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The Development of Trade Union Activity Among  
Nurses in Britain 1910 - 76

TWO VOLUMES : VOLUME ONE

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August 1985





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## SUMMARY

This thesis examines the uneven development of trade union activity among hospital nurses in Britain between 1910-1976, within a 'situated' materialistic perspective on union growth. It is argued that both professionalism and unionism developed as a result of the decay of traditional nursing ideology in its home base of the voluntary hospital, and the failure of its proponents to win total hegemony in areas where nursing reform spread, notably the asylums, workhouse infirmaries and private nursing. In explaining these developments due emphasis is given to both material changes in the labour process and the influence of 'subjective' predispositions that are the result of prior and continuing orientations, and of the extent to which wider economic and political conditions are favourable. Thus, the expansion of the medical division of labour in the 'acute-oriented' voluntary hospitals, involving the delegation of more tasks to subordinates, encouraged the development of professionalism; while in private nursing the attempt to realise the value of nursing as a commodity was the key material influence. However, in both instances the social background of recruits was also influential in determining that 'professional strategies of occupational closure would be the favoured 'solutions' to problems caused by material changes. The partial success of professionalism in achieving the 1919 Nurses Registration Act was influenced by the temporarily favourable political and economic situation.

Trade unionism arose out of the contradictions with traditional nursing ideology and the failure of professionalism to solve them fully. These contradictions were most intense in those sectors where work was of lower status, like the asylums and workhouse infirmaries, and where the social background of recruits would also incline them to be more inclined towards trade unionism. Changes in the tempo of popular struggle are also shown to have had an important influence on the development of trade unionism. Successive chapters follow the unfolding of these contradictions, ideological responses and wider influences through to the 1970's, where it is argued that, despite continuing differences, there has been some convergence between the apparently competing strategies of professionalism and unionism. The relative importance of the purported 'proletarianisation' of the nursing labour force, is also assessed.

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## INTRODUCTION

This thesis is both an historical narrative and a theoretical examination of the uneven processes of unionisation among hospital nurses in England and Wales from 1910 to 1976, within a 'situated' materialist account of their course. The purpose of this introduction is to examine the methodological issues behind this set of objectives, as the meaning of such words as 'uneven' and 'unionisation' is not as self-evident as might at first appear, while the concept of 'situated' is also difficult to articulate. The choice of period also requires some initial justification, as does the decision to spend so much time and effort on the investigation of trade unionism among hospital nurses in the first place.

The last two are the easiest to explain. I first embarked upon my programme of research in 1974 as a dissertation for my MA in Industrial Relations at the University of Warwick. The research for this was conducted at the height of an unprecedented campaign of pay militancy among nurses which was associated, in succeeding years, with the largest-ever surge in trade union membership among them. I was particularly interested in following through the campaign, and its aftermath, at local level, and I continued this research for a doctoral thesis through to 1976, when I withdrew from full-time fieldwork to begin, on a part-time basis, the process

of analysing and writing up the results. Hence this date marks the formal end to my period of review. I had a personal interest in nurses as an ex-nurse myself. I had trained and qualified as a general hospital nurse during the latter half of the 1960s. I also considered nurses to be a significant group of workers who had been little studied by students of industrial relations in comparison, for example, with printers, coal miners, car workers and other members of the archetypically male industrial working class. I also felt that nurses were a theoretically interesting and problematic group of workers in terms of their class position: a predominantly female, public sector group of 'intermediate' service workers. Despite their exclusion from texts on industrial relations and industrial sociology (except perhaps as a minor part of a chapter on 'professions', where they had been overshadowed by an almost obsessive focus on doctors) nurses, and similarly placed workers such as teachers and social workers, were taking an increasingly prominent position in the organised labour movement. The shift to a greater historical focus was also dictated by the need to place the militancy of 1974-6 in its evolving context. I discovered that hospital nurses had much longer established traditions of collective organisation than was often realised, and I increasingly sought, after 1976, to remedy their neglect by labour historians.

The year 1910 was selected as a starting point because that year witnessed the first successful attempts to establish permanent trade union organisation among nurses (in Lancashire asylums).



However I have not stuck rigidly to my chosen period. I have tried to place the development of trade unionism within a broad understanding of the development of hospital nursing since the mid 19th Century. In a postscript to Chapter 11 I have also sought to sketch out developments in trade unionism among hospital nurses since 1976.

It also seems important to point out that the thesis is in the main confined to an investigation of hospital nurses. Other groups - such as midwives, health visitors, community nurses - receive cursory attention in this study, but at least I have not made the common assumption that hospital general nurses are 'nursekind', which is implicit in much of Abel-Smith's 'History of the Nursing Profession' (1). These other groups require study in their own right. I have selected hospital nurses partly because I am more familiar with them and the hospital has increasingly become the locale where the majority of nurses work even though this may change in the future. There is also more to say about their collective trade union activities - though this is not to imply that other groups, such as community nurses, have insignificant traditions of collective organisation. For similar reasons, the historical section of the thesis gives more weight to the collective activities of psychiatric nurses than general hospital nurses. If general nurses have been neglected by students of the profession, psychiatric nurses have been virtually ignored. For example Abel-Smith's account gives the basic details of the development of

general hospital nursing and the fate of attempts to unionise them in a fairly systematic way (2), but before I undertook this research, there was only one significant article on attempts to unionise psychiatric nurses (3), and just one article on the history of psychiatric nursing in Britain (4). Historians of psychiatry and psychiatric institutions had tended to ignore the group of staff on whom the success or failure of institutions often rested, concentrating attention solely upon doctors (5). The only real prominence given to them was by sociologists in the 1950s, particularly in the USA, who were interested in the underlife of institutions, such as Goffman (6), and Scheff (7). And it is also worth observing that mental handicap nurses have been almost invisible members of the psychiatric nurse community, reflecting their even lower status ranking. I have therefore tried to give some prominence to their separate history and traditions of collective organisations.

Delineating the different segments with the hospital nursing force is also necessary from a methodological point of view, not just from the need to redress a research injustice. The 'unevenness' of trade union organisation among nurses is closely linked to emerging lateral divisions in the labour force, with psychiatric (both mental illness and mental handicap) nurses having markedly higher trade union affiliations for most of the period under review. Vertical cleavages are also an important dimension of unevenness, as are the external 'latent identities' which nurses bring to the

job and the effect these have upon their prior and continuing 'orientations' to work and work attachments - class, gender and ethnicity being the most significant of these. Above all, there is a need to examine the dialectic between internal structures and 'latent identities' and the way these are both mediated through the impact, over time, of wider social and economic forces. This seems crucial to explaining why unionisation is characterised by sudden shifts at particular historical moments, followed by longer more stable periods of little change.

The most difficult issue left unresolved by the thesis is how to conceptualise class, gender and ethnicity in ways that make for an integrated analysis of the processes under investigation. The notions of class, gender and ethnicity used tend to be largely descriptive and empiricist, not ones that could easily integrate conceptually an exploration of the dialectic between social background, the organisation of the labour process, and wider social and economic forces. I touch on some of these issues at times - for example, in Chapter 12 I spell out some of the difficulties involved in using a Marxist concept of proletarianisation - as outlined by Bellaby and Oribabor (8) - to account for the recent growth in trade unionism among hospital nurses. However I would not claim to have solved these complexities, let alone to have found ways of adequately connecting class analysis with analysis of gender and ethnicity.

In hindsight I would regard as my basic problem that while I rejected an empiricist, 'fact gathering' approach in principle, I did not fully transcend it in practice. Though not absolving myself of responsibility, it seems valid to place this in the wider context of research into industrial relations at Warwick during the mid 1970s. The dominant, so-called 'Oxford School' emphasised fact gathering both from a practical concern with reform and administration, and also out of a disdain for the abstract theories of economists, and their assumptions concerning 'rational' human behaviour. Better just to 'go out into the field' and see what was really happening; and given the empiricist approach which regarded reality as something easily yielded to the senses, method was not seen as a particularly problematic issue.

Marxists attacked these assumptions of empiricism - fact gathering served particular political purposes and there could be no such thing as a neutral observer, for the class position of the observer mediated their perceptions. On the whole this did not lead to the articulation of an alternative method of field research, (though in particular the work of Beynon and Nichols, and those associated with them, must be counted as an exception (9)). Instead the tendency was to disdain empirical research as 'tainted', or as a deviation from more urgent tasks. The first led to Althusser's extreme retreat into 'theoretical practice', and the examination of sacred Marxist texts as a guide to action (almost reminiscent of the mediaeval scholars' retreat into Aristotle, against which the

empiricists' attempt to 'hold a mirror up to nature' was a reaction). The second came from other Marxists who attacked this but often from the point of view that the needs of political practice should be uppermost and that methodological sophistication was a luxury that could not be afforded. In practice this meant relying on existing research, whatever misgivings one may have had of it. As Martin Shaw put it,

The technology of research must be as rich as the materials which are available. The researcher will have little time, even if ideally he feels the need, to collect further 'raw' evidence of social conditions. Even a 'descriptive' social survey may well be a diversion. (10)

Both responses were conditioned by a sense of superiority that Marxist thought and method already provided a sufficient alternative, and the only point was to change things. A feeling, in other words, of already being 'in the know'. Sociology was in crisis, as it could not integrate analysis of the economic and the social, and Marxism was superior. Today that confidence has for the most part evaporated. Shaw now talks of a 'crisis in Marxism' every bit as deep as the crisis in sociology, and regrets the neglect of the social and its relegation to the sidelines, that his earlier stance involved (11).

Whilst not all Marxists rejected sociology as such (12), it was undoubtedly a common response. This gave rise to considerable

contradictions for this Marxist who was undertaking field research, and who inevitably fell back upon the dominant Warwick empiricism in gathering his material, only to find that this did not easily lend itself to be written up within a Marxist perspective! I found some help in the methods of enquiry established by British social history following Thompson (13), and its emphasis upon 'process' as well as 'structure', and of the validity of personal experience as historical evidence. I have belatedly discovered Giddens' call for a sociology which deals with both 'the production and reproduction of society' which must incorporate a treatment of action as rationalised conduct ordered reflexively by human agents, and must grasp the significance of language as the practical medium whereby this is made possible. (14). This approximates the 'alternative situated perspective' which I seek to outline in Chapter 2 and which I must emphasise was constructed largely after the field-work, as part of my process of reflecting upon the problems I had encountered by adopting an empiricist approach in practice. However Giddens himself explains that his discourse in method is 'primarily an exercise in logical issues' and 'is not a guide to "how to do practical research"' (15).

It seems unfortunate, even perhaps untenable, to divorce questions of method from practical research strategy, and it is significant perhaps that this is an issue which has been directly addressed by feminist sociologists in their attempt to construct a

'feminist methodology' (16). In place of the often crude rejection of social research by some Marxists, is a more sensitive, ('reflexive') awareness of both the possibilities and contradictions involved in undertaking social research as a social practice (17). 'Feminist research' has in fact often distanced itself from some of the assumptions often made by Marxists concerning what Stanley and Wise call the split between structures and everyday life.

Structures are somewhere above and beyond the everyday, and structures ... are where it's at. Structures are where the revolution will happen and so there is no point in changing ... your relationship with your husband, or your children, or your anything else.

(18)

Feminist research has typically treated the area of 'everyday life' and personal experience as significant, and worthy of research, whereas Marxism has often tended to regard it as peripheral or secondary and hence has often ignored it.

Feminist research has, above all, of course, asserted the importance of the gender order as an issue at least as significant as class. Although I certainly touch on gender issues throughout the thesis I would say in hindsight that they are not adequately theorised and given the prominence they deserve in a thesis upon what is one of the most predominantly female occupations of all. I am aware that the thesis tends to adopt by default an implicit position that class is a more important issue than either gender or

ethnicity. This of course has political implications in that a class perspective makes it easier for me to legitimise my position as a former nurse with a continuing research interest in nurses. This becomes much more problematic if a more explicitly feminist analysis were adopted, for the thesis could then be regarded as parasitic 'research on women' undertaken by a man. This is underlined by the fact that my own findings (particularly in Chapters 10 and 12) suggest that men have come increasingly to oppress women within nursing as managers and also as union officials. If I had stayed in nursing I might well have followed one path or the other, but instead I have made a good career for myself as a male researcher into nursing! I do not pretend to have resolved these contradictions. I raise them simply to make clear that I am aware that men - a white man at that - cannot deal with the problem of sexism simply by annexing feminist research methods as the answer to their methodological problems. They (we) must think through the full political implications of adopting them. In any case, as Morgan has emphasised, there is nothing inherently non-sexist in the rejection of positivistic for more qualitative research techniques.

Qualitative ethnography after all has its own branch of machismo with its image of the male sociologist bringing back news from the fringes of society, the lower depths, the mean streets, areas traditionally off-limits to female investigators. (10)

This obviously has a bearing on my attempts in this thesis to



develop a 'situated' perspective on my subject matter, one which as I outline in Chapter 1, is 'aware both of structural constraints upon human agency and of the possibilities that are created by its intervention', rejecting the voluntarism of attitude surveys and the determinism of those who emphasise 'structural' causes of unionisation. In a more narrow sense 'situated' refers simply to the need for an empirical examination of these processes as they are mediated through the social relationships at particular workplaces. But as this could, as I increasingly became aware, drift from an empirical into an empiricist approach, I sought - after the field research was conducted - to expand my conception of a 'situated perspective' to include the meanings that nurses themselves attach to their work, and the extent to which union membership and collective action is congruent with particular ideologies of nursing. 'Situated' in this sense is more akin to C.Wright Mills' conception of 'situated actions' and 'vocabularies of motive'. This emphasises analysis of the language used by people to justify their past conduct, and 'indicate' their future actions. Mills was interested in language and meanings as indicators of motives, which are not random as they 'vary in content and character with historical epochs and societal structures', and are not necessarily 'freely' chosen but subject to collective constraints, as

'acts often will be abandoned if no reason can be found that others will accept'. (20).

In the context of nursing this meant situating the account within the 'vocabularies of motive', implied by three 'core' ideologies of nursing: 'vocational', 'professional', and 'proletarian'. These are outlined in Chapter 4 in some detail, although admittedly not in sufficiently sharp focus. However this is the subject of continuing research, (21), and this thesis could be regarded as a stage reached in a long-term programme of work.

The notion of a 'situated' approach was therefore an ideal constructed after the research was conducted - a product of it more than its method of investigation, at least in the second more expanded sense which I have outlined. However, my very brief discussion of feminist research methodology indicates that there is a third way in which the notion needs to be expanded. I need, in other words, to situate myself as a male, white, left-wing academic who began his research in the mid 1970s convinced that unions were inherently superior to professional associations as a means to the self-emancipation of nurses. At least my empiricism has uncovered a more muddled picture: professional associations have adopted an increasingly collective approach focussed on the problems which ward level nurses face as workers, while trade unions themselves often help, as I show in Chapter 12, to reproduce existing divisions of rank, gender and ethnicity. The meaning of 'unionisation' itself in such a context becomes problematic, and hence in Chapter 13 I point to the 'convergence' that has taken

place between unions and professional associations. If the positive side of my practical empiricism was that I did not just confirm my male-left prejudices, there was, however, a negative side. In practice I did tend to assume too often that nurses were just another group of workers, and failed sufficiently to theorise nursing as 'women's work' and its link with other kinds of work, particularly household labour, and the continuing relation between the two in the lives of the majority of women nurses. This is the central limitation of the thesis. At the very least, then, it serves as an illustration of the heightened contradictions of seeking to apply a one-sided materialist analysis to this sector of employment. Hopefully, despite this, the reader will also find that it sheds sufficient light on its subject matter to be of greater use than simply an exercise in the problems of method.

PART ONE

THEORETICAL ISSUES IN INDUSTRIAL RELATIONS

## Chapter One - A Critique of Voluntaristic and Deterministic Approaches

One result of the dominant empiricist approach to industrial relations is its growing separation into sub-specialities, with analysts tending to specialise in one area rather than another, whether it be union growth, government, or wage bargaining processes. It could be argued, however, that this holds inherent dangers: In industrial relations as in medicine, too narrow a focus upon one particular anatomical aspect may lead to the whole patient becoming lost to view. This chapter is therefore a critique of available theories of union growth, in two senses. First, that they are inadequate in themselves, but second that they fail to show us how processes of union growth are linked to wider processes in workplaces. Though the focus of social science analysis must inevitably be upon one particular area, some kind of holistic conception is still necessary in order to understand 'what makes Sammy run'. The next two sections of this chapter therefore discuss more general problems of analysing the source of workers' collective activity, as a necessary preliminary to a specific critique of theories of union growth.

### (1) Constraints and Possibilities

One of the most enduring questions in social science is the extent to which Sammy runs according to his own inclinations, or whether his speed and direction are governed more by forces external to him -- about which he may (but more likely may not) be aware. It would be foolish to pretend that this fundamental problem can be resolved here, but it does touch on central issues in the substantive sections of the thesis. Some discussion of it is therefore required,

however schematic it may appear.

The balance between what is materially or socially determined, and the room remaining for conscious human action, is a methodological problem not peculiar to a single political perspective. A deterministic Marxist approach, which views history as rolling inexorably from one mode of production to another according to preordained 'laws of motion', leaves little room for voluntaristic human action. Similarly, the dominant systems approach to industrial relations, in stressing the 'institutional', purely formal aspects of industrial relations leads, according to Hyman's Marxist critique, to 'reification', the error of

... treating abstract collective entities, which are the creation of human activity, as the active agencies in social relations and in consequence, devaluing the part played by human actors'

(1)

A prime example of extreme determinism within the non-Marxist mainstream of industrial relations analysis is the work of Leonard Sayles. Sayles argued that values and behaviour were largely determined by factors extraneous to the individual, in particular by the social and technological organisation of the workplace. He sought to explain variations in workers' grievance activity and what can only be called their 'collective personality' as work groups as the product of management decisions about the organisation and layout of work tasks. Different forms of technological arrangements led to very different patterns of grievance activity.<sup>(2)</sup>

The extreme determinism of writers such as Sayles was questioned by those advocating a more 'humanistic' sociology. From the 1950s sociologists working with the 'action frame of reference' challenged the managerial orientation

of orthodox industrial relations. As one of their number, John Goldthorpe, subsequently argued, industrial relations 'reformism' as an applied social science tended to start from its own perception of 'problems' requiring resolution, rather than those of the workers themselves.<sup>(3)</sup> In assuming a consensus upon such problems as strikes, 'restrictive practices', and earnings drift, it was implicitly siding with management.

Those working within an action frame of reference consciously sought to avoid such dangers by taking seriously the 'definition of the situation' held by actors themselves. The emphasis upon motivated behaviour strongly influenced Alvin Gouldner's approach to strike behaviour. In Wildcat Strike he insisted that a strike was more than merely a cessation of work, but also an act of defiance, 'a refusal to obey' and, he claimed, a focused form of aggression by workers against management.<sup>(4)</sup> The approach departed significantly from the accepted systems model of organisational behaviour. He did not assume the existence of an over-arching organisational purpose, which the 'wildcat' strike threatened. Neither is an 'adaptive' model of change advocated. Structures changed as a result of the clash of expectations between the main collectivities in the plant, but the resolution of this conflict - a more bureaucratised structure is not explained by reference to an equilibrium model. Instead he refers back to the expectations of the actors in the situation, and the objectives they were trying to realise.

The action approach reached its peak of popularity in the mid-1960s, as a result of telling criticisms of the structural-functional tradition in sociology. Its focus upon voluntaristic

action and the possibilities inherent in social situations fitted in with the mood of the times: the birth of the 'new left' and the growth during the 1960s of radical activism. It was responsible for a wide number and variety of interactional studies which cast new light on the micro-politics of institutional life. Some of these were, inevitably, studies of workplace behaviour.<sup>(5)</sup> Yet though it provided valuable insights, the approach suffered from some serious defects. It was one thing to emphasize the creative volitional aspects of collective behaviour as a counterweight to the over-deterministic views associated with structural functionalism.

But in its extreme forms, it could lend credence to the view that the social world was solely constructed according to the designs of the actors participating in it. By emphasizing choices it could underplay the role of constraints.

In some instances the emphasis upon cultural values led to an almost complete neglect of material relationships at the place of work. Nowhere was this more apparent than in Goldthorpe and Lockwood's study of 'affluent' Luton workers. Seeking to combat the technological determinism of Sayles and others, they argued that workers' key values or 'orientations' were determined prior to their becoming 'affluent workers'.<sup>(6)</sup> Their pronouncements have generated a voluminous discussion in industrial sociology. Without going deeply into the entrails of these debates, one or two points seem worth making.

Perhaps the failure of 1960s radicalism to induce fundamental changes in western capitalist societies led, as its influence waned, to a reappraisal of the influence of 'structural constraints'. And perhaps also the declining impetus of revolt by 'marginal' groups like students and ethnic minorities led to a renewed emphasis in



the 1970s upon the working class as agents of social change - with considerable disagreement as to whether the declining, 'traditional' sectors, or the expanding 'new working class' represented the best hopes for radical change. Undoubtedly this new emphasis upon structure and the working class as potential agents of change, led to a renewed emphasis upon classic Marxism and the analysis of workplace relationships. In particular, this led to a 'rediscovery' of Marx's writings on the labour process in Capital Volume I, particular as given currency and updated by the work of Braverman.<sup>(11)</sup>

It could not be claimed that Braverman's work was a conscious refutation of the voluntaristic approach of writers like Goldthorpe, but its mode of analysis stood in stark contrast to it. Instead of the emphasis upon prior orientations, the primacy of workplace relationships was stressed, with the creation of surplus value seen as the prime dynamic force leading to the constant reorganisation of the division of labour. It is interesting to note that many of those following Braverman have looked at the 'radical' potential of 'deskilling' generating trade union and even socialist consciousness among traditionally quiescent and collaborative sections of the working class.<sup>(7)</sup> Braverman's own work was, however, suffused with a profound pessimism. The 'degradation of work' which he (perhaps correctly) diagnosed was more likely to lead to demoralisation than revolt.

There is already an extensive commentary upon Braverman's work and the issues raised by it.<sup>(8)</sup> I would here only want to draw a few rough and ready conclusions in order to guide the approach taken in subsequent chapters. First, the emphasis placed by Braverman upon workplace relationships and the dynamic processes underlying them seems

to me to be the correct starting point, and any account which ignores them is almost bound to be severely deficient. However, whilst labour process analysis is a robust and indispensable approach it is prone to a number of dangers, two of which I would emphasize. One, it can lead at times to a technological determinism, in some ways reminiscent of the work of Sayles, in ascribing to management an all-powerful influence, and underestimating the ability of workers to frustrate their intentions. Second, and once again reminiscent of the work of Sayles, the emphasis upon the labour process can lead to an exclusion of all external, communal influences upon work behaviour. In both instances, it seems to me the basic error is in confounding an abstract conception of capitalist social relations with the real thing. In practice capitalism is not simply an economic system in which the law of value grinds the division of labour in the workplace into the most appropriate shape. It is profoundly affected by the struggles of workers, whom Marx recognized to be the active, creative 'elements' in the labour process. Nor is capitalism simply a system of social relations at the point of commodity production - it is a total society. So as well as the notion of structure, which emphasizes constraints, we need also to identify processes, which show how things got to be as they are, without assuming that particular outcomes are predestined - and we need also to link processes in the workplace with those in the wider society.

The problem of how to combine in our explanations both an awareness of the narrowing effects of material constraints on values and behaviour, with a sensitive appreciation of the widening of possibilities that can come through the role of conscious human agency; of giving due emphasis to relationships at the point of commodity production, while seeing that class and other social

divisions extend into many spheres - both these issues have been confronted most successfully in recent years within social history. The work of Edward Thompson in particular, showed the way. For Thompson, class is not a 'thing' but a 'relationship', even an 'event':

I do not see class as a "structure" nor even as a "category", but as something which in fact happens (and can be shown to have happened) in human relationships ... And class happens in human relationships when some men, as a result of common experiences (inherited or shared), feel and articulate the identity of their interests as between themselves, and as against other men whose interests are different from (and usually opposed to) theirs.

(9)

The structure of The Making of the English Working Class, shows how Thompson regarded class in multi-dimensional ways, rooted in relations at the point of commodity production, but ranging far beyond, to religion, politics, family life (the last admittedly to a far too limited extent). An emphasis on the narrative of history does not imply a recourse to empiricism, for process is still linked to theoretical constructs without which what is written would have little meaning. But these are deployed in a self conscious way, in the full realisation that:

If we stop history at a given point, then there are no classes but simply a multitude of individuals with a multitude of experiences. But if we watch these men over an adequate period of social change, we observe patterns in their relationships, their ideas and their institutions. Class is defined by men as they live their history, and, in the end, this is its only definition.

(10)

## (2) The Role of Prior and Continuing Orientations

This thesis watches men - and also women - over what is hopefully an 'adequate period of social change' in order to explain how their common experiences led them to 'feel and articulate the identity of their interests', by recourse to collective action. Behind processes of 'union growth' lie always the aspirations of real men and women trying to make sense of their lives. Only by understanding the foundations of unionisation in these common experiences can collective action be understood. Common experiences at the place at work must be the starting point, but in many cases recruits also share prior common experiences which will play a significant role. In nursing the socialisation of women might lead to particular kinds of orientations being adopted prior to entry, that would not necessarily be true of men. But gender is only one element to be taken into consideration. The orientations engendered by different class backgrounds among women may also play a part, as may any previous work experience prior to entry to nursing.

However the notion of 'prior' orientation is a rather limited one, because workplace and communal influences continue to interact after entry to an occupation. This is a point that has been emphasized by Beynon and Blackburn:

The way in which work is experienced depends neither on work factors nor on orientation alone but on the interaction of the two. Furthermore, an orientation to work should not be thought of as arising outside and brought into the work situation but as something which derives from the individual's total experience. In moving outside the factory gate we should beware of creating a false dichotomy between work and non-

work life. The rejection of the adequacy of explanations based on technological determinacy and systems needs should not lead us to adopt one which replaces an analysis of the work situation with one based on prior orientations.

(11)

We must also avoid the danger of making an unhelpful dichotomy which views prior or continuing orientations as the voluntaristic element in the narrative, and experience on the job as deterministic. This is precisely the assumption that Goldthorpe and Lockwood seem to have made in the affluent worker studies - the voluntaristic adoption of particular sets of 'prior orientations' being seen as the chief explanation of industrial behaviour. What was missing was a sensitive awareness of the material factors which constrain and influence the formation of orientations, generating certain expectations rather than others. For example, are the prior orientations that women have tended to have towards nursing merely the result of free choices or have they been socially constructed?

The aim therefore is:

(1) to analyse the interplay of constraints and possibilities in both the formation of prior orientations, and in the articulation of collective strategies in the workplace;

(2) to analyse the continuing interplay of orientations and workplace experience in the formation of occupational ideologies, and the ways in which these then work through to the articulation of collective strategies for change. This is represented diagrammatically in Figure 1. Within the sequence [Prior Orientations

→ Work Experience → Work Ideologies → Collective Strategies for Change] there will be a discoverable dynamic process which will

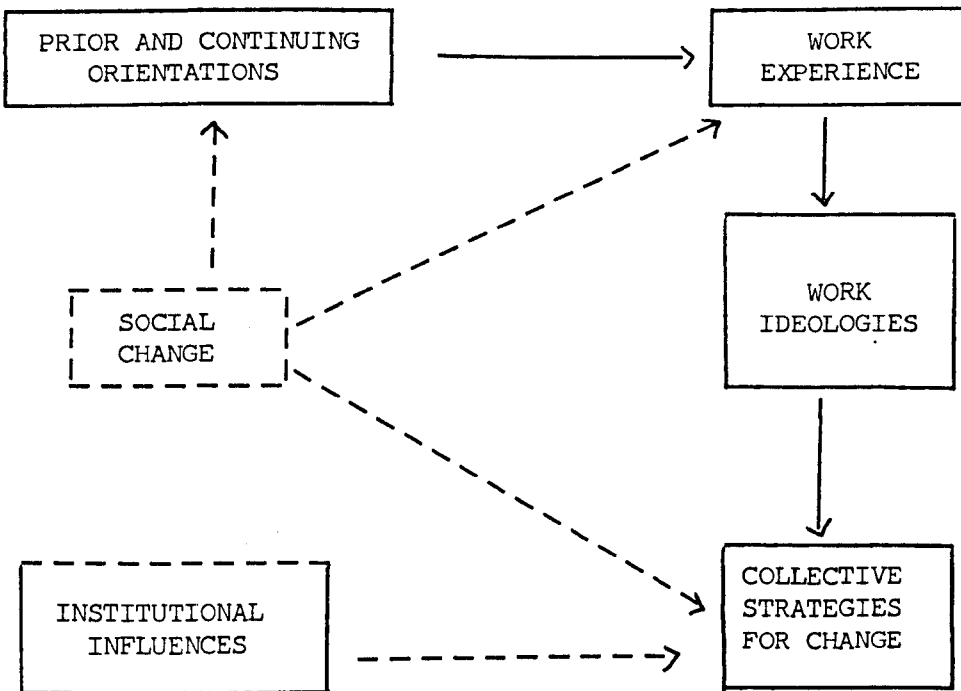


Figure 1 Basic Influences on the Development of Collective Strategies

lead in one direction rather than another. Goldthorpe and Lockwood, for example, discovered a considerable congruence between all the elements in the sequence. However, this is only one possibility. Commentators on nursing have frequently spoken of the 'reality shock' experienced by recruits, as their prior orientations come into profound conflict with the realities of work experience. For example Bevington's classic study in 1943, described the probationer nurse's 'primary difficulty' in adjusting to ward work to be

... losing the illusions cherished before entering hospital. Chief among these, perhaps, was the belief that she would be given "real nursing" to do (i.e. being in close contact with individual patients) from the start. Instead of this, for a year or more ... her work will largely consist in serving meals, washing up 'special' crockery, making beds, carrying out

"sanitary round", dusting or cleaning bedside furniture or baths, and giving minor, if any, attention to convalescent patients.

(12)

How the process of being stripped of illusions works through, or not, to the articulation of collective strategies for change, will vary partly according to individual personal choices. One person may leave nursing disillusioned, while another stays to try to change things. Expectations may continue to be 'cherished' against the odds or abandoned. There may be a desire to transform reality to conform to the cherished ideal, or else cynicism may set in. Nor should too many assumptions be made that recruits' prior orientations are always **congruent** with cherished ideals. Indeed I shall argue that nursing has always attracted significant numbers of men and women whose attachment, if any, to 'illusions' was marginal, and that these formed the spine of those who became committed trades unionists. Those who needed to be stripped of illusions joined later, if at all.

Therefore variations in patterns of unionisation were partly dependent on the prior class and gender experiences of nurses, which led to differential types of orientations. Contrary to the Goldthorpe and Lockwood study, therefore, orientations and work experience can clash. The extent to which this is the case will, however, also be subject to variation:

(1) Between different types of nursing work; (2) In the same field of nursing work over time. The first is important horizontally and vertically. Horizontally acute general nursing may be the basis for greater illusions than care of the chronically ill, if the image of what it entails is more romanticized. Vertical variations are important, especially in relation to

career paths, for example, how far the unpleasant experiences are likely to be temporary or permanent features of an individual nurses' job situation. The second is important because the nature of nursing work changes over time and prior orientations may be based on past realities rather than present ones. In which case the contradictions between cherished ideals and work realities may be that much greater. On the other hand, it is also possible that orientations have changed more than the work situation. For example, the orientations of women to work and to life have undergone a revolution since the end of the 19th Century. Former expectations, of self-denial and limited career prospects have changed dramatically. Perhaps changes in the institutions of nursing have occurred at a much slower rate. Rather than speculate at this point, we can conclude that there is a complex dialectic between changing orientations and changes in the labour process in nursing. One needs a sensitive understanding of both the changes themselves and how they interact together in the creation of ideologies of nursing work.

Yet though the influences upon work ideologies are crucial to the understanding workers' collective action they do not provide a complete explanation. As already noted a deviant work ideology may lead simply to demoralisation or a decision to leave nursing. Other factors affect the situation, such as, for example, the general employment situation, inflation, the degree of aggressiveness by other sections of the working class. Therefore in the diagram these are represented as wider forces of 'social change'. However even this is not sufficient, for as will hopefully become apparent, the intensity and focus of collective action cannot simply be read off from the ideological disposition of



workers, even taking account of wider environmental factors. There are other 'institutional influences' which are the consequences of the practical imperatives of organising collective action. The remainder of this chapter therefore, explores the possibility of constructing a model of union growth which while giving due weight to the role of prior and continuing orientations and work experience, is nevertheless sensitive also to the importance of 'institutional influences' which may have a degree of **autonomy** from them both.

### (3) Attitudinal versus Structural Approaches to Union Growth

Different interpretations of the relationship between attitudes and union growth divide the two dominant approaches, the 'attitudinal' and the 'structural'. It will be argued here that both are deficient. The 'attitudinal' approach is naively voluntaristic, assuming an almost automatic congruence between ideologies and collective action. The 'structural' approach is superior in recognizing the limitations of the attitudinal approach. However, it is excessively deterministic, reifying the processes of union growth in ways that almost discount the role of human agency. While it correctly recognizes the importance of institutional and environmental influences, it has not integrated these into a situated account rooted in an analysis of changing workplace relationships.

Until recently the 'attitudinal' approach led the field. Its prime method was the social survey. Workers were asked questions about their attitudes and reasons for joining/not joining. The answers were added together, correlations were calculated, and inferences drawn.<sup>(13)</sup> This approach suffers from

the general problems of validity and reliability associated with the social survey. Above all, however, the attitudinal approach wrenches the act of joining a union from its social context in assuming that attitudes are normally the key determining factor. Yet, for example, in a closed shop situation there may be no correlation or, with some individuals, even a negative correlation between attitudes and membership of a trade union. Even where joining a union (or not joining one) is apparently an individual's 'free choice', there may be still pressures of circumstance and situation which lead to a breach between attitudes and behaviour. From this it follows that the pressures involved in the social context of joining must be thoroughly explored, and not just individual attitudes.

At first sight it seems that the 'structural' approach overcomes these deficiencies and its proponents are often critical of the attitudinal approach. Yet though it appears to take situational factors into account, these are considered at such a high level of abstraction that it too divorces recruitment to unions from the pattern of workplace relations into which it fits. While the attitudinal approach exaggerates the degree to which people choose to join a union, the danger of the structural approach is the opposite one of excessive determinism. The most developed structural approach to union growth is that pioneered by Bain and his colleagues. In his early work Bain set out to identify the prime causes or 'strategic variables' in union growth, while not entirely discounting the role of 'secondary' phenomena, in the belief that it is possible to separate the

'aggregate' from the 'less aggregated' causes of union growth. As he argues:

... while the strategic variables may explain the existence of unionism per se among a given group of workers, which particular union is successful in organising the group may be determined by union structures and recruitment policies. Similarly the explanation of why one worker in a given environment joins a union while another does not, may well be found in the different personality structures of the two individuals. But the strategic variables predominate and unless they are held constant any explanation of these less aggregate patterns of union growth is likely to be obscured or distorted.

(14)

The beauty of Bain's approach lies in its simplicity, for he identifies only three strategic variables - employment concentration, union recognition, and government action - which appear to provide a good 'fit' to explain the density of white collar unionism. He claims therefore that recognition is the result of employment concentration and the readiness of employers to recognize trade unions, prodded at times by the state. (15)

Underlying the first two is what Bain calls the process of 'bureaucratisation'. Employment concentration leads to the massing of workers in large administrative units. They have collective problems as workers and, since personal supervision by managers is no longer so feasible as previously in smaller units, it is carried out by means of impersonal rules from a distance. In such circumstances, Bain believes, both workers and management will be more ready to accept the role of an intermediary. In the white collar field, Bain insists, workers are usually reluctant to join a union unless it is sanctioned by their employer especially because they do not want to injure their career prospects.

This theory has a great deal of mileage in it and is clearly superior to the attitudinal approach. In some respects it is not dissimilar to a materialist approach, if the underlying processes behind bureaucratisation were to be spelled out. There are however a number of problems with it. The discussion of career prospects shows first his assumption that male white collar workers are the norm despite the growing 'feminisation' of the lower ends of white collar work,<sup>(16)</sup> and indeed the role of gender is specifically discounted. Second, there is in the last resort a reliance on psychologistic explanation which appears to be speculative rather than based on empirical research. We are not given any real evidence to support his contention that management recognition is important since:

... because they (workers) are less likely to jeopardise their career prospects by joining, they can more easily reconcile union membership with their "loyalty" to the company.

(17)

In discounting the importance of a whole range of phenomena, not just gender, but also 'economic' factors such as earnings and 'conditions' such as insecurity, as well as features of the 'work situation' such as mechanisation and blocked career mobility, the theory is at times compressed to the point of crudity.<sup>(18)</sup>

The analysis and emphasis placed on management recognition can also be questioned. Since Bain himself admits that in most cases recognition is due to some prior density, there must therefore exist at least a significant minority of people who are prepared

to risk their career chances to join a union, without whom white collar trade unionism would not be possible. What is needed is a perspective which can also account for growth in the work place prior to recognition.

#### (4) Conclusion

This chapter has focussed briefly on problems of method in the social sciences, with particular reference to the analysis of union growth. The need for a holistic approach was argued, one which recognised the central importance of work ideologies - the meanings that work holds for the individuals performing it - to the subsequent articulation of collective strategies. General and particular problems of method were identified: the general issue of how at all stages of analysis to be aware both of structural constraints upon human agency and of the possibilities that are created by its intervention. The particular questions concerned first the influences upon ideologies themselves, and second a recognition that though necessary to an explanation of collective strategies for change, they are not sufficient in themselves for wider institutional and environmental influences mediate the linkages between ideology and action. The available approaches to growth were criticised as deficient from the methodological standpoints adopted. They were either excessively voluntaristic or excessively deterministic, either focussing too single-mindedly upon ideologies or virtually ignoring them; above all neither was able to link ideology or structural influences to a situational narrative of the processes behind union growth.

The following chapter seeks to sketch out an approach consistent with the chosen methodological stance. The issues are so large that, within the constraints imposed by a thesis, the discussion will be inevitably tentative. However, a critique is not a useful exercise unless it can be combined with an approach that shows how the deficiencies identified by it might begin to be overcome.

## Chapter Two - An Alternative, Situated Perspective

This chapter seeks to develop a 'situated' approach to the analysis of union growth which is congruent with the methodological stances outlined in Chapter One. Rather than assuming attitudes are determinate (or irrelevant), rather than separating aggregate from less aggregate analysis, it seems more useful to examine the interplay of ideological and structural (both environmental and institutional) factors in specific situations. It is an approach which treats union growth as an event which happens, and tries to theorize from a more 'grounded' analysis of the constraints acting upon collectivities and the meanings members of it attach to their behaviour. As we shall see by the conclusion of this thesis, many of the factors Bain identifies as significant to explain the density of white collar unionism are highly relevant to nursing as a whole, and its segments. But they will be situated within a framework which looks at unionisation as an active, creative process, rather than almost an epiphenomenon of aggregate factors.

### (1) A Situated Analysis of Union Growth

The most significant attempt by a social scientist to take specifically a processual approach to these issues is the work of Donald Roy in the U.S.A.<sup>(1)</sup>

Roy sees union recruitment as a battle for the affiliation of workers that takes place between the management and the union, and he describes the outcome over the course of a union recruitment campaign. In his model, workers affiliate to the union by psychologically disaffiliating from their firm, affirming this by the act of union membership. Similarly, this process can occur in the reverse, when workers actually disaffiliate from their union and psychically reaffiliate to their firms. Roy then proceeds to construct a

sevenfold typology of workers, classified according to their type of affiliation: a continuum which runs from 'pro-union "actives"' through the 'indifferent' or 'undecided' to the 'pro-company "actives"'. Following this he begins to assess the factors, in the make-up of the people concerned, and the surrounding ecological conditions, which encourage affiliation-disaffiliation, towards and away from the union.

There is much to commend in Roy's approach but there are, as always, problems with such simple typologies. In the first place, it describes a situation of profound confrontation between management and unions, where loyalty to one political system and community of interest is seen as incompatible to loyalty to the other. While it may have been true in this particular instance, it would be simplistic to assume that trade union affiliation is universally, and totally, oppositional in character. However, as many writers of various political persuasions have emphasized, trade unions are an integral part of capitalism, and are often collaborative as well as oppositional institutions: loyalty to the firm, the union and the nation state are by no means incompatible with each other. Even when it is 'oppositional' in its day-to-day operations, a union may be so in a way that questions the distribution of rewards but not fundamentally the distribution of power in society.<sup>(2)</sup> Nevertheless, this is not to assume that such integration is perfect. Even in the most apparently harmonious situations, trade unionism may represent at least an implicit challenge to the legitimacy of management's power, and even the germs of a reorganisation of industry and economic life upon co-operative, more humane lines. Furthermore, though day to day union activities may often not be an intentional challenge to Capital, their long run effect (for



example, upon profitability) may be to pose a threat to it. Trade unionism, then, if it has become part of the status quo, sits rather uncomfortably within it.

In any case, these issues must be considered dynamically. The extent to which unions are judged oppositional or collaborative institutions is an empirical question; varying across different employment settings, at different points in time, and even within collectivities. Neither should absence of militant collective activity be taken necessarily as evidence of quiescence, for this may be influenced by tactical considerations. Among the factors to be considered are undoubtedly the dominant ideological attitudes held by both workers and management. In his earlier work, for example, Fox emphasized the importance of 'pluralist' and 'unitary' frames of reference among management; the former recognizing (to an extent) that workers had legitimate identifications with their own collectivity as well as (i.e. not instead of) the firm. Managements operating within a 'unitary' frame of reference, however, recognized only one source of loyalty.<sup>(3)</sup> It requires little imagination to see that management's approach to trade unionism would vary considerably according to whether they adhered to a 'pluralist' or 'unitary' frame of reference. What was missing, however, from this influential account was a discussion of the material and social factors which influenced managerial ideology, the absence of which encouraged an explanation based on 'nice guys' versus 'bad guys'. Were 'pluralists' merely making a virtue of necessity faced by powerful worker collectivities? Were they cleverly trying to manipulate trade unionism for their own ends and neutralise its oppositional effects? Were they able to be 'nice guys' because of relatively soft market conditions?

It is not necessary to deny the independent effects of ideology, to stress that material circumstances profoundly affect the ideologies held by management as well as workers, and some of these will be explored in the specific context of nursing in the next chapter. We will now, however, seek to develop a theoretical approach which shows the influence of structural (environmental and institutional) factors through events in particular locales.

As we saw, the prime error made by the 'attitudinal' approach is to assume that membership or non-membership of a union (or other organisation) is typically the result of an act of personal volition. What this ignores is that joining a union occurs in a social context, and may take place without reflection or even (as in closed shop situations) despite the opposition of individuals concerned. Indeed, it could be argued that unions are more likely to flourish where the act of joining is seen as an integral part of other obligations they have in the employment setting. Thus we can make an initial distinction between recruitment situations where individuals have to make a special effort to join a union, and those where they have to make a special effort not to, where joining a union or other organisation is seen to be the line of least resistance. Sometimes joining or failing to join will involve explicit penalties (such as dismissal), sometimes the use of more informal sanctions (disapproval, being 'sent to Coventry' etc.). In fact we can begin to construct a taxonomy of recruitment situations - as long as we remember that these will always have a past history, which must always be examined. Yet heuristically recruitment situations can be classified according to the different nature of the social obligations implied in them.

What follows is not intended to be an exhaustive list, but an indication of a number of possible 'ideal-type' recruitment situations.

For example: (1) Those situations where dominant managerial groups seek to encourage positively a membership organisation without any noticeable pressure from below. Sometimes this will be because they wish to promote one organisation rather than another, perhaps a professional association in preference to a trade union, or a less militant trade union. (2) Those where management and the workforce collaborate to enforce or strongly encourage membership of a union or other association (again sometimes in preference to an alternative). (3) Those where dominant managerial groups are relatively indifferent, either in relation to unions generally, or between particular organisations. They do not particularly place obstacles to membership, but do not seek to encourage it either. Faced with pressure from below, or outside, they may grudgingly grant facilities. (4) Situations where there are varying degrees of management hostility either to trade unionism as such or a particular organisation. Such hostility may be combined with some degree of 'recognition', either forced from below or from outside (e.g. by the Government). However in such circumstances management will be likely to attempt to frustrate the activities of organisations as far as the balance of forces will allow.

As one can see the concept of 'recognition' can thus cover widely differing situations, where only the most basic criteria for it are met, to ones where unions have a 'recognised' and considerable influence upon a wide range of managerial decisions. The complex relation between 'recognition' and 'legitimacy' needs on all occasions to be thoroughly explored. The one may, but also may not,

imply the other. One can 'recognize' another party's power without necessarily according it legitimacy, simply because there seems little practical alternative.

From this one could go on to suggest that whether membership is actually compulsory or not, defining non-membership to be a deviant act is likely to be most successful when joining a union (or some other occupational association) is an integral part of the wider process of occupational socialisation. This ensures that union membership is reproduced, at the most basic level, at the same time as the reproduction of the labour force. The more that membership is seen as a normal part of inhabiting a particular work role, the more likely that indifferent, ambivalent, or even hostile 'recruitees',<sup>(4)</sup> will be restrained from committing the deviant act of declining to join. Of course these customary obligations may be encouraged by management, or jointly by management and unions, or purely from within the work group in the face of opposition or indifference from management.

As I emphasized, the model is only a starting point. The four ideal type situations identified: (1) Management promoted, (2) Jointly administered, (3) Worker promoted/management indifference, (4) Worker promoted/management hostile - are unlikely to be found in their pure form. Hybrids may well be found and, most important, divisions may occur among levels of management, who do not always act in a unified way. In applying it to nursing, analysis is complicated by the existence of competing methods of collective organisation. Traditionally trade unions and professional associations have vied with each other, with management (as we see in subsequent chapters) encouraging the view among rank and file workers that joining a professional association was part of the customary obligations

of becoming a nurse. Joining a union was viewed as incompatible with it - as 'un-nurse' like. In this situation, not joining a professional association, or actually joining a union, could both be viewed as deviant acts.

These are very rough and ready distinctions, but already we can begin to theorize about the relationship between ideological predispositions and the social pressures embodied in recruitment situations. In both situations (1) and (2) above it is likely that only strongly 'hostile' recruits will be likely to resist the pressures to join, or to join a deviant organisation. In recruitment situation (3) above, some indifferents or ambivalents may join, especially if there are strong informal pressures within the work group. However, in situation (4) the union will have to rely much more on those strongly committed to fly the flag. This is only a starting point, for the next immediate question is what determines the mix of 'hostiles', 'indifferents' and 'ambivalents' and 'strongly committed'. The answer, though complex, depends on a number of crucial factors, including prior and continuing orientations, present position in the division of labour, future anticipated position, courage and obstinacy, and judgements of what is possible. What is also interesting is how this 'mix' changes during campaigns, how both union and management seek to mobilize for them, and the tactical twists and turns, chance events, as well as the wider structural issues (such as the general employment situation) that can affect their course.<sup>(5)</sup> And as well as these questions, one must also look dynamically at the recruitment situations themselves. How did they arrive in their current form, both in relation to their concrete history and the phases they have passed through, and in looking at the constraints and choices made by both workers and managerial groups in shaping them?<sup>P</sup>

(2) Recruitment Channels and the Reproduction of Membership Organisations

What is required, essentially, are forms of explanation which show 'how' as well as 'why'. The problem with both attitudinal and structural approaches is their tendency to say why without giving convincing explanations of how. Obviously there is a danger that situated accounts will be too concerned with 'how', at the expense of 'why', simply focussing upon the narrative surface of social events, without probing their deeper recesses. But there is no necessary reason why this should be the case. It should be possible to adopt an approach which focusses on the means by which unions, in particular locales, manage or fail to be reproduced, and then to go on to account for all the influences, both immediate and structural, which have contributed.

The most vital means by which organisations become reproduced, is of course through the establishment of recruitment channels, via which recruits become admitted into the organisation. These channels can vary considerably in form. They may temporary, such as the opportunity presented by an irregular mass meeting which non-unionists have attended. Or they may be more permanent channels which yield a regular flow of recruits. They may be in the place-of-work, or away from it (e.g. at the union office or the branch meeting in a public house). They may be informal, as when one worker casually enlists the worker next to them, or they can be formally institutionalised, for example, when the union steward is accorded the right to speak to every new recruit. Other distinctions can be built upon these basic ones. The channels may depend on the recruitee to approach the union, or vice versa. Most important, there is a dynamic aspect. Where workers must pay their dues at

regular intervals, then membership must be constantly reaffirmed. Where, however, dues are deducted from wages or salaries, it is the decision to leave that requires an initiative by the member.

Changes in recruitment channels are situational factors which can obviously have a profound influence upon unions' ability to survive or grow. There are two kinds of significant changes which require explanation, once it is ascertained which is involved in either growth, stability or decline of an organisation. (1) The successful establishment of new recruitment channels in fields where they never existed before, either in departments of the same firm where the union never previously had a foothold, or in an entirely new work organisation; or the elimination of recruitment channels from a department or entire firm. (2) An increase or decrease in the effectiveness of existing recruitment channels. Invariably the more permanent, formally institutionalised they become, requiring a positive initiative from workers to leave, the more effective, other things being equal, they will become. The less permanent and institutionalised then, all other things being equal, the less effective they will become.

This basic model helps us to examine both the influence of institutional and structural factors in the way that unions develop in particular 'recruitment locales'. For example, the establishment of new channels may occur against a background of government action to compel recognition, but it still requires the initiative of workers to take advantage of these. In practice, too, these 'rights', as in the Grunwick recognition dispute of the mid-1970s, may prove more apparent than real.<sup>(6)</sup> Quite apart from 'attitudinal' and 'structural' influences, situational factors can have considerable effect upon the relative effectiveness of recruitment channels. For

example an increase in the instability of the workforce as reflected by higher turnover rates will, in the absence of a closed shop, be likely to reduce the effectiveness of recruitment channels. Of course, these changes may be related to either attitudinal or structural changes, in which case they can be situated in real processes within workplaces.

Especially in the context of the present thesis it seems essential to develop a comparative approach to different organisations' recruitment activities in the same locales. Why do some unions, with identical or overlapping fields of recruitment, grow at the expense of others? What determines the different balance of power between professional associations and unions at particular locales? Are these variations due to more than random variations? According to Bain's heavily deterministic analysis, the recruitment activities of unions are not particularly significant:

Much more detail could be given on union recruitment policies. But the purpose here is not to provide a manual on recruiting practices. Rather, it is to determine what effect, if any, these have upon union growth, and ... it is very doubtful if the pattern of aggregate white-collar unionism can be explained to any great extent by the nature of union recruitment policies (p.98-99)



This seems an unnecessarily extreme view. However, without taking up a particular position on the issue, the relative influence of 'purely' situational versus structural influences can be determined at particular locales. The balance of power between organisations (particular unions, and unions and professional associations) will be particularly influenced by differential access to recruitment channels, some of which will be more effective than others, or will yield different sectors of the workforce. There is a need also to look at the resources which different organisations can mobilize to protect and extend their own channels and restrict the access of other organisations. In other words whether there is a relatively 'open' or 'restricted' environment for recruitment, favouring one organisation or indifferent to any.

### (3) What and Who are Unions For?

But the identification of these processes, important though they are, describes only the mechanics of growth. How do we relate them to the aspirations of the participants, the meanings unionisation holds for them which, it will be recalled, is the central methodological stance of the thesis?

Implicit in many discussions of trade unionism is a conception that the analyst holds about their purpose. Bain, for example, may be influenced by the pluralist conception of the purpose of unions being to participate in job regulation activities. Hence he emphasizes those aspects which fit in with this notion (particularly job regulation) and discounts others which do not (notably workers' concern with pay). In discussions of union 'character', Blackburn has formulated a concept of 'unionateness' which, too, seems to embody a notion of what they are ideally for -

to engage in the militant activity, affiliate to the Labour Party, and so on.<sup>(8)</sup> To define unions is therefore almost inevitably to engage, perhaps sometimes unwittingly, in statements concerning their ultimate purpose.

Common to most definitions, whether left, right or centre, seems to be a focus on instrumentalities, whether it be 'regulation' or 'control'. What is often omitted by such reification is some reference to the existence of conflicting ideologies of union purpose, as well the possibility that some members may see in unions not just a means of obtaining instrumentalities, but also as an expression of solidarity, a means of self identity and purpose valued for itself. The meaning of unionism is not necessarily determinate but the subject of deep rooted struggle. Indeed, power struggles within unions are often centred upon conflicting ideas of purpose.

These issues are rarely tackled by social scientists, but they do figure explicitly in Batstone and his colleagues' recent study of shop stewards. Behind shop stewards' attempt to mobilize the plant workforce as a collectivity lies, Batstone argues, an appeal to 'the sanctity of 'union principles'. Their ability to shape the strategies adopted by the domestic organisation, depended to a large extent on stewards' ability to convince the mass of workers to acquiesce in them, in a situation where they were held more strongly by the dominant group of stewards than the membership as a whole.

Batstone et al conceptualize union principles very much as a moral construct serving to structure and give meaning to the social world. Trade union ideology, they confess,

... is notoriously difficult to define. But essential to it is the furtherance of the common interests of the collectivity. In particular, trade union principles stress mutual protection, looking after the less fortunate within the collectivity, and ideas of fairness and justice.

(9)

They also seem to view them as not entirely in accord with 'reality'; indeed almost an attempt to run counter to it. Now in a sense this is true, for such principles do run counter to some pronounced tendencies in industry and society, which encourage individualism, and loyalty to the state rather than the working class. But one danger of such an approach is to view union principles as external creations imposed on the situation, rather than actually growing naturally out of common experiences of exploitation and deprivation, which can only be countered by collective action. Batstone et. al's approach is firmly embedded in the action frame of reference, and consequently suffers from the deficiencies identified in the previous chapter. It is one thing to emphasize the expressive, value oriented aspects of trade union principles - quite another to deny implicitly that they have any basis in material instrumentalities whatsoever.

Ironically, for an approach emphasizing the voluntaristic basis of collective action, it ends up imposing one conception of union principles rather than another, identifying them almost entirely with the views held by the plant leadership. They are continually motivated by 'altruism', while the members would, if they remained 'uneducated' by the plant leadership, articulate only

sectional demands. Whilst not denying that such a dynamic may in reality often exist Batstone et al have interpreted it almost entirely within the world view of the leadership group. I would like to focus on two consequences posed by such a stance, which in a sense the remainder of the chapter seeks to resolve:

(1) In seeing the leadership group as the only guardians of 'union principles', they fail to allow for the possibility of legitimate conflict over such principles among groups within the plant. (2) In accepting uncritically the 'altruistic' motivations of the plant leadership they do not allow for the possibility that to an extent union principles may provide the cover for ideological and material domination. To do so would require a move from excessively isolated focus upon values, to an analysis of the contradictory social position of stewards, with one foot on the shop floor and the other in a union career, and the material conflicts of interest which may thereby be created. Therefore the focus on values does not provide an adequate basis for understanding collective action. We need also to analyse the material influences underlying different sets of values, including not just the membership, but also those who have distinct sets of interests as a result of holding a union position.

#### (4) Trade Unions as Communities of Interest

Nevertheless, it is true that without some adherence to the kinds of principles described by Batstone et al, trade unionism as a living vital force could not survive. What these principles refer to is a collective 'community of interest' which, when it is expressed, is the only way in which class 'happens' (as Thompson put it). There are perhaps moments in history when such a class 'community of interest' is expressed as a single force, through 'universalising' political

movements and parties. Sometimes this can be articulated through the trade union movement - as recent events in Poland have demonstrated. However class - or any other expression of solidarity - is more often built up by a complex mosaic than as a single image, with many pieces missing, and often with other images superimposed upon it.

Capitalism as understood in an abstract sense makes working class social movements possible, because it is both vulnerable to them and gives rise to a class which will tend to form a sense of its own separate interests and seek to press them collectively. However, this explains little regarding how this will occur under capitalism as a real temporal and spatial phenomenon, in a particular culture, geography, divided into different industries developing at a different rate - and so on. In looking at trade unions, the most significant determining aspect, as Hyman and Fryer have noted, is their 'secondary' character. Trade unions'

... existence and activity presuppose the existence of economic institutions employing wage labour ... (Furthermore) a union's temporal and geographical location is derived almost wholly from the organisations which employ its members ... The trade union lacks the physical facticity of the factory or hospital or prison.

(10)

This fundamental 'constraint' on union activity is also that which, ironically, makes it possible. The point, however, is that the inevitably secondary character of trade unions will have a profound effect on the shape it takes, which will be under strong pressure to in some way follow the contours of the industrial structure, moulding itself around the key points of power and decision making within capitalism at any given point of time. Communities of interest

are therefore defined in terms of an initial (1) boundary, those included in the term 'us' and those excluded from it, 'them'. 'Them' can either be seen as in some/<sup>way</sup>allied to us ('them' as 'us') or else opposed to us ('them' as 'them'). In many instances, this may not be an unambiguous distinction, but the point I am seeking to establish is that collectivities crystallise around communities of interest in which 'us' is defined partly in terms of formal membership, but also in patterns of alliance beyond it, in which the mosaic of class interest is assembled.

'Who' is closely associated with 'What' both in terms of 'what' binds 'us' together and those whom we are allied with. This we can call the (2) 'scope' of the community of interest. On what issues do we see ourselves sharing a collective destiny and what are excluded from it? Is it only in relation to our work selves, or even our total selves when the 'community of interest' forms the basis for a wider 'occupational community'?<sup>(11)</sup> And also on what kind of issues do we see ourselves having a common interest with our allies? Generally speaking it would seem that the greater the number of issues on which we agree to have a common interest, that is, the wider the scope of the common interest, then the greater its (3) intensity or centrality to our lives. But we must bear in mind that there may also be variations of (4) focus within a perceived community of interest. Those issues accorded greatest priority could be said to be in the sharpest focus.

This simple taxonomy does not deny that the way that collectivities form, develop and decay around shared communities of interests is highly complex and difficult to penetrate. The aim here has been to provide only rough and ready distinctions to guide analysis. The fundamental points to be made are: first, that

communities are not monolithic entities in the sense that they are assumed to have within a normative functionalist framework. Rather than assuming necessarily a consensual adherence to the 'central value system' within a community of interest, they are often the subject of conflict around any of the four dimensions identified: boundary, scope, intensity, and focus. Furthermore, dominant groups within a collectivity may seek to impose their definitions on others when, as previously inferred, the values expressed may become part of the pattern of domination. Second, that communities of interest may have varying degrees of 'formal' existence (e.g. as expressed in union rulebooks) or be largely informal, but that the latter are none the less just as real, and in some instances may be more 'organically' alive than those which have a formal reality, but no longer express themselves genuinely in shared feelings and experiences. Third, a dynamic aspect must always be introduced into the analysis, for communities of interest can only be understood in terms of continuing relationships that are sustained, or fail to be sustained over time - and, after all, the subject of this thesis is processes of organisational growth.

In explaining these dynamic processes the secondary character of unions must always be the starting point. But within this there are still a bewildering variety of bases upon which collective action can be established. In the first place there is nothing given about its formation. Unless that community of interest is perceived by real men and women in real time, it will never become articulated. In the second place, collective action does not slavishly follow the contours established by capital. Adherence to old, well-established communities of interest remain strong, even though the conditions for them change - as the history of the British

trade union movement bears witness. And working class people also often seek consciously to transcend the fragmented bases of collective action under the persuasion of a wider community of interest.

We can begin to see perhaps how the development of trade unionism can be linked to the development of capitalism, in ways which are sensitive to both constraints and possibilities. In general it is possible to argue that developments in capitalism have to some extent favoured the development of wider communities of interest on some dimensions at least. These factors include: the development of a national economy, with increasing linkages between different regions; the growth of larger units of production and administration by both state and capital; the growing homogeneity of the conditions of labour, as some groups go through a process of 'proletarianisation' and others become deskilled; the growing importance of the state as the regulator of the economy, including the share of wages in relation to profits (through incomes policies). But other changes have tended to promote narrower communities of interest, at least on some of the dimensions identified above. One of the most important has been the growing separation between work and leisure, as represented by an individualist consumerist ethic, increased travelling times to work, and the break up of traditional communities situated around the place of work. This has tended to narrow the boundary of the community of interest to the factory<sup>(12)</sup> and also shift focus and scope towards economic (and to some extent job control) issues. Both tendencies are therefore present in the way that capitalist society has developed in the 20th century.

In practice, then, 'union principles' can take a bewildering



variety of practical forms, and who is to say which is most legitimate? Nor should one necessarily entirely view them as inevitably altruistic. To do so is to miss, as noted earlier, the fundamentally ambivalent relationship of unions to a capitalist society. Communities can be as much concerned with pressing a sectional advantage within capitalism as humanising its destructive tendencies. Sometimes gains are defended as much if not more against other sections of the working class, as against employers. In such circumstances, employers become 'them as us' and other workers 'them as them', as when other workers are excluded from monopolized labour markets - a tendency by no means restricted to craft unions. Sadly, a prominent focus upon sectional issues is quite compatible with union principles, and our definition of them would be incomplete without their inclusion.

This also holds consequences for the analysis of 'character'. Blackburn's concept of 'unionateness' applies the same kind of criteria to organisations as Batstone did for trade union ideology. The assumption is that it is possible to distil the essence of trade unionism, and that this essence is oppositional, independent of management, with a strong emphasis upon wider class alliances. Within the approach adopted here there can be no single conception of 'unionateness'. Instead there are varying ways in which communities of interest are articulated and the four dimensions of unionateness, opposition, independence and wider alliances need not run together.

Rather than advocating<sup>a</sup> monolithic conception of unionateness, it seems much better to view varieties of collective communities of interest along a series of continua and to recognize that one is primarily discussing tendencies. Organisations which call themselves trade unions are more likely than those which do not to espouse a dominant ideology which recognizes a community of

interest among those in subordinate positions, to be opposed to those in superordinate positions. They are more likely to stress collective advancement than individual mobility and recognise a wider boundary of common interest than a narrow sectional one, and to articulate wider political objectives.

This discussion is all the more relevant in the health service where professional associations have traditionally sought to organise nurses, according to principles which have usually been in opposition to those I have identified as more congruent with trade unionism. Thus proponents of professionalism have advocated a community of interest which emphasises an identity of interest between those in subordinate and superordinate positions, and whilst advancing the general status and influence of the 'profession' collectively, emphasizing individual mobility by merit. 'Profession' is also a community of interest associated with the promotion of a narrow boundary of interest (the 'profession' rather than the 'working class'), traditionally, at least, by cautious industrial and political means. However they are quite capable of militancy in furtherance of a sectional cause as, for example, the history of the British Medical Association demonstrates.<sup>(13)</sup> Given these considerations, there will tend to be less emphasis upon maintaining a separate identity from one's employer, than is more usual with trade unionism.

To emphasize the point once again - these are only tendencies. It would be misleading to posit an incompatibility between trade unions' and professional associations' communities of interest. For one thing, as Bain Coates and Ellis have pointed out, in some industrial capitalist

societies a distinction between trade unions and professional associations is not made.<sup>(14)</sup> We will return to this discussion in the concluding chapter. At this point it is enough to note that in any case, dominant ideologies do not always tally with actual behaviour. As always the secondary character of unions (and professional associations) must be emphasised. Dominant ideologies may express an ideal which may be difficult to sustain in practice. By the end of the thesis it should be apparent that material 'realities' of the employment situation have profoundly modified both the strategies of unions and professional associations, and that this has been both a cause and consequence of their relative degrees of success in growing.

#### (5) The Role of Cadres in the Reproduction of Membership Organisations

What is called organisational 'character' is not simply a reflection of membership predispositions. As Batstone et al's analysis has shown, significant power holders (in their case shop stewards) played a key mediating role. Furthermore, as Turner has emphasized, 'character' emerges in a dynamic way from the interaction of expectations between members, activists and officials.<sup>(15)</sup>

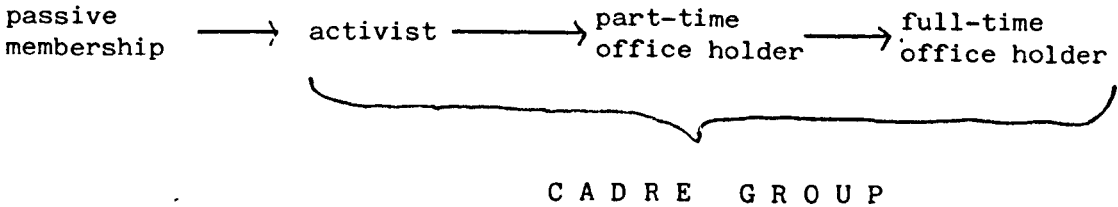
There are two competing theories which take account of differences in the opinions of the rank and file membership and officialdom. The first, derived from Michels 'iron law of oligarchy', emphasizes the conservatism of the official who has escaped, by means of achieving his office, the conditions of oppression and exploitation of the workers.<sup>(16)</sup> The second, arguing precisely the opposite, argues that unions tend to be dominated by leaderships who are more militant and politically motivated than the ordinary

membership.<sup>(17)</sup> Since it is possible to find evidence to support both points of view, it may be that they reflect contradictions in the role of officials, that can lead them at times to be more conservative and at others more radical than the rank and file. However these are very crude notions, for unions are not simply divided into a leadership, on the one hand, and a rank and file on the other. There is often a continuum stretching from passive membership, to activism, to increasing involvement with union duties (sometimes with time off), to being involved solely with union activities. Most if not all organisations depend upon a spine of active cadres, whose commitment is greater than the mean for the membership as a whole. Within the cadre group, which includes activists, and lay and professional officials, that commitment can derive from two potential sources: that which derives from the 'vocation' of the official and the pursuit of a union career, and that which derives from a greater commitment to the 'community of interest' of the general collectivity of workers.

Most of the cadre group - like the rest of us - can be expected to be motivated by a mixture of motives. It would be wrong to see all officials as motivated purely by careerism, though it is likely to be a salient concern. Nor should it be assumed that all cadres, even at local level are entirely motivated by altruism. Achievement of union position, even at steward level, can represent a degree of upward mobility - time off the job, prestige among the membership, being on equal terms with the powerful, etc. The same influences which affect the 'bureaucracy' away from the workplace also affect some of the supposed 'rank and file' within it, because of similarities in their social position and

material interests.

What the cadre group face are the contradictions inherent in two social principles: collectivism and individualism. As an individual moves from left to right along the continuum -



the greater the potential for their distinctly separate interests as cadres to come to the fore. The extent that this will lead them to become more individualistic and protective of their 'careers' as cadres, however, depends on a number of things. For example, it must be remembered that we are identifying tendencies, as always, avoiding excessive determinism. Neither can it be seen simply as an issue of choice for cadres may be subject to powerful constraints, from management, the collectivity of other cadres, and so on. It is often assumed that the tendency for an ethic of collectivism to become diluted increases as the activist becomes more removed from the daily working lives of members. However, this must be situated in some kind of prior understanding of the extent to which that daily working life is more favourable to the development of individualism or collectivism, responses which are, of course, not necessarily mutually exclusive of each other.

It must be remembered that a cadre career has not been, and is not, always a means to upward social mobility. It has often led to exposure and potential victimisation, for example. In the white collar and professional fields becoming cadres may prevent

individuals achieving mobility in their primary careers. Or alternatively a cautious and conservative approach may not only be due to the effects of holding union office, but also the desire to keep both options open - a union and a professional career. Indeed, to become a cadre in a professional as opposed to union organisation may even be a means to social mobility in the employment sphere. As we shall see in subsequent chapters, these kinds of issue are highly relevant in nursing trade unionism.

Perhaps this discussion helps to make the competing theories concerning the alleged greater conservatism or radicalism of union cadres more intelligible. Their contradictory position as both guardians of the collective community of interest and bearers of their own separate interests, means that both are possible. In any case, they are not entirely mutually exclusive of each other: to advance him/herself a cadre must usually help deliver some goods to the membership as well. It may also be the case that where there can be said to be (in general terms) a shared community of interest among the dominant group of cadres and the membership at large, the focus may still be different. Thus some cadres may sometimes become more intensely involved in wider issues associated with promoting the collective community of interest, with the general membership perhaps much more interested in immediate interests. This need not of itself generate conflict within membership organisation, but will be more likely to do so when either group fails to connect narrower with wider, or wider with narrower communities of interest.

The nature of the cadre force, its internal composition and the internal relations of power, and its relationship with the members as a whole, are key influences determining an organisation's 'character'. We cannot read off character from the ideological predispositions of the members because unions (and professional associations) are, though formally democratic, hierarchical organisations where cadres often have a considerable influence on decisions and stances taken. Which group or groups of cadres is an open question. Some authors have suggested a pluralistic model for understanding power relations among union cadres. Unions are 'polyarchies' where

... neither the members nor the leaders alone  
are decisive, but leaders and active members,  
by means of the democratic rules, keep each  
other in a balance of power.

(18)

Though a corrective to simplistic theories exaggerating the extent of bureaucratisation in the trade union movement, the notion of 'polyarchy' is problematic for a number of reasons. First it is not sensitive to the existence of considerable variation among trade unions, some of which approximate to the polyarchic model, others of which conform more to the bureaucratic one. Second, the general membership tends to get left out of the picture altogether. Indeed it may be the quality of the relationship between active members and the general membership, and the resources that are mobilized through them, that gives rise to polyarchy. In other words leaders are not kept in check simply by active members but only to the extent that the latter have the power, actual or potential, to mobilize the membership as a whole.

A key task is therefore to explore the relationship between the 'active member' cadres and the membership as a whole. This entails looking at the complex patterns of interest within the cadre group and between them and the membership at large, which leads to areas of shared and areas of divergent values.

When we examine the literature on cadres (particularly shop stewards) close to the membership we find the same divergence of opinion. The dominant view, at least in academic circles since the publication of the Donovan Commission Report in the late 1960s<sup>(19)</sup> has been the pluralist one. Their prime image of the steward was as a 'lubricant rather than a irritant', a calming influence upon militant members, a defender of orderly relations in a disorderly environment. But the 'deviant' view was not totally relegated. Even within the pluralist camp, the actions of some 'anomic' union activists was castigated.<sup>(20)</sup> Among the political right and populist media imagery, the view of the shop steward as the 'ring leader' and trouble maker has survived largely intact. Often the focus of the deviant view is as much upon the wider political orientations of cadres, such as Moran's 'study' of the Union of Post Office Workers.<sup>(21)</sup> As I argued above, there is no necessary reason, however, why this will necessarily mean the adoption of a more militant stance on industrial issues.

In subsequent chapters I will be making no prior assumptions regarding whether cadres are either trouble makers or 'lubricants', but recognize that not only will it vary, but also that the two roles are by no means incompatible. The problem with both images, perhaps, is that they assume that the influences are only in one direction, and that a line of command exists downwards



from cadres to members. The merit of Batstone et al's approach is that it shows that there are different models of steward behaviour which to varying degrees emphasize cadre autonomy from the members. They perceived two main types of steward, 'leaders' and 'populists'.<sup>(22)</sup> The former believed in the importance of 'educating' the membership, adhered more to 'union principles' (as Batstone et al define them) and were more concerned with promoting a plant-wide rather than simply 'sectional' interest. The 'populists' on the other hand, adhered less to union principles, and believed in the importance of acting as a delegate of the workgroup, simply representing their viewpoint rather than articulating their own views. Unfortunately Batstone et al's voluntaristic emphasis upon values prevents them from exploring the possible social and material constraints operating upon cadres which might tend to make them either 'leaders' or 'populists'. After all, it may not be entirely a matter of choice, for the membership may possess ideological and material resources in relation to cadres: either negative powers to prevent cadres pursuing goals they would otherwise have sought to realize and positive powers to compel them to pursue a line of action with which they do not sympathise.

We need therefore to analyse what determines the psychological make up and predispositions of cadres. What led them to become involved in the organisation - to what extent did prior orientations or experience at the place at work play a part in determining cadres with particular viewpoints and degrees of active or passive roles in relation to the membership, and those in positions of power in the organisation above them. We need also to look at the constraints on the cadres, as they perceive them, for example their view of the legitimacy or otherwise of managerial prerogatives and what I would describe as their

'social theory' of the membership. Phenomenological sociologists have convincingly argued that everyone is a sociologist, theorizing about the social world in order to successfully negotiate a way through it.<sup>(23)</sup> We can therefore examine the social theory of 'the membership' as held by cadres, by many criteria, for example: are they optimistic or pessimistic regarding the possibilities for mobilizing them collectively; do they see 'them' (a significant word!) as having different goals and objectives to themselves; do they differentiate among different groups of members in these respects? We need also to look at the processes by which these 'social theories' have, through experience, been modified over time. In such ways, perhaps, we can begin to identify how the influence of members predispositions as perceived or made known to the cadres, have had their effect upon the 'character' of collective strategies.

Ideally one would then go on to contrast these with the <sup>though</sup> actual predispositions of the members, /that task was beyond the research resources of the present study. However, it should be emphasized that we must not necessarily accept the social theories of cadres as 'true' characterisations of the membership at large. Indeed they often tell us as much about cadres as members.

This does not mean that no examination of members resources in relation to cadres is possible. It is, for example, possible to identify the extent to which they are able to mobilize collectively to influence cadres. This potential cohesiveness may be mobilized against management, or as a means of constraining such a mobilisation (e.g. by packing out meetings to defeat proposals for industrial action). As Vic Allen pointed out some time ago,

one of the most powerful membership constraints, where the possibility exists, is to 'vote with their feet' to leave one organisation, either to lapse from membership or to join a rival organisation.<sup>(24)</sup> There is no doubt that in recent years this has become a powerful dynamic governing the relative growth and decline of membership organisations among National Health Service nurses, in a situation of widespread competition between unions and professional associations. Whether in the long run this aids the development of overall cohesiveness, is quite another question.

### Conclusion

This chapter has attempted to move from a critique of deterministic and voluntaristic theories of union growth to articulate an approach which makes possible a sensitive analysis of both constraints and possibilities, starting from an appreciation of the subjective aspects of workers' collectivism but also rooted in an understanding of social relations in the workplace, and connected to a holistic approach to workers' collective organisation. Without it, the analysis of union growth inevitably becomes a mechanistic exercise divorced from an understanding of the meanings that such activities hold for those engaging them. Equally, however, I have been aware of the inadequacies of simply 'reading off' growth and/or character from the ideological predispositions of members. This chapter has focussed particularly on the role played by 'cadres' in mediating through the 'social theories' they hold the development and character of organisations. Thus the institutional frameworks established by working class collective action may come to have a 'relative autonomy' in relation to the general predispositions of members, the nature and extent varying and open to empirical investigation.

The bulk of this chapter has therefore focused on the active, creative elements in the creation and reproduction of collective action. In the following two chapters the focus returns to constraints, in particular those set by the emergence of 'modern' (ie 19th Century) nursing and its division into various branches in different types of institution and hospital. The emergence of collective organisation post-dated the creation of modern nursing - unlike, for example, the development of craft organisation, which grew up alongside the developing division of labour.<sup>(25)</sup> The following two chapters therefore seek to demonstrate how the ways in which nursing was organised and the social background of the recruits it attracted, led to different groups of nurses experiencing their work in different ways. This would ultimately lead to the articulation of contrasting collective strategies. Subsequent chapters follow this process through to 1976, when we return once more to some of the theoretical issues identified in chapters 1 and 2 of the thesis.

PART TWO

THE BACKGROUND TO NURSES' TRADES UNIONISM

### Chapter Three - Nursing and the Emergent Division of Labour in Health Care

This chapter examines the emergence of modern nursing and its position in the evolving division of labour in health care, as preliminary to an analysis of the development of trade union and professional ideologies. This structure is largely dictated by the fact that, chronologically, this was the sequence of events. The first part of the chapter examines competing general theories of the development of the division of labour, before moving on to an empirical examination of the sphere of nursing in the 19th century.

#### (1) Models of the Division of Labour

Theories of the development of the division of labour can initially be divided into 'functionalist' or 'power' approaches. The dominant approach tends to view the increasing subdivision of tasks and roles as functional, necessary to achieve complex, interrelated purposes at the maximum level of efficiency. This case was put most systematically by Adam Smith:

The greatest improvement in the productive powers of labour and the greater part of the skill dexterity and judgment with which it is anywhere directed, or applied, seem to have been the effects of the division of labour.

(1)

Within this model, changes in the division of labour propel society towards higher and higher levels of perfection and satisfaction.

Or as Durkheim categorized its precepts:

According to the most widely disseminated theory ... (of progress in the division of labour) ... it has its origin in man's increasing desire to increase his happiness. It is known, indeed, that the more work is specialised, the higher the yield. The resources put at our disposal are more abundant and of better quality. Science is perfected and more expeditions; works of art are more numerous and refined; industry produces more, and its products are nearer perfect.

(2)

Since Smith's time, however, the boundless optimism embodied in his assumptions has become somewhat tarnished, and various bourgeois thinkers have modified his claims. Two significant 'schools' of criticism have emerged within the functionalist tradition, the Weberian and Durkheimian.

The Weberian theory of bureaucracy emerged to account for the problems of large scale administration - not something with which Adam Smith was concerned. Yet it shares Smith's concern with the need for growing technical efficiency (now defined as 'rationality') and associates it with an increasingly complex division of labour and specification of roles. For Weber, bureaucracy is the most 'rational' solution to the administration of large scale tasks. Roles become specialised, circumscribed, and arranged in a hierarchical pyramid. Administration is carried out according to the technical expertise of office holders for their assigned tasks.<sup>(3)</sup> Yet Weber also recognised that such legal-rational efficiency might subvert other socially desirable goals, and lead to bureaucratic absolutism. His own view of his most famous concept was thus strangely ambivalent.<sup>(4)</sup> Since then, scholars working in that tradition have added to his reservations, drawing attention to the problems of routinisation and resistance to change that occur either as a result of a rapidly changing external environment (e.g. the socio-technical systems approach<sup>(5)</sup>) or the narrowness of vision found with extreme forms of specialisation

(e.g. Merton's notion of 'goal displacement'<sup>(6)</sup>). Thus within this tradition can be found various responses, varying from Weber's own ambivalence, to others downright pessimism.

While the Weberian tradition remains concerned at the problems of achieving efficient administration, the Durkheimian approach starts from different 'moral' premises. For Durkheim, the functionality of the division of labour lay not so much in its ability to expand human happiness by maximising the amount and variety of goods and services. Instead, it lay in its integrative potential, which was being threatened by the remorseless drive towards technical efficiency. Durkheim believed that human happiness could only be achieved by the collective regulation of individual passions. Though through history the division of labour had generally served to regulate and contain 'egoistic' tendencies, the modern form - as represented by the market on the one hand and the factory on the other - released them, with the most socially destructive consequences. The result is an anomic division of labour, amounting to a 'debasement of human nature'. The worker:

... does not know whither the operations he performs are tending ... relates them to no end ... (and) can only continue to work through routine. Every day he repeats the same movements with monotonous regularity, but without being interested in them, and without understanding them. He is no longer anything but an inert piece of machinery, only an external force set going which moves in the same direction and in the same way.

(7)

This also represents a 'forced' division of labour, for society is divided into 'castes or classes' in which one group restricts the mobility of others. The division of labour is forced, however, not because of inequality itself, but because it is not organised



'spontaneously' on the principle that 'social inequalities exactly express natural inequalities'.<sup>(8)</sup>

At least some of the differences in emphasis between Smith, on the one hand, and Weber and Durkheim on the other, can be attributed to their having addressed themselves to problems posed by different moments in the development of capitalism. Both Weber and Durkheim raise the issue of hierarchy in the division of labour in a much more direct way. But then Smith was writing during the earlier competitive phase of capitalism. He can partially be forgiven his excessive optimism, as feudal institutions crumbled around him, that the development of the market would itself create limitless horizons for the development of human freedom. He could not have foreseen, perhaps, how the market would in the final analysis create new structures of inequality. Nor was he troubled by the spectre of class war which troubled later bourgeois theorists. Above all, he wrote at a time when large scale production was only just emerging. The famous pin manufactory visited by Smith, and regarded by him as a most highly advanced example of the division of labour, contained only ten workers.<sup>(9)</sup> The large bureaucratised factory, with its distinct divisions of hierarchically arranged roles had yet to emerge. The writings of Weber, Durkheim and those following in their wake, in different ways reflected the need to justify the new inequalities created by the market and the factory system. They are thus much more concerned with restraint than freedom.

Marx's writings provide the basis for a 'power' rather than a 'functionalist' model of the division of labour. The mechanisms behind changes in the division of labour are not so much to do with efficiency

per se, but the means by which one social group is subordinated in the interest of another. The hierarchical arrangements which result are dictated as much, if not more, by the need to maintain antagonistic social relationships, as by considerations of productive efficiency. These antagonistic social relationships are expressed above all in the subordination of workers' creative powers to the creation of surplus value in the interests of the owners of the means of production, and the struggle to contain and channel workers' efforts to these ends dictates the organisation of the labour process. In the first volume of Capital Marx analyses the development of the division of labour, through the process of class struggle, first over the lengthening of the working day and secondly the intensification of labour within it. He shows how in the process it passed through a number of phases towards large scale factory production ('machinofacture').<sup>(10)</sup>

This discussion scarcely does justice to the complexity and richness of Marx's writings on the division of labour. The present objective, however, is simply to make the point that Marx saw the division of labour not just as a means of achieving instrumentalities (the output of goods and services), but at the same time was a means of reproducing relations of power and domination. As David Gordon has emphasized, 'efficiency' has both a qualitative and quantitative aspect, the 'qualitative' aspect being that 'it best reproduces the class relations of a mode of production'.<sup>(11)</sup> Sometimes this need for 'qualitative' efficiency will mean that alternative ways of organising the division of labour which might be 'quantitatively' efficient, are not adopted. Indeed, Marglin has argued that the changes in the division of labour eulogized by Smith were technically inefficient, dictated more by qualitative 'needs' of the transition to capitalism.<sup>(12)</sup>

Marx himself drew attention to the large army of supervisors and techniques of surveillance required to ensure compliance with an antagonistic system of production, an argument amply enlarged upon by Braverman in more recent times.<sup>(13)</sup>

The sphere of professional employment provides, however, interesting contrasts between the Durkheimian, Weberian and Marxist approaches. For Durkheim, the growth of professions represented the possibility of overcoming the 'forced' and 'anomic' character of the division of labour<sup>(14)</sup>. His functionalism was echoed in Parsons' view that their 'collectivity-orientation' contrasted with the 'self-orientation' of the business community,<sup>(15)</sup> nicely corresponding to the way that professionals often view themselves. The Weberian tradition, by contrast, has given rise recently to a much more critical 'power' analysis of professionalism as somehow 'outside' the class structure. The (early) work of Johnson and that of Hughes and Freidson has been most influential. Hughes first articulated the notion that 'professionalism' was a form of occupational control and also sought to dispel the idea that they were entirely 'unique' occupations.<sup>(16)</sup> For Freidson a profession was an organised form of work autonomy achieved via the state in which 'a persuasive claim' has been made to both expertise and ethicality, 'which may or may not be true', but which occupational members have a collective material interest in making.<sup>(17)</sup> Johnson focussed more on the market aspects of the process whereby 'collegiate' control became a means of establishing a monopoly over the market for professional goods and services.<sup>(18)</sup>

Such critical writing is often very insightful but fails to connect professions to the wider system of society, except insofar as professions are, in Weberian terms, an 'economic group', or in defining the 'laity' as a subordinated group in a society in which professionalism and the associated monopolisation and/or mystification of professional knowledge has become the chief form of domination.<sup>(19)</sup> Marxists have responded to this by seeking to situate professionals into the class structure both by position (including their domination of nurses) and by social function (e.g. Navarro<sup>(20)</sup>). A variant on this is to suggest that processes within capitalism are in fact undermining this form of control, leading to 'proletarianisation'. There is in fact an analysis of the growth of nursing trade unionism in this tradition, which is discussed in more detail in Chapter 12.<sup>(21)</sup> In addition to the Marxist approach feminist 'power' analysis of professions draws attention to the fact that the position and function of dominance often connects to a wider system of patriarchal power, the classic analysis being that of Ehrenreich and English<sup>(22)</sup>. These two forms of power perspective on professions have tended to develop independently of each other. More recently attempts have been made to synthesize class and sex/gender analysis, most systematically in Cockburn's study of craft control among printers<sup>(23)</sup> and Pollert's study of women tobacco workers<sup>(24)</sup>. I have attempted to give weight to both class and gender in this thesis, but would not claim to have achieved such a successful integration. However, work on integrating class and sex/gender perspectives in the analysis of the specific position and function of professions has scarcely begun. One fundamental issue

which I raise rather than seek to resolve, is the problematic nature of the discourse of 'profession' itself, which a power analysis by itself does not necessarily overcome. Fridson has recently spoken of the 'inevitability of apologetics', meaning the difficulty if not impossibility of reaching a definition of profession which does not 'play into their hands':

Because of the very nature of the concept,  
one cannot avoid its intrinsic connection  
with the evaluative social processes which  
create it.

(25)

Even critical writing on professions from either a class or sex/gender basis can reinforce professionals' sense of power and of being 'special', and does not always successfully demystify.

(2) Explaining the Emergence of Modern Nursing:

(i) The Background

Without doubt, a functionalist approach has implicitly, and sometimes explicitly dominated accounts of the emergence of modern nursing. Approaches which simply isolate the history of nursing are implicitly functionalist in that they take the relation of nursing, particularly to the medical profession, for granted. The ways in which health care is divided into tasks appropriate to nurses and those appropriate to doctors is seen as unproblematic, as are the power relations between them. More explicit functionalist approaches systematise this acceptance of the nursing/doctoring division as having timeless relevance, rather than being historically contingent. Most of these bear upon the patriarchal aspects of the nursing role. As just one example, Johnson and Martin draw heavily upon Parsons' theoretical framework, when they claim that:

... there is a clear division of labour in which the nurse assumes the role of expressive specialist and the doctor that of instrumental specialist ... Compared with the activities of the doctor, the nurse's activities are not directly related to the external problem of getting the patient well but are designed - as it is sometimes put - "to establish a therapeutic environment". This may include a variety of specific

behaviours from creating a comfortable, pleasant physical setting to the more directly nurturant activities of explaining, reassuring, understanding, supporting and accepting the patient. These acts are mainly meaningful as direct gratifications to the patient which serve to lower his tension level. It is important to recognise that many of the nurse's physical acts of care, although they may involve technical procedures, are primarily significant to the patient as reflections of her attitude towards him. By caring for the patient she shows that she cares about him. By making the patient comfortable, she comforts him. Thus both her physical acts and the attitudes they symbolize are direct gratifications to the patient which serve to maintain his motivational equilibrium. (26)

The doctor's activities, on the other hand,

... in examining, diagnosing, prescribing, and treating ... are not directly gratifying to the patient. The patient understands that these activities are necessary as a means to his recovery but in themselves they are often felt by the patient to be embarrassing, painful, and anxiety-provoking. Indeed it is the doctor's instrumental activities which tend to produce the high levels of emotional tension in the patient which the nurse, by her explanations, reassurance and comforting ministrations, can seek to reduce. (27)

Nowhere have the stereotypical relations between doctor and nurse, with the patient as a passive object ('in no position to assume leadership in the interaction') (28) been better expressed. Underlying this analysis, of course, is the notion that the system is designed to meet the needs of the patient. Notice, too, that when nurses are concerned with instrumentalities these are redefined to fit the assumptions of the functionalist model. Yet irrespective of how poorly they actually describe what nurses and doctors do, the stereotypes tell us a great deal about the ideological rationale underlying their roles in the division of labour. To the extent that the analysis does say something (however distorted) about reality, what it cannot explain is first, why these two different elements in health care (instrumental and expressive) have become assigned to different labourers, one typically a high status male and

the other a low status female. Second, it does not explain why, if both are essential to the healing task, those carrying out 'expressive' functions are subordinated to those responsible for instrumental ones. Why not an equal partnership, or even a reversal of power relations?

The distinctive feature of Marxian and feminist approaches is their refusal to take existing hierarchical relationships for granted. Instead they seek to uncover their origins in power struggles between social groups. There are, however, a number of problems in the straight application of a materialist analysis to the division of labour in health care. The first is that at first sight there is no mechanism for the creation of surplus value, by which independent producers could be said to be expropriated and subordinated to the owners of the means of production. A second problem is that, even if one could be found, class relations are only one aspect of the patterns of domination in health care. Here, perhaps more clearly than in other spheres, they have become suffused by patriarchal characteristics. Finally relations of domination are not only reproduced between paid labourers in the division of labour. Patients, who should not simply be regarded as passive 'consumers' but unpaid labourers, need to be brought into the analysis. This makes health care to some extent (29) different from manufacturing industry, quite apart from the existence or absence of a surplus-value creating process. The creation and consumption of use values occur in a single sequence in health care, whereas with manufactured articles they typically occur separately, and this adds an extra dimension to the patterns of power and domination. These remarks open up immense issues which would require at least another thesis to explore satisfactorily. They are raised here in order to emphasize that what follows - an attempt to situate the emergence of nursing within a wider social division of labour - is a very tentative

exploration of some of these issues.

As good a starting point as any is the functionalist model of the doctoring/nursing division. In so far as it signifies, at least in part, a real dualism in the division of labour in health care, what are the origins of this dualism? Historically, health care has taken two basic forms, as a marketable commodity, and as a form of social control. These forms have often, but not on all occasions, been separated. For example, the mediaeval hospitals of England were primarily concerned with social control, the alleviation of the poverty and dislocation caused by urban growth and decay of serfdom in the countryside. (30) At the same time, for those who could pay, there was a growing market for commoditized medicine, which began to be separated into physicians (for the rich), apothecaries (for the growing middle classes), and surgeons, as different practitioners struggled to control the market and exclude competitors. (31) Most health care, for the mass of the population was provided outside this system, often by 'wise-women' in the community. (32)

The modern division of labour in health care originated in a partial combination of these two elements. What are dubbed as 'instrumentalities' within the functionalist model may be thought of as more often (though not always) to do with those features of health care which are most marketable. Those described as 'expressive' are more closely linked to social control, or at least subsidiary to the realisation of health care as a commodity. This then provides us with a basic materialist theory for the development of the division of labour in health care. The modern medical profession emerged to monopolize the sale of health care as a commodity and exclude (and hence expropriate) 'wise-women' and other so called



'quacks'. This was one feature of a general transition to a market economy in which human needs are channelled into the consumption of commodities, the production of which is controlled by a ruling class. This monopolisation was underwritten by Parliament which established, within limits, a degree of 'professional' autonomy. By 1858 (the year of the Medical Act) the machinery of the British state was increasingly dominated by the industrial bourgeoisie. Why did they grant doctors such autonomy? The basic answer - even if for the sake of brevity I must put it very schematically - is that they perceived it to be in their interest to (1) protect the quality of a commodity which they consumed (2) to win the compliance of the medical profession as agents of social control in the reproduction of a class society. The first emphasises the ruling class's dependence as mortal beings, upon the profession, the second the profession's dependence on the ruling class for their status, prestige and power.

These contentious statements could only be substantiated by a much more detailed analysis of the forces leading to the professionalisation of medicine, which cannot be undertaken here. I want to turn instead to the crucial role played by the hospital in this process, from which it will also be possible to identify the role of nursing within this overall scheme of things. The emergence of the voluntary hospitals during the 18th Century saw a closer linkage between health care as social control and as a commodity. Although primarily concerned with social control, these institutions also helped to reproduce health care as an increasingly valuable commodity.

Through the new voluntary hospital system of the 18th Century, the linkage between health care as a commodity and as a form of social control is made really for the first time, even though it must be

remembered that the two forms are still kept distinctly separate. The physician donated his services free to the poor in the voluntary hospitals, but spent most of his time on private practice. The Restoration physician needed more accomplishments as a gentleman than in medical knowledge and techniques. Indeed their training in liberal Arts was designed to help them merge in with the upper class. Their assistance to the poor sick through the voluntary hospitals and Dispensaries perhaps gave the profession a veneer of reform as a defence against growing criticisms.

However, these influences only partly explain the emergence of voluntary hospitals. They are perhaps better understood as one response of mercantilist society to the growing problems of social control, especially within the capital. The philanthropic response was determined by two things. First, the existence of a significant surplus from trade. Second, the decline of militant puritanism's opposition to good works as a means of salvation. But the picture is rather confused. The creation of the voluntary hospitals fitted into a complex pattern of early and mid 18th Century social policy which also included attempts to restrict the poor from settling in London. In London and elsewhere, the voluntary hospital formed the basis for a public class alliance between the middle and upper classes. The movement is usually traced to the initiative of Henry Hoare and others to found the Westminster Hospital in 1720 and St. George's in 1733, which according to one glowing account, 'soon captured the support of the Court and the leaders of society - the names of Lord Chesterfield, Sir Robert Walpole, David Garrick and Beau Nash appear on the early subscription lists'.<sup>(33)</sup> The system which made this class alliance possible was a widening of the financial base to include subscriptions as well as endowments. This

enabled the rising middle class to participate.

Philanthropy has traditionally been motivated by a mixture of motives, not excluding a sense of religious duty and a desire to help humanity. But as far as the voluntary hospitals were concerned, part of the interests of the middle class lay in the fact that subscribing and the rights to management of institutions that went with it gave an opportunity to marginalised middle class elements especially to gain an accepted position of influence within existing society, at a time when the bourgeoisie had not yet captured state power. Thus we find that Quakers like John Bellers were active in the voluntary hospital movement. Nevertheless the problems of social control between rich and poor probably formed the most direct incentive for the establishment of voluntary hospitals. As Jordan has shown, <sup>(34)</sup> through the ages the most active philanthropists have always been the employers of the poor, and philanthropy has served not just to salve their own consciences but also to cement social relations between them, based on 'the gift'. <sup>(35)</sup> In the voluntary hospitals, a subscriber's letter was necessary to gain admittance to hospital. In part this was an attempt to restrict relief to the local poor, but its undoubted attraction was also the power of patronage and status in the community that accrued to subscribers, and the obligations that it created. These patterns of obligation were also extended into the hospital itself. For example, at the London Hospital:

The Committee met at 11 a.m. on Thursdays ... First the patients '... cured by the Physician' followed by those 'presented cured by the Surgeon' were called in to render thanks to their Benefactors and exhorted to go to their parish churches to return thanks to God 'for the cures they had received at the hands of Charity'. Any patient who refused to return thanks was never treated again (a black list was kept). Those who conformed were given a certificate entitling them to further relief should they ever need it. Then the

Committee adjourned to the Angel and Crown  
 "for the better transacting of the Business  
 of Charity". (36)

But obligations were not simply desired in themselves. The aim was often to reform the poor, or to ensure that the 'respectable poor' (who formed the category most likely to be admitted) did not slacken. Thus one stated reason for establishing a hospital at Winchester, was to create a regime to instil

a spirit of Religion and Virtue amongst the Common People; which by degrees may recover them out of that profligate State of Life which is the general complaint of these Times. The most certain method of recovering Men from their evil Courses, is to remove them out of the way of bad examples for so long a time as is necessary to beget contrary Habits ... great numbers of the Poor will be insensibly reclaimed by the exact regularity of Manners, which is maintained in a Hospital. (37)

In addition, as Foucault,<sup>(38)</sup> and others have amply demonstrated, the role of the hospital in providing a captive population for research purposes, enabled doctors to study the 'natural' course of diseases, classifying them as a first step towards more effective forms of treatment. This provided the basis for a class alliance between high-ranking physicians and surgeons, and the ruling class, given the poor state of medical knowledge and the growing threat of communicable diseases, which was to culminate in the cholera epidemics of the 19th century. As Foucault emphasised, donations were an investment for the future, and he quotes Du Laurens in 1787:

Yea, rich benefactors, generous men, this sick man lying in the bed that you have subscribed is now experiencing the disease that will be attacking you ere long; he will be cured or perish; but in either event his fate may enlighten your physician and save your life.

(39)

Looked at in this way, voluntary hospital care was an opaque form of exploitation, like the system of wage labour that was emerging parallel to it. Apparently receiving philanthropic assistance, patients had, in return, to become subject to religious and social discipline, and contribute to the advancement of medical knowledge by serving as teaching and research material. The need for social control and the improvement of the medical care given to the ruling class were united in a single mode of operation.

(3) Explaining the Emergence of Modern Nursing:  
(ii) Nursing Reform

This therefore forms the background against which modern nursing emerged in the 19th Century Voluntary hospitals. By the mid-19th Century a number of changes were maturing which favoured nursing reform. The first was the development of academic medical education based on the hospital. Formerly many of the delegated medical tasks had been carried out by trainee apothecaries, as part of a form of apprenticeship. But professionalisation was changing this, and as medical students retreated to the lecture and dissecting rooms, (40) there was a need for some suitable subordinate to take over some of these tasks. Another significant change was the growing ruling class interest in the health of the poor themselves partly due to the realisation, following the cholera epidemics of the mid 19th Century, that disease was 'not a respecter of persons'; and also a 'human capital' notion of working class health as an investment that might yield future gains to the ruling class.

It is a commonplace in labour economics that the provision of occupational services depends on the intersection of the forces of demand and supply. The emergence of nursing at the end of the 19th century in the voluntary hospitals is almost a textbook example, just

as the later loss of impetus in nursing reform was in many ways due to these forces coming into more or less permanent disequilibrium. On the supply side, the story has often been narrated of substantial numbers of unmarried middle and upper class women becoming a burden to their parents. Victorian England was characterised by paradoxical developments. On the one hand there was the romantic celebration of the nobility of 'womanhood'. This had many precedents, but it was encouraged by the development among the bourgeoisie of the idea of the family as a 'refuge', from which they could escape at least temporarily from the competitive baseness of the world of Capital. At the same time, there were the stirrings of a women's consciousness among them, as they saw a life spread before them without any real social functions.

Nursing emerged as a compromise. Although some leading individuals were involved in the feminist movement, the main thrust of nursing reform was largely congruent with the prevailing male definitions of womanhood. Nursing enabled the desire for some measure of self determination to be realised in terms agreeable to the prevailing male imagery of women. The work itself was not to be tainted with the world of Capital. It was to be carried out as a service, and pecuniary motives were to play no part, just as the home was supposed to be the place where goods and services were provided for love, not money. But work in hospitals exposed women to intimate contact with male patients, and put them in close proximity to male doctors. The cloistered separateness of the nursing community served to reassure fathers anxious about allowing their daughters to leave home and take up nursing. The espousal of religious virtues helped to protect the nurse during intimate contact with male patients. The class distance between these

women and the majority of their patients, and the ban on 'familiarity' were reinforcing factors. The rigid discipline and the seclusion in the nursing home, were also part of a network of devices which served to protect the fragile notions of womanhood from the world at large and, more closely, from doctors. Thus increasing numbers of middle class women exchanged one rigidly authoritarian environment for another, compensated by some promise of social position.

This occupational infrastructure helped to change the existing imagery of the nurse, from a generally disreputable character to that of a ministering angel. It helped to make available a sufficient supply of ladies (and aspiring ladies) for nurse training in the voluntary hospitals. Clearly, however, 'demand' factors were equally important. That there existed work for them to do, which was either not being done or not being done adequately, was a necessary but not a sufficient condition for nursing reform. In addition, it depended on the extent to which it threatened established occupational interests and, where it did, what resources nursing leaders could deploy against opponents. In the voluntary hospitals these conditions were more or less met, resulting in the intersection of the forces of demand and supply.

A vacant occupational space occurred initially because reformers could claim that the somewhat diverse elements which were to make up the new occupation: delegated treatments from doctors, care of patients' physical needs, the maintenance of the ward in a clean and proper condition, and so on, all could be viewed as a unified whole, in terms of the 'sanitary idea'. This idea emerged before, but was systematized scientifically by the acceptance of the germ theory of disease. As Celia Davies has pointed out, the sanitary idea formed the knowledge basis of early nursing. (41)

The complexities of the 'sanitary idea' as a central feature of mid-Victorian bourgeois ideology have been explored in detail by Geoffrey Pearson. The concern with dirt and disease was only one part of a much wider concern with deviance, which was viewed as a form of 'moral filth'; and the 'cleaning-up' exercise spread its tentacles much wider than actual dirt and disease, to encompass a notion of 'moral cleanliness' that fitted in with the idealised bourgeois lifestyle. (42) The sanitary ideology of Edwin Chadwick and his fellow reformers can be interpreted in a number of ways. Thus, quoting Schoenwald's psychoanalytical view that reformers had a secret task to produce persons with habits 'more productive and more disciplined than the insides of any creatures known to history', Pearson then places this in its wider context by claiming that:

... this hidden agenda concerns the creation of a stable working population within the rising domination of a factory system of labour. (43)

Thus the centrality of the sanitary idea in the knowledge system of 19th Century nursing links it very closely with the wider connections between health and the reproduction of labour power. It defined the position of the nurse in relation to the working class patients and to the adjacent occupations in the hospital superstructure. Thus Dean and Bolton have emphasized the role of the nurse as an agent of 'disciplinary power' within the hospital. (44) This image may not fit easily with the idea of a ministering angel humbly tending the patient's every needs. However, as the functionalist model described earlier makes clear, this was on terms dictated by the nurse rather than the patient.



And as Abel-Smith has shown, one of the central features of nursing reform was that working class men were 'forced by members of a different sex and class to conform to standards of behaviour quite foreign to

(45)

their normal lives'. An influential nursing textbook of the early 20th century described this relationship in the following way:

Be tactful also with your patients; treat them with sympathy and kindness but be firm, for firmness is essential, but it should not be too severe in dealing with the sick; "the steel hand in the velvet glove" is what is required. (46)

Within the hospital itself, the emphasis on the 'hygiene' idea had a number of important consequences for the claim to occupational recognition. It meant first that 'the proper duties of the nurse' straddled both the scientific and non-scientific worlds, the medical and administrative divisions of labour. The vocational idea that care of the sick and attention to their needs was noble in itself was certainly present, but just as important was the idea that either nurses should understand the importance of hygiene in carrying out all their various menial and less menial duties, or that those who did understand should control those who carried them out. At the outset, therefore, nursing tasks were defined less by what they practically involved, more by the principles underlying them. Even the scrubbing of floors was partly lit by the glow of medical science.

The beauty of the sanitary idea lay in its simplicity, serving in turn to unify the occupation into a single community stretching from the lowest ranking to the highest ranking nurse. The crucial element in the situation was the power of the matron. As Nightingale wrote:

The whole reform in nursing both at home and abroad has consisted in this; to take all power over the nursing out of the hands of the men, and put it into the hands of one female trained head and make her responsible for everything regarding internal management and discipline . (47)

The power lodged in the single figure was a means of practical reform. As upper class women the matrons were able, if required, to go above the heads of stewards and sometimes even doctors, to influence social peers on the Boards of Governors and beyond. They used their powers to bring to heel or if necessary replace (under the banner of the sanitary idea) the existing nursing staff and domestics on the wards. At the same time as they recognized the importance of obedience in clinical matters to the doctors, they asserted their partial autonomy by insisting that physicians could not themselves directly discipline nurses. This also helps to explain why matrons on the whole resisted trade unions. They undoubtedly had a 'unitary frame of reference' which derived from the practicalities of achieving reforms. This made them unlikely to countenance any independence of thought and action among subordinates. They were charismatic figures demanding total loyalty to the ideals of the unified occupational community which they led.

