

Fever Hospitals and Fever Nurses

A British Social History of Fever Nursing:
A National Service



Margaret R. Currie

Fever Hospitals and Fever Nurses

Margaret Currie has produced an excellent study of a much neglected subject... in a highly readable and rigorously researched way. Dr Currie has done us a great service by reminding us of the relevance of fever nursing to contemporary debates in nursing. I commend her book to you.' *Professor Anne Marie Rafferty, Dean and Chair in Nursing Policy at the Florence Nightingale School of Nursing and Midwifery, King's College, London*

This book is the first in-depth account of the development of fever hospitals and fever nursing – mainly in nineteenth and twentieth-century Britain. Rare social aspects are provided through probationers' views of their training and patient impact case studies, and key nurse leaders are featured, including ex-fever nurse Edith Cavell. *Fever Hospitals and Fever Nurses* provides new insights into how the predominantly female work force coped with epidemics, some of which were of national significance. The book also reflects current concerns, including the challenging nature of infectious disease and biological warfare.

Fever Hospitals and Fever Nurses will be vital reading for academics and students in nursing history and of great interest to current and former medical and nursing staff. Patients and their relatives, medical, social and family historians, students of women's history and control of infection nurses will all discover relevant data.

Margaret Currie, a registered general nurse, nurse tutor, and recently a senior lecturer at the University of Luton, has carried out extensive research into fever hospitals and fever nursing, and lectured on the subject in Britain and Canada. Her publications include articles on fever and small-pox nursing and she is a contributor to the *Dictionary of National Biography* (2004). She is currently Health Care Historian at the Luton and Dunstable Hospital NHS Trust and a Senior Research Fellow (Hon) at the University of Luton. Margaret is also a committee member of the Royal College of Nursing History of Nursing Society and she chairs the London and South East Group.

**For
James, William, Edward, Victoria,
Emily, Oliver and Dominic**

Fever Hospitals and Fever Nurses

A British social history of fever
nursing: a national service

Margaret R Currie

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Foreword

Margaret Currie has pulled off an impressive feat in producing this book. Not only has she produced an excellent study of a much neglected subject but she has accomplished this in a highly readable and rigorously - researched way. Dr Currie is to be congratulated on her foresight, tenacity and talent in writing this book. She has approached her subject from a variety of vantage points and, in the process, deployed different methods. This study is an exemplar of what a multi-method approach to historical writing and research can be. Blending survey data with oral history, biographical case studies as well as the more conventional documentary analysis, this study casts rare shafts of light into the lives of nurses, their careers as well as the settings in which patients were cared for. Furthermore, Margaret reminds us that fever nursing was not only about care but cure, at a time when therapies were rudimentary or involved little beyond reassurance.

I am delighted to see this book appear in print; not only because my mother features as one of the subjects surveyed but because fever nursing has been strangely sidelined. This book helps to retrieve fever nursing, nurses and their patients from the shadowlands of history and relocate it at the heart of health care history and contemporary debates in nursing. Dr Currie has done us a great service by reminding us of the relevance of fever nursing to contemporary debate in nursing; the essentials of care and the re-emergence of infectious diseases. I applaud Dr Currie's efforts and commend her book to you.

Professor Anne Marie Rafferty
Dean and Chair in Nursing Policy,
Florence Nightingale School of Nursing and Midwifery,
King's College, London
2004

Preface

This book had its origins in a small local study of hospitals and nursing care in south Bedfordshire, written primarily for the benefit of pupil and student nurses I was teaching at the Luton and Dunstable Hospital, but also for local historians. There were no other texts on this subject. Of the twelve main institutions discussed, two were isolation hospitals and one was for smallpox patients. While carrying out this research in the early 1980s, I interviewed some doctors and former patients and a few nurses who had worked in isolation hospitals. Their testimonies, combined with primary source evidence, built up an interesting yet at times disturbing picture, so I was keen to pursue it further, at national level.

In the late 1980s, nurse education was due to be transferred into higher education and nurse teachers, like myself, were expected to become graduates. As I had not previously had the opportunity, I took a degree in English and Historical Studies at the University of Hertfordshire, and was then encouraged by the University of Luton, where I was a senior lecturer, to undertake a doctoral study. It was originally to include fever hospitals and fever nursing, and I duly collected information at record offices and libraries. Conference papers were given at Nottingham, Cambridge, Edinburgh, London and in Winnipeg. Through debate with delegates, and discussion with nursing, midwifery, psychology and sociology students I taught at diploma, degree and master's level, my own knowledge was enhanced. Unfortunately, for various academic reasons, fever hospitals and fever nursing could not form part of my thesis, so I determined to write this book.

