THE EMERGENCE OF MILITANCY
IN THE NURSING PROFESSION,

by

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SUMMARY.

Two fundamental aims motivated this research: (a) to determine whether in the nursing profession, there existed a condition which could legitimately be classified under the generic heading of nurses' militancy, and (b) if evidence is available to make this a meaningful concept, then place the empirical findings into a theoretical model, which is generated from the research data itself.

The approach to this study was mainly by documentary analysis. In this connection, a study was made of the history of the profession, followed by a review of the literature of the concepts of 'profession' and 'white-collar unionism'.

'Key' and other informants, together with other sources, were used to make a detailed study of every claim submitted by the Staff Side of the Nurses and Midwives Whitley Council for the period 1960 to 1972. These claims formed the basis for an investigation of the various manifestations of militancy by nurses during this period, together with an analysis of the interactive effect they exerted on the participating nurses' organisations.

A comparative study of nurses' salaries, as a component of the market situation, was undertaken, and this was facilitated by an analysis of Government Statistics.

Finally, a model generated from the research data itself was postulated. This asserted that within the profession of nursing a synthesis of 'union' and 'profession' had been occurring in such a way that the emerging image held by nurses in the '70's of union and professional organisation was no longer as divergent as hitherto had been the case.
In the hope that this specific model could be extended to make a contribution to a theory of professional militancy, grounded in generalisation about the content and structure of such behaviour, the hypothesis was tested against the organisational forms of other comparable groups.
ACKNOWLEDGEMENTS.

Warm thanks are due to many people who have helped with advice, criticism and support. In particular I should like to express my gratitude to my supervisor, Professor Asher Tropp, whose sympathetic understanding and sense of humour has done much to ease what would otherwise have been an extremely long haul. My work and thinking has benefited enormously from his comments and the stimulus of many discussions.

Of course, my sincere thanks are also due to all the nurses, nurse administrators and nursing organisations who took part in the research. Among those who have patiently answered my questions, or suggested areas of investigation, I should like to thank the following:

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Finally my greatest debt is due to my wife and son who allowed this work to intrude for nearly four years into our domestic privacy.
INTRODUCTION.

There are various ways of approaching any piece of research, and the method which is finally chosen will depend to a certain extent on the theoretical model the researcher has in mind; his own predilections and the constraints imposed upon him by the nature of the research itself.

At the outset it should be stated that this research was not initially undertaken with any preconceived theoretical model in mind. It was not the intention to verify any of the 'Grand Theories' of the Masters, nor indeed, to engage in a logico-deductive approach based upon certain *a priori* assumptions that I may hold about the social system.

My thinking was largely influenced by the work of Glaser and Strauss in their *Discovery of Grounded Theory*¹, and was based on the assumption that theory could possibly be generated from the research data itself.

I selected a mainly qualitative approach which depended heavily on documentary analysis. This was augmented by both structured and unstructured interviews with a number of people connected with the nursing service. In the case of the structured interviews these were mainly with ten 'key informants'.

Of course, this research could have been structured in such a way as to have adopted a predominantly quantitative approach. I decided against this emphasis primarily for two reasons. Firstly, having been initially trained as a mathematician, and as a consequence spent the past twenty years in teaching the subject, an approach which was not highly mathematised emerged as a refreshing change. Secondly, and perhaps more significantly, I find probability theory and its various derivatives, such as parametric and non-parametric statistical theory, games theory, etc., a branch of mathematics which for me, holds little appeal.

¹ 1968.
Moreover, I am inclined to the view that all sociological explanations do not necessarily require quantitative verification for their validity. Nor do I believe that it necessarily follows that because a number of disciplines in the natural sciences are highly mathematised that this is the only legitimate methodology for every piece of scientific work, especially in those sciences which are conducted mainly by observation rather than by experiment, although it must be conceded that mathematics, by its nature, can at times help in reducing the ambiguity of language. One should perhaps also make the point in this context, that mathematical induction, so widely used in the experimental sciences and from which many mathematical formulas, not amenable to a direct mode of proof are derived, is not free from certain logical difficulties. This does not mean, however, that I view the inductive method with the degree of hostility that some do; as for example Dantzig who stated: "The process of induction which is basic in all experimental sciences, is forever banned from rigorous mathematics". Although an extreme position, I can understand why Dantzig and others subscribe to such a view. In order to prove a proposition in mathematics, even a vast number of instances of its validity would not be a sufficient and necessary condition; whereas one exception will suffice to disprove it. The propositions of pure mathematics hold only if they do not lead to a contradiction. Outside of pure mathematics, especially in other human activities such a restriction would have a paralysing effect. Suffice to say however, that there is nothing especially sacrosanct about the inductive method and I offer this point merely as a contention to those who see quantitative analysis as the only legitimate research methodology.

At first glance a study directed towards the emergence of militancy in the nursing profession would seem reasonably straightforward and unambiguous. There is an assumption, of course, that some phenomenon called 'nurses' militancy' actually exists and the emergence of this militancy, rather like

1. 1933. (vi)
'natural law', merely requires discovery. However, when I began thinking seriously about the approach, this assumption itself caused me some concern. There have been in recent years reports by the media concerning militant behaviour of nurses, but whether one was entitled to infer from such reports that there existed a movement which could be classified under the generic heading of 'nurses' militancy' was an entirely different matter. There is also the concept of 'militancy' itself; like so many other concepts used in the social sciences, militancy has a colloquial usage not entirely free from emotional overtones. Frequently in popular usage, 'militancy' not only describes a state but can connote associations of either approval or disapproval. This makes the matter more complicated since the implication of either approval or disapproval goes beyond mere factual description. Hence, because of this complication it is essential that I define my usage of the term. My attitude to its use is solely descriptive. I take militancy to be the manifestation of public protest behaviour that groups of individuals or organisations pursue in what they consider to be a legitimate grievance or cause. I place the emphasis on public behaviour, that is, when they parade their grievance or cause to society at large, as distinct from limiting their discussion to the private confines of their group or organisation. There are therefore various gradations of militant behaviour, and these can range from demonstrations at one end of the spectrum to the partial or total withdrawal of labour at the other.

The aim of this research is twofold: (1) To determine whether the description of 'nurses' militancy' is a meaningful area of research; and (2) Given that this is so, to place the findings of the research into some theoretical perspective using a model which emerges from the research data itself.
In order to try and achieve these two aims this thesis is presented, subject to minor modifications, in the order in which the research was undertaken.

Chapter 1 attempts to place contemporary nursing within a historic perspective. Inevitably this chapter is only a synoptic view of an activity which encompasses most of recorded history, but a genuine attempt has been made to record the main strands in the history of the profession.

Chapters 2 and 3 are devoted to the concepts of 'profession and white-collar unionism' respectively. The main purpose of these two chapters is to review some of the literature on the topics, and an attempt has also been made to extrapolate from the general discussion, aspects and questions which may have some relevance for the nursing profession.

It would be quite misleading to suggest that militancy is exclusively confined to trade unions, and I should not wish to be responsible for perpetrating such an erroneous notion. However, it is true that various forms of industrial militancy are regarded, both by trade unions and others, as an integral part of trade union history and generally part of the trade union ethos.

Any project purporting to examine the militant behaviour of a particular group would probably start with an examination of the degree of unionisation and the history of industrial disputes. Chapter 4 sets out to examine both these factors by tracing the development of trade unionism in the different sections of the nursing profession, and the effects of the early attempts of politicisation of nurses by the Labour Party.

Up to this point the approach had been entirely documentary. However, since the period specifically under review is within living memory of many, it occurred to me that in addition to documentary sources I could derive additional information and check possible hypotheses, from people
who were involved in the events. In order to do this I constructed an interview schedule and used this with ten 'key informants'. Thus Chapter 5 begins with a theoretical discussion connected with this field technique, and then goes on to give the full interview schedule. Finally it summarises the replies of the respondents to each question. Each interview was tape recorded in full. The transcriptions from all the interviews are presented in Appendix 1.

Chapter 6 is essentially factual in character and traces in detail each of the nurses' salary claims for the period 1960 to 1972; whereas in Chapter 7 the various manifestations of militant behaviour by nurses is correlated to each of these claims. The following chapter is devoted to an analysis of nurses' salaries as compared to the salaries of other non-manual workers in the public sector.

Finally in Chapter 9, I have attempted to gather together the various strands of the research, and frame them within some theoretical concept. This chapter, therefore, attempts to do two things: (a) to put 'nursing militancy' into a theoretical context, and (b) to attempt to broaden this specific aspect, with a view to making a contribution to the comprehensive study of professional militancy.
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<td>A.H.A.</td>
<td>Area Health Authority.</td>
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<td>A.M.A.</td>
<td>Assistant Masters' Association.</td>
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<tr>
<td>A.S.T.M.S.</td>
<td>Association of Scientific, Technical and Managerial Staffs.</td>
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<tr>
<td>A.U.T.</td>
<td>Association of University Teachers.</td>
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<tr>
<td>B.A.H.A.</td>
<td>Berkshire Area Health Authority.</td>
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<tr>
<td>B.A.L.P.A.</td>
<td>British Air Line Pilots' Association.</td>
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<td>B.M.A.</td>
<td>British Medical Association.</td>
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<td>B.S.A.</td>
<td>British Sociological Association.</td>
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<tr>
<td>C.O.H.S.E.</td>
<td>Confederation of Health Service Employees.</td>
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<tr>
<td>C.S.U.</td>
<td>Civil Service Union.</td>
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<td>D.A.T.A.*</td>
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<td>G.M.W.U.</td>
<td>General &amp; Municipal Workers' Union.</td>
</tr>
<tr>
<td>H.V.A.</td>
<td>Health Visitors' Association.</td>
</tr>
<tr>
<td>I.M.A.</td>
<td>Institute of Mathematics and its Applications.</td>
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<tr>
<td>N.A.S.</td>
<td>National Association of Schoolmasters.</td>
</tr>
<tr>
<td>N.A.S.E.N.*</td>
<td>National Association of State Enrolled Nurses.</td>
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<tr>
<td>N.A.T.F.H.E.</td>
<td>National Association of Teachers in Further and Higher Education. (Formerly the A.T.T.I.)</td>
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<td>N.A.W.U.*</td>
<td>National Asylum Workers' Union.</td>
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<td>N.H.S.</td>
<td>National Health Service.</td>
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<td>N.U.B.E.</td>
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<td>N.U.C.O.*</td>
<td>National Union of County Officers.</td>
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<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>N.U.C.W.*</td>
<td>National Union of Corporation Workers.</td>
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<td>N.U.T.</td>
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<tr>
<td>M.H.I.W.*</td>
<td>Mental Hospital &amp; Institutional Workers' Union.</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>Prices and Incomes Board.</td>
</tr>
<tr>
<td>R.C.N.</td>
<td>Royal College of Nursing.</td>
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<td>S.E.N.</td>
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<td>S.R.N.</td>
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<tr>
<td>T.G.W.U.</td>
<td>Transport &amp; General Workers' Union.</td>
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<tr>
<td>T.U.C.</td>
<td>Trades Union Congress.</td>
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* No longer in existence.
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CHAPTER 1.

THE NURSING PROFESSION: AN HISTORICAL SKETCH

It is not the purpose of the present work to write a comprehensive history of the nursing profession, indeed there are many such excellent works as indicated by the bibliography. However, it is not possible to divorce the history of any group from its present behaviour, attitudes, frustrations and aspirations, since like nations, these are inextricably interwoven with the fabric of its history. It is with these considerations in mind that the writer was prompted to include the following historical sketch.

From the beginning of recorded history people have struggled to improve their social way of life. It would appear possible to extrapolate from all the multifarious factors, four which have considerably influenced their chances of success. These are namely religion, war, self-determination and education. It is a characteristic of most religions that they attempt to influence human behaviour by directing the actions of men and women to goals which appear to lie outside of the domain of purely self-centred and hedonistic ends. Military conflict has always created suffering and oppression, and whilst undoubtedly being instrumental in a large number of people being subjected to oppression, it has also often been the means whereby people have been released from tyranny. Moreover, many discoveries and technologies which have emerged directly from war, have had profound long-term humanitarian consequences. The struggle for self-determination and self-improvement through education has also been a feature of western development. It is possible to trace these four elements in the development of the nursing profession.

Pre-Christian Times

There are only fragmentary references to nursing in ancient times.
There is a considerable amount of recorded information pertaining to
medicine and hospitals, but hardly any reference to nurses or nursing.
Between 4500 and 2000 B.C. Mesopotamia had reached a fairly high degree
of social organisation, exhibiting all the classical symptoms of
civilisation, cities, agriculture, the calendar, refinement of weapons,
armies and taxation, yet there are no records, as such, of the existence
of nurses. Also in ancient Egypt "the only reference to nursing among
the old Egyptians" says Bett, "is on an ostragon (an inscribed slab of
limestone, No.3634 from the reign of Ramesses II, about 1250 B.C. in the
British Museum, according to which certain labourers engaged on the
construction of the tombs in the Valley of the Kings at Thebes, were
excused from work because they were nursing sick members of their
family".1

The ancient Hebraic literature is equally negative on the subject.
Moses, when in charge of a whole concourse of nearly a million people,
specified rigorous, almost modern rules for such things as the inspection
of food, disposal of waste, and for the notification of quarantine of
contagious diseases. The need to visit the sick was a religious duty
for the ancient Israelite, as indeed it is a mitzvot (a commandment,
duty) for the present day Jew. "There were", says Bett, "houses for
strangers and houses for the sick — prototypes of the inn and the
hospital — and separate houses for lepers, as witness 2 Kings XV.5.
"And the Lord smote the King, so that he was a leper unto the day of
his death, and dwelt in a several house". Strangely however, no records
of nurses attending the inmates of the hospitals have been left by that
enlightened people".2

The early literature of the Indian Continent is, however, considerably
more informative of the position occupied by nurses in medicine. It
is evident for the period 600 B.C. to 200 A.D. that nursing played an
integral part in the treatment of the sick, though experts suggest that

the nurses tended to be male rather than female. This conclusion is arrived at by the fact that Sanskrit references invariably used the masculine gender. There are a number of references to 'attendants' (nurses) in a number of Hindu medical treatises. The Ceraka Samhita, for example, specifically lists a number of nursing skills, and further reference to nursing is made in the Astranga Hridaya and the Kasyapa, while Susruta Samhita demands that the nurse gives absolute loyalty to the doctor in charge of the patient. Nursing is classified into six categories: general nursing, midwifery, wet-nursing, surgical nursing, and massage.1

Asoka, a Northern Indian Emperor, was greatly influenced by the Buddha and he eventually became one of his disciples about 225 B.C. He built 18 hospitals which were also medical schools, and in which older men and women acted as nurses to the patients. Asoka, filled with proselyzing zeal, sent missionaries to Ceylon; the island eventually became converted to Buddhism. Much later King Dutugamuna, following the example of Asoka, endowed several hospitals. What was the position of nurses and to what degree were they trained in these Singhalese hospitals? Bett says "those attending the sick had to be proficient in cooking, in caring for bed patients, and in other nursing procedures, and it has been suggested that training schools for nurses must have been in existence then".2

There are few significant references to nursing — as we understand the term, in the literature of ancient Greece. In Greek mythology the omnipotent father of the Gods and men, Zeus, consigned to the Goddess Hecate the role of a nursing mother. Both Homer and Herodotus mentioned nurses from time to time, but there is no mention, either of nursing or nurses in the collection of the 70 books on medicine attributed to Hippocrates. He certainly specified procedures which would today come

1. For further details the reader is referred to Radhalaxmi & Rad 1956, 36-40.
within the sphere of nursing, such as the making of beds, the sponging of patients, the preparation of dressings and bandages, etc. But as Bett asks, "who carried out these procedures? The Greek physicians were fully occupied, for malaria was endemic, typhus was epidemic, tuberculosis was prevalent".¹ It seems unlikely that doctors themselves had time for such nursing. The burden probably fell on the patient's family. However, there is a passage in the Hippocratic Book, Decorum, which seems to suggest that in serious illness nursing duties were performed by the physician's apprentice which appears to be similar to the situation described by Abel-Smith in England in the early 19th century.² It should perhaps be mentioned that in ancient Greece there were midwives, known as omphalotomai (navel cutters); these women possessed neither formal training nor any connection with the practice of medicine. Thus, although Hippocrates laid the foundation of modern western medicine, he made no provision for the training of nurses.

The Romans with their facility for public administration developed public and private hygiene to an advanced level. Their cities had complex systems of fresh water supplies, aqueducts and sewers. Bathing was a cult and there were public and private baths. The Roman cult for bathing was to be destroyed by Christian monasticism. Medical and surgical staff were an integral part of the Roman armies and there are several remains of their military hospitals in various parts of Europe. Slaves specifically trained for the purpose, served as hospital attendants and worked under the direct supervision of physicians and surgeons. These were always male; there were no female nurses in pre-Christian times.

2. Abel-Smith, p.6.
Monasticism

The rise of Christian monasticism is of some interest from the historical viewpoint of nursing, since it marks the beginning of women being engaged in nursing. It is generally agreed that the period began in the year 305 A.D. when St. Anthony, an Egyptian, built the first Christian monastery near Aphroditopolis – now known as Atfih. St. Pachomius (292-346 A.D.), another Egyptian, established nine male monasteries, and the first recorded nunnery at Tabennisi. His was the first Christian monastic order – the Pachomian Monks.

Perhaps more significant from the point of view of the development of nursing was a Greek, St. Basil, who as the Bishop of Caesaren in 370 A.D., initiated the building of a whole hospital complex outside the city gates. This hospital town became known after him as the Basileas. The Basileas provided isolated buildings for lepers, homes for the elderly, for the physically and mentally afflicted and for orphans. Also provided was a separate residential area for medical and nursing staff. "St. Basil took an enlightened interest in nursing, which he described as the most noble profession. He had a beautiful and pious sister Macrina, a Deaconness, whom he appointed superintendent of nurses."¹

Little is known of the training programmes of monastic nurses, or the principles and practice upon which their nursing was based, however, historical knowledge of the period would suggest that it shared little of the scientific notion of the natural causation of disease of Hippocrates. Sickness was considered to be of divine origin serving the dual purpose of punishing the transgressor and serving as a test of faith for the righteous. More than likely nursing was concerned primarily with the preparation of the soul for eternity rather than ministering to the needs of the body.

It was mentioned earlier that the Roman practice of bathing was destroyed

¹ Bett: op.cit., p.20.
by Christian monasticism. Illogical as it may seem, viewed from contemporary knowledge, the bathing or washing of patients was categorically forbidden in monastic nursing. The basis of this anachronism is apparently explained in the implicit assumption that cleanliness of the body implies impurity of the soul, "whosoever was once washed in the blood of Christ need not wash again."

The Middle Ages

Although this period in European history is characterised for its intellectual inertia, it has some significance in the development of nursing insofar that it marks the foundation of a number of nursing orders.

The Father of western monasticism, St. Benedict, (480-543) built the famous monastery at Monte Cassino and established the Benedictine Order of Monks (the Black Monks). He also formulated a strict humanitarian code for the caring of the sick. The code specified that the sick must be "Ministered unto as though indeed it were unto Christ".

During this period nursing could broadly be classified into three classes; the military, known as the Knights Hospitallers, secular orders having their origin outside the Church, but receiving its protection, and the regular orders, an example of which was the Augustinian Sisters (the white robed and black robed sisters) of the Hotel-Dieu in Paris.

The Hotel-Dieu was established in 650 and for twelve centuries its Augustinian nuns were inspired by a remarkable religious fervour which found its outward expression in ministering to the sick. There can be little doubt of their altruism, but their religious fervour and piety co-existed with intellectual atrophy. These Augustinian nuns nursed the sick knowing virtually nothing of anatomy or physiology. Indeed a knowledge of the human body and its functions was considered sinful.
The student nurse received no formal training; she was placed in the charge of a nursing sister from whom she received personal tuition. There is no record of the form that this personal tuition took.

A student nurse first underwent a period of probation, usually not less than twelve years, during which she was known as a filie en approbation; she was then permitted to wear a white robe and was known as a filie blanche, finally she received her hood and became a filie a chaperon. In tracing the connection between the monastic orders and the present day nursing profession, Mildred Newton had this to say; "The dedication or setting apart of the worker, began with the nun novitiate, and was followed by the taking of the veil. You will find the counterpart in today's pre-clinical educational period in nursing and in the various capping and banding ceremonies. The Augustinian novices, the white-robed Sisters and the black-robed Sisters have their parallel in the modern system in nursing. The nuns coif became your nurse's cap, and her scapular your bib and apron. The convent, where the Sisters lived apart, evolved into the nurses' residence with its communal living".¹

It may be argued however, that the links between the religious orders and the present day nursing profession are somewhat tenuous. Abel-Smith suggests that it was not the religious orders that were "the antecedents of the nursing profession" but "domestic servants".²

In any event the nursing administered by the Augustinian Sisters bears little relation to contemporary nursing practice. It was essentially empirical for the cause of sickness was rarely diagnosed; patients shared beds, often six to a bed. These beds were too heavy to be moved so consequently the floor on which they stood was never scrubbed.

¹ Spalding & Noster, Ch.2 p.5. This chapter was prepared by Mildred & Newton, R.N.Ed.D. Director School of Nursing, Ohio State University.
² Abel-Smith, p.4.
The nuns were responsible for all the cooking and laundering but the only laundering facility was the Seine. "Fully habited, the novices had to wade into the river. In winter they broke the ice and stood for hours in the water, frozen to their knees. The patients also had to share the discomforts of this primitive system, for wet clothes and sheets were hung in the unventilated wards to dry".¹

In 1908 the Augustinian nuns were expelled from the Hotel-Dieu, some eventually returned but only after they had received appropriate training in standard nursing practice.

Prior to the Reformation there were many monastic nursing orders. As early as 794, a Saxon hospital existed at St. Albans; at York, St. Peter's Hospital was built in 794; and Nahere founded St. Bartholomew's Hospital in London in 1123.

The dissolution of the monasteries in 1536 effectively closed the only places where a woman could fulfil a vocation for nursing. Nearly all the nuns were scattered far and wide with the exception of those belonging to the order of St. Bridget of Sweden, who built a wealthy convent at Syon House, Isleworth.

The monasteries were restored in 1554, only to be suppressed again in 1559 when the Crown confiscated all monastic possessions. In 1547 Henry VIII refounded the Royal Hospitals of St. Bartholomew's and St. Thomas's. At this point in the history of English nursing one can see the significance of Abel-Smith's remarks on the antecedents of the nursing profession, because there certainly was a change in the social composition of entrants to nursing in the refounded hospitals; "no longer did they come from old and wealthy families, but from the poor districts of Smithfield and Southwark".²

Of this situation Mildred Newton makes the following comment; "Hence after the Protestant Reformation; countries that became predominantly Protestant were in a serious predicament. Monasteries, convents and hospitals were closed and personnel driven out. The cities had no staff prepared to direct and give care to the sick, the orphans and the aged. As civil institutions sprang up staffed by crude and ignorant servant-type nurses," — c.f. Abel-Smith's description of pauper nurses. — "nursing plunged deeper into its own Dark Age".

In Italy the son of a wealthy merchant Francisco Bernadone (1182-1226) — better known as St. Francis of Assisi — established the first Franciscan Order (Grey Friars). These Friars became nursing missionaries to the sick. St. Francis had a young disciple, Clara of Assisi, whom he appointed Abbess of the Convent of St. Damiano — a post she was to hold for forty years. St. Clara created the Second Order of Franciscan Nuns, known as the Poor Clarisses, whose duties were primarily directed to the nursing of the sick and caring of lepers. St. Francis was responsible for creating a third secular order. This tertiary order was a religious association of lay men and women. It was under religious control but without vows or monastic control. The role of the Tertiary Order was analogous to that performed today by voluntary agencies such as the Red Cross and St. John's, it assisted in transporting patients to hospitals and aiding nurses in the care of patients. Perhaps the best known of the Tertiaries was Queen Elizabeth of Hungary who built a number of hospitals.

In the 17th century a Frenchman, Vincent de Paul was examining better ways of caring for the sick. He tried various experiments, for example enlisting the services of prominent wealthy women to work in the Hotel-Dieu and other hospitals as 'Dames of Charity', but this — together with other schemes — was not altogether successful. However, he managed to

1. Abel-Smith: op.cit.
elicit the support of Mlle. le Gras (St. Louise de Marillac), who was well travelled and extremely knowledgeable, and they were both convinced that in order to make nursing more efficient it was necessary to carefully select entrants. Having done this it was necessary that they all should receive the same systematic instruction and live as a separate community under supervision.

"In addition to these early principles, Vincent taught moderation, encouraged the Daughters to substitute the patients chamber of suffering for a nun's cell, emphasised that this group, to fulfil its mission, must be secular — not cloistered. These Daughters must be able to go to the patient, wherever he was; they were to wear the everyday dress of the peasant woman with its grey-blue robe and great white coif; and they were to take the vows of poverty, chastity and obedience for only one year at a time. Mlle. le Gras became the first Daughter or Sister of Charity on March 25, 1634; and since then, on March 25th, all Sisters renew their vows for another year if they so desire. These Sisters have rightfully been called the bridge between nursing as a religious vocation and as a secular occupation".

The Deaconess Movement

In the early centuries of the Christian era the Deaconess Movement formed an integral part of the activities of the Church. However, the rise of monasticism tended to diminish this activity until it was virtually eclipsed by the increased influence, activity and power of the monasteries. During the Reformation a rather weak attempt was made to revive the early church deaconess orders. In 1836 Pastor Theodor Fliedner of Kaiserworth near Dusseldorf, whilst on a fund raising trip, met Miss Elizabeth Fry, and as a result of this meeting became very interested in prison reform. He was enormously impressed by the reforms that she had brought about at Newgate Prison. Also in his travels he witnessed

some of the activities of Deaconess Orders in Holland.

His enthusiasm and proposed plans for prison reform were frustrated by the authorities in Kaiserwerth so he and his first wife, Friederike, in 1836 decided to start an institute for the training of Deaconesses. This training institute incorporated a number of activities, amongst which were the caring for discharged women prisoners, the caring for orphans, the caring for the physically and mentally afflicted and the training of teachers. A scheme for training Deaconess nurses was also instituted.

At Kaiserwerth a hospital was developed and the reform of the nursing profession unquestionably owes something to the early work at Kaiserwerth. Mildred Newton says that "probably the first syllabus in nursing was Friederike's notebook".\(^1\)

The influence of the Kaiserwerth Institute was far reaching. It spread to several countries including the U.S.A., where the first Motherhouse was established in Pittsburgh, Pennsylvania in 1849.

Florence Nightingale spent two weeks at Kaiserwerth in 1850 and three months there in 1851, and although, as will be seen later, she "was not impressed by the discipline or the standards, still Kaiserwerth was one of the first places in the world where some attempt at organised nurse training was carried out".\(^2\)

Another remarkable woman who was to contribute markedly to nursing reform, Agness Jones, spent 8 months at Kaiserwerth in 1860.

**Military Influence**

War by its very nature inevitably creates special medical problems, so it is not surprising therefore, that a part of nursing history is linked with this unfortunate activity.

It was previously mentioned that the Roman armies had both medical and nursing staff, however, the military branch of nursing in the Christian era did not make its appearance until the period of the Crusades with the emergence of the Knights Hospitallers. There were two groups of Hospitallers: the Knights Hospitallers of St. John or Jerusalem (later known as the Knights of Rhodes, and the Sovereign Order of the Knights of Malta), and the Teutonic Knights Hospitallers. The former was established in 1087 by "a certain Gerard or Gerald, head of the hospital dedicated to St. John the Baptist, to relieve pilgrims".\(^1\)

Originally the role of this Order was to collect the wounded from the battlefield and to attend to them in hospital. Later the Knights found it necessary to establish a fighting branch for the purpose of defending the wounded during their transit to hospitals and also for the purpose of defending pilgrims under attack. Raymond du Puy succeeded Gerard as Grandmaster of the Order in 1120, and he imposed the Augustinian rule on the Order. Moreover, he divided it into three distinct categories; priests, knights and freres sergents (serving brothers), and it was the latter who actually performed the nursing.

The Order of the Hospitallers of St. John was extremely wealthy; it established and equipped its "own hospitals in Jerusalem - splendid institutions in which patients were lovingly cared for and supplied with plentiful good food. The hospital of St. John the Almoner for men was associated with the church of Santa Maria della Latina, and in the middle of the twelfth century had accommodation for 2,000 patients".\(^2\)

A female branch was established simultaneously to the male, and during the first Crusade a Roman lady Agnes established the Hospital of Mary Magdalene in Jerusalem. When in 1187 Jerusalem was captured by Saladin the sisters were evacuated to Europe, where for a time they carried on

\(^1\) Bett: op.cit., p.48.
\(^2\) Bett: ibid.
their roles as nurses, but eventually became a purely contemplative order. Similarly when in 1291 Acre fell, the Knights Hospitallers of St. John were forced to relinquish all their possessions in Palestine and flee to Cyprus, from which they took Rhodes, and successfully held it from 1310 – 1523 when it eventually fell to Sulieman the Magnificent. The Knights sought refuge in Crete.

In 1530 Charles, the Holy Roman Emperor, installed them in Malta where they remained until driven out by Napoleon in 1798. "The history of this order now virtually ends. The Grand Priory in the British Realm of the Most Venerable Order of the Hospital of St. John of Jerusalem, founded in the twelfth century, was reconstructed in 1827. In 1888 it was granted a Royal Charter by Queen Victoria, and Edward VII whilst Prince of Wales, served as the first Grand Prior. The order maintained three foundations; The Ophthalmic Hospital in Jerusalem, the St. John's Ambulance Association and the St. John's Ambulance Brigade".

The Teutonic Knight Hospitallers were formed near Acre, and approved by Clement II in 1191. Initially they were under the jurisdiction of the Order of St. John, but their Grand-Master was always German. Women were also members of this Order and these were engaged in nursing the sick. From this point on, the history of the military is so multifarious and disconnected that it is only possible to mention a few incidents.

During the many wars which accompanied their reign, Ferdinand and Isabella are said to have introduced the first tented hospital in which women were employed as nurses. Philip II, the Grandson of Ferdinand and Isabella, employed the services of the Brothers of St. John in his several campaigns.

There are also records of women acting quite independently in the nursing of the sick. One such woman was Elizabeth Atkins who nursed wounded sailors who landed at Ipswich and Harwich after their various battles.

She provided this service largely at her own expense. The Government in recognition of her services granted her a small pension. Sir John Pringle in his Observations on the Diseases of the Army (1753) indicated that nurses, as distinct from apothecaries and other auxiliaries, were present in military hospitals.

"There was a regular establishment for female nurses in the English expeditionary force sent to aid the Portuguese against Spain in 1762, under the command of Lord Loudon. The first hospital was set up at Lisbon. One of the surgeons was the great Lord Hunter. The nursing detachment consisted of a matron, who was paid 2s. 6d. a day, 2 head nurses (1s.), and 18 nurses (6d.).".

In the American Revolutionary wars women were enlisted on the orders of General Washington to 'attend the sick as nurses'.

In the British army prior to the time of Florence Nightingale, most military nursing was performed by the wives of N.C.O's. On overseas tours the army employed local nurses wherever possible.

Florence Nightingale's Military Influence.

Florence Nightingale exercised a profound and leading role on the movement for nursing reform, however, within the present context; the significance of her going to Scutari with 38 nurses in 1854 is that it marks the beginning of a nursing service within the British Army.

Occasionally in an individual's life, the right combination of time and circumstances creates the conditions for action that provides the climax for a lifetime's experience and preparation. The Crimean War did precisely this for Florence Nightingale. For out of the nightmare of this bungling affair emerged Florence Nightingale, the pioneer of nursing training, and the birth of modern nursing practice.

Miss Nightingale was invited on the 15th October 1854, by the then Secretary-at-War, Sir Sidney Herbert, to organise a nursing detachment to the Crimea. This she agreed to do and selected a heterogeneous group of Anglican Sisters, Catholic Nuns and Lay Nurses. The party left London on the 21st October 1854, eventually reached Constantinople on November the 3rd.

The military hospital to which the party was assigned was a vast Turkish barracks, containing miles of corridors with floors of broken tiles, circumscribing a centre courtyard which had become a dumping ground for all kinds of refuse. The hospital had been built directly over a sewer which had no outward ventilation. There were four miles of beds, and the wounded were stacked up on filthy floors that were alive with vermin. The wounded were unwashed, lice-ridden; those with suppurating wounds did not have them dressed, and those with fractured bones did not have them set. There were neither washing utensils nor soap.

From this "inferno of filth and horror and misery that Florence Nightingale, then in her 35th year, single-handed and 'raging insatiably' - to use the Homeric phrase applied to her by the Master of Balliol - organised a highly efficient hospital and sanitary system......and laid the foundation stone of modern nursing". 1 She effectively diminished the rate of mortality in six months by better care and sanitary reforms from 315 per 1,000 to 22 per 1,000. She "created in her dissecting room, the nucleus from which the Army Medical School developed; she refused to accept men's deaths without trying to find out why they had died". 2

Her worst enemy, however, was not the appalling conditions and the whole host of diseases and complaints that the soldiers were suffering from, but the sheer administrative ineptitude, and red tape of the authorities.

Large consignments of materials sent to Scutari were allowed to rot in the Western Black Sea port of Varna. Similarly, large quantities were stowed

beneath munitions and transported uselessly back and forth across the waters of the Black Sea before they were accidentally discovered. And often, when urgent medical supplies did arrive, they were frequently unnecessarily delayed by the failure of the local Board of Survey to carry out their inspection.

Florence Nightingale was never to forget, or indeed forgive, these experiences. In the Balaklava Cemetery she took a vow that was to become the central part of her life for years to come. "I stand at the altar of the murdered men, and while I live, I fight their cause".¹

Miss Nightingale was to play an active part in the various Commissions relating to the Health and Sanitary conditions of the British Army. This followed almost axiomatically on the one hand from an almost Messianic desire to initiate reform, and on the other, her ability to perform the role of an agent provocateur in lobbying many influential people, including Royalty, who were in a position to initiate such enquiries, and then having the facility to influence those who participated in such Enquiries and Royal Commissions. She exerted tremendous influence, for example over Sidney Herbert whose "term of office is marked by the first improvements in the health administration and living conditions of the British Army".² These improvements flowed directly from the Barracks and Hospital Commission which Miss Nightingale was largely instrumental in bringing about. He also succeeded, in the face of wide opposition, in forming the Army Medical School, which was eventually to form the nucleus of the Royal Army Medical Corps.

This aspect of Miss Nightingale's work is, however, outside the purview of the present sketch, suffice to say, that she exercised one of the most significant influences on all matters relating to the

health of the British soldier. She advised on all matters relating to his diet, his clothes, his barracks and the administration of the medical attention he should receive. The reader who is interested in pursuing this aspect of Miss Nightingale's work, is referred to both the Florence Nightingale biographies of Woodham Smith and Sir Edward Cook.

From the point of view of the present study, what is relevant, is that stemming directly from her activities was the inclusion of nursing as a branch of the armed forces. In March 1902 the Queen Alexandra's Imperial Nursing Service was established – a Territorial Army Nursing Service was also to be formed. In 1949 the military nursing service became the Royal Army Nursing Corps.

The other branches of the service also formed nursing branches; in 1902 the Queen Alexandra's Royal Naval Service was formed. In June 1918 a nursing branch of the Air Force was formed as a wartime emergency measure. This branch was made permanent in 1921, and in June 1923 was given the title of Princess Mary's Royal Air Force Nursing Service.

Both World Wars gave rise to the formation of an auxiliary nursing corps. Both the Voluntary Aid Detachment (VAD) and the Civil Nursing Reserve were to be a source of irritation and contention to the nursing profession, especially in the early days of Registration, in the case of the former and on the question of the Ass. Nurses' role in the case of the latter.

So far in this historical sketch, the tendency has been to look at the development of nursing on a fairly wide canvas, encompassing different countries and cultures. From this point on, however, it is the intention to trace the development mainly as it relates to the United Kingdom.

The point has been previously made that although one may get the impression that the origins of the profession are to be found in the various religious orders, in point of fact as it relates to the United Kingdom this was not so. Nursing at the beginning of the 19th century, as Abel-Smith says,
amounted to "little more than specialised charriages."

The use by the public of hospitals in the last century was by no means as extensive as is the case today. The wealthy tended to be treated exclusively in their homes, every large house possessing a purpose designed sick room; and amongst the working classes there existed a marked fear of hospitals, they being regarded as the penultimate stop to the grave.

During this period there were basically two types of hospitals, the voluntary hospitals, as for example St. Thomas's, St. Bartholomew's, etc., and the infirmaries associated with the workhouses, administered by the Poor Law Guardians.

Admission to hospital in the 19th century was often determined by social rather than medical criteria; people were admitted simply because there was no one to look after them at home. If a patient was admitted to one of the voluntary hospitals then he was relatively fortunate by comparison to what he would have experienced had he been admitted to one of the infirmaries administered by the Poor Law Guardians. However, since the voluntary hospitals were administered by charitable trusts the availability of beds within them was severely limited and indeed, throughout the country the existence of such hospitals themselves were few and far between.

The census report shows that "as late as 1851 there were only 7619 patients recorded by the census enumerators as resident in hospitals in England and Wales". Furthermore, the choice between a voluntary hospital or workhouse institution, was not just determined by (a) whether there was a voluntary hospital in the area, and (b) whether it had a vacant bed, because frequently a voluntary hospital's policy was such, that it would refuse to admit patients with certain kinds of diseases. Miss Twinning remarked that there were "a large number of persons afflicted with incurable diseases who are not the objects for admission into the general hospital".

1. Abel-Smith: op.cit., p.4
2. Abel-Smith: ibid.
In the workhouse infirmaries nursing duties were performed by able-bodied paupers, many of whom could neither read nor write. Their predilection towards alcohol often resulted in their stealing stimulants intended for patients, and doctors frequently complained that such nurses were instrumental, by their inadequacies, in causing unnecessary suffering, and even death.

The Poor Law Report of 1866 revealed that "sometimes a patient would miss ministrations for days because the pauper charged to give it was herself bed-ridden. The rule of one nurse was to give medicine three times a day to the very ill and once a day to the rather ill. It was administered in a gallipot; the nurse 'poured out the medicine and judged accordingly'. Cases were reported in which patients had no food from 4 o'clock on the afternoon of one day until 8 o'clock in the morning of the next; and patients died, or to speak more correctly, were killed by the most wanton neglect".¹

Two years prior to this report, Miss Nightingale wrote a letter to Sir John Lawrence dated September 26th, 1864 of the inhuman conditions that were then extant, in which she says: "For I have seen, in our English Workhouse Infirmaries, neglect, cruelty, malversation such as can scarcely be surpassed in semi-barbarous countries".

One could continue in this vein almost indefinitely, since there are, within the field of English Social History, innumerable documents and works which testify to the abject conditions to which the inmates were subjected, and it really is not that surprising when one considers the prevailing [laisse-faire] philosophy of the period. Pauperism was generally considered an unacceptable burden on the local rates. The intention, therefore, was to make the conditions excessively harsh with the decided aim of discouraging people from going into these institutions. Such then, were the conditions in the workhouses.

¹ Sir Edward Cook: op.cit., p.124.
The conditions in the voluntary hospitals were undoubtedly superior to those of the workhouses, but even here the general standard of nursing was poor. The majority of nurses were recruited from the domestic class, and because of low pay and poor conditions, the occupation rarely attracted recruits who were in any way educated.

In theory it was possible for a nurse to be promoted to sister, but in practice this rarely occurred; sisters were usually recruited separately from a higher social class. Abel-Smith says, for example, that "in St. Thomas's the sisters had usually been head servants in gentlemen's families". Matrons on the other hand, were generally recruited from a still higher class. Their duties were entirely administrative and rarely did they possess any form of nursing training.

Of nurses in general Miss Nightingale made the following scathing comments: "they were too old, too drunken or too bad to do anything else". The problem of drunkenness appeared to be equally as acute amongst nurses from the voluntary hospitals as amongst those in the workhouse infirmaries.

On the question of drunkenness, Miss Nightingale in a letter to Miss Bonham Carter, dated January 8th, 1852 had the following to say: "Poor Cassandra has found an unexpected ally in a young surgeon of a London Hospital, a son of Dr. Johnson who sits next to papa at the table d'hote. The account he gives of the nurses beats everything that even I know of. This young prophet says that they are all drunkards, without exception, Sisters and all, and that there are but two nurses whom the surgeon can trust to give the patients their medicines. I thought you would be pleased to hear how bad they are, so I tell you. Johnson is extraordinarily careful, but he does not strike me as having genius like Gully......".

1. Abel-Smith: op.cit.
Of course, the language in both the quotations of Miss Nightingale is not exactly restrained. The first suffers particularly from the fallacy of composition, the inference being that all nurses were either "too old", or "too drunken" etc. The second is based entirely on hearsay. However, there is a tendency for reformers, quite naturally, to overstate their case; undoubtedly there had been good and efficient nurses as well as the bad and inefficient before the Nightingale reforms. An indication of this may be gleaned from the testimony of one of Miss Nightingale's favourite pupils, Miss Pringle, who after some years in hospital work wrote: "Some of the hospital nurses were of the best type of women — clever, dutiful, cheerful and kind, endowed above all with that motherliness of nature which is the most precious attribute of a nurse". But there is, notwithstanding, sufficient evidence in the literature to indicate, that by comparison to present day standards, the general level of nursing was very poor. It perhaps needs to be stated, however, that the malpractices of the period, both in the voluntary hospitals and workhouse infirmaries, arose as much from the system under which these services operated as any other reason. Given the general lack of concern by the public, and the adverse conditions under which nurses were expected to work, little better could really be expected.

**The Nightingale Nursing Reforms.**

After the Crimean War there was a marked change in the public attitude towards both soldiers and nurses. In both cases this change is directly attributable to actions of Miss Nightingale. "Never again was the British soldier to be ranked as a drunken brute, the scum of the earth. He was a symbol of courage, loyalty and endurance, not a disgrace but a source of pride...... Never again would the picture of a nurse be a

tipsy, promiscuous harridan. Miss Nightingale had stamped the profession of nurse with her own image.¹

It would appear, from reading Miss Nightingale's biographers, that when she returned from Scutari it was her intention to devote the rest of her life to improving the conditions of the British soldier. This, according to Woodham-Smith, was not possible. "Her knowledge, her genius and experience were such that she could not be allowed to limit herself to military affairs".²

One can gain an insight into the extent of this "knowledge" and "experience" from the following account of her evidence to the Royal Sanitary Commission of 1857. In the course of the proceedings she was asked whether she had given much consideration to the organisation of civil and military hospitals. She replied as follows: "Yes, for thirteen years I have visited all the hospitals in London, Dublin and Edinburgh, many county hospitals, some of the Naval and Military hospitals in England; all the hospitals in Paris, and studies with the "Soeurs de Charite", the Institution of Protestant Deaconesses at Kaiserswerth on the Rhine, where I was twice in training as a nurse, the hospitals at Berlin, and many others in Germany, at Lyons, Rome, Alexandria, Constantinople, Brussels; also the war hospitals of the French and the Sardinians".

During this period Miss Nightingale was engaged in a multiplicity of activities connected with hospital administration and construction. Lord Shaftesbury in 1858 arranged for two of her papers on hospital construction to be read at the Social Science Congress. These met with such resounding success that she was encouraged to expand and publish them in book form under the title 'Notes on Hospitals'.

The opening paragraph of 'Notes on Hospitals' focuses the problem

2. Woodham-Smith: ibid.
and indicates the state of the hospitals in the mid-nineteenth century:
"It may seem a strange principle to enunciate as the very first
requirement in a hospital that it should do the sick no harm. It is
quite necessary nevertheless to lay down such a principle, because
the actual mortality in hospitals, especially those of large crowded
cities, is very much higher than any calculation founded on the
mortality of the same class of patient treated outside of hospital
would lead us to expect".

This, at the time, was an extremely revolutionary approach, because
clearly she is saying that the high mortality rate which was character­
istic of the large hospitals of the day, was in fact preventable by the
application of the elementary principles of hygiene and sanitation.
"The answer", as Woodham-Smith says, "to hospital mortality, was neither
prayer nor self-sacrifice, but better ventilation, a higher standard of
cleanliness, better drainage and better food". 1.

Florence Nightingale was involved in so many activities during this
period of her life that it would be tempting to examine in detail.
However, since we are concerned primarily with the development of
nursing, this temptation must be resisted and we must focus our attention
exclusively on those aspects of her work which are concerned primarily
with nursing.

The Nightingale School.

Miss Nightingale faced two major difficulties in the Crimean War.
One we have already referred to, namely the problem of maladministration,
and the other was the major personnel difficulty which stemmed from the
scarcity of trained nurses. Miss Nightingale had long since resolved
to remedy this situation. Her experiences at Scutari merely intensified
her resolution. Although deeply religious herself, she was nevertheless
critically aware of the dangers attendant to nurses being selected and
trained within different religious orders, where often nurses were

selected not by qua nursing, but by qua sectarian considerations. She felt, therefore, that religion tended to exacerbate rather than to ameliorate the problem. "The case, says Sir Edward Cook, "is excellently put, in terms which doubtless reflect Miss Nightingale's own views, in a letter from Lady Verney* to Mrs. Gaskell (May 17th. 1855):

"Until women have gone through a real training, it is a vain hope that four or five weeks in a hospital can fit them for one of the most difficult works that anyone can be called on to undertake. I cannot tell you the details, you can guess many of them; but when I hear estimable people talking as if you could turn 40 women of all ranks, degrees of virtue, and intelligence, into a Military Hospital, with drunken orderlies, unmarried Chaplains, young Surgeons, etc., etc., and expect that they are not more likely to be unwise or tempted astray than the R.C. Sisters of Charity who are bound by well-considered vows, to love of their kind and the fear of Hell fire, then we feel that the "estimable people" have very little knowledge of human nature. F's form of Sisterhood is infinitely higher, I believe than the R.C., and will be carried out, I doubt no more than in her own existence, but as it must exist without the checks and safeguards of the other and inferior form, so it requires higher elements in the actors and a more severe training and examination. Instead of which the loosest possible choice takes place by people most excellent but not in the least qualified to choose; goodwill, and a "love of nursing" is enough for the Lady class".¹

Thus Miss Nightingale had for some time considered the possibility of introducing an effective form of nurse training and this was to materialise in the form of the Nightingale School.

+ Lady Verney was Miss Nightingale's sister.
The Nightingale School was really a direct outcome of Miss Nightingale's service to the British Army in the Crimean War. The Nightingale Fund, which made the formation of the school possible, was an expression of gratitude by the peoples of Britain and the British Empire for her services to humanity in the Crimean War. It amounted to £44,000 and was placed in trust for the purpose of establishing "an Institution for the training, sustenance, and protection of Nurses and Hospital Attendants".

On returning from Scutari, Miss Nightingale was not in the best of health, but in spite of this she became immersed in a whole host of activities related to the Army, and as a consequence "saw no early prospect of strength or time available for the superintendence of a new institution; she was unwilling that money subscribed for the public should longer be idle".¹ She therefore wrote to Mr. Sidney Herbert — Chairman of the Council of the Nightingale Fund — indicating that she wished to be relieved of further responsibility, and that the Council should apply the fund to any end that it deemed fit. The Council replied that it did not wish to do this, and the delay was, in a sense, compensated by the increased yield that the fund was earning. Moreover, it was pointed out that the contributors desired that Miss Nightingale's "mind and intention should animate the work".² She was asked, therefore, to postpone such a decision, to which Miss Nightingale acceded.

It became clear however, that her state of health would not permit the establishment of a completely new institution with her as its superintendent. And it was in fact, Miss Nightingale who decided that the scheme would only become viable if it were applied within the framework of an existing hospital. Finally, St. Thomas's was chosen for the main application of the scheme. There were several reasons for this choice.

¹ Sir Edward Cook: op.cit., p.457.
² Ibid.
It was a fairly wealthy and well-managed hospital; Mr. R.G. Whitfield the resident medical superintendent was sympathetic to the scheme, but above all the Matron, Mrs. Wardroper was a remarkable woman, and one who identified completely with Miss Nightingale’s position, and indeed one who could be relied upon to initiate and explicitly carry out the Nightingale plan of nurse training. Of this remarkable woman Florence Nightingale later had this to say:

"I saw her first in October 1854, when the expedition of nurses was sent to the Crimean War. She had been then nine months Matron of the great hospital of London, of which for 33 years she remained head and reformer of the nursing. Training was then unknown; the only nurse worthy of the name that could be given to that expedition, though several were supplied was a "Sister" who had been pensioned some time before, and who proved invaluable.\footnote{Sir Edward Cook says this was Mrs. Roberts.} I saw her next after the conclusion of the Crimean War. She had already made her mark; she had weeded out the inefficient, morally and technically; she had obtained better women as nurses; she had put her finger on some of the most flagrant blots, such as the night nursing, and where she laid her finger the blot was diminished as far as possible, but no training had yet been thought of....

Her power of organisation or administration, her courage and discrimination in character were alike remarkable. She was straightforward, true, upright. She was decided. Her judgement of character came by intuition, at a flash, not the result of much weighing and consideration; yet she rarely made a mistake, and she would take the greatest pains in her written delineations of character required for record, writing them again and again in order to be perfectly just, not smart or clever, but they were in excellent language. She was free from self-consciousness; nothing artificial about her. She did nothing, and abstained from nothing, because she was being looked at. Her whole heart and mind,
her whole life and strength were in the work she had undertaken. She never went pleasuring, seldom into society. Yet she was one of the wittiest people one could hear on a summer's day, and had gone a great deal into society in her young unmarried life. She was left a widow at 42 with a young family. She had never had any training in hospital life, there was none to be had. Her force of character was extraordinary. Her word was law. For her thoughts, words and acts were all the same. She moved in one piece. She talked a great deal, but she never wasted herself in talking; she did what she said. Some people substitute words for acts; she never. She knew what she wanted, and she did it. She was a strict disciplinarian; very kind, often affectionate, rather than loving. She took such an intense interest in everything, even in things matrons do not generally consider their business, and never tired. She had great taste and spent her own money for the hospital. She was a thorough gentlewoman, nothing mean or low about her; magnanimous and generous rather than courteous. And all this was done quietly. She had a hard life, but never proclaimed it. What she did was done silently.¹

It should not be assumed, however, that nurse training met with universal favour, in fact there were many in the medical profession and laity alike who were opposed to the idea. Miss Nightingale was indeed fortunate in having the support and active co-operation of Mrs. Wardroper and Dr. Whitfield. But there was strong opposition manifested from St. Thomas's itself. This was led by the senior consulting surgeon, Mr. J.F. South. When the scheme was first discussed in 1857 Mr. South published a book entitled "Facts Relating to Hospital Nurses". Also "Observations on Training Establishments for Hospitals". In addition to being the senior surgical consultant to St. Thomas's, Mr. South was

¹ Brit. Med. Journal; Dec. 31, 1892. N.B. Mrs. Wardroper died in 1892.
a leading member of the medical profession, being conjointly both the President and Huntarian Professor of the College of Surgeons, and he was "not at all disposed to allow that the nursing establishments of our hospitals are inefficient, or that they are likely to improve by any special Institution for training". 1 Moreover, he agreed that sisters could only effectively learn their craft by practical experience and that nurses were subordinates, "in a position of housemaids" and required only the most elementary of instruction. 2 Furthermore, he asserted that the nursing at St. Thomas's Hospital was already at a high level. Mr. South went on to say: "That this proposed hospital nurse training scheme has not met with the approbation or support of the medical profession is beyond doubt.... The small number of medical men whose names appear in the enormous list of subscribers to the (Nightingale) Fund cannot have passed unnoticed. Only three physicians and one surgeon from one London Hospital, and physicians from a second, are found among the supporters". 3 Thus the Nightingale Training School was launched amidst an atmosphere of scepticism, and its first probationers were subjected to severe and critical scrutiny.

After considerable consultations with Dr. Whitfield, Mrs. Wardroper and other interested parties, and after appropriate meetings with members of the Council of the Nightingale Fund and the Governors of St. Thomas's Hospital, an agreement was reached for the founding of the Nightingale School. The basis of this agreement was that the hospital would provide the facilities and the Fund would pay the costs, including payment to the nurses.

In the May of 1866 advertisements were placed in the press inviting applicants for admission to the school. The response was not particularly encouraging. However, fifteen candidates were admitted on June 24th 1866

1. See Woodham-Smith: p. 345.
2. Ibid.
3. Ibid.
for one year's training. From this modest beginning and indeed, a
tremendous amount of forethought and planning, began a project which was
destined to establish the modern practice of nursing.

The Nightingale scheme of training was composed essentially of two
principles. "(1) That nurses should have their technical training in
hospitals specifically organised for the purpose; (2) That they should
live in a home fit to form their moral life and discipline".¹

The scheme at the Nightingale School was carefully devised to meet these
dual ends. The probationers served as assistant nurses on the wards
where they received instruction from sisters and medical staff. They
were also obliged to attend formal lectures which were given by various
members of the medical staff. Each probationer was continually assessed,
and her progress was shown on the 'Monthly Sheet of Personal Acquirements
of each Nurse'. This document was drawn up by Miss Nightingale for the
matron to complete. Just how stringent was this assessment may be seen
from the following account by Sir Edward Cook:

"The Moral Record was under five heads; punctuality, quietness,
trustworthiness, personal neatness and cleanliness, and ward management
(in order). The Technical Record was under fourteen main heads, some of
them with as many as twelve sub-heads 'observation of the sick' was
especially detailed in this manner. Against each item of personal
character or technical acquirement, the nurse's record was to be marked
as Excellent, Good, Moderate, Imperfect or 0. Those who 'passed' the
examiners, as it were, at the end of their year's course, were placed on
the Hospital Register as Certificated Nurses. As rewards for good conduct
and efficiency, the Council offered gratuities of £5 and £3, according to
two classes of efficiency, to all their certificated nurses, on receiving
evidence of their having served satisfactorily in a hospital during one
entire year succeeding that of their training. Decidedly Miss Nightingale

¹. British Medical Journal; Dec. 31st. 1892.
emphasised the educational side of her new experiment. No public school, university or other institution had so elaborate and exhaustive a system of marks. Equally thorough and scientific are the 'General Directions' which the Residential Medical Officer presently drew up at Miss Nightingale's earnest request 'For the Training of Probationer Nurses in Taking Notes of the Medical and Surgical Cases in Hospital'.”¹

Miss Nightingale's second principle was equally cared for. The probationers lived in a separate wing of the hospital and this was designed so as to provide each girl with an individual room, in addition to which, there was a common room and two rooms for the sister in charge of the probationers. Their board and lodgings, uniforms and laundry were provided out of the Fund and in addition they each received £10 for personal expenses. For all purposes they were under the direct authority of the matron.

The emphasis on appropriate moral behaviour was very stringent. This was not only because Miss Nightingale shared the value system of her time, but also for very practical reasons. Mothers of literate daughters were not likely to allow their daughters to take up nurse training if they considered that their daughters' reputations were, in any way, likely to be at risk. Thus the degree of propriety required of the probationers was as strict as that for any religious order. "One piece of indiscretion, one false step, and the hopes of reforming the nursing profession and elevating its status might be set back for years".² Miss Nightingale and her co-workers were not ready to allow this to happen.

Of the fifteen girls who embarked upon the first course in 1860, thirteen satisfactorily completed it.

The Effect of the Nightingale School.

Admission to the Nightingale School rapidly became sought after. This

2. Woodham-Smith; op.cit., p.267.
was partly due to Miss Nightingale's own example and charisma, and partly
due to "demographic factors", which as Abel-Smith says, "had created a
pool of idle spinster labour". This point is borne out by Veblen in
his 'The Theory of the Leisured Class', which shows the complete function-
lessness of women in the prosperous Victorian family. "She was prevented
by strong social pressures from engaging in trade or competing with the
superior sex in the learned professions. If she was to escape at all
from the boredom of family life, it could not be from any commercial
motive. The performance of good works was already sanctioned by her class
and promoted by the High Church movement. Caring for the sick was a
logical extension of such activities, but nevertheless still closed to the
respectable girl by the low character of the women who were believed to be
engaged in the work. If nursing could be made respectable, it could
provide an outlet for the social conscience and frustrated energies of the
Victorian spinster".

The Nightingale School provided precisely such 'an outlet', and it was not
long before the idea of nursing as a suitable career, alongside teaching,
was enthusiastically propositioned.

By carefully selecting entrants to the school, Miss Nightingale was able
to recruit girls from some of the wealthiest families in the land. This
resulted from a combination of factors. Firstly, because it was necessary
for a probationer to be able to read medical textbooks, take notes and keep
a diary, a high degree of literacy was required. This prerequisite
inevitably narrowed the catchment area. Secondly, as indicated earlier,
nursing had become a respectable career for a gentlewoman at a time when
the only other legitimate career she might follow without losing caste was
teaching.

It should be stated, however, that unlike some of her successors, it was
never Miss Nightingale's intention to restrict entry to the nursing
profession exclusively to the higher social classes, nor indeed were the

1. Abel-Smith; op.cit. p.17.
2. Abel-Smith; op.cit.
early probationers selected entirely from this group.

At the beginning of the scheme it was held that the most suitable candidates would be daughters of small farmers. However, after a few years a distinction was introduced into the Nightingale School between those on the one hand who received their tuition free together with the £10 allowance, and the 'lady pupils' on the other, who contributed to their cost of tuition. Certainly, there appears to be some evidence to suggest that Miss Nightingale herself came to view the recruitment of lady pupils more sympathetically. Certainly one of the advantages of the two-entry system was that it relieved pressure on the Fund and in so doing enabled the training of more nurses. The other factor was that Miss Nightingale envisaged that the majority of these 'lady pupils' would form a nucleus of an elite of the profession, and when they were in positions of authority would serve as vehicles for the propagation of her own views on nursing reform. In fact it was clearly laid down that lady pupils had "to desire to qualify themselves for the superior situations". 1.

So it was that in the field of nursing the 'lady pupils' became Miss Nightingale’s disciples and the propagators of her reforms. For the period 1860 to 1903 the Nightingale School certificated 1,907 nurses, and their influence became considerable. But this figure is not really representative of their sole influence, because many of them became matrons and established their own schools, so the growth tended to develop exponentially as each nurse tended to train other nurses. In fact, the Nightingale School became a clearing house for some of the top nursing positions in the country. Miss Nightingale made it her business to know all the sisters, she met each of the probationers personally, and she was able to engineer candidates of whom she approved into most of the leading nursing posts in the country. As Abel-Smith says; 'Viewed historically,

1. Dunbar: 1936, p.36.
the Nightingale School became in practice more important as a training school for matrons, than a training school for nurses. Ladies were sent there with the special object that they should be passed on to be first assistant superintendents, and ultimately heads of nursing departments in hospitals

Just how influential the school became may be seen by the fact that in 1887, the year of Miss Nightingale's Jubilee, the following hospitals, institutions and organisations had matrons or superintendents who had been trained at the Nightingale School: The Westminster Hospital, St. Mary's Paddington, the Marylebone Infirmary, the Metropolitan and National Nursing Association, the North London District Association, the Cumberland Infirmary, the Edinburgh Royal Infirmary, the Huntingdon County Hospital, the Leeds Infirmary, the Lincoln County Hospital, the Royal Infirmary Liverpool, the Workhouse Infirmary Liverpool, and the Southern Infirmary Liverpool, the Royal Victoria Hospital at Netley, the Royal Hospital for Incurables Putney, and the Salisbury Infirmary

The matrons of the new type fought a number of battles when they took over; one such skirmish was fought out at Guy's Hospital when Miss Burt became Matron. On joining the hospital she did not hold the existing nursing force in particularly high regard; "They were untrained; they took money from the patients; they spent their evenings off in public houses and in music halls, they did not keep their patients clean and lastly they even wore jewellery"

She dismissed many of the old nursing staff, introduced a standard uniform which the nurses had to purchase for themselves, and placed an absolute prohibition on the wearing of jewellery.

Also she introduced a system of rotation by which all nurses moved from ward to ward. "If the hospital was to serve as a training school for nurses, in much the same way as it was a training school for doctors,

nurses must be moved about and given the opportunity, before going out into the world to practice their calling, of acquiring experience in the different departments of the hospital".¹ The last change upset a number of the staff, and resulted in a letter of complaint being sent to the Governors. "The Matron was accused of undermining the position of the sisters by centralising all the nursing arrangements in her office. Moreover, the notes kept by the pupils were interpreted as a method by which the Matron spied on the sisters. The Governors supported Miss Burt".²

There were several reasons why some sections of the medical profession did not overwhelmingly support the 'new ladies'. Firstly, many of the new nurses were of a higher social class than many of the doctors with whom they worked. Secondly, irrespective of how the new nurses protested to the contrary, many doctors felt their authority with the patients would be undermined. Moreover, many doctors saw the new trained nurses as a direct threat to their own economic survival, because they felt that some people — because it was cheaper — would call on the services of a nurse rather than a doctor.

However, by the turn of the century the new Matrons were firmly entrenched. In the many power struggles the new Matrons had two disadvantages, firstly they were women and they were young, but they also possessed two inestimable advantages; by virtue of their social class they could usually exert considerable influence in the areas where real power resided, and thus they were able to go over the heads of medical staff and lay administration. Secondly, they could appeal to Miss Nightingale herself. She invariably used her influence with doctors or hospital governors to "ensure that the Matron got her way".³ So the new Matrons usually won. In the voluntary hospitals they were able to obtain a distinct area of absolute authority.

¹. Cameron: op.cit. p.203.
³. Abel-Smith: op.cit., p.28.
independent of both medical staff and lay administration. As Abel-Smith says: "By 1892 it was accepted in the voluntary hospitals that the Matron was the de facto head of an independent department. She controlled her own staff and reported direct to the Hospital Committee. It was a well understood arrangement that the lay administration never interfered in that department". Also by the turn of the century, nearly all of the voluntary hospitals in England and Wales had their own nurse training schools.

