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1

Nursing and Midwifery: Historical Approaches

Anne Borsay and Billie Hunter

Health-care professionals have long recognized the significance of history for contemporary practice.¹ As early as 1921, for example, an article in the *British Journal of Nursing* insisted, ‘No occupation can be quite intelligently followed or correctly understood unless it is, at least to some extent, illuminated by the light of history.’ The nurse familiar with ‘only her own time and surrounding’ was ‘unable to estimate and judge correctly the current events whose tendency is likely to affect her own career’. Therefore, it was essential to ‘know how the work of nursing arose; what lines it has followed and under what direction it has best developed’.² Histories of nursing and midwifery have perpetuated the commitment to studying the past to improve the present. This is said to be especially useful at times of social change when practitioners struggle to assess new professional values³ or come to terms with new political directives.⁴ But learning from history is a complex process. As Nicky Leap and Billie Hunter found in their oral history of midwifery, there is no inevitable ‘treasure chest of forgotten skills’ to inspire today’s midwives and enhance their practice; quite the opposite, prevailing attitudes were authoritarian.⁵ Moreover, history never repeats itself; contrary to popular opinion, ‘nothing in human society . . . ever happens twice under exactly the same conditions or in exactly the same way’. Consequently, though drawing analogies or parallels between the past and the present may deepen our understanding of current problems, it is unlikely to offer simple solutions.⁶

So is it mistaken to see relevance in the history of nursing and midwifery? Not at all! In recent years, multidisciplinary working and the reconfiguration of roles have seriously challenged traditional professional identities. At the same time, confidence is being shaken by economic uncertainties, the political dilemmas of trade union action and the social reverberations of shifting gender, class and ethnic relations. Therefore, neither nurses nor midwives are any longer ‘ascribed a single identity by virtue of their . . . occupational group’. Instead, they are compelled ‘to construct their own identities on an ongoing basis by thrashing out the multiple meanings of their changing roles’.⁷ *Nursing and Midwifery in Britain since 1700* is designed to contribute to the critical reflection that such identity-building requires, by illustrating how historical analysis can help to compile professional narratives that explore present-day experiences with reference to the past.

Origins

The words ‘nurse’ and ‘midwife’ passed into the English language during the Middle Ages: a long period in British history, which stretched for a thousand years from the departure of the Romans in the fifth century to the arrival of the Tudor monarchy in 1485. ‘Nurse’ – derived from the Latin *nutricius* or *nutritius*, meaning ‘to nourish’ – became ‘norse’ or ‘nurice’.⁸ ‘Midwife’ – derived from the Anglo-Saxon – was translated as ‘with-woman’, meaning the midwife herself and not the mother.⁹ In the early medieval period, the boundaries between nursing and midwifery and between medicine and obstetrics were permeable and the division of labour less gendered than it is today. From the twelfth century, however, the barring of women from the universities, and from the guilds that governed surgeons and apothecaries in towns, slowly eroded their formal healing roles if not their domination of family and community medicine.¹⁰ Midwifery fared better than nursing. Therefore, in her study of *Women’s Healthcare in the Medieval West*, Monica Green chose to include midwives but exclude nurses from the list of health-care practitioners. Whereas midwifery had a clearly identifiable role around the autonomous care of mothers and babies, the ‘modern, quite specific professional medical connotations of “nurse” . . . [had] no place in the Middle Ages’. As a result, she decided, it was ‘best to restrict the term to those women . . . [usually children’s nurses] who were so designated in medieval documents’.¹¹

The well-defined modern nurse who serves as Green's benchmark is a figment of the imagination. By the time the verb 'to nurse' and the noun 'nursing' joined the person of 'the nurse' in the sixteenth century, the meaning of all three terms had broadened to include the tending and nourishment of inanimate objects such as land and money as well as the care of patients of all ages.¹² However, exactly what that care entailed remained far from certain. Therefore, when Florence Nightingale – Britain's most famous nurse, renowned for her exploits during the Crimean War (1853–6) – published *Notes on Nursing* in 1859, she acknowledged that nursing was not well understood:

I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet – all at the least expense of vital power to the patient.¹³

Twentieth-century nurses continued to emphasize their jurisdiction over this distinctive healing environment, regarded as essential for effective medical diagnosis and treatment. The focus thus fell on 'patients as whole beings' rather than as the victims of specific diseases; and well-being was construed as not just 'physical intactness' but also as 'emotional and social integration'.¹⁴ By the 1960s, nursing was beginning to collaborate more directly with medicine, moving towards a role that demanded 'independence of thought and action'.¹⁵ However, there is no greater clarity about its definition. As the authors of the recent *History of the Royal College of Nursing* (RCN) conclude, 'The answer to the question... "what is the proper task of a nurse", remains open.' Too many groups describe themselves as nurses. Therefore, it is impossible for the profession to secure its position, as medicine and midwifery have done, by exhibiting command of a unique body of knowledge and skills.¹⁶

For some historians of nursing and midwifery, this preoccupation with professional status is a distraction. In 1996, for instance, Christopher Maggs made a powerful case for advancing beyond 'the discipline of the technologies' – 'that of medicine or nursing or physiotherapy' or indeed midwifery – and developing 'a history of caring... to cross over all of the disciplines which contribute to health'.¹⁷ To date his call has gone largely unheeded. Outside the modern period during which nurses and midwives established their professional credentials, studies have looked at caring in families and local

communities. But post-1800, the drive towards professionalization has eclipsed this perspective and research has concentrated on themes such as the battle for registration, the debate about trade unionism and models of organization, education and training.¹⁸ Nevertheless, the historical analysis of these issues has not stood still. In response to broader historiographical trends, it has evolved from hagiographic celebration at the end of the nineteenth century into an energetic area of scholarship dedicated to locating nursing and midwifery within their economic and political, social and cultural contexts.

Histories

The history of nursing and midwifery has its roots in Victorian biography, which praised the lives of ‘women worthies’ as exemplars for female readers.¹⁹ At the Midwives’ Institute, four women were particularly prominent between the 1880s and 1914 as the organization campaigned to achieve registration and promote the expertise of its members: Zepherina Smith, Jane Wilson, Amy Hughes and Rosalind Paget. Though Paget has been described as ‘the Florence Nightingale of midwifery’,²⁰ her work failed to generate the biographical interest provoked by nursing’s ‘lady with a lamp’. Nightingale herself wrote on maternal mortality and midwifery training following an outbreak of puerperal sepsis in 1867 which led to the closing down of her school for midwives at King’s College Hospital in London.²¹ However, such failures were of no concern to early biographers such as Sarah Tooley, whose romantic *Life* – published in 1904 to mark the 50th anniversary of Florence’s departure to the Crimea – was an unadulterated celebration of womanly self-sacrifice.²²

Over the course of the twentieth century, the genre of *critical* biographies emerged,²³ and in their later studies of Nightingale neither Sir Edward Cook²⁴ nor Cecil Woodham-Smith²⁵ indulged in Tooley’s brand of personality whitewash. Until the late 1990s,²⁶ however, Nightingale’s performance at the Scutari Military Hospital during the Crimean War remained untarnished. Mark Bostridge destroyed this orthodoxy in a pungent piece on the BBC’s history webpage. Historians, he argued, were only just

waking up to the shocking truth that the death toll at Nightingale’s hospital was higher than at any other hospital in the East, and that her lack of knowledge of the disastrous sanitary conditions at Scutari was responsible. 4,077 soldiers died at Scutari during Nightingale’s first

winter there, ten times more from illnesses such as typhus, typhoid, cholera and dysentery, than from battle wounds. Conditions at the hospital were fatal to the men that Nightingale was trying to nurse: they were packed like sardines into an unventilated building on top of defective sewers.²⁷