Much of my career has been in nurse education, in clinical patient care and in the classroom, but my early career, as a registered general nurse (RGN), took me into private nursing, industrial work, theatres and accident service. The job which made the greatest impression on me was as the sister in charge of a special clinic for patients with what are now termed 'sexually transmitted diseases'. The stigma attached to those with, or suspected of having, these diseases was plain to see. Patients ranged from infants to elderly people; all needed care and understanding, a non-judgemental attitude, and a readiness to listen to their perspective in confidence.

Nursing has, therefore, given me the context for this book, which required considerable extra research. I hope that this study will become a source of reference for others seeking knowledge about the past, for without this we cannot progress.

Margaret R Currie
Leagrave, Luton
October 2004

Note to the reader

Notes and brief references are appended to each chapter; full references appear in the Bibliography at the back of the book.

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When a doctoral thesis was first contemplated, in 1992, Dr Anne Marie Rafferty, then at the University of Nottingham, suggested the subject of fever hospitals and fever nursing, as it had not previously been researched nationally. Both Dr Rafferty and Dr Anne Hardy at the then Wellcome Institute for the History of Medicine, London, gave sound guidance in the initial stages. Although the direction of the thesis changed, they had set me on the right road which eventually materialised in this book. Dr Rafferty also read Chapters 4 and 5, and subsequently the whole book in draft form, as she had kindly agreed to write the foreword. My thanks are given to these two ladies for their academic advice and support.

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Librarians and archivists at various libraries, record offices, museums and other institutions have been very helpful, especially Susan McGann, the Royal College of Nursing (RCN) Archivist, who placed relevant material at my disposal in Edinburgh, and reviewed Chapter 7. Dr Gerard Fealy, University College, Dublin, carried out research for me at An Bord Altranais (the Nursing Board) in Dublin, made relevant comments on Chapters 2 and 3 and also enhanced my general knowledge about Irish matters. Jonathan Evans, Archivist at the Royal London Hospital, gave me valuable advice about Edith Cavell and reviewed Chapter 6 about her, and Dr James Gray, retired Consultant in Communicable Diseases at the Edinburgh City Hospital, drew useful data to my attention. I have cause to thank all these people for their interest and authoritative guidance.

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However, I owe the greatest debt to my husband, John Currie, not only for his unfailing support during the long gestation period of this book, but also for his ability to discuss issues and for his word-processing skills, without whose expertise this book would not have reached publication. Finally, the staff at Routledge, especially my Editor, Karen Bowler, and her assistant, Claire Gauler, have been unfailingly polite, pleasant and positive – I thank them.

Abbreviations and common terms

AIDS	Acquired Immune Deficiency Syndrome
BCN	British College of Nurses
<i>BJN</i>	<i>British Journal of Nursing</i>
BLARS	Bedfordshire and Luton Archives and Records Service
BNA	British Nurses' Association
BTТА	British Tuberculosis and Thoracic Association
CCSRN	Central Committee for the State Registration of Nurses
DMTSN	Dublin Metropolitan Technical School for Nurses
FNA	Fever Nurses' Association
FRCN	Fellow of the Royal College of Nursing
GNC	General Nursing Council
GP	general practitioner
HAI	hospital acquired infection
HIV	Human Immunodeficiency Virus
ICD	infection control doctor
ICN	infection control nurse/International Council of Nurses
ICNA	Infection Control Nurses' Association
IHMA	Infectious Hospitals Matrons' Association
IHMNA	Infectious Hospitals Matrons' and Nurses' Association
JNMCNI	Joint Nursing and Midwives Council for Northern Ireland
KCLA	King's College London Archives
LCC	London County Council
LFH	London Fever Hospital
LGB	Local Government Board
LMA	London Metropolitan Archives
MOH	Medical Officer of Health
M&B	May and Baker
MRC	Medical Research Council
MRSA	Methicillin Resistant Staphylococcus Aureus
NA	National Archives
NHS	National Health Service
NLI	National Library of Ireland, Dublin
PHS	Public Health Service

PRO	Public Record Office
PSA	Port Sanitary Authority
PTS	preliminary training school
RBNA	Royal British Nurses' Association
RCN	Royal College of Nursing
RCNA	Royal College of Nursing Archives
RFHA	Royal Free Hospital Archive
RFN	registered fever nurse
RGN	registered general nurse
RIDN	registered infectious diseases nurse
RLHA	Royal London Hospital Archives
RMPA	Royal Medico-Psychological Association
RSCN	registered sick children's nurse
SCM	state certified midwife
SRN	state registered nurse
SRO	Scottish Record Office
STD	sexually transmitted disease
TAF	toxoid antitoxin floccules
TB	tubercle bacillus (tuberculosis)
TUC	Trades Union Congress
VAD	Voluntary Aid Detachment
VD	venereal disease
WHO	World Health Organization

Common terms

Endemic – a disease commonly present in a localised area.