The Workhouse Reform Movement.
The changes which came to the voluntary hospitals possessed the dual attributes of ruthlessness and swiftness. This was not the case in the workhouses. Of course, a different kind of philosophy prevailed in the case of the workhouse administration. The workhouses were mainly administered by committees of tradesmen, who considered their main duty to be that of actively discouraging the poor from receiving any kind of relief, and in so doing saving the ratepayers' money.

Miss Louisa Twining, a workhouse visitor, was mainly instrumental in bringing to the public's attention the inadequacy of these institutions. She assembled information from a collection of reports from other workhouse visitors and published them. "This led to a debate in the Lords, but their Lordships were not disposed to listen to the interfering women and workhouse visiting was banned. Miss Twining's ladies reacted by forming The Workhouse Visiting Society which enlarged its membership and visited other workhouses; the Society became a powerful instrument in reform and Miss Twining was still visiting and reporting workhouse conditions in 1890".

Among the many failings of the workhouse system which these ladies highlighted was that of inadequate and incompetent nursing. During the same period William Rathbone, a wealthy philanthropist from Liverpool, had come to a similar conclusion after his visits to Brownslow Hill Institution

1. Ibid.
in Liverpool. He was appalled at what he saw; "The place housed over a thousand helpless, aged, mostly incurable people in every stage of infection and contagious disease. There were no trained nurses at all. What care the inmates got was from those of their number still able to move about, and from pauper women from the local workhouse. Many of these were alcoholics or prostitutes down on their luck. What food there was was badly cooked, and only got to the helpless patients after the more active had taken the lion's share. Some of the wards containing mental cases were patrolled by policemen to 'keep order'. This was in 1866, and although Rathbone was almost as shocked as Dunant had been at Solferino, the infirmary was in reality neither worse nor better than the average throughout Britain at the period".1

The agitation of Miss Twining and other workhouse visitors was soon joined by the more progressive of workhouse doctors; "Dr. Rogers' of the Strand Workhouse, in particular was so outspoken in his criticism that he was suspended from his appointment. In 1866 he formed the Association of Poor Law Medical Officers as a pressure group for reform".2

Once the need for nursing reform within workhouse infirmaries had been acknowledged, discussion arose on how such reforms should be implemented. One suggestion was that paupers should be given training as nurses, and this view was endorsed in 1885 by a number of eminent doctors. Self-evidently such a plan appealed to the Poor Law Guardians because of its obvious economy, and it was implemented until it met with severe criticism from Miss Nightingale:

"Are we to expect (she wrote) that we should find suitable women for, an occupation which requires perhaps above every other occupation, sobriety, honesty, trustworthiness, truthfulness, orderliness, cleanliness, good character, and good health, among those who, nearly all, at least in the workhouses of the large towns, are there because they have not been sober,

not been honest, not been trustworthy or truthful, not been orderly or cleanly, not had good character or good health, because they have not been one or other of these things, because they have failed in one or all of these? Is it likely? ¹

William Rathbone persuaded Miss Nightingale to send a Matron and a team of nurses to Brownslow Hill. In order to secure permission for the experiment he offered to meet the costs of the venture for three years. Miss Agnes Jones, one of Miss Nightingale's "best and dearest pupils" was selected as Matron. She arrived with a team of twelve nurses and within a month sacked thirty-five of the pauper nurses for drunkenness. She struggled to train other able-bodied paupers as nurses, but in this she failed, they appeared to be incapable of learning and could not be trusted to perform the simplest of tasks without supervision. By the second year Miss Jones received a further complement of trained nurses and achieved remarkable results. "The Local Authority then began to realise that it was cheaper to pay fair wages to skilled women who could get patients well enough to leave, than to pay pauper rates to those who kept the beds occupied". ² Eventually the Local Authority took over the responsibility of the infirmary and made its financial upkeep chargeable on the general rates.

Miss Agnes Jones worked unremittingly for three years, but her efforts were to culminate in tragedy. With resistance low from overwork, and refusing to take a rest, she contracted typhus fever, from which she never recovered. Of Agnes Jones Miss Nightingale wrote:

"She died as she had lived, at her post in one of the largest workhouse infirmaries in the Kingdom. She lived the life, and died the death, of the saints and martyrs; though the greatest sinner would not have been

¹ Nightingale: "Suggestions on the subject of providing training and organising nurses for the sick poor in workhouse infirmaries": Letter to Sir Thomas Bart, 1867 p.3. Quoted in Abel-Smith: op.cit., p.39.
more surprised than she to have heard this said of herself. In less than three years she had reduced one of the most disorderly hospital populations in the world to something like Christian discipline, such as the police themselves wondered at. She converted a vestry to the confection of the economy as well as humanity of nursing pauper sick by trained nurses. She had converted the Poor Law Board - a body perhaps not usually given to much enthusiasm. She had disarmed all opposition, all sectarian zealotism; so that Roman Catholic and Unitarian, High Church and Low Church, all literally rose up and called her "blessed". All, of all shades of religious creed, seemed to have merged their differences in her, seeing in her the one true essential thing, compared with which they acknowledged their differences to be as nothing. And aged paupers made verses in her honour after her death.

In less than three years - the time generally given to the ministry on earth of that saviour whom she so earnestly strove closely to follow - she did all this."^{1}

The experiment in Liverpool demonstrated the value of employing paid trained nurses. However, the fact that this was shown locally did not mean that it would be accepted as a general principle nationally.

Miss Nightingale knew from her previous connection with the reform of the Army medical administration that such reform could not be achieved on an ad hoc basis. Without widespread changes in the whole system of workhouse administration it would not be possible to introduce changes in its nursing system. She developed, however, a pilot scheme for London. As early as 1864 Miss Twining suggested that different kinds of paupers should be housed in different and separate institutions. Miss Nightingale knew that this was impracticable unless there was a separate administration for London which would be financed out of the general rate. Small authorities could not afford to meet the costs of these different institutions.

Miss Nightingale first took her ideas for reform to the President of the Poor Law Board, Mr. Villiers, but she quickly came to the conclusion that he neither possessed the predilection, nor the energy, to initiate reform legislation, so she took the matter to Cabinet level through Lord Palmerston. Unfortunately for her Lord Palmerston died in 1865 and the Government collapsed a year later.¹

The Association for Improving Metropolitan Workhouse Infirmarys formulated a more modest plan. This Association, which was formed in 1886, suggested that for the purpose of treating the sick poor, London should be divided into six administrative unions, "governed by elected rate-payers and financed by a general infirmary rate equalised over the metropolitan area. Each union was to build an infirmary for the care of 1,000 acute cases. Miss Nightingale supported the scheme.²

Miss Nightingale was concerned with the necessity of introducing teams of trained nurses into the Poor Law Infirmarys. One trained nurse, as Matron, would be of little use. She discussed the question with Henry Bonham Carter and suggested the possibility of trying to establish training schools in Workhouse Infirmarys. "Bonham Carter thought it was wiser to infiltrate new Matrons with teams of nurses into the larger workhouses and fight out the battles with the Guardians if this proved necessary".³

Following the death, through gross neglect, of a pauper in a Holborn workhouse, the Lancet commissioned three doctors to examine the conditions in all Metropolitan Workhouses. The publication of their report in the Lancet led to an official enquiry and report. In a letter to Sir John McNeil, Miss Nightingale wrote, "I was so much obliged to that poor man for dying".⁴

The Metropolitan Poor Act of 1867 resulted from this official report. Separate institutions were established for the treatment of the insane and infectious. For the rest, namely the non-infectious sick, a greatly

1. See Abel-Smith: op.cit., p.41.
2. Abel-Smith: ibid.
3. Abel-Smith: op.cit., p.42.
modified version of the plan of the Association for Improving Metropolitan Workhouses was implemented. "Some of the smaller unions and parishes were grouped together to form sick asylum districts, while larger unions were encouraged to provide separate infirmaries for the sick. Thus from 1867 onwards were built the infirmaries which came to be called hospitals at various dates between 1931 and 1948, and were to be found, with few exceptions, ninety years later".¹

So in London, a structure was developed which would effect an improvement in the nursing of the sick poor. As far as the rest of the country was concerned a beneficial result also stemmed from the 1866 enquiry, and this was that the Local Government Board advised the Guardians to employ a sufficient number of competent nurses, with at least one year's experience. Regretably the Local Government Board made no mention of training so it was relatively easy to nullify the effect of the advice.

As time went by the Boards of Guardians became aware of the efficacy of employing experienced nurses, and some even went as far as to recognise the need for trained nurses. But there was a shortage of trained nurses. The voluntary hospitals were not training sufficient numbers to meet the demand, even assuming that trained nurses would be prepared to accept positions in workhouse infirmaries. Eventually however, probationary nurses were admitted for training in appropriate sick asylums under the provision of Section 29 of the Metropolitan Poor Act.²

The Local Government Board in 1875 indicated that for the purpose of meeting their own supply needs they would favour the extension of nurse training in all the new infirmaries being built within the Metropolis.³

Later, 1887 – 89, the Local Government Board reported that the practice of employing pauper nurses had ceased. Abel-Smith shows that this was

1. Abel Smith: ibid.
2. Abel Smith: op.cit., p.43.
3. Ibid.
demonstrably untrue, in fact "the minority report of the Royal Commission on the Poor Laws (1909) drew attention to the large role still played by paupers". ¹

Thus by the beginning of the 20th Century, there were still wide variations in the standards of nursing between the voluntary hospitals on the one hand, and the poor infirmaries on the other.

District Nursing.

The latter part of the 19th Century also saw the birth of the District Nursing Service. To recount the events which led up to the formation of this branch of nursing it is necessary to return to the Rathbone experiment in Liverpool in 1861. Mr. Rathbone, having personally benefited from the services of a private nurse during an illness, arranged for her to extend her service for three months to nurse the poor in their homes. He had long and detailed discussion with Miss Nightingale concerning the possibility of starting a district nursing scheme and appealed for Nightingale nurses in order to start the scheme. Miss Nightingale was sympathetic to the idea, but suggested that such nurses should be trained within the Liverpool Infirmary.

William Rathbone accordingly donated a new building as a school of nursing, which in 1862 began training nurses both for the hospital and for the district. "Once the nurses were trained, Liverpool was divided into eighteen districts, each with a ladies' voluntary committee responsible for the dispensation of medical comforts, and a trained nurse attached to each committee". ² Mr. Rathbone was moved to extend the district nursing scheme to London, and the Metropolitan Nursing Association was formed with Miss Florence Lee — another of Miss Nightingale's special pupils — as the first Superintendent in General. "She filled the post with high efficiency for some years, and throughout her work was in constant consultation with Miss Nightingale". ³

2. Baly: op.cit., p.32.
In 1887 the movement for District Nursing received a considerable impetus from the action of Queen Victoria, who had always taken a keen interest in Florence Nightingale and nursing; she devoted the bulk of the sum presented as the 'Women's Jubilee Gift' £70,000 for the extension of nursing schemes. In 1888 the Queen Victoria Jubilee Institute for Nursing was established and the methods of training were very similar to those which Miss Nightingale and William Rathbone had advised for the Metropolitan Association. These principles of training continued to apply until State Registration which made registration a prerequisite for training in District Nursing. In 1928 the Charter was amended and the name changed to the Queen's Institute of District Nursing.

"Like so many other health services, district nursing started as a voluntary service run by voluntary committees; as time went by and the value of the service proved, legislation required local authorities to accept responsibility; in most cases they discharged this responsibility directly or indirectly through the Queen's Institute. Later in rural areas, after the establishment of health visitor training, the district nurse often combined both roles. The Institute is itself an executive and advisory centre, but it has now ceased to be an examining body".\(^1\)

**The Struggle for Registration.**

The events which led up to the registration of nurses was largely the result of the effort and struggle of one woman, namely Mrs. Bedford Fenwick.

Mrs. Bedford Fenwick was born Ethel Gordon Manson on the 26th January 1857, the daughter of a wealthy physician who died when she was three. Several years later her mother married George Stover, a prosperous Member of Parliament. She thus grew up in a very comfortable and cultured home which was conducive to learning, and as she was extremely intelligent and articulate she was able to benefit intellectually from such circumstances.

\(^1\) Bally: ibid.
"She must have been exactly the sort of person Florence Nightingale hoped to attract, and she decided early to be a nurse". 1. She enrolled as a lady probationer at the Children's Hospital, Nottingham, in April 1878 and in the September of the same year went on to take her General Training at the Royal Manchester Infirmary as a paying probationer. Some writers have stated that there are no records of an Ethel Manson having attended the Royal Manchester Infirmary. 2. However, Winifred Hector includes a photograph of an entry from the Infirmary's cash book showing a payment of £6.10s. for her year's training. 3.

At the age of twenty-one she was the Sister of Charlotte Ward at the London Hospital, and three years later was appointed Matron of St. Bartholomew's. In 1887, six years after her appointment as Matron, she married Dr. Bedford Fenwick, a wealthy medical practitioner and one who was very active in medical politics, and as a consequence retired from active nursing. However, she was not to retire from nursing affairs, in fact she "embarked on the second stage of her career, which was to make her name famous in nursing circles around the world". 4.

Mrs. Fenwick's main preoccupation was that there should be an official register of all nurses who had completed a prescribed form of training, and only those whose names were entered upon the register would be entitled to describe themselves as 'Nurse'.

To this end she formed the British Nurses' Association - a breakaway group of the British Hospital Association - in the drawing room of her London home. She became its permanent President, and the Association had as its specific aim "to petition Parliament for a state register or two categories of nurses - nurses with three years' training and a certificate of good character, or educated ladies with only one year of training". 5.

5. Bowman: op.cit., p.3.
Not all the leaders of the profession shared Mrs. Fenwick's fervour for registration, in fact, the most influential of them all, Miss Nightingale, was firmly opposed to the movement. On the question of registration Miss Nightingale wrote: "Seeking a nurse from a Register is very much like seeking a wife from a Register, as is done in some countries".¹

Miss Nightingale and her allies maintained that the arguments of the Registrationists were, in fact, misleading. "Who was to be protected? Not the hospitals; they protected themselves, without any general register, by their own methods. If anyone was to be protected it must be the public, but the Register would rather mislead than protect them. The placing of a name on a register would, at best, only certify that at a certain date the nurse had satisfied the required tests; but the date might be long ago and the fact of registration would tell nothing of her subsequent competence....

As for the three years' training in a hospital, there were hospitals and hospitals, training schools and training schools and who would guarantee the guarantors? The General Register would not raise the profession of nursing; it would do an injury to the better nurse by putting her on a level with the worst, and to the profession by stereotyping a minimum standard".² This seems a weak argument since one could replace the term 'nurse' with 'doctor' and 'training school' with 'medical school' without any loss of meaning, and yet this situation was quite acceptable for doctors and had been since the Medical Registration Act of 1858.

Miss Nightingale's opinions carried great weight for she had many influential friends in the nursing profession, many of whom were the Matrons of leading hospitals, and she exercised considerable influence over these and the hospital management boards of which she was a member; also outside the profession she had many influential contacts in politics.

¹ Quoted in Abel-Smith: op.cit., p.65.
² Cook: op.cit., p.359.
So commenced the struggle which has been variously described as the 'Thirty Years' War', or the 'Battle for Registration'. The medical profession was divided on the issue; the B.M.A., which in the main represented the leading specialists from London and the Provinces, was in favour of Registration. Dr. Fenwick exerted a considerable influence within the B.M.A. and in 1889 he "...proposed and got the General Medical Council of the British Medical Association to pass a resolution in the following terms: 'That an Act of Parliament should, as soon as possible, be passed for providing for the registration... of nurses''.

The Incorporated Association of Medical Practitioners, which claimed to represent the average doctor of the profession, was in the main against the movement. This was partly because it felt that a recognised and registered nursing profession would constitute an economic threat, especially in rural areas where people might seek the services of a nurse rather than a doctor. But the strongest opposition came from the two hospitals where Mrs. Fenwick had worked. Sidney Holland of the London Hospital and Dr. Moor of St. Bartholomew's were vehemently opposed to registration on the grounds that it would restrict the supply of nurses by narrowing the field of recruitment.

Registration could be achieved in two ways, by an Act of Parliament, but Miss Nightingale and her allies were able to circumvent this. The British Nurses' Association had to seek the less satisfactory method of applying for a Royal Charter. In this connection the B.N.A. had a tremendous advantage in that it had Princess Christian as its head, so that when the B.N.A. sought a Royal Charter it was Princess Christian "who petitioned the Queen". Also the B.N.A. obtained permission from the Sovereign to use the title "Royal" and its prestige was thus considerably strengthened.

2. Cook: op.cit., p.357.
The application was considered by the Privy Council and a Charter was granted. In seeking a Royal Charter the R.B.N.A. sought to include in it, the keeping of a register. However, the word 'register' was substituted by 'list'. This was largely due to behind the scenes activities of Miss Nightingale and her followers, "and they came out in a letter to The Times that 'the list will have nothing in common with legal registers of the medical or other professions, but will simply be a list of nurses published by the Association'". ¹

With the granting of the Charter to the R.B.N.A., the substitution of the word 'list' for 'register' was not the only change that was made. Under the old Constitution, Mrs. Fenwick and other founder members were permanent members of its General Council, whilst other members were elected every three years. Mrs. Fenwick was to have a disagreement with the rest of the leadership of the R.B.N.A., and in 1893 she suffered the indignity of being voted off the General Council. However, apparently undaunted, she went on to form a number of rival organisations; in 1894 the Matrons' Council of Great Britain and Ireland; 1899 The League of St. Bartholomew's Hospital Nurses and in 1902 The Society for State Registration. In 1904 Mrs. Fenwick founded the National Council of Nurses, which became the British Section of the International Council of Nurses. "These new organisations and the acquisition of the Nursing Record were used as a means to promote the cause of state registration and higher standards of nurse training". ²

An event which considerably strengthened the nurses' movement for registration was the Midwives' Act of 1902. Under this Act it was required that all practising midwives must undergo training and be registered with the Central Midwives' Board. This Act was to have a

1. Abel-Smith: ibid.
2. Baly: op.cit., p.137.
cataclysmic effect on the nursing organisations seeking registration, and the R.B.N.A. was in the vanguard of this movement. In 1905 a Parliamentary Select Committee was appointed to examine the question of nurse Registration. The Committee came out in favour of Registration. "It is desirable that a Register of Nurses should be kept by a Central Body appointed by the State, and whilst it is not desirable to prohibit unregistered persons from nursing for gain, no person should be entitled to assume the designation of Registered Nurse whose name is not upon the Register". 1

"These registered nurses were not necessarily to be the only persons engaged in nursing work. Four years after the passing of any registration act, the central body should submit a report to the Privy Council on the advisability of instituting a separate Register of Nurses whose training is of a lower standard than that laid down for Registered Nurses". 2

This did not meet the demands of the lobbyists who were totally against there being more than one type of registered nurse; "had the recommendation been accepted nursing would have developed a more flexible training pattern and much of the ensuing trauma would have been avoided". 3

Following the Select Committee's recommendation, Bills of Registration became a familiar aspect of Parliamentary life; every year "from 1904 to 1914 a registration bill lay before Parliament". 4

In 1908 a Registration Bill was successfully passed in the House of Lords, but time was not allocated for it in the Commons. Moreover, at one time there were three different bills on registration in the field at the same time.

At this stage an umbrella organisation, the Central Committee for the Registration of Nurses was formed from a coalition of the various nursing

1. Select Committee on Registration 1905, p.v. quoted in Abel-Smith: op.cit.
4. Abel-Smith: op.cit., p.82.
organisations in favour of registration, and an agreed bill was presented to Parliament every year up to the outbreak of the 1914-18 War.

The War inevitably increased the demand for nurses. Many girls who, under ordinary circumstances, would not have considered working in any field, enlisted in the Voluntary Aid Detachments. But before long friction broke out between the trained nurses and the V.A.D's; both sides were unduly touchy about their status and the Joint Red Cross Society had the unenviable task of sorting out the squabbles.¹

The presence of this large number of untrained V.A.D's brought to a certain extent, a degree of unity amongst the fractious elements of the profession; simply because professional nurses saw the existence of the V.A.D's as a potential threat to their economic security, in a way very similar to the Incorporated Medical Association's fears associated with the registration of nurses. In order to seek ways of finding more nurses the War Office appointed a Committee under the Chairmanship of Lord Knutsford. The establishment of this committee, in fact, exacerbated an already difficult situation because the nursing organisations resented the fact that there were no nursing representatives on the committee, "and the outcry was so great that Lord Knutsford resigned".²

In an attempt to bring order to a chaotic situation, Dame Sara Swift, Matron-in-Chief of the British Red Cross Society and previously the Matron of Guy's Hospital, suggested to the Hon. Arthur Stanley, Chairman of the Joint War Committee, the idea of forming a College of Nursing, which would be constituted and would function in a way similar to the Colleges of Physicians and Surgeons. Thus the idea of the College of Nursing — later to become the Royal College of Nursing — was born.

The College of Nursing was registered with the Board of Trade as a limited company in April 1916; its Articles of Association were drawn up by Cooper Perry, Superintendent of Guy's Hospital. A Council was established

1. Baly: ibid.
to administer its affairs; its main objectives were:

1. to promote the better education and training of nurses and the advancement of nursing as a profession in all or any of its branches,

2. to promote uniformity of curriculum,

3. to make and maintain a register of persons to whom certificates of proficiency or of training had been granted,

4. to promote Bills of Parliament for any object connected with the interest of the nursing profession and, in particular, with nurse education organisation, protection, or their recognition by the state.

After a short time the College approached the Royal British Nurses' Association concerning the possibility of an amalgamation. There were a number of reasons why such an arrangement would be advantageous to the College: (1) it would unite the profession; (2) it would attract both funds and members; (3) it would gain a Royal Charter from such an amalgamation and hence be able to remove the invidious word "Limited" from its title. Princess Christian, the patron of the Royal British Nurses' Association was in favour of such a combination, but Mrs. Fenwick objected on the grounds that the control of the College of Nursing Ltd., was excessively in the hands of lay members. Negotiations proceeded, but the R.B.N.A. vacillated. Eventually the College, having about four times the membership of the R.B.N.A., decided that it could afford to ignore them and informed the R.B.N.A. accordingly.

At this stage both the Royal British Nursing Association and the College of Nursing were urging registration. The Government of the day accepted registration in principle, although there was no agreement of the exact form it should take.

As far as the long term was concerned, it was agreed that a Council, elected by newly registered nurses, should be formed, and its composition
should be at least two-thirds nurses. During the interim, however, some form of 'caretaker' organisation had to be established to initiate registration, and establish an electoral roll.

"The battle centred on the composition of this caretaker council which would be able to influence who was registered and who was not, which would in turn affect the ultimate council with its wide powers over the whole nursing profession".¹ Thus, it was really a struggle of who should ultimately be the spokesman of the nursing profession.

The Royal British Nurses' Association stood for a high level of technical competence, even if this conflicted with the staffing requirements of the country's hospitals. It was allied with the powerful British Medical Association, whom it hoped would not permit any dilution of nursing standards, any more than it would permit any compromise in the training of doctors. The College of Nursing, on the other hand, was more sensitive to the needs of the hospitals, and in a way perhaps, more realistic to the nursing needs of the country. Given the situation as it was, it was quite impracticable that a large section of the existing nursing force should be prevented from practising because they were unable to meet the high standards required by the R.B.N.A.

Both of these organisations presented their own bills to Parliament. In June 1919 the Royal British Nurses' Association bill was introduced in the Commons. Under the terms of this bill the composition of the first Council was to be as follows:

The Royal British Nurses' Association ... 4 seats
The College of Nursing Ltd., ... 4 seats
Other Nursing Organisations ... 10 seats

It also provided for the appointment of eight doctors, of whom four were to be appointed by the British Medical Association.

¹ Abel-Smith: *op.cit.*, p.93.
On the surface this bill gave equal representation to the R.B.N.A. and the College. However, this was more apparent than real. Of the ten seats allocated to other nursing organisations, seven were allocated to organisations which were part of the Central Committee of Registration and therefore, were allies of the R.B.N.A. Also four of the doctor's representatives were to be allocated to the B.M.A., a powerful ally of the R.B.N.A. So the terms of the bill predicated, in fact, that the R.B.N.A. would dominate the Council.

The bill of the College was introduced in the House of Lords in May 1919. It provided for representation on the Council in the following way:

- The College of Nursing Ltd. ... 12 seats
- The Royal British Nursing Association ... 12 seats
- The British Medical Association ... 3 seats
- Managers of Hospitals ... 6 seats.

The composition of the proposed Council was also superficially fair, but although the B.M.A. would support the R.B.N.A., it was almost certain that the Hospital Managers would support the College; so effectively the College would control the Council.

In the ensuing debates in the two Houses of Parliament, each side claimed respectively that its proposals were more democratic. "The R.B.N.A. camp argued that the doctors must have 'if not a predominant influence, at any rate a very great influence in any body framed to conduct the affairs of the nursing profession'. The Lords bill was dubbed 'a hospital governors' and matrons' bill'.

In the Commons the bill sponsored by the Royal British Nurses' Association received quite widespread support, but as the Colleges' bill was criticised in the Lords, so did the R.B.N.A. have its critics in the Commons. One member had the following to say:

1. Abel-Smith: op.cit., p.95.
"We have got to see that the avenue into the nursing profession is kept open for the daughters of the working classes, as much as any other class. I observe that we are putting the whole future of the nursing profession outside the control of Parliament....... I am not at all certain in this handing over to a body which must necessarily become, to a certain extent at least, an aristocratic and autocratic body...... Quite naturally they desire to keep the profession preserved to those particular people and their friends".¹

The argument continued between the protagonists of both sides, with the effect that Parliament became the forum through which two professional associations engaged in the undignified spectacle of airing their grievances about each other in public.

The Minister of Health (Dr. Addison) tried in vain to reconcile the differences between the two rival organisations, and finally the Government decided to introduce its own bill on Registration.

The Nursing Registration Act received the Royal Assent in December of 1919, and a General Council was established for England and Wales. The Register established under the Act consisted of the following parts:

(a) a general part containing the names of all nurses who satisfy the conditions of admission to that part of the register,
(b) a supplementary part containing the names of male nurses,
(c) a supplementary part containing the names of nurses trained in the nursing care of persons suffering from mental diseases,
(d) a supplementary part containing the names of nurses trained in the nursing of sick children.
(e) any other prescribed part.²

Nurses not possessing formal training were, at the outset, allowed to be admitted to the Register. The Council was obliged to admit nurses:

2. Nurses Registration Act, 1919.
"on producing evidence to the satisfaction of the Council that they are of good character, are the prescribed age, are persons who were for at least three years before the first day of November 1919 bona fide engaged in practices as nurses in attendance on the sick under conditions which appear to the Council to be satisfactory for the purposes of this provision and have adequate knowledge and experience of the nursing of the sick." ¹

The fee for registration was one guinea. The Council was responsible for approving all nurse training schools, although schools that did not obtain such approval could appeal directly to the Minister of Health.

Although practical nurses could be admitted to the Register, there was no provision in the future for a separate register for nurses of lesser training, even though the Select Committee of 1905 recommended the creation of a separate register for nurses whose training did not entitle them to be Registered Nurses.

The first General Nursing Council was established in 1920. The composition of the Council was as follows:

2 members to represent the public, nominated by the Privy Council,
2 members nominated by the Board of Education,
5 medical men,
9 members from the College of Nursing,
4 members from the Royal British Nurses' Association,
3 members from the Poor Law Infirmaries and Hospital Matrons.

There were 16 nurses appointed to the General Nursing Council and indicative of the College's strength was that it had the majority. Mrs. Fenwick was appointed to the Council and elected to the position of Chairman of the registration sub-committee. One year's bona fide

¹ Nurses Act: ibid.
practice was specified as a necessary condition of admission for all applicants. Mrs. Fenwick examined each application with such meticulous care that after 4 months only 984 out of the 3,235 applicants were placed on the register.

There was a great deal of personal friction; Mrs. Fenwick resented the fact that the College of Nursing held the majority of the nursing members on the Council, and many members thought that she was deliberately sabotaging the registration procedure by the inordinate length of time her sub-committee was taking to examine the applications. As a result sixteen members resigned, leaving the minority of six unable to form a quorum. The Minister of Health intervened. Under the terms of the Act it was necessary for the existing Council to end in November 1922, at which time a new Council would be elected by nurses who were on the Register. It would have been an intolerable situation for the Council to be elected by such a small proportion of the profession. If the present situation continued "many of the nurses would be dead and buried before they got on the register". 1

The Minister was able to persuade those members of the Council who had resigned to withdraw their resignations. They returned, and the composition of the Registration Sub-Committee was changed. In the future only doubtful cases for admission would be examined by the sub-committee, ordinarily nurses would be admitted on the production of certified copies of their certificates.

Mrs. Fenwick lost her seat in the election to the G.N.C., and although a question was asked on her behalf in the House of Commons, the decision was not reversed.

Nurses were now being registered in substantial numbers. For existing nurses the closing date for registration was July 14th, 1923. However,

1. Sir Alfred Mond, Minister of Health, H of C. Deb. 22 March 1922, col.626.
at this stage, late in the day as it was, there developed some discussion within the profession as to a definition of an existing nurse. The General Nursing Council had specified that one year's training in a hospital approved by the Council was the necessary qualification for admission to the Register. The College objected on the grounds that it was unfair to admit one candidate with a year's training, in perhaps a small hospital and two years practical experience, whilst denying registration to a nurse with perhaps a shorter period of training, but far more practical experience. After a great deal of acrimony, the Minister intervened and Parliament over-ruled the G.N.C. and ruled that nurses could be admitted to the Register who could present:

(a) a certificate of good character,

(b) a certificate signed by a matron of a general hospital or infirmary, or by two medical men setting out that the applicant has been in attendance upon the sick in the capacity of a nurse for a period of not less than three years prior to November 1st 1919; and

(c) a certificate signed by a registered nurse and two medical men, one of whom shall be on the staff of a general hospital, setting out that the applicant has adequate knowledge and experience of medical and surgical nursing and is competent to attend upon the sick in the capacity of a nurse.

Provided that the Council may require the applicant as a condition precedent to registration to present herself for special enquiry before a medical officer.¹

This amendment was only applicable to female nurses, it did not apply to men, nor indeed to applicants to the supplementary parts of the register. Initially the G.N.C. syllabus of training was advisory only, but in March 1925 the G.N.C. would not recognise the Royal Medico Psychological

Association (this became the Royal College of Psychiatrists in 1971) as the examining body of mental nurses. To replace this examining body the G.N.C. instigated the Mental Nurses' Training Committee. After the 1949 Nurses' Act the G.N.C. established the Role for State Enrolled Nurses.

"The Council continued to be partly appointed by the Minister and partly elected by registered nurses, but after the Act of 1949 registration ceased to be yearly and those entitled to registration paid one fee for life".¹ This in fact resulted in the lists being overloaded with non-practising nurses. The cost of elections therefore became commensurately more expensive. In 1964 it was suggested that membership to the Council should be by appointment only. This proposal "did not find favour with the profession, who, even if they were dilatory at filling in voting papers, were determined to preserve the right to do so. Democracy is still seen to be done, but it does nothing to solve the problem of a live register. The Council operates on a limited budget and is restricted both by finance and the fact that it is a statutory body answerable to Parliament and must work with a system where those for whom it is designing training are primarily a labour force in training hospitals".²

Further Development of the College of Nursing.

The aim of the College, as already indicated, was to secure registration for nurses, and to this end it was envisaged that it would become the registration authority. When subsequently it failed to become this, the College was free to develop along its own lines as an independent professional association.

Initially its entry requirements for admission were higher than those required by the General Nursing Council, but after the Registration Act it decided to admit those nurses that were registered on the general part

of the G.N.C's registers; men were not admitted until 1960. The
decision to restrict admission to nurses registered on the general part
of the register was consistent with the College's general principle 'to
promote the better education of nurses', for it anticipated that the
supplementary registers were only temporary expedients and would
disappear eventually when all nurses would have to take a comprehensive
basic training. The College with a membership of 20,000 and a new
headquarters at No.7 Henrietta Street (later to be renamed Henrietta
Place), began its work on research into the salaries and conditions of
service of nurses.
The College published, within the first two years of its formation, what
has become known as the Nurses' Charter. This was a report and recom­
mandations of a committee appointed by the College in 1918 to investigate
the salaries and conditions throughout the nursing service. Its recom­
mandations were based on responses to a detailed questionnaire sent out
by the committee. "The Nurses Charter; calling for a 48 hour week,
improved and co-ordinated training, better salaries, accommodation and
a pension scheme" was published in 1919, and circulated to the various
nurse employing agencies. Thus starting what was to become a significant
area of its work in the ensuing years.
The letter sent by the Hon. Arthur Stanley to the Nurses' Training
Schools in 1916 made the following point:
"Just as the Royal College of Physicians and Surgeons through the
Conjoint Board organised the teaching and examination of medical students,
as the chartered institutes of accountants, of surveyors, engineers and
other bodies, as barristers and solicitors organise the teaching and
examination of candidates for entrance to their respective professions,
so do I feel most strongly that now is the right time for some such
movement in the nursing profession". 2.

This was clearly an offer of some degree of participation to members in their own internal affairs, and as such gave the College its major attraction.

Under Article V of its Charter the members of the College elected its Council, and to increase participation branches were set up throughout the country. These provided a forum for the discussion of matters relating to the profession and those of specialist interest. In 1921 the Council set up a Public Health Section which marked the emergence of a new branch of nursing, placing a strong emphasis on preventive methods. A Sister Tutor Section was established towards the end of 1922, and one of its first tasks was the consideration of appropriate syllabuses for the Sister Tutors' Course. In 1930 the College established its own Department of Education. In 1928 the College was incorporated by Royal Charter, and in 1939 was given the title "Royal".

The College played an active role in the field of salaries and conditions of service, and when joint negotiations were established, firstly under the Rushcliffe Committee and later with the Whitley Council, the R.C.N. because of the size of its membership, held the majority of seats on the staff side.

The College's Charter was changed in 1958, to permit it to accept as members, nurses who were registered on parts other than the 'general' part of the G.N.C. register. In 1963 there was an amalgamation between the R.C.N. and the National Council of Nurses with the result that the College became the United Kingdom's official representative on the International Council of Nurses.

The R.C.N. established the Nursing Reconstruction Committee under the Chairmanship of Lord Horder, which reported in favour of making the assistant nurse an integral part of the nursing service. As a consequence

1. Now The Institute of Advanced Nursing Studies.
of its pioneering work in this area, the College established strong
and friendly relations with the National Association of State Enrolled
Nurses. In 1969 the College's Charter was further amended to allow
enrolled nurses to become full members. Also at this time the Student
Nurses' Association, which had been formed in 1925, disbanded to become
the Students' Section of the R.C.N.

In 1964, the R.C.N. had a membership of 64,000, this had risen to 83,000
in 1971 and further to 100,000 by 1975. It is not apparent whether this
increase is the result of an isolated incident, or as a result of an
intensified membership drive, or campaigns to raise salaries. Also
the figures have to be interpreted with caution because it is not
possible to determine how many members have dual membership in trade
unions and other professional associations.

In 1967 the internal structure of the R.C.N. was changed by the estab­
ishment of a Representative Body. This body includes representatives
from the following R.C.N. sections:

Community Health Committee,
Enrolled Nurses Committee,
Nurse Administrators Committee,
Occupational Health Committee,
Private Nurse Committee,
Psychiatric Committee,
Student Committee,
Ward and Departmental Committee,

Together with representatives of all the R.C.N. branches.

The Representative Body is not an absolute policy formulating body, it
can make recommendations to the Council, but the latter is not bound to
implement such recommendations.

Abel-Smith argues that the main threat to the College did not come from
other professional associations, but from the trades unions. This
aspect will be dealt with in more detail in Chapter 7. An increasing
number of nurses belong to trades unions and as these are represented on the staff side of the Whitley Council, they must, to a certain extent, represent an implicit threat to the College's position as main spokesman for the profession.

Shortage of Nurses.

There was an acute shortage of nurses following registration, and this shortage continued almost unabated to the present day.

In order to enquire into the reasons for the shortage of nurses the proprietors of the Lancet established on the 30th December 1930 a Commission under the Chairmanship of the Earl of Drawford and Balcares. This subsequently became known as the Lancet Commission and it reported in January 1932.

The Commission sent out questionnaires to all types of hospitals and the evidence collected was based on 686 replies. It revealed that 90% of the hospitals had full establishments, but this was often attained only by the utilisation of untrained staff and auxiliaries. The average wastage was 25% which in fact, compared quite favourably with the earlier Nightingale School. Of the voluntary hospitals 61% were able to insist that their candidates for admission to training had received secondary education, whereas in the case of the Municipal Hospitals only 6% could make a similar insistence. The Commission found that in most hospitals nurses worked in excess of 55 hours a week, and in some cases probationers were spending as much as 7\(\frac{3}{4}\) hours a day on domestic work, for which they received £20 - £30 per year. Moreover, the Commission concluded that of the girls leaving secondary schools, nursing was receiving a smaller proportion than other occupations, "the nurses' conditions of training and service have fallen into relative disfavour, not only with young people in search of a career, but also with their advisers, and with women in other professions".

1. Secondary Education during the period meant selected education.
The Lancet Commission made several recommendations. There should be scholarships available for girls of 16 years of age, with the possible extension to girls of 14 years of age, to attend pre-nursing courses in preparation for the first part of a divided State Preliminary Examination. It also proposed that ward sisters be relieved of some of their duties in order to be engaged in instructing probationers, for which they should receive extra payment. On the question of salaries, the Lancet Commission recommended the adoption of the scales recommended by the College of Nurses, namely, a staff nurse £50 - £70 per annum; a ward sister in a training school £100 - £160, other salaries to be in line with those recommended by the College. The Commission was not in favour of the legal enactment of hours of duty, but it clearly indicated that the possibility of an 8 hour day should be examined.

The Commission made other suggestions for example, it recommended a separate bedroom for each nurse; telephone facilities; improved catering arrangements, nurses' homes to run on informal lines; not less than 3 weeks annual leave; nurses to know in advance their off-duty periods; and to be relieved of domestic duties not directly connected with patient care.

In November 1937 the Government set up an Inter-Departmental Committee on Nursing Services under the Chairmanship of the Rt. Hon. The Earl of Athlone, subsequently known as the Athlone Committee. Its terms of reference were broadly to enquire into the training, recruitment and conditions of service of nurses and to make recommendations for the maintenance of "an adequate service both for institutional and domiciliary nursing".

The Committee sent out detailed questionnaires, from which it received 2,200 replies, and it was from these that the main findings of the

1. The G.N.C. would not permit this. The rules were changed in 1953 see the Nurses' (Amendment No.2) Rules Approval Instruments 1953.
Committee were based, supplemented by evidence given by various institutions and organisations. Compared with the evidence of the Lancing Committee there appeared to be a 13% increase in the total nursing staff, however, this was mainly attributed to the increase of untrained staff; the number of assistant nurses had apparently doubled. In the voluntary hospitals over 70% of the probationers had received a secondary education compared with 29% in the municipal hospitals and 8% in the mental hospitals. Probationers worked 55 hours a week on day duty and 60 hours on night duty. Their average payment was £25 a year in voluntary hospitals and slightly more in municipal hospitals. The salary of staff nurses was £66 - £80 per annum and 65% and 84% of the voluntary and municipal hospitals respectively operated a superannuation scheme. The Committee attributed the shortage of nurses to the expansion of hospitals; a high degree of wastage in early training; high marriage rate and increased competition from other occupations.

Because of the outbreak of war, the Athlone Committee did not issue a final report. It did make an interim report in 1938 in which it made several recommendations including the establishment of a role of assistant nurses; improvements in salaries and conditions of service, the formation of a Nurses Salaries Committee, similar to the Teachers Burnham Committee, and the suggestion that nurses should work a 96 hour fortnight, and have an annual leave entitlement of 4 weeks. It also suggested that grants should be made available to voluntary hospitals in order to help them meet the costs of increased salaries. The Committee further recommended "the establishment of a system of grants from national funds to recognised training hospitals in respect of national work done by training of nurses".1

The recommendations of the Athlone Committee had a number of far-reaching implications for the Government. If the Government were to grant any form of aid to the nursing departments of voluntary hospitals, this would imply a long term commitment on its part, and thereby change the established relationship between the voluntary hospitals and the Government. But the Government was under continuous pressure from the nursing organisations and the T.U.C., and it feared that if it did not do anything it would be vulnerable to criticism.

"The Ministry urged the local authorities to review their arrangements in the light of the Athlone Committee's report and to take such necessary action as was immediately possible without additional expenditure..... When the British Hospitals' Association was asked to address a similar circular to the voluntary hospitals, it needed strong persuasion. Some of the suggestions were considered to be 'not very palatable', and it was feared that the hospitals might take offence".¹

In the event, the Government decided against offering grants to the training hospitals on the grounds that it was "neither sound nor proper for the Government to make itself responsible for the payment of salaries to members of a particular profession. A war was needed to change the Ministry's mind".²

1939-45 War.

The acute shortage of nurses still existed at the outbreak of the war. Prospective recruits were deterred by both poor pay and conditions, and improvements could only be made if the Exchequer gave direct assistance to the voluntary hospitals. But such unprecedented action would not really solve the problem, since if there was a marked increase of secondary school girls recruited to nursing, this would be at the expense of other occupations who recruited from the same field. "No one was prepared to suggest that the standards demanded by the General Nursing Council for

1. Ferguson & Fitzgerald; 1954, p.293.
2. Ferguson & Fitzgerald; op.cit., p.294.
admission to the General Register should be lowered. The only solution therefore, was to introduce a new grade of nurse. This would require legislation, which would be violently opposed by a vocal section of the nursing profession".  

Given the political climate of the period a peace-time government could, within reason, disclaim responsibility for the shortage of nurses being experienced by the voluntary and municipal hospitals. However, in the advent of a war it became its natural responsibility to provide an adequate nursing service for the military and civilian wounded.

In 1939 it had been calculated by the Ministry that in the event of a war the armed forces would require 5,000 trained nurses and between 34,000 – 67,000 would be required to man the first aid posts and emergency hospitals in order to cope with the anticipated air raid casualties.  

Clearly something had to be done. A Civil Nursing Reserve was formed composed of all grades of nurses. The Reserve recruited 7,000 trained nurses and 3,000 assistant nurses. In addition to this force a further 10,000 experienced untrained nurses were recruited. These were described as Nursing Auxiliaries.  

The nurses that were recruited into the forces were given officer's privileges and status, but private's pay.  

In the summer of 1940 it was further calculated that 100,000 nurses would be required "if all the emergency beds were to be staffed at adequate standards. In the event this estimate proved excessive".  

In actual fact there was no total shortage as "about 14,000 hospital beds had been emptied of patients", in order to provide for the anticipated air raid casualties. However, the Ministry of Health projections predicted that there would be a shortage, and it was this belief that determined

2. Titmus; 1950.
3. Abel-Smith: op.cit., p.162.
government policy. Thus giving the Government's beliefs at the time, it no longer seemed politic to ignore the pressing problems of the nursing profession. The Times in a leader column in January 1941 called for an increase both in pay and status of the profession.¹.

The Athlone Committee’s report was re-examined by the Ministry of Health and it was decided to implement its major recommendations, both in respect of salaries, and the recognition of the assistant nurse.

On the question of salaries the Ministry of Health guaranteed a payment of £40 a year for a first year student, with yearly increments of £15. This compared with a pre-war salary of £21 in voluntary hospitals and £33 in municipal hospitals. It is interesting to note that the Royal College of Nursing opposed this figure as being too high......"...and did not take into account the cost of expensive training".². Thirty pounds a year was considered sufficient by the Royal College of Nurses.

When allowance had been made for the rise in the cost of living, these salary scales represented slightly more than those received by trained nurses in the voluntary hospitals before the war, but represented no real increase when compared to average pre-war salaries received by nurses in the municipal hospitals.³.

The Royal College of Nurses "recommended a salary scale of £100 - £150 for trained staff and £150 - £200 for ward sisters".⁴.

In 1941 the Ministry of Health established a salaries committee for England and Wales under the chairmanship of Lord Rushcliffe, a similar committee was constituted for Scotland under the chairmanship of Professor Taylor. The employers side had 20 representatives on the

1. Abel-Smith: op.cit., p.165.
2. Ferguson & Fitzgerald: op.cit., p.34.
Rushcliffe Committee; six from the voluntary hospitals, one from the Queen's Institute of District Nursing and thirteen from the local authorities. The staff side consisted of 20 representatives; nine from the Royal College of Nursing; one from the Association of Hospital Matrons; one from the British College of Nurses; one from the Royal British Nurses' Association; three from the National Association of Local Government Officers and five from the Trades Union Congress. The professional associations were, therefore, in the majority; a situation which has continued to the present day.

For the period 1941 to 1944 there was an increase in the nursing force from 89,000 to 98,000, however, there was only an increase of about 2,000 auxiliary nurses, and the number of trained nurses actually fell by 1,500; the increase was mainly made up by an increase of about 9,000 more students. The shortage was not evenly spread. There was no shortage for the armed forces, but there were acute shortages in the maternity and tuberculosis hospitals. Also the mental hospitals were especially short of staff. These hospitals had always recruited a large number of male nurses, and of course, they were adversely affected by the conscription of men to the armed forces.

By 1946 the total number of nurses had declined from its 1944 peak of 98,000 to 80,000.1 Furthermore, the expansion of the hospital service envisaged by the creation of a National Health Service would create an unprecedented demand for nurses. To review the situation the Ministry established in January 1946 a Working Party under the chairmanship of Sir Robert Wood to enquire into such questions as: "what is a proper task of a nurse? What training is required to equip her for that task? What annual intake is needed, and how can it be obtained? From what groups of the population should it be made? How can wastage during training be minimised?"2

1. See Ferguson & Fitzgerald: op.cit., p.335.
2. Wood Committee Report; p.iii.
The working party was small, consisting of only four members in addition to the chairman; a doctor, a psychologist and two nurses. There was no consultation with the nursing organisations regarding its composition.¹

"A majority report was published in the next year, and a minority report in 1948 by Dr. John Cohen (the psychologist). Although Dr. Cohen did not sign the majority report, his way of thinking strongly influenced it. In the short time it sat, the Committee assembled a range of new empirical evidence which would have done credit to many a leisurely Royal Commission. It did not take formal evidence in the usual way. Instead it concentrated on field work undertaken by trained investigators. It attempted 'to carry out a scientific study of the problems confronting the nursing profession'.²

Above all, the Wood Committee wished to increase the number of trained nurses. Its method for achieving this was (a) by attracting more students and (b) by a reduction of the wastage rate during training.

Among the reasons given for the existing wastage were, too rigid hospital discipline, the span and pressure of working hours, poor food, accommodation and recreational facilities, the high amount of domestic work that students had to perform and the attitudes of senior staff towards students. The report was in fact, an outspoken criticism of senior nursing staff in hospitals. It is not surprising therefore, that its nursing members were out of favour with their colleagues in the Hospital Matrons' Association.³

"Nurses", wrote the Committee "in training must no longer be regarded as junior employees subject to an outworn system of discipline. They must be accorded full student status so far as the intrinsic requirements of

3. Later to become the Association of Nurse Administrators.
nurse training permit". The Committee undertook a job analysis of a small group of student nurses and found that first year student nurses spent 33% of their time in performing domestic duties that "could be properly performed without any nurse training at all".¹ For second year students it was found that they spent 24% of their training time in a like manner and for third year students 16% of their training time was spent in the performance of domestic duties. It was felt that if domestic duties were eliminated from the student nurse's programme, the general training period could be commensurately reduced from 3 to 2 years.

The Committee, therefore, made a strong recommendation for nurses in training to be regarded as students. The training course should be determined by the needs of the students, not by the staffing needs of the hospital. The financing of nurse training should be under an authority independent of the hospital, and students should be under the control of a training authority, not under the hospital. There should be one common register for all nurses. Moreover, the Committee was of the opinion that the unit of training was too small. There were in England and Wales 389 complete, 167 affiliated and 5 associated general schools. "It is unlikely" the Committee wrote, "that so large a number of training schools could all have adequate clinical material, proper training facilities and equipment, well-trained sister tutors, or students in the numbers needed to run a training unit efficiently".² Thus the Committee recommended the establishment of composite units under the direction of a Regional Nurse Training Board. The Committee was against the principle of perpetuating the grade of assistant nurse. In its view, duties performed by assistant nurses should be reallocated, partly to trained nurses and partly to a new grade of nursing orderly. Moreover, the Committee argued that by distinguishing and differentiating students'

requirements from those of the hospital, would diminish the wastage rate between 33% and 50%. However, it estimated that 20,000 additional staff (nursing orderlies) would be required in order to facilitate this arrangement, but it concluded that this need could be met by the reduction in wastage, the removal of the restriction on married staff and the development of a part-time nursing staff. It also argued for an extension in the use of male nurses.

In 1948 the General Nursing Council made known its views on the Wood Committee's recommendations. By and large it was generally against the main recommendations, being opposed to any reduction in the training period, the separation of training organisation from hospitals, and the notion that anyone other than itself should have responsibility over the control of training schools and their inspection. The National Health Service was established on July 5th 1948 and most of the hospitals in England and Wales became the responsibility of the State. The planning of the hospital services became the responsibility of fourteen Regional Hospital Boards. These new boards were responsible for all hospitals with the exception of the teaching hospitals, who had their own governors.

A general Whitley Council was established to negotiate the conditions of service of all grades within the National Health Service; in the case of the nurses and midwives the Rushcliffe Committee was replaced by the Nurses & Midwives Whitley Council for Great Britain.

The professional organisations were determined, at all costs, to hold the majority of seats, and in this they succeeded. They secured over half of the 41 seats. The Royal British Nurses' Association was not represented, neither was the British College of Nurses. Seats previously held by the Trades Union Congress were distributed among specific trades unions. The National Union of Public Employees were given 4 seats; the National Union of General & Municipal Workers secured 3 seats, and the
Confederation of Health Service Employees (formed in 1946) was given 4 seats.

In absolute terms, as indicated by the following table, the nursing force increased during the 50's, 60's and early 70's.

**Table 1.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Qualified</th>
<th>Unqualified</th>
<th>Ratio of Unqualified to Qualified Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>61,664</td>
<td>71,090</td>
<td>.87 : 1</td>
</tr>
<tr>
<td>1961</td>
<td>70,961</td>
<td>86,596</td>
<td>.82 : 1</td>
</tr>
<tr>
<td>1966</td>
<td>115,509</td>
<td>128,199</td>
<td>.90 : 1</td>
</tr>
<tr>
<td>1968</td>
<td>124,623</td>
<td>131,018</td>
<td>.95 : 1</td>
</tr>
<tr>
<td>1970</td>
<td>134,101</td>
<td>139,627</td>
<td>.96 : 1</td>
</tr>
<tr>
<td>1971</td>
<td>138,827</td>
<td>149,238</td>
<td>.93 : 1</td>
</tr>
</tbody>
</table>

These figures demonstrate however, the extent to which the nursing service is being provided by untrained staff. It should also be remembered that a percentage of qualified personnel are engaged in administration and teaching and not directly involved in the clinical situation. It is in this latter situation that the ratio of qualified staff to unqualified staff becomes more meaningful. For example, if one takes the figures produced by the Committee on Nursing\(^2\) as set out in Table 33 of its report, it is possible to identify the proportion of nurses engaged in direct patient care as at the 30th September 1971. In terms of percentages this stands at 95.19% overall (this covers all types of hospitals in the United Kingdom) and in respect of the acute hospitals in England the percentage is 95.9%. Thus the qualified nursing personnel involved in direct patient care are reduced respectively by 4.81% and 4.1%.

1. These figures are derived from 'Health & Personal Social Services Statistics for England.
On this basis, taking the overall figure, the 1968 figure (England and Wales) for qualified nursing personnel directly involved with patients, is reduced by 11,813. So the figures become 112,810 qualified staff and 131,018 unqualified staff, giving a ratio of qualified to unqualified staff of .86 : 1. By using the same approach the ratios for 1970 and 1971 became .94 : 1 and .89 : 1 respectively.

The Royal College of Nursing in its submission to the Secretary of State for Social Services: 'The State of Nursing 1974', argued that the demand for nursing was increasing, and would continue to do so because of a number of distinct factors. The advance of medical science and technology have resulted in the earlier diagnosis of diseases and disorders. This has increased the pressure on hospital beds, at a time when it has been National Health Service policy to reduce the number of beds. Speedy mobilisation in patients has led to a decrease in the average length of stay in a hospital of a patient, which "has resulted in more patients being 'processed through' fewer beds. As a result a higher percentage of patients in hospitals at any one time and more seriously ill, and therefore, more heavily dependent on the nursing service". The Royal College of Nursing produced appropriate statistics to substantiate its contentions.

A further factor which has contributed to the higher demand for nurses has been the reduction of the working week of nurses to 40 hours.

The policy of early discharge from all types of hospitals has inevitably thrown an increased burden on the community services, with the result that the community nursing service has been expanding for a number of years.

Similarly for the geriatric services. In 1965 the number of persons in Britain aged over 65 was 3,983,000, in 1972 the corresponding number was

4,417,000, an increase of nearly 11%, and the trends suggest that this is likely to increase still further. The R.C.N. argued that the National Health Service is already ill-equipped, both in terms of manpower and resources, to deal with this situation. And the submission goes on to give further examples of acute shortages in the Psychiatric field.

In summary then, although in absolute terms, the number of trained nurses has increased over the past decade, the service is still dependent on unqualified staff. Furthermore, the expansion of the National Health Service, and the changing demographic distribution of the elderly in the population, has increased the demand for nurses to such an extent that it outweighs the increase in the supply of qualified personnel, so there remains a very real nursing shortage.

The Development of Nursing Education.

At the outset of this sketch it was suggested that it was possible to extrapolate four factors which have exercised considerable influence on the development of the nursing profession viz. religion, war, self-determination and education.

In the foregoing each of these have, to some extent, been touched upon. It was shown how the religious orders, and those motivated by religious zeal, contributed to the development of nursing. The association of nursing with the military has also been traced. Similarly the struggle, as manifested in the movement for registration and the formation of professional associations has also been touched upon.

The development of nurse training has also been dealt with in some detail. If one were not to distinguish too categorically between education and training, then it would be possible for the purpose of nursing, to classify training as education, and conclude accordingly that this fourth factor had also been adequately traced. However, to the extent that higher education has some bearing on the function of professionalism, a topic that will later be discussed, it may be profitable
to trace this development, as it relates to nursing, in more detail. But before doing so, it might be useful to briefly trace the development of post-registration certificates and diplomas.

Post-Registration Certificates and Diplomas.

Ever since 1847 district nurses had undergone some form of training with the Queen's Institute. The position for health visitors was, however, somewhat anomalous, for although they had also received training since 1890, nurse training was not a pre-requisite for health visiting. In an attempt to remedy this anomaly the College of Nursing approached the Ministry of Health in 1925 with a view to initiating a change in the requirements, and following from this, regulations were issued defining the necessary previous training and experience necessary for health visiting. In 1928 the Royal Sanitary Institute (now the Royal Society of Health) was approved as the examining body for the Health Visitors Certificate, and after this time the certificate became an obligatory qualification for all those engaged in this area of community work.

The Department of Education of the College of Nursing, which in turn became the Division of Nursing Education, and the Institute of Advanced Nursing Studies, has throughout the past 50 or so years, organised many post certificate courses. It now offers ten full-time certificated courses:

Nursing Administration (Hospital)
Sister Tutor's Diploma - Year 1.
Sister Tutor's Diploma - Year 2.
Clinical Teaching.
Community Health Nurse Teachers.
Health Visitors,

1. The Council for the Training of Health Visitors has now replaced the Royal Society of Health as the examining body for Health Visitors.
University Diplomas

In 1918 the College of Nursing, in association with the Kings College of Household Sciences (now Queen Elizabeth College, University of London), established a course which led to the qualification of Sister Tutor. In 1921 a Diploma in Nursing course was established in the University of Leeds and in 1924 it was suggested to the Extra Mural Department of the University of Leeds that an appropriate course should be arranged for suitable candidates wishing to equip themselves for further responsibility. This was agreed and the Diploma in Nursing was established. The examination was taken in two parts: Part A covered the general sciences, the history of nursing and ethics; Part B dealt with a special aspect of nursing offered by the candidate. For those engaged in the teaching of nurses, or for those wishing to specialise in this area, this aspect of the work could be included as an optional extra. In response, to meet the needs of changing conditions, the syllabus was amended on a number of occasions. In 1945 the Royal College of Nursing, in consultation with the University of London, decided that a Diploma in Teaching should be a necessary condition for the registration of tutors. This necessitated a reassessment of the Diploma in Nursing. It had, for some time, been recognised that there were basically three career paths in nursing, namely clinical, teaching and administration. The University was now offering a Diploma in Teaching, so it seemed that the Diploma in Nursing would serve those who were intent upon a clinical career. Logically therefore, it would seem that a Diploma in Nursing Administration was
needed in order to complete the trio. Certainly after the reorganisation of the diploma course a Diploma in Nursing was contemplated. However, before such a course could be introduced "the Committee on Senior Nursing Structure reported, which after receiving evidence from the University, felt unable to support this type of further study; the matter, therefore, remained in abeyance and the trilogy incomplete. The prestige of nursing administration suffers accordingly".\(^1\)

**Higher Education for Nurses.**

Thus, although over the past fifty years a number of post-registration courses have evolved, the situation in the United Kingdom has not, until recently, been characterised by the provision of full-time degree level nursing education in Universities. The Robbins Committee on Higher Education, published as recently as 1964, indicated that nursing as a subject was not worthy of academic consideration. For example, in the first sentences of Chapter 1 it dismissed the question of nursing as follows:

"We received evidence about training for nursing and some occupations associated with medicine. Since this does not form part of higher education as we have defined it, we have not specifically considered this wide opportunity for girls. But we are aware that at certain points, contact with universities and colleges are now being established".

For the situation appears, as Margaret Scott Wright\(^1\) says, "in this country there has been little interchange of ideas or official interaction between the nursing profession and the universities".\(^2\).

The British universities, outside the area of extra mural studies, have shown a remarkable reluctance to consider the possibility of nursing being a suitable discipline for university study. This situation can be contrasted with that which obtains in North America, where even at the beginning of this century there existed a considerable body of professional

\(^{1a}\) Galy; op.cit

1. Formerly Professor of Nursing Studies in the University of Edinburgh.
and academic opinion in favour of the provision of nursing undergraduate education.

The contemporary situation within the United States is indicated by the following table:

**Table 2.**

**NURSING PROGRAMMES IN THE UNITED STATES**

<table>
<thead>
<tr>
<th>LOCALE</th>
<th>No. of PROGRAMMES</th>
<th>Approx. No. of STUDENTS GRADUATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRACTICAL NURSING</td>
<td>Vocational Schools</td>
<td>1350</td>
</tr>
<tr>
<td></td>
<td>Community Colleges</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospitals</td>
<td>37,000</td>
</tr>
<tr>
<td>DIPLOMA</td>
<td>Hospital</td>
<td>641</td>
</tr>
<tr>
<td>ASSOCIATE DEGREE</td>
<td>Community Colleges</td>
<td>23,000</td>
</tr>
<tr>
<td>BACHELORS DEGREES</td>
<td>Colleges and</td>
<td>450</td>
</tr>
<tr>
<td></td>
<td>Universities</td>
<td>27,000</td>
</tr>
<tr>
<td>MASTERS DEGREES</td>
<td>Universities</td>
<td>270</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20,000</td>
</tr>
<tr>
<td>* DOCTORAL DEGREES IN</td>
<td>Universities</td>
<td>73</td>
</tr>
<tr>
<td>NURSING</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

* A number of nurses study in related doctoral programmes.

From the table it may be seen that the number of graduate nurses (not counting those with associate degrees) is just over 20%, a percentage also mentioned by Scott Wright. And clearly a number of American nurses continue to read for higher degrees.

The encouragement of nurses to engage in research has also been a feature of the American experience. As early as 1929 Miss Isabel Steward,

Director of the Department of Nursing in the Teachers College, Columbia University wrote:

"If nursing is ever to justify its name as an applied science, if it is ever to free itself from these old superficial, haphazard methods, some way must be found to submit all our practices as rapidly as possible to the most searching tests which modern science can devise. Not only bacteriological, physiological and chemical are needed, but economic, psychological and sociological measurement also, if they are appropriate and workable. There is not much use waiting for someone outside our own body to recognise our critical situation and to offer to do the work for us".¹

To some extent the development of higher nursing education had some bearing on its development in this country. "One nurse in particular, who herself was a graduate, was among the earliest members of the profession in this country to see the need for nurses to study in institutions of higher education, especially universities. In her book "New Deal for Nurses" published in 1939, strong arguments are made in this respect, and as a visiting professor in various North American universities, she made contact, among others, with the Rockefeller Foundation, who donated £100,000 in 1956 for the establishment of a Nursing Studies Unit in the University of Edinburgh".²

However, as Scott Wright argues, there existed a background of 'lethargy and disinterestedness' on the part of the universities and the profession.³

In 1953 the Department of Public Health and Social Medicine in the University of Edinburgh and the Scottish Board of the Royal College of Nurses agreed to accept the responsibility for administering the Boots Research Fellowship. This fellowship was offered for a period of 7 years

2. Scott Wright: op.cit.
3. Scott Wright: op. cit.
and Miss Gladys B. Carter was its first holder. This position enabled her to work for the creation of a Nursing Studies Unit within the University.

The present situation is such that there are basically two types of degree course for nurses, (a) a degree in other subjects, as for example sociology, economics or life sciences, and these are combined with a nursing qualification, and (b) a course leading to the award of a Bachelor of Nursing degree. In the case of the former, in some courses nursing studies form part of the final degree examination, whereas in others, the nursing subjects are not examined by the university. There are also 'end-on' nursing courses for graduates.

The first ever degrees conferred in Nursing were by the University of Edinburgh in 1965; Bachelor of Nursing degrees were awarded in the University of Manchester in 1969. Nine other courses in England and Wales, leading to a degree and nursing qualification have been approved by the General Nursing Council. Among those universities providing undergraduate education of nurses are Edinburgh, Manchester, Southampton, Surrey and Liverpool. The Council for National Academic Awards has approved three courses in Nursing subjects.