Bostridge's assessment is more restrained in his seminal biography of Nightingale, where he concedes that 'the dramatic decrease in mortality at Scutari in the first months of 1855' was 'directly attributable' to her.²⁸ Nevertheless, it was the sanitary commission, despatched by the British government six months after Nightingale's arrival, which significantly cut the mortality rate by flushing out the sewers and improving ventilation. And only while preparing evidence for the Royal Commission on the Health of the Army did Florence herself realize that she had helped soldiers 'to die in cleaner surroundings and greater comfort, but she had not saved their lives'.²⁹

Such critical biographies have many virtues as a historical tool, bringing people to life and enabling neglected figures to rise from obscurity. Exemplary in this respect is Jane Robinson's rehabilitation of the black nurse, Mary Seacole³⁰ – quickly forgotten after her death, but greeted with 'rapturous enthusiasm' at the public banquet held in London to honour Crimean soldiers.³¹ Nevertheless, biographies do overlook the everyday lives of ordinary nurses and midwives, not to mention the patients for whom they cared. One way of broadening the focus is to look at the institutions through which the two professions evolved. Early institutional histories were as eulogistic as early biographies, making little attempt to dig beneath the surface and question achievements or acknowledge shortcomings.³² But even in contemporary studies, there is a tendency to exaggerate. Susan Williams may thus be a little bullish in asserting that the 1936 Midwives' Act, which set up a national salaried midwifery service, was an achievement of the National Birthday Trust Fund.³³ Moreover, institutional histories tend to gravitate towards the 'big names'. Therefore, the recent RCN study noted: 'Although the views of its leaders were undoubtedly influenced by changing climates of opinion, and shifts in social and gender relations, they were also active in contributing to some of these changes.' It followed that 'due weight' had to be given to 'the role of... [the organization's] leaders, not as a celebratory "institutional history", but to explain how an organization of this type survives, and how it adjusts to new circumstances'.³⁴

Given the tenor of personal and institutional biographies, the past experiences of both nurses and midwives also need to be situated within their broader historical context. This call for context underpins Sioban Nelson's 'fork in the road': the division between nursing and midwifery histories, which tells a story of progress from 'the dark and chaotic past to the glorious present'; and *histories of* nursing and midwifery, which engage with mainstream historical scholarship by addressing the complex economic, social, political and cultural environments in which nurses and midwives worked.³⁵ The implementation of context was both empirical and conceptual. In the history of nursing, empiricism – the belief in evidential as opposed to theoretical or logical justification – was pioneered by Brian Abel-Smith, whose *A History of the Nursing Profession* was published in 1960.³⁶ Abel-Smith examined the politics of general nursing, paying particular attention to the role of structure, recruitment, terms and conditions, professional associations and trade unions. As Christine Hallett says, he 'deliberately challenged the progressive perspective by revealing... the tensions and conflicts which existed within the nursing establishment'; the 'profession's leaders' were 'No longer a group of noble women driving towards the same goal, ... [but] fallible ... fractured ... [and] capable of sabotaging as well as promoting ... [their] own interests.'³⁷

The history of midwifery has also attracted empirical investigation. In his monumental study of *Death in Childbirth* between 1800 and 1950, Irvine Loudon tested 'the effectiveness of various forms of maternal care by means of the measurement of maternal mortality'. His nuanced conclusion was that 'high maternal risk could be associated with cheap untrained midwives or expensive over-zealous and unskilled doctors'. On the other hand, 'Sound obstetric practice by well-trained midwives could produce low levels of maternal mortality even in populations that were socially and economically deprived.' 'Monocausal explanations' of these patterns were criticized, given the potential influence of 'clinical or pathological factors', 'social and economic changes', 'the politics of maternal care' and 'the quality of medical education'. But, equally, social-historical and feminist accounts 'with scarcely a statistic, let alone a statistical evaluation, in sight' were severely chastised. For if demography detracted 'attention from features of central importance which are inherently unmeasurable – attitudes or sentiments for example – there ... [was] also the danger that without statistical analysis large conclusions are often based on the shaky foundation of thin evidence and small unrepresentative samples'.³⁸

