision by the London Obstetrical Society which defended it on the basis that it would be harmful to the public if partly qualified persons were to gain entry to the Register (Donnison 1988).

The women were supported by some men in their fight for the registration and protection of female midwives. George Morant wrote a pro-midwife pamphlet *Hints for Husbands* and Job Caudwell published many such pamphlets against male midwifery (Donnison 1988). Several of the male supporters were also involved in the more general feminist struggles of the times, for example, Professor F. W. Newman who was a leading social reformer in both the feminist and temperance movements and later became a champion against the Contagious Diseases Acts. The three named above were all members of the Female Medical Society formed in 1862 by Dr James Edmunds who was also involved in various temperance movements (Donnison 1988). Dr Edmunds was an early disciple of Semmelweis when many leading obstetricians were still sceptical of his work. Dr Edmunds was convinced that doctors carried infection from their medical and surgical practice and post mortems to maternity wards with the subsequent high maternal mortality incidence. He wanted to detach midwifery from medical practice and save sensitive Victorian women the distress of male attendants. One of the Female Medical Society's first aims was the reformation of midwifery as an occupation for gentlewomen. Donnison (1988) suggests that the rationale for this centred on several premises. Firstly that midwives were responsible for the lives and health of a vast number of the population and as yet had very little training, secondly that some women wished to be attended by female midwives, for social and domestic reasons, and at that time had few skilled practitioners to choose from and thirdly as an honourable profession for young educated women it would open up opportunities to those who would otherwise have become governesses.

In 1865 the Female Medical Society became the Ladies Medical College and twenty gentlewomen enrolled to study, most were women from professional families, a few were seeking information that could be useful to them in the future and some were midwives who chose to undertake the course to improve their knowledge (Donnison 1988). It included lectures over two winter sessions with the intervening summer being spent at a lying-in hospital or maternity charity and “personal attendance upon at least twenty five deliveries” (Aveling 1872, p. 161). The College received encouragement and enthusiasm from those opposed to men-midwives and reformers for women’s rights for example, Lord Shaftesbury, Lord Houghton a trustee of the Nightingale Fund and Dr Farr. The lady-pupils qualified and were eagerly greeted by the public. They had clientele from a cross section of society including upper class women and received fees comparable to doctors (Donnison 1988).

Needless to say Nightingale did not approve of the College. She supported the need for highly skilled midwives and she also acknowledged that those from the College were the best taught in the country (Nightingale 1871) but she looked forward to starting her own School of Midwifery where pupils would be trained to attend all cases, both normal and abnormal. In *Notes on Lying-in Institutions* Nightingale (1871) in an appendix suggests that 25 deliveries are not enough to enable the pupil to learn how to deliver abnormal cases (Aveling 1872). Nightingale’s definition of a midwife included the delivery of both normal and abnormal cases, otherwise the pupils would be midwifery nurses. This is the centre of her objection, she felt that the scheme was proposing to do something in six months that she believed could not be done in less than two years. It needs to be remembered that the College’s first cohort of lady-pupils finished in 1866, the year before Nightingale closed her own School at King’s College Hospital. Donnison (1988) reports that she could find no record of the Society and its College from mid 1873. She speculates that it is because the College appealed for funds to expand its scope so that it could develop into part of a full medical college for women, should this be feasible in the future. The College therefore lasted eight years, just three more than Nightingale’s own School at King’s College Hospital. The College demonstrated that educated gentlewomen could become midwives and undertake valuable work without losing their respectability, although it was unable to provide the vast number of educated midwives needed to attend all childbirths. Following the folding of the Ladies Medical College the idea that England would educate midwives to the same standard as the European midwives, Nightingale’s hope, seemed doomed. However Aveling (1872) supported Nightingale’s idea of “rearing a race of midwives competent and creditable to the age in which we live” (p. 163). Donnison (1988) states that even in Europe midwives were beginning to find their practice restricted to routine cases and men were attending the more wealthy clients.

The Ladies Medical College could train a few women each year who mainly practised in towns amongst the middle classes. However the vast majority of women all over the country were still attended in labour by uneducated, unskilled midwives, many of whom combined midwifery with other work for example nursing the sick and laying out the dead, just like Sairey Gamp.

In 1872 the London Obstetrical Society also implemented proposals for granting midwives a diploma after an examination. It set up a Board of Examiners with Dr Aveling as its Chairman (Arthure 1873). The midwife had to meet demanding criteria before she was eligible to sit the examination, including providing a certificate of moral character, proof of having attended practice at a lying-in hospital for not less than six months, of having attended not less than 25 labours under supervision and a course of theoretical teaching the details of which were to be submitted and approved by the Board of Examiners. She could then sit the examination which required knowledge on subjects such as anatomy, normal midwifery, deviations from the normal, obstetric emergencies, management of the puerperium and baby, hygiene, duties of the midwife and seeking medical aid (Aveling 1872, Baly 1986). The essence of these criteria is still part of the education and examination of student midwives in the twenty first century. The successful candidate would receive a diploma certifying that she was a skilled midwife, competent to attend natural labour (Baly 1986). The fee for the diploma was one guinea and unsuccessful candidates were required to pay a fee of five shillings (Aveling 1872). Following the Medical Act of 1886 a footnote was added stating that the diploma conferred no legal qualification to practice under the Medical Act (Arthure 1973).

The diploma had support but also criticism from amongst others Nightingale, who was still hoping to establish her own Midwifery School. She shared the view of some other critics that the diploma was limited in that it only qualified holders to attend natural labours and Nightingale wanted midwives to be educated to attend abnormal labours as well. Smith (1982) suggests that Nightingale's lack of support was a sign of her own failure with midwifery training and this drove her to oppose the plans of other bodies. However Baly (1986) suggests that this opposition was in line with Nightingale's general attitude to nurse training in that she was against certificates and registration. Certainly this was a view she held for many years as she thwarted the attempts of various bodies over the years to attain both the registration of midwives and nurses. Although eventually even Nightingale agreed that the case of midwives' registration was different to nurses (Donnison 1988). Baly (1986) further suggests that Nightingale opposed the scheme because she

felt that certificates of moral character and having attended 25 deliveries were of little value. The Nightingale School's principle was that trained nurses and midwives must have undertaken formal instruction. The London Obstetrical Society only proposed to hold examinations four times a year and made no mention of formal instruction of any kind (Baly 1986). Finally the proposal contained the suggestion that the General Medical Council be responsible for the registration of midwives, with the authority to grant yearly licences and to remove names from the register. Baly (1986) suggests that this was Nightingale's major objection; that midwives would then be subject to a separate profession which had a vested interest in maintaining the low status of midwives and restricting their practice and earning capacity. In *Notes on Lying-in Institutions* Nightingale (1871) writes about the need for women to be attended by women in childbirth and also that the midwives should be accountable to head midwives. Dr Acland from the General Medical Council and Nightingale corresponded for several years on the issue of the registration of midwives and nurses. By 1876 Nightingale and Acland were more in agreement, especially about the need to train women to be midwives, although Nightingale still maintained that it should be a government backed initiative (Baly 1986).

Few women were seeking formal instruction in midwifery, with only around a hundred midwives being trained in the Lying-in Hospitals in the country (Donnison 1988). Of those even fewer were availing themselves of the Obstetrical Society's examination. After 1880, when the Society established regional examination centres the figures rose. By December 1890 1,130 candidates had taken the examination in preparation for registration, but not all had passed (Loudon 1992). The number of midwives training in the London hospitals also increased, but were still outnumbered by monthly nurses and medical students.

The women's medical movement was supported by those who believed that women were best suited to attend women and children in medical matters. This included midwifery, although the endorsement given was mainly to support women gaining entry to the Medical Register through passing its midwifery examinations. It is unfortunate that the struggle for the education and registration of midwives became tangled in the struggle for women to become doctors. The two professions are not the same and yet their histories are closely entwined during the nineteenth century and blurred with so many different societies and colleges concurrently eager to have their say in the education and development of female midwifery, the main ones being described in this chapter. Those that were against female midwives and female doctors were mainly those male

doctors working in London, who appear to have been a small but very vocal and influential group. They thwarted the education and development of the midwifery profession, as distinct from the medical profession for several decades in the late nineteenth century. As it became easier for women to gain entry to medical schools the female doctors who had then got what they wanted dropped the midwifery cause (Donnison 1988).

The women's movements also did not support the moves by the Obstetrical Society to register midwives. Dr Tilt, the Society's President could not understand why women would not support a scheme aimed at giving all women the right to safe childbirth. However the women wanted to break the monopoly men had in both medicine and midwifery. They did not want female midwives confined to the normal midwifery cases and low pay, whilst male midwives and doctors attended the cases that required instrumental delivery and charged much larger fees (Donnison 1988). If midwives were registered, some doctors believed that they would lose some of their lucrative practice to them and also put the public at risk from less qualified practitioners. Further, they believed that all working men could afford to pay for a doctor if they saved for the occasion. Various provident clubs existed to help working men save for medical expenses. Only the very poor and imprudent were thought unable to pay the fee and therefore the registration of midwives and midwives themselves were unnecessary (Donnison 1988). The reality was somewhat different. A woman may be able to save sixpence a week, if her husband was careful with the money, however, even with provident clubs Donnison (1988) suggests that in most cases saving was not possible. It was hard enough to keep the family together, housed, clothed and fed on the wages a working man received in Victorian England. The guinea for the doctor or midwife was a large sum to find, even putting some money away each week.

The doctors also did not want large poor practices paying a guinea or less per confinement. Dr Aveling had had such a practice and described how continuous attendance on poor women had a deleterious effect on him "mentally, morally, physically and pecuniarily" (Donnison 1988, p. 105). General Practitioners therefore had a dilemma in that undertaking midwifery for the poor was tiring, time consuming and poorly remunerated, yet if the doctor safely delivered the baby then often he gained the whole family as patients for the future and hence the concept of the family doctor was established (Loudon 1992). Dr Aveling suggested the doctor should hand over to the midwife all those patients who could not pay remunerative fees. This describes a two tier midwifery practice; doctors for the rich and midwives for the poor. The poor who needed a

doctor could apply for the services of the Poor Law doctor. However many Poor Law Boards did not allow midwifery attendance by the Poor Law Doctor, unless there were already four or five children in the family, because receipt of poor relief undermined the individual's determination to lead an independent life and encouraged idleness at the rate payers expense (Donnison 1988).

Hence the educated midwife could expect to find the majority of her cases amongst the poor who may only pay four to six shillings per confinement. However a salary of eighty pounds a year could be earned in such a practice. This was equivalent to that of an assistant schoolmistress (Donnison 1988). The midwife would work long hours, day and night with a large number of cases, to earn such a salary. She could undoubtedly accumulate wealth, as she would have very little free time in which to spend her earnings. Cash flow could be a potential problem, as many of her fees would be collected in instalments, or possibly in kind, if paid at all. Midwives could also obtain posts in Poor Law Infirmaries at a salary of twenty five to thirty pounds a year, equivalent to that of an upper servant in a private household. According to Donnison (1988) the hours were long, time off irregular and the diet monotonous. It was probably slightly less hectic than practice amongst the poor in the community, but the salary was less than half and board and lodging would not have made up for this.

Following pressure from various medical associations in 1873, the Government set up an Enquiry to look into the laws and regulations governing the practice of midwifery in other European countries. It discovered that practice had been controlled in France since 1803, in Austria since 1810, Norway, Sweden and Holland since 1865. However this knowledge did not spur the Government into action (Towler and Bramall 1986).

In 1880 a group of diploma-holding midwives formed the Matrons' Aid Society which became the Midwives Institute in 1881 and had the support of Dr Aveling. Its main objective was to gain legislation to regulate the training and practice of midwives so that all mothers would be able to have the services of a trained midwife. Other objectives included giving mutual support to their members and publishing a list of qualified midwives. Nightingale cautiously supported the Society. She was concerned that the Society would achieve little in respect to raising the status of midwives, despite its rules and regulations, if it only concerned itself with the Obstetrical Society's diploma and a three month training course (Donnison 1988). In 1884 the Institute drafted

proposals for a Bill to regulate midwifery, but it was aborted. The Institute also launched a journal called *Nursing Notes* as a supplement to the magazine *Woman* (Towler and Bramall 1986) as a way of providing professional communication between midwives. However the name midwife still had such negative connotations that according to Donnison (1988) lay subscribers had it delivered in closed envelopes in case someone saw the word midwife. It also set up a series of lectures and a library for midwives (Cowell and Wainwright 1981). The Institute was committed to raising the status of the midwife and to persuading educated women to take up the role. Central to this was the remuneration that the qualified midwife might receive. The middle class spinster who had taken up the work may be subject to moralising with members of the poorer classes and would not get many clients. She would need to be in private practice, or a subsidised charitable employee or have a private income to make any sort of living (Donnison 1988). The Midwives Institute eventually became the Royal College of Midwives in 1947.