The social position occupied by the matron in the hospital power structure, involving the supervision of the majority of aspects of the care structure, bore a close relation to the position she might have occupied, as an upper middle class woman in the Victorian home, had she married. In claiming supreme authority over all female staff there was the precedent of the Lady of the House, whose supervision of servants complemented rather than subverted the authority of her husband. Towards the end of the 19th century the term 'matron' therefore took on a new and additional meaning. Previously

it had not meant a figure of authority in its own right, but powers exercised in an institution by virtue of being the wife of the steward. In the case of nursing in the voluntary hospitals, the matron exercised a new power by becoming the symbolic wife of the doctor, and in so doing helped to establish a sphere of autonomy and not just submission. Her sphere of autonomy lay chiefly in the managerial control of those under her.

At this time doctors were becoming increasingly interested in the diagnostic aspects of illness rather than treatment, with the growing influence of ~~mechanistic~~ models of disease. They were thus prepared to allow some functions to be delegated under their control. They were in particular neither interested in nor equipped by their training to deal with matters of ward and hospital administration. Then as now, their focus was largely upon the collection of symptoms making up the individual patient. Management of the Institution was regarded as significant only to the extent that the physician could take it for granted. In the voluntary hospitals of the time, there was nothing like an organised lay management. The emergence of a new occupation which was prepared to carry out clinical and administrative tasks offered great advantages for doctors. It meant that they could retain their narrow scientific focus and take the carrying out of these vital tasks for granted, even if it meant at times that the new nurses were not quite as amenable as the ones they replaced.

What emerged was the reproduction of the Victorian class structure in the hospital, based on the division of labour between the sexes, and between women of different classes. With the initial advances in medical science and the new forms of social organisation which developed in voluntary hospitals at the latter end of the 19th century, the idea took root that the 'instrumental functions' of 'cure', were

separate from and superior to the 'expressive functions' of 'care'. Sex, class and later racial insignia were attached to this division as the basis for hospital stratification. Cure functions were seen as primarily male and upper class, and care functions predominantly lower class and/or female but carried out under the moral leadership of upper class women. What primarily defined the superiority of 'cure' instrumentalities, however, was their marketability as valuable commodities. Nurses were allowed to participate so long as they made no claim to annex this most precious resource. They were primarily involved in assisting in the smooth running of the institution, and the control of patients by the reform of their habits along the correct paths. The terms upon which they were admitted into the medical arena were carefully circumscribed. To quote from a renowned 19th century textbook of nursing:

The science of medicine and the art of nursing materially assist each other in their ultimate objects ... It will be your part to efficiently carry out the doctor's orders and to intelligently and carefully observe for the purpose of reporting with absolute accuracy, what occurs in the doctor's absence .. A plan, based upon scientific principles is laid down by the doctor to himself, and he entrusts much of the carrying out of that plan to you. (48)

Foucault has emphasised the importance of the medical 'gaze' in the scientific revolution which created clinical medicine. (49) In the 19th century Voluntary hospital the nurse became the lens through which it shone, kept steady through the surveillance and feminine, 'expressive' control of patients and, finally, reflected faithfully back to the doctor. But though the nurse was allowed to substitute for the doctor's eyes and even, on occasion, his healing hands, by no means could she substitute her mind for his. The doctor formulated the 'plan' and this defined his superiority in the division of the

labour. His position over the nurse therefore bears a close similarity to the hierarchical principle existing in private manufacturing industry, where those who conceive of tasks to be done are accorded greater prestige than those who merely execute them. (50)

### Conclusion

This chapter has sought to demonstrate the utility of a materialist and gender analysis of the development of the division of labour in health care and, in particular, nursing's relation to it. The next chapter focusses on the dominant ideology associated with nursing reform and the reasons why it was increasingly challenged from within the occupation.

## Chapter Four - The Decay of Traditional Nursing Ideology

### 1. The Meaning of Traditional Nursing Ideology

The central dominant meaning embodied in traditional nursing was that of 'vocation', and the institutions of socialisation, set up through the training school were established to reproduce it. As Fox has emphasized the meaning of work is not simply 'personal' but also 'social', the latter being

that currently embodied in the existing design, organisation and institutional and legal context of work.

(1)

Caplow has defined these meanings in terms of 'occupational institutions':

The occupational milieu is best defined ... by a set of institutions which reflect the occupational culture. It is the nature of these institutions, the conditions from which they develop, and the attitudes which they encourage that fix the character of each occupation and determine its effect upon other aspects of life.

(2)

Caplow goes on to list a number of aspects of occupational institutions: manner of recruiting, evaluation of merit and seniority, control of occupational behaviour and extra-occupational behaviour, and the formation of an occupational stereotype, which

... is based on certain "real" elements in the working situation ... However the stereotype is itself the most important agent for the conditioning of roles.

(3)

The stereotype of the self-motivated, vocational nurse, faithful handmaiden to the doctor and kind but firm mother figure to the patient, always putting the needs of others before those of her own, was painstakingly constructed by Nightingale and other nursing reformers during the second half of the 19th century.

It was intended for both public consumption and the internal control of nurse behaviour. As an ideology, the notion of vocation embodied a number of elements. In the first place it showed the influence of the Protestant work ethic upon women, that they were affected by what Houghton has called

The arraignment of idleness, the value of work for the development of the individual, and the sense of mission to serve society in one's particular calling and to further the larger destinies of the human race.

(4)

Guilt at what Olive Schreiner called 'Parasitism',<sup>(5)</sup> was as much if not more than material necessity a driving force behind the desire of middle class women to enter the labour market. It formed the background against which talented and intelligent women like Florence Nightingale rebelled against the comforts, boredom and trivialities of their home environment. These likely predispositions meant that what some might regard as disadvantages of the work - such as, long hours, poor pay, menial and often seemingly distasteful tasks, and a closely supervised existence in the nurses' home - were not necessarily perceived as such. For unmarried 'burdens' on their fathers, these conditions might even be seen as a bold and risky adventure, at the end of which some promise of power and social position might be offered.

Other features of the work reinforced the dominant vocational ideology. As Fred Davis has observed, nursing reform emphasized some feminine virtues and screened out others:

In general the occupation crystallized around certain virtuous feminine themes: responsibility, motherliness, femininity, purity, service and efficient housekeeping.

(6)

Nursing was not degrading because it was the embodiment of these virtues. As Everett Hughes has emphasized 'dirty work' can mean work that is physically dirty, but its wider meaning is work that is regarded as personally degrading to those who perform it. An occupation

... may be dirty in one of several ways. It may be simply physically disgusting. It may be a symbol of degradation, something that wounds one's dignity. Finally it may be dirty work in that it in some way goes counter to the more heroic of our moral conceptions.

(7)

Yet what is dirty work can vary in other ways, too. What some regard as dirty and degrading, others might regard as noble and fulfilling. As an early 20th century psychiatrist put it, before the efforts of nursing reformers,

... no woman with self or regard for her reputation nursed adult males in our general hospitals. Women from every rank of society are prepared to do so now, and are held in the highest esteem if they do. Is it not, then, clear, that it is not the work alone that matters, but that the spirit in which it is done, the methods that are employed and the character of the person who comes to the work, are essential elements in any judgment upon it?

(8)



The definition of what constitutes 'dirty work' can not therefore be solely a naturalistic one. As Woollacott points out:

Hughes, like many interactionists, rarely deals with the organisation of power in societies, which is precisely what makes categories like 'dirty work' and 'deviance' understandable in a broader context.

(9)

Nursing combined tasks which were potentially both physically disgusting and morally degrading. However in vocational ideology they were transformed. Partly this was a result of their being subsumed under Victorian notions of femininity, which would tend to encourage those doing them to see them as a means of personal fulfilment. This was reinforced by the middle- to upper-class background of recruits to nursing, who could hardly be accused of materialistic motives. But there were other features of general hospital nursing which 'ennobled' it. The role of the invalid was by no means socially despised; as a form of grace achieved through suffering it might even be regarded as a metaphor for the class system itself. According to the Oxford English Dictionary, to be a 'patient', originally meant 'to suffer without complaint'. However, nursing was also linked to the emergent 19th century curative ideology, and thus became a form of socially productive labour. Much of this, as was described in Chapter 3, centred around the idea of hygiene. Many of the obsessive nursing rituals which have been described by many authors, could also be regarded as means by which dirty work is 'purified'.<sup>(10)</sup>

Thus a combination of the features related to the work itself in its institutional and wider context, and the predispositions of recruits due to their class and sex background, fused to produce traditional nursing ideology, in turn reinforced by control mechanisms

in the wider society and at the place of work. Another and very 'real' feature of the work situation was also the extent to which wage labour relationships were masked: first, by the charitable nature of the institutions; second, the lack of any immediate relationship between effort and financial reward; third, the fact that the institution took care of nurses' material needs for food and shelter.

## 2. The Contradictions of Vocationalism

So far we have concentrated upon the 'real' features of the work situation which helped to give rise to traditional nursing ideology. However this is only part of the story. There were other equally 'real' features which contradicted with it: which matured within nursing's home base of the voluntary hospital, and which were combined with others as reform was extended into the workhouses and the mental asylums. These contradictions gave rise to competing ideologies of professionalism and proletarianism, based on perceived meanings of nursing work in conflict with traditional ideology. These in turn gave rise to occupational strategies consistent with these meanings.

Features of the work were proletarian, despite efforts to mask them. Many women only 'chose' nursing because of the lack of alternative, more attractive opportunities. The 'heroic' ideology may often have been no more than making the best of it. When new opportunities opened up, in teaching and secretarial work, and as the doors of traditional professions were prised ajar, with higher rewards, more personal freedom and easier conditions, nursing began to lose its appeal. Furthermore, structured inequality was built into the occupation from the beginning in the distinction between Lady Pupils, who paid for their training and rose rapidly to the top, and ordinary probationers, whose mobility was blocked. Lady Pupils could knuckle

down to the discipline and privations of nursing in the sure knowledge that it was only a temporary phase. For others, it was more likely to be their permanent lot.

In addition to these proletarian aspects, the expansion of the medical division of labour, especially with the growth of surgery following the development of (relatively) safe anaesthesia, meant that doctors became more prepared to surrender the more routine aspects of the medical task. This meant that some nurses among the elite of the occupation might be able to seek allies among the medical profession to sponsor nursing professionalism, and restore the attractiveness of nursing to middle-class recruits. In order to do so, they had to 'reform' aspects of the traditional occupational institutions, those which served to deter potential recruits. Among these, at least in the long run, were the more menial parts of the nursing role. Under the influence of professional ideology, which emphasises the technical rather than 'caring' features of the nursing role (i.e. 'instrumental' rather than 'expressive' functions), routine tasks were shed, first to ancillary workers, and (much later) to assistant and auxiliary nurses. The tasks which had been glorified in traditional nursing ideology were now defined as 'dirty work'. Alongside this went the attempt to emulate the achievement of the medical profession by pressing for state registration, the 'closure' of the occupation and the creation of state sponsored institutions of self-government, as a means of transforming nursing into a middle class occupation.

The differences between vocationalism and professionalism have been summed up by two ideal-types of nurses described by Habenstein and Christ, as the 'traditionaliser' and the 'professionaliser'. The 'traditionaliser', they suggest:

... does not ask to be judged in her actions by competent colleagues, but by an alignment of her actions against those which have traditional legitimation ... Within the limits specified by the folk wisdom of nursing she dissolves a major portion of her personality in each nurse-patient situation.

(11)

The 'professionalizer', on the other hand,

... is not motivated by any blanket dedication to an ideal. Accepting the principle that good health is better than bad, her focus is not specifically upon the patient to be healed but upon the special things that must be done and the special modes of operations that must be evolved if the problem of healing is to be more adequately met. Her case rests with knowledge, and knowledge in this case represents the application of rational faculties to experience.

(12)

This difference in orientation was represented by profound division in the elite of the occupation which occurred in the closing years of the 19th century. The chief bone of contention, on the surface, appears to have been the issue of state registration to which Florence Nightingale, on one side of the divide, was implacably opposed. In her opinion,

Seeking a nurse from a Register is very much like seeking a Wife from a Register, as is done in some countries.

(13)

As Abel-Smith observes:

Her principal objection was that registration would involve the introduction of examinations for nurses: the professional competence of a nurse could not be judged in this way ... She laid great stress on the personal qualities required by nurses.

(14)

Within the perspectives outlined here, the 'battle for registration' within the occupation was a conflict between two conflicting images of nursing. The issue of registration was symptomatic of this more deeply rooted conflict.

The standard-bearers of the new emphasis upon technical 'professional' nursing were among the Lady Pupils. It was a strategy generalised from their material position. The leading individual was Mrs. Bedford Fenwick, former matron of St. Bartholomew's hospital and wife of a leading medical politician. Underlying the attempt to 'close' the occupation and restrict it to middle-class women was a desire to transform nursing into a valuable commodity. At a time when only the poor went into hospital she was concerned particularly with excluding competitors from private domiciliary nursing. While standards were to some extent supervised in the hospitals, there was virtually a free market in domiciliary nursing.

A prime difference, then, between the professionaliser and traditionalizer is that the former regards her skills and abilities as a commodity and is concerned to establish occupational institutions which, it is claimed, will both protect the public (that is, the middle and upper class purchasers of the commodity) and at the same time advance the personal interests of the nurse. Nursing is still in a sense a vocation, but the nurse has become dedicated to improving her skills rather than focussing directly on the patients, and the notion of self-sacrifice has been dropped. The professionalizer instead sees an equivalence between advancing her own material interests and her need for personal autonomy and serving the general good.

(3) The Contradictions of Professionalism

The means through which these objectives were articulated was the British Nurses Association, later the Royal British Nurses Association (RBNA), founded in 1887, with Mrs. Bedford Fenwick as President, in theory run jointly by medical men, matrons and sisters, but in practice dominated by the matrons of London teaching hospitals. Despite considerable activity, it had failed by the beginning of World War I to achieve its central objective, a state register for nurses. There were many factors, the personality splits between figures like Nightingale and Bedford Fenwick being significant; yet suggest that behind these 'personality conflicts' (which may have been very real), lay conflicting ideologies (which must in turn have exacerbated them!). Underlying these in turn was a difference between those who were seeking to realise the potentially high value of nursing as a commodity on the open market, and those matrons who were more concerned of the effects that this would have on the hospitals, given their perennial financial and staffing problems. The professionalisers therefore tended to link with elite members of the medical profession, while traditionalisers' natural allies were hospital administrators. The former promoted Bills in Parliament, while the latter saw that they were blocked.

But the professionalising strategy faced other contradictions. Some doctors, particularly provincial General Practitioners, were worried that such state registered nurses would be potential competitors for middle class customers with only moderate incomes.<sup>(15)</sup> Furthermore, despite the attempt to mystify nursing tasks along the same line as medical ones, many of tasks looked similar to the skills that women were expected to have acquired through the normal processes of socialisation, especially at a time when nurses were insistent that

they should not surrender basic nursing to auxiliaries. Nursing skills were therefore not as 'scarce' as medical ones and the attempt to close access to them in order to restrict supply was like shutting the stable door after the horse had bolted. Finally there was an added contradiction that professionalisation was based on the model of self-government achieved by medicine. Nurses needed the sponsorship of the medical profession to achieve professional autonomy, yet medical interests would never allow nursing to achieve complete autonomy and rival their own power in the division of labour in health care. Nursing professionalism was therefore bound to be a poor imitation of that achieved by the medical profession, involving more of the nebulous advantages of status without the more material ones of power and economic rewards. In such circumstances professionalism among nurses was in danger of becoming a form of 'false-consciousness', a means of ideological control which masked subjugation and economic oppression. Perhaps that was one reason why some doctors felt sufficiently confident to sponsor this form of professionalism - as a means of control by doctors over nurses, rather control by nurses over their work situation.

There were thus contradictions in both traditional and professional strategies which, in the years before the First World War had led to a kind of stalemate between them. The war changed all that, creating new alignments and - in the U.K. at least - a partial reduction of the 'cognitive dissonance' between traditionalism and professionalism which, in the first instance, led to the creation of the College of Nursing and, in the second instance, the achievement of state registration (of a kind) in 1919. With the War administrative concerns came to the fore. There was a need to expand the nursing labour force as rapidly as possible, as well as the need to put

aside old feuds. The College of Nursing emerged in these circumstances in 1916. Its two leading lights indicate the dominant interests at its inception: Sarah Swift, former Matron of Guys and, since 1914, in charge of the Nurses Department of the British Red Cross Society; and the Hon. (later Sir) Arthur Stanley, Chairman of the British Section of the Red Cross Society and Treasurer of St. Thomas's Hospital.<sup>(16)</sup> The objectives of the College reflected the administrators' concern to rationalise nurse training schemes (as Abel-Smith says 'to develop some order in the nursing profession'<sup>(17)</sup>) as well as the need to allay the resentment and fears of existing 'professional' nurses about the introduction of wartime Voluntary Aid Detachments (V.A.D.s). In the wartime situation the two sets of interests therefore came into closer alignment to create the new College of Nursing.

The College was formed to establish a Register but, initially at least, one of its own, without statutory force. Its professional aspirations were modest. As Dame Swift put it to Mr. Stanley:

You see it's like this. Nursing is in a state of chaos, no one knows where to turn for authority and direction. So I have come to you to suggest the formation of an effective central body - a College of Nursing - in some smaller way analogous to the Colleges of Physicians and Surgeons.

(18)

The commitment to state registration did not take a firm hold within the organisation until after the war. The College was by then some 13,000 strong; and a sympathetic Minister of Health (Dr. Christopher Addison) was still fired by the briefly-lived post-war reforming zeal to push through the Nurses Act in 1919. This was placed on the statute book despite the fact that the end of one set of hostilities (the War) had led to the opening of another (feuding between the



RBNA and the College of Nursing). A State Register and General Nursing Council were established, two thirds elected from among trained nurses. Professionalism, in 'some smaller way' analogous to that of medicine . had been achieved. Early conflicts on that body were to reduce it further by state intervention to prevent attempts by extreme professional elements led by Mrs. Bedford Fenwick, to turn nursing into an exclusive occupation.<sup>(19)</sup> This defeat established, or perhaps reflected, the compromise mixture of traditionalism and professionalism represented by the College of Nursing.

#### (4) The Emergence of Proletarian Ideology

There was however a remaining contradiction, which came to the surface as the war between professionalism and traditionalism died down. This was the emergence of trade unionism, based upon a third ideology within nursing, regarding it primarily as a form of work like any other. It was focussed less upon the supposed intrinsic attractions of the occupation, and much more upon the material needs for subsistence of those carrying out its tasks. It was, in other words, a deviant proletarian ideology whose adherents regarded nursing as a form of wage labour. And, indeed, as well as the 'traditionaliser' and 'professionaliser', Habenstein and Christ had identified a third 'ideal-type' of nurse, the 'utiliser', who:

... is motivated in terms of no goals that transcend her particular short-run needs. Likewise, there is no particular dedication to an ideal, and no life philosophy in which the work occupies a central role ... Her commitment consists only in an agreement to do her job when the job is specified ... Her work philosophy can be summed up in three short words "its a job".

(20)

The factors which gave rise to significant numbers of nurses articulating a utilizing ideology cannot by themselves explain the emergence of trade union activity, for the relationship between attitudes and behaviour is complex. Nevertheless, they form necessary if not sufficient conditions, which are now explored, before the discussion moves on to consider the actual processes by which these might be translated into action.

The contradictions of traditionalising/professionalizing ideologies were most manifest outside the voluntary hospitals, in the insane asylums and workhouse infirmaries to which nursing reform spread. These were precisely the areas in which trade unionism emerged to challenge for the loyalties of nurses. It did so because it more truly reflected the 'real' conditions under which nurses laboured, and was consistent with the prior and continuing orientations of staff themselves. The extent to which the response was more sluggish in the workhouse (later local authority) hospitals, than the asylums might, however, lead to a speculative discussion about (1) whether the contradictions were greater in the asylum sectors; (2) whether the sway of dominant ideologies reflected some difference in nurses' prior and continuing orientations rather than linking directly to features of the work situation; or (3) a combination of both of these explanations.

The extension of nursing reform to the workhouse infirmaries took two crucial stages: (1) the separation of sick paupers into wards and later infirmaries; (2) the gradual replacement of pauper inmate nurses by paid ones.<sup>(21)</sup> It was assisted by the many factors which, by the end of the 19th Century were leading to a softening of the harsher rigours of the Poor Law, including the development an imperialist concern to improve the health of the 'British race' on the one hand, and the threat posed by an increasingly militant and unified working class, on the other. But the process of

improvement was very uneven and a division of labour emerged in which the workhouse infirmaries handled the more chronic, 'less interesting' cases, those which the voluntary hospitals were reluctant to treat.<sup>(22)</sup> This meant that nursing in this sector was more likely to be defined as 'dirty work', and the nurses in that sector inferior to those in the voluntary hospitals. Many of the top posts, however, were annexed by voluntary hospital trained nurses with very limited mobility from below. The limited mobility and inferior image of the workhouse nursing led to shortages of labour. Competition for training schools in the voluntary hospitals meant that proof of motivation or educational ability, as well as 'background' could be insisted upon. In the workhouses, recruits would be much more likely to come from working class backgrounds with a much greater predisposition towards a proletarian outlook on life and work.

These proletarian tendencies were even more manifest in the asylums, to which nursing reform had spread by the 1900s. There was hardly a kind of work which was regarded as more degrading to those who carried it out, than care of the insane. As Scull has shown, by the end of the 19th century the asylum had become a convenient dumping ground for unwanted members of society:

The asylum's early association with social reform gave a humanitarian gloss to these huge, cheap, more or less custodial dumps where the refuse of humanity was collected together.

(23)

It was the junior doctors and above all the nurses and attendants who were primarily left to care for these rejected members of society, as medical superintendents retreated from the words to become 'insulated from the reality of asylum existence'.<sup>(24)</sup> The recruits to the occupation were almost exclusively working class, hours of

work were long and wages pitifully small.<sup>(25)</sup> It was also the only significant area of nursing where men were recruited in any substantial numbers, over whom the idealised feminine traits embodied in traditional nursing ideology were unlikely to have much appeal. Upward mobility was especially blocked for male attendants. In the first instance this was because of the 'dead man's shoes' method of promotion. With relatively low rates of turnover compared with the female sides, ambitious male attendants often had to wait years for promotion from the basic grade. In addition from the early 1900s, in what was called the 'hospitalisation' of the asylums, general trained nurses were recruited directly to positions of power as matrons and assistant matrons.

This created a power structure which was to survive for many years and place male attendants (later nurses) in a disadvantageous position. As late as 1959 Jones and Sidebotham found that there were distinct status divisions between male and female sides of mental hospitals, which, before the implementation of the Salmon Report in the late 1960s, were still separately administered. Matrons typically controlled the training school and the administration block, while the influences of Chief Male Nurses was 'confined largely to the male block and does not extend to the hospital as a whole'.<sup>(26)</sup> State registration in 1919 of nursing had exacerbated this in the interwar period by establishing a separate male register and barring men from training for the general register. They could therefore not acquire the general nursing qualification which, even in mental hospitals, counted higher than qualifications in mental nursing. These measures thus created an 'imperialistic' nursing structure, in which general hospital nursing dominated other nursing branches and by which men were defined as inferior nurses. It established occupational

institutions under which privileged mobility was accorded to female, general trained nurses, compared to male and/or mental trained nurses.

These structural differences between career opportunities were crucial in reinforcing the greater tendency for male and/or mental nurses to both adopt an instrumental ideology and to seek a collective solution to the problems they faced as workers. In any case, they were specifically excluded from membership of the College of Nursing (later the Royal College of Nursing (Rcn)) until as late as 1960. Not that it was an organisation which would necessarily have attracted the loyalties - at least at that time - of significant numbers of male nurses. There was an attempt by general trained nurses, psychiatrists, and senior attendants (significantly called 'inspectors') to establish a professional association for mental asylum attendants. Initiated in 1889, the Asylum Workers' Association was, by 1910, claiming around 5,000 members out of a total workforce in public asylums of just over 11,000. However, by 1920 it had disappeared from the scene.<sup>(27)</sup> The major reason was the creation of the National Asylum Workers' Union (NAWU) in 1910 which, as we shall see in subsequent chapters, both attracted members away and recruited staff who had never belonged to any organisation. An article in the management journal The Hospital in 1913 expressed horror at the NAWU's attempt to represent 'the interests of the superior officers, as opposed to that of the rank and file'. Its author ended with an appeal to asylum workers

... to remember that theirs is a "high calling" and that the tending and nursing of the insane, exacting as it does, the best qualities of heart and head, hardly falls under the same category as the daily job of the labourer or even the mechanic.

These remarks caused hilarity in union circles. The rewards of a

'high calling' were regarded as too intangible a compensation for low wages, poor conditions and harsh discipline. A male correspondent to the NAWU Journal summed it up very neatly:

Why should you grumble because a tradesman works 50 hours a week and you 80 or 90 or more? Have you not your dignity? Cling to that precious position; feed the wife and children with it when pay day is approaching; when the coalman comes with his bill, try paying him with a 'dignified' look. If the 'Super' [Medical Superintendent] has you up for some little offence, ask him how he dares meddle with one engaged in a 'dignified profession'. Grievances vanish and sorrows fade before the wonderful zephyr of dignity.

(28)

This should not lead to the assumption that professionalism had no appeal for men. Professionalism is more congruent with wider definitions of male attributes than traditional nursing ideology. Thus in the general hospitals, some excluded male registered nurses continued to look to the College of Nursing as a reference group and organised themselves along professional lines. They established the Society of Registered Male Nurses which remained in existence until 1960 when the Rcn amended its Royal Charter to allow men into membership.

#### (5) Conclusion

This chapter has focussed upon ideologies of nursing, relating them to different occupational strategies. Rather than claiming that either of the three ideal-types of ideology: 'vocationalism', 'professionalism', and 'proletarianism' represented a 'true' consciousness, we have looked instead at the development of contradictions which, it was argued, led to the decay of traditional ideology. In explaining these, reference was made both to changing prior and continuing orientations

of nurses, and changes in the labour process in health care.

The following chapters chart the actual emergence and development of trade unionism among nurses, in competition with rival professional organisations.

PART THREE

THE RISE OF NURSING TRADE UNIONISM



INTRODUCTION

The divided administrative structure under which nurses worked before the creation of the NHS in 1948 - the charitable voluntary hospitals, the poor law hospitals, and the asylums - had a profound effect upon patterns of unionisation differential. Nurses not only worked in three different types of hospital setting, but had to content with three very different types of managerial authority. One group of nurses was therefore relatively isolated from another, and gains made by one group could not immediately or easily be transformed into gains for another. The organisation of this section of the thesis takes such factors into account. Chapters 5 and 6 examine the separate development of trade unionism within the asylums (later mental hospitals). Chapter 7 examines the more modest development of trade unionism among general hospital nurses. Chapter 8 looks at how the separate streams of nursing came together with the creation of the NHS in 1948. Chapters 9 and 10 account for the development of nursing trade unionism within the unified bargaining structure of the post war NHS, taking the story up to 1976. But we start first with the asylums during the Edwardian period, to examine how and why trade unionism first became introduced into any branch of nursing.

Chapter Five - The Emergence of Trade Unionism in the  
Mental Health Service

(1) 'Lunatics Never Combine'

A visitor was once being shown round an "airing court"\*and, noticing the number of patients compared with attendants, said to his guide: "Supposing these patients were to combine, couldn't they overpower the attendant, and so obtain their freedom?" "Yes", said the guide, evidently a member of the National Asylum Workers Union, "but LUNATICS NEVER COMBINE".

Address by ex-attendant at Whittingham, N.A.W.U.  
Journal, May 1912.

The most crucial issue to the development of trade unionism in the asylums was that of pensions. At first sight this might seem odd, but it is not too difficult to discover why pensions, particularly for male employees, provided the spark which ignited the rebellion of what were officially described as 'subordinate staff'. Prior to the passing of the 1909 Asylum Officers' Superannuation Act, non-contributory pensions provided one of the few positive compensations for asylum work, for those fortunate enough to work for authorities who used their permissive powers. The 1909 Act, while making pensions obligatory also made them contributory, in line with the system operating in the poor Law service. Deductions of between 2-3% were to be taken out of already meagre wages.

In the past the obstacle to winning compulsory pensions, when Bills had been presented to Parliament, had been the opposition

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\* Patients' exercise yard.

of county and borough councils, concerned at the expense. Medical Superintendents, the day-to-day chief administrators of asylums, were generally in favour, since it would help ease their staffing difficulties and prevent turnover of staff. As one of them put it:

The bird of passage must be discouraged.  
The home-nester fostered and fed.  
(1)

In 1900 the Commission in Lunacy drew unfavourable comparisons between asylums and the poor law service. In the latter pensions were assured. Improvements for staff might help to stabilize the labour force.

Fair salaries or wages, with the prospect of liberal pensions after disablement or reasonable length of service, offer, we think, the most influential inducements to really suitable persons to enter the Asylum Service, and to remain in it as a permanent occupation.  
(2)

As an organised body, the local authorities, though not unmindful of such arguments, would not yield. Workers could have their pensions, but would have to pay for them out of their own pockets.

The 1909 Act had been the brainchild of the aspiring professional organisation for asylum workers, the Asylum Workers Association (AWA). It was steered through Parliament by its President, Sir William Collins, the Liberal MP for St. Pancras West. It is ironic that the measure the AWA regarded as its greatest achievement should have been the cause of its ultimate demise by the end of World War One. The AWA had been established by a number

of leading doctors in 1895 after the British Nurses Association, the foremost association of trained nurses, had rebutted a suggestion that asylum nurses should be allowed to join their organisation, so long as they had passed the Medico-Psychological Association examination for nurses.<sup>(3)</sup> The new organisation was dominated by doctors, hospital chaplains, and head nurses and attendants, even though rank and file ward staff were encouraged to join (i.e. by their superiors). It counted among its Vice-Presidents not only many Medical Superintendents but also such prestigious figures as the Archbishop of Canterbury and the Chief Rabbi.

Not surprisingly, the aims and objects of the AWA were distinctly 'professional': to raise the status of nurses and attendants, to promote co-operation among all grades of staff, and to found a rest home for asylum staffs. Membership was open to all those 'engaged or interested in Asylum Work'. Its Hon. Secretary for many years was Dr. G.E. Shuttleworth, who had once been a medical superintendent.

It was a distinctly deferential organisation, anxious to avoid anything which smacked of trade unionism. Through the Asylum News, it expressed a distinctive philosophy which emphasized

... a solidarity of interests between the superior officers and the rank and file in Asylum service.

The Association encouraged members to obtain the MPA certificate in order to 'lift' themselves above workers generally:

"Professional qualifications" should suggest to all Asylum workers the desirability of differentiating themselves from mere domestic servants.

The one 'union issue' which the AWA pressed was pensions, because it provided the basis for a common interest between senior and ward staff. But they would not raise issues on which there was a possible conflict of interest, such as discipline. Above all, they were concerned with 'dignity' and feared that trade unionism would do little to improve the public image of asylum workers. They claimed in 1913 not to be against trade unionism as such. However,

... we may safely say that any such methods are grossly out of place in the case of those workers who are concerned with the care of their mentally afflicted fellowmen.

In recent years workers had been granted the 'inestimable boon of assured pensions' and their status had generally risen. This

... carried with it an extra burden of responsibility, which implies the necessity not only for the maintenance of a high standard of efficiency in the discharge of duties, but also for a more dignified outlook on the various problems of living with which they are confronted.

(5)

There is no doubt that the AWA, which at its height claimed approximately 5,500 members or nearly half of all employees, was seriously out of touch with rank and file opinion. Few attendants and nurses had noticed a particularly marked improvement in their conditions. Even a medical sympathiser was forced to admit, in a post-mortem judgement:

... its constitution and government was entirely paternal ... and the Annual General Meetings ... consisted largely of uplifting speeches by distinguished Honorary Vice-Presidents; no mental nurse seems ever to have spoken and it is doubtful if any attended.

(6)

The pages of the Asylum News probably contained little that was of much interest to rank and file staff, and certainly no forum in which they might have ventilated their opinions. Instead, much space was occupied with 'institution Items' which reported on social activities and events conforming to the idealised image of asylum life the leadership wished was true. In 1911 Lancaster Asylum had been a hotbed of union activity. Very little of this found its way into the pages of Asylum News. Instead we learn that on 21st December harmonious relationships ruled at the staff social:

Dancing was entered into with unusual spirit, and the sweet strains of the noted Asylum band, under the able conductorship of Mr. R. Stavely, who is organist at the institution, sounded to great advantage, the selections being played being admirably suited to the occasion ... During the evening, ~~songs~~ were rendered by Dr. P.I. Cowen, Deputy Medical Superintendent, and Nurses A. Tipping and M. Egan. Dr. Cowen, who was in splendid voice, gave "Simon the Cellarer", and was enthusiastically applauded.

If the AWA had possessed a more representative structure, or some means of eliciting grass-roots opinion, then perhaps it might have been able to anticipate the hostile response to the 1909 Asylum Officers Superannuation Act. The fatal flaw of the leadership in the Association was to mistake its fantasy image of asylum life for the reality. They were soon to be brought abruptly down to earth; but by then it was too late, and the organisation too inflexible, to recover its lost ground.

Although asylums were typically isolated, this did not necessarily mean that they were immune from wider social influences. The years leading up to World War One were among the most turbulent in recent British history. The situation in Ireland was moving towards confrontation, spurred on by Conservative politicians. Suffragettes, after failing to win the extension of the franchise, were resorting to ever more militant tactics to win their ends, and the state more repressive methods to contain their challenge. Discontent spread through every section of society. When the Liberal Government's budget of 1909 proposed increases in income tax the House of Lords, in what has become known as the 'revolt of the upper classes', threw it out.

Labour, too, was becoming increasingly restive. According to a comment made in 1913 by Asquith, a senior civil servant:

There is a spirit abroad of unrest, of movement, a spirit and desire of improvement, of alteration.

(7)

The means for improvement existed in growing national prosperity, as Britain remained, throughout this period, the world's leading trading nation. However, according to one calculation, in 1911-13 the top 1% of the population owned 69% of the national wealth.<sup>(8)</sup> It was a time, too, when such disparities were becoming more noticeable, as a literate working class learnt of the lavish lifestyle of society men and women, through the mass circulation daily newspapers. Some indication of the immediate material reasons for the increased unrest can be interpreted from the table below:

Year	Total Union Membership	Average Retail Prices	Average Money Wages
1890	679,000	91	156
1900	2,022,000	89	179
1910	2,565,000	98	179½

The Growth of Trade Unionism Between 1890 and 1910

Source: H.A. Clegg, A. Fox and A.F. Thompson, A History of Trade Unions since 1889, Volume 1, Oxford, Clarendon Press (1964)

Since 1890 the trade union movement had grown steadily in strength becoming, in the process, more representative of the general body of workers. In 1910 it was poised to make, during the next decade, its greatest leap forward in membership, to just over 4 million by 1914, and to the interwar peak of over 8 million by 1920. From the table, it will be evident that prices after 1900 were rising faster than wages. Prices continued to rise until 1914, when they were further fuelled by the effects of the war.

The growing strength and assertiveness of labour was felt in both political and industrial spheres. From 1906, Liberal governments anxious to prevent the defection of working class voters to the recently formed Labour Party, were forced to make concessions. Trade Unions were granted immunity in strike situations from actions for damages; universal old age pensions, school meals, and health insurance were all introduced. On the industrial front, too, the influence of labour began to be felt. In 1908, miners succeeding in winning the 8-hour day. Yet it was from 1910, when the level of unemployment fell, that workers began to flex their industrial muscles. Between 1910 to 1913 there was an upsurge of militancy in many industries: strikes amongst miners, dockers, seamen,



transport workers, and on the railways. The principles of industrial unionism, and even syndicalism, lay behind much of the trade union activity of this period.

These were some of the features of the wider social context in which the NAWU was formed. In 1910, asylum workers formed a small section of the working class:

Male staff	5,687
Female staff	6,445
Total	12,132
Number of patients	102,000

Source: 64th Annual Report of the Commissioners in Lunacy for the year 1910.

The majority lived lives isolated from the rest of the working class, as a result of the policy of siting asylums outside the cities. They demonstrably lacked the kind of industrial muscle possessed, for example, by railway workers or dockers to bring the economy grinding to a halt. Nevertheless, they possessed a keen sense of grievance and collective solidarity, born out of harsh discipline, their marginal status in the wider society, and the fact that they spent most of their leisure and working lives in each other's company. They formed, in other words, an 'occupational community'.<sup>(9)</sup>

The emergence of the union in 1910 was not the first attempt by asylum employees to present a common face towards the authorities. One indication for this is that membership of unions had been officially discouraged, on pain of dismissal, at a number of asylums. For example from the late 1890s, Storthe's Hall Asylum Huddersfield, had a rule which ran:

Any discussion or other proceeding with a view to, or in the nature of a combination among Nurses or Servants, for any object connected with their duties or position in the Asylum, unless with the cognizance of the Medical Superintendent is strictly prohibited; and every Nurse or Servant joining therein, will be liable to dismissal.

(10)

There are reports of similar provisions elsewhere, but as the historian of Bodmin Asylum shows the move towards combination could not easily be suppressed:

In October 1854, after the dismissal of the head attendant and a nurse, the Chairman of the Committee found it necessary to admonish the keepers and nurses "that all complaints should be addressed to him and that all combinations of the servants will be visited by instant dismissal." It was a threat which was fairly certain to drive such an organisation underground and it is fairly clear that this is what actually happened. So when the attendants sent two of their number in August, 1873, to ask for a rise of pay the refusal was peremptory and final; the same reply was given in February of the following year.

(11)

Pressure mounted in 1890s when the Commissioners in Lunacy, in their report on Bodmin, singled out for criticism the lack of extra pay given to attendants in charge of wards. In subsequent years attendants petitioned the Committee over pay and pensions, with some success. In a letter to the Committee they voiced their feelings in no uncertain terms drawing attention to:

- (1) The small amount of remuneration we receive compared with the length of time we are confined within this institution;
- (2) The home comforts we have to sacrifice compared with other spheres of life.
- (3) The dangers we are daily subjected to.

- (4) The most trying, troublesome, unfortunate class of fellow creatures that we have to deal with in the execution of our duty.
- (5) The unhealthy, disagreeable injurious things we have to contend with daily.

(12)

The 1890s were also a period of growing unrest elsewhere.

In Ireland, attempts were made, without ultimate success, to establish a union for attendants. But perhaps the attendants at London County Council (LCC) asylums were the most active. A movement to establish a union in the early part of the decade did not succeed, but attendants continued to put pressure on the authorities. This culminated in a petition for reduced hours, submitted jointly in 1899 by male and female attendants at county asylums. This was turned down by the Asylums Committee, for reasons of expense. However at the full Council meeting there was a long debate in which strong criticisms were made of the Committee. Alderman Dew declared that:

It was a scandal that servants of the Council should be working 84 hours a week, and have to stand the risk of being fired if they were a few minutes late.

(13)

Sidney Webb (then a member of the majority Progressive Party on the LCC) expressed a similar view, and proposed that the Asylums Committee Report be referred back. It was, by a large majority, and subsequent years saw faltering steps to improve the lot of LCC asylums staffs.

The formation of the union in 1910 did not, therefore, happen out of the blue, but was the culmination of successive attempts to organise employees. The general conditions in that year were favourable: the spur of rising prices, the example set by other groups of workers, the improving employment situation. Above all, whereas previous movements had often been confined to single asylums

or groups of asylums, the pensions issue could potentially unify staff throughout the Kingdom. The movement sprouted first in Lancashire, partly because it was the most significant centre of asylum employment, but mainly because they were particularly affected by the adverse consequences of the 1909 Act. The Lancashire Asylums Board had used their discretionary powers liberally to grant non-contributory pensions under the Act of 1890. Initial pressure was limited to pensions. A group of 8 charge attendants from the Lancashire asylums were invited to a meeting convened by Martin Meehan, of Winwick, in December 1909. Visiting Committees, comprising representatives of local government, were petitioned with a view to obtaining wage increases to cover compulsory deductions under the Act. Eventually the matter came before the Lancashire Asylums Board on 26th May 1910 where petitions signed by attendants at Lancashire asylums were presented. A motion was presented:

That this Board recommends the Visiting Committee of each asylum in Lancashire to favourably consider the question of increasing the wages and salaries of their employees by the amount of their subscription to the new superannuation scheme.

(14)

However, only 6 councillors voted for the proposal, while 44 voted against. It was this refusal of the Lancashire Asylums Board to protect their employees that encouraged the informal pressure group around a single issue to turn itself into a trade union. In 1931, Martin Meehan recalled those early days:

In Lancashire, when the Asylum Officers' Superannuation Act of 1909, with its glaring anomalies and defects came along, I thought "Now is the time to form a union; this is a great chance, and something must be done"

... Well we succeeded, but not without an effort ... I thought to myself, now is the time when we have a national grievance; if we can only get a union started now, so much the better. I was instructed by several charge attendants to send out little circulars to other institutions in Lancashire.

(15)

The subsequent meeting led to the unsuccessful attempt to put pressure on the Lancashire Asylums Board, that has already been described. A further meeting was called for July 10, 1910 to be held at the Masons Arms Hotel, Whitefield, Manchester, attended by delegates from the five major Lancashire asylums. Martin Meehan was unable to attend:

I was one of the representative delegates who was chosen ... but the chief came round at 7.15 at night and said "Your day off tomorrow is stopped; you cannot go to that meeting". I made a big outcry against this. However seeing I could not go, I said to the other members: "Well I think we have a bright lad here in Gibson". He was only a lad. I said to him: "Look here, George, my day's leave is stopped tomorrow, and we are determined to form an organisation on trade union lines ... When you go there what I want you to do is to move a resolution that there shall be a union formed of asylum workers, and if there is a job offered you as secretary, accept it."

(16)

At that meeting a resolution was duly carried 'to form an organisation for Asylum Workers, and to ask for 4<sup>d</sup> a month to defray initial expenses.' George Gibson, the young attendant from Winwick, was duly elected to the post of Honorary General Secretary.

Events then moved rapidly, though for the time being the movement was confined to Lancashire. A second 'christening' meeting was held at the Boars Head Hotel, Preston, on September 24th 1910. In the chair was Mr. Williamson, a prominent member of Preston Trades Council. Through the Reverend Bankart, the

chaplain to Lancaster Asylum, an invitation had been sent to a famous socialist curate, the Reverend Samuel Proudfoot, to address the meeting. Because of their inexperience, asylum workers were inevitably drawn to seek help from the wider labour movement to bring the new organisation into the world.

The Reverend Proudfoot was a remarkable man. A co-founder of the Church Socialist League he had, as curate at Westhoughton in Lancashire, helped to obtain the return of its first Labour M.P. in the 1906 election. At his memorial service in 1933 it was stated that

He had a vision of the Heavenly City, and from this he had an inspiration which lay behind all his work ... With the vision of God before him, Mr. Proudfoot could not reconcile social injustices with the gospel he was called upon to preach. He saw in Socialism the counterpart of the Heavenly vision, and he preached it.

(17)

From this we can get some idea of the mixture of religious and political fervour that attended the Preston meeting. Fortunately we also have the Reverend's own account of that meeting as recollected in 1931:

I knew that trade unionism was the only hope for humanity, and I spoke to that audience for one hour. At the conclusion of the meeting I got up and asked if there were any questions they would like to put, or if they had any grievances they would like to mention. There was absolute silence for a considerable time, no one venturing to come forward. After what appeared to be an eternity one man got up and broke the silence. I thanked God for that man. Then he blurted out: "We're starving. It is time things were remedied, but they cannot be remedied and never will be. We are only slaves, and can only be slaves." You know the story! Now the climax of that meeting was when a woman got up (God bless that woman!) and said: "Mr. Proudfoot, you have spoken the truth, and

we shall all be fools if we do not join this Union" ... A resolution was then put to the meeting to support the movement for a trade union and this was well supported. (18)

The meeting decided also that the new union should be called 'The National Asylum Workers Union' and Bankart suggested that its motto should be "All for One and One for All: Thou shalt love thy Neighbour as Thyself'. A committee of five consisting of one from each asylum was appointed to draft provisional rules, and to approve the text of the recruiting pamphlet, to be written by the Reverend Proudfoot. 30,000 were printed and widely distributed throughout Great Britain and Ireland. Its style and content is as one might expect from its author:

#### NATIONAL ASYLUM WORKERS' UNION.

##### MOTTO:

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

#### THE END AND AIM OF THE UNION.

##### DEAR FELLOW WORKERS,

Several hundreds of our fellow-workers, male and female, in the Asylums of Lancashire, have decided that the time is more than ripe for all to unite in a determined effort to redress the grievances, great and small, from which many have suffered too long, and to procure a measure of industrial self-government, which they believe to be an indispensable means towards the realisation of a state of freedom and self-respect. The question has been brought to a head by the Pensions Act. This Act (which is a boon to very many, by granting pensions to some who otherwise would not have had any hope of them, and by *assuring* a definite amount to others), has many imperfections, *e.g.*, the deductions from the wages of those who had previously joined Asylums, attracted by that very expectation of pensions, and who are now unfairly mulcted ; and the *age limit*, which, added to the length of service limit, bears very hardly on some who joined whilst young. These faults, in an otherwise generally acceptable measure, however, are only too characteristic of the lack of real consideration accorded to Asylum Workers on the whole.

We have small hope of many important improvements in our conditions of labour apart from Union. Any single Asylum which feels that it labours under unnecessary and vexing disabilities—and there are many such—however it may strive to obtain better conditions, is helpless in its efforts to obtain redress. But if we all combine together in a spirit of loyalty to one another, we are certain to win industrial emancipation. We must have *justice*, and by this we mean : " A fair day's pay for a fair day's work," in other words, increased wages and shorter hours of labour ; more *freedom* ; a fair trial by the Visiting Committee of any member of the Staff before dismissal ; and also that in all things connected with the conditions under which we labour, we all should have a voice.

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

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

In reminding you of all this, we believe that we are discharging an urgent duty, not only to the body of workers to which we belong, but to the whole community. An injustice done to one is done to all. We deem tyranny a debasing and demoralising thing, and that is tyranny which imposes upon us conditions that no self-respecting man or woman amongst us can think to be fair or just.

We propose by this Union to bring to bear upon the "powers that be" the influence of a power greater than themselves—the power of a strong united public opinion, giving voice to our aspirations and our grievances. We propose, further, to make it an efficient means of social, educational, and moral growth. We seek to unite and not divide. We shall "serve one another" by organizing against injustice and misfortune, in the hours of weakness, and, if necessary, in suffering and death. We have no quarrels with man or men, but we are determined to fight with all our might against every sort of injustice.

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

JOIN US!

#### PROPOSED FUNDAMENTAL RULES.

(Agreed upon by our Lancashire Asylums).

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

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

3.—The objects of the Union shall be :—

- (i) To improve generally the conditions of Asylum Workers.
- (ii) To reduce the hours of labour by Act of Parliament.
- (iii) To abolish the age-limit of the Pensions' Act.
- (iv) To provide allowances for the protection of victimised members of the Union.
- (v) Generally to regulate the relations between employers and employed.

4.—That this Union be run on purely democratic lines, *i.e.*, one member, one vote; and the election of officials be entirely in the hands of the members.

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

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

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

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

Yours fraternally,

E. EDMONDSON,  
R. PARKIN,  
J. GOLD, } *Lancaster*  
                              *Asylum.*

JAS. SHANKS,  
J. PATERSON,  
J. SMITH, } *Prestwich*  
                              *Asylum.*

H. B. COOK,  
W. SPENCER,  
E. F. ISWORTH, } *Rainhill*  
                              *Asylum.*

M. MEEHAN,  
F. J. RICHMOND,  
GEO. GIBSON, } *Winwick*  
                              *Asylum.*

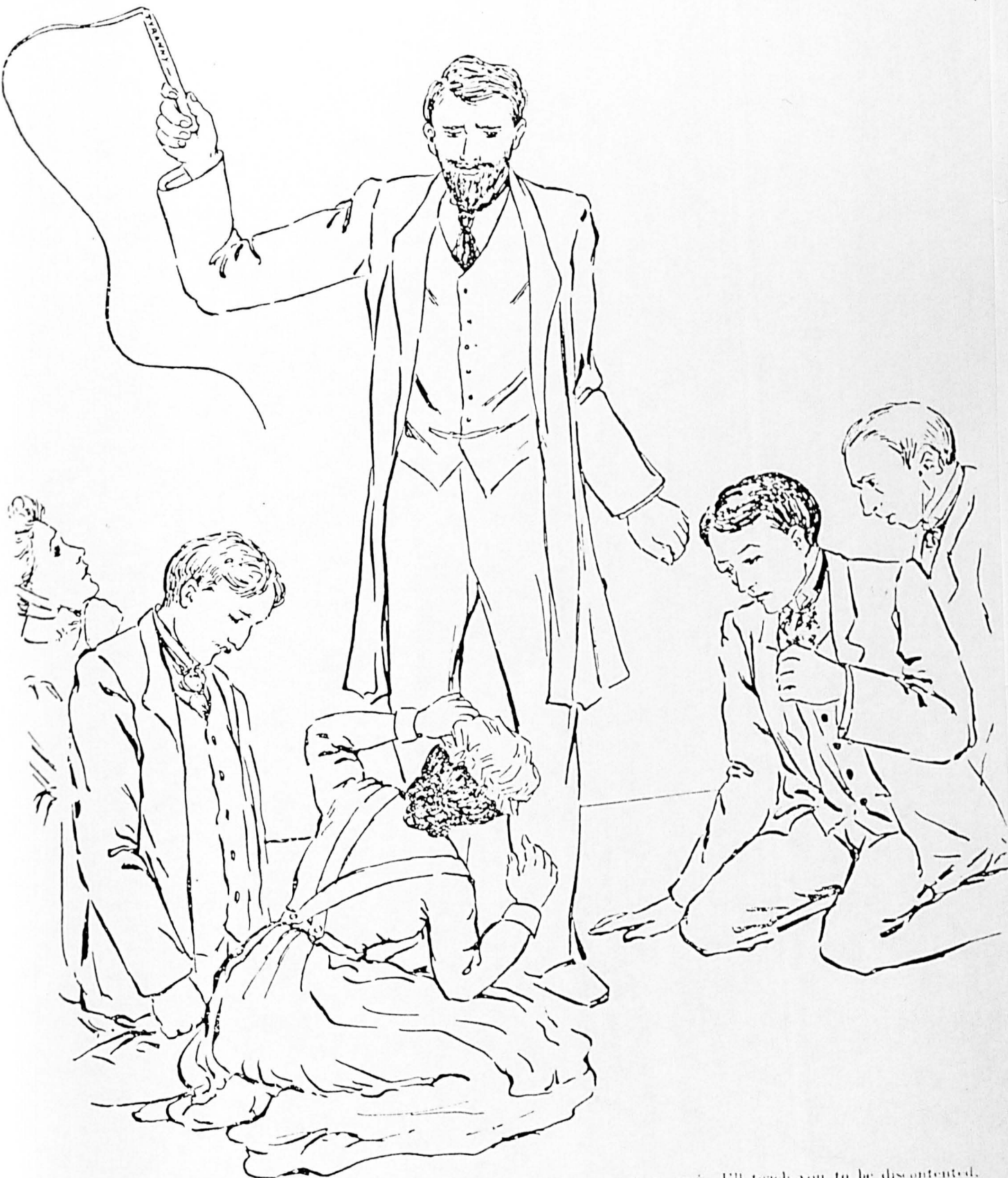
P.S.—All inquiries and communications to be addressed to the General Secretary, Mr. GEO. GIBSON, Winwick Asylum, Lancashire.



The third meeting, at the Victoria Hotel, Rainhill, on February 18th, 1911, was in some respects the most important. For the first time delegates came from outside Lancashire, from Yorkshire Asylums and Chester. The meeting approved an amended version of the draft constitution and then turned to consider the appointment of a paid officer. The chief candidate for the post of paid secretary was George Gibson. However, during the meeting, a telegram was received informing those present that the Reverend Bankart had been dismissed from his post as Chaplain as a result of his union activities. He had been disciplined for pinning up a notice encouraging staff to join the new union. George Gibson withdrew his name and the Reverend H.M.S. Bankart was unanimously elected to the position of General and Organising Secretary of the National Asylum Workers of Great Britain and Ireland at a yearly salary of £104.

Bankart took over at the end of March. In April, Herbert Shaw, an attendant at the Wakefield Asylum and Secretary of the local branch of the NAWU was dismissed from his post. He had been using official envelopes to send out circulars to other asylums encouraging other workers to join the union, though it was never officially admitted that this or his general union activities were reasons for his dismissal. In the same month he became the Assistant General Secretary of the union, working with Bankart at the Manchester Office. Thus both of the first full-time officials of the NAWU occupied their posts as a result of victimisation by their employers - a sequence of events not unknown in the history of other unions. By this time the union was already firmly established, with a membership of more than 2000 in eighteen institutions. Such acts of victimisation must only have strengthened the resolve of asylum staffs for, by the time of the first union Conference in September 1911, membership had doubled within

# CARTOON.



ASYLUM AUTHORITY: "How dare you complain of the treatment you get from me? I'll teach you to be discontented, you dogs! Don't you realize you are *slaves*, my slaves, and I can do what I like with you?"

CHORUS: "Pardon us, dread lord and master, thou art right; we are indeed thy slaves, and thou art the dearest, kindest, best of masters."

ASYLUM AUTHORITY (*slashing the whip so as to sting them all, and giving them oil for the wounds*): "There, rub that in, and away to your tasks, and don't dare to utter a word against my rule again, or even to think it!"

CHORUS: "Thanks, dread lord and master, many, many thanks. After such generosity we could not rebel; nay, we kiss thy feet. Oh lord, live for ever!"

Asylum Workers were not only frequently coerced into accepting authority, but were in addition expected to regard it as benevolent, as portrayed in this cartoon of 1912.

a few months. It now stood at 4,400 in 44 institutions.<sup>(19)</sup> It had rapidly become a truly 'national' union of asylum workers.

(2) Years of Frustration 1911-18

The early years of the Mental Hospital Workers' Union was not a honey-licking pastime. The campaign carried tremendous risks before the opposition of the governing authorities and their high handed and high notioned officials was broken down; and many people, and even wives and children were penalised, with the most inhuman consequences.

W. John, a past President, in 1931

(20)

The first eight years of union campaigning on behalf of asylum employees did not, generally speaking, result in significant improvements in pay and conditions of employment. The difficulties confronting the union were simply immense: most visiting committees were likely to oppose any measure which caused extra expense; most medical superintendents and other senior officials, to resist any relaxation of the extensive disciplinary powers they possessed over every aspect of their subordinates' lives. The first task, essential to an attempt to make an impression on the forces ranged against the union, was to secure the loyalty and commitment of the majority of eligible workers. As we shall see, this proved no easy task; but nevertheless it was during this period that a base of support was laid from which later, more successful campaigns for improvement could be launched. The NAWU survived and grew, and this was no mean achievement given the obstacles it faced.

Perhaps because of these difficulties, the NAWU was not from the outset a particularly militant body. The Reverend Bankart, though a professed Christian Socialist, was well to the right of Proudfoot, and in the first few years of its existence the union

adopted a moderate political stance. The reasons for this are clear: it was trying to establish a base of support and did not wish to antagonise potential members, at a time when the Liberal Party still claimed the allegiance of many active trade unionists. In the first issue of the Magazine a short article seeks to reassure those who objected to joining the unions on political grounds that '... this union is absolutely and entirely non-party'. The union's leadership at this stage took a tactical rather than principled position towards political parties. They sought allies among MPs in all parties.<sup>(21)</sup> This policy, formulated in 1912, was reiterated in October 1913, when (male) asylum workers were encouraged to use their vote in the forthcoming municipal elections:

Never mind what your political opinions may be  
... If the Visiting Committee member who fights  
you in Committee is a Liberal - fight him. If  
he is a Tory - smite him. If he is a pseudo-  
Labour man - smother him.

Forget that you are a Liberal, a Tory or a  
Labour Supporter. Remember that you are 'only  
an Attendant' after the Elections, and vote  
accordingly ...

(22)

Not altogether surprisingly, strikes were also deprecated. In March 1912 when there were strikes in a number of industrial sectors, readers of the magazine were advised: 'A fig for fashion: Let us be guided by common sense'.

It is hard to tell how far these views reflected a 'natural' caution among the leadership of the union or one they felt was pressed upon them. Certainly there were critics from the ranks who felt the Executive Council were treading too cautiously. An anonymous correspondent to the Journal from Hanwell Asylum complained in June 1912:

Your methods are regarded as antique and slow and fail to inspire confidence and enthusiasm, and the question is being asked throughout the service, as to why a vigorous forward movement, or an effective plan of campaign is not being launched.

The chosen 'methods' were those sometimes resorted to by groups of workers who lack the strength and confidence to secure their ends by pressure at the place of work: namely legislative change. This had the advantage of not requiring nurses and attendants to risk victimisation and, if successful, would apply universally, despite the uneven strength of the membership at this time. George Gibson succeeded in persuading the Conservative MP for Newton-le-Willows, Lord Wolmer, to introduce a Bill to bring in a 60 hour week in asylum employment and to amend the 1909 Act, to reduce the age at which women could collect a pension and to remove the upper age limit for joining the scheme. The Bill also sought to establish a right of appeal to Visiting Committees against dismissal. Wolmer was the eldest son of the Earl of Selborne and had been an MP since 1910. He was described in the magazine as holding

... the unofficial position of friend, helper and supporter of the N.A.W.U. ... he has early shown the stuff he is made of, and that there is something in heredity after all.

Initially the Government promised support if the Bill reached a second reading. However it only passed this stage with the proviso that the Bill go to a Select Committee for further investigation. Unfortunately for the union, the Asylum Workers Association had much greater influence in Parliament, and succeeded in gaining significant representation on the Select Committee. The Committee's Chairman became Charles Roberts, M.P., also a Vice-President of the AWA.

Only Bankart was allowed to give evidence for the union, even though the NAWU had originally sponsored the Bill. Only after great pressure was a survey into hours of work by the union - showing hours in excess of 80, 90 and even 100 hours a week in many places - published as part of the Committee's minutes of evidence. Considerable space, on the other hand, was devoted to the concerns of asylum management at about the supposedly pernicious effects of the Bill. Many of these figures were also associated with the AWA. The proposed 60 hours limit came under particularly heavy criticism from such witnesses. The Medical Superintendent of Lancaster Asylum, Dr. Cassidy (the man who had sacked Bankart) claimed (in an unforgettable phrase), that to reduce hours would harm the moral welfare of asylum employees:

I think the effect of too much leave, too much freedom, too many hours off duty, would be distinctly demoralising, especially to the female staff.

(23)

Other witnesses, perhaps with greater frankness, stated their concern at the possible cost of such a measure. Dr. Cooke, a Commissioner in Lunacy, estimated that the yearly cost in Britain would be £600,000, though provided little indication of how such a figure was arrived at. Only two attendants gave evidence, neither of them members of the NAWU. The AWA's statement of evidence opposed the 60 hour limit:

having the view the discomfort the patients would experience from passing under the successive care of three shifts of attendants in the 24 hours.

(24)

The subsequent Report recommended a 70 rather than 60 hour week (except for night staff), but it did recommend a reduction in retiring age for women and the right of appeal to a Visiting Committee against dismissal by the medical superintendent. The recommendations never became law, primarily because of lack of Parliamentary time. but despite the dilution of the original Bill, it did indicate the amount of pressure which the AWA (and hence the authorities); were under from the fledgling NAWU. By their own admission the AWA had lost over 1,000 members,<sup>(25)</sup> mainly in London and Lancashire. They were also forced to admit publicly:

It is obvious that large numbers of asylum workers have fallen into the error of thinking that because our association moves warily and deliberately in promoting legislation, or otherwise bringing about changes for the benefit of those on whose behalf they are working, they are loathe to take action with regard to certain matters affecting the general comfort and convenience of members of the staffs of asylums, also that we are not in complete sympathy with the point of view of the average attendant or nurse.

(26)

Not long after this statement was made the claimed membership of the NAWU exceeded 6,000, greater than that of the AWA. The latter had begun its rapid decline into oblivion, which finally occurred after the end of the First World War.

The Bill to reduce hours had fallen, but the NAWU had still shown itself to be a champion of ward nurses and attendants. The AWA, on the other hand though moving some way, had still shown a readiness to compromise in order to placate the opposition of the authorities to a 60 hour week. The NAWU therefore came out of this first test with considerable credit, if little materially to show for their encounter with the legislative process. Following

this, attention shifted towards increasing the membership in the localities and pursuing a more active policy, if not of confrontation, of pressure at particular asylums. In the process its no-strike policy was inevitably placed under strain, and also, as support was increasingly sought from the wider Labour movement, its neutral political stance.

The first kind of pressure exerted was simply to highlight the actions of officials in the union magazine, publicly criticising them. This also served to crystallize the sense of grievance of asylum workers and convince them that someone was championing their cause. It would be easy to underestimate the importance of this kind of activity; in the absence of material gains it allowed them to give vent to their grievances. In regular features such as 'The Pillory', the Magazine drew attention to grievances at particular places. Such items allowed union members to use the Magazine as a kind of graffiti board, Medical superintendents, not surprisingly, tended to be insulted the most. Notorious ones were given nicknames, like Dr. Gemmel of Whittingham, who was dubbed 'the Czar of Whittingham'. Another series 'We Have Our Eye On ...' warned asylum authorities that their acts and omissions would not go unnoticed. Among the 'watched' included:

- the Matron 'who wished to know how any Nurse at Cardiff dared to sign a petition to the Committee without first asking her permission'
- the Matron who pays the AWA subscriptions of the girls under her and then goes round demanding repayment; the girls have to pay if they are to get any days off or other privileges from the female at whose mercy they have the misfortune to be
- the Medical Superintendent who drinks too much whisky and swears at the nurses
- the Steward who cuts down the quality or quantity of the staff's food in order to bribe the authorities to give him a higher salary



- the Inspector and Matron who kow-tow to their superior officers and betray their fellow workers of their own class in order to curry favour with those in authority.

Anonymous poets often satirized their superiors, as in an acrostic published in January 1913:

#### AN ACROSTIC.

M stands for MIGHTY, which most Supers. think they are.  
 E for ERUPTIONS when with the Staff there's war.  
 D for the DUTY which Supers. sometimes do.  
 I for INSANITY, from which they squeeze their screw.  
 C is for the CONTEMPT they show to all each day.  
 A for the AGGRESSIVENESS they very oft display.  
 L is for the LIBERTY their Staffs have vainly sought;  
 And for the LOYAL way in which together they have fought.

S stands for SARCASM, for which they can't be beat.  
 U is for UNDOUBTED, meaning their conceit.  
 P will do for PEEVISHNESS, when anything goes wrong.  
 E for EGOTISTICAL, and now we shan't be long.  
 R stands for REASON, a quality that's rare.  
 I for IRRITATION; they often lose their hair.  
 N for their NAUGHTY expressions when they're vexed.  
 T will do for TYRANNY; they'll victimise "Nap" next!  
 E for EPICUREANISM, in food and other things.  
 N for their NEARNESS with all their underlings.  
 D for the DEFERENCE they show the Committee whom they serve.  
 E for all the EXTRAS I could mention if I'd nerve.  
 N for N.A.W.U., of which they are afraid.  
 T for their TERROR when our forces are arrayed.  
 S is for STRIKE, for which we're ready any day.  
 So please take heed, ye Medicos, and don't with fire play.  
 —"NAP."

The letters page of the NAWU Journal also served as a means by which staff could publicize their grievances, and express support for the union. 'Sir, your Union is an ideal one from the Workers' point of view', wrote a Waterford City Attendant in 1912: 'It is officered purely from the ranks, which is a sure guarantee that our interests will be closely looked after in every respect.' Following the opposition of many Medical Superintendents, to a lowering of hours to 60 a week, 'Langcliffe North' was moved to draw readers attention to

... the oft-repeated remark, that "the staff have the sympathy and help of the Med Supers in all things". I have for some considerable time past had my doubts about the truth of this statement. Today I have no doubts.

This letterwriter complained of the poor pay and long hours he had to work, and of the plight of married men, who only received 3/- a week towards rent.<sup>(27)</sup> The authorities had had ample opportunity to improve conditions:

But we have to now recognise that we must expect no help from highly paid officials. We must look to well-organised effort to achieve those results so desirous and beneficial to our welfare. We must depend upon the principle of TRADE UNIONISM - that unionism which has for its objects the regulation of wages and hours of labour, the promotion of brotherhood among wage earners and the advancement of the general welfare of trade union members. The history of these unions proves beyond doubt that these objects can be attained by organised effort. The wages condition in this, as well as in other countries have already been vastly improved by the combined efforts of the workers in this day of Awakening Democracy - an awakening which applies not only to male but also to female workers - to those thousands who are casting aside that narrow-minded selfishness, and apathy which has been so long the great stumbling block to their successful organisation, and who are now demanding the right to walk along the road of social progress side-by-side with their fellow men.

(28)

Such rallying cries were clearly designed to draw others to the union. Some letter writers, on the other hand had more immediate matters to get off their chest, like 'Liza Jane' from Winwick, who complained in 1912 that

She (i.e. the Matron) selects those who are likely or given to gossip, and encourages them to chatter, either in her office or other secluded places. Extremely nice girls they are. First opening for promotion that occurs these are the ones selected ... As for myself, I am clearing out; but before I hope before I do to let some light into the state of affairs here.

(29)

As well as these kinds of issues the union journal detailed attempts to exert real pressure to obtain much needed improvements. In a number of instances improvements occurred as a result not so much of the direct intervention of the NAWU, but as a result of a hope to forestall a move towards unionisation on the part of staffs. The issue of January 1912 draws attention to the 'unasked' for improvements that had recently occurred in a number of asylums, remarking ironically that 'it is only a most remarkable coincidence that they were not granted long years ago' instead of subsequent to establishment of the NAWU.

Not all authorities were hostile to trade unionism. Here and there we find an accepting and even sympathetic response. Bankart wrote to the Medical Superintendent at Burntwood Asylum near Lichfield, asking if he had any objection to his staff joining a union, and received an unambiguous reply:

Dear Sir, - I may be mistaken, but I do not think that the Attendants here are babies, and they know perfectly well that I never interfere with their conduct outside the Asylum in political or other matters, so if they desire to form a Branch of the Union of which you are Secretary they are quite well aware that they can do it, and if they do not wish to do it they won't.

- Yours Truly, J.B. Spence, M.S.

(30)

A very small minority of Medical Superintendents even gave positive encouragement. At Barnsley Hall, the Secretary of the newly formed branch informed the readers of the Magazine that the Superintendant had called the senior charge nurses to his Office to inform them that 'he was in no way antagonistic to our union' and also gave permission for female nurses to attend the meeting called to form a branch. In this instance a subsequent petition to the Visiting Committee met with success. The latter

... kindly granted the married attendants on the estate the privilege of having their food at home, allowing them 9/- a week in lieu of rations.

(31)

Sometimes senior officials were praised, so long as they combined 'fairness' with strict discipline. For example, the late Chief Attendant of Durham County Asylum was praised for having risen from the ranks and though 'a rigid disciplinarian, who word was law in matters of duty', he did not prevent staff from exercising 'the fullest liberty of action in regard to securing improvements in the conditions of service' - and was even a regular contributor to union subscriptions. Above all 'he would never condescend to shady or reprehensible tactics'. The most striking success, however, was at Portsmouth in mid 1913 where the union branch, which claimed to represent 96% of the staff, won not only concessions but full recognition from the Visiting Committee, which passed the following resolution:

That we recognise the NAWU and at any time we cannot agree with our staff on any question we will meet their representatives.

(32)

Such breakthroughs were rare. More usually, petitions for substantial increases met with no success or else trivial concessions were granted. At Lincoln the Visiting Committee granted two bars of soap a month to each member of staff! (see cartoon on next page). A fairly typical example was at Earlswood Asylum, where the newly formed branch petitioned the Visiting Committee over 'long standing grievances' for better food; money in lieu of rations; increasing lodging out allowances; better sleeping accommodation for single men; and increases in pay and 'a definite pension scheme'. The following reply was posted

# CARTOON.



**He Won't Be Happy Now He's Got It!**

The Lincoln Asylum Visiting Committee were petitioned for various reforms, shorter hours, longer pay, etc., and they graciously—while not granting all else—granted two cakes of soap a month to each member of the staff.

in December 1912:

EXTRACT FROM BOARD MINUTES

November 13th, 1912

The Medical Superintendent is ordered by the Board of Management to post the following notice with regard to the letter which was sent to the Visiting Committee dated September 1912.

If there is any member of the Staff who desires any explanation of any of the details of the following notice which may not appear quite clear, the Medical Superintendent will be pleased to give any such member an interview.

(Signed) C. CALDECOTT,  
Medical Superintendent

NOTICE

The letter of certain members of the Staff dated September last addressed to the Visiting Committee, having been referred to a special Sub-Committee, who have made the fullest enquiry into the matters referred to, the Board have unanimously decided as follows:-

- (1) They regret receiving the letter which, they point out, ought to have been sent through the Medical Superintendent, according to regulations.
- (2) It has been clearly established that the quality of the food is perfectly satisfactory.
- (3) It is financially impossible that they should consider the questions of
  - (a) Granting increased lodging allowance
  - (b) Allowing ration money when off duty
  - (c) Altering the hitherto existing system in regard to gratuities and pensions.
- (4) The Medical Superintendent has been requested to consider the practicability of meeting the wishes of the Male Staff in regard to the increased privacy of sleeping accommodation. The provision of separate bedrooms cannot be entertained.
- (5) The Board will be prepared to further consider the system of payments under the Insurance Act, as soon as the Act has become fully operative, as regards benefits.

- (6) The Board being reluctant to retain in their service any employee not fully satisfied, feel, under the above circumstances, that they must require the withdrawal of the letter referred to. The signatories are to communicate with the Medical Superintendent for that purpose before 12 o'clock noon on Saturday next, the 16th inst.
- (7) The Board further invite all members of the Staff who may be dissatisfied with the food, or other conditions of their employment, voluntarily to resign their appointment.

BY ORDER

The first strike among asylum workers centered on diet.

At Rainhill Asylum, in Lancashire, the substitution of oatmeal porridge in place of meat on the breakfast menu for Monday April 6th, 1914, led to industrial action among male attendants. The normal work of the asylum was stopped as 35 attendants occupied the breakfast room, refusing either to eat the porridge or return to the wards. The Medical Superintendent, Dr. Cowen, visited the scene of the trouble a number of times, but despite thinly veiled threats of disciplinary action, they refused to budge. By mid-morning the mood of revolt had spread throughout the Asylum where staff kept their eye on patients but would perform none of their normal duties. At midday Dr. Cowen had agreed to reintroduce the old diet sheets. The strike was over and the attendants left the breakfast room. The action appears to have been spontaneous and unofficial. The E.C. subsequently at its April 25 meeting congratulated Rainhill on its 'magnificent stand' but stated that in future grievances should come before them first 'in order that any action might be in accordance with the Constitution of the Union and have the full resources of the Union behind it'. In the aftermath of the strike, ten days later, the 35 attendants were hauled before the Visiting Committee and threatened with disciplinary

action, unless they apologised for taking such 'drastic' action without first consulting them. This they duly agreed to do.<sup>(33)</sup>

By mid 1914, there were therefore signs of an increasing restiveness by asylum staffs. Membership, having fallen during a spate of victimisations in 1912 and 1913, had now reached 7,900 - a goodly proportion of the 12,337 nurses and attendants in England and Wales. As a result the EC were beginning to exercise a more adventurous policy in the localities, reviewing their disapproval of strike action. This changed mood was also reflected in a more open commitment to the wider labour movement. This occurred partly, perhaps, as a result of the assistance provided by Trades Councils in a number of instances. In July 1912, a proposal to affiliate to the TUC was left on the table not so much as a matter of principle but due to financial difficulties. However, as was seen earlier, the NAWU was avowedly non-political. In 1914, however, the union's Conference passed a motion to put affiliation to the Labour Party to a ballot of the members. This followed the Trade Union Act 1913 which established the right of unions to set up political funds on the understanding that those opposed to the levy could individually contract out. Thus the NAWU affiliated to the Labour Party before it affiliated to the TUC.

### (3) Problems in Organising Before 1918

Union activists often had some difficulty in securing the support of the members. The key figure was the Branch Secretary: in those days to take office was often to be placed in an exposed position. Quite early on, the Union Journal observed that there are different types of members, with varying degrees of loyalty to trade unionism. For example, an editorial in January 1913 differentiates



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When Men or Women are dissatisfied with their conditions  
of employment there are two courses open to them:

**One is to Lie Down and Whine ;**  
**The other is to Stand Up and KICK.**

Don't keep your Wish-bone where your Back-bone ought to be.

**Do Something, and you'll Be Something!**

The N.A.-W.U. is waiting to assist you.

Our address is 29, Corporation Street, Manchester.

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One sign of a growing mood of militancy by staff before  
World War I: an advertisement in the Union Journal in September.

between 'true unionists', who join from 'principle' out of a sense of 'duty to help in the work of improving the service for others - for those who will come after'; 'selfish' members 'who join merely because they hope for some personal gain'; and 'discontented grumblers' who, it was argued, are 'more ready to criticize than sacrifice themselves', and were felt to be 'generally blacklegs at heart'. (34)

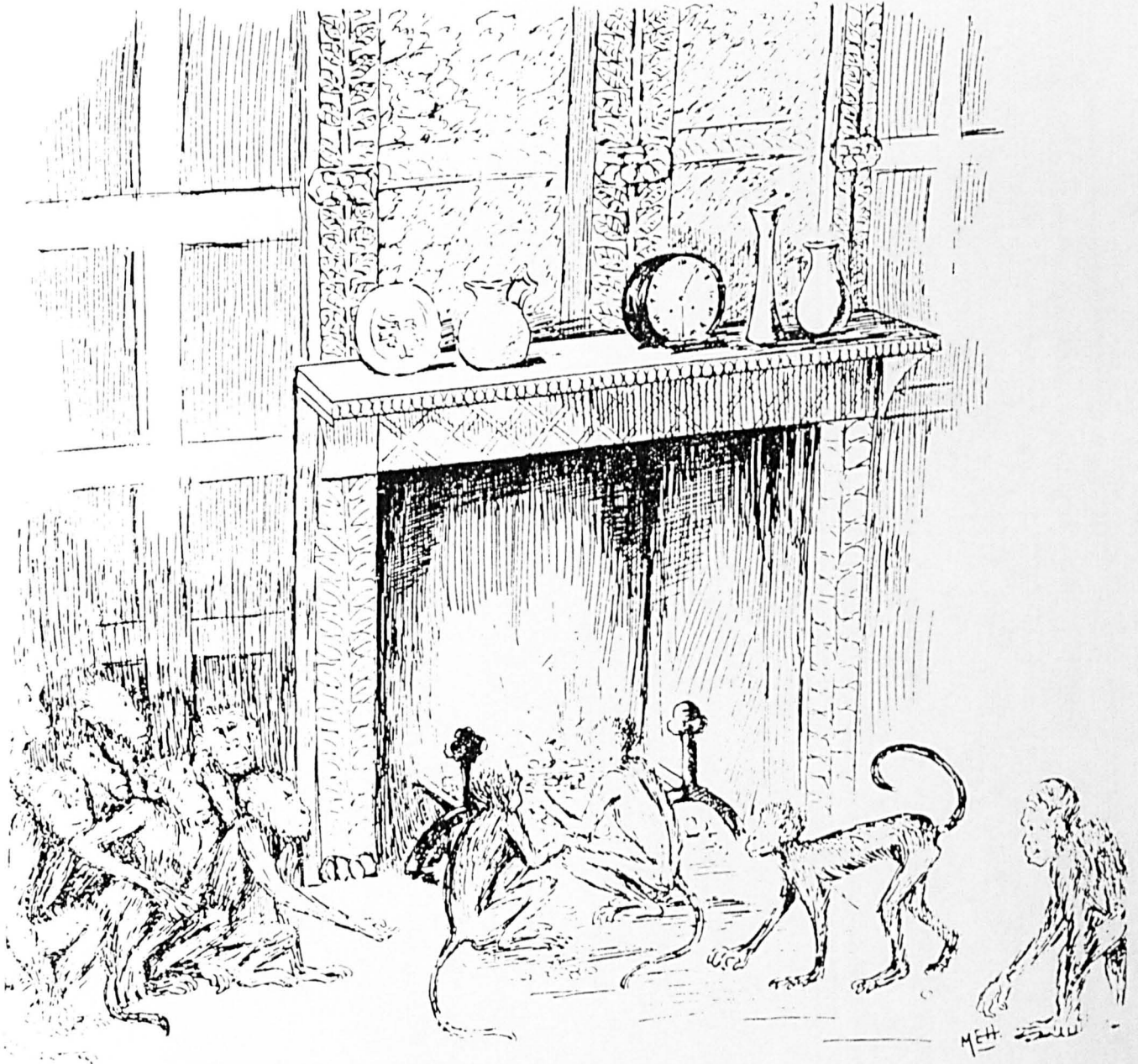
Clearly the journal was seeking to encourage the development of as many 'trade unionists' as possible, at a time when they relied upon the spirit of altruism to hold the union together and when few material gains were being made. Solidarity was seen very much by those who helped sustain the union in those days as an end in itself. For example, in February 1913, when a new branch of 30 members was formed at West Ham, the reason was said to be

... solely to carry out the first principle of unionism, - viz., to help others, and to improve the conditions of Labour by all legitimate means. As regards their own conditions they have no special complaints to make; but, knowing the conditions under which some Asylum workers live, they consider it their duty to support them in every way possible.

(35)

Neither was the union averse to deploying ironic humour to shame apathetic workers into supporting trade unionists, and the risks they took on behalf of fellow workers, as can be seen from the following cartoon.

# CARTOON.



## One Monkey at the Fire, to the Other :—

"Look at those greedy, lazy blighters! They want all the chestnuts we get out, and will enjoy all they can grab, but they are too cowardly to help to get them out for fear they burn their pretty little fingers!"

The major problems of recruitment, however, lay among women workers. In 1914, though overall membership was 7,900, men comprised 5,200, while women only totalled 2,700. One of the most important reasons for the disparity was the increased turnover among female staff which, of course, was largely a reflection of the different positions of men and women in the labour market. For example in January 1912 it had been reported that of the 100 or so changes during the year at Wakefield Asylum 85% had been amongst the female staff, a high proportion of whom were 'girls in their teens'. According to the Report of the Commissioners in Lunacy in 1914 55% of the men, but only 26% of the women had served for more than 5 years.<sup>(36)</sup>

Understandably, those women who did not stay long in asylum employment could hardly be expected generally to have strong commitments to trade unionism. This does not mean they were not dissatisfied, but rather their response was more often to 'vote with their feet' than to 'dig in their heels' and try to change things. Those women nurses who were longer-serving tended more often to look to general nursing as their reference group, and hence be members of the Asylum Workers Association. Furthermore, though the pensions issue was central to many men, it could not have excited the majority of women, who rarely stayed long enough to collect one. Part of the decline of the union between 1912-13 was put down to a move out of NAWU by some women members back into the AWA. High turnover created other problems, in particular, a continual emphasis has to be placed on recruitment, as staff leave. But since men generally stayed longer, recruitment of them was more frequently a once for all venture.

Yet this must be put in its proper context. Large numbers of women employees joined the union and were every bit as committed as the majority of men. Nevertheless, at a meeting in Prestwich in December 1911, George Gibson addressed women workers complaining that 'the ladies are the weak point, whereas they ought to constitute the strong point of the Union'. A major difficulty was that 'the majority of women did not intend to settle down to permanent employment in the Asylum. Nevertheless, he hoped they would 'stick to the Union', because it was best 'to leave a situation a little better for those who are to follow'.

Mrs. Eddie, an outside trade unionist, then addressed the meeting. Although it was widely considered that women's place was 'in the home' she asked

how many women are there who have no home and are obliged to go out on the labour market, and when they are admitted there they are given the lowest possible wage they can be coerced into taking?

She herself had become a trade unionist after having married and felt that trade unionism

... tends to counteract the narrowing influence of home life. Women are apt to regard their own immediate circle as being the only people who count, but this is because for generations they have been trained in this belief, and if men had been placed in the same position their outlook would have been as limited as that of the women.

(37)

Mrs. Eddie also drew attention to the lack of any woman on the NEC of the NAWU. The NAWU records also show that during this early period, one or two women attended Conference, but no woman's name appears on the lists of Branch Secretaries during the first years of the union's existence.

The onset of military hostilities in August 1914 led in general to a lessening to industrial and political conflict. The bulk of the Labour movement came out in support of the war effort, and the NAWU was no exception. Along with this, at least initially, was an acceptance of the need for economy. As an editorial in September 1914 put it

In common with other sections of the community, we shall have burdens to bear ... It is imperative however that Visiting Committees should be compelled to shoulder their share.

The fear at that stage was that authorities would not replace staff who joined up, and cited instances where Committees were

... saving the amount of their salaries by making the reduced staff perform the duties of others in addition to their own.

(38)

One who joined up in May 1915 was the General Secretary, George Gibson. (39) In many cases, however, 'temporary' staff were taken on.

These were encouraged to join the union and, indeed, many subsequently became 'established' officers after the War. One reason was that many who joined up to fight from 1914 never returned.

Conditions in the asylums deteriorated during the War as the plight of the mentally disturbed fell even lower than normal down the scale of national priorities. Some asylums were requisitioned for use as war hospitals and the evicted patients crammed into the already overcrowded existing accommodation. The standard of diet was in many cases reduced and little 'extras' like patient entertainments stopped in some asylums. These moves set the context for post-war developments: accumulated grievances among staff which would

almost inevitably erupt into major disputes, and deteriorating conditions for patients which would result in a spate of 'scandals' in the 1920s. The most immediate effect, however, was a staggering rise in the patient death rates. Before 1914 the overall deathrate was under 10% a year. By 1917 it had risen to 17.4% overall and 21.5% among male patients.<sup>(40)</sup> The big killers were dysentery and tuberculosis, associated with poor hygiene, overcrowding and inadequate nutrition. Staff were also at risk: one of the later battles of the union in the 1920s was to press for tuberculosis to become a scheduled industrial disease.

One of the major issues tackled by the union leadership during the War was their objection to female nurses working on male wards of asylums. Outside Scotland, this practice had been previously virtually unknown, but the pressure of staffing and finance due to War led to their introduction in England and Wales. The first reported instance was at Hull City Asylum in June 1916. The decision to employ them was immediately satirised in the pages of the Magazine (see below). The NAWU wrote to the recently established Board of Control calling upon it to halt the practice:

... it being strongly felt that, quite apart from the objectionable features invariably accompanying the introduction of cheap female labour in male departments of activity, the present departure is reprehensible and indefensible as being calculated adversely to affect the welfare and health of both patients and girls.

(41)

## A Hull Innovation.

Owing to the alleged difficulty of procuring male substitutes for the attendants now serving with the Colours (but really, we suspect, to secure for himself a cheap newspaper advert.), the medical superintendent at Hull City Asylum has adopted the expedient of transferring four female nurses from the female to the male side of the Institution, where, under the supervision of two charge attendants, they perform the duties usually falling to the lot of mere man.



One little Super., struck with brilliant thought,  
From the female side four little nurses brought :  
Dumped them on the male side— an idea quite inane ;  
Now wasn't that a silly scheme for curing the insane ?

The leadership's view was not just that employment of women on male wards threatened to undercut the price of male labour, but also that it was morally degrading to the women concerned, and exposed them to unmentionable dangers. Besides, if authorities were prepared to pay adequate wages, 'no difficulty would be experienced in obtaining the requisite number of male workers'. The Magazine complained also at the 'oppressive conditions' of asylum work and that staff were increasingly being expected to work unpaid overtime. It was also clear that some male nurses were worried about the prospect of coming under the authority of women nurses.



The culmination of the campaign was the publication of an EC 'Manifesto' in August 1915 (see photocopy on next page) and the publication in the journal each month of a 'Roll of Dishonour', listing those authorities who employed female labour on male sides. The strong response probably succeeded in slowing down the increase of women nurses on male sides, but by no means eliminated them. After World War One, opposition to the practice began to slacken, but it was still a live union issue (especially in LCC mental hospitals), in the 1930s.

The second major issue, which was festering below the surface, was concern at the rapid increase in the cost of living, at a time when people were not acclimatized to a constant inflation. Between July 1914 and August 1918 the Ministry of Labour estimated the increase in the price of items included in the working class family budget (food, clothing, rent, fuel and light etc) to have risen by approximately 110%.<sup>(42)</sup> The union early petitioned Boards and committees for 'War bonuses', but these were not always sufficient to cover the increased cost of living. Often the authorities were obstructive towards unions' attempts to petition them. For example, in August 1915 the LCC Asylums Committee had refused to see a delegation of staff to discuss wages, conditions and grievances. The most striking success of this period was the full recognition granted by the West Riding and the creation of a Conciliation scheme (see below). By August 1916, the Metropolitan Asylums Board was also accepting union delegations and granting at least some concessions. However, the Lancashire Asylums Board remained adamant in their refusal to recognize the union, despite the protests, in July 1917, of the Lancashire and Cheshire Federation of Trades Councils. The justification by the Board was that

# Female Nurses in Male Asylum Wards.

## A Manifesto from the Executive Council of the National Asylum-Workers' Union.

THE EXECUTIVE COUNCIL of the National Asylum-Workers' Union view with serious concern the adoption by many Asylum Authorities, with the approval of the Board of Control, of a policy which has for its object the partial substitution of Female Nurses for Male Attendants in the care and charge of insane male patients in public asylums, and desire to record their unanimous condemnation of a practice which will, they are convinced, if persisted in, prove physically and morally detrimental to the nurses and injurious to the patients, besides impairing the efficiency of internal Asylum administration, and possibly prejudicing the positions of those of our male members now serving with the Colours.

THEY FIRMLY BELIEVE, having each personal and varied experience of the duties attaching to the treatment of male lunatics of all classes, that the work is of a nature entirely unfitted for women to perform; involving degrading duties repellent to all the finer instincts of chaste womanhood, and accompanied by a danger understandable only by those actively, intimately, and constantly associated with Asylum work. From the point of view of the patients' welfare they deprecate the bringing of male patients, often morally perverted, into close association with persons of the opposite sex, and they give warning that the substitution of the **LESS EFFECTIVE CONTROL** of female nurses over male patients for the essentially firm supervision of male attendants is likely to give rise to an insubordinate and mutinous spirit among the least tractable inmates that may gravely endanger the safety of both patients and staff.

IT IS THE OPINION of this Executive Council that neither Asylum Authorities nor the Board of Control have given this subject the consideration which its importance demands, but have, on the contrary, prematurely embarked upon an experiment for which there is no justification; the alleged shortage of men for Asylum duties being more apparent than real, as is proved by the facility with which other Asylums, adjacent to those now employing females in male wards, are able to procure male substitutes for those of their staffs who have enlisted in the Army.

WHILE IT IS QUITE POSSIBLE to conceive that circumstances may arise before the conclusion of hostilities necessitating a departure from existing practices, none have yet arisen sufficient to warrant the substitution of female labour in a sphere where the employment of young women has hitherto, for the soundest medical reasons, been debarred; and in requiring their female employees, frequently against their wills, to undertake such duties the Asylum Authorities concerned are exercising an unfair advantage and exerting undue pressure, having regard to the Nurses' Contract of Service, which binds them, under penalty of dismissal, "to perform any duty allotted, although not of a nature which they usually perform."

WITH THE OBJECT of combating a pernicious and dangerous innovation the Executive Council are prepared to accord the fullest support to any protest made by female members of this Union, provided such protest is made in accordance with the procedure laid down in the Rules of the Union, and after approval by the E.C.; and all branches affected are requested to offer every facility to our female members to avail themselves of the effective backing of the Union in any steps they may determine upon. In the last resort the defeat of the experiment depends upon the good sense and womanly delicacy of the nurses themselves, and upon the amount of opposition which their finer feelings will engender against the scheme.

ONLY IN THE EVENT of it being conclusively proved that male labour is quite unprocureable on any reasonable terms will the Executive Council feel justified in suspending active opposition to the employment of female nurses in male Asylum wards, and then only on the understanding that equal pay, emoluments, and privileges shall be awarded to women who do men's work as to the men whose duties they perform.

they could not have the authority of the medical superintendents interfered with by the Union ... Were the asylums to be managed by the Union or the Board?

(43)

After this refusal, the Lancashire Federation of the NAWU declared that it would be considering strike action. A new mood of militancy was abroad in the union ...

## Chapter Six - Organising Mental Nurses 1918-39

### (1) Conflict and Accommodation 1918-31

The asylum workers of Lancashire had in 1910 been the spearhead of the social movement that had created the National Asylum Workers Union. Now, in the closing days of the War, they were again to be in the forefront, this time of a campaign to win real improvements and proper recognition from the authorities.

During 1915 and 1916 membership of the union had started to decline from its peak of nearly 8,000 in 1914, to under 7,000. In 1917, however, recruitment picked up, whilst the Magazine noted that:

... "A certain liveliness" is manifest among many of our branches at the present time, the unrest being due to an accumulation of grievances, which continue to be merrily piled upon asylum staffs.

(1)

These included the rapid increase in the cost of living and the inadequacy of war bonuses, the increased responsibility that had been placed on staff, and the reduction in the quality of rations. Other signs of a stirring among asylum workers are provided in the same issue of the Magazine. In March after Dr. Gemmell (the 'Czar of Whittingham') had substituted margarine for butter in their diet, eleven of the fifteen laundry maids, some with seventeen years service, tendered their resignations:

They gave the Matron to understand that although they objected on principle to the interference with their rations, they were prepared to eat good margarine - but not the sort dished out to them up to then.

(2)

The new mood among workers was given expression in an article by George Gibson:

Asylum workers, in common with all other workers, are looking forward to a better time in the future. They expect that they will be met by their visiting committees and governing authorities in a reasonable manner, and in return are prepared to assist in the work of reorganisation.

Two things they will demand:

- (1) Recognition of their Trade Union
- (2) A higher standard of living.

The movement in Lancashire dated from October 1916, when Branch Secretaries met at Union Head Office in Manchester to try to find a way to reverse the erosion of membership and commitment to the union. The outcome was a four point programme for recognition, improvement in pay and hours, and uniformity between all Lancashire asylums. The adoption of these objectives led to a bold announcement on the front page of the Magazine in November 1916, (see below).

During 1917, the workers began to petition the Lancashire Asylums Board with their demands. In May 1917, following a recommendation of the Finance and General Purposes Committee, the Board refused to grant recognition to the union. By this time talk of strikes was in the air. Mr. Bootham, a Labour member of the Board from Nelson, was reportedly shouted down when he said that

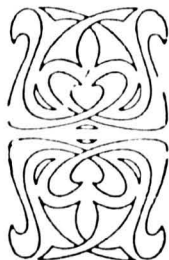
The greatest danger today was that of a strike. If he were a member of the Asylum-Workers' Union, and the Board refused to give him recognition, now was the time when he would strike.

(3)

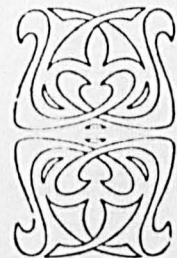
# WAKE UP, LANCASHIRE!

*Who Waits for To-Morrow, Misses the Opportunities of To-Day.*

At a meeting of Lancashire Branch Secretaries held at the Head Office, Manchester, on Saturday, October 14, it was unanimously decided to recommend the following programme to the branches for adoption and to urge upon members the desirability of concentrating the whole of the Union energies in Lancashire upon the attainment of these objectives:



1. Official Recognition of the Union.
2. A Reduction of Hours of Duty.
3. A Standard Rate of Wages.
4. Payment of Wages Weekly.



Plans were devised for effectively furthering the above programme, and will be put into early operation provided the members of each Lancashire Branch sanction the proposals recommended. These will be submitted to the next General Meetings of the Branches, and it is most important that as many members as possible should attend to express their opinions and record their votes.

Lancashire has not maintained its position in the Trade Union movement since the war started, owing, it is said, to the apathy of the members; it is up to the members to disprove this charge by attending the next General Meetings in force, and thereby show that they are willing to follow a strong lead.

## NAWU Magazine, November 1916

Labour, however, did not control the Lancashire Asylums Board.

Instead, it was dominated by Liberal employers. Yet again, on

June 29, 1917, the Board, presided over by Sir Norval Helme,

refused to grant recognition. Their clear intention was to uphold

the authority of the Medical Superintendent, in circumstances

of growing staff discontent. Thus Alderman Shelmerdine from

Liverpool claimed that:

It would be absolutely fatal to take any steps that would admit outside interference of any kind with the heavy responsibility of a medical superintendent, who had the welfare of some 3000 people in his hands night and day. At Whittingham recently the kitchen staff struck, walking out one morning as a protest against the employment of a woman they did not like. The superintendent gave them an hour to consider their attitude, but it was not till the afternoon that the kitchen staff changed their minds and wanted to start work again. In the meantime dinner was prepared for patients with the utmost difficulty. In that case the superintendent dismissed the whole of the strikers (Hear, hear)

Following this refusal, the Lancashire Federation of the NAWU met on August 4 and resolved unanimously to ask the Executive to conduct a strike ballot among members in Lancashire. In the meantime, Herbert Shaw (in Gibson's absence, the Acting Secretary of the NAWU) wrote to the Minister of Labour on 24 July 1917 complaining of the Board's 'persistent and stubborn refusal to recognize the union, or to allow any representations on wages and conditions'. The Chief Government Arbitrator Sir George Askwith, then wrote to the Board, offering his services. On August 10th, by a narrow majority of 21 to 19, the Board agreed to refer the issue of union recognition to arbitration. The Lancashire Asylums Board, however, communicated to Sir George Askwith that they were prepared to allow an extension of existing practices, where attendants first 'petitioned' Medical Superintendent for wage increases, the issue then being forwarded to the Visiting Committee of the individual asylum. But they would now permit a union representative to take the place of individual members of staff.<sup>(5)</sup> Sir George Askwith then wrote to Herbert Shaw, saying he no longer believed that arbitration was necessary.

This was recognition of a sort, even though the union was far from happy at the proposals. The Board were still insisting that all applications be made first to Medical Superintendents. Neither could the union make an application for staffs at all Lancashire asylums, without first submitting simultaneous claims at each asylum, and seeing them referred upwards. Nevertheless, the Executive Council recommended that the Lancashire members give the system a trial.

On March 7 1918, the first Union deputation appeared before the Finance Committee of the Board. Consisting of Mr. E. Edmondson (the President) and Herbert Shaw (as Acting Secretary), it presented a list of 9 demands (which had already been formally submitted on January 7th)

1. A permanent advance of wages of 5s. per week to all members of the indoor staffs, male and female.
2. Payment of all wages weekly.
3. All artisan's labourer's and stoker's wages on the established staffs to be brought up to halfpenny per hour below the Trade Union rates prevailing in the nearest borough: other conditions to remain unaltered.
4. A 60 hours' week, exclusive of meal times, for the indoor staffs; all overtime to be paid for at the rate of time and a half.
5. The discontinuance of the system of retaining a month's wages in hand, and the refund of any such monies now in hand.
6. One shilling and sixpence per night for married men compelled to sleep in the institutions.
7. For possession of the Medico-Psychological Association certificate £2.10s. per annum (Preliminary), £2.10s. per annum additional (Final).
8. Permission to post Union notices in the institution mess rooms.
9. Dietary lists to be posted in mess-rooms.

On 30th May 1918, the Board reached a decision. Whilst a war bonus (rather than a 'permanent advance') of 5/- a week was granted to all indoor staff, and it was also agreed that asylums should keep no more than a week's wages in hand, none of the other demands was met.<sup>(6)</sup>

By June 1918 membership had risen to more than 9000. By the end of July 1918, the NAWU Executive had sanctioned a 14 day ultimatum by the Lancashire Branches to the Board

That we again put forward the same requests to the Lancashire Asylums Board as our absolute minimum.



On August 9th Herbert Shaw wrote to the Board, informing them of this decision, saying that

... I wish to impress upon you that the position is extremely serious, involving, as it does, the contemplated withdrawal of over 1,200 members of this union employed at the Lancashire Asylums.

(7)

This ultimatum was, however, ignored by the Board who promised only to consider the letter at the next meeting of the Finance Committee on August 15. Herbert Shaw asked the Ministry of Labour to intervene but they claimed they were unable to, since the Board did not wish to proceed to arbitration.

According to his account in the Magazine, Herbert Shaw with Edmondson, the union's president, addressed meetings at the end of August at Rainhill, Whittingham, Lancaster and Prestwich, where they sought to calm the situation. However, staff were tired of waiting:

At all meetings we found the strike fever raging and practically all branches declared for a method of striking contrary to the policy submitted by the speakers on behalf of the Executive Council of the Union.

(8)

On their visits they discovered through Sir Norval Helme that a farcical mix-up had occurred: the Board had not refused arbitration at all. Instead the Ministry of Labour had got their application for arbitration confused with another, over a completely different dispute, from the National Union of General Workers. However, this did not substantially alter matters. Sir Norval still maintained that it could not be considered until the meeting of the Finance Committee, which was not due to take place until after the 14 day ultimatum had expired.

The national leaders were in no position to hold the membership back until the slow wheels of the Board rolled round. A strike finally broke out at Prestwich on September 4th. The evening before, all the paid officials, the President, Secretary, Treasurer and a leading Executive Council member, George Vernon had rushed to Prestwich,

... owing to information which had reached the Head Office of the imminence of trouble. The crowded meeting almost unanimously decided to cease work at six next morning and to leave the institution. The women would hear of nothing else, so the necessary arrangements were made accordingly. Duties were apportioned on to those members who were required to stay in the asylum to safeguard the patients, and instructions given to those who were to leave work.

(9)

The strike also had its humourous side. Some of the resident women were deliberately locked into their accommodation by the authorities to prevent them striking. Yet they got out, by means which 'the ladies themselves could best explain' and joined their brothers and sisters picketing on the gates. The strike was solid: only five members of staff went to work as normal. It was also reported that the Chief Constable of Lancashire had refused to allow his men to be used in the place of nurses and attendants. Police patrols were posted round the gates and reportedly made friendly contact with the strikers.

Events moved rapidly with telegrams and phone messages passing speedily between the Asylums Board, the Ministry of Labour and the union's leadership. The NAWU wanted immediate arbitration and a promise of no victimisation. By the end of the first day of the strike Sir Norval Helme had agreed to convene a special meeting of the Board for the next day, September 6th, invited the union

officials to address it and urged the staff to call off their strike. This they refused to do. News had reached them that the staff at Whittingham Asylum had come out at dinner time. Although they had returned to put the patients to bed at six in the evening, they had promised to come out again at six in the next morning.

This they duly did:

Those on duty were relieved by the strikers every three hours. No work was done inside beyond supervising of patients ... As at Prestwich, the staff administration was entirely taken out of the hands of the authorities, and the strikers provided such number of staff and reliefs for each ward as they considered necessary for safety. Pickets were placed at all approaches to the Asylum. A full service was provided from the boiler house for that part of the institution which has been taken over by the military for the accommodation of wounded soldiers, but the asylum supply was curtailed.

(10)

As at Prestwich support for the strike was solid, 'Particularly among the ladies'. Meals and accommodation were provided at the local pub, the Stags Head at Goosnargh, near Preston. Sleeping accommodation had been arranged by the strikers in readiness for a long dispute - one sign, if it were needed, of the strikers' determination.

On the same day, the specially convened meeting of the Asylums Board met at nearby Preston, and was addressed by Herbert Shaw. After discussion, the Board dropped an original insistence that the nurses return to work immediately. Instead the Board passed a resolution that the NAWU application be referred to an arbitrator to be decided by the Ministry of Labour. When pressed, Shaw stated he was confident that members would agree to abide by the arbitrator's decision. It also contained the fundamentality important clause:

That no employee at any of the asylums belonging to the Board be penalised for participating in the strike now taking place at some of the asylums.

Shaw went hot foot to Whittingham and, after telephoning Prestwich, addressed the assembly of Whittingham strikers from the upper storey of the Stags Head. The strikers applauded him and were back to work within the hour. At Prestwich, the President Mr. Edmondson gave the strikers the news. He was "chaired" by the assembly, after which a procession formed up and they marched triumphantly back to work. These celebrations were a little premature. The arbitrator, Mr. G.M. Le Breton, allowed only three of the original demands - on the 60 hour week with overtime rates for excess hours, artisans' rates to be increased to within  $\frac{1}{2}$ d an hour of the prevailing union rate in the borough, and a maximum of a week's wages in hand. All of these, Shaw claimed in the Magazine, the Board probably would have conceded anyway. (11)

Still, despite widespread disappointment at the results, the prestige of the union had risen considerably. Asylum workers had demonstrated an ability to stand united against their employers. Within two months of the strike, twelve new branches were formed and 2,500 new members enrolled into the union. It is perhaps worth noting in passing that the same meeting of the Board which voted the paltry increases through, also agreed, with some dissension, that the salary of Lancashire Medical Superintendents be increased by £200 a year or, expressed another way, an increase amounting to more than the yearly salaries of three attendants.

As might be imagined, there were accusations that patients had suffered as a result of the strikers' actions. The union denied all such accusations strenuously, saying that adequate cover had been provided and blaming the authorities for making the strike necessary. The Magazine also argued that the

patients' welfare will be better safeguarded and more adequately promoted by the services of free and intelligent men and women, working harmoniously under fair conditions, than it ever has been or could be under the old system of employing underpaid servants for an excessive number of hours on duties exceedingly trying to the nerves and tempers of those engaged in them, and subject to a ruthless discipline, the object of which seemed to be the creation of a class of slaves subservient to those in authority above them, and brutal to those unfortunate enough to be in subjection to them.

According to a report in the Manchester Guardian the bedridden patients had not received all the attention they had required. However:

An official at the Prestwich Asylum told a "Manchester Guardian" representative that during the absence of the Nurses and Attendants no troublesome incident occurred. The patients realised that they were suddenly living a more unrestrained life and they regarded the change as a picnic.

(12)

An article, purported to have been written by a Whittingham patient (and hopefully even genuine!) mocked the attendants' withdrawal of their 'herculean' labours to stop the asylum 'machinery' which normally only amounted to 'the observance of the clock':

## The Patients' Point of View.

[The following whimsical contribution from a Whittingham patient is well worth reproducing, if only for the purpose of showing how insane patients and certain Board members think and express themselves on similar lines.]