Epidemic – a widespread outbreak of a disease affecting many people simultaneously in a community.

Pandemic – a disease affecting people over a wide geographical area.

1 Introduction

The zymotic [infectious] diseases replace each other; and when one is rooted out is apt to be replaced by others which can ravage the human race indifferently wherever the conditions of healthy life are wanting. They have this property in common with weeds and other forms of life; as one species recedes, another advances. By improving the hygienic conditions in which men live, you fortify them against infection; and further, by isolating the infected, the chances of attack are diminished.

William Farr (1872)¹

The warlike metaphors in the above quotation epitomise and emphasise the fear which accompanied epidemics of infectious disease in nineteenth-century Britain. The increasing importance of a sanitary environment to individuals, and isolation measures to protect Victorian society, were fundamental to the nation's health and efficiency. Those most intimately involved with the isolation of patients in hospitals were fever nurses. Fever nursing now seems a particularly quaint term, its one-time importance almost forgotten, its history inextricably bound together with fever hospitals; both evolved slowly over two centuries and yet, by the 1970s, both had virtually disappeared.² However, this study continues beyond then, due to international concern about bioterrorism in relation to the possible wilful dissemination of the smallpox virus. It is necessary to include this issue, and how British society is coping with the challenges posed by different forms of fever, such as new viruses, drug-resistant organisms and new strains of old infectious diseases because, as William Farr observed in 1872, 'as one species recedes, another advances'.³

General nursing and most specialist branches of nursing have been well documented, but fever nursing has, for some reason, been avoided; this book, therefore, essays to fill the gap. Two methodological tools were used in this book. Historical research was carried out using mainly primary sources, and empirical studies were undertaken using a descriptive case study approach. These methods enabled the collection of quantitative and qualitative data and helped to determine both the final content and the form in which the

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research was presented. They enabled the drawing together of apparently disparate elements into a cohesive study. It draws on archival sources, the work of contemporary scholars, medical, nurse and social historians, journals, books, newspapers, doctoral theses and web pages. Local examples are included, as they illustrate how central government measures were applied to local situations. The book mainly covers the nineteenth and twentieth centuries, except Chapter 4, which is specific to the period 1921–71. Chapter 5 begins in the eighteenth century, earlier than other chapters, while Chapter 8 continues into the twenty-first century. The establishment of fever hospitals and the development of fever nursing in Britain includes the whole of Ireland, despite partition in 1922. Although independence was gained by Southern Ireland then, it was still thought relevant to include what is now known as the Irish Republic. What happened in fever nursing in Ireland is important to understanding the development and decline of the specialism. The Introduction now continues with the concept and effects of fever, the locus of care and the development of the fever nurse's role.

The concept and effects of fever

The word 'fever' derives from the Latin *febris*; its etymology is obscure and it was not in use until c. AD 1000. As late as 1933, the *Oxford English Dictionary*, defined it as 'A morbid condition of the system, characterised by undue elevation of the temperature, and excessive change and destruction of the tissues'. It also noted that it was a generic term for a group of diseases with the above characteristics, each of which have distinctive names: 'intermittent, puerperal, scarlet, typhoid, yellow, etc'. Although fever hospital/nest/patient/ward are mentioned, the term 'fever nurse' does not appear. Nevertheless, it is reasonable to assume that those who cared for patients with fevers became known as fever nurses.

Fever is then, associated with heat, hence the Latin *ferveo*, I burn, and from Greek origins, *pyrexia*, also meaning fever. Both are broad general terms, until associated with a particular infectious disease; in many cases, the fever is only secondary to the diseased state of the body. Fevers have existed since classical times. Wherever, and whenever, they occurred, the community was affected personally, but also nationally, because catastrophic epidemics reduced population levels. Thomas Malthus (1766–1834), in his *Essay on the Principle of Population* (1798), deduced that the Black Death, or 'Great Pestilence' (plague) in 1348–49, resulted in a loss of 30–45 per cent of the population. He regarded 'excesses of all kinds, the whole of train of common diseases and epidemics, wars, plague, and famine' as 'positive checks' on population.⁴

