This paper draws on two separate sets of information. The first in which I feel fairly at home, are the historical records of the Royal College of Nursing (RCN) in the UK, whose archives are in Edinburgh. The authors of this paper have also completed a history of the RCN, together with Rona Dougall. I think that most of you will know the RCN, which is the largest organisation of nurses in Britain. It was founded in 1916, before nursing in Britain came under state regulation, and its aim was to ‘promote the interests of nursing in all…of its branches.’ Its first Articles of Association specifically disclaimed any intention of trade unionism; and it maintained this position until 1977, when it unenthusiastically registered as a trade union. It is not affiliated to the Trades Union Congress in the UK, and until recently, has adhered to a no-strike policy. The RCN has always regarded itself as the defender of professional status for nurses. Its founders belonged to the British social elite, as seen in this photograph of the opening of its headquarters in London in 1926.
The prestigious connections of the new College are shown in this platform party, which includes Neville Chamberlain, the Minister of Health, the Archbishop of Canterbury, and Queen Mary, together with other dignitaries.

My second set of information comes from the detailed diaries, and oral reminiscences of a British nurse who spent most of her career working for the World Health Organisation in 6 countries in four separate WHO regions after the Second World War. I have not yet asked permission to use her name, so I shall refer to her as Nurse C. Nurse C’s first posting was to a hospital in rural India, where she arrived full of idealism: ‘[b]ecause I am only too keenly aware of the debt the British owe to India.’¹ She was a junior member of the WHO team at this stage, and her working and living conditions were a considerable culture shock to her. For some weeks her diaries were rather mournful. In the evenings she read Florence Nightingale’s *Notes on Nursing*, and reflected sadly on Nightingale’s instructions on the importance of good ventilation. She was unable to open her own windows for fear of rats. She, her team leader, and their national counterparts, were determined to improve conditions in the nurses’ home, but the main problem was making contact with the medical superintendent of the hospital, who was also Principal of its medical school. There were supposed to be regular meetings between the senior nursing and medical staff to discuss tactics, but the medical superintendent rarely attended. Nurse C.’s diary entry notes ‘for the third time this week I tried to see the Medical Supt. All to no avail’.² Four days later she managed to pin him down, after 7 attempts that usually involved sitting in the corridor for some hours. In her next posting, an Indian city, the Principal of the medical school was rather more organised. All those who wished to see him sat in a long queue, though when it was the turn of Nurse C. and her senior colleague, an Indian nurse, they were pushed aside by the man waiting behind them. The Director admonished him, but Miss C. had the strong impression that her Indian colleague would have lost her place in the queue had she been alone. It was not good form to ignore a British nurse from the WHO. In subsequent postings in Africa and the middle East, where Nurse C. was more senior, she found it easier to gain access to the medical authorities, but difficult to convince them that the professional status of nurses was worthy of respect.

**Professional Status.**

What is the connection between these two accounts: of the opening of a small, but prestigious, nursing organisation in London in 1916, and the experiences of a junior WHO nurse in India many decades later? The link lies in the problematic status of the nursing profession. Our researches into the history of the RCN expose this question repeatedly, and on reading further about the history of nurses, not only in the WHO, but in some of the international health organisations that preceded it, I was much struck by the way in which certain ideas about professionalism and status have been repeated over time, from one context to another. In this paper, I will draw on our experiences of the history of the RCN, and try to compare them with our information about international nursing, in hopes that this audience will be able to tell us whether we are wrong in our assumptions about these difficulties, which seem to be common amongst national and international nursing bodies.