In 1889 and 1890 pressure was growing, this time from the General Medical Council and the *Lancet* for the Government to act on the education and registration of midwives. Their argument focused on the need of women for qualified midwifery support in labour to reduce mortality, particularly amongst those women who could not afford the services of a doctor. The Midwives Institute and the London Obstetrical Society jointly proposed a Bill in 1890 for the registration of midwives and the protection of the title midwife. This too was defeated in Parliament, because Mr Bradlaugh, M.P. objected to midwives being required to produce a certificate of good moral character when this was not required of doctors (Arthure 1973, Towler and Bramall 1986). Its successor in 1891 was also defeated. In 1892 a Select committee of the House of Commons was set up to look into the work of midwives. The first report that year highlighted a serious and unnecessary mortality and morbidity to mother and child throughout the country and it resolutely recommended registration of midwives under Act of Parliament (Arthure 1973). The second report the following year highlighted the work of the trained midwives who were making a positive contribution to the welfare of the poor, unlike the untrained midwives. This report recommended the need for a list of trained midwives and for admission to the register a midwife had to pass an examination, which would then give her licence to practice midwifery (Towler and Bramall 1986).

Much lobbying by various newly formed groups continued during the 1890s, and there was another Bill in 1895 that included proposals for a Central Midwives Board to formulate rules

relating to the training, examination and practice of midwives. The Board, of course, was to be composed mainly of doctors. Similar Bills were introduced in 1896, 1897, 1898, 1899 and again in 1900. They were all defeated. In 1902 the Bill introduced by Lord Cecil Manners and supported by Sir Tatton Egerton was finally successful and resulted in the first Midwives Act (Towler and Bramall 1986). This Act was aimed at protecting the public, as current Acts do. It established the Central Midwives Board, which was composed of doctors and midwives, with doctors in the majority. The Board was empowered to keep a roll of midwives and framed rules and regulations for training and practice and conducted examinations. The training programme was initially three months. Local Supervising Authorities were established for the monitoring of the midwives. About one third of the midwives initially admitted to the Roll had the London Obstetrical Society's Certificate (Rhodes 1995). There was also honorary enrolment for midwives practising with one or more years of experience at the time of the Act (*bona fide* midwives). The last *bona fide* midwife ceased practice in 1947 (Arthure 1973). It became an offence for a woman to call herself a midwife unless her name appeared on the Roll of Midwives. Interestingly the three months training was less than that given by the Ladies Medical College and Nightingale's King's College Hospital School and far short of the two years Nightingale wanted to put English midwives on equal footing with European midwives and to enable them to conduct abnormal labours and deliveries. Loudon (1992) states that the Midwives Act of 1902 was the most important of all legislative landmarks for maternal care up to the commencement of National Health Service in 1948. Nursing was not regulated through the Nurses Act until December 1919 (Masson 1985).

Loudon (1992) suggests that midwifery was seen in 1902 as a branch of nursing rather than a profession in its own right, with many nurses training to be midwives to advance their careers rather than practice as midwives. Whilst the latter point is true, certainly later in the twentieth century, it is argued here that midwifery was not seen as a branch of nursing. It gained registration seventeen years before nursing, which would seem to indicate that it was seen as a separate profession then. Although with the Nurses, Midwives and Health Visitors Act 1979 and subsequent changes to midwifery education programmes it is not unreasonable to conclude that midwifery could now be considered to be a branch of nursing. However midwives in practice would argue that midwifery is still a profession in its own right, governed by both the same and separate legislation across the UK and Europe. Midwives can and do work independently without recall to the medical profession, although they still have a duty to call medical aid in certain circumstances.

However the general public's image of a nineteenth century midwife probably conforms more closely to the image of Sairey Gamp, partly owing to the descriptive genius of Charles Dickens. Author Flora Thompson in her autobiographical novel *Lark Rise to Candleford* portrays an altogether more intelligent and skilled village midwife, Mrs Quinton.

She was, of course, not a certified midwife; but she was a decent, intelligent old body, clean in her person and methods and very kind.... Complications at birth were rare; but in the two or three cases where they did occur in her practice, old Mrs Quinton had sufficient skill to recognise the symptoms and send post haste for the doctor. No mother lost her life in childbed during the decade...

(Thompson 1945, p. 80)

The case books of Sarah Roddry show that between 1817 and 1840 she delivered over 5,000 babies, including 63 pairs of twins. She states in a letter to the Manchester Lying-in Hospital that she never lost a mother (Arthure 1973). One can only hope that these midwives were more in abundance than the like of Mrs Gamp.

### **The Midwife in Europe**

European midwives were generally better trained, regulated, more highly respected by the public and the medical profession and mainly better paid than the British midwives (Loudon 1992). Therefore, in general, some European countries, or at least certain parts of them, were safer places to have a baby than Britain. Loudon (1992) suggests that this was mainly because of the emphasis some countries placed on home deliveries by trained midwives, whereas in Britain the majority of midwives were untrained. The maternity hospitals were also larger and more numerous in European countries than they were in Britain. Total deliveries in the four London maternity hospitals between 1860 – 4 was around 1,000, 0.7% of the total London births, whereas the ten Parisian maternity hospitals delivered over 7,000 women a year, 12% of all births in Paris. However in the rest of France possibly only 1% of all births took place in a maternity hospital (Loudon 1992).

In the first part of the nineteenth century all over northwest Europe men attended normal and abnormal deliveries, as men-midwives, accoucheurs or obstetricians. There were also lying-in hospitals either attached to general hospitals or separate institutions. The main difference across Europe was that between the British and Continental midwives. Almost everywhere, other than

Britain, midwives were trained and licensed by local government or the state. However the traditional midwife still existed across Europe. She was often preferred because she was cheaper, known to the family, able to help with the housework and would not intimidate the mother in her own home (Loudon 1992) and these were very important considerations for many families. Traditional midwives were mainly confined to the rural areas, but in towns there was a higher percentage of trained midwives who were influential and frightful women. However in 1820 in England medical practitioners, following the Apothecaries Act of 1815 conducted most normal deliveries. Midwives had no formal training and no licensing by any body, church or state and were only being used by those too poor to pay the doctor's fee, although this was probably half the women in England (Loudon 1992).

In Europe, initially the church regulated midwives and then when that faded out regulation was taken over by the municipalities and the state. This gave the European midwife a relatively high status and ensured that only respectable women became midwives (Loudon 1992). In France by the early part of the nineteenth century training had become more extensive and orderly.

Midwives undertook most of the deliveries in the lying-in hospitals. They were confined to two groups, the better-trained *premiere classe* and the *deuxieme classe*. The first class midwives dominated the lying-in hospitals and were trained by residence in the *Maternite* for one or two years. They were able to charge the equivalent of about six guineas for a delivery, which was a good fee. The second class midwives attended a theoretical course for six months spending a day and a night each week in clinical practice. They could only charge around one guinea for a delivery and were confined to practice within the area in which they were licensed and they were closely supervised (Loudon 1992). During the second half of the nineteenth century French midwives came under increasing competition from doctors for home deliveries and by a law in 1892 the midwives were restricted to births without complications (Loudon 1992). Similar restrictions were also occurring in other European countries to, in effect, bring the midwives in line with those in Britain where they had always only been able to conduct normal deliveries.

Doctors or lay authorities since 1663 (Loudon 1992) had regulated midwives in Sweden. Over the intervening years they had been trained by doctors to deliver both normal and abnormal cases, using instruments. But the use of instruments gradually became more and more restricted so that by the second half of the nineteenth century the rural midwives only used forceps in exceptional cases, roughly once every three to five years (Loudon 1992). Sweden also had traditional or

untrained midwives and until the mid nineteenth century they conducted more deliveries than both doctors and trained midwives together, despite regulation (Loudon 1992).

However regulation and training of midwives in general was considered important in European countries to ensure the midwives were “strong, healthy, and respectable women who, because of selection and training, were safer birth-attendants than the untrained traditional midwives” (Loudon 1992, p. 408). Loudon (1992) provides evidence that suggests that the increased number of trained midwives and the introduction of antisepsis in 1880 impacted on the maternal mortality rate in the latter half of the nineteenth century. The evidence indicates that deaths from non-septic causes declined as the number of trained midwives increased. However, the deaths from septic causes did not decrease in the same way and indeed peaked in 1874 all over Europe and Britain, due to the increased virulence of the streptococcus and only started to decline after the introduction of antisepsis in 1880. Loudon (1992) concludes that in a country that had evolved a system of maternal care that was established on an organisation of “trained, licensed, regulated and respected midwives the standard of maternal care was at its highest and maternal mortality was at its lowest” (p. 247).

In the Netherlands regulation of midwives did not begin until 1818 when a new law was enacted which affected doctors and midwives. At this time midwives were examined having spent twelve months studying the theory of midwifery and then a period of apprenticeship to a midwife. Schools for the training of midwives were established in six towns in 1823. Few midwives graduated in a year and the majority still followed the apprenticeship system. Loudon (1992) states that there is no evidence to suggest that the Dutch midwives experienced the same two-tier system as in France. A Dutch midwife could become a very important person in her community, whichever way she trained. However, a Medical Act in 1856 restricted the activities of the Dutch midwives. It restated the usual position that midwives could only attend normal cases. As in other European countries the number of doctors practising obstetrics increased and they then asserted that they were the only ones who were able to conduct abnormal cases. In the Netherlands the number of midwives then failed to increase with the growing population and those that did train came mainly from the lower middle classes rather than the middle or professional classes (Loudon 1992). However there were also moves to improve the training of Dutch midwives such that in 1865 examination and state licensing started and two new schools were opened in Amsterdam and Rotterdam (Loudon 1992).

Danish midwives had been strictly regulated since 1672 and a state service of midwives had existed since 1714 (Loudon 1992). The midwives were noted for their exemplary standard of hygiene, patience, and non-intervention in normal deliveries, to which they were strictly confined. They started their own journal in 1890 and the following year formed an union to protect their professional and economic interests.

In Ireland the preparation and supply of trained midwives was the duty of the County Authorities, which could send women to the Rotunda Hospital in Dublin for training, paid for by the rates each year (Donnison 1988). Ireland also had a scheme whereby midwives in some areas were salaried, although the pay was so low that the midwife would need to supplement it with private practice (Donnison 1988).

In nearly every country in Europe there was a Government School for midwives and Nightingale's intention was that her King's College Hospital School would not only give the rural poor a midwifery service but also be the forerunner for a national midwifery training under government control (Baly 1986). In order to determine how many grades of midwives there should be Nightingale sent out a questionnaire to contacts in other European countries. In Germany at the Midwives Clinic in Berlin one grade of midwife was trained during a five month course for which the pupil paid a substantial fee and took a qualifying examination (Baly 1986). Baly (1986) states that the course appeared to be more academic than the one offered by the Kings College Hospital School but less rigorous than that offered by the Ladies Medical College.

In 1872 Fleetwood Churchill, MD Edinburgh, MRIA, Fellow and ex-President of the King and Queen's College of Physicians in Ireland wrote a textbook entitled *A Manual for Midwives and Monthly Nurses*. In the opening chapters he clearly states the position of the British midwife in relation to the European midwife in the nineteenth century. The European midwife was expected to perform all the duties of the *accoucheur* including the various obstetrical operations. Whereas in Britain the midwives' sphere of practice was "limited to the lower classes and their duty is to attend upon ordinary labour" (Churchill 1872 cited in Baker 1985, p. 34). In Europe midwives had a thorough education and training, with lectures and textbooks to equip them for this role, whereas in Britain "little has been done to carry them beyond the most rudimentary knowledge, ...most of our midwives begin practice with no other qualifications than that of having had a

number of children themselves and having assisted their neighbours in their troubles" (Churchill 1872 cited in Baker 1985, p. 34). Churchill (1872) continues to state that a nurse who cannot read should not be trusted with the administration of medicines. This not unreasonably leads to a further conclusion, perhaps more significant in the twenty first century that a nurse who cannot do mathematics should not be trusted with the administration of medicines. Churchill (1872) though appears to have no desire to educate British midwives to the same position as their European counterparts; he only acknowledges the difference and aims to teach British midwives, through his textbook, only "something of their business. It would be quite superfluous to enter upon the minute anatomy of the pelvis and organs of generation so I shall merely notice in a general way such points as are of practical importance" (Churchill 1872 cited in Baker 1985, p. 34). If only he had included the rationale for his view, but a textbook is not the place. As an ex-President of the King and Queen's College of Physicians in Ireland, he was obviously not opposed to the education of women in medical practice as in the late 1870s women were able to qualify through the College for a degree in midwifery, medicine and surgery (Donnison 1988). Perhaps he considered only educated ladies able to undertake the study necessary to qualify in medicine and he aimed to differentiate between midwives and doctors, male or female, through his textbook, by suggesting that midwives were uneducated with only a minority able to read. This attitude would continue to perpetuate the authority and position of the male doctors and relegate midwives to the care of normal midwifery among the lower social classes, for small financial reward.

In 1872 Aveling states in his book *English Midwives* that in every European country except Britain (and a part of Belgium) the instruction of midwives was undertaken by the State. He calculated that there should be 11,500 midwives in England and Wales; one midwife to every 2,000 persons, as in Germany and France. He further states that as there needed to be so many midwives their education could not be to a high level. He concludes that the midwife's role was to comfort her patient as labour was a physiological occurrence "to be watched rather than interfered with" (p. 171). The midwife might however have to detect abnormalities and know when to call for medical assistance. He suggests that the attributes required of an ordinary midwife include the ability to "read, write, and calculate, and be healthy, strong, and moderately intelligent" (p. 171) in that she would have to live off a meagre income in a small village.