Factors known to have increased the incidence of infectious diseases were the immigration of people to Britain, the movement of the population within the country and urbanisation, which did not occur in Ireland. In the census of

1851, it was found that more people lived in towns than in rural areas in England and Wales. The living conditions of the poor in Britain were, at that time, often appalling. Inadequate sanitation and overcrowded houses exacerbated the spread of infectious diseases such as cholera, typhoid, relapsing fever, typhus and smallpox, but they were not confined to the poor: they could affect anyone. By 1860, Florence Nightingale had recognised that epidemics in children originated in schools.⁵ Compulsory elementary education for children aged 5–10 years, introduced in England and Wales in 1880, intensified the problem, so that measles, scarlet fever, diphtheria and other conditions, such as ringworm, became even more widespread. Although most infectious diseases could be fatal and premature death was common, the classical infectious diseases, which mostly affected younger age groups, waned to such an extent over the twentieth century that, by 1988, they accounted for only 1 per cent of all deaths in Britain and in all developed societies.⁶ It had taken many years, however, to reach this stage, due to ignorance.

Theories of infection causation differed before the late-nineteenth-century bacteriological advances. Various terms were used and meanings shifted. In medieval times, doctors adopted the Hebrew ritual of making lepers outcasts; it then became customary for certain groups of patients, such as those with rashes, to be isolated.⁷ Because the causation of infection was so poorly understood, it was attributed to a number of causes. For instance, in 1641, the causes of pestilence were declared as:

- 1 Sin, which ought to be repented of
- 2 an infected and corrupted air, which should be avoided
- 3 an evill diet, which should be amended
- 4 evill humours heaped together in the body, being apt to putrifie, and beget a Fever, which must be taken away by convenient medicines.⁸

Due to the connotation of 'sin', infectious diseases were often regarded as divine retribution. Consequently, those affected were looked at askance, distanced and often stigmatised. Miasmas, the noxious vapours from organic matter, particularly human and animal waste, the wrong diet and the Galenic humours were also considered possible causes. Galen (AD 129–c.216) deduced that fever could result from an excess of yellow bile, black bile, phlegm or blood. Instead of the earlier Hippocratic treatment of fevers by starvation (feed a cold and starve a fever), Galen advocated energetic blood letting by venesection, to remove such excesses and restore humoral balance, not only when a fever was present, but also prophylactically.⁹ In 1963, Michel Foucault, drawing on Herman Boerhaave's *Aphorisms* (1709), observed that the eighteenth-century concept of fever was not so much a sign of the disease, but resistance to it. Fever has, therefore, a salutary value, 'an excretory movement, purifactory in intention'.¹⁰

Infectious diseases were clearly different, but most continued to be known generically as fever diseases until the mid-nineteenth century; for instance,

it was not until 1855 that diphtheria and scarlet fever were recognised as different conditions.¹¹ In the 1870s, some doctors were still using the term 'typhus' to describe all types of fever. To avoid confusion, the term 'enteric' was frequently employed from the mid-1870s, instead of typhoid, as it sounded so similar to typhus.¹²

Until the late nineteenth century, almost all epidemics were thought to arise through transmission from person to person, generated from, usually, filthy, local conditions. Notions of 'contagion' and 'miasma', of a more or less undefined kind, were combined with 'stench', commonly thought to be at the root of disease.¹³ The bacteriological revolution is usually credited with changing medical thought and the dawn of a new modern age. For instance, in 1864, Louis Pasteur (1822–96) announced his germ theory of disease, which finally disproved the idea of disease causation through spontaneous generation, given the right circumstances. Robert Koch (1843–1910) demonstrated the existence of specific disease-causing organisms: anthrax in 1876, the tubercle bacillus in 1882 and cholera in 1883. A combination of careful observation and new scientific techniques advanced medicine. Observation of living patients at the bedside had resulted in diagnosis of some infectious diseases earlier, because they had particular identities and characteristics; those of diphtheria were published in 1826, typhoid in 1837 and typhus in 1849,¹⁴ but they were not proved scientifically until later in the nineteenth century.