### Asylum Strike (By an Inmate).

Thursday morning saw the glorification of those who toil not, neither do they spin. The fated day had arrived. For days and weeks those who had been *labouring* under delusions that they were ill-treated by the authorities of the County of Lancaster, downed their tools (exactly what these tools are is difficult to ascertain); however, they stopped the patients from working by this method reduced this hive of industry to idleness and greater imbecility than it usually exhibits. What was the cause of this? So far as we can ascertain the cause was to be found in the staff finding they had less work to do and more time to think. They came to the conclusion that they were underpaid and the only remedy for this state of things was to stop the machinery. Now the machinery of an asylum is very simple, the main factor being the observance of the clock. The workers in an asylum come to their business wondering how long it will be before the patients are in bed again, and when that time comes they devoutly thank God that they are another day nearer their pension. As to whether the patients have been fed or whatever has happened to them is of little or no consequence. And it was under such conditions as these they stopped their herculean labours. And what was the result? The patients sat around and looked at each other in the usual melancholy way, and expressed no opinion about anything in particular, not even wondering whether any dinner would arrive for them. In the meantime, a mass meeting of the busy workers was held somewhere outside the asylum, and their terrible grievances were being ventilated, probably by someone who knew nothing about the matter. The attendants themselves did not realise how they were suffering. After this, seeing the difficulties of the position, the authorities sent over a flag of truce, and suggested if they had any grievances they would give them an opportunity to talk about them, and they said: "For God's sake get back to the lunatics, get back to the sheep without a shepherd, lest they rise and rend the place to pieces, or walk out of the place." But the strikers knew well the sheep had not sufficient intelligence to walk out of a place which they regarded as a home from home. Dinner time came; how it came we don't know, but the dinner arrived, and was quite up to the sample of the extraordinary dinners sent out at this institution.

The patients showed sufficient capacity and intelligence to assimilate the dinner without the aid of any officials. This is evidence that the level of intelligence is not so low as medical men would have us suppose.

These patients have sufficient intelligence to recognise that they are hungry, and sufficient ability to eat and digest what little there is. The day wore on and about three o'clock the officials returned with the glad tidings that they had got something promised. On hearing this the delirious patients went mad with joy, they threw up their caps and shook each other by the hand and behaved as properly constituted lunatics naturally behave. They wept for joy.

The unrest in Lancashire was not an isolated phenomenon but ran throughout the service. And as in Lancashire, women were often prominent among those involved; referred to, in the Magazine, as 'the fighting spirit of the females'. In London a deputation to the LCC, led by the President, Mr. Edmonson, demanded many improvements, including the formation of a Joint Committee between the union and the LCC. Women employees were demanding equal pay. Unrest spread with staff threatening to resign unless pay rates increased by 11/- a week; but with the intervention of a Mr. D. Carmichael, the Secretary of the London Trades Council, as mediator, the authorities began to make concessions. The first of these was the granting of a 60 hour week.<sup>(13)</sup> In the West Country the unrest caused two famous strikes: one a dazzling victory, the other a bitter defeat. Today trade unionists in the health service take the wearing of union badges for granted, but in October 1918 it was the subject of a strike among women asylum workers at Bodmin Asylum. The matron, Miss Margaret Hiney, had been appointed within the previous eighteen months, and succeeded in antagonizing staff by introducing changes which led to an increased turnover. In any case, there appear to have been many accumulated grievances: hours in excess of 80 a week, no recreation room or even bathroom for staff and, as elsewhere, staff bitterly resented the quality of the food they were offered. The nurses were not provided with uniforms, only the material with which to make it up. Neither had the women staff received any cost of living increase since the beginning of the War.

Enter on to the scene a new nurse, Mrs. Hawken. She had been a NAWU member at her previous place of employment, Prestwich Asylum. When the nurses at Bodmin told her of their grievances, she advised them to join the union. 62 had joined out of a staff of 70

within two days, and most of them bought union badges and wore them. They were ordered to 'take off that thing' which they agreed to at first, but then changed their minds. On October 20th they were hauled before the Matron who ordered them to take off their badges, the pretext being a rule that nurses were not allowed to wear jewellery.<sup>(14)</sup> By October 22, the five 'ringleaders' Nurses Hawken, Hill, Adams, Richards and Whitford, had been dismissed by the Medical Superintendent, Dr. Dudley. When they went back to the wards 34 other nurses had decided to go with them. They met Dr. Dudley on the way out who told them they could wear badges, but refused to reinstate the rebel five. Their reply was adamant: 'All or none'. The strike had begun.

Herbert Shaw, summoned by telegram, arrived the next day, Wednesday the 23 October. At a meeting at the asylum with the Medical Superintendent and the Chairman of the Visiting Committee the suggestion was made that the 39 nurses should be reinstated, pending a meeting of the Visiting Committee on Saturday. However, Dr. Dudley was adamant that not all could be reinstated. Mr. Shaw then returned to the strikers and placed management's offer before them: thirty of them could return and the cases of the other nine would be put before the Committee on Saturday. According to the Magazine:

Without hesitation, immediately and decisively they said: "We all go back, or none of us goes back", and this spirit of loyalty to each other never wavered throughout the period of the strike. The motto of the strikers became "All or None".

(15)

The strike caused a sensation in the town, and support seems to have been widespread. Refreshments were provided for pickets on the gate and accommodation for those who needed it.



On Thursday the strikers paraded through the Cornish town, headed by their banner inscribed "All or None". As the week wore on, other workers joined the strike, and male staff at the asylum began to join the Union. On Saturday the meeting of the Visiting Committee was attended by the five rebel nurses and addressed by Mr. Shaw, who claimed that their dismissal was an outright act of victimisation. The Committee were most reluctant to reinstate the 'ringleaders' but, fearing that the strike would spread to the male side (65 of them had since joined the union), they passed a resolution permitting the wearing of union badges, and reinstated all strikers. Work resumed the next day, but more was to happen later. The Visiting Committee set up about revising staff pay and conditions. With the involvement, behind the scenes, of the Board of Control, tentative steps were made towards the establishment of a joint Advisory Committee between the staff and the Visiting Committee. Trouble had continued to fester between the nurses and the Matron. Miss Hiney was given a succession of periods of 'sick leave' and resigned in February 1919 'in view of medical opinion on the state of her heart'.<sup>(16)</sup>

The second dispute in which women members also figured prominently was at Exeter City Asylum, which lasted for six months from the end of April 1919. Phillip Glanville, a carpenter with 28 years service, and President of the local Branch of NAWU, had been dismissed from his post in December 1918, after presenting a petition to the Medical Superintendent for wage increases all round, plus trade union rates for artisans. Dr. Bartlett is reported to have told Mr. Glanville that he did not believe him to be worth trade union rates.

Glanville then told the Medical Superintendent that as he, a carpenter, was not capable of judging

the work of a medical man so a medical man was not competent to pass judgement on the work of a carpenter. Result: dismissed for "insolence".

(17)

The NAWU sought to achieve Glanville's reinstatement for four months before his appeal was finally turned down by the Visiting Committee on April 29. The strike began the next day with 42 of the total staff of 73 coming out in support of their dismissed colleague, 26 of whom were women. According to Mr. Shaw the authorities claimed that 'flighty girls led the men out, but the steady going conscientious men refused to embark on this escapade and stayed inside'. The authorities' response was to recruit blacklegs, some from ex-soldiers and wives of attendants who had continued working. The NAWU appealed for assistance to the local Trades Council, who attempted to blockade the hospital: road and rail supplies were blacked and gasworkers refused to deliver coke. At the Union's Conference later that year, the President expressed the view that

... when this member of ours met Dr. Bartlett in the representative capacity which we assert he was, for the time being, whether it was three minutes or five minutes, on an equal footing with the medical superintendent, and therefore could not be guilty of insolence. (Applause) I further contend that if there were insolent words uttered at that meeting, the insolence came from the medical superintendent - (hear, hear) - and that Glanville was perfectly within his rights ... to reply in the manner he did. ("Quite right")

(18)

The point of principle involved was of fundamental importance. Unless such a distinction was made, union representatives exposed themselves to great risks when pressing a case on behalf of their members.

At one stage the issue was taken so seriously that the NAWU Conference on July 5 1919 passed a unanimous resolution calling for a ballot on national strike action to enforce either arbitration or a Court of Inquiry into the dispute. On July 15, however, the Exeter City Council voted against referring the dispute to arbitration by 38 votes to 14. The next day, the Exeter Trades Council decided to ask all affiliated unions to ballot members on strike action - in effect calling for a local General Strike. Neither the local nor national strikes took place, however, and after the November municipal elections, the Executive reluctantly terminated the Strike. Since the strikers had lost their pension entitlements they were each granted, if they were over 35, an annuity by the Executive of £2 for every year of service. The remainder received victimisation pay until they found alternative employment.

## THE EXETER STRIKE.



THE MEMBERS ON STRIKE.

"All for One, One for All."

Nevertheless the membership and influence of NAWU continued to grow. Between December 1918 to December 1919 membership rose from just under 12000 to more than 15000. It was also more evenly distributed between the sexes. Nearly 7,000 of that total were women members. Central to the development of the union during this period was the formation of a National Programme. The idea for this had originally been mooted in the correspondence columns of the Magazine and taken up by the Executive Council. On September 28 1918 a Special Delegate Meeting - the first since before the War - was held to approve the proposed National Programme. The list of demands was impressive: a minimum wage, 48 hour week, conciliation boards, universal recognition of the union, equal pay for women, state registration for mental nurses (note that the term attendant has become redundant) amendment of the 1909 Asylum Officers Superannuation Act, abolition of the 'emoluments' system, and a political commitment to further the influence of the Labour Party. There was a renewed sense of purpose in the union. By this time, too, the NAWU had decided to affiliate to the Trades Union Congress.

The programme was duly ratified by the branches and presented to the Visiting Committees of Asylums in England and Wales in January 1919. These activities, as well as the mounting public pressure for reform of the Lunacy Laws led the Asylum Authorities to consider setting up a national body to protect their interests. On November 14 1918, a conference of South Western Visiting Committees had met in Plymouth to consider 'the vexed problems which they faced' among which was 'the question of the wages of Asylum employees'. It will be remembered that two of the most significant recent strikes had taken place in that corner of the country. According to press reports

# NATIONAL ASYLUM-WORKERS' UNION.

## NATIONAL PROGRAMME

*Adopted by Special Delegate Meeting held  
in London, on September 28th, 1918, x x*

1. A stipulated working week of 48 hours for all asylum workers, with payment of time-and-a-half for overtime.

2. A minimum wage (with weekly payments and a weekly contract of service) of £2 per week, with a national war bonus of 25s. per week, for both men and women.

3. Equal pay for equal work where women perform similar duties to men.

4. Abolition of the emolument system; all wages to be paid in cash.

5. The institution of wages boards or conciliation boards.

6. Official recognition of the Union by all Asylum authorities.

7. State Registration of Mental Nurses.

8. The furtherance of Local and National Labour representation.

9. Amendment of the Asylums Officers' Superannuation Act, 1909, in the following essential particulars:

(a) **1st Class (Men).**

A pension after 25 years' service, irrespective of age, computed at 1/40th of salary, etc., for each completed year of service, and based on full ordinary wages at time of retirement. The age at which a pension may be claimed as a right to remain as at present, viz.: 55 years.

(b) **1st Class (Women).**

Women to have the right to claim a pension, if desired, after 21 years' service (21/40ths).

(c) **2nd Class (Men).**

A pension after 33 years' service, irrespective of age, computed at 1/50th of wages, etc., for each completed year of service, and based on full ordinary wages at time of retirement. The age at which a pension may be claimed as a right to remain as at present, viz.: 60 years.

(d) **Subsequent Employment:**

This clause to be deleted entirely.

(e) **Transfers to another Asylum:**

Delete the clause which requires an asylum worker transferring to another asylum to remove only with the written consent of the Visiting Committee of the first asylum.

(f) **Allowance to Dependants of Deceased Employee:**

**Substitute:** The Visiting Committee shall pay to the next of kin of any officer or servant dying whilst in the service of an asylum after 10 years' service:—

A gratuity of one year's salary or wages and emoluments after 10 years' service up to 15 years' service; 1½ years' salary, etc., after 15 years' service up to 20 years' service; and 2 years' salary, etc., after 20 years' service up to 25 years.

In the event of a pensioned employee dying before he (or she) has received 2 years' pension, the next of kin shall be paid the balance of the 2 years' pension which the deceased employee would have received had he (or she) lived.

The Conference considered the means to be adopted for establishing a permanent method of cooperation between the Visiting Committees of Asylums in the South West area, and recommended that committees should combine to form a joint committee to consider from time to time the question of conditions and wages of staff.

(19)

This Conference also decided to recommend a working week of 63 hours, minimum pay rates, and to recognise the NAWU. Later in the month a national meeting of Visiting Committees was called to consider a number of issues, including the Lunacy Laws and

The increasing claim of the National Asylum Workers Union and other workers. At present Visiting Committees were often working at cross purposes ... There is a strong desire for cooperation amongst Asylum Visiting Committees. A good method of bringing this about would be to establish a National Council of Visiting Committees of Asylums in England and Wales.

(20)

The Board of Control were also turning attention, after long years of neglect, to the welfare of staff. Could it be that a few months of trade union militancy had achieved more than years of patient petitioning? As its Report for 1918 put it:

The general movement of the working classes towards securing better remuneration and conditions of work has extended to the nursing staff and other employees of Asylum authorities, and the claims advanced have received the careful and anxious consideration of the Board. The comfort and health of the patients are largely dependent on the existence of a well qualified and contented staff, and although the Board has always kept in mind the need for reasonable economy in the measures taken to meet the burden imposed on the nation by the mass of mental defect and disorder, they have for some time felt that the conditions under which Asylum Officers have worked called, in many instances, for improvement not only in pay, but in better provision for rest and recreation.

(21)

This statement, which appeared during 1919, had been the result of sustained pressure from the union. On February 7th of that year, the London County Council had seized the initiative and convened a Conference of Representatives of Public Asylum Authorities in Great Britain, which was addressed at length by Mr. Edmondson the NAWU President. Following that meeting, H.F. Keene, the LCC's chief Asylums Official wrote to the Ministry of Labour to inform them that the Conference had passed the following resolution without any voting against:

That in the opinion of this Conference it is desirable that a recommendation be submitted to the Minister of Labour that an Industrial Council representative of all Asylum Authorities throughout Great Britain and the NAWU shall be constituted on the lines of the Whitley Report, and that the number of such Industrial Council shall be ten on each side.

(22)

The letter also referred to the need to form the Industrial Council 'with the least possible delay' because of 'the urgency of matters which it is desired to place before the Council' (i.e. consideration of the NAWU's National Programme).

The Whitley Report referred to in Keene's letter was a direct consequence of the war, arising out of a Committee set up by the Government, comprising representatives of employers' associations, trade unions, economists and other public figures. It had been charged with finding ways both to secure 'a permanent improvement' in worker-employee relations, and to create machinery whereby industrial conditions 'shall be systematically reviewed by those concerned', to be improved in the future. The Committee's main concern was with industries in which workers were well organised, and this was the subject of their first Report. However, a

subsequent Report in 1918 suggested that their preferred scheme for National Industrial Councils might be extended to less well organised sectors. These recommendations occurred at a propitious time for the NAWU, which was daily growing larger, and its members increasingly restive. The convergence of these two sets of forces put strong pressure on the authorities to establish a national system of collective bargaining in the asylums service. There was just one snag. Despite the concord at the February conference of Visiting Committees on the need to set up an Industrial Council, no immediate moves were made to establish one. This was because the Ministry of Labour disapproved of the idea of forming a separate Industrial Council for the Asylum Service. Instead, it wanted asylum workers to be included within the scope of proposed National Joint Council for Local Authorities Non-Trading Services, and talked the asylum authorities round to this position.<sup>(23)</sup> After a frustrating meeting at the Ministry of Labour on February 26th, the leading officials of the NAWU contacted the Committee of Asylum Authorities. The latter finally agreed to the establishment of a separate Council but stipulated that other unions with some membership among asylum workers (except craft unions) should be represented on it. They also refused to consider the National Programme independently without the participation of these other unions: the Municipal Employees Association, the National Union of Corporation Workers, and the Workers Union.

The NAWU was determined that only they should be recognized to represent asylum staffs, and also to press ahead with the National Programme. The Executive Council threatened to boycott any body on which they were not the sole organisation representing asylum staffs and gave the Committee of Asylum Authorities until



April 1 1919 to consider the demands embodied in the Programme. To show they meant business they issued ballot papers for strike action, to be returned by 28 March. Nearly 8000 members voted for a strike but the threat itself was sufficient to effect a settlement. It was agreed initially to set up a Conciliation Committee between NAWU and the authorities to deal with indoor staffs.<sup>(24)</sup> A Committee covering artisans would be established later, the composition of the Staff Side to be subject to negotiation. The Joint Committee duly sat for the first time on April 4th 1919. The union did not succeed in winning its National Programme, but some important concessions were won, including:

- abolition of payments in kind (except for uniform and boots);
- weekly payment;
- different wage scales for 'urban' and 'rural' areas, the definition to be subject to arbitration in the case of a failure to agree;
- increments to be paid for years of service and on becoming staff nurses;
- female nurses to receive 80% of male rates, including increments;
- cost of living increases;
- encouragement of training for staff (but no financial reward for obtaining certificates);
- abolition of term 'attendant' and use of term 'nurse' for both sexes;
- a permanent Joint Committee to be set up.

Not everyone was happy at the establishment of collective bargaining between NAWU and the authorities. In October 1919, the Asylum Workers Association, excluded from the new machinery, was finally given a decent burial, and disappeared into oblivion. It was even reported that some patients, particularly those who worked for one or other of the 'asylum industries' were claiming comparable conditions of employment:

### 8-hour Day for Lunatics

Lunatics are demanding an 8-hour day. Their complaint is that since the National Union of Asylum Workers has been able to enforce an 8-hour day for its members, working patients have been obliged to labour for much longer hours.

"Naturally" writes one of these patients, "we cannot form a 'lunatics' union', and even if we did we should not be able to enforce our demands. But apart from that there seems to be no legitimate reason why we should be compelled to work longer hours than our attendants. We cannot help being mentally deranged, but we ought to have some form of protection.

(25)

Many medical superintendents were also more than a little peeved. Through their professional association, the Medico Psychological Association (latterly the Royal College of Psychiatrists) they had pressed strongly, from February 20, 1919, to be represented in an advisory capacity on the Industrial Council, 'to indicate how any alterations proposed would affect the welfare of patients'. At a subsequent meeting of the MPA on March 13, 1919 resolutions were passed unanimously opposing uniform hours and condemning overtime pay as 'contrary to the ethics of the Nursing Profession'. It pledged them to impress upon the Ministry of Labour and the authorities that the NAWU was 'unrepresentative' of asylum workers

... since it debars from membership all officers, whilst admitting domestic workers, artisans, and the most junior probationers, and makes no distinction between the trained and certificated, and the untrained.

(26)

The NAWU appears to have paid some attention to these objections, for in 1920 a separate Officers and Sub-Officers Section was created for senior attendants and nurses, in the aftermath of the disappearance of the AWA.

The MPA was unsuccessful in its attempt to establish an Advisory Board on the Industrial Council from which it could veto proposals it did not like. Undoubtedly, the establishment of collective bargaining in the asylum service strengthened not just unions, but also enhanced the standing of Visiting Committees in relation to Medical Superintendents. According to a correspondent to the Magazine:

They feel their God-like authority is being steadily undermined, and that the exercise of their previously unlimited and uncurbed powers is seriously endangered - and they don't like it. (27)

(2) Holding the Fort 1921-31

In 1920, the union reached its interwar peak of membership of 18,000. In 1919, the Nurses Registration Act had introduced state registration for nurses and provided for the setting up a General Nursing Council to govern the profession. The new Ministry of Health agreed that the NAWU should be represented on it. On February 20th 1920 a Permanent Joint Conciliation Committee came into existence, with the newly formed Mental Hospitals Association forming the management side. Further wage increases had been won but, ominously, only about a dozen authorities had observed the award. The South West Authorities, under the Chairmanship of Alderman Munro (who had played a leading part in the Exeter strike) deliberately flouted the award. On the other hand, in some areas, like the West Riding, local joint committees were in the process of being set up. The most important developments, however, were those looming in the external political and economic sphere. The strides made by asylum workers at the end of the war were sustained by a bouyant labour market, which was maintained during

the economic boom that immediately followed the Armistice.

However, by the end of 1920 the beginnings of an economic slump were becoming apparent. By 1921, it had definitely arrived. Exports slumped, unemployment rose, wages fell (but so did prices). By March 1922, over 2 million insured workers were unemployed, although the number subsequently began to decline. The Coalition Government's response were deflationary economic measures. From February 1922 the 'Geddes axe' began to fall and large amounts were chopped off public expenditure. Reductions totalling £86 million had to be found from somewhere and, although the bulk came from defence and education, £2½ million was lopped off the Ministry of Health's budget.<sup>(28)</sup>

By July 1921, the downward pressure on wages was already sufficiently intense for the union to call upon its members to 'stand firm':

## STAND FAST!

The attack on Wages is developing, and the initial steps have been taken by Mental Hospital Authorities for the purpose of reducing their employees to a low standard of living.

We have good reason to believe that the proposals which will be made are unacceptable to any Asylum employee of subordinate rank, whether a member of the Union or not, and a desperate struggle to maintain a reasonable wage is impending.

We appeal to every Asylum worker to join us, and take part in the fight for decent conditions. A revision of wages in a downward direction may be unavoidable, but drastic reductions which *some* authorities propose must be resisted to the uttermost.

**UNION IS STRENGTH. Sectionalism is weakness.**

**JOIN US NOW,** and show your determination to maintain decent conditions  
Labour!

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Membership between May 1920 and May 1921 had fallen by more than 2,500 to stand at a little over 15,000. In September 1921 the first dispute occurred. The Visiting Committee of Bracebridge Hospital near Lincoln withdrew from the Mental Hospitals Association and then, on September 5th, reduced the wages of male indoor staff by 6s. a week and took 4s. 11d. from the wages of female staff. Negotiations with the union dragged on, although the Committee agreed for the time being not to deduct any money. Frustration at the failure of the Committee to reach a definite decision led on October 13 1921 to a strike by all the 150 members of staff:

All working-out parties were brought in, the laundry shut down, the airing court duties were suspended, and all ward work ceased ... But the paramount duty of caring for the safety and welfare of the patients was never lost sight of ... Many of them entered into the spirit of the affair with zest. One male patient, a working-out man, exclaimed "If the - attendants have gone on strike, I'm going on strike too. I've worked long enough in this - institution."

(29)

The strike continued through the next day, with the staff in effective control of the institution, and refusing to provide any meals to senior officers. It ended when a meeting of the Visiting Committee was arranged to take place the following Tuesday, October 18. It was a sign of the times that the Magazine regarded as an honourable victory the agreement of the Committee to reduce wages by a maximum of 4s. a week, in line with the amounts imposed on NAWU nationally by the Mental Hospitals Association.

In the first months of 1922, as the economic crisis deepened, more asylums began to impose wages reductions on staff. In Carmarthen and Lancashire, the reductions were accepted by staff, but in Glasgow, threats of industrial action were in the air. It was at the Radcliffe Mental Hospital, near Nottingham, however, that the authorities experienced the stiffest resistance. 'Official tyranny' at Radcliffe-on-Trent resulted in a strike in April, 1922. The Committee decided to increase weekly hours to 66 and to reduce wages. Every member of the staff was given a month's notice. All those occupying hospital houses were given a month to get out. The strike began on 11th April. On 12th April, the Committee met and dismissed fifty females and seventeen males for insubordination. A busload of black-leg labour arrived at the Institution during the same afternoon. The strike was broken on 14th April, the attacking force consisting of sixty-three policemen, twenty-five bailiffs, black-legs and officials.<sup>(30)</sup>

The defeat of the Radcliffe strikers led the employers to press for further wage cuts. At the meeting the following month, on June 16, called at the behest of the Mental Hospitals Association, basic wages of probationer (i.e. student) nurses were reduced, annual increments were now to be subject to proof of proficiency, and sanction given for hours to be increased. The authorities in rural areas pressed particularly strongly for reductions. It was made abundantly clear to the NAWU representatives that unless they accepted the new conditions, the employers would disband the Conciliation Committee. Anxious to retain some semblance of national uniformity, and weakened by the onslaught against their members, they reluctantly acceded to the employers' determined offensive.

For the remainder of the decade, the NAWU was largely on the defensive. Outside the asylum service, massive defeats were being imposed on working class people, as hopes evaporated for a better world after the 'war to end all wars'. With the failure of the General Strike in May 1926, a mood of resignation set in. In some ways, asylum workers fared better than many. Their employment was not affected by swings in the business cycle; indeed numbers of patients and expenditure rose throughout the interwar period. The worst of the wage cuts were over for asylum workers by the early 1920s. Against the general trend their status and conditions were improving in real terms, and certainly relative to other groups of workers. Membership had fallen to 10,674 by 1926, but then began to rise steadily for the remainder of the decade, standing at 12,500 at the end of 1930.

Claud Bartlett who, following Edmondson's death, had become President of the Union put his finger on it in his New Year Address for 1927. Reviewing the dismal general situation, he observed that

... Unemployment has very considerably increased, and drastic wage reductions in many of the large industries have not been uncommon. Altogether it has been a year of much concern and anxiety to the trade unions catering for the interests of those affected.

However:

... As far as our conditions of employment are concerned, we are in a much more favoured position. Wages have not been drastically reduced, the hours of duty remain unaltered, and the general conditions unchanged. Furthermore we are free from the ever-increasing and menacing problem of unemployment and many of the other unhappy circumstances which are consequent upon economic and social instability.

(3) From Attendants to Mental Nurses

Asylum workers had made the transition from being 'keepers' of the 'mad', to attendants on the 'insane'. Now, during the interwar period, they were to become 'nurses' in 'hospitals' for the 'mentally ill'. Much of this simply involved changes in nomenclature, but underlying them were genuine changes in philosophy of care and (to a lesser extent) a greater preparedness to improve conditions for patients and staff. These changes held profound implications for staff. On the one hand, they held the promise of improvements in pay, conditions and status, an enhanced role in the division of labour which promised to be much less custodial. On the other hand, the adaptability of staff, who had become familiarized to well defined, rule-bound ways of carrying out their work, was put to the test.

Initially, however, the achievement of 'nurse' status had more to do with mental hospital staffs being swept up in the wave that was carrying general nursing towards professional recognition. The union had been ambivalent on the question of professionalism. The pretensions of the Asylum Workers Association were, as we have seen, remorselessly attacked. It seems, though, that the objection was primarily on the grounds that the AWA had not succeeded in winning real professional status, but were trying to convince subordinate staffs that it already existed. This did not mean that the union stood in opposition to professionalism as such, especially if it could lead to better pay, conditions and prospects for promotion. During the 1920s, then, a partial reconciliation occurred between 'professionalism' and 'trade union' principles,



that was also in tune with the more defensive outlook.

As early as 1912, the NAWU had supported the prewar agitation for state registration of nursing, partly as a matter of principle, and partly also because there might be something in it for asylum staffs. The war intervened before the campaign could succeed, and the issue was postponed in the face of more urgent preoccupations. Women's aspirations rose as a result of the War. Many of them participated in the munitions industries and in the hospital and nursing services. We have already seen that women played a central role in the post-war militancy of the NAWU. Some settling of accounts was imminent. Two of the most important were the extension of the vote to all women over 30 in 1918, and the achievement of state registration of nursing in 1919 - the latter one of the first acts of the newly formed Ministry of Health.

The Nurses Registration Act of 1919 established a register of trained nurses which was divided into a number of parts: general, mental, sick children and any other prescribed part (under which mental deficiency was later included as a separate nursing qualification). At this time male nurses could not become qualified as S.R.N. s and were admitted to a supplementary part of the Register. The Act also set up a new governing body for the profession: the General Nursing Council, with a majority of nurses, appointed initially by the Minister, and charged with compiling a syllabus for future examinations and compiling an initial register of nurses.<sup>(32)</sup> Mental nursing was included after a deputation from the Medico Psychological Association went to see the Prime Minister.

The College of Nursing were given a clear majority of the nurse members on the Council. While the Bill was going through, the NAWU pressed strongly for representation on the Council, and received assurances from the Ministry that they would be included. The first NAWU representative nominated on to the GNC was Tom Christian the President of Banstead Branch and a NEC member. In the first proper elections, although both he and Maud Wiese stood, only Miss Wiese was successful.

The union, though participating in the new Council, was also anxious to argue that the GNC was no substitute for proper trade unionism. A local official of a London Branch the NAWU had written to Head Office complaining that

There seems to be an erroneous idea among some members of the staff at this asylum that since they have become "registered nurses" there is no further need to belong to the Union.

The Magazine pointed out that the GNC had no powers over wages and conditions of work, and drew a few conclusions from history:

Mental hospital staffs improved their conditions of employment when they inaugurated and built up an effective trade union to protect and promote their interests, and not until then. They can only maintain those improved conditions in the future by the same effective methods. General hospital nurses are too dignified to organise and consequently they suffer an economic slavery which mental nurses would not tolerate.

(33)

The union therefore did not regard the GNC as a panacea for the problems confronting its members.

## General Nursing Council Election in December.

### Vote for the N.A.-W.U. Candidates.

In December next a new General Nursing Council will be elected, who will hold office for a period of five years.

Mental nurses will be entitled to nominate and vote for two candidates—one male and one female registered mental nurse.

Each candidate for election must be nominated on a *separate* nomination paper signed by not fewer than SIX nurses registered on the same part of the Register as the candidate.

Candidates for nomination and election must have applied for registration before October 1st, 1922.

Nomination papers (which will be ready by November 1st) can be obtained from the General Nursing Council for England and Wales, 12, York Gate, Regent's Park, London, N.W.1, and when filled in must be returned to the Returning Officer at the same address.

The nomination paper must be accompanied by a declaration in writing, signed by the person nominated, acknowledging that he or she consents to be nominated, and must be delivered by post or otherwise **NOTICE SOON ON NOVEMBER 24TH.**

On December 1st ballot papers will be sent out to all nurses who are registered, or who applied for registration before October 1st, 1922, and were subsequently approved for registration.

Any registered mental nurse who fails to receive a ballot paper by December 2nd or 3rd should immediately write to our present representative on the General Nursing Council, Mr. T. Christian, 1, Downs Road, Sutton, Surrey, who will look into the matter immediately.

Two official candidates of the N.A.-W.U. (one male and one female), whose names will be conveyed to all branches of the Union before November 1st, will contest the election.

Registered mental nurses should restrict their nominations to these two candidates and vote solidly for them. By these means the return of the N.A.-W.U. candidates will be assured, and the interests of mental nurses will be safeguarded on the new Nursing Council.

To nominate or vote for any other candidates will divide our forces and decrease our voting strength, and possibly let in the non-unionist nominees.

PLUMP FOR THE N.A.-W.U. CANDIDATES

An announcement in the NAWU Magazine for October 1922 urging support for the union's candidates.

The most contentious issue was that caused by the GNC's plans over the future of mental nursing. The national training scheme, begun in 1890s by the Medico Psychological Association, was well established by the time of the 1919 Nurses Registration Act. At first everything was sweetness and light: the GNC draft rules proposed that holders of the MPA certificate, or anyone else with 3 years training would, as a transitional arrangement, be permitted to register as Mental Nurses. In return, the MPA would in future cease to examine and award certificates to mental nurses. However, by 1924 this apparent alliance between general and mental nursing interestswas beginning to crack. In January Miss Wiese published a letter in the Magazine which disclosed that a GNC circular to the Matrons of 233 hospitals asking them to make facilities for mental nurses to take SRN within 2 years, yielded only 104 replies of which only 22 were in favour of such a scheme. Of the remainder, 46 simply acknowledged the circular and 73 declared that such a scheme was unacceptable. Miss Wiese quoted from two letters which revealed deep seated prejudices against mental nurses. One matron of a mission hospital stated that probationers at her hospital were

... those who intended taking upevangelistic work and they should possess definite spiritual qualities.

implying that they were evidently lacking in mental nurses.

Another was more blunt, claiming

They do not settle down in general hospitals, and as quite a number of my maids have been accepted as mental nurses I do not feel we should be doing what we are all striving to do, i.e., raise the status of our nurses, if we accept mental nurses for training. Also I do not consider two years sufficient for general training, even if the candidate has spent ten years in a mental hospital.

The problematic relationship between general and mental nursing went back many years, to the turn of the century when, first in Scotland, and later elsewhere, general trained nurses entered mental hospitals and rapidly rose to the top positions, leapfrogging over long serving staffs. Many of them never trained as mental nurses; for others a shortened training scheme was introduced to allow them to qualify within two years - a concession which, as we have seen, general hospitals refused to grant to mental nurses. It was clear that many women wishing to advance their career in the mental hospital service found their way blocked, and were keen to obtain general nursing qualifications. The issue dragged on until 1924, when the GNC decided to make a rule that (on paper at least) gave MPA Certificate holders the right to a shortened training.<sup>(35)</sup>

Yet more problems were looming on the horizon. A meeting of the GNC in February 1924 received a motion from the Matrons Council of Great Britain and Ireland claiming that the GNC had exceeded its authority in allowing members of the MPA to nominate examiners for the final examination for mental nurses. Behind this protest lay the view that nurses rather than psychiatrists should be responsible for examining nurses. The Ministry of Health was deeply concerned at the emerging rift, and the continuation of two virtually identical schemes of training. It seemed that the GNC would go back on its original decision and not admit MPA trained nurses to its Register.<sup>(36)</sup>

In December 1927 both the NAWU candidates, Miss Jean Brown and Mr. E.R. Blackman, won seats on the GNC. The issue of

RMPA\* Certificate holders came to a head in 1928. The July 1928 Conference of the NAWU also passed a resolution, instructing

its members on the GNC to continue to use all the efforts to obtain state registration for all holders of the RMPA Certificate.

After the resolution was carried, Mr. Blackman declared his opposition to its terms:

My personal views are absolutely against the resolution which you have carried here this afternoon. I do not agree that any outside body, apart from the GNC, should carry on examinations for mental nurses.

(37)

This led to an intervention from the General Secretary, George Gibson, who claimed that as long as the GNC fees were so high a separate RMPA examination was needed, and

... we shall be compelled to adhere to this resolution and insist on our representatives on the GNC supporting it.

(38)

Shortly afterwards the RMPA met and decided to press for Certificate holders to be admitted to the Register without further examination. These events were undoubtedly pushing mental nurses closer to the Medical Superintendents, with whom they now perceived a closer community of interest, at least in relation to general trained nurses.

On May 23 1929, a joint meeting was held between representatives of the GNC and the RMPA. In the previous four years in which GNC examinations had been held only 212 had become state registered, while in the same period 4,229 nurses had obtained the

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\* the Medico Psychological Association had by this time earned a 'Royal' prefix.

RMPA certificate.

After having pressed in the first place for mental nurses to be included within the 1919 Act the RMPA was now disappointed that so few were being registered. The feeling was that they were looked down upon by their general hospital colleagues. The College of Nursing excluded mental nurses from membership at this time. The GNC members at the meeting expressed the view that a statutory body could not delegate its responsibilities to a non-statutory body in such ways as the RMPA was asking. The meeting broke up with both sides agreeing to disagree.<sup>(39)</sup> Subsequently, the GNC finally rejected the RMPA's proposals. The two systems of training continued until after the 2nd World War, when the RMPA finally wound up its examinations.

The hopes that had initially accompanied the passing of the 1919 Act had therefore largely been frustrated. Not that this prevented the NAWU's continuing flirtation with professionalism. Professional topics began to appear in the pages of the Magazine. From January 1926 a series of articles 'For the Mental Nurse in Training' written 'by an assistant medical officer' appeared in successive issues of the Magazine. These were in 1927 issued as a booklet with a foreward by the eminent Professor J. Shaw Bolton M.D., D.Sc., F.R.C.P. and sold for one shilling. After that articles appeared regularly, often contributed by medical men. New forms of treatment being pioneered at the time - like malarial therapy for terminal syphilis - were regularly publicised and assessed. The union was beginning to mellow.

The 1920s were a time when the system of Lunacy administration which had survived intact since 1890 came under increasing attack. The view was gaining ground that mental disturbance was a form of illness which was treatable, especially if intervention occurred at an early ('incipient') stage. The chief obstacle was the deterrent effect of the Lunacy Laws in discouraging people from seeking help. In public asylums, help could not be given unless patients were prepared to go through the degrading process of certification. At the end of the war pressure mounted for change, especially after the publication in 1921 of a book about the Prestwich hospital, The Experiences of an Asylum Doctor, by Montagu Lomax. He complained of the drab routines, and that little attempt was made to treat patients. Their diet was poor, their clothing inadequate, and excessive recourse was made to sedatives and laxatives, saying that:

Chloral, bromide and croton oil are the  
three sheet anchors of all asylum medicinal  
treatments.

(40)

He complained that the 'asylum industries' exploited the inmates and that attendants and nurses had many causes for complaint from the asylum authorities. Although he suggested that attendants and nurses were responsible for cases of ill-treatment of patients, Dr. Lomax attacked the whole system: especially the legal framework which prevented early treatment of 'incipient' insanity. He singled out for criticism the fact that Medical Superintendents sought to control too many extraneous activities. They would be better advised to look more to the welfare of their patients.



The Government appointed a Departmental Committee of enquiry into Lomax's allegations at Prestwich, widened to examine the running of asylums generally. Both Dr. Lomax and the National Council for Lunacy Reform refused to give evidence, calling instead for a Royal Commission, and were echoed by the union. The Report appeared in the Autumn of 1922. It claimed that Dr. Lomax's accusations were on the whole unfounded; what truth was in them referred to the First World War, when conditions were not typical.<sup>(41)</sup> However, pressure continued to mount as a result of the Harnett case in early 1924. Mr. William Harnett had successfully brought an action of wrongful detention in a mental home against the doctor who had confined him and, on February 27th, was awarded £27,000 damages. On appeal the decision was altered, but sufficient doubts had arisen regarding the law to establish a Royal Commission on the operation of the Lunacy Laws. In its evidence the NAWU favoured an increase in national financial support, the restriction of the administrative role of Medical Superintendents, an expansion in outpatient facilities, and an increase in the percentage of trained staff. They also favoured the development of voluntary treatment of mental disorder and the end to pauperisation. Many of these proposals were in line with current thinking. The central philosophy of the Report which appeared in July 1926 was that mental disturbance was a form of illness, and this required a new approach. Even so, the proposals of the Commission were far from revolutionary, but they did advocate that where possible admission should be 'voluntary' or 'temporary', and that certification should be used only as a last resort. 'Voluntary' patients were to apply in writing for treatment, and could leave hospital by giving 72 hours notice. 'Temporary' cases were assumed to be unable to decide whether they would be unwilling or voluntary. They were to be detained for up to two six-month periods. If at any time they

recovered, the period was to be reduced to 28 days. After-care was encouraged and the legal distinctions between private and 'pauper' patients were to be abolished. The Board of Control was to be reorganised and streamlined. Many of its suggestions were embodied in the Labour Government's Mental Treatment Act of 1930, which was to survive intact until the passing of the 1959 Mental Health Act.

In 1930, in accordance with the Act, 'asylums' became 'hospitals', 'pauper lunatics' became 'rate-aided patients', 'attendants' became 'nurses' and the National Asylum Workers' Union changed into the Mental Hospital and Institutional Workers Union. Wages and conditions had been improved out of all recognition. The 48 hour week had been established in a quarter of the mental hospitals in England and Wales. Despite the scandals and allegations of the early 1920s, the status of mental hospital staff was steadily, if slowly, rising. The union itself had weathered the storm of the early 1920s. George Gibson, as General Secretary, had from 1928 been a member of the TUC's General Council. Only a few clouds gathered on the horizon - the gathering economic crisis.

(4) Surviving the Thirties

... but please remember that it is possible to move in two directions, either forward or backward, and if for two years we got nothing at all, at least we did not go backward. The trouble is this, that we are so apt to forget what we owe the J.C.C., and what it has done for us during the eighteen years of its existence.

Cliff Comer in 1938 as National Organiser of MHIWU.

After the economic crisis of 1930, the collapse of the Labour Government and the massive rise in unemployment, the main priority was to defend ground won previously, and aspirations were adjusted accordingly. In a period of stable prices, those with steady work were more fortunate than many. Even though economic conditions improved in the latter part of the decade, unemployment never fell below one million. In December 1930 unemployment rose to 2½ million, and in July 1931 the May Committee Report claimed there was massive government overspending. It called for big reductions, much of it to be achieved by reducing the level of unemployment benefit. While the sparks flew in the Cabinet, the New York banks insisted on cuts as a condition of financial assistance to Great Britain. When the Cabinet could not agree, the King asked Ramsay MacDonald not to resign but form a National Government. The Labour Government fell and remained out of office until after the 2nd World War. (42)

The most immediate impact in the mental hospital service was wage reductions, imposed as a result of a Ministry of Health circular, and negotiated through the Joint Conciliation Committee. For the majority of union members these amounted to 2½% a year, to take effect from January 1, 1932. They were regarded as 'temporary deductions', to be reinstated in two years time. The application of this agreement varied in the localities, above and below the norm. In a number of areas, particularly the North East, some visiting committees imposed no reductions. (43)

In succeeding years pay negotiations proved difficult. In July 1932, the applications to the JCC by the union for long service increments, the restriction of higher posts to certificated nurses in hospitals where no training facilities existed, sickness

pay where illness was due to contact with patient, and protection of superannuation rights against wage reductions - all were turned down. Only in the claim for substitution pay (for covering superiors' duties) was any headway made. Little progress was made on hours. In 1930 an application for reduced hours was turned down by the employers' side of the J.C.C. After further representations a Joint Enquiry was appointed, which reported in 1931. Not surprisingly they found that

... despite prolonged discussions and earnest effort to arrive at a unanimous decision, the two sides find themselves unable to agree.

Instead, the Mental Hospitals Association claimed that the arguments for a 48 hour week 'are not substantiated by the evidence submitted to us'. The M.H.A. suggested that the maximum hours be reduced from 66 to 62½ inclusive of meal times because of cost. The MHIWU, on the other hand, argued strongly for a three shift day as in 'the real interests of patients'.

In 1933 wage cuts were in most instances restored and in subsequent years small improvements were made. By 1937 when they were consolidated, hours were reduced further to 54 hours a week exclusive of meal times, separate keys for staff bedrooms were recommended, as was the abolition of charges for lodging to married staff with more than five years, who were still compelled to take a turn at sleeping in. At hospitals where staff were still obliged to ask the Medical Superintendent for permission to marry, the Visiting Committee now became the authority from whom it should be obtained! Probationers were to be informed if their progress was not satisfactory, and the union prevented the abolition of bonus for passing examinations. None of these were spectacular improvements and some critical voices were raised. For example a letter to the Magazine

suggested that the JCC might be retitled 'the Non-Intervention Committee' since

... the only useful purpose this Committee is now serving is to act as an Old Comrades' Association with periodical reunions, paid for by Mental Hospitals Association and our Union.

The writer found it 'monotonous' that

... except for a very few minor concessions, the principal applications are all turned down.

(44)

In 1937 a motion came before the MHIWU to withdraw from the JCC, but was defeated. In the debate one influential view was that the branches in 'backward areas' needed it in particular. The Union was in no position to take an aggressive stance. The general mood of resigned dissatisfaction was well expressed by a woman who wrote to Paul Winterton, a News Chronicle Journalist:

My husband is a Charge Night Nurse at the - - Mental Hospital. He has over 125 patients in his care for ten and three quarter hours five nights a week, besides issuing medicines and letting the female staff in at the lodge, receiving new patients, pegging a clock hourly, with hundreds of stairs to go up and down. I'm sure it is too much for one man, but he thinks it is better than being unemployed. He gets just over £3 a week.

(45)

At this stage in its existence, the JCC was a very fragile body. By no means all authorities were members of the employers' association, the Mental Hospitals Association; non-members included the London County Council which, since its absorption of the Metropolitan Asylums Board of 1930, was the biggest authority in the country.

Authorities around London, like Middlesex and Surrey did not belong to the MHA either. The separate Scottish JCC had fallen into disuse in 1923 and remained dormant throughout the interwar period.

Not surprisingly, the union was anxious simply to preserve the JCC, even if it was a largely ineffectual body. Such defensiveness is apparent in the spirit of conservatism that is noticeable in Bartlett's Presidential New Year Address in January 1934. Membership had risen, wage cuts had been restored, and Claud Bartlett talked warmly of

... the continuance of the good feeling and relations between the MHA and our own organisation in the settlement of disputes of a domestic nature, and the growing desire to take joint action upon questions of national importance affecting the service generally. Without loss of principle or dignity a spirit of reasonableness and accommodation has prevailed on both sides.

But beneath this apparent tranquility staff were grappling with great difficulties. The mental hospitals were no longer the centre of public attention. The Mental Treatment Act has been passed and the law liberalised. Just afterwards, however, the country entered into the worst economic crisis ever known, obliterating all good intentions in its path. The crisis was probably to a large extent responsible for the increasing pressure on beds. Figure 1 shows trends in the inpatient population up to the end of the second world war, for England and Wales.

Year	Number of Inpatients (000s)	per 1000 of the population
1914	138.1	3.77
1919	116.7	3.09
1929	141.1	3.56
1939	150.3	3.71
1949	144.7	3.34

Figure 1 Trends in admission to mental hospitals 1914-19

(Source: Kathleen Jones, A History of the Mental Health Service, 1971, Appendix 1)

In 1914, a higher percentage of the population were in mental hospitals than at any other time in our history. Numbers fell during the war but began to climb again in the twenties and thirties. Between the 19th and 20th centuries, the average size of institution grew, as can be seen from Figure 2:

Year	Number of county and borough asylums/hospitals	Average number of patients
1850	24	297
1890	66	802
1910	91	1072
1920	94	1109*
1930	98	1221

Figure 2 The growth in the size of mental hospitals

(Source: Jones)

\*available beds not all of which were filled

In addition to the increase caused by a rise in the population, the death rate among patients was falling. The population of Britain generally was ageing, giving rise to a higher admissions rate. Economic conditions also played their part. In August 1931, the Mental Hospitals Association Annual Meeting was preoccupied with the beds crisis. In Lancashire and LCC hospitals, the hospitals were overflowing with patients. Mr. Chalk of Durham said

In the North of England, I believe we are suffering through unemployment and ... owing to the anxiety and the worry, the vitality of the people is so low that they are passing into our institutions.

(46)

Unemployment also affected people's ability to care for aged relatives. There were suggestions, too, that some people were trying to get into the mental hospitals out of need for subsistence. Dreary though institutional life might have been, it did at least provide accommodation and a square meal.

The overcrowding caused pressure on already scarce resources, the effects of which were documented in a neglected classic of social observation, Paul Winterton's Mending Minds, published in (47) 1938. Nurses were working under great stress, and their health, as well as those of their patients, was threatened. Homeliness, and individual treatment, were impossible when beds were often only three feet apart. Patients often did not have locker space and could be seen carrying their possessions around in a bundle during the day. Occupations and recreations could not be properly organised. What building was going on, was inadequate, often depending on the general wealth of the area.\* Overcrowding was particularly bad in

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\* only part of the expenditure was met by block grants from central government at this time.



Lancashire, which was hard hit by the depression. Nevertheless, despite the difficulties, some authorities made improvements: outpatient facilities expanded barbers introduced for men and hairdressing salons for women; cinema shows; occupational therapy; individual rather than institutional clothing (especially for women patients). In some hospitals in the 1930s canteens and shops were opened. New 'progressive' forms of 'physical' treatment were pioneered, particularly the induction of malaria in patients suffering from the final stages of syphilis, prolonged narcosis for manic depression, insulin shock treatment in schizophrenia, phenobarbitone for epileptics, and various other kinds of experimental treatments. More research, though pitifully small in relation to medical research as a whole, was being carried out, encouraged by the Board of Control. After-care was in the main carried out by voluntary agencies. However, in the mid 1930s the LCC pioneered the appointment of professional social workers. The LCC had generally progressive intentions, but it has to be remembered that, especially in the latter part of the 1930s, there was considerable industrial expansion in the South East, in contrast to other parts of the country.

The uneven effects of the economic crisis in different parts of the country had an important influence on nurse staffing. Displaced workers, particularly men, uprooted themselves from distressed areas and started new lives as mental nurses. Already in their Report for 1930 the Board of Control had mused on the possibility that

By co-operation with the labour exchanges it might ... be possible to secure a carefully chosen supply of candidates from distressed areas such as South Wales.

Because of competition, many of those applying were expected to possess a skill useful to the hospital community, such as being able to play a musical instrument, or being good at sports. One retired mental nurse I interviewed had been a pianist in the cinema before talkies came along to make him redundant. The wages were not high and, if Winterton is to be believed:

Mental Nursing at the moment is no career for an ambitious man. It expects a high degree of ability and intelligence, but its rewards for capability are mean and miserable.

He asked one mental nurse why he continued to do it:

The trouble is that there doesn't seem anything else for me to do. Either I've got to leave the service and try for some better job or live all my life on £3.10s. a week.

(49)

The chief attraction was still security and superannuation rather than intrinsic satisfactions that might be gained from the work.

On the female side, the 1930s were a time of perennial shortage. All forms of nursing were experiencing similar problems, but mental nursing most acutely of all. The Board of Control in 1931 expressed its concern that many hospitals could

only maintain their numbers by the indiscriminate acceptance of all candidates not obviously suitable.

(50)

There was no obvious pool of reserve labour on which authorities could draw, as with men. Improvements for women nurses had occurred, largely as a result of pressure from the MHIWU but, as Winterton put it,

too often they accept the privileges it has  
won for them without bothering to join it.  
(51)

Female mental nurses suffered fewer of the petty restrictions faced  
by their sisters in general hospitals. Nevertheless, the work was  
not glamorous and was often undertaken in remote places. Conditions  
were not that much better, either. For example, the Board of Control  
found in 1938 that although 82 public mental hospitals had built,  
or were constructing nurses' homes

... it is still quite normal to find over  
20% of the nursing staff sleeping in the  
main building.  
(52)

The justification was often that they might be required to help  
deal with disturbances or other emergencies during the night.  
Yet in the Board's view

... the regular night staff should be  
adequate to deal with minor emergencies,  
and nurses on day duty ought not to have  
their rest interrupted because the night  
staff is too small to cope with the  
ordinary small disturbances which are  
inevitable in the observation dormitories  
for the more restless and excited  
patients.  
(53)

The most serious attempt to deal with the difficulties  
of recruiting women nurses was probably undertaken by the LCC.  
They issued a booklet which advised that

an office or shop affords little training  
for the management of a home. On the other  
hand, a nurse's training should help her to be  
a good wife and mother.  
(54)

Among the advantages listed were the pay (£2 a week rising to £2.6s a week on qualifying), a 96 hour fortnight, 'ample' leave, recreation 'of all kinds', and nurses' homes (at most of the Council's hospitals and institutions), with 'well equipped common rooms in which, as a rule, there are wireless receiving sets'. Above all it tried to convey an impression of mental nursing as skilled work, and mental hospitals as places where treatment of disordered minds takes place:

The old idea of the "lunatic asylum" as a place of restraint in which dangerous or raving persons were caged like animals is quite foreign to a modern mental hospital. The "dangers" of mental nursing are no greater in their special kind than the dangers of nursing transmissible disease: such dangers as there are can be controlled by the skilled nurse.

(55)

Although growing optimism characterised official attitudes to the mentally disturbed, it was rather different with the mentally handicapped. On May 1, 1929 Neville Chamberlain, as Minister of Health in the Conservative Government, told the Commons:

One must distinguish between insanity and mental deficiency. Insanity is a disease from which people may recover. Mental deficiency is an arrest of mental development from which there cannot possibly be recovery.

(56)

He was referring to the First Report of the Wood Committee, published in 1929, which had estimated that there were something like 300,000 mental defectives in England and Wales, about double the previous official estimate in 1908. Although the rise in numbers of the insane could be reassuredly explained by population growth, ageing, and so on, the size of the estimate of the growth of mental deficiency

caused more alarm. Legislation had been passed in 1913 and 1927 but so far not a great deal of action had been taken to implement it. The publication of the Wood Committee's Report increased the pressure for expansion of services, despite the difficult economic situation. Although it had been thought that the vast majority could be cared for in the community, it was assumed that about one third of the total urgently required institutional care, either because they were too severe, needed training, or were of 'incurable criminal tendencies'. (57)

It was the latter group on which much public attention focussed. It was almost as if the popular press, having more or less exhausted public interest in the sensational aspects of mental illness, were now turning their attentions elsewhere. This was fuelled by the Board of Control itself who described high grade 'defectives' as 'a menace' in their Annual Report for 1929:

The majority of defectives cannot support themselves, many cannot resist criminal impulses, and others, though not actively dangerous, are a menace to the community because they have no idea of truth or social obligation ... Many are sexually unrestrained or perverted, and are a constant danger to women and children.

(58)

In making such alarmist statements, the Board were widening the notion of deficiency to include not just the severely handicapped (formerly called 'idiots' and 'imbeciles'), to the mentally 'defective', a term which seemed to include moral as well as intellectual deficiencies.

Pressure mounted for the prohibition of marriage among 'defectives' and for sterilization of the 'unfit', as practised in many American States. Part of the reason for Britain's economic decline was said to be due to the fact that the 'better classes' were having fewer children, while the 'unfit' were continuing to breed. Newspapers devoted considerable space to court cases in which mental deficiency was held to be an underlying cause. Mr. Justice McCardie warned the nation in November 1931 that the 'curse' of mental deficiency could not be removed unless mentally defective women were compulsorily sterilized:

In one case that came before me there was a mentally defective woman who had bred nine mentally defective children, of whom seven were girls, and of those four in turn had bred mentally defective children.

(59)

He was supported by Dr. Barnes, Bishop of Birmingham, and other leading religious figures. Even labour movement organisations like the Women Public Health Officers Association, the Women's Co-operative Guild, and the National Council of Labour Women, supported the call for sterilisation at one time or another. In 1934 the official Brook Report urged legislation to permit voluntary sterilisation. The 'lowest tenth' - from whom most defectives were assumed to come - were propagating their own kind. (60)

The MHIWU's response to these developments was initially cautious. It opened its pages to the debate, in which two contrary views tended to be put: one which thought that defectives were a major social problem, countered by another which claimed that the country's problems were largely economic in origin. As time progressed, however, the union became increasingly opposed to sterilisation, for a mixture of practical and principled reasons. It argued

that both segregation and sterilization would be ineffective remedies; segregation because the cost would be enormous, and no adequate 'tests of fitness' could be devised. Sterilisation was only a solution if it could be proved that mental deficiency was always hereditary. However, Gibson argued,

... we cannot so certainly say we know enough of the genetics of mental deficiency to be confident that sterilisation is the remedy.

(61)

This position subsequently became union policy and in 1934 Gibson successfully moved a resolution at the TUC opposing the Brook Report's advocacy of voluntary sterilisation.

During this period, both institutional and community care of the mentally handicapped underwent expansion. In many cases, transferred workhouses rather than new buildings formed the basis of provision. Nevertheless some new building took place. The scale of the expansion in beds can be seen in Figure 3:

1924	17,101
1930	23,485
1934	35,794

Figure 3 The expansion of institutional care 1924-34

(Source: Board of Control Reports)

During the interwar period mental deficiency nursing developed as a distinct branch of nursing, with first the RMPA and subsequently the GNC organising examinations separately from those for mental nursing. However, by 1934, only 40 of the 67 institutions with more than 100 patients had training schools recognized by either the RMPA or the GNC.

Sterilisation may have been a major public issue, but public interest in the institutions themselves was virtually nil. They did not appear to merit even the sensational interest displayed in mental hospitals during the 1920s. Staff and patients were left to struggle on, virtually ignored by society at large. A rare exception was the general practitioner writing in the Lancet in 1937 who referred to the 'forgotten' inmates of mental colonies, and wondered

What proportion of those confined and shut  
up ... really are so mentally afflicted  
that they need segregation for their own  
safety or the safety of others?

(62)



## Chapter Seven - The Challenge of Trade Unionism Within General Hospital Nursing

### (1) Organising Poor Law Workers

The setting for the development of trade unionism among general nursing was the growing militancy of the working class in the years following 1918, in which women workers played a very significant part. This pattern, of nurses becoming drawn into trade union action at a time when there was a general rise in working class activity had, as we have already seen, also occurred from 1910-20, when asylum attendants began to organise. It would also prove to be the case in future waves of organisation and activity.

At this time there was no discernible move towards unionisation among nurses in voluntary hospitals. The reasons for this were various: it was the bastion of nursing traditions, the recruits to nursing were of a higher class background and were likely to enjoy more mobility, the work was more technically oriented and 'interesting', and the rule of the matrons was very strong. But another factor which militated against nursing trade unionism was the parlous financial state of the voluntary hospitals. Even if trade unions had formed, it is not certain where the money would be found to finance improvements.

The poor law hospitals and institutions provided a more promising recruitment field. Nursing traditions were not so strong, recruits were often of a working class background, matrons were not so all powerful and, through central and local government, resources might be made available to fund improvements. All these factors provided some stimulus to the growth of trade unionism among nurses. However, the differences with the voluntary hospitals were one of degree, and

the poor law did not provide a fertile environment for the development of militant trade unionism. Though a 'challenge' of trade unionism did take place, it was a much more muted variety than that associated with mental hospitals.

Indeed for many years, staff who joined any organisation belonged to the poor law's own professional association, the National Poor Law Officers' Association (NPLOA). The NPLOA, or the 'National', as it was not always affectionately called, was founded in 1885 and eventually absorbed into NALGO in 1930. As in the asylum service, trade unionism in the Poor Law Service was primarily born out of widespread dissatisfaction with a sedate, status-conscious professional organisation, and the workers' growing lack of confidence in its ability to further their collective interests. Some idea of the character of the NPLOA can be understood from the first issue of its official organ, in 1892:

The appearance of a journal devoted specially to the interests of the Poor Law Officers will not, we hope, strike terror in the breasts of the members of our Boards. There is no feeling on our part of hostility to these gentlemen. We seek, among other things, to elevate the service in public opinion, and work in harmony with both the representatives of the public and the Local Government Board.

(1)

The cautious approach of the National was strongly influenced by the fact that its decision making structure was dominated by higher officials in the Poor Law Service, particularly Clerks to Boards of Guardians. Manual workers in the Poor Law service were expressly excluded from membership. Its 'father' and first President was William Vallance, the Clerk to the Whitechapel Guardians where unemployed workers had rioted during the appalling winters of the mid 1860s. Vallance, and the National as a whole, were rigidly in favour of defending the most

repressive aspects of the New Poor Law, against mounting criticisms.

The Journal talked of the need to check

the inherent moral weakness of men, and to give room for the fostering and strengthening amongst the labouring and poorer classes of the spirit of independence and the habit of thrift.

(2)

The original aim of the National was simply to sort out the vexed problem of superannuation, but its aims were later widened to include 'improving the administration of the Poor Law'. By adopting such a position they hoped to

... bring Boards of Guardians and the public generally over to the support of officers interests ... It cannot be too widely spread that the NPLOA is not solely an organisation prompted by motives of self interest ...

(3)

In other words, it was not a trade union. As Mr. Simpson, its Vice President, proudly pointed out:

It cannot be aserted that any action of the Association has at any time been of an aggressive nature as regards the authorities which the officers have the honour to serve.

(4)

Its sole important achievement in the forty five years of its existence was the achievement of compulsory superannuation for Poor Law Officers. Then, at the National's own insistence, the scheme was made a contributory one, in order to save pensions from being a charge on the rates. This led to the Poor Law Officers' Superannuation Act of 1896, later the model for the Asylum Officers Superannuation Act 1909, of which we have already heard.

After this relatively successful accomplishment, the National tended to rest on its laurels. Membership grew to around 10,000, but at the same time pressure grew within the organisation to transform it into a genuine trade union, from two of the biggest areas, the South West and the North West. On February 16, 1918 the Gloucester and Somerset Branch passed a resolution proposed by Mr. Williams, a workhouse Master in Bristol, that the Management Committee of the NPLOA should

... immediately take into consideration the advisability of running the Association on Trade Union principles.

(5)

Letters in subsequent issues of the PLOJ were enthusiastic. One wrote that:

It seems that the subordinate officers in the Poor Law Service are at last throwing off the shackles that have hitherto kept them bound.

(6)

In April 1918 the Executive of the NPLOA responded to the mounting pressure, with a stubborn insistence that trade unionism was not necessary:

These members, we think, do not take enough account of the circumstances of Poor Law duty or recognize the value of what has already been accomplished for officers in the Poor Law.

(7)

In its deliberations, it was made only too apparent that the chief opposition had come from Clerks to Boards of Guardians: they had made it clear that in a strike situation they would have divided loyalties. Branches in Manchester led a deputation and a Conference of Branches keen to set up a union was held in Birmingham on October 5. Low-paid probationer nurses would be allowed to become honorary members if they could not afford the subscriptions. The union would become part of

the TUC but it would not affiliate to the Labour Party. A strong emphasis was placed on Friendly Society benefits, including an ambitious plan for an 'additional' pensions fund (providing benefits on top of the existing Poor Law Scheme).

No definite decision was made at that meeting to establish a union, and the Executive Council of the NPLOA promised to hold a special meeting on December 7 to reconsider their position. They were too late. On the day before, Friday 6, 1918, a large meeting was held at Paddington in the Board Room of the Guardian's Offices to consider a proposal, floated in the Journal in October to form a trade union for the Poor Law Service in England and Wales. It was presided over by Mr. A.D. Milne an Assistant General Relieving Officer and Collector for Paddington.

At the conclusion of the meeting the Chairman moved,

That in the interests of the Poor Law Service and of its individual members the time has now arrived for the immediate formation of a trade union.

This was passed with only one against and a provisional Committee was elected from those present. Arrangements were made for it to meet the next day if the NPLOA should decide against becoming a union.

On the evening of the same day the Executive Committee of the NPLOA met at the Connaught Rooms, Great Queen Street and decided not to become a trade union, a decision ratified by its Council the following morning.

## THE POOR-LAW WORKERS' TRADE UNION.

President (pro tem.)—Mr. W. HARDMAN, Manchester.

To Poor-Law Officers, Overseers and everyone connected with the Poor-Law Service.

This Trade Union is being created for Officers of all grades in the employ of Boards of Guardians (or who may be appointed by such Boards).

Every member of the Service is asked to join the above Association. We urge that it is desirable in the best interests of everyone to do so forthwith.

The main objects of the Association are:—

To improve the conditions of the members, and to protect their interests in matters relating to salaries, wages, and general working conditions, and to secure the settlement of any grievance in connection with their employment, by negotiation, arbitration, or any other constitutional means.

It will be a direct means of approach to our Boards or other Authority, to obtain uniform treatment for all. Voluntary Associations up to now have failed to do this.

Many officers are only on the bare subsistence level!

No officer is legally debarred from joining a Trade Union.

The interests of Officers, permanent or temporary, are the same, and both should join. In the interests of complete Unity. NOW is the TIME!

The wages and conditions secured by Trade Unions are adopted by every Government Department, and also by Public Authorities. We feel that we shall have the sympathy of the Local Authorities under whom we serve, to attain the same Status.

Contributions have been fixed at 4d. a week, which includes 1d. for Benefits. Entrance fee, 1s.

A Branch can be formed in any Union or Parish, with direct representation.

General Secretary (pro tem.) England and Wales—

Mr. A. D. MILNE,  
27A, FURNESS ROAD,  
WILLESDEN, N.W. 10.

From whom full particulars can be obtained.

**IMPORTANT.**—The CENTRAL EXECUTIVE COMMITTEE are incurring a HEAVY RESPONSIBILITY IN THE INTERESTS OF THE SERVICE. AND THEY CONFIDENTLY HOPE THAT ALL THOSE INTERESTED IN THE MATTER WILL SUBSCRIBE TO THE BEST OF THEIR ABILITY. A DONATION OF ANY AMOUNT WILL BE ACKNOWLEDGED BY THE GENERAL SECRETARY. IT IS HOPED TO IMMEDIATELY RAISE £100 TO DEFRAY THE INITIAL EXPENSES. ANY SURPLUS WILL BE MERGED IN THE FUNDS.

Caption: An Appeal to all staffs to join the New Union,  
in the Poor Law Officers Journal December 13,  
1918

The rules of the Poor Law Workers Trade Union were approved and confirmed at a special meeting in Holborn Hall on February 15, 1919 and the union was registered shortly afterwards. The PLWTU was open to Poor Law workers of all ranks; men and women below the position of Clerk could join the union and participate in its affairs. Clerks, and members of Boards of Guardians, could become Honorary Members, which entitled them to attend meetings but not to vote. The union's major objects were, as one might expect, to 'regulate' relations between Boards of Guardians and their officers and servants, to settle disputes by 'negotiation arbitration or other lawful means', to protect members against victimisation and to obtain 'reasonable' pay and conditions. The union did not at that stage seek to affiliate to the TUC, but the rules allowed for it to join any other Federation or Association of workers. No political objectives were stated, and the union, prior to amalgamation in 1946 to form COHSE, never affiliated to the Labour Party.

The union grew very rapidly in its first year claiming 14000 members in 1920. It was a time of favourable employment conditions, when trade unionism was rapidly advancing, beginning to recruit non-manual workers in larger numbers.<sup>(8)</sup> According to the editor of the Local Government Chronicle 'the war has taught us many things', not least the value of 'efficient organisation'. The article continued:

Past experience has shown that in order to obtain the most favourable terms and to be able to offer the most effectual opposition to what they may consider unreasonable demands, it is advisable that the workers should be possessed of an ORGANISATION which can present their case in a manner at once reasonable and firm, and with the best prospect of success.

(9)

Like the NAWU the PLWTU developed an ambitious National Charter, which included objectives such as:

- 44 Hour week with overtime pay for excess hours
- War bonuses to be made compulsory and consolidated into permanent wages
- A minimum wage for all grades
- Improvement of living-in conditions
- Extended holidays
- Trade Union recognition
- Uniforms to be provided for all staff
- Reform of Superannuation laws.

The National Charter developed out of the conviction that it was necessary to centralise efforts within the union. With the development of Whitleyism, industrial unionism and larger unions generally, power was moving towards the centre. However, the means envisaged by the PLWTU were local negotiations and the PLWTU advocated that branches should field candidates in elections of Boards of Guardians. An attempt had been made to establish a Conciliation Board in the service with the NPLOA but it had been a failure, and the PLWTU did not press its case as militantly as the NAWU. The rates set down were not usually followed locally and the Ministry of Health was not prepared to interfere with local autonomy - at least, where it would have resulted in extra cost to the rate-payers.

The PLWTU did not therefore win the kind of recognition at central level accorded to the NAWU. Nor did it succeed, as the NAWU had in the asylum service, in driving the professional association out of existence. There were a number of reasons. In the first place, relations were never as hostile between the two organisations as between NAWU and the AWA. It will be remembered that the PLWTU was formed only



after a ginger group within the NPLOA had failed to transform it into a union. It seems likely that there was a good deal of dual membership between the two organisations. Another important reason was that the NPLOA took seriously the challenge of the union and partially reformed its ways. The response of one Dorking Clerk was that the emergence of the union 'woke the National to life'.<sup>(10)</sup> The NPLOA was able, with the assistance of the worsening employment situation after 1920, to take much of the sting out of the union's attack. Membership of the union fell by half in the early 1920s and, though it began to pick up again in the latter half of that decade, never exceeded the peak membership figures of 1920 until the late 1930s. The balance of advantage was turning back towards the NPLOA.

## (2) Organising Poor Law Nurses in the 1920s

The NPLOA and PLWTU were in direct competition to enlist nurses to their respective organisations. The NPLOA from the end of the First World War created its own Nursing Section. 'Much of its efforts were, however, focussed upon securing adequate representation for 'poor law nurses on the Council of the College of Nursing.' It was a campaign which made little impression upon that status-conscious organisation, and at one stage the NPLOA considered opposing State Registration as a possible tactic. It held its own conference for nurses. Most of those attending were either Matrons, Superintendents or Assistant Matrons.<sup>(11)</sup>

Activity to remedy grievances among poor law nurses was not unknown before the 1920s. For example, a number of disputes broke out at workhouse infirmaries in 1911, one of them at the Carlisle Workhouse Hospital. The reprimand of two probationers by the Superintendent Nurse led to a protest among probationers when, according to the Nursing Times, they 'left the hospital in a body'.<sup>(12)</sup> They presented

a long list of complaints to the Board of Guardians, including accusations that Superintendent Nurse Kirwen had deliberately delayed leave passes, locked away the butter and hidden someone's false teeth, all of which she denied. A Guardian reportedly stated 'that it was clear to him that it was impossible for the probationers and the Superintendent Nurse to work together in the future' and sought her resignation. However the Local Government Board Inspector refused to countenance it. Similar events took place elsewhere. In Aberdare, two nurses walked off duty, went to the Medical Officer of Health and submitted charges against the Matron. At York Union Workhouse, nurses refused the sausages offered them for breakfast. According to reports in the nursing press; February 10, 1912

... two links of sausages were subsequently found suspended from a gas bracket in one of the wards bearing the inscription, "No further use for you", which was certainly not the right way to give expression to their grievance.

(13)

These events occurred against a background of rising working class militancy, and were the subject of an editorial in the British Journal of Nursing, the official organ of the Royal British Nursing Association, then the main establishment organisation of nurses. The editorial claimed that:

The lack of discipline in many of the infirmaries and sick wards of workhouses - as revealed in constant reports in the public press - point to the conclusion that the nursing staffs are out of hand in these institutions.

(14)

It concluded that 'further action is needed ... for where discipline is lax, the sick are the invariable sufferers'.

Subterannean rumblings were one thing, permanent organisation quite another. Nurses had no lack of grievances - poor pay and conditions, long hours, irksome and often petty forms of tyranny - but remedying them was another matter. The first obstacle was often the nurses themselves. Official ideology often taught them to make a virtue of bad conditions, and impressed upon them the necessity of absolute obedience - influenced by a fusion of religious masochism and military discipline in the origins of modern nursing. In the voluntary hospitals adherence to this ideology was greatest, but, as we saw in Chapter 4, reinforced by other things: the class background of the recruits, the acute and 'glamorous' nature of the work. The voluntary hospitals were both avenues to the higher posts in the nursing world, and marriage markets for the middle class.

It was in the public hospitals that trade unionism among general nurses became established in the 1920s. There the nurses were much less likely to be so starry-eyed about nursing traditions. A Professional Union of Trained Nurses was formed in 1919. It enjoyed a close relationship with the PLWTU, taking part in the short-lived Federation of Health Services with the poor law workers, the NAWU and the Medico-Political Union, now part of ASTMS. Its flamboyant leader, Miss Maude MacCallum, wrote in the PLWTU's Magazine in 1920 urging nurses neither to join the College of Nurses, because it was an employers' association, nor the Nurses section of the NPLOA, because its Secretary was a Barrister at law. Instead she urged them to join a union because it was run by the workers themselves ('wake up! and be free women instead of slaves'). She admitted that the long hours made it difficult for nurses to participate in unions:

I know what we all say; we are overworked and overtired, the short time we are off duty we want to go to the theatre, or see the shops and have a little relaxation. That is all true, but what is also just as true, unless we take the management of our own affairs into our own hands, we shall go on being tired and over-worked. "Wake up Nurses", and take a little interest in your own Business!

(15)

In the same issue Dr. Wiggins, then the Union's Vice-President, addressed an 'open letter' to nurses, emphasising that

... in the stress of modern conditions the individual has very little opportunity to secure improvement or to protect himself alone ... Equity and justice are best served by unity.

(16)

The Government had set up Whitley Councils for public employees employed nationally, such as civil servants. If something similar was to be achieved for locally employed public-servants, they needed to be

... properly organised on industrial lines, i.e. for EVERY member in the service to work together for mutual good, under the protection of ONE ORGANISATION.

(17)

These calls were not always heeded and it was a recognised fact that nurses were difficult to involve in the union. For example the magazine in February carried a report of a branch meeting in Dewsbury which, with the Guardians' permission, was being held in the dining hall of the Staincliffe Institution, on 6 December 1921. It was addressed by Councillor John Deasy, the newly appointed Northern Organiser of the PLWTU. One question that puzzled him was why no member of the nursing staff was present at an otherwise well-attended meeting. The union had done much to further the interests of nurses:

... the Union stands alone as the friend of nurses.  
 ... a nurse cannot live by the College of Nursing alone. The Guardians are her employer and provide the Bread, and we are out as Trade Unionists to see that it is buttered .... The nurses tonight, by their absence, suggest that they prefer other grades to find the money and fight their battles, yet ever willing to be present in the "share out", or is it that some quiet influence has been at work undermining their loyalty to their fellow workers?

(18)

The last comment by John Deasy suggests that there were other barriers to nurses' participation in trade unions which had little to do with dedication, snobbery or even apathy. It was more affected by the determination of their superiors to do all in their power to encourage professional associations and discourage trade unionism. These powers were often considerable. Nurses were vulnerable as probationers, if they were to be able to finish their training, and even after were dependent on good references to obtain a post at another hospital. Such issues lay behind the notorious Brentford dispute of 1921. According to the union's own version of events, night nurses at the Brentford Hospital (subsequently the West Middlesex Hospital) skipped their usual breakfast at 7.30 in the evening to prepare for the Easter dance. The following day all the night staff were summoned before the Matron for engaging in such an audacious act of insubordination. She suspended their "privileges", including the right to get up early on Saturday afternoon be allowed "out" until 8 p.m. As a result one Irish probationer would have missed seeing her sister 'who she had not seen for years'. She disobeyed this rule, was taken before the Committee, sacked on April 12 1921 for 'wilful disobedience', and ordered to leave by 9 o'clock the next morning.

Immediately 39 out of 52 nurses petitioned the Guardians for her reinstatement and were summoned to the Assembly Hall at 5 p.m., where the Chairman of the Board addressed them:

His address consisted more or less of a "jacketing" and looking at the petition he asked whether a Nurse Slatter was present. She answered - and was therefore summarily discharged and told to be out of the Institution by 9 o'clock the following morning - no reason whatever being given.

(19)

All of the nurses considered taking strike action but were persuaded that it would be better to send a delegation led by the union to the chairman. He refused to see them. The next day two other nurses were dismissed by the Matron, backed up by the Medical Superintendent and the Clerk to the Guardians. For a while the Assistant Medical Officer was suspended from duty for showing sympathy with the nurses. Other nurses who signed the petition were threatened with the sack. Miss Cumberbatch, Chairman of the Hospital Committee of the Brentford Board of Guardians was reported to have defended the dismissal of the nurses by arguing that

Those who are not prepared to give up EVERYTHING in the sacred cause of fighting disease should not be nurses at all.

(20)

The PLWTU took the case to the wider labour movement in Brentford and on Sunday May 8 1921 a meeting was convened by Reg Crook, Provincial Secretary of the union attended by representatives of 172 branches of unions in the area, said to be 'representative of 85,000 men and women of the world of unionism'. Brother Crook informed the meeting of the events leading to the dismissal of the nurses:

At the conclusion of the meeting the delegates unanimously promised the support of the local branches in any way Mr. Crook might request, while a deputation was appointed to wait upon the Board to demand a re-hearing of the cases.

(21)

The deputation was representative of the whole of working class people in the area. It consisted of seventeen trade unionists and twelve representatives of ratepayers, and on May 21 it arrived at the Guardians' office at Isleworth to ask for admission. They were invited up to the vestibule on the first flight of stairs by the Deputy Clerk and asked to wait peacefully.

Five minutes - eight minutes passed - and then to the complete astonishment of all concerned, there rushed up to the door on bicycles, a superintendent of police supported by constables. Then the Deputy Clerk made known the unjust treatment of the Board. "Officer", he said, "I am instructed to request you to remove these men and women who have forced their way into the Guardians offices. "Protests were advanced by the three leaders of the deputation but without avail. The police had formed up around the stairs - it was a case of go at once or come into conflict with the police.

(22)

So they withdrew: but matters did not end there. The eviction of a representative delegation of working class people in the area angered the local electorate. The next elections were to be held the following April, in 1922. Meanwhile the union's solicitor had advised against pressing the Ministry of Health for an enquiry into the dispute, but instead to issue writs against the Brentford Guardians. To finance this course of action the Executive set up a Brentford Dispute Fund, and began paying the four nurses 25s. a week victimisation pay.

When the time for the Guardians elections came round the Brentford Branch of the PLWTU had unanimously adopted Mrs. Councillor Cowell, the leader of the ratepayers' delegation to the Guardians in the previous May. They worked assiduously for her and Reg Crook addressed two meetings in support of her candidature at the local picture palace. By one vote, Mrs. Cowell topped the poll and subsequently became Chairman. The previous Chairman of the Board, Mr. Greville-Smith, who had played such a central role in victimising the nurses, was not elected. The legal case was not settled until May 1923, when it came before Mr. Justice Darling in the High Court. Eventually the case was withdrawn by the union after the Board - by now very different in composition from that which had dismissed her - agreed to furnish Miss Slatter with 'a testimonial to her capacity and character', in order that she might find another position. The cases of the remaining three victimised nurses was also withdrawn.

Trade unionism did not make rapid strides among general nurses at this time but, as John Deasy had claimed, nurses had few other 'friends' apart from the union. The Labour Party late in 1926 published a Report on policy for the nursing profession, which included a 48 hour week, proper student status for probationers and substantial increases in pay. By this time, however, the labour movement had suffered the decisive defeat of the General Strike, and the miners had finally been driven back to work. It was hardly the moment to press forward with a programme of improvements for one of the weakest sections of working people, when one of the most economically powerful and best organised sections had suffered such a humiliating defeat.



(3) Organising Local Authority Hospital Nurses in the 1930s

The next serious attempt to organise nurses into trade unions occurred during the 1930s. By this time Boards of Guardians had been abolished by Neville Chamberlain's 1929 Local Government Act. A rudimentary system of municipal hospitals began to be established. However, the process by which this occurred was very uneven. The counties hardly developed a system at all, and boroughs only to a limited degree. Most hospitals continued to be run through the Public Assistance Committees. The major exception was London. There the major result of the Act of 1929 was to transfer the Metropolitan Asylums Board, with its well developed system of separate infirmaries and mental deficiency institutions, to the London County Council. In addition a great number of poor law staff were transferred. The chronic sick and incapacitated continued to be maintained in institutions maintained by the LCC's Public Assistance Committee. However, the vast majority of hospitals became administered by the Hospitals and Medical Services Committee of the Council. By the end of the 1930s, the LCC had three fifths of the total number of municipal hospitals, services having been expanded very rapidly in the late 1930s.<sup>(23)</sup> It was also the largest employer of health service personnel. During 1938-9 its total nursing staff (including mental hospitals) was 18,400.

GENERAL HOSPITALS OF THE LCC IN 1938-9

11,000	Nurses
6,000	Maids
2,000	Porters
1,100	Laundry staff
400	Cooks
400	Matrons
400	Full time doctors
260	Machinists and Needlewomen

Source: Sir G. Gibbon and R. Bell, History of the LCC 1889-1939, London, Macmillan (1939) p.204

The expansion was carried forward by the Labour Party when it came into office in 1934. However, as we shall see, relations between the Labour controlled Council and its staff were not always entirely harmonious.

By the 1930s inter-union competition for the growing numbers of hospital staff became intense. The PLOU (PLWTU) became in 1930 the National Union of County Officers (NUCO) with very little change in identity, except that its recruitment field in theory extended over the whole area of local government. However, it now found itself confronted by other serious rivals, quite apart from the College of Nursing. The most immediate and formidable competitor was NALGO, already claiming 100,000 members, with its rate of growth continuing to accelerate. NALGO had been established in 1905 by Herbert Blain, who was later to become Principal Agent of the Conservative Party. Its form of organisation and ethos was to local government what the NPLOA was the Poor Law service. Thus its first full-time secretary, Levi Hill, said in 1910 that 'anything savouring of trade unionism is nauseous to the local government officer and his association,' and very prominent among its original aims was the desire to foster 'social intercourse' among its members.<sup>(24)</sup> However, during the period of post-war radicalisation it had, by 1919, registered as a trade union (but did not affiliate to the TUC until 1964). When the NPLOA finally merged with it at the end of the 1920s (after merger discussions with the PLOU - the PLWTU's successor - had failed), NALGO gained a presence in the ex-poor law services it had previously lacked. During the 1930s this merger, and the growing scale of hospitals and attendant bureaucracy, gave them an established base among hospital workers. Community nurses had prior links with NALGO through Medical Officers of Health Departments in town halls.

In London another competitor was the London County Council Staffs Association, an organisation fostered by management, who accorded it special privileges. It survived to become the Greater London Council Staff Association. Two of the large general unions, the TGWU and the NUGMW competed for members in what was one of the

growing sectors of employment during the 1930s. But these too became increasingly concerned, as the 1930s progressed, with competition from NUPE, which was experiencing phenomenal growth rates under the aggressive leadership of Bryn Roberts, an ex-miner from South Wales. NUPE can be traced back to a breakaway movement from the Municipal Employees Association, which itself had by this time been absorbed by the NUGMW and carried its bitterness towards NUPE into the outlook of the giant organisation. NUPE grew particularly rapidly among local government manual workers. However it also sought to recruit hospital workers. In 1938 the recently formed National Association of Nurses decided, following a ballot of its members, to amalgamate with NUPE. (25)

However, before the 2nd World War, NUCO was the most prominent amongst trade unions pressing the collective grievances of all sections of hospital workers, but particularly those working for the LCC. Not least of the factors stimulating the hospital and institutional workers to militancy were the hopes created and dashed as a consequence of the election, in 1934, of the first Labour controlled LCC. The first signs of unrest emerged in mid-October 1934.

... when a crowded meeting of employees of Hospitals and Institutions assembled to protest against the altered conditions being imposed upon them by the LCC. The Chairman and the three speakers were employees of the LCC (transferred officers from the late Guardians' service) who voiced in no uncertain terms the strong feeling which exists upon the conditions which have been and are being imposed.

(26)

Among their complaints were that hours were being increased from 48 to 50 and even 54 hours, reduction of annual leave entitlement, and that fully registered male nurses were being downgraded by being asked to scrub floors. The 500 strong meeting passed a resolution detailing other deteriorations in their terms of service and sought an early meeting between NUCO and the LCC. The next stage in the Campaign was a massive meeting in the Central Hall Westminster on January 8, 1935 attended by 1800 members and presided over by the President, Mr. Lunn. The meeting had originally been planned as one of thanksgiving for seeing their grievances remedied by the LCC. But no reply had yet been received as a result of the complaints submitted by the NUCO deputation. Nurse Iris Brook, a full-time organiser, addressed the meeting and

ventured to suggest that if Florence Nightingale were alive today she would be ashamed of the profession, would undoubtedly be the General Secretary of a Nurses union to see that nurses were not exploited. It is the duty of every nurse, not to regard a union as degrading but one of dignity and necessity, to meet the needs of today.

(27)

After further speeches a resolution was passed criticising the worsening conditions of transferred officers from Poor Law services in breach of an agreement made at the time of the passing of the 1929 Act. The meeting 'then closed to the strain of the NUCO song'.

Feelings were running high. In November 1935 an open letter in the Magazine addressed to Herbert Morrison, leader of the LCC, listed the grievances of many grades of the transferred staffs and declared:

What I fail to understand is  
 your condemnation of capitalism,  
 and all that it entails, and for  
 the council, the majority of whom  
 condemn such a system, to apply  
 it in a socialised service.

(28)

The mood of militancy passed through all groups of hospital employees, but those with the most highly developed sense of grievance, and determination to remedy it, were undoubtedly nurses. Though other unions, and the TUC, were involved, it was undoubtedly nurses belonging to NUCO who led the way. Throughout the 1930s, public attention was focussed on the plight of nurses. At the beginning of the decade, it was largely due to agitation on behalf of nurses, by the press, members of the medical profession, and sympathetic Members of Parliament. Towards the latter half of the decade, however, as these well meaning efforts came to nought, nurses themselves increasingly took the matter into their hands. It became agitation by nurses themselves.

Throughout the 19th and most of the 20th centuries, hospitals have been explicitly excluded from the protective legislation that began in the 19th century with the passing of the first Factory Acts. Only those workers who would have been covered outside - such as those

in workshops - have been included within their scope. Those on the wards have been largely unprotected by laws that were being extended - if not always applied - to increasing numbers of workers in outside employment. Periodic attempts were made to remedy this neglect by bringing in special legislation to cover health workers. We have already heard of one such unsuccessful attempt, by the NAWU in 1911, to place a statutory limit upon the number of hours worked by asylum workers. The reason why this, and all other subsequent attempts failed is a simple one: no Government ever adopted the responsibility for such legislation. Instead Bills have always been introduced as a result of the initiative of individual MPs sympathetic to such a cause. This invariable rule applied to the Bill introduced in Parliament in 1930 by the young Fenner Brockway MP, for a minimum wage of £40 a year and a maximum working week of 44 hours. Not only did the Labour Prime Minister refuse to give the Bill facilities, but it was bitterly opposed by the College of Nursing. With the fall of the Labour Government in 1931, the Bill disappeared into oblivion.

If Parliament failed to remedy the situation, what of the medical profession, which has often seemed to have a paternalist concern for nurses' welfare?

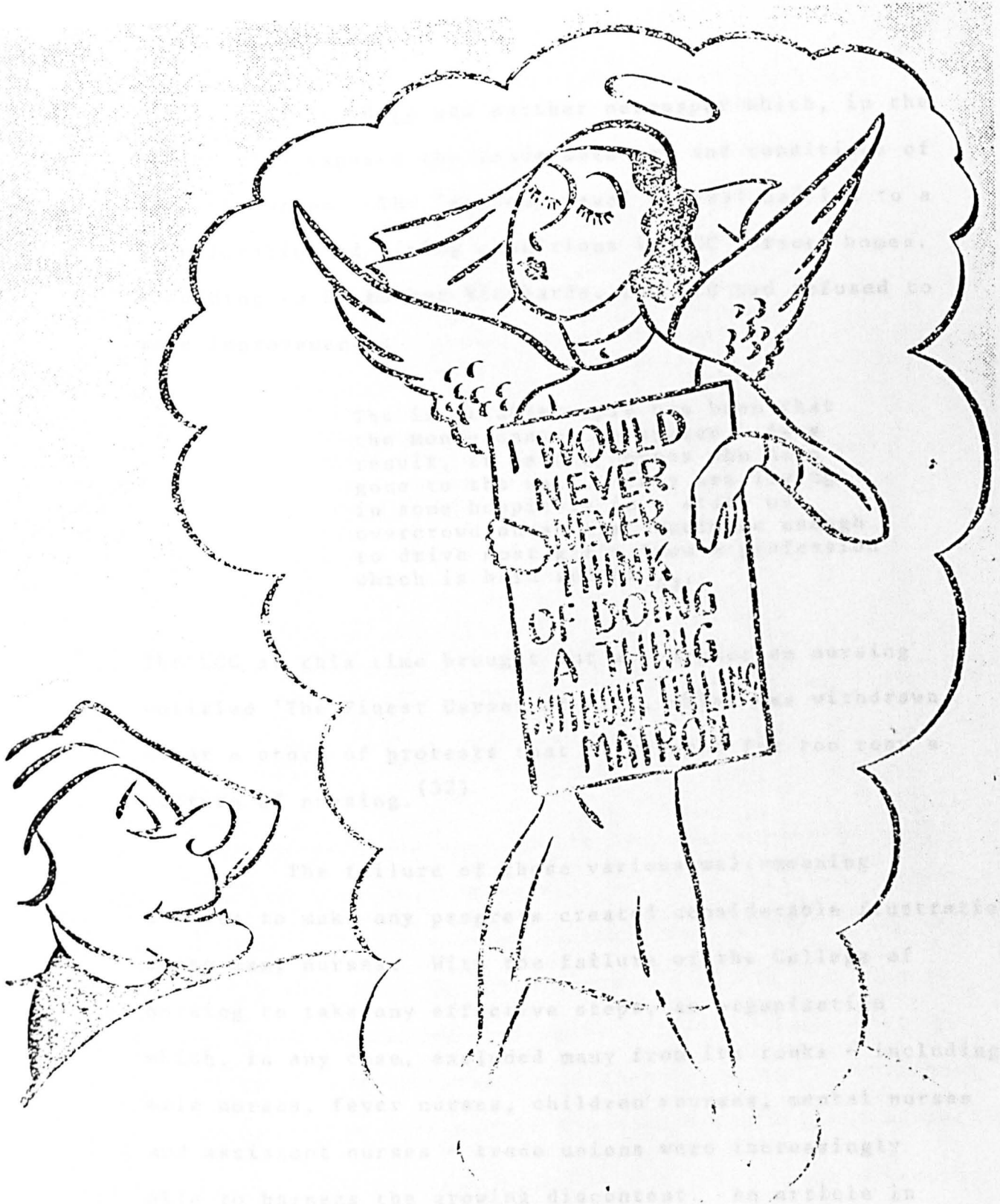
This came to the fore in 1930 when The Lancet, a medical journal with a reforming reputation, set up an enquiry into the reasons for the shortages of nurses and the means by which they might be remedied. Its Report, published in 1932, was the most comprehensive survey to date of nursing work and conditions, as well as being an indictment of hospital authorities. Pay was poor and hours were long. Much of the work of probationers consisted of the performance of backbreaking domestic duties. Living conditions in nurses homes typically left a great deal to be desired and were made worse by a great many petty and even tyrannical restrictions.<sup>(29)</sup> Much of this was already well known, and the Lancet's prime concern seems to have been the worry that nursing would not in the future attract its quota of middle class, educated recruits, at a time when other professions were gradually opening their portals to women. Yet concern for the welfare of the nurses themselves appears to have been a secondary issue. There were other reasons why doctors would be keen to see some reform of nursing: involvement of nurses in the innovations in treatment then being introduced required a less tradition-bound occupation, staffed by adaptable individuals capable of exercising some initiative.

It also led to an increased demand for their services, as more treatments were delegated to them. This was the real cause of the shortage, one more of increased demand than of reduced supply. The difficulty was that by the time the Commission reported in 1932 the country was in the grips of an economic crisis. A good many - but not all - of the reforms advocated had profound financial implications.

The press also took up the fight on behalf of nurses. Revelations of the appalling conditions under which nurses lived and worked made good copy, and newspapers could tap an almost abundant reservoir of public sentiment. One of the most strident was the Daily Express. One influential article in September 1933 by Charles Grayes on 'The Life of a Nurse' described it as 'the worst paid profession in Great Britain, and it is a crying scandal that this should be so'. Despite the fact

...that they have to pass very stiff examinations, they are paradoxically regarded as inferiors. They are treated as a cross between schoolgirls and domestic servants, except that domestic servants receive on an average more politeness from their employers than nurses do from the honorary doctors in the hospitals, or from their employers when they have finished training. (30)





'The Matron's Dream of an Ideal Nurse', MHIWU Journal, June 1935.

The Evening Standard was another newspaper which, in the early 1930s, exposed the inadequate pay and conditions of work of nurses. The 'economy wave' of 1931 had led to a deterioration of living conditions in LCC nurses' homes. According to Dr Esther Rickhards, the LCC had refused to make improvements:

The invariable reply has been that the money cannot be spared. As a result, it is the nurses who have gone to the wall. They are living in some hospitals in a state of overcrowdedness that would be enough to drive most girls from a profession which is hard indeed. (31)

(1) The LCC at this time brought out a pamphlet on nursing entitled 'The Finest Career of All', which was withdrawn after a storm of protests that it created far too rosy a picture of nursing. (32)

The failure of these various well-meaning efforts to make any progress created considerable frustration among many nurses. With the failure of the College of Nursing to take any effective steps, an organisation which, in any case, excluded many from its ranks - including male nurses, fever nurses, children's nurses, mental nurses and assistant nurses - trade unions were increasingly able to harness the growing discontent. An article in the NUCO's Magazine for 1932 dismisses the efforts of others

on behalf of nurses and draws out the most important lesson:

Let nurses get this firmly fixed into their heads: that only by organised effort will they achieve reasonable working conditions and fair salaries. It is not a bit of use envying other organised workers' wages and conditions ... Let us put a few questions to the nurses. Recently we had the Lancet Commission and its Report on conditions: here we had statistics galore and such publicity for nurses, giving descriptions and conditions which were published in the County Officers Gazette 12 months previously. But has the Commission achieved anything in the way of better conditions, and secondly, is it likely to do so? We think not. Suddenly the Evening Standard blossoms forth as a champion of the downtrodden nurses and probationers. Again we ask, will this achieve anything of a practical nature? A certain amount of publicity, a seven days flutter and then oblivion. The public soon forgets. (33)

The message was that public sympathy by itself would not win improvements for nurses, unless nurses were prepared to utilise it by organising on their own behalf. From the mid 1930s they made the most concerted effort yet seen to obtain improvements by collective activity, aided (but, it must also be admitted, partly hindered) by the wider labour movement. There were simply too many organisations competing to admit nurses into the ranks of the trade union movement. In addition to NUCO, the Transport and General Workers'

Union, the General and Municipal Workers Union, and the National Union of Public Employees were the main TUC unions seeking to recruit nurses, at a time when NUCO had only recently been accepted as a 'bona-fide' union and allowed in. But these difficulties were compounded by the activities of Nalgo, then outside the TUC, which also made concerted efforts to recruit nurses. As a result of its merger with the NPLOA, Nalgo had a well established base among ex-poor law nurses to add to those recruited from those working for the public health services, such as health visitors, school nurses and clinic staffs. It adopted many of the Lancet Commission's proposals and sought to work closely with the Royal College of Nursing, by seeking to entice them into its proposed bargaining machinery for local government nurses. In the proposed scheme, Nalgo and the Rcn would have shared all the seats between them. By the time these arrangements had been finalised in 1941, however, they were superseded by much more concerted efforts by the Government to regulate nurses' salaries and conditions. (34)

Nurses were therefore confused by the lack of unified opposition to the professional associations, an unfortunate fact which blunted the edge of the unions' thrust towards them. As Bryn Roberts, the General Secretary of NUPE put it 'the attitude of the nurse seems to say "a plague upon the damn lot of you"'. (35) Nevertheless in the early 1930s

NUCO made some headway forming, in 1933, a Medical and Nursing Section of the union. The two main areas where the union was to some extent successful in recruiting nurses - and some doctors - were the North East of England (with its strong trade union culture) and among those working for the LCC. In London there were the additional problems of competing against the management approved LCC Staffs Association. In April 1933 they tried to form what NUCO contemptuously described as a 'dumb organisation' of nurses. A meeting of Matrons of LCC hospitals was convened at County Hall, and addressed by Miss Banham, the authority's Matron-in-Chief, and Thomas Swinson, the Secretary of the LCC Staff Association. Plans were announced for the formation of a Section for State Registered Nurses. It was not to be anything resembling a union, and full membership was to be open to registered nurses only. Probationer nurses could join but not vote, but assistant nurses (who were being employed in increasing numbers in the 1930s) were entirely excluded. (36)

The steps had probably been taken as a result of a widely advertised meeting for nurses, called by NUCO for 25 April. According to the union's Magazine, a number of Matrons sympathetic to trade unionism resented being

used as an instrument to endeavour to force something upon the Nurses which, in many cases brought to our notice, is entirely against their principles. (37)

Their resentment was fuelled by a circular from County Hall, pinned to nurses' noticeboards and signed by Swinson, informing them that a meeting was to be held on 2 May, asking them in the meantime 'not to pledge themselves to joining any other organisation'. Nevertheless, according to the union Magazine, the NUCO meeting held on Tuesday, 25 April, at the Friends' Meeting House,

... was not the 'flop' we anticipated. In spite of every official effort to 'kill' any enthusiasm and prevent any attendance, quite a goodly number of Nurses assembled, in fact the room was well filled. (38)

Mrs Drapper, the National Women's Organiser, and Vincent Evans, the NUCO's General Secretary, argued the case for nursing trade unionism. A debate ensued between the platform and some College of Nursing members who had come to defend their organisation. From the Nursing Times, rather a different vantage point (since 1926 the College's official organ):

Heavy guns were brought to bear upon the College of Nursing and indeed if it could be proved as inefficient as the speakers and the 'voices from the gallery' asserted, and an act of oblivion could be passed on all the radical improvements it has brought about - affecting non-members as well as members, this great institution in Cavendish Square must need automatically close its doors not to mention those of its fine new extension. (39)

(For an account of the impact of that meeting on a young probationer nurse read the two attached articles, 'The Life of a Probationer').

By 1937, the organisation of nurses was proceeding apace, and the TUC was making concerted efforts to put its own house in order. On 23 July, 1936 a TUC deputation to the Minister of Health, arising out of a Congress resolution, put the case for a maximum working week of 48 hours in all hospitals and institutions, and one day off in seven. Subsequently, the Chief Medical Officer of Health's Report for 1937 gave prominence to the working hours of nurses. Whilst it urged local authorities not to

refrain from making desirable improvements in the working conditions merely because there are no definite breakdowns in the nursing service. (40)

it justified improvements by appeal to the criterion of efficiency:

A tired nurse, however devoted, cannot give the same assiduous attention to the patient as a nurse still fresh and alert. Moreover, undue fatigue in the nursing staff increases the risks of mistakes which may be attended with serious consequences. (41)



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# The Life of a Probationer.

## I.

(Contributed by a Probationer).

Am I disillusioned? After a little over 12 months service under the London County Council I can say very definitely, I am.

I left a good home, after a good education, to enter the nursing profession. I had other opportunities, but nursing appealed to me. Having read a brochure issued by the L.C.C., and by weight of argument, supported by the glowing account as issued by County Hall of the life of a probationer in training, I entered upon a four year course. Was I full of hope and enthusiasm? I should say I was. To-day—I have little hope and bitterly regret the day I ever entered this Hospital. However, I do not intend to give up, for I am determined to pass my examinations in spite of all obstacles and difficulties. I have lost considerable weight during the last 12 months, and, upon my returning home, my parents expressed surprise. Was I happy? Was I having good food? Was I housed in comfortable quarters?

How I lied—rather than admit defeat, because in the first place my parents were adverse to my coming.

Had I told them of the long weary hours of duty; the lack of proper exercise; the absolute insufficiency of food; the fact that I was dumped in a building which was not fit for housing cattle, let alone human beings (rumour has it that this hut was condemned by the late Guardians before the L.C.C. took over); that many of my chums had gone down with rheumatism in consequence of bad accommodation; that my life was made perfectly miserable because I was not a "favourite"; had they known these things, they would never have let me return. There are many like me—but we have found a friend—a real friend in N.U.C.O., and we are just beginning to realise it.

The General Secretary (and I hope he will not mind this reference) is affectionately known as "Uncle George." The reason is obvious. We know we must waste a great deal of his time—but whatever our trouble, he always arranges for either Mrs. Drapper or himself to see us, and this makes us feel that we have somebody whom we can trust to give us that advice and direction when we most need it.

When N.U.C.O. first issued its booklet last year, some of us attended the inaugural meeting. We returned to Hospital full of enthusiasm—having made up our minds to join. I went specially to hear Mr. Frank Briant, as, having come from a very staunch Liberal family, I had heard much about him. His advice impressed me. The following morning, however, our enthusiasm was stifled. It appears that the day previously our Matron had attended some Conference at County Hall and it had been decided to form an L.C.C. Nurses Association. She did not know what it was all about; what the contributions would be or anything like that. But—we were told we all must join. A certain Sister had been appointed by the Matron as Secretary. In passing, this Sister was most detested—was most unpopular amongst the Probationers. We were asked to sign some sheet of paper, and those who have been in Hospital will appreciate what this means. It is not a question of choice. The ones who do not sign are noted—and then comes the application of the "third degree." I had not served long—and was virtually on trial, but, I did say (somewhat timidly) "Matron I want to join this" and I held up my booklet. Matron looked somewhat stern—but she said kindly, "Nurse, you are young—and you are quite a novice. It's most undignified to join a Trade Union. I have joined the L.C.C. Nurses' Association: all the Sisters have joined—all the nurses are joining. So let's make one happy family." So—N.U.C.O. lost about 12 members that day. We were told that we should have regular meetings and if we had any complaints they could be ventilated. We've had no meetings since—and I do not know how many still belong to the Association—but N.U.C.O. to-day has more

than 12 enthusiastic members including some of the Sisters.

N.U.C.O.'s recent efforts in regard to the rationing business has created more enthusiasm—particularly as the evidence recently published definitely shows how we are being deprived of the necessary food to keep us in health and strength.

In view of the statements which are going round in fact we have been asked to say we are well fed and have no complaint to make) I have asked the Editor to allow me to give some impression of the life of a Probationer. This preamble shows exactly where I stand. I am a member of N.U.C.O.'s Medical and Nursing Section. I have confidence in N.U.C.O. and its officials: I was thrilled to hear the Nurse Speaker at the Memorial Hall Meeting and proud of her. I am more than proud of my organisation—Trade Union or not.

It's unprofessional to be a coward. It's unprofessional to be asked to submit to conditions which are grossly unfair. It's unprofessional for such a body as the L.C.C. to impose upon the Nurses conditions of service which they would not dare to apply to Tradesmen or Craftsmen, and to exploit females because of their "service to humanity." It's unbusinesslike from every point of view to underfeed the nurses and to expect from them continuous service in really strenuous labour at such unreasonable hours.

I hope as a result of these articles all L.C.C. Nurses will throw aside any professional bias and will join with me and my colleagues in the creation of the only organised effort which sincerely carries out its obligations. Since I joined I have felt invigorated and refreshed. I feel entirely different from the timid little damsel who held up the Book-let just 12 months ago. I have no more fear and am determined to stand up for what I think is right—and that right is that nurses should have a just reward for their labors.

## "WINDMILL PUDDING"

A correspondent asks "What is Windmill Pudding?" The reply is, Windmill Pudding is the name of a delicacy which, if it goes round, you get some.

# The Life of a Probationer.

## II.

(Contributed by a Probationer.)

The first three months of a probationer's life is a nerve racking experience. This is called the "trial" period, and I was not left in any doubt of this fact. What are my impressions.

Unfortunately I was not accustomed to any kind of domestic work, neither had I any elementary knowledge or experience in nursing. Just an ordinary (possibly spoilt) young girl, from a decent class home, whose life up to this point had been favoured with a rosy outlook. I had had no occasion to come across suffering, and as I look back on those first few days, I often wonder what inspired me to carry on. I was thus plunged into a new life entirely—something so vastly different from that to which I had been accustomed. I wonder if this change is appreciated by the Matrons and Sisters. If it is, they have a very unhappy manner of shewing any sympathy.

I was under the impression that I was to be "trained" and my idea of training, rightly or wrongly, is to be shewn how to do things—or how not to do them. My three months was spent in being transferred to various wards as a kind of "domestic help"—and I was expected to carry out instructions (carelessly given) with the knowledge of a fully fledged and experienced staff nurse. One had simply to adapt themselves and do their best. I always managed to do the wrong thing—and as a result was perpetually being told "off" in a manner which was not exactly ladylike in some instances. In some of the wards there appeared to be an absence of method. I pride myself on being methodical, and endeavoured with the wisdom of a "new entrant" to shew my abilities. This led to serious consequences and I was plainly informed that I was not a sister—yet. My "methodical" efforts became a poor experiment.

Some of the jobs I had to perform were particularly revolting. There is no necessity to give details in the "C.O.G." and it seemed to me that much of this class of work was left to the beginners. Here again, I was not shewn how to carry on in the professional way. One lesson would be sufficient for an ordinary intelligent being—but lessons were scarce. The "slap-dash" methods did not permit instructions. Yet in some instances I noted the sister and one of her probationers found heaps of time to discuss many matters in the private "sanctum."

I can safely assert that in that first three months I did not learn much. I did not know from one day to another in which ward I should be placed, and some of the sisters were so unkind that I often wondered, as I cried myself to sleep, whether they had ever been probationers themselves. If the time should come when I succeed to this coveted position, I hope I shall remember my first three months—and I shall attempt to "train" rather than "drive."