The last chapter of Aveling's (1872) book is looking prospectively to the future of the English Midwife. He suggests that she should be instructed in both a lying-in hospital and domestic midwifery as conducting a labour in hospital was a very different pursuit to one taking place in a poor home with few basic necessities. He further suggests that examining the practice of midwifery schools in Russia, Germany and France would save England a lot of effort and expenditure when designing her own schools. It is interesting to note that during the twentieth century the length and structure of midwifery training changed. At one point it was separated into two distinct sections; Part 1 which was based in hospital and Part 2 which was based in the community. A midwife needed to undertake both parts if she wished to practice. The training then became a twelve month integrated education and then an integrated eighteen month course. These courses were for those already qualified as nurses. A large proportion of midwives now train over a three year period, without any previous nursing experience. They are also qualified to practice in both hospital and community.

When writing about the future registration of midwives Aveling (1872) suggests that any infringement of the registration law should be met with penalties. He cites the case in Austria where midwives who practised without a diploma were fined for the first offence, fined a double amount for the second offence and imprisoned for the third. Aveling (1872) also wanted to see the supervision of midwives. He cites the example of Prussia where a midwife was not permitted to practice in a district without the permission of the authorities. The midwife was also required to practice in a county for five years, if the county paid for her training. Each midwife in Prussia also had to keep a diary of all her deliveries. An Inspector used the diaries as a way of collecting statistics and determining if there were any incidents that might need further investigation. This was a very accurate way of gaining information about every birth, regardless of the outcome. The Prussian Inspector also had the task of examining the midwife on her skills, knowledge and practice to ensure that she developed and maintained standards. Each midwife was given a manual on midwifery to help with this. Aveling (1872) argues that England could and should learn from various European countries the best ways of "remedying the present deplorably ignorant condition" (p. 179). He hoped that a Commission might be set up by the Government to investigate and report on the condition of midwives in England. He wrote very passionately about the subject and clearly worked for the improvement in the education and training of midwives and their registration through the various committees he sat on. However, he also felt strongly that this was a women's problem and one with which they should grapple and take forward, having first gathered all available information.

## KING'S COLLEGE HOSPITAL MIDWIFERY SCHOOL

*I call a midwife a woman who has received such a training, scientific and practical, as that she can undertake all cases of parturition, normal and abnormal, subject only to consultations, like any other accoucheur. Such a training could not be given in less than two years.*

*I call a midwifery nurse a woman who has received such a training as will enable her to undertake all normal cases of parturition, and to know when the case is of that abnormal character that she must call in an accoucheur.*

*No training of six months could enable a woman to be more than a midwifery nurse.*

Florence Nightingale (1871, p. 72).

### Introduction

The Nightingale Fund was launched in 1855 while Nightingale was at the Crimean War. Sidney Herbert was the instigator of the Fund. Its objective was to collect donations from a grateful nation. A public meeting was held on 29<sup>th</sup> November 1855 at the Willis's Rooms, St James Street. The Duke of Cambridge was chairman and the Duke of Argyll, Lord Stanley, Sidney Herbert and Richard Monckton Milnes all made speeches. Similar meetings were subsequently held throughout the country. The Nightingales did not attend the meeting, but heard glowing accounts from friends who did (Cook 1913a, Woodham-Smith 1950). The Fund was closed 20 months later in June 1856 when the total stood at nearly £45,000. The original intention of presenting Nightingale with a memento was discarded in favour of utilising the money "to establish a permanent institution for the training, sustenance and protection of nurses" (Baly 1986, p. 9); something that would enable Nightingale to continue with her work for others, "an English Kaiserswerth" (Cook 1913a, p. 268). This new intention was then detailed in the Deeds of Trust (Baly 1986). The formation of the Fund was mentioned in the General Orders to the Army of the East and nearly £9,000 was subscribed by the troops; a "voluntary" donation of a day's pay. Many doctors and upper class ladies did not support the purpose of the Fund. Most donations came from individuals including unmarried women (Baly 1986, Woodham-Smith 1950).

Nightingale was not enthusiastic over the collection of the Fund; she felt that she had more than enough to do whilst still out in Scutari. In January 1856 Nightingale replied to a letter from Sidney Herbert that included her suggestions of gentlemen to sit on a Fund Council. One of those was

Mr William Bowman, a surgeon from King's College Hospital. He had been impressed with Nightingale's organising abilities whilst in her Harley Street position and had encouraged her to take the post of Superintendent of Nurses at the newly built King's College Hospital. He had expected to be able to get her appointment organised by the autumn of 1854 (Cook 1913a, Baly 1986, Woodham-Smith 1950). In the meantime the Crimean War intervened. However, she was obviously equally impressed by Mr Bowman and nominated him to the Nightingale Fund Council. By the time Nightingale returned from the war other priorities, for example the reform of the army medical services and the collection of medical statistics had overtaken her consuming desire to nurse (Baly 1995, Woodham-Smith 1950). Nevertheless the Fund was still available to establish a training school for nurses. For over two years the Trustees invested the Nightingale Fund. Nightingale did not want to get involved in allocating the Fund and asked the Fund Council to be released from any obligation to it (Cook 1913a, Woodham-Smith 1950). However the contributors were anxious that Nightingale should activate a project utilising the Fund. The Trustees of the Nightingale Fund, especially William Bowman, favoured a liaison with the existing St John's House nursing school at King's College Hospital. However in 1859 Nightingale's attention was drawn to St Thomas's Hospital, which was selling its site to the South-eastern Railway, and was looking for a new site to rebuild. There was disagreement over the location for the new hospital and Nightingale supported the view that it should be rebuilt in a leafy suburb outside London. Eventually it was built on the banks of the River Thames and it still occupies the same site.

In March and April 1859 Nightingale saw and corresponded with most of the hospital authorities in London in an attempt to take the training scheme forward. She had several options in mind including "to tack ourselves onto St. John's House at King's College Hospital. For various reasons that will not do" (cited in Woodham-Smith 1950, p. 344) from a letter written to Sidney Herbert on 24<sup>th</sup> May 1859. Her interest in King's College Hospital was present even then. She obviously thought highly of the St John's House nursing sisters as she was exploring an association with them as an initial option for the Nightingale Nurse Training School. This could be a result of her experience with them in Scutari or from her admiration for Mary Jones, the Superintendent. It was during the St Thomas's campaign that Nightingale became acquainted with Mr Whitfield, the Resident Medical Officer. Mrs Wardroper, the matron was already a friend. Nightingale's identification with St Thomas's led her to commence the scheme to establish a nurse training school there (Baly 1995, Woodham-Smith 1950). It would be a small beginning, like the Institution at Kaiserswerth.

In March 1860 Nightingale and Jones were corresponding about the cost of training and the age of entry of probationers and/or their fitness irrespective of age (BL Add. MSS. 47743, ff. 3, 16). A letter from Mary Jones to Nightingale on 15<sup>th</sup> May 1860 on this issue reads:

It does not answer to admit women under 24; and that women of 40 are still less desirable except where their previous life has been in some sort a preparation...

28 – 34 most satisfactory.

It may seem hard to reject deserted wives but I think on the whole it is wisest, at least for a society like ours.

(BL Add. MSS. 47743, f. 16).

It seems strange that they should correspond regarding a venture in which Jones was not going to be part. This demonstrates the strength of their friendship and professional regard for each other, which appears to have commenced just prior to Nightingale's departure for the Crimean War in 1854. It was not just a friendship through correspondence. Nightingale and Jones exchanged visits and Nightingale sent gifts and food parcels to Jones and the Sisters (Cook 1913b). Indeed Jones was one of the few people who Nightingale permitted to visit her during her illness in the 1860s (Cook 1913a, Smith 1982). However as is well documented, the nursing school was established with fifteen probationers on 24<sup>th</sup> June 1860 at St Thomas's Hospital (Cook 1913a). Detailed descriptions of the establishment and history of the Nightingale Training School at St Thomas's Hospital are documented in Cook (1913a), Woodham-Smith (1950) and Baly (1986, 1995).

### **St. John's House and Sisterhood**

Nightingale was not well enough to visit St Thomas's Hospital, but had thought the whole training scheme through. Cook (1913a) states that she "took constant counsel from her friend Miss Mary Jones, at King College Hospital, who gave her valuable suggestions," (p. 462). Mary Jones was the Anglican Superintendent of St John's House and Sisterhood which originated in 1848 following a request from a group of physicians who wanted to improve the calibre of nurses in London Hospitals. The order was named after St John the Evangelist parish in which it was first located. Pastor Fliedner from Kaiserswerth advised the Council, who set up the order. It was established as a training institution for Nurses, for Hospitals, Families and the Poor. A Master, an Anglican Priest and a Lady Superintendent administered the institution under a Council. The focus of the Order was nursing and Christian charity. There were three levels of membership; sisters who were the well educated gentlewomen able to instruct and supervise, the nurses who

were employed to undertake the major part of the nursing in hospitals and homes and the probationers who were undertaking a two year training course. All levels had to be members of the Church of England and were required to follow the rules and regulations set out in the Sisterhood's Book of Order (A/NFC/66/10).

Mary Jones was born in Tamworth in 1812, an upper class Victorian woman who followed the Oxford Movement, a high church spiritual renewal group. Nightingale writes of Mary Jones' "firm and clear mind – perhaps the firmest and clearest mind I know" (Cartwright 1976, p. 169). William Bowman, in contrast, in a note to the Bishop of London says of Mary Jones "Her arrogance passes belief" (Cartwright 1976, p. 169). Her name first appears on the Council meetings of St John's House in 1853 and within six months she became the second Superintendent. At this point there was only one sister abiding in the House and 19 nurses. The following year, the Order was able to send six nurses to the Crimean War. St John's House was approached because Nightingale wanted the best nurses and the different churches to be represented. Cook (1913a) describes how there was initially some disagreement between the St John's House Council and Sidney Herbert and Nightingale because the Council wanted the nurses to be accompanied by the Master to act as their guardian. Following a meeting "the point of Miss Nightingale's exclusive control was conceded, and the Master stayed at home" (Cook 1913a, p. 159). Cook (1913a) suggests that following this first meeting Mary Jones "to the end of her life remained one of the most valued and tenderly devoted of Miss Nightingale's friends" (Cook 1913a, p. 159). Cook (1913a) states that Nightingale found the nurses a troublesome group to control and indeed four of the St John's House nurses returned to London not prepared to tolerate the discipline and privations of the life in Scutari.

Terms of Agreement were settled between the Committees of King's College Hospital and St. John's House on 7<sup>th</sup> February 1856, with the Agreement to commence on 31<sup>st</sup> March 1857. St. John's House was to take on the nursing at King's College Hospital and supply the nurses and domestics whilst the Hospital was to provide living accommodation and pay £800 a year to St. John's House for the service. This increased to £1,100 in July 1858 (A/NFC/66/9). Mary Jones became Sister-in-Charge and instigated a series of improvements to the care of the patients and the management of the hospital.

## The Midwifery School – its conception and birth

Death in childbirth was a common occurrence and one of which Nightingale would have been naturally aware. She would have had friends, acquaintances, relatives and neighbours who had died during or following childbirth. There is no obvious evidence indicating Nightingale had a particular interest in maternal mortality as early as 1860, but she had run a lying-in ward in Scutari. In a letter to Sir Harry Verney in 1859 she writes “I have no reason to doubt the wife’s story, which is that I employed her for six months in my lying-in house at Scutari” (MS 8998/14). Neither Cook (1913a) nor Woodham-Smith (1950) make reference to this venture. Yet clearly Nightingale was involved with maternal care during the Crimean War.

Between March and May 1860, date unclear, in one of her letters Jones asks Nightingale for her opinion of Bowman’s suggestion, but what the suggestion was is unfortunately not mentioned (BL Add. MSS. 47743, f. 7). Bowman was a surgeon at King’s College Hospital, a member of St John’s House Council and also a member of the Nightingale Fund Council. He signed a Memorandum of Agreement to act as a member of the Fund Council in June 1857 (A/NFC68/13). Bowman is the third central character to this initiative because of his connections with all the bodies involved. This is confirmed in a letter written by Nightingale to Bowman on 31<sup>st</sup> May 1860. The original letter is not held in any of the public record offices, but in the private Bowman family papers. A printed copy was discovered within the President’s Address of the History of Medicine from 1975. He acknowledges the source of the letter as Sir John Bowman (Cartwright 1976). In the letter Nightingale says that she wanted to inform Bowman of the results of conversations with Miss Jones. Nightingale was aware that Bowman favoured a connection with St John’s House and in her letter she tells Bowman that Jones has “started a new idea” (Cartwright 1976, p. 173). Mary Jones wanted “to have a class of midwives” (Nightingale 1860, cited in Cartwright 1976, p. 173). Nightingale continues:

Of all the numberless applications which have been made to me to recommend nurses since I returned to England, by far the most numerous have been for Parish nurses in the country, with a midwives’ education, to be paid and supported by the lady or ladies of the country parish.

I know therefore how immensely this class of nurse would be valued in England.

(Nightingale 1860, cited in Cartwright 1976, p. 173).

Mary Jones and St John’s House had been training nurses from the country since 1857 (Cartwright 1976). On 21<sup>st</sup> November 1859 Jones reports to the St John’s House Council regarding the trainee visiting nurses attached to St John’s House who were instructed in medicine

and surgery. She points out that the nurses ought to be competent midwives, especially if working in country districts and outside hospitals. She advises the Council that now is the time to start training midwives. The Council mainly composed of lay members, including the Bishop, was unable to decide the merits of the suggestion because it did not have the knowledge and so referred Jones' suggestion to the medical members of the Council in a small committee. This Committee included William Bowman (Cartwright 1976).

