

Cookery, Diet and District Nursing in late Nineteenth-Century London

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Abstract: While health education in late nineteenth-century Britain could be beneficial for every household, it was particularly so where district nurses understood family circumstances and adapted knowledge to individual needs. During this period sick room cookery training and lectures on hygiene and dietetics became standard for nurses—especially following the reforms of Matron Eva Lückes at the London Hospital. Because understanding about health was not widespread in society, due to the living conditions and poverty of so many patients, and because doctors had few opportunities to convey such knowledge, the active support of nurses in the community proved to be essential for translating professional knowledge into words commonly understood. By demonstrating cooking and other health-related skills in the homes of the poor, nurses played an important part in improving the nation's health.

Key words: district nursing, health education, London

The history of nursing has tended to investigate the institutions where nurses worked, their training and the professional opportunities it opened up for women in the late nineteenth and early twentieth centuries. The importance of nursing, of course, was dramatically brought to the attention of the British public by the work of Florence Nightingale in the Crimean war and both in the Army and Royal Navy improvements in care for the sick and wounded gradually followed. For civil society, attention has predominantly focused on public health measures and medical progress in combating epidemic diseases. By the late nineteenth century most towns and localities had appointed Medical Officers of Health who oversaw advances in sanitation, while legislation increasingly provided both the legal framework within which they worked and the limitations now placed on those whose economic activities created nuisances which jeopardized the health of others. The history of modern British people's health has, for some years, been prominently represented by the works of Smith and Wohl whose approaches to public health questions span the whole range of activities by the state, local government, medical professionals and voluntary work. Valuable research has also highlighted the problems, financial and otherwise, which were developing in many of Britain's larger hospitals by the beginning of the twentieth century and stressed the continuing importance of charitable organisations in helping the poor.¹⁾

The popularity of imperial ideas and the obvious defence implications of having an unhealthy and malnourished population gave added impetus to debates on public health and encouraged an interest in food—especially where deficiencies affected the poor. While an interest in fitness and better diet was manifest in the armed services, long-term improvement in wider society was believed by many reformers to be dependent on work in schools. In consequence, domestic economy education for elementary schoolgirls was extended from the 1870s onwards: a girl who knew the nutritional value of affordable

ingredients would grow up to be a good mother and in turn pass on the benefits of her knowledge. Of course, this might take generations to achieve and the effectiveness of such basic educational work among the slums of London and Britain's other great cities was always difficult to ascertain. More immediately, however, other educational opportunities were opening up with the growth of organised professional nursing. District nursing had began in England through the work of charitable or religious bodies to help the sick poor who needed home care and been developed by independent nursing associations. To date, district nursing has been mostly studied from its social perspective and its connection with health visitors' work for mothers and babies, as seen in the publications of Davies and Summers. It has been less investigated for its educational role to bring about improvements in domestic hygiene and eating, with at the time it was supposed should be its focus.²⁾ Knowledge about diet, cooking, and hygiene was indeed conveyed by nurses. The following is a study of their educational work outside hospitals and in the areas which Britain's poor inhabited. It is contended here that district and private nurses have been a neglected element in public health improvement, particularly in London, in the late nineteenth and early twentieth centuries.

District and private nurses often required more knowledge and skills than those working at the hospitals if they were to succeed in turning their visits into opportunities for health education. Some forms of visits to the homes of the poor had existed before the rise of professional nursing: before maternity health visitors for women and infants became common, pudding ladies, Bible women and a number of charitable women's associations went into poor neighbourhoods to provide help as almoners.³⁾ This, however, was very different from proper nursing care which, in Nightingale's opinion, was the most effective way of providing health advice. Even private nursing, though normally expensive, had a valuable role to play—especially that organised from the London Hospital. Practical health instruction was beneficial to every household but particularly so when delivered by nurses who understood the specific circumstances of the inhabitants and could adapt knowledge to individual needs. It was impossible to achieve such benefit simply by giving lectures or distributing printed pamphlets to the public.