One thing stands out as a vivid impression—a feature in human nature so entirely fresh to me. The petty jealousy and cattiness of nurses towards each other. One would not think that girls were capable of stooping so low as to deliberately carry tales with the object of giving one of their colleagues a "downer." In addition petty thefts; sneering comments; personal reflections; cunning borrowing with the avowed object of never repaying; all these have to be met.

Let me give an illustration of what I mean. In one of the wards a certain instrument was broken. I knew who did it—and she happened to be a favourite of the Sister. The blame was put on to another probationer—who had to face "office." I spoke to the Sister about the matter and was told to "mind my own business" and "remember you are only on trial."

I suppose I have got acclimatised to these everyday occurrences—but it is a very serious reflection on a body of women that they cannot be decent and loyal to each other.

In my three months trial I saw my Matron three times. She never made any personal enquiries as to how I was

progressing. I suppose she had some reports upon me and my work. One would assume that a young girl, in a big city like London, should be regarded as a kind of "responsibility." It seemed to be nobody's business as to where I went; whom I met; what I did and how I did it. I often wonder what my parents would have thought had they known the exact position—their darling spoilt daughter, working terribly long hours—with no one to accept any responsibility as to what she was "up to." I did not get up to much as I was too tired.

Perhaps, some day, the L.C.C. will wake up to its responsibilities in enticing young girls to their wonderful hospitals—and leaving them to their own resources.

This is one of the reasons why all Pros. should join N.U.C.O. In the officials can be found someone "outside" the official sphere to assist and advise. It's a great tonic to unburden oneself to a sympathetic and considerate listener. N.U.C.O. is developing schemes which are of material benefit to its nursing members—and the one feature which appeals to me is a real friend in the "hour of need." Have you tried it? If not—meet Mrs. Drapper or "Uncle George."

**N.B. "Uncle George",  
the nickname of G. Vincent  
Evans, General Secretary  
of NUCC.**

Not least, it deterred recruitment. However, the Ministry of Health was opposed to compulsion:

The problem is by no means a simple one, and it would be unwise to attempt to regulate the maximum hours of work by any rigid formula. It is accordingly by no accident that the Legislature has left hospital authorities, who alone are in a position to view in correct perspective all the factors which should be taken into account, with wide discretion to regulate the hours of work in relation to particular institutions. (42)

No accident, indeed! The Ministry in peacetime refused to entertain any proposals which might interfere with the autonomy of the county councils and county boroughs, or threaten the precarious finances of voluntary hospitals.

In 1937 the TUC took the initiative. It formed a National Advisory Committee for the Nursing Profession, consisting of all the affiliated unions with the object of promoting trade unionism among nurses: the MHIWU, NUCO, TGWWU, NUGMW and the Women's Public Health Officers' Association. In Parliament in late April, Mr Kirby successfully moved the second reading of a Bill drafted by the TUC. This would have provided all workers in municipal hospitals and institutions with a statutory 96 hour fortnight or 48 hour week, overtime payments for all hours worked in excess, and one full day's rest a week. Although it would not have

applied to voluntary hospitals, informed opinion suggested that they would have been compelled to follow suit or run into considerable difficulties in recruiting staffs. As might be expected, the College of Nursing, through an editorial in the Nursing Times, attacked the Bill, making the rather extraordinary assertion that

... this Bill will not be popular with the majority of nurses. (43)

Yet the College for the first time showed signs that it took the increased activities of unions seriously. The same editorial stated:

Nevertheless this goes to show that if we do not put our house in order there are others who will. (44)

The Bill failed, of course, going down in December 1937; but the amount of sympathy for hospital workers was evidenced by the closeness of the voting, 122 to 111, with only an eleven vote majority against the Bill.

The other significant event of that year was the production of a Nurses' Charter by the TUC Advisory Committee. The Charter had eleven points:

- (1) 96 hour fortnight and abolition of 'spreadover' system (split shifts)
- (2) Enhanced overtime rates and discouragement of time off in lieu.

- (3) Minimum month's holiday with pay.
- (4) Minimum sick leave of 13 weeks full and 13 weeks half pay
- (5) Compensation for sickness and disability incurred as a result of the performance of duty.
- (6) Trained nurses should have freedom to choose place of residence, and nurses home conditions to be fully adequate
- (7) Superannuation for all nurses, transferable throughout the service.
- (8) Abolition of unnecessary restrictions
- (9) The creation of a Whitley Council, settling pay and hours questions at national level, with joint Consultative Committees to be formed at each hospital to consider such questions as: hospitals' rules, arrangements for annual holidays, questions of physical welfare, dismissal, promotion, discipline or conduct, methods of organisation of work, recreational facilities, leave passes, ratio of patients on duty by night and day, adequate relief staff, etc.
- (10) All probationers to go through preliminary Training Schools before working on the wards.
- (11) Facilities to be provided for higher training in midwifery, massage (physiotherapy), dietetics, health visiting, sister tutoring, etc.

Many of its demands were well ahead of their time, and the chief initial purpose of the Charter was to serve as a rallying point for the trade union organisation of nurses. Bold in conception, it combined demands for the development of training and education, with traditional trade union

demands for improved material conditions, and greater democracy in the workplace. On a number of important issues, however, it said nothing, particularly the relation between state registered and assistant nurses. The Charter was the occasion for a massive publicity campaign among nurses including the issue of a special booklet 'Off-Duty'.

In late 1937 NUCO transformed the Nursing Services Section into the Guild of Nurses, as a central feature of its attempt to capitalise on the TUC Charter. It was, of course, a considerable concession to a sectional community of interest, the creation of an organisation within an organisation. It appeased the reluctance of many nurses not just to join a union, but to belong to an organisation in which they would be forced to associate with other health workers outside their occupational group. At a time when second year probationers would usually feel it beneath their dignity to associate with 'first years', many shuddered at the thought of being an organisation where they might even have to associate with porters and domestics.

The principles of industrial unionism in the health service, to which NUCO in principle adhered, attempted to cut across these divisions in the workforce. Workers

were urged to realise that the maintenance of often artificial status distinctions between grades of staff, would only prevent the formation of a wider unity in action, out of which much greater benefits can flow than the nebulous advantages conferred by feelings of superiority towards other workers. However, it has often proved very difficult to realise these principles in practice. The formation of the Guild of Nurses was such a compromise with these principles. It was an attempt in particular to give the union the kind of 'appeal' to potential nurse members as the College of Nursing.

The Guild was launched by Mrs Drapper, the National Organising Secretary of NUCO, and Iris Brook, a trained nurse and midwife, as Assistant Organiser. Its first Chairman was Mr. O'Gorman, a male nurse and later full-time officer. Doris Westmacott, also a trained nurse and midwife, increasingly became the central figure in the Guild, joining the union as full time officer in 1941 - a position she retained with COHSE until she retired in 1967. She remembers that Vincent Evans asked her to become an Official. She had originally been active at Mile End hospital and led a deputation to the LCC about the deterioration in nurses' food as a result of the economy drive of the early 1930s. In persuading people to join the

union, she remembers,

It was nearly always based on facts relating to the service, keeping before their eyes the things that could happen if they didn't have an organisation to support them. (45)

The Guild had the reputation for being an organisation that nurses could go to if they were in any difficulty. The General Secretary was known as 'Uncle George', and as a sympathetic listener. The male nurses led the way in developing the union. They 'encouraged the fearful' as Doris put it. Nurses were concerned that they might not get good testimonials from the Matron:

I never had one of these situations, it never arose, but you were always a bit scared that it might. (46)

She was also concerned at the effects of long hours and poor conditions, especially night duty, on nurses' health, making them prone to such diseases as tuberculosis.

The Guild's inaugural meeting was held on 26 November, 1937 at St Pancras Town Hall, and chaired by George Lansbury, by then Leader of the Labour Party. Before the meeting nurses had paraded in the Strand with sandwich boards bearing the insignia 'LCC nurses Demand Fair Play', many of them wearing black masks for fear of victimisation.



Their complaints were many but in particular they were incensed that the LCC had so far not agreed to meet a request made in May to see a deputation protesting against the LCC's decision to introduce 'spread over hours of duty' (split shifts) in all its hospitals. Spontaneous protests, verging on strikes, had emerged like that reported in the Daily Mirror:

Sixty nurses from an LCC hospital, St John's, Battersea, SW9 paraded before their matron, yesterday and demanded a rearrangement of working hours. After talking to the girls for a few minutes the matron agreed to call a general meeting of the staff at eight o'clock last night and the girls went back to work. (47)

The agitation continued into 1938 with the demand for a 96 hour fortnight and an end to the spread over system formed the most prominent demands. It culminated in a masked demonstration on the afternoon of Tuesday, 5 April, graphically described by a union participant in the union magazine. Twelve nurses, eight female and four male set off, preceded by a loud speaker van, to march from Central London to Fleet Street:

The demonstration is attracting the attention of thousands ... What's this? Everybody stops their immediate task to watch this unusual demonstration. Nurses actually demanding the right to a decent life! What is all this about? One only sees Nurses in uniform in the streets on flag days. This surely is something new. Sympathy is expressed on all sides. How else could it be? Every watcher may need one of these nurses some day. (48)

On the evening of the same day a mass meeting of nurses in St Pancras Town Hall listened as masked nurses detailed their complaints. Their speeches are reprinted in full in two issues of the County Officers Gazette, and provide us with a unique record of nurses' sense of grievance at this time. One sister told the meeting that while the LCC had spent a great deal of money on new buildings they had neglected the staff:

What is the use of finely built and equipped hospitals with an insufficiency of essential nursing staff, and a disgruntled existing staff? (49)

She also complained that

The life of a sister today is that of a 'clerical assistant'. Stocks; stock taking; countless forms to be filled in daily and weekly; reports etc. These have so increased in recent years that the welfare of the patients appears to be the last thing that matters. The primary job of a sister is lost sight of in the endless and purposeless routine of clerical work. She does not even have time to properly train the probationers. (50)

Living conditions figured very much in the complaints. The standardisation of conditions, of which the changes in off duty formed a part, was the focus of criticism from more than one speaker. Authority was becoming remote from the place of the work and hospitals were becoming administered as vast impersonal bureaucracies: .

We have become mere numbers in the machine and although we are the only people who are in a position to really know and understand the working of our particular hospital, we often have to remain silent and carry out the instructions of someone who does not even know where the hospital is situated, let alone what is needed. (51)

The spread-over system was seen to be the result of this 'bugbear of standardisation'. Another said it was 'a sign of incompetent administration' and complained

The Council quite indifferently ignores our petitions and we have been forced to take drastic action to obtain some redress. (52)

A Probationer said

... don't talk to us about this spread-over hours of duty. I bet the matron-in-chief doesn't work it, and I jolly well know our matron doesn't work it. I don't blame them, but why push it on us? (53)

The nurses - and London health workers generally - felt let down by a Labour Council that had been re-elected in 1937 on the promise to 'finish the job' first began in 1934. The LCC was trapped within a vicious circle: the rapid expansion of hospital beds in the late 1930s had exacerbated the shortages of the earlier part of the decade. The shortfall in the number of staff nurses, of 251 vacancies in June 1935, totalled 454 by June 1937.<sup>(54)</sup> The hours of staff could not be reduced until more staff were taken on, and the overworking of existing staff, combined with poor pay, unsatisfactory conditions and long hours, ensured that turnover of staff remained high. The available remedy for the LCC, if it wished to use it existed through the rates. Unlike the voluntary hospitals, the LCC hospitals were not in a precarious financial state. Unlike some parts of the country, the economy was booming in the South East with the rise of new industries like light engineering, and the expansion of office work.

The Government was worried at the shortage but probably more concerned at the growth of trade union militancy and the widespread public support for the nurses. It faced in Parliament in 1935 the TUC sponsored Bill to reduce all municipal hospital workers hours to 48 hours a week. It had to do something to sabotage the Bill. Under pressure

from a College of Nursing anxious at the challenge represented by the TUC Charter, it deployed a favoured device for getting Governments out of tight corners - it appointed a Committee of Enquiry. This was subsequently known as the Athlone Committee, after its Chairman the Earl of Athlone. Its terms of reference were to examine nursing 'recruitment, training, registration and terms of service'. The composition of the Committee was strongly criticised by the Guild. It contained only one working nurse (and two members of the nursing establishment) out of a membership of twenty two, yet included seven medical men.

The Athlone Committee did not report until 1939. Many of its recommendations closely followed the TUC's Charter, including the 96 hour fortnight and the formation of a national negotiating body for settling pay.<sup>(54)</sup> The Committee also recommended the training and certification of a second grade of nurse, the assistant nurse. Though there was little on offer to the probationer nurse in terms of increased pay, the Committee did recommend Government financial assistance to Voluntary hospitals to meet the costs of any pay increase to trained staff. A minority of four on the Committee were even prepared to suggest that this financial assistance be extended to the municipal

hospitals. After receiving a deputation from the TUC the Government response was to encourage local authorities to make those improvements that were possible without extra expenditure, but to turn down flat any suggestion that they should interfere in the setting of wages for professionals. After all, the Committee had served its purpose. Just enough MPs had been persuaded to vote against the Limitation of Hours Bill, and the militancy among nurses was finally beginning to die down. When the War came, the focus shifted elsewhere. The work of the Athlone Committee, originally anticipated as part of a continuing programme of investigations, was halted.

For the Guild of Nurses, and other TUC unions representing nurses, the 1930s had therefore ended on a note of disappointment. They had recruited several thousand nurses, and successfully presented the TUC Charter to a number of hospital authorities, especially in the North of England. However, it seemed that nationally regulated pay and conditions were as far away as ever. They were not to know that the War would finally hasten the development of national pay bargaining for nurses. Within three years, many of the recommendations made by the Athlone Committee would be implemented by a Government anxious to ameliorate wartime shortages of nurses in civilian hospitals.

## Chapter 8: The Assumption of State Responsibility

Before the War hospital nurses had worked for a variety of agencies: local authorities (formerly Poor Law), mental hospitals and the voluntary hospitals. Only the mental hospitals, as we have seen, possessed anything resembling a system of collective bargaining to determine pay and conditions. Pressure by unions had led by the end of the interwar period to the establishment of the Athlone Committee. However, the onset of hostilities pushed its proposals a long way down the list of national priorities. This chapter shows how this was only a temporary delay in the path towards national determination of pay and conditions. Trade union pressure was largely responsible for the creation of the Joint Conciliation Committee between the National Asylum Workers Union and the Mental Hospitals Association, and subsequently the setting up of the Athlone Committee. However, other pressures were more significant in the final stages of progress towards national pay determination. It shows how the decisive moves were taken during the War when the State had taken charge of the hospital service and needed to remedy staff shortages and justify direction of labour. This was sustained during the period after the War as a result of the creation of a National Health Service in 1946,

as part of the Labour Government's post-war settlement with the working class. However, by this time the concerns of the state would lie more towards containing the cost of the new service. Since the main impetus had now shifted from the trade unions, the professional associations would gain more from the creation of a single system of collective bargaining for all nurses. This can be taken as perhaps another example of the way in which the creation of the NHS, though often proclaimed as a socialist measure, in some ways reinforced professional power and traditional hierarchies.

#### (1) Towards National Pay Determination

The relation between the War and the development of national rates of pay and conditions is a complex issue. The first point to note is that, although the Government took hesitant steps to remedy the shortage of nursing staff for the new casualty service through the creation of a Civil Nursing Reserve, they showed no immediate desire to improve wages and conditions.<sup>(1)</sup> The appeal to non-employed registered and assistant nurses, and those prepared to be trained as auxiliaries to come forward, appears to have been largely aimed towards their sense of national duty. One problem not settled was the acute shortage of domestic staffs, for the auxiliaries were, as



a result of a Ministry of Health ruling, only supposed to relieve staff of routine nursing duties. The Ministry employed a strange logic, arguing:

They are not to be considered as nurses in training ... It would, therefore, be a waste of time to set them to those routine ward duties, such as cleaning and polishing, which rightly form part of the basic training of a student nurse.(2)

The Civil Nursing Reserve had its problems: resistance from individual hospitals against their experienced staff being moved elsewhere; friction (as in the First World War) between existing staff and the new 'dilutees', who it was feared, might ultimately take over their jobs; and the unwillingness or inability of members of the Reserve to go where they were directed. Nevertheless, though shortages remained, they were not as serious as it seemed at the time - largely because civilian casualties were never as great as were originally feared.

The most critical shortages appeared among the general civilian services for the sick. The attempt to remedy these shortages was strongly influenced by political considerations, as indicated by Ferguson and Fitzgerald:

In total war the efforts and the morale of the civilian population are of military importance. Social welfare acquires a significance and an urgency which it is not usually accorded in normal times. The needs of ordinary sick people which had been disregarded in the early stages of the war could not be indefinitely ignored. When the casualty services had been tested and found adequate, the Ministry turned to the crisis which was fast developing in the ordinary services. (3)

With so many beds set aside for casualty services, sick people often found they could not get treatment. With the conditions of war, the tuberculosis rate increased substantially, exacerbating the critical shortage of staff in sanatoria, caused both by the work's unpopularity and its remote location. Such considerations led the Government to take action, under pressure also from the TUC Advisory Committee on the Nursing Profession, which spoke of 'the chaos and resentment which is apparent in the profession'. It had demanded pay rises and the establishment of a Salaries Committee. The immediate line of action for the Ministry lay through its authority over those hospitals participating in the Emergency Medical Service, nearly 2,400 of the country's 3,000 total number. In April 1941 the Ministry urged the EMS hospitals to pay a minimum of £60 a year for assistant and £95 a year for trained nurses, and promised financial help to the voluntary hospitals to meet the increases. The Government

also undertook to create a Salaries Committee. Probationers were offered £40 a year, no greater in real terms than they had been receiving before the War in municipal hospitals. Even so the Rcn expressed the view that the new rates for students

were too high and did not take into account the cost of the expensive professional training. (4)

Both the employers' body, the British Hospitals Association (BHA) and the Rcn fought a determined rearguard action against the setting up of a Salaries Committee; the BHA because it felt that it would encourage trade unionism among nurses, the Rcn because it was still vainly trying to establish a Local Authorities Nursing Services Joint Committee with Nalgo. This only succeeded delaying the formation of the Committee until November 1941, when the Minister set up the Salaries Committee for England and Wales under Lord Rushcliffe and a similar body under Lord Taylor for Scotland. Its original brief was only to deal with the question of salaries, though under pressure from nurses' organisations, the terms of reference were subsequently widened to include other conditions of work.

The Rushcliffe Committee did not, in any real sense, constitute national bargaining machinery on Whitley Council lines. Nevertheless, it was divided into employer and employee 'panels' and nurses' organisations were invited to nominate on to it. Despite its long standing opposition to Government 'interference' in the setting of nurses' salaries, the Rcn swallowed its pride and succeeded in winning more seats on the new body than any other organisation. In so doing, it demonstrated an ability to adapt its principles when its credibility as an organisation was at stake - a trait which has helped it down the years.

	<u>Seats</u>
Royal College of Nursing	9
Royal British Nursing Association	1
British College of Nursing	1
Association of Hospital Matrons	1
TUC (one each from NUPE, NUCO, NUGMW, MHIWU and the Women Public Health Officer's Association)	5
Nalgo	3
	<hr/>
	20
	<hr/>

While Rushcliffe was deliberating, through 1942 and into 1943, the nursing shortage worsened. In chronic hospitals the staffing ratios fell from 14 to 12 nurses per hundred patients, between 1942-43. Surveys after the war were to show that old people and the chronic sick had, as a result, suffered neglect. (1)

In 1943 two events of importance in the development of nursing occurred. First, the Nurses Act was passed, following the final acquiescence of the Rcn: it gave Assistant Nurses a statutory existence and admission to a 'Roll' if not a 'Register' of the GNC after two years' training. Second, in February the Rushcliffe Committee finally reported nearly five years after the Minister first announced that it should be set up. Its recommendations largely followed those of the Athlone Committee in 1939, which in turn were based on those originally advocated in the TUC Charter. Trained staff were to receive substantial increases; entrance fees for student nurses were to be abolished; night duty to be limited to six months for trained staff and three months for students; sick leave for staff with two or more years service to be 13 weeks full and 13 weeks half pay; one complete day off a week and 28 days leave with pay each year.

Though the TUC can claim credit for many of the advances made by Rushcliffe (not least the fact that it was the first ever national award to nurses), the influence of the Rcn may be seen in two of the least satisfactory aspects of the Rushcliffe award. Student nurses were given no more than the £40 a year offered by the Ministry in 1941, and a 96 hour fortnight was to be introduced only 'as conditions permit' at a date to be

determined by the Minister of Health. The Guild of Nurses produced a critical commentary on the Rushcliffe Report. Pointing out the strong preponderance of the Rcn on the Employees Panel it suggested that:

It is hardly a coincidence ... that the Rushcliffe Committee with its heavy load of 'College' representatives has failed to deal adequately with the vexatious problem of hours of duty. (1)

The Guild's view was that even if a reduction in hours could not be granted because of shortages, nurses ought still to be paid for hours worked in excess of 96. It attacked the recommendations on pay as being biased in favour of grades above staff nurse and ward sister. As for the 'derisory' scales offered to students they did

... not amount to reasonable 'pocket money' for the modern girl. The leaders of the Nursing Profession, at any rate those who are pillars of the Royal College must realise that the girl of 1943 has a greater desire and appreciation of independence than her predecessor of 20 and 30 years ago. The requirements are greater; she desires, and indeed is entitled to dress as smartly and in the latest fashion as her friend who probably receives a far higher salary as a clerk or typist in some commercial office ... It is significant that the people who proclaim loudest that a student nurse does not seek a higher salary all come from the ranks of the 'higher-ups' in the Profession. (7)

While Rushcliffe, under the influence of the Rcn had stated that in calculating students' salaries, account should be taken of the 'valuable' training they received, the Guild declared:

The facts are that while a Student Nurse is being trained she is not merely regarded as being a student but she forms an important part of the nursing staff of the hospital and enables the employing authority to staff its hospital more economically than would otherwise be possible if it were not a training school. (8)

The Rushcliffe Committee recommendations were accepted by the Government and implemented rapidly. Hospitals paying the new scales received half the cost of increased expenditure from the Ministry (something which they were not later prepared to do for authorities employing domestics at recommended rates). The Government's reasons for implementing the award so rapidly soon became clear. From April 1943 all persons between 17-60 with some nursing experience during the previous ten years were compelled to register with the Minister of Labour. Restrictions were placed on nurses in civilian employment enlisting for Crown services.

In September 1943 the Control of Engagement Order, which covered women from 18-40, was applied to nurses.

This meant that the subsequent employment of nurses would be dealt with through the local Appointments Office of the Ministry of Labour. In other words, it amounted to direction of labour. At the same time, an extensive publicity campaign was launched to gain recruits. Angled towards middle class young women its motto was 'The War-Time Job which can be a Career'. In February 1943 the Ministry of Labour had set up a National Advisory Council for the Recruitment and Distribution of Nurses, and this now played a central role in the way that controls were operated. The controls were maintained until 1946, and the Ministry of Labour from 1944 directed women into priority fields, such as chronic sick and tuberculosis. However, despite fluctuations, shortages persisted and continued after the War. The Rushcliffe recommendations had not been sufficiently generous or bold enough to affect the situation fundamentally. Nevertheless the principle of national determination of pay and conditions long fought for by the trade union movement and long opposed by the Rcn, had finally been won. Ironically, though the credit for achieving must go mainly to the unions representing nurses, the chief organisation which benefitted was the Rcn. As soon as it saw that national pay bargaining for nurses was inevitable, it reversed its previous oppositional stand and succeeded, in conjunction with the other professional associations, in winning a dominant position on the new body.



The Rcn's dominance on Rushcliffe foreshadowed its later domination of the Nurses and Midwives Whitley Council, under the National Health Service. What had been constructed by the patient handiwork of the trade union movement was, when it neared completion, accepted gratefully by the Rcn. The truth was that though the challenge of unions was strong enough to force the reluctant Rcn to adopt an increasingly trade union role, they were not sufficiently powerful to relegate it to the wings. As previously with the NPLOA, the unions 'woke it to life'.

Nurses were by far the largest occupational group, but the recruitment and organisation of other grades of staff was also profoundly affected by war-time conditions. Shortages of domestics were widespread in all types of hospitals. As Ferguson and Fitzgerald comment:

Few women who had a chance of finding other employment were prepared to accept domestic posts in hospitals. (9)

The Government was much less prepared to take steps to improve their pay and conditions, except initially to issue a special badge for hospital domestic workers to show the importance of their work. When these forms of moral suasion failed, standards of ward cleanliness fell, and catering suffered as a result of shortages in kitchen staff.

By the middle of 1943, there were an estimated 8,000 vacancies. These circumstances led to the setting up of the Hetherington Committee and, while its Report recommended some improvements, the Government was not prepared (as it had been with nurses) to provide hospitals with any financial assistance to implement the award. They simply directed labour to hospitals paying the new rates.

Shortages of nurses, domestic and other grades of health workers continued into the post-war period. In 1946 the Confederation of Health Service Employees (COHSE) - newly created by the amalgamation of the Hospital and Welfare Services Union (the successor to NUCO) and the Mental Hospital and Institutional Workers' Union protested at these continuing shortages. In a submission The Hospital Services: The Problem Arising out of Existing Shortages of all Grades of Staff, it claimed that shortages were primarily the result of poor wages and conditions, but were also exacerbated by the lack of consultation with 'many professional and non-professional workers for the improvement in the running of their institutions or departments'. Furthermore, administrative officials were often remote and the career promotion of staff was blocked:

The majority of hospitals seem to make 'castes' of the various employees and all of them are segregated in 'water tight' compartments. This is bad for the welfare of the patients and the hospital services generally. (10)

The document contained many proposals for reform many of which, such as those for the career development for portering staff, were well ahead of their time. It also emphasized the need to renovate many hospital buildings. It ended by arguing that 'too much class distinction is maintained in the hospital service' and emphasized the need for all staff to join a union if conditions were to be improved.

The Government had itself recognized in 1945 that a grave shortage existed. It issued a document Staffing the Hospitals: an Urgent National Need<sup>(11)</sup> which halfheartedly acknowledged the need for improvements in working conditions:

Hospital work will attract and interest the right kinds of recruit in sufficient numbers only if it can offer interesting, well-organised and properly remunerated work. Does it offer this now? The answer, as in other fields of employment, is that sometimes it does and sometimes it does not. (paragraph 10).

This was an admission of a sort, but the next paragraph seemed to imply that people had a false image of what hospital work entailed:

The notion of hospital work as devoted endurance of discomfort in a good cause, is, of course, entirely out of date, but the actual conditions of present day hospital work, and its opportunities, are still not as widely known as they should be (paragraph 11).

This did not, however, explain why so many left hospital work shortly after starting. Nevertheless, the pamphlet admitted that standards were 'mixed', and committed the Government, in the light of the proposal to create a National Health Service, to improve the working conditions of staff, in conjunction with representatives of employees organisations. It cited the recently worked out 'Codes of Working Conditions' for nurses and domestics. These included provision for local joint consultation, and it was clear that the Government was working towards the establishment of national Whitley Councils.

The Government had some good intentions, but they were only to be partially realised. The Codes had stated that:

No obstacle should be placed in the way of trade unions in representing their members in negotiations with the governing body or authority.

This was far from a recommendation for full recognition, yet there is no doubt that in many instances management continued, in the newly created NHS, to place obstacles in the way of unions recruiting and representing hospital staff. Management did not generally believe it necessary to involve staff in decision making, and unions were not yet strong enough to compel them.

## (2) Towards Socialised Health Care

The Government's policies on industrial relations have to be set in the context of their overall policy towards the health service. The NHS is often seen as one of the most uniquely socialist creations of the post-war Labour Government. The combined forces of the trade unions, the Labour Party and the Socialist Medical Association are often given the credit for the emergence of this radical institution. Certainly, the NHS can be traced indirectly to the pressure on social insurance which the TUC brought on the Government during the 2nd World War. This led to the setting up of the Beveridge Committee, whose Report in 1942 recommended the creation of a National Health Service as an essential pillar. The Report's subsequent popularity, especially the idea of a comprehensive health service, made it a central plank of both major parties' political programmes.<sup>(12)</sup> It simply fell to the Labour Government of 1945-50 to implement the commitment.

There are also strong reasons to believe that, though the Labour Movement constructed the NHS, they were not its architects. A small group of left wing doctors had in 1930 set up a Socialist Medical Association, the prime aim of which was 'to work for a Socialised Medical Service, free and open to all',<sup>(13)</sup> and it had formally committed the Labour

part to its policy by 1934. However, the TUC was apparently more concerned about improving the existing scheme of national insurance set up by Lloyd George in 1911 (14). The Labour Party itself did not seriously press for the NHS until after Beveridge. As Eckstein has argued, it is possible to view the Labour Party's commitment to a NHS as one aspect of a growing tendency towards pragmatism rather than socialism, in which its politics of health shifted from a utopian 'sanitary' preventative perspective to an increasingly reformist 'curative' one:

The Labour Party's conversion to the idea of a free medical service may perhaps be considered a particular aspect of a much more general trend in socialist ideology of the change which transformed British socialism from a "reformative" to a "redistributive" social philosophy. It is broadest implications, it is a reflection of the increasing acceptance by the Labour Party of the fundamental structure of the non-socialist society. (15)

His argument that the NHS was simply a 'rationalisation' and that it is 'highly misleading to think of the NHS as a social welfare measure at all', perhaps overstates the case.

If the emphasis upon securing a national health service led to a shift of concern away from the prevention of the social causes of ill-health, which had more revolutionary social implementations, its creation still represented the application of criteria of

'need' rather than ability to pay. As such it shows the strength of 'statist' thinking had shifted the political consensus to the left during the 2nd World War. However, the form that the measure took certainly did mean that the 'need' to rationalise, as Eckstein put it, 'inefficient and malorganised activities' took precedence over democratic socialist principles. Above all, however, the acceptance of the privacy of 'clinical autonomy' meant, as Navarro argues, that the NHS was not so much a 'revolutionary step', but 'an expansion of the National Health Insurance to the whole population' <sup>(16)</sup>. Distribution according to 'need' meant 'whatever doctors decide'. Accordingly an earlier plan to amalgamate the hospital services with local government was dropped by Bevan, who created a structure similar to the nationalised industries. The professionals would run the service in conjunction with committees publicly accountable only through Parliament.

The reinforcement of professional power occurred as a result of Bevan and the Labour Government's anxiety to secure consultant and general practitioner co-operation with the new service. <sup>(17)</sup> It also meant that compromises had to be made on the desire to rationalise services - for example, the hospital and community services remained

separated. Compromises also occurred on other aspects of the plan. The nationalisation of the former voluntary hospitals went ahead. However, the 'teaching' hospitals (as they had now become) maintained a separate administrative existence with direct lines of communication to the Ministry. Professionals also resisted the complete nationalisation of medical care, for example, by establishing pay beds in NHS hospitals.

While at every stage it is easy to find evidence of how professional power and influence modified the introduction of the new service, it is hard to find much direct evidence of the influence of health service trade unions. In 1944, Ernest Brown, the Minister of Health, published in a famous White Paper, his plans for the National Health Service. The Hospital and Welfare Services Union (HWSU) - which NUCO had by then become - produced a surprisingly critical document on the proposals.<sup>(18)</sup> The union described the White Paper as

a most disappointing document failing to outline a comprehensive health service but mainly concerned in introducing a medical treatment service.

It **complained** that the Minister only consulted 'the upper hierarchy of the health service' in framing his proposals:



There is no evidence whatsoever that the organised Trade Unionists were consulted in any degree by the Minister of Health in the preparation of the document ... The majority of organised Health Workers come into daily contact with the people who require the service. They know what they want. They hear their complaints and grievances. They know the weaknesses of the present system. They are of the people. Because of this they are ignored. The Minister prefers the theories of the medical experts, the professional hospital administrators, the capable wire pullers, in preference to the practical experience of the average Health Workers.

It submitted that

... the Government would never have dared to skip over the principles of the Health Service as it will affect non-medical workers if such an organisation as the HWSU had a membership six times as large as it has today. (19)

It criticised the TUC for not calling together those affiliated unions with health service membership, to discuss the implications of the White Paper. Thus though the Labour movement may have conceived the health service, the shape it took showed more the interplay of governmental and professional interests. The demands for a NHS were strongly supported by working class people. However, their organisations were not strong within the health service and thus were not

able to shape significantly the development of the service at that stage.

### (3) The Mental Health Services

When War broke out in September 1939, as in 1914, many beds were turned over to the military authorities as part of the Government's Emergency Medical Service. By the end of 1941 these amounted to 20,000 from mental hospitals and 6000 from mental deficiency institutions.<sup>(20)</sup> Such was the extent of over-crowding, however, that many hospitals found themselves unable to participate in the scheme. The situation was partly eased by the reduced admission of male patients, partly due to call up, but the falling rate of unemployment also played a part.

Shortages spread from female nurses to other grades of staff. Within the first year of the War 2000 male nurses had left to join the forces and 600 women nurses for war work. Some of these were replaced, but in most instances by less experienced personnel. The situation deteriorated in the following year to the extent that many hospitals were up to one third under strength. The female sides suffered most, as the choice of work for women widened. Standards of care inevitably fell, and war time regulations, like those governing blackout, placed restrictions on the institutions.

At the very least the War led, as Kathleen Jones has suggested, to 'the return of the locked door, of inactivity, of isolation'.<sup>(21)</sup> At the worst it was responsible for higher rates of sickness, particularly tuberculosis and dysentery among patients and, to an extent, staff. As in the previous War death rates rose, but by no means to the same degree. A peak death rate of 9.17% was reached in 1941, with a substantial decline thereafter. The Board of Control claimed in the official history of the War that the health of patients in mental deficiency institutions suffered less because they

... were practically all employable and could be kept out of doors to a far greater extent than mental hospital patients.<sup>(22)</sup>

As we have seen, nurses were not the only grades to be affected by shortages. The popularity of domestic work was already low as a result of the abysmally poor wages and bad conditions and fell even further during the War. Throughout its existence, the employers' side of the JCC had consistently rebuffed approaches from the union to negotiate scales of pay for ancillary staffs. One of the few gains made by domestic workers between the wars had come in 1938, as a result of a Government decision to include them within the scope of unemployment insurance for

the first time. The shortages of domestic staffs, like management's neglect of their welfare, had deep roots. The shortfall could partly be met by that traditional and well-tried method, of getting patients to do the work. The growing shortage of doctors, on the other hand, was a direct result of the War and could hardly be remedied in the same way. Many doctors were attracted into the Army and, as a result, staffing ratios widened to about 1 doctor for every 400 patients. Many of the innovative forms of treatment halted, since they were often demanding of nursing as well as medical time. In any case the advanced treatment sectors were those most likely to be claimed for use by military psychiatrists. (23)

From 1940 the Aliens War Service Department allowed doctors and nurses of Austrian, German and Italian origin, to be employed in mental hospitals. They were not allowed to care for service personnel for security reasons, and were to be limited to a maximum of 10-20% of the total. Things were getting so bad that early in 1941 the Mental Hospitals Association and the MHIWU issued a joint appeal to staff not to take sick leave if they could avoid it (see next page). Finally the Ministry of Health acted, and in August 1941 issued the Mental Nurses (Employment and Offences) Order, which became known as the 'Standstill'. Its preamble indicates the Ministry

THE MENTAL HOSPITALS ASSOCIATION AND  
THE MENTAL HOSPITAL AND INSTITUTIONAL  
WORKERS' UNION

# AN APPEAL

*to Mental Hospital Staffs*

## ABSENCE FROM DUTY OWING TO ILLNESS

SOME Visiting Committees having recently expressed concern at the growing amount of time taken off in cases of illness of a minor nature, the matter has received the consideration of a Special Sub-Committee appointed by the National Joint Conciliation Committee.

It is recognised, of course, that the abnormal conditions prevailing in mental hospitals owing to the war and the consequent strain imposed upon mental hospital staffs may have a tendency to increase the incidence of sickness amongst mental nurses, but we feel confident that in the present emergency it will be the desire of all concerned to contribute their utmost endeavours to maintain the hospitals in a state of efficiency and to safeguard the welfare of the patients in their care.

The absence of members of the staff through illness, while unavoidable, causes a certain amount of dislocation, and in these difficult times everyone concerned will assuredly regard it as a public duty to take as little sick leave as possible and to return to work at the earliest possible opportunity consistent with medical advice.

That the staffs of mental hospitals are imbued with the spirit of public service is apparent to all who are acquainted with the many sacrifices expected from mental nurses, and we confidently rely upon their continuing to give devoted and loyal service during the period of grave emergency which now confronts the country.

L. T. FELDON,  
Secretary,  
Mental Hospitals Association.

GEO. GIBSON,  
General Secretary,  
Mental Hospital and Institutional  
Workers' Union.

was concerned

... that the serious and increasing shortage of nurses in mental institutions has been greatly aggravated by the tendency of many of the younger members of the nursing staff to seek a transfer to other types of nursing and to other occupations which appear to them, for the time being, to be more attractive or to be more directly concerned with the war.

The Ministry's view, on the other hand, was that the war effort could best be helped by such nurses remaining in post, and under the 1939 Defence Regulations issued an Order that nurses at institutions which observed the JCC pay scales, with more than twelve months service, could not leave without the permission of their Visiting Committee. Allowance in the Order was made for promotion to a post at another hospital, normal retirement, and for Appeal to the Chairman of the Board of Control. The regulations carried the penalty of a maximum fine of £10 and/or a term of imprisonment not exceeding one month. And prosecutions were made under the order, though most penalties were of a nominal kind.

## Prosecution under the "Standstill" Order.

When is a nurse not a nurse? Mr. W. F. Wallace, prosecuting in a case at Leicester County Police Court, said the answer is, "When he is employed as a mental nurse."

Eric Albert Revell, described as a male nurse, was summoned for leaving his employment at Narborough before his services had been dispensed with, contrary to the Mental Nurses (Employment and Offences) Order, 1941.

Dr. K. P. Drury, resident medical superintendent at Carlton Hayes Hospital, said Revell was a full-time male nurse. Revell, after giving written notice that he was going to leave, was warned that he might be prosecuted as he could not leave without permission of the committee.

Revell then stated, said Dr. Drury, that he had been told by the Labour Exchange authorities that he was not in a reserved occupation, and they had issued him with a green card which allowed him to go to work elsewhere.

### "ATTENDANT ONLY."

When the clerk, Mr. E. G. B. Fowler, said he would rule that Revell was a male nurse, Mr. Basil Edwards, defending, contended he was not, and claimed that he was an attendant only. He stated he would appeal.

"I shall ask you to state a case and shall go to a higher court," Mr. Edwards stated to the magistrates.

Revell said he had been discharged from the Army owing to asthma. He was sent from the Labour Exchange to the hospital in the first instance in connection with a vacancy for a male attendant.

As cycling 10 miles daily to and from hospital proved a strain on him, he went to the Labour Exchange to seek advice. He was told he could use his own discretion, and in view of that he thought he was in order in giving notice.

### Technical Offence.

Revell stated he was now at a Government training centre. He denied that he had been a nurse.

Mr. Edwards: You were doing what I should term the work of a domestic servant.

The Clerk: Or a nursemaid.

Revell, replying to the Clerk, said he had never seen the Mental Nurses' Order posted on the noticeboard at the hospital. The only uniform he wore was a khaki coat. Nurses wore blue uniforms and peaked caps.

After retiring the chairman stated that the magistrates found Revell had committed a technical offence. They were satisfied he was under a misapprehension as to his position, and in the circumstances, Revell would be fined £1.

In view of the nominal penalty, said Mr. Edwards, he would not ask the magistrates to state a case.

The Standstill Order stopped the drift of staff away from mental hospitals, but in some ways it exacerbated staffing difficulties, by deterring recruitment. To cope, authorities sought to bring back pensioners and married nurses. The Minister of Labour held back from direction of labour to mental hospitals, even though he introduced it elsewhere.

The Standstill only applied, however, at institutions which paid the union negotiated rates. The Coalition Government was anxious to secure the co-operation of organised labour in the war effort, and any restrictions on workers' normal free right to leave should not seem to give the employer an unfair advantage. It was not therefore surprising that a month before the Standstill Order, in July 1941, the JCC agreed a new national scale of wages which abolished the distinction between 'urban' and 'rural' rates of pay that had been maintained since 1920, and granted a rise in basic rates to cover the cost of living. The minimum starting pay for men was now £2.10s. a week, and for women, £2. The vast majority of authorities adopted the new scales, including many of those not members of the employers' association, the MHA.



In 1941, the Government had also taken action to set up the Nurses Salaries Committee under Lord Rushcliffe (and its counterpart in Scotland, the Taylor Committee) in order to settle national rates of pay and conditions of service for hospital nurses. As we have seen, it was divided into two sides with appointed representatives of nurses' organisations on the one side (with a majority granted by the Minister to professional organisations) and representatives of employing bodies on the other. The MHIWU viewed the Rushcliffe Committee with profound suspicion. Combining forces with the Mental Hospitals Association, they originally made representations to the Minister of Health that the terms of reference of the Rushcliffe Committee should not be extended to cover mental nurses.

When this was readily agreed by the Ministry of Health in May 1942, the decision was strongly attacked by Lord Latham, a Labour peer who had long been associated with the LCC (which, it will be remembered, had not participated in the Mental Hospitals Association or observed JCC agreements). The LCC having been one of the most generous employers at the beginning of the 20th century, had become among the most parsimonious, despite Labour having held office since 1934. In a speech in the House of Lords, Lord Latham pointed out that mental nurses

totalled something like one third of the 90,000 hospital nurses, and argued that it would be inconsistent to exclude them from the terms of references of the Rushcliffe committee.<sup>(24)</sup> Arthur Moyle of the National Union of Public Employees, and also a TUC member of the Rushcliffe Committee took the same position as Lord Latham, wishing to see mental nurses included. NUPE had a long standing objection to a separate Whitley Council for mental hospitals, having been excluded from the JCC when it was first set up in 1920. It had wanted mental hospital staffs to be included in the National Joint Council for Local Authorities Non-Trading Services. Seeing Rushcliffe as a means by which unification could be achieved NUPE, was eager to become a recognised union for mental nurses. Naturally enough, the MHIWU was implacably opposed. Yet inter-union rivalry was not the most significant reason. The MHIWU's main concern was to protect the relatively favourable conditions of their members in comparison with general nurses, by remaining a separate bargaining unit. With some justification, they were worried that to become included with the generality of nursing staffs would lead to a deterioration in their terms and conditions of employment. As Gibson put it:

Mental nurses do not desire 'equality'.  
They believe themselves to be entitled  
to something better. (25)

In his speech, Lord Latham had referred to the increased status and standing that would come as a result of mental nursing's closer association with the wider nursing community. At this juncture, at least, the union was more concerned to protect the material interests of its members than to exchange their established bargaining machinery for the uncertain advantages of a Government Committee of Enquiry.

The Report of the Rushcliffe Committee was considerably delayed and did not appear until February 1943, more than a year after the Committee had been set up. The key stumbling block was the old one: employer opposition to the possible expense. This was only overcome when the Treasury agreed to pay 50% of the cost. Even then, the proposals were not to be made binding on employing authorities. As we saw earlier, a 96-hour fortnight was to be introduced 'when conditions permit' (ie not to be introduced then or in the foreseeable future). Student nurses were to receive a paltry minimum salary of £40 plus emoluments, no more than they had previously been offered. Qualified staff nurses and sisters were, however, to receive substantial increases on the existing rates paid by most hospital authorities.

Meanwhile, the MHIWU was negotiating with the Mental Hospitals' Association over new pay scales. The MHA were keen to obtain the 50% Treasury Grant, but the Ministry were insisting on some formal link with the Rushcliffe Committee. In June 1943 a subcommittee of Rushcliffe was established for Mental Nurses, consisting of six representatives each from the MHA and the MHIWU. The Report of the Sub-Committee was not presented to Parliament until August 1944. It recommended higher percentage rises for basic grades than Rushcliffe had given to other types of nurses, and also maintained the relatively advantageous economic position of mental nurses. It also recommended that the division of training between the GNC and the RMPA should not continue and that for the purposes of remuneration the Certificate of the RMPA or Registration by the GNC should be considered of equal value. (26)

#### (4) The Birth of NHS Whitleyism

Both the main Rushcliffe Committee and the Mental Nurses sub-committee formed the basis for the formation of the Nurses and Midwives Whitley Council in 1948. In the period of social democratic consensus after World War 2 there was a renewed interest in the Whitley model of collective bargaining first advocated, as we saw earlier, during World War One. Its consensual assumptions were ideally suited to the service-oriented organisations to be found in the NHS. As a result, it became increasingly difficult for the MHIWU to sustain its opposition to mental nurses being incorporated into the mainstream system for determining wages and salaries.

The divided system of training between the RMPA and the GNC was to end, with the latter body becoming the sole training authority in the post war world. The mental health services were to become part of the NHS even though the legislative and administrative framework was not going to alter fundamentally with the Board of Control remaining in existence until 1959. Most important of all, when COHSE had been formed in 1946 with the aim of promoting one industrial union for the health service, the justification for separatism by mental nurses appeared very thin. A single bargaining unit was therefore, created for all nurses, including those working in mental hospitals.

It was also 'natural' at the time that 'Whitleyism' should form the basis for the new system, with its consensual assumptions seeming highly appropriate to the objectives of the new service. Whitleyism was in fact originally designed for private industry as a system especially concerned to prevent industrial disruption in the munitions industries and to achieve harmonious industrial relations in the post war world. J H Whitley, the Deputy Speaker of the House of Commons, chaired a Reconstruction Sub-Committee in 1917, whose reports advocated the establishment of National Joint Councils in all well organised industries, it being emphasised that they should deal not only with wages and conditions of employment, but also with

the better utilisation of the practical knowledge and experience of the work people .. [and] .. improvements of processes, machinery and organisation and appropriate questions relating to management and the examination of industrial experiments with special reference to cooperation in carrying new ideas into effect and full consideration of the workpeople's point of view in relation to them (27)

In order to achieve this the Committee envisaged the creation of local as well as national Whitley Councils.

Many of the Whitley Councils set up during the interwar period failed to survive the depression and the intensification of industrial conflict that was associated with that period. It was not until the 2nd World War that there was a revival in Whitleyism's popularity. During the war the Government sought to incorporate trade unionists at all levels, from Ernest Bevin at the Ministry of Labour to the joint production committees at shopfloor level. (28) The idea of a common purpose which sustained joint consultation during the War in private industry, proved difficult to sustain afterwards - the prime exceptions being in the newly nationalised sectors. Perhaps these notions stood a better in chance of success in the NHS than anywhere else in the public sector, since traditions of staff commitment to the service had been established before the state took over.

There was, however, nothing in the National Health Service Bill 1946 which prescribed any particular system of settling pay and conditions for NHS staff. However, there was a clause which, as Section 66 of the NHS Act provided that

Regulations may make provision with respect to the qualifications, remuneration, and conditions of service of any officers employed by anybody constituted under this Act ... and no officer to whom the regulations apply shall be employed otherwise than in accordance with the regulations

Nevertheless, the Lord Privy Seal gave assurances during the second reading of the Bill that the Government would either adapt existing machinery or set up new bodies 'of the Whitley Council type behind which there may be provisions for agreed reference to arbitration should the Whitley Council not be able to carry it out'.<sup>(29)</sup>

Accordingly the Rushcliffe Committee formed the basis for the new Whitley Council. The system, as finally established by the Government, was complex in operation. It was divided into Functional Councils, composed of management and staff sides, charged with negotiating the pay and conditions of particular sections of staff, and a General Council with the responsibility of negotiating common conditions of service and dealing with issues that affected all staff (though in practice medical staff have

often been excluded). In practice, the Functional Councils have played the most significant role in the system. Nine were established, for ancillary workers, nurses and midwives, administrative and clerical staffs, professional and technical staffs (divided between A and B Councils), pharmacists, dentists and opticians. In terms of numbers, the Ancillary Staffs, and Nursing and Midwives Councils were by far the most significant. At the end of 1953 there were 184,000 whole time and 55,000 part time ancillary workers, and 197,000 whole-time and 37,000 part-time nursing and midwifery staff employed by the NHS, approximately 80% of the total. In a service which was by definition labour intensive, with salaries taking approximately 70% of total revenue expenditure, nursing and ancillary staffs salaries were the single largest items of expenditure. The implications this held for the consensual assumptions upon which Whitleyism was founded will be examined in more detail in the next chapters.

The management side of the Nurses and Midwives Council was originally made up of 8 representatives of the Ministry of Health and Scottish Department, 4 from the Regional Hospital Boards set up by the 1946 NHS Act, and 2 from Boards of Governors of teaching hospitals. Local authorities were granted 8 seats because of their coverage of public health staffs, such as district nurses, health visitors and nursery nurses in day nurseries. Hospital Management Committees, the main employing body



at local level, were originally excluded from the management side of this, as well as the other Councils, despite the fairly strong representation of local authorities, who employ a small minority of nurses and midwives. As Lord McCarthy succinctly put it in his review of the NHS Whitley system published in 1976, the management sides of Whitley Councils are divided between 'employers who do not pay and paymasters who do not employ'.<sup>(31)</sup> The strong representation allowed to local authorities was perhaps due to their dual role as both employers and paymasters, with the cost of pay rises being met from local rather than central funds. The over-representation of the Ministry of Health and Scottish Department indicated a preponderance of paymasters rather than employers on management sides. This also seemed to point to the possibility that the concern would be more towards containment of costs than, say, responding to local needs such as shortages of labour. As Alec Spoor pointed out,

'The Ministry representatives were all civil servants, mostly with no background in or experience of, nor responsibility for the local administration of the service or the recruitment and control of its staff ... (However) none of the employers sides had any effective power to negotiate. Since all were financed from the national Exchequer none was allowed even to discuss, let alone agree, any improvements in pay unless the Treasury approved. And the Treasury was not represented on the Whitley Councils at all

(32)

The fact that in 1952 Hospital Management Committees were granted a single seat (subsequently increased to 2), after they had formed themselves into an association, made little material difference to this situation.

If the composition of the Management side did not bode well for the future advancement in pay and conditions of nursing and midwifery staff, nor did the composition of the staff side inspire confidence that the nurses' and midwives' organisations would press effectively for improvements. In the first place there were too many organisations representing too few staff. While many, perhaps, the majority of nurses did not belong to any organisation, the 41 seats on the staff side were distributed among 12 separate organisations, some of them covering only a few hundred members:

Composition of Staff Side of Nurses and Midwives Whitley Council in 1948.

Association of Hospital Matrons	2
Association of Supervisors of Midwives	1
Association of Hospital and Welfare Administrators	1
COHSE	4
Nalgo	4
NUGMW	3
NUPE	4
Royal College of Midwives (RCM)	6
Rcn	12
Scottish Matrons' Association	1
Scottish Health Visitors Association	1
Women Public Health Officers' Association	2

The problems deriving from the fragmentation and lack of representativeness of the Staff Side were compounded by the split between trade unions and professional associations. A majority of seats were held (and are still held) by professional associations, with the Rcn leading the field. These organisations had no previous experience of negotiations, yet the Rcn held the Secretaryship of the Staff Side, meaning that its officials would play the key role in shaping the overall structure of Staff Side claims, as well as possessing decisive voting strength. The traditions of the Rcn and other professional organisations emphasised service ideals. They adopted a trade union role very reluctantly and union functions had to compete with the many other professional activities they were involved in. Trade union methods were abhorrent but not simply because tactics involving industrial action would seem immoral. Considerations of status were also involved for it was feared that association with trade unionism might injure members' professional standing. The Rcn had also been strongest in the former voluntary hospitals where the Matrons, who had tended to dominate its affairs, had held back from pressing claims for improvement because of sensitivity to the chronically weak financial state of that sector. All these factors suggested that it

would take a cautious approach towards NHS negotiations and might put forward claims that were more favourable to senior nurse managers than rank and file ward nurses.

Therefore the achievement of central state responsibility for the pay and conditions of nursing staff did not necessarily herald a new era of improvement. While wartime shortages had led the state to make improvements in salaries, after the War state control tended to act to hold down wages in a bargaining structure where more power had been granted by the Labour Government to professional associations than trade unions. The NHS enjoyed a fair measure of commitment and good will from its nurses (if not the medical profession) in 1948. The next two chapters will show how the unrest which finally erupted in 1974 had its roots in the decision of successive governments to squander and finally exhaust the fund of staff goodwill granted to the service at its inception.

## Chapter 9: The Lean Years: 1948-60

'The Whitley Council machinery would deserve several chapters in any text book written on the art of government manipulation' - B Abel-Smith, A History of the Nursing Profession p.201.

On the face of it, it seems surprising that the development of trade unionism among nurses was so sluggish during the 1950s. The creation of a single, unified employer with a seemingly favourable attitude towards recognition should have promoted trade unionism, as it appears to have done elsewhere in state employment.<sup>(1)</sup> It is tempting to suggest that the likely explanation must lie in the attitudes of nurses themselves, either through continuing attachment to values antithetical to trade unionism, or apathy. Though there is some truth in this hypothesis, it requires qualification. As we shall see, the recognition granted to trade unions was an extremely limited one, and its nature was one which, ultimately, served throughout the 1950s to frustrate the development of collective organisation. Processes were also at work which would promote trade unionism as a delayed response in the 1960s and 1970s, and we should not assume that nurses' attitudes were not changing during the 1950s. And as we shall also subsequently see, it was a process accelerated by the restructuring of health care along 'industrial' lines that took place in the 1960s, and which had a profound

effect upon the already changing attitudes of nurses. The health service was nationalised in 1948, but in many ways was left intact until the 1960s, and this helps to explain why old traditions persisted, not just because of nurses 'backward' attitudes, but also because the occupational institutions underpinning them were not yet fundamentally transformed by their absorption into a National Health Service.

(1) The Survival of Traditional Power Structures in a Socialist NHS.

In large part this was because the post war Labour Government, in nationalising previous health services, thought it best to tamper with their existing power structures as little as possible. Bevan, as Minister of Health, decided that the best approach was to try to coax the medical profession into the new 'Socialist' health service by seeking to convince them that the fundamentals would remain the same. The objective was to appease what Bevan's biographer described as 'the strongest beat in the medical mind':

... a non-political conservatism,  
 a revulsion against all change, a  
 habit of intellectual isolation  
 which enabled them to magnify any  
 proposals for reform into a  
 totalitarian nightmare (2)

The poor representation of the labour movement within the health sector perhaps influenced this cautious approach. The miners had long sought nationalisation as a solution to the problems they faced. In the health sector a minority of doctors associated with the Socialist Medical Association advocated it (though for a brief period in 1942 they managed to define the British Medical Association's policy.<sup>(3)</sup>) This is not to say that doctors and other elite groups within the health services did not look to the state, for as Walters has pointed out, the creation of the NHS could be seen as in their interests, for it provided a firm financial base for health care, while at the same time shoring up medical autonomy.<sup>(4)</sup>

As we have seen, the NHS has been regarded as both the 'jewel in the crown' of socialist measures taken after World War 2, and hardly 'a social welfare measure at all'. That these two opposite judgements can be passed on a single measure perhaps indicates, more than anything, its contradictory character. In some senses genuinely socialist, it was nevertheless an integral part of Beveridge's plan in 1942, very much concerned with the

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stabilisation of post war British capitalism.<sup>(6)</sup> This integration of a 'socialist' measure into a 'capitalist' plan was surely only made possible because of a narrowness of socialist vision. First, there was the assumption that the NHS would be financially compatible with the requirements of state expenditure under capitalism, because it would quickly clear the accumulated backlog of ill-health. Second, the faith in 'experts' and professionals as neutral and efficient arbiters of the socialist order was a common theme at the time, as Addison has pointed out.<sup>(7)</sup>

Bevan went further and attributed an almost anti-capitalist ethic to professionals. Medical discoveries, he argued,

... were made by men and women whose values have nothing to do with the rapacious bustle of the Stock Exchange: Pasteur, Simpson, Jenner, Lister, Semelweiss, Fleming, Domagk, Roentgen - the list is endless. Few of these would have described themselves as Socialists, but they can hardly be considered representative types of the competitive society (8)

Therefore, while pragmatism may have been one reason why Bevan sought no major changes to the medical system, in order to coax doctors into the new system, another was perhaps an ideological deference towards the medical profession. A socialist health system was primarily one



which financially underwrote the traditionally private relationship between doctor and patients. According to Bevan's biographer, shortly after his appointment he sought to reassure doctors in an after-dinner speech that he wanted their help, ('for after all, gentlemen, you are the experts'):

I know that the doctors feel anxious lest there should close upon them a national machine which would obliterate their individuality. They need have no fear, no fear at all, I conceive it the function of the Ministry of Health to provide the medical profession with the best and most modern apparatus of medicine and enable them to freely use it, in accordance with their training, for the benefit of the people of the country. Every doctor must be free to use that apparatus without interference from secular organisations. (9)

Thus socialism and a judicious policy of non-interference with the traditional power structures of health care were apparently quite compatible. Socialism meant underwriting whatever the professionals thought best. It did not mean greater democracy for either non-medical staff or lay members of the public. To avoid 'interference from secular organisations' the original plan to integrate the NHS into local government was quietly forgotten and a separate administrative structure created, formally responsible to Parliament but with the key role played by doctors at each level of decision making, from the Ministry down to the bedside and consulting room. (10)

(2) The Implications for Trade Unionism.

The old power structures were therefore largely reproduced within the new state apparatus. The tripartite system was established in which hospitals, teaching hospitals and Executive Councils (of general practitioners and dentists) were separately administered. Trade unionists might have achieved a recognised place at government level, in negotiations over pay and conditions (even though they had to share it with professional associations), but at local level there was to be little encouragement to those who hoped new relationships would be established among staff as a result of the creation of the NHS.

In theory the means existed for staff to influence a wide range of issues at the place of work through the Whitley Council system. As well as the Functional Council (in this case the Nurses and Midwives Whitley Council) which settled wages and conditions for particular grades, and the General Whitley Council which determined conditions applicable to all (or nearly all) grades of staff, provision was made for the establishment of local Whitley Councils, or Hospital Consultative Committees. It was originally envisaged that these would discuss a wide number of non-wage issues and, in keeping with the consensual philosophy of Whitleyism,

improvements for the joint benefit of staff and patients alike. While local joint consultation was, for example, made compulsory for the National Coal Board under the Coal Industry Nationalisation Act 1946, it appeared in the NHS almost as an after-thought. No reference to it was made in the NHS Act of 1946. The first reference was through official circular HM48(1), paragraph 13 of which ran:

Steps should be taken by (Hospital Management) Committees to constitute Joint Consultative Committees on Whitley Council lines representing the management and staff and further information will be sent separately on this point

It was not until 1950 that more detailed guidance was sent out, including a model constitution which established that election to the committees was to be restricted to recognised Whitley Council organisations and that, significantly, medical personnel would be excluded from the proposals.

A systematic investigation of the experience of joint consultation in the NHS, published in 1969, concluded that:

... consultation in the hospital service must, with a few exceptions, be pronounced a failure... (It was) undertaken not in response to a deeply felt need, but as a concession to a fashion in social thinking (11)

Miles and Smith concluded that the lack of real enthusiasm from above was almost bound to be matched by at best a lukewarm response by managements at local level. According to their survey, from a peak of activity in 1951, committees steadily declined. Their survey in the 1960s of 197 hospitals found that meetings were only being held in 76 hospitals, and that in many instances meetings were irregular, had trivial issues referred to them and were extremely tardy in producing concrete results.

These findings fit in with the overall argument that there was, at central level, little desire to tamper with established power structures at hospital level, even within the consensual assumptions of Whitleyism. The proposal for local hospital consultative committees was therefore put forward as a token gesture rather than as an imperative. The reasons why staff groups themselves were not pressing harder for their extension is a complex issue. The requirement that representatives belong to recognised organisations discouraged nurses' involvement for few belonged to any. However, as Miles and Smith pointed out:

... an increase in nurse representation would increase interest and it would probably be difficult to find candidates to stand for election. There are many problems such as shift work, wastage, dispersion, and the hierarchical traditions of nurses which make their active participation difficult to secure .(12)

In other words the logistic problems of representation combined with the military emphasis upon duty discouraged nurses from coming forward, even for something as mild and innocuous sounding as 'joint consultation'. These were well established elements of the nursing culture and training primarily encouraged subordinates to follow the rules and procedures established by tradition and established authority. It was still very powerful at the hospital where I commenced training in 1965 (which incidentally did not possess a Joint Consultative Committee). Nurse training emphasised that there is a right way of doing everything, right down to the smallest detail. We were constantly being reminded that we were not to worry if a particular rule seemed unnecessary or even non-sensical, for it would not exist were there not a good reason for it!<sup>(13)</sup> Such a culture was not likely to encourage nurses to come forward with 'helpful suggestions'.

Yet reading between the lines of Miles and Smith's accounts one can see other reasons why health workers did not make more use of joint consultation. In certain instances staff rejected the consensual notion of a common interest and increasingly pursued grievance activity along traditional trade union lines. We hear of one instance, for example, where unions sought to turn them into negotiating committees, rather than accepting the dominant

meaning of 'consultation' (which is that management legitimately have the final say). This was

...occasioned by a disagreement with the management side over the details of a shift system. The matron held a particular view about the shift times which was supported by the management committee. As this was unacceptable to the unions there were not enough representatives to form a staff side (14)

They significantly conclude:

In cases in which management has embarked reluctantly on consultation, where they have been grudging about the disclosure of information and where they have tried to use the committees to exact small concessions from the staff, "consultation" has often produced increased militancy rather than co-operation. In hospital situations where there are often legitimate grievances about pay and conditions with which even the most sympathetic management finds it hard to deal, consultation is inevitably difficult. Staff representatives are faced with pressures from their members which offer great temptations to bang the drum and cause trouble. (15)

Thus joint consultative committees either became discredited and fell into disuse, or else tended to be transformed into negotiating committees. Joint consultation was caught in a pincer movement from two directions. The development of conflictual local bargaining was, however, still relatively uncommon, though where it did arise it is interesting to note that,

according to Miles and Smith, discontent over nationally determined pay and conditions spilled over into local militant action. It certainly also indicates that hair-line cracks were beginning to show on the smooth surfaces of staff loyalty or apathy.

Another implication of the survival of traditional occupational institutions is that while unions were recognized for negotiating purposes at national level, at local level similar kinds of obstacles were placed in the path of unions as in the past. Doris Westmacott, former Woman's Officer for COHSE, told me in an interview, that in the 1950s it was still usual for matrons to forbid trade unions to hold meetings, while the Rcn were allowed, even encouraged, to hold theirs. The control of the training school meant also that membership of the Student Nurses Association (a closely allied, even satellite organisation of the Rcn) was presented as a normal part of occupational socialisation. As we saw in Chapter 2, this can be one of the most effective kinds of recruitment channels. Needless to say, unions were typically denied access to new recruits. As Ms. Westmacott described it, in the 1950s there were:

... the beginnings of a breakthrough  
 here and there ... but the power of  
 the Matrons was pretty strong (16)

Joining a union itself may not have been regarded as a deviant act - even if it was frowned upon - so long as it remained an individual, private matter. But it became deviant when it became public and one member invited another to join with them collectively. This tended to be seen as a challenge to authority in itself. To engage in this public activity required a substantial degree of commitment to trade unionism. For Ms Westmacott, in the 1930s and in the 1950s male nurses formed the spine of cadres who possessed it. With the post 2nd World War unification of general and psychiatric nursing, male nurses from psychiatric hospitals were increasingly seconded to obtain the SRN which increasingly became a promotion ticket, and they brought trade unionism with them. As seconded nurses, they were in an ambivalent power relationship with the general hospital, which they were able to exploit. My own memory as a nurse in the 1960s is that they were also able to exploit their position as men: defying authority, especially of women, was much less likely to lead to sanction and could even be seen as an indication of 'manliness'. Nevertheless, this did not mean that trade union activities were tolerated. I have clear memories of how union notices



put up by a seconded psychiatric nurse caused horror in the administration and were immediately taken down. However, no action was taken against the individual concerned.

Though on the whole the survival of traditional structures worked against trade unions, there were instances where it worked in the opposite direction. This was especially the case in psychiatric hospitals where unions, particularly COHSE, were more likely to have a stranglehold on recruitment channels (such as the school of nursing), and where conformity would more likely involve joining the union, while membership of the Rcn was likely to be seen as deviant. Until 1960 men were excluded from membership of the Rcn, but those attracted to professional ideals joined (yet another) 'satellite' organisation of the Rcn, the Society of Registered Male Nurses (SRMN) which, indeed, disappeared from the scene when the Rcn began admitting men to membership.

In describing the SRMN (and the SNA) as 'satellites' of the Rcn I do not mean to claim that they were necessarily simply fronts for it. They may have been heavenly bodies with their own independent existence, yet their affairs were totally dominated by the gravitational pull of the Rcn. In most cases, satellite organisations have been established

when there is a status problem over admitting an occupational segment to the professional community as represented symbolically by membership of the Rcn. When this is resolved, the satellite is merged into the Rcn or disappears. This has occurred with all groups save auxiliary nurses, which is the only surviving satellite organisation. In this instance, however, the possibility of admission seems a very remote one. A satellite organisation is distinguished from an allied organisation, like the Association of Nurse Administrators (ANA) (which in the 1950s was called the Association of Hospital Matrons) because the latter exists to articulate a distinctly separate 'community of interest' of its own. This is the case even though there appears to be a considerable overlapping membership between the ANA and the Rcn. However, a satellite's only reason for existence is its exclusion from a desired community of interest.

In one or two other instances the survival of traditional power structures in the 1950s worked in favour of unions. Thus, some Matrons were convinced of the need for membership of a trade union for themselves and encouraged their subordinates to join for the same reason.

Sometimes, according to Doris Westmacott, it also worked the other way round: with Matrons and other administrators joining after male nurses and male tutors had 'encouraged the fearful ones', and then went on to persuade the Matrons that it was in their interests also to join a union. In Nalgo, Miss Marion Curtin, Matron of Moxley Hospital, Wednesbury, became a member of its NEC, took a leading part in its negotiations on the Nurses and Midwives' Council, and in 1966 became its first woman President.<sup>(17)</sup> Some may have had a prior orientation to trade unionism, or acquired it on the way.

Even for Matrons, trade unionism was not in total contradiction with their social position in the health service. Although they often had immense power, they were also employees. They may have been 'taskmasters', but they were not 'paymasters', so possessed a potential common interest with other nurses and health workers against their paymaster, the Government. They were also occasionally vulnerable as employees. In 1959 COHSE fought a successful appeal to reinstate a sacked matron.<sup>(18)</sup> This was an extreme example of a more general problem: that while having authority over others, they were also subject to those above them. But since the hierarchy in nursing was becoming more extended it was by no means applicable solely to Matrons. In theory within the union all were equal members of a single community of interest, but as we shall see in the Case Studies it is by no means unusual for authority relations at the place

of work to be reproduced within trade unions. Perhaps it is not so pronounced a problem as in the Rcn, but nevertheless it exists as a tendency.

Thus while it should not be assumed that trade unionism among nurses automatically represents a challenge to existing authority relations, there is no doubt that its potential for doing so was restrained by the survival of traditional occupational institutions. Those in control of them gave little encouragement to the development of collective organisation by ward level staff because it would have threatened the unitary pattern of managerial authority represented by the Matron system. Through the 1950s central government did not seek to interfere with this state of affairs. It 'recognised' unions at national level, but did not follow this through with any imperative policy at local level which would have strengthened nurse trade unionism. In fact it turned a blind eye to management abuses.

### (3) Turnover and Problems of Union Reproduction

Quite apart from the problems imposed by the traditional management structure, the mobility of the labour force made stable trade union organisation extremely difficult to attain. Nurses tend to move around in search of work and leisure experience and further qualifications. (19)

This fact by itself need not be disadvantageous for trade unionism. In the past the 'tramping artisan' formed the backbone of craft unionism.<sup>(20)</sup> As we have already seen, male psychiatric nurses taking general training from the 1950s, helped to spread trade unionism in that sector. Nevertheless, turnover due to career advancement can inhibit the formation of a stable cadre force, as workers move away and/or move upwards in the hierarchy. In a professional association like the Rcn such movement is not liable to be so disruptive, especially since activism in a professional organisation is usually considered to be more compatible with career development. However, in one way it can: the Rcn has always been aware that when students qualify they often do not extend their membership of the student section of the Rcn to full membership of the organisation.<sup>(21)</sup> In the 1950s and 1960s it was a problem exacerbated by the Student Nurses' Association's separate existence from the Rcn.<sup>(22)</sup>

Quite apart from career mobility, nursing in the 1950s was subject to what managers described as a high rate of 'wastage', leading to a plethora of research studies, many of which have been collected, summarised and commented upon by Macguire.<sup>(23)</sup> Most research was conducted upon student and pupil nurses, with some consideration given

to recently qualified staff nurses but little to unqualified nursing auxiliaries. The most extensive study of students was that undertaken by the General Nursing Council, who followed the progress of all 57,776 student nurses who commenced training between January 1957 and December 1959. The overall withdrawal rate during training was approximately 30%, but this varied according to type of hospital. Teaching hospital rates were much lower at 20%, while the rate in non-teaching hospitals was on average 34.5%. Rates were also much higher in mental and mental subnormality hospitals than in general hospitals. (24)

For trade unions, such turnover is significant not only because it sets up formidable problems in simply recruiting and retaining members, but also because it might be the result of discontent with pay and/or conditions at the place of work, which if not expressed as an individual decision to leave might have led instead to a more collective determination to change things. Of course there is no certainty that this would occur, but there is good cause to believe that the occupational institutions have operated (not necessarily as part of a deliberate plan) to expel those whose attitudes and behaviour threatened to disturb traditional hierarchical relationships, and who, if they had stayed, might also have

challenged poor pay and conditions. In the first place the imagery projected by the occupational institutions to the world at large may have served to deter many such potential recruits. A survey of attitudes of girls and young women to nursing, undertaken during the 2nd World War, showed that the traditional imagery was strong, even to the extent of underestimating the degree to which improvements had occurred.<sup>(25)</sup> This also indicates something about the kinds of expectations which many actual recruits were likely to possess. There is considerable evidence that this imagery persisted into the 1950s and '60s. For example, a survey in 1963 of 'intelligent school-girls' (ie those taking 'O' levels) found that 67% expressed no interest in nursing and, of the remainder, only 13% expressed 'a strong and unqualified degree of interest'.<sup>(26)</sup>

As well as having a deterrent effect, occupational institutions also operate to expel those who cannot conform to standard expectations. In the GNC survey Student Nurse Wastage, already cited, this did not however appear an important factor. Out of 16 reasons for withdrawal from training, 'personal' reasons ranked highest at 34% and marriage was next highest at 11%. For men, 'transferred to other work' (19%) and insufficient salary (10%) were significant differences from the female sample, but even so 'personal reasons' still ranked highest (32.5%). Such general surveys

are, of course, not particularly illuminating, and Dingwall has claimed that they involve an inherent bias towards blaming the individual concerned (eg for having the wrong motivations, poor educational qualifications, etc.), rather than drawing attention to the structural features in the situation that lead people to leave.<sup>(27)</sup> This cannot be said of all studies, however. Hatty's more ethnographic study of 77 students in 1963 found that it was when students left the training school to work on the wards that major problems of 'adjustment' surfaced. She concluded that:

The comments of the students indicated that the major factor which determined to what degree the students became successfully adjusted to the ward situation was their relationship to the sister. Arbitrary authoritarianism was what the students disliked most (28)

This finding was confirmed by Revans. In his analysis of turnover among types of nurses, he also found 'communications' between the ward sister and the rest of the ward staff to be the most crucial factor.<sup>(29)</sup>

Can we reconcile this emphasis upon authority relationships at the place of work with the GNC finding that personal and domestic reasons figured most prominently as reasons for withdrawal? Perhaps, if it is recognised that there is a dialectic between voluntary and non-voluntary, and personal and structural reasons for withdrawal, and that



it is the analyst's task to uncover the links between them. Reasons are not always clear cut. A student may conceivably 'opt' for marriage as a form of withdrawal if work is not going well, for example. The high number who gave 'personal reasons' might have been reluctant to criticize or could have been blaming themselves in a situation which structurally led to such a response. Though most withdrawals were 'voluntary' we do not know what pressures, intentional or otherwise led them to occur. In the USA, one social researcher found a group of student nurses to be divided into cliques according to their acceptance of nursing authority. The most popular among the administration were the 'Goody-Goods' who either conformed to the rules or broke them surreptitiously. What distinguished the self-ascribed 'Wild Ones' was their bravado. It seems that it was their 'general attitude' and behaviour in leisure time that gave most offence rather than their ability as nurses. While the school tended towards tolerance,

... the administrators who had day-to-day contact with the girls ... had tougher views of these girls' activities. The dossiers of the girls contained rather unflattering "total evaluation" of their nursing performance - though their cumulative grade averages and relationships with patients and hospital personnel didn't seem to warrant this (30)

Unfortunately we are not told whether the 'Wild Ones' had a higher withdrawal rate, but it seems reasonable to assume that the pressures upon this group, which might lead to more of them withdrawing, would tend to be greater.

The end result of a combination of poor pay and conditions, and/or the perseverance of traditional hierarchical relationships was an acute staffing crisis in the hospitals, especially non-teaching hospitals. Rather than deal with the underlying causes management responded in the first instance by expanding the numbers of overseas nurses, particularly in the South East, (where alternative job opportunities for women were greatest), and in the isolated mental hospitals.<sup>(31)</sup> Many were recruited for pupil nurses training leading to State Enrolment: a qualification enabling very limited subsequent career progression, not generally accorded much recognition overseas. An attitude survey of 46 West Indian pupil nurses at a London geriatric hospital from 1958-64 concluded that

The desire of pupils to conform was high in the first months of training but declined as training progressed ... Aggressive attitudes were more frequently expressed, by those further on in training (32)

While this article tended to blame the nurses themselves for failing to integrate, it does indicate the existence of feelings of resentment which in principle might be

expressed through trade union activity. A later survey showed that:

There was widespread feeling among overseas nurses that senior nurses did not always treat them the same as they treated English nurses. Only 1 in 10 said they had never experienced what they interpreted as unfair treatment from a senior nurse. (33)

But there were a large number of reasons why this would not necessarily express itself in collective action. Foremost of them was (and is) the vulnerability of the overseas nurse due to immigration regulations. Also, trade unions would tend to be seen as part of the same network of institutions from which overseas nurses felt vulnerable and alienated. The survey just cited showed that 3 out of 10 overseas nurses felt there was no one to whom they could go if treated unfairly by a senior nurse, and the other 7 out of 10 all mentioned figures higher in the nursing hierarchy. None mentioned trade unions. (34) In the absence of conscious efforts by unions to raise the problems of overseas nurses, there was no necessary reason why overseas nurses should turn to trade unions in large numbers. Such initiatives were not forthcoming from any major union representing nurses.

#### (4) Whitleyism and the Character of Nursing Trades Unionism

The difficulties inherent in local trade union organisation meant that, almost inevitably, the prime activities of both unions and professional associations in the 1950s and into the 1960s were focussed around nationally determined pay and conditions. A vicious circle was created in which the lack of solid local organisational back-up meant that national negotiators were not taken seriously by management. In the process they and the unions they represented became discredited, and this retarded the development of grass roots organisation. As a result, trade unionism languished.

Though circumstances were difficult, the unions could have made greater, more imaginative efforts to break out of the impasse. There was no attempt, for example, to expand significantly the numbers of full-time officials in the regions in order to service the development of local organisation, no attempt at this time to create a network of stewards able to make the most of bargaining opportunities. Shop stewards in private industry had developed their role from dues collecting to become increasingly involved in negotiations over piece rates, workloads and other matters. The department in such a dynamic situation provided a natural bargaining focus in the 'tight' labour market conditions of the 1950s when, as one commentator observed 'for most members the shop steward is the union'. (35)

In the health service circumstances were rather different. Strong centralised control of nurses' wages meant that local hospitals could not seek to outbid each other on the labour market. This absence of a direct money nexus between the local cadre and the member did not mean that there were no bargaining opportunities. However, they needed to be painstakingly and imaginatively created, in circumstances where, due to staff turnover, cadres still spent much of their time collecting dues. The service ethic, with its requirement that the consequences on the patients be considered, acted as a self-imposed restraint upon trade unionists against the full exploitation of possible bargaining opportunities by threatening to disrupt services.

In the absence of strong local organisation, the key union figure at hospital level was typically the Branch Secretary, who chiefly served as a (not always efficient) means of downward communication from head office concerning the state of negotiations. If a problem emerged, the Branch Secretary and the Hospital Secretary would tend to deal with it; rarely would issues reach Branch meetings or be dealt with collectively either on the union or management sides.<sup>(36)</sup> The power and influence held by branch secretaries appears to have provided a powerful check against the development of strong steward networks.

By custom they tended to prefer sorting things out by their own individual initiative, and a growth in the influence of stewards, involving a wider dispersion of power, might have eroded their own. But ideologically, too, health service unions frowned upon shop stewards. Among the status conscious, the association with trade and industry seemed demeaning, and also not in keeping with the defensive service-oriented trade unionism of the 1950s.<sup>(37)</sup> The bloody minded shop steward, as portrayed in such films as I'm All Right Jack, seemed wholly inappropriate to health service traditions and circumstances.

This already difficult recruitment environment was compounded by the unions themselves, whose focus was very much upon the negotiations over pay and conditions at national level, and who therefore did not seek sufficiently to provide an immediate relevance to the membership at large at the place of work. The limited recognition accorded by the Whitley system encouraged unions to pay little attention to strengthening their organisation at the base. As a result unions became remote bodies. If nurses would receive their pay increases anyway what was the incentive for joining a union? The fact that unions were in a minority on the Nurses and Midwives Whitley Council did not absolve them from blame for unsatisfactory pay deals. And it became increasingly apparent from the

1950s that the uniform Whitley system, framed originally as a means of uplifting the wages and conditions of nurses, was increasingly serving as a means of depressing them in relation to the general level elsewhere. Those trade unionists who had eagerly anticipated that state responsibility would end the economic exploitation of nurses, became sadly disillusioned.

The reason was quite simple. As a labour-intensive undertaking salary expenditure formed upwards of 10% of NHS revenue expenditure; nurses accounted for a high proportion of the total pay bill; and during this period the central obsession at government level was to contain the escalating costs of the service. Since only a small proportion of such costs were recouped from insurance contributions and charges (and none from alternative means of finance such as the rates in local government) the majority of costs of improvements for staff would have to be borne from general taxation. Furthermore, costs were rising much faster than anticipated. Beveridge's original assumption that the need for the NHS would wither away as health workers cleared the backlog of ill-health, was shown to be extremely naive. Right-wing accusations of extravagance led in the mid 1950s to the appointment of a  
(38)  
Government Committee of Enquiry, which commissioned

research showing that the accusations were unfounded. Much of the increase was due to the expansion of hospital nursing and ancillary staff against the background of an increasing gross national product and rising population.<sup>(39)</sup> The subsequent Report of the Committee exonerated the NHS and, at the height of consensus politics silenced for two decades the alarmist fears of the right.

Nevertheless the overall policy of containment of costs, remained unaltered, and controlling the overall wages and salaries bill became the prime budgetary control. During a period of constantly rising prices, negotiations on the Nurses and Midwives (and indeed other) Councils became increasingly subject to delays that were only in part due to the complexity of negotiating deals for such a varied workforce. It became increasingly clear that an external force, the Treasury, who were unrepresented 'ghosts' at the bargaining table, were determining the key financial aspects of management side offers. This led to considerable frustration and widespread accusations that the Government was cynically manipulating the bargaining machinery from a distance.

The 1950s saw a great deal of 'shadow boxing' between staff side and management side representatives. Each knew where the real power lay, and disputes were referred with regularity to arbitration under continuing war-time



regulations. It was when this avenue of escape became permanently closed with successive incomes policies from the early 1960s that such 'shadow boxing' no longer became viable. Some alternative means of pressure needed to be found. Clegg and Chester's survey of Whitleyism in the 1950s showed that the pay of health workers was slipping behind workers in private industry. They ominously concluded that:

Amongst the many reasons for differences in pay between the Health Service and the engineering or mining industries is that employers in these industries fear the unions more than the management sides fear Health Service staff organisations (40)

In an increasingly tough bargaining situation, this lack of credibility of unions with management was bound also to affect their credibility with their actual and potential memberships. Unions were therefore obliged begin to distance themselves from the Whitley 'charade', and adopt a more oppositional stance towards an apparently paternalistic employer, whose rhetoric of paternalism was increasingly contradicted by its actual practice.

(5) The Beginnings of Opposition

There were rumblings of discontent among nurses before the 1960s, much of it spearheaded by the Confederation of Health Service Employees (COHSE). In 1948 student nurses were faced with the prospect of paying the new National Insurance contributions out of a meagre salary of £70 - £90 a year. While the staff side of the Whitley Council wanted increases all round, the management side wanted to promote a deal which would encourage more student nurses to live out and which would, as a result, financially penalise those living-in. Negotiations dragged on and branches organised protest demonstrations culminating in a demonstration in Hyde Park.<sup>(41)</sup> Mental nurses played a prominent role in the protests,<sup>(42)</sup> showing the possibilities that the unification of general and psychiatric nursing could hold for trade unionists. The situation was resolved by granting temporary increases, but the aftermath was considerable conflict and recriminations between COHSE activists and negotiators on the Whitley Council. In fact the period of intense internal conflict which COHSE experienced in the 1950s<sup>(43)</sup> was probably a significant factor preventing them from concentrating their efforts on recruiting more nurses and other health workers.

The second major dispute involving nurses also involved COHSE as the central 'actor', but this time in a scenario confined to the mental hospital sector. The dispute erupted in 1956, as an unofficial overtime ban which, according to government estimates, involved 3,017 nursing staff in 24 mental hospitals.<sup>(44)</sup> Ostensibly the issue was pay. However, the state of neglect of the mental health services and its effects upon staff were the underlying factors. Even the management oriented Hospitals Year Book of 1956 described mental hospital conditions as 'little short of scandalous'.<sup>(45)</sup> In 1949, when the General Nursing Council (GNC) finally allowed Royal Medico Physical Association (RMPA) Certificate holders to register, the divided system of training which had plagued the service for many years was ended. A new era of mental nursing appeared to have been ushered in. One COHSE member described in the union journal how he had sold his wife's bicycle to pay for the GNC examination:

One could not pass merely with a good  
batting average in the hospital eleven.  
One had, in short to be a nurse (46)

In subsequent years doors were opened, 'therapeutic communities' established, peaked caps and brass buttons abandoned, 'drug revolutions' instituted and public attitudes transformed, culminating in the final abolition of the Lunacy Laws by

the 1959 Mental Health Act.<sup>(47)</sup> Yet behind the facade of apparent progress, the 'Cinderella' status of the mental health services was not fundamentally altered. Depressed wage rates, the existence of wider employment opportunities than in the 1930s, and the isolated geographical position of the hospitals themselves led to severe shortages of staff. For example, in 1955 a Working Party of the Birmingham Regional Hospital Board showed that its 15 mental hospitals were below establishment by 1566 nurses.<sup>(48)</sup>

Instead of substantially increasing pay and conditions the Government had, from 1953, introduced untrained nursing auxiliaries into this sector of nursing. It was a move strongly condemned by COHSE as 'dilution', and a 'shameful' attempt to return to the former system of attendants. The Ministry also organised 'Mental Hospital Exhibitions' in different localities to encourage people to come forward to train as student nurses, which COHSE claimed were no substitute for higher pay.<sup>(49)</sup>

At the same time the authority structure in mental hospitals was undergoing modification. The autocratic power of the medical superintendent was, for a number of reasons, in the process of erosion. The NHS Act placed the legal responsibility for care on consultants and, according to Gilsenan, by 1963:

The NHS effectively broke up the tight hierarchy surrounding the medical superintendent, by superimposing hospital management committees to take over general control of functions in all areas of management, especially those relating to finance and personnel. (50)

It was not a transition easily achieved, however. There is at least one recorded instance of a threatened strike at Lancaster Moor hospital in the 1950s over the continuing exercise of autocratic powers by the medical superintendent of that hospital.

This was the background to the dispute of 1956, which again was the subject of much internal conflict with COHSE, and was not resolved until its Special Delegate Conference of 1957. (51) According to Clegg and Chester's contemporary account of the Workings of Whitleyism, the action had some effect. As they suggest:

This (ban) may have had some influence on the Minister's decision to increase the capital allocation to the region mainly concerned (Manchester) for modernizing such hospitals and institutions, and to set "aside special monies for improving the diet" (51)

In the long run, however, it did not fundamentally alter the Cinderella status of the psychiatric sector, and even 'progressive' moves like the decarceration' of the mentally ill to the community from the 1950s, were, according to Scull,

probably motivated mostly by the desire to curtail expenditure. (52)

Thus any trade union militancy among nurses in the 1950s was sporadic, limited to a few hospitals and the psychiatric sector in particular. Apart from COHSE, Nalگو and NUPE also sought to recruit nurses, and to a more limited extent so did the General and Municipal Workers Union (GMWU), all of whom had some seats on the Nurses and Midwives Whitley Council.

NUPE during this period was growing very rapidly. The creation of the welfare state and expansion of public services, combined with NUPE's own aggressive recruiting tactics, enabled it to steal a march on the giant general unions which sought to recruit in both the public and private sectors. Since it sought chiefly to recruit manual workers, a union like Nalگو was not vulnerable to its advances, indeed, could grow alongside it. COHSE was however vulnerable to the activities of NUPE. There had been conflict with both the constituent organisations of COHSE in the past, when NUCO had been outside the TUC and when the MHIWU had successfully prevented NUPE from being recognized by the Mental Hospitals Association. Now, with the amalgamation of the nursing services into one bargaining unit, COHSE's home base among nurses in mental hospitals

was no longer a protected recruitment field. Furthermore, though COHSE espoused the principles of industrial unionism, there is no doubt that NUPE proved a more attractive organisation to manual workers in the NHS. In the 1950s it campaigned vigorously to increase the pay of ancillary staffs and led the trade union agitation against management's failure to implement the 44 hour week, emphasising the disruptive effects that resulting labour shortages had upon the quality of service.<sup>(54)</sup> Although it succeeded in recruiting some nurses, its main campaigns and activities centred around the problems of ancillary staffs.

Nalgo was potentially an attractive organisation for many nurses: non-political and, until 1964, still not affiliated to the TUC. As we saw in Chapters 7 and 8, it enjoyed a close relationship during the 1930s with the Rcn, seeking to set up a bargaining unit which would have excluded TUC affiliated organisations. Nalgo's first woman organiser, appointed in 1942, was a nurse, Miss Angela Gaywood. Around the same time Conference asked Nalgo's NEC to form a separate union within Nalgo, open to all nurses whether they worked in municipal hospitals, voluntary hospitals or private nursing. This proposal was never put into effect. During the war years Nalgo made strenuous efforts to recruit nurses in municipal hospitals, but with only limited success:

Both women worked hard to bring the nurses in, holding meetings in and outside hospitals all over the country and enrolling hundreds. Yet within a few months, most had vanished without trace (55)

In 1946, Miss Gaywood resigned and Nalgo abandoned its dream of a separate Nurses Association.

It appears to have been tacitly accepted that Nalgo

... could not compete with the Royal College (ie Rcn) ... (which) was the kind of organisation nurses wanted and went as near to trade unionism as most were ready to do (55)

There was even a proposal from the NEC in 1951, that nurse membership in future be restricted to those of ward sister rank and above. Though this was defeated by Conference in practice Nalgo had decided that it would only see a token presence among nurses; apparently in the belief that an unwarranted amount of organisational effort was required to recruit and retain them. By 1965, Nalgo claimed 3,000 nurses, though some at least of these worked for local authority nursing services rather than the NHS. (57) No figures are available for the GMWU but it is likely that they had far fewer nurses in membership.



### Conclusions

Most of the factors that have been described in this Chapter militated against the development of trade membership and activity among nurses in the 1950s. These included: the remoteness and apparent inability of nurses to influence the bargaining institutions; the perpetuation of traditional hierarchies even in a 'socialist' health service; the safety value of turnover and the attraction of alternative opportunities in the employment and domestic spheres; the promotion of professional associations by local management, particularly in the general hospitals, and their reluctance to accord unions facilities to represent staff; the failure of joint consultation - all of these factors and others worked against the development of nursing. However, the State's prime concern to curtail trades unionism and depress pay levels merely served, as it turned out, to postpone processes which would break out as trade union militancy in the 1970s, hastened by the dismantling of some of the traditional occupational institutions themselves. It is to these combination of circumstances that we now turn.

## Chapter 10: The Road to Halsbury

### Part 1: The Foundations of Militancy

#### (1) Introduction

On Tuesday, 17 September, 1974, Britain's nurses received their biggest and most comprehensive pay award ever from a specially appointed Committee of Enquiry chaired by Lord Halsbury. Its recommendations, subsequently accepted by the then Labour Government, offered the kind of pay deal that it had never been possible to negotiate through the Whitley Council system. The appointment and deliberations of the 7 person committee had been attended by an unprecedented outburst of militant activity, including industrial action by some groups of nurses. The members of the Committee claimed to have arrived at their conclusions dispassionately. In their preamble they state that:

'... the pressure which the industrial action was designed to create has not influenced our recommendations in any way'. (1)

I shall be looking later at the Report and the context in which its recommendations were made in more detail. The assumption made throughout this Chapter, however, is that while the specific details of the pay deal may not have been

directly affected by militant action, the decision to set up the Halsbury Committee and the speed with which it was urged to report, were a product of the militant actions of nurses, and the Government's fears that these might escalate further. But whether this assumption is a fair one or not, a much more significant factor was that the deal was widely interpreted by nurses themselves as a triumph for militant tactics. The Halsbury Report had an extremely important 'demonstration effect'. In an environment which was in any case more favourable to the development of trade unionism, the success of the 1974 pay campaign tipped the balance. The subsequent year saw a massive increase in trade union membership among nurses, particularly favouring COHSE, the union which had adopted the most militant stance during the campaign. For example, COHSE claimed that its nurse membership increased by 26% during the 2 months prior to the Halsbury Report,<sup>(2)</sup> launching COHSE's spectacular growth ascent which was maintained until the late 1970s. Other health service unions also recruited increasing numbers of nurses, if on a less spectacular scale.

Without necessarily adopting an historicist stance, the militant campaigns of 1974 can be seen as a natural culmination of the frustration and dissatisfaction which had been increasing since 1960 and were already becoming manifest by 1974.

This seems to fit the course of development of nurses' oppositional activity, far better than a portrayal of the 1974 action (common in the media at the time) as a sudden and unpredictable outburst. This thesis has sought to demonstrate that trade union activity stretch back much farther than is often imagined. They are as much a part of nursing tradition as 'the lady with the lamp', and not, as is often assumed, a deviation from those traditions. Instead, this thesis has sought to approach nursing history from a perspective which explores competing traditions, rather than identifying with the dominant tradition.

As we saw these traditions had been established long before 1960, let alone 1974. Yet unlike some other groups of workers it was not in the main a self-conscious oppositional tradition, and those acting in it often felt that they needed to justify themselves by deference to the dominant traditions (eg 'Florence Nightingale was all right in her day, but ...'). The fact that oppositional activity still emerged against the dominant traditional ethos, gives credence to a materialist analysis of its development. There is no need to claim that trade unionism is the 'real' consciousness, and other ideologies and bases for action 'false' ones. The reality itself is a complex one, the

mix of 'reality' varying according to the differing positions of groups of nurses in the hierarchical division of labour, and the nature of the work tasks they undertake. Nevertheless, trade unionism as a response to the realities of economic oppression (and also exploitation in the classic Marxist sense, when their labour power helps to reproduce the high value of medical care as a commodity, which is then largely expropriated by others),<sup>(3)</sup> and task subordination in the division of labour is understandable, even to be expected. The perpetuation of traditional ideology through its dominant institutions in the hospitals and professional associations acted to 'smother' or, at best, create an extremely sluggish response to these realities.

However, these underlying material pressures mounted during the 1960s, and the purpose of this chapter is to chart their course and effects to the years immediately following the 'victory' of the Halsbury Report. The economic oppression of nurses by the state, combined with the reorganisation of nursing within the division of labour along industrial lines in health care were the two crucial influences which ruptured the domination of traditional ideologies, with profound consequences for both unions and professional associations.

## (2) The Industrialisation of the National Health Service

If economic oppression and the reorganisation of the nursing division of labour along industrial lines were crucial influences in the formation of a wider oppositional consciousness among nurses they should not be seen as separate but linked processes. Firstly, they both indicated a decline in paternalistic methods of managing the nursing labour force. The first took advantage of nurses' weak bargaining stance to keep the wages bill low. The reorganisation of nursing along industrial lines either assumed the decline of nurses' traditional forms of commitment, or else considered that they were no longer appropriate. Although the processes of 'industrialisation' did not go so far with nurses as with other groups of health workers (notably ancillary workers), they proceeded far enough to have a significant impact. Second, they may be regarded as linked processes in the sense of having a common source, being two sides of a single policy. The Marxist analysis of the capitalist labour process emphasises that the reorganisation of the division/ labour and the extraction of surplus value by means of exploitation are closely linked. The present issue is whether this also is the case in a public service undertaking which, unlike nationalised industries, is explicitly committed to the welfare of those in receipt of its services.

Initially in the post war period these two processes (economic oppression and reorganisation of the division of labour) were not closely linked. This was because, as we saw, Beveridge, Bevan and other reformers assumed that the efficiency and effectiveness of health care was largely something that could be left alone to be sorted out internally. The state's role was largely limited to guaranteeing the financial resources to allow health professionals to 'get on with the job', on the assumption that in the long run costs would fall as people's health improved. Costs did not, of course, fall but rose sharply, leading to hostile right wing criticisms of an extravagant service. In a period of rising population and economic growth, however, these did not carry much weight. In 1959 confidence in the ability of professionals was rededicated with the passing of Mental Health Act, which largely dismantled the legal codes which, since 1890, had surrounded the mental health services. Now considerable powers of discretion were granted to doctors and social workers in the exercise of control and supervision over those now dubbed 'mentally ill' rather than 'insane' (4)

It should be made clear that at the heart of the State's response was a benevolent faith in the curative powers of medical care, which emphasised medicine's productive functions in the wider political economy. Very little emphasis was placed either on the importance of

prevention of ill health, or on giving care in its own right a status and priority. As was claimed in the last chapter, the lack of emphasis given to prevention derived from a political acceptance of the main contours of capitalism. The only major breach with this principle in the period under consideration was the Clean Air Act of 1956, passed by a Conservative Government.<sup>(5)</sup> Given the shifting distribution of disease, away from acute infections towards the degenerative diseases of middle and later life, care rather than cure became an increasingly significant part of the health service's work. However, this was in a structure which accorded a greater status and priority to curative activities. The fact that nurses were associated more with 'caring' activities and doctors with 'curing' activities, underlined the subordination of care within the division of labour, as did the assumption that 'curing' activities were more 'productive' in capitalist terms. 'Cure' represented a greater return on investment of health workers effort than did care. Care of the elderly, the permanently handicapped and disabled provided very little economic pay off, even though it was socially necessary work, the significance of which was growing, especially with an ageing population.

The growing industrialisation of the NHS, from the 1960s, was by no means a fundamental departure, which despoiled in the process a politically neutral health care



system. Even in 1948 the dominant assumptions were those of a capitalist cure-oriented medicine contributing to the greater productivity of the economic system. The difference was that until the 1960s it was widely assumed that this could be achieved without much outside interference. By the 1960s there was a growing tendency towards the view that, though there should be no direct assault upon the principle of clinical autonomy, the original aims of the NHS could only be achieved by a reorganisation of health care inspired by the methods of administration adopted in capitalist industry. The particular form that it took was both an erosion and a confirmation of professional power. Administrative skills, derived from principles external to medical science, needed to be brought in to a much greater extent than in the past, since a consequence of the development of scientific medicine was the growing concentration of health care upon large hospitals. Combined with this was the fact that growing specialisation had created massive problems of co-ordinating increasingly fragmented activities, quite apart from the problems attendant upon running large institutions with a resident population.

These developments led to the growth of hospital administration as a 'professional activity' in its own right, and administrators as potential rivals to the

medical profession. However, the bureaucratic - professional conflict can be over-emphasised. Managerialism to a large extent confirmed professional power, not just from protocol, but because it was supportive of the curative ideology of scientific medicine. Beveridge's original assumptions had proved wrong; the costs of health care rose over time rather than fell. However, rather than blaming the medical profession for failure, the assumption was rather that greater resources needed to be invested into health care for medicine to fulfil its productive potential. Though this would be more 'efficiently' spent, doctors would be involved and perhaps re-educated into taking wider administrative considerations into account. Rather than being replaced by managers, the aim was therefore, to integrate them and other professionals into the managerial process; in return they would be granted massive resources.

The Hospital Plan of 1962 exemplifies the new philosophy - a capitalist solution to the problems of running a costly socialist institution,<sup>(6)</sup> creating a consensus view on the solution to the growing crisis in the NHS which culminated in the reorganisation of 1974. Both measures originated with Conservative Governments. Between these two measures Labour Governments took the health service down the same path. The Hospital Plan involved a massive increase

in resources to be allocated to health care, most of it to be concentrated upon large District General Hospitals. As Manson shows, in 1960-1 capital expenditure had amounted to approximately 3% of total costs. By 1967 it had increased to 8%.<sup>(7)</sup> As Manson also shows, much of this investment was towards the mechanisation and centralisation of ancillary services, their removal from the nursing sphere of influence to be placed under functional management. As we saw in earlier chapters the nursing authority structure originally encompassed all activities broadly concerned with hygiene in the institution. From the 1960s, under the impact of the growth of scientific medicine, and the delegation of more responsibilities to nurses, many 'hygiene' tasks were defined as 'peripheral' and often also as degrading 'dirty work'. Patient care and ward administration became seen as the core features of the nursing role. What is interesting is that this desire by nursing leaders to shun such tasks when they originally claimed that nursing authority over them was absolutely necessary, coincided with the desire of the state to reorganise such activities along capitalistic lines. I want to chart now the coming together of these two sets of forces in the 1960s.

### (3) The New Managerialism in Nursing.

By the 1960s, and for reasons made explicit in the previous chapter, nursing management was still based largely on the authority of the Matron. A system primarily designed to push through reforms against anticipated opposition had remained fixed and increasingly inappropriate, and there was a chronic shortage of applicants for nursing administration posts. An enquiry by the Rcn into the fate of administrative posts

advertised in the Nursing Times between October 1959 and March 1960 ... revealed that one-fifth of the posts were still vacant, over one third were unfilled or had attracted one applicant ... most candidates were over forty years of age and had no qualification other than state registration. (8)

Nursing leaders also became increasingly concerned with the declining status of nurse managers in comparison to other occupational groups, especially in their own base, the teaching hospitals. As the Salmon Report on Nursing Management noted in 1966:

While the status of matrons in former local authority hospitals generally improved, in many voluntary hospitals it declined. The intimate relation of the Matron with Governors who were concerned with a single hospital could not be maintained in a group of hospitals, perhaps fifteen or more each with its own Matron with access in some groups only to a House Committee. In some groups the position of Matron compared unfavourably with that of the Group Secretary and of the medical staff, whose influence was exercised at the level of the governing body. (9)

Although policy throughout the 1950s had been that nurse managers should have access to all relevant committees, the fact that reports and circulars continued to harp on this subject indicated that the conditions were not always met. There had never been any doubt, however, that Consultants would outshine lay management on medical committees.

In particular the Hospital Plan of 1962 and its technocratic notions of the large district general hospital provided the most explicit basis for the alliance between the occupational elite and the state for a managerial solution. The view of the Salmon Committee with regard to the Hospital Plan was that technological hardware is 'usually expensive and expert management will be needed, in which nurses should play their part, if costs are to be held in check'.<sup>(10)</sup> Within that framework the state sought manageable labour costs in the use of nurses. What was felt could be practically and aesthetically subjected to work study was hived off to lay management. For nurses themselves, there were pressures to divide skilled and unskilled elements of nursing work, and it was increasingly argued that the implementation of more progressive personnel policies would enable a fuller exploitation of an available labour force. In contrast to traditional values this meant increasing the number of part time and married women in the labour force, to fill the jobs with very little career opportunities. For example,

the National Board for Prices and Incomes (NBPI) called in their Report Number 60 for the ending of petty restrictions and interference in the personal lives of student nurses living in homes. This had an explicit economic rationale. The report did not believe that big increases in student nurses' pay were necessary for 'the problem is more one of retention than recruitment, and retention can be helped by means other than a general pay increase'.<sup>(11)</sup> Indeed, the increasing popularity of the term 'wastage' at this time, seems highly indicative of a new managerial approach to labour resources. A more participative style of management might help increase job satisfaction at ward level and lessen nurses' tendency to leave especially since local managers were unable to raise the wages of nurses. By creating a new image for nursing and flexibility on the part of management, trained staff could be attracted elsewhere in recent decades. Above all the strategic position of nursing in the hospital division of labour and its importance for the continuity of care, made it much more imperative to plan the utilisation of labour resources.

Thus the desire of leadership elements to restore some of their lost influence and increase the status of nursing as an occupation, coincided with the state's desire for greater efficiency in the use of labour. This necessitated,

however, that members of the occupation's elite engage in a thorough self-criticism of the traditions for which they presumably stood. This occurred when, as the sole nursing voice on the Salmon Committee (which was largely set up as a result of pressure by the Rcn<sup>(12)</sup>), they participated with managerial experts in a savage attack upon the Matron system of management. The tenor of the resulting report was twofold. First, traditional nursing and modern business administration were contrasted and the former pronounced inferior to the latter. Second, the established methods of business administration were assumed to form a separate body of knowledge - managerial science - as suitable to be applied to nursing as any other form of administration. Thus the report states:

In nursing administration effective delegation is rarely seen ... the Matron of a sizeable hospital may head an array of deputy assistants and administrative sisters to whom she assigns duties, but she does not find the relief that the top person of a business seems to find. She often retains work that she could well hand over to assistants. (13)

The point essentially being made in the Report is not that industrialised methods of control be lifted in their entirety and applied to nursing. Rather, in general terms, Salmon implicitly called for a managerial structure based on the industrial model of professionalised management as

under advanced monopoly capitalism, where a corps of professional managers have tended to replace individual owner entrepreneurs. This structure is more pluralistic in the sense that authority, because of growing complexity, needs to be distributed widely amongst a growing army of middle management. The Matron system of managerialism is almost an archetypal system of unitary<sup>(14)</sup> management that, though quite adaptable to small institutions, and less complex ones, is inappropriate especially for the larger hospitals that official thinking now favoured. All this seems to come together in a following quotation from the report:

The job of a Matron of a 1000 bedded General Hospital and of the Matron of a Cottage Hospital of say, 30 beds should have about as much in common as those of a Sales Director of a fair sized manufacturing firm and the manager of a small business. (15)

Thus the Salmon Report advocated a fundamentally different form of nursing management from the traditional system. It was not so much that nursing was to become bureaucratized for the first time, but that a different form of bureaucracy based on a fundamentally new kind of rationality was being implemented. Its essence was that the managerial chain was lengthened both above and below the Matron, both to meet the demands by Matrons for



influence at group level, and also in the hope of creating a career structure which would enable nursing to compete again with other middle class occupations. The new structure is summarised in Figure 1.