At the research level there have also been some recent developments, "some beginning studies of various aspects of education and practice have been carried out in certain universities in Scotland, England and Wales under the aegis of the Royal College of Nursing", and by sponsorship of voluntary organisations, e.g. the World Health Organisation, Nuffield Provincial Hospital Trust and the British Commonwealth Nurses' Association. However, the main sponsor has been the Government, through awards made by the Department of Health & Social Security, but Government research grants

3. Scott Wright: op.cit.
in this connection are minimal, especially when compared to the Government's sponsorship of medical research.

What is the present situation vis a vis the number of nurse graduates and their contribution to the profession? There is some data available concerning the number of students taking courses and the career patterns of graduates. However, because the integration of nursing studies in university courses is such a recent phenomenon, the number of students engaged in such courses is inevitably small. For similar reasons it is difficult to arrive at any judgement regarding the graduates' contribution to the nursing profession.

Up to the end of 1971 the study undertaken by Bendell and Pembery revealed that there were about 300 graduates in the nursing profession, although conceivably some graduate nurses were not classified in this study.

So given that the total qualified nursing force, including registered and enrolled nurses, of Great Britain is 260,000 and taking Bendell and Pembery's figure, then the percentage of graduate nurses is 0.1.

Undoubtedly the number of graduates in the United Kingdom is greater now, but not significantly enough to make a great deal of difference - graduate nurses are still a minute percentage of the total qualified nursing force.

Of the future, "about 100 undergraduate students of nursing are now starting courses in, or associated with, British Universities each year, and so it can be anticipated that graduates in the profession will increase slightly in the future".3

There is a certain amount of information available about this group. The work of MacGuire has yielded results concerning the number of graduates in nursing by comparing their career paths with the type of degree taken. It is possible to identify three types of graduates;

2. Scott Wright: op.cit.
3. Scott Wright: op.cit.
those who took nursing training after the acquisition of a degree, nurses who read for a degree subsequent to registration, and now those taking integrated degree courses. Of course, the nursing profession has for many years had a few members belonging to the first category. MacGuire's findings on the first two categories suggest that nurses who enter nursing after the acquisition of a degree are more likely to remain in the service than those who take degrees subsequent to registration. The study revealed that over 75% of the first group are engaged in some area of the nursing service, whereas those of the second group were more likely to leave the service. There is only a little data available on those nurses taking integrated courses. Of this group some data is beginning to emerge; for example Scott Wright, writing in 1973, says that "out of 43 graduates who have completed the integrated degree programme, it is known that 17 are currently employed as sisters or staff nurses, 6 have completed - or are completing - the health visitors course, and are in community nursing, four have been - or are currently - working in nursing research, and one has become an assistant matron abroad". 1

The Committee of Nursing, who reported in 1972, recognised specifically for the first time, the desirability of having some nursing graduates, and recommended that 2 to 5% of the nursing force should be graduates. This recommendation, if implemented, will have considerable implications for the profession, because as Scott Wright says "in a few years time out of approximately 85,000 student nurses preparing for certificates and registration in Britain, up to 4,000 of them should be taking university-based courses either in preparation for registration or afterwards". 2

Thus, if compared with other similar groups; e.g. teachers, social workers, etc., the number of graduate nurses is still extremely small. This is also true if compared to the number of nurse graduates in the

2. Scott Wright: op.cit.
United States, viz. 0.1% as compared to 20%.

However, the recent development of university-based integrated courses for the period 1956 to 1974, and the development of 'end-on' courses for graduates, for the same period, even if very slow, has made a positive contribution in this direction.
CHAPTER 2.

PROFESSIONALISATION.

Throughout the preceding section the term 'nursing profession' was used quite arbitrarily without any attempt of definition. What would now seem necessary is an examination of the concept of profession together with an examination of the characteristics embodied in it. It may then be possible to see to what extent nursing fits into this classification.

Contemporary usage of 'profession' is by no means clear. The increased application of the term to institutions which lie outside of traditional connotation have tended to make the concept somewhat ambiguous and ill-defined. It is the intention in this chapter to try to clarify the concept by viewing it from an interdisciplinary approach.

The Forerunners of Profession.

In attempting to analyse the nature of this institution it may prove useful to briefly review some of the earlier forms of the idea. Whitehead argues that the earliest forms of professions were to be found in the Athenian academies established by the disciples of Plato, Aristotle and those established by the Stoics.\(^1\) A.M. Car-Saunders and P. Wilson, on the other hand, do not accept this view, asserting that there is no evidence to suggest that there were extant in the ancient world, any institutions corresponding to present-day professions. For them, the early Greek lawyer was not a professional advocate, but merely a friend of the litigant. The early Greek physician is seen as an apprentice of a non-professional practitioner. In the case of Rome the position of the lawyer was similar to that of Greece, and the Roman physician was usually a slave. Furthermore, these authors note, that although engineers, accountants and architects existed within Roman society they did not belong to distinct corporate bodies.\(^2\). On the other hand,

Parsons asserts that "... the closest parallel is the society of the Roman Empire where, notably the law was very highly developed indeed as a profession".  

However valid the argument for the pre-Christian origin of the professions, Cogan suggests that there is little doubt that the antecedents of present-day professions are to be found in 11th. century Europe. It was during this period that those occupations, destined to become professions first organised into associations. In England, for example, teachers and students formed exclusive societies from which the universities were eventually formed. The Church gained control of the early universities, and the practice developed whereby the students of universities took minor ecclesiastical orders.

Early in the 14th. century the Royal College of Physicians was established, and at about the same time the surgeons also organised themselves into a craft guild.

There occurred in most medieval institutions a gradual erosion of ecclesiastical authority, the dogma of the Church being gradually replaced by an appeal to rationality, as the final authority. This process was intensified, "when early in the fifteenth century, the specialists in common law split off from the Church. Within two-hundred years the English universities had become completely secularised".

Whitehead argues that the decline of feudalism and the emergence of an authoritarian state, militated against the growth of professionalism, on the general grounds that the formation of associations, of any type, detracted from the indivisible sovereignty of the government. However, it can be argued that the spirit of the Scientific Renaissance itself, contained the seed of association, insofar as there existed among scientists a desire to form association for the exchange of ideas:

3. Cogan: ibid.
"... the advance of scholarship and of natural science, transformed the professions. It intellectualised them far beyond their stage of earlier times. Professions first appear as customary activities largely modified by the strains of theory".¹ Moreover, he argues that the earliest emergence of this characteristic is to be found in the academies founded by the theorists Plato, Aristotle, etc.

Carr-Saunders and Wilson, although agreeing with the implicit view that association and intellectual techniques are the salient features of professionalism, do not, as mentioned previously, find sufficient evidence to suggest that the antecedents of this institution are to be found in the Greek polis. On the contrary, they see their origin in the emergence of the guilds, and the intellectual techniques associated with engineers; "and thus indirectly to the coming of science".²

The Problem of Definition.

A number of social scientists after conscientiously reviewing the relevant literature on the subject, have reluctantly come to the conclusion that it is virtually impossible to formulate any satisfactory definition of the concept. The notion is too static, and the material too amorphous to be systematised. Hughes, for example, suggested that questions directed to answering what is a profession are sterile, such questions should be directed to evaluating the degree of professionalisation exhibited in a given occupation. In short, Hughes is arguing that the notion of 'professionalisation' is a dynamic process, whereas that of 'profession' is essentially static.³ This line of argument follows, more-or-less, the approach proposed by Carr-Saunders and Wilson, which suggests that initially the complex elements characterising the typical profession should

be delineated; since according to these authors, "the typical profession exhibits a complex of characteristics, and that other vocations approach this condition more-or-less closely owing to the possession of some of these characteristics fully or partly developed". ¹ Cogan concludes that given the system specified by Carr-Saunders and Wilson, midwives, masseurs and patent agents are defined as near professionals.²

In a thesis dealing with some of the problems associated with licentia­ship, Francis P. De Lancy concludes that the problem eludes precise definition. Furthermore, she concludes, that attempts to create a model by the listing of characteristics inevitably becomes arbitrary. She states quite categorically, moreover, that "there is no absolute definition for a profession. The traditional characteristics often associated with the term are frequently ignored in twentieth century civilisation".³

Garceau argues that the contemporary notion of a profession is in such a state of flux that definitions tend to depend on individual interpre­tation. But in spite of this he concludes, "... there is one common factor. Definition is in eulogistic terminology, unless perchance the author is trying to discredit the idea altogether. It has apparently been impossible to express the thought in neutral words".⁴

Dictionary Definitions.

Meaningful discourse on any subject, can only take place when the nomenclature has been defined. "If you wish to converse with me define your terms", said Voltare. Various dictionaries have attempted to record the historical and contemporary meaning of 'profession', and often they have served as the final resort for a person seeking clarification. Moreover, their definitions have often provided the foundation upon

2. Ibid.
which individual writers have based their own definitions.

An early use of the term is given in the New English Dictionary, in which profession is associated with vows of consecration made by those entering a religious order. By 1362 its usage had been extended to include any solemn affirmation or vow. A touch of irony had crept into its usage by about the early 16th. century, in the sense that it was used to contrast truth or practice, e.g. 'purveyors of lies often make a profession of their veracity'.

As far as they apply to this section the definitions given are: "The occupation which one professes to be skilled in and to follow. A vocation in which a professed knowledge of learning or science is used in its application to the affairs of others or in the practice of an art founded upon it".

Cogan on the lexicographical approach to a definition suggests that the study of dictionary definitions reveals an important implicit criterion. Firstly he notes that "professions are described as dealing with practical affairs of men". He then goes on to say that the term profession is traditionally applied to the learned professions of divinity, law and medicine. And by combining these two aspects he concludes that "the traditional professions mediate man's relation to God, man's to man and state, and man's relation to his biological environment". The professional practitioner then, is involved in activities which are of the most fundamental concern to man, and Cogan suggests that this might explain why such power, status and privilege have accrued to the traditional professions. Cogan goes on to discuss various legal definitions of the term, but such definitions tend to be symbolic, deriving their interpretation from lexicographical sources, so they do not add greatly to the clarification of the concept.

1. Cogan: ibid.
2. Ibid.
3. Ibid.
4. Ibid.
The Problem of Semantic Confusion.

Additional problems are created by semantic confusion attendant to the term. It will be noted from the discussion in the preceding section that the term may be taken as being synonymous with occupation, and this is partly where the confusion arises. "It may refer to any occupation from the oldest profession of prostitution to physician, legitimate or illegitimate occupation". Sutherland describes the activities of the thief by reference to professional characteristics. The term is also used in an elitist sense, 'professional sportsman', 'professional scientist', 'professional soldier', etc. The distinction being implied of the superiority of the professional over the amateur who participates in the same activity. On the other hand, 'professional' is sometimes contrasted with 'amateur' by a curious inversion, which accords a higher status to the amateur.

Applied Definitions.

Census statisticians use the term for the classification of certain occupations which now contain over 5% of the population, as compared to 1% in 1901. Often when the term is used in this way, it appears to be a shorthand title for 'professional scientific or technical worker'.

In an extensive examination of the concept the Webbs proposed five classes of professional associations:

a) Learned Professions: law, medicine, teaching,

b) Technicians of Industry: engineers, architects, surveyors, chemists, etc,

c) Technicians of the office: accountants, clerks, etc.,

d) Manipulators of Men: managers, foremen, canvassers, etc.,

e) Professional Artists: painters, musicians, actors, writers, etc.

2. Sutherland: 1937.
Thus for the Wehhs professionalism would seem to depend on the corporate nature of their organisation. Following from this assumption they have tended to classify associations on a kind of descending scale of solidarity and length of their corporate history. At the top are the learned professions who have a relatively long history of corporate organisation, and at the bottom of the scale, professional artists whose corporate organisation is still only of a rudimentary nature. Implicit also in the scaling, is the length of formal specialised training and education.

The Practical Intellectual and Altruistic Aspects of Profession.

A large preponderance of the opinion surveyed for this chapter tends to confirm that the application of practical skill is inextricably interwoven with the idea of professionalism. Certainly the requirement of theoretical knowledge is specified, but the practical application of a core of theory appears to be implicit, together with the notion that theoretical knowledge should not be solely applied to research investigation. Also linked with the idea of the practical application is the notion of service. In this sense 'service' is taken to be a responsibility by the practitioner for his client or patient. Conceivably, however, duty to the client or patient may be in conflict with a duty to the wider society. E.A. Ross argues that duty to society should, if they conflict, over-ride a professional's duty to his client. He denounces the legal ethic which permits a lawyer to undertake the defense of a client who is known to be a threat to society. This, of course, is an extreme view, what, for example, does he mean by society? ... the state? Presumably Anti-Nazis in pre and war-time Germany constituted a threat to German society! Ross is also critical of the medical etiquette which, in his view could prove inimical to society, when for example, professional loyalty may prevent the exposure of an incompetent doctor. He seems to be arguing that society's prior claim on a professional's loyalty is based on a kind

1. 1923: p.477.
of principle of indebtedness. He reasons that society is owed this obligation because society has protected and recognised the professions.

In nearly every source consulted on the subject there is some explicit mention of the intellectual or scientific basis of profession. Louis D. Brandeis lists this first among the elements of a profession. And if one uses the sliding scale proposed by Carr-Saunders and Wilson, those professions which approximate to the ideal type model come very close to the apex of professionalism, perhaps by virtue of the intensive intellectual training they require.

It is Whitehead who goes unambiguously to the core of this subject. He succinctly cuts through the ambiguities surrounding the nature of the intellectual basis of a professional occupation, and his definition is worthy of closer examination. He states: "...the term profession means an avocation whose activities are subject to theoretical analysis, and modified by theoretical conclusions derived from that analysis. This analysis has regard to the purpose of the avocation and to adaptation of the activities for the attainment of those purposes. Such criticism must be found upon some understanding of the nature of things involved in those activities, so that the results of action can be foreseen.

Thus foresight based upon theory, and theory based upon understanding of the nature of things, are essential to a profession." 2

It should be noted that Whitehead's definition is not dependent upon association of licentiateship.

Many writers have included an altruistic element in their definitions of a profession. In a table of analysis of elements included in various definitions of the concept Millerson 3 shows that of twenty writers, the

1. Quoted in Cogan: op.cit.
3. 1964.
following included the element of altruism:

Cogan, Crew Drinkner Flexner,
Howitt, Marshall, Milne, Ross.

Is altruism therefore a distinguishing feature of profession? And if this is one of the differentiae, can commercial activity be thus eliminated from professional activity?

McIver puts a view which seems to represent those of many writers, when he suggests that although the profession is obviously a means of securing a "livelihood and financial reward," the kind of service it inspires is motivated by factors outside of these two criteria. Furthermore, he suggests that the acquisitive nature of the commercial world make "it impossible for the intrinsic professional interest to prevail". 1

Barber includes primary orientation to the community interest as being one of the main attributes of professional behaviour. 2 Flexner categorically asserts that the main criterion of a profession is the devotion to the interests of others and denigration of the mercenary spirit. 3 In Garceau's view the fundamental motivation of a profession is a sense of deep obligation to society, 4 and Laski considers that the preoccupation with the service to others to "a subtle alchemy in the historic tradition". 5 Millerson in his comprehensive review of qualifying associations includes "the service to the public good" as one of his six characteristics of a profession. 6

Thus, in trying to gather together the various strands in the arguments of those writers who include altruism as a distinct differentiae, the consensus seems to be, that in occupations exhibiting a high degree of professionalisation members are socialised by a commitment to an ideology

1. 1962, p.7.
2. 1915.
4. Quoted in Cogan: op.cit.
5. 1935: p.676.
of service. In a recent paper Harries-Jenkins refers to the degree of correlation between a high degree of professionalisation and a collective belief that the service which it renders to society is essential, and that withdrawal of this service, partial or otherwise, will inflict incalculable harm. The writings of Palmer exhibit the extreme of this view insofar as they suggest that the professions perform a redemptive role in society.

The unanimity suggested above may be more apparent than real. The dissenters to this view, although in a minority, do not put their case with less vigour. The Webbs for example, although not denying the existence of altruism among the professions, were not oblivious to some of the disadvantages associated with professional practice. The restriction of the supply of entrants operated by professional associations can, as they suggest, amount to "a conspiracy against the public", rather than a manifestation of altruism. Ben-David also makes a similar point, when he says that "control of entry into medical societies boosts the incomes of doctors out of proportion to that of comparable professions the same way as monopoly increases profit".

Many writers who argue against the view that altruism is a special attribute of the professions seem to do so, as Cogan suggests, by a "compulsion to demonstrate that profession is no better than a business". Fairly typical of this view is the position adopted by C.W. Mills. His work would seem to suggest that the demarcation line which separates profession from business is becoming increasingly blurred. Mills argues that with the increased tendency for businessmen to become highly trained the dividing line between the two groups becomes indistinguishable. Thus, for Mills, the increase of specialism among businessmen is a means of them

2. 1914: pp.18-19.
4. 1964, p.250.
being transformed into professionals. "The main trend is for bureau­
cratic organisation of businessmen and professionals to turn both into
bureaucrats of specified and specialised tasks". 1 Hence the proclivity
towards bureaucratisation, has tended to create a synthesis between
professionals on one hand, and businessmen on the other, into a single
class of bureaucrats. To a certain extent, an example of this can be
seen in the Area Health Authorities, where nursing and medical admini­
strators co-operate with specialists from non-medical disciplines to form
Area Health Teams. But it is difficult to see how this process is
applicable to general practice, either in law or medicine. Mills, perhaps
more significantly, discards as no longer valid, the altruistic–egoistic
differentiation. In order to support his contention he introduces some of
the concepts proposed by Parsons. First it is necessary to ascertain
precisely what, and in what context, Parsons did say on the subject.
Unfortunately Mills does not state precisely the aspect of Parsons' 
writing to which he is referring, but it was probably "The Professions
and the Social Structure". 2 In this essay Parsons uses structural
analysis of the profession as a vehicle to develop a sociological
perspective of the larger occupational structure. He states that the
dominant feature of western society is that of 'acquisitiveness', and
'self–interest', and "there is a tendency for empirical concentration on
the business world in characterising this society.... For the dominant
keynote of the modern economic system is almost universally to be a high
degree of free play it gives to the pursuit of 'self interest'".

Parsons goes on to say that the professions are characterised by
disinterestedness and the performance of service to "patients or clients

1. 1951.
2. 1945.
or impersonal values, like the advancement of science". In this sense
the professions "appear to be atypical, to some even a mere survival of
the medieval guilds". However, he does go on to say that putting
aside the question of self interest for a moment, both institutions have
elements in common. Modern industry and commerce is technologically
orientated, which is really saying that it is based on applied science.
Now a dominant feature of science is the combined characteristics of
disinterest and rationality, and insofar as both institutions exhibit
these features they are similar. Moreover, both administrators in large
businesses, and professional practitioners have roles which are function­
ally specific, and that as individuals, neither businessmen nor profes­
sionals can be characterised as altruistic or egoistic. "The difference",
says Parsons, "may be rather in the definition of the situation than in
the typical motives of the actors". Thus far, there seems to be a certain
amount of concurrence between the views of Mills and Parsons. However,
Parsons makes an important distinction, in that he suggests that the
institutional situations of both groups are different; in that professional
institutions instigate altruistic behaviour, whereas those of business
instigate egoistic behaviour. It would appear as Cogan says, that "Mills
has apparently failed to point out that according to Parsons' analysis the
difference between business and profession still exists". 2.
In summary then, Parsons is saying that at the level of the individual
agent there are no marked motivational differences between businessmen
and professionals. However, at the institutional level altruism appears
to be a motivational element of the professions.
In any event, a review of the literature on both sides of the altruistic­
egoistic argument leads the writer to the conclusion that the majority of

authors have identified altruism as a significant feature of profession.

An increase in bureaucratic organisation of professional activity, however, may lead to an increase in egoistic behaviour. Writing in 1953 Cogan makes the following comment:

"If ever those professional services are guaranteed to man by the sheer force of political or social organisation, then it may well be that profession will become egoistic". ¹

**Association as a Function of Professionalism.**

Thus far, the tendency has been to deal with professionalism at the level at which it relates to individuals. However, in much of the literature there appears to be a conviction that profession cannot exist without formal association. In this section therefore, a consideration will be given to the types of associational organisation, and to some of the infra and extra-associational relations of professionals.

Lymam Bryson insists that any exact definition of a profession must explicitly include formal organisation, ² also in this connection Carr-Saunders and Wilson state: "A profession can only be said to exist when there are bonds between the practitioners and these bonds can take but one shape – that of formal organisation". ³ Indeed, one of the criteria used to measure the degree of professionalism within an occupational group is the amount of conscious integration.

Professional associations, however, are quite complicated to deal with, since they vary enormously in their activities. The confusion which surrounds the concept of profession also surrounds the concept of professional association.

¹ Ibid.
Most writers would make a distinction between trade unions and professional associations, but this distinction is rarely specified, and as Blackburn says, "... becomes apparent from the general argument". There seems a generally widely held view among writers that trade unions exist to engage in collective bargaining on behalf of their members, whereas professional associations have significant other activities.

It is precisely these other activities where the difficulties emerge, "... for different associations have quite different functions and there is no consensus on which are the defining characteristics". Blackburn, following the approach of Millerson, delineates four types of professional association:

1) The Prestige Association;
2) The Study Association;
3) The Qualifying Association;
4) The Occupational Association.

In a detailed analysis of these forms of association he concludes that the character of the first two categories is such that they do not function to provide direct protection of their members' employment interests. If such advantages accrue, they do so from a spin-off effect.

Qualifying Associations do not usually seek to perform a direct collective bargaining role. Their power lies in seeking to determine the level of competence of their members. "The influence of an association depends on the proportion who are members (completeness)". Associations that are able to exert a monopolistic control on the supply function of the market, e.g. medicine and law, are extremely powerful, a concomitant of which "... is of prime importance in determining pay and conditions."

2. Ibid.
3. Ibid.
5. Ibid.
On the other hand, the Institute of Mathematics and its Applications (I.M.A.), which like the Royal Colleges of Physicians and Surgeons, has Licentiate Members; Graduate Members; Associate Fellows and Fellows, and conducts its own examinations, is relatively weak in this area because a large number of practising mathematicians do not find the necessity of taking out incorporated membership.

The final two of the above categories can be divided into two sub-divisions of Co-ordinating Associations and Protective Associations. The former is concerned primarily with bringing members who work in specialised fields together to enable "... them to discuss occupational problems which are too parochial for discussion in a more general association".¹ There are innumerable examples of such associations among the various professional groups — The Association of Medical & Dental Hypnosis; The Guild of Engineers; The Association of Nurse Administrators; The Association of Teachers of Mathematics, etc.

Protective associations often also perform the function of being the principal collective bargaining agent, viz., the R.C.N., the N.U.T. and the B.M.A. (under another guise).²

This raises the question of what constitutes the difference between a professional association and a trade union. Clearly the difference can be seen when considering the first three of Millerson's classifications, but when considering protective, the distinction is likely to become blurred.

Blackburn argues that there are three criteria which can be employed to distinguish a protective association from a trade union. "The first is a concern with status on the part of a protective association, which is linked with a need for the protection of the public."³

¹ Blackburn: ibid.
³ Ibid.
However, the question of status is not distinct from remuneration and good working conditions; indeed, a high level of remuneration and good conditions of service may well be the outward signs of status. Nor is there any reason to suppose that professional trade unions are not also concerned with status. The nurses' and teachers' organisations have made this a feature of their campaigns. Nevertheless, says Blackburn, "status has some relevance, for a useful distinction can be made between trade unions as 'class bodies' and professional associations as 'status bodies', even though the two may merge (Prandy, 1965, esp. ch.11)".  

Blackburn's second criterion is that of the behaviour of the organisation. Trade unions are class bodies and recognise the existence of a conflict of interest between employers and their members. Furthermore, they are prepared to take militant action in furtherance of their claims. 'Status bodies' according to Blackburn, avoid taking such measures. One wonders how he would account for the militancy exhibited by the Consultants' Association in 1975. Was the Association behaving as a status body or trade union? It was certainly exhibiting a high degree of unionateness. In fairness to Blackburn he does say that as the level of 'unionateness' rises in professional associations, then the distinction between them and trade unions becomes increasingly blurred. Blackburn's third criterion is associated with the other activities in which professional associations engage.

**Regulation of Professional Conduct.**

Professional conduct is regulated by the professional association both at the formal and informal level. Perhaps the most effective way of maintaining intra-associational regulation is in the selection of recruits,

1. Ibid.
and to the extent to which it subjects entrants to a set of socialising processes. It is usual to establish a code of professional practice, and the extent to which it can impose this code on its members will depend upon the level of integration within the profession.

Thus far, the tendency has been mainly to look at a static model of profession, and consider those elements, or characteristics, which various authors have considered to be embodied in the concept. Although, as we have observed, there is by no means unanimity among the authorities, there is nevertheless, a tendency towards a unitary conceptualisation of profession. Perhaps at this stage it might prove useful to note the various elements that it has been possible to extrapolate from these various sources, and these would appear to be as follows:

1) A skill that requires training and education;
2) A core of knowledge extended by research;
3) A level of professional competence, usually manifested in the possession of some form of certification achieved by examination. Ideally the level of the examination is controlled by the profession;
4) Integrity is maintained by adherence to a professional code;
5) The occupation possesses an element of altruism;
6) The practitioner possesses a large degree of autonomy;
7) The profession is organised.

The Tendency Towards Professionalisation.

Other writers, rather than study a static model, have found it useful to consider the process towards professionalisation. In this approach an occupation is considered in the process of dynamic change, and the question is not whether it is a profession, but how professionalised it is. However, this strategy does necessitate the formulation of the criteria of professional occupation, and as Green says: "... the ideal type is difficult to avoid if only at the end of a continuum of professionalisation".

1. Cogan; op.cit.
Greenwood¹, who is one of the writers favouring the approach of professionalisation, considers the phenomenon as a continuum, ranging from the prestigious occupations of medicine and law at one extreme of the spectrum to the labouring occupations at the other. However, he lists a number of characteristics which have a remarkable similarity to those of Flexner and others who use the ideal type model. Habensteine², applying the continuum approach, suggests that when considering the elements involved in the professionalisation process, one can apply a sort of constellation theory to the elements, that is, some elements shine brighter than others.

Hickson and Thomas³ attempted to construct a statistical measure which can be used to scale different professions on degrees of professionalisation. Their approach was to take the qualifying associations and fit them into a cumulative scale by using the Guttman scalogram (1950). However, since they restricted their selection to the qualifying associations specified by Millerson, they omitted, as Green says, "53% of the professional labour force in this country as listed in the sample census table of 1966."⁴ Green quite correctly points out, that this was hardly an unbiased approach, since "they therefore commenced with an inbuilt value judgement by excluding a number of so-called professions".⁵

Wilensky⁶ limited the set of criteria for distinguishing the degree of professionalisation of an occupation to two: (1) a profession possesses technical knowledge (based on a systematic knowledge acquired only through long professional training) and (2) a professional person adheres to a code of professional norms. Wilensky argues that a professional ideal and expertise are of considerably more importance than subjective criteria, which if stretched far enough can be applied to almost any occupation.

1. 1957.
2. 1963.
3. 1969.
5. Ibid.
6. 1964.
For Wilensky professional development is in five stages:

1) The establishment of a full-time occupation;
2) Formation of training schools;
3) The development of professional associations;
4) The formation of a code of ethics;
5) The elimination of the unqualified.

The constraints imposed on an occupation, which in Wilensky's view inhibit its progress to professionalisation are:

1) Organisation contexts which threaten autonomy and the service ideal;
2) Bases of knowledge which threaten its exclusive jurisdiction.

Caplow adopted an approach similar to that of Wilensky. He too, considered the notion of professionalisation to be a more fruitful approach than that of the static model of profession. On the sequence involved in the professionalising process, he specified stages similar to those enunciated by Wilensky, with the additional proviso that on seeking professional status an occupation should change its name.¹

He considered this to be a very important element in the process, since by such apostacy the occupation is able to sever its links with its previous identity, and by so doing create a climate whereby it can monopolise the use of its new title.²

Many sociologists have given considerable attention to the question of the organisational context, especially in relation to the position of a professional within a bureaucracy. On this question Wilensky³ is of the opinion that bureaucracy militates more against the 'service ideal' than against 'autonomy'. Not all agree. Hall,⁴ for example, argues that hierarchical authority associated with bureaucracy tends to diminish professional autonomy. On the other hand, Kornhausser⁵ regards

1. 1954.
2. A group of teachers endeavoured to do this when they banded together to form the College of Preceptors.
4. 1968
5. 1963.
bureaucracy and profession as different systems requiring different analytical approaches.

Many writers therefore, including Wilensky, Volmer and Mills\(^1\) do not view the problem as a straightforward dichotomy of profession and non-profession, because one occupation may be more developed in respect of some aspect than another. These writers tend to view the problem as a continuum on a uni-dimensional scale. But methodologically the problem is not that simple, the problem is probably multi-dimensional, and many of these dimensions may not be amenable to a quantitative approach.

Yet another technique used by a number of writers is to differentiate between occupations by adding a prefix to 'profession'; e.g. 'quasi-profession' is used by Hughes\(^2\); and 'semi-profession' by Etzioni\(^3\).

According to Etzioni the distinguishing features between a semi and full-profession are: the length of training, access to privileged information and whether the agent operates a life or death decision. Goode (1969) argues that semi-professions will never reach full-professional status because they are unable to transcend the level of service and knowledge required.

Usually when sociologists are discussing professions they are referring to occupations that have achieved professional status according to a set of preconceived notions that sociologists hold about profession. This is not a very rigorous approach since the inclusion or exclusion of elements attributes or characteristics, often depend on value judgements. Perhaps this is what led Habenstein\(^4\) to conclude that "the concept" of profession "does not have the structure of a sociological category", and Johnson to suggest that there has not been sufficient theoretical analysis.

3. 1969.
of the concept. If this is so then it follows that as a category of occupation it lacks real analytical power.

Even though there may be doubt about the sociological efficacy of the concept, there is little doubt that it will continue to be used. Also one cannot ignore a social phenomenon which may effect behaviour depending whether individual groups believe that they are, or are not, a profession.

Is Nursing a Profession?

The preceding section would seem to suggest two ways of examining the status of nurses. In short, to try to answer the question posed by Abel-Smith of whether nursing is a "profession or trade". The first approach is to list the elements of characteristics connected with the ideal type model of profession, and then determine how many of these are incorporated in nursing. The second approach would be to apply the model of professionalisation to nursing and then determine how far nursing has progressed along the continuum. In both approaches the methodology is essentially similar; it is in the models chosen that the differences lie.

The Ideal Type Model.

Previously it was stated that a review of the literature suggested that the following elements or attributes were basic to the ideal type of profession:

(a) Skill that requires training and education;
(b) A core of knowledge extended by research;
(c) A level of professional competence usually manifested in the possession of a form of certification achieved by examination. Ideally the level is controlled by the profession;
(d) Integrity maintained by the adherence to a professional code of conduct;
(e) An element of altruism;
(f) The practitioner possesses a large degree of autonomy.

There is little doubt that nursing is an occupation which requires both skill and aptitude, the former is acquired through nursing training and education, whereas the latter can presumably be satisfied by appropriate selection procedures. Nursing therefore, qualifies on this element.

On the question of whether nursing possesses a body of systematised and specialised knowledge, there appears to be disagreement among nurses themselves. Professor Scott Wright categorically asserts: "... there is a common core of professional expertise called nursing, as there is another range of professional activities called medicine, the specialist knowledge required by the health visitor or the sister working in an intensive therapy unit will be as different as that of the medical officer of health and the renal transplant surgeon". Others, on the other hand, suggest that nursing lacks a distinct core of knowledge. Green, for example, argues that not only does nursing lack a core of knowledge, but historically moreover, nurses have not possessed jurisdiction "over their own theory". They remained the hand maidsens of doctors. Whether or not nursing possesses a core of knowledge is a matter of debate. However, it is possible to make some empirical observations about research activities orientated towards the development of a scientific content in nursing. It has been noted elsewhere that although there is a tacit acceptance on the part of nursing authorities to accept graduate and post-graduate training as a part of nursing education for some nurses, this development has been exceedingly slow, and its effect on the nursing force marginal. By far the greater majority of nurses qualify from programmes undertaken exclusively in hospitals, where they lack student status, and the educational level of entry as compared with the requirements of other professions is low. The minimum "being at least 3 'O' level passes". c.f. this for example, with a minimum of 5 'O' level passes for a non-graduate Teacher's Certificate course in Colleges of Education. However, the tendency has been upwards. "In the year 1962/63 18% of those entering general training had qualifications "in

excess of the Council's requirements", i.e. at least 3 'O' level passes. In the year 1972/73 for all students, the figure had risen to 59%. In the year 1962/63 59% of those entering general training came through the entry gate of a pass in the G.N.C. test(s), in 1972/73 this figure had dropped to 32%\(^1\). Thus on the question of a core of theory, nursing may, or may not, qualify according to which authority is consulted. However, when it comes to the second proviso, namely that this core of theory should be extended by research, then nursing within the United Kingdom is found to be particularly wanting. The number of graduates is small and the number of nurses with higher research degrees or pursuing such degrees is excessively small, especially compared with the United States, or indeed say with teachers in this country. So, at best, nursing only marginally qualifies as a profession on this element.

Certainly a level of competence is required in nursing as indicated by the qualifications of S.R.N., and S.E.N. But in the struggle for registration the nursing profession lost — perhaps largely due to the inter-rivalry of the various factions — the control over nursing qualifications, and also as Green says, "basic nursing education".\(^2\).

There can be little doubt that the nursing service adheres to a code of professional conduct. This is exemplified by the fact that a nurse's name can be removed from the Register or the Role for unprofessional conduct. Nor generally is there any doubt of the spirit of devotion to duty, or put another way, the element of altruism in the nursing service.

On the question of autonomy it may be argued that the Salmon Report has created a structure within nursing which conforms almost to an ideal type model of Weberian bureaucracy, giving concomitantly more autonomy to the upper echelons of the nursing service but associatedly a diminution at the lower levels, together with an increased level of supervision in the clinical situation. It can be argued therefore that the individual nurse.

1. Ibid.
is not an independent practitioner. So in the sense that nursing within the National Health Service is highly bureaucratised, and in so far as: "A bureaucratic system tends to foster a controlled routinised work situation, one not compatible with the notions of professional autonomy or responsible participation, and certainly not compatible with the exercise of creativity or initiative." So at the lower level the nurse may be lost in a rule bound system in which her influence is only slight. However, in point of fact, under the Salmon structure "she participates in meetings at unit level", where as Green says, "she meets her colleagues on equal terms in decisions of execution of policy; but the policy will have been programmed at a higher level. Although concensus can be obtained and subsequent commitment to plans programmed the identification with decision making will be lacking at the first level". Furthermore, the nurse, the same as any professional working within a bureaucracy, faces an ideological conflict of being an employee on one hand and a professional on the other.

Nurses today work in a larger organisation than was the case in the pre-war situation when she worked in a voluntary or municipal hospital. There has been a tendency for hospitals to be grouped into larger units. The hospitals and other services are organised into Health Authorities and Regions and superimposed over the whole system is the amorphous National Health Service. Thus in this system nurses are subject to all the exigencies of a large organisation, with all the disadvantages that this implies; but in addition to this most of them have trained under conditions which Goffman would describe as a total institution, together with the hangover of the former matriarchal authority of matron. This total situation can perhaps effect group morale, for the disadvantages of a "large centralised organisation are often associated with undesirable bureaucratic tendencies.

Rules may become ends in themselves, administrators may pursue goals as

2. Green: op.cit.
large empires, greater security, administrative convenience, or smooth operational control systems may frustrate creativity, initiative and the rewards may go to conformists.¹

It would appear therefore, that nursing has many of the attributes of a profession. However, when compared to the ideal type model it does not totally conform to the precepts of this model. And this is to be expected because one would not normally expect with any profession to get a completely isomorphic one-to-one relation on each element. This perhaps is the disadvantage of using the static ideal type model.

The Professionalisation Approach.

Writing in 1960 on nursing Abel-Smith² stated that they wanted "too much too soon". However, on the question of professionalisation it might be said that they were satisfied too quickly, and as Green says "have not developed sufficiently in this century".³

In using Wénsensky’s 5 stage development towards professionalisation, nursing established itself as a full-time occupation, established training courses, organised to form professional associations, established a code of conduct and eliminated the unqualified. At first glance then, they would appear to have arrived at a professional status. But again, as with using the ideal type model, further examination would suggest that the profession is lacking in several important respects. Their service ideal cannot be doubted, and this is important to patients in spite of Wright Mills'⁴ views to the contrary. They did not change their name as Caplow⁵ suggested, and although a monopoly of title was granted under registration, it still remains a general title e.g. dental nurse, children’s nurse, and both student and pupil nurses are referred to as 'nurse' by patients. The

use of this "general term in popular usage" has according to Green, "resulted in a less well established professional identity". 1

The question of autonomy has also been dealt with in the preceding section and much of what was said also applies here, but one might also add, that a major characteristic of the National Health Service is to be found in the lack of consumer control. This lack of consumer control is to be found in the intangible nature of the product i.e. the restoration of health, the prevention of ill-health and the amelioration of suffering etc. The recipients, the patients, are not in a position to evaluate the medical process. Nurses generally are in a position to do so, but the influence they might like to exert may be frustrated because of their position as subordinate employees, and also by their historical role which has made them subordinate to doctors - 'the hand maidens of medicine'. These considerations may affect their group morale and may possibly be one of the explanations for the change in nurses' attitudes and behaviour which have occurred during the past decade.

On the question of professional associations there are 40 or more different associations to which a nurse may belong. These are either professional organisations or trades unions, with vastly differing ideologies and policies. This lack of unity among nurses and the fragmentation of associations has mitigated against nursing "becoming a well organised profession". 2 Nor as mentioned previously, do the professional associations have control over nursing entry requirements or qualifications, this resides in the General Nursing Council, which is a statutory body.

On this model then, nursing appears to possess many of the trappings of professionalisation. And although nursing has moved steadily towards professionalisation it falls short in several aspects. Thus, if we take the ideal type model or the model of professionalisation nursing is much nearer to a profession than not. But the ambiguities which we discussed earlier are inevitably reflected in the analysis, because one

2. Green: o cit
is bound to ask is the model of profession a suitable one for the con­
temporary analysis of occupation. It perhaps became more imprecise as
changes in the sociological categories occurred in the traditional
professions. For although historically the professional was an
independent enterpreneur, charging fees to clients and patients, the
contemporary professional is increasingly becoming an employee, the
doctor in the National Health Service, the architect working for a local
authority, the company lawyer, etc. It may be then, that as professionals
become employees their occupational strategy changes. Doctors, especially
the young doctors dispute of 1975, took the type of industrial action that
hitherto was thought alone to be the preserve of manual workers. Teachers,
University Teachers and Nurses, have acted similarly. It may be the
realisation on the part of doctors, nurses, teachers and other professional
and near-professionals that "the power of merit" as Clive Jenkins, General
Secretary of A.S.T.M.S. put it, "was no longer enough in itself";¹ that
they felt that they had to resort to more militant action. In many cases
this took the form of joining trades unions, or professional unions, e.g.
the N.U.T., N.A.L.G.O., A.T.T.I., etc., joining the T.U.C. And also many
of these professional workers adopted tactics that manual workers had long
ago come to regard as acceptable.

CHAPTER 3.
THE PRESENT STATE OF KNOWLEDGE

Before we approach the question of militancy as it relates to the nursing profession we should consider some of the work that has been undertaken on white-collar unionism in general. This would appear relevant since nurses are a group which exhibit many of the characteristics of other non-manual workers. Moreover, it can be argued, as discussed later, that trade unionism is often considered as a significant factor in the manifestation of militancy.

Before starting this examination we should perhaps determine the level of white-collar union density.1 Certainly there appears to have been a tremendous expansion in white-collar unionism in recent years. But is the growth of the Association of Scientific, Technical and Managerial Staffs, for example, indicative of a general trend?2 Bain, after carrying out considerable research, said in 1970, no. He then argued that in the United Kingdom only three out of ten white-collar workers belong to a trade union as compared to five out of ten manual workers. Furthermore, he argued that although in absolute terms white-collar unionism had increased since 1948, in real terms it "has done little more than keep abreast of the increasing white-collar force, and the density of white-collar unionism has not increased significantly during the post-war period".3 However, in a recent paper Price and Bain show that the growth of white-collar unionism has "...outstripped the steady rate of growth of white-collar employment, and consequently white-collar union density rose by 5.6 percentage points to 35.2 per cent in 1970, and by

1. Density is the term used by Bain 1970, and others to indicate the level of unionism and is given by the formula:
\[
\text{Density} = \frac{\text{Actual Union Membership}}{\text{Potential Union Membership}} \times 100
\]

2. Blackburn 1967 uses the term completeness of unionisation, and this is given by \(\gamma' \sum \gamma' \zeta - \sum \zeta\), where \(\gamma'\) is the corresponding level of completeness and \(\zeta\) and at least one organisation \(S\) where \(S \leq r\).

another 4.2 percentage points to 39.4 per cent in 1974. By 1974, 36 per cent of all union members were white-collar employees compared with 26 per cent ten years earlier, and with 21 per cent in 1948.¹

There have been a variety of theories advanced on the phenomenon of white-collar unionism and within this variety there appears to be a certain amount of common ground. It is more-or-less agreed that the attitudes of white-collar workers differ from those of manual workers in several important respects, and these differences are manifested in their different attitudes towards trade unionism.

Fairly typical of this approach is that which argues that one of the fundamental factors in understanding the character of white-collar unionism is a knowledge of the kind of people that white-collar employees typically are. One way of obtaining such information may be through analysing the social class origins of white-collar workers, especially as it relates to trade union membership.

**Social Class Origins.**

Several sociologists have argued that many aspects of social behaviour are determined by the social origin of the participants. Thus, in relation to the question of the unionisation of white-collar workers, the hypothesis that those whose parents were manual workers or trade unionists are more predisposed to join trade unions than those whose parents were white-collar workers or non-unionists, has often been advanced.

A possible explanation for this is given by Lipset and Gordon who suggest that non-union parents are likely to possess anti-union attitudes, whereas those who are members of a trade union are more likely to be favourably disposed towards them, and these attitudes are transmitted to their children.² The lack of adequate data has tended to make this hypothesis difficult to test. There have been a number of studies which have

generated a considerable amount of data on the relationship between social origin and union membership, but comparisons between the various data are made difficult because of differences in the methodologies employed.

There have been several studies in the U.S.; Lipset & Gordon carried out a study on 953 Californian manual workers and these results suggested that workers whose fathers had non-union occupations were less likely to belong to trade unions.¹

Tuck showed that N.Y. immigrant Jews' opinions were greatly influenced by socialist trade unions.² The evidence for this view seems to be borne out by the work of Cole. He showed that the large Jewish composition in the New York teaching force was a significant non-teacher status in explaining the rise in unionisation and militancy among New York teachers.³

Cole also suggests that class origin was a non-teacher status that can influence a predisposition towards unionism. In referring to a survey of New York teachers, he says that "of N.Y. City Teachers from lower class homes 61% — as opposed to 47% from middle class homes — were militant. This greater predisposition to support the union movement may be the result either of growing up in a certain kind of family or the process of upward mobility itself".⁴

In 1952 Kornhauser analysed the data derived by a national public opinion survey, and as a result of this analysis, together with the analysis of a survey of labour mobility undertaken in six American cities in 1951, found no correlation between social class origin and union membership.⁵ Similarly Goldstein and Indik found no correlation between social class origin and union membership in a survey of 705 professional engineers. However, they did find that union members were more likely to have fathers who were union members.⁶ Kliengartner's work suggests that there is no

¹. Ibid.
². Tuck: 1956, Ch.10.
significant association between union membership and union membership of father. There have been a number of studies undertaken in the United Kingdom. Routh in a sample of 941 members of the Draughtsmen's and Allied Technicians' Association (DATA) found that 63 per cent came from manual working class homes and perhaps more significantly 43 per cent became draughtsmen after serving craft apprenticeships.

Blackburn's work with a sample of 35 male clerks show that there is a teniency for those who come from lower status homes to join the National Union of Bank Employees (NUBE), whereas those from the higher status homes tended to be either members of staff associations or nothing. In the case of women Blackburn's sample of 66 showed that they tended to come from lower status homes than the men, but there was no relationship, and when Blackburn took a second sample of 58 of both male and female clerks the findings were the same.

Is it really possible to draw any firm conclusions from these studies? The samples in the American studies were reasonably large and selected at random, whereas the British studies tended to be small and not random. Moreover, none of the studies controlled for other factors which could have an affect on workers joining a trade union. The work of Bain tends to suggest that the variation in the density of white-collar unionism is too large to suggest an association between social origin and union membership. Bain's work shows that foremen for example, who in the main once came from manual occupations, are poorly organised in private industry. The growth of the A.S.T.M.S., representing as it does many supervisors, may contest this last assertion of Bain's. In the present state of empirical knowledge there appears to be insufficient evidence to suggest that as a general principle there exists a connection between social class origin and union membership.

Status.
A frequent explanation for white-collar resistance to trade unionism is their concern with status, or put another way, their 'false sense of class consciousness'.

However, in spite of the changes which have occurred in the social mix in the white-collar work force, it is nevertheless argued by many writers that the white-collar worker, irrespective of his social origin, is primarily concerned with status. The assumed result of this status consciousness on the part of white-collar workers is that they "formed an image of themselves" which bears "little resemblance to economic realities".¹

They see themselves as being superior to manual workers, so in a sense, forming a trade union may be perceived by the white-collar worker as removing one of the distinguishing features between himself and a manual worker, and this could be one of the factors which inhibits union recruitment of this class of employee.

The white-collar worker's status is constantly being eroded. "Every basis on which the prestige claims of the bulk of the white-collar employees have historically rested has been declining in firmness and stability".² The extension of educational opportunity, the narrowing of the pay differential between them and manual workers, the tendency towards economies of scale with the concomitant concentration of large numbers of white-collar workers in one place of work, the separation of white-collar employees from management, the increase in the number of white-collar workers from lower social origins, and the sheer increase in the total white-collar labour force have all tended to erode the "... foundations of the white-collar rejection of unions on the basis of prestige".³ So it could be argued that the increased proletarianisation of white-collar workers could reduce their resistance to trade union membership.

Social status may be defined as the position occupied by an individual or group, according to some specifiable criteria, within a given hierarchy. "Status" says Lumley is based on each assessor's subjective opinion.\(^1\) The usual way of determining an occupational status is to assess it on a number of variables, as for example economic position, type of education and training necessary for it and the typical background of the people involved in it.

The economic position of white-collar workers in the 19th Century was generally superior to that of manual workers. However, this relative advantage has declined with respect to the lower levels of white-collar employees and this has led to a commensurate diminution in their status.\(^2\)

In the 19th Century the majority of white-collar workers had middle-class origins, however, the expansion of commercial activity has been accompanied by an increase in the proportion of white-collar employees whose social origin is working class.\(^3\)

By about the 1950's there is evidence to suggest that the number of clerks who came from working class origins was over 50 per cent. The change in the social class mix had come about mainly by the increase in educational opportunities.\(^4\) Although there has been a tendency towards an increase in the number of white-collar workers coming from working class backgrounds some occupations have remained predominantly middle class. A survey conducted by Bain & Price into the social background of bank clerks showed that 95 per cent of male bank clerks came from the middle class.\(^5\)

It is probably true that most white-collar workers perceive themselves

2. Ibid.
5. Bain and Price: 1972, op.cit., pp. 368–9, Table 1.
as being socially superior to manual workers, identifying more with the values and social aspirations of the management and middle-class. Nor can there be much doubt, as shown by the work of Lockwood and Runciman, that the status of the white-collar worker in general has been deteriorating during this century. But as Bain argues, the first fact does not necessarily mean that white-collar workers are deterred from joining trade unions, or that the second means they are encouraged to join.

Concern with status is normally a concern with snobbery, so what is really being asked is whether the snobbishness of white-collar workers inhibits them from joining unions. Lockwood writes succinctly on this question and it is worth quoting him in some detail.

"Has snobbishness varied through time? If so, assuming that it has lessened, say between 1921 and 1951, why has the proportion of commercial and industrial clerks in unions hardly increased at all? If not, how is the fact to be explained that twice as many black-coated workers are unionised nowadays as thirty years ago? Is snobbishness a factor which operates 'all along the line', sometimes displayed by all clerks equally? If so, why are there very significant differences in the degree of clerical unionisation from one field to another? Alternatively, is snobbishness connected with relative social status among blackcoats? If so, why have certain groups of clerks with high social status been highly unionised, and others with a low social status poorly unionised? Most perplexing of all, why have two groups of clerical workers, both with a relatively low standing in the black-coated world — railway clerks and industrial clerks — joined their respective unions to such radically different degrees? It is unnecessary to pursue this line of argument.
in order to conclude that no clear connection can be established between a factor such as 'snobbishness' and the empirical variations in clerical trade unionism. Whatever influence snobbishness has on the mutual relations of clerks and manual workers, it does not seem to have prevented the former from organising themselves in trade unions".\(^1\).

Lockwood's argument can clearly be extended to other groups, for example journalists enjoy relatively high social status and are also highly organised in the National Union of Journalists, whereas shop assistants whose social status is comparatively low are poorly organised.\(^2\).

Also, as Bain points out, "Craftsmen are obviously very status conscious, but this has not prevented them from organising some of the strongest and most militant unions in the country".\(^3\). Thus, most of the foregoing would suggest that it is not possible to specify a general correlation between social status and trade union membership.

Even if one were to assume that the white-collar worker's concern with status has tended in the past to prevent him from joining a trade union, it does not follow that a diminution of this status will necessarily motivate him to join a union. Indeed, he may well react to the contrary. An increase in the proletarianisation of white-collar workers may, as Mills suggests, cause a "status panic" and this may cause them to accentuate the remaining differentiae which distinguishes them from manual workers. Faced with this situation the white-collar worker may seize upon minute distinctions as a basis for status and this can lead to status estrangement from work associates and to increased status competition".\(^4\). Thus in this situation the emergence of white-collar unionism is extremely unlikely.

2. Bain: 1970, op.cit. — shows a density of 15; Table 3.2 p.23.
The Market Situation.

We have seen from the above that there appears to be no correlation between union membership and social class. Where then can we look for a possible causal relationship? Lockwood (1958) suggests that the market and work situation is a major factor with status not exerting very much affect upon either the level of union density or character. The evidence reviewed would seem to suggest that Lockwood is correct in one respect. It is now necessary to examine the market situation in some detail to try and ascertain to what extent it influences the level of unionisation.

The market situation is made up of a number of components, one of which is the level of earnings, and perhaps this would be a convenient point at which to begin our examination.

Earnings.

Although there is, and indeed always has been, a certain degree of overlap between the earnings of white-collar and manual workers, as a class white-collar workers have historically earned more than manual workers. This advantage has been maintained. However, during the course of the past forty years the relative differential between the earnings of white-collar workers and manual workers has decreased. "The average annual earnings of all male white-collar groups relative to those of all manual workers declined between 1922-4 and 1960 by amounts ranging from 2 per cent for industrial clerks to 48 per cent for civil service clerks." Indicative of this trend is the report of a survey undertaken in 1964 which revealed that an average manual worker with two children was in the region of 55 per cent better off than just before World War II. The same survey revealed that many white-collar workers were between 20 and 30 per cent worse off.3

I & II.
This tendency seems to have been arrested. "From 1956 to 1967 average salary earnings rose by 94.7 per cent compared with a 92.3 per cent rise for all manual workers, but since this date wages have increased at a slightly higher rate than salaries".¹

Several writers, e.g. Klingender (1935), Mills (1956), Syriax and Oakeshott (1960) have argued that the level of income, both between and within groups, is an important determinant of the level of union density. But there does not appear to be any empirical evidence to support the view that those white-collar workers whose relative earnings have declined compared to manual workers are more predisposed to join unions. Certainly civil service clerks whose relative earnings have declined are highly unionised, but there are also groups whose relative incomes have not markedly deteriorated, e.g. female industrial clerks who are poorly unionised.²

If one looks at the level of absolute earnings and union membership, no relationship appears to hold. Draughtsmen, who are highly unionised, earn more than industrial clerks whose level of union density is low. Railway clerks, male and female civil service clerks earn more than their counterparts in industry, yet by comparison industrial clerks have a low union density.³

Nor in the manufacturing industries does there appear to be a relationship between the level of white-collar union density and the degree to which pay differentials between white-collar and manual workers have narrowed. In the leather goods, fur, clothing and footwear industries, the average annual earnings for the period 1959-1963 of white-collar workers have increased relative to manual workers, but the level of union density among this group of white-collar workers is low. In metal manufacturing, paper publishing industries, the relative earnings of white-collar workers have

1. Lumley: op.cit., p.43.
increased, and in these industries the level of white-collar unionism is comparatively high. On the other hand, in the shipbuilding and marine engineering industries the relative earnings of white-collar workers, compared to manual workers has decreased, but the level of white-collar union density is high. Then again the relative position of white-collar workers has declined in the food; drink; tobacco; timber; furniture and chemical industries, and in these industries the level of white-collar unionism is low.\(^1\)

In order to determine the nature of the relationship between union membership and relative earnings in the various industries mentioned above, Bain carried out a regression analysis and found that over 90 per cent of the correlations fell below the required 5 per cent level of significance. Admittedly the failure to secure significance does not necessarily dispute a relationship between relative earnings and union density; there are too many methodological difficulties for this to be so. Also one cannot discount the possibility that the two variables may be mutually dependent, that is union density can affect the level of earnings and vice versa. But one can cautiously assert that both empirical and statistical data would seem to suggest that no relationship exists. However, recent work by Bain and Elsheikh suggests that price rises generally have a positive effect upon union growth.\(^2\) The point was made earlier that the proletarianisation of white-collar workers does not necessarily cause them to join trade unions. Runciman\(^3\) has made a similar point. He suggests that workers may respond to a diminution in relative earnings in two ways; egoistically or fraternally. Self evidently the egoist lacks any fraternal sentiment and merely wants to better himself, even at the expense of his co-workers.

2. 1976.
Fraternalis on the other hand, see the means of their own improvement through the collective improvement in the earnings of their co-workers. Runciman’s research led him to conclude that relative deprivation is more likely to manifest fraternal behaviour on the part of manual workers, whereas white-collar workers tend to react against it in egoistic terms. If Runciman is correct then diminution in the relative earnings of white-collar workers is unlikely to motivate them to join trade unions.

It is also suggested by some writers that not all white-collar workers necessarily compare their earnings with manual workers. Indeed Runciman suggests that groups of workers tend to compare like with like when it comes to earnings. Thus, according to this view the reference group for manual workers is other manual workers; similarly white-collar workers compare their earnings with those of other white-collar workers.  

**Other Factors in the Market Situation.**

Apart from the differential in earnings which has characterised one of the market differences between white-collar workers and manual workers, their tenure of employment has also been more advantageous in several important respects. In 1916 the editor of the Clerk noted that "although by reason of their unorganised state, clerks suffer from many economic disabilities, yet they have a great many economic advantages not enjoyed by manual workers". Among which he cited "permanency of employment, periodical increases of salary, payment of salary during sickness and holidays, comparatively reasonable hours of work, and in certain sections superannuation". And in 1965 Jeremy Bugler argued that in almost all of the aspects noted above, white-collar workers were still better placed than manual workers, and apparently this tendency has continued.

A Department of Employment survey undertaken in 1970 revealed that of male

2. Quoted by Lockwood: op.cit.
and female non-manual workers 91.6 per cent of the former and 82.3 per cent of the latter were covered by various sick-pay schemes. This compared with 62.9 per cent for male and 48.8 per cent for female manual workers. The survey also revealed a similar advantage to white-collar workers in relation to pension schemes; 73.2 and 38.6 per cent for males and females respectively compared with 45.3 for male and 11.93 per cent for female manual workers.

However, the narrowing of the gap which was observed between pay differentials of white-collar and manual workers has spilled over to fringe benefits in general. In the area of sick pay and pension schemes for example, these are increasingly available for manual workers, and an increasing number of manual workers now receive an annual paid holiday in excess of two weeks. A recent Government White Paper revealed the intention that "the normal job will be seen as providing not only a wage or salary but an earnings related pension as well". There is, however, a crucial difference between the fringe benefit schemes in the two groups; those applicable to manual workers are based not on their average earnings, but on their basic wage, and this places them at a considerable disadvantage to white-collar workers.

It has been argued by Lockwood that security of tenure in employment "was perhaps the most significant difference between manual and non-manual work, for although it fell short of the full independence which comes with property, job-security did constitute partial alternatives to ownership, conferring on the clerk a relative immunity from those hazards of the labour market which were the lot of the working class".

3. Lockwood: op.cit., p. 204.
And most writers would tend to agree that the job security of white-collar workers has traditionally been more advantageous than for manual workers. "Even during the decades of the twenties and thirties when being out of work was the normal situation for a large proportion of the population, white-collar workers were less affected by unemployment than manual workers. Those on the railways as well as those in public service and banking hardly suffered from unemployment at all."¹ But even though unemployment in the twenties was not substantially high among white-collar workers, its presence was sufficiently felt "to destroy the traditional association of security and blackcoat employment."²

It was estimated that in 1934 between 300 and 400 thousand white-collar workers were unemployed.³ Moreover, as Bain says, the "older and more senior white-collar workers were particularly hard hit. They often fell outside the National Insurance limit and were therefore ineligible for unemployment relief payments."⁴ Bain has argued that the fear of unemployment is not likely to have been a major consideration for the post-war white-collar employee. The majority of white-collar workers have had no experience of pre-war unemployment, "and do not share the fear of unemployment which overshadowed their parents."⁵ What unemployment that existed in the post-war period was, until recently, structural and mainly confined to manual workers. Even when there was fairly heavy redundancy in specific areas — as for example the 1,000 white-collar workers made redundant by an aviation company in 1962 — most were able to secure alternative employment reasonably quickly.⁶

As stated previously, when pay is taken as a quantitative measurable factor it has been possible to investigate its relationship with the

2. Lockwood: op.cit.
3. Letter to the Manchester Guardian from the General Secretary of the National Federation of Professional Workers, cited by Klingender, op.cit., p.57.
4. Ibid.
5. Ibid.
levels of union density. Those who have applied this strategy have found no demonstrable relationship. Similarly no connection has been established between the relative decline in differentials and fringe benefits of white-collar workers and union density.

No comparable analysis has been undertaken into professional or staff associations, but it is likely that these would show a similar pattern.

Insofar as there is not a rigorous quantitative measure of unionism, it is methodologically difficult to apply statistical analysis of the type that will indicate the degree of association between pay and fringe benefit differentials and union density. But since some organisations who represent high income groups are often fairly militant, e.g. the B.M.A. and B.A.L.P.A., while others are fairly passive, e.g. the Principals Association, and similarly some lower income groups are fairly militant e.g. T.S.S.A. while others are reasonably passive e.g. the C.S.U., it would seem reasonable to infer that either the absolute or relative level of fringe benefits of a white-collar group exercises little relationship on the level of their union membership.

However, fringe benefits like pay, cannot be ignored as general factors which might lead to an overall increase in white-collar unionism.

Contrary to the view of Runciman, Lumley argues that there is among many white-collar workers a general feeling of dissatisfaction with their position relative to manual workers.

In a survey of teachers carried out by Margerison & Elliott, it was found that even allowing for their long holidays they felt that their pay and fringe benefits fell short of those working in industry.

2. Bain; Lumley; op.cit.
3. Lumley; op.cit., p.49.
5. 1970.
And because "many white-collar employees see the advance of the blue-collar labour force as due to strong organisation, and so they seek to emulate this in order to defend their position. Unions such as ASTMS pledge themselves to increase differentials. Professional associations seek to maintain salaries and along with them status".  

In a situation where a choice exists, Prandy suggests that those who are less dissatisfied with their pay tend to join a professional association rather than a trade union.  However, this view is not completely free of difficulty because, as we observed in our discussion on professions, the term is not free of ambiguity. The more dissatisfied a group becomes with its position the more likely they are to behave in a militant way. It should be said perhaps that dissatisfaction is determined largely by the groups perception of what should be rather than any objective criteria. Such an example is the Junior Doctors' Association which broke away from the B.M.A.

One could conceive of circumstances where fringe benefits affect the level of unionism. "Non transferable pension rights can restrict labour mobility and so make employees more dependent on their employer, and less willing to antagonise him".  

The relative advantage in fringe benefits, like pay, of white-collar workers relative to manual workers is likely to continue to diminish, and groups will continue to compare their position unfavourably with those of different reference groups. So fringe benefits like pay "will remain a general factor leading to the growth but will not by themselves act as a stimulus to this growth or distinguish the relative growth between and within occupations and industries".

1. Lumley: op.cit., p.50.
4. Ibid.
Promotion.
There is another aspect of the market situation which may affect the level of unionisation among white-collar workers, and this is the question of promotion. C.W. Mills in the United States stated that he found a "close association between the feeling that one cannot get ahead, regardless of the reason, and a pro-union attitude". Research undertaken in the United Kingdom on the process of bureaucratisation which has developed both in the civil service and in school teaching tends to suggest that the tendency towards bureaucratisation "has been accompanied by a policy of recruitment from outside at two or more levels, with little or no opportunity for those recruited at a low level to surmount the internal barriers blocking their promotion" and it is claimed as a result of this process:

"Elementary school teachers, and civil servants without a university training who entered the clerical or executive classes, have had such poor chances of upward job and social mobility and their efforts to improve their lot have inevitably taken the form of creating powerful interest groups restricted to those whose promotion was virtually barred in this way. As the lower salaried often attracted socially aspiring individuals for whom the blockage of their upward mobility was especially frustrating, they often became the leading spirits in the formation and running of such organisations".2

While it can be argued that the blockage of promotion tends to create conditions favourable to the growth of unionisation, the converse is not necessarily so. Bain for example, argues that "promotion prospects were not blocked in banking, but a considerable degree of unionisation was nevertheless possible simply on the basis of large scale bureaucratic organisation. Draughtsmen are a highly unionised group yet their promotion prospects are quite good and highly valued. While there

is no quantitative evidence available, it is also fairly obvious that another highly unionised group in private industry, the journalists, have considerably better promotion prospects than poorly organised groups such as clerks. ¹

The Place of Work.