Training clearly had a vital role to play. By the end of the nineteenth century nurses received practical training regarding sick room cookery and they attended lectures on hygiene and dietetics delivered by doctors. Such training was accepted as standard after 1895 following Matron Eva Lückes's efforts at the preliminary training school for nurses attached to the London Hospital. Lückes was also influential via the hospital's private nursing service which despatched skilled nurses who had undergone her training scheme to people's homes.⁴⁾ In the home and in the hospital, food for the patient was becoming an important consideration when delivering medical care: indeed, in the three investigations of the Metropolitan Hospitals held by the House of Lords in 1890–92 hospital food was one of the issues examined. Usually in large hospitals the ward Sister wrote up the diet tables for each patient according to a doctor's orders and it was her duty to check that patients were supplied with proper meals.⁵⁾ Reforms of diet and in providing food for patients were done regularly: at King's College Hospital in 1885 Sister Matron prepared a new diet table to be discussed at the medical committee, while in St. Thomas' Hospital the diet table was revised under John Buckmaster, from the National Training School of Cookery, regarding the mode of cooking and serving meals.⁶⁾ The issue of diet reform at the London Hospital was also considered many times by the House Governor and doctors: William Nixon, House Governor, began this

after the 1870s when the refurbishment of the hospital kitchen aimed to provide better food at lower cost. It was continued by hospital doctors Robert Hutchison and Henry Head, who were experts on nutrition, as part of their dietetic studies after 1900.⁷⁾

Improvements in hospital food notwithstanding, home nursing had several benefits for families. If a sick mother could stay at home she could take care of children when feeling better, and if the husband was sick at home then the wife could nurse him when her own work was done. Furthermore, hospitals did not always accept the sick poor. Home nursing work had started with independent nursing associations drawing upon the services of either lady nurses or ordinary nurses. Pioneering work was undertaken by Elizabeth Fry who in 1840 trained middle-class protestant visiting nurses. In London, Dr. Robert Todd of King's College Hospital commenced the work of the St. John's House to train Anglican women to nurse the sick poor in 1848, and in the same year Ellen Ranyard started the scheme of Bible women nurses known as the Ranyard Mission.⁸⁾ Organised district nursing was planned and started in Liverpool by William Rathbone; its theory and methods were based on the ideas of Nightingale who believed in the importance of home nursing as the most comfortable way for the sick poor to recover from illness.⁹⁾ Nightingale frequently mentioned the benefits to be derived from district nurses teaching health in poor people's homes—expecting that they would work as health missionaries as well as medical nurses. The essential point was to have opportunities for inspecting progress regularly through direct contact with people's domestic circumstances.¹⁰⁾ Nightingale thereby stressed a practical way of nursing, especially suitable for London with its widespread poverty. More generally, however, instruction in the home by qualified visitors was recognised as being the most effective way of promoting healthcare in society; care of the sick, sanitation, domestic hygiene, and infant care might all be addressed. Lastly, but significantly, so might the pressing issue of eating nutritional food, and thereby maintaining better general health, via cookery lessons.

District nursing involvement became greater as health promotion work expanded after the 1890s. It was influenced by the systematic training for nurses now provided at different hospitals and also by the way in which district nursing was affected by the merger of organisations which conducted it. There were two large voluntary societies which ran district nursing in London. One was the East London Nursing Society, established in 1868 with non-lady nurses for the very poor. The other was the Metropolitan and National Association of Providing Trained Nurses formed in 1874. Of course, it was impossible to provide help for all who needed it. In 1890 the latter had 50 nurses in London who could each attend eight cases a day. In comparison, the East London Nursing Society had 27 nurses divided into four divisions with a matron in each. The results of the Metropolitan and National Association were highly acclaimed by doctors who called them Bloomsbury nurses. It was a professional organisation for gentlewomen, supported by subscriptions, which undertook both charitable and private nursing and whose members were given annual salaries ranging between £35 and £50. They were normally sent to cases by doctors who had applied to the Association.¹¹⁾ Its reputation and influence was strengthened by the founding of the Queen Victoria's Jubilee Institute for Nurses in 1887, which adopted the Association's training methods as organised by Florence Lees (later Mrs. Dacre Craven). Training required one year spent at a recognised training school for nurses attached to one of the general hospitals, with six months' district training and three months' maternity training. Craven's educational plan was to maintain the high standard of general nursing established at the Association's Central Home in Bloomsbury, with