Figure 1. The Salmon System of Nursing Management

<u>Grade</u>	<u>Title</u>	<u>Sphere of Authority</u>	<u>eg Formerly</u>
10	Chief Nursing Officer (CNO)	Group	-
9	Principal Nursing Officer (PNO)	Division	Large Hospital
8	Senior Nursing Officer (SNO)	Area	Medium sized Hospital
7	Nursing Officer (NO)	Unit	Small Hospital, Group of Wards
6	Sister/Charge Nurse	Section	Ward
5	Staff Nurse	Section	Ward

It was recommended that nurses be relieved of direct control of what were called 'non-nursing' services. These had often been carried out since the early days of nursing reform. Since then, nurses had absorbed many more complex managerial functions and wished to relieve themselves of these routine tasks. As Muriel Powell (a member of the Salmon Committee) expressed it in an interview given to Nursing Times:

I sometimes think we haven't really changed the work of administrators to meet the needs of today. In many Matron's offices nurses are seen to be concerned with bookkeeping, or the care of linen or equipment, tasks that would be much better done by secretarial staff or the supplies department or others (16)

Once freed from these onerous tasks, nurse managers would be better placed to engage in higher planning functions and move closer towards parity with other elite groups.

The report advised that the new structure be gradually introduced following experience with localised pilot schemes. It made some small and inexpensive concessions to tradition by suggesting that terms like Matron could continue in use, a forlorn hope that was not realised. It placed great emphasis on the expansion of management education from ward sister level and above in order that they should be able to cope with the increased managerial responsibilities that had accrued over the years.

The proposals of the Salmon Report closely mirrored Rcn policy: the occupational elite had seen in them a way of renewing themselves and for that reason had been prepared to cast tradition to the winds. This was bound to create new rifts, some of which they might have foreseen, but others which could not have been anticipated. Three main

sets of factors must be considered. The first is the effect of the new nursing managerialism on other occupational groups, primarily in the hospital superstructure. The second is the effect on the managers themselves. The third the effect upon more subordinated nurses. These sets of factors are not entirely separate. A dialectic exists between them, so a neat order is not possible.

However, let us begin with the medical profession, for medical interests were unusually absent in formulating the Salmon changes. There was, for example, only one physician present on the Salmon Committee. Yet clearly hospital doctors and consultants were going to be profoundly affected by the new-won power of the nurse managers. The drama can be acted out in a number of possible ways and alliances formed in different directions. A traditional-minded ward sister and a reactionary consultant can combine against an energetic nursing officer who attempts to 'interfere' in the ward situation. On the other hand, an independent minded sister who looked to her nursing officer for support against an unreasonable consultant might be frustrated to find a meek individual unprepared to back her up. These kinds of variations make generalisation difficult and tell us, incidentally, that we learn little about social reality in hospitals simply by looking at Salmon job

descriptions. Clearly reactions to the Salmon reorganisation depended on a wide number of factors including personality, age, sex, sensitivity by doctors to their prerogatives, emotional attachment by nurses to traditional symbols of authority, and so on.

Nevertheless, the Salmon reorganisation created some potential for greater control by nurses over clinical situations, and not surprisingly this has tended to irritate some consultants.<sup>(17)</sup> Doctors seem to have woken up rather belatedly to this potential threat, like Dr Paulley who in 1971 asked in Nursing Times: 'Is it Too Late to Scrap Salmon?' He referred possessively to 'my ward sister' and ward sisters generally whom he saw as 'doomed to extinction'.<sup>(18)</sup>

The defence of Salmon has tended to be that there is nothing intrinsically wrong with its principles. Rather that nurses fail to understand them and do not work to the spirit of its recommendations. It is argued that many nurse managers either carry on as before or mistakenly interpret the Report as implying an excessively bureaucratic view of managerial functions. As the official report Progress on Salmon noted in 1972: 'One of the most pressing problems remains; this is the lack of understanding about what the Salmon Report actually says'.<sup>(19)</sup> Not surprisingly this view also coincided with 'advanced' thinking in the profession. Eve Bendall warned in 1966 for example, that 'while the structure is clear on paper, the inbred attitudes in the

profession will make the changeover far from easy'. (20)

Was it so clear? The proposals seem to face both ways: towards greater bureaucracy in order to create the career structures to satisfy the aspirations of the occupational elite and towards decentralisation to improve the job satisfaction and retention of ward level staff. Perhaps much of the misunderstanding generated by Salmon might be due to the fact that it appears to pursue contradictory objectives.

Undoubtedly these problems were exacerbated by the haste with which the proposals were implemented following the publication of the NBPI Report No.60, without fully testing them in pilot schemes. This generated considerable anxiety amongst existing nurse managers, many of whom were finally assimilated to new positions of responsibility the demands of which they did not fully understand. (21)

Given the particular authoritarian milieu it is not surprising that the bureaucratic rather than the decentralistic tendencies of Salmon tended so often to get the upper hand.

Haste in implementation had a further highly significant effect, in that there was no transition period during which larger numbers of middle class women could be attracted to nursing as hoped by the elite. The target date set by the

NBPI Report No.60 in March 1968 was 1 January 1969. As noted earlier, there had been a continuous shortage of numbers applying for administrative posts in the past. Despite appearance to the contrary, it seems untrue that Salmon greatly expanded the number of available posts. (22) However, despite open competition for posts it seems that large numbers of people were rapidly assimilated from old to new positions with little time to prepare them for assuming their new responsibilities. In this situation male nurses were well placed to compete for positions. As NBPI Report No.60 noted in the psychiatric field, male nurses

are older and give longer service than the equivalent grade in General Hospitals. Their promotion prospects are much poorer than those of female nursing staff. Male staff nurses have an average length of service of nearly seven years in that grade, female staff nurses of three years (23)

Female opportunities in this field had traditionally been greater. An article in Nursing Times as late as 1963 on 'How to Become a Matron' advised ambitious girls that they could become Matrons much more rapidly in psychiatric than general hospitals. (24) In contrast to general hospitals there were no shortages of applications for administrative posts. Yet despite the fact that career

'bottlenecks' existed at ward level, nursing tended, as Robert Dingwall argued, to represent 'upward social mobility, which leads them to emphasise the professional and career aspects of the occupation'.<sup>(25)</sup> Thus, as we have seen, during the 1950s and 60s many male psychiatric nurses sought secondment for postgraduate general training to obtain the SRN thought so necessary for career advancement in any field. Some mental handicap hospitals, for example, had Matrons with SRN but no qualification in the subnormality field.<sup>(26)</sup>

Salmon suddenly provided outlets for longstanding and largely frustrated aspirations. Many male nurses possessed traits which tended to propel them up the new hierarchies: they were more likely to stay longer in the service, to work full-time (part-time status often being a bar to promotion), to possess a desire to escape low pay and perhaps a feeling of marginality in the clinical situation and, perhaps most significant of all, greater geographical mobility than their female competitors. By ending the sex-divided structure in particular the Salmon reorganisation opened up new channels of mobility for men to rise to high administrative positions. Yet there were other, less transparent reasons why men should suddenly be favoured. Salmon hardly mentioned the role of men, but there is no doubt that in redefining

'female' positions into strictly functional managerial ones they were made ripe for male capture. In the past men were caught in a Catch-22 situation in nursing. As men they could not be expected to possess the 'qualities' of a good nurse, and if they did, they were often considered effeminate and thus less than men. Following Salmon the image of men in nursing was suddenly transformed. They were now perceived to possess 'managerial' traits. The wheel has turned full circle in that what was seen previously as disadvantages of being bound to be 'bad' nurses makes them potentially good administrators.

It must be understood that although Salmon hardly mentioned male nurses, the Report was an implicit critique of female authority and as such is laced with sexism. Female nurses are viewed almost as inherently unable to exercise administrative skills. They may be 'meticulous in details on which the life of a patient depends', which may be admirable qualities for a ward nurse, 'but when, on promotion to posts in Matron's office they venture on to "administration" many seem unable to take decisions.' Men are less open to the charge of trivial and obsessive spinsterhood that seems to lie behind the talk of being 'meticulous in details'. Apart from this, men are considered tougher material for the world of management, or as the Nursing Times put it in 1963, 'men may find it easier to stand the physical and nervous strain of the top job than many women do'. (27)



All these factors contributed to the dramatic trends noted by Brown and Stones in 1972:

'In all types of hospitals the number of men in the top two grades of PNO and CNO increased eightfold between 1969 and 1972 compared to only a five-fold increase for females. In 1972 men occupied a third of all these posts. There was only one female PNO in a mental hospital'. (28)

The new male managers were grasping opportunities for mobility as they appeared, and in the process helping to transform the nature of social control within hospitals. In the past nurses had tended to be indirectly dominated by men in the medical profession, but the immediate structure of domination has been primarily that of class through upper middle class women. These women are now increasingly being replaced by male nurse managers of much more humble origins. Without assuming a conspiracy, it is almost as if the declining potency of class domination of women by women necessitates a much more direct form of sex domination of men over women from within nursing.

The logic of such changes as have been described is that, especially at the highest levels, there is no logical reason why management of nurses need be carried out by nurses. The further one travels from the ward the less one can talk of 'nursing' or even 'nursing management', but

simply management which applies the techniques derived from aspects of capitalist rationality to an area which just happens to be nursing. In the future the new managerial elite may increasingly feel themselves to be managers first and nurses second, or simply managers who are ex-nurses. By contrast under traditional definitions the Matrons of the traditional elite were always nurses first. The reorganisation of the NHS in 1974 carried these tendencies much further. The teaching hospitals were brought firmly within the same management structure which can only narrow the social distance between them and other types of hospitals so characteristic of the traditional system. The managerial content of roles (judging by the 'Grey Book')<sup>(29)</sup> was much expanded on Salmon. So much so, indeed, that some personnel functions were hived off to specialised personnel managers. However, against the logic of these changes, and after much heart searching, nurses were appointed to the new personnel positions.

Self-evidently the full inclusion of nurse managers in the consensus teams at district level and above is the most crucial factor. Initially perhaps the effect might not be all that great as each occupational interest group perceives the teams largely as forums for pursuing their own sectional interests. Yet inclusion of nurses as full

members of these bodies is creating strong pressures towards the adoption of managerial rather than nursing reference groups. For example, the District Nursing Officer is able to include himself in the same group as the District Administrator in order to obtain personal advancement in ways simply not open to a Matron in relation to a Group Secretary. In this the new structure continued and amplified a feature of all previous structures. To achieve any kind of meaningful equality with other elite groups in the health service nurses have had to remove themselves from the sphere of clinical decision-making and enter the political sphere. This is a contradiction the medical profession has not had to face. It has used its dominance in the clinical sphere as a lever to maintain much of its political power within the reorganised NHS, even though it was only retained by granting, for the first time, formal equality to other groups in the management teams. (30)

Chapter 11: The Road to Halsbury,

Part Two: The Rise of the 'New Unionism'

(1) The Implications of the New Managerialism

The breakdown of the old matron system of management undoubtedly assisted the development of trade unionism among nurses. In the first place, as we have seen in the previous chapter, authority had become more pluralistic, less based upon a single authority figure whose word was final. To the extent that management became more diverse, an environment was created in which those in subordinate positions might more confidently articulate an independent point of view. The charismatic authority of 'the Matron' had gone, replaced by the impersonal authority of the 'nursing officer'. To judge by letters to the nursing press, and my own fieldwork, the disappearance of the matron was widely mourned by staff subordinated to her. It seems that the creation of impersonal structures of management led to widespread alienation among nurses, especially as the new nurse managers were often assumed to be motivated more by careerism than concern for nursing. While this may have been based on a rather naive view of what motivated the old fashioned Matron, there was nevertheless some substance to the view that the prime reference point for the new nurse managers was often the

exercise of their managerial role, particularly for those involved in management beyond hospital level. The growing remoteness of the new managerialists would, in any case help to dissolve the charismatic ties formerly bound tighter by personal contact. This remoteness also served to create considerable uncertainty among nurses, an awareness that they were vulnerable to decisions made from afar, in a new managerial structure, the workings of which seemed often a total mystery. This too, led to an enhanced awareness that trade unionism might be an appropriate response, both because union cadres were likely to be more familiar with the labyrinthine workings of the new system, and because decisions (say over change in use of a hospital) could often only be affected by collective action.

These kinds of influences will be more apparent in concrete terms in the case studies of development of unions at particular hospitals to be found in Chapter 12. . The key issue at this point is whether Salmon was the cause or effect of growing alienation among nurses? While many nurses did (and still do) scapegoat the Salmon reorganisation, the truth is a little more complex. Before attempting a more sophisticated analysis, however, the concept of alienation itself requires some further clarification, for it is a word which is often used with imprecision. For me, its attractiveness as a Marxist concept is that makes possible

a unified analysis of both 'objective' material reality and the subjective experience of work. Marx himself saw alienation as both the consequence of working as a wage labourer, and as the result of performing personally degrading tasks.<sup>(1)</sup> Later Marx established the links between these two forms of alienation more closely in his discussion of the labour process and valorisation process in Capital Volume 1. Most non-Marxist accounts of alienation focus on the second aspect identified by Marx, showing it to be variable according to the social and technological organisation of work, tending to identify it solely as subjective experience. Seeman, for example, identifies the 'meaning of alienation' as a sense of 'powerlessness', 'meaninglessness', 'normlessness', 'isolation', and 'self-estrangement'.<sup>(2)</sup> The Salmon reorganisation and its integration into the NHS reorganisation of 1974, may certainly have increased many nurses' sense of alienation in the terms described by Seeman, but other developments in nursing were tending in that direction also, and it is possible that the Salmon reorganisation provided a focal point for them. In particular the growing size of the hospitals, the fragmentation of health care (for example by speciality or separating care at different stages of an illness), and the increased 'throughput' of patients'.<sup>(3)</sup> Then there is the rather different kind of alienation experienced by those who care for the long term chronically ill,

with insufficient resources, for inadequate rewards, in a health service dominated by a curative ideology. In the USA, Leonard Pearlin examined the extent of 'alienation' (according to Seeman's definitions) among nurses in a large mental hospital, focussing particularly on the dimension of subjectively experienced 'powerlessness'. He identified three important influences on the degree of alienation an individual nurse experienced: his/her relation to (1) authority structure, (2) opportunity structure, and (3) the composition of work groups. He found that the most alienated were first those who felt unable to influence decisions in the complex hierarchy in which they operated and those frustrated or prevented from career advancement:

'Pervading the nursing force are strong desires for advancement; but the structure in which they are located has fewer positions than there are people who would like to attain them'. (4)

Isolation, for example, of night workers and those who did not establish extra-work friendships with their fellow workers were some of the factors at the workgroup level which promoted feelings of alienation.

These findings generally support the approach taken here. First, that the changes generally occurring in nursing, particularly in its authority structure were promoting considerable disenchantment, particularly following the Salmon reorganisation. Secondly, there were also other changes in the 'opportunity structure' and 'workgroups' which though not affecting all nurses in quite the same way, had the overall affect of increasing the extent of alienation among nurses. An unpublished study by Margaret Gasson, just prior to the Salmon reorganisation, showed considerable alienation among male ward staff at a large British mental hospital. For example, she found that:

Most nurses at X (hospital) felt that doctors and administrators did not appreciate their importance but regarded them as necessary adjuncts to the hospital. Administrators were not prepared to take their ideas and suggestions seriously. They did not consult them about ward changes, treatment of patients, types of stocks supplied or aspects of nursing that in some way affected them'. (5)

As far as the opportunity structure was concerned:

Poor promotion opportunities and unfair or inexplicable promotions are sources of a great deal of dissatisfaction. (6)



COHSE, the main union catering for psychiatric nurses, conducted a survey in 1963 which argued that much of the problem lay in the failure of the Government to spend money in order that the nursing role could become less custodial following the 1959 Mental Health Act. Under the Hospital Plan, the long run closure of the large psychiatric hospital was envisaged and, as a result, mental hospitals became starved of resources. COHSE called, unsuccessfully, for the appointment of a Royal Commission into nursing.<sup>(7)</sup>

The industrialisation of the nursing labour force made these feelings of resentment more typical of the generality of nurses. There had always been status distinctions among different types of nurses from the early days when Lady pupils, who paid for their training, received preferential promotion over paid probationers. From the 1960s, one can detect the distinct emergence of a 'dual labour market' in nursing's 'opportunity structure'. On the one hand, the growing army of state enrolled nurses, nursing auxiliaries and even trained ward staff whose mobility was largely blocked (in the case of trained staff often because they increasingly worked part-time); a mass labour force recruited to carry out the routine caring responsibilities - in other words, the bulk of the NHS's daily activities. On the other hand, a relatively small

group of often usually white, increasingly male 'high fliers', scrambling for positions in the new managerialist structure, a structure which left most nurses as they were before, and hence tending to heighten their sense of alienation.

The notion of alienation that has so far been deployed, is the non-Marxist one. Nevertheless, it does appear to provide a plausible framework for understanding the growth of nursing trade unionism in the late 1960s and early 1970s. Marx's use of the concept extended beyond the subjectivist framework which became popular in bourgeois sociology. For Marx alienation is inseparably linked to the notion of wage labour, of work involuntarily done at the behest of others, in order to obtain subsistence:

His work is not voluntary but imposed, forced labour. It is not the satisfaction of a need but only a means for satisfying other needs ... The alienated character of work for the worker appears in the fact that it is not his work but work for someone else, that in work he does not belong to himself but to another person ... the activity of the worker is not his own spontaneous activity. It is another's activity, and a loss of his own spontaneity (8)

As we saw in earlier chapters, traditional nursing sought to avoid the experience of alienation, by attracting individuals with commitment. Nursing replicated the

religious experience of the 'calling' - nursing as a form of destiny. Still today this idea that nurses are 'special' kinds of people, 'born' rather than 'made', holds considerable sway, and shapes public attitudes to nurses. These romantic notions apart, however, the vast majority of nurses have been compelled to work from material necessity, though traditional institutions - such as living-in - served to obscure the wage-labour relation. With the decline of the completely committed nurse, whose sole existence was centred on nursing and hospital life, the realities of the wage labour relation began to be felt more acutely. Nursing became for more and more nurses, work that was increasingly

external to the worker, that it is not part of his nature, that consequently he does not fulfill himself in his work but denies himself, has a feeling of misery, not well being, does not develop freely a physical and mental energy, but is physically exhausted and mentally debased ... It is not the satisfaction of a need but only a means for satisfying other needs .(9)

This proletarian experience of nursing, totally at variance with the notion of nursing as a high calling, stimulated by the creation of a more definite dual labour market in nursing, was

congruent also with wider developments in the 1960s. Since more nurses lived away from the cloistered environment of the hospital, they became subject to the growing 'instrumental' attitudes predominant since the 2nd World War, and nourished by consumer capitalism. They would have mortgage commitments to meet, holidays to pay for, groceries to buy. In an increasingly materialistic society, where patterns of consumption tended more and more to determine people's own sense of personal identity and worth in relation to their neighbours, those unable to achieve them were not only materially hard pressed. They also felt an acute sense of personal exclusion. (10)

This general climate coincided with the changes in nursing work that have been described: the increased load of routine care of the chronically ill, the creation of a dual labour market which consigned those carrying out care to dead-end jobs, the embrace of managerialism by the occupational elite, and the growing concentration of care upon large, impersonal institutions. It was perhaps inevitable in the context of the 1960s and early 1970s that the resulting alienation would find expression in trade union economism. This was only one possible focus - the 'opportunity structure' itself, not just in relation to nursing administrators but also medicine, was a central feature of the objective alienation of the majority of nurses.

The growth of trade unionism could have led to the articulation of strategies which sought to transform the experience of nursing as a form of self-estrangement. This aspect has, however, been much less dominant. Economism - the desire to achieve by collective means the highest price possible for alienated wage labour - can either be a bridge to a wider challenge to the relations of production or it can be an end in itself. In the context of the 1960s and early 1970s, however, it represented a necessary cathartic release from an ideology which insisted on the suppression of personal needs, which were always placed second to the needs of 'the service', 'the patient' - always someone or something different from the nurse herself.

## (2) Growing Militancy and its Impact on Nurses' Organisations

The State's action in restraining the pay of nurses during the 1960s and 1970s finally prised these feelings out into the open, even though they were not, as is sometimes assumed, the only reasons for them. As we have seen, there were other just as significant underlying causes within the changing labour process and social organisation of nursing within the division of labour in health care. Nurses's pay became trapped in the snare of successive incomes policies from the 1960s. As central government employees, they

were a highly visible workforce. As Burton claims, this makes it very much harder for them secretly to get round incomes policies, than it is for less visible groups of workers.<sup>(11)</sup> Secondly, in the late 1960s groups of workers were able, through negotiating (often bogus) productivity deals, to escape the full rigours of incomes policy. To a limited extent this option was open to other NHS employees through the growing use of work-study and incentive bonus schemes.<sup>(12)</sup> These were not introduced in nursing, partly for aesthetic reasons but partly because professional interests would have resisted it as demeaning. If professional tasks can be analysed and routinised by such techniques, they then become stripped of their 'mystique'. For whatever reasons, nurses were therefore unable to use 'productivity deals' as an escape route from low pay, and the fact that ancillary workers could fuelled nurses growing resentment. Finally, faced by these constraints, there were the difficulties posed by their previous collective inertia, and the growing awareness that their loyalty to their employment had been taken for granted, and their pay and conditions allowed to slip behind. If they were concerned to restore their position in an era of inflation, there was no alternative to collective militant action to ensure that wage levels did not drag behind the rising cost of living.

These painful facts became apparent early on. In 1961, the Chancellor of the Exchequer, Selwyn Lloyd, in response to a worsening economic situation, introduced a 'Pay Pause' in the public sector, ending arbitration as an option in public sector wage and salary negotiations. The General Whitley Council rejected the 'pay pause' on 17 August and sought an early meeting with the Chancellor, who instead referred them to the Minister of Health. They received little comfort, but undiscouraged pressed ahead with claims on the Functional Councils. The Staff side of the Nurses and Midwives Council put in for average increases of 35%. Negotiations dragged into 1962, until finally nurses were offered 2½% from April 1962, when the 'pause' would be replaced a 'guiding light'. (13)

The offer was rejected by the Staff side, who then ushered in a period of unprecedented protest activity. Interestingly this was led by the Rcn as the dominant organisation on the Council, with trade unions playing a supportive role. The response of nurses themselves seems to have surprised the Rcn. To quote their official historian:

In March the College called an emergency meeting in Cowdray Hall - the number who came astounded the organisers. The building was veritably jammed with nurses who overflowed the hall and crowded the stairways and other floors to which proceedings of the meeting were relayed by loudspeakers.

At the meeting it was resolved that the Government must be put under pressure by protest meetings all over the Country. When these were held they proved to be just as crowded and enthusiastic as the original one in Cowdray Hall. Deputations to Members of Parliament were organised and the national Press, radio and television gave publicity to the nurses' cause. The nurses however, unanimously agreed at every meeting that the one weapon none of them would use - or even threaten to use - was that of the strike. (14)

But the Rcn was not alone in organising protest demonstrations. COHSE also organised rallies throughout Britain. The union records show that it was realised that this was an opportunity to be grasped to increase nurse membership. COHSE went further than the Rcn, and held a strike ballot of the membership. The results showed the strength of militant feeling:

7,296	'unreservedly in favour' of strike action
16,068	'in principle' for strike strike action
5,375	against. (15)



The ballot was not acted upon.

however, including token strikes by industrial workers in support of the nurses,<sup>(16)</sup> and a national rally of nurses in May 1962 organised by the Staff side of the Whitley Council. Finally the Government allowed the matter to go to arbitration. In September, 1962 the Industrial Court accepted the original staff side claim. It awarded an interim backdated increase of 7½%, and ordered that negotiations over the remainder be completed by March, 1963.<sup>(17)</sup>

The deal was a watershed, for its success demonstrated two of the laws by which the jungle of collective bargaining operated. First, that the employer in the public services was unlikely to be any more generous than employers in the private sector. (In fact it might prove tougher in the NHS, where very little of the cost was recouped from charges, and it could not, as a private employer might, finance pay deals by charging higher prices). Second, that pressure and even force was more likely bring results rather than reasoned argument. As a consequence the deal ushered in a period of growth for NHS Trade unions and increased competition and friction between unions and professional associations. COHSE was continually snapping at the Rcn's heels, even if

Nalgo (for reasons discussed in the previous chapter) still tended to go along with the College. COHSE, however, continually criticised the College's tendency to favour senior nurses in pay claims. For example, the 1964 Whitley Council pay deal excluded student nurses from eligibility for extra duty payments for working nights and Sundays, largely because of Rcn opposition. To have allowed it would have meant Rcn acceptance that they were 'workers' rather than 'students'. COHSE seized the initiative and organised protest meetings of student nurses. Their wages were described as 'Beatle Money', a reference to the song 'A Hard Days Night'. The union journal ran a competition for the best arguments against the College. The winner questioned:

Should Stirling Moss decide the rates  
for long-distance lorry drivers? (18)

The position of the Rcn was becoming increasingly exposed, even among its own membership. In 1961 it had finally agreed to accept men into membership, and these encouraged it to adopt a tougher negotiating stance. Though it remained dominated by senior nurses, to maintain its domination in the face of growing competition from the unions in a bargaining unit covering all nurses, trained and untrained, it had to maintain its relative density. This required it to search its soul concerning rules not

admitting groups like men, students and enrolled nurses to membership. By the 1970s these rules had gone, with the exception of untrained nursing auxiliaries who are still excluded from the professional 'community of interest', while remaining in the same bargaining unit. But the Rcn needed also to 'include' these groups in another sense, by developing bargaining strategies which were able to draw support at ward level. Hence the growing 'populism' of the Rcn's leadership from the 'Pay Pause' campaign of 1962.

Their position was not assisted by the stance towards wage negotiations taken by Labour Government's 1964-70. Despite the fact that the unpopularity of Conservative incomes policies and their effect upon state workers was a factor in Labour's 1964 election victory, the Labour Government of 1966 responded to the economic difficulties of the second half of the 1960s by extending them. Though in theory these now covered all workers, they were applied more rigorously in the public sector.<sup>(19)</sup> The growing frustration of staff was reflected in the growth of health service unions. It was also aided by growing uncertainty engendered by reorganisation in larger units from the mid 1960s. Authority became more remote and its decisions more mysterious. At the same time, nurses felt more exposed by media accusations of ill-treatment in long-stay hospitals

and well publicized examples of mistakes during the course of treatment. The double sense of insecurity and vulnerability that these developments engendered provided an added spur to unionisation. The importance of 'protection' as a reason for unionisation among nurses is one of the clearest common threads showing through the Case Studies in the Appendix, despite considerable 'cultural variations' between the particular hospitals (see below).

NUPE tended to recruit greater numbers of ancillary workers, while COHSE attracted more nurses. Breakthroughs were occurring in the industrialised general hospitals. As a result the composition of unions changed. COHSE, for example had still been predominantly a male union, but from the 1960s numbers of women members have exceeded male members, and now amount to 75% of the total the second highest proportion of women to men in the TUC. (20) By 1968 COHSE's strength had grown to more than 75,000 although not all of these were nurses, in comparison with the Rcn's membership of around 70,000. Part of this growth of female membership was due to the overall growth in the size of the workforce. It also occurred because nurses were laying to one side the long-standing objections to joining unions. In the three years between 1968 to 1971 the growth of health service

unions was even more staggering:

	<u>1968</u>	<u>1972</u>
COHSE	75,163	102,554
NUPE	283,471	397,085
Nalgo	373,046	463,798

(21)

Although not all of this growth - with the exception of COHSE - was accounted for by NHS workers.

That management attitudes towards trade unionism were also softening, was highly significant. The social democratic 'pluralist' perspective on industrial relations, which influenced the Labour Government of the time, sought to encourage a 'realistic' management appreciation that workers had divergent loyalties from management that with sensitivity could be reintegrated to create a more 'organic solidarity'. Essential to this was an attempt by the 'Oxford School' of Industrial Relations, through the public platform provided by the Donovan Royal Commission, to re-educate management, the 'public' and official opinion on the nature of shop stewards. Instead of 'ring-leaders' or 'trouble-makers' the new post-Donovan image of the steward as 'a lubricant rather than irritant' emerged.<sup>(22)</sup> This affected not just management's views but also the unions'. In some ways management was more positive. The new Department of Health and Social Security acted to encourage greater union recognition, at a time when the Labour Government, at the end of the 1960s, was considering promising legislation

to enforce recognition of unions generally. This legislation never materialised, but as Bain points out, many managements preferred to grant or extend recognition voluntarily in anticipation of legislation. (23)

This does not necessarily mean that the extension of recognition in the health service was entirely compelled by external circumstances. The industrialisation of the health service in some ways dictated it from within. For example the standardisation of procedures involved in bureaucratising the structure, and the growth in the size of the work force, made the continuation of 'personal' style of management, as Bain pointed out, increasingly untenable. (24) It becomes increasingly time consuming for management to deal with workers as individuals and much simpler to deal with representatives of workers. As Millard points out, in 1972:

Hospitals are not used to getting people to represent their colleagues: it is common to hold a meeting of all staff rather than to speak to representatives, eg sisters meetings or meetings of all consultant, medical staff. Good representation is difficult and hospitals have been unable to achieve much success. (25)

The 'industrialisation' of the health service created conditions in which management now wanted to create a representative structure in order to negotiate change when

it was becoming increasingly difficult to consult with every worker individually. This is cited specifically in Circular HM(69) 63 when, for the first time in the history of the health service, staff were officially advised rather than simply permitted to join a Whitley Council organisation. It had been preceded by an agreement that union subscriptions could be deducted from pay (DOCAS - Deduction of Contributions at Source). Professional associations could not make use of this scheme because members paid by annual subscription. It was followed in 1970 by a union facilities agreement on the Ancillary Staffs Council to allow stewards to take time off work to represent their ancillary members: a practice which then spread to nurses.

The Rcn was faced with an acute difficulty. To maintain its traditional influence it had to respond to this new mood, caught by union pressure from outside and growing disaffection within. A pressure group led by the charismatic figure of Sister Patricia Veal, unashamedly described themselves as 'bedpan bums' and grabbed headlines by noisy demonstrations in 1968. I participated as a third year student nurse in one of the major demonstrations held. Despairing of changing the Rcn the 'bedpan bums' broke away and formed the United Nurses Association (UNA).

As it turned out the fate of the UNA was as ignominious as those of most breakaway organisations. By 1970 Veal had quit the NHS, founding a nursing agency which she claimed

will be a modern, efficient  
organisation run on old-fashioned  
principles' (26)

In its heyday, however, the UNA caused consternation among Rcn leaders who were clearly surprised and alarmed at the public display of anger and bitterness displayed by those nurses who took part in Sister Veal's short-lived movement.

It is easy to regard the Rcn as an extremely sluggish conservative-minded organisation. Though generally true, it could easily obscure the fact that more than once in its history it has acted swiftly when it has seen the 'writing on the wall'. In 1966 an article in Nursing Times - then still the official organ of the Rcn - asked rhetorically 'What exactly is the Rcn?' and replied that:

Members in fact are the College, although not all of them seem aware of this ... Occasionally the membership will rise up in its wrath and assail the rulings of Council ... But by and large, College members are not vocal, do not play an active part in College affairs, at least at national level, and in many cases regard the organisation and its officers as some benignly autocratic body whose word is law. (27)



The article showed an awareness of growing problems. It conceded that

There is still some bitterness at membership level over the fact that the Rcn failed to go down with all flags flying over the overtime question. Betrayal is perhaps too strong a word in this connection, but certainly many members felt let down'. (28)

While the College's policy was defended, the article admitted: 'Perhaps the College is presenting the wrong image'. While not developing a representative steward network, the Rcn had recently developed a 'Key Member' system. However, as the article stated:

No one seems really sure what the role of the Key Member is, least of all the Key Member... In the main their task seems to be largely that of displaying the latest college notice and making sporadic attempts to recruit new members from among the newly trained with limited success. (29)

There was a realisation in the article of the need for change, although how far this would actually involve a transformation of the organisation or move towards presenting a new 'image' was not entirely clear:

Whatever happens the College must compete, not necessarily for members, but in terms of the quality of the service it offers. ... Certainly there are signs that for many nurses the Rcn is failing to meet their needs. It will be interesting to see how and to what degree the Rcn changes over the next few years. (30)

This new awareness and preparedness - up to a point - to be self-critical, was undoubtedly magnified by the activities of Sister Veal, and the growing membership strength of trade unionism. This was the background to the Rcn's vociferous, if not militant, 'Raise the Roof' campaign of the Rcn in 1969 which sought to recapture the ground it feared it was losing. The roof was to be raised in two senses. First, the sedate 'flowery hat' image of the College was to be exorcised by a determined publicity campaign of meetings and demonstrations to convince 'the public', and through them the Government, of the justice of the nurses' pay claim. Second, the pay claim submitted by the Rcn assumed that 'raising the roof' by concentrating on massive pay increases for senior nurses would, in the wake of the publication of the Salmon Report, restore nursing's status as an occupation attractive to career-minded middle class girls (as well as swelling the bank accounts of those who dominated the Rcn's affairs). At the top end of the scale the Rcn was demanding an extra £1,500 a year for a Chief Nursing Officer, while for staff nurses it was only claiming £325 maximum increase. (31)

The 'Raise the Roof' campaign was therefore an odd combination of populist pressure in the service of a salary demand biased considerably towards nursing administrators.

According to Widgery the campaign was 'strictly controlled' from above and he quotes an un-named nurse's account of her involvement in the campaign:

The slogans and demands were already prepared. The meetings were dominated by speakers from the platform - the establishment - and any independent militant spirit was crushed wherever possible. The nurses were told they could not strike; we were not left to think about this and decide for ourselves - even though many possibly would not anyway. Eventually most nurses stopped attending the meetings - they could not be bothered to be talked at yet again .(32)

According to press reports, the militancy was not always easily contained. For example, according to a report in The Times in November 1969:

One thousand nurses, unable to find room in an Edinburgh music hall where 3,000 of their colleagues were attending a meeting on nurses' pay, marched along Princes Street last night chanting "More Pay for Nurses". Police were called as the demonstrators marched back to the hall and banged and pushed the large oak doors, demanding to be addressed by Mrs Catherine Hall, General Secretary of the Royal College of Nursing, who travelled from London for the first of the nurses' "Raise the Roof" campaigns. She was escorted by a police inspector to address "locked out" nurses .(33)

Undoubtedly the College had seized the initiative and though COHSE organised demonstrations of nurses, these were smaller and overshadowed by the Rcn's activities. Some critical voices were raised against the tenor of the Rcn's campaign. A COHSE Branch Chairman, for example, wrote a letter to the Guardian complaining that:

Many nurses deplore the "Raise the Roof" campaign, and believe that the claim submitted by the Rcn to be unrealistic and not in the interests of nurses generally ... The campaign appears, to some of us, to be an attempt to use public sympathy to gain large increases for senior grades at the expense of the lower grades .(34)

'Unrealistic' or not the campaign enjoyed some success.

Towards the end of January 1970 management offered a pay deal averaging 22% overall but phased in two stages of 15% in April 1970 and a further 7% to be paid a year later. (35)

As a result of further staff side pressure, including a lobby of the House of Commons attended by thousands of nurses, the management conceded a single 20% pay rise a fortnight later. (36)

The success of this campaign - it was the largest ever pay deal for nurses - had two major effects. It spurred the Rcn to modernise further in subsequent years. It also showed to the trade unions, particularly COHSE,

that there remained vast reservoirs of militancy among nurses that hardly had been tapped. The next immediate step in the modernisation process of the Rcn came as a result of its registration under the Heath Government's Industrial Relations Act. Following the lead of the British Medical Association, it joined the Special Register set up for professional associations. Subsequently the Rcn replaced its 'key members' with elected work place stewards, to cover administrative areas under Senior Nursing Officers. Initially Nursing Officers were not originally permitted to be stewards, but the scheme was subsequently extended to cover them.<sup>(37)</sup> During this period the Representative Body came to exercise a growing importance in the Rcn's affairs. Set up in 1967 it occupied a similar position to a trade union conference, except that it was (and is not) the Rcn's supreme governing body. That power remained vested in Council, from which student and pupil nurses - in 1970 approximately 30% of Rcn membership - were excluded. The Rcn Handbook for 1977 indicates clearly the limited powers of the Representative Body, which

... plays a major part in the formulation of policy and in initiating action in the name of the Rcn. Resolutions carried at its Annual meeting are referred to Council for consideration and action. In the event that the Council determines not to give effect to a resolution carried by the Representative Body it is committed to report back to that Body giving reasons for its decisions .<sup>(38)</sup>

Faced by growing competition from trade unions and the impending reorganisation of the health service, the Rcn Council in 1972 commissioned a review of the membership structure, to be undertaken by the Tavistock Institute of Human Relations. In its method of working, the Institute actively sought the views and impressions of the rank and file membership. It suggested that the hierarchical structure of nursing was reflected in the organisation of the Rcn:

While the Council often occupies the symbolic role of the latter-day "Matron" the General Secretary often appears in the image of "Medical Consultant" .(39)

It called for a more 'pluralistic' and participative structure in which greater numbers of issues were devolved to the membership at large 'rather than always being referred "upwards" to some "authority"'.(40) The way that it suggested that this be done was by an adaptation of the existing structure rather than a substantial transfer of power from the Council and permanent officers. The Report's main suggestion was for the creation of local Rcn Centres coterminous with the new administrative units of the reorganised NHS, which would at local level unite all Rcn activities, professional and trade union, business and

social, sectional and general. In their words:

The Centre may be seen as a building block out of which the divisional and national organisation can be constructed, while still having a real meaning in their own right in the local context . (41)

They were thus seeking to strengthen the periphery, through decentralisation within the existing power structure. As they conclude:

Our evaluation of the future needs of the College leads us to place a greater emphasis on the participative process than on the form or content of the model as such . (42)

One glaring gap in the Report was the failure to perceive the need substantially to develop Area Organisation in the Rcn, where the College lost out in competition with the unions. Then, as now, Head Office dominates the administrative structure of the Rcn.

The Council implemented the Institute's main recommendations, as well as taking the opportunity to streamline its complicated sectional structure. In future members would be linked to one of four 'Associations': Nursing Management, Education, Students, and Practice. These would have a local presence in Centres; while

representation on Council and Representative Body would be determined jointly by Associations and Centres.<sup>(43)</sup> The new structure therefore partially eroded the pronounced 'sectionalism' of the past, representing a step towards a 'cosmopolitan' nursing 'community of interest'. In addition, specialist societies were set up, initially in Research, Occupational Health, Geriatrics, Psychiatry and Primary Health Care, but these had become primarily 'study associations', no longer the basis for representation within the organisation, nor wielding the kind of power formerly exercised by Sections. Interestingly, however, though the significance of horizontal cleavages of speciality had now been minimised, the hierarchical divisions remained, perhaps even heightened. In the long run perhaps, this will help foster the development of a wider trade union 'community of interest' amongst 'practice' nurses viz-a-viz managers. Certainly the overall tendency in this period was to strengthen the trade union activities of the College and to place them much more to the fore.

The Rcn was not the only health service membership organisation to streamline and reorganise its structure during this period. Similar processes occurred within both NUPE and COHSE. Prior to the 1970s NUPE's phenomenal success depended partly on luck: it was recruiting in the



most rapidly growing employment sector where the greatest reservoirs of non-membership still remained. However, its aggressive recruiting policy, assisted by a higher ratio of full-time officers to members than typical of the union movement as a whole, helped it in the scramble with other unions for public sector workers.<sup>(44)</sup> Two factors now forced the leadership to review its structure. First the impending reorganisation of the health service, local government and water industry; second, the outmoded structure of local organisation, still largely based on the Branch, when there had been a phenomenal growth in union stewards in recent years. The integration of stewards and stewards' committees could take place at the same time as the union adapted itself to meet the challenge of a new 'industrialised' pattern of management, as a 'Consultative Document' made clear.<sup>(45)</sup> Shortly afterwards, a study was commissioned from a team of researchers from the University of Warwick. Their Report, published in 1974, recommended the creation of units of membership representation parallel to all levels of the new administrative structures of reorganised services. Furthermore, through a system of what subsequently became known as 'sponsored democracy' (ie sponsored from above) the Warwick team sought to establish substantial representation for union stewards within the new structure

at both the sectional level and above, as well as means by which the Executive Council could become more accountable to them.<sup>(46)</sup> The team rejected the proposal that periodic election of officers was necessary for greater democracy. It choose instead to substantially increase the power of stewards within an organisation previously heavily dominated by full-time officers and powerful branch secretaries.

COHSE did not undertake a major review of its structure. However, from the later 1960s it did seek to streamline its administrative structure and devolve greater powers to stewards. The Union's Head Office was reorganised with the arrival of Frank Lynch as General Secretary in 1969. Lynch placed a considerable premium on recruitment activities and emphasised the region's role in developing the union branch and Head Office's key role in servicing the regions. He saw himself largely as an administrative figure at the head of a corporate machine and devolved negotiating responsibilities upon his senior officers.<sup>(47)</sup> From an organisation which had first look suspiciously upon union stewards, it sought actively to encourage them in the 1970s, realising that it was in the workplace that the competitive struggle between organisations would be determined. Thus it can be seen that managerial changes

and growing expectations from members - for improved pay and conditions, and greater democracy in the workplace - led in the 1970s to a 'new unionism' in the health service. In the process the unions and professional organisations themselves became, to greater and lesser degrees, transformed from the previous conservative, cautious, remote and largely loyal organisations of the past.

There is no doubt that the key struggle, at least during the first half of the 1970s, was over wages. From the rumblings of the 1960s an upsurge of wage militancy erupted, affecting every group of health workers. The reorganisation of the unions and professional organisations helped to fan the flames by creating a more responsive structure in which rank and file anger could be expressed. Officials themselves often sought, within limits, to sponsor and perhaps contain the militancy as a means of helping their organisation to grow at the expense of competitors. Thus in 1970 COHSE announced that the 20% was only:

... a beginning. We were determined the offer should be without strings and this we have achieved. Now we can and shall press for urgently needed reform in overtime, split duties, and the often horrifying conditions of work in hospitals. (48)

There was clearly an awareness that if the Rcn had seized the initiative in the 'Raise the Roof' campaign, COHSE would seek to regain it in the years that followed. The industrial militancy of nurses that erupted in 1974 was not, however, directly created by COHSE. Rather it was the result of sustained pressures from below in all nurses' organisations, which COHSE proved able to capitalise upon more than other unions and professional associations. That militancy was initiated (as often in the past) by student nurses, and foreshadowed from late 1973 by rumblings over increases in canteen charges (eg see Case Study in Appendix on Kings College Hospital Nalgo). But few could have predicted the degree of anger that would find public expression in the following year.

### (3) The 1974 Pay Campaign

The roots of the 1974 dispute lay in the so-called 'Revaluation' claim of 1972 which took account of the impending NHS reorganisation, growing shortages of staff and the extent to which nurses' salaries had slipped back in relation to comparable occupations, at a time of increased inflation. The claim, lodged on 12 January 1972, ranged from 26% to 40% according to grade, and was (for once) biased towards the lower rather than the upper end of the scale. It thus commanded considerable support among rank and file

nurses. An interim award of 8% was granted in 1972 on the assumption that negotiations would proceed on revaluation. However these negotiations were halted in November 1972 by a statutory pay freeze imposed as a result of the 'U-turn' by the Conservative Government of Edward Heath.<sup>(49)</sup> The claim, periodically updated, was trapped by the three 'phases' of the Government's incomes policy, until its defeat in the February 1974 General Election.

Ironically, negotiators on the Nurses and Midwives Council had settled under Phase III of the Conservative Government's incomes policy. It was not until the new Labour Government was elected and concluded a favourable deal with the striking miners, that signs of dissatisfaction among nurses began to appear. As Barbara Castle, Minister of State for Social Services, wrote in her diary at the height of the dispute:

... I really do seem to have walked into a pack of trouble. Unions always seem to let their pent-up frustrations explode as soon as there is a Labour Government .<sup>(50)</sup>

The basis for its expression undoubtedly existed, since between April 1970 to the end of 1973 nurses' pay had risen by approximately 24% while prices had risen by 35% and average earnings by 50%.<sup>(51)</sup> The factor which finally

sparked the dispute was the delays caused by the Conservative Government's Pay Board which had not yet been abolished by the new Labour Government. By the end of April nurses had still to receive the interim pay increases promised for 1 April, let alone a promise of a wider review of their pay and conditions. However, the Government sanctioned the implementation of higher canteen prices that were due to come into effect in April. This combination of factors lit the fuse which exploded in militancy over the summer months of 1974. On April 25 the Nursing Times reported that:

Throughout the Country the Rcn and the unions are reporting a militancy at the grass roots, the like of which has not been seen for a long time .(52)

The first salvo in the campaign was fired within the Rcn - and to some extent at it. At the mid April meeting of the Rcn's Representative Body in Blackpool the Chairman of the Student Section, Brian Lamond proposed an emergency resolution that Mrs Castle should be sent a telegram asking her to come to Blackpool to 'hear about the gross injustices to which we have been subjected'. When this resolution was threatened by a proposal to move to next business, Brian Lamond threatened that the Students' Committee might 'consider withdrawing support from the Rcn'.(53) Finally

a compromise demand for a 44 strong delegation was reached and agreed by the Government for 13 May. (54)

Now were the trade unions idle. A demonstration was organised by Nalگو and COHSE, at just a few days' notice for the meeting of the Nurses' and Midwives' Council on 30 April at which the staff side were to demand an independent review of nurses' pay. 1,000-1,500 nurses, mainly from London hospitals, were turned back by a cordon of police as they tried to force their way into the DHSS. They then set off to march to Parliament to lobby MPs, but were stopped at Putney Bridge because Parliament was sitting. (55) This demonstration more than any other event sparked off the nationwide campaign. It was addressed by Albert Spanswick, newly-elected General Secretary of COHSE. His speech, for the first time in the campaign, raised the possibility of industrial action if the Government did not move swiftly. (56) A few days later, at Storthes Hall psychiatric hospital near Huddersfield, the first token walkout took place, and such actions rapidly spread elsewhere. The Rcn momentarily recaptured the initiative on 13 May when it met with Barbara Castle and presented an impressively researched document, The State of Nursing 1974. (57) This suggested that while efficiency had improved as a result of fewer beds, a faster 'throughput' of patients,

and an increased workload in the community. this had not been reflected in better pay, nor had allowance been made for the growing complexity of treatment and care. The document expressed concern that the promised reform of nurse education outlined in the Briggs Report<sup>(58)</sup> had not yet materialised. Quoting DHSS figures, it showed that more than half of nurses in the NHS earned less than £30 a week, and a quarter of them less than £22 a week. But the biggest stir was caused by the Rcn delegation's announcement to Mrs Castle that unless the Government took 'effective steps' to set up a speedy enquiry into nurses' pay and conditions, then (in the words of a statement issued by the President of the Rcn):

All members of the Rcn employed in the NHS will be advised to submit to their employing authorities notice of Termination of their employment as required by their contract .(59)

The Rcn was in a dilemma. Its traditions and ideology forbade the taking of industrial action, yet it needed to respond to the growing moves from below for strong action. The plan for mass resignations was the farthest it dare go. It planned to set up a limited company which its members would join, and which would then sell back the services of



nurses to the NHS. Whether it was a practical proposition, especially for students whose repudiation of their contracts might seriously jeopardise their training, was in some doubt. However its impact upon the Government was very great.

The unions were angry that Mrs Castle had agreed to see the Rcn first.<sup>(60)</sup> COHSE in particular was determined not to be upstaged. It convened a meeting of its NEC on 16 May, and threatened to go one step further and take immediate industrial action if no money was placed 'on the table' by 20 May. When this was not forthcoming it instituted a six point campaign of industrial action on 21 May:

- (a) a ban on clerical duties;
- (b) a ban on domestic duties;
- (c) a ban on 'acting up';
- (d) a ban on all overtime;
- (e) selected and short withdrawals of labour;
- (f) ancillary staff to refuse to fill-in  
with domestic jobs usually carried out  
by nurses.<sup>(61)</sup>

As well as these pressures there were widespread demonstrations of nurses throughout the United Kingdom. Some of these were officially organised by trade unions. Others were semi-

official, like the 'Fair Play for Nurses Campaign' organised by Sister Diana Dawe from Surrey, with the support of the Rcn. A great many, however, were established as informal Action Committees, and Nurses Action Groups, which attracted many, particularly student nurses, who were not in any organisation. I took part in a number of demonstrations during this period. My notes for a demonstration in Epsom, Surrey, on 17 May, 1974 read in part as follows:

Attended by 300 plus nurses from general and psychiatric hospitals in the vicinity. Most if not all were probably off-duty ... The march itself was high spirited and noisy. There was quite a bit of chanting eg 'What Do We Want? - More Pay! - What Do We Get? - Nothing!' I talked to a couple of male nurses on the march: one from a general hospital and one from a psychiatric hospital. Both favoured industrial action ... The initial impetus for the demonstration had seemed to come from student nurses, and members of the Student Section had taken the lead in organising it. The central office of the Rcn, however, had declined to offer a speaker for the demonstration. (62)

There was considerable competition for the loyalty of marchers between COHSE and the Rcn, with the COHSE Regional Official castigating the Rcn's policy of mass resignations. He claimed to have recruited three Rcn Stewards by the end of the march. In response to a letter

of mine in the Nursing Times in 1978, Mrs Harrison wrote to me explaining the role of the Action Committee in her area (Liverpool):

I believe the action committees which grew during this period were a very natural outcome of the events leading to the campaign. Nurses were at the end of their tether and the official unions were slow to take any real action. Only when the rank and file members of COHSE and NUPE put pressure on the union leaderships did they actually initiate activity. Experiences of responses from other trade unions was immensely gratifying. However, the attitude of the health service unions, particularly my own union, COHSE, left a lot to be desired .(63)

When Ken Price a member of Swansea Nurses' Action Committee was interviewed in the alternative press about the advantages of such committees, he replied:

The good thing about the Action Committee is that there is no leader, everyone shares responsibility, everyone plays their part .(64)

These semi-anarchistic tendencies worried leaders of unions and professional associations alike. The kinds of tensions which occurred locally are illustrated by the Case Study on Walsgrave Hospital (see Appendix). Nationally, tensions occurred in the influential 'Fair Play for Nurses Campaign' was boosted by the coverage it received.

in the mass media (and the good weather), which encouraged nurses to come out on to the streets. The cause of nurses' pay was taken up by the Sun, which ran its own 'Fair Play for Nurses Campaign' linked to the movement. For example on 13 May, when the Rcn delegation were confronting Barbara Castle, the front page headline announced 'Into Battle' and a story inside described the 'Plight of "Slave Angel" Lucy':

... a State Enrolled nurse at a big London maternity hospital. She's done everything - from nursing TB patients, being in charge of wards in large hospitals and running a VD clinic. And she earns just £20 a week after deductions. But Lucy is no youngster - she retires in two years after 40 years nursing .(65)

Previously, it had given wide and unfavourable publicity to the comments on Enoch Powell, a former health minister, writing in the Rcn's student newspaper (!) SNAP, who had claimed that marriage prospects with doctors still served as a major advantage for intending nurses:

Teaching hospitals could probably recruit nurses for board and lodging alone ... The pay lost would still be a sound investment in future prospects.(66)

However, as the campaign advanced, Rcn officials rapidly lost control of it. The semi-autonomous Action Committees began to play the major part, the most powerful of which was

the London Coordinating Committee spearheaded by Kings College Nalgo. As well as trade unionists, left-wing groups like the International Socialists through its linked 'rank and file' group Hospital Worker began to play an influential role in the campaign. Links began to be formed with ancillary worker trade unionists, and the Labour movement at large, particularly through local trades councils. Hospital Worker brought out a 'Nurses Special' as a means of organising a 'Nurses' Emergency Conference' on 1 June 1974.<sup>(67)</sup> The climax of the campaign was the national demonstration in London on 6 June, attended by more than 3,000 nurses. The 'Fair Play' organisers had intended it to be a silent march, but it became a very noisy one. They were also dismayed that so many trade unionists and political activists were present. Sister Diana Dawe was reported to have said:

I could weep. If they want a screeching march by all means let them have one - but not under our banner. They are using the march for their own political ends. Fair Play for Nurses is totally non-political.  
(68)

However by this time the campaign was already faltering. Barbara Castle had taken the heat out of the situation on 23 May by acting before the Rcn deadline for mass

resignations and two days after COHSE had instituted industrial action on 21 May. She established an independent review body of enquiry outside the Whitley Council system under Lord Halsbury, the Chairman of the Doctors' and Dentists' Standing Review Body. She hoped that this would defuse the growing militancy of nurses and that the energies of their organisations would be concentrated on the gathering and presenting of evidence to the Enquiry. In fact nearly all organisations suspended their actions. The Rcn, for example, withdrew its support from the Fair Play Campaign, including the demonstration planned for 6 June. COHSE, however, was under considerable internal pressure<sup>(69)</sup> and recruiting members so fast that its NEC was encouraged to continue its militant position. It demanded an immediate interim payment in advance of the Enquiry's findings. When this was not forthcoming it stepped up its action on 20 June, banning work with private patients, agency nurses and all non-emergency admissions.<sup>(70)</sup> The last was the most telling. In some mental hospitals psychiatrists sought to get round this ban by admitting all patients as 'emergencies' under the Mental Health Act 1959. COHSE branches responded by setting up committees of trade unionists to vet all admissions, hence directly challenging medical prerogatives.<sup>(71)</sup>

As far as its immediate objectives were concerned, COHSE's campaign of industrial action was a failure. An interim payment was not achieved, and the NEC managed only to extricate themselves on 29 June with vague promises from Mrs Castle that she 'will consider asking him to recommend an interim payment' if the Report was unduly delayed.<sup>(72)</sup> As her statement to Nursing Times made clear this was not to be interpreted as any kind of promise to make such a payment.<sup>(73)</sup> The appointment of the Halsbury Enquiry had indeed taken the heat out of the situation, though increasingly Mrs Castle faced confrontation on other fronts, with radiographers angry over their pay and conditions, and action by ancillary workers and some nurses against private beds in NHS hospitals. However she was successful in defusing the nurses' pay campaign. Most of the industrial action initiated by COHSE involved emergency cover and only occasionally did it go beyond the bounds set by the NEC. An isolated exception was at Highcroft Psychiatric Hospital where 300 nurses belonging to both COHSE and NUPE walked out for a 24 hour period.<sup>(74)</sup> However, the action did not spread to other hospitals and in many ways the Highcroft Hospital strike signalled the end of the pay campaign rather than the beginning of a new phase of more intense struggle.

However, the actions of COHSE do seem to have increased the pressure on the Committee of Enquiry to produce speedy results. These materialised on 17 September. The award amounted to 30% overall with some groups of ward sisters and charge nurses receiving 58% salary increases. It argued that such large increases were necessary to combat an estimated 20% manpower shortage, and to create a more attractive career structure in anticipation of the reform of nurse education proposed by the Briggs Committee. The Report's recommendations in detail covered a wide range of issues, from increased overtime pay to increased holidays.<sup>(75)</sup> However it did not recommend any diminution in the length of the working week, and in general terms, as John Berridge has suggested, the Report was unadventurous.<sup>(76)</sup> Even though its terms of reference covered the structure of nursing as well as pay and conditions, it made no recommendations which might have disturbed the traditional patterns of subordination to the medical profession - for example by calling for an enhanced clinical role for nurses within the division of labour.

Nevertheless the outcome was very favourable, especially for COHSE. Despite the protestations of the Enquiry members themselves, the pay award was interpreted as a vindication of the principle that 'militancy pays'. The



Rcn could justifiably claim that in substantive terms its State of Nursing document had enjoyed the greatest impact on 'official' opinion. However, even the Rcn had felt it necessary to back up its 'reasoned argument' with mass demonstrations and threats of resignation from the NHS. Among nurses at large, there is no doubt that the results of the Halsbury were identified as the products of militancy and that COHSE, as demonstrably the most militant organisation during the dispute, gained most through it. At demonstrations, for example, COHSE was able to embarrass other organisations and use them as recruitment channels for bringing in large numbers of nurses at one go.<sup>(77)</sup> Members of Action Committees could often be convinced of the need for permanent organisation and frequently joined COHSE as their preferred organisation.<sup>(78)</sup> Not surprisingly the year following the Halsbury Campaign was COHSE's most successful recruitment period ever, and it achieved a rate of growth that has hardly ever been enjoyed elsewhere in the trade union movement. By 1979 membership had almost tripled on its 1970 figure to 215,000. (During the same period the membership of the Rcn stagnated below the 100,000 mark.) In the process it was transformed

from a relatively small organisation, mainly influential among psychiatric nurses, to become the twelfth largest union in the TUC. It had achieved a much greater coverage among general nurses, and had become for the first time a serious rival to the Rcn for the leadership of the occupation. Nalgo and NUPE had, respectively, become the fourth and fifth largest unions in the TUC. No longer could it be said that the typical nurse was not a member of any organisation.

(7) Postscript: To the 'Winter of Discontent' and Beyond

The wave of industrial unrest which shook the service in the mid 1970s - in the latter period of the Conservative and early part of the Labour Government - was primarily economic in character. It was followed by the period of the Labour Government's 'social contract', in which advancing union organisation focussed increasingly upon non-wage issues. In part this was due to 'spillover' effects of industrial action over wage issues, because, as we saw, these raised control issues. Ancillary workers' and also psychiatric nurses' experience of involvement in determining the nature of emergency admissions, disturbed traditional relations of deference to consultants. Some ancillary

workers had blacked private beds ('pay beds') in NHS hospitals during the 1973 dispute, and afterwards went on with the support of some nurses to campaign for their elimination as a demand in its own right.<sup>(79)</sup> Psychiatric nurses went on to seek a larger say in determining admissions policy of 'difficult' patients. The nature of industrial action in the health service therefore tended to raise control issues in ways that do not always happen in strike situations in manufacturing industry. However the fact that COHSE, unlike NUPE, did not take a major part in industrial action over pay beds, probably further assisted its recruitment of nurses. Perhaps this indicates that nurse trade unionism remained much more economistic and less politicised than that among ancillary workers.

From 1975 onwards, in return for TUC cooperation with the Labour government's pay policy as part of the Social Contract, new employment legislation was passed, which in the NHS extended bargaining frontiers over non-wage issues. The Employment Protection Act 1975, the Trade Union and Labour Relations Acts of 1974 and 1976, the Health and Safety at Work Act 1974, and legislation against sex and race discrimination, gave new rights to local union activists, putting management on the defensive.

As a result, competition between TUC and non-TUC professional associations intensified. With growing confidence, stewards began to form committees at local level which cut across union boundaries and, in a number of areas, boycotted consultative committees and refused to sit down with professional associations. This forced the associations to reorganise their structures and (if they had not already done so) to introduce systems of workplace representation. To take advantage of the new legislation they had to prove their 'independence'. Ironically, the fiercer competition from trade unions has probably strengthened professional associations by forcing them to become more efficient. The Rcn by the late 1970s was beginning to recover some of the ground lost during the early 1970s. Relieved that they were not excluded by the Labour Government from the Whitley Council, they could register as a trade union, and take advantage of the new bargaining rights offered by its legislation.

From 1976 job security also became an issue of concern for nurses and other health service trade unionists, because of the Labour Government's programme of public expenditure cuts. These were combined with a new system of budgetary controls - cash limits - in which the amount spent was limited to a predetermined inflation allowance, regardless of its actual rate. Public service unions were quick to organise

protests at the cutbacks in expenditure, though a steering committee of unions was not joined by the NUGMW, a union traditionally loyal to the Labour Party establishment. Some primarily private sector unions, such as the 1.5 million strong Amalgamated Union of Engineering Workers actually wanted to see a redistribution of expenditure away from public services towards the 'productive base of the economy'. (80)

At local level the fight against cuts often centred upon the defence of small hospitals against closure. Though such closures had taken place previously, they were accelerated by the cuts. As powerful groups of consultants sought to protect acute services, more small hospitals, often caring for the chronically ill or covering low-status specialities, were sacrificed. Spirited defence campaigns around particular hospitals, such as the Elizabeth Garrett Anderson Hospital and Bethnal Green Hospital, secured partial victories or stays of execution. In the process new alliances were often formed with groups of users in the wider communities; and notions of an alternative health care system, more responsive to people's needs, began to be articulated. (81)

Yet such campaigns, as activists realised, could not affect the operation of cash limits at national level.

Of course, campaigns around non-economic issues are not always entirely altruistic. For example, in the late 1970s both COHSE and the Rcn fought vigorously against a proposed reorganisation of mental handicap services which would have caused a shift towards local authority, community based services, with a declining role envisaged for hospital-based nurses. COHSE and the Rcn alike were motivated mainly by concern about the career prospects of their nurse members. (82)

The dilemmas facing unions - and professional associations - in the long stay geriatric, psychiatric and mental handicap sectors, are difficult ones. Members who pay subscriptions do so expecting their organisation to protect them if accusations of neglect or ill-treatment are made. This can easily push organisations into a purely defensive stance. However, COHSE members at Normansfield mental handicap hospital in Middlesex went on strike to call for the dismissal of Dr Lawlor, a consultant at the hospital, dissatisfied with his treatment of patients and staff. The official Report, though critical of the strike, confirmed many of their accusations and, as a result, Dr Lawlor was relieved of his post. (83)

As we have seen, from the end of the 1960s and through most of the 1970s, trade unions in the NHS were riding on

the crest of a wave that seemed, with each new development, to rise higher. From the election in 1979 of the right-wing Government of Mrs Thatcher, that progress was checked if not reversed. Mrs Thatcher came to power partly as a result of the fact that public sector workers in the NHS and local government had rebelled against a further stage of incomes policy imposed by the Labour Government of Mr Callaghan. The 'winter of discontent' 1978-9 brought many public service workers out on strike against the Government's 5% policy. In contrast to previous occasions, they found very little media support for their actions. Public sector workers had since 1976 been the target of much criticism from monetarist economists who claimed that featherbedded jobs in the public sector had 'crowded out' investment in Britain's 'productive base'. The critical media attention given to the militant actions of public service workers and the alleged effects on patients flowed naturally from the dominant view that these workers were in any case a burden. The manipulation of these feelings helped Mrs Thatcher to power.

The 'winter of discontent' was portrayed as the result of the irresponsible and unfeeling trade unionists in the NHS and elsewhere, who thought nothing of putting patients' lives

at risk. After the election, a favourable atmosphere existed in which to begin to try to dilute the strength of NHS unions. The Government found natural allies in many consultants, who had resented the 'interference' of ancillary workers' unions in their 'right' to practise privately within the NHS, and local management resentful at the loss of prerogatives. They were also joined by professional associations like the Rcn who seized the possibility of making significant membership gains by associating with the new anti-union mood.

The result was a much tougher management response to a number of significant disputes that occurred immediately following 1979. For example, there was a rise in the number of disciplinary cases against union activists and a number of hospital work-ins against closure were forcefully ended. Two nurses were disciplined by their professional body, the General Nursing Council, for taking part in industrial action during the 'winter of discontent'. The Government's general approach was embodied in the Employment Act 1980 which, among other things, restricted picketing to the immediate place of work and (in an associated 'Code of Practice'), limited the numbers who can take part to six. As far as the NHS is concerned, the DHSS, late in 1979 issued Circular HC(79)20 encouraging local management to



send home staff who take industrial action short of a strike, or to dock their pay accordingly; and to make use of volunteers or agency staff in order to break disputes. The circular produced a hostile response from health service unions, who described it as 'provocative' and a 'scabs' charter'. Shortly afterwards, the Government made it plain through a secret circular sent to Regional Personnel Officers that workers in a 'managerial' position who actively participated in union activities exposed themselves to the risk of disciplinary action.<sup>(84)</sup> Given the infinite gradations of rank to be found in the health service, this implied an effective proscription against the majority of its staff.

The tide at the end of the 1970s was running against trade unions. There was some loss of membership, COHSE in particular losing some nurses to the Rcn, whose growth and recovery was quite dramatic. In 1976 membership of the Rcn was only 86,000, yet by the end of 1980 it had more than doubled to 177,500. Undoubtedly its opposition to industrial action was an important factor.

It would be hasty to conclude, however, that trade union numbers and influence are permanently on the wane.

The industrial action of 1979 led through the Clegg Commission on Pay Comparability to large increases, at least for skilled and white-collar workers. The gap between public and private sector earnings was closed.<sup>(85)</sup> Nalgo's health service membership as a result continued to increase for some time. Certainly the health service unions have not yet suffered the dramatic defeats and losses of some traditionally better organised groups, such as car workers, dockers, and steel workers. Despite cuts and the growth of private health insurance schemes, the NHS is not yet in decline, though it is more than a little frayed at the edges. It could be argued perhaps that the health service's public popularity (which is still strong) to an extent protect it. There is no room for compacency however. The 'winter of discontent' perhaps showed the limits of fighting a traditional trade union campaign in a human service setting. If health service unions are to recover their strength, they will have to find ways of mobilizing rather than alienating the support of working class people using the service. In taking public support for granted health service trade unionists have often failed to be sensitive to the negative as well as positive experiences that ordinary people have of the health service.<sup>(86)</sup>

By 1985, health service trade unionism had maintained itself. The pay campaign of 1982 served for the first time to unit all grades of staff in a single cause. That dispute, eclipsed though it was by the Falklands War, showed in its conduct that some of the lessons of the 1978-9 'winter of discontent' had been learnt. One consequence was that authority for the conduct of the campaign was centralised through the Health Service's Committee of the TUC. Massive <sup>action</sup> solidarity for the health workers' cause was taken by outside workers. In the end, though, the TUC backed away, in the face of a newly re-elected Conservative Government, and from the political implications of its campaign. The alternative was considerable demoralisation, for the dispute was a failure. The 12% claim was not achieved, and nurses were split off to be catered for in future by pay review machinery similar to that already in existence for doctors and dentists. The Government was able to seize the initiative by centralising authority within the NHS (e.g. by replacing Chairpersons of RHA's and DHA's, and the appointment of general managers, many from outside industry). It is now, at the time of writing, seeking to force through 'privatisation' of many ancillary services, to undermine union strength and nationally determined pay and conditions.

How nurses are reacting to this is as yet unclear.

Poorer standards in ancillary services are intensifying their working conditions and the Review Body Pay levels are still low. Many are worried by the continued decline of the NHS. Yet longstanding conservatism, and understandable reluctance to put patients at risk, continues to act as a powerful constraint. The approach of unions like COHSE and NUPE, at least at central level, now appears to place most hope on achieving a future Labour government, and little enthusiasm exists at the moment for mounting aggressive campaigns. Unions are very much on the defensive within the NHS.

My researches into trade unionism among nurses began during the pay dispute of 1974. I examined its impact at three hospitals in the West Midlands, and followed the developments here and at other hospitals in the following year. I wanted to see how and why a particular hospital responded to the national dispute in the context of its previous, or non-existing traditions of trade unionism. I also wanted to see whether mobilization around a national dispute had an effect subsequently upon the development of trade unionism organization and collective bargaining at the local level. The theoretical framework, as mentioned in the introduction to this thesis, was clearly the dominant Warwick approach to industrial relations.

These fieldnotes are attached as appendix to this volume. In this chapter, I seek to summarize their findings, in part within the terms of the theoretical framework under which they were collected, but also in an attempt to grope towards the 'situated' approach advocated earlier. I have tried to do this honestly, within the limitations of the data. As far as possible I have indicated where I think I am speculating from, rather than drawing conclusions from the evidence available to me. At the very least, the material provides a deeper understanding of the complexity of the national pay dispute of 1974, and the events in the following year or so, as mediated through the experiences of workers at a number of hospitals.

### 1. Summarising the Case Studies

I visited eight hospitals during the period of field research 1974-5. This included one new District General Hospital with all disciplines on site (Walsgrave Hospital, Coventry); an older District General Hospital (East Birmingham); a London teaching hospital (Kings College); a long-stay Geriatric hospital on the outskirts of Coventry (High View); an urban mental illness hospital (Highcroft, Birmingham),

and a rural one (Hatton Hospital, Warwick); and an urban and a rural mental handicap hospital (Chelmsley, Birmingham and Lea Castle near Kidderminster). In addition I also made a brief visit to New Cross Hospital, Wolverhampton. The case studies therefore represent a fair cross-section of types of hospital. With one exception (Kings College) they were all situated within the West Midlands which, I will suggest later, may be of some significance. I did not include community nurses within the scope of my study as I felt I was already overreaching myself and also that they merited separate study.

### THE GENERAL HOSPITALS

#### Walsgrave Hospital, Coventry.

This was in reality not a single hospital, but three separate hospitals on a single site: general, maternity and psychiatry. The hospital was scarcely five years old when I conducted my research there. Trade unionism among nurses had been introduced into the hospital by the trained psychiatric nurses, most of whom had previously worked in more traditional mental hospitals. The Branch Secretary of COHSE was one of these, a Charge Nurse in his 'thirties. These formed the COHSE 'loyalists' who set about recruiting the untrained nursing auxiliaries, primarily women, who formed much of the staff of the unit. The newly-formed Branch was also able to make 'recruiting raids' into the two other units on the site. They recruited a 'key' nursing auxiliary on nights in the maternity unit, who was able to persuade many of her colleagues to join COHSE. They also recruited a militant learner nurse, an Rcn dissident, who had become disillusioned with the College's lack of militancy in the 1974 pay dispute. As the only organisation taking official industrial action, COHSE appeared to be a much more dynamic organisation. She was able to bring in some of her fellow learners, but very few trained staff on the general side,

The Rcn was the dominant organisation among this group, and the militant learners became isolated when the local Rcn leadership disowned their activities.

The dominant group in the COHSE Branch - the male mental nurses - were, with the help of regional official keen to recruit the students, at the same time as they were determined to control them. The charge nurses were in positions of authority in the hospital, and looking for more upward mobility. They did not want to get the Branch a 'bad name', particularly since it had not yet achieved full recognition. There were also unspecified fears about the activities of left wing organisations and their influence among the learners. The process of control was achieved smoothly without the learners themselves being aware of it.

The cautious approach of the Branch leadership was seen in their approach to industrial action. They refused to cooperate with the opening of further wards in the psychiatric unit. This had a big publicity impact, but in fact would not have been possible in any case because of staff shortages. They sought in every way to display their 'responsible' approach to management. This appeared to have been influenced by the values of the dominant group within the Branch; their uncertainty regarding the cohesiveness of the staff group within the Psychiatric Unit; their desire to win acceptance from Unit management, and also to appeal to a wider community in the general hospital which, they assumed, was non-militant.

This approach to building a trade union at local level can perhaps be compared to building a house of cards. The activists proceed carefully one step at a time, in trepidation that any sudden movement might ruin all previous efforts. It is an approach associated with circumstances where union cadres feel their legitimacy is problematic

with both management and the mass of workers. It is therefore understandable that the activities of the militant learners were perceived as a threat to the success of this strategy. The latter's approach, by contrast, was based on a high degree of mass mobilization, by which support was built and authority challenged. Much more like erecting a circus tent - coordinating the efforts of everyone into a strenuous attempt to achieve a single object in a short space of time.

The different strategies derived from different experiences of the world: of position in the organisation and world at large, of having learned to compromise. And behind these experiences, different material interests. The 'established' staff group within the union were concerned to preserve the gains they had already made. The 'dissident' learners were much more prepared to take risks with the future. The cautious approach eventually won out, partly because the learners bowed to what was felt to be the superior experience of the dominant group within the Branch. They continued, however, to adopt a more activist approach to building the branch, seeking issues on which to mobilize support for the Union in the General hospital. They do not appear to have enjoyed much success, perhaps because in this sector their base was too confined to learners. They did not succeed in winning over any significant 'opinion leaders' among the trained staff.

By 1976 the Branch was firmly established and, in limited ways, was tackling local issues. It had secured the loyalties of most trained and untrained nursing staff in Psychiatry and untrained nursing staff in Midwifery. It was an alternative to the Rcn among general learners, but not trained staff. The Branch did not seek to recruit non-nursing staff, as this would have antagonised NALGO and NUPE, which was contrary to the approach of the COHSE Branch Secretary, who also



extended his caution to this area. The trained psychiatric nurses were already predisposed to support COHSE or were in fact members as a result of previous work experience in traditional mental hospitals. The nursing auxiliaries were also predisposed to trade unionism. They were excluded as 'non-professionals' from the Rcn and the Royal College of Midwives (RCM). Many were part-timers, who were married to men in the highly unionised local car factories. Their own position in the organisation and experiences outside it, inclined them to favourable attitudes to trade unionism. They had not, by 1976, become active in positions of responsibility in the Branch. They deferred to the more experienced male trade unionists, in circumstances where as part-timers or on nights - and as women - there were powerful barriers against their full involvement. High turnover also prevented more participation. It is not perhaps surprising that few trained staff in the General hospital defected to COHSE. As a new, 'high technology' hospital, one would expect commitment to a professional association to remain strong enough to resist at least the initial challenge from trade unionism. Some of the learners in a contradictory position as students and workers, but without an established position in the hospital, embraced trade unionism more wholeheartedly. It could be argued that the union served to integrate, control and deaden the potential for change that was contained within their movement. On the other hand the dominant group within the COHSE Branch did 'take on' the learners and seek to involve them in its affairs, albeit for opportunistic reasons of building membership. The Rcn branch, on the other hand, rejected them altogether.

An interesting sequel to this account is that by 1985 the chief officials of the COHSE Walsgrave Branch were both women auxiliary nurses. The process by which this 'handover' took place is in fact the subject of further research being undertaken in collaboration with others.

High View Hospital, near Coventry

This was a small long-stay geriatric hospital situated within a mining community on the outskirts of Coventry. An adverse report on subsidence had placed the future of the hospital in doubt, but the staff felt that this was a pretext. They suspected that the Coventry Health Authority wanted to transfer all beds to a proposed new Geriatric Hospital on the Walsgrave site.

The COHSE branch was mobilized around the defence of the interconnected work and residence community. Many of the staff, trained and untrained, were married to miners. They had strong attachments to the patients, many of whom they had known for a considerable time. Some of this seemed paternalistic, even proprietorial, but genuine enough. The move to a Walsgrave site would have been difficult for staff, in terms of travelling times, but they also wished to preserve their work community as something of value in itself. They contrasted the ethos of their hospital with that of the Walsgrave, which in their eyes represented the new reorganised and impersonal NHS, which was threatening the continuation of their community.

It is hardly surprising that it was hard to discern the divisions that had been so noticeable on the Walsgrave site between specialty, gender, experience and qualifications. The homogeneity of the work, its low status in relation to dominant forces within the nursing community, the threat to the existence of the community, all served to fuse their sense of a single community of interest, which became embodied in the COHSE Branch. Membership spread rapidly among the nurses at the hospital as they looked to it to preserve the group, a process in which the Union's Regional official played a key role. The aim of the union in such circumstances is naturally to defend what is already there from external attack. The most appropriate metaphor is therefore that of the medieval siege. In many such hospitals threatened with closure

this metaphor has become almost a reality, as staff occupy them in a last-ditch attempt to prevent closure.

In this particular instance, the COHSE Branch fought a highly successful campaign. A large part of their success stemmed from their ability to draw upon wider support in the community - including the local NUM Branch, and the Constituency's Labour MP. The link was in some instances very direct in that husbands were often involved in the wider labour movement, and helped mobilize support. The campaign was also a positive one for the participants as an event in itself. They discovered a latent sense of solidarity in action, learnt skills of political campaigning and began to overcome their occupational isolation. A number of the women commented on these aspects of the campaign.

By 1985 the hospital was still open, and had even been upgraded. However, it was still under threat of closure, in a service which had been squeezed by years of cash limits.

#### East Birmingham Hospital (EBH)

The EBH was really two separate hospitals with rather different traditions. A larger and considerably expanding district general hospital, and a smaller and rather static chest hospital.

Attempts to unionise the nurses at the EBH extended at least as far back as the 1950s when some qualified male nurses sought to organise a NUPE branch. They had entered nursing as a career through wartime experience in the forces. They did not get very far as the Matron was implacably opposed to trade unionism. Success came in the 1960s when Irish psychiatric nurses, seconded for general training, managed to get a permanent COHSE Branch off the ground. A number of factors were responsible for their success. They went out of their way to reassure management of the compatibility of trade unionism with the

maintenance of authority. The male nurses themselves also felt relatively secure. Since they were seconded, they were not formally accountable to the management of the EBH but to the psychiatric hospitals which sent them. They could not therefore be victimised for what was regarded as normal activity in their home hospital. The hospital itself was expanding, and relations becoming more impersonal. The 1960s was also a period during which nurses' pay became squeezed by successive incomes policies. These forces continued to exert an influence into the 1970s, when COHSE's recruiting activities were also aided by DOCAS (Deduction of Contributions at Source), which relieved activists of the responsibility of constantly having to chase up members in arrears. The grouping of hospitals together and the Salmon reorganisation of management (it was one of the first hospitals in the country to go through it) appears to have had a favourable effect on membership growth. Relationships became more impersonal, and authority shifted from the hospital. In such circumstances nurses at the EBH began to look increasingly to unions to 'protect' them in a changing health service. This reflected their general sense of vulnerability as employees who, though nominally independent professionals, were subordinated as employees to higher management.

This growing sense of insecurity and need for 'protection' helped to build the Union at the EBH. Help with individual problems is only available to members, who then become 'indebted' to the activists. The Branch Secretary, a nursing officer, concentrated on individual casework as a means of demonstrating what the Union could do. He was ambitious in career terms, and preferred to play a low profile so as not to jeopardise his chances. Perhaps, though, this was the best way to carry the Union forward among nurses at the hospital.

The nurse membership was highly unstable, largely because of staff turnover. Untrained staff left under the pressure of the work. Learners either left before completing their training or moved on after qualifying. For such reasons the male nurse activists in COHSE sought to stabilize membership by recruiting among ancillary workers. This was successful - it became one of the largest COHSE Branches in the Region. However the growing militancy of ancillary workers culminating in industrial action in 1972-73 put the male nurses' 'softly-softly' union building strategy at risk. The Branch only just managed to survive the traumas of that experience.

There was also an active Rcn branch at the hospital. Interestingly, this too was dominated by male nurses, who were rising to rapid prominence in senior nursing positions. The District Nursing Officer was male, and a former psychiatric nurse. Learner nurses tended to join the Rcn, which controlled recruitment channels in the training school. They had a separate, and apparently ineffective representative Council. The Rcn however found it difficult to retain their loyalty once they qualified. The Student Section was more social than union oriented, organising dances and other activities. When nurses qualified, they often lapsed their membership of the Rcn. At this point they became particularly ripe for capture by COHSE activists, as they became permanent members of the hospital's workforce.

By 1977, the Branch had grown to 700 strong and had passed into the more militant leadership of a (male) left wing learner nurse. However, it did not seem that the basic individual 'casework' approach to the problems of nurses had changed. Membership was stronger in terms of numbers, but as a group they were rarely active as a collectivity. This may be due to the fact that though technical and managerial change had reinforced their status as employees it did not necessarily

precipitate a strong sense of collective identity. What problems they experienced as employees were experienced as individual problems and a solution was sought at that level. The Union had established a solid reputation as the organisation best capable of dealing with such problems. This mode of trade unionism contrasted dramatically with that displayed by the ancillary workers in the COHSE Branch, where changing work methods and management had led them to seek a collective solution to what were perceived as collective problems (e.g. the operation of the domestics' bonus scheme). Much of the new Secretary's time was therefore taken up with ancillary matters.

#### Kings College Hospital, London.

Teaching hospitals have traditionally been poorly unionised with levels of collective organisation low among all levels of staff, not just nurses. The charitable traditions created an ethos of paternalism which survived long after they had been absorbed into the NHS, and this was an important mechanism of control over ancillary staff. For nurses, the position of the training schools, as means of access to senior positions in the nursing world, and their subsidiary function as marriage markets, seemed to attract recruits from a 'superior' class background. Once they arrived, the training school would further reinforce notions of elitism. Loyalty to the training school was the prime ethos. Even now, one of the first questions a nurse asks another on meeting for the first time is 'where did you train?'. (It happens to me all the time!) And loyalty to the training school is also seen as highly compatible with membership of the Rcn. Joining its student section is almost part of student nurse initiation rites. And since those who obtain ward sister and managerial positions in the teaching hospitals are regarded by themselves and others as at the pinnacle of the profession, it is not surprising that membership of the College has always been most solid in such hospitals. This pre-eminence,

however, began to erode in the 1970s, and Kings College Hospital was one place where trade unions began to make greater headway among nurses and all grades of staff. Why did it occur at this particular time?

The evidence presented here relates to one London teaching hospital. Some of the factors responsible for unionisation among nurses at the hospital are particular to Kings College Hospital (KCH) while others are connected with changes at other London teaching hospitals, and indeed hospitals generally. Thus learner nurses at KCH were aware that the hospital's reputation was that of the 'poor relation' of London teaching hospitals. They were some way down from the peak of the status hierarchy and their relatively inferior canteen facilities and living conditions seemed to reflect that fact. It was among the learners and younger trained staff that trade unionism spread at the hospital, and canteen facilities were the first point of focus for the growing militancy which in the following year erupted into the 1974 pay dispute. In the history of nurse's protest activity, among both general and psychiatric nurses discontent over food and living conditions has often seemed symbolic of deeper discontents at the way they have been treated.

The fact that the largely spontaneous militancy was turned into semi-permanent trade union activity was largely fortuitous. A young theatre sister, a socialist, already committed to trades-unionism, played an important role in its development, and recruited many of the militant learners to NALGO. A further impetus for the trade union militancy of the nurses was the demonstration effect of the ancillary workers' militant campaign against low pay, culminating in strike action in 1973, as part of their national dispute. The NALGO Secretary and others organised solidarity actions, which included standing on picket lines in nursing uniform. Although their campaign was not

immediately successful it showed that poor pay and conditions need not be permanently suffered without complaint.

Nor should the influence of left wing groups at the hospital be underestimated. In the early 1970s organisations like the International Socialists (IS) and the International Marxist Group (IMG) succeeded in gaining influential positions in newly organising sectors, like hospitals, while they often enjoyed less success in already organised sectors. They were able to take advantage of the power vacuum that existed in the absence of established collective organisation and were particularly influential in large urban centres like London, Bristol and Manchester. They were a force helping to promote unionism and militant action even though they were not the primary cause of it, and were influential at KCH.

Another not inconsequential factor was the high visibility of activities at the hospitals to the media and its proximity to the nation's political institutions. The media took a considerable interest in the activities of militant learners, in the process helping to amplify their campaigns. Parliament and the DISS were just a stone's throw away from the hospital. It was easy to mount demonstrations and the nurses at the hospital began to feel they could actually influence events, especially when the campaign over canteen prices led to reductions.

As the militancy grew, the NALGO Secretary was able to push forward the idea that trade unionism would be a more appropriate solution to the problems they experienced, by laying much of the blame on the Rcn. As the 1972 leaflet 'Who Speaks for Nurses?' put it disparagingly:



"They seem determined that RCN should read "Real Cheap Nurses". The reality of 1972 is that no-one speaks for nurses. For years we have been the lowest paid professional group, and our future wage prospects are sure to keep us at the bottom. Yesterday's platitudes and cliches about "dedicated" nurses are no longer relevant or acceptable as excuses for our low pay scale. Today's nurses are just ordinary people doing a hard day of work. Professionalism means nothing unless we are paid as professionals. We still have rents to pay, food to buy; and status is no substitute for cash" \*

The final section of the above quote draws attention to the material pressures nurses were under. The inadequacy of nurses' pay was probably particularly apparent to those living and working in the capital, where the cost of living was high. It served to unite sections of the younger trained staff (like the NALGO Secretary herself), and the learners, in a common cause.

Apart from pay the biggest issue pursued by the Union was its campaign against agency nurses. NALGO argued that their employment was a false solution to problems of staff shortages as it perpetuated low pay for directly employed staff. The union also argued that it created problems for permanent ward staff, and made continuity of care difficult. In wider terms, the Union saw the growth of agency staff as a futile response to a growing crisis in the NHS - as represented not just by staff shortages but the intensification of work for those staff that remained, following upon rising technical standards and more rapid throughput of patients. As their leaflet 'NHS in Crisis' put it:

Widespread unrest and disillusionment is growing in all London hospitals and throughout the entire country. \*\*

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\* Full text of leaflet in Appendix

\*\* Full text in Appendix

Management were generally unprepared and taken aback by the growth of nurse militancy. Highly conscious of the considerable public sympathy for the nurses they had made concessions (e.g. by reducing canteen prices) and had sought to stabilize the situation by formalizing negotiations. They therefore reacted defensively to NALGO's campaign to phase out agency nurses, particularly since it was backed up with the threat of industrial action (refusing to work with agency staff) supported by NALGO's NEC. Management agreed to limit the number of agency nurses to 190, even though this involved closing six wards.

The NALGO Branch made some efforts to contact the agency nurses themselves. They asked them in a letter to rejoin the NHS and fight alongside them for the 55% pay increase:

"What we are fighting for is a realistic wage for all nurses. Many nurses are forced to leave the health service and work for agencies because of poor pay, particularly in London where the cost of living is so high that it is almost impossible to live properly on the pay of the national health staff nurse." \*

However, the letter pointed out agency nurses lose hard won rights such as sick pay, superannuation, job security and promotion: 'The only people who really benefit are the agencies'. It urged agency nurses 'to join with us, and fight with us' by taking a post at the hospital, warning them nurses would refuse to work with them and ancillary workers would refuse to enter wards where they were employed. The letter in reply from a group of agency nurses asked them to reconsider the proposed action as 'we find this most distressing for nurses to fight against nurses', and declared that 'we do not intend to enslave ourselves under such severe hardship with the present pay scale'.

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\* Full text of letter in Appendix

Not everyone on the left in Britain supported the campaign against agency staff, though most did. The exception were the black militants on the periodical Race Today. They argued that many of the agency nurses were black, and were turning to agencies as a means of freeing themselves from the constraints of the hospital hierarchy. (1) The letter from agency nurses quoted above emphasised low pay as their prime motivation for leaving NHS employment, but that does not necessarily totally contradict Race Today's argument. It does illustrate that the alienation of black nurses led them to choose this route as a solution rather than trade unionism. However, NALGO KCH was the one Union Branch where I found black nurses were well represented in positions on the Branch Executive. I did not find the racism that was certainly noticeable in a number of other hospital union Branches (such as EBH and Central Hospital).

KCH was not typical of the other general hospitals I visited because it had sustained a high degree of activism and campaigning, over a long period of time. This did not mean, however, that the Branch neglected the individual casework that seemed to dominate other hospital union branches. Relations with ancillary workers' unions were good. NALGO had supported them during the 1973 ancillary workers' dispute, and nurses in turn received considerable support for their campaigns. NALGO fully participated in the joint Shop Stewards Committee that had recently sprung up at the hospital.

As at other hospitals, managerial change and restructuring formed the background to the growing trade union militancy. The re-organisation of the NHS in 1974 had finally integrated the teaching hospitals fully into the NHS administrative structure. The previous direct channels of influence between the teaching hospitals and the DHSS were now removed. Following upon this the report of the Resources Allocation Working Party (RAWP) led to the redistribution of

resources away from teaching hospitals to less well-provided areas, in the context of overall cuts in funding. They were therefore beginning to be stripped of many of their long-established privileges. At the time my investigations concluded, these threats were certainly looming on the horizon, but their full impact had yet to be felt. I would conclude that the major impetus behind unionisation at KCH was low pay, exacerbated by the dual pressures of increasingly stressful working conditions (due primarily to staff shortages) and the abnormally high cost of living in the capital.

New Cross Hospital, Wolverhampton.

I made only one visit to this large NALGO Health Services Branch - at that time the biggest in the Union - spread over many hospitals in the Black Country. My remarks are therefore only intended as initial impressions. 800 of the Branch's 2,000 members were nurses, most of whom had joined within the past 5 years. The Secretary was a junior manager - a fire officer - who seemed to have developed the Union partly to build an alternative power position for himself. He was certainly preoccupied with his own status, was a Tory trade unionist, and a magistrate of the 'hanging and flogging' brigade.

His position as Fire Officer provided him with the mobility to travel round and recruit new members. He believed that nurses were standing up for themselves much more than in the past. He saw his prime role as twofold. First, enforcing the rules made by the Whitley system, which local management were often shy in implementing. He was particularly critical of management's ignorance of nurses' entitlements at Nursing Officer level, and claimed that he often went straight to higher management. Second, engaging in caseworks over nurses' individual problems. He cited two successful instances where he had defended nurses. One when a black male nurse on a psychiatric wing

had been falsely accused of sexual relations with a patient. The other where a sister had resuscitated a child, too roughly, according to the relatives. Nurses were joining unions in much greater numbers than ever before, and the growing need for 'protection' against such happenings was a strong motive. As the NALGO Secretary put it: 'Nobody can anticipate when it might happen'.

He was very interesting on the problems of organising nurses. The recent introduction of deductions of contributions from salaries (DOCAS) had considerably eased problems of retaining members. Fewer people than in the past left when subscriptions were raised. It also freed representatives from chasing members in arrears and allowed them to spend more time representing their members. However nurses were still difficult to organise. Learner nurses moved from ward to ward. Staff turnover was generally high and though men retained NALGO membership, women often did not, he suggested. Communications were also difficult when the workforce was spread across a number of shifts and so many staff were part-time. However despite such problems, the branch was still in the process of expansion. Fifty new members a month was 'a bad month', according to the Secretary.

THE MENTAL ILLNESS HOSPITALSHighcroft Hospital, Birmingham.

This urban mental illness hospital situated in north Birmingham had been unionised by NUPE for some considerable time. It achieved national fame as the only hospital to take all-out strike action during the pay dispute of 1974. There was a more or less total 24-hour walkout at the hospital, and the nurses' normal ward work was carried out by teams of volunteers.

Although the militancy was ostensibly concerned with pay, my investigations indicated other underlying concerns. These included the effects of managerial change, and reorganisation, and concern that the hospital was being starved of resources and being 'downgraded' from a psychiatric to a geriatric hospital. Rivalry between COHSE and NUPE was a secondary but in some ways influential factor in the growing militancy of the nurses at the hospital.

NUPE's hold on all nursing and support staff at the hospital had been broken with the formation, early in 1974, of a COHSE branch at the hospital. Despite its official espousal of 'industrial unionism', the driving force behind the formation of the Branch was separatism among some nurses. They felt 'dominated' by ancillary workers in NUPE and were also to some extent influenced by status considerations. Not surprisingly, this released deep concerns about declining status that may have been in the air for some time. The dynamic force behind the branch were male charge nurses. It was this group which formed the core of COHSE support, while nursing auxiliaries tended to remain more loyal to NUPE.

One of the first actions initiated by the COHSE Branch during the 1974 pay campaign was a ban on the carrying out of what were called 'non-nursing duties' - such as buttering bread for patients' tea.

This action tended to antagonise ancillary workers because it increased their workload, and defined what they did as inferior. The nurses, on the other hand, were not just making a statement of opposition to the levels of pay they endured, but were also protesting at the role they occupied within the hospital. They had an image of themselves as nurses, and the responsibility and status that attached the nurse's role, which was not fulfilled through their daily work practice.

If relations to ancillary workers were one point of tension, relations with doctors were another. The COHSE nurses I spoke to were much more likely to view their status vis a vis doctors as problematic, and see union activity as a means of resolving it. There seemed to be a number of factors behind their concern. The ratio of doctors to nurses in psychiatric hospitals is much smaller, the sway of the curative model is less, and nurses play the major therapeutic role. It could also be that gender was also of some significance. It was the male charge nurses who seemed most concerned about their status in relation to fellow male psychiatrists.

The context in which anxiety was expressed was one of rapid managerial change. The implementation of the Salmon Report at the hospital had two effects. It had led to the creation of middle management Nursing Officer posts which impinged on charge nurses. At the same time, with the creation of more senior nursing officer positions beyond the hospital, authority became more remote. This coincided with the absorption of Highcroft Hospital into the North Birmingham Group of hospitals. The reorganisation of the NHS in 1974 also fuelled nurses' anxieties, not just because change in itself generates anxiety, but also because it was believed that Highcroft Hospital was receiving a poor deal. Comparisons were made with the chief

general hospital in the group, which was believed to be receiving more than its fair share of resources. Rumours abounded about the future of the training school, and that District management were seeking to turn Highcroft into a geriatric hospital. This served to fuel the growing anxiety among nurses that their status was in decline.

The strike initiative primarily came from COHSE, with NUPE going along in order to maintain its credibility. The strike itself did not succeed in winning its publicly stated objectives, of spreading the strike among Birmingham hospitals in order to speed up the Halsbury Committee's deliberations. By that time most nurses were resigned to waiting. Yet it had a considerable impact upon local level industrial relations. Union activists began to be taken much more seriously by District Managements, and some extra resources were shifted in the direction of Highcroft Hospital. This in turn disrupted the formal hierarchy at the hospital, for ward staff appeared now to be better informed and to have access to channels of influence denied to middle management level nursing officers. This was a theme which surfaced at a number of hospitals I visited.

#### Central Hospital, Warwick

This was an isolated, rural mental illness hospital towards which the COHSE regional official had guided me as typical of the traditional COHSE Branch. If so, then it indicates that a very low level activity was the norm, for though there was a fairly high density of union membership at the hospital, it was largely quiescent. The Rcn appeared to be largely dormant, with only half-a-dozen members.

As far as I could tell, the Branch Secretary was the Union at the hospital, which at the time of my visit had around 800 patients and 400 nurses, and was continuing on its path of gradual decline.



The COHSE Secretary was a middle-aged charge nurse, originally from Eire - typical of the group which has traditionally dominated COHSE. He was in fact one of the two regional representatives on COHSE's NEC. He lived with his wife, who also worked as a nurse at the hospital, in their house on the rather shabby hospital estate.

He was gloomy both about his job and the prospects of doing anything through the Union at the hospital. He worked on a geriatric ward and seemed to see his role as one of maintaining a warehouse: (2)

Work in mental hospitals is depressing  
and monotonous ... You've gone beyond  
the stage when you notice it. All I'm  
interested in is getting it done smoothly  
and getting the money at the end of the  
week.

He had accustomed himself to the fact that this was as far as he would progress in his job, and was marking time.

This approach seemed to carry over to his activities as COHSE Secretary. There had been a COHSE Branch at the hospital since 1937, but it had been an uphill struggle all the way. There had been a Joint Consultative Committee at the hospital, but it had not worked very well. Discussions over relatively minor issues, such as resurfacing the road outside the staff houses, had dragged on interminably and in the end got nowhere. He thought that the basic problem was that trained staff were 'frightened'. They wanted promotion and in order to get it they had to display blind obedience to the nursing hierarchy, which did not encourage initiative. His wife also agreed that the system encouraged 'yes men'. These were not circumstances in which it was possible to get much collective union activity going. The Secretary felt that if he tried he would not get support from the staff.

His approach to trade unionism was therefore to keep things 'ticking over', not unlike his approach to his job. He did what had to be done -

sought to recruit new members from each new 'set' of learners, represented members on individual matters to management, especially discipline cases. Perhaps not surprisingly, the senior nursing management at the hospital regarded him, in the words of the Senior Nursing Officer as,

"very helpful and considerate. Its because of his personality. We have a happy working relationship with COHSE."

It seemed to me that the Secretary got his prime satisfaction from his external Union responsibilities on COHSE's NEC. These appeared to compensate him for the frustrations he endured in his job and local union activities. Unfortunately for him, he was deposed in the elections shortly after I interviewed him.

The one issue on which he appeared to hold passionate views, was opposition to the growing number of overseas learners at the hospital. In response to staff shortages the management of this hospital, like many of the rural mental hospitals, had sought to fill vacancies by recruiting overseas nurses. His attitudes were, frankly, racist. Instead of seeing that the problems of staffing the hospitals would have been much greater but for their contribution, he blamed them for many of the hospital's troubles. 'They' were responsible for the fact that psychiatric nursing was low paid and of low status (as if these problems did not exist before their appearance on the scene).

There were too many of 'them' - the hospital was 'overloaded' with them, as opposed to the 'permanent' staff. It was clear that he perceived overseas nurses to be a threat to the established culture at the hospital, based on work and residence, and reinforced by age and marital status. The racial divisions at the hospital also extended to separation outside working hours. On the one hand, the dominant white culture of the trained staff, the Union Branch and the hospital estate, and on the other the subordinate culture of the training school and

the nurses' home.

Greater numbers of the nursing staff were being recruited from the towns beyond the immediate vicinity - particularly Leamington and Coventry, and bussed by hospital transport to and from work, The long day from early in the morning to about 9 p.m. was still being worked at the hospital. Such staff seemed to want to do their stint and go. They seemed as unlikely as the staff whose whole life was centred on the hospital to want to get involved in the Union. Ancillary workers were, however, becoming more restive. They had taken industrial action during the 1973 national dispute (and hospital transport had been one of the targets). Most of these workers were, however, in NUPE.

The most prominent prospects for change in the COHSE branch seemed to lie with the learner nurses. They were becoming more active in the Union, particularly around the Halsbury campaign, while the trained staff held back. Most of these activists appeared to be white, but at a local pay demonstration in nearby Leamington, I did notice quite a few black participants of both sexes from the hospital. In fact, within the space of a couple of years, learners had 'taken over' the COHSE Branch. Central Hospital COHSE is the subject of further collaborative research in which I am involved. It will be interesting to see whether and how far the very apparent divisions and problems of mobilization of 1974-5 have been overcome.

THE MENTAL HANDICAP HOSPITALSLea Castle Hospital, near Kidderminster.

This was a relatively new 576 bed hospital, built at the end of the 1960s, and, for a mental handicap hospital, prestigious, as it was the home of the Institute of Mental Subnormality. It was also one of the best organised, most cohesive hospital branches I came across, which was why I was directed towards it by the COHSE Regional official. It had taken strong industrial action during the Halsbury pay campaign of 1974, banning all but emergency admissions, and insisting that these be vetted by the Union branch. I soon discovered that the militancy over pay had been preceded by a tussle for control at the hospital over shifts between ward staff and nursing management, which the union had won. It was this that had provided the cohesion. But underlying the pay militancy itself were deep anxieties about the present and future status of mental handicap nursing, which provided the material basis for the strong sense of unity among the nurses.

Both NUPE and COHSE were active at the hospital and there were agreed spheres of influence, with COHSE monopolising nurses and NUPE ancillary workers. As far as I could tell, there was little poaching by either organisation. The COHSE branch included learners, nursing assistants and trained staff, but it was the last group which dominated the union. The Secretary was a ward sister who was also a Labour Councillor. She was the driving force behind the Union, an energetic and charismatic individual. The Chairman was a Charge nurse. Most of the organisation at the hospital was informal. There were two stewards on each shift at the hospital and communications were maintained through the internal phone. Meetings were only held when there was a crisis that demanded mass participation.

The recent trial of strength between ward staff and management had, everyone agreed, 'made' the Union. Senior management had sought to impose a new shift system without consultation, which would have made life difficult: particularly for those married staff who worked opposite shifts to each other. The staff refused to work the new shifts, and the COHSE branch organised its own rotas and virtually 'ran the hospital'. The management caved in, and the experience of control seemed to have lifted the ward staff's morale generally. One consequence was the creation of a much more dynamic Union branch. They now regarded themselves as the COHSE Branch which 'showed the way' to others in the region.

There was no doubt that as a result local management now took them very seriously and treated them very gingerly. Since the recent reorganisation of the NHS, district management had now stepped into the breach in order to deal with the militancy. This, as at other hospitals I visited, enhanced the power of the Union in relation to hospital management. The medical staff seemed sympathetic to the nurses' cause, but critical of their decision to take industrial action. But it was muted criticism, and I got the distinct impression that they rather feared the nurses.

Although the COHSE Branch was led by sisters and charge nurses, there did not seem to be the deep rifts among levels of staff that were apparent at some other places. Most of the charge nurses/sisters were from the locality, though some were passing through. The Nursing Auxiliaries seemed well integrated into the ward team, and shouldered most of the care. They had received in-service training and appeared to carry considerable clinical responsibilities. They were all local, recruitment depending - according to the nurse manager - on the state of the local carpet industry. She also suggested that the lack of

divisions might be due to the fact that ward sisters and charge nurses at the hospital did not remain aloof from other grades.

The group who did not seem quite as integrated into the ward culture were, perhaps not surprisingly, the learners. The Union was strong in the training school, and many learners joined COHSE. On the whole, however, those to whom I talked did not tend to see the Union as an avenue through which to articulate grievances and sort out problems. Some apparently wanted to break with COHSE because, as a tutor put it, they felt it was a 'charge nurses' union'. There was some Rcn membership among learners, which seemed to some extent to be in reaction to this image of COHSE. It was clear from what some of them said to me, that they experienced real difficulties on some wards and felt hesitant about raising them with permanent ward staff (see Volume 2, pp. 225-29, and 244-49). Management had, however, made some attempt to deal with their problems by creating special 'training wards'. Students I talked to were also often full of praise for the COHSE Secretary, as a good and sympathetic ward sister.

This relative degree of unity did not mean, however, that organising across the hierarchy created no problems for the union. It appeared to be particularly problematic over the question of ill-treatment of patients, which was a sensitive issue at the hospital. A News of the World reporter had recently worked secretly as a nursing assistant on the wards, and made accusations that patients were being ill-treated by trained staff. The union activists I spoke to were angry that he had operated by subterfuge, and also at the way, in their view, that nurses were being scapegoated for poor conditions. But they were also concerned that the union should not be seen to be condoning cruelty. The problem was that in such circumstances the Union was being asked to represent one member against the accusations of another. At the same time, COHSE pushed the need for 'insurance' and 'protection' as

reasons for joining the Union, so was placed in a quandry<sup>a</sup>.

However in one instance recently where the Branch were certain that the accusations were justified, they had recommended to the region that the Charge nurse concerned should not receive the Union's legal protection. My guess was that the Branch's sensitivity to media exposure was an influential factor.

The issue of ill-treatment was only one area where the problems of organising across the hierarchy were manifest. At this hospital, I felt that it was particularly problematic for learners, as only temporary members of the ward team, to use the Union to raise their problems. It was not just that COHSE was a 'charge nurses' union', as some of them undoubtedly felt, but that permanent ward staff, trained and untrained, formed a united bloc from which they sometimes felt excluded.

There was, however another issue which united the learners with the trained staff - one which untrained nurses were less concerned about. That was the whole future of mental handicap nursing. It was a topic which evoked strong feelings and which appeared to be central to the nurses' sense of group identity. They felt themselves to be a group at bay, misunderstood and looked down upon by members of the public and other nursing specialties, and accused in the newspapers of ill-treating patients. The growth of community care threatened to leave them with a 'rump' of difficult and severely handicapped patients to look after, while the growth in influence of physiotherapists, teachers and psychologists was undermining their position in the hospital. But what they found most threatening was that the value of their qualification - Registered Mental Nurse (subnormality) - had been put in doubt by the proposals of the Briggs Report (1970), on the future of nurse training. This had questioned the value of nursing, with its emphasis on hierarchy and uniforms, as a basis for the care of

the mentally handicapped. Instead responsibility for care should be shifted progressively to social services, and the training of workers to the Central Council for the Education and Training of Social Workers (CCETSW). This had recently been followed up by the incoming Labour Government of 1974, by the appointment of the Jay Committee to consider in detail the future of mental handicap nursing.