Abel-Smith was more apologetic about missing the essence of professional practice, admitting that nursing as ‘an activity or skill’ – and ‘what it was like . . . to nurse . . . or to receive nursing care’ – was largely absent from his picture.³⁹ Monica Baly started to fill these gaps in the first edition (1973) of *Nursing and Social Change*. For her, ‘The development of nursing . . . [was] like weaving a cloth with social change as the warp, and running to and fro with the weft . . . [was] the shuttle of care.’⁴⁰ Yet although the endorsement of contextualization was unequivocal, Baly’s narrative retained the progressive ethos. From the late 1970s, this confidence was shaken as the forces attributed with determining the economic, social and political structures of modern societies since the late eighteenth century – the nation state, industrialization, social class, science and religion – were dethroned by economic crisis, industrial conflict, faltering political institutions and procedures and a virulent attack on public services.⁴¹ The result was a collapse of the consensus built around the welfare state, which had emerged post-1945 in the aftermath of the Second World War.⁴² This crisis set the stage for nursing sociologist Celia Davies to attack the supposition that ‘progressive and humanitarian ideas . . . [would] eventually win out against the opposition of vested interests’. No, this was not the case. Reforms were ‘double-edged, always in part at least reflecting the views of the most powerful’.⁴³ It was this assault on the inevitability of progress, derived from a background in the social sciences, which supplied the history of nursing with its conceptual toolkit for the analysis of context.

Midwifery as well as nursing is closely aligned with the social sciences, using them to oppose ‘the alleged positivistic and technocratic values of medicine’.⁴⁴ Consequently, concepts derived from the social sciences have been a friendly medium for historical contextualization. This new orientation has encouraged research forays into patient interests⁴⁵ and the employment of overseas nurses,⁴⁶ but most activity has concentrated on gender and labour histories.⁴⁷ Although both nursing and midwifery are predominantly female professions, the concept of gender has been differentially employed. In the history of nursing, the organization of nineteenth-century hospitals has been explained in terms of domestic patriarchy, with the ‘doctor/nurse relationship’ becoming ‘the man-father/women-mother relationship’ and being ‘subsumed under the rubric of male-female relations’.⁴⁸ Furthermore, it has been suggested that at times of war, these gendered roles are destabilized,⁴⁹ nowhere more so than when the ‘nurse entered into a direct physical relationship with the wounded

soldier'.⁵⁰ But, otherwise, surprisingly little attention has been paid to gender issues.

The history of midwifery, on the other hand, has embraced gender more enthusiastically. Confrontation with the predominantly male medical profession for the control of childbirth may account for this difference. Midwives have used history to track the 'medical take-over' of their role which, allegedly, gathered momentum after the introduction of ante-natal care in the early twentieth century and peaked in the 1970s with the acceleration of hospital births. It has been argued that midwifery 'belong[ed] to a woman's world where instinct, intuition and emotion as well as clinical competence and theoretical knowledge play their parts'. Therefore, routine hospitalization and the indiscriminate use of technology have not only threatened midwives' careers but have also reduced pregnancy and childbirth to a 'mechanistic exercise' for women.⁵¹ More recent histories have been cautious about the decline of midwifery, stressing diversity rather than uniformity. As Hilary Marland and Anne Marie Rafferty concluded after reviewing the chapters in their edited collection, midwives' practice is a product of not only the 'development of the obstetric professions' and 'levels of institutional provision' but also of 'economic forces, urbanization, changes in family life and the employment of women, religion ... [and] the input ... of various pressure groups'.⁵²