The pathological significance of heat in fevers may have been known since classical times, but little progress was made in calibrating body temperatures until the eighteenth century, when Gabriel Fahrenheit (1686–1736) developed an alcohol, then a mercury thermometer (1714), based on earlier models. His temperature scale ranged from a freezing point of 32° to 212°F boiling point. Despite the work of some continental scientists, there was little interest in the measurement of temperature until the mid-nineteenth century, when Carl Wunderlich (1815–77) published his manual of thermometry in 1868, *The Temperature in Diseases*, which was particularly useful in the differential diagnosis of fevers. Normal temperature (98.4°F) signified health and fluctuations indicated disease. Although the temperature had to be recorded at least twice daily, absolute accuracy was not essential: 'nurses and even relatives could take temperatures'.¹⁵ However, as will be seen in Chapter 2, this was not necessarily wise in the mid-nineteenth century when nurses were drawn from the, often uneducated, servant class.¹⁶

Locus of care

During the nineteenth century, the term 'fever hospital' gradually evolved into 'isolation hospital', and in some cases a 'hospital for infectious diseases'. In this book, these terms are used synonymously. Such nomenclature highlighted the disease aspect and, because of its associated stigma, hindered isolation. It was for this reason that Dr Thorne Thorne, Medical

Officer to the Local Government Board (LGB), advocated in 1881 that hospital names referring to diseases should be avoided.¹⁷ Despite this advice, a confusing variety of names continued to be used for such institutions; smallpox hospitals, however, seldom had alternative names. As will be seen in Chapter 2, early fever hospitals were often hastily constructed temporary buildings, before necessity and legislation resulted in more permanent structures, particularly when workhouse fever wards could not cope in epidemics. Smallpox was different. The origins of institutions, specifically for this one disease, and the care that patients received is discussed in Chapter 5.

Hospitals in Britain were founded for different reasons. In some ways, the charitably endowed voluntary hospitals provided a model for municipal isolation hospitals, for example, in the medicalisation of care and the development of specialist roles for doctors and nurses. Before the Anatomy Act, 1832, acquisition of medical knowledge through dissection was strictly limited,¹⁸ but it could be gained from living bodies. This was one of the reasons many voluntary hospitals were established in the eighteenth century, followed by specialist and children's hospitals, although their foundation also gave rein for the charitable impulse.¹⁹ In the eighteenth century, the submission of a body could be regarded as 'docile' if it was committed to a medical institution, in much the same way as to a military, educational or industrial establishment. It might then be 'subjected, used, transformed and improved'.²⁰ Thus, docility came to be regarded as a prerequisite of patients, who were expected to accept meekly whatever care was available.

Access to patients' bodies improved knowledge and gave doctors the opportunity to take paying pupils, who duly deferred to them. Through working in an honorary capacity with the 'deserving poor' in voluntary hospitals, they met 'the great and the good', people in high society and the upper-middle classes, who had often founded them and still contributed to their maintenance, often by taking out subscriptions. When they or their families were ill, they would be cared for in their own home, but would consult these new experts. Consultants were, then, self-employed men with private patients, who 'walked the wards' of general hospitals in an honorary capacity, the élite of their profession. Small districts had different needs.

The cottage hospital movement began in England when the first one was established in 1859 in Cranleigh, near Guildford, Surrey, by Mr Albert Napper, a local medical practitioner.²¹ General practitioners (GPs) in the new cottage hospitals began to carry out a similar role to consultants, particularly in surgery; long-stay medical patients were generally discouraged. Cottage hospitals provided a locus of care for respectable people of the artisan class, who did not have to travel to distant voluntary hospitals, nor did they have to enter the infirmary at their local union workhouse. Due to the risk of wound infections in the pre-antibiotic era and the possible spread of infectious disease, some groups of patients were excluded. For example, at Luton Cottage Hospital, which opened in 1872 with just three beds, the rules stated that patients suffering from pulmonary consumption, unless deemed

urgent by the Medical Officer, were ineligible, as were 'cases of Mania, Epilepsy, Infectious and Incurable diseases'.²²

Isolation hospitals were very different in that they were founded by local authorities, initially for the poor, in much the same way as workhouses. Patients, particularly children, rarely entered them willingly, and the doctors who provided medical care were paid employees of the local authority and often, therefore, regarded as inferior by self-employed doctors. Small hospitals managed with a non-resident local Medical Officer of Health (MOH), or sometimes a GP. Large hospitals, however, had their own resident medical superintendents, who were, in effect, consultants by virtue of their experience and specialist training; consequently, medical students were frequently sent there for clinical experience and ward rounds. Nevertheless, by 1907, one eminent doctor, at the University of Manchester, felt that 'in the minds of many ... there exists a strong prejudice against the fever hospitals'.²³

It was in this context that the specialism of fever nursing developed through the nineteenth and twentieth centuries. It has become apparent during this research, that doctors in the nineteenth century were relatively helpless in the evolution of disease patterns. They 'affected epidemics no more profoundly than did priests during earlier times. Epidemics came and went, imprecated by both but touched by neither'.²⁴ Although the use of vaccines was significant, medical management was limited, hence fever nurses, who were trained to assist the doctor and obey orders, gradually played a more and more important therapeutic role in the patient's recovery.