Other things being equal, the level of union density is likely to be higher among larger rather than smaller groups of employees. This is not surprising because in a situation where there are economies of scale the emphasis tends to be "on the office rather than the individual office holder".² And in this situation a sense of alienation can emerge because employees are not treated as individuals, but as a group. In such a situation rules are more likely to be made for the group rather than the individual, and the individual employee is, as Dubin says, likely to be affected in several different ways:

"He becomes aware of his personal inability to make an individual 'deal' for himself outside the company rules and procedures, except under the circumstances of a 'lucky break'. He tends also to view himself as part of a group of similarly situated fellow employees who are defined by the rules as being like each other. In addition uniform rule making and administration of the rules makes unionism easier, and in a sense, inevitable. It should be reasonably clear that the collective is joint rule making. It is no great step to the joint determination by union and management of rules governing employment from the determination of them by management alone. Both proceed from the basic assumption that generally applicable rules are necessary to govern the relationship between men in the plant. Once a worker accepts the need for general rules covering his own conduct, he is equally likely to consider the possibility of modifying the existing ones in his favour (sic) rather than to seek their total abolition.³"

Other writers (Prandy 1965 pp.159—160; Mills 1956 pp.305—13, Bain 1970 pp.72-5) have argued that given a situation in which salaries and conditions are determined for the group, then collective action is the only viable option open to employees for the protection of their interests. But the level of bureaucracy associated with large concentrations of employees is not the only explanation for the likely high density of unionisation. Unions by and large tend to concentrate their recruitment activity on large organisations of workers. Furthermore, in a situation where there is high concentration of union members, rates of pay tend to be determined by collective agreement and therefore union effort has a greater impact on the general level of salaries than individual agreements. There exists a large amount of empirical evidence to support the contention that there is a relationship between the size of the establishment and the level of unionisation. In the United States, Cleveland found a positive relationship, and studies in Austria, Japan, Norway, and Sweden tend to demonstrate that the level of unionism is higher in larger than in smaller office establishments. In the United Kingdom Lockwood has produced an abundance of evidence to support this contention. He demonstrated that the growth of the Civil Service Clerical Association can be traced from the civil service reorganisation in 1920. Moreover, he shows that "the growth of NALGO has gone hand in hand with the subordination of local particularism in the working conditions to a set of natural standards common to the service". Bain also points out that in private industry, draughtsmen and journalists, both of whom are highly unionised, tend to be highly concentrated.

Attitude of Employers.

Perhaps one of the most significant factors in the work situation is the employer, and therefore the attitude of employers can presumably be a factor in affecting the level of union density. Fox's work suggests that the pluralistic nature of industrial organisation in the public sector tends to create a situation which is favourable towards white-collar unionisation. This perhaps follows from the realisation that in the industrial situation there is a potential element of conflict, and trade unionism can assist in containing and resolving such conflict. Thus in the public sector, not only do the various authorities recognise white-collar organisations, but they encourage their employees to join such organisations.

Employers in the private sector often exhibit quite a different attitude towards trade unionism. Fox suggests that many employers in this sector of the economy perceive industrial organisation as a unitary system with a single focus of authority, and consequently they see trade union organisation as an explicit threat to their authority. They especially see the unionisation of white-collar workers as unnecessary, and fear "that union membership will challenge managerial prerogative, provoke a conflict of loyalty for individuals, particularly managers and supervisors, and that it will stifle ambition and promote general mediocrity".

One of the traditional ways in which employers expressed their hostility towards trade unionism was by refusing to recognise them. In 1964, for example, about 27 per cent of the total labour force worked in areas of the economy where employers did not recognise trade unions. This included white-collar employees and many manufacturing industries.

2. For example, see Staff Relations in the Civil Service (London H.M.S.O.1958) p.3.
3. Fox: op.cit.
4. Lumley: op.cit.
The Department of Employment estimates that about 85 per cent of white-collar employees in the manufacturing industries do not have terms of employment regulated by collective agreements.

This strategy of not recognising trade unions was often accompanied by the offer of various fringe benefits and the provision of staff associations. However, since the Industrial Relations Act of 1971 this practice has become increasingly difficult to implement, and thus, "the Act will remove a factor which is artificially depressing the membership of unions and could lead to a great increase in membership".¹

Nearly all the aspects discussed above operate to a greater or lesser degree within the nursing profession, and will become evident in the ensuing chapters.

¹ Lumley: op.cit.
CHAPTER 4.

EARLY ATTEMPTS AT THE UNIONISATION OF NURSES

It has been argued elsewhere that one cannot divorce the contemporary
behaviour of a group from its history, and this is especially so on the
question of militancy. Any attempt, for example, to study the current
attitudes of say, steel-workers on manning, or dockers on the 'container
issue', would not make significant progress if account were not taken of
their trade union history. So too with nurses, contemporary behaviour
and attitudes cannot be divorced from their past.

It would be tempting to attempt a comprehensive survey of all the events
connected with the emergence of militancy and unionisation of nurses,
and from a purely historical approach it could prove a useful research
exercise. However, being mindful of the constraints of time and space,
and indeed the enormity of the material that would require researching,
it would seem within the present context an impossible task. To
distinguish the wood from the trees a ruthless pruning of the undergrowth
is needed, and the treatment must of necessity, concentrate on more recent
events rather than a detailed history of the more distant past. But
given this limitation it would be incorrect in my view to ignore completely
the earlier emergence of unionisation and manifestations of militancy.

As suggested previously, militancy is an attitude of a group or organis­
ation which believes in the correctness of taking some form of direct
action in pursuance of what is perceived to be a legitimate claim. It
follows therefore, that militancy is not the sole prerogative of trade
unions — farmers in both England and France have organised demonstrations
and recently doctors in the National Health Service have taken industrial
action. Thus, although recognising that the phenomenon of militancy is
not necessarily restricted to a particular social stratum, it is
nevertheless true that the concept is more often than not associated with
trade unionism. With this in mind, our analysis initially begins with
the development of unionisation among nurses as prerequisite for the early emergence of militancy.

**Brief History of the Unionisation of Nurses.**

Although the nursing profession today may be regarded as a unity, it will be remembered that the recent origin of the profession can be traced from three sources, namely, the voluntary hospitals; the municipal hospitals and the mental institutions.

Trade unions found it exceptionally difficult to organise the general nurses in the voluntary hospitals. This should not be explained purely in terms of the fact that the majority of them were women; Lockwood showed that under certain circumstances women are as willing to join clerical unions as men.\(^1\)

"There were", as Abel-Smith says, 
"...a number of special difficulties in organising nurses in the hospital service; the tradition of selfless devotion to the sick, the rapid turnover of staff, the strong and close personal influence of the matron who was the immediate representative of the management".\(^2\) Furthermore there was a general objection to the strike weapon on the altruistic principle that it would cause harm to patients. These were not the only reasons; joining a trade union predicates — at least during the first quarter of the 20th Century — a certain sympathy and identification with the broader working-class movement. Many of the nurses in the voluntary hospitals were ladies, and others aspired to be thought of as such. Association with the working class movement was diametrically opposed to their social aspirations. It is not surprising therefore, that the nurses from the voluntary hospitals were in the vanguard of the registration and the general movement towards professionalisation, rather than the movement for the unionisation of nurses. This was not the case with the nurses in the municipal or mental hospitals, and it is these areas

where we should perhaps begin our investigation of militancy and the unionisation of nurses.

The Mental Hospital and Institutional Workers' Union.

The conditions of employment in mental hospitals before 1910, and indeed for some time afterwards, were extremely poor.

Nursing staff on average worked 84 hours per week, "and many Public Mental Hospitals employed their staffs on average of 90 hours per week".¹

Wages were comensurately low, and the turnover of labour rapid.

The conditions of a constantly changing labour force did not present the optimum conditions for trade union organisation, and although there had been previous attempts at organising the staff of mental hospitals within the framework of existing industrial unions, these had been mainly abortive.

The Mental Hospital and Institutional Workers' Union came into being largely through a general sense of grievance which ensued from the Asylum Officers' Superannuation Act of 1909.

This Act made provision for the deduction of contributions from staff wages towards a Statutory Superannuation Scheme. The main point at issue was that the proposal under the 1909 Act was less generous than the voluntary schemes previously operated by many authorities under the provision of the Lunacy Act of 1890, and amounted in fact, to a wage cut.

Resentment to the scheme was particularly strong in Lancashire "because the provision of the Lancashire Pension Scheme had been printed on the application forms when one entered the service and constituted at least an implicit contract".²

As a result of this discontent several meetings were arranged, the first being convened by a Mr. Martin Meeham at Winwick, Lancashire in December 1909, and several subsequent meetings met with little success. However, on

1. The History of the Mental Hospital & Institutional Workers' Union 1931.
July 9th, 1910 a meeting was convened at the Mason's Arms Hotel, Whitfield, near Manchester, where delegates from the following institutions attended: Prestwick; Rainhill; Whittingham; Lancaster and Winwick.

"The Minutes of that meeting (still in existence) record the attendance of the following delegates:—

Lancaster — Messrs. E. Edmondson, J. Gold and B. Parkin.
Winwick — Messrs. P. Richmond, J. Brennan, Geo. Gibson and W. Ellwood (Convenor)."¹

At this meeting it was agreed to form a trade union, "and to ask for a subscription of 4d. per month to defray initial expenses".² Also present were two clergymen, the Rev. H.M.S. Bankart, Chaplain to the Lancashire County Hospital and the Rev. S. Proudfoot. A second meeting was convened at which the name of the organisation was decided — The National Asylum Workers' Union. It was also agreed that the union should issue a pamphlet which the Rev. Proudfoot offered to write.

"A Committee consisting of one from each of the five hospitals was appointed to consider the proposed pamphlet and to approve of provisional rules".³

The Growth of the Union.

The pamphlet which was distributed throughout the United Kingdom, and which caused a major sensation throughout the mental hospital field is reproduced below:

1. Ibid.
2. Ibid.
3. Ibid.
NATIONAL ASYLUM WORKERS UNION

MOTTO:

"All for one; one for all
Thou shalt love thy neighbour as thyself".

THE END AND AIM OF THE UNION

Dear Fellow Workers,

Several hundreds of our fellow workers, male and female, in the Asylums of Lancashire, have decided that the time is more than ripe for all to unite in a determined effort to redress the grievances, great and small, from which many have suffered too long, and to procure a measure of industrial self-government, which they believe to be an indispensable means towards the realisation of freedom and self respect.

The question has been brought to a head by the Pension Act. This Act (which is a boon to very many, by granting pensions to some who otherwise would not have any hope of them, and by assuring a definite amount to others), had many imperfections, e.g. the deductions from the wages of those who had previously joined Asylums, attracted by that very expectation of pensions and who are now unfairly mulcted; and the age limit, which, added to the length of service limit, bears very hardly on some who joined whilst young. These faults, in an otherwise generally acceptable measure, however, are only too characteristic of the lack of real consideration accorded to Asylum Workers on the whole.

We have small hope of many important improvements in our conditions of labour apart from Union. Any single Asylum which feels that it labours under unnecessary and vexing disabilities — and there are many such — however it may strive to obtain better conditions, is helpless in its efforts to obtain redress. But if we all combine together in a spirit of loyalty to one another, we are certain to win industrial emancipation.

We must have justice, and by this we mean: "fair day's pay for a fair day's work", in other words, increased wages and shorter hours of labour; more freedom; a fair trial by the Visiting Committee of any member of the
Staff before dismissal; and also that in all things connected with the conditions under which we labour, we all should have a voice.

The end and aim of a Trade Union is that men should rule and not money; that capricious autocracy should be replaced, or, at any rate, restrained by an intelligent representative government, regulated by the general body of all classes of workers. What others have accomplished in this way, we also should be able to do.

We need — society needs — that we all should realise ourselves. To do this we must have more of the means of existence and an increased leisure. Our long hours weaken and depress us, and make it impossible for us either to give a perfect service or to expand in the scale of being. Our minds are not improved, because of the conditions of our labour are such that they shut us off from the wider life of the world of Humanity and books. Our inadequate wages render it impossible for us ever to hope to procure many of the refinements of life. We have small opportunities for getting away very far from the scene of our labours, nor can we ever hope to sit in the seats of the cultured or the wise, unless, as if by a miracle our existence is enlightened by the rare lamp of genius. Apart from education, we cannot attain to any real moral greatness, and when any individual among us realises by painful toil and superior gifts something of moral excellence, and labours for us, he often finds himself ignominiously driven from a post which just enables him to procure the barest means of existence. And true education can never be ours unless we govern ourselves.

In reminding you of all this, we believe that we are discharging an urgent duty, not only to the body of workers to which we belong, but to the whole community. An injustice done to one is done to all. We deem tyranny a debasing and demoralising thing, and that is tyranny which imposes upon us conditions that no self-respecting man or woman amongst us can think to be fair or just.
We propose by this Union to bring to bear upon the "powers that be" the influence of a power greater than themselves – the power of a strong united public opinion, giving voice to our aspirations and our grievances. We propose, further, to make it an efficient means of social, educational, and moral growth. We seek to unite and not divide. We shall "serve one another" by organising against injustice and misfortune in hours of weakness, and if necessary, in suffering and death. We have no quarrels with man or men, but we are determined to fight with all our might against every sort of injustice.

In loyalty to your true selves, and, therefore, to your fellow workers, we invite you to join us. United we stand, divided we fall. We have nothing to lose but our selfishness and our wrongs; we have everything to gain – liberty and justice.

JOIN US!

PROPOSED FUNDAMENTAL RULES.
(Agreed upon by our Lancashire Asylums).

1. That this Union shall be called "THE NATIONAL UNION OF ASYLUM WORKERS", and its centre shall be temporarily in Lancashire, at such place as may be decided by the Council.

2. The Union shall be open to all grades of workers in Asylums throughout the United Kingdom, and shall consist of an unlimited number of members, each of whom shall subscribe to its funds, twelve monthly payments of 4d. a month, 4/- yearly.

3. The objects of the Union shall be:-

   (i) To improve generally the conditions of Asylum Workers,
   (ii) To reduce the hours of labour by Act of Parliament,
   (iii) To abolish the age-limits of the Pension Act,
   (iv) To provide allowances for the protection of victimised members of the Union,
   (v) Generally to regulate the relations between employers and employed.
4. That this Union be run purely on democratic lines, i.e. one member, one vote; and the election of officials be entirely in the hands of members.

5. The officers shall be a President, Vice-President, Treasurer and Secretary.

6. The management of the Union shall be vested in a Council and Executive Committee.

7. The Council shall consist of the Officers, together with one or more delegates from each institution according to the number represented.

8. That contributions shall be paid during the first week of each month to the collectors appointed, and these sent in their returns, along with number of membership to the Branch Treasurers not later than the 7th of each month, and that they shall forward these on to the General Treasurer on some date to be decided by the Council.

Yours fraternally,

E. Edmonson
R. Parkin
J. Gold
H.B. Cook
W. Spencer
E.F. Isworth

Lancaster Asylum
Asylum
Rainhill Asylum
Asylum

Jas. Shanks
J. Patterson
J. Smith
M. Meeham
F.J. Richmond
Geo. Gibson

Prestwick Asylum

P.S. All enquiries and communications to be addressed to the General Secretary, Mr. Geo. Gibson, Winwick Asylum, Lancaster.

There was an immediate, and widespread response to the circulation of the pamphlet, and within a year of its inception the union claimed a total membership of 4,400, spread over forty-four institutions. This growth continued and by 1920 its membership was in excess of 18,000 but it is not possible to determine how many of these were actually nurses.

1. I am indebted to the Confederation of Health Service Employees for letting me have a copy of this document.
The Union's First Strike - 4th/5th September 1918.

This was the first recorded strike in the history of the English Asylum service in which nurses and attendants took part. During this strike over 200 of the staff from Prestwick Asylum withdrew their labour, and 429 attendants at Winwick also stopped work for a short time.

Up to this time a great deal of hostility had existed between the Board and the Union. It was not until 1917, after several years of agitation, culminating in a threat of a strike and the direct intervention of the Ministry of Labour, that the Board officially recognised the Union, and conceded to its officers the right to submit the union's application before the Visiting Sub-Committee and Finance Committee.

The first application was made to the Lancashire Board on January 7th 1918 and consisted of the following:

1. A permanent advance of wages of £3— per week to members of the indoor staff, male and female.

2. Payments of all wages weekly.

3. All artisans', labourers' and stokers' wages on the established staff be brought up to a halfpenny per hour below the Trade Union rates prevailing in the nearest borough; other conditions to remain unaltered.

4. A 60 hours week, exclusive of meal times, for the indoor staff; all overtime to be paid for at the rate of time-and-a-half.

5. The discontinuance of the system of retaining a month's wages in hand, and the refund of any such monies now in hand.

6. One shilling and sixpence per night for married men compelled to sleep in the institutions.

7. M.P.* Certificate: £2.10s. Od. per annum (preliminary £2.10s. Od. per annum additional (final).

8. Permission to post Union Notices in the institutions' mess rooms.

* Medical Psychological.
(9) Dietary lists to be posted in the mess rooms.¹

The application, with the exception of a few minor points, was rejected. The Lancaster Federation met to consider the situation, and unanimously passed the following resolution:

"That we again put forward the same requests to the Lancashire Asylum Board as our absolute minimum; that we attach a time limit of 14 days in which to receive an answer, and that the written notices of the members be placed in the hands of the Executive Council to enforce our demands."²

This resolution was sent to the branches and subsequently approved, and on July 27th, the Executive Council of the union gave its formal approval.

In the event the Board virtually ignored the fourteen days' ultimatum, and pursued, what can only be described as a policy of procrastination, i.e. union officials were informed that the matter would be discussed at the next meeting of the Finance and General Purposes Committee of the Asylum Board on September 19th.

It is not necessary here to give a detailed account of the strike, suffice to say that the union was unable to induce the Chairman to call a special meeting to consider the application, and the Prestwick staff withdrew their labour on September 4th, this was followed by a cessation of work by the Whittingham staff on the following day.

On September 5th a special meeting of the Board was convened at which a union official was present. This meeting passed the following resolution:

(a) That this Board agree to the approach of the N.A.W.U. being referred to arbitration, and the Ministry of Labour be requested to appoint the artibrator.

(2) That no employees at any of the asylums belonging to the Board be penalised for participating in the strike now taking place at some of the asylums.³

The findings of the arbitration were not very successful for the union. Only three of the union's demands were allowed, namely: (3), (4) and (5), the others were designated "not established" except for items (7) and (9) which had previously been withdrawn.

The Bodmin Strike
Another strike followed at Bodmin Asylum in October of 1918 and lasted for five days. There had been a great deal of discontent brewing in this establishment, but the strike was aggravated by the suspension of some of the nurses for wearing union badges; in all fifty women were dismissed. This dispute was a victory for the N.A.W.U. The Visiting Committee, after hearing a deputation of strikers and union officials, passed the following resolution:

"That the Visiting Committee recognise the N.A.W.U., and that Asylum employees, being members of the union, be allowed to wear the official badge in such a position as not to cause any injury to patients".

"That this Committee have solely in the interest of patients to reinstate all the attendants on strike". ¹

The Exeter Strike.
On April 30th, 1919 there was a strike of forty-two members of the Union following the dismissal, on the grounds of insolence, of a union member. This strike engendered a great deal of support from other trade unionists in the area. The Exeter branch of the National Union of Railwaymen refused to handle goods for the Asylum and their action was followed by other sections of organised labour. The strike continued until November 8th when the Executive decided to call it off; it had cost the Union over £2,000, of which £1,500 had been contributed voluntarily by members and sympathisers. "As the Asylum Committee refused to reinstate any of the strikers, male or female, who thus lost their employment and pensions to which many of them were rapidly becoming entitled, the Executive decided to grant to each member on strike who

¹. O. cit.
was over 35 years of age, a gratuity of £2 for each year of asylum service. As the aggregate of service of those involved totalled 335 years, the total of this gratuity was £6,700. The other strikers received victimisation pay until they found fresh employment. Thus ended one of the worst cases of individual victimisation in the history of the Union.¹

The Radcliffe Dispute.

There were, in the Union’s history, several other disputes in which nurses were involved, e.g. the Radcliffe dispute in March 1922 when union members resolved not to work the increased hours that the Board had applied. On March 5th the night staff, both male and female, refused to go on duty until a non-union nurse "who had been placed on duty contrary to the arrangements of the staff, was withdrawn".²

A temporary truce was arranged by union officials in which it was decided that at a meeting to be convened within 14 days, the Visiting Committee would make a decision on hours of duty. Three days later, however, every member of staff was given notice terminating his or her employment with the hospital. It was also intimated that if they wished to form part of a new staff at the hospital a special application form should be completed and handed into Matron or the Head Male Nurse not later than 4 p.m. on April 5th. Married men residing in cottages within the Asylum estate also had their tenancy terminated.

The strike started on April 11th and ended three days later. This was a particularly vicious dispute which culminated in the police being called in to evict the strikers. The following is a copy of the office instructions for their eviction.

(COPY) Notts. County Mental Hospital, Radcliffe-on-Trent, Notts. 13th April 1923.

SCHEME OF EVICTION

All unnecessary doors to be locked at 1.0 p.m. to 1.15 p.m.

Ten policemen on duty at entrance door.

Commence 1.15 p.m. to proceed through laundry and round female corridors, to enclose any staff in mess room. Leave 10 policemen on corridors, also send out 16 policemen with Goodwin, who must place two policemen on each of the female courts and two policemen on three male courts.

Remaining policemen together with 15 agents and officials, proceed to Ward 2; the engineer and two joiners immediately endeavour to gain entrance by forcing door or lock. Immediately entrance is obtained, take keys from the nurses and escort them to the female sitting room. Miss Collins to bring in all loyal staff and artizans to this ward as headquarters, then she will immediately proceed to tie up each nurse's property in sheets, if no boxes are available, and take down to the sitting room as early as possible.

Proceed to obtain entrance to wards in the following order:
Female Wards 4, 6, B. A, 5, 3, 1 and 8. When all nurses have been removed to female sitting room, escort them down corridors and put out at main entrance.

Policemen and officials together with remaining agents proceed as before on the male side, using the billiard room placing male nurses, after removing their keys.¹

One can glean some notion of the intensity of the strike from the following reports.

**Daily Sketch, April 15, 1922.**

Nottingham, Friday. — After a fierce hand to hand struggle the nurses on strike at Radcliffe Asylum overpowered and ejected by the police, assisted by a newly appointed staff. By cutting off the water at the main the strikers were deprived of their effective use of the fire hoses.

¹ Quoted in the History of the Mental Hospital & Institutional Workers' Union: 1931, p.50.
The main attack by the police and their supporters was directed against Ward 2. Crowbars were used to force the outer doors and the police then removed the piled up barricades of heavy furniture, bedsteads, and in one case a piano. Beyond the barricades they were met by the strikers and a hand-to-hand conflict took place. A number of inmates reinforced the strikers' efforts, but fortunately most of the inmates contented themselves with smashing furniture rather than attacking the police. Driven in succession through three wards, the strikers took refuge in the common room where they sang "Britons never shall be slaves". That marked the end of a two-hour struggle. Recognising that they were out-maneuvred and overpowered the strikers packed up their belongings, and drove in a motor char-a-banc to the village of Radcliffe.

Glasgow Citizen, April 15th, 1922:

Proceedings began by the strikers, 14 women and 17 men, being summoned to leave. A number of them refused and locked themselves in their wards. To carry out the eviction the authorities had enlisted the aid of a party of bailiffs and a large posse of police. Operations began at one o'clock in the afternoon. A cordon of police was drawn round the buildings, and bailiffs armed with heavy crowbars proceeded to break down the doors of the wards each in turn, demolish the barricades that had been improvised, and remove the recalcitrants. It was a lengthy process, and it was not until five hours later that their task was accomplished.

Opposition was greatest in the female wards, where the nurses put up a strenuous fight.

A good deal of trouble was experienced in the refractory ward. Here some patients, armed with various implements, began to smash the windows. When the attacking party burst into the room, Superintendent A. Smith, in restraining one lunatic, had his hand so badly bitten that medical treatment was necessary.
As each ward was cleared, the new staff waiting in readiness took charge. The old staff were taken to an ante-room, where they packed their belongings, and were seen off the premises in motor-buses provided by the Union.

_The Nottingham Guardian, April 15th, 1922:_

Mr. Gell, Clerk to the Asylum Committee, led the attacking forces. Barricades were forced, doors smashed with iron bars and in some cases violent fights with patients, who got out of hand, took place. For four hours the "battle" raged and then the strikers had to give in. So ended perhaps the most sensational strike of modern times. Not the least amazing thing about it is the manner in which the Union Officials kept in touch with the strikers themselves — by semaphore signalling from a lane close by. Radcliffe inhabitants took the keenest interest in the proceedings, and at a meeting of ratepayers on Thursday night called for a public enquiry into the whole affair.

The Officials of the Asylum Workers' Union before leaving the district for their Manchester headquarters informed a Journal representative that they had decided to make a grant of £100 apiece to seven married men who had lost their positions, were going to maintain the rest of the members thrown out of employment, and would endeavour to find them fresh positions”.

Even after making due allowance for journalistic licence, it is evident that the Radcliffe dispute was, in terms of intensity, quite unprecedented in the field of mental hospitals.

_Moves Towards Amalgamation._

In 1919 negotiations were in process between the National Union of Corporation Workers, the N.A.W.U. and various other organisations concerning the possibility of forming, either an amalgamation or a federation of these trade unions. A delegate conference was called of the N.A.W.U., N.U.C.W., the Poor Law Workers' Union and the National Union of Waterworks' Employees.
"The Executive Council of the N.A.W.U. at its next meeting decided, however, not to affiliate with the N.U.C.W., but to obtain the view of the Poor Law Workers' Trade Union and kindred unions catering for the health services only, respecting federation between the unions. Negotiations between the N.A.W.U. and the Poor Law Workers' Trade Union continued and eventually terms of federation between the two bodies were agreed upon from January 1st 1921. This federation was dissolved within the year.

In April 1923 the N.U.A.W. affiliated to the T.U.C., and in 1935 the Union changed its name to the Mental Hospital and Institutional Workers' Union, and in 1945 a merger was approved between the Mental Hospital and Institutional Workers and the Hospital and Welfare Service Union.

The Hospital and Welfare Service Union.

The formation of this union represented the first trade union inroad into the area of general nursing. Abel-Smith states that the "union actively made more progress in the local authority hospitals than in the voluntary hospitals. The former were larger institutions, their nurses came from lower social backgrounds, and there was some evident source where the money could come from to pay higher salaries."

The union developed out of the Poor Law Workers' Trade Union, which was formed in an underground room at Holborn, London. Shortly after its formation it changed its name to the Poor Law Officers' Union. It was open to all employees in the Poor Law Service, including doctors and nurses.

The first expression of militancy among general nurses was in April 1921 at the West Middlesex Hospital. It resulted from the dismissal, without notice, of Nurse O'Dwyer, a second-year student for alleged breaches of the rules. Further dismissals followed a petition signed by 75 per

2. Ibid.
cent of the nursing staff requesting the reinstatement of Nurse O’Dwyer. ¹

The Board of Guardians of the Brentford Union, by a vote of 18 to 4, confirmed the action of the Hospital Committee with respect to the dismissal. The Poor Law Officers’ Trade Union organised a campaign, and Mr. R.D. Crook,² provincial secretary of the union addressed two or three open-air meetings a night in the Districts included in the Brentford Union Area, and these meetings were attended by many nurses. At these the union gave an official account of the reason that "had led to the dismissal being impugned; it has been stated that the nurses are prepared with sworn testimony to support their case, and petitions have been extensively signed praying the Ministry of Health to hold a public enquiry".³

The union secured the advocacy of Mr. Thomas Griffiths, Member of Parliament for Pontypool, who was instrumental in getting the Ministry to request the Guardians to furnish them with particulars of the dispute. A delegation which went to a meeting of the Guardians was evicted by the police. However, at the next election the Board of Guardians were voted out, "and a union nominee became the new Chairman. In 1923, the previous Guardians were held by the King’s Bench Division to have been guilty of breach of contract when they dismissed the student without notice".⁴

The union worked for the standardisation of wages and gradings within the Poor Law Service, and in 1925 Conciliation Councils were established, largely as a result of the union’s effort. In 1930 the union changed its name to the National Union of County Officers (N.U.C.O.), also in 1930 the Guild of Nurses was formed as the nursing section of the N.U.C.O., and Mrs. Iris Brook, a qualified nurse and midwife, was appointed as its full-time organiser. The Guild of Nurses became one

1. Abel-Smith: op.cit.
4. Abel-Smith: op.cit.
of the most militant sections of the nursing profession, and in 1937 it organised a demonstration at the County Hall at which the members of the London County Council were "showered with leaflets from the visitors' gallery demanding a 96 hour fortnight, and a sandwich board march was organised through London of nurses in white uniforms wearing black masks to avoid recognition (for fear of victimisation)".¹ That evening 500 nurses attended a meeting at St. Pancras Town Hall at which Mr. George Lansbury took the chair.

In 1941 Miss D.E. Westmacott was one of the first two nurses to join the N.E.C. The union changed its name again; this time to the Hospital Welfare Service Union, and in 1946 it merged with the Mental Hospital and Institutional Workers' Union to form the Confederation of Health Service Employees (C.O.H.S.E).

Attempts have been made to organise nurses by four other major organisations, namely the National Union of Public Employees (N.U.P.E); the National Association of Local Government Officers (N.A.L.G.O); the National Union of General and Municipal Workers (N.U.G.M.W.); and the Health Visitors' Association, and the early development of these unions, as it relates to the unionisation of nurses, will be briefly reviewed.

¹ Abel-Smith: op.cit., p.145.
recognise our most serious evils in the unrestrained, unscrupulous and remorseless forces of capitalism". 1.

If such sentiments expressed from the platform of the T.U.C. caused apprehension among the old-style conservative trade union leaders, subsequent events would afford them small comfort. In 1888 the successful strike of the match girls of Messrs. Bryant and May to whose poor conditions Mrs. Annie Besant had publicised in her weekly paper "The Link"; the successful organisation of the Gas Workers by Will Thomas in 1889, and the success of the London dockers' strike during the same year, 2 demonstrated that unskilled workers could employ militant trade unionism and secure victories. It is against this background that the organisation which was the antecedent of the National Union of Public Employees came into existence.

N.U.P.E. stems directly from the L.C.C.* Employees Protective Association which was established in 1888. One of the leading organisers of this new union was Albin Taylor, a labourer employed in the engine workshop at the L.C.C.'s sewage plant at Crossness. Taylor had been greatly influenced by militant socialists such as Gyndman and Quelch, and indeed he joined the Marxist inspired Social Democratic Federation. "With others he began to build a new union, the L.C.C. Employees' Protection Association to unite all classes of workers employed by the L.C.C. Soon there were forty branches in existence, enrolling L.C.C. employees in many departments. Encouraged by this success, Taylor and a group of members obtained a fortnight's leave of absence from work and launched an organising drive which resulted in the establishment of branches in many parts of the country". 3.

The union expanded at such a rate that its name became inappropriate, and as a consequence was changed to the Municipal Employees Association in 1894 with Albin Taylor as its part-time secretary. In 1908 a

3. Dix and McKeown: op.cit.

* London County Council.
number of branches of the M.E.A. split from its promoter Albin Taylor. 

"While the part of it which remained loyal to Taylor formed under his leadership, the National Union of Corporation Workers"; the other part of the M.E.A. continued until 1924 when it merged with several other general unions to form the National Union of General and Municipal Workers. 

The National Union of Corporation Workers changed its name to the National Union of Public Employees at a special conference of delegates in 1928.

During the pre-war period N.U.P.E. made a continuous effort to bring hospital and institutional staffs into the trade union movement, "and obtain for them sorely needed improvements in their standards of pay and general working conditions". But this could not, in their view be achieved without a national wage standard agreed between a single organised body of employers and a single body of employees. Thus, according to the view of the N.U.P.E. leadership the inadequacy of the wages paid in hospitals "resulted from the absence of unity at both ends, from the unco-ordinated manner in which the wages and the terms of service were imposed by the employing authorities and the unorganised state of the employees". This view was substantiated in 1938 by the Inter-Departmental Committee for the Nursing Service which stated in its Report that "only if the two fundamental matters of salary and pensions are treated on a national basis will the present condition improve".

N.U.P.E. had been reasonably successful during the inter-war period in gaining members among ancillary and clerical workers in the hospital service. The nurses however, proved more recalcitrant to trade union organisation. "With, perhaps the exception of domestic servants in

4. Ibid.
private employment, nurses have proved about the most difficult to organise among those working for a living. Yet no section of the working community has suffered more from the lack of trade union organisation".\(^1\)

It has not been possible to secure either pre or post-war membership figures of nurses belonging to N.U.P.E., but a review of the literature connected with the union would suggest that N.U.P.E. made comparatively little inroad into the area of general nursing during this period. What evidence that does exist would suggest that those general nurses that were organised were members of the National Union of County Officers (after 1941 The Hospital Welfare Service Union); similarly, those psychiatric nurses that were unionised tended to belong to the Mental Hospitals and Institutional Workers' Union. Moreover, since both these unions amalgamated to form the Confederation of Health Service Employees, one can infer that, say by 1946, the majority of unionised nurses in the hospital service were members of C.O.H.S.E. This, of course, is difficult to substantiate because of the difficulty in securing data e.g. in a letter to the writer from N.U.P.E.'s research department the 2nd paragraph reads as follows:

"I'm afraid there is very little we can do to help your research. We don't keep membership records for particular grades, let alone sex breakdown by occupation within each service".\(^2\)

On the other hand, in 1958 C.O.H.S.E. claimed a membership of 26,300 nurses i.e. 23,500 mental nurses and 2,800 general nurses.

**Amalgamation.**

One of the major trade union organisational problems within the hospital service was the confusion caused by the duplication of unions vying for members. There existed in 1941 five T.U.C. affiliated unions competing

1. Craik: op.cit.
for membership, the Mental Hospital and Institutional Workers Union,
The National Union of County Officers, the Transport and General
Workers Union;¹ the National Union of General and Municipal Workers
and N.U.P.E. Of these it appeared to N.U.P.E. that the first two
suffered from having a too narrow structure, whereas the two general
unions suffered from the converse. It is not surprising therefore,
that having this view N.U.P.E. was calling for reforms in trade union
structure; and at the T.U.C. Congress in 1941 Bryn Roberts, the General
Secretary moved his Union's resolution which called upon the General
Council "to examine every aspect of the trade union movement, including
the functions and structure of individual unions with a view to
reporting to a future Congress what alterations will be necessary to
enable the trade union movement to safeguard the workers interest to a
greater degree, and to enable it to exercise the greatest influence upon
the anticipated social and industrial changes, and to conform to the new
needs that will arise". The resolution further specified the questions
which should be determined, and these were:—

"(1) Whether general unions shall be circumscribed or permitted to
extend to all industries;
(2) Whether the existing boundaries of craft union organisation
should in the light of present and anticipated developments,
be altered; and
(3) Whether or not greater effectiveness would be attained if the trade
unions were to be recast on industrial lines.
Congress requires that the General Council shall, during its enquiry,
call before it any person who may be of assistance, and that
affiliated unions shall also be invited to submit to it both
verbal and written consideration.

¹ The T.& G.W.U. did not however, attempt to unionise nurses.
Congress requires that the General Council shall, as soon as possible, present the results of its examination, and if thought necessary, convene a Special Congress to consider same".1

This resolution was rigorously opposed by the two general unions and on a card vote was defeated by 164,000 (2,384,000 for and 2,548,000 against).2

Thus, during this period N.U.P.E. was unsuccessful in bringing about any rationalisation of trade union organisation within the hospital service, or any amalgamation of unions aimed at achieving such rationalisation.

The National Association of Local Government Officers (N.A.L.G.O)

At the turn of this century local government was a congeries of innumerable different authorities. Each one being an autonomous unit, and as a consequence could fix, according to its own set of criteria, salaries and conditions of service of its employees. "In some towns each chief officer picked his own staff, fixed their salaries and paid them out of his own".3 In others staff were appointed by committees, and often salaries were fixed "at the committee's whim",4 irrespective of what the salary may have been in other authorities for the comparable post. In spite of these disadvantages, a position within the municipal service was considered reasonably secure, and carried a certain amount of status; consequently such posts were widely sought after. The comparative attractiveness of the municipal service led to all sorts of abuse, especially that of nepotism. "Almost everywhere, appointment was by patronage. With posts so coveted, councillors and officers alike awarded the prizes to relatives, friends, supporters, personal servants or unemployed men they wished to help".5

4. Ibid.
5. Ibid.
As a reaction to the excesses of the system, and to protect the interests of municipal officers N.A.L.G.O. was formed in 1905. It was not an affiliated union of the T.U.C., and only became so in 1964.

A detailed history of the Association lies outside the purview of the present study, and in this section I will only concentrate on those aspects of its history as they relate to the recruitment of nurses in the inter-war period.

In the course of its development N.A.L.G.O. had recruited a number of nurses who were employed in the local government service but it achieved little success among those employed in the hospital service. In 1932 when the Lancet Commission made sixty-one proposals for reform N.A.L.G.O. supported the majority of these. However, the Association was unsuccessful in getting the local authorities to adopt the Lancet Commission's proposals, so in 1934 it adopted the recommendations of the College of Nursing, and N.E.C., urged its branches to press for their implementation. The branches rejected the College of Nursing proposals out of hand as being too meagre. In fact J.B. Swinden, Organising Secretary, told "the N.E.C. in 1937 that not a single branch had sought adoption of the scales". Meanwhile the T.U.C. had produced its own Nurses' Charter, together with proposals for a Whitley Council for all nurses. Moreover, it had initiated membership drives in order to recruit nurses into affiliated unions. Thus, if N.A.L.G.O. was to maintain the membership of its existing nurses, and recruit more to its ranks, the whole question of the organisation of nurses had to have its immediate attention.

The National Executive Council was under considerable pressure from the branches to produce its own proposals, and as a result of which produced its own 'Public Health Officers' Charter'. This was adopted by the

1. See page 61.
Association in July of 1937. It went much further than any of its predecessors, and the recommended salary scales were well above those proposed by either the College of Nursing or the Lancet Commission. In addition to the question of salaries it recommended further——three weeks annual paid leave; more freedom from petty restrictions within hospitals; the establishment of a 48 hour working week; and the creation of local collective bargaining joint committees. "Once again, branches and districts were asked to urge these proposals on local authorities and to use them to recruit more nurses into membership. By June 1939 the N.E.C. reported that twenty-two authorities, including some of the biggest, had agreed improvements. At the same time, the N.E.C. appointed a "Womens' Service Committee" to advise it on all nursing problems, run summer and week-end schools for nurses, offer scholarships for sister tutors, midwives and health visitors, and give prizes to those doing well in examination".1.

N.A.L.C.O, along with other unions, gave evidence before the Inter-Departmental Committee in 1937, and many recommendations made by the Association were accepted by the Committee. In particular the recommendation for the establishment of a joint committee consisting of nurses and their employers.2.

Immediately on the publication of the Committee's findings, Haden Coaser and Edward Bishop, joint secretaries of the National Whitley Council,3: suggested that the council should become the sole negotiating body for all types of nurses. Following from this recommendation the Whitley Council sent a deputation to the Minister of Health and Labour "claiming that

2. Inter-Departmental Committee of Nursing: op.cit.
3. The self-styled National Whitley Council was formed in 1936, but it was 'national' in name only; out of 1530 local authorities in 1940 only 553 were members. For a detailed discussion of its development see Spoor: 1967, op.cit.
it, and it alone, was the proper body to settle the conditions of local
government nurses, and offering to appoint a separate panel which, with
the addition of representatives of the voluntary hospitals and other
nurses' organisations, might become a National Nursing Council,
legislating for all nurses".¹

This plan was far too revolutionary in its ramifications for it to be
acceptable to other bodies. Neither the voluntary hospitals or the
nurses' organisations were likely to acquiesce in a scheme which would
place a nursing body so firmly within the domain of local government.
Thus in view of the predictable recalcitrance of the College and the
voluntary hospitals to such an arrangement the National Whitley Council
agreed to the formation of a joint committee for local authority nurses
only. In this connection N.A.L.G.O. proposed that nine members be appointed
to this joint committee from the Staff Side of the National Whitley Council
(in effect this meant nine N.A.L.G.O. members because of the Association's
dominant position on this body); six from the College of Nursing and one
from other organisations. Predictably the College of Nursing would have
no part in this. The College had no intention of taking a subordinate
role on a Nurses' Committee, and there ensued a long bitter wrangle
between the two organisations. The matter was finally resolved in 1941
when N.A.L.G.O. had to give way by agreeing to share the membership equally
with the Royal College of Nursing. In the event the scheme never
materialised because the Minister of Health announced the Government's
decision to establish a national committee representing all the organis-
ations of both the employers and nurses for the purpose of determining
conditions and salaries for all nurses. The advent of this development
presented a dilemma for N.A.L.G.O. If it were to accept a position on

¹ Spoor: op.cit., p.475.
the new council it would be seen to be betraying its own Whitley Council that it had striven to build, on the other hand if it refused to participate in the new committee, it would stand to lose a negotiating position on the part of its own nursing members.

"Though several members of the N.E.C. urged that the Association must stand by its own Whitley Council and have nothing to do with the Minister's negotiating committee, the majority agreed, reluctantly, to accept this offer. They were reinforced in this decision by the disclosure that, in May—while it was still discussing them with N.A.L.G.O.—the Royal College had taken its salary proposals direct to the Ministry, by-passing the Whitley Council, and that the T.U.C. had also begun talks with the Ministry".1

The Government Committee under the chairmanship of Lord Rushcliffe was appointed in 1941 and reported in 1943.

N.A.L.G.O. undertook a further recruiting campaign, offering £350 scholarships to nurses and running week-end and summer schools. It published leaflets and directed its branches to undertake recruitment drives. Initially it was not too difficult to recruit nurses, but it proved to be virtually impossible to keep them. Firstly the nurses in the general hospitals had little interest in trade unionism, and if a nurse did overtly become a member she risked incurring the displeasure of her matron. Secondly, nurses were a floating population, moving from municipal to voluntary hospitals or private practice, and in the case of the latter two cases were not eligible for N.A.L.G.O. membership. The solution appeared to be in the formation of a separate nurses' union, open to all nurses, within the framework of the Association. This the annual conference of 1943, instructed the N.E.C. to do. Plans were produced "for a separate Nursing Association, open to all nurses and

midwives, administered separately from N.A.L.G.O., yet closely linked with it. Before any action had been taken on these the government published in 1944 a white paper outlining a National Health Service. Since this promised far reaching changes the N.E.C. put its Nursing Association into cold storage, agreeing instead to amend the Association's rules so that a nurse recruited into N.A.L.G.O. while working in a municipal hospital might retain her membership on moving to a voluntary hospital. In the event, the amendment was not implemented. In 1945 the Service Condition Committee was informed that the Association's desire to recruit nurses in the municipal hospitals had been unsuccessful. "It was all too clear that nurses lacked 'trade union consciousness' and - as other unions were finding - could not be persuaded to collective action. And if N.A.L.G.O. had failed in the municipal hospitals, it must fare even worse in the voluntary ones where the 'matron complex' was stronger." In 1965, out of a total nursing force of around 186,000, N.A.L.G.O. had only about 3,000 members, although all nurses within the National Health Service and local authority service were eligible for membership. The Association had therefore, been completely unsuccessful in its attempt to organise nurses.

The General and Municipal Workers Union (G.M.W.U).

This union came into being in 1924, as a result of an amalgamation between the National Amalgamated Union of Labour, the Municipal Employees Association³ and the National Union of General Workers. It is generally agreed that the G.M.W.U. endeavoured to organise workers in the health sector, but I have been unable to secure any specific references to the unionisation of nurses from the union's literature. A letter to the

2. Ibid.
writer from the General Secretary of the G.M.W.U., states: "we have no information as to any recruitment campaigns (directed at the recruitment of nurses) conducted during the 'twenties and thirties". Moreover, it would appear from Clegg that N.U.P.E. was generally more successful than the G.M.W.U. In a reference to N.U.P.E's general secretary's activity in this area he makes the following observation: "he concentrated much of his efforts on the County Council employees and the hospital and institutional staffs which had been taken over by the local authorities from the Poor Law Guardians under an Act passed in 1929. The strength of the General and Municipal Workers, by contrast, was mainly in the great urban authorities". 

Thus although the G.M.W.U. is represented on the Nurses and Midwives Whitley Council, and probably has a few nursing members, such members have not been conspicuous in nursing campaigns, and the headquarters appear to have no knowledge of its national membership among nurses, viz. "In answer to your query concerning G.M.W.U. organisation of nurses, I regret to inform you that all records on nursing membership are held at Branch level, and therefore it is not possible to provide you with a national figure". Moreover, it has not been possible to elicit from the union's records any specific reference to nurses or their recruitment. It would appear from the scanty sources available, that the G.M.W.U. secured its place as a negotiator of nurses' salaries by the reallocation of the places held by the Trades Union Congress on the Nurses and Midwives Whitley Council in 1948.

The Health Visitors' Association (H.V.A.)

This Association was founded in 1896 as the Women Sanitary Inspectors' Association by seven women sanitary inspectors working in London. In 1906 the majority of members still worked in the London area, but in the October of that year a direct appeal to join the Association was

1.  Signed by David Basnet and dated 24th May 1976
3.  Letter from General Secretary, op. cit.
circulated to sanitary inspectors working in the provinces and this resulted in the recruitment of a few new members. The membership had risen to 63 in 1906. ¹

In 1908 the London County Council (General Powers) Bill was placed before Parliament. Clause 19 of this Bill made provision "to appoint health visitors to give advice on the feeding and rearing of infants, these appointments to be ratified by the Local Government Board".

The Association viewed the appointment of a new kind of official whose status and salary was lower, but whose duties could conceivably overlap with those of sanitary inspectors, constituted a threat to their members. The views of the Association were expressed in a letter to the Clerk of the London County Council in which the following paragraph is indicative of its concern:

"The women Sanitary Inspectors now appointed to the Borough Councils are already engaged in carrying out sanitary work in lodgings and tenement houses — besides workshops and work places. The recognition by the Local Government Board of a fresh class of official would, in many cases, lead to the appointment of health visitors in the place of sanitary inspectors, and our women would therefore be deprived of valuable influence that they are now able to exercise through the statutory powers in the Public Health Administration." ²

The Association proposed its own amendments to Clause 19, but was unsuccessful in getting these included.

In 1909 a number of members were expressing an interest in trade unionism in general, and women's unionism in particular, and as a result of this interest, Miss Mary MacArthur, secretary of the Women's Trade Union League, was invited to address a special meeting of the members of the Association on April 22nd, 1909. At the next Annual Business Meeting the following resolution was moved:

"That this Association having definitely adopted the policy of promoting and protecting the interests of its members, be affiliated to the Womens' Trade Union League".

After further discussion the resolution was amended and passed as follows:

"That this Association having definitely adopted the policy of promoting the interests of its members appoint a special committee consisting of the officers, the mover and seconder of the resolution, and the mover of the amendment to investigate and collect information with regard to affiliation with the Womens' Trade Union League". ¹

The report of this committee was discussed, but it was subsequently decided that it was contrary to the interests of the Association to affiliate with the Womens' Trade Union League. However, the Association did register as a trade union in 1918.

Although the Association initially resisted the creation of health visitors; faced with its failure to amend Clause 19 of the L.C.C. (General Powers) Act, it embarked on recruiting health visitors into its ranks, and by 1914 sufficient numbers had joined the original sanitary inspectors for it to change its name to "The Women Sanitary Inspectors and Health Officers Association". A further extension of membership was undertaken in 1921 when membership was extended to other women engaged in different branches of public health, as for example, school nurses, domiciliary midwives and matrons of day nurseries. Furthermore, in addition to members and associate members a new grade of membership, that of 'student associate' was included in its constitution.

In 1925 the Association affiliated to the Trade Union Congress and there followed regularly, T.U.C. resolutions, and deputations to the Ministry of Health on matters relating to public health. The

¹. Annual Report 1907/8, op.cit.
Association's representative acted as the T.U.C's spokesman on such deputations.

The inclusion among the Association's membership of those grades referred to above brought another change in name in 1929 to that of the Women Public Health Officers.¹

By 1947 the Association had a membership of 2,853, and its membership has continued to grow as indicated by the following table:

Table 3.

Membership of the H.V.A.*

<table>
<thead>
<tr>
<th>AS AT</th>
<th>MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.12.1948</td>
<td>2,948</td>
</tr>
<tr>
<td>31.12.1951</td>
<td>3,295</td>
</tr>
<tr>
<td>31.12.1964</td>
<td>3,343</td>
</tr>
<tr>
<td>31.12.1966</td>
<td>4,641</td>
</tr>
<tr>
<td>31.12.1968</td>
<td>5,063</td>
</tr>
<tr>
<td>31.12.1970</td>
<td>5,432</td>
</tr>
<tr>
<td>31.12.1971</td>
<td>5,995</td>
</tr>
<tr>
<td>31.12.1972</td>
<td>5,489</td>
</tr>
<tr>
<td>31.12.1973</td>
<td>6,826</td>
</tr>
<tr>
<td>31.12.1974</td>
<td>7,172</td>
</tr>
<tr>
<td>31.12.1975</td>
<td>8,603</td>
</tr>
</tbody>
</table>

* Source: Annual Reports of the Association.

Although the Association was, and continues to be, active through normal channels of communication between the trade unions and the Government and local authorities, the writer has not been able to discover any record of disputes in which its members played a militant role. In fact, even in 1976, it is unconstitutional for the H.V.A. to call a strike or provide for any form of action fund. However,

¹ The name Health Visitors' Association was adopted in 1962, by which time health visitors constituted the vast majority of members.
even though it represents comparatively a small number of nurses, it
is unique, insofar as it is the only extant trade union affiliated to
the T.U.C. catering specifically for nurses, even though its members
are drawn from a specialised field. Like other trade unions the
H.V.A. has to compete for members with the R.C.N. which has a separate
Health Visitors' section.

The Labour Party and the T.U.C.
The various attempts, referred to above, directed towards the
unionisation of nurses did not go unnoticed by the Labour Party,
whose leaders undoubtedly saw the advantage of endeavouring, as
Abel-Smith says, to "associate the new trade unions, or at least
nurses who were 'trade union minded' with the wider Labour movement". 1
The Labour Party organised a conference to consider the 'Organisation
of the Nursing and Kindred Professions', which was to be held in the
Caxton Hall, London on January 28th 1927. To this end the Sub­
committee of the Standing Joint Committee of Industrial Womens'
Organisations and the Labour Party's Advisory Committee on Public Health
produced a Draft Report for submission to the conference. Apart from
reviewing the existing nursing services, it made a number of observations
and recommendations in each of the sections specifically reviewed. On
the question of organisation the Report made the following observation:
"The nursing profession is at present imperfectly organised, though a
few nurses belong to Trade Union organisations, and a good many to the
College of Nursing, and some other organisations of hospital and other
employing authorities. Some of these organisations have assisted in
improving the status of nurses, but no substantial progress can be made
until the organisation of the nursing profession is undertaken by
associations governed exclusively by the nurses themselves. Those
members of the nursing profession who occupy positions of authority,
such as matrons, are of necessity representative of the employers

rather than of the employed. Unfortunately, owing to the tradition of the profession, the average nurse thinks of a Trade Union as a body of manual workers continually taking part in strikes. She does not realise that every profession has found organisation necessary. Thus, doctors and lawyers have formed their own professional associations, and Civil Servants, teachers and health visitors have also their own Trade Union associations. The only way in which nurses can deal effectively with their conditions and exercise any sort of equality in bargaining power is for the profession to be organised on Trade Union Lines".1.

In many other respects the Draft Report made recommendations that were to become operable when the National Health Service was established many years later. But it was its reference to trade unionism which offended the nursing establishment. The Nursing Times, the official organ of the College of Nursing, launched an attack on the Labour Party Report. It was extremely critical of "the recommendation of an absurdly high salary for the nurse in training" and by the denigration of the matron's authority by "the insistence on authority being in the hands of a committee rather than in those of responsible officers".2. The main anathema to the College, however, was the notion that the profession should adopt trade union organisation and tactics. It argued that the ethos of trade unionism had been built on the assumption that trade unionists were prepared to use the threat of, or in the final analysis to organise strikes in pursuance of their claims. But the threat or use of a strike would be "a betrayal of trust", and was tantamount to "putting their own professional advantage before the needs of the people they served". It is interesting to note that the Nursing Times felt it could make such a statement in view of the fact

that a number of nursing trade unions, as for example the Health Visitors, had virtually ruled out the possibility of strike action by their members. On the question of organisation the Nursing Times commented that "The need for organisation had already been met by the establishment of the College of Nursing".¹

In 1930 a Labour M.P., Fenner Brockway, presented - without prior consultation with the nursing organisations - a bill to Parliament "to lay down minimum wages and maximum working hours for the nursing profession". A 44 hour maximum working week was proposed for "all nurses whether in institutions and hospitals or district nurses".²

"The minimum rates of pay mentioned in the bill were substantially higher than those recommended by the College of Nursing - particularly for probationers. It was proposed that probationers should be paid salaries ranging from £40 to £60 in the three years of training. Trained nurses should start at £75 and sisters at £85".³

The College of Nursing attacked the bill on the grounds that no professionals would tolerate their hours of work being determined by external legal regulation.⁴ In the event the Government did not grant facilities to the bill and it was never reintroduced as Mr. Brockway was not returned to Parliament in the election following the fall of the Labour Government.⁵

The Draft Report and the subsequent activities undoubtedly made some contribution to the general climate of unionisation of nurses, but it did not effectively break the College of Nursing dominance over the major sectors of the profession, especially in the area of general nursing.

¹ Nursing Times: op.cit.
³ Abel-Smith: op.cit., p.138.
⁵ Abel-Smith: op.cit., p.138.
The Trade Union Congress.

The Trade Union Congress at its 1935 Conference passed a resolution proposed by the National Union of County Officers, instructing the General Council to use its influence in securing a working week of 48 hours for all employees in the hospital service. "The Minister of Health received a deputation from interested trade unions on 23rd July 1936 and N.U.C.O. wrote to local authorities asking for the immediate introduction of a 48 hour working week. A bill to secure this objective was presented to Parliament in April 1937. The Royal College sent a circular to members of Parliament opposing the bill".1

The College of Nursing opposition to the bill was vigorously attacked by the T.U.C. Furthermore, it attacked the College of a number of other issues, as for example, the discrimination that it operated over membership to the College — male nurses, student nurses or nurses on the Supplementary Register were not eligible for membership. It concluded its attack by describing the College as "an organisation of voluntary snobs", which in effect was saying that the college was only interested in representing the nurses in the voluntary hospitals.2

Certainly during the period the T.U.C.'s criticism of the unrepresentative character of the College was valid; apart from the limitations on membership referred to above, there were very few nurses from the municipal hospitals represented on the governing bodies of the College.3

The T.U.C.'s strength lay in its realisation that it stood a good chance of recruiting to the trade union movement those members of the nursing force who were ineligible for College membership, and of course, it entertained no inhibitions of the efficacy of this policy.4

1. Abel-Smith: op.cit., p.143.
3. Abel-Smith: op.cit., p.143.
4. Ibid.
The source of real conflict between the T.U.C. and the College was on the question of whether nurses should be organised on an industrial basis. The College perceived the unionisation of nurses not only as a threat to its own hegemony, but also as a direct threat to the professional status of nurses. "In effect" as Abel-Smith says, "the T.U.C. by attempting to organise nurses was blurring the distinction between a profession and a trade - it was challenging professionalism at its very roots".\(^1\)

Conclusion.

Perhaps the first point which should be made is the absence of hard data prevents one from arriving at any firm conclusions based on statistical analysis. However, the quantitative approach fortunat\(^{\text{e}}\)ly is not the only tool applicable to social science research; quite often the use of documents yields valuable information, and by using this approach a number of observations may be made about the inter-war position of nurses with reference to unionisation and manifestations of militancy. The literature shows that the unionisation of nurses was initially established and became reasonably entrenched in two main areas of nursing; namely in mental hospitals and in the public health sector. In the former, the foundation was laid by the National Asylum Workers Union. Why unionisation should have first occurred in this field of nursing is an interesting question, and one can hazard a number of possible explanations. In the first place, both the social class and sex factors were markedly different in the mental hospital field than in the voluntary hospitals. The overwhelming number of attendants and nurses in the Asylum Service were from working class backgrounds, whereas, the method of recruiting, training and ethos of the prestigious

voluntary hospitals tended to attract those who were either middle-
class or aspired to be so. Thus to use a Marxist analogy, although
the workers in the asylums were not members of the proletariat insofar
as they were not involved in the production of surplus value, the
originators of the union were located in an industrial area, and in many
cases came from similar social and geographic backgrounds as the
productive workers in the area. This may well have had two important
consequences. In the first place they could conceivably have had an
image of society similar to, and derived from their association with
the industrial working class of the area. An image which conceives
of society in terms of a dichotomy between "two antagonistic classes".
Secondly their class consciousness may have been a factor in their
tendency to combine to form a trade union (the historic method) in
order to secure better wages and conditions. Their proclivity to
organise in this specific manner, as distinct from joining the
movement of professionalism, may have been a corollary of their close
proximity to the industrial working class. We have assumed the
Marxist model, but their action could be explained in terms of the
'social psychological' approach of Geiger,¹ which asserts that "a
man belongs to a class that he feels he belongs to". In a word,
since they were closely associated with that group which Marx called
the proletariat, they shared the value system of that class and
perceived themselves as being members of that class. It is reasonable
to infer therefore that they were much more oriented to the form of
organisation that was typical for the working class. This consciousness
is exemplified in that part of the pamphlet circulated by the union
which refers to 'the end and aim of a trade union'.²
The other factor was that of sex, a large number of the nurses were
male and they were precluded from membership of other nursing professional
associations.

1. 1949.
2. See page 135.
In the case of health visitors, these worked mainly in the local government field, and as a consequence, came into contact with other organised workers in a way in which the nurses in the voluntary hospitals did not. Their predilection towards trade unionism and thus their tendency to organise, may have been due to the effect of contagion, which in this context can be taken to mean the rapid speed of an idea or pattern of conduct by spontaneous imitation. In their association with local authority employees they came into contact with many organised quasi-professional and professional workers, as for example local government officers, teachers, and in a few cases even accountants, lawyers and physicians who were members of NAIPC.

In the general hospitals it is clear that NUP and GMW made some recruits among nurses, but on their own admission, their pre-war record was not an overwhelming success. What progress was made in unionising general nurses was in the area of the municipal hospitals. The unions virtually made no inroad into the voluntary hospitals where the influence of the Royal College remained supreme.

However, this brief review has dispelled the myth that up to the late '60's and early '70's nurses had never taken any form of militant action. There are, as has been shown, clear records of strikes in which nurses were involved in the mental hospital field — evidence has been given of the manifestation of militancy in a municipal hospital in 1921 and a further demonstration in London in 1937.

However, the major difficulty in trying to assess the extent of unionisation during this period has been, with the exception of the health visitors, the complete absence of union membership figures among nurses.
CHAPTER 5.

THE USE OF KEY INFORMANTS

The research connected with the preceding chapters uncovered a number of individual incidents of militancy by nurses. However, as one proceeded at the empirical level, the main research problem became one of determining the chronological point at which the post-war militant movement began. Also, at this stage I had reached a point when it was possible to formulate a number of tentative causal hypotheses which might possibly explain the phenomenon.

I therefore decided to construct a simple interview schedule which would perform the dual function of (1) indicating a point in time where I could start my study of post-war militancy among nurses, and (2) providing data which could be used for generating theories. Not having the resources to mount a full-scale survey based on a large sample of nurses, I decided upon the use of 'key informants'.

However, before recording the responses of a number of key informants to specific questions, perhaps a brief note on the methodology of the technique would be appropriate.

Key informants have always been used in journalism, but as a field technique it has its origins in social anthropology. In recent years, however, its use has been extended to other disciplines, such as sociology, political science and journalism: (Becker et al., 1961, Blackman et al., 1970, Camp bell, 1955, Dahl, 1961, Glaser, 1966, Hunter, 1953, Rossi and Crain, 1968, Tremblay, 1957). And more recently Houston and Sudman, (1975), who set out to test the hypothesis that "A specific information item is more salient to an informant whose role is directly related to the item, than to an informant whose role does not relate to the item".

This study showed that "when significant effects were observed these were
always related to one or more of the informants.

One is, of course, conscious of the serious methodological problems involved in asking a respondent why a certain event occurred, and the problem is not necessarily minimised because the social role of the respondent happens to be connected with the item of information under scrutiny. Why this should be so is almost axiomatic; one is entering into an area of subjective judgements which may well be value laden. In essence, moving into an area of controversy which Zelditch says is either for or against quantification. "To some extent the battle lines correlate with a relative concern for 'hardness versus depth' and reality of data. Quantitative data are often thought as 'hard' and qualitative data as real and deep".¹

My own view on this kind of controversy is that excessive polarisation of this nature poses a false dichotomy. Some kinds of data are, by their nature, more amenable to a quantitative approach, whereas other kinds will perhaps yield more from a qualitative interpretation. The researcher who favours the 'hard' approach will certainly argue that opinions are not a satisfactory substitute for facts. However, if one finds, for example, that a substantial majority of respondents have the same opinion about the reason for, or description of, an event, then this is, of course, a fact. But then it may equally be argued that opinions may be formed on the basis of emotional factors, and may, as a consequence, only give factual information of the emotional state of the respondent. This is an argument which is difficult to contest, in as much as the recollection of an event, and the interpretation that a person gives to it, is inextricably interwoven with the emotional intensity with which the person views such an event. But this is not to say that recollections are invalid because they are too subjective to have any scientific value.