In labour history too, similar refinement has taken place. Sociologist Mick Carpenter is one of a few people who have taken an interest in nursing from an employment perspective. Characterizing how nurses became professionalized in Britain, Carpenter identified 'three main attempted transformations'. Nightingale's name was attached to the first phase, which 'lasted from the mid-nineteenth century to around the time of the First World War' and tried to establish an autonomous 'nursing structure', despite 'subordination' to 'the managerial needs of the local hospital' and to medicine. The second phase – 'the professionalization of care' – was 'initiated in the late nineteenth century by Mrs Bedford Fenwick'. Its mission was to achieve the 'social closure' of nursing 'as an exclusively middle class occupation' by seeking professional independence from 'the state and local managements', by extending the control of 'general nursing over the nursing universe' and by attaining a 'complementary' (though 'still subordinated position') in relation to 'an ascendant medicine'. The third phase – 'the new professionalism' – crossed the Atlantic to Britain in the 1970s and was predicated on a 'renewed' effort 'to achieve the longstanding goals of professionalization'.

But ‘whereas previous movements...sought to professionalize the whole occupation’, the new professionalism concentrated on clinical nurses, aiming to provide them with a knowledge base – separate from medicine – that challenged biomedicine in the name of the patient by developing nursing plans that were ‘rational, rigorous and individualized’.⁵³

Professionalization has dominated the histories of both nursing and midwifery, as the chapters in this volume demonstrate. In her 2005 Monica Baly Lecture, however, Celia Davies issued a plea to ‘ditch’ the concept of professionalization in favour of a ‘professional identity’, which was better able to absorb the complexities of ‘nursing knowledge, practice, regulation and caring’.⁵⁴ This call is now being answered. Building on Christopher Maggs’s pioneering study of nurse recruitment at four provincial hospitals,⁵⁵ Sue Hawkins has continued the task of unpicking the stereotypical images of nineteenth-century nursing and providing the historical detail to hone sociological models such as that of Carpenter. Using St George’s Hospital, London, as a case study, she has shown that although there was some movement towards the reformers’ ideal of the young unmarried nurse from the higher social classes, working-class women had not been excluded from hospital nursing by 1900. Moreover, far from being ‘the docile, saintly nurse of myth’, they had taken a positive and informed decision to enter the profession as a career choice within a labour market that was offering women an increasing number of options.⁵⁶

This contextualization of nurses within an economic environment is indicative of a wider maturity in the history of nursing and midwifery. So too is the broadening of focus beyond the fortunes of general nursing to encompass both hospital specialties⁵⁷ and community services.⁵⁸ The trend away from ‘an internalist and triumphalist form of professional apologetics to a robust and reflective area of scholarship’ – noted by the editors of *Nursing History and the Politics of Welfare* in 1997 – has been consolidated.⁵⁹

Doing History

The transition of scholarship in the history of nursing and midwifery was underpinned by a lively debate about sources and methods. When established as an academic discipline during the nineteenth century, history embraced the rational pursuit of objective truth in line with the mindset of the natural sciences; in the words of the German historian Leopold von Ranke, it sought ‘to show how, essentially, things happened’.⁶⁰ From the 1970s, however, the economic and political

decline that undermined faith in progress also threatened intellectual confidence in objectivity, emphasizing the relativity of knowledge and reducing it to power. 'We should admit . . . that power produces knowledge', declared the French philosopher Michel Foucault, 'that knowledge and power directly imply one another'.⁶¹ Accordingly, the past could not be understood in a rational way, because every interpretation was merely the outcome of political values. Yet while this postmodern approach has provoked vibrant debate about the nature of history,⁶² it has never been more than a marginal force in Britain, with some impact on the range of sources that historians deploy but little on the methods that they use to construct historical arguments.