further hospital training as specified for district work. Rathbone believed that district nursing by the Bloomsbury ladies in London would become an example for the nation. It would provide extensive opportunities for educated women to commence special training, with the ambition of becoming superintendents who would extend district nursing work to the provinces.¹²⁾

Although the main objects of district nursing were sick nursing and instruction, it followed that if nurses came from a better educated class then their visits would be more productive because they could also report on sanitary defects in their districts to superintendents and Medical Officers of Health after checking on drainage systems and the use of back yards. Nightingale expected this. It was generally accepted that the training of district nurses had to be systematic and to a high standard, and progress here owed much not only to Nightingale but also to Amy Hughes—later appointed Superintendent of the Queen Victoria's Jubilee Institute for Nurses. Although from their beginning Bloomsbury nurses had trained following the same curriculum as hospital nurses, including practical instruction, this type of practical instruction had not been much emphasised in hospitals in the 1880s.¹³⁾ Alterations in wider hospital training, following the experiences of district nurses, would be a consequence of Hughes's work.

Hughes started her career as a lady probationer at St. Thomas' Hospital in 1884 and first met Nightingale in the following year. Nightingale recommended that she became a district nurse since that offered a good way to contribute to the national welfare. Hughes then trained at the District Nurses' Home in Bloomsbury. Later she wrote articles on district nursing in the journal, *The Hospital*, and finally compiled a manual, containing additional advice from Nightingale, which the latter hoped would raise both the standards and the ideals which attached to district nursing. Like Hughes, Nightingale believed that the nurses' work in the district should be primarily to care for the sick with only limited midwifery training.¹⁴⁾ In her opinion, district nursing had already proved its worth with the scheme in Liverpool, with the Bloomsbury nurses in London and with the Queen Victoria's Jubilee Institute nurses trained by the Metropolitan Association from the 1890s; it was therefore time to set up a specific standard for the training of district nurses. This would involve more practical knowledge and skills on how to manage hygienic conditions in homes. Hughes clarified these in her book, *Practical Hints on District Nursing*.

There was already a large circulation of Craven's *A Guide to District Nurses and Home Nursing* in 1890 which explained the basic method of nursing and the theory of district nursing, referring to the nurse as a sanitary agent.¹⁵⁾ Beyond this, Hughes now tried to illustrate the more practical application of district work. On the principle of free nursing for the poor at home, she pointed out that it had to be more focused than free nursing in hospital; from such work it was expected that more influence could be extended into the neighbourhood of the patients. To bring basic rules regarding health into the home, teaching children would be one option and this should be seen as pioneering work. In meeting these challenges, district nurses could choose appropriate instruction for individual homes. It was, for instance, no use talking about the importance of a sunny room and avoiding dampness if it was not feasible or affordable. Hughes recommended that nurses spend about half an hour giving a practical demonstration during their work, instructing a family how to prepare a savoury meal economically. With regard to children, nurses might encourage girls at home, especially if the latter had learnt some cookery at school, because such practical instruction given to them by nurses would be beneficial for the whole family.¹⁶⁾ This last suggestion of cookery training for girls could, in fact, be quite effective if district

nurses had the chance to try. The nurse would teach the eldest girl in the patient's family to help alongside her mother, thereby providing revision lessons on any prior knowledge of cookery. The benefits arising from this were potentially extensive since, according to the records of the Education Department, 134,930 girls from 2,729 schools received classes on cookery in 1895–96; in the London area this subject was further encouraged by the London School Board, so girls there had even more possibilities.¹⁷⁾ District nurses therefore came to play a useful role as an adjunct to elementary education regarding aspects of domestic economy and hygiene.