Development of the fever nurse's role

Florence Nightingale believed that observation of the sick by nurses was essential, but deplored the fact that it was 'little exercised'.²⁵ Gradually, technical innovations were introduced to provide objective, accurate results. Taking and recording the patient's temperature, using the Fahrenheit scale (32–212°F), was initially the doctor's role, but as the doctor was not constantly present, nurses assumed the task. Great emphasis was placed on this aspect of their work in lectures and at the bedside. Textbooks for fever nurses often carried pages of illustrations of temperature charts indicative of different febrile diseases, which reinforced their importance in diagnosis and prognosis. Excellent examples of temperature charts have been seen in patients' medical notes held in various record offices. It is clear that most nurses took a pride in this aspect of their work.

The glass thermometer, which contained mercury, was usually inserted under the tongue, but in young children it was placed in the axilla or groin and in infants, the rectum. Gradually, the term 'pyrexia' superseded the term 'fever', hence the still vague diagnosis of 'pyrexia of unknown origin', but children who have fits due to a raised temperature are still described as having febrile convulsions. The frequency of taking and recording the temperature was specified by the doctor in charge of the patient, but at least

twice daily; the more pyrexial the patient, the more frequent the recordings. Such close attention took the nurse to the bedside, where any other changes could be observed, such as whether the patient was sweating and needed clean bedclothes, the changed character of a rash, obstructed respirations, or if the patient was no longer able to be roused. Means were taken to reduce temperature locally by free ventilation, reduction of bedclothes or use of a bed cradle. A free intake of water was encouraged and the bowels were kept open. Tepid sponging of the whole body was a frequent nursing measure. Hence, temperature control became part of the advances in clinical nursing.

The nurse in isolation hospitals may have assisted the doctor by monitoring the patient's condition and reporting any change, but essentially, the nurse's role was to provide basic nursing care, particularly while the patient was on bed rest, which could last for many weeks. This included feeding and the administration of fluids and prescribed drugs, hygiene, care of pressure areas, and any special measures relevant to patients with particular diseases. These could be relatively simple, like care of the mouth and eyes and application of poultices, or more complex, such as the application of lotions to prevent permanent disfigurement, particularly in smallpox, and ensuring that the airways of patients with tracheotomies, carried out as a result of laryngeal diphtheria, were kept open.

This discourse, concerning the concept and effects of fever, the locus of care and the development of the fever nurse's role, has been provided to further the reader's understanding of the following chapters, which trace the origins of the care of patients with infectious diseases in Britain from *c.* 1800 to the early twenty-first century. Chapter 2 outlines the transition from community to hospital care, the consequent need for nurses and problems of retention which led to fever nurse training schemes. Chapter 3 focuses on state registration in relation to fever nursing, and on some issues in the inter-war years. A rationale is then given about the role of men in fever nursing. Health risks to fever nurses and a discussion on hospital admission versus care at home follow. A rare glimpse of care is provided in patients' perspectives. Pay and conditions of service are discussed before the effect of the National Health Service (NHS) is considered. Finally, the closure of fever registers is analysed before a conclusion is drawn.

Chapter 4 is devoted to first-hand narratives from former fever nurses in the period 1921–71, based on a study of fever nurse training carried out in 1994–95. Of the 130 self-selected sample of fever nurses targeted, 118 respondents returned the postal questionnaires, a 91 per cent response rate. Research continued until June 2002, as a further 9 respondents had a valuable contribution to make. Although social historians like Paul Thompson and Robert Perks advocate personal interviews to collect and record oral histories,²⁶ this method was not practical due to the scattered nature of the target population throughout the United Kingdom and the Irish Republic. However, the study gave the respondents an opportunity they welcomed to recall, analyse and reflect on their fever nurse training and nursing practice. The

original study was published in 1998,²⁷ but this chapter draws on a more extensive range of data than was possible in a journal article.

Chapter 5 focuses on smallpox nursing, beginning in the eighteenth century, with the use of case studies. Chapter 6 is devoted to Edith Cavell, exploring her reasons for becoming a nurse, initially in fever nursing, and how this experience affected her subsequent career. Chapter 7 concerns two influential fever nurses, who made their mark on the specialism, in the twentieth century. Chapter 8 examines the consequences of closing the fever registers and most fever hospitals in the light of the single qualified nurse. Consideration is then given to the wisdom of isolation hospitals. Infection control nursing is then reviewed in the context of changing disease patterns and possible bioterrorism; it brings the book up-to-date. Chapter 9 draws the book to a conclusion.