Given the affinity of nursing and midwifery with the social sciences, it is not surprising that the histories of the two professions have emphasized the different source bases; whereas social scientists design a project to collect the data required, historians generally have to work with what has survived.⁶³ Until recently, they used to rely almost exclusively on documentary evidence. Inevitably, there are problems. Documents can be damaged or destroyed, for example; there may be major gaps in their coverage; and, in the case of eighteenth-century nursing, references are few and far between because nurses were only slowly forming as an occupational group. Striving for a robust methodology, historians ask three key questions: Is this source what it says it is? Who wrote it? And for what purposes?⁶⁴ The history of nursing and midwifery is no exception. Therefore, the chapters in this volume will call heavily on sources such as government papers (e.g. Acts of Parliament, government reports, criminal records from courts such as the Old Bailey and statistical series such as the ten-yearly Census and infant and maternal mortality rates); materials relating to non-state institutions (in particular, the rules, annual reports, minute books and casebooks for hospitals, charities and professional organizations); nursing, midwifery and medical books; advice literature for patients; professional journals; lecture notes for students; diaries and correspondence; and trade directories and advertisements.

Complementing these documentary sources is oral history. Originating in ancient songs and legends passed on by word of mouth, oral sources were later rejected as incompatible with the scientific mentality of the discipline. Their revival was facilitated in the 1960s by the rise of social history, its potential for more democratic, socially conscious research resonating with the decade's egalitarian ethos. Of course, there are drawbacks. Only recent history is accessible, dates may be uncertainly remembered, meanings may be reconstituted

over time and stereotypical social roles may be reproduced. But the capacity of oral history to rescue groups missing from the written record and to correct distorted images makes it an invaluable tool for the history of nursing and midwifery.⁶⁵ Some studies were informally conducted, penetrating uncharted territory. In Lindsay Reid's collection of 20 testimonies from Scottish midwives, for instance, Joan Spence, who trained in 1970, recalled how:

The wee chap came out and he was grossly deformed. His limbs were all round the wrong way. I ran out of the room with him and I ran into a paediatrician. The baby was barely alive. The paediatrician wanted to take him from me and resuscitate him but he died within minutes. The poor woman, I've never forgotten her. I don't think she ever saw that baby again.⁶⁶

Sweet and Dougall's systematic oral histories – one element within their investigation of twentieth-century community nursing – are equally revealing on subjects as sensitive as inter-professional relations; for example, one narrator described the district nurse and the health visitor as 'like you know chalk and cheese' before the introduction of general practice (GP) attachments in the 1970s.⁶⁷

The source base has been further expanded by the way in which postmodernism has eroded the importance attached to society's economic, social and political structures and hence created the potential for artefacts, visual imagery and imaginative literature to shape – and not just reflect – historical experience.⁶⁸ Consequently, these media have become sources to which at least some historians resort. In the history of nursing and midwifery, as in the discipline as a whole, extracting the meaning of artefacts such as the nurse's uniform or the midwife's bag is a struggle in which few have as yet participated.⁶⁹ Visual imagery – paintings, photographs, films and television – and imaginative literature – novels, drama, poetry – are also underexploited, history failing to follow the example of literary studies.⁷⁰ Therefore, it would be a mistake to exaggerate the effects of postmodernism on history's commitment to documentary sources. What has happened, however, is their more inventive deployment.

In her study of nursing periodicals, Elaine Thomson grasped the new agenda by understanding their advertising as a way to 'structure the meaning for products and commodities'. As she explains:

advertisements aimed at nurses form a discursive space where definitions of femininity, and of professional roles and identities, are endorsed

and reproduced. They tell us much about the aspirations of the nurse, the way she was perceived – by herself and others – and her place in medicine and in society.⁷¹

New information technologies have also enabled the pioneering treatment of documentary sources. In this spirit, Sue Hawkins has broken new ground with her prosopographical methodology. Undaunted by the lack of letters and diaries regarded as essential for biographical projects, she set about building a database of nurses at St George's Hospital in London between 1850 and 1900. Nurse registers, wage books and minute books were scrutinized, together with the *Census*, *The Hospital* and *Nursing Record*, and a mid-1890s survey of matrons in the capital. It was with these data that she was able to substantiate the continued presence of working-class women in the nursing community.⁷²