The role of district nurses as hygiene instructors was developed further by Christian Guthrie Wright, as Hon. Secretary of the Scottish branch of the Queen Victoria's Jubilee Institute. She also acted as Secretary of the Edinburgh School of Cookery which delivered sick room cookery classes for medical students after 1878. The training of nurses in the Scottish branch was the same as that in England: hospital training, maternity and district training, with lectures and practical lessons on hygiene and food and with cookery lessons.¹⁸⁾ As a representative of the Queen Victoria's Jubilee Institute for Nurses at the Sanitary Institute Congress held in Glasgow in 1904, Wright stated that district nurses were a more suitable agency for sanitary improvement than sanitary inspectors and health missionaries and she tried to demonstrate this in a speech entitled 'District Nursing as a Hygiene Agency.' In her correspondence with Alice Leake, Secretary of the Queen Victoria's Jubilee Institute for Nurses in London, she regretted that her paper was read at the end of the congress and that her audience was small; however, she justified her attendance by explaining that district nurses now had the training to give valuable instruction on hygiene and sanitary subjects and that they were the people who could work effectively among the poor by knowing their real living conditions.¹⁹⁾ Wright's speech pointed out seven topics that nurses might deal with when giving advice and instruction during their work: household sanitation (drainage, disinfection, fresh air), incipient consumption (preparation of the sick room, obtaining nourishing milk or eggs by contacting other agencies to help combat disease in its early stages), infectious illnesses (vaccination), care for the mother after confinement (including asking family and neighbours to help her), the newborn infant (feeding and clothing), care of young children's health, and, finally, cooking instruction. Even if only done briefly, lessons in cooking by district nurses among poor families would raise the standard of living and nutrition. Much benefit was expected when nurses had 'an opportunity *teaching and improving cooking*, not only for the sick, but for the other members of the family. ... Nurses can show that good cooking is not only cheaper than bad cooking, but also aids nutrition and is pleasant.'²⁰⁾

Similar comments were also made by Hughes after she became Superintendent of the Queen Victoria's Jubilee Institute in 1905. She stressed that instruction about cookery for poor families would help them to feed themselves more nutritionally without additional cost. These educational functions of district nurses would raise them from being merely assistants to medical doctors in so far as they could now act as the health missionaries envisaged by Nightingale.²¹⁾ District nurses always tried to encourage ideas of progress and to act as spurs for health improvement. Direct instruction from them had a stronger impact than any other home visiting, as one district nurse, Greta Allen, asserted in her book for health visitors: it was more effective than charitable ladies, club activities, health lectures, coal-funds or clothing-funds because the influence of the district nurse spread into the community far beyond the individual home.²²⁾

Yet to be able to conclude that spreading important aspects of health education throughout society

relied on the nurses who worked out in the districts and at the homes of the poor it is necessary to demonstrate how their training was put to practical effect. By the turn of the century the common image of a district nurse was that of a professional woman not afraid to walk around narrow alleys by herself, carrying such necessities as dressings, ointments and matches with her to use in the patients' lodgings. When she arrived she usually cleaned up and ventilated the room, then inspected, washed and dressed the children. Often she was the only person looking after the patient at home on the day of her visit who could maintain the sanitation of the household. If the nurse did not visit, the patient sometimes could not even have a warm tea because of the lack of matches and a fire.²³⁾ In poor families, instruction for girls and their mothers at home was more likely to be accepted as trustworthy information when delivered by such sympathetic professionals. Charles Booth, in *Life and Labour of the People in London*, also offers evidence regarding the effectiveness of district nursing, citing it as a better strategy to improve the living condition of the poor than dependence on charitable work. District nursing was judged to be educational not only by delivering care in sick rooms and cleanliness for infants but also by instructing on the preparation of food for both the healthy and sick of the family. All this, Booth considered, could be combined with other aspects of domestic economy. Booth's section on district nursing was based on interviews conducted by a surveyor, George Duckworth, with nurses and matrons who were engaged in it—most significantly with Lückes and the Superintendent of the Queen Victoria's Jubilee Institute. Booth concluded: 'of all the forms that charity takes, there is hardly one that is so directly successful as district nursing. It is almost true to say that wherever a nurse enters, the standard of life is raised.'²⁴⁾ Since Booth's survey incorporated widespread research into poverty in London, district nursing came to be seen as a key element in analysing social needs and medical welfare.