The COHSE activists rejected this approach absolutely, and its insinuation that nurses were too authoritarian, could not reproduce a home like atmosphere in the hospital, and were not suited to care for the mentally handicapped. With some justification, they claimed that conditions in some hospitals rather than the quality of the staff were the roots of the problem. But it did seem to me that there was too unflinching refusal to face up to some of the valid criticisms that might be made of hospitalisation and the 'nursification' of the care of the mentally handicapped. Be that as it may, the nurses at this hospital were determined to use their union to fight for what they saw as the future of their profession. In the short term, they appeared to have had some success. The nurses at Lea Castle were highly influential in formulating COHSE's uncompromising 'anti-Jay' policy, which formed the basis of the critical Minority Report to Jay, submitted by David Williams - then COHSE's Assistant General Secretary. This, combined with pressure from the nursing press and other organisations like the Rcn, led to the shelving of the Jay Majority Report's proposals. Whether such a purely defensive stance is tenable in the long term, is, however, another question. Yet Lea Castle nurses had been influential in preserving in the short term the status and integrity of their group.



Chelmsley Hospital, Birmingham.

The COHSE Branch at Chelmsley provided interesting points of comparison and contrast with Lea Castle. It had been growing rapidly in recent years, and was in some ways just as 'militant', if not more so, over defensive issues. But there the similarities seemed to end. The focus of the Chelmsley Branch was much more local. They did not seek to engage in a cosmopolitan crusade to defend mental subnormality nursing, only what they defined as the immediate interests of the local group. This was defined as wider than a nursing community of interest. It encompassed all workers at ward level, for at this hospital COHSE was the chief union for both nursing and ancillary staff. As the Secretary put it, the Union was based on 'the lower dog'. Sometimes this community of interest was extended to include local nurse managers who, however, had their own separate 'Officers and Sub-Officers' Branch, as provided for under COHSE's rulebook. Although one cannot be sure, I think the differences were probably due to the fact that Lea Castle was a much more prestigious hospital, and also that as a newer hospital many of the staff at middle to senior positions were much younger. As we shall see 'age' figured very prominently as an issue at Chelmsley Hospital.

Chelmsley is one of the older generation of mental handicap hospitals. Though it does not date back, as a mental handicap hospital, like some do, to the 19th Century, its buildings do. It began life as a boys' orphanage in the 1880s, and was adapted into a 'mental deficiency' hospital during the 1930s, when the eugenicist 'moral panic' over mental handicap was at its height. (3) At that time, Chelmsley was an isolated rural asylum, but the post 2nd World War growth of Birmingham has now engulfed it. The hospital is now adjacent to the huge, bleak Chelmsley Wood housing estate, from where many of the ancillary workers and untrained nursing staff are recruited.

From early on the hospital was organised as a rigid hierarchy. Jobs were at a premium because of the economic depression, and this gave management the upper hand. Some of my most enjoyable research moments were spent talking to staff who had worked in the institution at that time. I learnt, for example, that every worker had to bring a skill with them to contribute to the hospital community. Some were cinema pianists made redundant by the arrival of talkies! They often continued to practise their skills. As 'nurses' their main job might be to supervise patients' bricklaying gangs.

There had been a COHSE branch at the hospital since the 1930s, but it had not been very active. The Matron had been very powerful. It appears that even the medical superintendent was a bit frightened of her, and she had certainly intimidated the nursing staff. As one long-serving nurse told me: 'The matron's left but her ghost is still here' - indicating that staff were still a bit nervous about sticking their necks out.

The COHSE Branch at the hospital had in fact been languishing until the past few years when it was taken over by a male, middle-aged charge nurse, who built it up from around 70 to around 350 members at the time of my visits. It had also expanded into a nearby maternity hospital. Management had tacitly recognized his union role by appointing him to a ward which was virtually a hostel. His charge nurse duties were very light and he could devote much of his time to union activities.

Some of the issues which had created anxiety at Lea Castle, also surfaced here. For example, accusations of ill-treatment of patients, made recently by the hospital's League of Friends, had obviously created tensions. The fact that the Secretary was often asked to represent one member against another also perplexed him. The example he cited was of circumstances where working relationships had obviously

broken down. His approach was, where possible, to leave such matters to the personnel Department to sort out.

He described his approach to building trade unionism as that of 'chipping away'. He preferred not to take an antagonistic approach to issues, but that did not mean that he was not prepared to exert relentless pressure. It seems clear that since he took over, COHSE has had an impact in improving conditions for staff at the hospital - for example in getting the pathway to the canteen from the wards lit for the benefit of night staff. It is through such definite, if small changes that the union at the hospital was built. The branch also had a well developed system of fifteen stewards, who could take up immediate issues of concern to staff.

The generally cautious 'chipping away' approach of the Branch did not, however, preclude militant action when members felt the circumstances demanded it. Ancillary workers had taken industrial action during the national pay dispute, and this had generated some tensions with nursing staff. The nurses themselves had participated in COHSE's programme of industrial action during the 1974 pay dispute. But the issue which had generated the most heat, and which seemed to define COHSE's character at the hospital more than any other, had been the concerted opposition to senior management's attempt to introduce a policy of compulsory retirement for all staff on reaching 70.

In common with other hospitals I visited during my researches, authority at hospital level became eroded by the introduction of the Salmon system of nurse management, and the grouping of hospitals that culminated in the 1974 reorganisation. At Chelmsley this process unsettled well-established and rather paternal relations among ward staff and nurse managers. The new senior nursing officer was an 'outsider', a young 'whizz kid'. He fell out with his deputy, a long serving member of staff regarded as a kind of father figure by many of the

nurses under him. The new manager's attempt to enforce retirement at 70 united long-serving ward staff and middle management. A walk out of COHSE members was only narrowly averted by a management climb down. In time the 'whizz kid' moved on to the next stage of his career elsewhere, and calm appeared to return to the hospital community.

This issue, more than any other, seem to symbolize the 'localist' focus of the union. It had mobilized successfully around the perceived threat to the continuation of the community it represented in which norms of respect for seniority were strong. It was the trade unionism of those who had built their whole lives around the hospital, and saw the union as a means of collectively preserving their settled, rather torpid way of life.

## (2) Discussion of the Case Studies

The examples of hospital trade unionism related above defy simple generalisation. They reflect the general pattern of longer traditions of trade unionism among psychiatric (including both mental illness and mental handicap) nurses, and greater collective activity and militancy. But there were considerable variations among general hospitals and among psychiatric hospitals. There were variations both in degrees of collective organisation and in its focus.

It is also difficult to assess how far the hospitals were representative of hospitals generally. Certainly COHSE and NALGO were overrepresented in the sample, to the neglect of NUPE and perhaps also the Rcn. Most of the hospitals were situated in the West Midlands, which, more than one informant suggested, does not have a particularly militant reputation in the NHS.

The regional dimension is certainly significant, for on the basis of the evidence presented in earlier chapters hospital trade unionism emerged

earlier in the London area (excluding teaching hospitals) and the north of England and South Wales - perhaps following belatedly the general development of the labour movement.\* Analysis of industrial action taken in hospitals during the 1970s showed that it was not dispersed evenly throughout the country, but concentrated in a few urban centres, particularly in London and the north of England.<sup>(4)</sup> If so, the pattern I found in the Midlands is probably more representative of the generally less militant norm. Yet the case studies still display an interesting range of manifestations of a growing collective consciousness and trends towards greater industrial militancy in which some common themes can be identified, which were probably influential throughout the country.

Thus all the psychiatric hospitals (except Lea Castle and Walsgrave which were relatively new) displayed far longer traditions of trade union organisation. On the evidence of the hospitals studied, and the personal reminiscences of previous places where informants had worked this organisation in the past was of two types, depending on the power of the nursing hierarchy. The first, and probably the most common pattern, was a fairly solid amount of membership, but only limited collective activity. Workers were essentially loyal to trade unionism but feared the nursing and medical hierarchy. This pattern of trade unionism emerged out of the economic Depression of the 1930s where there was an influx of working class men and women into the mental hospitals, often from the industrial areas with traditions of loyalty to the labour movement, but who felt in no position to assert themselves. Eventually these defensive traditions became part of workers' habitual approach to the world and survived even though the economic conditions changed.

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\* An exception to this general trend is the early development of asylum trade unionism in South West England.

Evidence was found for this at Central Hospital, at Chelmsley, and in the reminiscences of some workers, for example Dave Crowe at Lea Castle:

In the depression, discipline was easy. At one hospital 25 years ago, the nurses were lined up outside the Chief Male Nurse's Office. The same chief never talked to me until I was a staff nurse. We used to call him 'Mr Gestapo'. He was straight as a board and, with his keys behind his back. We used to get a phone call that he's on his way and it would create panic. (p.252, Volume 2).

The second, probably less common pattern, was that found in such hospitals as Shenley near St. Albans, as related to me by Ted Rogers at Walsgrave. It was particularly associated, I would speculate, with those hospitals where trade unionism extended back to before the 1930s, and where staff had gained some measure of control during the first wave of trade unionism at the end of World War One. Shenley was in fact opened in the 1930s but the mental hospitals around London, along with those of Lancashire and Yorkshire, were traditionally the best organised. According to Ted Rogers account, ward staff controlled the institution:

The charge nurse was king. If a doctor wrote up something he did not approve of, he would say, 'I'm not going to do it'. The consultant would say, 'I'm going to send you a new doctor, set him straight' (p.38, Volume 2).

It was a solidarity bred of danger, and the backing up of workmates and, unfortunately, a sometimes repressive approach to patients.

Contrasting the Walsgrave with Shenley, Ted said:

If something happened here and other staff were asked to make a statement, they would do it. In Shenley they would refuse and get in touch with the union first ... Shenley never had a scandal. The press men wouldn't get in. The staff closed ranks (p.39-40, Volume 2).

As it happens, we know that is probably an accurate account, because it tallies with one written in the 1950s by a disillusioned student nurse. (5)

In most general hospitals, on the other hand, trade union membership hardly existed outside a few pockets of strength in the north and some ex-local authority (especially ex LCC) hospitals. Whereas conditions in the asylums and mental hospitals seem to have led spontaneously to the creation of nursing trade unionism, it has tended to be taken from the outside into general hospitals, if the evidence of the case studies is anything to go by. This has occurred in a number of different ways: (1) By individuals who entered nursing with a prior commitment to trade unionism and sometimes also socialist politics; (2) by the entry of individuals from other branches of nursing which were already unionised. (3) By the spread of trade unionism from other grades of staff within general hospitals. With the exception of High View, all of the general hospitals were unionised in one or more of these ways. At Walsgrave the union spread from the adjacent Psychiatric hospital and initially brought in individuals who were already disposed to support it, such as the 'dissident' learner who was already a member of the Internationalist Socialists. She then used her influence as an 'opinion leader' to influence others in her peer group to join. Growing by the recruitment of 'key individuals', who had influence among others was mentioned time and again by many activists, when asked to describe their recruitment strategy.

Recruitment across grades within the general hospital was definitely a feature of the NALGO branches I visited. At New Cross in Wolverhampton the Fire Officer had used his position of mobility to recruit nurses. At Kings College Hospital (KCH) the union had been sought out by an individual who herself had a prior commitment to trade unionism and whose husband was a Labour councillor. Had I included a NUPE general hospital branch, it seems likely (from those that I do know about) that it would have spread across from ancillary workers.

Attempts to unionise East Birmingham Hospital (EBH) in the 1950s seem to have followed this model, by the recruitment of 'deviant' individuals - male nurses demobbed from the forces, who had not been socialised into the culture of general nursing through a hospital training school. Their organising activities were not, however, successful. Not until the 1960s did Irish male psychiatric nurses on secondment successfully introduce trade unionism into the hospital.

In explaining the spread of trade unionism from the 1960s onwards, we therefore need to explain how it spread first to deviant individuals, and then more generally. Congruent with the analysis of earlier chapters the explanation lies, perhaps, in varying degrees of disillusionment with what the Boston Nurses Group have called 'the false promise of professionalism'. As they suggested:

Our nursing textbooks talked about what professionalism was in very vague terms, removed from the real work-life of the nurse on the shop floor. We learned that a professional is someone who has had specialised training, which includes a code of ethics, through which members learn standards of behaviour to which they are expected to conform. One thing that gives a professional group power is the fact that it is a legally recognised entity: a profession is self defined, self-regulated. (6)

The reality often departs from this norm. As we saw, historically, those nurses who rejected the 'promise' earliest and turned to unions, worked in asylums and Poor Law hospitals where the contradiction between the myth and reality was greatest, and where their own gender or class background made them less likely to be 'taken in' by it. The Boston nurses described their own process of disillusionment:

Professionalism teaches us to see ourselves as unique and better than other health care workers. And the more we talked about professionalism, the more we saw that it was used by administrators to make us work in certain ways which are not beneficial to us or to our patients. In other words professionalism



can be used to exploit nurses ... (and) often leaves us feeling unsatisfied, powerless, and isolated from other health care workers. (7)

In explaining the spread of trade unionism from the 1960s beyond individuals to a wider layer of nurses, as happened in such hospitals as the EBH, it could be argued that the gap between what was promised and what was delivered appeared to increasing numbers of staff to grow wider. Pay levels fell behind workers generally, the power of administrators increased along with their salary levels, and the Government appeared to exploit rather than reward nurses' sense of commitment. Many nurses in fact 'voted with their feet', leading to chronic staff shortages which intensified work pressures and discontent. This was a factor of importance, for example, at KCH, exacerbated by the fact that agency nurses appeared to escape many of these constraints, yet added to the problems of established staff.

For some nurses, the promise had little relevance in the first place; particularly the nursing auxiliaries who had not been socialised by the training school into such values. They came to form an increasing proportion of the workforce, as qualified nurses shunned basic care and as management sought to make good shortages of nursing staff. They provided unions with a growing base in general hospitals, even though their high rates of turnover could create organising problems. They were in any case excluded from professional associations like the Rcn and RCM. State enrolled nurses were another group for whom the 'promise' amounted to little more than a dead-end qualification on low wages, often looked down upon by other nurses. They also joined unions in increasing numbers, even though they were finally allowed to join the Rcn in the 1960s. At EBH, part-time qualified nurses also formed a considerable proportion of the COHSE branch's nursing membership. Perhaps partially because 'the promise' was exchanged for more immediate material objectives for staff who, as part-timers,

had no prospect of career advancement. Further research would be required to provide more certain answers.

The evidence from the case studies regarding learner nurses is uneven. At KCH and the Walsgrave, dissident students were attracted to trade unionism, whereas the EBH the Rcn seemed to be more of a focus for their activities. Learners are those who are most likely to have been exposed, through the training school to the claims of 'the promise' in its purest form. They can then test its premises, as they have not yet become habituated to the ways that the 'promise' contradicts with daily reality. They may become shocked by the extent of the gap, and it can make them angry. In the training school, the Rcn is usually pre-eminent, but on the wards the learners may be exposed to the alternative 'deviant' views of reality provided by trade unions. Since the reputation of the Rcn often stands or falls depending on whether the promise is held to be true or false, they are at this point often capable of being won over to unions. This would be a plausible explanation for what happened at KCH and the Walsgrave. It would not so easily fit the EBH. Perhaps this was because the school particularly through the Nurse's Representative Council and the Rcn, had a tighter control of the situation, and successfully preserved the separation and insulation of the learners from the hospital generally. The Union at the EBH was clearly based primarily upon the ward staff.

One of the clear themes that emerged from many, if not all, of the case studies was the potential for change that the energy and criticism of learners represented, particularly in general hospitals. At KCH and Walsgrave, they were the driving force behind the pay campaign of 1974, at the former uniting with some of the younger trained staff, though at the latter these were more aloof. In the psychiatric

hospitals studied, by contrast, the trained staff on the wards took the initiative in the Union. The organisation of the students was often loose-expressed in 1974 through semi-anarchistic Action Committees. The Committee at KCH played a significant role nationally, by helping to organise demonstrations that sparked the national campaign, and in helping to build the London Nurses Action Committee. Sometimes, as at the Walsgrave, the approach of Action Committees conflicted with the sober, procedurally based trade unionism that was associated with permanent ward staff. At KCH on the other hand, there was no apparent difference between the style of organising adopted by the Action Committee and that at the NALGO branch. In fact the NALGO activists generally pushed the Committee into a more militant stance, which exposed the hesitancy of the Rcn.

I am not able to explain fully why the learners in the psychiatric hospitals adopted such a lower profile. Perhaps they regarded themselves less as students and more as fellow workers, and there did appear to be greater unity of purpose. But there were evident points of conflict(e.g. at Lea Castle) and some learners felt that they could not use the union to solve their problems as it was associated with 'the charge nurses'.

This connects to a wider theme which emerged at a number of places. Trade unions were often posed as alternatives to the Rcn because they are said to be 'more democratic'. As opposed to the emphasis on individual career advancement and respect for hierarchy, are countered norms of non-elitism and collective advance. While the Rcn is controlled by the employers (the senior nurses) the Unions are controlled by the workers. This view has been put forward by Sue Lewis, as the chief reason why nurses should join trade unions:

For the individual 'professional' goals are singular and not collective. Emancipation is viewed in terms of individual careers, wealth, and personal prestige. For the working class member of a union, however, emancipation can only be viewed in collective terms. Emancipation for members of the working class only exists in their emancipation as the working class. (8)

As an ideal it may be fine, but in practice, it does not prove so simple for unions to overcome the divisions in the workforce, which may indeed come to be expressed through them. This is not, of course, a problem that is restricted to the health service. The history of the trade union movement is replete with examples where unions have been used to defend collective privileges either internally or externally - traditions of sectionalism have been a strong organising principle. As Hyman points out:

When workers organise in trade unions, these divisive tendencies are naturally expressed in their organisational boundaries, shaping the lines of demarcation. The very name trade union implies sectionalism; the inward looking unity of those with a common craft or skill. (9)

As Hyman points out, there are forces pulling unions in both directions and the balance in practice between the two is subject to considerable variation.

Some of this variety was noticeable in the case studies. At Highcroft Hospital, the formation of the COHSE branch expressed a separatist community of interest of nurses, who wished to pursue their own interests independently of ancillary workers - despite the fact that COHSE's official ideology espouses industrial unionism through the motto 'All for One and One for All'. But formal boundaries do not of themselves express an intransigent sectionalism, only if workers themselves give it such a meaning. For example at KCH, the fact that NALGO was the chief union among nurses did not signify a white collar 'elitism'. It appeared to be almost an accident- it was the union

which seemed most suitable to the chief instigator of the movement towards trade unionism. In practice, the NALGO Branch made a point of supporting the campaigns of ancillary workers, and coordinated its activities closely with manual workers' unions. At New Cross, on the other hand, the fact that NALGO was seen as a 'cut above' manual worker trade unions, was certainly emphasised as a recruitment strategy. At Chelmsley more than anywhere else, the COHSE Branch seemed to correspond closely to its official ideology of industrial unionism, as a vehicle for what were called the 'lower dogs', regardless of grade.

But it is the internal balance of power within Unions that most often contradicted the claims sometimes made that they are a complete contrast with professional associations. There are real differences between them. For example, in unions the Conference, made up of representatives of branches, is the supreme governing body. In professional associations power is vested in more remote Councils. For example, the Rcn's Representative Body (equivalent to Conference) has only advisory powers. Learner nurses, as unqualified staff- not yet professionals - do not have full voting rights in the Rcn. In Unions, all members have voting powers. These are real differences.

Yet it cannot be denied that in practice the divisions in the hospital power structure were often reproduced through union Branches. For example, it could be seen at EBH in the paternalistic relations between the dominant male activists and the 'serviced' ancillary workers. The breakaway of many of the male ancillary workers to the TGWU after the 1972 dispute can be seen in part as a reaction against such paternalism. At the Walsgrave and Lea Castle, the dominance of established wardstaff, especially the trained staff, impinged on the ability of students to pursue their interests.

One factor that often influenced the style of trade unionism

associated with the trained staff was their ambiguous position as both managers and workers. This was particularly noticeable with the COHSE Branch Secretaries at the EBH and the Walsgrave. The EBH Secretary, a Nursing Officer, walked a tightrope between his role as union activist and his role as manager. It was not that he did not believe at one level in collective advance for all workers, but he was also seeking individual advancement for himself, and seeking to avoid compromising himself as a manager. To be fair, he did not always seek to stifle threatening initiatives from below, but 'handed over' when they became too difficult.

There is no necessary incompatibility in such a 'dual strategy.' It is in fact a frequently observed feature of the recent growth in 'white collar' and professional worker unionism, of which that of nurses is one part. As Price has suggested:

There is no incompatibility between a militant commitment by, for example, local government officers, teachers, civil servants or nurses, to ensure that the 'normative framework' within which their pay and grading structure are determined, reflects a 'fair' assessment of their social worth, and a strong individualistic commitment to scramble as far as possible up the hierarchy of grades which are presented as a potential career path. (10)

This does not necessarily preclude trade unionism as a response to growing 'proletarianisation' and 'blockage of 'the promise' of career advancement, but it does help to explain the trade unionism of those who are both active on behalf of the collectivity and on their account. It is reflected in the existence, among some layers of the nursing hierarchy, of 'dual membership' of unions and professional associations (though it is an expensive option which is beyond the reach of many nurses). A number of the male managers I talked to (e.g. at the Walsgrave and EBH) either held dual membership or had once been a member of unions. If the latter, they tended to push the Rcn to take a stronger trade union line, which would fit in with the argument of Price.

Such a strategy may fit the material interests of those in middle to higher positions in the hierarchy, but these may also predominate against the interests of others whose prospects of individual advancement are distant, if they exist at all. This clash was most evident at the Walsgrave, where the activities of the dissident learners threatened the strategy adopted by the CONSE secretary. As we saw, the dominant group within the Branch in this instance acted to curtail the activities of a dissident group. In many instances, however, domination and reproduction of the hierarchy through the Union may occur by default, or even with the assent of an oppressed group.

One of the most striking features to emerge from the case studies is the predominance of men - particularly Irish men - in union positions, out of proportion to their numbers in the workforce as a whole, and despite the fact that growing numbers of women were joining unions. Men were also rising to prominence within the Rcn, as evidenced by the EBH and Walsgrave case studies. Since men were rising to take over many of the top positions in the nursing hierarchy, at these hospitals, it could be argued that unions have become complicit in the growth of patriarchal authority that has taken place within nursing. In order to explain this we need to understand both (1) Why trade unionism came to be associated with men in the first place, (2) Why the increased membership of trade unions among women has not lessened male dominance within them.

One possible explanation is the marginality of men in relation to nursing traditions of 'self sacrifice' or else a much greater unwillingness to be bought off with 'false promises' of professionalism which are not fulfilled in practice. Trade unionism in nursing did originate among men in the asylums who rejected such an ideology advocated by the Asylum Workers Association, and fought in the first

instance for immediate improvement. But the nature of the work itself and not just the gender of those engaged in it, made it marginal to general nursing traditions. The spread of trade unionism among general nursing in the 1930s was strongly carried forward by male nurses, as related to me by Doris Westmacott, a Guild of Nurses Organiser in 1930s. They were excluded not only from professional associations, but also from the main register of the GNC. They were regarded as inferior or as a potential threat to the female authority structure - the latter perhaps in hindsight with some justification. (11)

By the 1950s formal discrimination against men through the separate register had been abolished, but according to Woodward's study of Wirral hospitals, male nurses displayed characteristics of an aggrieved 'minority group', resentful of 'female authority'. (12) This provides some evidence for the idea that trade unionism might be organised around men's marginality to nursing traditions, particularly since, as Garmanikov has pointed out, these were constructed around wider social definitions of 'femininity'.<sup>13</sup> A survey investigation of male student nurses' attitudes undertaken during the 1960s by Brown and Stones did find some resentment of female authority, but attributed more weight to the fact that

Compared with female nurses and with the general population ... these male entrants had a more down to earth image of nursing. They were bothered about pay and status, and were more likely to think in career than in vocational terms. They started training with a more realistic picture of what hospital life is like and did not share the popular view of the nurse as a paragon of virtue, self-sacrifice and unremitting industry. (14)

Perhaps one of the most significant factors affecting their attitudes was the fact that, unlike women nurses, they came to the occupation late, after their attitudes to work had already been forged outside a



hospital context. Brown and Stones also found that:

Compared with female entrants, fewer of the British men came from the middle class backgrounds and correspondingly more from Registrar-General's Social Class IV and V. Nearly two-thirds of the sample had fathers in manual work. (15)

From this evidence we can begin to construct a plausible account of why men are found in higher numbers in trade unions as well as management. They are, in the first place, one of the most stable elements in the workforce - their careers are not interrupted by marriage or childcare responsibilities. And as the survey found, they were concerned with both present pay and future prospects. As the numbers and influence of unions has grown, both sides of industrial relations have been regarded as areas of 'male expertise' as has of course nurse management in general. Both men and women appear to hold such attitudes, associating trade unionism with masculinity. A survey undertaken for the New Statesman in 1980 found that roughly equal proportions of men and women union members - about one third - agreed with the statement 'Men make better Shop Stewards than women do'.<sup>(16)</sup> Similar attitudes were expressed by many women to Anna Pollert during her ethnographic investigation of a Bristol tobacco factory during the 1970's.<sup>(17)</sup> She also found that women regarded union affairs as boring, even though that did not mean they were not concerned with the immediate material issues that affected them. Of course there are other influences that preclude women from becoming more involved in trade unions. An investigation, conducted by Jane Stagemen, of five union branches (including two health branches) in the Hull area, found not surprisingly perhaps that child care and other domestic responsibilities prevented greater participation in union affairs. Those women who did get involved and sometimes occupied official positions tended to be either in relatively senior positions in their job, or had no children under 18, had been in their job longer, were

full-time and had relatives (husband or father) who had been or were active in the union movement. (18)

The two female Branch Secretaries included in my case studies, conformed to the same characteristics. The COHSE Secretary at Lea Castle was a ward sister, had worked full-time for some considerable time, and though married had no children. The NALGO Secretary was younger, but was also a full-time sister who had no children. In all the other branches men held the leading positions, though in a number women were becoming more active. Very little was being done at the time I visited the branches, to make it possible for women to involve themselves more easily. In one however (EBH) women were by 1977 being actively encouraged to become more involved. The spread of the stewards' system was leading to increased involvement from women at a number of the hospitals, though typically the Branch Secretaries remained male.

My research was too superficial to get behind the reasons why women were not more active. At all of the hospitals, however, a growing number of the members were part-time married women, for whom the practical obstacles to participation are greatest. As Ann Sedley points out, part-time work for women has both advantages and disadvantages:

By working early in the morning or late in the evening they are able to combine (paid) work with childcare and housework. The drawback of course is that there is not time for anything else. (19)

The expectation that women (and not men) will work a 'double shift' therefore often precludes them from greater participation in trade unions. That should not be taken to mean that they would not be interested. An investigation by Nicola Charles found that though union representatives often assumed that women were not interested in

unions, this was often far from the case. They were in fact often critical of their unions for 'working too much with management' and paying 'little attention to issues of importance to women'. (20)

Another way in which unions may wittingly or unwittingly serve to reproduce divisions within the workforce, is by failing to tackle the problems of racism. A growing proportion of nurses during the period of my study came from overseas, many from the countries of the new Commonwealth. They were found in increasing numbers in the lowest grades, such as nursing auxiliary and enrolled nurse grades, and in unpopular specialties such as nursing the mentally ill and mentally handicapped. (21) They are under-represented in senior positions, some of which at least, it has been suggested, is due to direct discrimination. (22) Overseas nurses formed a growing number of those recruited to unions in a number of the hospitals I visited. Only in KCH were there any signs that they were becoming active in the union structure, despite some evidence, from demonstrations I attended, that they played an active and militant role in the 1974 pay campaign. As with women, my research was too superficial to provide convincing answers. However, two of the COHSE Branch Secretaries - both, perhaps significantly, themselves migrant Irish nurses - displayed explicitly racist attitudes. The EBH Secretary thought that West Indian nurses had 'chips on the shoulders' which indicated that he did not take their complaints of discrimination seriously. The Secretary at Central blamed overseas nurses for the low pay and status of psychiatric nursing. Although I did not raise it as a salient issue at every hospital I visited, except when it was raised by informants, (my own implicit racism), it does strike me now how typically 'white' the trade union branches were. Unfortunately I have no evidence on how trade unionism was perceived by overseas nurses themselves.

My case studies provide some limited evidence of the tendency towards convergence in unions and professional associations, which is seen as a broad historical trend in the next chapter. At the EBH and the Walsgrave, the Rcn were becoming more active on 'union' issues, such as pay and 'protection', though both types of organisations stressed the latter in their sales pitch to potential members. However, professional associations still did not give these issues the same focus and intensity as the unions. Similarly there were signs that unions were beginning to take up 'professional' issues, most notably at Lea Castle where nurses saw the future of mental handicap nursing as a vital union and professional issue, but this was not typical of most hospitals studied. It could be that the evidence of the case studies shows the beginnings of the process of growing convergence at hospital level. It will be interesting to see how far the continuing research at Walsgrave and Central confirms this assumption.

### 3. Assessing the 'Proletarianisation' Thesis.

At all of the hospitals I visited, most of the growth of membership, and certainly of militant activity, was of comparatively recent origin. How is this to be explained? While the evidence of the case studies is largely suggestive, they do provide some clues. According to Bellaby and Oritabor's Marxist model, the growth of trade unionism among general nurses is a response to a growing 'proletarianisation' of the labour force, which is connected to an erosion of control over work processes, leading to 'deskilling'. (23) On first appearance this is an attractive theory for it enables us to link nurses' trade unionism to the wider processes of white collar and manual workers' trade unionism within capitalist society. Thus it can be viewed as just one instance of the process spelled out in general by Braverman (24) and applied to white collar workers by

Crompton. (25) I do not want to deny the general validity of this approach. I want, however, to argue here that as far as nursing is concerned (and perhaps it is a general fault of the approach) the explanation is too 'internal', and also ignores the independent influence of gender; that the combined pressures of pay policies and inflation have had an independent effect; and finally that something more complex than a straightforward deskilling process has been taking place.

The core of the argument is that 'proletarianisation' is a process of erosion of control over the means of production, and not, as Parry and Parry suggest, a process of 'downward social mobility'.<sup>(26)</sup> In their view the erosion of control began in the 19th century when nursing was subordinated within a (capitalist) division of labour, although Nightingalism created a sphere of autonomy for the 'nursing structure'. In their view this autonomy has been eroded ever since. Registration did not halt the process as the state acted to ensure the occupation remained open rather than closed. In particular the introduction of the Salmon reforms eroded the power of the ward sister and hospital matron, and the growing specialisation and fragmentation in the division of labour deskilled the nursing process itself. Unionisation, they argue, is one way of 'fighting back' against this process. They suggest that this can occur to some extent through the Rcn. (I would agree with this judgment - the shift to the steward system and the higher profile on industrial relations issues at local level would seem in part at least to be a response to such developments.) The loss of power that occurred at hospital level as a result of the managerialism of reorganisation does appear to have been an influence at most of the hospitals studied. This was especially evident when it led to rationalisation - e.g. attempted closure at High View, changed shift systems at Lea Castle, compulsory retirement at Chelmsley, and so on. It created a general sense of vulnerability, the

vulnerability of proletarianised workers rather than autonomous, self-governing professionals. A sense that there was a growing need for 'protection' was the single most important theme that emerged from the case studies - at all types of hospitals.

Another strength of the Bellaby and Oribabor approach lies in the fact that they do not assume an automatic relation between 'proletarianisation' and unionisation. They argue that it can also give rise to a 'new' professionalism based on the assertion that 'nursing is a distinctive technology of "care" as opposed to cure'. This is because they do not assume that nursing has been completely proletarianised, but see nurses as part of the 'middle layers', performing in part both the functions of labour and capital, as Carchedi puts it. (27)

My quarrel with this analysis is that this might be fine for those who fit this categorization - the ward sisters and middle management 'Matrons' who seem to be the main focus of the article. However this does not help explain the position of those - like the large number of enrolled nurses, learners and nursing auxiliaries - who, to varying degrees, seem to have become more thoroughly proletarianised. The weakness of the article in other words lies in the fact that it does not adequately analyse the changing division of labour within nursing, and the way that it has resulted in the separation of groups with rather different interests from each other. It assumes that nursing is a homogenous occupation, not one prone to divisions. In reality a differential 'opportunity structure' has emerged within nursing, linked to degrees of career mobility and also associated with other 'latent' social identities - class, gender, and race. I have tried to show through my discussion of the case studies how these different sets of interests give rise to different forms of union activity which sometimes conflict with each other. General hospital nursing, therefore, is not a homogenous occupation and general explanations of

trends in collective organisation are not sufficient.

Nor is a unicausal model of explanation adequate. Erosion of control over the means of production is an important influence but it is not the only one. It is an internalist explanation which takes little account of independent changes in ideology, particularly among women. Thus the 'Power of Women Collective' in 1975 argued that one factor behind the growing economic militancy of nurses during the early 1970s was the rejection by increasing numbers of women, whether in the household or the paid labour force, of the principle that they should sacrifice their needs for the sake of others. They argued that the rise of the women's liberation movement gave women growing confidence to assert their own needs. (28) That of course requires explanation in itself, but it seems plausible to suggest that this operated independently, even though it of course also interacted with changes in the labour process. Another important causal factor was the impact of state controls of nurses' pay in circumstances of inflation; as well as provoking 'economic' discontent this worsened work conditions by causing staff shortages. In a situation of strong bargaining power due to full employment this process represented a further independent cause of nurses' militancy, not as Bellaby and Oribabor suggest, simply a 'catalyst' for changes already set in train by the proletarianisation process. (29) As O'Connor has suggested, the 'fiscal crisis of the state' has been a profoundly important factor in the growth of trade union militancy among public sector workers. (30) This particularly seemed to fit the circumstances of union growth and activity described at KCH and the Walsgrave. It is 'fiscal crisis' that has in fact led both to restrictions on public sector workers' pay, and pressures to save costs by the constant rationalisation of the NHS labour process.

The foregoing applies in the main to general hospitals, but in many ways the analysis could be extended. The main difference is that whereas with general hospitals the process of rationalisation occurred in the context of overall expansion (at least during the period of study, and with the exception of High View), in the psychiatric hospitals studied it was against the background of contraction and decay of the work community. As Scull has pointed out, 'fiscal crisis' is indeed a factor in this contraction, and has promoted 'decarceration' of the mentally ill. (31) (The argument could be extended to the mentally handicapped).

At a number of the psychiatric hospitals studied a recent growth in trade union militancy over pay had indeed been associated with, or was even predated by, struggles over control of the labour process. The introduction of the Salmon structure and reorganisation had caused tension and conflict, for example, at Chelmsley, Highcroft and Lea Castle. There was also more apparent resentment and overt conflict between nurses and doctors - for example at Highcroft and at Lea Castle. At the latter, industrial action over pay was also a control issue: about who had the right to say who was an 'emergency' admission. 'Protection' for psychiatric nurse trade unionists mean something different than for nurses in general hospitals. Although it was forged in response to the same sense of vulnerability to higher management, it was also much more likely to mean protection from accusations of ill-treatment to patients. The 'protection' issue in general hospitals was much more connected to fears about making clinical errors - something the Rcn played on by emphasizing the merits of its professional indemnity scheme as a reason for joining. The spate of scandals since the late 1960s had made psychiatric nurses much more sensitive to the issue of patient ill-treatment. In its way this too was an issue which focussed on their concern over an 'erosion of control over the labour process', in this instance their control



over the chronically ill people in their care. This can lead to what Martin has described - in what is not primarily an anti-union discussion of hospital scandals - as 'the darker side of staff loyalty'.<sup>(32)</sup> Sometimes this can lead to a defensiveness which just seeks to protect the power of the staff group as an end in itself. This may give staff control over their alienated environment; it does not, however, lead to the articulation of alternatives which might in the long run be more satisfactory for both staff and patients. It can also stray beyond a legitimate concern to see that staff are properly represented in such circumstances, and due process observed, to the actual suppression of complaints and the victimisation of complainants.<sup>(33)</sup>

I did not find evidence of this at the hospitals I visited, though of course, such information would not necessarily be volunteered. There was, however, considerable sensitivity to the issue of ill-treatment and often a strong feeling of resentment that nurses, even if guilty of ill-treatment, were in their view being made the scapegoat for the poor conditions which made abuse likely. This often fed into a general feeling of resentment against senior management, especially at district level, who were held responsible for starving the institution of resources.

Deskilling was also a strong focus at both Lea Castle, Highcroft, and also Central, in the sense that decarceration was leaving behind greater numbers of the chronically ill or most severely handicapped, heightening the routine caring as opposed to the more rehabilitative aspects of the nurse's role. At Lea Castle, the nurses also felt constrained by the increasing power exercised by other professionals - psychologists, teachers, and physiotherapists. The growth of 'paramedicals' in the general hospital was, interestingly, cited by Bellaby and Oribabar as a significant factor in the erosion of nurse

control over the labour process.

Whilst the evidence of the case studies is no more than suggestive, they do as a whole support an approach which sees 'proletarianisation' as an important influence; but they also suggest that this has had a differential impact within the hierarchy, across specialties, and mediated also by wider sex/class/race identities. This has also been influenced by ideological changes, particularly among women, linked to their growing participation in the labour force at large, and greater self-assertiveness since the late 1960s. As well as erosion of control, 'economism' has been an important influence in the development of trade union militancy, relatively independent of changes in the labour process, through state attempts to control the wages bill in a period characterised by inflation and growing 'state fiscal crisis'. These cannot however be entirely separated, for fiscal crisis was one of the major influences behind the increasingly rapid transformation of the labour process. In any case in a society where money rules, economic and control issues cannot be easily separated. That apart, the trade unionism of psychiatric nurses did raise control issues more often and in a more heightened form than typical among general nurses.

In both general and psychiatric hospitals the 'proletarianisation thesis' therefore provides a useful explanatory tool, as long as it is also linked to an awareness of divisions in the workforce, the influence of latent social identities (especially of race and gender as well as class), and wider environmental influences. If too much reliance is placed upon it, as a singular form of explanation, however, the proletarianisation thesis becomes rather vulgarized.

#### PART FOUR: CONCLUSIONS

### Chapter 13 : Analysing Broad Historical Trends 1910-76

This thesis has set out to describe and explain processes of union growth among hospital nurses during the period 1910 to 1976. Three key questions have been confronted:

- (1) Why was membership of unions traditionally weak, but strong in particular sections of the work force?
- (2) What determined the complex pattern of nurses' membership affiliation to a variety of organisations?
- (3) What were the dynamics of change in (1) and (2),

In seeking to explore these issues both psychologistic 'attitudinal' and deterministic 'structural' approaches were rejected, in favour of an examination of the dialectic existing between a framework of constraints, and the possibilities inherent in conscious human activity. In the process, three key sets of influences have been identified: (1), the 'latent social identities' that recruits to nursing bring with them, and which have a continuing influence upon their work ideologies and behaviour in interaction with their work experience; (2), the complex restructuring of the labour force that has taken place during the period under study, leading on the one hand to the creation of a mass labour force, on the other, to a fragmentation of the division of labour as a result of the expansion of 'scientific' medicine

and growing division of 'cure' and 'care'; (3), the dynamism and character of wider 'popular' struggles. In this country, those of the labour and women's movements have had the greatest impact. In the USA, there is evidence that during the 1960s the black civil rights movement played a more significant role than it has in this country.<sup>(1)</sup>

This final chapter therefore briefly seeks to summarize some of the ways in which the three 'key questions' are related to the three 'key influences'. The evidence from the historical data is suggestive, and many issues cannot be absolutely settled. In particular the nature of the historical evidence does not enable the articulation of the fully 'situated' account of processes of union growth that was argued for in Chapter 2. At most it is possible to identify the major factors of significance and suggest a plausible connection between them. The previous Chapter, however, did try to link these to a more situated account of developments during the late 1960s and early 1970s.

A major reason for the weakness of trade unionism has of course been the hold of traditional ideology, based on notions of 'vocation'. This was a significant 'prior orientation' of middle class female recruits to nursing in

the voluntary hospitals during the 19th century, and congruent with women's wider social role. It was also reinforced by the occupational institutions themselves. The hospital provided for the nurse's material needs and in return labour was donated as a 'gift' rather than offered as part of an exchange. Relationships of wage labour, to the extent that they existed, were only latent. This ideology has had an important, if declining, influence ever since. It works against the development of a trade union consciousness by espousing an ethic of self-denial; or at least in situations of conflict between needs of self and needs of 'the service', the latter are deemed always to have the greatest priority.

However, though it remains influential, it is important to realise that vocational ideology - and the institutions in the hospital and wider society supportive of it - began to decay before the end of the 19th century. It is therefore just as important to try to document the causes of its decay as the causes of its survival. As will be apparent from the theory already outlined, this process of decay cannot be understood purely from an 'internal' account, but must be linked to changes in the wider society and in the social backgrounds of recruits to nursing. Thus significant external influences on the initial decay of vocationalism were the examples of rising working class militancy, and the development

of feminism as a social movement in the final quarter of the 19th century. The latter coincided with internal changes in nursing, the development of an elite of lady pupils distinguished from ordinary probationers by the fact that they paid for their training, and who began to articulate a 'professional' as opposed to a 'vocational' community of interest. Its internal basis was, on the one hand, the development of 'scientific' nursing skills in the wake of the development of 'scientific' medicine and delegation of 'medical' tasks; and on the other, the growing market for private nursing outside hospitals. The focus for its expression was the Royal British Nurses' Association (RBNA) formed in 1887 around the charismatic figure of Mrs. Bedford Fenwick. The RBNA was in some ways militantly collective. It certainly did not espouse an ideology of feminine self-denial, as can be gauged from this pronouncement in 1897 from the Nursing Record, the organisation's mouthpiece:

That "Union is Strength" is a lesson which mankind has long found out, witness the force of unions in the commercial world, and the power which the working man possesses, in union with his fellows, of influencing the labour market, and determining the relative positions of capital and labour. This lesson of cooperation is one which women have hitherto learnt somewhat imperfectly, but they are daily becoming more and more alive to the necessity for it, and when once Nurses have thoroughly learnt that power which they possess, there is no doubt that their united demands for the improvement of their profession will come with a force which will be irresistible. (2)

This statement could almost have been a manifesto for trade unionism among nurses, but it was not. Nurses were only being asked to learn from the example of the trade union movement. There was no suggestion of an identity of interest between nurses and the labour movement. Indeed quite the opposite, as the RBNA wished to transform nursing into a closed middle class occupation, through state registration on the lines already achieved by the medical profession. Nor must one exaggerate either its 'feminism' or 'professionalism'. As Garmarnikov points out:

Traditionally, nursing history has implicitly employed a sociological model of professionalisation ... What this approach fails to recognise however, is that the conflict between the anti- and the pro-registrationists was not concerned with occupational hierarchy in health care and its effects on nursing so much as with definitions of nursing within an unquestioned hierarchical mode of work and authority distribution between nursing and medicine. The two factions disagreed about the desirable class origins and educational background of applicants, and about the length and type of training required for entry. But all this was prefaced by and inferred from identical models of the nurse-doctor relation, the central interprofessional relationship which subordinated nursing to medicine. (3)

This had to be so, as they were seeking to transform nursing along similar lines to that achieved by the medical profession in the 19th century. They wanted, as it were, to join the small 'club' of closed, self-regulating occupations



selling their scarce labour at high prices, to a largely middle class clientele<sup>(4)</sup>. Since their overall aim was to be included, they were unlikely to risk antagonising existing members of the club by seeking to wrest aspects of their control away from them.

The RBNA's middle-class radicalism was, however, to become superseded by the more dilute professionalism of the College of Nursing. At its inception in 1916 this ideology was combined, with due respect to traditional values: and subsequently with a reluctant shift towards 'trade unionism'. The context was that of a War in which the need to mobilize women to enter nursing took precedence over peacetime movements towards closure and restriction of entry. The RBNA's single-minded pursuit of the community of interest of a segment of the occupation - the Lady Pupils - gave way to a looser 'amalgam' of interests represented by the College of Nursing: an 'aristocracy'<sup>(5)</sup> of nursing administrators paying some heed to the needs of 'professional' nurses in private practice, but also to the growing numbers of ward nurses who, though trained, found themselves in employment settings.

The achievement of state registration in 1919 greatly enhanced the power of the College in its battle against the 'militant' professional associations who thereafter

began to decline and eventually disappeared. State registration seemed to validate the College's cautious and consensual approach through which it had, in just three years, achieved more than many years of bitter internal feuding.

Although the College overcame the militant professional associations, the challenge of trade unions was more enduring. They early pointed out that registration would not, of itself, solve nurses' material problems. As disillusionment gradually spread and trade unions became its standard bearers this was linked to other changes, most notably the growth of general hospital nursing in the interwar period which created a mass labour force. Many trained nurses formed themselves in settings where their collective problems as workers might be solved by the adoption of union methods. Registration, as Bellaby and Oribabor have pointed out, did not lead to closure, because the State acted to ensure that it was not used to limit the supply of nurses and drive up the price of trained nurses' labour. In addition for the growing army of assistant nurses<sup>(6)</sup> who were being recruited to the hospitals registration was not a relevant issue. These, along with such groups as male nurses, were also excluded from membership of the College, as beyond the professional pale. In order to survive the College was forced to modify its original uncompromising anti-union stance, so that it would

retain the loyalty of those who found themselves in employment settings. It was painfully difficult for the College because it implied acceptance of the idea that Matrons (as employers) might have divergent interests from ward nurses (as workers). It is therefore not surprising to find that as it has occurred in practice, this adaptation did not lead to major shifts in the College's official ideology. In addition, in order to retain its hold over its constituency the College was forced gradually to widen the notion of the professional nursing community of interest. As previously excluded groups - students, men, mental nurses, enrolled nurses - were admitted, so the College became an even looser amalgam of interests than that originally constituted vertically (administrators) and horizontally (general trained nurses)).

The initial challenge of trade unionism had emerged as a result of the expansion of nursing reform from the voluntary hospitals into new fields. Earlier chapters have described the specific conditions in the Poor Law nursing service and the mental asylums, which proved favourable to the development of a proletarian consciousness. The nature of the work itself was different - less glamorous and more routinised, the recruits included more men, and also women from more working class backgrounds. Furthermore it was worked carried out for the State, rather than for private charity.

The question<sup>as to</sup> why trade unionism emerged first among asylum rather than Poor Law nurses is more difficult to settle. However, it can be observed that both emerged during periods of rising popular mobilisation. Asylum workers' industrial trade unionism emerged in 1910 alongside the increasingly syndicalist-influenced mobilisation of working class forces before World War 1. The initial unionisation of Poor Law nurses occurred in the period after the Russian Revolution of 1917 when ruling class trepidation, combined with the tight labour market conditions to the early 1920s, created favourable conditions for general working class advance. It was also a period when women, as a result of their massive participation in the paid labour force during World War 1, were demanding greater recognition of their contribution to Society.

Such conditions, however, produced a background of constraints and possibilities which generally fostered collective action, but which varied in the different sectors and segments of nursing. In the asylums greater homogeneity of the conditions of labour was undoubtedly an important influence. There were, of course, significant divisions of the labour force: not only hierarchical patterns of authority between Medical Superintendents, doctors, Matrons and supervisory staff on the one hand, and the generality of 'sub-ordinate' staffs on the other, but also horizontal cleavages

between subordinate staffs. The most significant of these were the division of asylums into non-communicating male and female sides; the different work experiences of 'indoor' and 'outdoor' staffs (the latter largely supervisors of patients' work gangs); and the rudimentary divisions between 'refractory' and more stabilised wards. In the Poor Law service the horizontal divisions were greater, not just among nurses themselves but also among Poor Law staff in general. There was also much variation in the size and structure of institutions in the Poor Law between rural and urban areas, including the degree of separation of medical from other Poor Law services.<sup>(7)</sup> This contrasted with the asylum service, where the typical institution was large and in areas like Lancashire, London and the West Riding of Yorkshire, grouped into single administrative 'Asylum Boards'. Bain, as previously noted, has drawn attention to the importance of 'bureacratism', closely connected to size and employment concentration, defined as the processes by which:

... working conditions tend to become standardised ... (as) terms and conditions of employment as well as ... promotion prospects are determined not by the personal considerations and sentiments of ... managers but by formal rules which apply impersonally to all members of the group.

(8)

Such an analysis, though rooted in material changes, places the creative role for unionisation upon management, and Government action rather than the workers themselves. In this thesis it has been possible to identify creative processes springing from among workers. Thus it was shown that the NAWU was formed as a result of disillusionment with the management-promoted Asylum Workers' Association, and generalised anger over the pensions issue. But the opportunities for organisation were seen and seized by a group of far-seeing (male) cadres committed to trade unionism. There is also evidence of growing discontent within the Poor Law nursing service at around the same time. This led to informal walkouts, 'strikes', but not until after the First World War, and then only on a rather shaky base in the service, to the erection of permanent organisation. One significant difference was the absence in Poor Law nursing at that time of a group of such cadres able to translate immediate grievances into permanent organisation. If due attention is given to these creative aspects of unionisation then it becomes clear that 'bureaucratisation' (as Bain defines it) may just as often be the consequences as the cause of unionisation. In neither the Poor Law nor Asylum services was unionisation a response to 'standardisation' of procedures. Unions sought to obtain standardisation by pressing the authorities to act as a 'fair employer' in circumstances where power was typically exercised by Medical Superintendents and Matrons, in an

arbitrary fashion.

Within the overall analysis outlined here, the influence of gender (discounted by Bain) cannot be ignored. However it must always be remembered that in this context 'gender' refers not to inherent physiologically based differences between men and women, but to the total, socially constructed patterns of life and work which lead to different attitudes and forms of behaviour. Thus Bain related any differences in patterns of unionisation between men and women primarily to the size of enterprises in which women typically worked.<sup>(9)</sup> However, within the social definition of 'gender' adopted here this difference itself might be regarded as highly significant and worthy of examination. Both the NAWU and the PLWTU were pioneered by disgruntled male employees. Initially women nurses were less likely to be active in promoting a collective community of interest, and where they did so were much more likely to look to professional associations. Thus, for example, the male activists in the NAWU once dismissed the AWA in sexist terms as the 'Asylum Women's Association', and the only nurses' trade union set up by women after World War One bore the significant title of 'Professional Union of Trained Nurses'. It did not survive for long. The most important influences on these tendencies were the different experiences among women nurses. The career nurse from a middle class background was more likely to embrace a formalised

professional community of interest (i.e. through membership of an organisation, as an expression of her permanent commitment to the labour force, while the working class nurse often did not stay long enough in the labour force to express a formalised proletarian community of interest. This latter tendency was of course influenced by the relationship between women's position in the labour market and the household division of labour.

Thus ideological differences remained among men and women with a similar lifetime's commitment to nursing. In explaining these, clearly the nature of the work - especially the low status and custodial ethos of mental nursing - needs to be taken into account. Other factors were, however, also important. Male nurses, confined to male sides of asylums and discriminated against in general nursing even after the 1919 Nurses' Act, <sup>(10)</sup> experienced considerable 'blocked mobility' throughout their careers (another factor largely discounted by Bain as an influence on unionisation). For those relatively few career-minded women nurses, the general conditions of high turnover enabled them to rise rapidly to the top. This formed the background against which male employees sought to promote a form of collective organisation linked to the wider labour movement, which emphasised the importance of collective working class advance. For aspirant career



minded women on the other hand, this did not seem appropriate. As Abel-Smith notes, this was probably just as important an objection to trade unionism as 'selfless devotion to the sick':

Many nurses were ladies and many others had become nurses in the hope that they would be regarded as such. Association with working-class activities would have been in conflict with the social aspirations of many members of the profession. (11)

For men, the expression of professionalism as the sole community of interest did not originally seem to be a practicable proposition. This changed in 1930 with the formation of the Society of Registered Male Nurses. This was a movement of male general nurses dedicated to the removal of discrimination against men within the profession (e.g. as represented by their confinement to a special register) and by their exclusion from the Rcn. In 1960 the organisation was dissolved, having achieved its major goals.

In both the asylums and the Poor Law service male employees took the lead in actively initiating trade unionism, and they remained largely more loyal to it as members when the general conditions became unfavourable, with the rapid rise in unemployment. It is difficult to explain this fully. Since the vocational ideology, of sacrificing oneself to nursing, was modelled on Victorian notions of

womanhood, it is understandable that they would be among the first to reject it, at least in its most extreme form. In early union propaganda, resistance to an unreasonable hierarchy was linked to masculinity - joining the union was the 'manly' thing to do. Economic considerations clearly also played a part but these too were linked to notions of masculinity. There was a growing expectation among men that their jobs should provide a 'family wage', sufficient for them to marry and 'keep' a wife and children.<sup>(12)</sup> This, together with their permanent attachment to the labour force, provided a strong spur towards adopting trade unionism and a high focus on wage issues.

However women nurses in the asylums were more likely to join unions than those in general hospitals. This indicates that class background and the nature and status of the work were also influential alongside gender. Of course the two interacted for the historical evidence suggests that asylum nursing failed to attract middle class female recruits, largely because the work had little glamour, and was in fact often regarded as contaminating to those who engaged in it. Yet very few indeed of those women asylum nurses came to occupy official positions with the NAWU. This does not mean that they were necessarily less committed to trade union principles. Indeed they played a more prominent part than men in the militancy of the 1918-22 period. Ironically, their typically lower attachment to

nursing as a permanent career made them more prepared to take risks, where men showed more caution. As Kate Purcell insists, the widespread assumption that women workers are less militant than men cannot be historically validated.<sup>(13)</sup> It is difficult to say why women asylum nurses were not more prominent in official positions within the Union, because the evidence is not available, but the following factors were probably all influential: men's greater stability in the workforce, the ideology that men are more fitted for such positions, and barriers to greater participation, such as the woman's (and not the man's) domestic responsibilities outside paid work. These influences persisted into the 1970s, as was clear when we looked at patterns of union activity at a number of hospitals affected by the rise in militancy during the 1970s, in Chapter 12.

In the Poor Law service there were fewer male nurses, but they too were prominent in the developing trade unionism after World War One. The PLWTU enjoyed an initial success in recruiting nurses, who were much more likely to come from a working class background than nurses in the voluntary hospitals.<sup>(14)</sup> The work involved more care of the chronically ill (though this was beginning to change). It was also under the control of Local Government, which could be subjected to militant pressure aimed at recognising the rights of nurses as workers. Labour controlled authorities might even be sympathetic to trade unionism. Trade

unionism was not on the other hand established in voluntary hospitals. As Abel-Smith suggests, the higher social class background of the recruits, the elitism bred into them by the training school, and the charitable status of the Institutions, all militated against it.<sup>(15)</sup> However even in the asylums and Poor Law service, the depression severely reduced the number of women members of unions. The NAWU and the MHIWU became predominantly male unions.

In the Poor Law service the nurse membership of unions was virtually wiped out by the mid 1920s. The recovery of trade unionism which took place among general nurses in the 1930s had almost to start from the beginning again. In the asylums it started from a base of recognition of trade unionism by the authorities.

Bain's analysis of the causes of union growth places considerable emphasis upon management recognition as an influence, especially under pressure from the State (which after World War I certainly encouraged Whitleyism in the public sector). However there remains a problem of why Whitleyism was established in the asylum service and not among Poor Law employees. It is tempting to suggest that the greater degree of collective organisation and militancy among asylum employees was the most significant difference in compelling management recognition in one

service and not the other. The state stepped in to encourage recognition and the establishment of collective bargaining machinery in one service and not the other, as a result of greater pressure from below. Certainly, as I have suggested, the material circumstances of the different services influenced the degrees of cohesiveness among staff, but this still required a group of activists able and ready to exploit its potential.

One secondary, but not insignificant factor affecting the development of trade unionism, was the lack of unity within the labour movement itself, especially in the general hospitals. As we saw, when the NHS was created in 1948 only among nurses in mental hospitals was union density high. There the recognised place of the MHIWU (NAWU's successor) on the established bargaining machinery had served to deter the intrusion of other organisations, and enabled it to maintain a virtual stranglehold on membership recruitment channels. The union's hold tightened during the Second World War, as coverage of the bargaining machinery increased with Government pressure. It is true that the Rcn gained a limited membership in the mental hospitals; but this was solely confined to those general trained nurses who carried their Rcn membership with them, attracted by high position or a desire to participate in the new forms of treatment (e.g. electro-convulsive therapy) introduced from

the 1930s. It was not until after World War Two, when mental nursing was finally integrated into the General Nursing Council (GNC), that significant numbers of nurses originating from within mental hospitals began to espouse a professional community of interest as their dominant ideology. As far as other trade unions were concerned, NUPE from the 1930s sought to establish itself in mental hospitals. But because of its exclusion from the national bargaining machinery, and the hold of the MHIWU over the recruitment channels, it enjoyed only limited success until the creation of Whitley Council machinery in 1948 unified general and mental nursing into a single bargaining unit.

In the general hospitals it was partly the absence of recognised collective bargaining machinery in the inter-war period that encouraged a multiplicity of organisations to enter the field. Two of these, Nalگو and NUCO, originated at least in part from within the health service. The NUGMW and NUPE on the other hand had established bases elsewhere in the public sector and were now seeking to extend their membership into new territories. In these circumstances, the community of interest represented by loyalty to or vested interest in a particular organisation cut across the need to further the collective community of interest of nurses, which might have been better served by a more united approach. The TUC's attempts, through their Advisory

Committee composed of unions recruiting nurses, did not resolve the situation. Though united on basic demands from 1937 through the TUC Charter for Nurses, the question of which union a nurse should join was tactfully avoided. Furthermore, Nalgo, one of the main unions recruiting nurses, was not then a member of the TUC, and was, as we have seen, more closely linked to the Rcn. It was often said that this lack of unity among unions often confused nurses, and adversely affected trade unions' credibility.

As well as the fact that the trade union movement was divided, the continuing hold of professional associations was assisted by the fact that the Labour Party and Labour Governments sometimes accorded them legitimacy when one might have expected them to be more favourable towards trade unionism. In 1926, for example, the Party produced a Report which originally called for the organisation of nurses 'on Trade Union lines'. However, this was modified by a subsequent Conference on the Report where, according to Abel-Smith:

Mrs. Bedford Fenwick and other nursing representatives attended. Ramsay MacDonald made a smooth opening speech. "I am a tremendous believer in status" he said with more tact than Socialism. When the Conference got down to business, it became clear that the issue of trade unionism was the major barrier which would prevent the nursing representatives from supporting the report. Mrs Sidney Webb, who took the chair, sensed the feeling of the meeting and proposed that the word "purely vocational" should be

substituted for "trade union" in the offending paragraph. According to Mrs Fenwick this was "a touch of genius" (16)

This was not to be the last time that the Labour Party and/or Government would lean more favourably towards professional associations than trade unions, thus legitimating the former's claim to be the 'voice' of nurses. Thus in 1931 the Labour Government bowed to pressure from the Rcn and other professional interests and declined to provide facilities for a Private Members' Bill to reduce nurses' hours and set minimum rates of pay.<sup>(17)</sup> When it achieved power again in 1945, it was a Labour Government which accorded professional associations the dominant position on the Nurses and Midwives Whitley Council. This followed the attempt by a number of local authorities in 1945 (when they still had control of the hospitals) to bring in a closed shop excluding professional associations such as the Rcn.<sup>(18)</sup> In 1974, as we saw in Chapter 11, Barbara Castle gave special heed to a demand from the Rcn for a separate meeting on pay and conditions. Through the course of the 1974-9 Labour Government no moves were made to exclude professional associations from Whitley Council machinery despite the demands of NHS trade unions. Indeed, professional associations were able to use the favourable employment legislation of the period to strengthen their trade union functions. Thus the crucial decision in 1948 on the constitution of the bargaining machinery was



consistently reinforced by Labour. The Government, by taking the 'neutral' attitude that any organisation that claimed seats and could show some membership would be represented, ensured that, with minor modifications, the pattern of representation of 1948 was maintained.

The patterns of representation have remained constant, but the overall density of membership, and its relative weight between different organisations and sectors, has changed. For example, the absorption of mental nursing within the Nurses and Midwives Whitley Council has enabled other unions, particularly NUPE and the Rcn, to make more significant inroads into that field, even though COHSE remained, through its control of most recruitment channels, the most significant organisation. The most pronounced tendency however has been the growth from the 1960s of union membership among all groups of nurses, until by the mid 1970s trade unions were seriously rivalling professional associations as the most representative organisations. Most of this involved a belated tendency of female nurses, especially in general hospitals, to join unions. Thus throughout the 1950s a majority of COHSE's members were male; this changed from the 1960s and by the end of the 1970s women represented 75% of its membership. The three sets of influences outlined at the beginning of this Chapter all appear to have been significant. First, changes in orientations most notably due to the growth of economism in a consumer society, where women increasingly combined participation

in the paid labour force with their role as domestic labourers. The growth of part-time work was one associated factor, the decline in 'living-in' was another. Second, the development of a mass labour force employed by a single employer - the State - administered by the 'new managerialism' and economically exploited as a means of minimising the costs of the service during a period of growing fiscal crisis, cemented a common community of interest favourable to trade unions. Profound divisions of course remained. Some were linked to hierarchical deriviations (e.g. between SRNs, students, SENs, untrained nurses and other hospital staff) that had emerged as a result of the expansion of the division of labour and growing separation of 'care' and 'cure'. Others were lateral - between different specialities, wards, shifts, part-timers and full-timers, and so on. At the minimum such divisions could affect the degree of cohesion achieved; as an active force, they were one factor behind the 'backlash' against trade unionism among nurses during the 'Winter of Discontent' of 1978-9.

The third factor, the general tempo of popular struggle in the wider society, was also significant throughout the period covered by this thesis. The initial spurt of unionisation among asylum workers and the spontaneous rebellions of general nurses occurred in the years running up to World War I, during a time of rising militancy and civil disobedience among women and manual workers. The background was that of tight labour market conditions, and

price inflation exceeding wage increases. The next wave of unionisation came after the War, in very similar circumstances, during a period of increased female participation in the labour force. Its impetus was lost in the economic collapse and rising unemployment of the 1920s. The renewal of trade union activity among general nurses in the late 1930s was particularly concentrated in London, where Labour market conditions were tight, especially for women's labour with the growth of office work and light industry in the South East of England. Chronic staff shortages of nurses during a period of general expansion in the service enhanced nurses' bargaining power.

Membership of unions grew among nurses during the 1939-45 War, when conditions of 'total war' enhanced the power of the labour movement, but as far as can be ascertained most of this growth took place among mental nurses. Perhaps the crucial difference lies in this instance in the differential impact of Government action. In the mental hospitals the existing bargaining machinery and power of the MHIWU was strengthened, as employers were nudged into following the JCC rates by a Government intent of making mental nursing a reserved occupation. In the general hospitals, however, only an 'interim' Rushcliffe Committee was established on which professional associations were given the majority voice, because unions were too weak to resist it. Given the general radicalisation caused by War, and the presence of a Labour

Government in power from 1945-51, it seems rather puzzling that there was no significant growth of trade unionism among general nurses during this period. Government support for professional associations and its reproduction of the traditional nursing power structures with their hostility to trade unionism within a 'socialist' National Health Service, provide part of the answer. Perhaps the continuing low levels of unionisation through this period and into the 1950s provides, more than anything, confirmation of the independent influence of ideology among nurses and its delaying effect upon trade union growth.

The processes of change accelerated, however, so that by the 1970s, this ideological resistance was rapidly eroding. The later 1960s and early 1970s was indeed a period of increasing working class industrial militancy, in which action from 'traditional' sections such as miners and dockers was matched by participation from groups which had previously held back from militancy.<sup>(19)</sup> This included both white collar and professional employees with long-standing ideological objections to participation in industrial action, and low paid manual workers who had previously lacked the confidence to press a collective community of interest. Interpreting the causes of this upsurge of militancy both generally and among nurses is a complex matter. The pressures of rapid inflation;

changes in labour processes leading to 'proletarianisation' of new groups of workers; the growing crisis of the welfare state and its effects on the morale and working conditions of those working for it; the decay of consensus from the end of the long post-war boom; attempts by the State to create, through incomes policy and industrial restructuring, the conditions for greater 'efficiency' and the renewed growth of capitalism - all these were of significance, and have been contextualised for nursing in Chapters 10 and 11. Furthermore, the renewal of the women's movement from the late 1960s, emphasised that women had personal needs which deserved expression, and challenged the received wisdom that they should always suppress their own needs in the interests of others - husband, children, or patients. The growth of student militancy from the end of the 1960s also invited student nurses to compare their lot with students in general, and may well have had an important influence on the militant tactics adopted by many student nurses during the 1974 dispute. These are all issues which were explored in the context of case studies of developments of a number of hospitals, in Chapter 12.

Finally, these three sets of influences not only have a quantitative influence on numbers joining unions, they also have a qualitative effect on the character of collective organisation, affecting unions and professional associations

alike. The most discernible trend in this respect during the period 1970 to 1976 seems to be a growing convergence between trade unions and professional associations, which on the whole confirms the validity of a materialist analysis. The most important reason for convergence has been the slow and fitful, yet pronounced tendency for professional associations to give much greater prominence to trade union demands and activities. Regardless of the dominant ideologies held by their cadres, the 'real' situation of the members has forced them to behave in such a way in order to survive and grow. They have survived in the competitive struggle against trade unionism, but they have had to change considerably. The long-run tendency in capitalist society is for all work organisations, regardless of their social purpose, to conform to the same patterns of work relationships to be found in the dominant capitalist sectors of society. Nursing is only one public service occupation that has been remoulded in this way, creating, in consequence, a workforce dependent on wage labour as a means of subsistence, and subject to a hierarchical authority towards which they feel vulnerable and increasingly alienated. The reality of wage labour, and nursing as a 'job like any other', has been in profound conflict with both the traditional imagery of nurses as 'angels', and the professional image of the autonomous and highly skilled technician. As Abrahamson wryly comments, the reality of bureaucratic subordination contradicts 'the dominant legend - Florence Nightingale in

the Crimea - (which) views the heroine as free of any organisational affiliation'.<sup>(20)</sup> The history of the unionisation of nurses has been governed by a titanic struggle between occupational legends and occupational 'realities'. Of course these do not struggle by themselves. Trade union cadres at first consciously denied the validity of legends. College of Nursing cadres, on the other hand, set out to gain general support for legends, specifically prevented by the College's articles of association from making 'any regulation' which if an object of the College, would 'make it a Trade Union'. The College has been slowly but steadily retreating from this position ever since. As early as 1919, only three years after its formation, the College had produced a 'Nurses Charter' for improved pay and conditions which was

... circulated to all nurse-employing authorities in 1919 with the request (sic) that the improvements in salary scales and working conditions recommended should be adopted.

(21)

This was followed by further judicious 'retreats'; Rushcliffe, the Nurses' and Midwives' Whitley Council, and finally the decision to seek certification as a trade union in 1976. Nevertheless, the Rcn still remained outside the mainstream of the trade union movement - unlike Nalco, which had in some respects similar origins - by deciding not to seek

affiliation to the TUC.

However, another reason for convergence has been the willingness of trade unions to make peace with aspects of professionalism. For unions like Nalgo, this was nothing new. Even the NAWU from the 1920s had begun to adopt a more professional outlook, as post-war militancy faded with growing unemployment and the defeat of the general strike, and as asylums began to change from custodial to treatment institutions. Some versions of professionalism are perhaps compatible with trade unionism, and can be pursued in tandem. Hence dual membership of a union and a professional association became relatively common, a reflection of the contradictory position of many nurses as both employees and part of management. Another reason why professionalism and unionism are not inevitably dissonant is the fact that unionism itself is not simply or always an oppositional force, to the extent that it only seeks to obtain 'fair' employment conditions within an existing hierarchical division of labour and rewards.<sup>(22)</sup> In the context of health care, this approach can leave many areas relating to the content and social relations of care unquestioned, and the right of professional associations to speak on them unchallenged. Furthermore, unions, and not just professional associations, can reproduce and even reinforce the hierarchical and lateral divisions in the workforce, of class, sex, race and speciality. This may be yet another reason for convergence,



as both unions and professional associations provide better vehicles for pursuing the interests of full-time, white, male, trained staff than those who do not fall into these categories.

A final reason for convergence is that there can be no simple division between 'union' and 'professional' issues. Both, as Bain, Coates and Ellis argue, are ultimately concerned with control over work processes and the market distribution of rewards.<sup>(23)</sup> This concern forced professional associations to adopt methods of collective bargaining, and compelled unions to take up issues relating to standards of service which have implications for their members. This does not mean that there are not real and continuing differences in methods, goals and ideologies, but considerable areas of overlap have emerged as both have succeeded in recruiting large numbers of previously unorganised nurses to their ranks.

The case studies, discussed in the previous chapter, have hopefully given some impression of the main lines of convergence, and of continuing divergence. The final and perhaps most important point to bear in mind is that these lines are not permanently fixed. The long term trends, towards convergence, are not determined and there have certainly been swings in a contrary direction - towards

divergence following the 1979 'winter of discontent'. The signs recently point to further convergence - a decline in militant trade unionism in the wake of the failure of the 1982 pay dispute and the miners' strike of 1984-5, matched by growing disillusionment among professional associations that a Conservative Government would look after the interests of professional workers. The renewed push towards 'community care', which particularly affects the job security of those working in long-stay hospitals, is also compelling unions to give greater emphasis to 'professional' issues. Finally the economic and political climate of the 1980s, has led to a decline in militancy by unions, which is likely to foster greater convergence, at least in the near future.

Within this more subdued context, the battle for the loyalties of nurses goes on, by appeal to one or more of the relevant meanings of nursing as a 'job', 'profession' or 'vocation'. Sometimes an organisation will refer to one meaning for one purpose, and another meaning for another purpose. Both unions and professional associations have and continue to be influenced by the meanings that nurses attach to their work in formulating their approach. They in turn also help to influence and change the work ideologies of nurses, as well as the material working environment from which these arise. A closer examination of how these processes operate in practice would seem to be a highly worthwhile direction for future research.

The Development of Trade Union Activity Among  
Nurses in Britain 1910 - 76

TWO VOLUMES : VOLUME TWO

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August 1985

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## INTRODUCTION

These case studies initially developed from research for my MA Dissertation in Industrial Relations, carried out during the Summer of 1974. I was then particularly interested in the impact of the national nurses pay dispute at local level, and followed its effects through at three hospitals where action of some sort was being instituted. After this immediate project was completed<sup>(1)</sup> I received a studentship from the SSRC to continue this research by extending the study of workplace unionism at the original three hospitals, and also to include other hospitals. This research proceeded through 1974-5, and consisted chiefly of interviews with cadres at the hospitals concerned, though I was able sometimes to include interviews with ordinary members, members of management and also full-time union officials. The interview material was supplemented by attendance at union meetings and examination of branch records (such as minute books).

The prime aim of the research was to provide as representative a picture as possible of workplace trade unionism among nurses. To this end I selected case studies according to a variety of criteria: type of hospital, union concerned, degree of militancy, degree of

membership involvement in union activities, and so on. I do consider that in this respect I have been successful, but on reflection, realise that what was gained in breadth may have involved some sacrifice in depth.

My work on these Case Studies was responsible in large part, in helping me to articulate the situated theory of union growth which appears in Chapter Two of the main body of the thesis. Rather than remould the Case Studies to conform with the theoretical constructs of Chapter 2, I have decided to leave them in the shape they took when I conducted the original research.\* Nevertheless, I believe the Case Studies do reveal the variations in 'culture' at different hospital 'recruitment locales', which need to be taken account of in any theory of unionisation among nurses - even though there are important 'common threads' running through all of them. Taken as a whole, the Case Studies below provide, I believe, a substantial body of documentary material on the patterns of local union activity during the crucial transitional period of 1974 to 1976.

\* However, see my analysis of the results in Chapter 12, Volume 1.

- (1) M J Carpenter, Changing Work Attachments and Trade Union Activity Among Nurses in Three Hospitals  
MA Dissertation, University of Warwick (1974).

(i) Coventry Hospitals

Inaugural Meeting of COHSE's Branch at  
Walsgrave Hospital 6 June 1974

On June 6 I went along with Bob Loftus\* to the Inaugural Branch Meeting of COHSE at the Walsgrave Hospital at 7.30 pm. The meeting was being called to elect officers and there were about 20 present. None of the posts were contested and the Chairman and the Vice Chairman were both men who worked in the new psychiatric block at Walsgrave. However, the majority of nurses in the room were 'girls' from the general side. A couple of them were nominated for the branch executive.

Bob Loftus was very nervous before the meeting, because there was a rumour that the Workers Revolutionary Party were going to intervene at the meeting. Perhaps he felt they had scaly skins and breathed fire. At least I got that impression. However, they were nowhere to be seen. The student who was said to be influenced by them was nominated to serve on to the Branch Committee.

Bob Loftus suggested this expressly (he told me afterwards) for the reason that it would bring her under trade union control. As part of his introductory talk Bob also described the present pay campaign. He recommended that they should set up an action committee consisting only of

\* COHSE Ass Regional Secretary

COHSE members and mentioned that any action they take must be sanctioned by the Regional Secretary. The new members were clearly overawed by the occasion.

After the meeting I talked to Helen McAteer, the student concerned. She stated that it was difficult to recruit nurses. 'They are more or less told to join the RCN'. The students held a meeting to organise a local demonstration. This had originally been called by the Rcn who had by that date, however, suspended their action. The nurses were trying to carry it on. They had tried to recruit the sisters to the campaign but it was mainly student nurses who had become involved in militant action. When canteen prices were put up earlier that year they set up a committee of all grades and organised petitions. They tried to get a residents committee going in the home without success. They had received support for the action from Coventry Trades Council. The new branch had 55 members, most of them from psychiatry, although some were from midwifery. Although the General Hospital had been opened in 1969, the psychiatric block had only been opened since December 1973.

### The Walsgrave Hospital

The 'Walsgrave' is an ultra-modern hospital on the outskirts of Coventry, opened since the late 1960s. A wide variety of facilities are brought together on one site. General and maternity provision is well established. Psychiatric services, however, were not fully launched at the time of the research - at the end of August 1974 five out of eight wards remained unopened because of staffing difficulties - and building for a geriatric unit had only recently got under way. When completed, the hospital's 600 general beds, 200 maternity, 300 psychiatric and 200 geriatric beds would serve an approximate population of 600,000. A significant feature of the Walsgrave is the apparent lack of integration of the various units. Each operational unit is housed in a separate tower block. They are administered for many practical purposes as separate hospitals, especially since (at the time of the study) the hospital had no Chief Nursing Officer.

Protest activity was initiated during the Spring of 1974 by members of the Rcn's student section at the Walsgrave. It followed closely on a revolt of the student section as a whole against the sluggish traditional leadership of the Rcn, at the national conference in Blackpool held during March 1974, and described in Chapter 11. At the Walsgrave the learners went ahead with plans to organise action

from a protest meeting, without waiting for the sanction of Rcn headquarters. The hospital administration was disturbed. The Hospital Secretary insisted that the meeting be approved by the Rcn as a whole at the Walsgrave, or it could not be held on hospital premises. Not without misgivings, the local Rcn branch supported the learners' call for a meeting, which proceeded as planned. From it an action committee was set up, as at many hospitals up and down the country. Petitions and letters to MPs were organised, and contingency arrangements made for a local demonstration. Shortly afterwards, however, the Rcn withdrew its threat of action, and all protest activity, following Mrs Castle's announcement of the setting up of the Halsbury Committee of Enquiry on the 23 May.

The frustration of the learners in finding all action called off at the very point when their local campaign was gathering steam, can be easily imagined. They called a further meeting which, by all accounts, was stormy. It was chaired by the Rcn Branch Secretary, Mr Thomas, who was also the Senior Nursing Tutor at the hospital. The fact that some local trade unionists present at the meeting (he claims, uninvited) addressed him as 'Brother', caused him some irritation. Soon afterwards, he lost control of the meeting, and in exasperation walked out, disowning any Rcn responsibility for any decisions that the meeting might take. The learners tried to continue their campaign, but rapidly became isolated within the hospital.

At this time, during early June, a Branch of COHSE was launched at the hospital, consisting of a nucleus of psychiatric nurses. The wards in Psychiatry had only been open for about seven months, and many of the trained staff had been COHSE members at the more traditional psychiatric hospitals where they had previously worked. However, since by that time COHSE was the only nurses' organisation still pursuing official industrial action, it also provided a pole of attraction at the Walsgrave as a whole for dissident elements among the Rcn's Student Section. Yet those predominantly female learners who joined COHSE, found it difficult to adjust. Their loyalties were to the student peer group, and they had no previous experience of trade unionism. By contrast, the more experienced trade unionists were older, more likely to be trained, often male and possessed a greater sense of commitment to the hospital as a whole. Through their lack of numbers and experience, it was difficult for the learners to make much of an impression in the union Branch. The problems they had previously experienced in the Rcn of relating to more senior and older members of staff, were partly replicated when they joined a trade union.

The more experienced trade unionists were almost as alarmed as the trained members of the Rcn at the militant activism of the dissident learners. The driving force of the newly formed COHSE Branch was Ted Rogers. He had previously been



a Branch Secretary in a large psychiatric hospital in another part of the country. He was worried that the learners might alienate other potential union members amongst other grades of nursing staff, by their approach. This lay behind the Branch Secretary's complaint that, for example, the learners went round 'putting up posters all over the place' and not just on the noticeboards earmarked for union announcements. At COHSE's inaugural Branch meeting, he had nominated Helen MacAteer, a leading figure among the dissidents - for a position on the union's Branch Executive, with the express purpose of curtailing her activities. On her part, she was not aware of the nature of this outflanking move.

It is rather ironic that the trade union succeeded in bringing the dissidents to heel more successfully than the Rcn. As a condition of being allowed to join the union, they agreed to call off the planned demonstration and disband the Action Committee. Neither had been initiated by COHSE and, in any case, all action had to be sanctioned by the Regional Secretary. It was a slick exercise in the 'management of discontent' by the experienced trade unionists.

The only local action initiated by COHSE at the Walsgrave involved a refusal to co-operate in the opening of new wards in Psychiatry. Even at this early stage, a majority of psychiatric nurses were COHSE members. Both the union and management knew that this action was a publicity exercise, as the wards in question could not in any case be opened because of staffing difficulties. Of course this could also be said of much - though by no means all - of the industrial action taken by COHSE members throughout the country. Nevertheless, at the Walsgrave the action was particularly low-key, both because the union was not well established throughout the hospital and because of fear by the experienced trade unionists of where action by the learners might lead.

The full composition of the Branch membership at the end of August 1974 was as follows:

<u>Psychiatry</u>	4 Nursing Officers (Salmon Grade 7)
	12 Charge Nurses
	3 Staff Nurses (RMNs)
	34 Nursing Assistants/Nursing Auxiliaries
=	<u>53</u>
<u>Maternity</u>	1 Sister
	4 SRNs (either staff nurses or engaged in postgraduate training)
	2 Domiciliary Midwives
	10 Auxiliary Nurses
=	<u>17</u>

<u>General</u>	3 Staff Nurses (SRNs)
	2 Learners
=	<u>5</u>

Total Branch Membership = 75

Membership was deliberately restricted to nurses as NUPE Nalgo and ASTMS were already well established among non-nursing staff. Outside Psychiatry, COHSE had made something of a breakthrough in Maternity, largely because it recruited a sister who was able to influence others to join with her. The Branch had yet to recruit a similar figure on the general side. The high number of nursing assistants, especially among the psychiatric membership, is a reflection of their preponderance in the workforce. Their numbers have been increasing proportionally in recent years throughout the health service, but Psychiatry at the Walsgrave relied on them to an excessive degree. This was partly because of a shortage of trained staff, and also because the hospital had not yet commenced training psychiatric nurses.

A major reason why it was difficult to attract trained staff was due to the geographical location of the Walsgrave in (what was at that time) a high wage area, where accommodation is in short supply and expensive. Unlike many traditional psychiatric hospitals, there were no hospital houses for male nurses. Accommodation reflected the priorities of the

general side: either single accommodation or short-stay residences for medical officers. The DHSS did not at that time allow hospitals to provide assistance with mortgages, even though nurses' salaries were not sufficient to meet the cost of many mortgages.

The other principle reason for the shortage was the selectivity of Mr Nichols, the Senior Nursing Officer for Psychiatry (ie the head of department) with regard to recruitment. He told me he was convinced that many of the problems associated with the psychiatric hospitals were due to the calibre of staff. Because the Walsgrave is new, he insists on high standards even when the Authority is constantly pressurizing him to open more wards. Yet these attempts to recruit the very best staff - there had been nearly 400 applications for the charge nurse posts - seemed to be plagued with contradictions. In the first place they might worsen the staffing situation elsewhere in the health service. In the second, wards remained closed and in the three that were open the bulk of work was being carried out by untrained personnel.

By the end of August 1974 the union was beginning to establish itself. It was beginning to take up issues where it could, such as pay slip enquiries, and the desire for more choice over holidays. The Branch Secretary seemed happiest when engaging in this routine, but vital, union work. He was

attempting to create a core of stewards: one for Maternity, one each for days and nights in Psychiatry. He was passing on his accumulated experience and familiarising stewards with their 'rights' under ASC Circular 1025.

The Senior Nursing Officer's avowed intention was to cut across the common lines of group identification among nursing staff found in more traditional hospitals, which might impinge on trade union loyalties, if successful. Indeed, there were already features of the work situation at the Walsgrave Psychiatric Unit which would tend to constrain the development of such identifications. There was first the very newness of the hospital that meant that stable relationships between staff had yet to gel. There was no established culture into which new staff were socialised. The new unit was also different. The hospital was not isolated and the pattern of life familiar to many trained staff, oriented around the hospital in work, residence and leisure, could not easily be replicated here. Traditional psychiatric hospitals also often experience low turnover. The largest staff group at the Walsgrave Psychiatric Unit - the nursing assistants - were subject to very rapid turnover and, in any case, typically had no previous experience of psychiatric nursing.

The intake of the unit was also different from a traditional mental hospital, primarily intended for 'acute' admissions, while for more 'chronic' patients a system of day hospitals and community care was planned. Most wards were no more than dormitories. On the ground floor was the Activities Area with gymnasium, games and dining areas. Nurses were allocated to teams of patients, and spent their shift away from the ward setting. The Senior Nursing Officer admitted to a desire to shape the development of the staff group in new ways, but claimed that he wished to redirect staff unity rather than undermine it. He is a member of the Regional Branch of COHSE - where Senior Nursing Personnel's interests are catered for by the Regional Officer - and declares himself a committed trade unionist. The danger as I saw it was that he could only achieve his aims by frustrating staff unity, by fostering an identification with management as identical to the best needs of the patients. Staff might move from one kind of dependence to another, and lean on management, rather than move from group conformity to personal autonomy. This might lead to similar problems of blocked communication and staff frustration recognised as undesirable within traditional mental hospitals.

Although speculative, these observations of mine were given some weight by the evident nostalgia of the COHSE Branch Secretary for the mental hospital where he had previously worked. There, he said, if an issue was raised at a

meeting staff would back each other up. He recalled the widespread collusion at ward level between grades of staff. For example, when a charge nurse was known to be drunk on duty, the Chief Male Nurse sent his deputy ahead to ensure the man was sent off sick before he himself arrived at the ward. At the Walsgrave he complained, staff were rather in awe of the Senior Nursing Officer. They grumbled rather than raised grievances openly. He was worried that staff sheepishness might in the future have a debilitating effect on the development of the Branch. Perhaps some, but by no means all, of the uncertainty might be resolved if the hospital had some proper representative machinery, but there was at that time, nothing like a Joint Consultative Committee in existence.

Interview with Mr Thomas, SNO Teaching, Walsgrave Hospital, 10 September, 1974.

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Mr Thomas is a leading member of the Rcn at the hospital and a member of the Liberal Party. At the time of the Whitley Council Meeting he called a Branch Meeting in Coventry to follow the Rcn's National Pay campaign. However, two events overtook it. The first was when COHSE and NUPE jumped the gun and the second was the press publicity about industrial action. Some ward sisters at Coventry and Warwickshire Hospital (another local hospital) held a spontaneous meeting and wanted to form an Action Committee. Soon after some students and young staff nurses called a meeting at Walsgrave Hospital. They called an open meeting as did the sisters at Coventry and Warwickshire Hospital. The students were told by the Administration that they couldn't hold a meeting on hospital premises unless it was officially sponsored by the Rcn. This the Rcn agreed to do after some brief internal discussion. After this meeting an Action Committee Meeting was held. This planned to do a number of things: to get members of the public to sign a petition, to write letters to MPs, and to organise a march through Coventry on 31 March. Then the Rcn nationally decided to suspend all activities. Marches were suspended but the petitions were allowed to continue. The students at the Walsgrave objected to this and called



another meeting. At this meeting were shop stewards from outside industries who 'tended to dominate the meeting'. Mr Thomas walked out when one of these shop stewards called him 'Brother Thomas'. An unofficial body was formed but it did not get very far.

Rcn Branch Meetings were apparently attended mainly by senior nursing staff. There was no real student section at the hospital to speak of because its officers had qualified. The students did not attend Rcn Branch Meetings. 'They still look upon themselves as separate from the college. They look for different things from senior nursing staff'. He found stewards difficult to find. 'There isn't one for Walsgrave but there are some at the other hospitals in Coventry'. He does have access to students to talk about unions and the Rcn. He claims that he 'pushes membership of an association'. He denied that he pushed the college. One of the problems was the rapid turnover of staff, even of trained staff. 100 beds were closed on the general side and 50% on the psychiatric side because of shortage of staff.

He felt that a lot of the discontents were associated with reorganisation. 'A lot of people feel insecure and this has been transmitted to others, even those not affected, for example, ward sisters'. He felt there were considerable conflicts ahead. 'People above will be frightened of those below, who will become frustrated'. This was because with the increase in technical knowledge, that's where the real expertise lay. He changed to the Rcn when he became a tutor. He felt that the Rcn was the best organisation for those grades. Previously he had been in COHSE.

Report of COHSE Branch Meeting at Walsgrave  
Hospital 20 March 1975

It met again in the psychiatric wing. There were 14 present of whom two thirds were women. There had recently been 25 new members join the organisation. The branch was affiliating to the Trades Council and Peter Halpen was the delegate at the previous meeting. Mr Nichols, the Senior Nursing Officer, was leaving and the Branch suggested a £10 present to buy a candelabra. This says something about the character of Health Service Trade Unionism, that the Union Branch buys the manager a present when he leaves. It was also reported that

COHSE's NEC had recommended to Branches the idea of one or two monthly newsletters. It was also asking them to comment on the pay beds issue. Ted had said that he was worried that Branch meetings focussed so much on the problems of the psychiatric side of the hospital. He emphasised the role of shop stewards and how they should be able to hold meetings in their own section. Mr Linton, who is the steward for the trained staff on the general side said that 'people are suspicious of the union because of strikes and things like that'. The Branch Secretary sought a volunteer to run the newsletter. Someone from the body of the meeting volunteered and she was told that the kind of material that ought to go in it was stuff from different 'sections' of the membership, events in the Branch, and feedback from Regional Council and Conferences.

The Branch talked next about the pay beds issue. One or two nurses complained because they had to drop their own work to get coffee for pay bed visitors. However, they did not think that they could carry through action on the general side. There were some pay beds also in the maternity wing on each ward. There are no private wards as such in the hospital. The revised meal charges were reported to the meeting. The differences between the holiday allowances of day and night staff were reported

to the meeting. The calculations involved were quite complex. I couldn't properly understand them. The shop stewards training, sponsored by the West Midlands RHA, was being offered to COHSE. There was some difficulty with the GNC. If learner nurses went on a course they might have difficulty in fulfilling training requirements. The pay offer of 40% and the elimination of the age range for nursing auxiliaries was reported to the meeting. It was also stated that the problem of improving first year students' scales was one of the things holding up an agreement.

Complaints were raised that the Hospital Secretary had sent out a letter increasing meals by 6% without consultation. Membership of the Branch was now 180. There were complaints about the quality of meals. There is supposed to be somebody on duty 24 hours a day on the catering side to whom complaints can be made. However, it does not quite work like that. Complaints were made that meals were bad at weekends, on evenings and on nights. The Branch Secretary and Chairman are to go to see the Catering Officer and report back to the meeting.

Branch meetings are very much morale boosters for stewards. One of them, who was visibly embarrassed, was presented with a merit badge for having recruited a large number of members.

The problem of cover for female staff on nights in the psychiatric hospital was mentioned. The Branch Secretary feels very strongly about this issue because wards are mixed. He said that if management would not give the date for both sexes cover on all wards they would not co-operate with the opening of new wards. He believed it was dangerous on admission wards and that it takes time to get staff up from the ward on the next floor. A ward sister spoke and said that she wanted some system of getting people there quickly. The telephone was just not good enough. The situation was difficult on nights because on some nights there were no male nurses. She was from the general side and said it wasn't restricted to the psychiatric side. She worked on Ward B5 and though it was possible to call out the porters some of the consultants didn't approve of this practice. There has also been some reluctance from porters on the general side to deal with aggressive patients. Mr Halpen felt something must be done immediately before a bad incident occurred. Ted Rogers said that the problems of the psychiatric side were different. On the general side a patient can be sued for assault. However, on the psychiatric side, he claimed someone who had been admitted on a section of the Mental Health Act could not be sued. The problem was one of shortage of staff. Ted Rogers put a resolution on the issue and it was passed.

The meeting was attended in equal proportions from the psychiatric, maternity and general sides.

Interview with Mr Nichols SNO (Psychiatry)  
Walsgrave Hospital, 10 September, 1974

He said that the psychiatric block had been open less than a year and the staff had been recruited from all over the country. Most were from more traditional hospitals, so there would be a 'long shakedown period before a group identity begins to jell'. He was critical of many of the aspects of the structure of traditional hospitals.

'Traditional staff form interests among themselves rather than with the patients'. He was trying to shape the development of the staff group. It was not just a question of newness but he was trying to act in ways different from that which staff expected. For example, he would get involved in restraining a patient when it was necessary.

He felt most of the staff were used to a more authoritarian structure. He wanted to see a lot of feedback from staff.

'I want to redirect their unity rather than take it away from them'. He's trying to get them to identify more with the patients. 'When a confrontation occurs, for example, over off-duty, the patient is left out of the equation'.

He believes he has evidence that attitudes are altering. An example of this was that charge nurses were reporting things much more about their junior staff. He felt the calibre of staff in the psychiatric field was not too high. However, the hospital was dependent on national policies. Other hospitals accept lower standards. But he does not think that's why they have not appointed more

staff than they have. The AHA and the RHA are putting greater pressure on him to appoint more staff because they want to see the place fully operational. The unit is the newest and largest purpose built psychiatric unit built in Britain since the war. So that he wants to produce high standards in what will eventually be a 284 bedded hospital. It is not based on the DGH concept of 30 beds to 60,000 population. Instead it serves a population of 620,000 throughout Coventry, Rugby and Nuneaton. There would not be a training school at the hospital until the next year. Turnover is high. They had already lost 3 trained staff as a result. However, the greatest amount of turnover was amongst nursing assistants. 'They don't know what the job's about'. A lot are married women who find they can't cope when the school holidays come around.

He believed the high rate of turnover to be quite common in new hospitals. This is especially true amongst junior staff. It happened in the Maternity and General wings of the hospital as well. There are eight psychiatrists which makes a higher ratio in relation to nursing staff than is common in most psychiatric hospitals.

He emphasised the different treatment regime from traditional hospitals. Patients spend their day away from the wards which are just dormitories. This is true for six out of the eight wards. Charge nurses are not ward based as they are in psychiatric hospitals but spend their time going with the patient to the ground floor activities area.

There were some advantages to being on the same site as the General Hospital. It made it easier to get access to medical and diagnostic aids. However, he emphasised the disadvantage, which was that they had to impose restrictions on people with behavioural problems who could not be allowed to wander through the grounds. The General Hospital and the surrounding community imposed restrictions on them.

On married accommodation he said that some staff couldn't come because of the lack of it. The hospital is tied by national policy because of the general hospital emphasis on the site, accommodation policy is orientated to short stay problems of female staff and registrars. All they provide, for example, are furnished flats. There was a great need for unfurnished houses for staff. 'However, I wouldn't want a hospital estate. I lived on one and it leads to institutionalisation.'



He talked about how gossip happens everywhere, but how much of it was associated with traditional structures. Conflicts were set up between chronic and acute wards. The staff on acute wards were seen as 'good' staff and those on chronic wards were seen as 'bad' staff. 'We are trying to avoid that here'. I asked him if he felt standards had declined amongst staff in the post-war period. He felt that in the 1930s mental hospitals often received a high calibre of staff but they were attracted mainly for reasons of job security. He felt there was some decline in the 1950s which was disguised by the development of community care. He felt that apathy in some COHSE branches led to bloody-minded people taking over.

He joined the Rcn for 'purely mercenary reasons'. When he was doing his tutor course he joined because it made it easier to use the library. He is originally from North Yorkshire. His father was on the National Executive of the AEUW. Although he is in both the Rcn and COHSE he would leave the former before he left the latter. 'I identify with the trade union movement'.

CONFEDERATION OF HEALTH SERVICE EMPLOYEES.  
WALSgrave BRANCH.

From: Branch Secretary

To:

Date: 28th February, 1975.

Branch Officers and Union Stewards.

The following are appointed the Branch Officers and Union Stewards for the year 1975.

Chairman

Mr. H. Long.  
Community Psychiatric Charge Nurse.

Vice-Chairman

Mr. D. Miles.  
Nursing Officer, Psychiatric Hospital.

Secretary

Mr. E. Rogers.  
Charge Nurse, Psychiatric Hospital.

Union Stewards

Miss H. McAteer.  
Student Nurse, General Hospital.  
Representing Untrained members employed in the  
General Hospital.

Mr. J. Linton.  
Charge Nurse, General Hospital.  
Representing Trained members employed in the  
General Hospital.

Mrs. J. Smith.  
Sister, Maternity.  
Representing all members employed in the  
Maternity Hospital.

Mr. P. Halpin.  
Acting Charge Nurse, Psychiatric Hospital.  
Representing members employed on day duty  
Psychiatric Hospital.

Mrs. M. Rogers.  
Staff Nurse, Psychiatric Hospital.  
Representing members employed night duty  
Psychiatric Hospital.

E. Rogers.

25 June 1974, Second COHSE Branch Meeting at Walsgrave  
Hospital

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Membership at the moment is 8 general nurses of whom one is trained. There are 51 psychiatric nurses. 19 midwives on night duty. The ancillaries are in NUPE as are some general nurses. Two NALGO members, one TGWU, and 2 NUPE members want to join COHSE. Technicians at the hospital are organised in ASTMS. Nurses are the major unorganised group.

There were 12 members present at this branch meeting. The first item was election of stewards. Stewards were being appointed as follows: 2 for psychiatric (one on days and one on nights) one midwifery, and one from general. All the nurses in the room apart from one were psychiatric nurses and the branch meeting was held in the psychiatric block. One midwife came in and she was elected to the executive committee. The majority of members in the room were women. The meeting also sorted out two nominations for the COHSE Regional Council. The next item of business was the nurses' pay campaign. Ted Rogers, the Branch Secretary, reported that he had received no circular on new action from Banstead. He suggested that they should only seek to propose withdrawal of co-operation over the future opening of new wards in the hospital. He recommended that they should not ban overtime because 'the hospital is very dependent on it'. Mr Halpen, however, was in favour of

banning overtime. He was the day steward on the psychiatric side. However, he recognised that most of the nurses in the room worked nights. He wanted the executive committee to consider banning overtime after discussing it with all grades. He criticised the lack of publicity on the general side for the meeting. However, the Chairman of the meeting (the Branch Secretary) saw the lack of attendance at the meeting as a desire not to take industrial action. Mr Halpen then withdrew his suggestion because of the low attendance, agreeing that a small meeting could not commit the membership to action. The plan to withdraw co-operation in opening the new psychiatric wards (said to be imminent 'in the near future') was accepted. However, he warned that if non-members decided to staff the ward it could ruin the action, but that the majority of trained staff were members of COHSE. Thus he felt that some limited action of this kind was feasible in the psychiatric block. He suggested that the action committee should consist of the Branch Executive, Branch officers and stewards.

On the future venue of meetings a woman suggested that it should be held in the nurses home to attract more staff. She pointed out that attendance at meetings was difficult when staff covered 24 hours. Ted Rogers said there was a

problem with publicity because they did not yet have a union notice-board. However, they were getting one. The Branch Secretary's view was that 'if people don't come, they are not bothered. Notices are enough'. However, Mr Halpen felt that stewards should encourage people to come.

Finally, the Branch Secretary warned of the activities of the Workers Revolutionary Party. He said that if any member was approached by them they were to see the Branch Secretary. They were not to sign petitions, because under the union rule-book (and he referred to the relevant rule) a member could be suspended.

Subsequently on 17 August 1974 I conducted an interview with Ted Rogers. He stated that they were increasingly organising the hierarchy. Numbers sevens and eights (ie nursing officers) were joining the union and next year he believed that it would be feasible to start a Sub-Officers Branch. The Branch Vice-Chairman, Mr D Miles, is a Nursing Officer. He complained that there was considerable turnover in this hospital. 'You lose the membership and have to keep building it up'. He was asking the principal tutor, Mr Cook, if he could talk to intakes of students about the union. However, he was an Rcn man. There is a charge

nurse attached to the school who is a COHSE member. He said that he would be entitled to go if he could prove that the Rcn was giving talks and putting pressure on people to join. He believed that if he could get into the school it would make a big difference. He is wary of the Rcn because it lost control of the pay campaign at the hospital.

There is a bit of unrest about the adjustments that have to be made in shifts because of the new agreed hours. Before the Branch Meeting there was an informal meeting between the Principal Nursing Officer and COHSE. There was also dissatisfaction with the pay agreement of last April and its effect on night duty and unsocial hours payments. These were based on the previous hourly rate and so nurses did not get their full time and a quarter. He thought that a lot of nursing assistants were leaving. Some were leaving because they were promised training as psychiatric nurses, but there have been delays in introducing RMN training. The psychiatric hospital is not fully operational and won't be recognised by the GNC. He complained that the assistants were not experienced trade unionists and didn't understand much about trade unions. 'Their understanding about trade unionism is not very great, even those in the union'. Most of the trained staff have been in COHSE before. Some were

on the Regional books or had lapsed membership because there was no branch when they came to work here. Six members from NUPE wanted to transfer but they are having difficulty getting forms from their union. COHSE has made more gains in maternity because there is a sister who is a steward of COHSE and is very active. He would like someone similar to push the union on the general side but there isn't one. He himself has only worked at the hospital a couple of months. There are meetings of Heads of Departments of all disciplines every month and COHSE, along with the other unions, is looking for access to it. There is no JCC at the hospital or anything like it. The hospital Secretary called a meeting of all unions to discuss 'communications'. However, the meeting also discussed meal charges. There is at present a consultative document on JCCs with the Regional Health Authority. There has been an interim staff consultative committee set up without formal powers. The Chairman was appointed three weeks ago. Communications between himself and his members are difficult at the moment. This is for two main reasons: 1) Because he is new and doesn't know enough about the place and 2) because the site is geographically split into three hospitals.

The hospital had considerable difficulty attracting psychiatric nurses because there was only limited accommodation that it could offer them. However, through the Council, they will provide temporary accommodation for 12 months and will loan up to £500. There is also an excess rent allowance which is based on difference between present rents and the one you were paying in your old job. This lasts for five years and can be also claimed on mortgages. However, staff nurses do not get removal expenses. There are too few RMNs at the hospital and charge nurses are relying on assistant nurses. The system of working is different from a traditional psychiatric hospital. Patients are divided into groups and one nurse is made responsible for a group of patients during the day. Most qualified staff work on admission wards and considerable overtime and split shifts are worked. All the wards are mixed so there is a need for male and female staff on both days and nights. He is worried that there are no male nurses at night. On Ward D3 a male patient tried to cut his wrists and there were only two women nurses on the wards. This is going to be brought up at the next Branch Meeting. 'Management look at it from the angle of male nurses working with female patients rather than the risk to female staff on male wards'.



He believes that the loyalty to the Senior Nursing Officer is strong and based 'a little bit on fear'. He thinks that charge nurses don't take up issues in Branch Meetings. For example the holiday list is very fixed at the moment and the branch want some choice. 'Things are not raised in meetings. Instead they complain in the dining room'. He believed that the staff group was very different from a traditional psychiatric hospital because staff were not so cohesive. In Shenley if something was brought up at a meeting the staff group would back each other up. This solidarity does not exist in this hospital, partly because the staff are so new. He said that the staff were in awe of the Senior Nursing Officer because he appoints them. However, they were starting to come with pay queries to the Branch Secretary.

Follow-up Interview with Ted Rogers, Branch  
Secretary of COHSE at Walsgrave 14.3.75

He felt that when pressure on staff increases, sickness rates go up. They were still very short of staff. Halsburg hadn't helped things because it had concentrated most of the increase to the higher grades. They were losing Nursing Auxiliaries to other psychiatric hospitals ; 'the better ones who wanted to do training'. The training of psychiatric nurses had still not got underway at the hospital.

There had been some discontent about the Divisional Nursing Officer job which had become vacant since Nichols left. Someone from outside had got it.

Again, he contrasted conditions at the Walsgrave and Shenley, and the kind of qualities required of applicants. At Shenley 'if people could play football or play a musical instrument they would get the job'.

There are now 4 wards open. He claimed that 'Nichols wanted COHSE. He thought it was soft. Staff who left thought he was a dictator. At a charge nurses meeting before he left he really went into them. He strongly believed in a separate identity for nurses. He didn't want consultants ordering nurses around.' Ted said that 'I agree with some of his aims'. However at meetings 'he would discuss

certain things, and with others insist on doing it his way'. He intervened in the ward situation very little, 'but he knew everything that was going on. He did it through the Nursing Officers. Another fact that had caused resentment was the replacement of Nichols by a woman. Psychiatry was 'almost a separate hospital'. He thought the Area Nursing Officer may have tried to get someone softer than Nichols. The NO who got the job 'was the only woman applying'. The new appointment has caused uncertainty. 'They don't know in what direction she's going'. Nichols 'stopped the community spirit. He frowned on fraternisation between RMNs and nursing auxiliaries and porters, for example sitting together in the coffee lounge'.

Nichols, in other words, was imbued with professionalism and was trying to get the psychiatric nurses there to adopt it. Ted reflected that in Shenley 'the nurse was nowhere near the top - occupational therapists are higher'. Here 'the OT is not very good. There has been pressure from nurses'.

Nichols did not approve of parties attended by all grades of staff - something they had at Shenley. 'Senior and junior nurses are not on Christian name terms. He proscribed it'. Similarly between patients and staff, Nichols felt that 'where there's a large number of untrained nursing auxiliaries there's a danger of them

getting over-involved'. Ted himself thought that 'perhaps it's a good thing for nursing assistants not to use christian names. They can't cope emotionally. It's a protective device for them. I wouldn't defend it for other staff'.

By December 1974 COHSE had recruited 180 members and it was still growing. There were now 2 stewards on the general side: Mr Linton and Helen McAteer. Ted's wife was the steward on nights for psychiatry, and Peter Halpen was the steward for psychiatry on days. There had been a branch executive meeting 2 weeks ago. What he now wanted to organise were more sectional meetings 'at the base'. Branch meetings were held regularly.