The letter from Nightingale continues with her asking Bowman if six lying-in beds could be allocated under Dr Arthur Farre "for the training of midwives alone - if the Nightingale Fund Council would pay for a class of (say) six midwife nurses" (Nightingale 1860, cited in Cartwright 1976, p. 173). The midwifery nurses were to be under the rules and belong to St John's House. Nightingale stipulates that the beds had to be in the hospital, nursed by St John's House nurses and that medical students should be excluded, otherwise it wouldn't work. "Midwives being in this respect somewhat different from ordinary nurses" (Nightingale 1860, cited in Cartwright 1976, p. 173). It is encouraging, as a midwife, to note that Nightingale acknowledges the difference between midwives and nurses. What she doesn't say in this letter, (but it can be inferred from her writings in general), is that she thought more positively about midwives and their knowledge and skills. This is particularly clear in later writings when Nightingale totally disagrees with the idea of female doctors. She fervently believes that women should train as midwives to undertake all midwifery cases, not just the normal ones, and undertake care for women and children only, eventually being trained by lady professors (Nightingale 1871, Baly 1986, Woodham-Smith 1950). She was also more supportive of a register of midwives and yet strongly opposed the registration of nurses (Baly 1986, Donnison 1988).

Nightingale realises that King's College Hospital might not want to be associated with a scheme that was not its own, partly because of its limited space. She assures Bowman that as far as she is concerned there would be no difference from the current practice. She ends the letter by asking Bowman to think about it in his triple capacity. This then is the set of events that led Nightingale to set up the Midwifery Training School at King's College Hospital. Nightingale had in-depth discussions with her respected friend and colleague, Jones, about nursing and midwifery in general and training and skills in particular. This was supported by other information that highlighted a need for nurses in the country parishes to have some midwifery training. Jones then makes the suggestion, undoubtedly in the full knowledge that there was money remaining in the

Nightingale Fund, that a training school for midwifery nurses be established under her and St John's House at King's College Hospital. This would solve problems for both of them and have a positive beneficial outcome for the poorer members of society, whilst enabling them to work together professionally. William Bowman, as a friend and member of the three organisations involved in this potential venture, was the perfect broker to carry this idea to fruition.

On 29<sup>th</sup> June 1860 Jones writes to Nightingale "... and now must say one word about our own plan for midwifery nurses" (BL Add. MSS. 47743, f. 20). Jones had spoken to colleagues and was pleased that they did not find the proposal "impossible or difficult" (BL Add. MSS. 47743, f. 20). She hopes to get it resolved at the next St John's House Council meeting. Clearly Nightingale and Jones were in correspondence regarding a midwifery training school before the School at St Thomas's opened. On 16<sup>th</sup> July 1860 St John's House Council wrote a letter to King's College Hospital in support of the scheme and recommending them to provide a ward for training midwives. On 16<sup>th</sup> October 1861 the Council recorded that King's College Hospital had agreed to supply a ten-bedded ward "for the reception of poor married women during their confinement, as well as for the education under Dr A. Farre, and under the charge of the Lady Superintendent of a certain number of midwifery nurses" (H1/ST/SJ/A28/2). The Council decided not to accept more than ten probationers, who would be seen as temporary members of St John's House. They were to be trained in general nursing duties and midwifery to enable them to act as "single-handed parish nurses" (Cartwright 1976, p. 174).

There is further evidence in a letter from Henry Bonham Carter to Nightingale dated 14<sup>th</sup> August 1861. The letter is difficult to read but the first sentence says, "I am now prepared to take up the King's College ...and have written today to ..." (BL Add MSS 47714, f. 3). "now prepared" would suggest that there had been a delay for some reason, not necessarily connected with the scheme itself. The Nightingale Fund Council held its first meeting on 19th December 1859. Present were the Right Honourable Sidney Herbert, Sir Joshua Jebb, Mr Bracebridge, Professor William Bowman and Mr Bence Jones. A Sub Committee was appointed and its membership was the Right Honourable Sidney Herbert, Sir Joshua Jebb, Professor William Bowman, Sir John MacNeill, Sir James Clark and Mr Arthur Clough as secretary. It was this Committee's purpose to manage the Fund and it held its first meeting on 7<sup>th</sup> March 1860 (A/FNC/2/1).

Arthur Clough was not a well man and by the summer of 1861 Henry Bonham Carter was acting as secretary to the Committee owing to Clough's illness. It is unclear therefore whether Nightingale would have written or spoken to Clough or Bonham Carter regarding her plans for midwifery nurse training at King's College Hospital. It is likely that it was Bonham Carter, given his letter of 14<sup>th</sup> August 1861. The Committee met quarterly and at its meeting on 5<sup>th</sup> October 1861 held at 45 Parliament Street Bowman, Spottiswoode (a new member), Jebb (chair) and Bonham Carter (secretary) were present. Minute 5 records:

A memorandum containing the particulars of a plan proposed by Miss Nightingale for the consideration of the Committee, for employing the available surplus income of the Fund in affording means for training Women as Midwife-Nurses for Country places was read.

(A/FNC/2/1 p. 29)

The full Minute 5 and Minute 6 can be found in Appendix 3. This indicates that 5<sup>th</sup> October 1861 was the first time the Nightingale Fund Council Committee heard, discussed and actioned the plan to train midwifery nurses at King College Hospital. A copy of a draft memorandum of agreement between the Committee of the Council of the Nightingale Fund and the Council of St John's House Training Institution for Nurses is found in the Nightingale papers dated November/December 1861. The agreement is "for the purpose of providing means for training women in King's College Hospital as midwife nurses with a view to their being employed for the benefit of the poor in County Parishes and Districts" (BL Add MSS 47714, f. 15). The agreement set up the relationship for two years initially. Minute 4 of the Fund Committee meeting on 25<sup>th</sup> January 1862 reads "The agreement with the Council of St John's House as signed by the Chairman was read" (A/FNC/2/1). Progress was therefore relatively fast. The Nightingale Fund Report of the Committee for the Year ending midsummer 1862 includes a report on the new midwifery nurses training school at King's College Hospital (A/NFC/5/2/1). It gives an account similar to that in the Statement of the Appropriation of the Nightingale Fund (A/NFC/73/4), both were written by Sir Joshua Jebb who was Chairman of the Nightingale Fund Council Committee. The Report includes the reasons for starting the School (see Appendix 4) and also the Regulations as to the Training of Midwifery-Nurses under the Nightingale Fund.

The "Nightingale Ward" for lying-in patients was opened on 7<sup>th</sup> January 1862 at King's College Hospital. This then was the start of the "Nightingale School for Midwives" (Cartwright 1976, p. 174). The ten beds were maintained by the Fund and the number of Probationers was initially limited to six. A small fund for board and lodgings was given to the Lady Superintendent, Miss

Jones, but was not expected to be required after the first year. In November 1862, there were five probationers in training (A/NFC/5/2/1).

In the Abstract of the Report for the year ending 24<sup>th</sup> June 1864 (A/NFC/5/4/1) Henry Bonham-Carter wrote that ten women had completed training during the year. Many had also spent some time on the medical and surgical wards and were now employed in country parishes. The Midwifery Nurse School was proving to be a success, although the numbers of women training were small and recruitment was clearly a problem. Interestingly in 2002, little has changed. There is a shortage in the number of midwives who are qualified and working in the profession. Terms and conditions of employment may be related to this. However, the number of women (and men) training to be midwives has always been small because of the number of maternity beds and pregnant women that can support a training school. A part of Nightingale's problem was also the cost involved.

These probationers were not trained under the same system as those at St. Thomas's Hospital. The Nightingale Fund could not support the enterprise to the same extent. The parishes that sent women for training were expected to contribute to the cost. Baly (1986) suggests that those parishes with the greatest need for a midwife were undoubtedly the poorest and could not afford to support their village nurse going away for six months to train. Equally the nurse could not afford to forgo six months salary whilst at King's College Hospital. Parishes could also not guarantee to pay a salary of at least £20 to the midwifery nurse and provide comfortable lodgings on her return to the parish. The nurse had to sign an agreement that she would return to the parish and work for four years under the direction of the managers. This was part of the Regulations as to the Training of Midwifery-Nurses under the Nightingale Fund (A/NFC70/10/3). There was also a penalty clause, should the probationer leave because she married or did anything to interfere with the proper discharge of her duties then she could be instantly dismissed, with notice sent to her employer and with no reimbursement of fees paid. Interestingly there were two cohorts a year at the end of April and October, with applications to the Lady Superintendent of St. John's House required at least two weeks before the commencement of the training (A/NFC70/10/3).

On 24<sup>th</sup> September 1861 Nightingale wrote a long letter to Harriet Martineau and included details of the midwifery school at King's College Hospital. She said they were going to open it in October. Clearly this did not happen as it was the month that the Nightingale Fund Council Committee first heard about the project, but obviously plans were well advanced, at least in her mind and what she describes in her letter came to fruition. Nightingale says that she is sorry that they have to charge a weekly sum for their board "but which will merely be the cost price – not less than 8/- or more than 9/- a week" (BL Add MSS 45788, f. 131, 132). This was obviously in addition to the sum given to Miss Jones for the purpose. Nightingale hopes to be able to give free board to a number of parishes in another year. She explains that the Fund does not allow them to do it any other way, as they have had to establish a lying-in ward at the Hospital for the purpose of the training school. The doctors had agreed to give teaching sessions free and the head midwife was to be paid by the Fund so that the Probationers would never be left on their own. The Probationers would deliver poor women both in the hospital and in the women's homes, as out patients to the hospital. Nightingale said that she would be happy to send her own younger sister (if she had one) to the school because she was sure of its morality. Nightingale hopes that the school will lead the way for a government school for midwives like there is in other countries. She feels that if they start quietly and train a few good country nurses then more candidates will follow (BL Add MSS 45788, f. 131, 132).

St John's House published a document on 13<sup>th</sup> February 1865 entitled "As to the past and present state of the Institution" and records:

...in connection with the Nightingale Fund. This consists in the training of midwifery nurses, and more recently of several nurses also, for country and town districts. The manner in which this work has been, and continues to be carried on has received the emphatic approval of those most qualified to judge, viz.: the Committee of Management of King's College Hospital, and of Miss Nightingale herself; and it is hoped that future years will see it get further extended.

(H1/ST/SJ/A29)

Cartwright (1976) states that the demand for the parish nurses grew and in the 1860s there were often more applicants for the limited number of places at King's College Hospital than at St Thomas's Hospital. Gradually a selection process developed that separated those more suitable to institutional nursing from those better suited to parish nursing. However, Baly (1986) suggests that recruitment to both training schools was poor and that St Thomas's, in particular, was not initially the success it claimed. Baly (1986) further suggests that the inability of poor parishes to fund places for midwifery nurse training was part of the reasoning behind Nightingale wishing to develop a government funded midwifery training scheme. There may be some truth in this, but it is proposed here that there are other reasons. Nightingale's previous involvement with the

government during the Crimean War led her to believe it was the government's responsibility to respond to national concerns, although her own experience of trying to stimulate government responses would not have been encouraging. Equally Nightingale's arrogance would lead her to expect the government to follow her lead and do as she said, as they had previously. Baly (1986) further suggests that perhaps the scheme was forty years ahead of its time, given that the first Midwives Act was in 1902. One could argue that this is true of all Nightingale's activities.

### **The Midwifery School – its decline and death**

If the school was small, but successful, then the next issue is the reason for its closure in 1867. Baly (1986) and Smith (1982) have examined this in particular. Mary Jones was in dispute with the Council of St. John's House. In a letter dated 19<sup>th</sup> September 1866 seven of the nursing sisters wrote to the Lady Superior regarding their desperate need for a chaplain to minister to their souls. They acknowledged that she had been trying to get one and asked her to copy their letter to the Chaplain. Mary Jones copies it and says in a note to the Chaplain that she will raise it with the Bishop and Council at the next meeting in November but thought that he should be acquainted first. Mary Jones then wrote to the Council on 12<sup>th</sup> November 1866 (H1/ST/SJ/A35/1). During November 1866 there was a lot of correspondence between Mary Jones and William Bowman concerning the sisters' complaint regarding the Chaplain. On 25<sup>th</sup> November 1866 Nightingale writes to Jones that the Chaplain should not be master of a female order and that Miss Jones should not retire unless sure it is the will of God (HI/ST/NC1/66/7). This is followed up on 20<sup>th</sup> December when Nightingale asserts that Jones is right to attempt to have the Chaplain removed. Nightingale continues that a religious society and a secular government in a hospital achieve the highest average good nursing. If Jones surrenders Nightingale will say that Sisterhoods are impossible in the Church of England because of the way the clergy are worshipped (HI/ST/NC1/66/25). This was a view Nightingale came to in 1855 in the Crimea, but Baly (1986) suggests it was pushed to the back of her mind when planning the midwifery school because of her admiration for Jones. However, Nightingale did not place a training school in the hands of a sisterhood again.