Certainly a respondent's account of an incident cannot be taken on its face value, but must be referred back to some form of documentary evidence on the general grounds that library material has a disadvantage because, information yielded by a writer (whether about himself or the description of an event), can be purposely misleading, I would refer them to Kenneth Block who, in my view has correctly remarked "The belief that what men have observed and recorded about human social life is but a distorted subjective reflection of what was really there is a debilitating assumption. This sort of scepticism jeopardises the entire study of man, for not only does it deny us access to the great bulk of human experience but it eventually casts doubts upon the reliability of all observation. For all recorded observations were at one time 'contemporary' and there is little warrant for the current conceit that the intelligent and careful observer is an exclusively modern phenomenon. The bright-eyed young sociologist with his scheduled interview might generously concede that the shrewd perceptions of Hesiod, Machiavelli or Voltaire, deserve a place alongside his own findings in the broad fund of social knowledge. All records call for careful scrutiny, but the techniques devised by historians for establishing the reliability of their data are by no means inferior to those employed by the social sciences". ¹

I would sum up my own position by saying that if one can correlate information yielded by respondents with similar information derived from documentary sources and observation, then one is essentially in an area of empirical research. Moreover, if one can use such information in an attempt to ascertain causality, one is therefore in the domain of the 'scientific method'. The fact that the collection and evaluation may not be quantitative, does not in itself detract from the scientific approach.

In the course of considering into which categories these 'key informants' might be placed, it occurred to me at the occupational level, I might be able to use the concept of social imagery.

There has been a great deal of work undertaken on social imagery, most of which has been directed towards an image of society, although as Benetti and Sheehy says '... no clear definition of the term is widely accepted'. One can, however, confine this approach to a more narrow domain, as for example, the perspective of an occupational image. Such an approach follows one of the four usages distinguished by Willener.

In considering the use of the concept of social imagery with key informants it occurred to me that it would be useful to classify each informant according to the image they perceived as being the most suitable for the organisation of nurses. This suggested three possibilities:

1. The older traditional model of professional organisation,
2. Trade Union, and
3. A synthesis of (1) and (2).

I will be returning to the question of an alternative model of trade unions and professional associations when I discuss the changes which occurred within the Royal College for the period 1960-1972. In order to get a crude indicator of where these informants stood vis-a-vis the trade union, professional association issue, I classified them as:

(A) Member of Professional Association only,
(B) Member of a trade union only,
(C) Member of both.

Because they are key informants, they have been deliberately selected for their position, and cannot therefore be taken to be representative of the population of nurses. Their value lies in their special knowledge or the particular role they played in the question under discussion.

2. 1972.
For the sake of confidentiality, only the sex, approximate age, qualifications and position within the profession is indicated.

Each of the respondents were asked the following open-ended questions:—

(1) As far as you can remember, when did the first signs of militancy occur among nurses?

(2) From which section of the profession did this materialise?

(3) Why do you suppose that nurses have been more militant in the post-war than the pre-war period?

(4) Do male nurses have a greater tendency toward militancy than female nurses?

(5) Do you think the trade unions are gaining membership among nurses?

(6) Do you think that the younger nurses were influenced in any way by the students' protest movement?

(7) To what extent do you think that nurses' militancy was, and is, part of a wider expression of middle-class militancy, e.g. teachers, local government officers, junior doctors, etc?

(8) Why do you suppose that this happened?

(9) Which, in your view, is the most militant trade union representing nurses?

(10) Does the name Sister Patricia Veal have any significance to you?

(11) Have you ever heard of an organisation known as Marxists in Medicine?

(12) Have you ever heard of an organisation known as 'Nurses Action'?

(13) Has the character, structure or style of leadership of the R.C.N. changed say between 1960 and 1972? If so how?

Each interview was tape recorded and full transcripts are given in Appendix I. Supplementary or probing questions are indicated by 'Q' in the transcripts.

Ten informants were selected, 3 were practising nurses; 1 a nursing journalist; 2 nursing administrators; 2 trade union officials (one from N.U.P.E. and the other from C.O.H.S.E); 1 full-time R.C.N. official;
and one engaged in research, but who also worked as a night sister on one evening a week.

The organisational membership of the informants was as follows:

R.C.N. - 4, Trade Union - 4, and 2 were members of both the R.C.N. and a trade union.

Summary of the Interviews.

In replying to question (1) 9 out of the 10 informants said either emphatically 1960-62, or the early 60's. Informant 10 suggested 1968, but then confirmed that he had only worked in the health section of his union since that time, and did not possess knowledge of earlier events. Informant 7 mentioned an incident in 1947 but then went on to say unequivocally that the nursing campaign started in 1962.

Informant 5 was of the opinion that the nurses' campaign really started in 1968 with the 'Raise the Roof' campaign, but suggested that changes had been occurring since the early sixties.

In responding to question (2) 8 of the informants out of 10 said without doubt that nurses' militancy started in the psychiatric field. Informant 10, although stating that he did not know, in fact said by implication that this was the case when, in question (2) he said: "They (C.O.H.S.E) were always better organised than the general nursing side". I was not surprised by this majority view. A review of Chapter 4 will clearly show that the psychiatric section had the highest density of trade union membership, and indeed, it was the area of nursing having the greatest occurrence of pre-war disputes.

In question (3) all the informants attributed the reason for more militancy among nurses in the post-war period to changes in the social climate.

Question (4). 9 out of 10 of the informants thought that male nurses were more militant than their female colleagues, although some indicated
that this situation was changing.

All informants, both trade union and R.C.N. members, were of the opinion that the trade unions were gaining members among nurses. Naturally T.U. officials put it more strongly than R.C.N. members, although I was surprised at just how affirmative some of the R.C.N. members were, for example Informant 4 who is an official for the R.C.N.

On the question as to whether young nurses were affected by the students' protest movement, the consensus view was that it only had a marginal affect, and this operated where hospitals tended to be located near universities in which student activity was taking place.

Eight of the informants saw nursing militancy as an expression of a wider middle-class or white-collar movement. Informant 1 did know the reason why it occurred, while Informant 3 was certain that the nurses' movement occurred quite independently of other trends.

As to the reason why militancy developed among nurses in the 60's, the replies of most of the respondents could be classified under the heading of 'changes in social attitudes'.

On the question of the most militant nurses' trade union; the informants were equally divided between C.O.H.S.E. and N.U.P.E. It is interesting to note that 2 of the informants who said N.U.P.E. indicated that it used to be C.O.H.S.E.

Miss Patricia Veal apparently made quite an impact on nearly all the informants. 9 out of 10 were well aware of her activities in 1968.

Of the peripheral activist groups operating within nursing, 4 informants had heard of "Nurses' Action" and 2 "Marxists in Medicine", however, these two were included in the 4 above.

All the informants indicated that the R.C.N. had changed its structure —
style since 1962. Several indicated that it was now projecting a more trade union image.
CHAPTER 6.


There were, of course, many claims in the 'fifties, but the first rumblings of recent militancy can most clearly be seen as indicated by the key informants, in the 1962 salary dispute, and it was the campaign which surrounded this dispute which set the stage, as it were, for a style of bargaining which was to become a feature of future nursing disputes. It was perhaps this campaign which represented a watershed in the change of attitudes and behaviour of nurses in relation to their demands for increased salaries and improved conditions of service. In dealing with this stage, it might prove useful to deal initially with the various claims between 1962 and 1972, and then to go on to discuss in the next chapter the campaigns and the varying degrees of militancy which they engendered.

The 1962 Claim.

The negotiating machinery within the health service is both divided and complex, and issues are frequently blurred by political pressures. Within the service there exists a framework for negotiation, which on the face of it, takes place between employers and employees, however, the principal protagonist in such negotiations, the Government, is neither present nor accessible. The problem has always been there and is really a concomitant of the way in which the service evolved. The National Health Service took over the municipal hospitals and some of the municipal services, together with the voluntary hospitals. The service was managed by a congeries of different agencies - Boards of Governors managed the teaching hospitals. Special hospitals (Broadmoor, Rampton and Moss Side) were under the jurisdiction of the Home Office. Other hospitals were managed by a hierarchy of Regional Hospital Boards and Hospital Management Committees. Executive Councils maintained overall responsibility for family doctors, dentists and ophthalmic services;
and the local authorities managed a number of services including ambulance and health visiting. Each of these various bodies employed and paid their own staff, but with the exception of the local authorities, none raised any money to do so, and were therefore "totally dependent on moneys voted annually by Parliament, distributed by the Ministry of Health (now the D.O.H.S.S.) and controlled by the Treasury".¹

Some have argued, as for example Mr. Griffiths of N.U.P.E., that the management side of the Whitley Council have no real power to negotiate, invariably they request an adjournment in order to secure Treasury approval. "There was no guarantee that the nurses' case was put to the Treasury as the staff side would put it, or that the Treasury case was relayed as they would wish. Everything was at second hand, there ought to be direct negotiations".²

Thus in a time of economic difficulty the Government tended to use such bodies as the Burnham Committee and the Whitley Councils, as means of setting the pattern for its incomes policies. The difficulties implicit in the structure of the Whitley Council are exacerbated in times of economic crisis.

In July 1961, Mr. Selwyn Lloyd, the Chancellor of the Exchequer, announced the Government's intention to implement a pay pause. Speaking to the representatives of a million government employees, the Chancellor informed them that they could have no increase beyond that which the Treasury are committed, for at least six months. The Chancellor indicated that "negotiations can go on", but agreements reached will not be put into effect until "circumstances permit". Even then it might be decided to implement agreement by stages, and that there would not be any retrospective

¹ Spoor: op.cit., p.348.
² Quoted in 'The Times': June 27th. 1962.
payments. Money lost by delays would be lost altogether.¹

The Minister of Health, Mr. Enoch Powell, then issued a statement indicating that a similar principle would apply in the Health Service.

The situation then, did not augur well for the claim that was being submitted to the Nurses and Midwives Whitley Council in August of 1961. Notwithstanding, the claim was considered with some degree of urgency by the staff side, for although compared to the pre-war period, conditions and pay of nurses had improved, nevertheless nursing, if considered in relation to comparable occupations, was poorly paid. At the time of the submission of the claim a student nurse was receiving £299 per annum, a staff nurse between £526 and £628; considered on the basis of a 44 hour week — this amounted to an hourly rate of 5 shillings (25p), which in fact was one shilling and sixpence (12½p) less than many hospital cleaners received and a ward sister, responsible for the lives of up to forty patients between £656 and £840, less than many typists. Even a matron in a teaching hospital could be paid less than £1,000 a year.²

Certainly it appeared that there was possibly a case for a substantial increase in order to attract more recruits to the nursing profession — according to the Minister of Health's own estimate there were 26,000 nurses short. Not surprisingly the nursing organisations attributed the shortage to the low salaries of nurses.

As already stated, the staff side of the Whitley Council submitted a claim in August 1961. The claim called for a complete reconstruction in the nurses' scale to give an average increase of 35 per cent. The management side asked for time to consider such far-reaching proposals. "Next day each Whitley Council Chairman had a letter from the Minister informing them that, whilst claims might still be negotiated on their merits, the Government would decide the date when any settlement reached might be applied".³

¹ The Times: August 10th, 1961.
² Spoor: op. cit. p.364.
³ Ibid.
The staff side met the management side subsequently in October, November and December 1961 and on each of these occasions the management side postponed discussing the claim. All the representatives of the staff side resented these postponements and tended to view this policy as one of evasion of negotiations (although in announcements of its pay pause the Government had stated that salary negotiations could continue in the normal way, but any increases could not be effected until the pay pause finished at the end of March 1962).

On the 6th February 1962, the Government published its White Paper entitled "Incomes Policy — the Next Step", which indicated the limits of the increases the Government thought might be acceptable when the pay pause ended. Such a limit was 2\(\frac{3}{4}\) per cent. One week later the Whitley Council met and the management side made an offer of a flat rate increase of 2\(\frac{3}{4}\) per cent to become operable from April 1st, 1962. This offer completely confounded the staff representatives. Six months previously the staff side had presented their case, to be a reasonable and justifiable one for the reconstruction of nurses' salaries based on two factors. Firstly, they conceived the principle of equity to be important and secondly, the increased financial inducement to attract sufficient recruits of the right calibre to the profession to be necessary. Both the Minister and the Chancellor had emphatically stated that negotiations should continue and that claims should be settled on their merits. The claim had neither been discussed or examined, and there had been no negotiations. Moreover, it was felt by the staff representatives that the management side wanted to apply the policy of the White Paper in advance of it coming into operation.

This situation prompted the staff side to put to the management side a number of specific questions. For example, did the 2\(\frac{3}{4}\) per cent offer represent a response to the merit of the nurses' case, or did it reflect the response to a Government directive? Given the shortage in the supply
of nursing recruits, and the falling behind of nurses salaries, could not
the nurses be considered as a special case? Was there any possibility of
the claim being negotiated in the usual way? In replying to these
questions the management side made their position explicitly clear. The
offer was in direct response to the claim. In their view, neither nurses
or midwives could legitimately be considered as a special case. There was
no justification for the offer exceeding 2½ per cent. If negotiations
entailed going above this there could be no negotiations.¹

An indication of the dilemma with which the staff side were faced can
be seen from the following report:

"In the face of the Management Side’s absolute intransigence the Staff
Side had to consider what in these very unusual circumstances could best
be done. They were in a quandary. Of the many problems that confronted
them there was only one thing of which the Staff Side was quite certain,
and that was they would not accept 2½ per cent. The representatives of
all the organisations were confident that they would have the support of
all their members in rejecting the offer".²

In the following chapter the various actions undertaken by the nurses in
relation to this claim and others will be reviewed in detail. Here,
however, the main concern is to deal just with the factual details of
this and subsequent claims.

Returning then to this particular claim. There was no contact between
the two sides of the Whitley Council for nearly three months. However,
on May 14th Mr. Enoch Powell, in a debate in the House of Commons,
amounced that the Chairman of the Management Side of the Whitley Council
had, on that day, written to the Staff Side suggesting that negotiations

¹ For a more detailed account see Spoor: op.cit.
² General Secretary’s Report, Health Visitors’ Association
between the two sides be resumed. The Staff Side's reply was read to a mass meeting of nurses at the Albert Hall and concluded by stating: "... in any event I am directed to remind the Management Side that it is now nearly ten months since the claim was submitted, and as negotiations for a complete salary review is bound to be a protracted process, it is the view of the Staff Side that it is becoming essential there should be an interim increase in salaries, substantially in excess of 2\(\frac{1}{2}\) per cent which has, and remains rejected by the Staff Side".

The two sides of the Whitley Council met in June, the first meeting for three months. At this meeting salary increases were offered by the Management which would cost £10m, of which one third was to be made available immediately. This was rejected by the Staff Side because the immediate increase still only constituted 2\(\frac{1}{2}\) per cent, moreover, the stage of the balance was unspecified and the period of time for the complete settlement unstated.

After the rejection of the claim it was then agreed that the whole question should be referred to the Industrial Court of Arbitration.

The Staff Side's decision to ask the Management Side to agree to arbitration was arrived at with great reluctance. They regarded arbitration as a means of resolving a deadlock, but in their view, there had been no negotiations, in that the claim had never been discussed on its merit, and therefore by implication, no deadlock.

The nurses' case was presented to the Industrial Court on August 17th, by Miss Davies, Secretary of the Staff Side, who detailed the events of a year's non-negotiations, and outlined the claim which sought to raise the scale of student nurses from £299 to £450 at the maximum, of enrolled nurses from £656 to £850 at the maximum, and of the key ward sister from £840 to £1150 at the maximum. She conceded that the cost of the claim would be £43m. a year to the hospital and £11m. a year to the local authorities. She argued that the claim was so large because it aimed.

at long last, to give the economic justice denied to nurses for so long, and because it was necessary "to recruit and retain staff of the calibre needed to sustain a worthy service".

She requested the court to order both sides to start immediate negotiations but further, to also impose a time-table designed to prevent the Ministry employing delaying tactics. She suggested that the time-table should be such, that preliminary discussions should be completed by Christmas and a final settlement by March 1963. She asked the Court to award an interim award of 7 1/2 per cent and this should be retrospective to the 1st April.

Mr. J.A. Willis of the Ministry of Health for the Management Side stated that the nurses' claim was impossible. He refuted the claim that nurses were underpaid and suggested that staff shortages had been exaggerated, and that in fact the present staffing provided 'a good service comparable with that in almost any other country and steadily improving'. He suggested an immediate increase of 2 1/2 per cent, followed by further increases with an overall ceiling of 7 1/2 per cent.

The Court gave its decision on September 6th; it awarded a 7 1/2 per cent increase to nurses and midwives, backdated to April 1st. The award also specified that the two sides of the Nurses & Midwives Whitley Council should open discussions on the revision of salaries and grading structures and refer back to the Court for a decision by March 31st, 1963, if they failed to agree.

Between September and December of 1962 the nurses' negotiating committee met the Management Side four times. Thus, for the first time since the dispute began, the nurses' representatives were in a negotiating position. At a meeting which took place on October 9th 1962, the Management Side argued that the 7 1/2 per cent increase awarded by the Court now made the pay of students, pupils, nursing auxiliaries and nursing assistants adequate. It offered minor improvements for enrolled nurses, and substantial improvements for senior ward sisters — making their maximum £1,000
a year at the top of the scale, i.e. after eight years service*. For matrons an additional increase of 7½ per cent i.e. 15 per cent was suggested, which meant that the highest paid matron would receive £1,900 per annum. The Management Side also made an offer for unsocial hours. This was to take the form of a special duty allowance of £1 for each week that a nurse either worked continuous nights or performed a Sunday duty.

The Management Side refused to consider any additional increases to the lower grades, and this was felt by the Staff Side to be going contrary to the Industrial Court's assertion that 'the level of salaries is in general too low'. Moreover, some of the staff representatives argued that since the cost of living had increased by about 6 per cent since December 1960, the increase, in real terms only amounted to 1½ per cent in two years.

In December the Staff Side although still holding the claim had been a justifiable one, were prepared to reduce the claim substantially for all grades below that of ward sister. The Management Side refused, however, to go beyond its original offer, stating that "the proposals by the Staff Side would add about £25m. a year to the £10m. cost of the 7½ per cent award"; ¹ and suggested that the problem be referred back to the Industrial Court.

In March 1963 at a hearing of the Industrial Court it was asked to determine the salaries of seven 'key groups', ranging from student nurse to matron. Instead of awarding what the staff asked for, it followed its more usual practice of awarding increases which were a compromise between what was asked for and what was offered. But the award, if a compromise, tended to veer towards the side of the employers rather than of the staff.

* Many thought that this was inadequate, when at that time a non-graduate teacher without allowances received a maximum of £1,170.

¹ 'The Times': December 12th, 1962.
The details for some of the grades of the final position are given below.¹

Table 4.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Current Pos.</th>
<th>Claim</th>
<th>Offered</th>
<th>Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>£ 321 - 361</td>
<td>£ 375 - 450</td>
<td>NIL</td>
<td>£ 325 - 365</td>
</tr>
<tr>
<td>Nursing Auxiliary</td>
<td>£ 321 - 564</td>
<td>£ 375 - 590</td>
<td>NIL</td>
<td>£ 325 - 570</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>£ 564 - 705</td>
<td>£ 610 - 810</td>
<td>£ 575 - 715</td>
<td>£ 600 - 750</td>
</tr>
<tr>
<td>Ward Sister</td>
<td>£ 705 - 903</td>
<td>£ 900 - 1150</td>
<td>£ 730 - 940</td>
<td>£ 800 - 1050</td>
</tr>
<tr>
<td>Matron (Training Hosp. over 1,000 beds)</td>
<td>£ 1495 - 1760</td>
<td>£ 1950 - 2200</td>
<td>£ 1600 - 1900</td>
<td>£ 1700 - 2000</td>
</tr>
</tbody>
</table>

Thus the long series of negotiations on a salary claim that was submitted in August 1961 was brought to a conclusion in July 1963.


By comparison with the preceding two years, 1964 was reasonably quiet. However, following the conclusion in 1963 of two years of negotiations of a claim that was originally advanced in August 1961, it was felt by the Staff Side of the Whitley Council that because of salary agreements in other parts of the public sector nurses and midwives salaries were, once again, falling behind. Consequently on May 12th, 1964, after approving an offer of special payments for nurses' night and Sunday duties, the Nurses & Midwives Council announced that it had approved a claim of 5 per cent a year over a period of 3 years without prejudice for revaluation of any specific grade which might be considered necessary in the meantime.

Mrs. Mary Newstead, (formerly Miss Davies), Secretary of the Staff Side said, "that this long term claim of 15 per cent affected all grades".²

¹ For full details of the award see Appendix 2, Section A.
Negotiations on the general claim in fact, proceeded quite speedily and by the middle of July 1964, both sides of the Nurses and Midwives Whitley Council agreed on an increase of 3 per cent on all salaries and allowances. In response to the original claim of 5 per cent in each of the three years, the Management Side made an offer of $\frac{3}{3}$ per cent in each of the two years, but in return for which had insisted on the inclusion of a 'stability clause', which would prevent, without the approval of the Management Side, the raising by the Staff Side of any major issue during this period. This constraint proved unacceptable to the Staff Side who, in the event, decided to settle for a single increase of 3 per cent on the explicit understanding that they would be free therefore, to raise any issue at any time.  

On Tuesday, September 23rd 1964, the Staff Side decided to submit a claim for an increase in the training allowance of student and pupil nurses. These were not included in the above settlement.

At this time these nurses were receiving training allowances ranging from £335 to £367 per annum, out of which £135 per annum was deducted for board and lodging. Furthermore, it was unanimously agreed among the staff representatives that, again following from fresh increases to other staff in the National Health Service, nurses' salaries were once again falling behind. Thus, in December 1964, the claim for improved training allowance was composited into a general claim that was composed of three parts. The first dealing with student and pupil nurses; the second with service grades in the public health service, and the third dealing with the remaining grades. Each of these parts was to be presented separately.

The claim was presented to the full Whitley Council on Thursday January 14th, 1965. The Management Side asked for time to consider the proposals.

1. For full details of the outcome of the claim see Appendix 2 - Section B.
as they "were not yet prepared to give their reply to the claims for a substantial increase in pay for nearly 300,000 nurses, and for higher training allowance for student nurses and pupils. They would be ready to give a detailed answer on February 9th."¹

On February 9th a settlement was reached on the increased training allowance for student and pupil nurses. Increases from 8 to 11½ per cent. In terms of cash the increases were in the range from £30 to £44 and these were to become operable from March 1st, 1966. The agreement was to run for at least two years. However, it was decided to increase the board and lodging allowance from £135 to £143.

At the same meeting the Management Side made offers on the other grades, but no settlement was reached; the Staff Side requested time to consider the proposals. It was agreed that another meeting of the Whitley Council would take place on April 13th.

On this date both sides of the Whitley Council reached a settlement on this claim under which hospital nurses received increases from just under 9 per cent to just over 15 per cent.

The amounts awarded were far in excess of the Government's wage policy norm of 3 to 3½ per cent, but it had been thought that nurses would be regarded as a special case.

Increases ranged from £46 a year for nursing auxiliaries, who prior to the claim were on a scale rising from £474 to £587 per annum, to between £159 and £175 for most senior matrons who prior to the claim were on a scale rising from £1,751 to £2,060. Enrolled nurses with two years practical service received from £80 to £85 more; staff nurses (£618 to £733) from £72 to £107 and ward sisters (£824 to £1,082) from £66 to £123.

These higher salaries were accompanied by increases in the charge for board and lodgings. Deductions for enrolled nurses were to rise by £28 a year; for staff nurses by £25, for ward sisters by £23, and for the highest paid matron by £37 a year. ¹

The Secretary of the Staff Side of the Whitley Council said that "two-thirds of the nurses were non-resident and would not have to pay these sums".²

The final part of the settlement was made public by the Ministry of Health on June 9th, 1965 and granted increases to district nurses from £54 to £115 a year bringing their scale to £785 to £1,135 per annum. Health Visitors received increases from £65 to £123 bringing their scale to £1,615 to £1,995. Domiciliary Midwives received increases of £66 to £125 bringing their scale to £1,615 to £1,995.

Commenting on the award Mr. Robinson, Minister of Health said: "I am sure that these higher salaries will help to bring the pay of nurses and midwives in line with that of other professions, and to ensure that the number employed in all branches of the profession goes on steadily increasing".³

The award came into operation from July 1st, 1965.

Thus from the point of view of salaries, 1965 was a memorable year for the nursing profession since it produced the third successive pay increase in as many years.


In 1965 salary agreement referred to in the previous section was, as indicated, conditional upon no major issue being raised for a period of two years. This period was due to end on June 30th, 1967, by which time the Staff Side had prepared a claim for the revision of salary structures.

1. For full details of the claim see Appendix 2, Section C.
In a press statement on May 18th, 1967 the Royal College of Nursing gave some indication of the pay asked for: staff nurses £800 to £1,200 (previous scale £690 to £880); ward sisters £1,400 to £1,600 (£890 to £1,205); qualified nurse tutors £1,600 to £1,800 (£1,105 to £1,300); matrons £1,500 to £3,250, depending on the size of the hospital £1,210 to £2,235.1

This statement, however, revealed only one aspect of the claim.
Actually the claim incorporated two distinct parts:
1. A complete revision of the scales within the existing salary structure; i.e. those referred to in the press release;
2. Appropriate salary scales for the new grades envisaged under the structure proposed in the Salmon Report.

Unpropitiously, once again a nurses' pay claim coincided with a government incomes policy which, subject to certain criteria, specified no increase in wages or salaries — a nil norm.2 Notwithstanding this major obstacle, the Nurses and Midwives Council decided — as they had previously done in 1961 — to continue with the claim. Both parts of the claim were submitted to the Whitley Council on June 13th, 1967, and according to the Royal College of Nursing, the reasons for doing so were:

"1. the obvious justice of the claim for the lowest paid grades;
2. the urgency created by social conditions to produce in nursing, salary prospects favourably comparable in other occupations, and
3. the desirability of establishing negotiated salaries for the 'Salmon' grades, and in particular of achieving an appropriate ceiling to the structure".3

The claim was presented to the Nurses and Midwives Whitley Council on June 13th, but under the constraints of the 'Prices and Incomes Policy'

1. 'The Times': May 19th, 1967.
the management side were unable even to start negotiations on a claim of such magnitude. Faced with this impasse both sides of the Whitley Council decided that the whole question of nurses' salaries and conditions be referred to the National Board for Prices and Incomes.

On two occasions the Board met the negotiating committee of the staff side, and it also extended the facility of meeting separately the representatives of individual staff organisations. In addition the Board's officers and consultants interviewed many nurses in their working situation.

The Board published its recommendation on March 28th, 1968. Broadly speaking it recommended that the salaries of the 334,000 nurses, hospital matrons and other nursing staff should be increased by 9 per cent subject to negotiations. It recommended that 4 per cent should be paid retrospectively to the beginning of October 1967. The balance, together with certain other recommendations, should come into effect in January 1969, and there should be no further improvements before the end of March 1970.

For top nursing administrative posts the maximum potential recommended in the hospital service was £2,950. Also recommended was a reduction in the board and lodgings allowance, but to off-set this a 'pay as you eat' scheme was recommended.

The government accepted the Board's recommendations, and following this acceptance negotiations between the two sides of the Whitley Council started immediately. A revised salary structure became operable from January 1st, 1969. Some of the features of the revised structure are indicated below:

1. Report No.60, Pay of Nurses & Midwives in the National Health Service (Cmnd.3585) H.M.S.O.
The lead of the psychiatric service was increased to £100 p.a., and a similar lead was established for all nurses (with the exception of the Chief Nursing Officer) working exclusively in the geriatric field.

No agreement was reached concerning the staff engaged in the 'Salmon' pilot schemes and the Department of Health continued to lay down the salary scales for the various posts involved.

Thus, although nurses were one of the first victims of a Government's income policy when Mr. Selwyn Lloyd introduced his income policy in 1961, the treatment that was meted out to them on that occasion did much to bring the innovation into disrepute. Under the more elaborate procedure of 1968 — although as we shall see in the next section, the nurses were far from satisfied — they fared somewhat better than on previous occasions.


The 'pay as you eat' scheme introduced in the previous salary agreement elicited a great deal of anxiety and public discussion concerning the well-being of student and pupil nurses, many of whom claimed that under the new arrangements they could not afford to eat adequately. The formation of the United Nurses' Association by Sister Patricia Veal, and its subsequent campaigns directed against both the Department and the nursing staff organisations, received a great deal of publicity.

In the face of such intense feeling the Staff Side of the Whitley Council submitted a claim for £1 a week meal allowance. In May 1969 both sides agreed on a meal allowance of £48, an agreement that was immediately accepted by the Government.

Mr. Emmals, Minister of State for the Department of Health & Social Security

1. For full details see Appendix 2, Section D.
2. This phase of nursing militancy will be examined in more detail in the following chapter.
indicated that the allowance would cost the country more than £4m a year. He added: "We can be sure that no nurse would be hungry or be out of pocket as a result of the new scheme".1

A spokesman for the Whitley Council said of this agreement: "The allowance is an interim measure introduced in view of the special dietary needs of this group of young people and will take effect from April 1st, 1969 or the date on which the new system comes into operation in each hospital, whichever is the later".2

In November of 1969 the Staff Side submitted a substantial claim for nurses on the then new 'Salmon' structure and also for other nurses employed in general hospitals.

For a Chief Nursing Officer a top salary limit of £4,500 was demanded. A spokesman for the Royal College of Nursing commented at the time that many of these officers earn as little as £2,180; "a paltry salary for someone controlling the nursing services for a group of maybe 20 hospitals, a budget in the millions range and nursing staff in thousands".3

The proposed salary scale for a Matron of a training hospital was a salary in the range of £2,400 to £2,900 for a Ward Sister £1,400 to £1,600, a Staff Nurse £1,000 to £1,200. A salary scale of £850 to £1,020 was proposed for an Enrolled Nurse.

The proposed rates for other grades were as follows:
Auxiliaries aged 18, £525 rising at 21+ from £700 to £875.
Student nurses aged 25 and over, a training allowance of £700 - £750 - £800 and those under 25 one of £525 - £575 - £625; pupil nurses 21 and over £700 - £750, under 21 £525 - £575.

The discontinuation of the meal allowance was also a feature of the claim. On the claim a spokesman for the Royal College of Nursing said: "something

2. Ibid.
3. 'The Times': November 18th, 1969.
has to be done now to give nurses the reward they deserve. We feel that these demands are reasonable and we are going out to get them in March 1970.¹ Similar comments were made by other nursing organisations.

On Thursday, November 27th, a claim, comparable to that submitted for nurses in general hospitals, was submitted on behalf of the 34,000 psychiatric nurses. This claim preserved the £100 psychiatric lead.

In direct response the Management Side on January 13th, 1970 made an offer amounting to 22 per cent; in certain grades its application to be spread over a two-year period. In so doing it described it as a "substantial offer recognising the special considerations called for in nursing, but the official announcement recorded that the staff side were unhappy at the proposal to spread the increase over two years".²

In broad terms the offer amounted to an overall increase of nearly 15 per cent to become effective from April 1st, 1970 and a little over 7 per cent to become effective one year later.

An offer was also made to senior nurses appointed to posts in the new 'Salmon' structure, for which there were then no negotiated salary scales. The offer made for a Chief Nursing Officer gave a maximum of £3,927 for the highest scale. The claim submitted for this grade was for a maximum of £4,500.

The announcement followed a four hour meeting of the Whitley Council, commenting on the proposals a staff representative said that "they appear to be a reasonable beginning to salary negotiations".³

Speaking on behalf of the National Union of Public Employees, the general secretary, Mr. Alan Fisher said: "The pay offer is the first hint of a change of policy towards the lower paid, but it will not mean the end of

1. 'The Times': November 18th, 1969.
2. 'The Times': January 14th, 1970.
cheap labour in hospitals. The government should go further and pay all the increases".¹

Later in January the nurses' representatives decided to accept the 22 per cent offer, but to press for its full implementation from April 1st, 1970; i.e. not to be spread over two years. Moreover, they resolved to maintain pressure for their original demands of increases between 27 and 54 per cent.

A further meeting of the Whitley Council, lasting all day, took place on January 28th, 1970, and ended with the matter still unresolved. At this meeting the management side sought certain guarantees; Mr. William Griffiths, Chairman of the Staff Side said: "The Management Side wants to impose a restriction of our raising any major issue during the next two years".² He indicated that he thought the offer of 22 per cent to be reasonable, provided the nurses could get the full amount on April 1st, 1970.

A third meeting of both sides took place on February 17th, 1970 out of which came an agreement on an overall increase of about 20 per cent (some scales would vary above and below this figure). The agreement would operate on a one year basis. Another meeting was scheduled in March in order to settle the final details.

On March 25th, the new salary scales to operate from April 1st, 1970 were finally agreed.

A ward sister would be on a scale of £1,200 to £1,554 (previous scale £930 to £1,182). A staff nurse's scale would be £930 to £1,182 (£785 to £985).

The higher grades under the 'Salmon' structure, for whom there had hitherto been no negotiated scales, would receive salaries as follows:

Chief Nursing Officer - £2,550 to £3,010 for grade 10C;

£2,814 to £3,414 for grade 10A.

¹. Ibid.
In effect the range of increases varied between 18 and 26 per cent.
Student nurses over the age of twenty-one were considered as key grades and received increases between 25 and 26 per cent, whilst students between the ages of eighteen and twenty received increases amounting to about 20 per cent.

The £48 meal allowance referred to under the 1968 heading was incorporated into the above training allowances.\(^1\)

The first move towards the continuation of pressure to bring the 1970 agreement up to the original claim came from the National Union of Public Employees. On July 12th at the union's executive council meeting a decision was taken to instruct the N.U.P.E. negotiators to act swiftly on a new demand for 15 per cent.\(^2\) In addition to the 15 per cent there were further demands; payment of all overtime; improved pay for night and weekend duties; the abolition of the 'split shift' system and free meals for student and pupil nurses.

By September all the nurses' organisations on the Whitley Council unanimously agreed to press for an overall 15 per cent increase to become effective from April 1st, 1971, together with additional payments for night duties and a cut in the working week from 42 to 40 hours.

Answering criticisms that the nurses had only recently received a 20 per cent pay award, a spokesman for the R.C.N. commented: "The 20 per cent increase a year ago barely puts the nurses on a realistic level".\(^2\)

During the course of the ensuing meetings of the Whitley Council the Management Side made an offer of 7\(\frac{1}{2}\) per cent on the basic rate, together with additional payments for night duties and a shorter working week.

It was estimated that these last items would add a further 2 per cent to the claim.

1. For full details of the claim see Appendix 2, Section E.
Although this offer was considered derisory by the nursing organisations, they were not able, however, to secure a better offer in the three meetings which took place in the early part of 1971. There seemed little prospect of this deadlock being broken, but in a meeting on February 23rd, 1971 the management side offered a way out of the situation by making an improved offer of 1 per cent on the basic rate, together with the promise of implementing a 40 hour week from January 1st, 1972.

A spokesman for the Department of Health and Social Security said: "adjustments would add 4 per cent to the salary bill".  

After this meeting Mrs. Mary Newstead, secretary to the staff side, commented: "I feel the staff side may well decide to accept the settlement", and in fact the nurses' representatives did recommend its acceptance.

A representative of the Royal College of Nursing said: "The recommended settlement is a reasonable outcome to negotiations in the very difficult economic situation".

On March 9th, 1971 the nurses' representatives voted to accept this settlement.

In January of 1972 a revaluation claim previously prepared by the staff side during the last quarter of 1971 was submitted to the Whitley Council. It proposed several changes in the relationship of the scales, including parity of district nurses with ward sisters. "It also proposed a new higher salary scale for those ward sisters and local authority field workers who had acquired outstanding skills or experience, but had chosen to remain at the field level rather than transfer to management or teaching".

3. Ibid.  
4. For full details of the settlement see Appendix 2, Section F.  
Recognising the fact that the claim would take considerable time to negotiate, the staff side decided to ask for an interim percentage increase for all grades to become effective from April 1st, 1972. Agreement was eventually reached in February 1972 on a general increase of 8 per cent with some other improvements. ¹

The remainder of 1972 was taken up with negotiations on the full revaluation of scales.

¹ For full details see Appendix 2, Section G.
1962 Campaign.
The intransigence of both the employers and the Government in a sense, united the competing factions within the profession by creating the conditions for a united campaign predicated towards changing official policy. The strategy was to arouse public opinion in support of the nurses’ case.

The campaign was organised under the aegis of the Staff Side of the Whitley Council, but in fact, was mainly organised by the Royal College of Nursing with the support of all the other organisations involved.

Initially it commenced with enthusiasm and a spirit of co-operation between the professional associations and the trade unions. As it developed, however, marked differences in style and opinions as to the kind of measures deemed appropriate emerged between the various organisations of the Staff Side. Such differences were to give rise to a great deal of bitterness. This was especially so between the Royal College of Nursing and the Confederation of Health Service Employees. The enmity which such differences elicited from both these organisations bore testimony to the fundamental cleavage which existed between the professional associations and the trade unions. Moreover, the public utterances by officials of the R.C.N. and C.O.H.S.E. about the other’s organisation did little to camouflage the schism.

In this chapter I will attempt to trace the various manifestations of militancy that each of the salary claims engendered, and then go on to discuss the interactive effect that these had on the participating organisations. Finally, I will attempt to analyse whether the character of the nursing organisations were, in any way, modified as a result of the experience.
The campaign took mainly three forms: demonstrations, the exertion of political pressure, and widespread publicity through the media.

**Demonstrations.**

The employer's offer of 2½ per cent brought forth a number of militant rumblings, especially from C.O.H.S.E., some of whose branches were calling for a 'ban on overtime', 'working to rule', and selective strikes.

Perhaps as a reaction to C.O.H.S.E., the Royal College of Nursing organised a protest meeting at its headquarters on Monday, March 12th, 1962. This meeting was attended by about 1,000 nurses and chaired by Dame Irene Ward, Conservative Member of Parliament for Tynemouth, who said "the meeting is to demonstrate the solidarity of the nursing profession in a constitutional manner against the decision of the Whitley Council on salaries".¹

At this meeting it was decided to send a deputation to the Minister of Health which would consist of representatives of the R.C.N., the Association of Hospital Matrons, the Royal College of Midwives, and the Association of State Enrolled Nurses. The decision to send a deputation to the Minister followed from criticism that a resolution proposed by the platform was too weak. "The platform resolution moved by Miss Hall, General Secretary to the College, expressed dismay at the offer and suggested that nurses and midwives colleges should lobby M.P's and get the situation known to the public".² However, an amendment to the platform resolution which stated that the organisation should seek a meeting with the Minister was proposed from the floor and passed unanimously.³

Miss Hall, perhaps in a snipe at C.O.H.S.E., said that they "would not tolerate any withdrawal or limitation of services given by nurses".⁴

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³ Ibid.
⁴ Ibid.
Whether the professional associations would tolerate restrictive practices or not seemed of little significance to the Confederation. In a militant mood the union's general secretary announced to 'The Times' that he would be reporting to the union's national executive on the following Wednesday. "I hope they will take some action. The General Council seems to be just a medium to act as the mouthpiece of the Government. Though people continue to serve and give of their best to humanity, there comes a time when they reach breaking point and normal circumstances do not apply." ¹

N.U.P.E. on the other hand, appeared to be less committed to the principle of direct action. Commenting realistically on the situation,
Mr. W.L. Griffiths, General Secretary of the union, remarked "that the weakness of the nurse's case was that they could take no action without harming innocent people. But they had reached a point at which they must consider what they could to in their own interests." ²

The other two trade unions, namely N.A.I.C.O. and the N.V.A., made no statements appertaining to the proposed unilateral action by C.O.H.S.E. On March 21st, 1962 the national executive of C.O.H.S.E. held a meeting specifically to discuss the action they might take in pursuance of the claim. The demand by the branches and regions for a 'ban on overtime' was rejected, but plans were discussed for holding a 'strike ballot' of their members. At this meeting it was also agreed to send a telegram to the Prime Minister, seeking his personal intervention to resolve the deadlock, and also to send a deputation to the T.U.C. in order to seek its support for any of the nurses' unions in any action that they may consider necessary in the future.

1. 'The Times': March 14, 1962.
2. Ibid.
Mr. MacMillan, replying to the C.O.H.S.E. telegram said that the Whitley Council 2½ per cent offer was in line with Government policy and he was not therefore prepared to intervene.

Meanwhile, towards the end of March 1962, the views of the various nurses' organisations were beginning to coalesce around the notion of the need for some form of united and co-ordinated action. Subsequently, the Staff Side of the Whitley Council appointed a committee to mobilise in the most effective way public sympathy and support for the Nurses' case.

Thus on April 3rd, 1962, the special committee called a press conference at which Miss E. Davies said "The traditional image of the nurse never having a thought of money or anything but cooling the fevered brow must go if she is to have rewards that match her service".

Miss Davies went on to say that because of the nature of the nurses' work the most potent weapon they could use was to mobilise public opinion, and in order to achieve this the committee would organise a series of meetings, marches and other means, that would gain public and Parliamentary support.

Of the twelve organisations represented on the special committee, only C.O.H.S.E. indicated that it would take further action if all else failed. Its general secretary reiterated his threat that in the event of the failure of the publicity campaign, C.O.H.S.E. would ballot its nursing members on their willingness to take strike action.

On April 4th a lobby was organised at the House of Commons. Prior to the lobby, in perhaps one of the most impressive shows of militancy ever manifested by nurses, more than 4,000 nurses, many in uniform, held four simultaneous meetings in Westminster. All the meetings passed resolutions condemning the Government for its deliberate obstruction of negotiations to improve sub-standard salaries. At one point on the lobby the police

2. Ibid.
had to intervene to restore order when about 150 nurses crowded into the central lobby.

A large number of cards were sent in to the House requesting to see Mr. Powell, the Minister of Health, but the Minister sent back a message that he was dealing with the official representatives of the nurses, and was not prepared to come out to see individual nurses.

Also, at this stage, the T.U.C. became involved, when following a deputation from C.O.H.S.E., it decided to convene a meeting of all the nurses' unions.

On April 10th, more than 1,000 nurses, many in uniform, gathered in Manchester's Houldsworth Hall; the meeting passed a resolution condemning the Government's obstruction to free negotiations. Mr. W.J. Jepson, general secretary of C.O.H.S.E., was one of the speakers who addressed the meeting. This was followed on May 2nd, by a large protest meeting in Birmingham at which two thousand nurses attended. Prior to this meeting more than half of the nurses marched through the city's centre, carrying placards and banners. Many of the nurses who marched were in uniform, which in itself was indicative of their mood, as most of the hospital committees had explicitly forbidden the wearing of uniforms at marches or demonstrations. Once again the general secretary of C.O.H.S.E., was one of the speakers who addressed the meeting. He informed the meeting that strike ballot forms would shortly be going out to the 40,000 nursing and 20,000 other C.O.H.S.E. members.

"If the decision is overwhelmingly in favour of a withdrawal of labour" said Mr. Jepson, "I will implement that decision. I pray on my knees it will not be necessary, but if it is, I will do it".

As the campaign developed a growing rift appeared between the professional associations and the trade unions, particularly C.O.H.S.E. At a meeting of the Staff Side of the Whitley Council on May 8th, that was called to discuss the forthcoming protest meeting at the Albert Hall, London, on Sunday, May 29th., a suggestion was made that the trade unions in general and C.O.H.S.E. in particular, was taking advantage of the present dispute to recruit members at the expense of the other organisations.

Following the meeting the general secretary of C.O.H.S.E. said "I don't let any professional body tell me how to run my organisation. The time has arrived when there is a need for trade union machinery to represent nurses, not professional bodies appointed for other purposes". 1.

On May 11th., Mr. Powell, Minister of Health, was confronted by protesting nurses, when he was attending a foundation stone ceremony for a new district hospital in Truro, Cornwall. Prior to the confrontation, the nurses and their supporters, including dockers from Falmouth Docks, and the prospective Liberal Parliamentary candidate, Mr. William Hosking, held a protest march through the city.

May 17th. 1962 marked the first of seven days of lobbying M.P's by nurses. The lobby was based on the successful initial attempt of four nurses from Witherington Hospital, Manchester, who on May 11th., organised a deputation to the House of Commons. "They then took a weeks holiday to tour the country to tell other nurses how to do it". 2. On this lobby a total of 176 nurses came from Newcastle, Hull, Leeds and Bradford with the intention of interviewing more than forty M.P's.

On May 19th., C.O.H.S.E. organised a mass rally where 1,000 nurses, drawn from all parts of South Wales, marched in uniform through the streets of

1. 'The Times': May 9, 1962.
2. 'The Times': May 18, 1962.
Cardiff. Also marching with the nurses were some Members of Parliament, representatives of the Fire Brigades Union and the National Union of Seamen. At the meeting which followed, Mr. W. Whitehead, president of the South Wales Miners, conveyed a message of support sent by 80,000 men in the coalfields.

During the course of the campaign C.O.H.S.E. made frequent allegations that young nurses were being intimidated by matrons against joining trade unions. And on occasions C.O.H.S.E., intimated that there was some form of collusion between these matrons and the Royal College of Nursing insofar that pressure was being exerted on nurses to join the appropriate professional organisation only. The following extract typifies the intensity of feeling which was engendered during this period.

"Once again anti-trade unionism, never far below the surface in the health service, has reappeared in the North, where they are usually more sensible in these matters. A hospital authority, which I prefer not to name at this stage, is reported to have displayed a notice advising its nursing staff "they must be members of their professional association and no others". One does not have to be a Sherlock Holmes to detect in this all too familiar smear technique of some "higher-up" telling nurses that it is infra dig to join a trade union. At the same time this snobbish mentality never loses a chance in boosting cultural organisations which so far, have forgotten their cultural principles as to publically proclaim their intention to usurp the function of collective bargaining which brought trade unionism into being".

"The Confederation is a trade union, proud of its record in bringing improved conditions into a service which for far too long exploited the theory that status is more important than salary. The sooner that some of these so-called professional associations publically state where they stand on the trade union issue, the better it will be for all concerned".
"Meanwhile we await the results of the investigations promised by the Hospital Board Authority on the representations made by the Confederation".

"In the general hospital field, however, continued opposition to nurses joining a trade union by matrons and other senior staff has resulted in many juniors being advised to seek employment elsewhere".  

And the following report in 'The Times' is also fairly typical of the allegations that were being made: "A nurse aged 23 stood up today at a nurses pay protest meeting at Bradford and asked the platform speakers if they knew how difficult it could be to join a union at some hospitals in the face of disapproval by matrons". Alderman Joseph Blackburn, a members of C.O.H.S.E., said in reply "disapproval does exist, but don't be afraid, if there is any victimisation, not only my union, but the T.U.C. will come down on the authority who victimises anybody".

After the meeting, the nurse concerned said that she had been told by a staff nurse that if it was known at the hospital that they were members of a trade union, they would be out of a job. The nurse added, "I have not approached the matron myself, but I have applied in secret for membership of a union for myself and nine others". A union official said, however, that the allegations will be investigated".

On May 21st, C.O.H.S.E., intensified its campaign when its executive decided to ballot their members on strike action in support of the claim. It was also decided to approach the T.U.C. to ascertain what support it would give, and also to seek the support of other trade unions directly.

"If the strike took place", Mr. W.J. Jepson said yesterday, "they would ask every trade union in Britain to come out on strike as well".  

1. National Health Services Journal: Notes and comments by the General Secretary, March/April 1962.  
to repeat this astonishing declaration, he said "yes, it would mean a
general strike". Mr. Jepson went on to say "we have already had a
promise from a number of other trade unions that they will solidly support
us in whatever action we may take to bring about a just and fair settlement
in the nursing service".

The reaction of the professional associations to the C.O.H.S.E. proposal
was immediate and direct. The Royal College of Nursing issued a statement
saying "that it read with dismay that a strike ballot is to be taken by
C.O.H.S.E. Throughout the campaign the College has stated emphatically
that in no circumstances would action be contemplated which was detri­
mental to the interests of the patients. The College continues to
believe that the majority engaged in the nursing services of the country
possess such a strong sense of responsibility that they would not be led
into any action which would betray the trust placed in them by those whom
they serve".

The Association of Hospital Matrons, similarly, issued a statement deploiring
the decision of C.O.H.S.E. to hold a strike ballot in support of the nurses
claim.

I have not been able to obtain any documentary evidence concerning the
attitudes of the other three trade unions, but in interviews with the
nursing organisers of these unions I received the impression that
N.U.P.E. and N.A.L.C.O. did not support the action because they felt that
it would only receive minimal support among nurses and therefore did not
justify the deep divisions it would create within the campaign. In their
view it was better to maintain a campaign which would receive the widest
possible support. The position of the H.V.A. was unequivocal, the
association could not possibly support strike action by nurses, as its
own constitution prohibited its use.

2. Ibid.
The hospital authorities reacted to this expression of militancy by their nursing staff in various ways, but the most widespread reaction was to place a ban on the wearing of uniforms at protest meetings and marches. In this connection perhaps the most bizarre report was that of the matron of Paddington General Hospital who imposed the wearing of a white penance gown on Miss Margaret Gosling as a punishment for attending a nurses rally in uniform.

In view of the publicity given to this incident, apparently the matron reconsidered her decision and permitted the nurse to wear the proper uniform.

Commenting on this incident, Mr. C.R. Jolly, secretary to the Hospital Management Committee said "in view of the risk of cross infection, wearing of indoor uniforms had not been allowed in the interests of patients. I should like to point out that my Hospital Management Committee supports the nurses' claim for increased pay. The disciplinary action taken by the matron has no relevance to the occasion on which nurses were in uniform". 1

However, judged by the number of nurses who defied the ban and wore their indoor uniforms at demonstrations, rallies and picketing of the Minister, etc., the prohibition by the Hospital Management Committees proved to be ineffectual in counteracting the movement which was developing.

On May 29th, 1962 the much publicised meeting at the Albert Hall, London took place. The meeting was chaired by Mr. Joe Grimond, leader of the Liberal Party, who assured the nurses that they had "the deep sympathy of millions of people in the country". "The pay pause" he said "was an expedient that worked to the detriment of those least able to defend themselves". Dame Irene Ward, Conservative M.P. for Tynemouth said that

while she supported the Government's income policy, the nurses called for special treatment. Mr. Kenneth Robinson, Labour, declared that their claim was overdue and overwhelming; Miss Mary Davies, secretary of the Staff Side "pledged its determination to use every constitutional means to attain a square deal for every nurse".¹

As the campaign developed the staff side brought other pressures to bear on the Government.

**Political Pressure.**

In March the staff side was successful in organising a 12½ hour debate in the House of Commons. During the course of the debate M.P.'s from all parties protested about the unfair treatment being meted out to nurses. But in spite of the pressure exerted by M.P.'s, Mr. Powell would not change his position. "Nurses and health service workers" he said, "must be subject to the Government's policy: to make an exception of them must open the door to claims from all quarters".²

In May, the opposition forced a second debate, and once again the Government came under pressure from all sides. Even the Minister's predecessor, Sir Derek Walker-Smith, condemned Mr. Powell for imposing a situation on nurses, which virtually made it impossible for them to extricate themselves from their 19th Century predicament, when the profession was made up of "Betsey Prigs" who were paid little because they were not thought worth much, and Florence Nightingales who were paid little because it was thought they did not want much".

With remarkable clarity Sir Derek was at pains in his speech to show the need for a basic revaluation of nurses' pay, and once again asked for — as he had previously done fifteen months earlier — a Royal Commission to survey the financing of the social services in relation to contemporary economic conditions.

2. Ibid.
Other Conservative M.P.s supported Sir Derek, and the Government was embarrassed when Dame Irene Ward, Conservative M.P. for Tynemouth openly congratulated Mr. Kenneth Robinson, the opposition spokesman on health affairs, for his deployment of the nurses' case. Furthermore, 100 M.P.s, including many Conservatives, had, on the day of the debate, signed a motion urging the Government to review the position on nurses' salaries, "as soon as economic circumstances permit." 

In the face of all this, the Minister was unmoved and gave cool responses. He argued that nursing recruitment figures had increased, cast doubts on the accuracy of the Ministry of Labour's statistics of vacancies and shortages. At the end of the debate, however, Mr. Powell announced that with the Chancellor's approval he was writing to the Management Side of the Whitley Council to suggest that the two sides "resume contact and engage together in a study of the salary structure to see what changes and improvements can be made within the various limits of cost and what relative priority should be attached to these changes." But any final agreement would of necessity have to be "implemented by stages." Mr. Powell indicated that there was "everything to be said in favour of this essentially creative job being started now." 

In retrospect this move by the Government would seem to have been designed primarily to overt a possible revolt by Conservative M.P.s. If this was the case then "it succeeded; several interpreting it, in the words of M.F. Deedes as promising "implementation of the increases which have been foreshadowed" with the Government leaving the matter with the negotiators and interfering less itself." But the Opposition speakers remain 

1. If viewed in a certain way Mr. Powell was correct: between 1949 and 1960 the total number of nurses had increased from 126,000 whole time in England and Wales to 162,000, and the number of student nurses from 46,000 to 54,000. However, in 1960 the number of student nurses declined for the first time for several years. (Source: The Economist, March 17, 1962, p.984.)
suspicious — and when Sir Edward Boyle, Financial Secretary to the Treasury, wound up the debate they exposed the hollowness of the gesture. Pressed for specific assurances, he admitted that any increase over 2½ per cent would have to be deferred, that the period of deferral must depend on the Government's policy and economic circumstances, and that while the Government would accept an arbitration award, it would first make sure that the Court knew what it conceived to be in the public interest. ¹

The Government's statement did nothing to placate the opposition's suspicion, as can be seen from the comment of Mr. Kenneth Robinson, Labour's spokesman on health "the more we learn about the new initiative, there is less likely to be in it for nurses". ²

The sincerity of the Government's intention was to be put to the test. On May 23rd, 1962, the Staff Side asked the Management Side whether it intended to resume "free and unfettered negotiations".

**Supporting Action by Other Workers.**

Also as the campaign developed, and the details of the dispute became disseminated by both the media and the nurses' own publicity campaign, many other sections of organised labour took unilateral action in support of the nurses. The following are examples of some of the actions that were reported.

May 3rd — more than 100 men on a Hammersmith building site stopped work to stage an hour's protest march in support of the nurses. Six thousand production workers in the paint trim and assembly buildings in the Ford Motor Company, Dagenham, decided to hold a one day strike. Nearly 1,000 men in the E.N.V. Engineering Co., Willesden, stopped work for half a day. About 1,000 workers at West Thurrock Power Station, Essex, stopped work for an hour.

2. Ibid.
Representatives of the 35,000 miners in Derbyshire sent a resolution to the Minister of Health, the T.U.C., and to their own union's national executive stating "we support any action the nurses can take in resisting the Government's attitude."

May 8th. Dockers stopped work for an hour in the Royal Group of Docks in London in support of the nurses' claim. More than 500 factory workers at Hyton, Lancashire, staged a 90 minute demonstration in support of the nurses. Both men and women walked out of the Huntley and Palmers biscuit factory and marched to the local council offices.

From May 10th onwards the support among industrial workers for the nurses continued to grow, and there appeared to be a widely held view that "because the nurses cannot go on strike, we must help them."

A hundred oil tanker drivers marked to Greenwich Town Hall. Also many industrial workers donated money in support of the nurses' campaign, as for example, the 4,000 tractor workers at the Massey Ferguson plant who contributed about 10/- (50p) per head.

The manifestations of solidarity however, appeared to be relatively short-lived. Whether they were an expression of genuine sympathy for nurses, or an expression of frustration and opposition to the Government's pay pause, is an open question. Certainly, the bulk of the trade union movement was opposed to the Government's incomes policy, but I think it is also true to say that the nurses' case caught the public imagination, and as a consequence derived a large measure of support from organised labour.

Many workers who took action in support of the nurses undoubtedly did so because of a genuinely held belief that they were obliged to do so because nurses could not take action for themselves. The fact that such action provided a catharsis for their own frustration with the Government's income policy was an added advantage. Such actions were no doubt a
contributory factor in underpinning the C.O.H.S.E. view that the Confederation would be able, if the necessity arose, to elicit the support of the whole trade union movement, even to the extent of a general strike. In retrospect, however, such demonstrations by other workers were somewhat ephemeral and I have not been able to discover a movement of similar magnitude in subsequent nurses' claims.

Coverage of the Campaign by the Media.

During the course of the 1962 campaign, the nurses' case received a great deal of publicity by national papers and the television networks. Nursing representatives frequently appeared on television and were interviewed by national newspapers. By and large the media were sympathetic—sometimes maudlin—to the nurses' case.

The Conclusion of the Campaign.

Following the request of May 23rd for a meeting with the Management Side of the Whitley Council, the Staff Side had to wait until June 12th, when once again it rejected, what in effect was an offer of 2½ per cent rise.

In the meantime C.O.H.S.E. carried out its threat to ballot its nursing members on their willingness to take industrial action. More than half of the nurses who voted indicated that they wanted to go out on strike, but added that they could not do so on grounds of conscience.

The questions asked and the votes cast were announced by C.O.H.S.E. on August 12th.

I unreservedly support the withdrawal of labour .... 7,296.
I do not support the withdrawal of labour .... 5,375.
I support the withdrawal of labour, but on conscience grounds I cannot do it .... 16,068.

Sixty thousand ballot papers were sent out, and the fact that only about half were returned was attributed by the union's general secretary to "certain branches not voting in view of arbitration proceedings and holidays."¹

¹ The Times: August 15, 1962.
The Industrial Court's decision and the final settlement have been discussed in the preceding chapter. Thus ended a campaign, which perhaps had attracted an unprecedented amount of publicity and public support on one hand, and more acrimony among the nurses' organisations on the other.

The degree of militancy that was exhibited by nurses in this dispute was of a very minor order if compared with what is usually meant by the term when applied to other sections of organised labour. But nurses, as a whole, did demonstrate on a scale hitherto unprecedented in their history. Moreover, large numbers of nurses did openly defy hospital regulations by wearing uniforms on these occasions, which in itself can be construed as a small but definitive expression of militancy. On the other hand, the dispute did demonstrate the lack of unity which existed within the nursing profession and exacerbated the bad feelings existing between the R.C.N. and C.O.H.S.E.

And for all the militant utterances on the part of C.O.H.S.E., when it came to the crunch this union appeared something of a "paper tiger"; only 7,296 out of its total membership were prepared to take industrial action. Furthermore, its leadership, perhaps being influenced by the spontaneous unilateral support given by other industrial workers, were extremely naive in their assumption that they could conceivably get the T.U.C. to support the proposition of a general strike in support of the nurses. Since 1926 the T.U.C. has looked askance at a general sympathetic strike and has even been more cautious about strikes, which seems to directly challenge the elected Government. This can be clearly seen in the T.U.C.'s unwillingness to support the London Busmen in their 1958 strike.

1967-72

There was not a great deal of activity between the years 1965 and 1967; mainly because, as stated in the preceding chapter, the 1965 salary agreement was not due to end until June 30th, 1967.
What would seem necessary now is to trace the events which followed from the salary claim dealt with on page 182 above.

There were a number of activities that can be directly traced from this event; but from the viewpoint of clarity it may be advantageous to deal with these under separate headings.

The R.C.N. "Raise the Roof" Campaign.

The R.C.N. Council held a special meeting on May 16th, 1968 to study the Prices and Incomes Report on Nurses' Salaries and Conditions of Service. The College took exception to what it regarded as two major issues; (1) the inadequacy of salary ceilings, and (2) the implications for nursing education.

The College was of the view that a ceiling of a maximum salary of less than £3,000 a year recommended for the post of a Chief Nursing Officer was derisory, and would do little to attract people of the right calibre into the service. "... a low ceiling depressed the whole salary structure and leaves little room for adequate rewards all round". 1.

On the question of nursing education the R.C.N. view was that certain aspects of the Board's recommendations placed this in jeopardy.

"Student nurses emerge from the Report as an important part of the labour force, rather than as students of nursing - a disaster for any profession. While acknowledging the shortage of tutors, the Report does nothing to attract and retain those who teach". 2.

The College therefore decided to embark on a nationwide "Raise-the-Roof" campaign and a ten point plan of action was sent out to all R.C.N. members extolling them to action and also calling for a concentrated membership drive.

The plan of action is reproduced below.

2. Ibid.
1. READ the National Board for Prices and Incomes Report No. 60: failing this READ the main recommendations of the report in Nursing Standard (May issue). Encourage others to do likewise.

2. READ the Comment of the Rcn. Council on the Report. Encourage others to do likewise. Copies have been sent to Branches, Section Groups, Key Members and Public Relations Officers; individual members may obtain copies from Rcn. Headquarters; price 2/- post free.

3. DISPLAY the two campaign posters in a prominent place on Notice Boards. Where Boards are not exclusively Rcn. put up under a Rcn. Title card. Any Rcn. member without a title card should apply at once to Headquarters.

4. CALL a special meeting of your Branch/Section Group to discuss the Emergency Resolutions on the P.I.T.B. Report and the Council's 'Raise the Roof' campaign. Try to hold this in the week commencing 24th June ... a bigger impact will be made throughout the country if meetings are held and reported over a concentrated period of time.

5. INVITE the Press to the special meeting. The interest and support of the general public are vital to the campaign.

6. INFORM members of Health Authorities, Local Authorities, doctors and other influential people in the community of what the profession wants and why. Encourage them to write to their newspapers in support of the Rcn. 'Raise the Roof' campaign. A copy of the Comment of the Rcn. Council with covering letter is being sent from Headquarters to all Hospital and Local Authorities and to appropriate National Bodies.

7. WRITE to your local Member of Parliament. The attached draft is a guide not a form letter; please vary style or it will be boring for the recipients and reduce impact. Send an official letter from
your Branch/Section Group after your special meeting and encourage members to write individual letters too. Volume can impress! A copy of the "Comment of the Rcn. Council" and covering letter will be sent from Headquarters to all M.F.s and some members of the House of Lords during the week preceding 24th June.