No major issues had yet cropped up. 'The staff are not very militant. It's the kind of people Nichols picked'. What's also interesting about this remark is the way consciousness is so focussed on the Psychiatric side of Walsgrave hospital. Ted wanted to take up the issue of always having male and female staff on the mixed wards for (a) security and (b) 'protection against false charges'. Nichols said that they would try in the future but could do nothing now. 'I wanted them to take it up but they wouldn't. They won't do anything until someone gets hurt'. He noticed, in passing, 'that men tend to get attacked more than women'.

He talked amiably of the best methods of controlling violent patients. The most effective way was first round the neck, then someone grabs hands and another the feet. The 'old style' male nurse used to go for the patients tie. Codes, if formulated, are often ignored. 'It doesn't matter what they write down'. The worst method is grabbing someone's clothes, because then they might get free. However, incidents of violence 'aren't very common here'. There were more in Shenley because of locked wards and patient frustration he said. Patients on 'refractory' wards couldn't get out and frustrations mounted. Exercise on these wards was seen as a means of relieving tension. Hence patients were set to 'bumping' all day long - polishing floors with wide mops. 'The charges used to try to tire them out. They would do it for years'. He also reminisced that 'people would stay in padded cells for 4 and 5 days at a time. This was used as a form of punishment for patients who hit nurses at Shenley.

On every ward 'there were one or two big patients who were the charge nurse's "pet"'. A ruthless charge nurse would have a tough patient on the ward who controlled the other patients for him. Ted started work at Shenley in 1962 on a locked ward which still, in 1972, was described as a 'refractory' ward. 'It was amazing the relationships which did emerge in those breeding grounds of violence.

Nurses had power in the wards. They walked around with a chlorpromazine bottle, and sodium amytal, and if a fellow lifted his head or coughed, they would give it to him. They would tell the doctors what to do. The Charge Nurse was king. If a doctor wrote up something which he did not approve of he would say 'I'm not going to give it'. The Consultant would say, 'I'm going to send you a new doctor, set him straight'. But he said that things were much better here than in the USA. He said that a lot of the staff were ex-convicts who did it as a form of parole and that patients were often chained.

He recalled how in Shenley one reforming doctor came in and stopped all medication. This led to considerable conflict with the night staff. In the past 'he'd got everyone in bed by 10 o'clock so he could get his head down' but now some of the patients were up playing cards until 4 o'clock in the morning.

Ted worked in Villa 21 (the famous ill-fated experiment by David Cooper). During the course of it Cooper's wife left him and went to London. One of the two charge nurses, totally committed himself to it. Afterwards, the dedicated one, Frank Atkins, came back to a traditional ward in the hospital 'and had problems'.

The other one 'sat on the fence' more, and is now a nursing officer. There were great pressures in the hospital against the experiment. 'Many nurses refused to work there'. Ted worked on it as a student. 'Patients disintegrated and started to build up again. Patients were doing their own thing'. The place was allowed to get dirty. This in a place where staff 'used to spend days polishing the floor'. Because there were so few domestics, these jobs were often done by student nurses.

Ted started at another hospital, Saxondale, and 'had to polish morning, noon and night'. One charge nurse insisted on doing it diagonally so marks of electric polishers wouldn't show. We had to do shaving with cut throats, so we were told to fill our pockets with cotton wool.' There was a COHSE branch there 'but it was almost a secret organisation'. He started up a Student Nurses Association 'but it was a very authoritarian place. I got fed up and went to Shenley. It was a totally different place. I was lost at first because no-one told you what to do'. One of the features of the place was suspicion of newcomers. 'Nobody accepted me for 6 months. Nobody said "hello". They watched newcomers, waited to see how they performed on the wards.' He lived in the nurses home and felt very isolated because no one talked to him - a young Irish lad away from home. 'They were suspicious of newcomers and very suspicious of management. Shenley

never had a scandal. The press men wouldn't get in. The staff closed ranks.'

He compared it with the Walsgrave. 'If something happened here and other staff were asked to make a statement, they would do it. In Shenley they would refuse and get in touch with the union first'. This kind of attitude makes it difficult to build the union at the Walsgrave, because 'nobody backs you up'. On the ethics of representing someone who had ill-treated patients, he said: 'It's the unions job to defend a member even if he's a bastard'.

He said that 'Sans Everything was an exaggeration but if COHSE wrote a book they could make it seem as bad without exaggeration'. He gave as an example an incident at Shenley where a patient had got a beating after coming back off leave. However the staff concerned were cleared at a disciplinary meeting. 'It didn't matter who got away as long as the hospital didn't get a bad name. If you complained and were responsible for getting someone the sack you were ostracised'. Shenley had been opened in 1939 and 'didn't start off as a dump. Hospitals had the pick (of staff) then. They were good nurses, considering the conditions they faced'. To start off with it came under the administration of the Middlesex Hospital. 'How would the nurses of today cope with those conditions?' he mused.



When Shenley was expanded, much of it was done with patient labour. They built the occupational therapy department and the church, under teams run by charge nurses. Charge nurses worked on days and nights on the farm villa. Nurses slept in. Ted did it. 'In the morning the patients brought me a cup of tea'. The kind of people who got these jobs permanently 'were those they didn't want on the wards'. For example, a nurse that wasn't considered very good but was due for promotion to charge nurse. 'They would send him there (to the farm villa). The next stage after the farm villa was retirement'.

At the present moment, Mr Allen's acting as the Divisional Nursing Officer, before the newly appointed woman takes over on April 7th. We talked a little about the union presentation to Nichols when he left. 'Some members are a little surprised and upset. The resentment is there but it has not been expressed'.

Psychiatry and Geriatrics (the block was then in the process of being built) are going to be under the same division. (It was scheduled for opening in 1976). Six houses had by then been bought by the hospital for trained staff on the psychiatric side.

The regime is based on patient teams, to which nurses are assigned. However, 'patients can just go about as they please. In the old hospitals you might have him (the patient) in pyjamas for the first few days just to see how he got on. Then you'd let him go to town or OT (Occupational Therapy). There's none of that here'.

The problems are (1) fears by the local community near by. (2) Those of the nearby general hospital and (3) Nichol's different approach. He went on a 'first line' management course and found that 'most general nurses don't know anything about psychiatry. They still think in terms of padded cells and chains'.

Interview with Helen McAteer ex Walsgrave Hospital  
COHSE 13.4.78

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Helen is no longer on the Branch Committee although she remains a member of COHSE. She was unaware of the manoeuvrings that went on when student nurses were admitted to the Branch and herself pushed forward by the Branch Secretary to be a Branch Committee member. After the Halsbury award, she and John Linton, a charge nurse in the General Hospital, experienced great difficulty in building membership among general nurses, either by specific recruitment campaigns, or in the more round about way of trying to win issues. This lack of success was a factor leading to her demoralisation and subsequent withdrawal from trade union activities.

When the pay dispute got off the ground in 1974, Helen was a first or second nurse. Although she was a member of The International Socialists (she had been before she came to Coventry) she knew nothing of trade unionism or how to set about organising one. She described herself then as 'naive' and 'shy'. Thus her main activities in IS were in the Branch and in selling Socialist Worker. When the pay dispute got going, however, she and a couple of 'girls' she lived with in the nurses home decided they'd try to do something. At that time most of the 'girls' were in the Rcn 'but had broken with it'. This led to meetings

and the formation of an Action Committee, following others that had been set up elsewhere. Initially the Rcn went along but then backed out. The 'girls' became increasingly militant (even though she says 'it was all talk'). They discussed such action as 1 hour stoppages and a march to Chrysler's (a local car factory). The other reason for the Rcn backing out (and the withdrawal of support from the School of Nursing) were the growing links with outside trade unionists. 'We all agreed that the best way to go about it would be to get in touch with the Trades Council'. They felt very inexperienced.

The discussions never led to action. After the Halsbury Committee of Enquiry had been set up a lot of heat was taken out of the situation - the momentum went out of the campaign. 'The Halsbury thing was a good excuse to drop it'. The militancy wavered. Helen felt that students were easily bought off by it because they were new to militancy and didn't have a very fine appreciation of tactics. 'All they knew was that their pay was too low'.

The Action Committee consisted mainly of students though a couple of staff nurses and a sister were involved, and John Lenton. All of them subsequently joined COHSE.

No nursing auxiliaries were involved in the Action Committee, but a number subsequently joined COHSE, around the same time as the other nurses did. John Lenton was quite good at recruiting people, but he 'was very conservative, saying join the union for your own protection'. He was quite a shy person, too.

After the dispute 'things calmed down'. Branch meetings were fairly regularly attended, by about 15 people - mainly from the Maternity and Psychiatric blocks. 'The meetings were interesting in the beginning'. They were discussing the after-effects and repercussions of the Halsbury settlement. However interest and attendance began to tail off. The nurses from the General side (those involved with the union) decided to launch a recruitment campaign. 'The Branch Meetings were so oriented to psychiatric problems' eg the fact that the hospital didn't want their psychiatric nurses to wear uniforms. Some of them felt a little uneasy, but others were more concerned about getting a proper clothing allowance instead. This was a discussion upon which she felt she had little to contribute. 'A few of us from general felt we had to have a separate branch'. They did lots of notices. At first they got into trouble for putting them all over the place. Then management gave them a proper noticeboard. They used head office

posters. They leafletted everywhere. They went round the nurses home, putting leaflets under the doors.

'Very few people joined as a result and this led to a bit of disillusionment.' The Branch meeting voted her as shop steward for the general side. She drew up a list of issues which, if they were successful on, might bring people in. eg:

- except in theatre, shower facilities were non existent
- creche for staff
- more NHS abortion facilities, which was a big issue at the time.

They had informal discussions on these things in the Branch. Although issues were taken up - she wrote letters off to the administration, - they never got anywhere with them.

She complains that 'nurses had no trade union consciousness'. They held lunch time meetings for nurses in the Committee room, which attracted some people, but few joined. At this time, too, meal prices went up, and they tried to campaign around this issue, saying it was eroding the Halsbury pay increase.

She thinks that they would have 'definitely' had more success if they had tried to do more about getting nurses in at the height of the pay campaign. She believes 'the mood of militancy lasted a few days'. However, things hadn't gone right back to as they were before.

'Attitudes have changed. The Rcn had respect then. Talking to students now, they don't.' The generation of students after her 'have got a different outlook'. She recalled how she had only 'just come through Preliminary Training School when she became active and believes that, if she had known more, and been less inexperienced, she could have done more. ie She puts some of it down to herself, not that nurses are inherently difficult to organise. Surely this is hopeful - it shows her demoralisation is not complete. She plans to go to Sheffield to do an Intensive Care Course. Maybe she'll resume her activities there.

She remembers how nurses on their first day in training school were handed out Rcn forms to fill in. They were advised to join. They weren't told about any other organisations. 'If it's your first day you know sod-all about the Rcn'. It was easy to get people in because they looked up to tutors and assumed it was part of becoming a nurse. Helen thought this particularly unfair. In

the contract of employment it was stated how people were encouraged to join an organisation of their choice, but this wasn't being implemented at this level. She felt that, new students should have a chat from COHSE as well 'and make up their own mind.' She and Eddy Rogers wrote to the school. 'I was in a difficult position, so Eddy Rogers saw Mr Cook' (the PNO Education). He refused to grant COHSE access. The reason he used was that time was not allowed for it by the GNC in the syllabus. They would not accept this and took it to Mr Warley the Area Nursing Officer. Meantime, since the school was next to the nurses home 'I sneaked down to put COHSE posters up and left forms around everywhere'. Mr Warley backed up Mr Cook and they got nowhere. 'I was advised not to push it for my own sake by Eddy Rogers'. However, nurses weren't enthusiastic about the Rcn either. 'People don't want to join the Rcn because it's so dear. I must admit I've used that argument on people'. (This indicates that when you try and get people in the union, you may think their reasons are different from yours and then bargain with your own conscience about how you can use what you imagine their reasons are. For Helen, emphasising that the Rcn was more expensive represented the outer limits of personal acceptability).



In selling the union to student nurses, they emphasised pay, 'or just talked about food prices. The nurses home was disgusting'. There were rules against having male visitors in rooms and female visitors had to leave by a certain time. There were difficulties getting clean linen. 'We resented the Rcn because it had nothing to do with us students'. She associated it with sisters and trained staff. 'When you're a student you think you're doing everything and they have an easy time'. She realised that that was not quite fair now. However, there was considerable resentment among the students against qualified staff, and the Rcn came into that bracket.

She dropped out of the IS and trade union activities more or less around the same time. It was the time when management were setting up an Area JCC. She wanted and worked for an inter-hospital Joint Trade Union Committee. This was the initiative of COHSE and also NUPE at Walsgrave. The latter had a new Branch Secretary and she thought he was quite good. A joint committee 'seemed a feasible idea' to her. However, it didn't get very far. She felt people didn't really understand the kinds of things management were trying to do by setting up a consultative committee. There were a couple of meetings at Walsgrave of the unions but nothing further came of it. She worked hard for a couple of months and in the end it got nowhere. At the

same time the lay administration were putting all sorts of obstacles in their way. They would not provide a room for a COHSE office. 'In the end we were just going to take over a room', and they reluctantly provided one. There was also grudging agreement that they would provide some duplicating facilities.

Meanwhile COHSE was getting on well in the psychiatric block. 'They had a good working relationship with management. It was impossible for us to do anything'. Management didn't victimise or try to take them on on the general side.- just ignored them. She puts it down to (a) her own inexperience, (b) lack of support from management, and (c) above all, the fact that 'management didn't take us at all seriously'. Again she said she felt 'guilty about the past. I could have done more'. Now she felt she could more easily recruit people if she put her mind to it. She is older, has more self-confidence and gains what she calls 'respect' - but not in a hierarchical sense - from the people she works with. "I get on with people at all ends of the scale'. She discusses things with people - racialism, about what should be happening on the wards. She struck me as someone just coming out of a period of demoralisation, with more composure and self-knowledge; without having become cynical.

She felt that Eddy Rogers did try to involve her in the Branch, but not others. 'He wasn't interested in the General side. He had enough on his plate'. She thought 'he was okay at first, but, it's worn off'. She felt 'he can talk militantly,' but not go much further. He did spend quite a bit of time telling her about the rule book, how to formulate Branch motions etc; Branch procedure generally.

At this point in the interview, two other Walsgrave nurses (one of whom used to work there) joined the discussion. They were both members but when Helen asked them if they knew anything about unions they said 'no'. Penny is now an enrolled nurse. She said that the Rcn was beginning to be active. It was organising a list for people to sign if they didn't get their uniform back from laundry. Penny explained how and why she joined the union. 'I made a mistake' she said. She had drawn up a wrong injection and though she hadn't given it, 'it frightened me'. This was two months before she actually joined, but it had stuck in her mind. That was the only reason she joined the union. 'But', said Helen, 'you're always complaining about staffing levels'. Penny agreed. On the Cardiac-Thoracic ward where she worked, 'the staffing level

is dangerous'. The day before a man had died with no nurse being there, and though he was expected to die, someone should have been there. There were other staffing problems, particularly on nights, on a ward with 5 patients on ventilating machines.

The importance of this is that it shows how the limits of trade union consciousness operate. The other nurse said, 'most join for protection, nothing else'. Trade union consciousness is different things. In the act of joining, if her comment is true, it implies no necessary collectivism. The existence of trade union consciousness in a fuller sense implies more than membership - it implies seeing the union as relevant to the problems encountered in daily work - as a possible collective solution to them. In the main, these nurses just didn't think in these terms - trade unionism was not seen as relevant to them. Of course, as well as not seeing unions as relevant, it could also be due to lack of confidence in their collective strength. There are also the processes by which nurses become 'hardened' to working in poor conditions. One response, as another nurse explained to me, is for night staff to blame days and so on - as long as you personally are absolved from blame, you

can carry on. You complain, but in a ritualistic fashion and never seek to translate this into effective action. You tell the night sister that there wasn't a certain piece of equipment - and then forget it.

The last thing we discussed (Helen, Penny and Angie, who all took their finals together) was when during an economic crisis in 1976 the Authority was threatening to sack nurses when they qualified. What particularly upset them was the way people's records were discussed when it came to the few jobs that were available. Angie said, 'They were insulting'; people were criticised because they had had 20 days sickness over 3 years. Angie was asked 'Don't you like getting up in the morning?' Yet, although Helen was elected spokesman, 'we did it as a class' not through the union. They had a meeting with Mr Cook. They joined forces with pupil nurses and got in touch with the Coventry Evening Telegraph (one of them had a boyfriend on it). However the subsequent article was toned down in comparison to what they had told them. Those who applied for a job were assessed according to their sick record, 'not how good a nurse they were'. Helen said 'we did contact the union but nothing was done'. But after the fuss most got jobs, and the next student intake was cut. However there

were a high number of failures. They were told this was because 'the GNC had put standards up because of jobs'. Those qualifying with SEN were more likely to be made redundant by the hard-pressed Authority than SRNs. It was also claimed that those with more than 25 days sick were 'only' able to get jobs on geriatric wards - choice being virtually non-existent. They threatened that if they were made redundant 'there would be trouble', said Helen.

The interview ended with a general judgement on why nurses weren't interested in being involved with unions. All agreed that they were too tired after their shifts to bother with things like that. 'We're too tired to do anything', one of them said.

Whitley Hospital, Coventry Nightshift 15 June 1975

The union which organises amongst the night nurses at this hospital is NUPE. There is one steward for the three geriatric wards and one for the general side. One SEN told me that she had left NUPE and joined the Rcn because she had heard the branch secretary say that if an intruder came onto the wards they should run and forget about the patients. She said that she had joined for protection originally, the trouble is that protection can mean all sorts of things and people can feel vulnerable to all sorts of parties. I think it is usually a euphemism to mean the situation where someone is accused of something in relation to a patient.

The nursing auxiliaries are the most active members of the union here. There is considerable resentment by the night sisters against the union who are believed to interfere with 'professional' decision making. As Sister Gardner said 'they try to tell the night superintendent what to do. They complain about little things like off duty and so on and are not concerned with patient care'. (Of course they might be little to her, but they may make a lot of difference to the people concerned). She feels that 'staff nurses are hiding behind nursing auxiliaries skirts'. That is, that they use the collective strength of the nursing auxiliaries. She cited the example of a

staff nurse who was being moved to Gulson Road General Hospital and the auxiliaries tried to tell the night superintendant that they couldn't do it, that they were 'contracted to work here'. She said that this was 'not the case, they have to work anywhere in the group'. It is clear that what the union is primarily being used here for is to ensure flexibility of working arrangements between staff and management who would like to maintain their prerogatives on the deployment of staff. It is very much concerned with workers control. Sister Gardner thinks that 'men are better in nursing management, they know how to handle the unions better'.

She recognised the problem over transferring staff, of course, which was that many of the nurses, especially the nursing auxiliaries live close to Whitley Hospital. Any transfer will lead to a situation where they have to travel longer distances to work.

Another night sister, Sister Rogers claimed that the 'union is very militant here. We have to treat them seriously, I never knew of them before I came here'. She did two years as an agency nurse in London. The Geriatric Unit which covers some hundred patients is especially dependent on nursing auxiliaries. There is a shortage of



trained staff especially at night. Sister Rogers says that 'staff are more trouble than the patients here'. One dispute concerned an objection to laying out a body just as it was going off time. Another issue was whether nurses should run when an intruder came onto the ward. She was worried that some of the trained staff were beginning to feel conflicts of loyalty. Some of the staff nurses are trying to get out of the union but the nursing auxiliaries won't let them. Thus the trained nurses on the ward are torn between the people they work with, the nursing auxiliaries, and the senior nurse managers who, from my experience - I worked there for 3 months - sit in the office most of the night smoking and drinking cups of tea. The night sisters are extremely opposed to the union and view it as purely obstructive to the kinds of objectives they are trying to realise.

Interview with members of the High View Action Committee  
26 June, 1975

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The leading light of this committee appears to be Mrs Palmer whose husband is a lay activist in the Post Office Engineering Union. The hospital was built in 1908. It is pretty dilapidated and there are cracks appearing in the ceiling. Coventry AHA want to close it down and transfer the patients to the new geriatric wing at the Walsgrave.

There are eight on the committee which was set up by the union and elected at a branch meeting. However there is a hard core of four people who do the work: Sister Lunes, a part time staff nurse on night duty, an SEN, and the night sister Mrs Palmer.

The union branch was set up a year ago or so by a male nursing officer who has since left. The branch secretary's name is Sister Holmes. They are also working through the local MP for Nuneaton, Les Huckfield. The staff heard about the closure when they were called in at 11.00 am one day for a meeting. However they could get very little information. So the union Assistant Regional Secretary (Bob Loftus) wrote and asked for information without much success. They are also working with the Coventry Community Health Council.

What it comes down to say, the Action Committee, is that the Walsgrave is on the verge of opening its geriatric unit and they want the staff that work at the High View Hospital. In fact it appears that many of the patients would not be going to Walsgrave but to the Central Hospital at Warwick instead. One of the staffs' major arguments was that the patients had got used to the staff. Some of them had been at the hospital for 20 years. Of course the convenience of the staff plays no small part. Mrs Palmer claimed that 88% of the nurses lived within walking distance of the hospital in Bedworth. Many of their husbands are miners and they work out their shifts accordingly.

Despite the fact that it was a dilapidated hospital, involved in geriatric nursing of long stay patients, the nurses seemed to have a positive identification with the work. As one of them said: 'if you didn't love it you couldn't do it. You get terribly attached to a lot of them that don't have relatives. If you stay here 6 months you stay here permanently'. They felt that the decision to close the hospital was being taken at a high level beyond the hospital. They believed that the hospital secretary 'is really on our side'. Decisions

were being made by a mysterious authority 'right at the top'. They admitted that 'conditions aren't very good but the patient can walk around the grounds. That is something they can't do at the Walsgrave. It's no good for long stay patients'.

The union is in a bit of a marginal position at the hospital and is not really accepted by the nursing management. They complained that 'there is a lot of red tape about getting meetings'. They also said: 'we think that people listen into calls. They make it difficult to get information and only allow us to put one notice on the board'. They seemed to be getting support from relatives and are surprised at their success. They managed to get the National Union of Mine Workers involved. The authorities had said that one reason for closing the hospital was the dangers of mining subsidence. However the NUM had got onto the MP to say that subsidence was minimal. They praised the COHSE regional office. The Action Committee had been very inexperienced and COHSE had helped 'by showing us the channels to go through'. They also helped them by sending out circulars.

Les Huckfield had raised the matter in Parliament and David Owen in reply had said that the hospital would not be closed. Then the same evening there was a report in the Coventry Evening Telgraph that the Walsgrave Hospital would replace High View. This obviously led to exasperation. 'They don't know what they are doing'. It seemed that although the staff had won some sort of victory they nevertheless felt a bit insecure. There was a feeling that 'the press is being hushed'. Then Huckfield raised the matter again and this time there was a more definite answer. The nurses said 'without our MP we wouldn't have known what we would have done'.

Another major issue was that the Walsgrave Unit was supposed to have provided extra geriatric beds rather than being a replacement for High View. There exists also a certain amount of ill-feeling between the Walsgrave Hospital and High View. As one of them put it, 'they think that we are the lowest of the low' - 'what do you want to work in a dump like that for?'. At one time there used to be a pupil training school at the hospital, but no longer. (Thus one sign of a hospital having low status is not having a training school attached to it).

The hospital consists of 198 beds, and 8 wards. Two of these are male and five female. One ward is closed for repair. One ward is half open, that is the one with a cracked ceiling. Again the strong identification of the staff to the hospital came shining through. One described the hospital as 'a world of its own'. Another said 'you get attached to the patients and they to you'. Another said 'you can't really explain how you feel'. Almost all of these nurses had worked at other Coventry hospitals and they didn't like it. They felt estranged. There was a strong feeling of solidarity amongst them. 'We all keep together. They will back you right to the end'. All of them said that they would rather stay at the hospital. 'Patients were breaking their hearts when they thought we were moving'. Another said 'I would rather work here than the Walsgrave. I don't mind if they knock down each ward and build it up but we want to stay where we are'. There was a very low turnover rate. 'Staff have been here for donkeys' years'. 'They either like it or they hate it'.

In the past the matron had been one Miss Kimberly. The hospital had always been part of Coventry Hospital Management Committee. 'Before re-organisation nobody bothered about us. Then all of a sudden they have taken this interest, just to get us closed'.

I asked a few questions generally about the union. The problem was that 'we can't leave our kids to come to a union meeting because our husbands are at the pit. There are usually not too many grumbles'. There are three geriatric consultants at the hospital and the Action Committee believes that they don't want to keep the hospital open. The nurses also have links with a local Councillor, Mr Walker. 'A lot now in Part 3 accommodation will need places soon' (ie at the hospital).

Again and again the strong sense of identification came through. 'We don't want to be part of a big General Hospital. We want to be a community on our own. We would be swamped. A lot of girls couldn't go. They would move people around and chop and change. This is what goes on'. That is, they had known from those who had worked in other Coventry Hospitals that nurses are often shifted from Ward to Ward. They felt that the Walsgrave had 'a bad reputation, there is no nurse-patient relationship. Its like a conveyor belt. All of us who worked there hated it'. Another said 'we have them until they die. We get to know their little ways'. At the Walsgrave the nurses did not get to know the patients.

They said that 'almost everybody's in the union. They went in before the present fracas because of the need for protection'. Another said 'if we hadn't been in the union we wouldn't have stood a chance'. They found out through the NUM that the National Coal Board was prepared to mend the cracks but was stopped by someone in the AHA. The foreman was furious. The heat opens the cracks. 'They have always been there'. Again they complained about the distance of management. 'Management has told us nothing'. The state of the hospital had been deliberately exaggerated in the press. The Architect had said that the cracks were nothing to do with subsidence, just that the hospital was old and weak. They said that the houses around expected minimal subsidence.

The whole campaign had been a new experience for these women and they were deeply conscious of it. One said 'before we wouldn't dream of going to an MP. We thought that what the AHA said was law. It has made us more political. Without the union we would probably have had a petition and a local demonstration and left it at that'. The girls were worried at first that people



would start to leave once the threat of closure hung over their head. However they didn't. Nobody wanted to leave or even talked about it. All said they would stay to the bitter end'.

Again they voiced their difficulties with organisation.

'We are not allowed to put notices up. Every meeting we hold we have to ask permission. There is even a notice to say that there are no notices allowed. We have to ask every time'. One or two of them were in NALGO but they never received any help. When the opportunity presented itself they switched to COHSE. All of them were firmly in favour of the union. Part of this must be due to their social background as part of a mining community. However it clearly has a lot to do with the work as well. As one of them said 'you never know, because of funny relatives and because of confused patients'. The present branch secretary was Sister Holmes. They admired her because 'she is not bothered by authority'. However she was not all that experienced in union affairs. They got into trouble over meetings. They assumed it was okay to hold them and got into 'deep water'. It is sometimes difficult to arrange meetings across shifts but 'we do it okay though'. Mr Smith the Nursing Officer (who has since left) who got COHSE going in the hospital was 'on the carpet over getting everyone in the union but he could

take it. He put up notices and that started it'. There is a complicated procedure for getting meetings at work. This union first goes to the Hospital Secretary, who then goes to the Senior Nursing Officer for permission. Although the regional secretary of COHSE had helped their campaign he had not greatly helped them over organising the union. Nor did he tell them that they had every right to hold their meetings. Perhaps there was a lack of communication on this. They talked of the fact that 'we were frightened to put our names to letters'.

Mrs Palmers husband, the one in the POEU, had been sitting in on this part of the conversation. He was an experienced trade unionist and said 'I think they are doing it all wrong. If management refuse to give us information we would do something about it'.

#### Postscript 1982

High View Hospital has still not been closed, and has indeed been guaranteed existence in the mid term, by a £250,000 plan for upgrading of wards, approved by Coventry AHA during 1981. The Action Committee's campaign, the wide support it achieved, and favourable press reports (see John Stolls' article of 29 April 1975) had forced a complete turn around of management's original decision.

Coventry Tel. 16 Aug 74

# 'Disgrace' hospital report held up

By JOHN STOLLS

A VITAL REPORT on High View Hospital, Exhall, which has been described as "a disgrace to civilised people," has been delayed for a record time in Whitehall.

The report is that of a team from the Hospital Advisory Service, which toured the old people's hospital in November.

Normally, reports from the officially-back service are submitted to the Department of Health and forwarded from there to the local health authority concerned within three to six months after an inspection.

Despite the report on High View having been written and submitted to Whitehall early this year it has still not even been released to the West Midlands regional health authority.

## 'Scathing'

The report is believed to contain scathing comments on conditions at High View. It has been suggested that it is being delayed on political grounds.

Mr. G. B. Jonas, a member of the Coventry area health authority, asked: "Are they holding it up because it commits them to a lot more money being spent and would add fuel to the fire of the call for more money for the health service?"

"If so, that is a very poor reason. This is a most unsatisfactory hospital for old people. Old people should be given a much higher priority in the service."

The members of the authority, which came into being in April, were due to go on a familiarisation tour of High View in June.

This was postponed for a month in view of the non-arrival of the report.

Mr. Harry Clarke, another member of the AHA, has expressed grave concern at the

there. It should be number one priority for replacement in the city," he said.

It would be impossible to do a "make-do and mend job" on the hospital, he said.

A Department of Health spokesman said that he was unable to account for any delay in the forwarding of the report.

The leader of the Hospital Advisory Service team which toured the hospital, a Middlesbrough geriatrician, Dr. D. M. Prinsley, was surprised to hear that the report had still not come through.

"I was responsible for writing the original report. The normal arrangement is for such reports to come back in about three months."

## Inadequate

Dr. Prinsley, who was seconded for a period to the HAS, would not comment on the contents of his report.

The Coventry area health administrator, Mr. C. G. Condon, has admitted to being unhappy about High View.

He has described its sanitary standards as "grossly inadequate" and heating and ventilating as "very poor and patchy."

After a visit to High View, Dr. D. F. Lisle Croft, of Leamington, last month stated: "It is one of the worst hospitals I have seen and a disgrace to civilised people."



One of the wards where staff have to be seen to.

# Mining may force hospital to close

By JOHN STOLLS

HIGH VIEW Hospital at Exhall could close within 18 months.

The geriatric hospital, once described by a doctor as "a disgrace to civilised people," is threatened with damage or even collapse from renewed mining underneath it.

When he announced the probable closure at the Coventry Area Health Authority's meeting today, the chairman, Mr. Claude Payne, gave assurances that everything possible would be done to safeguard the jobs of the staff.

## Huts

The new threat to the hospital — parts of which date back to the early years of this century — has come through a change of policy by the National Coal Board.

At one time, it was thought that mining below the hospital would not continue. But this decision has been changed and the hospital, much of which is contained in huts provided in 1941, could need replacement through mining damage within 18 months.

The hospital has 198 beds, although one ward of 24 is temporarily closed for heating improvements.

High View, and other geriatric provisions in the city, have been heavily criticised in a secret report by the national Hospital Advisory Service. The report is believed to have suggested closure of High View as soon as possible.

Some of the criticism was to have been met by the opening of the 192-bed geriatric hospital at Walsgrave next year. This is now likely to be absorbed entirely by the closure of High View and no great expansion of the service will take place.

## Chance

Mr. Payne said today that meetings had been held to give the staff the latest information.

He hoped that everything would be done to give them the chance to take up work elsewhere in the Coventry hospital area.

It was necessary, also, to take the Warwickshire Area Health Authority into consultation on the High View situation, he said.

Coventry  
Evening  
Telegraph  
25 March 1975

COVENTRY AREA HEALTH AUTHORITY

EXTRACT FROM REPORT OF THE AREA MANAGEMENT TEAM TO BE SUBMITTED TO THE MEETING OF THE AUTHORITY TO BE HELD ON TUESDAY, 29th APRIL 1975

HIGH VIEW HOSPITAL

It has been advised by the Regional Team of Officers that, in the opinion of the RHA's consulting engineers, further mining at High View Hospital will make the building an unacceptably high risk and it therefore appears to the RTO that further mining will almost certainly mean the closure of High View Hospital. There is no prospect of replacing it in toto.

It will be appreciated that the former bed allocation related to Coventry HMC area rather than the Area Health Authority.

The geriatric beds available to Coventry on completion of Phase IV at Walsgrave will approximate to Coventry's needs only and it is therefore likely that any new provision will be in Warwickshire.

The National Coal Board has been asked by the Region to reconsider their proposed workings and a reply is awaited.

Services provided for geriatric, psychogeriatric and psychiatric beds are inter-related and a discussion paper has been sent to the Warwickshire Area Team of Officers with a view to discussions being held with them at an early date. As soon as we have had the meeting with the Warwickshire Team, a meeting between the Chairmen of the two Authorities and the Teams will be held with a view to a report being prepared for the Authority as soon as possible.

CGC/JT/A.3.35  
17th April 1975.



## COHSE to fight hospital closure

THE Confederation of Health Service Employees is spearheading a fight against the proposed closure of High View Hospital, Exhall.

The hospital is probably to close within 18 months due to the danger of subsidence from renewed mining, it has been stated.

Independent surveyors

have reported to the Regional and Area Health Authorities.

Now a committee formed among COHSE members at the hospital is calling on the Coventry AHA to publish the reports in full.

Their action comes after a National Coal Board spokesman suggested that the hospital could suffer

only "minor damage" from mining subsidence.

Last night the committee finalised a letter to be sent to local MPs, the National Union of Mineworkers, the Social Services Department in Coventry, and all local churches and organisations. The letter appeals for their help in the fight to keep the hospital open.

Coventry Evening Telegraph  
18 April 1974

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services what is the weekly cost of keeping a patient in High View Hospital, Exhall.

**Dr. Owen:** In 1973-74 the average cost per in-patient week was £48.10.

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services (1) what is the weekly cost of keeping a geriatric patient in Walsgrave Hospital, Coventry; (2) what is the weekly cost of keeping a geriatric patient in George Eliot Hospital.

**Dr. Owen:** In 1973-74 the average cost per in-patient week at Walsgrave and George Eliot Hospitals was £130.51 and £91.07 respectively. It is not possible to identify separately the average cost for geriatric patients.

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services (1) what is the weekly cost of keeping a geriatric patient in the Manor Hospital, Nuneaton;

(2) how many geriatric beds there are in the Manor Hospital, Nuneaton.

**Dr. Owen:** There are no geriatric beds at the Manor Hospital.

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services (1) how many geriatric patients are currently awaiting admission to hospitals in the Nuneaton and Coventry areas;

(2) how many geriatric patients currently residing in senior citizens' accommodation provided by local authorities are awaiting admission to hospital in the Nuneaton and Coventry areas.

**Dr. Owen:** Eleven patients in Nuneaton and 59 in Coventry are on the waiting list for admission to a geriatric bed. Of these three in Coventry, but none in Nuneaton, live in local authority residential accommodation.

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services how many geriatric beds there are in Walsgrave Hospital, Coventry.

**Dr. Owen:** Twenty-six at present but a further 196 under construction are expected to be ready later this year.

23 E 48

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services how many geriatric beds there are in High View Hospital.

**Dr. Owen:** 198.

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services how many geriatric beds there are in George Eliot Hospital.

**Dr. Owen:** 60.

**Mr. Leslie Huckfield** asked the Secretary of State for Social Services whether she will make a statement about the proposed closure of High View Hospital, Exhall.

**Dr. Owen:** There is no proposal at present for the closure of High View Hospital. The health authorities are considering the implications of the National Coal Board's plans for mining in the area.

#### Mortgage Repayments (Women)

**Mrs. Hayman** asked the Secretary of State for Social Services why a woman with obligations to repay mortgage repayments and wishing to claim social security benefits to cover interest repayments is not allowed to do so, but has to have such an application made by her husband on her behalf.

**Mr. O'Malley:** In the determination of entitlement to supplementary benefit, including housing costs, the Supplementary Benefit Act provides that the requirements and resources of a husband and wife in the same household are to be aggregated.

#### Supplementary Benefit Claimants

**Mr. Robin F. Cook** asked the Secretary of State for Social Services what was the total number of supplementary benefit claimants at the latest convenient date in (a) Scotland and (b) the United Kingdom.

**Mr. Alec Jones:** As at February 1975, about 277,000 and 2,786,000 respectively.

#### Retirement Pension

**Mr. Loyden** asked the Secretary of State for Social Services what steps she can take to protect the purchasing power of retirement pensions against the price increases created by the Budget.

Excerpt from HANSARD



EST. 29 APR 1975 Coventry Evening Telegraph

# A hospital that doesn't want to die...

HIGH VIEW, Exhall, hospital under a death sentence, is the finest in the city — in one respect.

It may not have the size and equipment of Walsgrave, but the 198-bed High View almost certainly has the most dedicated staff. It is a living community that will be killed off within 18 months because of mining subsidence.

The hospital started life in the early 1900s as the four small brick blocks of an isolation unit, then became a workhouse. Five insubstantial hutted wards were added during the second war, and there it has remained ever since — out of sight.

By  
John  
Stolls

out of mind, for the people of Coventry. About 96 per cent of the patients are from the city, although the hospital is just in the county. This is no dumping ground for old people. Four of the wards are for long-stay patients. An average of 450 patients a year pass through High View.

"One big happy family" is a cliché almost excusable here. The staff are appalled at the prospect of its being broken up.

"These patients are like relatives to us. We worry about them when we go home," says Ethel Watson, 19 years a nurse at High View. "I think everyone might consider moving with the hospital if we felt it would keep the same atmosphere for it."

She came to High View to work 60 hours for her St. John certificate — and is still there. Well over half the staff, nursing and lay, live within walking distance, but it is not for their personal convenience they resist the closure.

## UNIQUE ATMOSPHERE

Sister Josephine Daly has worked in other Coventry hospitals. "But High View has an atmosphere that is unique. I would not want to work anywhere else," she says.

The planners and technicians point



It looks comfortable, as smiling Sister Josephine Daly makes the rounds. But behind the shining paintwork and bright curtains lies a substandard building.

# High View— dim prospect

to the frail hollow tile construction of High View's huts. When a builder came to add a toilet block, he found it almost impossible to join it to the existing structure.

Proper central heating is only now being provided in some of the wards. Meals have to be wheeled to the huts in insulated containers.

But it's very homely. Many of the patients are of humble origin and easily overawed by today's glass and concrete structures. In warm weather, the old people wander out into the grounds at will. There are few steps and the buildings are mostly grouped around a lawned court. The intimate atmosphere is something no modern hospital could ever attain.

"The patients would not be happier anywhere else," says Sister Daly. "If we went further out of town, many of our patients with elderly relatives would get fewer visitors."

The patients know little of the shadow that lies across High View. As Nursing Officer Trevor Gibbs puts it: "They know the staff will do the best for them. The staff think for them and worry for them."

Victor Layland, 74, is one of the few patients who have been able to think coherently about the future. "I don't think you would better this place for folks our age. Many of the nurses are middle-aged and understand the feelings of the patients," he says.

Formerly in the building trade, he believes the hospital could stand any amount of mining underneath. But the experts have decided otherwise.

After six years at the hospital Sister

Jean Covell does not find the buildings depressing. "It's not our fault it's in a dilapidated condition. We don't look at buildings. We try to keep the patients happy."

Edwin Law, hospital secretary, has been there since 1948. He lives next door. And, naturally, he dreads the break-up of this close-knit entity. "If they could move it en bloc there would be no problem," he says, adding that this is his personal point of view.

"The staff are afraid that the patients are going to be spread out here, there and everywhere. Travelling would be a big problem for them. Probably 75 per cent of the nursing staff live within walking distance."

## WORLD OF ITS OWN

He, like many others of the staff, would move to a modern hospital with reluctance. And, if the patients were dispersed, half the staff might decide to leave rather than travel each day.

High View may be a cosy little inward-looking world of its own. But isn't that just what old people like? Nursing Auxiliary Moyra Larson sums it all up in two short sentences.

As she completed the revolting task of cleaning up an incontinent old lady, she told me: "I love this place. I love the old people."

I don't think you'll hear a remark like that in any other hospital in Coventry.



COMMUNITY AREA HEALTH AUTHORITY

STATEMENT BY THE AREA MANAGEMENT TEAM

TO ALL STAFF AT HIGH VIEW HOSPITAL

The Area Management Team promised to keep you informed of changes in the situation regarding the mining damage which it was thought would occur at High View Hospital. A copy of a letter sent by the National Coal Board to the Regional Health Authority was received this morning and indicates that, following a review of the forward planning for mine operations, it has been decided not to work 5A's panel in February 1978. The National Coal Board say the working of this seam may be considered at some future unspecified date and has promised to give adequate notice of any such intention.

The effects of this have yet to be considered by officers at Regional and Area level and also by the Regional Health Authority and the Area Health Authority but present indications are that the serious damage which had been anticipated to occur within the next twelve to eighteen months will not happen, although the possibility of mining damage of the relatively minor kind experienced over the last few years may well continue.

There remains the problem of the physical condition of the hospital but the probability of closure about which Miss Hickey and Mr. Condon spoke to you a few weeks ago was related entirely to damage caused by mine workings.

CGC/BE/A. 3.35.  
6th May 1975

# Exhall hospital gets reprieve in new NCB plan

HIGH VIEW Hospital, Exhall, which is threatened with closure because of mining subsidence, has been given a temporary reprieve and will probably not close before 1978.

The hospital, which has beds for 196 old people, has been given a life of only 18 months.

Hospital staff have been told that the National Coal Board had written to the Regional Health Authority stating that work on a coal seam underneath the hospital would not commence in February, 1978.

Closure was threatened by the proposed work from Newdigate Colliery. Mr. Charles Condon, the hospitals area administrator, said he had expected the work to begin in the next 12 to 18 months.

The Coal Board said their decision was due to a planning review. They would give adequate notice of any change.

Mr. Leslie Huckfield, Nuneaton's M.P., said: "I would like to think that it is now highly unlikely that High View Hospital will close in the immediate future, but we still didn't get a guarantee about the plans in the longer term."

Mr. Condon said: "The present indications are that the serious damage we were expecting in the next 12 to 18 months will not now happen."

The Action Committee plan to press for improvements so that there will be a better chance of preserving the hospital if the situation arises again.

The Coal Board have already carried out extensive repairs to two wards damaged after previous mining at the site.

Coventry Evening  
Telegraph  
9 May 1975

(ii) East Birmingham Hospital

The East Birmingham Hospital (EBH) serves a large urban concentration and competes for labour in a high wage area. For a general hospital, trade unionism is well established among the nurses, dating back to the early 1960s. The 'EBH' is a large, 1000 bed general hospital which had, in the past decade, undergone considerable redevelopment, involving substantial capital outlays on buildings and the most up-to-date technological hardware. There is, for example, no workhouse appearance to its geriatric unit of 106 beds, opened in 1972.

An important feature of the hospital is its division between two main sites. These are the Chest Branch - formerly a tuberculosis hospital - and the General Branch - once a fever hospital. The hospital has around 2000 staff, including approximately 750 nurses, of whom about half are learners. The membership statistics for the COHSE Branch at the end of August 1974, are presented in the following table:

<u>Nurses</u>		<u>Other Staff</u>	
Senior Nursing Officer	1	Administrative and	
Nursing Officers	5	Clerical (Ward Clerks)	5
Nursing Tutor (Male)	1	Catering	1
Charge Nurses	5	Professional and	
Ward Sisters	43	Technical (Medical	
Staff Nurses (SRNs)	28	Physics Technicians)	2
Enrolled Nurses (SENs)	58	Female Ancillaries	197
Male SEN	1	Male Ancillaries	10
Nursery Nurse	1		
Female Learners	39		215
Male Learners	3		
Nursing Auxiliaries	77		
	<hr/>		
	262		

TOTAL MEMBERSHIP = 477

The nursing density - of the order of a third - is not, however, spread evenly through the hospital. There are concentrations, such as the night shift on the geriatric unit, which often seem to be associated with influential members in such areas. There had recently been an influx into the Branch of about 100 nurses, related to the unrest over pay and conditions, many of whom came from learners, enrolled nurses and staff nurses. About one third of the nurse members are apparently black/foreign; the majority of these from the West Indies. The Branch

found it particularly difficult to recruit and retain Asian and Malaysian learners, presumably because of fear of victimisation, their social class origins (generally fairly high) or, simply, lack of knowledge and contact with trade unionism. The Branch Secretary of COHSE, a male nurse of Irish origins, was of the opinion that West Indian nurses joined 'because of chips on their shoulders'. He also felt many tended to be 'lazy'.

The low strength of membership among learners seems to be an indication of the power of the Rcn in the training school. The Student Section does not seem particularly active. However, the Principal Nursing Officer (Teaching) is a prominent figure in the Rcn, and there is also a separate system of representation for learners apart from the Hospital's Joint Consultative Committee. The union has always faced difficulties in gaining access to the School of Nursing to talk to students. In many respects, training schools are strategic. They do not just instruct in technical skills but also attempt to transmit a set of values about nursing as part of a particular mode of socialisation of new recruits. Even if membership of the Rcn is not 'pushed' in schools - as a number of Rcn tutors

insisted to me was the case - the transmission of professional ideals is probably more favourable to learners joining a professional organisation like the Rcn rather than a union.

An interesting feature of the EBH was the fact that COHSE apparently had fewer male nurses than the Rcn. Part of this difference was because many were learners and so almost automatically became Rcn members. The Rcn was, however, also well represented among more senior male nurses. A number of the most senior male nurses were joint members of the Rcn and COHSE. They had been in nursing for many years, since before 1960 when Rcn membership first became open to male nurses. Dual membership is often to be found among male nurses who did not relinquish union membership when joining the Rcn from 1960.

Thus contrary to what is often supposed, there is no automatic relation among nurses between maleness and union membership - at least in this hospital. They may well be more likely to join some organisation, and to be active in it, but in general hospitals it may as often be the Rcn as a trade union. There are a number of reasons why this should be so, but perhaps the major

reason lies in the tendency for male nurses in the general field to be highly ambitious for managerial positions.<sup>(1)</sup>

Due to the more frequent turnover of nursing staff in general hospitals, the opportunities for promotion have in the past been wider than in psychiatric hospitals. Indeed blocked channels of promotion may be one factor in the greater density of unionisation among psychiatric nurses. The ambition of the general male nurse is also stimulated in other ways. In general nursing the average earnings are less than in the psychiatric field. There is less opportunity for paid overtime and the psychiatric 'lead', though only £165 a year (post Halsbury), helped to boost the earnings of psychiatric nurses. Research has also shown that male nurses in the general field tend to be conscious of their marginal status, and also to resent being under the hierarchical command of women.<sup>(2)</sup> Such factors are also likely to spur ambition, in order to avoid or lessen the intensity of such hierarchical command.

As a nurse advances up the hierarchical chain, he or she is not unnaturally likely to find trade union activism increasingly problematic. This is partly because being a member of management creates pressures on individuals to act in ways different, in crucial respects, from those



expected of a union activist. As industrial action has reappeared in hospitals, such difficulties have been magnified. Some members might also distrust the intentions of line superiors, especially if they hold branch office. Whilst being a member of the nursing hierarchy and engaging in union activities may create difficulties for an individual, both in relations with fellow union members and other members of management, activism in the Rcn is likely to have opposite effects. It can be a positive advantage to career advancement, both in terms of exhibiting the 'right' kind of attitudes and, also, perhaps less opportunistically, because of the important educational activities undertaken by the Rcn.

Nevertheless, the COHSE activists at the EBH still tended to be qualified male nurses. They showed a commitment to trade unionism untypical of the rest of the membership, especially female nurses. These commitments appeared to have been forged before they had worked in a general hospital, and were sufficiently strong to overcome the factors in their work situation unfavourable to trade unionism. Sometimes loyalties had been formed when they worked in the psychiatric field, or else they had a parent or close relative who had been a union activist. The difficulties that the male activists experienced in retaining and involving the nurse membership, led them early

to seek a base for the Branch in the ancillary field. Although many ancillary workers presented similar problems of turnover, some work groups are relatively stable, at least in some hospitals: female domestics were one such group at the EBH. Most were non-immigrant women who had worked at the hospital for some years. Porters were less stable, but before the 1973 ancillary workers strike many joined COHSE. By the mid 1960s, the pattern of activity of the Branch had been established - led chiefly by male nurses though, on the whole, ancillary workers were the most active members, and whose problems tended to pre-occupy the Branch.

The Branch had been started by psychiatric nurses engaged in post graduate training for SRN. There do not seem to have been any serious problems over union recognition. There was a brief skirmish with the (then) matron regarding the wearing of union badges on duty. The purported pretext for the objection to union badges was that of hygiene. However, the COHSE badge was smaller than the hospital's own. Perhaps the underlying reason was that management felt that if nurses must join unions they should not publicly exhibit such unprofessional traits. Or perhaps it reflected a unitary managerial view that loyalty to the union conflicted with loyalty to the hospital - a problem

been with  
which has not/raised/membership of the Rcn. In the end,  
however, the dispute did not come to much and the Matron  
gave in.

The most substantial problem of the Branch in the 1960s was  
the high turnover of staff, leading to a situation where  
recruitment became the major focus of Branch activity.

A special Recruiting Committee was set up. Events like  
open meetings were sponsored. One of these consisted of  
a forum of the COHSE regional secretary, the hospital  
matron and hospital secretary on the 'role of trade unions  
in hospitals'. Getting the matron and the hospital  
secretary to participate in a union meeting was a device  
to demonstrate to reluctant nurses that membership of a  
union was not necessarily in conflict with loyalty to  
superiors. Such activities met with some success. The  
hospital became the fastest growing Branch in the region.

This emphasis on 'responsible' trade unionism - typical  
of COHSE generally at this time - proved less acceptable  
to the ancillary workers, who were less inhibited by  
status considerations in their desire to improve pay and  
conditions. In the late 1960s, as elsewhere, they became  
increasingly restive, following the considerable expansion  
in the numbers that joined unions in the early 1960s.  
Changes in their work situation originally made this

possible. At the South Birchstone, for example, domestics had until the 1960s, been under the formal command of Matron, in practice typically under the control of ward sisters. The domestic was very much part of the ward team and embroiled in traditional nursing relationships, but at the same time the one with the lowest status and esteem. The reference group of the domestic tended to be the ward rather than other domestics. This altered dramatically when responsibility for them became transferred to a domestic supervisor, crystallising the domestics as a separate workgroup, as workers suddenly conscious of a collective identity.

At the same time old, paternalistic relationships dissolved and newer forms of functional management emerged with far more transparent objectives - the lowering of unit costs by bonus schemes based on work study. Yet the attempt to subject domestics to a more intensive work discipline was only achieved at the cost of creating the conditions of workgroup cohesion which enabled them to fight back. Thus it is hardly surprising that the bonus scheme was plagued with difficulties to the extent that, at the end of August, 1974, they remained the only group of workers at the hospital on bonus - even though the original intention had been to spread the schemes gradually from domestics to cover other groups of ancillary workers. The complaints

were familiar ones - that the schedules were too tight, that the supervisor was rude, that they were moved from ward to ward too often. The difficulties led to a number of disputes and a walkout, after which the domestic supervisor was disciplined.

Other groups of ancillary workers were also fairly active. In contrast to the nurses they had a fairly well developed stewards system - four for each shift. The problems of porters and domestics dominated the minutes of Branch Meetings. Only rarely did problems of nurses appear. Similarly with pay and conditions, ancillary workers showed more interest. In 1970, the first rumblings of discontent were felt at the hospital, after several years of frustration due to successive incomes policies. The ancillary worker activists complained that COHSE was a 'no-go' union, and that nationally it was sitting back and waiting for local authority workers to do the bargaining for them.

In any case, the health service unions were forced to fight in 1973, when Phase 1 of the Conservative Government's incomes policy caught the ancillary workers in a pay freeze while narrowly letting local authority workers through. NUPE took the lead in initiating industrial action, forcing COHSE and other unions

representing fewer ancillary workers to go with it. Locally, the official COHSE intentions were for single day strikes at each hospital in turn in the area. The EBH had balloted for 15 March and, even at this late stage, there was only a slender majority in favour of strike action. Part of this original plan allowed for emergency cover for operating theatre; the Central Sterile Supply Department (CSSD), and Pathology were to continue as usual. Until the strike a go-slow and work-to-rule were to be instituted.

The plans were soon overtaken by events, precipitated by the management's encouragement to ward sisters to order extra supplies in anticipation of the strike. Extra work was put on stores workers. A walk-out by them on 1 March 1973 snowballed into a total, all out strike by ancillary workers at the hospital, which was to last fourteen days. However, nationally COHSE withdrew industrial action on 14 March. The decision was announced to a mass meeting on that day, by the COHSE regional secretary. The instruction to return to work from midnight created pandemonium. The Branch Secretary of COHSE at the time - an ancillary worker - resigned from the union. He went over to the TGWU, taking some 150 ancillary workers with him mainly, it appears, the Branch's male membership.

What happened can be summarised as follows: although the ancillary membership had previously been reluctant to take industrial action, once initiated it developed a dynamic of its own. This went beyond the control of the traditionally moderate Branch leadership as typified by the male nurse activists. The leadership of the strike was taken over by the joint stewards committee, spanning several unions. Once engaged in joint action the COHSE ancillary workers - many of whom were fairly fresh to trade unionism discovered different traditions, such as those of the TGWU, far less inhibited by considerations of status. They came to be influenced more by ancillary workers in other unions than the restraining influence of the majority of the Branch leadership.

After such a body blow, the Branch organisation could only slowly recover. The remaining membership was dispirited, and rumours circulated that the COHSE Branch was on the point of collapse. It was probably only saved by the efforts of one or two male nurse activists, in particular, those of Jim Toner, by this time a Nursing Officer. He can be said to have held the Branch together, a task only reluctantly assumed given his position in the nursing hierarchy and the focal position of the Branch Secretary

for the union. In his case it was not so much that being the leading official of COHSE at the hospital damaged his chances of promotion, for management recognised that any influence he might have was for moderation. Rather it was that the acute conflict that he felt between his administrative and activist 'roles', would be rendered intolerable by any further promotion - despite his moderate interpretation of his trade union functions.

Given the low level of activity in the Branch, his dual functions had previously not placed him in many positions where one or the other would be compromised. Industrial action created most difficulties. Yet during the 1973 ancillary workers' strike he had not been the central figure in the Branch - though he was during the nurses' pay campaign of 1974. He managed by delegating as much responsibility as possible to the stewards while he, as required, helped with the organisation of practicalities. He resolved such potential conflict situations, after a fashion, by placing his union leadership responsibilities on ice for their duration, whilst continuing to discharge his managerial responsibilities in a muted way. Further promotion would prevent him from being able to walk such a tightrope.



The fact that the Branch Secretary was a Nursing Officer bestowed a number of advantages on the union, especially in the weak situation at the hospital following the 1973 strike. The first was his access to management, as a fairly prominent member of the nursing hierarchy. The second advantage was the Nursing Officer's mobility around the hospital, enabling some contact to be maintained with a scattered membership. The two nursing stewards are both charge nurses who are tied to their wards with only limited possibilities of communicating with the membership during working hours, except via the internal telephone. The Nursing Officer, although responsible for one unit, finds it much easier to get away and become known throughout the hospital as a union figurehead, which is an asset in recruitment of nurses. The charge nurses' field of recruitment was much narrower, hardly extending beyond their wards.

Contact with the membership had been assisted, rather than hindered, by the introduction in 1971 of deductions of union contributions from wages and salaries (DOCAS). This is sometimes said to lead to the neglect of the membership's interests, but at the South Birchstone it freed stewards to deal with constituents' problems. Previously, much of their time had been spent pursuing individual members in

arrears. It has made possible some expansion of stewards duties, where before collection of dues was the major Branch activity. Regular contact with the membership is still maintained, by the distribution of the union's monthly journal, Health Services. After the ancillary workers' strike, when demoralisation had set in and the Branch was being carried by Jim Toner deductions at source probably prevented the dissolution of the Branch.

The Branch has only just begun to recover from the effects of the 1973 strike, especially since most of the active elements went over to the TGWU. This was one reason for the sluggish response by nurses to <sup>the</sup> national pay campaign of 1974. During April 1974, considerable pressure built up within organisations representing nurses, expressing extreme dissatisfaction with the Phase III settlement of around 7%. It did not arise from the EBH Branch of COHSE. In April, according to the minutes, a meeting 'was called in connection with the nurses' pay campaign and to outline the latest developments on the National Conference'. In keeping with the character of the Branch: 'Nursing attendance was nil and ancillary staff totalled 10'.

By the end of May, with the transformation of the national situation, more interest had been aroused. Following the decision of COHSE's NEC to initiate action at its meeting

of 21 May, 60 nurses attended a Branch meeting called at the South Birchstone. Yet according to the minutes:

'Due to staff shortages no serious action which would jeopardise patient care was planned'. Because I was not present at this meeting I cannot assess how far the Branch Secretary 'guided' the meeting in this direction. Eventually the meeting agreed on the following programme of action: (1) a ban on extra nights. This was the only significant form of overtime worked at the hospital.

(2) A ban on clerical duties. This mainly involved filling out forms for patient investigations. It only affected the Chest Branch, where by tradition nurses filled out such forms. At the General Branch, the forms were the responsibility of doctors. This difference may be a reflection of the greater autonomy of nursing staff in long stay institutions such as Chest Hospitals.

(3) Adequate notice for staff going on temporary nights.

(4) A ban on split duties. These were only done by staff on infrequent occasions, such as to cover a shortage at a particular time of day. (5) Collection of evidence to be presented to the Halsbury Committee. The EBH was one of the hospitals visited by them, out of a list of twenty 'typical' hospitals suggested by the Staff side of the NMC. (6) Local petition and 'picket' on the hospital gates on night a week. This was much less than the official programme of action recommended by COHSE's NEC.

The response of ancillary workers to the nurses' pay campaign merits some attention. As noted some attended meetings to support the campaign, even when nurses themselves did not bother. Generally, however, there was an undercurrent of resentment towards nursing staff, based on a belief that nurses had sold them short during the 1973 dispute and 'blacklegged' on their strike.

By the end of August 1974, it could hardly be argued that the presence of trade unionism amongst one third of the nurses, had greatly transformed the hospital. The EBH had certainly experienced rapid changes, which must have aided the development of trade unionism. For nurses, the vast increase in the size of the institution, combined with the introduction of more functional management in the wake of the Salmon Report led to the breakdown of the more extreme forms of paternalistic relationships. Management were prepared to recognise the union, perhaps seeing the advantages of some kind of intermediary between the new management and an increasingly atomised nursing workforce. Change also brought uncertainty. In very immediate ways reorganisation created fears of job insecurity. In less identifiable, but still influential ways, old identities and expectations dissolved and new demands were made on staff to cope with the requirements of a rapidly changing service. Yet new identities take time to gell, especially

at a hospital like the EBH which has been regrouped several times over the past twenty five years.

The regrouping of the hospital into increasingly larger units of administration, the geographical dispersion of the hospital sites and the ever complex division of medical labour have combined to create a 'departmental' consciousness among nursing staff. There seems to be a poorly developed awareness of a common interest among nurses, as well as an apparent failure to identify with the metaphysical entity of 'the hospital'. There thus seemed to be little loyalty towards either the union or the hospital.

Perhaps the union could help to overcome the extreme staff fragmentation, by uniting nursing staff in joint activities like the pay campaign. Perhaps in the long run what is required is a fuller development of a stewarding system among nurses, to take up issues at unit level. Lack of hospital consciousness might also be associated with the inadequacies of the JCC at the hospital, which has not dealt with many major issues.

One cannot help but sympathise with the union activists in such a difficult milieu. Over the years they have made many efforts to surmount the apathy of the nursing membership without much success. Occasionally a note of

despair creeps in, as in 1968 when the Minutes state that: 'In his monthly report the Secretary stated that he intended to make some searching remarks about the passive attitudes of most of our members, but since only the more active members were present at the meeting, doing so would be a waste of time'.

Due to the unflagging efforts of the activists, the union had made a certain amount of solid progress at the hospital and was well established among nurses. It had performed a valued role in protecting the individual interests of nurses. Beyond this, however, the union activists had failed in their attempt to fire the rest of the membership with their own enthusiasm. They were at rather a loss to know how such problems could be overcome. The nurses at the hospital had yet to use the union to forge a collective identity. It remained to be seen whether the less defensive and more militant face shown by COHSE in 1974 would result in any changes in membership attitudes among more 'moderate' and less active members like those at the East Birmingham Hospital.

## References

- (1) In one survey, 46% of general male nurses compared with 24% of female nurses said that they wanted promotion. Only 44% (compared with 72% of female nurses) wanted to stay in their present posts in order to remain in contact with patients. Interestingly, 35% of male nurses thought of nursing as a 'profession' compared with only 13% of female nurses. By contrast, 48% of female nurses thought nursing a 'vocation', compared with only 25% of men. For fuller details see Juanita G Rosen and Kathleen Jones, 'The Male Nurse', New Society, Volume 19 (9 March, 1972), 493-4.
- (2) In a survey of the Central Wirral Group of Hospitals in 1950, Joan Woodward found that 'male nurses and nursing trainees are in a definite minority and they have acquired many of the defensive characteristics of a minority group' (p.70). Men were more likely to want changes in supervisory attitudes. They felt, for example, 'More civility needed from ward sisters towards male nurses'. Others complained that 'They treat men like little girls' (p.77). Joan Woodward, Employment Relations in a Group of Hospitals, London: Institute of Hospital Administrators (1950).

Follow-up Interview with Jim Toner COHSE Branch Secretary  
at EBH May, 1975.

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He gave me a few items of news since last we met. Subs were going up again. Kevin Moynihan, who had been a shop steward and charge nurse, had got a Nursing Officers' job elsewhere. Jim didn't have the same job. Before he worked on surgery and was able to get about more. He complained that in EBH 'there are so many specialities. There is not very good communication between departments'.

Membership is now around the 500 mark. COHSE HQ have been pushing branches to try to get more community nursing staff in. He was lukewarm about the idea because he didn't have any channels there. A Professional Advisory Committee has been set up covering Birmingham community and hospital. 'I sat on it initially and then Solihull went their own way. There has also been an attempt to set up a Joint Staff Consultative Committee for Birmingham but there have been squabbles over its composition.' In the past there had been a JCCS for the hospital but a few years ago Bob Loftus had got it dissolved because not all of those sitting on it were members of Whitley organisations (according to the rules). There used to be two meetings a month.



The domestics have been on a bonus, but the porters turned one down. Management are currently trying to get path lab technicians involved in one. He finds that a lot of issues that he deals with don't come up at Branch meetings. For example, a male nurse (who worked in his spare time for an agency) was suspended from the agency because some patients accused him of a sexual assault. The agency suspended him and then so did the hospital. He was off for about two months. The nurse made a statement and Jim took the case up with the agency. However there appeared to be little as evidence. The case went up to the GNC who decided there was not enough evidence to proceed formally.

Another common item that he deals with are pay queries, where people are paid short. He has a good rapport with the wages department and claims that its new boss, Ken Garfield, is 'pro-union'. People got confused after Halsbury, wondering why some people got more than themselves, forgetting that people's tax rates are different. Halsbury also disturbed differentials and senior nursing personnel are up in arms about it. Another problem that he had dealt with was the timing of meal breaks on nights. At the Chest Branch it was by custom at 11 pm and on the general side 12 pm. The nurses on the Chest side wanted to go at 12 and they also wanted a sitting room, which they got. One or two

nurses also complained about their laundry. The usual story about sending 6 and only getting 2 back. However he had dealt with this as a Nursing Officer rather than a union cadre. He raised it at a Nursing Officers' meeting, which are held once a week.

There had been some changing patterns of union communications. COHSE Head Office had asked for a list of stewards of designated areas so that they could be sent union circulars as well as the Branch Secretary. 'This is working very well'. Home wardens are also prominent members of the local branch. Two of them are in the union and are disgruntled that they have to hump laundry upstairs. This will change because new residences are being opened later in the year. They are also concerned about their grading. The branch put a resolution at the October Regional Council for a 40 hour week for home wardens plus special duty payments. 'They are lumped in with catering supervisors and others on the Admin. and Clerical'. (Whitley Council).

Jim believes that the changeover at regional level has not disrupted the work of the region all that much. (The Regional Secretary was sacked for being convicted of a gross indecency charge). This is because 'there are many experienced Branch Secretaries. However, people are thinking twice before going to regional level'.

Jim continued about the cases that he dealt with. Most were for individuals. In January a night sister had been working on the geriatric block but didn't get the lead. However she hadn't pushed for it. Nevertheless she happened to mention it to Jim who took it up with the Senior Nursing Officer and got it for her. In Bob Loftus's (former Secretary's) day on the same issue a Nursing Auxiliary had gone to him 6 months later. He also found that she could have been entitled to sick pay from the union and hadn't claimed it. Jim made the observation that 'ancillary workers are much sharper - they are there 24 hours later'. Jim had a staff nurse who had done her tuberculosis certificate at the London Chest Hospital. In the meantime she had missed her Halsbury lump-sum payment, and joined the union so that they could take it up through London. He will not handle issues for non-members any more, though he will give them advice. 'I did it in the past and got in trouble with the members'. So now if a non-member comes with a problem he will advise them that they should join first if they want him to take things up. By handling cases in this way, news of the union spreads and more and more people get in. He doesn't particularly broadcast it because he thinks that it has more impact if the people themselves do it.

A female nurse joined the union. She 'allegedly' had a back injury. She hadn't been sending in sick notes and was getting no money from either the hospital or social security. He claimed she was 'unstable' and was on drugs. She was a pupil nurse and she hadn't filled in an accident form for her supposed back injury. Jim didn't like to be involved on these cases right from the beginning. 'I tend to get the nursing administration to deal with it first. Let them make the mistakes first'. He reeled off more cases that had been dealt with - again mostly via him, without apparently involving the branch, such as it is. Many of the collective issues appear to involve the domestics, obviously because of their bonus arrangements. Domestics in outpatients needed better equipment. He had a meeting with them and also the supervisor (she also being in COHSE). He got them a polisher. Nurses issues - at this hospital at least - are much more typically individual in character, despite the fact that they are employed as a mass labour force.

Not all of the problems of domestics are collective, but individual problems often have, at root, a collective base. This became apparent in one case Jim handled. At the Eastcote Grange Convalescent Home the domestic supervisor wanted to reduce the hours of a particular lady because of

health reasons. In this case, it appeared to him to be justified. However, Jim got onto the work study people because the lady could not afford to lose that many hours. According to his account, they gave him 'a nod and a wink' that they were trying generally to build up staff in order areas by running them down in this one, and this lady had served as the pretext. The domestics had suspected this to be so. With the assistance of Bob Loftus, by then Assistant Regional Secretary, the domestics sorted it out for themselves. 'If the nurses were as alert to this sort of thing, as the domestics and porters, we'd have a rampant health service'.

The Branch Chairman is an instrument curator in the operating theatre. He wanted a member upgraded and got it. The person concerned had applied for a job advertised at a higher grade. At the interview they asked her to take a lower grade, promising to review it later. 'They forgot about the 'review later', bit'. Another case: two RMNS from Eire came to do their postgraduate SRN training. He had been a staff nurse and she had been a ward sister. They were told that they would not qualify for an April incremental increase. They joined the union and asked them to sort out the problem. It depended on their previous experience which had to be sorted out through the GNC (as to whether work in

Eire counted). At the time of the interview it was still being sorted out.

From the last time when I was at EBH, when I had concluded that the branch was being carried pretty single-handedly by Jim, the steward organisation had expanded considerably. Branch meetings are held in the evenings at alternate venues - the Chest and general sides. Attendance is still low, but has improved. There are some ten stewards now - which is quite a development in organisation since 1974.

Jim's comments confirmed earlier reports suggesting a different 'culture' on each side of the hospital. 'The atmosphere is different at the Chest Hospital - it is more easy going'. There could be a number of reasons - patients and staff stay longer, and less of an emphasis on high technology. On the general side, if night staff or other grades leave he might not hear about it. 'At the Chest branch, the membership is more stable, even though some of them are passing through' (due to career mobility, largely). 'The enrolled nurse tends to stay with us more than the SRN. The population is more transient on the general side'. This would indicate a greater proportion of SENs on the Chest side. He felt that domestic staff, too,

were more stable on the Chest side, than on the general side. At the Chest branch, 'there is a feeling that they have been taken over. Nursing administration is based at the general side'. However the distinction between the two sides is breaking down, as some chest wards are moving over.

Relations at the hospital were, he felt, pretty good. 'We may be unique at EBH, but the rapport at local level is excellent. But if we weren't there, they would try to work a fast one'. Disciplinary problems created the most difficulties. 'I can know someone's a right nutter, and feel that someone should be booted out'. Its not just the case that the nurse concerned is in COHSE, so often are the nurses who complain. At Arden Lodge (the small geriatric hospital in the group), a male SEN was reported for striking a patient by some night nurses, some of whom are in COHSE. The Nursing/<sup>Officer</sup>at Arden Lodge is also in COHSE. This case was still proceeding at that time. Jim clearly feels that there is something wrong at Arden Lodge but feels constrained to do anything about it due to lack of evidence. For example, he knows that on more than one occasion the breakfast trolleys have come back without any breakfasts being given out.

Interview with Bob Loftus, Assistant Regional Secretary,  
COHSE, Midlands, 17 September, 1974.

Bob was one of the leading individuals in the early activities of COHSE at East Birmingham Hospital. He started work in 1963 at Yardley Hospital which is now the Chest branch of EHB. At this time however, it came under the Birmingham Sanatorium Group. However, in November of that year a new lay administration was set up with a group HMC. A lot of meetings were held to keep staff informed. Bob felt himself to be an outsider. There was resentment at Yardley Green about being taken over by Little Bromwich, which was the general hospital in the group and a much larger one. There were some union members at the general hospital. They were in the GMWU and were mostly ancillary workers. Bob joined NUPE because it was the main union at the Chest Hospital. However, he lapsed and joined COHSE in October 1964. He became an individual member with two other people: Fred Duffy and Erol Jones. Erol Jones was, like himself, from a psychiatric hospital. COHSE started off among the nurses and spread to ancillary workers later. The Coleshill Group of the hospitals also became part of the same group in 1969. Bob believes that the grouping together of hospitals into new and larger units created considerable anxiety which



made it easier to build the union. The decision to spread to ancillary workers was a conscious one. They found that nursing staff membership used to fluctuate considerably and the turnover of staff was less among ancillary workers. So that the COHSE branch went from a nursing to an ancillary worker base. The main group became the domestics who took a very active part in the union. These had had a domestic superintendent from the mid 1960s. However at the Chest hospital the Assistant Matron was in charge of them until much later, which meant that at ward level sisters were in charge of domestics.

He felt that the fact that Jim Toner was a Nursing Officer 'can be an advantage'. He has direct access to management and can solve things informally'. He coped with the stresses caused by the pay campaign of 1974 by 'delegating to Moynihan'. Irish male nurses appear to have played an important part in the development of the union at EBH. Jim Toner, charge nurse Moynihan and Bob Loftus himself are all Irishmen. When I did my training at St Albans hospital I found that Irish male nurses were very trade union minded. Perhaps this has something to do with the fact that for many of them nursing is just a job. However with the English male nurses, for some of them nursing is a form of social mobility and therefore they are much more likely to become active in professional associations. The other main group of English male nurses from the end of the second world war came from the army, which is not renowned for producing trade union minded people.

Bob felt that the grouping together of administration into large units had created alienation among staff. 'Staff don't identify with the hospital, it's too removed. There is no great feeling of unity, no great amount of loyalty to the hospital. The PNO is very remote. She delegates work. She is very shy but a nice person'. He described the Rcn as weak in the nursing school. It had the membership but it was not very active and its officers in the hospital were apathetic. There was talk of setting up a student section in the Midlands within COHSE but Bob found 'that there was not a great deal of interest in it'.

At the time of the interview Bob was the assistant regional secretary for the Midlands region. Soon afterwards he became the National Conference Officer for COHSE and moved down to Banstead.

Interview with assorted Rcn people at East Birmingham  
Hospital 21.7.75

Mrs Hawten and Pat McGinty

Mrs Hawten is Chairperson - she is a midwife - of the Birmingham branch of RCM and a senior manager of community nurses and midwives. She complained that community nursing was in a bad state because Mayston (ie Salmon) had only been implemented 1 year prior to reorganisation. 'Many senior nurses left the community to become, for example, Area Nursing Officers. There was no one left at the top (ie of the community nursing structure). SNOs had to take the decisions. It's not yet been sorted out.'

Pat McGinty (the Divisional Nursing Officer of EBH and formerly from Chelmsley Hospital) said that there were now 1000 nurses at EBH. He said that the Chest Branch was 'a closer knit' community. It had the feeling it was being taken over'. Midwifery and community nursing were in together in the East Birmingham District. The 'identity question' was important. Health Visitors, midwives and district nurses, he felt, inhabited separate little worlds and 'never talk to each other'. The advantage of Mayston was that it unified things, but it was now splitting again. Pat McGinty was trying to revive interest in the Rcn. Guy Hemmings is the steward. It was pretty dormant at the hospital.

Mr McGinty felt that 'you can have too much consultation. In the end someone has to take the decision'. He felt that 'nurse managers are resented by consultants and GPs. Consultants see it as "my Ward Sister on Ward X". Consultants don't identify with the problems of the hospital' (ie as do nurse managers). This meant that he 'had to walk a tight-rope'. He also felt, 'people are suffering from a change of titles. They've just learnt what Principal Nursing Officer means and it changes to Divisional Nursing Officer'. There was 'a lot of empire building going on, which is a sign of insecurity. Mrs Hawten referred to the fight between Solihull and EBH over community nursing. The community nurses were frightened that they would be taken over by Solihull, which had a local authority that didn't spend and a more middle-class clientele. Reorganisation had been traumatic. 'It will take 5 years for hospitals to get back as they were functioning before'. In terms of numbers EBH had around 1000 nurses but around 870 in whole time equivalents (WTEs). They were going to expand considerably.

Guy Hemmings is the Rcn Steward at EBH and a Clinical Instructor. The students were the most active group in the Rcn. However, all the offers had come from one group

of nurses, many of whom had recently left. He was trying to get it going again. They were all students last time, though he felt that pupils were 'more politically aware', because of their marginal status. The students have a non union Students Representative Council where each 'set' ie class of students, has one or two representatives. The major reason he felt for joining the Rcn was 'professional interests. Unions are only strong because the College was closed to men before 1960'. Male nurses were now very career conscious. He knew of a male nurse who had moved 13 times in 10 years in order to get a Chief Nursing Officers job. 'They're often sitting in jobs they're not doing, because they're applying for other jobs'.

He felt that the Student Representative Council wasn't a phoney organisation - 'it has real powers'. It had been in existence some 10 years. 'It has gained more power and become more vociferous'. Mr McNamara, the Rcn Chairman, and a Tutor said, 'they invite who they want to talk to, the Hospital Secretary, and Home Warden. They come and act as Aunt Sallies' (whoever won anything on an Aunt Sally?). It meets monthly.

Guy said that if someone had a crib, for example, about holidays, 'I sometimes take it. But if its serious, say discipline, I would give it to Mrs Gibbs (the Rcn full timer). If it were a student, I'd go to Mrs Hodgkinson (the Senior Tutor) and then Mr Hoare (the District Nursing Officer). I've got a young bloke in from engineering (ie as a student nurse), who's going to take on the student section'. He deals with the intake and 'I encourage them to join the Rcn'. He described himself as 'anti-union?'.

He was in some conflict with the Rcn's Council. He was in favour of deduction at source, but the Treasurers of the Rcn were against it. He felt that Rcn elections should be on a regional basis, mentioning that Birmingham was the biggest region. He described tutors as: 'mentors'. We try to modify attitudes. He had noticed 'a growth in student awareness. They are more vocal. They see things more clearly than the hierarchy. We have to be diplomatic about students grievances on the wards. On most occasions the ward sister is right'. The biggest problem was that 'ward sisters often don't have the time to teach'.

Next it was arranged for me to talk to the Secretary of the Students Council. She described herself as an 'inactive' member of the Rcn, which indicates that she does not see her activities on the students behalf as part of Rcn activities. She complained that there wasn't a great deal of interest from many 'sets'. Some reps did not attend meetings. There were 18 members and 9 attended because 'some are leaving and some aren't interested'. The major issues had been uniforms and catering. The latter was 'trouble' between nurses and the dining room staff because of new supervisors. A Catering Forum had been established 'but it didn't work'. The minutes of meetings were usually distributed widely eg to the wards. (I asked if I could see the minutes and the Senior Tutor told me 'you don't want to do that'. The interview was all she would allow).

Another issue had concerned the nurses home where room visitors were not allowed. They tried to change things but it was blocked. They had problems with uniforms being pinched and materials used. That hadn't got anywhere because of lack of money.

The SRC meeting is not run collectively. Each rep can in turn raise an issue. It doesn't appear that they meet together to prepare beforehand. She claimed to be thinking

of starting a bulletin 'but its controversial stuff.

You have to be careful in case of complaints'. Meetings are held in hospital time. They last about an hour.

'Most sisters let nurses go. The sisters are interested.

Some qualified staff ask representatives to raise things'.

She claimed that a lot of things were blocked, like asking for a telephone in the male nurses home at the Chest

branch. The only thing that came out of the meeting was the promise to write to Chest branch administration.

'I'm not particularly militant. I just like to get things done', and she finds that on many issues, she gets to a point where 'I can't get any further'.

There was no split in the Committee between COHSE and the Rcn. She thought it was 'a good idea to have a committee across the board'. The problems in the nurses home related more to conditions than the running of it - eg the furniture in the rooms. 'When somethings out of order I try to get things done'.

If a student is unhappy about something she can go with her to a sister of Nursing Officer. 'If conditions on the ward are bad I can raise it, but not personal things. Sisters say they (students) go running to the school. So I keep out of it'. Did she believe that students couldn't influence things? Yes, 'especially' first years. As



you go up you realize their (ie sisters') problems'. When she is in school it is then possible to communicate with her group, but at other times they are all on different wards and shifts. It's easier to contact those living in. She doesn't put things on noticeboards. 'It was easier when we had study days' - ie contact is only intermittent when the set are on block release. She hoped the bulletin would improve communications. The minutes only go to reps (this seems to contradict with what she said earlier about them being 'widely' distributed - perhaps that is what she meant by that!) Otherwise communication is 'by word of mouth'.

The Vice Secretary and Secretary of the Committee are elected at the Annual General Meeting (AGM) of reps and by rule the positions can be contested. Groups are all student or all pupil - and there are no restrictions on either having the Secretaryship. The last three Secretaries were all students.

She talked a little about the dining room problem. The students had complained about the appearance of dining room staff. 'It nearly caused a strike. We got it back. They said "They should look at themselves first"'. The Secretary of the Committee gave an 'unofficial' apology. She sent a letter to the Catering Officer which was showed around kitchen staff.

Social life among students was pretty much based on sets. 'Pupils and students don't mix a great deal'.

At the meeting, as I said, the procedure is to go round in a circle. If they have a discussion on a relevant item they invite the Catering Officer and Dining Room Supervisors. There are three people with a standing invitation: Mr McGinty, the Divisional Nursing Officer; the Senior Nursing Officer (Miss Ebbs?); and the Home Warden Mrs Whelan.

There are 3 homes, a sisters extension and a medical students residence. A residential manager had been appointed and he was gradually taking them over. She hoped things would go better. The present Chief Warden Miss McMahon was 'a bit unapproachable. She won't let visitors in the homes'. There are half a dozen wardens (some in COHSE), some of whom are part time. 'Most aren't around late at night. Conditions in the home are grotty. The walls are filthy'. The problem was lack of funds. They have now decorated one of them and they are building flatlets - but qualified staff will have the first option on them.

Miss Hodgkinson the Senior Tutor talked to me about the Council. She said it was her 'brainchild' and a former Chief Nursing Officer. It was set up without bringing in any organised group on the discussion. The Student Nurses Association was present. It provided a rep for each intake and met monthly. She was the first Chairman, but the Students Secretary took over most of the work. 'I had the idea that it would teach them about committee procedure. I didn't guide the issues which came up. When it decided on action, I insisted that the Secretary took the action'. (I was a member of a similar committee when I was a student nurse - again it was individualistic, ie going round in a circle. But the EBH one seems better since the Secretary chases up issues. The one I was concerned with didn't. Its fate was sealed when student nurses set up their own ad hoc canteen boycott without reference to the Committee. I remember, to my horror, that I also raised issues such as the fact that dining room staff were rude to nurses as well as more positive items such as the harsh quality of toilet rolls). The committee 'had the privilege of bringing anyone along', from an early date.

The old Student Nurses' Association was on the JCC. She claimed that they got more out of the Students Council. It's quite a long standing one - goes back to 1961. There

are about 520 learners at the hospital. The Council started at EBH but later took in other hospitals, in the pre-reorganisation group: Hollymoor, Chelmsley, Coleshill. There used to be a Group Council as well as ones for individual hospitals. They still get together with other hospitals and compare conditions, such as cooking facilities at the different hospitals. The aim of the Council was for learners to raise educational, social needs and patient care. 'It taught them how to talk to people and negotiate, and to be constructive'.

Mr D Mullan is also a tutor at EBH. He is Chairman of the Rcn centre at Solihull. He believed that Salmon was not working properly, because only a limited amount of acting up was taking place. In the past the system was abused because people were being asked to act up for extended periods without pay. Now the period of eligibility had been reduced to a week and less of it was being encouraged from above. 'People are working across rather than up'.

He was quite critical of aspects of the Rcn. 'They don't always come up to scratch with personal problems. It often falls down at headquarters. Many think its remote'.

He was critical of some of the past activities of the Rcn there. 'The old school were anti-student. The Rcn was not very active and it was dominated by the Matron'.

He also said that the Home Warden doesn't like the Nurses Representative Council much. 'She complains that people complain at the meeting when she's not there, for example, about the Colour TV being broken, while no-one had told her'.

Yet although he was critical of many respects of the Rcn he was firmly for a professional association and against trade unions, claiming 'with unions its more a question of self-interest, whereas a professional organisation is concerned with standards of care'.

Interview in 1976 with Joan Fretwell, former Tutor at EBH.

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Joan is now (at the time of research) a student in the Sociology Department at Warwick University. She remains a Rcn member and professionally oriented, despite considerable disillusionment.

The Chest hospital had 'a family atmosphere', whereas the General side was a former Fever hospital and this fact, 'led to very rigid rules. The Matron, Miss Smith was of the Fever hospital. The hospital had many difficult problems because it never had enough staff. Student nurses had a difficult time: on night duty, especially, too much responsibility was thrust upon them. They were in charge of surgical and renal wards. Hodgkinson (the Tutor) demanded essays, 'so they had to write them on nights as well as take charge.' Joan was very opposed to this.

She wasn't at all keen on 'the flood of men into management', still less on the fact that many of them were from psychiatric hospitals. 'A lot of psychiatric nurses have slid over into general and don't know the field'. (This is only the reverse of similar processes which occurred in the mental hospitals). She didn't have many good words about any male nurses. She described

Jim Toner, the COHSE Secretary as ignorant of many nursing procedures, saying he didn't know how to set up traction on a patient (quoting an incident which was purported to have happened). She didn't think much of the male tutors in the school: 'They don't like to go on to the wards. They want a life of peace.' She thought that male nurses weren't interested in the same kinds of things as female ones - like the condition of sluices. They were less fastidious.

The Matrons' role in the EBH had declined for two reasons. The first was the expansion in importance of the school and the position of Principal Nursing Officer (PNO) (Education). The second was the creation of group Chief Nursing Officer positions beyond the hospital.

She complained that the Rcn would not do anything about unqualified staff taking charge of wards. Resolution had been put to the 1974 Rcn Conference but Catherine Hall had opposed the moves, claimed Joan, because she felt it might compromise Council.

The President of the Birmingham Rcn; a lady called Dodwell, was the PNO of QE2. One of her tutors had wanted to stand for the GNC, she had forbidden it because it would take up time, saying that she would have to review her position as

tutor. 'It's dominated by senior management. That's why they're going over to COHSE. It's mostly senior nurses. The same thing happens at the (Rcn) Tutors Conference. Miss Friend of the DHSS. She wanted ammunition that she could use from it. I didn't get up and complain because you have to give your name and hospital. You feel as if you've been disloyal to your hospital. It was only last year that everybody started speaking out. People are afraid of victimisation'.



Interview with Mr Hoare, District Nursing Officer,  
East Birmingham, 16 May, 1975.

Mr Hoare is a leading figure in the Birmingham Rcn, and also nationally. He moved here from Hollymoor psychiatric hospital where he was a Senior Nursing Officer. He is a member of the Labour Party but says he is 'anti-union' because 'they are not radical enough' but didn't expand on this. He complained that time that is spent by managers on industrial relations 'interferes' with the running of the hospital. He emphasised that East Birmingham was located in a working class district.

He was aware of the existence of divisions of interest in the Rcn, saying 'College meetings are often concerned with the demarcation between SENs and Staff nurses'.

By the same token, he is opposed to the idea of graded contributions, 'it destroys the idea of equality'. He stated that Rcn subs were recoverable from tax and therefore, joining the Rcn was in effect cheaper than unions. If the College went on to deduction at source (DOCAS) it would mean changing its Articles, he claimed.

He finds that the student unit of the Rcn is quite active but they don't join the Rcn when qualifying. He said that the Student Committee of the Rcn had threatened to leave.

Most students join unions when they qualify rather than the Rcn. The home was not run by nursing administration. He claimed most nurses had keys, but said, 'you can't have complete freedom in a hall of residence'. Nurses when they go to Preliminary Training School, wear uniforms. But in blocks after that they wear their own clothes. He praised Miss Hodgkinson the Director of Nurse Education, as 'very liberal minded in her approach'.

He had a pretty low opinion of union activists. 'Nurses who become COHSE secretaries are disappointed Nursing Officers'. As far as the Birmingham Branch of the Rcn was concerned he said 'it has peaks and troughs', ie it had lapsed into its former state after the Halsbury Campaign. They still had money left over from the 'fighting fund'.

He is spending his time getting used to things. He is impressed by the young management team including lay administrators. He gets to hear of things, he claims, before they're taken to the union. He claimed that the staff 'are used to liberal management and are worried by it'. (He thus thinks of himself as one of the 'new managerialists'). An example was the Mary Green visit as part of the Halsbury investigation. 'Management

attempted to get staff to participate but they wouldn't'. She offered to accept their comments in sealed envelopes but only two nurses took up the offer.

Quite a few of the learners were from abroad. They were also 'good contacts' with local schools. Of the two sites, the Chest side had 'more identity'.

Snatch of Conversation with Guy Hemming, 20 June, 1975

Guy claimed that during the 'ASC rumpus Jim Toner nearly came over to the Rcn. He came and asked me for a form and let it be known that he had asked. I don't know whether he was serious or just being manipulative'.

## Further Follow-up Research

### EBH Branch Meeting 6.7.77

Jim Toner is now on COHSE; National Executive having displaced someone at a recent Regional Council. Pat Sikorski, a student nurse and a member of the International Marxist Group is the Branch Secretary. The meeting was held on the Chest side, it being their turn. There were about 40 present, mainly women; but this was exceptional. Revision of the domestics bonus was the main item on the agenda.

The first item was Conference Report. This was introduced by Jim Toner. The first item was the report that subs had increased to £1.17, which produced sighs all round. Jim justified this by arguing for the need for research facilities, and the need to fight disputes. On pay a motion had been put by EBH Branch against the Social Contract, because we threw out the domestic bonus review last year, because we didn't know what it contained. It's the same with the Social Contract'. However, Phase 111 had been accepted conditionally. A motion for overtime payments; also put by EBH, was passed overwhelmingly. The NEC had not been in favour of the Conference motion in favour of Joint Shop Stewards

Committees. The EBH Branch were in favour, they co-operated with EBH and wanted to see an Area one, and spoke for the motion - it was passed by Conference, but a lot of anti-NUPE feeling surfaced.

There were a number of motions concerning Women's Rights. There were women observers at the Conference from the Regions from small and large branches. The Working Women's Charter was adopted - which included a clause in favour of abortion - and COHSE has affiliated to the Working Womens Charter. However, a motion against the Benyon Bill tightening up the 1967 Abortion Act, was defeated. On subs those on reduced rates of 6p will be asked to become full members soon - women's categories are being abolished. A motion on nurses and special procedures was remitted to the NEC. As a result of the amalgamation of the Federation of Ambulance Personnel COHSE had gained 3000 new members. 37 Special Delegates to Conference (women) and a Special Delegate to each Regional Council. 'We must extend the role of women in this union. We must get you interested and not leave it to the boys'. he said rather paternalistically. He felt that 'the NEC stymied some debates. It's good that the NEC didn't get all its own way'.

The next item, the contentious domestic bonus review was introduced. The problem was, Jim felt that the scheme had never really made any savings. Pat introduced the discussion as the one who had conducted most of the negotiations. They had held a series of group meetings in the past and rejected the new hours. The Branch Executive had gone through the new proposals (a meeting had already been arranged for domestics on the other side of the hospital). He told them to 'ignore rumours of the bonus being withdrawn if you throw out the proposals'. On the form it appears that about 500 new hours are being offered for the whole Domestic group, ie around the same. However, he warned those present that their hours would be down. Since there was also some new work, the hours had been shifted rather than increased. 'There are still black spots not solved by the offer. The Executive of Stewards felt that there was no real change. They are juggling with the hours cut last December'. He recommended rejection. If they wanted to withdraw the scheme they'd have to give notice. At Area level they'd been told that the scheme had overspent - but it hadn't changed since 1971. The real reason was that the Government cash limits for the Area were too low.. The Branch Executive was prepared to

negotiate but could not accept the loss of bonus money - £2.60 a week. 'We absolutely oppose that. Management had suggested a ballot but he didn't agree. There were more women on the morning shift, and on wards rather than departments. They would vote for the scheme and the rest lose out. He reminded the meeting that COHSE's rule book said 'One for all and all for one' and a ballot would be an 'abdication' of it. The meeting at the General Branch had voted 'stay as we are'. It wanted more staff taken on for the relief pool. There was a meeting with management the next day and he wanted to know what they felt. They would be the ladies most affected.

The discussion then began. At first it centred upon whose job was hardest. It was pretty unstructured - about laundry skips, etc. At first no-one said anything about whether to adopt or reject the scheme. They talked of the problems they encountered in their work - for example, how they often had to search high and low to find vacuum cleaners. The carpets lead to more breakdowns. Then some of them said that the Chest side worked harder and that the new schedules would mean even more work being put onto them. Pat said 'you obviously have a lot of problems still. There's never enough relief or a relief pool. It's falling flat during holidays or when people are off sick'. They

were taking people off departments to go onto the wards.

'If we stay as we are, don't sit back. We need to press for extra ladies being taken on'. There was a need to watch the quality of equipment. Pat tried, through the Chairman, Fred Duffy to put the scheme to the meeting.

It was then that one lady said 'the new hours won't be that much shorter'. But others were very angry with her, and disagreed. They said help would only be available for 5 days not 7. I found out subsequently that the lady in favour of the scheme was the domestic supervisor, who creates all sorts of arguments. She is a COHSE member. Fred pressed them to a vote, and no-one was in favour of the revised hours.

The next item was Quinton Hall, a rather decaying geriatric home in Birmingham which was threatened with closure. They had got a petition through the Trades Council mailing. This had been filled up and sent back. But they also wanted delegates and a motion in support of their action committee. Pat suggested they do both. Then there was an interesting debate. A lady - I think a domestic - said 'it's a dungeon and ought to be shut down'. She described the place as dismal. Pat agreed, but said it ought not to close if there were no alternative accommodation.



Fred Duffy described it as one of the oldest homes in the city. Management had refused, however, to upgrade it. The two proposals were passed unanimously. Fred asked the lady if she would agree to be a delegate (it seemed to be the first time she'd said anything in a union meeting) 'because you feel strongly about it'. She said she'd go and say they ought to find another place, but Fred said that someone was wanted to prevent closure. After some chivying 2 ladies nervously volunteered - one was from Arden Lodge. Pat told them not to worry, he would let them know all about it.

On any other business Jim Toner pointed out that the National Steering Committee on Cuts had sent out petitions on school meal increases, trying to get them reduced.

Since I last attended the Branch has become considerably more dynamic and politicized, - and much more outward looking.

After the Branch meeting, Fred and Pat, and myself had a discussion over a drink in the staff club. We talked about the Joint Area JCC that management had set up. They claimed it wasn't representative and had only achieved trivial things. It had discussed bank holidays,

grievance procedure, disciplinary procedure and regrading. Also the new contract for nurses which makes night work obligatory. Part of the problem is that some of the members - like engineers - are on the staff side, but also part of management.

However, more interesting developments have occurred at District level. Last November (1976), Fred approached the TGWU Senior Steward to have joint meetings, which they agreed to. There had been a bit of friction over Christmas holiday arrangements. (Complex stuff about days off in lieu for those working over the period).  
Porters and those on shifts/<sup>were</sup> affected differently from those who work mainly days. In fact they found it difficult to reach an agreement. He complained that NUPE and the TGWU weren't properly organised and didn't hold regular meetings. Fred, who's been here a long time, said NUPE were better organised (on the Chest side) in the 1950s. In the 1940s the GMW had been the predominant union, because they were associated 'with municipal employees in the past, with a uniform and a badge'. Fred said that NUPE fell apart in the 1950s. 'A chap from Wales had been the Branch Secretary', but I think he left. This is one of the troubles of relying on the Branch Secretary to hold things together.

COHSE now has around 700 members at EBH. The TGWU represents all the morning staff 'on both sides of the road' as well as porters. Fred described it as 'the fish and chips union' because 'all kinds are in it'. He thought COHSE 'looks after NHS staff'. Pat agreed, even though a revolutionary socialist, since COHSE had 'the expertise'. A separate identity did not prevent unity.

He described the Joint Shop Stewards Committee as 'the joint idea of COHSE, UCAAT and NUPE. Fred said that union growth at the hospital 'was a gradual process. It was not an overnight sensation'. He referred to the 1973 strike saying that 'the members lost confidence in COHSE because they didn't get strike pay'. However, people were swinging away from the TGWU now. Pat said there were no clear agreements between unions on 'spheres of influence'. 'I'll come here and I'll work and then someone will come up and ask me if they can join COHSE? The TGWU had everyone on mornings, but if someone gets transferred to that shift, COHSE gets some requests to join. He said 'there is no vicious poaching'. Fred said that the GMWU was 'suffocated' when people retired. Two TB hospitals had been run by the City of Birmingham Corporation in the 1930s.

Pat is a 2nd year student nurse. He tries to get his off-duty arranged in such a way as to make union work easy. So most union work is done outside hours. If not, it would create problems with the GNC. Too much time off and you could have to do extra training before being allowed to sit for the exam. He didn't think it was generally possible to approach Nursing Officers if he felt treatment was wrong, eg 'if someone was getting too much 'Brompton Cocktail', a strong sedative given to terminally ill cancer patients. However, it is possible to change opinions, eg if a patient has pain and people say he's malingering, it's possible to bring up social factors to explain it'.

As mentioned earlier, the supervisor had come to the union meeting. Fred was angry that she didn't ask permission, but 'blustered into the meeting'. Fred is more 'flexible' - can do more union work in the hours allowed. The supervisor in question, has power of hire and fire. Fred, although he's second in line, could have disciplinary powers in conjunction with his senior, 'but I've never done it yet. I've never made out a written report on anyone. I've only got three years to go. It's alright for empire builders. Why report?'. He felt

there were 'more careerists nowadays'. They 'are not so intimately involved, they're blasé'. In the past 'the supervisor took an interest. There are so many tiers. People are climbing on the backs of others'. In the past, workers accepted a great deal more. 'The only union was the General and Municipal. You belonged to a union, that was it. It was respectability, the badge in your lapel. Unions are more powerful now'.

He remembered the deprivations of the 1930s and being out of work. He went to 'the panel' for relief and was given 2/6d from the Bishop of Birmingham's fund. With which he bought a bottle of milk, 4 ozs of butter and a loaf of bread. He compares his condition then to the plight of ASTMS working in sweatshops in the Ladypool area of Birmingham now. He remembers that on each ward the nurse did the cleaning of window sills because 'it was their prerogative' and got 10/- a week, while 'the skivvy' got 12/6 a week. The floors were done by porters attached to each ward - but they also did things like take temperatures. 'Bumping' was the method, using a Ronwick polisher. The Medical Superintendent was the power in the Chest hospital: 'If you wanted a rise in pay you went to see the Medical Superintendent. If you wanted a bar of soap you went to see the Medical Superintendent. He was appointed by the Home Office

and not the Public Health Committee'. He described the Medical Superintendent and the Matron as 'almost like a married couple. She was concerned with the moral side'. She used to report people to the Medical Superintendent, if she thought their behaviour had been immoral. He remembers with awe the Medical Superintendent's 'huge office'.

The place changed after the war. 'Male nurses from the forces came in. They had different attitudes. They decided to get together. At that time 'any man that was in nursing was thought of as queer'. They wanted to start a union but they were regarded by the Matron as 'unsuitable material. They didn't win'. They were sick berth attendants who'd got SRN during the war. As far as he could remember the Rcn had always been at the hospital.

He has bitter memories of 'being pushed around', and doesn't feel secure. 'It could happen again'. Memories of the deprivations of the 20s and 30s 'make me glad to be in a union'. He felt that people in hospitals 'are on to a good thing. Pay has gone sky high in the NHS since the ancillary workers' strike'. Yet he accepted that his view was conditioned by his

experience: 'Young people accept things as their right. They've got different attitudes'. But they could become complacent: 'The young ones don't realise what's gone into it'. In the past union organisation was a clandestine affair. 'The T & G planted someone in the hospital and distributed leaflets'.

He recalls that the power and status of the Hospital Secretary had declined considerably since then. He described the Group Secretary in the 1960s, whose name was Rawcliffe, as someone 'who didn't believe in unions. He was one of the biggest bastards in the health service. He tried to sack me at a minutes notice'. Another time he had been underpaid and Geoff Baxter (a COHSE Regional Secretary) had got him regraded. 'These are two things you recollect. If you multiply them they come to something'.

He recalled the 1960s when COHSE got going at EBH. It was organised by Bob Loftus (now a National Officer of COHSE). It was heavy going and on more than one occasion Bob wanted to fold the Branch up. However the Regional Organiser told him he had no right to demolish the Branch and he had a change of heart.

He recalled the big meeting in the Recreation Hall sponsored by the union. On the platform were Rawcliffe and Miss Smith, the Matron. It was COHSEs bid for acceptance. Bob Loftus introduced the speakers. 'A lot of them didn't like to stand up and be counted, not with Rawcliffe there'. There were about 40 there, including a number of nurses. 'Even I wouldn't stand up and be counted. I stood in awe of this bloke'. Two or three stood up and said things. 'Complaints came up but they weren't militant. They were suppliant. They asked, "do you mind if I speak, Sir?" This was the trend of this meeting. They were so powerful'.

Yet, ironically, attitudes to the past were ambivalent. Another long standing member of staff, sitting beside us said, 'we're not names now, Fred, we're numbers.' He felt things before the NHS 'were more humane, more personalised. This was when they were called stewards, not administrators. Then they started to give orders. They plucked people from everywhere'. (Outsiders came in).

The Medical Superintendent, Dr Ross, had recently retired. 'He'd lost all vestiges of power. People had pandered to him. Now there's a Medical Committee. He had been here since 1930. Now the throne has disappeared. We're



being run from down the road'. This, he thought, 'is a bad thing. He was a leader, a godfather. This hospital remembers Dr Ross. It's rudderless. His style was more personal. He knew you. He would fight for the sisters, for example, to get a ward upgraded. He could be a bastard at times. He could be a bastard and a saint at times. He used to work till 8 and 12 at night. He put patients, equipment and sisters first. There's nobody here now. The Medical Committee couldn't care less about the Chest Branch. It's devoid of human understanding. It's not like it used to be. You younger people think this is progress. It has to be a vocation for looking after the sick'. Fred feels this way. He is an appliance maker. In the past, patients stayed a long time. He made their plaster beds and fitted them (for TB of the spine). 'You saw them grow up and become juveniles, and now they know me'. He would see patients through their illnesses for years. Now chemotherapy had reduced the period of cure to 6 months - and this had totally changed relationships at the Chest Hospital.

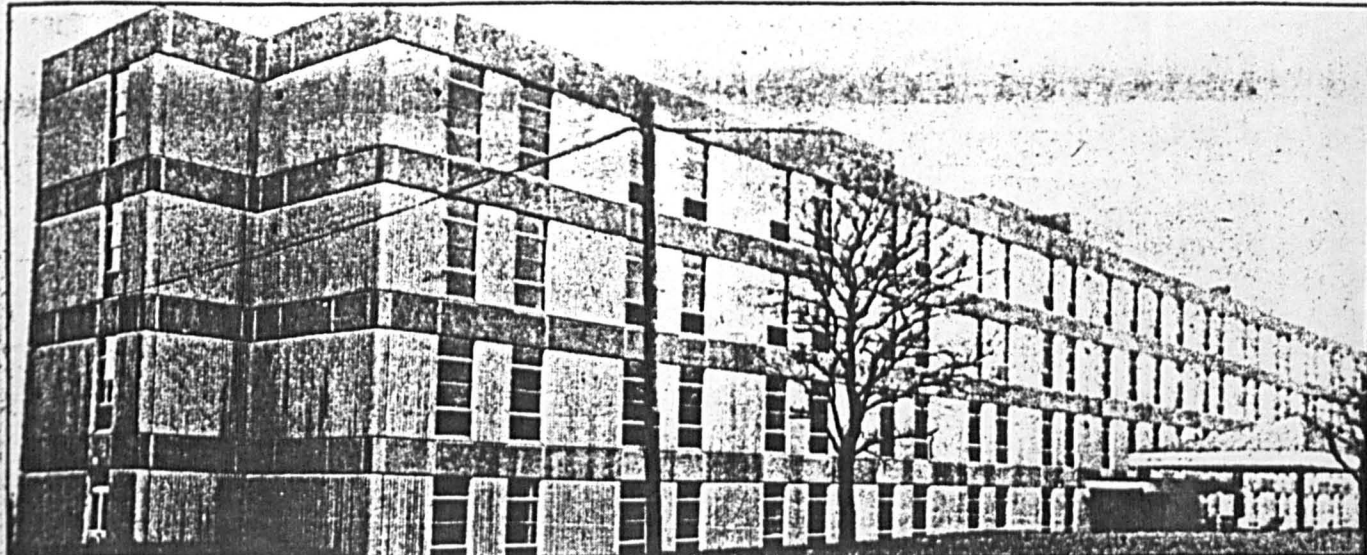
In the past a bloke called Fred Nicholson used to organise appliance workers in Birmingham. He was an orthopaedic appliance maker. They joined the National Union of Furniture Operatives - 'which included coffin makers; he joked'. Nicholson trained at Royal Cripples Hospital

(which he called a 'dirty word'). They sold flags at Birmingham. So Fred joined the NUFTO. He sat in a meeting where there were people from the Morris and Rover getting high rates. 'One of them said "I feel sorry for you mate. I get £19 a week and I design bottle tops"'. Fred was getting £8. 'I was working there making appliances for mankind'. He dropped out and wasn't in anything until later when he joined NUPE. A telephone operator, Bill Taylor 'set himself up as a NUPE Branch Secretary. He was on speaking terms with the Management Committee, nearly all of whom were JPs. I challenged him one day. I said "who elected you?" He said "I did"'. Branch meetings were never held. Fred went to Bill Griffiths of NUPE and told him. 'He wasn't all that bothered. He said "everything's going smoothly"'. He dropped out - then joined the Association of Scientific Workers (a forerunner of ASTMS).