The Chaplain of St John's House wanted to be head of the nurses. The correspondence continues into the following year with Nightingale on 8<sup>th</sup> January 1867 urging Jones to make clear to the Bishop of London her reasons for leaving or staying at St. John's House. She asserts that the discipline must be in the hands of the female head (HI/ST/NC1/67/1). At this time Jones was in

contact with William Bowman over proposals written by her, but incorporating Nightingale's suggestions for the organisation of St. John's House. Nightingale also lobbies Sir Harry Verney to try and intervene. On 1<sup>st</sup> February 1867 she writes to him that "either Chaplain must go or the whole Sisterhood must resign" (BL Add MSS 45791, f. 64). In that same letter she pleads "Miss Jones so kindly organised and so efficiently carried out our little Training School for midwifery nurses for the poor at King's College Hospital" (BL Add MSS 45791, f. 64). However Jones wanted to make herself the spiritual as well as the nursing head (Baly 1986). Baly (1986) states that this was not as outrageous as Smith (1982) suggests because there were several sisterhoods being formed with Mother Superiors. However Baly (1986) intimates that it was "the suggestion that an altar be set up and the sacrament exposed" (p. 71) that was unwise and brought protests from the St. John's House Council and the Bishop of London. Jones first offered to resign on 7<sup>th</sup> April 1867 but had had no response by 24<sup>th</sup> April when she next wrote to Nightingale (BL Add MSS 47744, ff. 103, 110).

The Rough Minute Book of the St John's House Council for the meeting on 9<sup>th</sup> May 1867 notes:

Resolved that when the office of paid Chaplain becomes vacant the Sisterhood be at liberty to present to the Bishop for his sanction the name of a clergyman whom they may desire to assist them in a spiritual capacity and to acting Chaplain with salary. And in the event of no person whom the Bishop shall judge fit being so presented within three months, the Bishop shall appoint.

Signed William Bowman.

(H1/ST/SJ/A6/5)

The Council was also looking at the need for alteration of the rules to assist the resolutions as stated. On 23<sup>rd</sup> May 1867 the Rough Minute Book states that the Chaplain was to have notice to retire in three months from the end of the current quarter. A further entry reads "the Bishop will be requested to propose a suitable person to the Council for appointment under Fundamental Rule 5" (H1/ST/SJ/A6/5). This is a slightly different ending to the previous quote, but does indicate that the Council was taking seriously the concerns of the Lady Superior and trying to find a way of resolving the issue. On 6<sup>th</sup> June 1867 the Council held a special meeting to decide on the alterations of the Rules and Byelaws (H1/ST/SJ/A6/5).

On 18<sup>th</sup> June 1867 Jones writes to Nightingale listing deaths and causes. The midwifery wards had been isolated from the general wards on the same level. Jones suggests that the post mortem

theatre's close proximity was the cause of the deaths, with the medical and surgical wards underneath (BL Add MSS 47744, f. 123). Jones writes again on 23<sup>rd</sup> June still blaming the post mortem theatre for the deaths and advising Nightingale that she need not call a meeting of the Nightingale Fund Committee to close the ward yet. It was due to be closed for routine cleaning of the walls. She then gives a detailed account of the layout of the wards and ventilation. Jones ends the letter saying that if the King's College Hospital Midwifery School was to close then she would prefer it was re-established in a workhouse (BL Add MSS 47744, ff. 125, 126). These two letters are therefore important in that they introduce the issue of maternal death and Jones makes clear her position, should the School close.

On 15<sup>th</sup> July Jones writes that she has written to King's College Hospital Committee but had not had a reply. A further letter on 1<sup>st</sup> August states that she now has a reply and that "they desire to do all they can to remedy the evil" (BL Add MSS 47744, ff. 130, 132). Nightingale replies urging Jones to oppose any chaplain forced on her (BL Add MSS 47744, f. 136). Nightingale also suggests that Jones sits down with the Council and tries to give a little on each side and work it out (BL Add MSS 47744, f. 137). On 29<sup>th</sup> July the St John's House Council meet and read a letter from the Lady Superior to the Treasurer requesting the Council to take steps to terminate the connection of St John's House with the Galignani English Hospital in Paris (H1/ST/SJ/A6/5). During 1867 the Minute Books indicate that the finances of St John's House were in a poor state and on 3<sup>rd</sup> July support was given to withdraw £300 from deposit at the London Joint Stock Bank (H1/ST/SJ/A5/2). The Minute Books mainly itemise the financial statements of St John's House, giving very little detail of other concerns of the Council.

There are some hand written pencil notes by Nightingale dated 12<sup>th</sup> November 1867 in which she writes about the situation, possibly as a summary note to herself. She starts with "Bowman has got himself into an impossible position. Miss Jones has got herself into an impossible position" (BL Add MSS 45752, f. 252). Both had visited Nightingale independently to ask her advice. Jones had written to the Council to resign, giving two reasons. Firstly that the Report was not honest and straightforward and secondly that the Bishop would not let them have the Chaplain they would pay from Sisterhood money, without interfering with him. Jones was Sister-in-Charge at King's College Hospital and Charing Cross Hospital and had also written to both saying that she had removed her connection with St. John's House. In the meantime the Bishop of London had written to Bowman saying he had received Jones' resignation to St. John's House and asking

Bowman what was Jones' connection to St. John's House. The Bishop was a member of the St. John's House Council but was clearly not an active member. Jones and the Sisters had resigned in November 1867. The Bishop had vetoed the appointment of a Chaplain because the Sisterhood wished the Chaplain to administer vows. The Report that Jones mentions includes the financial details of the Sisterhood, but strayed off its remit to include other information that Jones found unacceptable concerning the running and organisation of the Sisterhood (BL Add MSS 45752, f. 252).

The pencilled note continues "...that I shall never dream of leaving the midwifery ward under either the University Sisterhood or the Clewers or Miss Twining.... I should not remain at King's" (BL Add MSS 45752, f. 253). Clearly Nightingale was not enamoured with other potential organisations that might take over the nursing and midwifery at King's College Hospital should St. John's House depart. She continues saying that Bowman and the Bishop do not see "the entire superiority of the training principle of Miss Jones" (BL Add MSS 45752, f. 254). This would suggest that part of the reason for the great friendship that had developed between these two women was Nightingale's admiration for Jones as someone who was a good teacher. This is supported in a letter that Nightingale writes to Sir Harry Verney on 13<sup>th</sup> October 1867 in which she says that if Jones leaves then Nightingale will take the midwifery school away and start it again wherever Jones goes (BL Add MSS 45752, f. 240). In another letter written on 1<sup>st</sup> February 1868 to Nathaniel Powell, Nightingale states that it was the high capabilities and qualities of Jones that led to the selection of King's College Hospital in the first place. Women who were midwives needed not only the knowledge of their art but also instruction in character and conduct, which they received from Jones (BL Add MSS 45800, f. 217). Clearly Jones was the central reason for founding the midwifery school at King College Hospital and not the hospital itself nor St John's House Sisterhood.

Continuing with Nightingale's pencilled summary she notes that the Council, without consulting Bowman, had asked Miss Bryson of All Saints to undertake the hospital work. Nightingale was concerned that only one of those Sisters knew about nursing in hospitals and all the Sisters took vows. Baly (1986) suggests that the Nightingale Fund was also not consulted over the appointment of the All Saints Sisterhood and it was this that so infuriated Nightingale and the Fund that they withdrew the training school. Nightingale is arrogant enough to propose such an idea to the Fund Council, but it is maintained here that the integrity of the men on the Council

would not have allowed then to close the training school just because the nursing sisters had changed, without them being consulted, not even in the nineteenth century. The Fund Council minutes made no reference to this at the time and it was too important a decision to be left out of the minutes.

The notes continue that Jones was to ask King's College Hospital to ask St. John's House to ask the Nightingale Fund Committee "to withdraw from the midwifery ward: Is that the right way?" (BL Add MSS 45752, f. 256). Nightingale clearly felt burdened by this continuing saga involving close friends on opposite sides and tried to listen and advise both, without getting involved herself, but aware that the future of the Midwifery Nurse School was at risk.

Nightingale was also in correspondence with Bowman on 22<sup>nd</sup> December 1867. It appears that the Bishop had considered the idea of a Mother Superior for the Order and the Fund Council had tried to further reconciliation by suggesting amendments to the Rules. The revised rules did not embody all of the Fund Council's suggestions (Baly 1986). In December 1867 Nightingale also writes to her mother about the situation. There is no date on the letter, but by its content it may be legitimately inferred that it was early December:

We are going to leave King's College Hospital with our Midwifery Nurses. And all that has to be done over again.

Then I have seen Mr Bowman three afternoons and Miss Jones two, about their quarrel between the Sisters and the Council – which is wearing her to death. God only knows how to settle it.

(MS 9002/196)

This indicates that negotiations between Jones and St. John's House Council continued in December 1867, despite her resignation.

As can be seen by the dates of the correspondence and notes this saga lasted over a year with neither side prepared to relent nor firmly stand their ground. The end of the Midwifery School therefore remains confused. Mary Jones and her Sisters finally resigned from St. John's House and King's College Hospital in November 1867 (BL Add MSS 45752, f. 252, Smith 1982), but in January 1868 according to Cook (1913a). Cartwright (1976) states that Mary Jones and the whole Sisterhood left on 12<sup>th</sup> January 1868, but he does not provide a contemporaneous reference to

substantiate this claim. The Minutes of the St John's House Committee note that at its meeting on 26<sup>th</sup> December 1867 it met with the Lady Superior regarding the conduct of a nurse.

Unfortunately the Minutes do not give the name of the Lady Superior (H1/ST/SJ/A5/2).

Perhaps Jones served a period of notice that accounts for the confusion over which happened first and was therefore the cause of the closure. The Midwifery School closed in December 1867. On 2<sup>nd</sup> December Nightingale wrote to Henry Bonham-Carter saying "I consider it quite settled that we leave King's College Hospital and am rather glad that it is not left to us to say we will go" (BL Add MSS 47715, f. 128). She does not want more midwifery beds in a hospital, perhaps a workhouse under someone like Miss Jones. Two days later she writes another letter to Henry Bonham-Carter marked Private. In it she states that the King's College Hospital Committee is going to intimate to St. John's House Council to intimate to the Nightingale Fund Committee

that circumstances have arisen which have shown that a midwifery ward is found in practice not to answer in King's College Hospital (or something to that effect)...in any public document it would be well that it should appear that the agreement has been terminated by mutual consent – not that we have been turned out

(BL Add MSS 47715, f. 132).

This would appear to indicate that early in December Nightingale, even in a private correspondence, was not planning to orchestrate the closure of the Midwifery School. She was aware that it was imminently going to happen and in many ways whilst resigned to it, her writings would suggest that she was relaxed about it. The letter continues "...our preferring not to be connected with a general hospital or a School of Students and because of the peculiar disadvantage of King's College Hospital as to position and constraints we should look out for something quite independent of them but under her" (BL Add MSS 47715, f. 133). The letter ends with a sentence in brackets "[the PM theatre is just as poisonous as ever]" (BL Add MSS 47715, f. 133). Nightingale does not elaborate on the "peculiar disadvantage" but the reference to the PM Theatre would seem to suggest that she was aware of continuing deaths from puerperal fever and felt the cause of these was the close proximity of the post mortem theatre to the lying-in ward. There is no evidence to suggest any other cause for the deaths of nine women in 1867.

The St John's House Council met on 23<sup>rd</sup> December 1867 and had as an agenda item, noted in the Rough Minute Book, a letter from Mr Bonham Carter relating to the Nightingale Fund (H1/ST/SJ/A6/5). Unfortunately it does not say what was in the letter. Dr Priestley, the Physician-Accoucheur at King's College Hospital at the time advised the Hospital Committee to close the ward because of the rising maternal mortality rate. In 1867 the rate rose to 1 in 13.8,

whereas the previous year it had been 1 in 30. The mortality in the Nightingale Ward was higher than other institutions, both in England and abroad. The average over the six years was also higher at 1 in 28.9 than the Rotunda Hospital, Dublin, which over the same six year was 1 in 34.9 and the British Lying-in Hospital was 1 in 54.8 (Rowling 1869). Given these statistics, even though unsure if like has been compared to like across hospitals, a mortality rate of 1 in 13.8 would suggest that Dr Priestley made the correct recommendation to the Committee. Nathaniel Powell, from the King's College Hospital Management Committee writes, dated 29<sup>th</sup> January 1868, to Nightingale informing her that he had closed the midwifery ward due to deaths from puerperal fever. Nightingale acknowledges, on 1<sup>st</sup> February, that she was aware of the increase in deaths for seven to eight months. She says that she made the decision "that the midwifery training should be discontinued as soon as possible" (BL Add MSS 45800, ff. 215, 217).