In this context of the practical importance of nurses engaged in district work, it is also helpful to look at the work done by private nurses since even in more affluent homes instruction for the sick was often found to be necessary. Patients who benefited from this type of nursing usually did not obtain charitable treatment at the voluntary hospitals, so their options for medical care were by private nursing and by general practitioners—although the paying patients' wards of some voluntary hospitals might also be accessible. In London, although district nursing by both the Metropolitan and National Association and the East London Nursing Society was based on the principle of nursing the sick poor, if necessary without any payment, and many associations in other parts of the country had the same policy, nevertheless their work often overlapped with private nursing. One case illustrating this was that of a barrister whose circumstances made him unable to board or lodge a private nurse. Occasionally, therefore, he asked help from the district nursing association.²⁵⁾

Private nursing generated extra income for hospitals to support their voluntary provision when the private nursing institutions were attached to them. According to the report of the Metropolitan Hospitals there were 50 private nurses attached to Guy's Hospital, 70 to the Westminster Hospital and 25 to the London Hospital. However, the number of nurses in such establishments was never large enough, and since between cases the women needed to have holidays the number working at the same time was always slightly reduced from the total membership.²⁶⁾ The London Hospital formed its Private Nursing Institution in 1886 as an alternative work opportunity for nurses who had trained there. Lückes inaugurated this private nursing, which was not only for the financial support of the hospital. She considered it to be part of the hospital's extended nursing care to all in society who needed help; she even observed

that 'the sick rich were not as well looked after as the sick poor.'²⁷⁾

Lückes's idea regarding private nursing staff was to keep them employed in the hospital wards with other nurses when they were not undertaking outside work. There they could update their skills and knowledge by working alongside doctors while, at the same time, their independence through private work might be a beneficial influence on other hospital nurses during regular duty. Furthermore, it provided alternative work for nurses who were not strong and could not work regularly as hospital staff.²⁸⁾ While this system provided profits for the hospital financially it was also considered that a good nurse would be 'an excellent advertisement' for the hospital to which she belonged. This 'advertisement' involved encouraging donations and material support for the benefit of patients in the hospital, such as fresh subscriptions and gifts.²⁹⁾

The Private Nursing Institution of the London Hospital charged two guineas a week (infectious cases) or one and a half guineas as its lowest rate; this was an average charge for private nursing. There were also commercial associations for private nurses in London: for example, the London Association of Nurses started in 1873 with nurses possessing an average of seven or eight years of hospital experience and charging one to four guineas a week. The fee for private medical practitioners was a little lower: its average was between two shillings and two shillings and sixpence for a visit to a working class home and a little more for the middle classes.³⁰⁾ According to Booth's survey, two guineas a week was unaffordable for poor people whose incomes were small and irregular; they would have to depend on voluntary hospitals, district nursing or charitable infirmaries. But working-class families who lived more comfortably might sometimes be cared for by private doctors or by part payment towards the cost of the Metropolitan and National Association's nurses. The latter thereby helped modest tradespeople and artisans who could afford five or ten shillings a week from their average weekly income of between 25 and 35 shillings.³¹⁾ Private nurses, then, usually provided services for people whose diet was different from that of the poor; nevertheless, not all of them had proper knowledge and practical skills regarding sick diet and cookery, personal or domestic hygiene, or care of a sick room.