8. RECRUIT new members to the Rcn. Numbers count in achieving results. The larger the membership of the Rcn, the louder its voice becomes in the interests of the profession.

9. ENSURE a record attendance at the meeting of the Rcn. Representative Body in Cardiff, 16-18 July. All Rcn. members may attend and all may speak. Make sure YOUR representative who has the right to vote, knows YOUR VIEWS by taking part in the special meeting of your local Branch/Section Group.

10. REMEMBER that to be effective, general ACTION must be concerned with major issues not with detail. The main issues of this campaign are (1) promoting nursing education and (2) "Raising the Roof" of the salary structure. The education and training of students/pupils on sound lines and salaries and conditions for trained nurses which will attract and retrain in nursing the people required to give the service, are essential for the provision of good quality nursing care. Therefore this campaign is of importance to every man, woman and child in this country. REMEMBER, the Rcn. is fighting to improve standards of nursing care.

This was followed by the R.C.N. Headquarters sending out the Council’s "Comments" to all Hospitals and Local Authorities and other National bodies. It was also sent to M.F.s and members of the House of Lords. This publicity exercise was completed by June 24, 1968.
Over the next 18 months the "Raise the Roof" campaign proved the largest publicity exercise ever mounted by a nursing organisation. It far exceeded that undertaken by the combined staff committee in 1962.

Public meetings were organised throughout the United Kingdom, and these were of such size and intensity that they received much public attention, although strangely enough, the movement did not elicit demonstrative support — as in 1962 — by other sections of organised labour. Some indication of the momentum of the movement among nurses, however, may be gleaned from the following report in "The Times":

"One thousand nurses unable to find room in an Edinburgh music hall, where 3,000 of their colleagues were attending on nurses' pay, marked along Princes Street last night chanting "more pay for nurses".

Police were called as the demonstration marched back to the hall and pushed the large oak doors demanding to be addressed by Miss Catherine Hall, secretary of the Royal College of Nursing, who had travelled from London for the first meeting of the nurses' "Raise the Roof" campaign. She was escorted by a police inspector to address the "locked out" nurses.

According to R.C.N. sources, over 450,000 car stickers, one million Grossman letters, 420,000 posters, and 436,000 pamphlets were written, designed, printed and distributed.

Immemerable petitions were organised, as for example, the petition containing 30,000 signatures presented by nurses from Orpington to Mr. Eric Lubbock, M.P.

The campaign attracted a great coverage from the media, having attracted — according to R.C.N. sources — 10,220 column inches in the press, and also the College participated in many television and radio programmes. The campaign and the general condition of nursing formed the basis of many news items on both radio and television. The College also took part in documentaries for the B.B.C., Independent, Canadian, Dutch and Japanese television.
By 1970 the Royal College of Nursing was congratulating itself on the success of the "Raise the Roof" campaign, which according to the College "helped to achieve, without the usual trappings of irresponsible militancy, so well-beloved by many sectors of society, the biggest single salary increase in the history of nursing. Similar success was achieved by the R.C.N. in its claim for £1.00 per week increment on meal allowances for nurses in training".

It is worth noting here, although it lies outside the period of the present study, that the R.C.N. was to follow the tactics of the B.M.A. by threatening the mass resignation of its members from the N.H.S. and establishing itself as a private nursing agency.

Sister Veal and the United Nurses Association.

During the course of the "Raise the Roof" campaign a unique demonstration was organised under the slogan "Unite and Fight" by four nursing sisters from the South Western Hospital, Clapham Junction, London. The demonstration was unique in the sense that it was organised completely outside the framework of any of the official organisations of the Staff Side of the Whitley Council. The demonstration took place on Sunday, August 15th, 1968, when more than 1,000 nurses marched from Speaker's Corner, Hyde Park, to 10 Downing Street, where a protest petition was handed in.

The moving spirit of this protest was Sister Patricia Veal, then aged 33, who said that she was "stung into action" by the fact that when she went to a lobby at the House of Commons in July, organised by the R.C.N. "Raise the Roof" campaign, she was the only one there.

Sister Veal appeared to hold the National Health Service, the Royal College of Nursing and the lack of temerity of nurses in equal contempt.

Commenting to "The Times" she said "The R.C.N. is not for ordinary nurses", and she went on to say that the nursing profession as a whole is characterised by "all talk and no action".

1. Ibid.
The demonstration organised on August 15th did not receive the support of any of the Whitley Council Staff organisations. In fact, the R.C.N. instructed its members not to participate in it. In a press release in July 1968, after outlining the strategy of the R.C.N. "Raise the Roof" campaign, the statement went on to say: "These are the considerations which members are asked to bear in mind. Side issues and emotive gimmicks serve only to confuse and fragment. For these reasons the R.C.N. will NOT be supporting the march of Miss Patricia Veal and her 'Unite to Fight' group, (or should it be 'Divide and Fight') on August 15th, to march along Whitehall when Parliament is in recess and the Prime Minister is away on holiday at the least is a pointless exercise".

After the march, Sister Veal announced her intention of forming a new nurses' organisation and she invited the marchers to join. The name of the organisation was to be the United Nurses' Association, and according to Miss Veal "would be a body of nurses, run by nurses, and would be big enough to have representation on the Whitley Council". 1

Once again allegations were made that matrons and other senior staff were intimidating young nurses. Sister Veal asked the demonstrators to leave their home addresses so that they would be sure of receiving correspondence from the Association. "She said she had received a letter from a matron after sending out literature about the march, in which the matron said she did not think her nurses should read this sort of thing. Nurses indicated that they had been subject to pressure not to join the march. Some said their off-duty time had been blocked, some had to 'go sick' in order to go, and several said that the literature sent by Sister Veal had not reached them". 2

From hereon until 1970 the United Nurses' Association was to receive a great deal of publicity.

2. Ibid.
On Friday, December 13th, sixteen nurses of the U.N.A., were removed from the Public Gallery in the House of Commons and detained for more than an hour. The trouble apparently followed when Sister Yeal and fifteen other nurses went to the House of Commons to see different M.P.'s. As none of the M.P.'s would come out to see the nurses, they decided to go into the Public Gallery. "We sat there for a time listening to a boring debate about a boring Bill - a lot of drivel".1

During the course of the debate - on the conditions under which ponies are exported - Sister Yeal shouted out "I want to talk on behalf of the nurses. The nurses want support, listen to the nurses". At this point doorkeepers removed the nurses, some of them struggling, from the gallery. As Sister Yeal was removed she shouted out "The nurses want to fight for the patients in the country. Will M.P.'s listen instead of talking about ponies".

The nurses were detailed for more than an hour, then released after being told by the Sergeant at Arms, Rear Admiral Gordon, that they had been "Naughty girls".1

During the months of April and May, Miss Yeal led several demonstrations. On April 23rd, she organised a demonstration outside the headquarters of the Department of Health and Social Security, and was successful in getting Mr. Richard Crossman to come out and address the nurses. And again she organised a demonstration outside the D.H.S.S. on May 13th, when the Whitley Council was meeting there to discuss the question of a meal allowance. Also in May, Miss Yeal posed for photographers outside the headquarters of the Royal College of Nursing, using a yard broom to sweep dirt under a carpet on the pavement to symbolise that inside the

headquarters there was far too much of sweeping difficulties under the carpet.

Later, in a statement, a spokesman for the College said that cheap publicity stunts like the United Nurses' Association demonstration were doing a grave disservice to the profession, and were unlikely to achieve results. Nor did Sister Veal gain any support from the trade unions; they were not anxious to have yet another nurses' organisation on the scene competing for members.

By May 31st, the Staff Side of the Whitley Council had satisfactorily negotiated an annual meal allowance (see page 191), and this success appeared to remove most of the impetus from the U.N.A. By July of 1970, its leader, Miss Patricia Veal, had apparently become disillusioned and had left the National Health Service to work for a London Nursing Agency. In a press statement she said "I will not fight for nurses again. I fought for their pay last time but without thanks. The trouble with nurses is they expect everything to be done for them".

Although Sister Veal and the U.N.A. received a great deal of publicity, its impact on the movement was residual. Its actual membership figures were never known, but so far as it is possible to ascertain, it neither had a permanent office or a full-time secretariat. Moreover, Miss Veal's approach did not strike the right note with the majority of nurses. Perhaps because, as Ruth Miller said in an article in "The Times", that although they had a "sense of grievance at being grossly underpaid and overworked... their cloistered tradition seems to have conditioned them against rebelling. They grumble and get on with their job or they quit".

In one respect the U.N.A. exhibited certain characteristics which have been discernable in the wider trade union movement. It was, essentially

a grassroots protest movement, reacting as much against the official nurses' leaders as against the conditions which gave rise to the discontent. In this respect, it had points of similarity with the militant movements which sprang up within the trade union movement in the 1930's, e.g., the London Busman's Rank and File Movement, the Railwaymen's Vigilance Movement, the Members Rights Movement of the Amalgamated Engineering Union, and the Building Workers' Rank and File Movement. And in more recent years one can see an example of this phenomenon, not only in the traditional manual unions, but among white-collar workers, as for example N.A.G. - a militant protest movement within N.A.T.F.H.E., and perhaps more dramatically, the Rank and File group within N.A.T.F.H.E., and the N.U.T. In the N.U.T., "the movement claims about 2,000 subscribing members, probably has many more adherents, and achieves disproportionate publicity by staging noisy walk-outs and demonstrations at N.U.T. conferences." But the U.N.A. was quite different from any of the movements, in as much as it did not operate within the organisational framework of any of the nurses' associations. Moreover, its leaders possessed neither an ideological base, nor collective bargaining experience, and in this respect it was markedly different to any of the organisations discussed by Glyn and Sutcliffe.

The U.N.A., as already mentioned, received a great deal of publicity, and its tactics may have had some effect on the other organisations in that, its show of militancy may have caused them to pursue their own campaigns more rigorously than may have otherwise been the case. But overall it effected little change on the movement. Its rebellious and anti-establishment image undoubtedly appealed to a number of young nurses. Protest had become a feature of the youth culture following from the

1. See Glyn and Sutcliffe: 1972, p.34.
2. Ferris: 1972, p.73.
C.N.D. campaign, the Students' Protest Movement, the Civil Rights Campaign in the U.S.A., and the worldwide Vietnam Protest Movement. But the initial momentum of U.N.A. was not sustained, and it did not develop any structural organisation from which it could pursue a continuous campaign, nor did it have formal or informal contacts from the wider trade union movement from which to draw both moral and material support. It did not gain the support of the majority of nurses, many of whom disapproved of its publicity tactics, nor was it able to gain, even implicitly, the support from any of the nurses' organisations. Its impact, it would appear, was derived largely from the personality of its leader. With the cessation of Miss Veal's activities, the U.N.A. withered away until, by 1970, it had become completely defunct, and now only provides a colourful episode in the history of the movement.

The Hospital Matrons' Association.  

This Association was perhaps, one of the most conservative organisations in the whole nursing spectrum. Up until April 24th, 1969, its annual conferences had never been open to the public. Nor had its leaders ever given press conferences. Yet on this day it deemed to do both. What was even more extraordinary was the public statements of its leaders which had a distinctly militant flavour.

Dame Muriel Powell, Matron of St. Georges Hospital, Hyde Park, said "We have eschewed marches and demonstrations. How long can we see this heartbreaking situation go on? The real danger is that we are not going to get into the profession the women and men we need. We are dedicated spinsters but we are a vanishing generation. We do not see the nursing profession for the future able to meet the demands which are going to be placed on us”.

1. Now the Association of Nurse Administrators.
More remarkable perhaps, was that Dame Muriel Powell said that militant action on her part, even possibly chaining herself to the House of Commons railings, could not be ruled out as a last resort - that is if something drastic was not done, and soon, about nurses' pay, and equally important updating recruitment and training. Even stronger was the fact that several of her colleagues, all senior matrons and pillars of the establishment, said that they would be right alongside her, chained if need be.

The interesting fact about this situation was not the upsurge of suffragette fervour, although this was remarkable in itself, but the unusual degree of congruency manifested by the Association with other nurses' organisations.

Perhaps it was this unexpected change in the matrons' attitudes and behaviour that moved a Times leader writer to observe that the sense of grievance of the profession "at being grossly underpaid and overworked is indeed near flashpoint".  

Health Visitors' Association.

The H.V.A. did not initiate any activity during the period of the 'Raise the Roof' campaign. When asked why this was, an official of the union told me "We, of course, supported the campaigns undertaken by the College and others, and we urged our members to individually write to their M.P.s and the press, but we just didn't have the resources to mount our own campaign".

National Union of Public Employees.

While the R.C.N. was concentrating on raising the ceiling of the salaries of the higher grades of nurses, and on the implication for nursing education in the P.I.B. report, N.U.P.E. concentrated its efforts on gaining the

support of the lower paid nurses. To this end it launched a country-wide 'Charter Ballot'.

This nationwide vote of nurses was organised in order to draw up a list of priorities for a Charter of Nurses.

News of the unions intention was given by Mr. Alan Fisher, General Secretary, at a press conference in Newcastle upon Tyne in November 1968.

After recalling N.U.P.E.'s commitment to a 'Nurses' Charter' the union's General Secretary informed the press that arrangements were in hand for nurses, including those who were not members of N.U.P.E., to participate in a referendum to decide which features should be given priority in the Charter.

In outlining the form of the referendum, Mr. Fisher listed a number of points to be included in the ballot. Nurses would be asked to list the points in order of priority. "The points listed on the ballot paper include a wide range of union demands aimed at improving nurses' conditions. Hours featured prominently. A 38 hour working week to bring nurses into line with other professional staff in the hospital service is suggested, and any hours worked in excess of this should be paid for as overtime. Turning to duty arrangements the Union urges adequate notice of off-duty times - so that nurses can arrange their social lives; the abolition of split shifts; the right to live outside of the hospital and provision of married quarters for nurses. Recognising that many hospitals are still organised on Victorian lines, the referendum calls for an end to petty discipline and restrictions and for the establishment of effective joint consultative machinery so that nurses, along with other staff, can have a real say in hospital affairs. On the welfare front, the referendum points out the need for adequate health and welfare facilities for hospital staff. It adds that nurses should be provided with free meals while on duty."
Recognising that the health service is becoming increasingly aware of the need for efficiency, the Union suggests that nurses should receive pay related to improvements in efficiency. It also wants improved training arrangements for nurses. In one point, the Union singles out local authority nurses for mention. They should, it says, receive payments for week-end and night duties.¹

The union would analyse and collate the responses to the ballot and use them to form the basis of a 'Nurses' Charter'.

The ballot for the Nurses' Charter received a fair amount of publicity in the popular press.

In an editorial the 'Daily Mirror' urged nurses to 'speak up'. This month's N.U.P.E.'s ballot gives them the chance to tell the nation what irks them most in hospital routine and what reforms they would most welcome. The nation – as well as the Union – would like to know.

The 'Daily Express' conducted its own poll of the points in the N.U.P.E. charter. Top of the list, in order of priority, came the demand for a 38-hour week closely followed by overtime payments.

The charter was not without its critics; some sections of the profession felt that the demand for a 38 hour week and the payment of overtime was impracticable. The Association of Hospital Matrons criticised it for ignoring the needs of patients.

Shorter hours, overtime payment and an end to petty discipline were the key issues for an improvement in the nurses' conditions listed by N.U.P.E.'s General Secretary, Mr. Alan Fisher, in an interview for the B.B.C. programme 'Ten O'clock'. Also in the programme, he criticised the "Whitley Council negotiating machinery." Mr. Fisher said there were far too many organisations which were not geared to do a trade union job of negotiating on pay and conditions.

¹ Public Employees: December 1968.
He said that in the past many nurses had the idea that trade union membership was not quite the thing for the nursing profession. Happily this idea was not dying out.¹

FIG.1.

N.U.P.E's NURSES' CHARTER

BALLOT SHEET

NURSES' CHARTER

All nurses, whether members of NUPE or not, are invited to participate in a ballot to draw up the Nurses' Charter. Place the twelve points below in order of priority, by placing number in the boxes, and post completed form to the address shown. The result of the ballot will then be used to draw up the final version of the Charter.

To: Nurses' Charter
NUPE, Civic House,
Aberdeen Terrace,
London, S.E.3

1. A 38-hour working week in □
common with other professional staff
2. Adequate notice of off-duty time
3. End of petty discipline and restrictions
4. Payment for all overtime □
work
5. Free meals on duty □
6. The right to live outside □
the Hospital
7. Abolition of split shifts □
8. Improved training arrangements
9. Pay related to efficiency □
10. Effective joint consultative machinery
11. Night duty and weekend payments for Local Authority nurses
12. Adequate health and welfare facilities

Name_____________________________________Grade____________________
Address_____________________________________________________________

Hospital_____________________________________________________________
NUPE Branch (if a member)__________________________________________

This information is for record purposes only and will not be divulged.

I have not been able to discover from N.U.P.E. sources exactly how many nurses took part in the union's ballot, but the Union's journal 'Public Employees' in August claimed 'the participation of thousands of nurses - members and non-members alike'.

At a meeting of the Staff Side of the Whitley Council, N.U.P.E. called for action arising out of the P.I.B. report.

"Hours: Urging action to win a 38 hour week to bring nurses into line with other professional staffs in the hospital services. N.U.P.E. points out that the P.I.B. rejection of this claim was based completely on inadequate evidence. Nurses, says N.U.P.E., work longer hours than any other grade of hospital staff - and this in itself is sufficient justification for the claim.

"Overtime: Describing the rejection of the claim for extension of paid overtime as totally unsatisfactory, N.U.P.E. urges the Staff Side to pursue its declared policy of overtime payments for all nurses and midwives.

Special Duty: Although the P.I.B. report lead to improvements in special duty payments, these fell short of reasonable expectations, says N.U.P.E. It urges a claim which would give double time for Sunday duty; time and a half for afternoon on Saturday; and time and a quarter for night duty.

Shift Arrangements: Pointing out that the P.I.B. recommended the introduction of straight shift systems by 1st January 1970, N.U.P.E. asks for a check to determine how many hospitals will follow this recommendation. And, as an incentive to change, it suggests that hospitals who do not act on the P.I.B. suggestion should make a penalty payment to nurses and midwives who are still working split duties in the New Year.

In placing these issues before the Staff Side of the Nurses and Midwives Whitley Council, N.U.P.E. is following a pattern which appeared following its ballot on a Nurses Charter". ¹.

¹. Public Employees: August 1968.
Thus the four points that were put to the Staff Side of the Whitley Council were the opening shots in the N.U.P.E. campaign to win wider support for the 'Nurses' Charter'.

In June 1970, the Union, when giving evidence to the Briggs Committee, drew attention to its ballot and stressed in particular the reduction of the working week and the payment for excess hours worked, as aspects of working conditions with which nurses were most concerned.

By and large, the N.U.P.E. campaign did not have the momentum of the R.C.N's 'Raise the Roof!' campaign, nor was it altogether very successful in realising the aims of its campaign. The Whitley Council salary agreement which came into effect on April 1st, 1974 was based on a working week of 40 hours, but it did not make provision for special duty payments, in keeping with the P.I.B's recommendations. Just how far the N.U.P.E. campaign fell short in achieving its aim can be seen from the following extract from a D.H.S.S. Advanced Letter on Nurses' Salaries - "The revised salaries and training allowances set out in the Appendices are not enhanceable in respect of special duty payments for night and weekend duty performed within the normal 40 hour working week, but they are enhanceable in respect of special duty payments for such duties performed outside the normal working week. The revised salaries and training allowances for the grades eligible for special duty payments marked 'A' in the Appendices, and so far as special duty payments are concerned, these salaries and training allowances should be used only for night and weekend duties outside the normal 40 hour working week. The salaries and training allowances which are marked 'B' should be used to calculate special duty payments for night and weekend duty performed within the normal working week".

During the time that the R.C.N. and N.U.P.E. were engaging in their

1. Department of Health and Social Security: Advanced Letter (NM)3/74
"Raise the Roof" and the "Nurses Charter" campaigns, the activities of C.O.H.S.E. were by comparison relatively restrained.

According to C.O.H.S.E. sources, they did not regard the College's campaign as having much relevance to the plight of the ordinary nurse. They interpreted the slogan "Raise the Roof" as meaning raise the salary scales of the higher grades. As one full-time C.O.H.S.E. official informed me, they thought that any campaign at that time "as in most other times in the nursing profession, should have been directed at the salaries of the lower grades, rather than those of the higher grades". In their view, therefore, the College campaign, although "catching the public imagination", had little significance to what C.O.H.S.E. perceived to be the real issues. Hence they organised a series of protest meetings designed to give emphasis to the salaries of the lower paid nursing staff.

In short, it organised a traditional style C.O.H.S.E. campaign. However, as I understand the situation, C.O.H.S.E. felt no obligation to give the campaign an alternative label or slogan in order to compete with the campaigns of the R.C.N. or N.U.P.E. It maintained in fact, a relatively low profile and continued so to do until the eruption in 1974.

The Interactive Affect upon the College.

A significant problem which faced the R.C.N. in 1960, and has continued to this day, is that of the diversity of its activities and interests of its membership. Members of the R.C.N. are not a cohesive group, and do not necessarily identify as a united profession. This is because they are so fragmented: student and pupil nurses; ward sisters; health visitors; community nurses; theatre sisters; psychiatric nurses; fever nurses; children's nurses; nurse tutors; nurse administrators and enrolled nurses, are all nurses, but their role, status and salary vary enormously within the nursing service.
The College endeavours to represent all these interests with the result that it has a high tendency towards conflictual functioning. In attempting to perform diverse, as well as complementary ends for its membership, it frequently engages in activities which, although desirable in themselves, may be viewed as being in competition with each other.

The College is by no means unique in this respect. This is a problem faced by most other professional institutions and industrial trade unions. The principal dichotomy however, which the R.C.N. faces, is its dual function of (a) acting as a professional body, and (b) being the principal collective bargaining agent in the Whitley Council.

The main characteristics of the concept of profession have been discussed elsewhere and there is little point in reiterating the discussion here, suffice to say that the 'service ideal' characteristic of 'profession', i.e. the well-being of patients, can be at variance with the means of collective bargaining.

Before considering the ramifications of this dichotomy, it might prove advantageous to clarify the basic elements involved in the collective bargaining process.

Collective bargaining is essentially a power struggle in which the participants, usually adversaries, vie and manoeuvre with each other to improve and enhance their own advantage. This process necessitates the development of a long-term strategy and the use of highly developed negotiating skills in order to make demands and offers, counter-offers and counter-demands. It is a process in which the participants seek to compromise, influence and in the final analysis, 'act'.

It is an activity in which the participants essentially require highly developed skills. Experienced negotiators are knowledgeable of the process, the plays and ploys and are adept in the efficacy of timing their various manoeuvres in order to secure maximum advantage, knowing
when to be intransigent or flexible, aggressive or conciliatory, when to attack and when to retreat.

In the collective bargaining power struggle, management seeks to maintain and strengthen the organisation, while at the same time preserving what it conceives to be legitimate managerial functions. These include, but are not necessarily restricted to, appointing and transferring personnel from one job location to another, determining policy, initiating different methods or facilities, and disciplining and discharging personnel.

Employee's organisations, on the other hand, seek to improve salaries, hours and working conditions, and in recent years, secure a presence in the decision making process.

The very character of collective bargaining is that of a power struggle in which each side requires an ultimate form of coercion to force acceptance of its demands. For employees the ultimate weapon is strike, or similar failure to work technique, such as 'sit-ins', 'work to rule', or the threat of the same by the use of or the threat of mass resignation. For employers the ultimate weapon is 'lock-out', or 'lay-off', and in the last resort dismissal.

An employees' collective bargaining organisation must have a philosophy of insatiability. Moreover, each new negotiated settlement must repeatedly prove its worth by being an improvement on the existing agreement, thus reaffirming its essential character by securing enlarged benefits for its members. The greatest threat to an employees' collective bargaining is the fear of replacement by a competitor which may appear to be pursuing a more vigorous policy on the part of employees.

From 1962 onwards the College experienced considerable difficulties in reconciling its pluralistic functions, especially its two main functions of being both a professional body and a collective bargaining agent. In this latter aspect it emulated the approach of the B.M.A., N.U.T., etc.

1. This threat had been used by doctors, nurses and teachers, and seems to be a favourite technique of professional associations.
by couching its claim in language which stressed the well being of the client. Better pay for nurses, it argued, would attract higher quality recruits to the profession. Shorter hours and improved conditions of service would ensure more alert nurses who would thereby be able to better care for patients.

From 1962 also, the College was very conscious about the increased trade union activity among nurses. The question of replacement was one which would have to be considered in the long term.

The unionisation of nurses and the pressure exerted by the trade unions, especially C.O.H.S.E. in 1962, on the collective bargaining process, and the later development of Sister Veal and the United Nurses' Association has already been traced. Clearly, if the R.C.N. was to hold its hegemony in nursing politics and collective bargaining, it would have to be seen to be pursuing vigorous campaigns on behalf of all nurses, and also to be seen as being truly representative of all nurses, and not dominated by the interests of the London teaching hospitals. For this to happen, both changes in the College's attitude and its structure would be necessary.

Changes in Structure and Style of the R.C.N.

One can see certain events which would suggest that 1960 was the watershed for the changes that the R.C.N. was to undergo.

Nearly all the key informants suggested that one of the most recent significant changes in the College's policy and structure was the admission of men to the College. It would be difficult to assess the extent of the impact that this exerted, but it is generally believed among those in the profession to be of a major significance.

The majority of male nurses were originally employed in the psychiatric field, and it has been shown elsewhere, had a tradition in both trade unionism and militancy. The Deva Report showed that, generally speaking, male mental nurses tended to be recruited after they had tried a variety
of different occupations, and thus, conceivably they may have come into contact, and been influenced by, the wider trade union movement before coming into nursing. Psychiatric nurses, both male and female, on the other hand "are more concerned than general nurses with the material aspects of their work, such as hours and wages, possibly because their work is less highly rewarding, and unfortunately, less highly regarded in the community". But within psychiatric nursing, male nurses tended to be more concerned with material aspects of their work than females. Possibly because as a group they tended to be older than their female colleagues and therefore more likely to have family commitments. This was precisely the point made by nearly all of the key informants. Thus the men who came into the College entered with a completely different perspective.

One of the changes that the R.C.N. was to undergo was a change in the composition of its Council. Up until 1961 the Council was dominated, both in terms of numbers and influence by Matrons of the London Teaching Hospitals. These women had risen to the top of their profession, so it was supposed natural that they should rise to the top of the College hierarchy. Natural attrition caused many of these older members to be replaced by younger people who had grown up in a different social milieu. Such changes undoubtedly effected a difference in the way in which the College conducted its affairs. Gradually, also, other organisational structures changed. The Annual Delegate Meeting changed its complete format to the Representative Body, and this was a much wider forum. As one key informant put it 'lots of individuals came to the fore who had never been heard of before'. Now presumably they had been exercising their own little bit of militancy in their own little world, but now, it manifested itself in the Representative Body, and the next thing that

1. 1954, Page 1.
2. Deva: op.cit.
3. Ibid.
happened was, once people were on their feet speaking at the Representative Body, they became known to the membership overall, and they became elected to Council. So the compositional changes originally caused by natural attrition were reinforced by a change in the situation attributable to the creation of the Representative Body.

Other organisational changes occurred within the College. Branches were replaced by centres, and R.C.N. representatives, previously known as "key members" were replaced by "stewards". This latter development constituted more than just a change in name. Prior to the establishment of the steward system a key member could be, as a full-time official of the College, informed me "anyone in the hospital, but it was nearly always Matron, and this made it very difficult to have a dispute with Matron". I also understand from this informant that, although technically these "key members" were elected, the system was so complicated that they were virtually College appointees. The stewards, on the other hand, are directly elected and are more representative of the membership. Moreover, again according to this Area Officer, they have a completely different style of operating, "in many ways we have turned the bend. I find it very difficult these days to prevent them from becoming hyper-militant".

The institution by the College of a system of representation in the hospitals which is remarkably similar to a shop stewards system in industry is indicative of the R.C.N. adopting a more industrial relations approach. Still more indicative of this industrial relations approach is the College's recent abandonment of its opposition to overtime payments and various other fringe benefits, hitherto vigorously opposed on the grounds that they were unprofessional.

1. Informant No.5: Appendix 1
Throughout the sixties, the R.C.N. sought, in the face of increased trade union activity, to consolidate its position and extend its influence. The first step in this direction was, of course, the allowing of membership of men, which has already been dealt with. In 1962 an amalgamation was successfully negotiated between the College and the National Council of Nurses of the United Kingdom. After achieving these two accretions the R.C.N. embarked upon the task of extending its membership to other groups of nurses hitherto not entitled to full participating membership. In 1967 its Charter was amended to provide for the full admission, at some future date, of State Enrolled Nurses. A resolution to give full effect to this merger was passed at the College's Annual General Meeting in 1969. After subsequent negotiations between the College and the National Association of State Enrolled Nurses, the latter unanimously decided to dissolve and form an Enrolled Section within the R.C.N. This became effective from October 1st, 1970. Previously in 1968, student membership was established within the R.C.N., and as a result, the Student Nurses Association discontinued as a separate organisation and became the Student Body of the College.

The membership of the College showed a consistent growth throughout the sixties, as shown in the table below, which reflects the various accretions discussed above.

Table 5c

<table>
<thead>
<tr>
<th>Year</th>
<th>Full Registered and Enrolled Members</th>
<th>Student/Pupil Members</th>
<th>Associate Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>42,211</td>
<td></td>
<td>1,754</td>
</tr>
<tr>
<td>1968/9</td>
<td>46,613</td>
<td>15,413</td>
<td>1,844</td>
</tr>
<tr>
<td>1970</td>
<td>48,254</td>
<td>19,719</td>
<td>1,831</td>
</tr>
<tr>
<td>1971</td>
<td>53,829</td>
<td>25,676*</td>
<td>2,097</td>
</tr>
<tr>
<td>1972</td>
<td>60,877</td>
<td>30,331</td>
<td>-</td>
</tr>
</tbody>
</table>

* including 1,816 pupil nurses. Source: R.C.N. Annual Reports.
Conclusion.

Within the institution of the R.C.N. a synthesis of the models of trade union and professional association appears to have been taking place over the period 1960 – 1972. It has been possible to trace during the period very definite indicators of a shoft to a perceptively more industrial relations approach, both in relation to the steward system, and the attitude towards overtime payments.

Its full-time officers, especially the men (there are now three full-time male area officers out of nine, all of whom originally came from trade union backgrounds), are forceful negotiators at local level, exhibiting the behaviour patterns and attributes usually associated with full-time union officials.

The College has also changed its elitist character, opening up its membership to enrolled and student nurses, and its Council to members drawn from a much wider field than was previously so.

Although avowedly a non-trade union, the College decided, as did many other professional associations, to obtain certification as a trade union under the 1974 Trade Union and Labour Relations Act. Of course, this action in itself does not signify a move towards trade unionism, but in order to maintain its negotiating position in the Whitley Council, the College was forced to take this action. What is a significant change is that, I understand from some full-time organisers of the College, two important trends are emerging. (1) College officers have been instructed to project a more trade union image, and (2) there is a demand from a certain section of the membership for affiliation to the T.U.C. In this sense the R.C.N. may well be following the path that other professional associations e.g. N.A.L.G.O., N.A.S., N.U.T., N.A.T.H.F.E., and so on, have followed.

What seems to have happened therefore, over the past fifteen years, is the new image of profession and union are not so divergent as they
traditionally were. The presence of increasing union activity and membership in the hospital field is presenting nurses with a choice between two organisational models.

It would appear that in order to ameliorate the effect of this tendency, the College has moved towards a more unionised, or as Blackburn¹ would say 'unionate' form of organisation. To argue that this has been a conscious movement on the part of the College authorities would be to stretch the relationship too far. However, events do not take place in a vacuum, and the interaction of the events which have been traced over the past fifteen years have inexorably exerted pressure on the College, and as a result, caused the R.C.N. to move towards a synthesis of the union and professional model of organisation.

This dialectical process I believe to be of major theoretical significance, and tends to effect all professional associations who have a large percentage of their members in the public sector.

The Interactive Affect upon the Unions.

Throughout the sixties and seventies both N.U.P.E. and C.O.H.S.E. claimed enormous increases in their nursing membership. N.U.P.E. now claims to have 70,000 nursing members, and I understand from C.O.H.S.E. sources that their current membership figures now stand at 200,000, of which at least half are nursing members. These figures, however, be viewed with a certain amount of circumspection, as stated elsewhere, neither of these trade unions - unlike the R.C.N. - can give a breakdown of their actual nursing membership.

During the 1960-62 dispute one can clearly see a major cleavage between the trade unions in general, and C.O.H.S.E. in particular, and the R.C.N. However, when one looks at the position more recently, the major struggle appears to have shifted, being now primarily between the two trade unions: N.U.P.E. and C.O.H.S.E.
C.O.H.S.E. clearly perceives its position as being the only legitimate trade union for nurses. For although it cannot be argued that the Confederation is an exclusively nurses' organisation, it is, as a C.O.H.S.E. official informed me "a health service organisation", and he claimed that a breakdown of the union's membership (I have not been able to obtain such a breakdown from C.O.H.S.E.), "would show that we had a membership of people roughly the same proportions as are to be found in the health service. So we mirror the service, and certainly have more nurses who are members than any other trade union or professional association". Whereas it was suggested that N.U.P.E. represents many other sections which lie outside the N.H.S.

One gets the feeling that C.O.H.S.E. views the position of N.U.P.E. in the health service as being an incursion into its legitimate territorial domain. In short, it thinks that N.U.P.E. is poaching. This view ignores completely N.U.P.E.'s historical role in the unionisation of nurses. The bad feeling between the two organisations came to a head when C.O.H.S.E. voluntarily registered under the Industrial Relations Act and was temporarily expelled from the T.U.C. for so doing. Many N.U.P.E. members saw this act as a betrayal of trade union principles on the part of C.O.H.S.E. and they further perceived this as being indicative of C.O.H.S.E.'s desire to present an image of it being a professional body in order to attract less committed trade union minded nurses, and to form itself as the main nurse professional body in competition with the College. In short, a synthesis, in the reverse direction to the R.C.N., of the trade union profession model.

One can see below just how sharp this divergence between C.O.H.S.E. and N.U.P.E. was to become when in 1974 N.U.P.E. members would not support any of the industrial action undertaken by C.O.H.S.E. members.

1. See Informant No.7, Appendix 1.
The position, vis-a-vis this difference is so well known in the health service that many management nurse informants have suggested that they are frequently able to take advantage of it in the resolution of local disputes.

Epilogue.

As more militancy emerged after the period under review, it might be useful here to give a brief summary of events which were later to follow.

The most recent manifestation of militancy among nurses began after the Phase Three settlement of 7 per cent in February 1974. This settlement however, did not appear to satisfy many nurses because, in the April of that year both meal charges and lodging allowances were increased, and subsequently it was argued that they had not in fact received any real cash increase.

On April 30th 1974, C.O.H.S.E. launched a campaign for an increase in nurses' pay with a demonstration outside the Department of Health and Social Security. This was timed to coincide with the meeting that the Staff Side of the Whitley Council was having with the Secretary of State, Mrs. Castle. Among the demonstrations demands, a full independent inquiry into the whole salary structure of nurses and midwives, and a salary target of £3,000 per annum for a ward sister.

On May 13th, a mass rally of nurses took place at Hyde Park, London. A Royal College of Nursing delegation from this rally met the Secretary of State, and Miss Prentice, President of the R.C.N. announced that unless an independent inquiry was announced within three weeks, the College would be obliged to recommend mass resignation of its members from the National Health Service, and it would establish itself as a private nursing agency, for hire to the N.H.S. The State of Nursing 74, was also presented to the Department. This document outlined the deterioration in nursing, and demanded that an enquiry be established, free from any predetermined

For further comments on this action see Informant No.5 - Appendix 1.
limitation on the cost of implementing its findings. It went on further to demand improvements in working conditions, relief from non-nursing duties, a full scale review of standards of nursing care and immediate and positive action to put a stop to a rapidly deteriorating position.

During this period also, the Whitley Council made an announcement to the effect that it had taken a decision not to negotiate the £18m. which had been offered for the implementation of the Brigg's Report. This report dealt with nurse training mainly, and therefore only affected a minority of nurses actively involved in the teaching and education of nurses.

Fig.2.

Demonstrating C.O.H.S.E. Nurses outside the Department of Health and Social Security.
The National Executive of C.O.H.S.E. met on May 16th, specifically to discuss proposals from their branches throughout the country. At this meeting the executive called for a national ballot among nurses in order to ascertain the degree of support for an industrial stoppage. On the same day C.O.H.S.E's National Secretary, Mr. Albert Spanswick, announced to the press, "We have unanimously decided that, unless the Prime Minister clears the way for immediate extra cash to be made available when we see him next Monday, we will commence a nationally co-ordinated campaign of industrial action which will include strike action".

The meeting took place on May 20th and the Prime Minister, Mr. Wilson, indicated that the Government would reply to the request for an immediate enquiry and an interim cash settlement of 6 per cent through the normal Whitley Council machinery. As a result of these statements C.O.H.S.E. called off its all-out strike action, but decided to retain its campaign of industrial action.

A decision to institute an independent enquiry into nurses' pay was announced by the Government on May 23rd. The committee was to be under the chairmanship of Lord Halsbury.

It was also announced that any pay award resulting from the Committee's recommendations would be retrospective to May 23rd. At this time however, no terms of reference were specified or the names of the committee members given. Moreover, no indication was given concerning the time by which the Committee should report.

On May 25th, C.O.H.S.E's National Executive met yet again. At this meeting it was decided that the Confederation would continue its industrial action in support of the 6 per cent interim award. On the following day C.O.H.S.E. began working to rule. This involved:
A complete ban on all overtime in excess of 40 hours,
A ban on all clerical work unrelated to patient care,
Limited withdrawal of labour for periods up to 4 hours.

As in 1960–62, C.O.H.S.E. had decided to go it alone. On May 25th, at a meeting of the Staff Side of the Whitley Council, other member organisations called on C.O.H.S.E. to call off its action pending the outcome of the Halsbury Report. This time the situation was slightly different from the 1962 episode. Then the main acrimony was manifested between the R.C.N. and C.O.H.S.E. This time, however, it appeared to be between C.O.H.S.E. and N.U.P.E. Inter-union rivalry reached new heights when Mr. Alan Fisher, General Secretary of N.U.P.E. called the action of C.O.H.S.E. "the irresponsible act of amateur adventurers".

No form of industrial action was supported by N.U.P.E., except demonstrations by nurses in their off-duty hours.

The R.C.N. of course, criticised the C.O.H.S.E. action, but not apparently with the same degree of vehemence as did N.U.P.E. Perhaps the College was content to let its principal rivals fight it out between themselves. For its part the R.C.N. was prepared to bide its time, and it urged the Halsbury Committee to take as long as it required to be thorough.

During this period Nurses' Action Committees were formed in many hospitals. Links between these committees were established with Local Trades Councils, thus attempting to form communications with other groups of organised labour. As in 1960–62, solidarity action was taken by other groups of trade unionists including the miners. It was a time when nurses' militancy was at its height. In May and June demonstrations, strikes, meetings of nurses and other trade unionists were organised. Both official and unofficial financial support was organised from the wider
trade union movement. A number of conferences were arranged to discuss the campaign, including the one organised by the paper 'Hospital Worker' in Manchester.

The members of the Halsbury Committee were announced on June 7th. It contained 3 members of the Doctors and Dentists Review Body, an industrial sociologist, a member of the London Co-operative Society, and a member of the D.H.S.O Staff Committee for Nurses and Midwives. It is worth noting that the committee contained no trade unionists nor members from any of the professional nursing bodies.

On June 15th, an inaugural meeting of the National Nurses' Action Group Co-ordinating Committee was held in London. It was decided at this meeting to press for several demands: £35 for a 35 hour week; canteen prices to be fixed at the April levels; no agency nurses in the N.H.S; an end to private practice; an increase in the London waiting allowance. It also stressed the necessity to strengthen rank and file organisation within a trade union structure. The meeting called for a national day of action for health workers.

Throughout June action by health workers resulted in a closure of several private and N.H.S. wards.

On July 1st, the Secretary of State announced that she would be prepared to consider an interim award if the report of the Halsbury Committee was delayed. As a result of this statement C.O.H.S.E. decided to call off all of its industrial action except its ban on admission of all but emergency patients.

The day of action called by the Nurses' Action Committee received little support, and thereafter militant action by nurses declined.

The dispute again demonstrated just how fragmented the nurses are.

N.U.P.E. executive at no time gave support for any industrial action. Although C.O.H.S.E. nurses were willing to withdraw their labour on
May 20th, as a result of their strike ballot, and had even prepared emergency cover for the wards, the action was called off by C.O.H.S.E.'s leadership until the work-to-rule on the 26th. And as far as I have been able to ascertain this decision was taken without any explanation being given to the members.

Again, official action by C.O.H.S.E. was called off prior to July 8th, day of action, which, although initiated unofficially, had received the official support of many branches. These vicissitudes on the part of C.O.H.S.E.'s leadership lowered the morale of the Confederation nurses. Explanations of C.O.H.S.E.'s decision to call off action after the Secretary of State's offer of an interim award of an unspecified amount have not been forthcoming.

The official work-to-rule called by C.O.H.S.E. was difficult to maintain because members were working in wards where N.U.P.E. and R.C.N. members also worked, and these latter did not support it. No solidarity was achieved. It was however, effective enough to close wards in several hospitals.

The R.C.N. for its part, threatened mass resignation but did not put it into action. So there was a kind of polarisation between C.O.H.S.E. and the R.C.N., the former using a typical trade union strategy and the latter using the threat of action associated with professionals. N.U.P.E. played no significant role at all, and the other two T.U. organisations, namely N.A.L.C.O. and H.V.A. were not to be heard of during these events.
CHAPTER 8.

THE MARKET SITUATION, RELATIVE TO NURSES' PAY.

Most nursing journals, newspapers and other media referred to during the course of this work have asserted that nurses are underpaid, both in relation to their contribution to society and in relation to other similar occupations. This was a view held by most nurses. Nearly every informant whom I interviewed, mentioned the poor pay of nurses in some context or other. It would, therefore, seem necessary to examine this contention in order to try and ascertain whether the perception of poor pay held by the nurses had, in fact, any basis in reality.

I propose to do this exercise for the year 1973. The reason why I have selected this particular time is because it falls within the period when in 1970 nurses "received the biggest single salary increase in the history of nursing". 1 As we have seen this was followed by an overall salary increase of 8 per cent in April 1972, and thus if it can be shown that in 1973 nursing was a low paid profession, we can infer by induction that this was the case for the whole period 1962 – 1972. Moreover, 1973 seems a good time for the analysis, since it just precedes the Halsbury Committee which was established by the Government in 1974.

It should be stated at the outset that it would be difficult to quantify the nurse's economic contribution to society. This would necessitate a major cost-benefit analysis beyond the scope of this study, and given this constraint, pay relativities will inevitably assume a significant role in the analysis undertaken here.

General Pay Relativities.

As a group of workers, nurses fall into the general class of non-manual employees, and the vast majority are public employees. A starting point then, would be to make general comparison between the salaries of nurses and other non-manual workers employed in the public sector. Such

1. Annual Report of the R.C.N.
comparisons are made possible by extracting data from the annual New Earnings Survey (N.E.S.) compiled by the Department of Employment. This survey gives details of earnings of specified grades of non-manual employees covered by the major collective bargaining agreements in the public sector. The tables set out in Appendix 3 are derived from the 1973 N.E.S., and refer to gross earnings which include overtime payments etc.

Table 1A shows the median and lowest decile of a male nurse employed in the N.H.S., and other categories of male non-manual employees covered by other public sector collective agreements. There are fourteen categories of employees included in the table. The median weekly earning of a male nurse is £28.9 and this ranks in the thirteenth place with only the Civil Service Clerical Grade category falling below it. The apparent prevalence of low pay among male nurses may be seen from the fact that the lowest decile shows that 10 per cent of them were earning less than £18.6 a week, which indeed is lower than any other group. One of the problems, however, of taking weekly earnings as an indicator is that they do not give any cognizance of the hours actually worked. When reference is made to the median of hourly earnings of male nurses the perspective is markedly changed. The median hourly earnings of 69.5p. is now at the bottom of the list, in fact 3.1 pence below the next group (Civil Service Clerical Grades), and 123.4 pence below the highest group (Teachers in Establishments for Further Education). In percentage terms the median hourly rate of a male nurse is 35.5 per cent of that of a F.E. Teacher in the same category.

The position of female nurses in the N.H.S. is shown in Table 1B. Of the appropriate occupations listed the median weekly earnings of £21.8 for female nursing staff is at the bottom of the list. Furthermore, the lowest decile shows that 10 per cent of these nurses were earning less than £14.7 a week, a figure which is considerably lower than any of the
nine other occupational groups. Applying these figures on an hourly basis, the median of 37.2 pence per hour for these nurses is 3 pence below the next category (Electricity Supply Administrative and Clerical Staff) and 73.4 pence below the top category (Teachers in Primary and Secondary Schools). So in percentage terms, the median hourly rate of a female nurse is 40.25 per cent of that of a teacher in the equivalent category.

The level of the lowest decile earnings gives a fairly sharp indication of the low salaries among certain groups of nurses. However, nursing in general appears to be a low paid profession. This fact is indicated by its median earnings as compared with other non-manual employees. This conclusion is confirmed in more detail in Tables 2A—D, which shows the distribution of earnings, on weekly and hourly bases, for nurses and other sections of non-manual public employees.

Interpretation of the figures presented in the 1973 N.E.S. would seem to lead to the conclusion that nursing staff are not only less paid, as a group, than other non-manual public employees, but considerably so. Given that the pay of all public employees suffers from the constraints imposed by Government, it would appear that as a general rule, nursing staff have had their earnings depressed more than any of the other groups considered.

**Particular Pay Relativities.**

So far, this examination has dealt with relativities on the basis of broad comparison between groups of non-manual employees in the public sector covered by specific collective agreements. Although this gives a general pay relationship, it could be argued that because of the spread of the grades at various salary levels covered by various collective agreements, it may well lack the requisite precision necessary to secure a definitive judgement. For example, as the situation obtained in 1973 the Nurses and Midwives Whitley Council agreement covered grades of staff from an eighteen year old student (on a salary of £816) to a Chief Regional
Nursing Officer (on a maximum salary of £5,169.)

In addition, however, to its broad classifications by service or industry, the New Earnings Survey also presents data based on occupational groups. This enables a more precise comparison to be made of earnings of specific grades of employees. For example, one of the categories presented is under the heading of "professional and related staff in education, welfare and health". The data on the medians, quartiles and deciles of weekly earnings of staff in this category is shown in Tables 3A - B.

As one would expect, nursing auxiliaries and assistants come at the bottom of this list (Table 3A), with the highest decile showing only 10 per cent of their earnings exceeding £24.7 per week. But of particular interest to the present work, and perhaps most significant, is the relationship between registered and enrolled nurses and primary school teachers. Given the nature of the work and the basic training for both these groups - and making allowance for the longer hours, shift and week-end duties for nurses - it is worth noting that the median for a nurse is £12.6 below that of a teacher. Furthermore, the lowest decile of a teacher is £4.2 above the median of a nurse. Nursing administrators and executives would appear to be reasonably well placed in relation to teachers (primary, secondary and others) in terms of median earning. However, this tendency is inclined to diminish when one looks at the data in the upper quartile and highest decile earnings. This suggests that even for senior nursing personnel the prospect of higher salary progression is not as advantageous as it is for teachers.

A consideration of the position for male registered and enrolled nurses suggests that their position is less favourable than for their female colleagues. Their median earnings are the lowest recorded and £11.7 below the next highest (Welfare Workers). If one considers the relationship of the earnings of registered and enrolled nurses to primary school teachers (where most of the staff are three year trained non-
the difference is sharper than was the case for women in the previous paragraph, with a median for a male nurse almost £20 a week below that of a male primary school teacher.

Tables 4A - B give the distribution of weekly earnings and from these tables it is possible to procure an overall picture of the position of nursing staff relative to other occupational groups.

Unsocial Hours and Overtime.

One of the distinctive features of the nursing profession is its unusual hours of duty. Again it can be shown from N.E.S. that the position of overtime payment is less favourable for nurses than the other groups considered.

Nurses are one of the few non-manual groups who work a forty hour week. Virtually all other non-manual employees, both in the private and public sector, work a normal week of 28 hours. It can therefore be argued that not only do nurses work longer hours compared with other non-manual groups, but are paid less for so going and these two factors combine to depress their overtime rates relative to other groups.

The foregoing analysis would seem to give some credence to the nurses' perception that they were badly paid and unjustly so. In fact, based on the N.E.S. nurses' salaries fell very much short of any other non-manual employees in the public sector. And this was at a time following, as we have noted earlier, two successive pay awards.

Now given that the situation had improved in 1973 following the highest "salary increase in the history of nursing"; it is reasonable to argue that their salary position was worse during the sixties. So in terms of salaries, the market situation could create a situation which was conducive to nurses feeling a strong sense of grievance, and this could have been a major factor in motivating them to militancy. It does not explain why it happened in this period because as Abel-Smith has shown, their pre-war position, in real terms, was less favourable than their
post-war position. This question will be considered in detail in the following chapter.
TOWARD A THEORY OF PROFESSIONAL MILITANCY

Throughout the present work the writer has, in the first place, endeavoured to determine whether there has been any activity amongst nurses which could justifiably be described as militancy. Then assuming that this was the case, document such incidents.

These two objects have in the main been achieved. The preceding chapters have dealt with the emergence of militancy in both the pre and post-war periods, this was followed by a detailed study of every salary claim submitted by the Nurses & Midwives Whitley Council during the period 1960 - 1972. In addition, a study was made of the various "voice" and other manifestations that was engendered by each claim.

A detailed analysis was made of the interactive effect upon the organisations who participated in these disputes. Finally, an analysis of nurses' salaries was undertaken with the purpose of ascertaining whether there was substance, in fact, in the assertion by nurses and their representative organisations that they were grossly underpaid.

As stated previously, this work did not start with any preconceived analytical model in mind, either in the form of verifying any of the 'Grand Theories' of the masters, or with any logico-deductive theory based on certain assumptions about the social system. The approach was motivated by a strong conviction that theory could be generated from the data itself. In this respect I must acknowledge the strong influence upon my thinking of Glaser and Strauss.

Inevitably as the work progressed certain theoretical possibilities which might conceivably lead towards a general theory of professional militancy

materialised. The problem was not a dirth of possible causative factors, there were indeed, innumerable possible influences which could have conceivably contributed towards the phenomenon: the students' protest movement; the advent of the women's liberation movement; the changing pattern in secondary education; the contagion effect from the activities of other manual and non-manual workers during the '60s; the rise of the consumer economy and its concomitant: higher economic and material expectations; the influence of immigrants, who perhaps had different attitudes towards voice behaviour and so on. However, the basic methodological problem was one of how to extrapolate from the congeries of these different factors, one that in a sense, was of fundamental theoretical significance, and from which these other factors could be said to be, either derived from — or an expression of. Unless one could engender a reasonably simple, albeit robust, model the tendency would be to become enveloped in a web of factors — all in themselves interesting, but nevertheless, from which it would be exceedingly difficult to become disentangled.

Militancy in the industrial situation has been widely studied both here in the United Kingdom, and in the United States. Until recently professional militancy has not received so much attention, and the few studies that have been undertaken have generally been devoid of theoretical consideration.¹ The lack of national standardised data has undoubtedly contributed to this lack of understanding.²

We have observed that in the case of nurses the increase in their militancy has been associated with the increased participation of trade unions in the field. What evidence that I have managed to obtain, especially from key

1. This has not been the case for white-collar workers, where there has been a number of penetrating studies.
2. Government Statistics, although showing annual incidents of stoppages in the N.H.S. do not indicate which groups of workers were involved. In connection with nurses, unions and professional associations are not predisposed to give any information on such events.
informants, would suggest that this tendency is on the increase. Thus, given the continuation of the present trend, there is a likelihood that nurses' militancy will increase.

A theory of professional militancy grounded in generalisation about the content and structure of such behaviour could make for a clearer understanding of the phenomenon. From this work two possible hypotheses suggest themselves which would, at least, go some way in explaining professional militancy in general, and the increase in nurses' militancy in particular.

The concept of 'profession', as we observed in the chapter on the subject, is fraught with all sorts of difficulties, and it would gain little here to re-engage in a semantic discussion of the term. Suffice it to say, that I am taking professionals to be groups of workers such as physicians, nurses, teachers, social workers, airline captains, administrators, etc.

The two hypotheses referred to above are (1) the market situation following from the approach of Lockwood et al and (2) a concomitant of (1) — the synthesis of union and profession.

The market situation in the sixties would in fact cover most of the possible contributory factors previously mentioned. It was a time in the United Kingdom of rapid consumer expansion, and also a time when industrial workers achieved — often by the application of militant tactics — many economic benefits in the form of increased wages. Furthermore, it does not seem unreasonable to suppose that nurses, seeing this situation, wanted as one informant put it "a share in it also".

In the previous chapter it was shown that in terms of the market situation in relation to nurses pay, nurses by comparison to other groups were poorly paid. Also there was, by comparison with the pre-war period, a wider spread of unionisation among white-collar workers generally. Throughout

2. Key Informant No.9.
the 'sixties the teachers, both in the N.A.S. and the N.U.T. were taking militant stands on a number of issues. This was also true for bank clerks, local government officers, and various other groups of white-collar workers. The nurses were not unaware of these trends, which perhaps explains why nurses were more predisposed to engage in various manifestations of militancy after the war than in pre-war times, when according to Abel-Smith, their economic position, relative to their post-war position, was less favourable.

This brings us to the second, and the main theoretical consideration, and that is that in the profession of nursing a synthesis of union and profession has been occurring in such a way, that the emerging images in the 70's of union and profession are no longer so divergent as hitherto has been the case.

The changes in the structure and style of both C.O.H.S.E. and the R.C.N. have been previously traced and discussed, and indeed, have been confirmed by both R.C.N. and trade union key informants.

This tendency towards synthesis I believed to be axiomatic in the public sector where quite often professionals, such as nurses, are presented with a choice of joining two traditionally divergent forms of occupational organisations. Usually in this situation, particularly in a period of intense activity by its members, the professional association is likely to change its style and adopt a more industrial relations approach. In short, it has to become more unionised simply in order to stay in the game. The main fear of any collective bargaining agent is that of replacement.

In other situations in the public sector, such as teachers, where there was not an alternative trade union organisation recruiting teachers, but

1. See Burke: op.cit.
2. See Blackwell: op.cit.
there were trade unions representing other workers in the local authority service, the tendency has been for the teachers' professional organisations themselves to become trade unions.

In one sense this theoretical model may be considered as antithetical to my approach, since it may be construed as being in keeping with the 'Grand Theory' approach, since the process bears remarkable similarity to the Marxist dialectical theory. The model suggests that interaction can cause a synthesis between the traditional trade union and professional association model, which of course, is the classic Marxist paradigm of thesis, antithesis and synthesis. There is evidence that this has certainly been occurring within the nursing profession. However, the model was not, in any way, inspired by Marxist epistemology, but rather from the data itself.

How to what extent can this theory be grounded in empirical evidence from other professional groups? If the theory can be shown to be generally applicable then one is on the way to postulating a general theory of professional militancy. The teaching profession for example, is in the main, organised into five associations; all but one - the A.M.A. - are affiliated to the T.U.C. The four which are affiliated are as follows:

The Association of University Teachers with a membership of 28,687;

The National Association of Teachers in Further & Higher Education, with a membership of 59,750;

The National Union of Teachers with a membership of 281,855;

The National Association of Schoolmasters & Union of Women Teachers with a membership of 82,763.

There are also a sizeable section of other groups which are affiliated to the T.U.C. which could broadly be described as professional workers: Actors Equity with a membership of 22,373; the Institute of Professional Civil Servants with a membership of 103,502; the British Airline Pilots Association with a membership of 4,495; the Association of Scientific
Technical and Managerial Staffs with a membership of 374,000, including 5,000 medical practitioners, the National Association of Local Government Officers with a membership of 625,163, which has a professional and technical section.

Affiliation to the T.U.C, although an indicator of the synthesis, is not in itself the key issue. The key issue is whether a professional association is adopting a more unionised approach, or to use Blackburn's terminology, becoming more 'unionate'.

It has been shown that this has been the tendency within the Royal College of Nursing — which incidentally, is now discussing whether to apply for T.U.C affiliation, but there is plenty of evidence to suggest that this process is occurring among other groups of professionals.

The case of the junior doctors, who have increasingly become disillusioned with their predicament in the N.H.S. "From the early 1960's" and as the Parry's put it:

"Problems of poor remuneration and excessive hours of work were regarded as fundamental. The 'exploitation' of juniors by seniors pre-dated the National Health Service and, indeed, had grown up since the early 19th century with the use of the hospital as an increasingly important focus of medical education. In the early days young men would pay to serve in a junior role and subsequently, even when they were paid the low rates of remuneration, were based on the notion that entry into the consultant grade and hence into private practice would enable the individual to more than recoup the low earnings at the start of his career by high earnings later on. The growth in the number of junior posts in the National Health Service decreased the chances for promotion to consultant and it became evident that a career structure was necessary. The traditional organisation of

of the medical profession within the health service tended to preclude this possibility and it was not pressed by the Ministry. More and more, immigrant doctors took posts in the service particularly in unpopular specialisms which offered little opportunity for entry to private practice. The outcome eventually was the formation of interest groups for junior hospital doctors such as the Junior Hospital Doctors' Association. Militancy became the order of the day during 1975 and widespread industrial action produced an increasing politicisation of junior doctors and a radical shift towards unionism as a form of occupational control.\footnote{1} And there are further examples of a trade union approach being adopted by members of the medical profession and other white-collar workers.\footnote{2}

Nor is the synthesis confined to professional associations which are protective bodies. Recently the Institute of Mathematics, which is both a study body and a qualifying association, urged its members to exert pressure on the Government against cuts in educational expenditure. I understand that other study bodies, as for example, the British Sociological Association, have acted similarly.

Conclusion.

Throughout the 60's there were a number of social factors which could offer an explanation why nurses have become more militant. The student protest movement for example, although the majority of my key informants were not of the opinion that this had much impact on the wider body of student and pupil nurses; the impact of the Women's Liberation Movement, or the increase in immigrant nurses. The rise of the consumer economy and the contagion effect, which has already been discussed. My work would suggest, however, that it was the market conditions which gave rise to a synthesis taking place between "union" and "profession" which is the significant and primary factor.

\footnote{1}{Paper presented by N.C.A. & J. Parry: B.S.A. Annual Conference 1976.}
\footnote{2}{See Eckstein; op.cit.}
\footnote{3}{See Blackburn, Lockwood; op.cit.}
This was more easily facilitated within nursing by the pressure of trade union organisation, especially in the first place, among psychiatric nurses, who were nearly all organised in C.O.H.S.E. And it is worth noting that nearly all the male nurses who entered the Royal College of Nursing in 1960 had received their earlier induction in C.O.H.S.E.

Given that the analysis is valid, there is likely to be an increase in nurse militancy in the 70’s and 80’s, particularly if their economic position vis-a-vis salaries decline as their importance in the maintenance of the National Health Service increases. It is likely that if nurses find that collective bargaining without the ultimate support of industrial action is unsuccessful, then militancy in general and work stoppage in particular is likely to increase. Also at the Area and District level, management staff conflicts, of which there are already signs, could erupt into local manifestations of militancy.

Here the approach has been confined to a very narrow study, and much of the approach has inevitably been oriented to empirically tracing the development of militancy among nurses. A simple, but I believe robust causative theoretical model has been advanced, however, as with all scientific concepts, the real test will be the application of the synthesis model to other areas of professional research.
APPENDIX 1.

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INFORMANT 1.

Sex: Female

Approximate Age: 43.

Professional Association/T.U. Category: A.

Qualifications: S.R.N.; R.S.C.N.

Present Area of Work: General Practice and Family Planning.

1. "I would have thought that it was just at the end of my training — about 1960. I cannot remember exactly because I left nursing soon after". (Had a break between 1960 and 1964).

2. "Well, it is generally accepted that militancy started with the psychiatric nurses".

Q. Why do you think that psychiatric nurses were more militant than their general colleagues?

"Their work is very exacting, but it doesn't have the same appeal as other forms of nursing, and I think they were regarded (by society) as being of a lower status than other nurses. Also their conditions of work were generally worse than in most general hospitals; and they used to be more isolated; until recently mental hospitals were separated from other hospitals".

Q. Questioned on the social class composition of psychiatric nurses the respondent indicated that she thought there were more men in the psychiatric field, and these tended to come predominately from working class backgrounds. In respect to general nursing the respondent made the following observation:--

"One of the reasons why you tended to get more middle-class girls into general nursing was because they were the only ones who could afford to go into it. They usually had the backing of their parents, who could perhaps financially help them out. Because the money was so poor when I started; I would have never got home if I didn't have my parents to pay my fares. And I think that is where a lot of the trouble started,"
because for a male nurse who possibly had to keep a family, the money was so poor, that he just couldn't cope. I mean, the money just wasn't sufficient to look after a family. It is not surprising that in such circumstances a mental male nurse would likely be more militant than a female nurse".

3. "The climate of opinion has changed".

4. "Definitely male nurses are more militant than female nurses — for the reasons I have indicated earlier. But then aren't men generally prone more to militancy than women?"

5. "I have the impression that they are, but I really don't know".

Q. Asked from where she thought she had got this impression she replied:

"There has been a great deal of talk about trade unionism in nursing literature lately".

Q. The following question was then put — "Assuming that the trade unions are in fact gaining ground among nurses, why do you suppose this is happening?"

"I think there is a change of attitude among nurses today, many of them neither behave as professionals nor have a professional attitude to the job".