The postmodern critique of objectivity served to remind historians that such sources offered no straightforward access to the past. However, it is important not to exaggerate the novelty of this warning. Firstly, the traditional interrogation of documentary material had always confronted the question of what had motivated the production of sources. Secondly, from the early 1960s, some historians had challenged the feasibility of objective knowledge, insisting that writings about the past were coloured both by the personal characteristics of their authors – social class, race, gender, age, politics – and by the contemporary societies in which they lived.⁷³ Therefore, the management of different interpretations of the same phenomenon was an integral part of historical analysis. In 1996, Angela Cushing attempted to reassert the case for objective methods in the history of nursing, maintaining that historical explanation was an 'inductive' process in which general arguments were inferred from particular instances or 'facts'; it was 'not a mere interpretation of the texts provided by the people of the past'.⁷⁴ Though her article stimulated heated debate in the *International History of Nursing Journal*,⁷⁵ the matter of objectivity has not been entirely resolved. Thus in their recent *Notes on Nightingale*, Sioban Nelson and Anne Marie Rafferty still found it necessary to urge 'an awareness of the nuances of historical scholarship and the complexity of the past, as opposed to seeing it as a set of "facts"'.⁷⁶

Nursing and midwifery history is not alone in resisting the implications of postmodernism. Yet if knowledge is informed by power⁷⁷ and the search for one objective truth is misguided, it remains possible

to pursue 'a multiplicity of accurate histories' whose divergence is an engine for exciting intellectual exchange.⁷⁸ So how do we do accurate history? There is now a splendid array of general texts supplying detailed guidance on how to read historical sources⁷⁹ and apply them to the shaping of historical analysis.⁸⁰ Moreover, the history of nursing and midwifery has also acquired relevant chapters and articles.⁸¹ At a mechanical level, the use of footnotes for referencing sources and the work of other authors allows each point to be checked and evaluated. But it is in the process of writing that the historian gets to grips with the competing interpretations that make objectivity unrealistic.

Writing involves constructing arguments by making claims based on primary sources, deploying concepts and theories and engaging with other accounts, drawn from the historical literature.⁸² Social science techniques such as discourse analysis are superficially attractive for this task. However, the minute way in which they examine texts means that 'it is imperative to have a limited body of data with which to work',⁸³ whereas research in history proceeds by identifying as wide a spectrum of sources as possible and placing them within their broad context. More useful is the way in which social scientists have conceptualized analysis as consisting of two complementary processes: 'the segmenting of data into relevant categories' and the reassembling of these data when 'the categories are related to one another to generate theoretical understanding'.⁸⁴ This exercise has been dismissed as an 'anecdotal approach' in which 'the representativeness or generality of... [the] fragments is rarely addressed'.⁸⁵ But in history, as in qualitative social research, the goal is not validation in the scientific sense. Rather, credibility grounded in 'structural corroboration' is sought, where 'the researcher relates multiple types of data to support or contradict the interpretation'.⁸⁶ It is a 'feat... only accomplished as a result of much trial and error'.⁸⁷

Using This Book

The enthusiasm of nurses and midwives for understanding the past is displayed in the personal recollections and historical series that have long graced the professional journals.⁸⁸ During the 1970s, for example, *Midwife and Health Visitor* ran a long series called 'History and Progress', which traced the development of a wide variety of health-care practices. Our review of histories, sources and methods in this chapter has shown that the assumption of progress – however

deep-seated – is an untenable one. In the chapters that follow, we attempt to demonstrate why. The research base for this endeavour is variable, not only because sources may be fragmented, but also because much activity was London-based and the provinces and Scotland, Wales and Ireland have been neglected. Moreover, the chronological demands of the project have led us to privilege the general nurse over the specialist nurse and the hospital over the community – ‘the key battleground for the various forces arrayed in the division of labour in health care’.⁸⁹ But for the first time since the path-breaking *An Introduction to the Social History of Nursing* was published in 1988,⁹⁰ we offer a long-range history of nursing and midwifery.