In *Notes on Lying-in Institutions* Nightingale confirms that Nightingale Fund Committee had not been aware of the annual puerperal fever deaths until the fifth year of the ward's existence (Nightingale 1871). The rates in those first five years were similar to other hospitals. It was the deaths of nine women in 1867 that lead to the closure of the ward. Smith (1982) believes that Nightingale was slow to respond to the maternal mortality in the lying-in ward and hints that she must have known about the deaths over the previous five years and yet did nothing. She may well have done, but as the rates were comparable to other lying-in institutions Smith does not state what action he expected from Nightingale. Smith (1982) goes further in suggesting that she and Sutherland were slow in writing the book and "that she at least regarded the *Notes* as a cover-up for her blundering connection with King's College Hospital" (Smith 1982, p. 164). It is argued here that this is rather harsh, and support given to Cook's view (1913b) that the closure of the ward was the likely catalyst for writing the *Notes*. In the *Preface* Nightingale acknowledges the arrangements with St John's House and King's College Hospital and that "hopes were entertained that this new branch of our Training School would confer a great benefit on the poor, especially in country districts, where trained Midwifery nurses are needed" (Nightingale 1871, p. vii). She also openly writes about the mortality rate and that nine deaths occurred in 1867 and states that "Under these deplorable circumstances the closing of the wards was a matter of course;" (Nightingale 1871, p. ix). The *Notes* were written "with the view of turning to the best account our past experience" (Nightingale 1871, p. x). This would not suggest a cover-up, but possibly a penance and a lesson for the future management of childbirth and the puerperium. However four years is a long time before publication. This could be countered by retorting that the extensive nature of the publication required detailed research across the UK and Europe, which takes time, particularly with nineteenth century technologies, in conjunction with all Nightingale's other

ongoing projects and the Franco-German War 1870 –71 (Cook 1913b). Smith (1982) concludes wryly, that Nightingale's search for self-satisfaction ended, yet again, in public good; the advancement of the antiseptic procedures into maternity hospitals and wards.

In a short account of St John's House and Sisterhood published by Harrison and Sons, but with no date on the pamphlet, it states:

It is a matter of deep regret to the Council that it has been necessary on sanitary grounds to close the Nightingale Ward.... The Physician, however, in charge of this ward reported in the autumn of 1867 that mortality of late had been so high, in spite of all precautions, as to prove the inexpediency of continuing a midwifery ward as part of a general hospital, and the Committee of Management accordingly closed it. The Council could not but entirely agree with Dr Priestley in the propriety of this sudden step, and the share they had had in the useful task of training midwifery nurses, in connection with one whom her country and the world honour, thus came to an unlooked for end.

(H1/ST/SJ/Y8001, p. 13-14)

King's College Hospital and Nightingale therefore both claim to have closed the ward because of the increasing maternal deaths, with St John's House Council publicly supporting the King's College Hospital claim. Although it has to be acknowledged that St John's House Council is unlikely to publicly admit that the Nightingale Ward and the Midwifery School had closed because the Lady Superior had been in dispute with the Council and had resigned. The maternal mortality rate of 28.9 per 1000 over six years was not particularly exceptional at that time and certainly no firm reason for closing the lying-in ward. For the previous five years the rate had been 33.3 per 1000 and in 1867 it more than doubled to 72 per 1000. This must be considered a good reason for closing a maternity ward, at least temporarily. Nightingale confuses this double claim further by adding in her letter to Nathaniel Powell on 1<sup>st</sup> February 1868 "The ward can no longer be used for the purpose. And unfortunately Miss Jones is no longer in the Hospital" (BL Add MSS 45800, f. 218).

The Nightingale Fund Report for the year ending 25<sup>th</sup> December 1867 states

The School for Midwifery Nurses.

This School is closed.... The training was in every way satisfactory and much good was resulting from it, when in June of last year this Committee were informed for the first time, that deaths had occurred in the Ward....

Certain improvements were proposed...but, the measures taken proved to be of no avail, and with the concurrence of all concerned, the Ward was closed in December last....

Although the School for Midwifery Nurses is thus for the present in abeyance, the Committee trust to be able to re-establish it whenever satisfactory arrangements can be made.

(A/NFC/5/7).

The Report was dated May 1868 and signed by Sir Harry Verney as Chairman and Henry Bonham-Carter as Secretary.

In 1867 three issues were dominating Nightingale's relationship with midwifery at King's College Hospital; the significant rise in maternal mortality, the religious conflict between Mary Jones and the Council of St John's House and Nightingale's own conceptualisation of midwifery as a profession more suited to training in workhouses than hospitals. The rising maternal mortality rate was the publicly stated reason, by the Nightingale Fund Council, the St John's House Council and King's College Hospital Committee of Management. A maternal mortality rate of 72 per 1000 in one year demanded action.

The School closed in December 1867 and Mary Jones resigned in November 1867, although she had threatened to do so for many months. She may or may not have left immediately or in January 1868. There is no correspondence in to St John's House available between December 1866 and April 1869. There is no record in the St John's House Council Minutes that there was a change in the Lady Superior at all. It was coincidental, but opportune that Jones resigned the month before and it was possibly the catalyst that sparked the final demise of the School, in that it was never reopened. It would seem reasonable to suggest that the relationship between the three organisations involved were close or indeed had broken down over the Mary Jones religious dispute. The relationship between Nightingale, Jones and Bowman was probably not severely or irreparably damaged. Indeed all three of them continued to work towards a solution to the dispute in December 1867, following Jones resignation. Smith (1982) says that Nightingale and Jones did not communicate for a year following the closure. He further suggests that Nightingale cut Jones off. However Cartwright (1976) states that Nightingale wrote to Jones on 25<sup>th</sup> January 1868 full of sympathy, suggesting that Jones now needed complete rest and offering help in taking forward any new ventures in the future particularly involving London workhouses. This reflects Nightingale's compassion for those in need as Jones was at that time. Nightingale could spurn those who did not agree with her and Jones had left St John's House and King's College Hospital, which Nightingale did not want her to do. Nevertheless they were dearest friends and close working professionals for several years prior to Jones' departure from St John's House and

Nightingale's compassion would have compelled her to care for Jones in any way she was able. They may then not have communicated for some time as Jones regained her health and refocused her life and work. Their friendship continued until Jones death in 1887.

The closure of the ward for the publicly stated reasons of infection and maternal deaths gave Nightingale and the Fund Council the opportunity to sever relationships with King's College Hospital and look to establish a link with another institution more suited to how their thinking had moved on, for example in a workhouse. Nightingale had been involved with workhouse nursing reforms for several years including sending a Nightingale nurse, Miss Agnes Jones, to be matron of the Brownlow Hill Workhouse Infirmary in Liverpool, which William Rathbone financially supported (Abel-Smith 1960). Any new Nightingale midwifery school would again be under the auspices of Mary Jones, who Nightingale made very clear she wanted to work with because of "the entire superiority of her training principles" (BL Add MSS 45752, f. 252). A second Nightingale School for Midwives was never established either by the Nightingale Fund or the government in Nightingale's life time.

These three issues are separate and yet in many ways interconnected, because of the relationships between the individuals and organisations involved. The public reason for the closure of the Nightingale School for Midwives is supported. Three separate organisations stated, in writing, that the rise in maternal mortality was the reason for the closure of the ward. Jones' religious dispute and Nightingale's desire to start a midwifery school in a workhouse made it easier for Nightingale to be part of closing the lying-in ward and the Midwifery School. However her compassion for the poor, as her prime motive, (Cook 1913b) would have compelled her to close the ward because keeping it open may have lead to further deaths. Nightingale still carried the knowledge (and guilt) that more soldiers died in her hospital in Scutari than in any other war hospital (Small 1998) and she could not allow a similar situation to arise again.

## DISCUSSION AND REFLECTION

*If we are permitted to finish the work He gave us to do, it matters little how much we suffer in doing it. In fact, the suffering is part of the work... But surely it is also part of that work to tell the world what we have suffered and how we have been hindered, in order that the world may be able to spare others.*

Florence Nightingale, *Private Note*, 1857. (BL Add MSS 43402, f. 166).

### Introduction

Howard and Sharp (1983) describe research as “Seeking through methodical processes to add to one’s own body of knowledge and hopefully, to that of others, by the discovery of non-trivial facts and insights” (p. 6). The journey through the research process in writing this thesis has been methodical, as each chapter was investigated in sequence to illuminate the story. It has added to my own knowledge from awareness that Nightingale was involved in some way with midwifery to an understanding and discovery of the reasons behind her involvement. It should also add to the body of knowledge of others through the unfolding of the life story and the interpretation given by a midwife (myself) to Nightingale’s relationship with midwifery care and education. The dissemination of the knowledge acquired is part of the process of adding to the body of knowledge of others. This thesis examines the commissioning and closing of the Nightingale School for Midwives from a biographical perspective. Initially Nightingale’s life is set in the social and cultural context in which it took place. This gives it authenticity in that Nightingale’s life was part of a wider social and cultural setting that impinged on her life as it was lived. Erben (1999) contends that biographical studies examine individual lives within a social context with a view to increasing awareness into how a cultural environment is formed and sustained, how its meanings are encountered and responded to by individuals and how it might be changed. In particular, this thesis considers briefly life in nineteenth century Victorian England and within that the life of Florence Nightingale. Her childhood, education and young adult life are discussed with special reference to the comprehensive education that she received from her father and her tours of Europe and how this influenced her later life. Her spiritual life, specifically her call from God and her religious convictions, combined with her determination to do God’s will are related and how this in turn led to conflict with her family as she strove to break free, against Victorian expectations for women of her social class. Nightingale’s exploits during the Crimean War are specifically excluded as much has been written on this particular sojourn elsewhere and it is not central to the thesis.

The immensity of maternal mortality, particularly from puerperal fever is expounded in the thesis and compared to recent mortality figures. It should not be forgotten that in the twenty first century parturient women still die from puerperal sepsis. *Notes on Lying-in Institutions* (1871) is an extremely sobering text, even if you take into account the likely under reporting of maternal mortality and the inaccuracies of the statistical comparisons between different time periods and populations. The point is made and Nightingale attempts to offer solutions in the latter part of the book. Nightingale appears to have a strong desire to share her knowledge and experience with others. Her writings tend to be instructive from the simple *Notes on Nursing for the Labouring Classes* (1861), including *Minding Baby* to the complicated *Suggestions for Thought to the Searchers after Truth Among the Artisans of England* (1860). This demonstrates the educative nature of Nightingale's work. Pearsall's 1998 (p. 589) definition of educative includes giving "moral and social instruction" which describes much of Nightingale's writing precisely. Her writings provided a moral and social informal education service. However it was nonetheless valuable education because it helped people understand their social context and be in a position to improve that context. The survival of individuals in nineteenth century England was often dependent on their continued informal education through the transmission of social, moral and intellectual skills that then became the standards of the time. Nightingale's writings contributed to this informal education.

The final nineteenth century context in which this biographical investigation is set surrounds the evolution of midwifery care and the development of the education and registration of the midwife. It is surprising some of the common sense ideas that pervaded midwifery care during the nineteenth century that research has latterly supported, for example feeding during labour. The history of the education of the midwife is convoluted. The majority of the medical profession was against the education and registration of midwives for most of the nineteenth century. It is difficult sometimes to establish if the reasons were because uneducated midwives were mainly women and it was a gender issue because the man-midwife tended to have had some training, the nature of which undoubtedly left a lot to be desired; or if the reasons were more financial and the doctors were afraid that the midwives would take away business from them, in the days prior to the National Health Service and care free at the point of delivery. The arrogance of the medical profession and the subservience of the nursing and midwifery professions are issues for a future debate. However progress was made and various attempts at training midwives occurred during the nineteenth century and the registration of midwives followed in 1902 after a long struggle. Today midwives still work autonomously in many instances and their practice is prescribed in statute both under UK and European law.

The primary time period investigated is that following Nightingale's return from the Crimean War and her utilisation of the Nightingale Fund. The original intention was to discover why Nightingale established a midwifery school at King's College Hospital. Very little is written about this use of the Fund, and as a midwife, I was previously unaware of any Nightingale connection with midwifery. It seemed an unusual use for the Fund, as Nightingale had no obvious connection with midwifery having spent her career, so far, mainly in matters concerning army nursing and sanitation. As a spinster she had no children nor did her sister, but she had many cousins who had children and will have known women that died as a result of childbirth. As I began to unravel the close relationship between Mary Jones and Nightingale and discovered the involvement of William Bowman on all three Councils, I was convinced that these were the three central characters in the commissioning of the Midwifery School. I thought the actual reason for its establishment was to elude me, given that much of the evidence has been destroyed and the actual reference could have been a spoken narrative. However Nightingale was a very prolific writer, even of notes to herself, so I then became convinced that I should find a reference eventually. Nightingale, in 1861, was in correspondence with William Rathbone regarding district nursing (Cook 1913b) and therefore it is more than likely that she would have shared this discussion with her dearest friend, whose nurses were also involved in district nursing. Nightingale would have acknowledged the argument for midwife nurses employed in Country Parishes because it conformed to her ideals of working for the benefit of the poor. From there it only required her determination and organisational skills to ensure that the available surplus income of the Nightingale Fund was utilised to establish the Nightingale School for Midwives, under the auspices of Mary Jones and St John's House and Sisterhood and situated at King's College Hospital.

As the birth of the Nightingale School for Midwives began to unravel an equally exciting and perhaps even more intriguing issue arose; the reason for the closure of the School five years later. There is clearly confusion over the true reason for the closure, however I am convinced that it was closed because of the staggering rise in the maternal mortality rate that year. Nightingale was proud, arrogant and determined, but she was also compassionate for those less fortunate than herself. She was determined to work to relieve poverty and misery by doing God's work. This can be seen throughout her life in her work in the villages around her homes in Derbyshire and Hampshire, her first post in the Institution for the Care of Sick Gentlewomen in Distressed Circumstances, her volunteering to go to the Crimean War and her writings on religion, hygiene, sanitation, hospitals and nursing during the remainder of her life. This compassion, I believe, would have compelled Nightingale to close the School and the lying-in ward because of the



deaths of the women. However, I am mindful that relationships with King's College Hospital and St John's House were fragile, because of the Mary Jones affair, and therefore the closure of the School was less painful than it could have been. I am also conscious of Silverman's statement that "any interpretative act is influenced, consciously or not, by the tradition to which the interpreter belongs" (1997, p. 12). As a midwife, my tradition would want her to close the ward because of the rising maternal mortality rate, and I believe that the evidence points to the fact that she did.