Notes and references*

- 1 W. Farr, Compiler of Abstracts (1839–79) at the General Register Office, London, in his annual letter to the Registrar General in the Thirty-Fifth Annual Report of the Registrar General of Births, Deaths and Marriages in England (abstract of 1872), 1874, C 1155, p. 224.
- 2 Regional centres remain, but their work, often involving infectious diseases imported from abroad, receives little publicity.
- 3 Farr, *op. cit.*
- 4 Anderson (1996), pp. 29, 256. Malthus' 'preventive checks' on population included celibacy or delayed marriage.
- 5 Nightingale (1969[1860]), p. 139.
- 6 Halsey (1988), p. 399.
- 7 Baly (1980), p. 20. See also Risse (1999), pp. 173–79, in which the author explores 'views of leprosy and the construction of stigma'.
- 8 Sherwood (1641), p. i.
- 9 Porter (1997), p. 75. Galen's theories held sway into the early nineteenth century.
- 10 Foucault (2003 [1963]), pp. 219–20.
- 11 Pelling (1978), p. 98.
- 12 Hardy (1993), p. 153.
- 13 Ranger and Slack (1992), p. 3.
- 14 Hardy (2001), pp. 5, 25.
- 15 Porter (1997), pp. 344–45.
- 16 Dingwall, Rafferty and Webster (1988). Chapter 1, 'Nurses and Servants', provides a background for this topic.
- 17 LGB (1882) Tenth Annual Report of the Local Government Board 1880–81, *C3290 Use and Influence of Hospitals for Infectious Diseases*, London: HMSO. (The Medical Officer's name is correctly cited as Dr Thorne Thorne.)
- 18 Richardson (1989).
- 19 Prochaska (1988).

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Full references appear in the Bibliography.

- 20 Foucault (1991[1975]), pp. 136, 314.
- 21 Emrys-Roberts (1991), p. 4.
- 22 Currie (1982), pp. 50–52.
- 23 A. K. Gordon (1907) ‘The Position of the Isolation Hospital in the Training of a Nurse’, *British Journal of Nursing*, 26 January: 65.
- 24 Illich (1990[1976]), p. 23.
- 25 Nightingale (1969[1860]), p. 105.
- 26 Thompson (1988); Perks (1992).
- 27 M. R. Currie (1997–8) ‘Fever Nurses’ Perceptions of their Fever Nurse Training, 1927–71’, *International History of Nursing Journal*, 3(2): 5–19. The data include some audio tapes and one video recording.

2 Institutions and the evolution of nursing care

Nursing is largely a woman's occupation and the women who nurse for gain are part of the female labour force in the community. They have an economic as well as a professional and humanitarian role. Many are also wives and mothers whose gainful employment has social implications.

Charlotte Searle (1965)¹

Introduction

In early-nineteenth-century Britain, fever hospitals were the only institutions founded, through the Poor Laws, specifically for the physically ill. They were not primarily for their patients' benefit; the aim was isolation of the sick, rather than the provision of care. The main workload was borne by women; fever nursing, therefore, arose as a specialism out of necessity to ensure the needs of patients were met. The accommodation for those affected by infectious diseases was determined by a number of factors, including the size of the local population, the available resources, legislation and demographic change. Undoubtedly, fear and panic, generated by the virulence of a particular fever and its rapid spread in the local community, was usually the main factor which spurred the local authority to establish some form of fever hospital, or fever ward, often in the local workhouse.

In 1961, Erving Goffman described prisons and asylums as 'total institutions'; inmates were removed from a 'home world', stripped of their identity and possessions and, in many institutions, deprived of the privilege of having visitors.² Patients in isolation hospitals were often in a similar situation, with their nurses, technically, their guardians as much as providers of care. Before these hospitals were established, and even when they were, most people, particularly children, preferred to be nursed at home, however humble the conditions.