Some of the most specific evidence as to how effectively knowledge about preparing food was being spread to individual homes has survived in the diary of Wilby Hart, who worked as a private staff member of the London Hospital in the 1900s. Hart kept an account from the time of her arrival at the hospital for training. She recorded her working days as private staff and later her work as a Sister at the London Hospital with details about the patients she cared for and her experience of training young nurses. On visiting one family, Hart needed to change the whole sick room because it was packed with furniture, interior decorations and carpets. Nurses often found that sunlight from windows was ignored and that the sick room remained dim without enough ventilation. Using a feather bed for home nursing also had to be avoided, both for hygienic reasons and because it became difficult for the patient to stay in a comfortable position. It also prevented a doctor's inspection. In one wealthy patient's sick room Hart moved her patient to another bed.³²⁾

Crucially, Hart also recorded her sick cookery at a private patient's home, especially in the case of a Mrs. B. who suffered from fibroids and was about 45 years old. She was in a very weak condition and the doctor who accompanied Hart to the house told Hart that the patient was going to die. He said that she became very ill if she ate eggs in any form, although he asked Hart to try to build her up with at least two eggs a day. Hart tried to do this through experiments; because of the patient's obvious dislike of egg

she mixed the eggs in other food. Firstly, Hart mixed egg with milk and gave it to the patient using a feeder in which the colour of the content was not visible. Then Hart tried the same for puddings, soups and custards flavoured with Bovril. Her trial did the trick and by the time Mrs. B. discovered that she had been fed eggs she was in fairly good condition, could eat whatever she preferred instead, and eventually recovered. Hart continued her educational work on cooking with the patient's sister, who was staying in the house, giving useful instruction about sick cookery.³³⁾ Mrs. B. clearly enjoyed a reasonable standard of living: she could both afford eggs and could take anything she preferred to them as nourishment. For someone in this position nurses did not need to ask for support from any other organisation regarding the patient's food nor to worry about cooking utensils and facilities in the kitchen. The latter were usually important matters in district nursing.

This educational influence delivered directly to the sick home by nurses clearly had many advantages compared to advice which might be given by doctors. Admittedly, research on food for patients was of growing medical concern; one of the earliest examples of this was a pamphlet from the British Hospital for Diseases of the Skin in 1872 giving guidance for patients who suffered from skin ailments and careful directions on preparing a daily diet.³⁴⁾ At the London Hospital, Hutchison delivered lectures on dietetics to medical students, referring them to his 1900 book, *Food and the Principles of Dietetics*. This work soon became a standard reference for the medical profession, including nurses, and it had a wide circulation. Hutchison analysed not only the nutritional value of food but also explained how scientific knowledge of it would be useful for both doctors and their patients, especially when the latter were from the poorer classes. Following Hutchison's research, doctors could recommend the cheapest sources for those patients who could afford to purchase fish, the cheaper cuts of meat, pulses, cheese, margarine and drippings, rather than more expensive foods with the same nutritional values. Hutchison encouraged poor patients to acquire a basic knowledge of food values because, in general, half a working man's wages was spent on food. Nevertheless, delivering such knowledge where most needed was a real problem.³⁵⁾ For in-patients, nurses could support them at least while they were in hospital, but for out-patients or patients who had left hospital it was almost impossible to look after them, whether health instruction at the hospital had helped them or not. Apart from district nurses' opportunities for visiting homes with their support and advice, doctors had very few chances to pass on instruction about diet or healthcare in any detail because of the large numbers of their patients. Visits to homes, as Amy Hughes insisted, were 'the best weapons' for this vital work.³⁶⁾

With the progress of sick room cookery in their training and in their work outside the hospitals, nurses conveyed information on food and healthcare directly into patients' homes. With its practical methods, this could be highly effective; indeed, even small improvements in cookery, diet and hygiene could change people's lives. Nurses out in the districts were instrumental in translating professional knowledge and vocabulary into words understandable by everybody. At times, it seemed modest work. It was, nonetheless, a far-reaching support for developments in medicine and for improvements in the health of the nation.