The historical literature on the history of nursing is full of anxiety on the professional status of nurses. In 1977, Dr. Ada Jacox, then associate dean of research in the nursing school of the University of Colorado, wrote

> Nurses’ view of themselves as a profession has not always coincided with other persons’ definitions of what is meant by professional.3

She noted the distinction, long upheld by nurses in many countries, that whereas medicine was the science of **cure**, nursing was the science of **care**. This attitude, she felt, had done nurses no favours. ‘Care’ was a term laden with gender significance, and was, as virtually any textbook in the subject will say, thereby devalued both socially and economically. In addition, in most countries, patients see the person who assists them at the bedside as a ‘nurse’ regardless of education or training, whereas doctors have managed to secure their status by elaborate legal safeguards over entrance to the profession and standards of practice. In Britain, as in many other countries, nursing functions have been carried out by people, mainly women, with very variable levels of training and status. For these reasons, nursing has been described as one of the ‘insecure’ professions, less able to defend itself through its scarcity value than professions such as medicine.4

This anxiety about the professional status of nursing was, and is, shared in many countries. Perhaps for this reason nurses throughout the world have adopted as

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their symbol the woman who seems to represent the highest standards of the nursing profession - the nurse whose work Nurse C. was reading so sadly in India.

If judged by philatelic evidence alone, Florence Nightingale is perhaps the most universally recognised symbol of nursing. Stamps with her image have been printed in many countries, and are certainly not confined to those that once came under British influence. Internationally, colleges, museums, and endowments are named after her. A further internationally recognised symbol is the lamp, which features in many symbols of nursing: it appears in the RCN’s insignia, and in many other countries. The lamp symbolises nursing, and claims for nursing the status of a learned profession; but it is also popularly associated with Florence Nightingale, whose birthday has been adopted as international nurses’ day, and in several countries is celebrated with ceremonies involving lamps.

But, as many historians of nursing have pointed out, Florence Nightingale is an ambiguous symbol. She certainly wished to elevate the status of nursing to a respected profession, and in Britain and in many other countries her example was very successful in attracting women from higher social classes into nursing at a time when few professions were open to women. But Nightingale was also believed to promote nursing as a vocation rather than a profession. Good nurses, it was believed, were born, not made; and they followed their vocation for altruistic or religious reasons. This interpretation probably does little justice to Florence Nightingale, who argued that nurses should be properly paid for the work that they did, but she also opposed state registration for nurses. Her views seemed appropriate in the late nineteenth century, when few women had much formal education, and she believed that many capable nurses would be prevented from joining the profession if they had to pass examinations for state registration. The British nursing profession was split between those who wished to see nursing as an educated profession, and those who saw it as a form of apprenticeship, best learned on the job. Supporters of state registration won the battle when the British government set up a regulating body for nursing qualifications in 1919\(^5\), but the minimal standards for becoming a state registered nurse were kept deliberately low because of the generally low standard of women’s education. Much hospital nursing, mental health nursing and health visiting in the

\(^5\) The General Nursing Council.
community, was still done by men and women with a shorter period of training than the three years required for state registration.

For a long period, membership of the RCN was confined to women who had passed the state nursing examination and were on the general register of nurses. After the Second World War, when the majority of health workers in Britain became employees of the state, the RCN became more inclusive, accepting male nurses, nursing students, and nurses with a shorter training into its membership. It has therefore grown from under 40,000 members in 1939, to around 300,000 today, roughly half of all state registered nurses in the UK.

The development of professional nursing organisations followed a fairly similar pattern in several Western European countries, some former colonial territories, and in north America, though at different speeds. In many cases the campaign for state regulation of nursing was part of a wider campaign for women’s suffrage and for improving the education and social conditions of women. The international nature of this movement was signalled in the foundation of the International Council of Nurses (ICN) in 1899, which was dedicated to improving the professional standards of nursing. It predated the RCN in Britain, and, indeed, had a very touchy relationship with it.6

Although its regular international Congresses became large and impressive demonstrations of nursing solidarity, in the early days the ICN’s leaders, like those of most nursing organisations, were women of means, who could afford the time and expense of international travel and political campaigns. The Council survived the disheartening splits of two world wars, and moved its headquarters from Geneva to London and back again; but the reason I refer to it here is that it was one of the first bodies to encourage the development of nursing beyond the basic training available in the hospitals, and to encourage specialised training. In order to support public health nursing after World War I, it used part of its endowment to take over from the League of Red Cross Societies, financial support for a public health course for an international body of nurses. This international course was offered in London, and taught jointly by the educational staff of the Royal College of Nursing and Bedford College, part of the University of London.