The book has five distinctive features. First, it brings together both professions on an equal footing, rather than limiting the coverage of midwifery and implying that it is a subsidiary of nursing. Second, it looks beyond the recent past, opening in 1700 and surveying the long eighteenth century to 1830, rather than taking for granted that nothing of any moment took place before the early nineteenth century. Third, though unable to do full justice to the international dimension,⁹¹ it presents a comparative assessment of Britain’s global sphere of influence in Australia, the United States and Canada. Fourth, the similarities and differences that have characterized and shaped the two professions are teased out. And, finally, a short epilogue explores the implications of the historical analysis for contemporary policy and practice.

Imposing a standardized format on this agenda, spanning two professions over three centuries, would threaten its historical integrity. However, six main themes in addition to professionalization recur throughout the book: the locus of care; gender, class and ethnicity; the emergence of specialisms; and interprofessional relations between nursing, midwifery and medicine. The six chapters (Chapters 2–7) on British nursing and midwifery between 1700 and 2000 conclude by relating their content to these themes. In this way, we put forward a co-ordinated history of nursing and midwifery.

You can approach the volume in several ways: by reading it from cover to cover, by focusing only on nursing or midwifery and by looking at each profession chronologically – in other words, by tackling Chapters 2 and 5, Chapters 3 and 6 and Chapters 4 and 7 together. Whatever method you chose, we hope that the book will act as a stimulus for future study and research.

Notes

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Nursing and Midwifery: Historical Approaches; A.Borsay & B.Hunter .- Part I: nursing 1700-2000.- Nursing, 1700-1830: Families, Communities, Institutions; A.Borsay.- Nursing, 1830-1920: Forging a Profession; C.E.Hallett.- Nursing, 1920-2000: The Dilemmas of Professionalization; A.Hull .- Part II: midwifery 1700-2000 .- Midwifery, 1700-1800: The Man-Midwife as Competitor; H.King.- Midwifery, 1800-1920: The Journey to Registration; A.Nuttall.- Midwifery, 1920-2000: The Reshaping of a Profession; B.Hunter .- Part III: comparing nursing and midwifery.- International Comparisons: The Nursing-Mid Women in Russia, 1700-2000 is the first book to provide a lively and compelling chronological narrative of women's experiences from the 17th century to the present. Synthesizing recent scholarship with her own work in primary and archival sources, Barbara Alpern Engel skillfully evokes the voices of individuals to enliven the account, detailing how women of various social strata were affected by and shaped historical change.Â This may have been further eased by these documents undoubtedly being seen as having no military value. Unlike say a history of Soviet rocketry or microbiology. I found the most interesting sections to be on the Communist period. They did put the first female astronaut (V. Tereshkova) into orbit, and proudly trumpeted this. Nursing within the United States took a decidedly different path than in similar countries. Due to the absence of a stronghold of Catholicism within America, the nursing field was not comprised of nuns. Nursing officially began in the early 1700s when the first almshouse was opened in Philadelphia. However, many of the hospitals that were created in the ever-expanding United States throughout the next 2 centuries were largely derived because of the fear from local governments of diseases spreading to the more wealthy population. PART I: NURSING 1700-2000. 2 Nursing, 1700-1830: Families, Communities, Institutions Anne Borsay Domestic Nursing Community Nursing Institutional Nursing Matrons and the Voluntary Hospital Nurses and the Voluntary Hospital Conclusion. 3 Nursing, 1830-1920: Forging a Profession Christine E. Hallett The "Pre-Reform" Nurse The Rise of Sisterhoods The Influence of Florence Nightingale The "New" Nurse The Poor Law Nurse The District Nurse The Military Nurse The Professionalizing Project.