Notes

- 1) Smith (1979) and Wohl (1983) covers the broad range of sanitary reform. Hardy A. (2001), p. 12–46. Waddington (1995) explains one example of the conflict between doctors and nurses. For more details regarding food and healthcare in modern Britain, see Akiyama (2008).
- 2) Davin (1978), p. 24–8, 35–43; Ross (1993), p. 208–9. Regarding district nursing, for example, see Davies (1988); Summers (1992–93).
- 3) L.N.R. (Ellen Ranyard) (1875); Miss Bibby, Miss Colles, Miss Petty, and Dr. Sykes (1912), p. 1–29. Also, see Abel-Smith (1960), p. 53–60; Prochaska (1980), p. 97–181; Summers (1979).
- 4) Lückes to Nightingale, 15 June 1893; ‘Hospital Nursing Report for 1893’, March 1895; 16 March 1895, British Library, Nightingale Papers, Add.MSS.47746, ff.166, 237, 270; The British Journal of Nursing, 17 January 1903, p. 48. For Lückes, see McEwan (1958) and Collins and Parker (2003).
- 5) British Parliamentary Papers (hereafter BPP), Select Committee of the House of Lords on Metropolitan Hospitals, etc. (hereafter cited as SCMH), First Report (BPP, 1890, XVI), p. 489; SCMH, Third Report (BPP, 1892, XIII), p. liii.
- 6) King’s College Hospital, Minutes of the Committee of Management, 29 July 1885, King’s College London Archives, KH/CM/M12; St. Thomas’ Hospital, House Committee Minutes, 3 January 1883, 4 April 1883, 6 June 1883, London Metropolitan Archives (LMA), H01/ST/A/010/001. At King’s College the Matron was called Sister Matron.
- 7) London Hospital, House Committee Minutes, 13 November 1877, 3 January 1882, 14 March 1882, 12 March 1889, 7 October 1901, 2 December 1901, Royal London Hospital Archives and Museum (RLHA), LH/A/5/38, LH/A/5/40, LH/A/5/47, LH/A/5/48. Also, Henry Head and Robert Hutchison, ‘Report upon the Diets at the London Hospital’, 25 September 1901, LH/A/17/19; London Hospital, Medical Council Minutes, 27 April 1901, 15 November 1901, 28 November 1901, 21 January 1902, 24 April 1903, RLHA, LM/1/3, LM/1/4; Ellis (1986), p. 59.
- 8) Stocks (1960), p. 20–5. This is still the basic history for district nursing.
- 9) Hardy G. (1981). For rural district nursing, see Howse (2006). From the early twentieth century, following the Midwives Act of 1902, district nurses had more midwifery training and it became one of the skills required for district nursing. Fox (1994), p. 305–6.
- 10) A note by Nightingale, May 1895. ‘Sick Care as for Technical Education’, Nightingale Papers, Add. MSS. 45813, ff. 68–69; The Lancet, 1 June 1895, p. 1392–3. Nightingale (1881), p. 3–7; Nightingale (1893), p. 191–2; Nightingale (1894), p. 1–26; Anon. (1893).
- 11) SCMH, First Report (BPP, 1890, XVI), p. 538–40.
- 12) Rathbone (1890), p. 52–3, 59–60.
- 13) Metropolitan District Nursing Association, Superintendent’s Reports, vol. 1 (1876–80); Annual Reports, vol. 1 (1876), vol. 2 (1877–84), Guildhall Library, London, MS. 14616, MS. 14618; for the Queen Victoria’s Jubilee Institute for Nurses see Baly (1987), p. 1–86.
- 14) Nightingale to Hughes, 5 June 1894, 8 September 1896, 20 October 1896; Hughes, n.d., Wellcome Library for the History and Understanding of Medicine, Archives and Manuscripts (Wellcome Library), London, MS. 5478/4, MS. 5478/8/2, MS. 5478/11, MS. 5478/20/1.
- 15) Dacre Craven (1890), p. 10–13.
- 16) Hughes (1897), p. 2, 39–40, 55–6.
- 17) Pillow (BPP, 1897, XXV), p. 159; London School Board (1904), p. 122–6.
- 18) British Medical Journal, 2 February 1878, p. 165; Rathbone (1890), p. 105–6. Also, Begg (1994), p. 56–8.
- 19) Wright to Leake, 28 September 1904, The Queen’s Nursing Institute Collection, Wellcome Library, SA/QNI/S.1/1/7.
- 20) Wright (1904). Italics are by Wright.
- 21) Hughes, ‘The Ideal District Nurse’, The Nursing Times, 8 May 1909, SA/QNI/P.7/13.
- 22) Allen (c. 1905), p. 76–9.
- 23) M. R., Queen Victoria’s Jubilee Institute, ‘A Round with A District Nurse’ [circa 1909], SA/QNI/P.7/14. This is reported from Edinburgh. However, some studies suggest that working-class women did not always depend on or welcomed support given by official agencies. For example, Lewis (1986).
- 24) Booth (1902), p. 154–7. Survey notebooks by George Duckworth, A letter from Lückes, p. 145–7, A27; Lückes interview, p. 219–28, B153; Queen Victoria’s Jubilee Institute for Nurses, Miss Hadden interview, p. 1–11, A55, Charles Booth Collection, British Library of Political and Economic Science Archives.