6 Relations between the RCN and ICN are covered in some detail in our forthcoming book The Royal College of Nursing 1916-1990: A Voice for Nurses (Manchester University Press, 2009).
Although this course in its early days was criticised for lack of rigour by the nursing representative of the Rockefeller Foundation, Susan McGann’s research shows that its standards were appropriate to the challenge of teaching nurses with different educational standards, and from several countries; and that its quality steadily improved. Most of the relatively small group of women who took the course in London in the inter-war period did go on to become prominent leaders of the nursing movement in their own countries.

From an early date the International Council of Nurses had a political dimension, pressing for universal systems of state registration for nursing, and also for the establishment of Departments of Nursing in central government. Although the

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ICN was often split by disputes of its own, it nevertheless became the most authoritative voice in international nursing. Accordingly, it was granted an ‘official relationship’ with the WHO in 1948, its leaders served on several WHO nursing committees, and its views were often cited in WHO nursing policy statements. In spite of early disagreements, the general viewpoints of the ICN and the more dynamic members of the RCN council were very similar. This is hardly surprising, since two prominent British nurses took leading parts in both. Florence Udell, who was secretary to the RCN’s organisation in Scotland, served on the RCN council, and then became its president, was the principal nurse in charge of the British section of the United Nations Rehabilitation and Relief Administration (UNRRA) responsible for maintaining and developing nursing services in countries devastated by war, and a leading policy maker on economic and welfare issues in the ICN. Olive Baggallay was a tutor on the RCN’s International Course, the first secretary of the Florence Nightingale International Foundation, UNRRA’s chief nursing officer in Greece, and then the first chief nursing officer at the WHO. These are just the British examples. The distinguished Canadian nurse Lyle Creelman also occupied leading positions in her national nursing organisation, in UNRRA, and in the WHO.9

Definition of a ‘Nurse’ and the Nursing Role
The longstanding pressure for professionalism in nursing, as reflected both in the ICN, and in national organisations like the RCN, had a strong influence in the formative years of the WHO and associated bodies within the United Nations. From its earliest days, the WHO was receiving advice on nursing from a number of bodies, particularly its Expert Nursing Committees. The first, in 1950, had both Olive Baggallay and Florence Udell as members, and made a series of statements, which were to be echoed, in one form or another, over several decades.

‘Nurses are needed in greater numbers than other categories of health workers because they have direct, individualized, and lasting contact with people, sick and well. In this sense, nurses are the final agents of health services’

...‘the stage of development of nursing varies greatly from culture to culture. It is limited by the stage of development of medicine and public

9 Susan Armstrong-Reid and David Murray, Armies of Peace: Canada and the UNRRA Years (Buffalo: University of Toronto Press, 2008), p. 355.
health…however…in countries where medicine is highly developed and nursing is not, the health status of the people does not reflect the advanced stage of medicine.’

‘Medical and public-health authorities contend that the lack of nursing personnel hampers progress of practically all health programmes.’  

Nevertheless, it was not easy to define exactly what a nurse was, or what her, or his, role should be. Internationally, nursing incorporated a very wide variety of workers, from university-trained nurses in the USA and Canada, to ward attendants or village midwives with a minimum of formal training. The high prestige of medicine was not mirrored by any comparable prestige for nursing (in India, for example, doctors actually outnumbered trained nursing staff just after the Second World War). The committee recognised that the state of nursing was crucially dependant on the state of education for women in each country, and that recruitment to nursing was much impeded by the low social status and poor rewards for nursing. Even in western Europe, in countries where nursing registration was in place, it was difficult to estimate the numbers of practising nurses, or to insist on advanced levels of school education as a basic qualification for nurse training. The Expert Committee described six main functions for nurses; significantly, the first was to carry out the therapeutic regime prescribed by the physician, while community duties as part of the health team came further down in the schedule.

All these comments would have been familiar to nursing organisations like the RCN, even in a country like Britain where nurses enjoyed considerable public esteem. There was an alarming shortage of nursing recruits after the war, and it was in the financial interests of government to resist increases in nursing salaries. As the largest group of employees in the National Health Service, any addition to their wages, however minimal, put the whole system under financial strain.