Q. Asked to what she attributed this she replied:

"Well, I went into hospital as a patient, just a few days, a couple of years ago and frankly, I thought that some of the nurses were pretty ghastly".

Q. Asked in which respect — their attitude to their work, their general efficiency, their education standard, etc.,

"Both in their attitude and their efficiency. For instance, things would get left at the side of the bed, and the patient opposite me was sick, the bowl wasn't removed, it was left there the whole night long. On another occasion, a couple of nurses talked to each other over the
patient's head, whilst they were taking her blood pressure. Frankly, this appals me, it really is an unprofessional way of carrying on.

Q. The respondent was asked whether she felt there was any relationship between what she thought was a diminution of professionalism among nurses and the tendency for nurses to join trade unions.

"Yes I do; if nursing becomes just a job, then they (nurses) are just like other workers, and other workers are members of a trade union, aren't they?"

Q. Asked why she thought that nurses had become less professional.

"Well, there was a great deal of dissatisfaction after Salmon, especially from the sisters. They were really mucked up. Fair enough, some change was due, but the radical changes made under Salmon were out of all proportion. In the old days, if you had a good ward sister, you had a marvellous ward. The nurses knew where they stood and the patients benefited. Now, the authority of the sister has been reduced and there is a very low morale among sisters. This is reflected throughout the whole profession."

6. "Yes, probably."

The respondent indicated that when she was in training she did not have much contact with students "although in a sense we wanted to give the impression that we were students. I wore a King's College Hospital scarf, but I did not have much contact with university students at all."

7. "Perhaps the nurses were influenced by these other groups, I don't know, but I wouldn't have thought so. Probably doctors' militancy would have influenced them more."

8. "I don't know."


10. "Yes, everybody has heard of Sister Veal - she formed a nurse organisation, didn't she?"

11. "No."
12. "No".

13. "I get the impression that it now puts the nurses' case more forcefully. In fact I have just currently read something about it becoming a trade union."
INFORMANT 2.

Sex: Female  
Approximate Age: 51.

Professional Association/T.U:  
Category: A.


Present Area of Work: Nursing Administration.

1. "It is very difficult, I think, because I am sure that it happened earlier than I am going to say, but I first became particularly aware of nurses really wanting to improve their conditions of service and salaries around 1960 to 1962. In 1962 I remember, I was health visiting in Reading and I was part of the Royal College of Nursing branch at that time, and also part of a delegation that went from the branch to the Houses of Parliament".

2. "I would like to say, if we could just qualify this word "militancy"; because this has always bedeviled the Royal College of Nursing, in my view. We have always accepted our professional ethic — 'the service ideal'. We believe that when we enter the nursing profession we are entering into a service commitment to people, and whilst we have always recognised the right to strike, because we are committed to a service, we deny ourselves that right. So, if by militancy you mean withdrawal of service, banner waving, and marching and that sort of thing, I would say, yes, C.O.H.S.E., was the more militant. If you mean a sort of quiet and dignified action which brought home many, many telling points, I clearly recall on one occasion with Members of Parliament, when we were sitting in one of their offices after we had been to the House, one thing that they said was that they had rarely seen such a well informed and courteous delegation, and the fact that we said, even in that room, that members of the Royal College of Nursing would not withdraw their services from patients who needed them, under any circumstances, was one of our most telling points".
Q. Pressed to say which nurses were the most militant, using the word in its generally accepted trade union usage.

"Without doubt C.O.H.S.E., and I would differentiate between sexes because I think the sex element is very significant. I think for some years, certainly before the war, nursing was considered to be totally a female profession, except in the mental hospitals where they tended to be rather custodial and took on the role that one sees in a Prison Warder. With the war a tremendous change gradually took place in that many men had demonstrated very considerably the ability to nurse the sick as opposed to mentally ill or the mentally subnormal, and yet were only a vast auxiliary force to the Force's female nursing service; whilst it is only within the last two or three years, I am not sure of my dates, but it is only this recently that male S.R.N's in any of the Forces have had the right to a commission, which was automatic for the female S.R.N. So you have this very real distinction between the sexes. Also, I would think that male nurses came from different backgrounds to female nurses. Many of them came into nursing from other occupations which were conceivably trade union orientated. The other thing about men, of course, is that the Royal College of Nursing for many years refused them admission. That is why 1960 is really a water-shed when they were able to come it. But in the fifteen years since the end of the war there had been this growth of militancy, if you like, of the men in the profession, and more and more the opportunity for men to train as nurses, and this gradual increase of the numbers of men in nursing, and their general movement into the general field which has had an effect upon the whole profession. Also, the prohibition of men joining the Royal College pushed them into the trade union movement.

4. Answer incorporated in (2).

5. "Yes, I think they are".
Q. Asked for an explanation.

"Yes, I think they are, obviously I find it sad, and not a little worrying because, perhaps I find it so because I don't understand it. I think in the past nurses never really felt the need to join anything or any organisation that would, in fact, work for their salaries and conditions of service. I don't know why".

Q. Asked whether she saw any relationship between increased trade union membership and increased bureaucratisation in the N.H.S.

"I find this one difficult. You are referring to the National Health Service management structure as being a bureaucratic structure. I haven't really understood. When I look back to three years ago to when I was a Director of Nursing Services in a large County Council, I urged and asked nurses and encouraged them to belong to something, but what they really belonged to was the Health Visitors Association, the Royal College of Nursing or they didn't belong to anything. And I think the larger percentage didn't belong to anything. One or two might have belonged to N.A.L.G.O., but N.A.L.G.O. never set out to, at that time, ever represent nurses. It was only a handful of nurses who belonged to N.A.L.G.O. But you see I found that quite suddenly one was pitchforked almost — it was as much a shock as that — into the whole context of industrial relationships, and unprecedented as far as I was concerned.

The involvement of nurses in the trade union movement in what is called trade union activities, and I think it is fairly significant that in this three years also, there has been a great deal of legislation, which has given a great deal to trade unions without giving parallel advantages to professional associations. Would you allow me to go back on men just once more? Because there is another point about men, and that is, I think in the time that you are talking about, in the 1960's, you had men moving into the career structure, and men moving more than before into much more general areas of nursing management and nursing education. And I think one of
the very interesting differences is — quite jokingly for many years,
I've often said to people, you're looking at one of the last spinsters
who commit themselves, by default or not is another matter, to their
career, whereas, in many ways we didn't intend it to be, whereas men
come into nursing and intend it to be so".

6. "I think they probably were, but mainly as a 'spin-off' effect. They
didn't associate much with the main stream of the students' movement".

7. "To some extent because of the changing attitudes that were occurring
throughout the 60's.

8. "In nursing the composition of entrants was different in the 60's than
say, before the war".

9. "C.O.H.S.E. without doubt".

10. "Yes, I have heard of Sister Veal. I remember that we all reacted, then
we were shocked, then we laughed. I think probably, what she was saying
was listened to. What was condemned was the way in which she was doing
it. It's very difficult, she and her movement shocked the Royal College
of Nursing out of it's complacency. You see, I think the Royal College
of Nursing was already doing far more than a lot of people gave it credit
for. It was already doing things, but it was doing it nevertheless, in
its own way. Sister Veal was relatively short lived, and it was all
going on when one didn't go out in one's uniform because it wasn't
dignified, because one was a professional".

11. "No, I never heard of this organisation".

12. "I have not come across them".

13. "There has been a power struggle within the Royal College of Nursing.
One of the things which has often been levelled against the Royal College
of Nursing is, it's Council doesn't always do what the body wants it to do.
And again, I believe you had Sister Quin coming in as Chairman of Council,
elected officers as opposed to the paid officers of the College, who have
made very clear inroads in what became 'Catherine Hall is the College" —
Catherine Hall, many thought, made many decisions which Council in the past tended to just agree with. She was a very able person, and very often what she said was right for the nursing profession, but it didn't always reflect what the ordinary body of the College wanted, and indeed, the interesting thing was that you had very able people who were not prepared to be ciphers coming into Chairmanship and Presidency and this kind of thing, who began to say "I'm sorry, it isn't what you and I want, but what all these people want who are members of the College". And I think it is by no means finished. A lot of the things which come up year after year in the Representative Body that College perhaps has written a letter on, and it's gone into the file and no more action has been taken".

Q. The respondent was asked what is the policy making process in the College and whether the resolutions passed in the Representative Body were binding on the executive.

"It depends on how the resolutions are worded. In fact when you go to R.R.B., you can have items put up for debate and discussion and they don't necessarily lead to a policy. You can have items put up as resolutions that the Royal College of Nursing does so and so or that this R.R.B. agrees that the policy of the College shall be so and so. So there is this sort of three-way thing; they resolve to take some sort of action, then I suppose such action will commit the College to it being its policy, and it can debate something which can give a thing just an airing, but may not necessarily result in any policy coming out of it, and there is the real resolution to make policy which is clearly declared that it is the policy of this body."

1. Royal College of Nursing Representative Body.
INFORMANT 3.

Sex: Female
Approximate Age: 65.

Professional Association/T.U. Category: B.


1. "Well I have been thinking about this knowing that I was going to talk to you. Only about 15 or 16 years ago. Somewhere about the early 'sixties'. During the Selwyn Lloyd freeze. I cannot recall any recollection of it earlier than that".

2. "My first real recollection of a national movement was, I think, probably due to the pay freeze, when a large contingent from the Royal College of Nursing — didn't take industrial action insofar as withdrawing their labour — but they lobbied in large numbers at the Houses of Parliament. However, I have the impression that either COHSE or NUPE wanted to take industrial action further".

3. "I think it is partly changing social patterns. It's more respectable, perhaps because it seems to be much more general now that so many other people have become noticeably militant, whereas before, they kept it rather to themselves, and certainly it was something you didn't tell the rest of the public, although you might go on about it in your own organisation. I think it's changing social attitudes, I think it is perhaps that the younger people in the profession of whom, of course, are growing all the time, have grown up in an age when this is much more general. One doesn't expect you to sit down under any kind of oppression nowadays. If you don't think that you are being fairly treated, you go to great pains to say so".

4. "I have never thought this through. I think it could be possible because, in fact, historically, unions, for a very very long time, were only really open to men. Or perhaps, it was because there were not many women who were in that sort of work that formed itself into unions. Traditionally,
of course, unions are basically men, and, in fact, I go to day conferences at the T.U.C. I was there a fortnight ago: there were very few women there, and not one of them got up and spoke. I've noticed this before when I go from time to time. I don't think I've ever been before, however, when not a single woman got up and spoke.

Q. Asked whether more men were engaged in psychiatric nursing and was there a relationship between militancy and psychiatric nursing.

"Only insofar that the militancy seems to come from these establishments. But of course, there are still more women in the profession, taking every branch of it than there are men. I think also, perhaps the fact that in mental nursing is to some extent to do with the way in which we treated people in mental hospitals. Maybe it was thought that you needed a higher proportion of the rather tougher element of the profession because of the kind of care that was given to them".

5. "Yes, I do. My own union has doubled its membership since 1967".

6. "I would think it is rather doubtful because, still in those days the training was entirely within the hospitals. While no doubt, they knew about it, I should be very doubtful whether they would relate their role within the hospital where virtually they were part of the staff — I mean, they (hospitals) were dependent upon them for service to the patient. I doubt if they would relate that kind of activity to their situation. They didn't see themselves as students in College of Education, and Universities did".

7. "I think it probably was, I should think a high proportion of the people we are really talking about had grown up since the war. Even if they were born during the war they really didn't know anything about it. To me who has lived long before it, in fact I was born before the first World War, although only just, I can see a dramatic change which is really marked by the 1939-45 war, and I think this is part of a wider movement".

Q. She was asked whether she thought that this change of attitude by
groups, such as the teachers, nurses and doctors was anyway related to the growth of bureaucracy in the public sector.

"Yes, I think this is so. My ex-matron, who is nearly 95, came back every year to our garden party, and if there is anybody who trained there in her days, she known their names and remembers what they did and where they came from. I think there is a lot in this, and I have thought for a long time that this is the basis of a lot of unrest in industry. Nobody can feel any sense of achievement, fulfilment in a way when you are part of such an enormous complex. You lose your individuality. There has in fact been a proletarianisation of these middle-class type occupations".

Q. Asked whether there had been any diminution of professional autonomy within the middle range of nurses.

"Yes, there has been. I think it started with Salmon, but I think it became much more acute and aggravating in 1974 with the reorganisation of the N.H.S., when we had this vast administrative structure superimposed on nursing. Yes, a very top heavy administrative structure. But this has been more so within general nursing. Health Visitors and Midwives have more autonomy. Strictly speaking they are not answerable even to doctors; they are only answerable to their own professional head. But this is certainly not the case with the present day ward sister, who has, in my view, lost a great deal of her former autonomy".

9. "It used to be C.O.H.S.E., but I think N.U.P.E. is now adopting a more militant attitude".

10. "Yes, she received a great deal of publicity at one time, but I haven't heard of her or her organisation in recent years".

11. "No."

12. "No."

13. "I am not really competent to answer that. I am not a member of the College. I know a few people who are; we do have links with them, as
do all the professional associations. I don't think I would like to comment on the College. Perhaps the style of leadership has changed, if only because the people who are coming into it are younger.

Q. Asked whether the respondent's own union mounted a campaign at the same time and comparable to the R.C.N's 'Raise the Roof' campaign.

"No, not really, not on a national basis. Certainly nothing which would have caused any sort of interest outside the organisation itself. From time to time we tried to get members to write and lobby their M.P.'s, but not really on any kind of national organised basis".

Q. Asked why the union didn't mount a national campaign.

"I think it didn't have the resources and our membership, which has now more than doubled, was considerably less at that time. I think that it wasn't that they weren't sympathetic in a way to the cause. I think it was that we just hadn't got the resources".
Informant 4.

Sex: Male. Approximate Age: 40.

Professional Association/T.U. Category: A.

Qualifications: S.R.N., R.M.N.

Present Area of Work: Full-time Area Officer, R.C.N.

1. "I would have said from my own experience some time about 1961. I was at that time a staff nurse in a psychiatric hospital, and we were concerned about the ridiculous levels of salary. To give you some idea, I was earning £650 per annum, and I remember having my 'take home pay' at that time at about £40 a month. And the other difficulty was the career structure — there wasn't any. And I think this was the beginning of it, plus also we were going through this metamorphosis of the 1893 Lunacy Act, and the 1959 Mental Health Act. Now, I had been nursing since 1954, and I started into psychiatric nursing in 1960. I caught, as it were, the old school of psychiatric nurses who were literally the attendants variety and who believed that there was only one method of treating patients. When I was interviewed, one of the questions was 'What's your weight and height?'. But I was very fortunate because the school of nursing that was the Sefton General, which was part of the Department of Psychiatry at the University of Liverpool and Professor Fitch was the head of it, and consequently we had a demand for academics, and it is worth noting that we did the study of psychiatry at the University. But all of us were trained nurses before that time. There were only three students taken in twice a year, and we were very fortunate because in that particular hospital the militancy wasn't so much there. Also, in the hospital there were 60 beds and 50 nurses, so there was never any argument about ratio. The first time I actually came across militancy was when I was sent from Sefton to a place called Rainhill, a major psychiatric hospital, and the people there were very upset about the whole shift system; about the fact that now you had unlocked wards and it
was definitely from the psychiatric side that militancy emerged. The chap who introduced me to unionisation, as it were, was an ardent communist by the name of ...(name given) ... he's still knocking about in the Liverpool area".

2. Answered in the above.

3. "Mental nurses of the older generation in the North West had often come from other trades which had experienced unemployment, and because of this insecurity they were more likely to accept things at any cost. In the 1960's however, many of the mental nurses were the children of this generation, like myself, who were looking back and saying "God, I'm not going to put up with this". The dress of the old psychiatric nurse, or in fact mental nurse, because it wasn't a psychiatric nurse until 1959, was a peak cap and a black coat".

Q. Asked whether mental nurses or later psychiatric nurses had a greater predilection towards trade unionism than general nurses.

"Many of them came from artisan backgrounds in the 30's, and they brought their trade unionism with them. Also, before 1960, unless you were a S.R.N. and female, you could not belong to the R.C.N., so the majority of male nurses, like myself, were members of C.O.H.S.E. I would think they do, the female of the species is more dangerous, the male of the species is more vocal, more likely to fight, because after all, it is your job for life. Another fact for mental nurses was that it wasn't only a career, you got a house as well, so it was all consuming. If you were in Rainhill for example, you would live entirely within the hospital without leaving it. It had it's own shops, farm, etc. It was a self-contained society".

5. "Yes, I think so, although it is virtually impossible to get membership figures from the unions. But you must remember that the trade unions do not differentiate between types of nurses, nursing auxiliaries, for example, who do not qualify for membership of the College are called nursing members of the trade unions".
6. "In no way. In fact, when I was a student nurse, I used to feel a deep antipathy for university students who were protesting, because I felt that they had nothing to complain of - they had, by comparison to us everything going for them".

7. "Yes, one saw militancy coming from a wide range of white-collar workers".

8. "They began to realise in the 60's that they were needed. Moreover, some of them had decided that they were linked with the bourgeoisie, but they weren't deriving the economic benefits of the bourgeoisie. They were the ones who produced, not the cream, but the technology behind the cream. They were being called professionals but they didn't have living standards associated with professionals".

9. "N.U.P.E. without doubt. In the 60's, it was C.O.M.S.E., but it is N.U.P.E. now. Another union which, as yet, doesn't have much bite in the N.H.S., A.S.T.M.S., is potentially the most militant".

10. "Yes, I remember her. She was a Sister - she complained bitterly about hospital conditions. She had a campaign and formed an organisation. She was vilified by the College".

11. "Yes, they are quite active in Ealing, Hammersmith and North London. Most of them seem to be research people".

12. "I've heard of them. They are mainly a Trotskyite group. They tried to back workers in a hospital at Reading on one occasion through an organisation called the Revolutionary Socialist Workers' Party. There is an interesting aspect of this Trotskyism which is going on. As you may already know that there is a proposed marriage between N.A.L.G.O. and N.U.P.E., and there are a number of Trotskyists in N.A.L.G.O. Indeed, the Area Secretary and his side-kick are both dedicated Trotskyists".

13. "Yes, I would say it's changed. In 1960 the only men who worked at the College were the cleaners in the male lavatory, and a couple of ex-army officers associated with P.R. and education, and now there are several full-time male organisers. The change was very, very slow. In 1971 you had the College 'Raise the Roof' campaign, and that was the first massive
organised campaign, and it was the student nurses who kicked that off. I was at Blackpool that year, and believe you me, they would have killed the Minister of Health had she been there. They wanted her "here and now". I was at the meeting, and without any doubt at all, I thought I'd gone to the wrong meeting. I heard people in the meeting shouting out really good four letter words. In one very important respect it has changed in a democratic sense. Up until 1971 the College had representatives in the hospitals known as 'key members'. And these key members could be anybody in the hospital, but it nearly always was matron. And it made it very difficult to get a dispute with a matron. The key member was appointed by the College rather than elected by the members. Now the stewards have replaced these key members and are elected by the members. In many ways we turned the bend. I find it more difficult these days to prevent them from becoming hyper-militant".

Q. Where is the policy making body in the R.C.N.

"The membership do not determine policy. The Policy Committee is the Council. They are the actual makers of College decisions. The way the Representative Body works is, we used to have branches, now it turns on centres. What has occurred now is that you have a smaller council. The Council itself actually pick up points which are brought up by the Representative Body, Council members are elected by the members. It's very similar to the City Council, where you have Aldermen, so every two years some seats come up and some go on, and then you have someone who, for example, will stand for Oxford Region and they will be elected. And the problem is, you see, they don't have to do any canvassing, you just put your name forward and if you are adopted, you just go on there. So the person who stands for this area could be someone who is not known at all. And I know a member of Council who has more people who dislike her, but the people who didn't like her didn't vote for her, but they didn't appreciate that they had to vote against her or for another candidate
rather than just not to register. The policy making of the College is invested absolutely in this Council. They are not bound by any decisions taken by the Representative Body. What they do is they will take up points raised by the Representative Body. The General Secretary is in general the memory holder for all the Council meetings and the structure is that centres will feed up general points which will go to the Council. Council then will ratify these and put them through internal sub-committees. The Council is the employer, and is the empirical factor for all of the College activities. They produce a book which is called the Policy Manual. The College has not really become more democratic in its structure, but does present a more unionised structure. The R.C.N. has now got 7 full-time area officers in the country, of which 3 are men, and we have had instructions to act in a more unionistic manner.
INFORMANT 5.

Sex: Female.

Approximate Age: 36.

Professional Association/T.U.: Category: A.


Present Area of Work: Research.

1. "It's not very easy to say. Let's sort of go backwards and work from that end. I think perhaps the big turning point was the 'Raise the Roof' campaign. That was about 1968 to 1970, and certainly there has been a lot since then. Before that the stirrings were there, they must have been, otherwise the 'Raise the Roof' campaign would not have got going as well as it did. Now, when did I first come into nursing? I came in as a student nurse in October 1962, after completing my degree at University College, London. I think that there was a lot going on then, although I don't remember the details too well. I was pretty naive at that time. I think it was about 1960 that men were allowed in, so presumably things were going on in the backroom in the early 60's. Now, when I came in 1962, I very rapidly became involved in the Student Nurses' Association, which then was a separate organisation, though linked with the R.C.N. I remember at that time, that would have been 1963-64, there were about half a dozen of us that were less conformist, and it was in 1964-65 that I had my first contact with the R.C.N. Council. At that time I would say - yes, there was still a great deal of decorum about the place. But I think there were two things happening at the same time; the students were getting 'uppity', and at the same time men were coming into the R.C.N., so the two things go together. Now, by the time I became really involved with the R.C.N., which was about 1966, I think the tides had already begun to turn, because, in the first year I was considerably the most junior, in terms of my status, as well as age, and within two years I wasn't. And it wasn't because I had gone up, but because there were far more fieldworkers
there. There was another thing that was happening internally in the organisation at this time; it had a minor sort of structure shuffle which meant that the mechanism for the Annual Delegate Meeting changed its complete format to what it is now, namely the Representative Body. This was a much wider forum, and it afforded the opportunity for lots of individuals who had never been heard of before to come to the fore. Now presumably they had been exercising their own bit of militancy in their own little world, but now it manifested itself in the Representative Body, and the next thing that happened was that these people were on their feet making militant speeches at the Representative Body, and as a result of which, became known to the overall membership who then elected them to Council. So there were several of these trends going on all through the 60's. Certainly in the R.C.N., and I think this reflected what was happening in the larger world of nursing.

2. "Well in the first place I imagine it came from the men in the psychiatric hospitals".

3. "I suppose that it was because of a difference in post-war student nurses who were coming in".

Q. She was asked whether she meant a difference in social class composition. "From an educational point of view, because I think this ties up with the changes in school systems. The sort of thing which went on in school 6th forms was very different to what had been going on ten years previously".

4. "Oh, certainly yes, and quite rightly so. As a group they are far more economically dependent on their salaries than females. The age composition is different between the two, the majority of male nurses are married and have domestic responsibilities, whereas the majority of practising female nurses are not".

5. "Yes, I am afraid they are. I say that not because I am anti-trade union. My father was a full-time trade union official. Even as a small child I remember being fascinated by the earnest discussions about industrial organisation, negotiation tactics and the resolution of disputes which
were part of my father's total commitment to the ideals of trade unionism. If I had been a boy and joined my schoolmates down the pit I would, without doubt, have joined the N.U.M.; and who knows, might have counted myself among its militants. But the model is inappropriate for nursing. You see, the difference between professionalism and traditional trade unionism lies in the difference between ends and means. It is the proper function of a trade union to promote and protect the interests, particularly the economic interests of its members. This is the limit of its function and is an end in itself. Nursing is a caring profession and therefore this trade union model is inappropriate.

6. "At the time of the student rumblings I was personally involved. I did my student nurse training at University College Hospital, having come straight from University College, London. There had been a sort of tradition that students from U.C. went out with nurses from U.C.H., and once I got involved in organising student nurses in U.C.H., we tried to establish a formal link, on a local level, with the students union at U.C.L. At the time this was happening, I think one or two local efforts were being made elsewhere. There was something going on down Plymouth way with student nurses and students from the local College of Technology. And a few nurses were making contact with the National Union of Students. I think I was the first chairman of the Student Nurses' Association to speak at a N.U.S. Conference.

Q. She was then pressed to say whether she thought student nurses in general were affected by the students protest movement.

"No, I don't believe they were really. I think we were probably the exception, mainly because of a few of us who were graduates and came into nursing with a background of student politics, and of course, the other factor was, we at my hospital were in very close geographical proximity to the University of London.

7. "No, I don't think they knew about it, the changes were occurring quite independently".
8. "There were changes in social attitudes".

9. "C.O.H.S.E".

10. "Who hasn't heard of Patricia Veal? She received a great deal of publicity, but her impact in the long-term didn't have much effect".

11. "No".

12. "No".

13. "When I first came into nursing the R.C.N. Council was dominated by a bevy of London Teaching Hospital Matrons. There was the one that everyone called "The Duchess", Estell Adamson, who had been Matron of 'Thomas's' for years and years, and she was a leading light then. Then there was Marjorie Marriott, who had been the leading light for 'Ninety-years or whatever' at the Middlesex. These were the kind of people that were making the opinions of the R.C.N., in the early 60's. And of course they projected a very conservative image. As I have indicated, the change in the composition of the Council changed markedly in the mid-60's. Perhaps in some way these changes were the result of an inter-active effect caused by the activities of the trade unions. But I believe this was minimal. At that time there were hardly any psychiatric nurses or men involved in the R.C.N., and yet there was occurring a change in attitude within the College, so there was something quite independent of other trends. Later, in the 'Raise the Roof' campaign the College was to play a much more forceful role, and later still, it threatened mass resignation of its members and this was taken very seriously. Within the organisation we spent a lot of money in getting the legal side sorted out so that we could exist as a legal nursing agency. It was no idle threat, the machinery was set up, and it cost us money to do it which we could ill afford. It was a deadly serious threat, although I think it was underestimated by other organisations. But then there was an agreement on Whitley Council of all the Organisations that there would be no action of this kind, so the R.C.N. had to withdraw its proposals. Such a threat would have been inconceivable
in the early 60's, so I would say yes, the character of the R.C.N. changed markedly during that decade. 
INFORMANT 6.

Sex: Male. Approximate Age: 45.
Professional Association/T.U. Category: B.
Qualifications: R.M.N.
Present Area of Work: Psychiatric Nursing.

1. "I should say about 1960 to 1962. It was during the time that Enoch Powell was the Minister of Health and Selwyn Lloyd the Chancellor of the Exchequer. The trouble started when the Government imposed a ceiling of $2\frac{1}{2}$ per cent on a nurses' salary claim. This so incensed the nurses that even conservative professional associations like the Royal College of Nursing were forced to take some action".

2. "Without doubt from the psychiatric nurses in the first instance. Neither was this surprising really, because the nurses in the mental hospitals were always less conformists and more prone to trade unionism than their general colleagues".

Q. He was asked to explain why this should be.

There are several reasons; in the first place there were, and are, more male nurses in this field. Up until 1960, male nurses were denied membership of the R.C.N. The nature of the work involved an element of personal risk and the mental nurse was extremely vulnerable to outside criticism. There was a real need therefore, for some form of personal protection, and since the professional associations were not prepared to grant this, these male nurses gravitated to organisations that would, namely trade unions. Secondly, many male nurses had to come straight into nursing, but from other occupations, and often in their first jobs they had been members of a trade union. Naturally, when they came into nursing they brought their trade unionism with them. Thirdly, and perhaps more significantly, the mental hospitals had a history of trade unionism so the infrastructure was there and most of them naturally joined".
3. "Well, I think that in the case of the nurses the notion of professionalism was exposed as a myth. For years people like teachers and nurses were told that they were professionals and therefore should not be tainted with vulgar materialism. Yet in the case of the nurses their salaries, especially in the early sixties, were far less than those of unskilled workers. With the rise of the consumer economy the gap between the living standard of nurses and other sections of the community widened. Well paid industrial workers acquired T.V., cars, etc., and were taking holidays abroad, and I think the nurses took the view that if it's good enough for 'them', then it's good enough for us. Moreover, I think the nurses saw, quite correctly, that manual workers had effected a real increase in their standard of living by strong industrial organisation. Also, I think that nurses came round to the view that acting like professionals, as the College would have us act, didn't pay the rent. Conjointly with these factors was the fact that we had a new generation of nurses who had grown up in a period of relatively full-employment, and they were just not prepared to passively accept the situation. They saw all round them that militancy paid off, not only with the traditional working class, but with the medics, airline pilots, teachers, etc".

4. "This is undoubtedly true, and for a number of good reasons. Some I have already indicated, but another factor is that male nurses intend that nursing should be a career for life, whereas I think the majority of female nurses see nursing as a stop-gap before marriage".

5. "Oh, certainly! My union has made considerable gains in recent years. I would think that we control the majority of psychiatric nurses and we are making inroads into the general field, especially in the provinces".

6. "I don't really think so. Student nurses are not really students in the true sense of the word, nor are they linked with the wider student movement. They are not in colleges or universities and therefore are removed from most student politics".
7. "In the sixties we witnessed the white-collar revolution, and the fact that other 'respectable' occupations, teachers, local government officers, airline pilots, and later hospital medical staff were becoming demonstratively more militant must have left its mark on nursing".

8. "Well, in the sixties status and security of tenure was no longer as significant as it had previously been, plus the fact that there had been considerable erosion of differentials between these groups and other sections of the community. All of these factors contributed towards them becoming more militant. But there is another factor, most of these groups worked in the public sector, and successive Governments of both parties unscrupulously used them in order to impose an incomes policy, which often wasn't applied to the private sector".

9. "Militancy tends to be a loaded term. If by the term you mean which union has consistently fought for a fair deal for nurses, then without doubt the answer is C.O.H.S.E".

10. "Yes, she was something of a 'flash-in-the-pan'. She really didn't have much experience of collective bargaining and when the N.U.P.E. members withdrew their support for her, she and her organisation folded up".

11. "No".

12. "Yes, they're an ultra-leftist group."

13. "Perhaps you should ask the College. However, I have the impression that due to our activities they are now projecting a more unionised image".
1. "1947. In 1947 there were some student nurses who gathered in Hyde Park, and marched with their masks on so as to avoid being identified. There was that sort of thing, if that can be called the beginning, but it was a sort of false 'storm' because it wasn't followed up with a period of sustained activity. Then there was 1962 if anybody asks in this office when was the nurses campaign? The Nurses' campaign was 1962. I don't think there is any doubt about that. We spearheaded this particular campaign - you know this was the 2½ per cent thing, instead of 7½ per cent. I was on the rally that marched from somewhere to Trafalgar Square, and appeared standing by the lions with everybody else, which was a fantastic sight in those days. It was the greatest demonstration of militancy that had ever been seen. And for that period it really was fantastic, and then this was followed a few weeks later by a similar demonstration which marched to the Albert Hall where a meeting took place under the chairmanship of Joe Grimmond. Also there were Dame Irene Ward and Mary Davies, who was later to become Mrs. Newstead, Secretary to the Staff Side of the Whitley Council".

2. "In my view, there is no doubt at all. It started in the psychiatric field. For two reasons. In the first place we were the spearhead of the movement, and our strength at that time was in the psychiatric hospitals. Certainly it started in the psychiatric hospitals, but certainly also it gained popularity in the general hospitals. But certainly it started in the psychiatric hospitals".

3. Answered in the above.

4. "You can't say. I don't think it would be wise to say there was a 'tendency towards militancy'. You see, if we are talking about militancy
we are talking about an attitude which is persistent. I think that what happened in '48 and '62, and to a certain extent what has happened since then, has been acute outbursts of frustration showing itself in this way. You know, when people are prepared to parade their policy in public and all this sort of thing. If you are talking about a militant group of people, of workers, I think that you tend to be talking about a group of people who are always tending to take a particular line".

5. "Without doubt, we have the most. And then I would say N.U.P.E. The H.V.A. is very specialised and N.A.L.G.O. has only a few nursing members".

Q. The informant was then asked whether C.O.H.S.E. caters more for nurses than say N.U.P.E.

"We certainly are not a nurses' organisation. We are a Health Services organisation. But you see, we are the only organisation which confines its membership to the Health Service, and a breakdown of our membership would show that we have a membership of people in roughly the same proportion as they are to be found in the Health Service. We mirror the service. If you break down the Health Service and find that 60 per cent are clerical, I think you'll find the same breakdown of our membership. So in that sense we cannot say — and I think it would be quite wrong for us to try and represent ourselves either as the nurses' union or the Raters' union. We are definitely gaining membership among nurses. We have now 200,000 active members. If you have been looking at our history you will know that in '68 and '69 we celebrated our 100,000 members, and now we actually have a membership of 200,000. Now say that we have only half of them as nurses, and I think we have got more than that, therefore we certainly have more nurses in membership that any other organisation be it trade union or professional organisation. The Royal College has about 80,000 at the moment, and it includes, of course, those people who are not in the Health Service".

5. "I think so. I think particularly in '62 there was emphasis on students.
And I think for the first time student nurses looked over their shoulders at other students elsewhere. This was the beginning of the claim for true student status, as opposed to being a pair of hands who worked like 'skivvies' and were given an hour's lecture now and again, and were called 'students'. And there was this call for professionalism, there was a call for student status, and they were looking at other student bodies. Certainly they identified themselves with students at that time. Also this was the beginning of the change in attitudes of employees generally after the war.

7. "I think the two things go hand-in-hand. There is certainly an increase in white-collar trade unionism, and we have sort of reaped the benefit of this new move. Our membership has increased phenomenally, and I think that other unions catering for the same sort of people would claim the same, and with some justification. I think that one of the reasons for this is that there is a new alignment. I think that people now in managerial posts or administrative posts and in nursing, they identify with employee groups rather than identifying themselves with the employers. In the past, if you were the foreman, then you were the 'gaffer', you know this sort of thing. And there was a great deal of this feeling in the Health Service, certainly among trained nursing staff. Once they got on a certain level, they certainly were not on the side of the workers, and they didn't want to identify with any workers' organisations at all. This changed because I think, that even though these people were very critical of what the engineers, the dockers, and all other people were doing, they found that it produced results".

Q. Asked if the young doctors had any effect on the nurses' attitude.

"I think this is a very significant point that you are making, because if the doctors do anything, it's alright for nurses. And when the doctors said things like we will ban overtime, nurses said, well, Good God! this must be alright if the doctors are doing it. They are still very much the
handmaidens of doctors, and I think this contributed to it. But what I think contributed more to it is, that white-collar workers and professional people discovered that a little bit of stick paid off. I would not have believed this a few years ago.

8. Answered in the above.

9. "I wouldn't want to be talking about the most militant union because obviously, I wouldn't want to make comparisons between ourselves and other unions, because it is obvious I am going to say 'ours'. We would say, of course, that we are the most effective union for this reason. The same mix that I was referring to earlier on, we reflect the membership. This is reflected also in our officership and in our negotiators, and therefore we have a team that services the nursing side of the business which comprises of nurses, technically still nurses on the Register, who should know something about nursing, who do in fact know something about nursing, and we have a National Executive Committee which is very active, which is composed again predominantly of nurses, who question and guide and instruct those people on the Nurses Advisory Committee. So our structure is such, and our democratic processes within the union are such, that we get resolutions and decisions on nursing right from the grass roots, which are usually the most radical things anyway, and these are channelled through committees and they arrive at the representatives on the Nurses and Midwives Council, who are themselves nurses, and I think we reflect the aspirations of the nursing profession in this way. Far more so than any other trade union, because their involvement, with other sections, N.U.P.E. for example, have the Local Authority involvement which dilutes their effect on their N.H.S. members. As for the R.C.N., you see the College is a College, it has to take into consideration certain things that we don't have to. For instance, because of their preoccupation with the maintenance of professional standards, they will sometimes find it very difficult to support a trade union's point because it would create problems for them in some other area. If a proposal creates management problems, you sometimes find the College
in a difficulty which they have to resolve. A dichotomy between the competing interests of their members

10. "Yes, there are so many people who see themselves as prophets. They appear on the scene, and they disappear. It so happens that she disappeared under something of a cloud. I think the significance of Sister Veal is this. There are times when these people emerge when they feel the trade unions or professional associations are not doing what they should be doing. For different reasons they feel that the trade unions and everyone else have become part of the establishment and there is a need for a 'breath of fresh air' to be blown through the whole thing".

11. "No".

12. "Yes, I have heard of these in connection with the '74 dispute".

13. "Some of the representatives from the College are making more trade union noises, and I think this has been forced on them by our activities. In other words, in order to 'stay-in-the-game' they have had to appear to be taking a more militant stand on a number of issues".
INFORMANT 8.

Sex: Female
Professional Association/T.U.
Qualifications: S.R.N., S.C.M.
Present Area of Work: Ward Sister.

Approximate Age: 40.
Category: C.

1. "It was just after I had completed my training, round about 1961-62. I remember that there was a great deal of activity, marches, lobbies, meetings, etc. I came down with a Midland contingent to attend a mass rally at the Albert Hall. I was quite young at the time and I remember that I was very impressed by the sheer numbers of the nurses that were present".

2. "It definitely started, in the first place, in the psychiatric hospitals. At that time the trade unions were fairly strong in the mental hospitals, in contrast to the general hospitals where they were very weak. So the nurses in the psychiatric hospitals were less likely to accept poor wages and conditions than general nurses".

3. "There are a number of reasons; changes in attitudes and values, but mainly because I think, that in the post-war period, particularly in recent years, nurses have joined trade unions in ever increasing numbers. In these unions they have come into contact with other N.H.S. workers who have tended to be on the whole, more militant than nurses. So the nurses have been pulled along, so to speak, by the wider movement. It is significant, I believe, that the nurses' stoppages in '74 followed in the wake of the industrial disputes of the ancillaries. Mind you, I am not saying that this was a bad thing, God knows; the nurses needed to develop some form of industrial consciousness. When the history of the post-war period is written, as far as trade unionism in the N.H.S. is concerned, I think 1974 and not 1962 will prove to be the watershed. During this period my union was involved in a tremendous campaign against private beds, etc., and in this campaign both nurses and ancillary workers were jointly involved".
4. "I think that they were originally, simply because the majority of male nurses were employed in the psychiatric field, and I have already said, this is where the main trade union organisation was. I'm not sure that this is the case now".

5. "Undoubtedly we are making major inroads in the general field, and to some extent, in the community".

6. "I don't think so at all. Nurses in training were not, and indeed are still not, organised as students. Certainly, when I was in training, we were extremely passive in the face of hospital authority and had next to no contact with the wider student movement. In the sixties I doubt for a moment, that student nurses were even aware of the protest movement that was going on in some universities. I doubt at that time, if most of us knew what the London School of Economics was. I think, however, that student nurses are less passive now. The students section of the R.C.N. was quite active during the 'Raise the Roof' campaign, for what that was worth, and a number of student nurses have joined N.U.P.E. and C.O.H.S.E.

7. "I think this is undoubtedly so, there has been a general increase in white-collar unionism, and of course nurses have been affected by this general movement".

8. "Different social climate".

9. "It is difficult to say. In 1962 it was certainly C.O.H.S.E. In recent years it would be difficult to say — it would certainly be between us and C.O.H.S.E. In '74 C.O.H.S.E. took a number of industrial actions. We didn't support them at the time because we thought them to be inappropriate and ill-timed. This has given rise to a certain amount of bitterness between the two unions, and it wasn't helped by the fact that C.O.H.S.E. registered and was expelled from the T.U.C. For my part, I think it's a pity that this bad feeling exists between the two trade unions".
10. "Many of our members initially supported Miss Patricia Veal, but when it became clear that she was intent upon forming a rival association we withdrew our support. I personally disliked the publicity gimmicks she used. Such 'gimmickry' isn't really a satisfactory replacement for the hard slog of trade unionism. In the event her movement dwindled and I understand that she left the Health Service under somewhat unusual circumstances".

11. "Yes, it is a movement made up of communist health workers".

12. "Yes, the movement developed in '74. I think that it may have had links with the Socialist Workers' Party".

13. "Well, let me say first of all, I have retained my membership in the College, and I am also a trade unionist. I personally feel that the College should concentrate on the area that it is best equipped to deal with, i.e. professional matters. It should, in my view, leave collective bargaining to the trade unions".

Q. Pressed to answer the question.

"Well yes, I suppose it has. The Representative Body is certainly more representative of ordinary nurses than the body it replaced. Also I think the College is perhaps more forceful in negotiations than it used to be, but this is a reaction I think, to increased trade union activity among nurses".
1. "In the overall national context, that is when one was more conscious of it emerging in the general nursing situation rather than just in the psychiatric field — I would suggest at the time just before the Halsbury Award. But in Psychiatry we have always tended to have strong trade union movements. I also vaguely recall something in the early sixties, but at that time I honestly wasn't very interested and I cannot remember the details very accurately".

2. "I would have to say from the psychiatric section. I think about the time of Halsbury. There was growing unrest, mainly because of the income situation. This was seen by those whom I would very loosely term the left-wing younger enthusiastic element of the psychiatric service, as an opportunity for them to manipulate other nurses. It was much easier for them to infiltrate the ranks of psychiatric nurses because 'psychiatrics' tended to attract the more radical type of person".

Q. Asked why this should be so.

"It is a more abstract form of nursing. It appeals to anyone with a degree of intellect. And because of its abstract content, there is the inclination for it to attract the more thinking person, and at the age group of say 18 to 23 this type of person tends to gravitate towards left-wing militancy and there was the right ground there for them to take advantage of it".

3. "I think the attitude of society generally, this covers a very comprehensive range of opinion, altered since the war. Relative to nursing — prior to the war the majority of nursing entrants were endowed with an attitude of
true vocation. They came to nursing because of a genuine desire to do something for their fellow beings. But the attitudes in the post-war period inevitably altered. The war gave rise to a very high level of unemployment and the socialist philosophy which followed, in my view eroded much of the liberal humanity tradition of service. These factors, I believe, caused a very rapid change in attitudes. Society became more materialistic, and nurses reflected these changes. Perhaps not initially in the post-war period, but it was something which 'snowballed'. Comparing attitudes of society today with for example twenty years ago, I would presume that you would find vast differences in the economic expectation of people. We behave much more materialistically now and this is why nurses, in my view, reflecting these values, have a greater tendency to militancy these days".

4. "My opinion is yes, however there is an increasing percentage of female nurses becoming militant, but in the first place it definitely came from the male nurses".

Q. Asked to enlarge on this question.

"Initially most of the male nurses were located in the psychiatric sector, and this area has always been strongly unionised, but as more male nurses went into the general field they took their militancy with them and this in turn influenced their female colleagues. This situation was also helped by the advent of "womens' lib".".

5. "Yes they are, I am quite positive of this. If it is an indicator to you I would suggest that 90 plus per cent of the nurses in my Division are members of a trade union, and I am not including auxiliary nurses".

6. "I wouldn't say across the board that they were, but I suspect that pockets of them were, and I think these pockets would be attributable to certain geographical areas, namely those that were near universities where there was student unrest. But I do not believe that the majority of student and pupil nurses identified with the wider body of students".
7. "Yes, I think there must be a common element, one has to make this deduction. I think I would suggest, as a nurse, that nurses would be the last bastion in this movement, but then I would question this now because I have seen militancy among nurses similar to that of teachers and others. I have actually had a strike here, which was a very great shock to me and I have to accept the situation. I can rationalise it to a degree, and I am still doing so, on the basis that it is not trade union motivated but politically motivated by nursing stewards who belong to an extreme left-wing political organisation".

Q. Asked whether the junior doctors influenced the nurses more than any other group.

"I would not have thought so, because the average thinking nurse does not necessarily go along with everything that doctors do or say. We are an emerging profession who in the past have always been a subservient body to medicine but recently we have emerged with a distinctive professional identity of our own. For these reasons I do not think we would have automatically followed the doctors' example".

8. Answered in the above.

9. "N.U.P.E. has always had a reputation in trade union circles of being left-of-centre and it was the obvious vehicle for the left-wing agitators to latch on to. They have done this very successfully and given, in my view, N.U.P.E. an unfair reputation. I think that N.U.P.E. are now somewhat biased and I must express my bias to you; I have here a group of 'Trotskyists', and most of them have become N.U.P.E. stewards".

10. "Yes, I remember her during the 'Raise the Roof' campaign."

11. "No".

12. "Yes".

13. "Yes I think it has, it has become less female dominated, it has become less Florence Nightingale orientated, and perhaps the most radical part of its change is its adoption of a more industrial relations approach".

Q. Asked why this has happened.
"Before the war they regarded themselves as the guardians of the professional ethic. Now they could continue along that line and attract a very small number of vocationally oriented nurses or they could project an image which would attract more nurses. They decided on the latter and in a sense they had to because of the increased gains among nurses that were being made by the trade unions".
INFORMANT 10.

Sex: Male
 Approximate Age: 40.

Professional Association/T.U. Category: B.

Present Area of Work: Full-time Official (N.U.P.E.

1. "I think the first indication of something happening in nursing was that they started joining unions. From my experience this started in 1968, during the time of the Nurses' Charter, and then in greater numbers in 1973-74. Obviously something had been going on much earlier, but I really cannot comment on it because I have only been working in the health section since 1968".

Q. Asked whether nurses had been joining in larger numbers than was previously the case.

"Certainly in larger percentages, to the extent that in our branch, which is over a thousand, the nurses' section is the fastest growing".

2. "I can't really talk about it in that context because in Oxfordshire, we have agreed to have divided spheres of influence among the unions. The psychiatric on the whole is organised by C.O.H.S.E. They were always better organised than the general nursing side. Just what has happened in the psychiatric area, I really wouldn't know, but I suspect there too there has also been fairly rapid growth".

Q. Asked whether the decision to have a division of union organisation was a reciprocal arrangement between N.U.P.E. and C.O.H.S.E.

"Yes, we agreed—ourselves, C.O.H.S.E. and N.A.L.G.O. We have a joint committee of the 3 trade unions, and this joint committee negotiates directly with the management, that is, as far as you can within the Health Service".

Q. Asked whether this co-operation between N.U.P.E. and C.O.H.S.E. operated nationally.

"No, there has been a certain amount of antagonism between the two unions."
This really stems from C.O.H.S.E.'s registration under the Industrial Relations Act. N.U.P.E. took a firm decision then that we would 'go after' C.O.H.S.E.'s members. We firmly believed that C.O.H.S.E.'s reason for registering was so that they could get an 'agency shop'. We were determined to prevent this. And we attacked. The branch that we have at (Hospital named in Berkshire), used to be a C.O.H.S.E. branch. We didn't have any members there. I started a N.U.P.E. branch with seven people, and put them in a local government branch. But during the period of C.O.H.S.E.'s registration the local C.O.H.S.E. branch opposed it, so we co-operated with them, whilst attaching C.O.H.S.E. members in other areas. So that is how the local co-operation originated'.

3. "It has been part of the general spread of white-collar trade unionism".

4. "I have not a great deal of experience of male nurses. Most of them are in the psychiatric field. From my personal experience I wouldn't really know the answer to that".

5. "I would imagine so. It is certainly the case here: both us and C.O.H.S.E. (I believe) have increased our members."

6. "I think they were here because of the closeness of the University, but I wouldn't have thought that this was generally the case."

7. "I think it is related, and another factor which affected teachers, local government officers and nurses, was the development of incentive bonuses for ancillary workers in the local authority and health service. What that did, in fact, was create the possibility of an ancillary worker earning more than a nurse. This happened also in the schools, when a caretaker could get £14 or £15 a week bonus on top of his wages. This situation certainly affected other people's thoughts about their status".

8. "A change in social attitudes".

9. "Ours is the most active, I prefer not to use the term 'militant'".

10. "Vaguely".

11. "No".
12. "No".

13. "I think to some extent they are changing but this has been forced on them by our propaganda and activity among nurses".
APPENDIX 2 : SECTION A

SOURCE: Whitley Councils for the Health Services
Nurses & Midwives Council

### TABLE 1

**TRAINING ALLOWANCES**

#### A. Student Nurses and Pupil Nurses.

<table>
<thead>
<tr>
<th></th>
<th>Annual cash training allowance</th>
<th>Payment to Hospital where board and lodging provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurse other than those taking mental training or trainees for the Certificate of the British Tuberculosis Association</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>1st year</td>
<td>325</td>
<td>135</td>
</tr>
<tr>
<td>2nd year</td>
<td>345</td>
<td>135</td>
</tr>
<tr>
<td>3rd year</td>
<td>365</td>
<td>135</td>
</tr>
</tbody>
</table>

Pupil Nurse

<table>
<thead>
<tr>
<th></th>
<th>Annual cash training allowance</th>
<th>Payment to Hospital where board and lodging provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>325</td>
<td>135</td>
</tr>
<tr>
<td>2nd year</td>
<td>345</td>
<td>135</td>
</tr>
</tbody>
</table>

#### B. Student Mental Nurses.

<table>
<thead>
<tr>
<th></th>
<th>Annual cash training allowance</th>
<th>Payment to Hospital where board and lodging provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students taking training in mental nursing or training in the nursing of the mentally subnormal (in Scotland, mental deficiency):-</td>
<td>£</td>
<td>£</td>
</tr>
</tbody>
</table>

(i) Age under 21 on entry:

<table>
<thead>
<tr>
<th>Age</th>
<th>£</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>380</td>
<td>135</td>
</tr>
<tr>
<td>19</td>
<td>400</td>
<td>135</td>
</tr>
<tr>
<td>20</td>
<td>420</td>
<td>135</td>
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</table>

(ii) Age 21 or over on entry

<table>
<thead>
<tr>
<th>Year</th>
<th>£</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>490</td>
<td>172</td>
</tr>
<tr>
<td>2nd year</td>
<td>518</td>
<td>172</td>
</tr>
<tr>
<td>3rd year</td>
<td>546</td>
<td>172</td>
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</table>
### A. Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Salary Scale</th>
<th>Increments</th>
<th>Board and Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Matron (Training School)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000 beds and over</td>
<td>£1,700-2,000</td>
<td>£60 (5)</td>
<td>£420</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>£1,565-1,850</td>
<td>£55(3), 60(2)</td>
<td>£375</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>£1,430-1,700</td>
<td>£50(1), 55(4)</td>
<td>£350</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>£1,315-1,570</td>
<td>£50(4), 55(1)</td>
<td>£345</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>£1,230-1,465</td>
<td>£45(3), 50(2)</td>
<td>£330</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£1,165-1,365</td>
<td>£40(5)</td>
<td>£315</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>£1,110-1,300</td>
<td>£35(2), 40(3)</td>
<td>£305</td>
</tr>
<tr>
<td><strong>Matron (Non-Training Hospital)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>700 beds and over</td>
<td>£1,315-1,570</td>
<td>£50(4), 55(1)</td>
<td>£340</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>£1,230-1,465</td>
<td>£45(3), 50(2)</td>
<td>£330</td>
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<tr>
<td>330-499 beds</td>
<td>£1,165-1,365</td>
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</tr>
<tr>
<td>200-299 beds</td>
<td>£1,110-1,300</td>
<td>£35(2), 40(3)</td>
<td>£305</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£1,060-1,245</td>
<td>£35(3), 40(2)</td>
<td>£295</td>
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<tr>
<td>Under 100 beds</td>
<td>£1,020-1,170</td>
<td>£35(2), 40(2)</td>
<td>£295</td>
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<tr>
<td><strong>Deputy Matron (Training School)</strong></td>
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<td></td>
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<tr>
<td>750 beds and over</td>
<td>£1,130-1,320</td>
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<tr>
<td>500-749 beds</td>
<td>£1,090-1,280</td>
<td>£35(2), 40(3)</td>
<td>£300</td>
</tr>
<tr>
<td><strong>Assistant Matron (Training School)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>£1,045-1,195</td>
<td>£35(2), 40(2)</td>
<td>£295</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>£1,005-1,155</td>
<td>£35(2), 40(2)</td>
<td>£285</td>
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<tr>
<td>under 300 beds</td>
<td>£965-1,115</td>
<td>£35(2), 40(2)</td>
<td>£275</td>
</tr>
<tr>
<td><strong>Assistant Matron (Non-Training Hospital)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>£1,005-1,155</td>
<td>£35(2), 40(2)</td>
<td>£285</td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>£965-1,115</td>
<td>£35(2), 40(2)</td>
<td>£275</td>
</tr>
<tr>
<td><strong>Principal Nurse Tutor</strong></td>
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</tr>
<tr>
<td>Category (a)</td>
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<td>£300</td>
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<tr>
<td>(b)</td>
<td>£1,090-1,240</td>
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<td>£300</td>
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<tr>
<td><strong>Nurse Tutor in sole charge</strong></td>
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<td></td>
</tr>
<tr>
<td>£1,045-1,195</td>
<td>£35(2), 40(2)</td>
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</tr>
<tr>
<td><strong>Registered Nurse Tutor</strong></td>
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<tr>
<td><strong>Unqualified Nurse Tutor</strong></td>
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<tr>
<td>Category (a)</td>
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<tr>
<td>(b)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Grade</td>
<td>Salary Scale</td>
<td>Increments</td>
<td>Board and Lodging charge where resident</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------</td>
<td>------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td><strong>Grade</strong></td>
<td><strong>£</strong></td>
<td><strong>£</strong></td>
<td><strong>£</strong></td>
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<tr>
<td><strong>Night Superintendent</strong></td>
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<td></td>
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</tr>
<tr>
<td><strong>(a) Training School</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,045-1,195</td>
<td>35(2), 40(2)</td>
<td>290</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,005-1,155</td>
<td>35(2), 40(2)</td>
<td>285</td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>965-1,115</td>
<td>35(2), 40(2)</td>
<td>275</td>
</tr>
<tr>
<td><strong>(b) Non Training Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,005-1,155</td>
<td>35(2), 40(2)</td>
<td>285</td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>965-1,115</td>
<td>35(2), 40(2)</td>
<td>275</td>
</tr>
<tr>
<td><strong>Senior Night Sister/Senior Night Charge Nurse</strong></td>
<td>830-1,080</td>
<td>30(7), 40(1)</td>
<td>240</td>
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<tr>
<td><strong>Night Sister/Night Charge Nurse</strong></td>
<td>800-1,050</td>
<td>30(7), 40(1)</td>
<td>235</td>
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<tr>
<td><strong>Departmental Sister/Departmental Charge Nurse</strong></td>
<td>965-1,115</td>
<td>35(2), 40(2)</td>
<td>275</td>
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<tr>
<td><strong>Group (1) Category</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>(a)</strong></td>
<td>965-1,115</td>
<td>35(2), 40(2)</td>
<td>275</td>
</tr>
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<td><strong>(b)</strong></td>
<td>830-1,080</td>
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<td><strong>(c)</strong></td>
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<td>235</td>
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<tr>
<td><strong>Group (2) Category</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>(a)</strong></td>
<td>965-1,115</td>
<td>35(2), 40(2)</td>
<td>275</td>
</tr>
<tr>
<td><strong>(b)</strong></td>
<td>880-1,080</td>
<td>30(6), 20(1)</td>
<td>240</td>
</tr>
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<td><strong>(c)</strong></td>
<td>850-1,050</td>
<td>30(6), 20(1)</td>
<td>235</td>
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<td><strong>Home Sister</strong></td>
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<td></td>
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</tr>
<tr>
<td><strong>Category (a)</strong></td>
<td>835-1,085</td>
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<td><strong>(b)</strong></td>
<td>800-1,050</td>
<td>30(7), 40(1)</td>
<td>235</td>
</tr>
<tr>
<td><strong>Housekeeping Sister</strong></td>
<td>800-1,050</td>
<td>30(7), 40(1)</td>
<td>235</td>
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<tr>
<td><strong>Ward Sister/Charge Nurse</strong></td>
<td>800-1,050</td>
<td>30(7), 40(1)</td>
<td>235</td>
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<tr>
<td><strong>Staff Nurse</strong></td>
<td>600-750</td>
<td>30(5)</td>
<td>200</td>
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<tr>
<td><strong>Enrolled Nurse</strong></td>
<td>500-650</td>
<td>30(5)</td>
<td>177</td>
</tr>
<tr>
<td><strong>Nursing Auxiliary:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 21 or over</td>
<td>460-570</td>
<td>20(3), 25(2)</td>
<td>170</td>
</tr>
<tr>
<td>Age 20</td>
<td>365</td>
<td></td>
<td>135</td>
</tr>
<tr>
<td>Age 19</td>
<td>345</td>
<td></td>
<td>135</td>
</tr>
<tr>
<td>Age 18</td>
<td>325</td>
<td></td>
<td>135</td>
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</table>
### Nursing Officers and Assistant Nursing Officers

<table>
<thead>
<tr>
<th>Group</th>
<th>Salary Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>£1,565 x £55(3) x £60(2) - £1,850</td>
</tr>
<tr>
<td>B</td>
<td>£1,480 x £50(1) x £55(4) - £1,750</td>
</tr>
<tr>
<td>C</td>
<td>£1,390 x £50(3) x £55(2) - £1,650</td>
</tr>
<tr>
<td>D</td>
<td>£1,305 x £45(1) x £50(4) - £1,550</td>
</tr>
<tr>
<td>E</td>
<td>£1,225 x £45(5) - £1,450</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group</th>
<th>Salary Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>£1,350 x £45(5) - £1,575</td>
</tr>
<tr>
<td>B</td>
<td>£1,275 x £40(3) x £45(2) - £1,485</td>
</tr>
<tr>
<td>C</td>
<td>£1,210 x £35(2) x £40(3) - £1,400</td>
</tr>
</tbody>
</table>

*NOTE: The Regions comprising the Groups are as follows:*

**Group A:** The four Metropolitan Regions, Birmingham, Manchester, Sheffield, Western Region (Scotland)

**Group B:** South Western (England), Leeds, Liverpool, Newcastle, Wales, South Eastern (Scotland)

**Group C:** East Anglian, Oxford, Wessex

**Group D:** Eastern (Scotland), North Eastern (Scotland)

**Group E:** Northern (Scotland)
APPENDIX 2 : SECTION B

SOURCE: Whitley Councils for the Health Services

Nurses & Midwives Council

# Training Allowances

## A. Student Nurses and Pupil Nurses Training in other than Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Annual cash training allowance</th>
<th>Payment to Hospital where board and lodging provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£</strong></td>
<td><strong>£</strong></td>
</tr>
<tr>
<td>Student nurse other than those taking mental training or trainees for the certificate of the British Tuberculosis Association</td>
<td></td>
</tr>
<tr>
<td>1st year 335</td>
<td>135</td>
</tr>
<tr>
<td>2nd year 355</td>
<td>135</td>
</tr>
<tr>
<td>3rd year 376</td>
<td>135</td>
</tr>
</tbody>
</table>

### Pupil Nurse

- (i) Age under 21 on entry:--
  - 1st year 335
  - 2nd year 355

- (ii) Age 21 or over on entry:--
  - 1st year 474
  - 2nd year 494

## B. Student Mental Nurses and Pupil Nurses Training in Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Annual cash training allowance</th>
<th>Payment to Hospital where board and lodging provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£</strong></td>
<td><strong>£</strong></td>
</tr>
<tr>
<td>Students taking training in mental nursing or training in the nursing of the mentally subnormal (in Scotland, mental deficiency):--</td>
<td></td>
</tr>
</tbody>
</table>

- (i) Age under 21 on entry:--
  - Age 18 391
  - Age 19 412
  - Age 20 433

- (ii) Age 21 or over on entry:--
  - 1st year 505
  - 2nd year 534
  - 3rd year 562

### Pupil Nurses training in psychiatric hospitals

- (i) Age 21 on entry:--
  - Age 18 391
  - Age 19 412
  - Age 20 433

- (ii) Age 21 or over on entry:--
  - 1st year 505
  - 2nd year 534
### Table II

#### SALARY SCALES: HOSPITAL SERVICE

#### A. Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Salary Scale</th>
<th>Increments</th>
<th>Board and Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Matron (Training School)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000 beds and over</td>
<td>£ 1,751-2,060</td>
<td>61(1), 62(4)</td>
<td>433</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>£ 1,612-1,906</td>
<td>56(1), 57(2), 62(2)</td>
<td>386</td>
</tr>
<tr>
<td>500-699 beds</td>
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<td>51(1), 56(1), 57(3)</td>
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</tr>
<tr>
<td>300-499 beds</td>
<td>£ 1,354-1,617</td>
<td>51(2), 52(2), 57(1)</td>
<td>355</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>£ 1,267-1,509</td>
<td>46(3), 52(2)</td>
<td>340</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£ 1,200-1,406</td>
<td>41(4), 42(1)</td>
<td>324</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>£ 1,143-1,339</td>
<td>36(2), 41(2), 42(1)</td>
<td>314</td>
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<tr>
<td><strong>Matron (Non-Training Hospital)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>700 beds and over</td>
<td>£ 1,354-1,617</td>
<td>51(2), 52(2), 57(1)</td>
<td>350</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>£ 1,267-1,509</td>
<td>46(3), 52(2)</td>
<td>340</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>£ 1,200-1,406</td>
<td>41(4), 42(1)</td>
<td>324</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>£ 1,143-1,339</td>
<td>36(2), 41(2), 42(1)</td>
<td>314</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£ 1,092-1,282</td>
<td>36(3), 41(2)</td>
<td>304</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>£ 1,051-1,205</td>
<td>36(2), 41(2)</td>
<td>304</td>
</tr>
<tr>
<td><strong>Deputy Matron (Training School)</strong></td>
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<tr>
<td>750 beds and over</td>
<td>£ 1,164-1,380</td>
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<td>314</td>
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<tr>
<td>500-749 beds</td>
<td>£ 1,123-1,318</td>
<td>36(2), 41(3)</td>
<td>309</td>
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<tr>
<td><strong>Assistant Matron (Training School)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>£ 1,076-1,231</td>
<td>36(2), 41(1), 42(1)</td>
<td>299</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>£ 1,035-1,190</td>
<td>36(2), 41(1), 42(1)</td>
<td>294</td>
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<tr>
<td>Under 300 beds</td>
<td>£ 1,018-1,148</td>
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<tr>
<td><strong>Assistant Matron (Non-Training Hospital)</strong></td>
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<tr>
<td>500 beds and over</td>
<td>£ 1,035-1,190</td>
<td>36(2), 41(1), 42(1)</td>
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<tr>
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<tr>
<td><strong>Principal Nurse Tutor</strong></td>
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<td>Category (a)</td>
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<tr>
<td>(b)</td>
<td>£ 1,123-1,277</td>
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<td><strong>Nurse Tutor in sole charge</strong></td>
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</tr>
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<td>£ 1,076-1,231</td>
<td>36(2), 41(1), 42(1)</td>
<td>299</td>
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<tr>
<td><strong>Registered Nurse Tutor</strong></td>
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</tr>
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<td>£ 1,035-1,190</td>
<td>36(2), 41(1), 42(1)</td>
<td>294</td>
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<tr>
<td><strong>Unqualified Nurse Tutor</strong></td>
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<td></td>
</tr>
<tr>
<td>Category (a)</td>
<td>£ 855-1,112</td>
<td>31(7), 40(1)</td>
<td>247</td>
</tr>
<tr>
<td>(b)</td>
<td>£ 824-1,082</td>
<td>31(7), 41(1)</td>
<td>242</td>
</tr>
</tbody>
</table>
A. Nursing Staff in General Hospitals