- 25) 'The Metropolitan and National Nursing Association for Providing Trained Nurses for the Sick Poor', 1881. This case was a barrister alone in chambers with rheumatism, only helped by his colleague. Nightingale Fund Council Records, LMA, A/NFC89/1-2. Private nursing organisations were different from those attached to the hospitals. Before setting up co-operative organisations, private nurses were not guaranteed the same quality of training as hospital nurses. Working conditions and payment also varied. Standardisation eventually led to the state registration of nurses. See Abel-Smith (1960), p. 77–8 and Seymer (1961), p. 234–5.
- 26) SCMH, Third Report (BPP, 1892, XIII), p. clxx, cvii.
- 27) SCMH, First Report (BPP, 1890, XVI), p. 477.
- 28) Ibid.
- 29) Lückes to Nightingale, 'Private Nursing Report for 1890', February 1892, Nightingale Papers, Add. MSS. 47746, ff. 87–88.
- 30) SCMH, First Report (BPP, 1890, XVI), p. 542–3; SCMH, Second Report (BPP, 1890–91, XIII), p. 704.
- 31) SCMH, First Report (BPP, 1890, XVI), p. 538; Booth (1904), V, p. 322–31.
- 32) Dacre Craven (1890), p. 24–5, 38–41; Lückes (1883), p. 16; National Health Society (1890), p. 3, 5; Weatherly (1880), p. 4–7; Wilby Hart Diaries, 'Case 3: 15 December 1907–22 December 1907, Mr. M.—Nervous Breakdown', 1–3; 'Case 6: 10 February 1908–16 March 1908, Mrs. B.—Fibroids', p. 8–9, RLHA, PP/WILBY.
- 33) Hart Diaries, 'Case 6: Mrs. B.', p. 8–9, PP/WILBY.
- 34) British Hospital for Diseases of the Skin (1872). General instruction for medicine and the use of ointment was explained, with the method of maintaining personal cleanliness.
- 35) Hutchison (1900), p. 7, 69–70, 82–3, 130–4, 377.
- 36) Hughes (1897), p. 55–6.

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