The WHO’s focus began to shift in the light of experience, away from a strictly medical viewpoint and emphasis on efficient hospital management, towards primary care. This shift was the basis of the declaration of Alma-Ata in 1978, which aimed at public health for all by the year 2000. The primary health care team was to be the main agent in achieving this ambition, and in this team, nurses and midwives were to play a major part, since they were, as the Expert Committee had stressed

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nearly quarter of a century previously, in the front line of public health. In the year leading up to the declaration, a number of bodies had met to discuss the position of nursing, which was still felt to be very unsatisfactory in the national context. The International Labour Conference in 1977 devoted much attention to the issue. It stressed the need for fair remuneration for nurses, and came up with the following statements:

National laws or regulations shall specify the requirements for the practice of nursing and limit that practice to persons who meet these requirements.

... Measures shall be taken to promote the participation of nursing personnel in the planning of nursing services and consultation with such personnel on decisions concerning them, in a manner appropriate to national conditions.

By this time, the International Labour Conference, and the WHO’s own committees, were citing the definition of a nurse as laid down by the International Council of Nurses in 1975. The ICN had finally decided to provide a more flexible definition of nursing, appropriate to national needs:

A nurse is a person who has completed a programme of basic nursing education and is qualified and authorized in her/his country to practise nursing. Basic nursing education is a formally recognized programme of study which provides a broad and sound foundation for the practice of nursing and for post-basic education which develops specific competency.

The ICN definition envisaged a ‘first level’ and a ‘second level’ of nursing. In the first level were the fully trained nurses, who were prepared to undertake nursing specialties as well as general nursing; while in the second level were nurses trained for a shorter period, who would work under the direction of the first group. It is worth noting that, although this definition left it wide open for each country to define the amount of nurse training appropriate to its needs, the definition nevertheless broke with the long traditions of the older nursing organisations. Mrs Bedford Fenwick, the founder of the ICN, to the end of her life opposed the use of the term ‘nurse’ for any worker whose training fell short of the full nursing qualifications approved in Britain. The RCN, too, though not as obdurate as Mrs Bedford Fenwick, had been slow to

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recognise the claims of the ‘second level’ nurse for membership of its own body, and was still very distrustful of any ‘dilution’ of the profession. Furthermore, despite their support for public health nursing as the basis of primary care, the older nursing organisations resembled the medical profession in giving the greatest status and respect to professionals in the more prestigious hospitals, particularly those nurses involved in management or in the more technical aspects of modern nursing. The founders of the Royal College of Nursing, and of the International Council of Nurses, had usually been matrons in the most famous teaching hospitals in their countries. In its early days the RCN was quite blunt in its attempts to draw members from women whose fathers and brothers belonged to the ‘officer class’; and although these social distinctions were weakening in the face of social mobility and much greater educational opportunity after World War II, the most prestigious nursing posts were still associated with the teaching hospitals. The RCN almost lost its public health members at one stage because they felt that their interests were not effectively represented, and it had to go to some lengths to conciliate them. Florence Udell and Olive Baggallay were nurses who had distinguished careers in public health administration, but public health nurses, whose numbers were relatively small, and who did not work in large groups, were less easy to organise than hospital nurses.

Nursing education
The question of appropriate education and training for nurses is also a theme common to both the national and the international nursing organisations, and was central to their conception of professional status. From the RCN’s earliest years, there was much division over the appropriate location for nursing education. Should training take place in the hospital wards, or in the classroom, or, if divided between the two, what proportion of time should be spent in each? In Britain, as elsewhere, nursing students were an indispensable cheap labour force for the hospitals, and both health authorities and senior hospital nurses colluded in maintaining this arrangement. Even the most professionally minded matrons were unwilling to release students from ward work, or to allow the students’ educational needs to determine the kind of work they did. The medical profession, also, tended to have strong views about the proper place of a nurse. Here is a Lancet editorial from 1946:

For most patients most of the time, nursing does not mean the more technical feats of the sister- the skilled dressing, the saline-drip, or even the regular careful dosage with medicines. It means having his bed properly made, having
his pillows well placed, hearing simple reassuring words at the right moment, getting a hot-water bottle as soon as he wants it, being prepared deftly for operation, being amused and stimulated at one moment, soothed and settled at another. The ‘born nurse’- the girl who does these things well- is extremely common, just as the maternal instinct is extremely common; and she may not necessarily be good at her books, though she often is.13