Smith (1982) suggests that Nightingale wrote *Notes on Lying-in Institutions* (1871) as a cover up for her failure with the Midwifery School. Yet, when Nightingale returned from the Crimean War she spent years gathering information and analysing statistics regarding the deaths and environmental conditions there and writing reports for various bodies. I believe this was her way of coming to terms with a traumatic event and also trying to discover what went wrong so that it could be prevented from occurring again. I do not think she saw it as a way of trying to vindicate herself or as a cover up. I would tend towards Small's (1998) conclusion, but in relation to the closure of the Midwifery School and phrase it that through her "ignorance and arrogance" (p. 203) Nightingale realised that she let the mothers die. In effect therefore I would claim that she wrote *Notes on Lying-in Institutions* (1871) as an exposition of the enormity of the issue of maternal mortality as a result of her personal experience.

## Methodological Discussion

This thesis is entitled a biographical investigation because it conforms to Denzin's definition of biographical method "the studied use and collection of life documents, ... These documents will include autobiographies, diaries, letters, obituaries, life histories, life stories, personal experience stories, oral histories, and personal histories" (1989a p. 7). In this thesis my research has included a literary autobiography (*Cassandra* (1860)), letters to and from Nightingale, life histories (Cook (1913a&b) and Woodham-Smith (1950)) and personal experience stories (personal notes) and contemporaneous records. It also conforms to the definition of biography "a disciplined way of interpreting a person's thought and action in the light of his or her past" (Berk cited in Cortazzi 1993, p. 14). As a biography this thesis includes an exploration of events from Nightingale's life, ordered and leading to the commissioning and closure of the Nightingale School for Midwives, so that sense can be made of Nightingale's experience, with an understanding of how she realised her relationship with midwifery reflected through her life story. It also conforms to Creswell's

(1998) definition of a biographical study in that it is a study of an individual, Nightingale, and her experiences as found in documents and archival material.

It is important to acknowledge the limitations of the documentary review in a thesis as well as highlighting the evidence the documents provide to substantiate the argument. Despite the searches through the main archival material in four major repositories it is acknowledged that some evidence is missing. It may be held in other collections, not necessarily in this country, or in private collections to which researchers do not have access. Evidence may also have been purposefully removed to hide an event either at the time the collection was established or indeed contemporaneously when it was initially written. Nightingale, for example, asked correspondents to burn all her letters at one time (Woodham-Smith 1950). Although she later changed her mind, some may have been destroyed. Some letters at that time were more like emails of today. The post came several times a day and people would correspond with short notes, as we would send emails or telephone. Other letters were more earnest and self-conscious and almost literary works; for example, Nightingale's descriptive letters from her travels abroad. The primary English sources available have been reviewed and it is acknowledged that they are an incomplete record, partly because so much has disappeared by accident or design and partly because much that happened in the past left no material trace to be used as a source, for example, afternoon tea during which business may also be discussed. Equally historical records only document those facts thought to be important enough to chronicle at the time (Tosh 1984), for example the Nightingale Fund Minute Book minutes are brief, as minutes should be, and therefore do not give the detail that a researcher may require to fully interpret the event. Researchers need to scrutinise sources for reliability and bias (Tosh 1984). "...diaries and letters are not necessarily true. All evidence is suspect but...there is plenty of evidence" (Thwaite 1988, p.17). Sources available are often tainted by the intentions of their authors, for example Cook (1913a&b), whilst having access to family held contemporaneous material, had to write a biography that would reflect the views of the family. Nightingale could be considered to be looking after her own interests first, rather than being totally altruistic. No forms of writing ever convey the bare truth. However the bias itself may be significant in reconstructing the past (Tosh 1984).

Although various previous biographies on Nightingale were utilised, they have been critiqued and reviewed essentially for the background information to the thesis. With regard to the central research original letters and manuscripts that were contemporaneously written in the 1860s and

1870s were primarily consulted. The four rules of Gottschalk *et al* (1945) that indicate why one set of documents might be given preference over another can be applied to the references used. Clearly the original letters and manuscripts are more reliable than the biographies because each of the rules is true, but even then there is still confusion over some events.

“..., biography is indispensable to the understanding of motive and intention” (Tosh 1984, p. 73). Nightingale was a very complex person but may be better understood by looking behind her actions and accessing her thoughts, feelings and desires; to grasp the meaning of the intention with which she undertook various actions. An attempt has been made to decipher both the obvious actions and meanings and also the deeper, hidden meanings through which the significance of the overt actions is revealed. Hence not only what she did is known, but also the “motives, memories, value-judgements and purposes” that led her to take the actions. (Erben 1993, p. 16).

The study of any life history requires the biographer to interpret the life within the social/cultural context in which it was lived. It calls for the interpreter to have knowledge of prior events, as understanding is referential to previous knowledge, experience and context. This is the rationale for the chapters concerning Nightingale’s early life and childbirth and midwifery in nineteenth century England. Hermeneutics is the science of interpretation and the biographical method is concerned with hermeneutical investigations and hence establishment of an hermeneutical circle. This acknowledges that cumulative interpretations may refine the understanding of the life but will not give a complete knowledge of it. The biographer cannot understand or interpret it, as the person who lived the life would have done within the social context of that time (Erben, in Scott & Usher, 1996). Biography is provisional, there can never be a definitive biography, only an account, which in time shows how all such attempts display the influence of the age in which they were written (Thwaites 1988). The biographer can only use imagination to approximate an interpretation using empathy, sympathy, speculation and critical distance (Erben, in Scott, 1999) coupled with analytical integrity and supporting documentation.

## Reflection

In the interpretative view, biographies are, in part, written autobiographies of the writers, thus blurring the lines between fact and fiction and leading the authors to 'create' the subject in the text. Biographers cannot partial out their own biases and values; thus, biographies become gendered class productions reflecting the lives of the writers.

(Creswell 1998, p. 50)

Having now journeyed through the process of writing this thesis I would concur with the above statement from Creswell. This interpretation of Nightingale's life story is influenced by my career as a midwife and midwife educator. The whole purpose of the thesis was to investigate Nightingale's relationship with midwifery because I am a registered midwife. I have tried to remain objective in my interpretation but am mindful that my own fascination with history, midwifery practice and education have influenced the structure of the thesis. "...the biographer brings all of his or her own personality, understandings, and experience to the task of creating a view of the individual under study" (Smith 1994, p. 292). Hence a biography should include an autobiography because the cultural and social context of the author will impact on the interpretation that he/she brings to the subject's life.

Part of my enthusiasm for this biography is due to my own physical location. I have lived for the majority of my life in Hampshire and know the places Nightingale visited when she lived at Embley. I too lived near Romsey and have visited East Wellow, where she is buried, for the commemorative service the last few years. I now live near Salisbury where Nightingale had initially hoped to undertake her nurse training at the Infirmary. The hospital building she would have gone to is now an apartment block but the new hospital commemorates her connection with the city. I was also Head of Midwifery Education in Winchester. The original part of the hospital is a Grade II listed building. Nightingale became actively involved in the design and planning of the hospital and even promised a contribution towards its building cost (Cook 1913a).

My reasons for writing this thesis though are even more personal than a physical location in the county in which Nightingale lived and worked for part of her life. I was a practising midwife and had been throughout my career in various roles until September 2000. My responsibilities as the "Approved Midwife Teacher", i.e. the person responsible to the English National Board for Nursing, Midwifery and Health Visiting for the education and training of student midwives in my educational institution, ended because the institution no longer held the Non-Medical Education

and Training contract. It lost the contract in 1997 through a competitive tendering exercise. In March 1998 it was decided not to enrol a final cohort of students for the coming academic year. The irony of this was that during that same month I was asked by the Florence Nightingale Foundation, as Head of School, if six of the student nurses could escort the Florence Nightingale lamp down the isle of Westminster Abbey at the annual Memorial Service to commemorate her birth in May. The students were a credit to the profession and the institution and I was both proud and emotional, given the irony of the situation.

However the irony continues. As I write this chapter in early February 2002, my Mother lies gravely ill in the Intensive Care Unit at the Royal Hampshire County Hospital, Winchester; the same hospital Nightingale planned all those years ago. My Mother had major abdominal surgery in early January and was recovering reasonably well. Then after about ten days suddenly became very ill and was transferred to intensive care in the middle of the night. She had an overwhelming blood infection caused by coliform bacteria, usually from the intestines. She was not expected to survive the following day. However I am pleased to say that ten days later, although still extremely ill, she is making slow progress. Her good general health prior to surgery has undoubtedly saved her life, so far. The irony is that had my mother just given birth, rather than had abdominal surgery, this would have been diagnosed as puerperal sepsis. I have now witnessed how quickly infection can overpower the body's natural defence mechanisms after apparent normal postoperative events and how quickly someone can die. My Mother has had intensive care with twenty four hour care and attention from nursing and medical staff. A woman on a lying-in ward in nineteenth century England would not have received such care and would have died very quickly.

"Biographical method is an educative exercise, its axiomatic purpose being not only the accumulation of information and the interpretation of data but also a development in the moral reasoning of the researcher". (Erben 1996, p. 159). Each life event is not a simple, singular occurrence, but a complex interaction between the individual and the cultural context; it is a mix of past memories and subjectivities. This is true of the life of the subject and the life of the researcher who can then bring to any interpretation an ethical appreciation of this complex mix of life events (Erben 1999). Through the studied use of life documents related to Nightingale's life, a greater understanding of periods in her life and the ethical dimensions within it are illuminated.

This process is educative in that the nature and meaning of Nightingale's life has already and will in the future influence my moral reasoning as I continue with my journey through life.

The journey through researching this biographical investigation has therefore been illuminating regarding areas of Nightingale's life that had not been previously expounded and also educative in that I have developed in my moral reasoning and indeed in other areas of my life through the reflection that this process has guided me through. "The writing of biography is more than a discovery of another person. It is a matter of self discovery. If the subject of the biography is not too alien or repugnant, the writer goes through a painful process of immersion in another's life, a baptism by research" (Sinclair 1988, p. 123). The joys and thrills of undertaking this task have only been dampened by the frustration and then panic when the "answer" was not as easily detected as I had expected. But the overwhelming emotion I felt when I discovered the letter from Nightingale to Bowman still amazes me. Nightingale was a complex and difficult person and not one with whom I should particularly wish to have contact. However throughout this journey I have come to know and respect her more and to appreciate her influence on the life of all women and indeed various poor sections of society at home and abroad in nineteenth century England.

## Appendix 1

### Chronology of the Life and Times of Florence Nightingale

Date	Life and Works	Historical Events
1818		William Edward Nightingale (WEN) and Frances (Fanny) Smith married. Honeymoon in Europe.
1819		19 <sup>th</sup> April, Frances Parthenope Nightingale, later Lady Verney, born in Naples. 24 <sup>th</sup> May, Princess Victoria born.
1820	12 <sup>th</sup> May, FN born in Florence, in the Villa Colombaia,	January, King George IV comes to the Throne.
1821	The Nightingale family returns to England and tries to settle down in W.E.N.'s inherited property in Derbyshire. W.E.N. had a new house built for the family, Lea Hurst and they lived there until 1823.	
1825	The Nightingales move to Embley Park in the parish of Wellow, in Hampshire. It becomes the family's main home with Lea Hurst as a summer home.	
1830		King William IV comes to the Throne.
1834		Tolpuddle Martyrs convicted. Houses of Parliament destroyed by fire.
1837	7 <sup>th</sup> February, God spoke to FN at Embley; but she is not clear on how to "serve" Him. September, the family travels to Europe while Embley is being remodeled. She meets Mary Clarke in Paris.	20 <sup>th</sup> June, Queen Victoria comes to the Throne. Charles Dickens publishes <i>Pickwick Papers</i> and <i>Oliver Twist</i> .
1839	April, the Family returns to England. June, the sisters are presented at Queen Victoria's birthday party. September, the family takes up residence at Embley.	
1840		Queen Victoria marries Prince Albert. Penny post established.
1842	FN meets Richard Monckton Milnes.	
1843		Nelson's Column erected in Trafalgar Square.