<table>
<thead>
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<th>Grade</th>
<th>Salary Scale</th>
<th>Increments</th>
<th>Board and Lodging charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Night Superintendent</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(a) Training School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,076-1,231</td>
<td>36(2), 41(1), 42(1)</td>
<td>299</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,035-1,190</td>
<td>36(2), 41(1), 42(1)</td>
<td>294</td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>994-1,148</td>
<td>36(2), 41(2)</td>
<td>283</td>
</tr>
<tr>
<td>(b) Non-Training Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,035-1,190</td>
<td>36(2), 41(1), 42(1)</td>
<td>294</td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>994-1,148</td>
<td>36(2), 41(2)</td>
<td>283</td>
</tr>
<tr>
<td>Senior Night Sister/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Night Charge Nurse</td>
<td>855-1,112</td>
<td>31(7), 40(1)</td>
<td>247</td>
</tr>
<tr>
<td>Night Sister/Night Charge Nurse</td>
<td>824-1,082</td>
<td>31(7), 41(1)</td>
<td>242</td>
</tr>
<tr>
<td>Departmental Sister/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Charge Nurse</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Group (1) Category (a)</td>
<td>994-1,148</td>
<td>36(2), 41(2)</td>
<td>283</td>
</tr>
<tr>
<td>(b)</td>
<td>855-1,112</td>
<td>31(7), 40(1)</td>
<td>247</td>
</tr>
<tr>
<td>(c)</td>
<td>824-1,082</td>
<td>31(7), 41(1)</td>
<td>242</td>
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<tr>
<td>Group (2) Category (a)</td>
<td>994-1,148</td>
<td>36(2), 41(2)</td>
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<tr>
<td>(b)</td>
<td>906-1,112</td>
<td>31(6), 20(1)</td>
<td>247</td>
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<tr>
<td>(c)</td>
<td>876-1,082</td>
<td>31(6), 20(1)</td>
<td>242</td>
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<tr>
<td>Home Sister</td>
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<td></td>
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<tr>
<td>Category (a)</td>
<td>860-1,118</td>
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<td>247</td>
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<tr>
<td>(b)</td>
<td>824-1,082</td>
<td>31(7), 41(1)</td>
<td>242</td>
</tr>
<tr>
<td>Housekeeping Sister</td>
<td>824-1,082</td>
<td>31(7), 41(1)</td>
<td>242</td>
</tr>
<tr>
<td>Ward Sister/Charge Nurse</td>
<td>824-1,082</td>
<td>31(7), 41(1)</td>
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<tr>
<td>Staff Nurse</td>
<td>618-773</td>
<td>31(5)</td>
<td>206</td>
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<tr>
<td>Enrolled Nurse</td>
<td>515-670</td>
<td>31(5)</td>
<td>182</td>
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<tr>
<td>Nursing Auxiliary</td>
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<td></td>
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<tr>
<td>Age 21 or over</td>
<td>474-587</td>
<td>21(3), 25(2)</td>
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<tr>
<td>Age 20</td>
<td>376</td>
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<td>135</td>
</tr>
<tr>
<td>Age 19</td>
<td>355</td>
<td></td>
<td>135</td>
</tr>
<tr>
<td>Age 18</td>
<td>335</td>
<td></td>
<td>135</td>
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</tbody>
</table>
### B. Nursing Staff in Psychiatric Hospitals (in Scotland, Mental and Mental Deficiency Hospitals)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Salary Scale</th>
<th>Increments</th>
<th>Board and Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Matron (Training School) and Chief Male Nurse (Training School)</strong>&lt;br&gt; Category (a)&lt;br&gt; 1,000 beds and over</td>
<td>£1,751-2,060</td>
<td>£61(1), 62(4)</td>
<td>£433</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>£1,612-1,906</td>
<td>£56(1), £57(2), 62(2)</td>
<td>£386</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>£1,473-1,751</td>
<td>£51(1), £56(1), 62(3)</td>
<td>£361</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>£1,354-1,617</td>
<td>£51(2), £52(2), 57(1)</td>
<td>£355</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>£1,267-1,509</td>
<td>£46(3), 52(2)</td>
<td>£340</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£1,200-1,406</td>
<td>£41(4), 42(1)</td>
<td>£324</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>£1,143-1,339</td>
<td>£36(2), 41(2), 42(1)</td>
<td>£314</td>
</tr>
<tr>
<td><strong>Chief Male Nurse (Training School - Category (b))</strong>&lt;br&gt; 1,000 beds and over</td>
<td>£1,612-1,906</td>
<td>£56(1), 57(2), 62(2)</td>
<td>£412</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>£1,473-1,751</td>
<td>£51(1), 56(1), 57(3)</td>
<td>£361</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>£1,354-1,617</td>
<td>£51(2), 52(2), 57(1)</td>
<td>£355</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>£1,267-1,509</td>
<td>£46(3), 52(2)</td>
<td>£340</td>
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<tr>
<td>200-299 beds</td>
<td>£1,200-1,406</td>
<td>£41(4), 42(1)</td>
<td>£324</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£1,143-1,339</td>
<td>£36(2), 41(2), 42(1)</td>
<td>£314</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>£1,092-1,282</td>
<td>£36(2), 41(2)</td>
<td>£304</td>
</tr>
<tr>
<td><strong>Chief Male Nurse (Training School - Category (c))</strong>&lt;br&gt; 1,000 beds and over</td>
<td>£1,473-1,751</td>
<td>£51(1), 56(1), 57(3)</td>
<td>£386</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>£1,354-1,617</td>
<td>£51(2), 52(2), 57(1)</td>
<td>£355</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>£1,267-1,509</td>
<td>£46(3), 52(2)</td>
<td>£340</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>£1,200-1,406</td>
<td>£41(4), 42(1)</td>
<td>£324</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>£1,143-1,339</td>
<td>£36(2), 41(2), 42(1)</td>
<td>£314</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£1,092-1,282</td>
<td>£36(3), 41(2)</td>
<td>£304</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>£1,051-1,205</td>
<td>£36(2), 41(2)</td>
<td>£304</td>
</tr>
<tr>
<td><strong>Matron and Chief Male Nurse (Non-Training Hospital)</strong>&lt;br&gt; 700 beds and over</td>
<td>£1,354-1,617</td>
<td>£51(2), 52(2), 57(1)</td>
<td>£350</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>£1,267-1,509</td>
<td>£46(3), 52(2)</td>
<td>£340</td>
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<td>300-499 beds</td>
<td>£1,200-1,406</td>
<td>£41(4), 42(1)</td>
<td>£324</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>£1,143-1,339</td>
<td>£36(2), 41(2), 42(1)</td>
<td>£314</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>£1,092-1,282</td>
<td>£36(3), 41(2)</td>
<td>£304</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>£1,051-1,205</td>
<td>£36(2), 41(2)</td>
<td>£304</td>
</tr>
<tr>
<td><strong>Deputy Matron (Training School) and Deputy Chief Male Nurse (Training School) - Category (a)</strong>&lt;br&gt; 750 beds and over</td>
<td>£1,164-1,360</td>
<td>£36(2), 41(2), 42(1)</td>
<td>£314</td>
</tr>
<tr>
<td>500-749 beds</td>
<td>£1,123-1,318</td>
<td>£36(2), 41(3)</td>
<td>£309</td>
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<tr>
<td>300-499 beds</td>
<td>£1,035-1,190</td>
<td>£36(2), 41(1), 42(1)</td>
<td>£294</td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>£994-1,148</td>
<td>£36(2), 41(2)</td>
<td>£283</td>
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### Nursing Officers and Assistant Nursing Officers

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<th>Group*</th>
<th>Salary Scale</th>
</tr>
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<td>Nursing Officers</td>
<td>£1,612 x £56(1) x £57(2) x £62(2) - £1,906</td>
</tr>
<tr>
<td></td>
<td>£1,524 x £51(1) x £57(4) - £1,803</td>
</tr>
<tr>
<td></td>
<td>£1,432 x £51(2) x £52(1) x £57(2) - £1,700</td>
</tr>
<tr>
<td></td>
<td>£1,344 x £47(1) x £51(2) x £52(2) - £1,597</td>
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<tr>
<td></td>
<td>£1,262 x £46(3) x £47(2) - £1,494</td>
</tr>
<tr>
<td>Assistant Nursing Officers</td>
<td>£1,391 x £46(4) x £47(1) - £1,622</td>
</tr>
<tr>
<td></td>
<td>£1,313 x £41(3) x £47(2) - £1,530</td>
</tr>
<tr>
<td></td>
<td>£1,246 x £36(2) x £41(2) x £42(1) - £1,442</td>
</tr>
</tbody>
</table>

*NOTE: The Regions comprising the Groups are as follows:*

**Group A:** The four Metropolitan Regions, Birmingham, Manchester, Sheffield, Western Region (Scotland)

**Group B:** South Western (England), Leeds, Liverpool, Newcastle, Wales, South Eastern (Scotland)

**Group C:** East Anglian, Oxford, Wessex

**Group D:** Eastern (Scotland), North Eastern (Scotland)

**Group E:** Northern (Scotland)
APPENDIX 2 : SECTION C

SOURCE: Whitley Councils for the Health Services

Nurses & Midwives Council

### A. Student Nurses and Pupil Nurses Training in other than Psychiatric Hospitals

<table>
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<tr>
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<th>Annual cash training allowance</th>
<th>Payment to Hospital where board and lodging provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student nurse other than those taking mental training or trainees for the Certificate of the British Tuberculosis Association</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£365</td>
<td>£143</td>
</tr>
<tr>
<td>2nd year</td>
<td>£390</td>
<td>£143</td>
</tr>
<tr>
<td>3rd year</td>
<td>£420</td>
<td>£143</td>
</tr>
<tr>
<td><strong>Pupil Nurses</strong></td>
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<td></td>
</tr>
<tr>
<td>(i) Age under 21 on entry:-</td>
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<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£365</td>
<td>£143</td>
</tr>
<tr>
<td>2nd year</td>
<td>£390</td>
<td>£143</td>
</tr>
<tr>
<td>(ii) Age 21 or over on entry:-</td>
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<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£520</td>
<td>£190</td>
</tr>
<tr>
<td>2nd year</td>
<td>£545</td>
<td>£190</td>
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</table>

### B. Student Mental Nurses and Pupil Nurses Training in Psychiatric Hospitals

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<th>Annual cash training allowance</th>
<th>Payment to Hospital where board and lodging provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Students taking training in mental nursing or training in the nursing of the mentally subnormal (in Scotland, mental deficiency):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Age under 21 on entry:-</td>
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</tr>
<tr>
<td>Age 18</td>
<td>£415</td>
<td>£143</td>
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<tr>
<td>Age 19</td>
<td>£440</td>
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<td>Age 20</td>
<td>£470</td>
<td>£143</td>
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<tr>
<td>(ii) Age 21 or over on entry:-</td>
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<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£570</td>
<td>£190</td>
</tr>
<tr>
<td>2nd year</td>
<td>£595</td>
<td>£190</td>
</tr>
<tr>
<td>3rd year</td>
<td>£620</td>
<td>£190</td>
</tr>
<tr>
<td><strong>Pupil Nurses training in psychiatric hospitals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Age under 21 on entry:-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 18</td>
<td>£415</td>
<td>£143</td>
</tr>
<tr>
<td>Age 19</td>
<td>£440</td>
<td>£143</td>
</tr>
<tr>
<td>Age 20</td>
<td>£470</td>
<td>£143</td>
</tr>
<tr>
<td>(ii) Age 21 or over on entry:-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£570</td>
<td>£190</td>
</tr>
<tr>
<td>2nd year</td>
<td>£595</td>
<td>£190</td>
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### TABLE II
**SALARY SCALES : HOSPITAL SERVICE**

#### A. Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Matron (Training School)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000 beds and over</td>
<td>1,910</td>
<td>1,975</td>
</tr>
<tr>
<td>700-900 beds</td>
<td>1,765</td>
<td>1,825</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>1,615</td>
<td>1,670</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,495</td>
<td>1,550</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>1,400</td>
<td>1,450</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>1,330</td>
<td>1,370</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>1,270</td>
<td>1,310</td>
</tr>
<tr>
<td>Matron (non-Training Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>700 beds and over</td>
<td>1,495</td>
<td>1,550</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>1,400</td>
<td>1,450</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,330</td>
<td>1,370</td>
</tr>
<tr>
<td>220-299 beds</td>
<td>1,270</td>
<td>1,310</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>1,220</td>
<td>1,260</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>1,210</td>
<td>1,250</td>
</tr>
<tr>
<td>Deputy Matron (Training School)</td>
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<td></td>
</tr>
<tr>
<td>750 beds and over</td>
<td>1,285</td>
<td>1,325</td>
</tr>
<tr>
<td>500-749 beds</td>
<td>1,245</td>
<td>1,285</td>
</tr>
</tbody>
</table>
### A. Nursing Staff in General Hospitals

<table>
<thead>
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<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
</tr>
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<tr>
<td></td>
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<tr>
<td><strong>Assistant Matron</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Training School)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,145</td>
<td>1,185</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,105</td>
<td>1,145</td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>1,065</td>
<td>1,105</td>
</tr>
<tr>
<td><strong>Assistant Matron</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(non-Training Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,105</td>
<td>1,145</td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>1,065</td>
<td>1,105</td>
</tr>
<tr>
<td><strong>Principal Nurse Tutor</strong></td>
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<td></td>
</tr>
<tr>
<td>Category (a)</td>
<td>1,245</td>
<td>1,285</td>
</tr>
<tr>
<td>(b)</td>
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<td>1,285</td>
</tr>
<tr>
<td><strong>Nurse Tutor in sole charge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Registered Nurse Tutor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unqualified Nurse Tutor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category (a)</td>
<td>920</td>
<td>955</td>
</tr>
<tr>
<td>(b)</td>
<td>890</td>
<td>925</td>
</tr>
</tbody>
</table>
A. Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Night Superintendent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Training School</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,145</td>
<td>1,185</td>
<td>1,225</td>
<td>1,270</td>
<td>1,315</td>
<td>1,360</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,105</td>
<td>1,145</td>
<td>1,185</td>
<td>1,230</td>
<td>1,275</td>
<td>1,320</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>1,065</td>
<td>1,105</td>
<td>1,145</td>
<td>1,185</td>
<td>1,230</td>
<td>1,275</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(b) Non-Training Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>1,105</td>
<td>1,145</td>
<td>1,185</td>
<td>1,230</td>
<td>1,275</td>
<td>1,320</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>1,065</td>
<td>1,105</td>
<td>1,145</td>
<td>1,185</td>
<td>1,230</td>
<td>1,275</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Senior Night Sister/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Night Charge Nurse</td>
<td>920</td>
<td>955</td>
<td>990</td>
<td>1,025</td>
<td>1,060</td>
<td>1,095</td>
<td>1,130</td>
<td>1,165</td>
<td>1,200</td>
</tr>
<tr>
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<td>890</td>
<td>925</td>
<td>960</td>
<td>995</td>
<td>1,030</td>
<td>1,065</td>
<td>1,100</td>
<td>1,135</td>
<td>1,170</td>
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### B. Nursing Staff in Psychiatric Hospitals (in Scotland, Mental and Mental Deficiency Hospitals)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Board and Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matron (Training School) and Chief Male Nurse (Training School) - Category (a)</td>
<td></td>
<td></td>
<td>£</td>
</tr>
<tr>
<td>1,000 beds and over</td>
<td></td>
<td></td>
<td>470</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>1,910</td>
<td>1,975</td>
<td>2,040</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>1,765</td>
<td>1,825</td>
<td>1,885</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,615</td>
<td>1,670</td>
<td>1,730</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>1,495</td>
<td>1,550</td>
<td>1,605</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>1,400</td>
<td>1,450</td>
<td>1,500</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>1,330</td>
<td>1,370</td>
<td>1,415</td>
</tr>
<tr>
<td>Chief Male Nurse (Training School) - Category (b)</td>
<td></td>
<td></td>
<td>£</td>
</tr>
<tr>
<td>1,000 beds and over</td>
<td></td>
<td></td>
<td>450</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>1,765</td>
<td>1,825</td>
<td>1,885</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>1,615</td>
<td>1,670</td>
<td>1,730</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>1,495</td>
<td>1,550</td>
<td>1,605</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>1,400</td>
<td>1,450</td>
<td>1,500</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>1,330</td>
<td>1,370</td>
<td>1,415</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>1,270</td>
<td>1,310</td>
<td>1,350</td>
</tr>
<tr>
<td>Chief Male Nurse (Training School) - Category (c)</td>
<td></td>
<td></td>
<td>£</td>
</tr>
<tr>
<td>1,000 beds and over</td>
<td></td>
<td></td>
<td>420</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>1,615</td>
<td>1,670</td>
<td>1,730</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>1,495</td>
<td>1,550</td>
<td>1,605</td>
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<tr>
<td>300-499 beds</td>
<td>1,400</td>
<td>1,450</td>
<td>1,500</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>1,330</td>
<td>1,370</td>
<td>1,415</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>1,270</td>
<td>1,310</td>
<td>1,350</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>1,220</td>
<td>1,260</td>
<td>1,300</td>
</tr>
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### TABLE III
REGIONAL HOSPITAL BOARDS

#### Nursing Officers and Assistant Nursing Officers

<table>
<thead>
<tr>
<th>Grade</th>
<th>Group*</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Officers</td>
<td>A</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1,190</td>
<td>1,975</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1,800</td>
<td>1,860</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>1,690</td>
<td>1,750</td>
</tr>
<tr>
<td></td>
<td>E</td>
<td>1,585</td>
<td>1,640</td>
</tr>
<tr>
<td>Assistant Nursing Officers</td>
<td>A</td>
<td>1,490</td>
<td>1,540</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1,520</td>
<td>1,575</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1,450</td>
<td>1,495</td>
</tr>
</tbody>
</table>

*NOTE: The Regions comprising the Groups are as follows:

Group A: The four Metropolitan Regions, Birmingham, Manchester, Sheffield, Western Region (Scotland)

Group B: South Western (England), Leeds, Liverpool, Newcastle, Wales, South Eastern (Scotland)

Group C: East Anglian, Oxford, Wessex

Group D: Eastern (Scotland), North Eastern (Scotland)

Group E: Northern (Scotland)
SOURCE: Whitley Councils for the Health Services

Nurses & Midwives Council

N.M.C. Circular No. 146 : December, 1968.
### A. Student Nurses and Pupil Nurses Training in other than Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Age on Entry</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age under 25</td>
<td>£395</td>
<td>£450</td>
<td>£480</td>
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<tr>
<td>Age 25 or over</td>
<td>£565</td>
<td>£592</td>
<td>£619</td>
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</table>

### B. Student Mental Nurses and Pupil Nurses Training in Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Age on Entry</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age under 21</td>
<td>£495</td>
<td>£550</td>
<td>£580</td>
</tr>
<tr>
<td>Age 21 or over</td>
<td>£665</td>
<td>£692</td>
<td>£719</td>
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### TABLE II
#### SALARY SCALES: HOSPITAL SERVICE

A. Senior Nursing Staff in General Hospitals (scales to be applied as indicated in Table IIB)

<table>
<thead>
<tr>
<th>Scale Number</th>
<th>Minimum</th>
<th>Incremental Points</th>
<th>Board and Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td></td>
</tr>
<tr>
<td>101</td>
<td>£1,160</td>
<td>£1,204</td>
<td></td>
</tr>
<tr>
<td>101A</td>
<td>£1,160</td>
<td>£1,204</td>
<td></td>
</tr>
<tr>
<td>102</td>
<td>£1,205</td>
<td>£1,249</td>
<td></td>
</tr>
<tr>
<td>103</td>
<td>£1,245</td>
<td>£1,289</td>
<td></td>
</tr>
<tr>
<td>103A</td>
<td>£1,245</td>
<td>£1,289</td>
<td></td>
</tr>
<tr>
<td>104</td>
<td>£1,355</td>
<td>£1,399</td>
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</tr>
<tr>
<td>104A</td>
<td>£1,355</td>
<td>£1,399</td>
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<tr>
<td>105</td>
<td>£1,440</td>
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<td>106</td>
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<td></td>
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<td>£1,916</td>
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</tr>
<tr>
<td>108A</td>
<td>£1,850</td>
<td>£1,916</td>
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<td>£2,080</td>
<td>£2,151</td>
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<tr>
<td>Grade</td>
<td>Salary Scale Number (See Table IIA)</td>
<td>Assimilation Table (where special assimilation is necessary)</td>
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</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Matron (Training School)*</td>
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<td></td>
</tr>
<tr>
<td>1,000 beds and over</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>700-999 beds</td>
<td>108A</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>500-699 beds</td>
<td>108</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200-299 beds</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100-199 beds</td>
<td>105</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>105</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Matron (Non-Training Hospital)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>700 beds and over</td>
<td>107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500-699 beds</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>105</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>200-299 beds</td>
<td>105</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>100-199 beds</td>
<td>104</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Under 100 beds</td>
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<td>10</td>
<td></td>
</tr>
<tr>
<td>Deputy Matron (Training School)*</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>750 beds and over</td>
<td>105</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>500-749 beds</td>
<td>104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Matron (Training School)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>103</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Matron (Non-Training Hospital)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Nurse Tutor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category (a)</td>
<td>105</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Tutor in sole charge</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse Tutor</td>
<td>103</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night Superintendent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Training School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>103</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>101A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Non-Training Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>101A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental Sister/ Departmental Charge Nurse</td>
<td>Salary Scale Number (See Table IIA)</td>
<td>Assimilation Table (where special assimilation is necessary)</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Group (1) Category (a)</td>
<td>101</td>
<td>See Table IIC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group (2) Category (a)</td>
<td>201</td>
<td>See Table IIC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTES:

*The Salaries of Matrons (Training School) Deputy Matrons (Training School) and Assistant Matrons (Training School) apply to Training Schools for the Register, the Roll or the Thoracic Nursing Certificate of the British Tuberculosis Association.*

*Where no special assimilation table is shown, assimilation should be in accordance with the provisions of paragraph 8 of the circular.*

*"A Nurse Tutor in sole charge shall receive an allowance of £50 per annum additional to scale No. 103."
### C. Other Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Board Lodging charge where applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Night Sister/Senior Night Charge Nurse</td>
<td>1,000</td>
<td>1,038</td>
<td>1,076</td>
</tr>
<tr>
<td>Night Sister/Night Charge Nurse</td>
<td>970</td>
<td>1,008</td>
<td>1,046</td>
</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse</td>
<td></td>
<td>See Table IIB</td>
<td></td>
</tr>
<tr>
<td>Group (1) Category (a)</td>
<td></td>
<td>See Table IIB</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>1,000</td>
<td>1,038</td>
<td>1,076</td>
</tr>
<tr>
<td>(c)</td>
<td>970</td>
<td>1,008</td>
<td>1,046</td>
</tr>
<tr>
<td>Group (2) Category (a)</td>
<td></td>
<td>See Table IIB</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>1,100</td>
<td>1,138</td>
<td>1,176</td>
</tr>
<tr>
<td>(c)</td>
<td>1,070</td>
<td>1,108</td>
<td>1,146</td>
</tr>
<tr>
<td>Home Sister - Category (a)</td>
<td></td>
<td>See Table IIB</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>1,000</td>
<td>1,038</td>
<td>1,076</td>
</tr>
<tr>
<td>Housekeeping Sister</td>
<td>970</td>
<td>1,008</td>
<td>1,046</td>
</tr>
<tr>
<td>Unqualified Nurse Tutor Category (a)</td>
<td></td>
<td>See Table IIB</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>1,000</td>
<td>1,038</td>
<td>1,076</td>
</tr>
<tr>
<td>Clinical Instructor</td>
<td>970</td>
<td>1,008</td>
<td>1,046</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>785</td>
<td>831</td>
<td>878</td>
</tr>
</tbody>
</table>
### C. Other Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Senior Enrolled Nurse</td>
<td>£ 820</td>
<td>£ 852</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>£ 680</td>
<td>£ 716</td>
</tr>
<tr>
<td>Nursing Auxiliary - Age 21 or over</td>
<td>£ 565</td>
<td>£ 592</td>
</tr>
<tr>
<td>Age 20</td>
<td>£ 455</td>
<td></td>
</tr>
<tr>
<td>Age 19</td>
<td>£ 425</td>
<td></td>
</tr>
<tr>
<td>Age 18</td>
<td>£ 395</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board Lod</th>
<th>Charge where</th>
</tr>
</thead>
<tbody>
<tr>
<td>£ 26</td>
<td>£ 24</td>
</tr>
<tr>
<td>£ 20</td>
<td>£ 15</td>
</tr>
<tr>
<td>£ 15</td>
<td>£ 15</td>
</tr>
</tbody>
</table>

**NOTES:**

Nurses who merely assist in the teaching department without the full responsibility of a tutor should be paid in accordance with their appropriate grading, e.g. as Ward Sisters/Charge Nurses or Staff Nurses and not as unqualified tutors.

^5After 3 years on this point the nurse shall receive a further increment of £60 to give a salary of £985 or £1,010 as the case may be.
### TABLE III
#### REGIONAL HOSPITAL BOARDS

<table>
<thead>
<tr>
<th>Grade</th>
<th>Group*</th>
<th>Minimum</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Officers</td>
<td>A</td>
<td>£2,750</td>
<td>£2,855</td>
<td>£2,960</td>
<td>£3,065</td>
<td>£3,170</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>£2,660</td>
<td>£2,765</td>
<td>£2,870</td>
<td>£2,975</td>
<td>£3,080</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>£2,575</td>
<td>£2,680</td>
<td>£2,785</td>
<td>£2,890</td>
<td>£2,995</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>£2,180</td>
<td>£2,260</td>
<td>£2,340</td>
<td>£2,420</td>
<td>£2,500</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*NOTE: The Regions comprising the Groups are as follows:

Group A: The four Metropolitan Regions, Birmingham, Manchester, Sheffield, Western Region (Scotland)

Group B: South Western (England), Leeds, Liverpool, Newcastle, Wales, South Eastern (Scotland).

Group C: East Anglian, Oxford, Wessex, Eastern (Scotland), North Eastern (Scotland).

Group D: Northern (Scotland).
APPENDIX 2 : SECTION E

SOURCE: Whitley Council for the Health Services
         Nurses & Midwives Council

N.M.C. Circular No. 152 : April, 1970.
# TABLE I
## TRAINING ALLOWANCES

### A. Student Nurses and Pupil Nurses Training in other than Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Age under 21 on entry:</th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18</td>
<td>£525</td>
<td>£27</td>
</tr>
<tr>
<td>Age 19</td>
<td>£588</td>
<td>£54</td>
</tr>
<tr>
<td>Age 20</td>
<td>£624</td>
<td>£54</td>
</tr>
<tr>
<td>Age 21 or over on entry:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£714</td>
<td>£108</td>
</tr>
<tr>
<td>2nd year</td>
<td>£744</td>
<td>£108</td>
</tr>
<tr>
<td>3rd year</td>
<td>£774</td>
<td>£108</td>
</tr>
</tbody>
</table>

### B. Student Mental Nurses and Pupil Nurses Training in Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Age under 21 on entry:</th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18</td>
<td>£624</td>
<td>£27</td>
</tr>
<tr>
<td>Age 19</td>
<td>£687</td>
<td>£54</td>
</tr>
<tr>
<td>Age 20</td>
<td>£723</td>
<td>£54</td>
</tr>
<tr>
<td>Age 21 or over on entry:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£813</td>
<td>£108</td>
</tr>
<tr>
<td>2nd year</td>
<td>£843</td>
<td>£108</td>
</tr>
<tr>
<td>3rd year</td>
<td>£873</td>
<td>£108</td>
</tr>
</tbody>
</table>

---

Student Nurses other than those taking mental training or trainees for the Certificate of the British Tuberculosis Association

<table>
<thead>
<tr>
<th>Age under 21 on entry:</th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18</td>
<td>£525</td>
<td>£27</td>
</tr>
<tr>
<td>Age 19</td>
<td>£588</td>
<td>£54</td>
</tr>
<tr>
<td>Age 20</td>
<td>£624</td>
<td>£54</td>
</tr>
</tbody>
</table>

---

Students taking training in mental nursing or training in the nursing of the mental subnormal (in Scotland, mental deficiency)

<table>
<thead>
<tr>
<th>Age under 21 on entry:</th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18</td>
<td>£624</td>
<td>£27</td>
</tr>
<tr>
<td>Age 19</td>
<td>£687</td>
<td>£54</td>
</tr>
<tr>
<td>Age 20</td>
<td>£723</td>
<td>£54</td>
</tr>
<tr>
<td>Age 21 or over on entry:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£813</td>
<td>£108</td>
</tr>
<tr>
<td>2nd year</td>
<td>£843</td>
<td>£108</td>
</tr>
<tr>
<td>3rd year</td>
<td>£873</td>
<td>£108</td>
</tr>
</tbody>
</table>

---

Pupil Nurses training in psychiatric hospitals

<table>
<thead>
<tr>
<th>Age under 21 on entry:</th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18</td>
<td>£624</td>
<td>£27</td>
</tr>
<tr>
<td>Age 19</td>
<td>£687</td>
<td>£54</td>
</tr>
<tr>
<td>Age 20</td>
<td>£723</td>
<td>£54</td>
</tr>
<tr>
<td>Age 21 or over on entry:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>£813</td>
<td>£108</td>
</tr>
<tr>
<td>2nd year</td>
<td>£843</td>
<td>£108</td>
</tr>
</tbody>
</table>
### TABLE II

**SALARY SCALES : HOSPITAL SERVICE**

A. Senior Nursing Staff in General Hospitals (scales to be applied as indicated in Table IIB)

<table>
<thead>
<tr>
<th>Scale Number</th>
<th>Minimum</th>
<th>Incremental Points</th>
<th>Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>101</td>
<td>1,386</td>
<td>1,452</td>
<td>1,518</td>
</tr>
<tr>
<td>102</td>
<td>1,386</td>
<td>1,452</td>
<td>1,518</td>
</tr>
<tr>
<td>103</td>
<td>1,440</td>
<td>1,506</td>
<td>1,572</td>
</tr>
<tr>
<td>104</td>
<td>1,572</td>
<td>1,638</td>
<td>1,704</td>
</tr>
<tr>
<td>105</td>
<td>1,656</td>
<td>1,722</td>
<td>1,788</td>
</tr>
<tr>
<td>106</td>
<td>1,761</td>
<td>1,836</td>
<td>1,911</td>
</tr>
<tr>
<td>107</td>
<td>1,902</td>
<td>1,977</td>
<td>2,052</td>
</tr>
<tr>
<td>108</td>
<td>2,139</td>
<td>2,220</td>
<td>2,301</td>
</tr>
<tr>
<td>109</td>
<td>2,394</td>
<td>2,484</td>
<td>2,574</td>
</tr>
</tbody>
</table>
### B. Senior Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Salary Scale Number (See Table IIA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matron (Training School)* 1,000 beds and over</td>
<td>109</td>
</tr>
<tr>
<td>700-999 beds</td>
<td>108</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>108</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>107</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>106</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>105</td>
</tr>
<tr>
<td>under 100 beds</td>
<td>105</td>
</tr>
<tr>
<td>Matron (Non-Training Hospital) 700 beds and over</td>
<td>107</td>
</tr>
<tr>
<td>500-699 beds</td>
<td>106</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>105</td>
</tr>
<tr>
<td>200-299 beds</td>
<td>105</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>104</td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>104</td>
</tr>
<tr>
<td>Deputy Matron (Training School)* 750 beds and over</td>
<td>105</td>
</tr>
<tr>
<td>500-749 beds</td>
<td>104</td>
</tr>
<tr>
<td>Assistant Matron (Training School)* 500 beds and over</td>
<td>103</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>102</td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>101</td>
</tr>
<tr>
<td>Assistant Matron (Non-Training Hospital) 500 beds and over</td>
<td>102</td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>101</td>
</tr>
<tr>
<td>Principal Nurse Tutor* Category (a)</td>
<td>106</td>
</tr>
<tr>
<td>(b)</td>
<td>105</td>
</tr>
<tr>
<td>Nurse Tutor in sole charge</td>
<td>104</td>
</tr>
<tr>
<td>Registered Nurse Tutor</td>
<td>104</td>
</tr>
<tr>
<td>Night Superintendent (a) Training School 500 beds and over</td>
<td>103</td>
</tr>
<tr>
<td>300-499 beds</td>
<td>102</td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>101</td>
</tr>
<tr>
<td>(b) Non-Training Hospital 500 beds and over</td>
<td>102</td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>101</td>
</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse Group (1) Category (a)</td>
<td>101</td>
</tr>
<tr>
<td>(b)</td>
<td>See Table IIC</td>
</tr>
<tr>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>Group (2) Category (a)</td>
<td>201</td>
</tr>
<tr>
<td>(b)</td>
<td>See Table IIC</td>
</tr>
<tr>
<td>(c)</td>
<td></td>
</tr>
</tbody>
</table>
NOTES: *The salaries of Matrons (Training School) Deputy Matrons (Training School) and Assistant Matrons (Training School) apply to Training Schools for the Register, the Roll or the Thoracic Nursing Certificate of the British Tuberculosis Association.

*Principal Nurse Tutors in charge of group Training Schools with at least 250 student and/or pupil nurses in training shall be provisionally regraded. The appropriate salary scale is scale number 107

*A Nurse Tutor in sole charge shall receive an allowance of £51 per annum additional to scale No. 104
C. Other Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Senior Night Sister/Senior Night Charge Nurse</td>
<td>1,245</td>
<td>1,237 1,329 1,374 1,419 1,464 1,509 1,554 1,599</td>
<td>207</td>
</tr>
<tr>
<td>Night Sister/Night Charge Nurse</td>
<td>1,200</td>
<td>1,242 1,284 1,329 1,374 1,419 1,464 1,509 1,554</td>
<td>201</td>
</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse Group (1) Category (a)</td>
<td>See Table IIB</td>
<td>1,287 1,329 1,374 1,419 1,464 1,509 1,554 1,599</td>
<td>207</td>
</tr>
<tr>
<td>(b)</td>
<td>1,200</td>
<td>1,242 1,284 1,329 1,374 1,419 1,464 1,509 1,554</td>
<td>201</td>
</tr>
<tr>
<td>(c)</td>
<td>See Table IIB</td>
<td>1,386 1,428 1,473 1,518 1,563 1,608 1,653 1,698</td>
<td>207</td>
</tr>
<tr>
<td>Group (2) Category (a)</td>
<td>1,344</td>
<td>1,386 1,428 1,473 1,518 1,563 1,608 1,653 1,698</td>
<td>207</td>
</tr>
<tr>
<td>(b)</td>
<td>1,299</td>
<td>1,341 1,383 1,428 1,473 1,518 1,563 1,608 1,653</td>
<td>201</td>
</tr>
<tr>
<td>(c)</td>
<td>See Table IIB</td>
<td>1,287 1,329 1,374 1,419 1,464 1,509 1,554 1,599</td>
<td>207</td>
</tr>
<tr>
<td>Home Sister - Category (a)</td>
<td>1,245</td>
<td>1,287 1,329 1,374 1,419 1,464 1,509 1,554 1,599</td>
<td>207</td>
</tr>
<tr>
<td>(b)</td>
<td>1,200</td>
<td>1,242 1,284 1,329 1,374 1,419 1,464 1,509 1,554</td>
<td>201</td>
</tr>
<tr>
<td>Housekeeping Sister</td>
<td>1,200</td>
<td>1,242 1,284 1,329 1,374 1,419 1,464 1,509 1,554</td>
<td>201</td>
</tr>
<tr>
<td>Unqualified Nurse Tutor</td>
<td>1,245</td>
<td>1,287 1,329 1,374 1,419 1,464 1,509 1,554 1,599</td>
<td>207</td>
</tr>
<tr>
<td>Clinical Instructor</td>
<td>1,245</td>
<td>1,287 1,329 1,374 1,419 1,464 1,509 1,554 1,599</td>
<td>207</td>
</tr>
<tr>
<td>Ward Sister/Charge Nurse</td>
<td>1,200</td>
<td>1,242 1,284 1,329 1,374 1,419 1,464 1,509 1,554</td>
<td>201</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>930</td>
<td>990 1,050 1,110 a  -  -  -  -  -  -  171</td>
<td></td>
</tr>
</tbody>
</table>
## C. Other Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Senior Enrolled Nurse</td>
<td>966</td>
<td>1,008</td>
<td>1,050</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>801</td>
<td>843</td>
<td>885</td>
</tr>
<tr>
<td>Nursing Auxiliary:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 21 or over</td>
<td>681</td>
<td>714</td>
<td>747</td>
</tr>
<tr>
<td>Age 20</td>
<td>519</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Age 19</td>
<td>558</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Age 18</td>
<td>525</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

**NOTES:**

* Nurses who merely assist in the teaching department without the full responsibility of a tutor should be paid in accordance with their appropriate grading, e.g. as Ward Sisters/Charge Nurses or Staff Nurses and not as unqualified tutors.

* After 3 years on this point the nurse shall receive a further increment of £72 to give a salary of £1,206 or £1,182 as the case may be.
APPENDIX 2 : SECTION F

SOURCE: Whitley Councils for the Health Services

Nurses & Midwives Council

N.M.C. Circular No. 158 : April, 1971.
## TABLE I
### TRAINING ALLOWANCES

A. Student Nurses and Pupil Nurses Training in other than Psychiatric Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Student Nurses other than those taking mental training or trainees for the Certificate of the British Tuberculosis Association</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>(i) Age under 21 on entry:</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Age 18</td>
<td>570</td>
<td>28.80</td>
</tr>
<tr>
<td>Age 19</td>
<td>639</td>
<td>57.60</td>
</tr>
<tr>
<td>Age 20</td>
<td>678</td>
<td>57.60</td>
</tr>
<tr>
<td>(ii) Age 21 or over on entry:</td>
<td>1st year 774</td>
<td>117.00</td>
</tr>
<tr>
<td></td>
<td>2nd year 807</td>
<td>117.00</td>
</tr>
<tr>
<td></td>
<td>3rd year 840</td>
<td>117.00</td>
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</table>

B. Student Mental Nurses and Pupil Nurses Training in Psychiatric Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Students taking training in mental nursing or training in the nursing of the mentally subnormal (in Scotland, mental deficiency)</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>(i) Age under 21 on entry:</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Age 18</td>
<td>669</td>
<td>28.80</td>
</tr>
<tr>
<td>Age 19</td>
<td>738</td>
<td>57.60</td>
</tr>
<tr>
<td>Age 20</td>
<td>777</td>
<td>57.60</td>
</tr>
<tr>
<td>(ii) Age 21 or over on entry:</td>
<td>1st year 873</td>
<td>117.00</td>
</tr>
<tr>
<td></td>
<td>2nd year 906</td>
<td>117.00</td>
</tr>
<tr>
<td></td>
<td>3rd year 939</td>
<td>117.00</td>
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</table>

Pupil Nurses training in psychiatric hospitals

<table>
<thead>
<tr>
<th></th>
<th>Annual cash Training Allowance</th>
<th>Payment to Hospital for lodging</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>(i) Age under 21 on entry:</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Age 18</td>
<td>669</td>
<td>28.80</td>
</tr>
<tr>
<td>Age 19</td>
<td>738</td>
<td>57.60</td>
</tr>
<tr>
<td>Age 20</td>
<td>777</td>
<td>57.60</td>
</tr>
<tr>
<td>(ii) Age 21 or over on entry:</td>
<td>1st year 873</td>
<td>117.00</td>
</tr>
<tr>
<td></td>
<td>2nd year 906</td>
<td>117.00</td>
</tr>
<tr>
<td>Scale Number</td>
<td>Minimum</td>
<td>Incremental Points</td>
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<tr>
<td>--------------</td>
<td>---------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£</td>
</tr>
<tr>
<td>101</td>
<td>1,545</td>
<td>1,620</td>
</tr>
<tr>
<td>102</td>
<td>1,545</td>
<td>1,620</td>
</tr>
<tr>
<td>103</td>
<td>1,605</td>
<td>1,680</td>
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<td>104</td>
<td>1,749</td>
<td>1,824</td>
</tr>
<tr>
<td>105</td>
<td>1,833</td>
<td>1,908</td>
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<tr>
<td>106</td>
<td>1,911</td>
<td>1,992</td>
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<tr>
<td>107</td>
<td>2,064</td>
<td>2,145</td>
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<tr>
<td>108</td>
<td>2,322</td>
<td>2,409</td>
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<tr>
<td>109</td>
<td>2,598</td>
<td>2,694</td>
</tr>
<tr>
<td>Grade</td>
<td>Salary Scale Number (See Table IIA)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Matron (Training School)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000 beds and over</td>
<td>109</td>
<td></td>
</tr>
<tr>
<td>700-999 beds</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>500-699 beds</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>200-299 beds</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>100-199 beds</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Matron (Non-Training Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>700 beds and over</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>500-699 beds</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>200-299 beds</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Under 100 beds</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Deputy Matron (Training School)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>750 beds and over</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>500-749 beds</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Assistant Matron (Training School)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>Assistant Matron (Non-Training Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>Principal Nurse Tutor* - Category (a)</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>105</td>
<td></td>
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<tr>
<td>Nurse Tutor in sole charge</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse Tutor</td>
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<td></td>
</tr>
<tr>
<td>Night Superintendent - (a) Training School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Under 300 beds</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>(b) Non-Training Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 beds and over</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Under 500 beds</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group (1) Category (a)</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group (2) Category (a)</td>
<td>201</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* See Table IIC
NOTES:  *The salaries of Matrons (Training School), Deputy Matrons (Training School) and Assistant Matrons (Training School) apply to Training Schools for the Register, the Roll or the Thoracic Nursing Certificate of the British Tuberculosis Association.

Principal Nurse Tutors in charge of Group Training Schools with at least 250 student and/or Pupil Nurses in training shall be provisionally regraded. The appropriate salary scale is number 107.

*A Nurse Tutor in sole charge shall receive an allowance of £51 per annum additional to scale No. 104.
C. Other Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Senior Night Sister/Senior Night Charge Nurse</td>
<td>1,350</td>
<td>1,395 1,443 1,491 1,539 1,587 1,638 1,686 1,734</td>
<td>225</td>
</tr>
<tr>
<td>Night Sister/Night Charge Nurse</td>
<td>1,302</td>
<td>1,347 1,392 1,443 1,491 1,529 1,587 1,638 1,686</td>
<td>219</td>
</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse (Group 1 Category (a))</td>
<td>See Table IIB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) 1,350</td>
<td>1,395 1,443 1,491 1,539 1,587 1,638 1,686 1,734</td>
<td>225</td>
</tr>
<tr>
<td></td>
<td>(c) 1,302</td>
<td>1,347 1,392 1,443 1,491 1,539 1,587 1,638 1,686</td>
<td>219</td>
</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse (Group 2 Category (a))</td>
<td>See Table IIB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) 1,449</td>
<td>1,494 1,542 1,590 1,638 1,686 1,737 1,785 1,833</td>
<td>225</td>
</tr>
<tr>
<td></td>
<td>(c) 1,401</td>
<td>1,446 1,491 1,542 1,590 1,638 1,686 1,737 1,785</td>
<td>219</td>
</tr>
<tr>
<td>Home Sister - Category (a)</td>
<td>1,350</td>
<td>1,395 1,443 1,491 1,539 1,587 1,638 1,686 1,734</td>
<td>225</td>
</tr>
<tr>
<td></td>
<td>(b) 1,302</td>
<td>1,347 1,392 1,443 1,491 1,539 1,587 1,638 1,686</td>
<td>219</td>
</tr>
<tr>
<td>Housekeeping Sister</td>
<td>1,302</td>
<td>1,347 1,392 1,443 1,491 1,539 1,587 1,638 1,686</td>
<td>219</td>
</tr>
<tr>
<td>Unqualified Nurse Tutor</td>
<td>1,350</td>
<td>1,395 1,443 1,491 1,539 1,587 1,638 1,686 1,734</td>
<td>225</td>
</tr>
<tr>
<td>Clinical Instructor</td>
<td>1,350</td>
<td>1,395 1,443 1,491 1,539 1,587 1,638 1,686 1,734</td>
<td>225</td>
</tr>
<tr>
<td>Ward Sister/Charge Nurse</td>
<td>1,302</td>
<td>1,347 1,392 1,443 1,491 1,539 1,587 1,638 1,686</td>
<td>219</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>1,008</td>
<td>1,074 1,140 1,203 - - - - -</td>
<td>186</td>
</tr>
</tbody>
</table>
C. Other Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Grade</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Senior Enrolled Nurse</td>
<td>1,047</td>
<td>1,095</td>
<td>1,140</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>882</td>
<td>924</td>
<td>966</td>
</tr>
<tr>
<td>Nursing Auxiliary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 21 or over</td>
<td>738</td>
<td>774</td>
<td>810</td>
</tr>
<tr>
<td>Age 20</td>
<td>642</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Age 19</td>
<td>606</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Age 18</td>
<td>570</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
APPENDIX 2 : SECTION G

SOURCE: Whitley Councils for the Health Services

Nurses & Midwives Council

N.M.C. Circular No. 163 : April, 1972.
### TABLE I

**TRAINING ALLOWANCES**

#### A. Student Nurses and Pupil Nurses Training in other than Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Age under 21 on entry:</th>
<th>£</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18</td>
<td>621</td>
<td>28.80</td>
</tr>
<tr>
<td>Age 19</td>
<td>693</td>
<td>57.60</td>
</tr>
<tr>
<td>Age 20</td>
<td>738</td>
<td>57.60</td>
</tr>
</tbody>
</table>

(ii) Age 21 or over on entry:

<table>
<thead>
<tr>
<th>Year</th>
<th>£</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>846</td>
<td>117.00</td>
</tr>
<tr>
<td>2nd year</td>
<td>879</td>
<td>117.00</td>
</tr>
<tr>
<td>3rd year</td>
<td>912</td>
<td>117.00</td>
</tr>
</tbody>
</table>

#### B. Student Mental Nurses and Pupil Nurses Training in Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Age under 21 on entry:</th>
<th>£</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18</td>
<td>720</td>
<td>28.80</td>
</tr>
<tr>
<td>Age 19</td>
<td>792</td>
<td>57.60</td>
</tr>
<tr>
<td>Age 20</td>
<td>837</td>
<td>57.60</td>
</tr>
</tbody>
</table>

(ii) Age 21 or over on entry:

<table>
<thead>
<tr>
<th>Year</th>
<th>£</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>945</td>
<td>117.00</td>
</tr>
<tr>
<td>2nd year</td>
<td>978</td>
<td>117.00</td>
</tr>
<tr>
<td>3rd year</td>
<td>1,011</td>
<td>117.00</td>
</tr>
<tr>
<td>Grade</td>
<td>Chief Nursing Officer (Grade 10)</td>
<td>Principal Nursing Officer (Grade 9)</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td></td>
<td>Scale (a)</td>
<td>Scale (b)</td>
</tr>
<tr>
<td>1</td>
<td>3,676</td>
<td>3,585</td>
</tr>
<tr>
<td>2</td>
<td>3,380</td>
<td>3,289</td>
</tr>
<tr>
<td>3</td>
<td>3,084</td>
<td>3,003</td>
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<tr>
<td>4</td>
<td>2,780</td>
<td>2,700</td>
</tr>
<tr>
<td>5</td>
<td>2,476</td>
<td>2,406</td>
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</table>

<table>
<thead>
<tr>
<th>Incremental Points</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Minimum</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade</th>
<th>Lodging charge where resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>£</td>
</tr>
<tr>
<td>2</td>
<td>£</td>
</tr>
<tr>
<td>3</td>
<td>£</td>
</tr>
<tr>
<td>4</td>
<td>£</td>
</tr>
<tr>
<td>5</td>
<td>£</td>
</tr>
</tbody>
</table>

TABLE II
SALARY SCALES : HOSPITAL SERVICE

A. Saloon Grades 7-10
<table>
<thead>
<tr>
<th>Scale Number</th>
<th>Minimum</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Lodging charge where resident</th>
</tr>
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<tbody>
<tr>
<td>101</td>
<td>£1,668</td>
<td>£1,749</td>
<td>£1,830</td>
<td>£1,911</td>
<td>£1,992</td>
<td>£2,073</td>
<td>£276</td>
</tr>
<tr>
<td>102</td>
<td>£1,668</td>
<td>£1,749</td>
<td>£1,830</td>
<td>£1,911</td>
<td>£1,992</td>
<td>£2,073</td>
<td>£276</td>
</tr>
<tr>
<td>103</td>
<td>£1,734</td>
<td>£1,815</td>
<td>£1,896</td>
<td>£1,977</td>
<td>£2,058</td>
<td>£2,139</td>
<td>£291</td>
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<tr>
<td>Matron (Non-Training Hospital) 700 beds and over</td>
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<td>500-699 beds</td>
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<td>300-499 beds</td>
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<td>Under 100 beds</td>
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<td></td>
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<tr>
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<tr>
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<tr>
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<tr>
<td>Principal Nurse Tutor</td>
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<td>(b)</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>300-499 beds</td>
<td>102</td>
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</tr>
<tr>
<td>Under 300 beds</td>
<td>101</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(b) Non-Training Hospital 500 beds and over</td>
<td>102</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Under 500 beds</td>
<td>101</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse</td>
<td></td>
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<td>Group (1) Category (a)</td>
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<td>(b)</td>
<td>101</td>
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</tr>
<tr>
<td>(c)</td>
<td>See Table IID</td>
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<td>Group (2) Category (a)</td>
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<tr>
<td>(b)</td>
<td>See Table IID</td>
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<tr>
<td>(c)</td>
<td>101</td>
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</table>
NOTES: The salaries of Matrons (Training School), Deputy Matrons (Training School) and Assistant Matrons (Training School) apply to Training Schools for the Register, the Roll or the Thoracic Nursing Certificate of the British Tuberculosis Association.

Principal Nurse Tutors in charge of Group Training Schools with at least 250 student and/or Pupil Nurses in training shall be provisionally regraded. The appropriate salary scale is number 107.

A Nurse Tutor in sole charge shall receive an allowance of £51 per annum additional to scale No. 104.
### D. Other Nursing Staff in General Hospitals

<table>
<thead>
<tr>
<th>Role</th>
<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Lodging charge where resident</th>
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<tr>
<td></td>
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<td>£</td>
<td>£</td>
</tr>
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<td>1,458</td>
<td>1,506</td>
<td>1,557</td>
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<tr>
<td>Night Sister/Night Charge Nurse</td>
<td>1,407</td>
<td>1,455</td>
<td>1,503</td>
</tr>
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<td>(Group 1) Category (a)</td>
<td>See Table IIC</td>
<td>(b)</td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td>1,407</td>
<td>1,455</td>
</tr>
<tr>
<td>Group (2) Category (a)</td>
<td>See Table IIC</td>
<td>(b)</td>
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</tr>
<tr>
<td></td>
<td>(c)</td>
<td>1,506</td>
<td>1,554</td>
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<td>1,407</td>
<td>1,455</td>
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<td>1,557</td>
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<tr>
<td>Ward Sister/Charge Nurse</td>
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<td>1,503</td>
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<tr>
<td>Staff Nurse</td>
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### D. Other Nursing Staff in General Hospitals

<table>
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<th>Minimum or Age Point</th>
<th>Incremental Points</th>
<th>Lodging charge where resident</th>
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<tr>
<td>Enrolled Nurse</td>
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<td>1,162</td>
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<tr>
<td>Age 21 or over</td>
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<td>846</td>
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<td>Age 20</td>
<td>702</td>
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<tr>
<td>Age 19</td>
<td>660</td>
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<tr>
<td>Age 18</td>
<td>621</td>
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</table>

**NOTES:**
- Nurses who merely assist in the teaching department without the full responsibility of a tutor should be paid in accordance with their appropriate grading, e.g. as Ward Sisters/Charge Nurses or Staff Nurses and not as unqualified tutors.
- After 3 years on this point the nurse shall receive a further increment of £84 to give a salary of £1,383 or £1,413 as the case may be.
APPENDIX 3.
## TABLE 1A

**LOWEST DECILES & MEDIAN'S OF GROSS WEEKLY & HOURLY EARNINGS**

*Non-Manual Men - Full Time*

<table>
<thead>
<tr>
<th></th>
<th>Weekly Earnings</th>
<th></th>
<th>Hourly Earnings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>Median</td>
<td>Lowest Decile</td>
<td>Median</td>
</tr>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>Pence</td>
<td>Pence</td>
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<td>54.5</td>
<td>72.6</td>
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<td></td>
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<td>64.6</td>
<td>92.3</td>
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<tr>
<td>Supply -</td>
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<td></td>
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<tr>
<td>Administrative &amp;</td>
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<td></td>
<td></td>
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<tr>
<td>Clerical</td>
<td>32.2</td>
<td>40.5</td>
<td>58.0</td>
<td>73.1</td>
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<td></td>
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<tr>
<td>Gas Supply</td>
<td>27.6</td>
<td>39.7</td>
<td>71.4</td>
<td>98.8</td>
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<tr>
<td>Industry -</td>
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<td></td>
<td></td>
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<tr>
<td>Administrative &amp;</td>
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</tr>
<tr>
<td>Clerical</td>
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<tr>
<td>Local Authorities (England &amp; Wales)</td>
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<td>42.5</td>
<td>73.7</td>
<td>97.5</td>
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(Source: 1973 N.E.S., Department of Employment)
<table>
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<th>Industry/Position</th>
<th>Weekly Earnings</th>
<th>Hourly Earnings</th>
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<td>Civil Service - Executive Grades</td>
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</tr>
<tr>
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<td>22.9</td>
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<tr>
<td>Gas Supply Industry - Administrative &amp; Clerical</td>
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<td>26.3</td>
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</tr>
<tr>
<td>1. Administrative, Professional &amp; Technical</td>
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<td>2. General &amp; Clerical</td>
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<tr>
<td>Teachers, Primary &amp; Secondary Schools</td>
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<td>35.1</td>
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(Source: 1973 N.E.S., Department of Employment).
### TABLE 2A
DISTRIBUTION OF GROSS WEEKLY EARNINGS
Non-Manual Men - Full Time

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<th></th>
<th>£18</th>
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<th>£40</th>
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<td>18.5</td>
<td>34.9</td>
<td>72.0</td>
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<td>91.2</td>
<td>93.4</td>
<td>94.7</td>
<td>97.1</td>
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<td>32.5</td>
<td>47.3</td>
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<td>79.9</td>
<td>87.0</td>
<td>94.7</td>
<td>98.2</td>
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<td>0.0</td>
<td>2.8</td>
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<td>70.9</td>
<td>73.9</td>
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<td>0.7</td>
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(Source: 1973 N.E.S., Department of Employment)
### TABLE 2B

**DISTRIBUTION OF GROSS WEEKLY EARNINGS**

**Non-Manual Men – Full Time**

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(Source: 1973 N.E.S. Department of Employment)
TABLE 2C
DISTRIBUTION OF GROSS WEEKLY EARNINGS

Non-Manual Women - Full Time

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<th>£12</th>
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(Source: 1973 N.E.S. Department of Employment).
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</tr>
<tr>
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</tr>
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<tr>
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(Source: 1973 N.E.S., Department of Employment)
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(Source: 1973 N.E.S. Department of Employment).
### TABLE 3B.

**MEDIANs, QUARTILES & DEcILES OF GROSS WEEKLY EARNINGS OF PROFESSIONAL & RELATED STAFF IN EDUCATION, WELFARE & HEALTH.**

**Full time – Men**

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(Source: 1973 N.E.S. Department of Employment).
<table>
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<td>3.6</td>
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<td>6.5</td>
<td>10.9</td>
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<td>77.6</td>
<td>91.1</td>
<td>98.2</td>
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(Source: 1973 N.E.S. Department of Employment).
TABLE 4B

DISTRIBUTION OF GROSS WEEKLY EARNINGS OF PROFESSIONAL & RELATED STAFF IN EDUCATION, WELFARE & HEALTH.

Full-Time - Men

<table>
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<th>% with weekly earnings less than:</th>
<th>£18</th>
<th>£20</th>
<th>£22</th>
<th>£25</th>
<th>£30</th>
<th>£35</th>
<th>£40</th>
<th>£45</th>
<th>£50</th>
<th>£60</th>
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<td>University Academic Staff</td>
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<td>13.7</td>
<td>19.4</td>
<td>30.2</td>
<td>62.9</td>
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<tr>
<td>Teachers (Further Education)</td>
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<td>0.4</td>
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<td>8.9</td>
<td>14.7</td>
<td>31.9</td>
<td>59.4</td>
<td>92.5</td>
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<tr>
<td>Teachers (Secondary)</td>
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<td>0.9</td>
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<td>2.8</td>
<td>9.9</td>
<td>22.6</td>
<td>31.9</td>
<td>42.3</td>
<td>60.3</td>
<td>83.0</td>
<td>97.6</td>
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<td>0.0</td>
<td>2.2</td>
<td>12.6</td>
<td>25.7</td>
<td>37.4</td>
<td>49.9</td>
<td>66.7</td>
<td>91.3</td>
<td>100.0</td>
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<td>0.9</td>
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<td>39.1</td>
<td>57.5</td>
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<td>Vocational/Industrial Trainers</td>
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<td>17.6</td>
<td>38.8</td>
<td>57.6</td>
<td>76.4</td>
<td>87.9</td>
<td>95.8</td>
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<td>3.4</td>
<td>8.1</td>
<td>19.9</td>
<td>41.5</td>
<td>55.5</td>
<td>65.3</td>
<td>76.3</td>
<td>90.7</td>
<td>97.5</td>
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<tr>
<td>Medical Practitioners</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
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<td>8.0</td>
<td>15.6</td>
<td>22.4</td>
<td>49.8</td>
<td>64.1</td>
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<tr>
<td>Registered &amp; Enrolled Nurses</td>
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<td>19.3</td>
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<td>46.0</td>
<td>59.7</td>
<td>81.8</td>
<td>92.6</td>
<td>97.2</td>
<td>99.4</td>
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(Source: 1973 N.E.S. Department of Employment).
<table>
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<tr>
<th>Components as Percentages of total pay</th>
<th>Percentages of Employment who receive</th>
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<tr>
<td>Overtime Pay</td>
<td>Shift etc. Premium Payments</td>
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<td>All Industries &amp; Services</td>
<td></td>
</tr>
<tr>
<td>Civil Service Clerical Grades</td>
<td></td>
</tr>
<tr>
<td>Electricity Supply, Administrative &amp; Clerical</td>
<td></td>
</tr>
<tr>
<td>Gas Supply, Administrative &amp; Clerical</td>
<td></td>
</tr>
<tr>
<td>Local Authorities (England &amp; Wales)</td>
<td></td>
</tr>
<tr>
<td>1. Admin. Professional &amp; Technical Staff</td>
<td></td>
</tr>
<tr>
<td>2. General &amp; Clerical</td>
<td></td>
</tr>
<tr>
<td>National Coal Board - Non-Manual Staff</td>
<td></td>
</tr>
<tr>
<td>National Health Service, Admin. &amp; Clerical</td>
<td></td>
</tr>
<tr>
<td>Nurses &amp; Midwives Whitely Council</td>
<td></td>
</tr>
<tr>
<td>Police Services</td>
<td></td>
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<tr>
<td>Post Office, Clerical &amp; Executive</td>
<td></td>
</tr>
<tr>
<td>Railway Salaries Staff</td>
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<tr>
<td>Fire Service</td>
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<tr>
<td>Teachers, Primary &amp; Secondary</td>
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</tr>
<tr>
<td>Teachers, Establishments for Further Education</td>
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(Source: 1973 N.E.S. Department of Employment).
### Table 5B

**Make-up of Average Gross Weekly Earnings**

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<th>Components as Percentages of total pay</th>
<th>Percentages of Employ</th>
<th>Overtime Pay</th>
<th>Shift etc. Premium Payments</th>
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<th>Shift etc. Premium Payments</th>
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<td>All Industries &amp; Services</td>
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<td>0.2</td>
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<td>2.2</td>
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<tr>
<td>Civil Service - Executive Grades</td>
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<td>0.4</td>
<td>0.3</td>
<td>5.9</td>
<td>2.9</td>
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<td>Electricity Supply, Administrative &amp; Clerical</td>
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<tr>
<td>Gas Supply, Administrative &amp; Clerical</td>
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<td>2.4</td>
<td>0.0</td>
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<tr>
<td>Local Authorities (England &amp; Wales)</td>
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<td>0.7</td>
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<td>5.1</td>
<td>2.4</td>
</tr>
<tr>
<td>1. Admin. Professional &amp; Technical Staff</td>
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<td>0.1</td>
<td>6.9</td>
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<tr>
<td>2. General &amp; Clerical</td>
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<td>0.0</td>
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(Source: 1973 N.E.S. Department of Employment).
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<td>Lockwood, D.,</td>
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