It was around this time that our WHO nurse, Nurse C. joined the profession. Following WHO nursing policy, her main task was to set up nurse training courses, and to teach those who would in turn train the next generation of professional nurses in their own country. Like all WHO activities, her work was based on operational plans (PLANOPS) agreed between the WHO and the government health authorities of the host country, but, as her diaries show, she encountered much opposition from the medical staff. In many cases, they had not been party to the operational plan, which had been agreed over their heads; and even if they knew about it, they often disagreed with it profoundly. Nursing, they argued, should be learned in the wards, not in the classroom, and particularly, not in a university. Hospital matrons, as in Britain often shared this view. Nurse C.’s African experiences were particularly fraught, since nurse training was being incorporated into the medical faculty of the local university. This was unusual, for in most countries where nurse training had been incorporated into university education, medical faculties often refused to accept the nurses, and they were placed in Social Science or Arts faculties. Almost as soon as she arrived, Nurse C. was subjected to lectures on the subject.

‘[The Dean of Medicine]…said quite clearly that he did not see the need for degrees for nurses. Miss N [the matron of the teaching hospital] spent one hour telling me the same thing [that]… our grads. will only want to sit at desks and push pens- unwilling to go to villages- Miss N [says that] already she must “kick her sisters off their bottoms” “her new grads when asked what they want to do say to take the degree programme”’.14

Judging by the comments of Nurse C. and her WHO colleagues, the WHO nurses came from backgrounds where their national nursing organisations had been carefully patrolling the boundaries between the nursing and medical professions. Although eventually successful in her tasks, she found it difficult to negotiate with doctors who

13 Lancet, 1 June 1946, p. 819.
were even more inclined to relegate nurses to an inferior role than those she had trained under. The problem was brought home to her most sharply in India, during a flood emergency, when packets of medical aid had to be prepared for airlifts in great haste. The nurses worked around the clock, while the medical students ‘stood by.’ Part of the nurses’ training in public health took place in a remote community health centre. They worked without medical supervision, because the medical students resisted training in such conditions, and refused to leave the hospital. Although these examples are extreme ones, opposition to ‘over education’ for nurses has gone deep into many national debates on nurse training, and can be guaranteed to start arguments in almost any medical setting.

Nurses and policy

In this paper, I have tried to argue that long-standing anxieties about the professional status of nurses, closely associated to more general problems of the status of women and their education, can be seen both in national nursing organisations such as the RCN, and in the international nursing context. I shall end this comparison of national and international nursing concerns by commenting briefly on the demand made by the International Labour Conference, which closely echoed the ICN’s resolution of 1933, that nurses be consulted in the making of health policy. British nurses did not have a place in the Ministry of Health until 1941, when the government found it useful to include them in wartime planning. It is usually argued that the government’s nursing division had little influence on public policy, and there was a long struggle by the RCN to establish a nursing foothold in policy making at the regional and local level.15 The new National Health Service, which included the medical profession in its policy making, gave the most minimal representation to nurses, and even this was largely lost when Mrs Thatcher’s government introduced professional lay managers into the system in the 1980s. It would be interesting to trace the role of nurses in policy making in other countries. As previously noted, several bodies in the 1970s asked for a role for nurses in national policy making. This supportive attitude was of little use to Nurse C. whose senior position in one of the WHO regions had been terminated a few years earlier as a result of financial cutbacks in the WHO, though she managed to re-establish herself in Europe. When economies were necessary, nursing was not a

15 An alternative view is taken by Elizabeth J. C. Scott, ‘The influence of the staff of the Ministry of Health on policies for nursing 1919-1968 ‘, PhD thesis, University of London School of Economics (1994), but there is little evidence that nurses had much influence at the regional dimension of health service policy.
high priority. I am told that even now, nursing representation in the WHO is somewhat restricted, but I am not brave enough to enter this area. Rather, I would be extremely interested in the comments of an expert audience on this divisive subject.