1845	FN asks to train at Salisbury Infirmary nearby. Fanny and Parthenope are horrified.	
1847	Selina and Charles Bracebridge take FN to Rome with them. She meets Elizabeth (Liz) and Sidney Herbert.	William Makepeace Thackeray publishes <i>Vanity Fair</i> .  Emily Bronte publishes <i>Wuthering Heights</i> .  Charlotte Bronte publishes <i>Jane Eyre</i> .
1848		St John's House (Anglican Order) founded to train nurses.  Queen's College opens higher education to women.
1849	After seven years of waiting, Milnes is given a final answer of no to his proposal of marriage. After much agonizing, FN concludes that she could not have "work" of her own if she chooses to follow her heart into this society marriage. Marriage would destroy her chance of serving God's call.	
1849	December, FN accompanies the Bracebridges to Egypt and Greece.	
1850	On 31 <sup>st</sup> July –13 <sup>th</sup> August, FN has her first visit to the Institution of Kaiserswerth.	
1851	From 6 <sup>th</sup> July –7 <sup>th</sup> October FN is again at Kaiserswerth as a probationer.	The Great Exhibition, at Crystal Palace, Hyde Park, London.
1853	FN went into residence in her first "situation" as superintendent of An Establishment for Gentlewomen During Illness at no. 1 Upper Harley Street, from 12 <sup>th</sup> August, 1853 to October, 1854.  Her father gives her a yearly allowance of £500.	John Snow administers chloroform to Queen Victoria for Prince Leopold's birth.
1854	Sidney Herbert, as Secretary at War asks FN to nurse British soldiers. She assembles a party of 38 nurses and goes to Turkey to the Barrack Hospital on 21 <sup>st</sup> October.	England, France and Sardinia come to the aid of Turkey against Russia: the Crimean War. Through the first war correspondent, the public learns of needs of wounded soldiers.  5 <sup>th</sup> November Battle of Inkerman.  Charles Dickens publishes <i>Hard Times</i> .
1856	July, war is over, the last patients and nurses leave. FN goes home to Lea Hurst, arrives in August. Upon request she visits Queen Victoria and Prince Albert to talk about her war experiences.	March, Peace signed.  Rubber teats for nursing bottles become available.

1857	<p>May, the government issues a warrant to establish a "Royal Commission" to investigate the disasters of the Crimean War.</p> <p>The Sepoy Rebellion in India calls FN's attention to sanitation problems in India and she begins a life-long project to sanitize the country.</p> <p>Sir Harry Verney proposes to FN but she declines.</p>	<p>Victoria names Albert Prince Consort.</p> <p>St. John's House takes on nursing at King's College Hospital.</p>
1858	Her father increases her allowance to include all her bills for food and lodging and to allow her £500 besides.	Sir Harry Verney and Parthenope are married at Embley Park in June. They move to Claydon House.
1859	<p>FN publishes <i>Notes on Nursing</i>. It is expanded and published again in 1860 and in 1861 with special section on "Minding Baby".</p> <p>FN publishes <i>Notes on Hospitals</i>.</p>	<p>Charles Darwin publishes <i>On the Origin of Species Through Natural Selection</i>.</p> <p>John Stuart Mill publishes <i>On Liberty</i>.</p> <p>Elizabeth Blackwell has name placed on register of qualified physicians.</p>
1860	June, The Nightingale Training School for nurses opens at St. Thomas Hospital.	<p>George Eliot publishes <i>The Mill on the Floss</i>.</p> <p>Wilkie Collins publishes <i>The Woman in White</i>.</p>
1861	2 <sup>nd</sup> August, Sidney Herbert dies.	<p>14<sup>th</sup> December, Prince Consort dies of typhoid.</p> <p>Charles Dickens publishes <i>Great Expectations</i>.</p>
1862	<p>January, the Nightingale School for Midwives opens at King's College Hospital.</p> <p>FN publishes her <i>Observations</i> concerning sanitation problems in India.</p>	Mary Elizabeth Braddon publishes <i>Lady Audley's Secret</i> .
1864		Convention of Geneva signed and start of the International Red Cross
1865		<p>Joseph Lister promotes use of antiseptics to prevent infection during childbirth.</p> <p>Lewis Carroll publishes <i>Alice's Adventures in Wonderland</i>.</p>
1867	The Nightingale School for Midwives and the Lying-in ward close at King's College Hospital.	Mary Jones leaves St. John's House and King's College Hospital.
1869		<p>Josephine Butler founds Ladies National Association for Repeal of the Contagious Diseases Act.</p> <p>First group of women medical students admitted at Edinburgh.</p>

1870		W. E. Forster's Education Act. First Married Women's Property Act. Charles Dickens dies.
1871	FN publishes <i>Introductory Notes on Lying In Hospitals</i> .	Women's Education Union founded. Stanley and Livingstone meet at Lake Tanganyika. Charles Darwin publishes <i>Descent of Man</i> . George Eliot publishes <i>Middlemarch</i> .
1874		January, WEN dies. London Medical College for Women established.
1879		Louis Pasteur identifies the organisms that cause puerperal fever.
1880		February, Fanny dies.
1882	FN writes an article for Quain's Dictionary of Medicine	Robert Louis Stevenson published <i>Treasure Island</i> . Charles Darwin dies.
1883	FN awarded the Royal Red Cross	
1886		Robert Louis Stevenson published <i>The Strange Case of Dr Jekyll and Mr. Hyde</i> .
1887		Mary Jones dies.
1888		"Jack the Ripper" murders
1890	The Edison company records FN's voice on a cylinder in her house on South St. It is restored and issued in 1939.	Parthenope dies.
1894		Sir Harry Verney dies. Oscar Wilde published <i>Salome</i> . Rudyard Kipling published <i>Jungle Book</i> .
1899		First milk depot offering sterilised milk for infant feeding.

1901		<p>22<sup>nd</sup> January, Queen Victoria dies.</p> <p>January, King Edward VII comes to the Throne.</p> <p>Rudyard Kipling published <i>Kim</i>.</p> <p>Edward Elgar performed <i>Pomp and Circumstance</i>.</p> <p>Beatrix Potter published <i>The Tale of Peter Rabbit</i>.</p>
1902	FN can no longer read or write except with great difficulty.	
1907	June, FN honoured by the Red Cross Congress in London. November, King Edward VII bestows the Order of Merit on FN; it is the first time that the Order is given to a woman.	
1908	March, FN given the Freedom of the City of London.	
1910	13 <sup>th</sup> August, she fell asleep about noon and died. Burial in Westminster Abbey was declined. She was buried in the family grave at East Wellow and six sergeants of the British Army carried her coffin. Her only memorial is a line on the family tombstone "F. N. Born 1820. Died 1910."	May, King George V comes to the Throne.

## Appendix 2

### A Selection of Writings by Florence Nightingale

#### Including privately printed articles, books and reports.

*The Institution of Kaiserswerth on the Rhine for the Practical training of Deaconesses, Under the Direction of the Rev. Pastor Fliedner, Embracing the Support and Care of a Hospital, Infant and Industrial Schools and a Female Penitentiary.*

London: Printed by the Inmates of the London Ragged Colonial Training School, 28 St Anne's Street, Westminster, 1851.

#### *Letters From Egypt*

Privately printed: A. & G. A. Spottiswoode, New Street Square, London, 1854.

*Statements Exhibiting the Voluntary Contributions Received by Miss Nightingale for the Use of the British War Hospitals in the East with their Mode of Distribution in 1854, 1855, 1856*  
Harrison and Sons, St Martin's Lane, W.C., 1857.

*Mortality of the British Army, at Home, at Home and Abroad, and During the Russian War, as Compared with the Mortality of the Civil Population in England*

Harrison and Sons, St Martin's Lane, London, 1858.

#### *Introduction of Female Nursing into Military Hospitals*

Harrison and Sons, St Martin's Lane, W.C., 1858.

*Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army, Founded Chiefly on the Experience of the Late War.*

Harrison and Sons, St Martin's Lane, W.C., 1858.

#### *A Contribution to the Sanitary History of the British Army in the Late War with Russia*

London: John W Parker & Son, West Strand, 1859.

*Notes on Hospitals: Being Two Papers Read before the National Association for the Promotion of Social Science, at Liverpool, in October, 1858. With Evidence Given to the Royal Commissioners on the State of the Army in 1857.*

John W. Parker and Son, West Strand, London, 1859.

*Notes on Nursing: What it is and What it is Not*

Harrison, 59 Pall Mall, London, 1859.

*Suggestions for Thought to the Searchers after Truth among the Artisans of England. vols. I-III*

(Privately printed by) George Eyre and William Spottiswoode, London 1860.

*Notes on Nursing for the Labouring Classes*

Harrison, 59 Pall Mall, London, 1861.

*Hospital Statistics and Hospital Plans*

Emily Faithfull & Co., Victoria Press (for the employment of women), Great Coram Street, London, 1862.

*Army Sanitary Administration and its Reform Under the Late Lord Herbert*

McCorquodale & Co., Cardington Street, Works, Newton, 1862.

*Notes on Different Systems of Nursing*

Harrison and Sons, St Martin's Lane, W.C., 1863.

*How People May Live and not Die in India*

Emily Faithful, London, 1863

*Organisation of Nursing in a Large Town an Account of the Liverpool Nurses' Training School, its Foundation, Progress, and Operation in Hospital, District, and Private Nursing.*

A Holden, 48 Church Street, Liverpool, 1865.

*Memorials of Agnes Elizabeth Jones*

Strahan & Co, London, 1871.

“Una and the Lion”. A paper in *Good Works*, June 1868.

*Introductory Notes on Lying-In Institutions. Together with a Proposal for Organising an Institution for Training Midwives and Midwifery Nurses*

Longmans, Green, and Co, London, 1871.

*Address from Miss Nightingale to the Probationer-Nurses in the Nightingale Fund' School at St Thomas's Hospital, and the Nurses who were formerly trained there. May 23, 1873.*

Spottiswoode & Co., New Street Square, London, 1873.

*Life or Death in India: With an Appendix on Life or Death by Irrigation 1874. [A Paper Read at The National Association for the Promotion of Social Science, Norwich, 1873]*  
Spottiswoode & Co., New Street Square, London, 1874.

*Address from Florence Nightingale to the probationer-nurses at St Thomas's Hospital, and the nurses who were formerly trained there. April 28th, 1876.*

Spottiswoode & Co., Printers, New Street Square, London, 1876.

*Nightingale, Florence Nurses, Training of: [and] Nursing the Sick' in A Dictionary of Medicine edited by Richard Quain MD FRS*

Longmans, Green & Co, 1882.

*To the probationer-nurses of the Nightingale Fund School, at St Thomas's Hospital. Florence Nightingale. New Year's Day, 1886.*

Blades, East and Blades, 23 Abchurch Lane, London EC, 1886.

*Sketch of the History and Progress of District Nursing, from its Commencement in 1859 to the Present Date; Including the Foundation by the Queen of the "Queen Victoria Jubilee Institute" for Nursing the Poor in their own Home.*

London: Macmillan, 1890.

*Health Teaching in Towns and Villages. Rural Hygiene*

Spottiswoode & Co., New Street Square, London, 1894.

*To the nurses and probationers trained under the Nightingale Fund.' London, June 1897.*

Spottiswoode & Co, printers, 54 Gracechurch Street, London EC, 1897.

## Appendix 3

### Extract from the Minutes of the Nightingale Fund Council Committee Meeting

held at 45 Parliament Street on 5<sup>th</sup> October 1861.

Present: Sir Joshua Jebb (Chair)

Mr Bowman

Mr Spottiswoode

Mr Bonham Carter (Secretary)

5. "A memorandum containing the particulars of a plan proposed by Miss Nightingale for the consideration of the Committee, for employing the available surplus income of the Fund in affording means for training Women as Midwife- Nurses for Country places was read. The short outline of the plan was as follows. The Authorities of Kings College Hospital being willing to set apart a Ward with 10 beds for Lying-in cases on being indemnified against all expense and St John's House having agreed to undertake the care and training of a limited number of Women in consideration of a fixed payment for Board, Lodging and Washing, it was proposed that the Fund should supply and maintain the Beds and pay the salary of a Midwife as Instructor and should in addition provide the sum of £100 towards the maintenance of the Women during the space of two years, the period for which it was proposed that the arrangement should continue in force.

It was there upon resolved that the plan laid down in the memorandum be approved and that the Secretary be directed to prepare and the chairman to approve and sign on behalf of the Committee an agreement with the Council of St John's House for carrying the scheme into effect, the expenditure to be incurred thereby being limited to the sum of one thousand pounds (£1,000) for the first two years.

The draft of certain Regulations for the training of the proposed Midwifery Nurses as submitted by Miss Nightingale was read and approved.

6. It was further resolved that for the purpose of carrying out the plan the Trustees be requested to direct Messrs Coutts Co. to honour the Drafts of any two members of the Committee countersigned by the acting secretary for any sum not exceeding the current balance for the time being."

(A/FNC/2/1)

## Appendix 4

### The Nightingale Fund

#### Extract from the Statement of the Appropriation of the Nightingale Fund.

(Reprinted, with slight additions, from a Paper read by Sir Joshua Jebb, at a Meeting of the Social Science Association, 1862).

“... was the training of midwife nurses. It is believed that the want is deeply felt, especially in country parishes and provincial towns, of women properly qualified to attend upon the wives of the poor in their confinements, and to take charge of the infants. As a rule, the class of women who are so employed are most incompetent, and often, if fairly competent, do not bear the most respectable characters. It was therefore considered that, if means were afforded for acquiring the requisite training at a small cost, those who are interested in the welfare of their poorer neighbours would be induced to select and send a fitting person to be trained, with a view to their subsequent permanent employment in the immediate locality, and under the superintendence of those who should undertake this responsibility. It is believed that women so trained, acting under the clergy and medical men, would be a great boon to every populous parish, and that whilst probably requiring some pecuniary aid in the outset, they would eventually be enabled to support themselves.”

(A/NFC73/4 p. 7)

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