Nursing care in the community

Traditionally, knowledge about fevers, rashes and remedies was handed down by word of mouth from generation to generation, now termed 'received

wisdom'. Reciprocity of care, neighbours helping each other in adversity, was equally important. From the late eighteenth century, industrialisation and urbanisation in England and Wales, and in Scotland, meant that these benefits were often lost as people moved away from their rural roots. In Ireland, fever, famine and emigration, mainly to North America, had virtually the same effect. Ignorance could mean that the early signs and symptoms of fever (raised temperature and general malaise) were not recognised and, apart from smallpox, one rash was hard to distinguish from another. The problem was compounded by failure to summon a doctor soon enough, often owing to poverty. The houses of the poor were often squalid, overcrowded, seldom equipped with the basic necessities to nurse the sick, and there was rarely enough money for medical attention. In any case, doctors in private practice tended to work in more affluent urban areas in order to earn their living, so access to them was often difficult. Although sanitary reform began to improve living conditions and reduce the incidence of cholera and typhoid, it failed to address the spread of other infectious diseases. Diarrhoeal diseases were common in infants, leading to high infant mortality rates. Where there were horses and cattle, flies were attracted, now known to spread infection.³

Local MOHs were appointed in urban and rural areas to advise their local authority of epidemics of infectious diseases, problems with sanitation, or any other adverse influences on the health of the community. Some large urban areas found it necessary to appoint them in the early nineteenth century, under local powers, as was the case in Liverpool and the City of London; other large towns had appointed qualified medical men under the Public Health Act, 1848.⁴ In London, 48 MOHs were appointed in 1856 as a result of the Metropolis Local Management Act, 1855, and others were appointed in all urban and rural sanitary districts in England and Wales under the Public Health Act, 1872.⁵ However, the prevention and spread of infectious disease was really dependent upon the early detection and reporting of the problem to the local MOH. Until legislation was enacted, this was unlikely to happen.

Statutory notification was first introduced in England and Wales in the Public Health Act, 1875, in which cholera was made notifiable. Any local authority in Britain could introduce this measure. For instance, compulsory notification for infectious diseases was introduced in Edinburgh in 1880.⁶ The Infectious Diseases Notification Act, 1889, was mandatory in London and permissive elsewhere in England and Wales, and the Infectious Diseases Notification (Extension) Act, 1899, made notification compulsory throughout England and Wales (see Appendix 1). The benefit of these Acts was that the MOH was immediately informed about the presence of certain diseases in his district,⁷ and could take necessary action. Venereal diseases, now termed sexually transmitted diseases (STDs), have never been listed in this legislation, although successive Contagious Diseases Acts, 1864, 1866, 1869, which required the compulsory medical examination of prostitutes in

military towns and naval ports, served this purpose. Lock hospitals (from the medieval *locques*, meaning lepers) were used to detain women forcibly. Fear, mainly of syphilis, created alarm in the community, which, together with outrage at their forcible detention, resulted in controversy; campaigns were launched to revoke the Acts and they were finally repealed in 1886.⁸

During the second half of the nineteenth century, nurses began to be employed in the community to help the sick, such as parish nurses funded by local churches. Following Queen Victoria's Golden Jubilee in 1887, general nurses with extra training, including care of patients with infectious diseases, were appointed Queen's nurses in her honour.⁹ Following Joseph Lister's battle against hospital sepsis and his use of carbolic acid (phenol) to prevent wound infection in the mid-1860s, nurses began to be taught the importance of hygiene in hospital and in the home. Queen's nurses strived hard to bring the new Listerian hospital standards of hygiene to households struggling, often through no fault of their own, against filthy conditions inside and around the home. Queen's probationers in Dublin had five questions on 'Fever' in their examinations in December 1892 and March 1893, which mentioned patients with smallpox, measles and scarletina, and one question that asked 'How would you arrange a sick-room for the treatment of an infectious patient?'¹⁰

Horace Sworder, part-time MOH to the Borough of Luton, had seen the problems that infectious diseases, such as scarlet fever and diphtheria, wrought on families nursing the sick at home, often in unhygienic circumstances; in 1893 he published a simply worded, 82-page guide,¹¹ but it would also have been useful for nurses in the first isolation hospital established in the town that year.¹² The middle classes, who usually lived in more spacious surroundings, were likely to cope better with infectious disease; a doctor in private practice would be called, maids could act as nurses, or if a professional nurse visited, the maid could assist her. Whether the family was poor or 'well-to-do', there was a reluctance to surrender feverish relatives into isolation hospitals when they were established as, initially, most were intended for paupers and had a poor reputation. This could lead to concealment of infectious disease and less chance of recovery, although, even when a patient was admitted to hospital, there was always the risk of contracting another, perhaps, more serious disease.

Demographic change

Various factors determined the prevalence, morbidity and mortality rates of infectious diseases, but the larger the community, the greater the impact of an epidemic and the greater the urgency to separate the infected from the healthy. The census of 1851 showed that, for the first time, more people in England and Wales lived in towns than in rural areas. A survey carried out in 1908 in the British Isles, published in 1909, revealed great disparities in population between the four countries (Table 2.1).