There were attempts to organise nurses. A female staff nurse tried to get some of them in NUPE. She got the male nurses from the forces in. Meetings were held in a local pub. When NUPE was in decline he joined COHSE by approaching Wates, the Regional Secretary. He paid his dues into the nearest Branch, at the Birmingham Accident Hospital. He seems to have sought out unions.

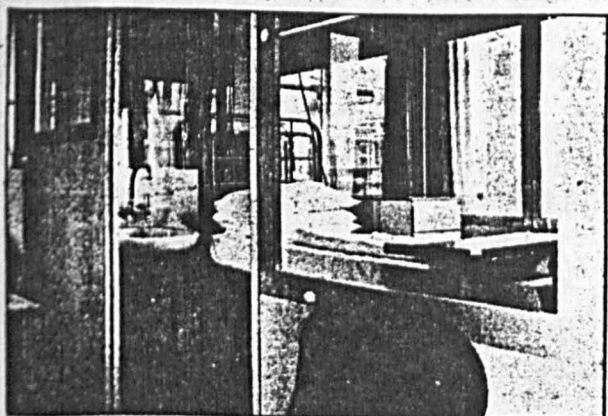
Fred still has aspirations to go a bit higher. He wants his supervisors job. He is also professionally oriented - a licentiate of the Institute of British Surgical Technicians. Yet he is very modest about his skills - surprised that I would want to hear about his life story. He complained that there were too many domestics attending Branch meetings. He would like to see more nurses there. He's out of sympathy, I feel with the instrumentalistic attitudes of the domestics. 'The husbands of the women work in the big factories. They're interested only in money, not the health service'. So he feels more in sympathy with the nurses.

Fred foresaw Pat becoming a Trade Union official. Although a nurse, he had familiarized himself with the complexities of bonus schemes. However, subsequently, when he qualified, Pat Sikorski left the NHS. The last time I heard, he had become a full-timer for the International Marxist Group (IMG).

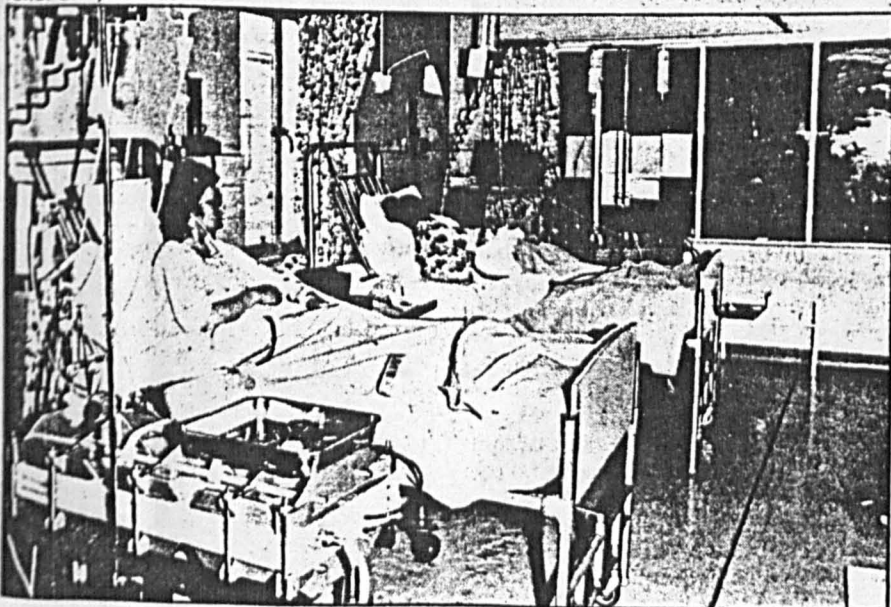


Arden Lodge, the 196-bed purpose-built geriatric unit opened in 1972

## East Birmingham—growing up



Above: the 'patient island' gives a completely sterile environment. Below: patients learn to care for themselves in the renal dialysis unit



'WE DON'T have many problems here—we get quite bored sometimes', says James Pearson, PNO at East Birmingham Hospital.

'But then they come along and build something else again', adds Miss P. A. Edwards, NO (allocation and personnel).

Which just about sums up the transformation story of East Birmingham, nicknamed 'the hospital that has everything'.

Certainly it seems to have an awful lot, acquired rather quickly. In the early fifties, East Birmingham had no district general hospital. But it did have—on opposite sides of the same road—an elderly fever hospital, and a tuberculosis hospital.

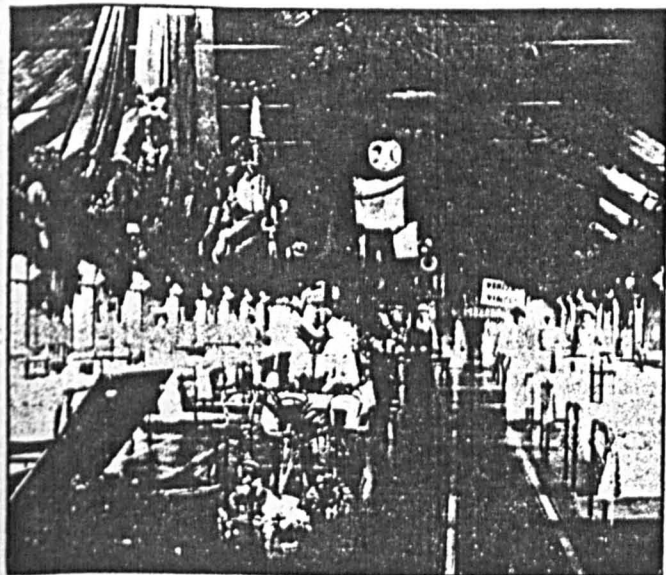
Both were running out of patients. Both—for obvious reasons—had large areas of empty space around them. So with the opening of an ophthalmology ward at the fever hospital in 1951, the development began.

Today, with 1,000 patients and a staff (including part-timers) of 2,000, it is the biggest general hospital in the area. It has also attracted a number of regional specialty jobs, partly because of its origins.

For instance, it has regional responsibility for smallpox. A 56-bed isolation hospital in the country is inhabited only by a caretaker, but at two hours' notice it can be filled with volunteer hospital staff—from stokers to consultants—and put into use. It had two patients last year (none so far this year) and they got the full treatment—locked doors, ambulances disinfected and rolled out down a slope...

The hospital also has regional responsibility for tropical diseases, and is a designated cholera centre. It houses the region's immunology and virus labs. Many patients, appropriately for the Midlands, are immigrants, who have little built-in resistance to some diseases. There are still a number of tuberculosis cases, and a very few cases of typhoid.





The children's ward, before . . .



. . . and after

diphtheria and even leprosy. The modern communicable diseases ward has 133 beds.

On a rather less nineteenth century note, East Birmingham is one of the two hospitals in the country to have 'patient islands', installed this year. These were developed by the UK Atomic Energy Authority and provide a completely sterile environment for patients with highly infectious diseases, burns or transplants.

Each of the two units has an air lock and an ante-chamber, a nurse call system and its own air-conditioning. The sole occupant when I visited was watching football on television, and the acoustics were good enough for us to have a normal conversation through the walls.

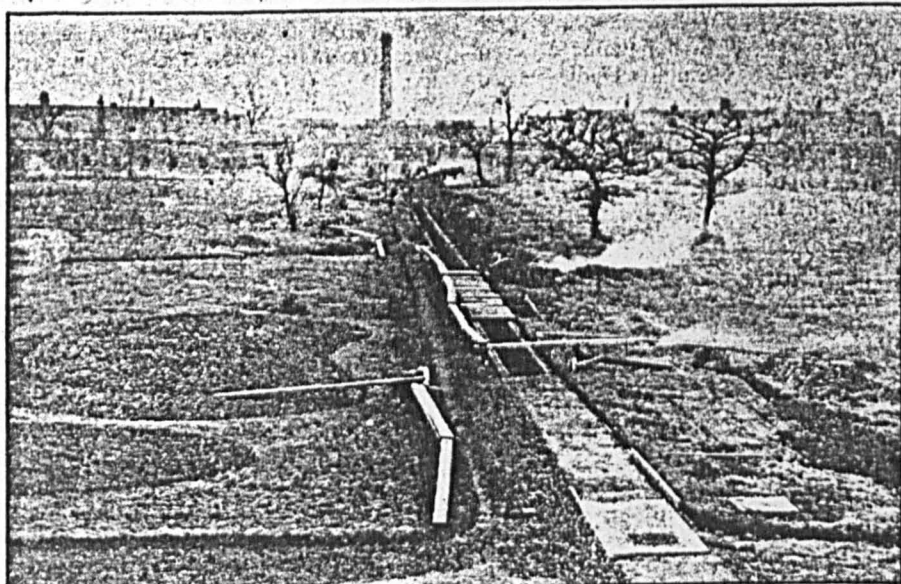
Renal dialysis is another specialty. The unit serves 64 patients living at home, and has 10 beds for patients learning how to manage for themselves. A special two-bed unit is set up like a normal bedroom and the patient's spouse is encouraged to 'live in' for the final three-week training period. The room has a telephone and the patient can practise making routine calls for advice to the staff in the same building.

The pharmacy department, built in 1972, has a quality control laboratory to check supplies for this hospital and others. It also manufactures supplies and has a sterile water bottling plant.

The accident department has Birmingham's 'accident flying squad' which uses police cars and ready-packed equipment for speedy access to the scene of the accident.

Arden Lodge, also built in 1972, is purpose designed throughout for geriatrics. It has 196 beds in different-shaped wards, a day hospital with 50 places and its own staff of occupational and speech therapists, plus physiotherapists.

Organising all this must be quite a



A site no longer seen. New developments have covered it

problem, and the administrators have had quite a few ideas about coping with them. Each of the eight nursing officers specialises in a branch of medicine, and links with consultants are informal but frequent. With the constant new building, they have to be.

The country's first nurse bank was set up three years ago, when the Birmingham Regional Hospital Board decided to find alternatives to using nursing agencies. Now, it supplies the whole-time equivalent of 12 people, mainly for night duty. The accident department has its own branch of the bank. Requirements are kept very flexible—one man works in the accident department for just two hours at night.

'These are responsible people, who are genuinely interested in nursing', says Miss Edwards. 'They are keeping their hand in, ready to do more hours later'. With developments at the hospital by no means over, keeping an eye

on future requirements is vital. A typically demanding plan in the pipeline is a new 10-bed intensive care unit, to replace the existing four-bed unit.

With all this in mind, Miss Edwards came up with another new idea last year—a 13 week refresher course for nurses who felt they were out of touch with modern techniques. Up to 60 nurses came weekly for lectures and demonstrations by trained staff in such subjects as intensive care, new drugs and new treatment for infectious diseases.

The hospital has a nursing school with about 400 places. It is trained staff who are at a premium, as most newly-qualified nurses like to move about and gain experience.

Recruitment is always a priority, simply to keep up with the hospital's growth. There is no desperate overall shortage, says Mr Pearson. 'Other hospitals in Birmingham are closing wards—we are opening them'.

(iii) Highcroft Hospital, Birmingham

Highcroft Hospital, Birmingham

This section concerns itself with events at Highcroft Psychiatric Hospital, Erdington, part of the North Birmingham Group of Hospitals, where nurses in the Summer of 1974 staged an all-out 24 hour strike. I try to trace the strike's complex antecedents, and some of its more significant consequences.

(i) Narrative.

The hospital, which caters for some 850 patients, still visibly retains the appearance of its original purposes - a workhouse. Staff at the hospital are very highly unionised - prior to the dispute around 98% - a feature which can be traced back some considerable time. The main union for both nurses and ancillary workers has always been NUPE. Before May 1974, no Branch of COHSE existed there, only a few isolated members.

In recent years there had been an intensification of rivalry among organisations seeking nursing membership. Nationally, NUPE had planned a nurse recruiting campaign for February 1974, which included advertisements in all major nursing journals, appointment of a nurse recruiting officer, and the distribution of a recruiting

journal, News for the Working Nurse. In response COHSE launched a similar campaign around the same time, but on a lesser scale. As part of this, COHSE members at Highcroft attempted to set up a separate Branch, by poaching some of NUPE's membership. NUPE stewards now admit that COHSE was to some extent successful, because of their previous complacency concerning the solidity of their nurse membership.

As an organisation, COHSE has always espoused the virtues of industrial unionism, of one union for all health service employees. COHSE members are often deeply committed to this aim. Yet there undeniably also exists, especially among nurses, strong tendencies towards a sectional outlook. In launching their Branch, COHSE members exploited such sentiments in attracting nurses from NUPE. They restricted membership to nurses. They pointed to the fact that the Branch Secretary of NUPE, Ben Price, was a porter, and argued that this led to practical problems of representation. It was said that Ben would side with ancillary workers rather than nurses, if a conflict arose between the two groups of workers. The domination of the Branch by ancillary workers was said to have led to a neglect of the nursing membership.



Despite such criticisms, the NUPE Branch appeared to have a fairly well developed system of nursing stewards, even though a fairly high proportion were learners. The truth was that COHSE attracted NUPE members who were particularly status conscious about being in the same union as ancillary workers, as well as those who wanted to pursue sectional interests without feeling obliged to compromise with other groups of workers. Not surprisingly these status considerations, as well as COHSE's poaching, generated considerable tensions between the two unions. Free to pursue sectional nursing interests, COHSE was able to generate a new spirit of militancy among nurses at the hospital. NUPE attempted to match this in order to retain its membership; apparently with some success, for by the end of August 1974 COHSE membership seemed to have stabilised around the hundred mark. The great majority of the rest of the 350 or so nursing staff were still organised by NUPE.

It was, of course, the national pay campaign which really stirred the nurses' militancy. Even though the ancillary workers' strike of 1973 had been soundly defeated by the Conservative Government, it had nevertheless demonstrated that the strike tactic could be employed in hospitals.

The Glasgow firemen's strike later that same year had also shown how far some public sector workers were prepared to go. At Highcroft Hospital, NUPE members in particular were alarmed at the speed with which their national negotiators on the Whitley Council had settled under Phase Three of the Conservative Government's Incomes Policy, without submitting the settlement to the recently established process of Area Delegate Conferences (where rank-and-file members register their vote on major pay deals.) So when COHSE's National Executive Committee initiated industrial action on May 21st, the NUPE nurses agreed to the setting up of a joint NUPE/COHSE Action Committee to pursue such action at local level. The Joint Action Committee soon floundered, even though industrial action continued. COHSE wanted equal numbers on the Committee, while NUPE insisted on proportional representation. On June 11th NUPE stewards pulled out of the Action Committee when COHSE could not agree to such conditions.

There matters lay until the ballot of all COHSE hospitals in the Birmingham area for a possible one day strike on August 12th. After this was decided, however, COHSE's NEC called off all action, without winning the interim payment demanded while Halsbury conducted their enquiries.

On Friday, July 16th, NUPE stewards were drinking in the Queen's, Erdington; quite by chance so were COHSE stewards. One thing led to another, and stewards of both unions agreed to ballot all nurses for strike action, regardless of their Unions' national policy. August 5th was chosen rather than the 12th. They decided to proceed jointly, but not to revive the joint Action Committee.

The ballot took place over three days: Monday to Wednesday, July 29th to 31st, and supervised by members of the Nursing administration at the hospital. The result of the ballot was:

NUPE	FOR	119	AGAINST	26
COHSE	FOR	75	AGAINST	8
		<hr/>		<hr/>
TOTALS	FOR	194	AGAINST	34
		<hr/>		<hr/>

These are remarkably high figures in favour of strike action, and the response was undoubtedly influenced by the previous weekend's resolution of the hospital engineers' and building supervisors' pay dispute. Mrs Castle awarded the engineers, one of the highest paid groups in the health service, big increases of the order of 20%. The West Midlands RHA, which includes Highcroft Hospital, had been one of the

regions most seriously affected by the dispute. Within a week of initiating action, the engineers had brought the Birmingham hospital service to the point of collapse and forced the DHSS to accede to their demands.

The demonstration effect on Highcroft nurses on the eve of a strike ballot hardly requires more emphasis. Ironically, on July 30th, in the middle of their ballot, Albert Spanswick announced to the press that as far as he, the General Secretary of COHSE was concerned, all action had now finished and nurses would now wait the outcome of the Halsbury Committee's deliberations. Nevertheless, Highcroft nurses' determination to pursue strike action for an interim flat-rate payment of £5 a week was unshaken. As might be imagined, from Thursday to Sunday of that week, the eve of the strike, intense pressure was placed on union stewards to call off the strike, from union full-timers as well as management. The Regional Officer of NUPE, Bill Griffiths, was also Chairman of the Staff Side of the Nurses and Midwives Whitley Council. On the management side, the greatest pressure came from Mr Ronald Griffiths (not to be confused with his namesake), the District Administrator. He publicly denounced the impending action as irresponsible. Meetings were held more or less continuously from Friday to Sunday. On Sunday, the Chairman of the RHA, Mr David Perris (also Chairman of Birmingham Trades Council), and the Area Administrator,

Mr John Bettinson, were brought in for a last ditch attempt to avert the dispute, but without success. Finally, Ron Griffiths threatened to seek an injunction on the grounds that due notice had not been given and that the ballot had been improperly conducted. There does not appear to be any substance in these two accusations. In any event, he did not carry out his threat and it only succeeded in hardening the stewards' resolve.

The strike commenced at 7.55 am on Monday August 5th, at the start of the day shift. Pickets had been posted at 6.30 am and were present throughout the ensuing 24 hours. According to union activists, many nurses were reluctant to picket, finding it more offensive to their sense of professional dignity than striking itself. Through the day representatives of other psychiatric hospitals in the area visited the picket lines, as did some medical students and even a couple of general practitioners. Only a small minority of nurses disobeyed union instructions not to go in. Some of these resigned from their union, believing the stewards would then have no objection to their crossing picket lines.

Although the strike was intended as a total effective stoppage of ward staff, every attempt was made to reconcile this aim with that of minimising the risk of harm to patients.

Ancillary members were not requested to join the strike, so long as they were not asked to do work outside their normal range of duties. The Stewards agreed that their members in positions above ward sister/charge nurse level should continue working, as long as they did no more than supervision of volunteers. With staff cooperation, admissions were held back until after the strike. As many patients as possible were sent home and the remainder grouped in fewer wards. On the day of the strike free transport and meals on duty were provided for volunteers. White coats were piled in strategic positions throughout the hospital.

The nurses were impressed by the degree of management preparedness. Indeed, one of the strongest arguments against the strike, from a union standpoint, was that it gave management and the DHSS the opportunity to learn how to deal with a nurses' strike, without there being much likelihood of spreading action to other hospitals or of winning a £5 interim increase. It could also be argued that the strike rebounded against the nurses. This was a view forcibly expressed by a leading article in The Times on August 7th, two days after the strike. As it argued: '...the Birmingham strike seems to have had less regard for the well being of the patients than the series of carefully safeguarded walkouts which gained the nurses so

much public support in April and May. When volunteers have to be called in to man the wards, then it is they who appear in an heroic light'.

Naturally, the Highcroft nurses understood that a one day strike could not win their demands, and knew local management could not pay up even though the demand for an increase was placed on them for propaganda purposes. However, they had hoped to spread the strike to other psychiatric hospitals in the area as the first step in an attempt to enlist the support of engineering workers. The strategy was prompted by memories of the aid given by engineering workers to the miners in 1972, at Satley coal depot. The best chance of spreading the dispute lay through COHSE which is generally better organised in Birmingham mental illness and handicap hospitals than NUPE. The COHSE Action Committee for Birmingham hospitals met the day after the dispute. However the Highcroft nurses failed in their attempt to use it to spread the dispute. COHSE sent up one of their ablest national officers for the meeting - Terry Malinson. Although the meeting was long, and stormy, it eventually endorsed official COHSE policy of no further industrial action. The truth was that by this time fatalistic attitudes had set in, reinforced by the regular 'threshold' payments nurses were receiving in their pay packets. The majority of nurses

were by this time resigned to waiting for the outcome of the Halsbury Committee. If the Highcroft strike had occurred in mid-May, when feelings were running very high, it might well have had a more explosive effect. So in the last analysis, it was perhaps less true that Highcroft nurses were too far ahead of their colleagues in other hospitals, and more true to say that they had delayed taking action for too long.

#### Why Highcroft?

Perhaps it would be better to ask why nurses have tolerated such appalling pay and conditions for so long. Nevertheless, the atypicality of Highcroft nurses does require explanation.

Local factors, for example, were of some importance. The fact that Highcroft Hospital is situated in one of the densest industrial concentrations in Britain, not far from huge factories like British Leyland Longbridge and Pressed Steel Fisher, may have had a diffuse effect. The hospital was situated in an area where there was nothing greatly exceptional about going on strike. There were, however, much more significant direct influences, in particular, the administrative changes which culminated in the reorganisation of 1973. In 1971 Highcroft Hospital lost its separate



identity to become part of the North Birmingham Group of Hospitals, in keeping with the national trend towards larger administrative units.

The effect of this change was complex and far reaching. In the first place, management became more remote, especially when, under reorganisation, power slipped farther from the hospital with the introduction of a District Management Team for the Group. Perhaps of even more significance was the fact that the grouping together of hospitals led the Highcroft nurses to compare themselves and their situation with that of other hospitals, to a much greater extent than in the past. In particular, they compared their lot with that of the general hospital in the group, Good Hope Hospital, Sutton Coldfield. Good Hope is a modern general hospital which has undergone substantial redevelopment. Its relative luxury deepened the Highcroft nurses' sense of grievance. They also felt that the grouping together of the hospitals worsened Highcroft's position as the backwater in the group. They felt that the bulk of capital expenditure was being channeled to Good Hope, that the political priorities of the general hospital dominated the group. Nurses were worried about the future of Highcroft Hospital, that it would increasingly be turned into a geriatric hospital. They suspected that the general hospital wanted to run down the training school at Highcroft, for since 1971

the intake of learners had declined. They were particularly anxious about the lack of psychiatric representation on the District Management Team.

Whether all or some of these fears are justified is not the main point; they were factors which shaped the nurses' attitudes. Prior to the dispute management appeared to have done little to dispel such fears and generally appeared to have a rather complacent attitude towards staff morale. The minutes of the JCC meetings show, for example, how staff demands for basic facilities such as changing rooms are raised time and again with little result.

I have deliberately emphasised these factors as important background causes to the dispute, because in public the COHSE branch was not entirely candid about such aspects in its press releases. In an article for Nursing Mirror, on 30 August, 1974, three of the stewards wrote: 'Some people may have the impression that Highcroft is a hot-bed of dissent, and may wish to associate the strike with low morale and poor conditions. The converse is true ... Team-work is a reality, and there is a close family relationship between all grades and categories of staff'. Perhaps this cover up is in its way indicative of a tendency in institutions such as psychiatric hospitals, that however much staff and management might be at loggerheads they present a solidly harmonious face to the outside world.

After the Strike.

In one sense, of course, the strike was a failure. It did not win any interim payment, and the members of the Halsbury Committee have collectively stated that industrial action by nurses did not influence their conclusions. In the opinion of some senior administrators with responsibility for Highcroft Hospital, an aura of shame had permanently descended upon it as a result of the strike. The District Administrator, for example, according to the Coventry Evening Telegraph of 5 August, 1974, felt that 'no one will come out of this unscathed'. Yet it seemed that the strike, far from having a debilitating effect on staff morale, led to its immediate improvement. Perhaps this was in part due to the flare of publicity on their actions, but there seemed other, more significant reasons for the boost in morale. There was the liberating effect of being able to release the pent up frustrations of many years standing, and also that by demonstrating their capability of carrying out threatened strike action both lay and medical management were forced to treat them with greater respect. Some nurses even suggested that since the strike doctors addressed them in a more considerate manner.

However, there were more tangible gains. As a result of the strike the nurses, through their union, won more immediate access to senior nursing management - not just to

the Principal Nursing Officer (the highest hospital position) but also beyond to the District Nursing Officer. Although it is a little early (at the time of writing) to be certain, it also seems that new progress was made on some of the long standing issues, and management was initially favourable to many of the new demands which nurses wished to raise. Despite the highly centralised bargaining over pay associated with the Whitley Councils, there are nevertheless a whole range of issues which unions can take up at local level even for groups of workers not covered by bonus schemes. The range of issues raised by Highcroft nurses were certainly wide: from representation of staff at all levels on policy making bodies, full consultation over promotion and movement between wards, manning levels, to other more substantive issues such as demands for an occupational health scheme at the hospital, improved staff facilities and in-service training for all grades of staff.

Not surprisingly, one of the major problems faced by nurses especially over substantive demands, lay in assessing the sources of finance. Clearly the lack of resources is itself a national problem. However, there was also the danger that management might meet some of the nurses demands by diverting some of the money intended

for the benefit of patients. Fortunately, some of the immediate demands (for example, over changing rooms) could be met by spending money earmarked in the estimates for any repairs which become necessary during the year, some of which can be released after six months. It could also be argued that the demands made by nurses which require greater expenditure of resources, might not be met at the expense of patients if, as a result of the nurses' greater militancy, more of the group's resources were to flow towards Highcroft Hospital. The fact that some of the issues - such as occupational health - may prove to be a matter for national negotiation, did not deter the Highcroft nurses from raising them as issues. They felt it was essential to build local support for them as a preliminary to exerting national pressure. There also seems to be some confusion about whether many are national bargaining issues.

Joint regulation of such procedural and substantive issues at Highcroft Hospital took place between ward staff and, initially, the nursing administration. Formal arrangements for such regulation is not established in many hospitals. An interesting issue was how far joint regulation was primarily concerned with a redistribution of power between ward staff and the nursing administration with some involvement of the lay administrative staff, and to what

extent medical staff were involved in the situation. As joint regulation extends through the hospital, would it inevitably impinge on the power of the medical staff? There had already been some minor frictions. For example, some psychiatrists disliked the unions' proposal for two charge nurses on each ward and threatened to disrupt any change by saying they would deal only with one sister or charge nurse on a ward. The nurses wanted some relaxation of policy regarding locked wards because they felt it led to increased patient frustration and tension with staff on these wards. These examples show that it was not always easy to compartmentalise problems into 'nursing' and 'medical' issues.

Other sets of bargaining relationships which were of importance concern the relationships between nurses and ancillary workers. The Highcroft experience perhaps demonstrates the difficulty of ensuring that, where both are members in the same branch, their legitimate and separate interests are acknowledged, but not in ways which threaten unity. As was mentioned earlier, the advent of COHSE at Highcroft stirred militancy partly because, recruiting only nurses, it enabled sectional interests to be articulated in a much less inhibited way. There exist many points of potential friction between

nurses and ancillary workers (though not, perhaps, so much as in the past when some, like ward maids, were directly subordinated to nursing staff). Some are a result of the uncertain authority relationships and took the form of, say, a row between a charge nurse and a porter about the rights (or lack of rights) of the former to give orders to the latter. Other points of friction concerned the vexed question of what did and did not constitute 'nursing duties'. Since there is no single, universally agreed definition, the issues raised should be seen more in the context of occupational ideologies rather than which definition is the most 'true'. For the desire of many nurses to shed 'non-nursing' duties is part of a strategy for higher occupational status. Yet many of these duties, though unpleasant or routine, are often among the most vital to patient care and welfare. It also follows that if the shedding of certain tasks is one route to higher occupational status, that inevitably earmarks those tasks as inferior and, thereby, the people who perform them. It is therefore not surprising that the off-loading of tasks from nurses to ancillary or auxiliary personnel can lead to a chronic problem in the relationship between these groups.

Prior to the strike the nurses banned 'non-nursing' duties as part of their campaign of industrial action. This

included, for example, a refusal to butter bread for patients' tea. The kitchen staff resented this move as much for the fact that they were short staffed as status considerations. Eventually - after a threat of strike action by kitchen staff - a compromise was reached whereby kitchen staff buttered bread for eight geriatric wards, while patients were to help nurses on the other wards.

Nevertheless, by far the most noticeable effect of union activity among nurses at the hospital was its impact upon nursing management. As noted previously, after the strike senior nursing management seemed to pay far more attention to the views of the ward level staff. This also meant that in many cases the middle ranks of management tended to be bypassed as the unions gained privileged access to senior management.

Furthermore, because middle-rank nursing management at this time was far from well established, positions tend to be occupied by personnel who are uncertain of their supposed functions, which are, in any case, very ambiguously defined. The present system of nursing management dates from the recommendations made by the Salmon Report in 1966. Salmon has often been vilified as the triumph of impersonal bureaucracy, and it certainly led to a greater rationalisation of nursing management. As far as the middle management roles



are concerned, the Report suggested they should 'be recast from a staff to a line relationship, so as to reproduce in them the desirable features that come from delegation and decentralisation'. (Para.5.20). The building block of the Salmon system of administration is the unit, for most purposes a group of wards, but also departments like outpatients, administered by a Nursing Officer to whom sisters and charge nurses are immediately responsible. However, Salmon is far from a simple system of line management. Rather it is an attempt to reconcile features of line management with the aspirations of the professional nursing interests so well represented on the Committee. Line management clashes with professional aspirations. It implies supervision, while 'true' professionals supervise themselves, through an internalised code of ethics. Furthermore, line management implies that the highest rewards should go to those farthest removed from the primary task. For those, like doctors, whose professional status is less in doubt, entry to administration can be considered entry to a lower status occupation.

The Salmon Report's conception of the Nursing Officer is therefore a curiously hybrid figure, in limbo between a bureaucrat and a consultant - at one and the same time a line supervisor over and staff advisor to ward staff.

Such features did not go unnoticed by ward level staff at Highcroft hospital and, indeed, served to deepen their sense of grievance. However, the disruptive effects of trade union activity on the middle management structure seems to have been largely unintended. It seemed that union activity reduced the scope of Nursing Officers in two particular spheres of the Salmon job description. The first in their administrative and the second, in their personnel capacities.

The narrowing of their administrative functions has been mentioned in passing. Stewards often bypassed Nursing Officers to deal with senior management directly. For example, a NUPE steward, like Monica Dibble, who is a staff nurse, appeared as a result to be often better informed and more up to date on hospital policy than the unit Nursing Officer to whom she was supposedly responsible. As a steward she also played a significant role in the formulation of policy, perhaps as much on many issues as any Nursing Officer. Stewards even found that they would be approached by Nursing Officers and asked what was currently going on. It was clear that stewards probably possessed greater political insight into many of the issues affecting the running of the hospital. In such ways are formal hierarchical relationships disrupted.

Nursing Officers should not, in theory, be so bypassed. A grievance procedure would no doubt have laid down that problems should initially be dealt with in each unit as they arise, and only go higher if they could be resolved at that level. With such a long chain that exists in nursing, proceeding one step at a time could delay issues for some considerable time. It also has to be faced that such steps could be no more than a formality in many cases. For example, at Highcroft nurses demanded repairs to flooring in a particular ward and knew the decision could only be taken at a high level because of the expenditure involved. In the last analysis, the most decisive factor in resolving the situation were staff threats to refuse to work on the ward which management took seriously, given the unions' ability to make good their threats.

Trade union activity also narrowed the personnel functions of Nursing Officers. The role conceived by Salmon would, on the face of it, appear to exclude any place for trade unions in representing nursing staff. For the Report envisages that individual counselling and representation of the views of unit nursing staff to a higher level would be important functions of Nursing Officers. Many

of these functions would seem to be those that an active trade union branch might like to take on for itself.

Once again, the advantage possessed by the stewards at Highcroft was to short-circuit the hierarchical chain to deal directly with senior management. They were able to get decisions on personnel questions more quickly than Nursing Officers.

#### References

'Mandate for Strike Action' Nursing Mirror, Volume 139 (August 30, 1974) pp.34-5.

Return to Highcroft Hospital 7 June 1975

Interview with John Wood and others in NUPE and COHSE

It was reported to me by John Wood that there had been some conflict recently between medical and nursing staff. Reorganisation had not been a success and the conditions of long stay wards were deteriorating, due to the fact that the hospital was being starved of resources. There was concern over the increased amount of community work nurses were being asked to do. Nurses felt more insecure and not covered legally. Both NUPE and COHSE had taken this up with the District Nursing Officer. 'The hospital has lost a lot of power. All the main decisions have gone to the DMT, and its various committees'. There had been cutbacks on expenditure on the long stay wards. In the past in the days before the 1974 reorganisation, the Regional Hospital Board had provided a global sum for the hospital, but since reorganisation this had not arrived until well into the financial year. One example of cutbacks was the amount of money asked for by local management for uniforms. (If local management are powerless, while the union has access to higher levels, this must encourage membership). The common union response was that the number of administrators had increased too much, while front line staff like domestics had been reduced. 'There are too many bureaucrats who are not doing anything for the patients'.

In 1971 patient labour on the wards had been stopped and 25 full-time domestics employed. There are now only 6 with 85 part-time domestics - and no cover. The fact that the porters and domestics had gone on to bonus had meant reductions in manning levels. The domestics had been 'thrown into it'.

The most recent demand of the Highcroft nurses was for greater 'worker participation' between themselves and consultants. They claimed that the Psychiatric Division was too medically dominated and wanted 50% trade union representation 'for a start'. John Wood claimed that 'doctors are against trade unionism since the strike. They ignore the unions'. They had asked for a meeting with all the doctors on the containment of violent patients. Dr Stevens (who used to be Medical Superintendent) will meet the unions but not with his colleagues.

There is a hospital consultative committee, but John complains that their attempts to bring issues up are frustrated. NUPE withdrew support from it for a while. They tried to bring up the issue of patient's pay. An important development at the hospital was the fact that management had requested the formation of a joint shop stewards committee. There had been a disciplinary case. A student had been accused of assault and there was an internal enquiry. The COHSE member had wanted instead to be suspended and have an

independent enquiry. The Lord Mayor of Birmingham I was told, had visited the hospital. He had spent 45 minutes walking round wards and 3 hours in the staff club.

I asked him what he thought the new militancy at the hospital had brought them. He claimed that £10,000 extra was diverted from Good Hope Hospital, and was used to upgrade three wards. They had got their Halsbury award early. He described this as a policy of 'appeasement' by management. The feeling was against district management rather than at hospital level. A Safety Committee was being negotiated and they had got an occupational health scheme from the 7 July. They were also discussing shifts at the moment and this was 'very involved'. I asked about relations between COHSE and NUPE since the strike. John felt that the presence of COHSE had done NUPE 'a lot of good. It made them buck up'. On the separate nurses organisation that had been mooted from Highcroft, John denied that this had serious intent, saying instead that it was designed to put the 'wind up' the national union leaders.

Since the strike, there had been other threatened industrial action. When management tried to transfer Ben Price (the NUPE Branch Secretary and a porter) the domestics had threatened to strike. Ben said that they were disgusted

that NUPE hadn't put the pay deal to a ballot or a delegate conference. It wasn't put to the nurses conference. He claimed that under rule it was supposed to be. Membership of the two organisations seems pretty evenly divided at the hospital, though COHSE specialises in nurses. The local Rcn 'consists of anti-strikers'. All agreed that the Nursing Officers and the Senior Nursing Officer were pretty powerless. 'They can't give us anything'. The dispute on shifts concerned the phasing out of the 'long day'. It had been impossible to staff the hospital because the GNC would not allow learners to work the long day. They had met with the learners and discussions were still proceeding. They had taken up the question of creche facilities. This was in line with NUPE policy (Highcroft had seconded the Conference motion). They complained that it was enormously difficult to get nurses to attend meetings, even though it was possible to hold meetings in working time. In NUPE a recent meeting of domestics had been attended by 70 of them. For other sectional meetings there had been a 100% turnout of the laundry (35) and the sewing room (6). However a meeting called for nurses had been attended by only 7.

Why was this so? Professionalism was given as one reason and 'the way that nurses are educated' which means that



'they look at them (ie ancillary workers) as shit' (NUPE Charge Nurse and stop steward). He also said 'either John (Wood) or I will get the next promotion', which he claimed would be management's way of trying to deal with militancy. Both of them have been moved to admission wards where, in contrast to where they previously worked, 'things are busy and there is not enough time for unions'. However, they are now seen as 'senior' and 'a cut above the rest of staff' because they work on acute wards. They see this as an 'attempt to soften and placate us'.

John Wood said: 'COHSE has fought the pay battle, but has not yet fought the battle for better conditions and participation'. He claimed that NUPE at the hospital 'like to lean more on Tony Nichols' (the Area Officer) than themselves. He claimed that NUPE's policy in the Midlands on nurses was, however, dominated by Bill Griffiths. He felt that methods of internal communication within COHSE had considerably improved. There is an office set aside for unions at the hospital but he works from the ward and uses that as his office. He claimed that the Nursing Officers were frightened to death. 'We have more power than the nursing administration'. He described Ben Price as a 'charismatic' individual who had enormous loyalty, especially from ancillary staff. However John McAteer, a Charge Nurse, handled a lot of the issues concerning

nurses for NUPE. Sometimes Ben was asked to take up issues with nursing management for nurses, and did so. John Wood also believed that Ron Griffiths (the Administrator) could have prevented the strike but wasn't adept at handling bargaining situations. 'None of us intended to go on strike. It was a fluke that it happened. I don't think we could get them out again. It gives Highcroft a bad reputation'. Ron Griffith was new to the district.

On the composition of the labour force, he felt that 10-15% were Irish and there is a fairly high proportion of nursing assistants and immigrants. He claimed that he had turned down promotion elsewhere. Similarly he hadn't been internally promoted because 'I have gone for an interview here and spoke my mind' eg on such things as Salmon and the power of medical staff. He very much believed that doctors had too much power: 'We do all the work for the medical staff. We do the assessment. We represent the biggest group of staff'. Again he raised the future status of the hospital - of it becoming increasingly geriatric. Of the GNC running down the training school because of problems over the long day (which indicates that behind the issue of shifts lies deeper things).

He believed that most nurses join over very basic things - like 'protection'. His approach to recruitment was 'to get them in over protection, and then try to change them'. They have managed to provide legal cover to and from work. It was easier to recruit nurses into COHSE. 'Some nurses say that NUPE is a dustmen's union and that is a bit of an obstacle in recruitment'. However he claimed that he could have still successfully recruited nurses from a NUPE base. On the strike he said 'We committed ourselves and had to go through with it'. It seems he partly regrets having taking strike action but felt that it was a credibility issue.

John also talked a little about the conflict with the Rcn. He illustrated this by means of example. A shop steward had complained that he was not getting his acting-up allowance paid. He or she contacted the Nursing Officer (who was an Rcn member) to ask why. The Nursing Officer had replied that the nurse, as only an SEN, was not entitled to it, because 'they don't have a career structure'. At 4 o'clock on the same day, John, the steward, and somebody else went to see the Principal Nursing Officer (PNO). It was agreed that the payment should be made, and also to circulate Nursing Officers on it. When the nurse

got back to the ward he/she was accosted by the Nursing Officer and demanded to know why he/she'd left the ward - even though it was tea-break. The Nursing Officer concerned was the Chairman of the Rcn Branch. He went to inform the PNO that the steward had been absent from the ward. 'He threatened that he'd get me'. John said he came back later, apologetic.

There were apparently great arguments following Halsbury concerning who was entitled to what. A NUPE steward said: 'The Divisional Nursing Officer came to me and asked me what its implications were. It proves a point: that in the health service promotion isn't due to ability. Why couldn't he get the information from his manager,' Ben Price mused on this and then said 'only in the last few years have unions been able to challenge management'. He believed that militancy in the hospital had started among domestics and spread to other grades of staff.

A N O F F I C I A L S T A T E M E N T

FROM

THE NATIONAL UNION OF PUBLIC EMPLOYEES (HIGHCROFT BRANCH)  
AND  
THE CONFEDERATION OF HEALTH SERVICE EMPLOYEES (NORTH B'HAM  
DISTRICT BRANCH)

Our complete withdrawal of Nursing Services from 0755 on Monday 5 August until 0755 on Tuesday 6 August at Highcroft Hospital is being made because:

1. There was a democratic ballot of members of both unions which produced an overwhelming YES vote for industrial action. The voters are those people who actually look after the patients at Highcroft Hospital.
2. We have been waiting for several months, if not for years, for a proper wage increase - and we are still waiting! Many nurses are living on the 'breadline', unable to afford the luxuries of life.
3. Working conditions and staff shortages locally, and the sorry mess the NHS is in at the present time all over the country, have contributed to the call for action.
4. All previous action has failed to get results, because it has not been of a strong enough nature.
5. Nurses are at last realising that they too are human beings who deserve consideration.
6. We are not going to be blackmailed or exploited any longer.
7. Nurses have seen that other groups of workers have gained huge wage increases by taking strike action.
8. We fear that an early General Election will mean a new Government and a possible non-acceptance of the Halsbury findings.
9. We all know that we cannot trust politicians, already the promise of an interim award has been broken.
10. The Hospital Engineers were given an 18-20% salary increase last week because of the industrial Action they took. This increase alone is greater than the total wage of some nurses.

11. Barbara Castle has announced that the radiographers are to receive a substantial interim award.
12. We feel that it is less cruel to withdraw our support completely now than to go on propping up an inept system which we feel in the long run is causing more harm to our patients than striking at the present time.

We want an immediate 85 per week rise as an interim measure. This CAN be paid to us if authorised by the Department of Health. Surely this is not unreasonable. We shall, of course, expect a much bigger increase later.

The nurses at Figheroft have set a high standard of work which other hospitals try to emulate, and are probably the most responsible group of workers on earth.

If anyone cannot see the need for urgent action then THEY are irresponsible.

We must not, we dare not delay any longer.

IT IS CLEARLY OUR DUTY TO ACT NOW !



# Public Meeting

## STRIKE A BLOW FOR THE NURSES!

**Wed. August 14<sup>th</sup> - 8-30pm**  
**Hare and Hounds**

MARSH HILL, ERDINGTON. (On No. 11 bus route)

The nurses are up in arms. The 24 hour strike at Highcroft by around 300 nurses was to draw attention to the way all nurses have been let down. Barbara Castle, the Labour Minister, said there could be an interim award. The union leaders of NUPE (Alan Fisher) and COHSE (Arthur Spanswick) called off action because of the promise. BUT NOTHING HAS HAPPENED. The government enquiry isn't even producing its report till September.

Meanwhile the National Health Service continues to fall apart. In Birmingham wards are closed for lack of staff, hospitals are old and inadequate and people leave the hospitals because they cannot live on the wages. (Did you know that a fully qualified nurse takes home just £20 a week?)

If you want the nurses to be better paid, if you want to stop the amputation of the Health Service put your shoulder behind the nurses. Come along to the meeting, hear the case and get stuck in.

### Speakers

From Highcroft

GERRY PHILLIPS (COHSE) and  
MONICA DIBBLE (NUPE)

From Socialist Worker

GRANVILLE WILLIAMS

Local Trade Unionist

ARTHUR HARPER (Engineering Union)(AUEW)  
East District President - in a personal  
capacity.

This leaflet printed and published by HOSPITAL WORKER, a rank and file paper for health workers, 30 Simms Lane, Hollywood, Worcs.

Staff at a Birmingham hospital who are planning to stage Britain's first all-out strike by nurses were last night condemned as "irresponsible."

Last night hospital authorities appealed for volunteers to help care for 850 patients at Highercoft psychiatric hospital, Erdington, where about two-thirds of the nurses plan to start a 24-hour strike on Monday in support of an interim pay claim.

Within hours at least 100 people had volunteered, and many more helpers were promised by voluntary bodies including the Red Cross, St. John Ambulance Brigade and the Women's Royal Voluntary Service. "The response has been very encouraging, but we would like more," a hospital spokesman said.

Mr. Ronald Griffiths, district administrator for North Birmingham hospitals, said: "We must sympathise with the aims of their action, but if the hospital is left to manage with only senior nursing staff and volunteers, their action can only be described as irresponsible."

## Unofficial

The strike will involve about 300 of the 450 nurses at Highercoft, and has been called by the local branches of two unions, the National Union of Public Employees and the Confederation of Health Service Employees.

The strike call is unofficial, and was made against the recommendations of regional officials of both unions, because it went against their national policy.

The nurses at Highercoft are demanding an interim payment of an extra £5 a



Mr. Ronald Griffiths

week, payable from next week, which they say could come from either national or local sources.

The nurses are angry because hospital engineers have been awarded interim payments of 18 to 20 per cent, after threatening action which would have closed many hospitals, while the nurses have so far received nothing.

The unions last night

Volunteers will be needed at Highercoft Hospital, Erdington, for the 24 hours between 8 a.m. Monday and 8 a.m. Tuesday.

"We need able-bodied people prepared to roll up their sleeves and do as they are advised by full-time staff, working up to six-hour shifts day or night during those 24 hours," a spokesman said.

Telephone: 021-373 2053 or 021-373 2278.

planned to send a joint telegram to Mrs. Barbara Castle, Social Services Secretary, asking her to intervene by making a cash offer to prevent the strike.

They warned that further action would be considered next week if no cash offer

was made. They have called on nurses at other hospitals to support their action.

They also warned that the union branches would consider extending the strike indefinitely if there was any intimidation of nurses by the hospital authorities, or if the hospital encouraged strike-breakers.

Pickets will be mounted on Monday, but the unions have said they will allow volunteers into the hospital.

The strike call was supported by a convincingly large majority of nurses, in a ballot scrutinised by senior hospital administrators yesterday.

Of the NUPE members on duty, 119 voted for industrial action, 26 against, with two spoiled votes. Of the COHSE members, 75 voted to strike, with eight against and three spoiled votes.

## 'Let down'

Mr. John Wood, Highercoft branch secretary of COHSE, said yesterday: "It was the settlement of the hospital engineers' dispute which sparked off our action."

"We feel we have been let down by the Secretary of State, having been promised an interim award we are still waiting for. All we have had are empty promises. Mrs. Castle can avert the strike if she starts talking about giving us more money now."

Mr. Den Price, Highercoft branch secretary of NUPE, said: "None of us like what we are going to do, but we reached the stage where we had to do something."

"Dedication is very nice, but it doesn't pay the gas bill. Nor does public sympathy. We want an interim payment now, not in September."

Will the fury?—Page 6

'Strike is  
irresponsible,  
official says'

Birmingham

Post 2 Aug 1974

Hospital staff at Highercoft Hospital yesterday in the boardroom where they discussed their proposal to strike for 24 hours on Monday. From the left: Mr. T. L. Wood, charge nurse, branch secretary, COHSE; Mr. Den Price, chargehand porter, branch secretary of NUPE; Mr. R. Kennedy, charge nurse, COHSE steward; Mr. E. J. ... student nurse, NUPE steward; Mrs. Monica Dibble, staff nurse, NUPE steward; Mr. John McAleer, charge nurse, NUPE steward; Mr. Charles ... charge nurse.



Times 6 Aug 74

# Fears that first 24-hour total strike by nurses may spread

From Our Correspondent  
Birmingham

Nurses at Highcroft mental hospital, Birmingham, began their first total strike in Britain yesterday, and there were fears last night that the unofficial 24-hour action would spread.

Mr Terry Mallinson, a national officer of the Confederation of Health Service Employees (Cohse), will address a meeting today in an attempt to dissuade militants from calling for a 24-hour strike at more of Birmingham's eight mental hospitals and clinics.

Mr Geoffrey Baxter, Cohse regional officer, said the Highcroft nurses had already approached other hospitals and that today's meeting might decide whether more strikes should be held in defiance of the union.

Mr John Wood, Cohse branch secretary at Highcroft, said of the strike which began yesterday: "We regret the need for this action. It is a sad day. But we must make some demonstration against our pay and conditions."

## Volunteers' response to appeal for help in caring for patients kept mental hospital open, administrator says

Nursing members of the National Union of Public Employees also took part.

Nurses' places on the wards at Highcroft were taken by volunteers yesterday. There were 140 of them for the first of the three shifts usually worked by the 350 nurses. The hospital has 850 beds, but 100 were empty as families had agreed to keep the patients at home during the strike.

Miss Susan Ashford, aged 19, a botany and microbiology student from University College, Swansea, whose home is in Birmingham, said she heard a television appeal for help. "I had plenty of free time. I thought I would go in to see if I could be of any help. I was a bit scared when I came in. I did not know what to expect."

She spent the time looking after 25 women patients, talking

to them, washing their hair and caring for their other needs. "I can see how difficult the job is," she said. "I think you have to have a vocation for it."

Mrs Kathleen Byrne, a former nurse, took the day off from her supervisory job at a convent. "It is frightening for anyone, particularly young girls, coming to this kind of nursing until you get to know the work," she said. "I have really enjoyed it. I think you have to be dedicated to it but dedication is no good without pay."

The hospital management said many nurses ignored the strike call but the strikers said that no more than 20 nurses had reported for work.

Mr Ronald Griffiths, administrator for north Birmingham hospital group, said that a

quarter of the nurses reported for the shift beginning at 8 am:

"Had it not been for the volunteers the hospital would have had to close today", he said. "They have been magnificent. Some are former nurses but some have no experience at all. Some elderly relatives are looking after patients. They are not capable of heavy physical work but they are doing small routine tasks."

**X-ray staff's action:** Another bout of industrial action in the troubled National Health Service will begin today when several hundred radiographers stage selective strikes in support of an interim pay demand (our Labour Staff writes). The stoppages will be confined initially to selected hospitals in Scotland, Wales, Devon, and Lancashire.

The Association of Scientific,

Technical and Managerial Staffs (ASTMS), the principal union involved, said yesterday that the action might spread to the rest of the country.

The radiographers' leaders are seeking up to 35 per cent more on basic pay rates, to take the weekly wages of X-ray technicians to at least £35 a week. The immediate cause of the strike action is the refusal of Lord Malsbury, who is conducting an inquiry into the pay of certain medical staffs, to state what interim increase he proposes to give the radiographers while his report is being completed.

But he hinted at how the increase might be calculated. He said that by keeping the relationship between the pay of nurses and midwives and that of medical supplementary professions, it would be possible to link the completion of his report on nurses and midwives pay with a parallel but interim recommendation for certain other health service workers, including radiographers.

Photograph, page 2

Morning Advertiser  
CUSTOMERS ADVISE  
TO THE RESCUE  
Aug 74

'Morning Advertiser' Reporter

CUSTOMERS OF a Birmingham pub were among the volunteer workers at the hospital which was hit by Britain's first total strike by nurses yesterday.

They joined the teams of emergency "staff" who manned the Highcroft Psychiatric and Psychogeriatric Hospital in Birmingham where there was a 24-hour stoppage in support of a pay claim. The help came from the Trade Winds, a large pub on the Castle Vale Estate which recently "adopted" two wards at the hospital. Customers raised £226 at an all-day fete at the Mitchells and Butlers house.

Yesterday, they readily answered an SOS for volunteers to keep services running while most of the 450 nurses at the hospital staged a one-day protest.

# NURSES : Highcroft shows the way

*Socialist  
Worker  
16 Aug 74*

THE REFUSAL of Barbara Castle, Labour's Health Secretary, to grant an interim pay award to nurses, radiographers and other hospital workers has set off another explosion of militancy in the hospitals.

In Birmingham nurses at the huge Highcroft Mental Hospital came out on strike on Monday—the first-ever 24-hour strike by nurses in this country.

In several areas radiographers have struck in protest against the Minister's decision. One radiographer at Middlesbrough General Hospital shouted as he walked out: 'Who is Secretary of State, Barbara Castle or Lord Halsbury?' It is no secret that Barbara Castle wanted to grant the nurses an interim award but has been restrained by Lord Halsbury, who heads the committee investigating nurses' pay.

Halsbury has insisted that an interim award will 'interfere with his committee's independence.' Halsbury is one of the richest industrialists in the country. He is a director of Distillers, the marketers of thalidomide. He is also a director of Head Wrightson, the heavy engineering company, and of Joseph Lucas. He owns all the shares in 12 Lucas subsidiaries.

An ingrained reactionary, Halsbury has no love for the Labour government. But 'Red Barbara' Castle is more worried about offending his lordship and his colleagues than she is about prolonging the misery of Britain's nurses, radiographers and other hospital workers.

*Granville Williams writes from Birmingham:*

THE STRIKE of more than 300 nurses at Highcroft Hospital, North Birmingham, on Monday has inspired a new militancy among nurses. Many other hospitals are now discussing 24-hour stoppages.

What was remarkable about the run-up to the strike was the pressure from hospital management and union full-time officials to get it called off. On Sunday the Highcroft NUPE and COHSE branch officers were subjected to 12 hours of threats, promises and pressurising, including the threat of a court injunction against the two branch secretaries Ben Price and John Wood.

One of the most shabby attacks came from Mr D A Perris, secretary of Birmingham Trades Council and chairman of the Area Health Board, who condemned the action as irresponsible.

But the nurses stood firm. The results of the strike ballot were as follows:

NUPE	FOR 119	AGAINST 26
COHSE:	FOR 75	AGAINST 8
TOTALS	FOR 194	AGAINST 34

Among the younger nurses on the strike was Catherine McAllister, a student nurse and a COHSE shop steward. She described how she was expected to buy books for study and support herself on a take-home pay of £68 a month. 'We are hoping the strike will snowball. It's disgraceful it's come to this, but we can't be dedicated and hungry at the same time.'

'We've been morally blackmailed for years, and we hope this action will show the government we're not standing for it any more.'

Two COHSE stewards from All Saints, another large psychiatric hospital in Birmingham, joined the picket to express solidarity. John Hope, one of the stewards, said: 'We are having a nurses' action meeting, and from it we are expecting combined action.'

Tom O'Sullivan, the other steward, pointed to the feeling of disillusionment that his members had with the trade union officials. 'Next action we take, we'll make sure they consult us before it's called off.'

Rank and file nurses must spread the action to other hospitals and win the active support of other trade unionists. Barbara Castle let the nurses down. The trade union officials, nationally and locally, have marched their members up the hill and marched them back down again for a broken promise of an interim pay award. The Halsbury Commission drags on and on.

The Highcroft nurses have learnt to rely on themselves. Through their action they have given a real lead. They can win a pay increase and get a better Health Service, and they need our support.

## BIRMINGHAM PUBLIC MEETING

Strike a Blow for the Nurses

Speakers: Gerry Phillips (COHSE) and Monica Dibble (NUPE), both of Highcroft Hospital; Granville Williams

Socialist Worker and a local trade unionist. Wednesday, 14th August

8.30pm. The Fore and Hound, Warley Hill, Edgbaston, B15 2JH

*Hopes that the Highcroft Hospital Strike would spread proved extremely over-optimistic, despite the intervention of the revolutionary left.*



A VITAL Why? Who will drop on to the desks of Britain's top management today with the warning: 'These people are out to destroy you! It is a warning that both management and the TUC, meeting at Brighton, would do well to observe.

It comes in 'The Agitators', a book which names revolutionaries dedicated to the overthrow of our way of life—and describes how deeply they are now entrenched in our society.

It is published by the Economic League, an independent body backed by big business, at a time when extremists are enjoying ideal breeding conditions amidst endless talk of economic disaster.

While most of Britain agonises over inflation, the agitators are busier than ever subverting workers and exploiting the freedoms of a society they detest.

Over and over again the book rams home this alarming point: The revolutionaries are winning ground. In pinpoints, for instance,

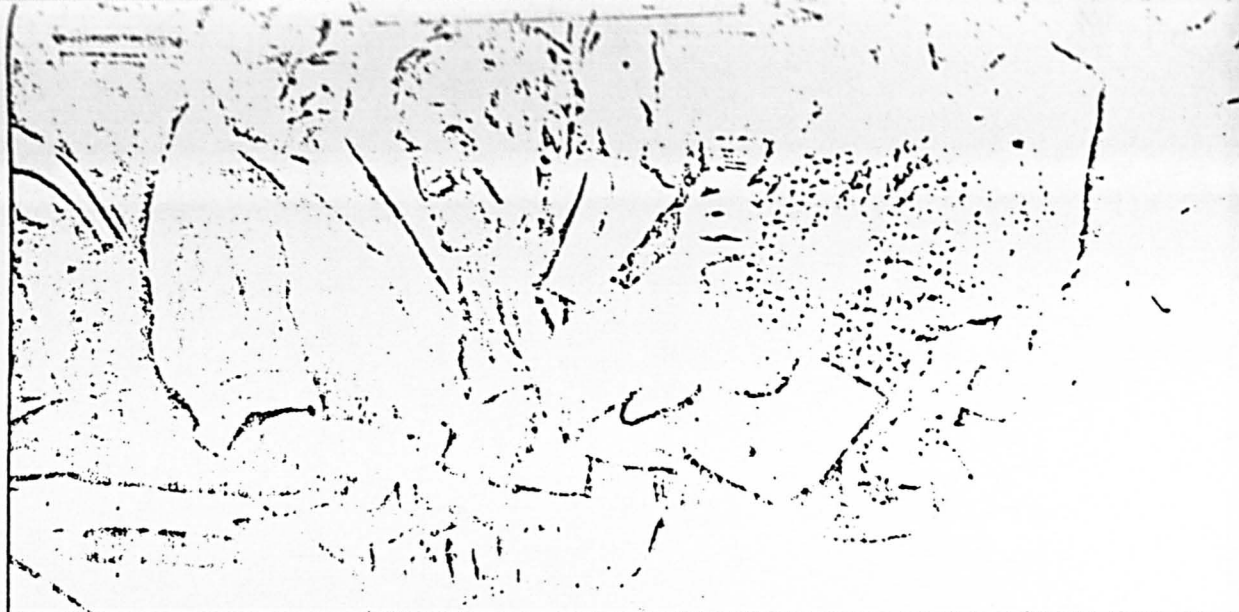
the International Socialists, who in less than five years have built an industrial apparatus which in some respects is even more extensive than that controlled by the Communist Party.

'They have created a national network of organisations criss-crossing unions, industries and professions with factory cells, industrial branches and "front" organisations.'

How does an organisation like the International Socialists go to work? The Daily Mail decided to go beyond the pages of 'The Agitators' to find out where the troublemakers are most active.

The answer: Among Britain's unhappy nurses, whose current pay demands have created an emotive dispute almost tailor-made for the revolutionaries.

This Daily Mail analysis provides a disturbing example of the ease with which extremists can infiltrate a dispute and use it as a weapon against a democratic system they seek to destroy.



Speaking for nurses... Gerry Phillips addressing Leyland workers. Beside her, leaning forward, is Arthur Harper

# Militants in action... hiding behind nurses' skirt

WHEN the nurses of Highcroft hospital, Birmingham, walked out in a unique 24-hour strike, the nation was shocked—but sympathetic.

Everybody agreed that nurses deserve a better deal. And if strike-action smacked unpleasantly of a breach of vocational ethics, at least it was a spontaneous demonstration of frustration and anger by a group of devoted workers. But was it?

## Eager

The Daily Mail inquiry reveals that the nurses are being skillfully exploited by left-wing agitators. Extremists have infiltrated the hospitals dis-

pute and undermined the authority of official—and more moderate—trade union leaders.

Significantly, members and supporters of the revolutionary International Socialists have been prominent where the dispute is most militant: London, Birmingham, Manchester and South Wales.

They have helped to form militant unofficial action committees to attack the more moderate approaches of elected leaders of the National Union of Public Employees and the Confederation of Health Service Employees.

They even organised a dial-militant service so that lively speakers for nurses' meetings were only a telephone call away.

At Highcroft, the nurses were infiltrated by the International Socialists' full-time Midlands organiser, Granville Williams. He eagerly offered his ser-

vices to the angry but industrially-naïve nurses. Today, although he is in no way connected with the hospital service, he is accepted as their unofficial adviser and tactician.

On August 2, Williams toured the hospital with openly militant NUPE branch leader Ben Price. Only three days later the hospital endured its historic 24-hour strike. Outside Granville Williams in a was three manning the picket line.

## Strategy

After that, temperatures cooled at Highcroft. The staff decided to wait for Lord Hailbury's report on hospital pay, due soon. This did not suit the extremists' strategy. Their aim was to keep the dispute boiling.

So Granville Williams organised a meeting in an upstairs room at the Hare and Hounds pub, near the hospital. He chaired it jointly with hospital shop steward Charlie Williams.

Most of the action com-

## HOSPITAL WORKER

Paper that urges action

mittee were there. But at least half of the 40-strong audience had no connection with the dispute.

For 70 minutes the room reverberated to down-to-earth, often ferocious rhetoric, mainly from non-nurses. The mood, at the beginning one of moderation and patience, turned into militancy once again with potential repercussions throughout many Birmingham factories.

It started with speeches from two nurses, ward sister Gerry Phillips—a 36-year-old Communist Party member—and a deputy sister. They called for support from other trade unionists stressing that hospital workers paid 'buses in arms' in disputes.

Respected Granville Williams was introduced as a journalist from 'Socialist Worker', his movement's newspaper.

He called for 'solidarity',

## WE MUST ORGANISE TO PUT THE BOOT IN

... and part of its policy

skating around any mention of Marxism or International Socialism. He did not reveal this was not the first time he had been 'unofficial tactician' for strikers.

Then some blunt but persuasive words came from well-known Communist Arthur Harper, engineering convenor at British Leyland's tractor and transmission plant, Birmingham.

Waving his clenched fist, he vigorously urged the nurses on.

'We learnt the hard way,' he said. 'You nurses are beginners at this game. Nobody gets past our picket lines—well, if they do they probably need hospital treatment.'

Then Harper offered: 'Let us show you how to strike and picket.'

'A kick up the arse, a few bumps on the head—that's the best way to get your message

over. Just ask for support from us, and my back will be with you.'

Harper turned to Sister Phillips. 'After listening to you, I'm glad I came here. I'm going to call a meeting of our members at the factory gates. Come and speak to the men. I guarantee full support. Then we can show you how to fight.'

Two days later Sister Phillips joined Harper in a luncheon meeting outside the British Leyland's factory gates. She told 200 workers: 'Look, we want your help. We're nurses—we don't know much about disputes, etc. We're new to it.'

That, no doubt, explained the hovering presence of Granville Williams, again, among the Highcroft Action Committee.

## Welcome

This was only one of several factory meetings where the nurses persuaded trade unionists to back them—with strikes if necessary. It is difficult to imagine that nurses alone could ever have organised such

action, or have known how to carry them out.

Afterwards Sister Phillips explained to the 10th Street, Granville Williams put us in the know about the union. He gave us names and addresses. It gathered momentum from there.

'I don't think the engineering unions have got control over us, but considering they are experienced in industrial relations their advice is welcome.'

Extremists have been successful elsewhere too. Internal bulletins reveal that Health Service members of the International Socialists have increased from 30 to 100 in 18 months. Rank-and-file supporters number many, many more.

The movement's newspaper 'Hospital Worker' prints 4,000 copies a month and is currently published at a 40 per cent loss.

In Manchester an action committee was formed after a proposal by 27-year-old Jack Sutton. NUPE alerted at the Royal Infirmary.

This year Sutton was listed as a member of the editorial

board of 'Hospital Worker' and he asked to form Workers' Fight a 'No' list for nurses.

Doctors and engineers have offered their support in Manchester.

In South Wales According to 'Socialist Worker', the action committee at Glamorgan was started by nurses and trade union members of the International Socialists.

## Ban

They brought out 100 nurses in support from picket at Middlesbrough, Grimsby and Barns.

In London's Unofficial action has hit hospitals there but the city since early this year. Extremists are undoubtedly involved.

For example Hammermith Hospital was given an ultimatum to ban private patients or have food cut off.

Bill Gledhill, the union's branch leader, is also listed as a member of the editorial board of 'Hospital Worker' and has recently addressed meetings organised by the International Socialists.



GRANVILLE WILLIAMS joined the picket

The  
Tribble  
Makers  
Daily  
Mail  
3/9/74.

# Strike leaders deny being 'led by militants'

Birmingham  
Evening Mail  
3/9/74.

Evening Mail Reporter

NURSES' union leaders today denied that the nurses at Highcroft Hospital, Erdington, had been exploited by left-wing militants.

The left-wingers appeared on the scene AFTER the nurses had taken a democratic vote and decided on their strike a month ago. It was claimed today by members of the Highcroft Action Committee.

The allegation was made in a national newspaper report, coinciding with the publication of an Economic League booklet. Mr. Alan Fisher, general secretary of N.U.P.E. said he did not believe it merited a union investigation.

## Strike leader

Bearded Highcroft strike leader Mr. Ben Price, a chargehand porter at the hospital said: "I have flirted with communism. I read 'The Workers' Press' and the 'Morning Star'. But that does not make me a communist."

He bristled at any suggestion that he and his 20-strong Action Committee had been "led by the

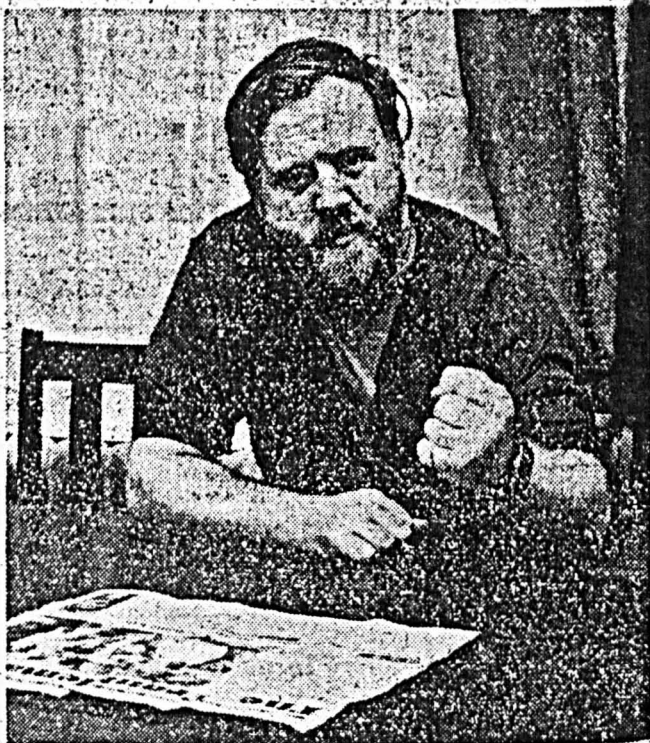
one."

He said he knew Mr. Granville Williams, who has been described as the International Socialists' full-time worker in the Midlands.

"He has his opinions and I use mine."

Mr. Price is Secretary of the National Union of Public Employees at Highcroft.

Mr. Price said nurses voted 19 to 26 for strike action. The ballot was carried out on July 3, 30 and 31. He said: "Granville Williams did not appear at the scene until August 2. The one-day strike was held on August 5."



Mr. Ben Price, at Highcroft Hospital, today.

## Angry

He said he did not meet Mr. Arthur Harper, the Communist convenor at British Leyland's tractors and transmission plant in Washwood Heath, Birmingham, until there was an Action Committee meeting at a pub near the hospital.

Equally angry over the suggestion of Communist infiltration at Highcroft today were two charge nurses, both union officials. — Mr. John McAleer, NUPE shop steward, and Mr. Terry Mitchell, vice-chairman of the Confederation of Health Service Employees at Highcroft.

Mr. Mitchell said: "We have not been used by anyone."

The shop stewards agreed that Mr. Harper appeared on the scene only to influence industrial workers to back the nurses.

Mr. McAleer added: "We wanted industrial backing and Mr. Harper invited us to a factory-gate meeting."

Mr. Granville Williams, asked "Are you the International Socialists' full-time Midlands organiser?" said: "I am a journalist with 'Socialist Worker', and I appeared at Highcroft only as a journalist. This is a witch hunt. I hope that the people at Highcroft will rebut suggestions of 'infiltration'."

## Isolated

Mr. Fisher said he was aware of pressure groups both from the extreme right and left wings.

"But I think the situation at Highcroft has been exaggerated by taking one or two isolated examples."

Mr. Bill Griffiths said the one-day strike at Highcroft Hospital would undoubtedly have happened, whether there were political agitation or not.

Mr. Griffiths, NUPE divisional organiser, is also chairman of the staff side of the nurses' and midwives' Whitley Council, and at the time he urged his members at Highcroft not to strike.

He recalled: "The objectives of the strike were to secure an interim payment of money. I said all along it was incapable of achievement. The Government had decided to set up a committee of inquiry."

(iv) Kings College Hospital, London

Interview with Sylvia Prentice, Nalgo Branch Secretary  
at Kings College Hospital on 11.9.75

Sylvia trained at Plymouth, did a postgraduate theatre course at Kings and stayed as a Theatre Sister. However, at the time I interviewed her she was just going off to become a health visitor - but was training within the locality. (Someone later told me it was because she was coming under a lot of pressure and being pushed out).

She joined Nalgo because it was strong among admin. and clerical staff. She started recruiting among nurses in 1972 - though I don't think a majority of nurses have ever been members. She started up over the 1972 Revaluation claim but says 'I was also bothered about standards. A lot of nurses were dropping out, and theatre became heavily dependant upon agency nurses. The Revaluation claim got trapped in the Tory Stage 1. Sylvia called a meeting and brought an anti-Rcn leaflet out called 'Who Speaks for Nurses?' (see documents at end of section). The meeting was held in the Recreation room and attended by about 50 people. 'I was naive, but felt I had to do something. All of us decided we had to go into a union.' She was a socialist and member of the Labour Party.

Kings College	-	Nalgo were strong
Dulwich	-	NUPE
St. Giles	-	GMWU and TGWU
St. Francis (Psychiatric)	-	COHSE

In addition Belgrave Hospital also came under the Kings Boards of Governors - which is now Kings District and part of Lambeth AHA(T) - but it is different also in that it doesn't have the direct ear of the DHSS as the teaching hospitals had in the past.

Nalgo was the most active in Kings so that's what they joined. Some 20 joined at the meeting after having been given application forms. They needed, however, a focus for building the organisation. 'We couldn't do much about Phase 1, we needed a local issue. It fell into our hands - we didn't have to look for it': canteen facilities and prices. 'It was a lousy dining room with very little choice. Salaries were being kept low and prices were going up'. Action started at Dulwich among NUPE ancillary workers. They collected money and put on alternative food, and organised a boycott. An IMG nurse Kath helped to organise it and Sylvia felt some of the leaflets were 'too political'. However, she contacted Kath and a meeting was called at St Francis to set up an action committee to organise a boycott throughout the Kings group of hospitals. Sylvia was elected to it as well as Kath. There were two ancillary reps on it, Sid Wilkes (the AUEW convenor for the whole district but the ancillary convenor at Kings). Sylvia became chairperson of the Committee. Since Kings had the largest canteen the campaign had to get off the ground



there. Their aim was to get prices reduced. She started the campaign off 'low key and got all nurses involved'. The pickets placed on the dining room were nurses, with medical students in support (ancillary workers had their own dining room). She wrote to Southwark Trades Council. Donations were received and posters were put up everywhere. 'Support snowballed'. A lot of people were using the alternative facilities and the 'hospital got worried' (ie the administration). At first management refused to recognise the Action Committee, but after the action started to bite a meeting was called and they recognised it.

The management were being called upon to make a 50% reduction in food prices - which they said was not in their powers - so a march on the DHSS (which isn't that far away) was planned. Included on the march were 60 nurses in uniform and when they got there they had a meeting with the Under Secretary of State. At Dulwich Hospital a piece of cottage pie from the canteen was analysed in the lab and found to contain: some bacon rind, chicken skin, some soya flour but no meat. When this news was related to the local press, Sylvia reports, hospital management were forced to recognise the committee. The latter blamed the quality of food on an agency chef. In December 1973 the DHSS said that they couldn't do anything. However, the local Boards of Governors reduced prices by 10%.



Sylvia describes this issue as symbolic. There was a generalised sense of grievance and it just happened to settle on that as the most available issue. However, the campaign was not without its problems. As a result of the boycott, ancillary workers in the kitchens nearly lost their bonus. She arranged a meeting with them and explained the case of the boycotts. At first they refused to talk to Sylvia. However, when the TGWU took up the case with the House Governor, and ensured that kitchen staff bonuses were protected, support among kitchen staff grew. A decisive factor was 'the tremendous support from the press. One patient collected £66.50. The press were on our side on that issue'. In addition the patients organised a petition and sent it to MPs. Questions in Parliament were asked about the possibility of subsidy. Sylvia puts the support of patients down to the fact that many of them in the Kings area are working class. She claimed that the patient who organised a petition was a trade union activist. She also said that most sisters and those at more senior levels were opposed to the campaign. The support mostly came from students.

Harry Lamburn the MP for Southwark (their constituency) asked a question in Parliament. Sylvia said 'he wasn't very impressive'. She thought John Fraser was better (see Hansard 4 Dec.1973. See also South London Press and Evening News for that period.) The committee was recognised

from early November; they wrote to Lord Normanby the House Governor asking for meetings to discuss things. He wrote back asking her to come on her own. She did this at first. However afterwards he claimed she agreed to things which she denied. So she refused individual invitations. She started to take a couple of people in with her. 'Then the invitations stopped'. She states herself as 'impressed by the grandeur' of the Governor and his fine office.

Eventually the Governors started negotiating with the DHSS about cutting prices, after the protest march of 12 December. They were going to raise prices just before Christmas, but agreed to 10% cuts. A trade union Catering Sub-Committee was also set up and a new dining room was accepted to be a major priority. By the end of this campaign Nalgo nursing membership had increased from about 20 to about 70. Many others joined NUPE. They included many of those who had been active in the boycotts. She believes that many more would have joined unions had they not been frightened off by the IMG's and IS's active involvement in the campaign. The left wing organisations were pushing all the time that the action committee should run things, whereas the individual unions, with their different policies, were rather more cautious on the whole

about joint action. Decisions were being made by open committee meetings and not just the reps of the unions. There was a strong IMG caucus in these meetings. She was pretty scathing about the IMG and its tactics. 'They alienated shop stewards. They wouldn't accept where people were at. The IS were better. They helped with practical things. The IMG insisted on having its banner on marches and buggered things up'.

Internal relations among stewards and activists appear to have become pretty sour as a result of the split between those who wanted to focus on the battle at hand and those who wanted to politicise things. For example, one shop steward who joined the IMG 'was dropped by his mates'. During the dispute of 1973, ancillary workers tried to get the support of nurses not to do their jobs. There was a one-week unofficial strike throughout the group despite the efforts of officials to get them back. 'In this hospital there is a huge demarcation line between nurses and ancillary workers. This was the first time they'd had any support. I went on to the picket line in a nursing sister's uniform and this really improved their morale. They then invited us to their action committee meetings. These were just morale boosters for them. But on Sunday they held an outdoor meeting'.

Sylvia claims that the organisation for this meeting wasn't very good. She described it as 'looking for leadership'. Nobody had a megaphone. The IMG pushed forward a medical student, Pat Byrne, to speak and he also chaired the meeting (how hierarchies get reproduced by revolutionary organisations,). According to Sylvia 'he hurled abuse at union leaders'. Sylvia then spoke, then she claims the meeting became chaotic. Someone from management appeared, called Sheen, and told them to go back to work. The IMG raised a great many issues, including private practice. There was one porter who wanted the strike off. He used to receive backhanders for doing work for private wards and wanted the strike off. Pat (the IMG medical student) pointed him out to the crowd. Feelings were high; according to Sylvia 'we felt we weren't in control'.

The nurses formed a joint action committee with St James Hospital in order not to do ancillary workers duties. One nurse resigned from Nalgo as a result. Nalgo put out a press report showing the support that existed for ancillary workers. Management claimed that they were an isolated group. One nurse on the paediatric ward, who was doing ancillary workers' jobs, phoned the Daily Express and claimed that many nurses were resigning from Nalgo (May 1973).

Interview with Sylvia Prentice Nalgo Branch Secretary  
at Kings College Hospital 17.9.75

Sylvia started off the second interview by correcting something she had said in the previous one. She said that Kath had joined NUPE after the ancillary workers strike and at the time of the boycott of agency nurses. Before the boycott there had been inter-union meetings at the hospital. This had been under the auspices of the Nalgo branch. After reorganisation of the NHS, however, they now meet as a sub-branch and have an EC at area level. She preferred a stewards committee.

She talked of the nurses pay dispute in 1974. They had organised mass meetings and demonstrations in conjunction with Guys Hospital. At the same time that they were taking action on pay they set up an action committee to fight the agency nurse issue. This consisted of two sisters, four staff nurses, one SEN, three students, one medical student from the medical practitioners union, and one charge nurse from COHSE who worked in the psychiatric hospital. There was also an engineer, a porter, a NUPE and a TGWU steward, and a representative of clerical workers. The committee therefore consisted of a cross section of unions and grades, not just nurses. 'It was the first time we seriously organised on an inter-union

basis and it frightened management'. This has now become the Joint Shop Stewards Committee of the hospital. It must be quite unusual for a committee of this kind to have sprung up out of a nurses issue. It was immediately recognised by management. The demands were for a 50% reduction in agency nurses but problems arose. COHSE and NUPE agreed with the policy of not working with agency nurses. Nalgo had been involved in a London weighting claim and banning of agency clerical staff, but the dispute by rule had to go through Nalgo's National Emergency Committee. There was pressure from the AUEW to take action unilaterally from the national leadership of Nalgo. They said 'we will support you but you must take action first.' The TGWU were wavering. Individual members of the Rcn supported the action, including a student steward Rcn member.

Leaflets were issued explaining the action, naming the committee members, asking for support and advertising meetings, at first these meetings were attended by over 100 people but gradually they tailed off. They were held in the recreation room. Meantime the Rcn had put a ban on industrial action on the 29 May.

A demonstration had been planned for the 6 June and originally this had been an Rcn inspired affair. However it grew

beyond that as it largely became planned through the London Nurses Action Committee of whom a leading light was Pam Dennard. This coordinated planning for the demonstration according to Sylvia. The three leading hospitals in London leading the fight were University College Hospital, Kings and Guys. However most of the meetings of the Nurses Action Committee were held at Guys. The Nurses Action Committee had originally started just after a canteen boycott against price rises the previous year. There were outbreaks of this kind at Kings and this led to the setting up of the London Coordinating Committee. Similar things happened elsewhere, she said, for example, in Peterborough. Correspondence started to be exchanged all over the country between nurses. Left wing groups like Militant and IS, and left wing bookshops and magazines like Time Out also helped to get the thing rolling. NUPE was also involved, particularly through Mike Taylor, a London full time officer, who worked closely with the committee. Sylvia describes him as 'a little bit NUPE minded, but cooperative. What he really wanted was a London NUPE nurses branch'.

There was also the Fair Play for Nurses Campaign which was heavily promoted by the Sun Newspaper. Sylvia said that 'the London Committee took it over from Di Dawe. She was let down by the Rcn'.

The demonstration over nurses pay and agency nurses took place around the same time, in May of 1974. At the same time the nurses, including Sylvia, were followed around by a 'World in Action' TV team. They got some support from consultants who said that patients were suffering because of agency nurses. They experienced some difficulty organising industrial action so they sent out forms to nurses for people to sign, saying that they were in favour of a ban on working with agency nurses except in emergency cases. 'We got lots of support. When the forms came back I thought we had masses of support'. The authorities asked her for the names but she would not give them to her. She wrote a letter to agency nurses 'partly playing for time to get support from the Nalgo Conference' of which she was a delegate. However she feels that she may have made a mistake because 'it gave them time to organise themselves'. The District Nursing Officer and the District Administrator went to the District Management Team who decided to close six wards in the group, and this was agreed. She went away to Conference and Roland, a student nurse, was left in charge of the branch. She believed that management used that fact and his inexperience to encourage the emergence of splits in the branch. In desperation Roland phoned Sylvia up in Brighton and she came back to attend an important meeting. At this they tried to cover up the splits. Then they had a meeting with Miss Brown the Divisional Nursing Officer. She tried to go round the



table asking everyone what they thought. However this they refused to do and Sylvia answered in the name of the branch as a whole. Miss Brown got very upset at this. However, 'we looked united but we weren't'. They then agreed to close six wards. 'We hadn't won our full demands'.

Then agency nurses formed their own group and tried to organise themselves. I said it had been suggested (by Race Today, August 1974), that much of the hostility towards agency nurses was due to the fact that they were black. Sylvia said 'I wasn't aware that there was any anti-black feeling, though many agency nurses were black'.

Kings College Hospital (like EBH and Highcroft) was one of the hospitals visited by the Halsbury Committee. Sylvia says that when they came around Miss Brown prevented Sylvia from meeting Mary Green. Nevertheless they were supposed to meet the staff organisations on site. However she met her in the theatre - where she works as a sister - as a member of staff not as a representative of an organisation. Sylvia however, had wanted them to meet Nalgo stewards as a whole.

Sylvia works closely with Steve Johnson, a National Officer for Nalgo and a member of the Whitley Council, 'who told us what happened on Whitley. They had accepted as a union

the principal of an early phasing out' of agency nurses. Then they got into discussion with local management and in her opinion, 'tried to cooperate too much. But we didn't want to stop the hospital'. At the end of 1974 it was agreed to limit the number of agency nurses to 190. The union was to be supplied with monthly returns on the numbers of staff and a working party was set up which produced a report. During all this she was holding lunchtime meetings and so on. She managed to get the local Rcn involved 'but they didn't have the support of the organisation'.

She said that Roland 'panicked over the letter of the 10 June' (see documents at end of section). This was the first day that Sylvia was away and she had to come back from the Conference. She took over as Branch Secretaryship at the end of 1973 and has had one day off a week for union business. The first offer on agency staff was a reduction of 12 to 14% which involved the closure of three wards. This was eventually extended to six wards. Then Sheila Waterman backed out. She had been involved in the campaign all along. She was a clinical instructor and had been in touch with students. Her dropping out therefore had quite an impact on them. She stayed in Nalgo a while before

moving to Canada. She was really 'pushed out' Sylvia said. 'We were all under lots of pressure'. Quite a lot of nurses refused to work with agency nurses. Sylvia was one of them. So she was moved from the operating theatre to outpatients department for two weeks. They also moved others to areas where no agency staff worked. She says that Miss Brown cooperated with that.

She talked about her relationship with the Area Branch. Motions have to go through there now. Before then the other hospitals were in a Central London Teaching Hospitals Branch. However Kings refused to join this because they were viable on their own. Nevertheless it is clear that motions from below have to be 'filtered through this apparatus. They cannot be sent direct'. She cited, as an example of this, motions they had formulated on private practice. The agency nurses dispute was obviously a bitter experience. After that the dispute spread to clerical staffs in the hospital. However it was easier to phase out agency clerical staff.

Another issue that had raised its head was the question of overpayments of money to students aged over 21. This was due to a clerical mistake. Some owed £20 and others £40.

There was the question of whether it should be recovered and district and area kept changing their minds on this.

Finally on the 25 June Nalgo's Executive had backed the action of refusing to work with agency nurses. They sent out an instruction. However, Sylvia went around all the unions on the site and got the signatures of all the branch secretaries for their support. Some student nurses who refused to work with agency nurses were told that they might have to lengthen their training because they could not be reallocated to the Paediatric Unit. I asked her generally how she managed to get support for the union. She said chiefly by 'taking up individual matters and getting things improved'.

Sylvia is also a member of Lambeth Community Health Council. There were objections from the region which claimed that an employee was not allowed to be on the CHC. However she was a nominee of Lambeth Council. Her husband, from whom she is now separated, is a well known Labour Councillor in the locality.

During the pay/agency campaign, World in Action wanted to do a film of a joint discussion between Nalgo and the Rcn. However the Nalgo branch wouldn't cooperate because the two Nalgo representatives would be two nurses who had only been

members of the union for six weeks 'they would have been eaten up by the Rcn'. World in Action refused to allow Sylvia on the programme so Nalgo backed out and a discussion was not shown. During the agency nurse battle the Rcn was represented on the Action Committee. They had two representatives, Sister Galashiels and a male nurse student. All the sister did however, 'was give a speal of the Rcn official position which was against any kind of industrial action'. So the Rcn was then excluded from the committee. A male student nurse in the Rcn however, couldn't understand why he should be excluded. He was still sympathetic to the action. However the committee said that he must have the backing of his organisation if he was going to take action, especially as he was a student.

There hadn't been much action over private practice at the hospital. However, Sylvia had complained individually to an MP about private patients being done on the list before NHS patients, some of whom were cancelled. An enquiry was still going on about this.

Interview with Clare Part, Assistant Secretary of  
King's College Nalgo during 1975

Clare believed that under the newly reorganised structure of the Health Service, teaching hospitals would start to suffer from cutbacks and was worried because King's the poorest of the teaching hospitals. In the past teaching hospitals were able to put pressure for themselves on the DHSS. She told me the story about the new ward block that had been built. Sir John Peel had wanted a new maternity unit in 1968 and was able to put pressure on the department. In the reorganised health service the teaching hospitals still had the edge but they have got to compete with other areas and regions. This is true to a much greater extent than hitherto. It became even more the case following the publication of the Resources Allocation Working Party (RAWP) Report in 1976, when Government sought more actively to redirect services away from London and the South East towards 'poorer' Regions.

Sylvia Prentice confirmed that King's was the least rich of the teaching hospitals. She said that Guys and St Thomas's have bigger endowments and better facilities. There is a thirty year plan for rebuilding and expanding wards at King's College Hospital. At the end of it there will be fewer beds in the district. At the time of the interview

the district was below establishment. Clare was cynical about Barbara Castle's promises (as Minister) that they were going to cut management and not services. King's is part of a four district area. This spreads over three boroughs: Lambeth, Southwark and Lewisham. Clare does not want to see any fewer districts because facilities might become centralised and patients would have to travel further. Clare was a Ward Receptionist. She now works in Community Health offices. She is taking over from Sylvia as Branch Secretary when Sylvia goes and does her health visitor training.

King's College Hospital has its own sub-Branch of Nalgo. This means that it has a Branch Executive of Chairman, Vice-Chairman, Secretary, Treasurer and other officers. They can have one departmental representative for every 25 members. There are 400 odd members of Nalgo at the King's College sub-branch, which means that they could have a committee of 20. There are about five and a half thousand employees in the district, of whom a thousand are nurses. Therefore the union has a long way to go in terms of recruitment.

Sylvia broke in to say 'the biggest problem with nurses is communication. With the Path lab technicians you can go down to the Path lab and you know where to get hold of them. But nurses are much more difficult. You can't get hold of them. They work in different wards and are geographically dispersed. Furthermore some live in and others live out. They work separate shifts. But even if they are accessible, you can't just go onto the wards and talk to them. Management find it much easier to communicate with nurses than we do'. Sylvia believed unions were much more efficient than the Rcn. She recalled the case of a theatre sister who was involved in a case where the wrong leg of a patient was cut off. She wanted help from an organisation and Nalgo was quick off the mark. 'Nalgo had someone in a couple of days. She had no reply from the Rcn after four months'. Sylvia talked also of the campaign to build the organisation in the hospitals. 'At the beginning management were as naive as us. They were scurrying around different places. They were on the phone to each other. Now they have learnt, like us, and are much cooler. They were prepared to make concessions at the beginning to prevent issues exploding. It doesn't explode here, though it is often threatening to, it has never come to it'. Sylvia said that although they had a disciplinary procedure they did not have a grievance procedure. She agreed with Clare



that a big factor in the development of the union was the fact that 'King's is the least well-off of the teaching hospitals. It doesn't have the big endowments of other hospitals. Therefore King's doesn't pamper its staff so much'.

Sylvia doesn't find senior management that difficult to deal with. However, she thinks middle managers are pretty incompetent and 'don't have training in industrial relations'. She had noticed a recent tendency for management to adopt the tactic of creating 'working parties on various topics some of which go on for years'. She mentioned as an example the one on creche facilities.

She believed that 'things are deteriorating fast'. One of the biggest problems was the turnover of staff. They now only have about 100 nurses in Nalco even though they have recruited some 500. She believed that many of the nurses at King's look upon work differently from other grades of staff. Many have 'A' levels. 'Not all of them are broke because they get subs from their parents who are quite well off'. They also come to King's College Hospital looking for a marriage partner. She thinks that the situation is very different from provincial hospitals. There are many fewer nursing auxiliaries at King's: more student nurses, plus reliance on agency nurses. She believed that there was a shortage of trained staff rather than of student nurses.

King's College Hospital Sub-Branch Meeting,  
EC Meeting 10 November, 1975

Before the meeting I was in conversation with a district nurse representative Clarine Russell who is West Indian and was once a member of the Rcn. However she claims that 'the subs were too high and they are too tied to Whitleyism'. She is bothered about mileage allowances and the amount of paper work she has to do since they have gone over to the NHS in 1974 from local government. 'I have been on the district for 7 years and this is my first meeting as a Nalگو representative'. She was also an elected member of the General Nursing Council.

There were seven female committee members and four male committee members in attendance. The first business was officer elections and Mrs Part was re-elected as Branch Secretary without opposition. The first matter of business was the overcrowding of finance staff. They wanted to call in the factory inspectorate and there was no reply to letters. There were a couple of new members. The mainstay of the branch, Mrs Part, complained that she was overworked. Representatives to the area branch were elected, one delegate for each fifty members and ex-officio officers. Mrs Part is also the Vice-President of the Area Branch, Mrs Prentice is on the District Council and Mr Day was

directly nominated to the area branch. The branch has 400 members. Someone says 'it looks as if we can all go'. They nominated six members but they were entitled to 8. Some people were a bit reluctant to be nominated. Somebody had to be nominated to Southwark Trades Council. The previous delegate only went once because of domestic problems.

The next item was correspondence. Somebody had written to the branch asking for support for an anti-Spain demonstration. It was generally agreed that they should not support it because it was 'political'.

It was reported that an Area Disciplinary code was being established. A Nalgo member, a supervisor, had written to another member saying that she would soon receive a formal warning. Clare was asked by the person, who wrote the letter for advice. Clare said 'are you asking me as a union member?' Mrs Part had said 'let's do it by the book'. She advised her to burn the letter because it could be viewed as a formal warning. Clare wrote and told her that she should not have written this letter. The supervisor showed the letter to her superior. This 'breached confidence'. No names were mentioned to the branch, this is apparently custom and practice. The decision of the meeting was to reply to the superior and censor the member for showing the letter to her and 'putting the secretary in an invidious position'.

The next item was the report of the branch AGM. Fewer people had been there than had been hoped for but it went well. Some people wanted to know what the Advisory Conciliation and Arbitration Service (ACAS) was up to in the Hospital. It was explained that they had been called in to improve staff management relations at the hospital - 'not before time'. It was felt that 'some good will come out of it because we can't regress further in this group with regard to industrial relations'. Cited as an example was the fact that a couple of years ago the management had refused a meeting place for a Nalgo meeting. 'They haven't moved far since then. Many still think in this way. I am not optimistic about the extent of improvement'.

The dispute over Manor House Hospital was mentioned. The feeling was that it should be given over to the NHS. There would be a branch meeting to discuss this issue. Canteen prices were going up and there would be another meeting. However, they were trying to hold out until February. (So far about 6 or 7 people had spoken at any length. Three or four had not spoken at all).

The Working Party Report on the creche had said that the hospital could not afford one. However the District Management Team had decided that the Working Party could

get together with reps of the staff side and one from the Community Health Council to discuss it. They could consider the question again in the future. It was agreed that it should be for all staff and not a section of it. So they are going to look for a site and in two or three years the hospital might get one. 'There is a lot of demand, a crush not a creche'. They are going to do a questionnaire and ask people what they do about their kids. 'Some are leaving them practically unlooked after. With this information how could they refuse'. The answer came from somebody 'they can't if they have got a conscience'. This caused laughter.

It then became clear that one reason why Mrs Part was overworked was because the Treasurer was not doing his job properly. There wasn't a balance sheet for the AGM. They needed to discuss whether he ought to be paid his honoraria. The new treasurer, who was black, said that the old treasurer didn't have his heart in the job. However, Mrs Part didn't have the time to help him. There were three black people on the branch committee. The district nurse already referred to, the male treasurer, and one man of Middle Eastern appearance. The next item was the Health Committee Report. The guy

in glasses who seems to dominate the meeting said that the Nalگو Health Committee nationally had a paper on the reallocation of resources 'threatening the Health Service'. (This was obviously RAWP). Money for the Health Service was going to be redistributed and reallocated but there would be no extra money. This would be done on a regional basis. Some hospitals were threatened with closure. It was felt that during the next two years there would be ten thousand redundancies. However, the Report had not been accepted by the NHS Committee. They had thought that 'they shouldn't be making recommendations by trying to do anyone out of a job as a trade unionist'. Audrey Prime (Nalگو National Officer), was going to draft a letter rejecting it. It was becoming apparent that cuts would hit London first. The paper had been sent to the union for comment but they were not being given enough time. 'We can only wait and see at the moment'.

On London weighting it appears that this should be exempted from Incomes Policy. There was a rumour that the Civil Service was going to come out with a new structure that had gone to arbitration. If they got it the NHS and Local Government would claim parity. There was a problem in Local Government however, because of the huge rate rises.

The next item was honoraria for last years officers. Usually the Secretary and the Treasurer get paid. Collectors get a percentage of dues collected. Sylvia is to get £25. A decision was deferred about the Treasurer's. The next item was a motion. Resident nurses now get part of the London weighting but resident home wardens don't since they are assimilated to the Admin and Clerical Council. They were a special grade. It was believed that this anomaly should be removed. Finally a disciplinary case in pathology was mentioned 'which was a serious charge'. The district officer was being brought in and the member had been suspended pending an enquiry. Again nobody's name was mentioned.

The meeting ended. I talked briefly to two student nurses afterwards who were members of the committee.

Interview with Sid Wilkes, the AUEW Convenor at  
Kings College Hospital in 1975.

Sid has been working here since 1947 but for a long time wasn't greatly involved. The turning point was when someone from admin and clerical was off-hand to a friend who was off sick. Sid got an apology. The man was in hospital and he had wanted to get his pay sent to his home. He got involved in the union after that. Sid felt that people from overseas or who were nervous, got worse treatment and he wanted to enforce uniform conditions in line with the nationally negotiated rates. He has been shop steward for plumbers about 12-14 years. Then he became the convenor for the engineering side. There weren't many men but quite a number of unions. He then became the Federation Steward for the building side (building and works).

His interests spread outside the hospital. He became Vice Chairman of Southwark Trades Council. He also acted as a steward for other unions, like the TGWU, that didn't have many stewards in the hospital. He was granted facilities (he now has a small office in the basement) and the job got bigger. In 1969 he saw the then Hospital Secretary about getting more time to do the job and it was granted. The membership of the TGWU on the works side was



originally 100 odd. It grew to around 400-500. They were difficult to represent because they were spread over 5 hospitals. It was at that time, he remembered, that there was official encouragement to join unions and this was having a stimulative effect on recruitment. He was then also serving as the rep for GMWU members, who mainly worked at St Giles.

Sid described himself as 'left-wing, but my first job is to represent the members, not to change the Government. You are dealing with enthusiastic but inexperienced ancillary workers. People got on the bandwagon of an industrial dispute and manipulated naive people, like domestics who are not industrially minded. You had college educated people manipulating the weakest part of organised labour'. He was referring to the intervention of the IMG at the hospital in 1973 during the strike, when they tried to politicise the dispute into an attack on the Heath Government.

Sylvia, when she first became active, had asked Sid what union she should join. His reply was 'you have to see what they're doing locally as well as at the top. Some are bad at the top and OK at the bottom, like Nalgo'. He graphically described his approach to building workplace

organisation: 'You've got to start off with bullshit - and it does grow primroses in the field. You slowly get through to people who have some discretion, and that's how you build up credibility'. He had formerly been a builder, and in that industry had adopted a more militant approach. 'You have to make horses for courses. We have improved working conditions and the environment in a constructive way.' He pointed to the existence of good sitting rooms and changing facilities, where they did not exist before, as examples. He doesn't believe in 'overdoing it or telling lies to those at the top'. Things took longer to resolve and there was a permanent bureaucracy in existence. Grading disputes were an example he had in mind. 'It's different from a building site, when you have to hit hard and quick. You need to realise that things take time. People at the bottom think you should be able to get a yes or a no. This is the trouble, with an impatient member who expects that an answer be given, when it's something which needs to be referred back'.

Another difficult was to know when to bring an official in, for example on bonus, or back up on a dispute over a Whitley rule. Often when this occurred, it was because management were being inflexible over rules which could be bent. Sometimes these issues go beyond hospital level.

First letter to Nurses <sup>circulated</sup> throughout  
hospital & Group.

KCH  
NALGO  
1972

## WHO SPEAKS FOR NURSES.

This week we are witnessing in our hospital a one day strike of all ancillary staff. They have a strong negotiating body behind them determined to fight for and get a substantial pay increase. Most nurses agree that their claim is justified as their basic pay rates are appalling, and most nurses will wish their action success. Because they are united, determined and well organised their chance of success is high. Good for them -- but what about us?

Who speaks for nurses? The hospitals? NO. The Royal College of Nursing, that austere body which has consistently failed to give nurses the backing they deserve? Again NO.

In January when many industrial negotiating bodies were demanding, and getting, substantial pay increases the Whitley Council submitted a claim for a 25% pay increase for nurses. What happened? 8% was offered as an interim, and without fight, or fear of nurses rebelling, but with smiles and thanks, this is what our negotiating body accepted. We all know what happened immediately: the price of hospital food and accommodation rose, and the cost of living soared.

### NURSES GAINED NOTHING.

This has been the record of the Royal College for years. Indeed they seem determined that R.C.N. should read "Real Cheap Nursing".

The reality of 1972 is that no-one speaks for nurses. For years we have been the lowest paid of any professional group, and our future wage prospects are sure to keep us at the bottom.

Yesterday's platitudes and clichés about ~~the~~ "dedicated" nurses are no longer relevant or acceptable as excuses for our low pay scale. Today's nurses are just ordinary people doing a hard job of work. Professionalism means nothing unless we are paid as professionals. We still have rents to pay, food to buy; and status is no substitute for cash.

Surely it's time for us to unite, to fight for an adequate living wage. We must demand equality with the rest of society, and to be successful we need the support of a body with expertise, experience and bargaining power. Trades unions have proved their influence in achieving for other sectors of the community what no-one has ever yet achieved for us.

Today's standards must begin to apply to nurses. We are already suffering from a gross shortage of staff, recruitment is low, and nurses are leaving the health service in ever increasing numbers. Hospitals are already paying large sums of money to Nursing agencies for temporary staff, and our working conditions are gradually deteriorating as the system begins to destroy itself. Is acceptance of this going to improve our health service? NO. Is this raising the standard of care for the patient? NO. And yet all arguments against nurses' unionisation state that it will lower the standard of patient care. This cannot be true. Fighting for higher wages and better working conditions can only improve the service, as more people will be attracted to join it and those already in it will be more willing to stay.

We are members of our community. Trade unions are our right. We need strong representation and we need it now. Public opinion is behind us -- it appears the R.C.N. is not. Joining a union is the only way we will get it.

1972.

COME ALONG TO A MEETING ON TUESDAY 21st OCTOBER AT 4.45pm. IN THE NURSES RECREATION ROOM KCH AND FIND OUT FOR YOURSELVES WHAT UNIONISATION COULD DO FOR US.

All enquiries to Sister Sylvia Prentice.

Resulted in meeting of about 60. Lots of criticism from

Nursing administrators who attended to find out what was going on. I objected to the 'Real cheap Nursing' bit! AS A RESULT of this meeting 31 nurses joined NALGO - I had been a member for about 1 week.



# CANTEEN PRICE CAMPAIGN.

KCH NALGO  
Leaflet 1973

La test News from Mondays Mee ting.

Prices are 20to 30% cheaper at Guys, St. Thomas' and the Maudsley. Other hospitals have showed concern for their staff by refusing to implement DHSS directives to increase canteen charges.

The concern for staff e pressed now by the King's Board was recieved by our meeting with scepticism. We wonder where that concern was when they put the prices up without even staff consultation. Only after our vigorous protests was the marginal reduction of 2p. on one type of meal even considered.

Lord Normanby has written to Lord Aberdare. If the reply is like the last letter recieved from the DHSS it will be a lot of long words saying NOTHING on crested notepaper. Apart from this the Board have given us no indication that they are willing to take further action to meet our demands.

WE HAVE DECIDED TO CONTINUE OUR CAMPAIGN.....

Boycotts of the canteen will continue but other forms of protest are now necessary as well.

Through our actions the management and board are now well aware of the situation in the canteens. The "all powerful" people at the Department are the next to be told.

## PROTEST MARCH - DECEMBER 12th

It was agreed to hold a peaceful protest march from King's to the DHSS at the Elephant and Castle. To be really effective this must be well organised and well supported. Mid-week will ensure maximum publicity, 4.30pm. is when most nurses are available.

Suggested time for a torchlight procession with nurses carrying lanterns and banners was:

WEDNESDAY DECEMBER 12th. leaving KING'S promptly at 4.30pm.

\*\*\*\*\* All hospital staff will be approached for support. This issue affects us all.

\*\*\*\*\* Southwark Trades Council have pledged their support. Other trade unions, students and teachers' organisations are being contacted for support.

\*\*\*\*\* Nurses from other London Hospitals have agreed to join us.

\*\*\*\*\* Speakers from the Health Service will be invited to talk to us about the crisis in the NHS outside the Department building.

A lot of effort will be made to ensure that this will be a successful demonstration but before we go any further we must know how much support to Expect from all sectors of hospital staff in this group,

PLEASE COMPLETE TEAR-OFF SLIP and return to a committee member or put it in the box at the reception desk in the nurses entrance.

I do/do not support the present campaign against increased canteen charges.

I will /will not support a protest march to the DHSS at the Elephant.

I do / do not agree that the low pay of hospital staff is directly related to the critical shortage of staff and the resultant deterioration of the standard of patient care.

OTHER COMMENTS:

NAME:

WARD/DEPT.

HOSPITAL

King's College Hospital,  
Denmark Hill,  
London S.E.5.

The Chairman and Governors,  
The Board of Governors,  
King's College Hospital.

21st November 1973.

Dear Lord Normanby,

If a nurse eats properly, the average cost at King's is now £5 a week. (Menu's enclosed).

If she is prepared to eat hard boiled eggs every day for breakfast, milk puddings at least once a day for sweet, and mince or cottage pie regularly, she can cut the cost by 55 pence a week to £4.44½p. If on the other hand she prefers more variety the cost goes up 50p. to £5.50p

If she drinks water with every meal and misses coffee and tea breaks she will have 94p. a week. If she eats only one meal a day the cost is, of course, halved. Often she cannot afford to eat at all.

A first year resident student nurse earns after deductions £47 per month. (Pay slip enclosed). Less average £20 a month for hospital food, leaves just over £6 a week for a young man or woman to live on in 1973.

We are seriously alarmed at this situation, the great shortage of nurses in London means that every nurse on duty in this hospital works harder and often longer. We ask the Board to consider ways in which hospital food may be served cheaper to the people who serve the hospital.

Yours sincerely,

(For and on behalf of all the nurses who have signed the enclosed petition).

Copy to:  
Miss I.C.S. Brown  
Mr. Harbord.

BOARD OF GOVERNORS OF KING'S COLLEGE HOSPITAL

To: All members of the Staff in the King's College Hospital Group.

Dining Room Meal Charges

The Board of Governors at their meeting on Thursday 20 December 1973 discussed the current level of meal charges in the Dining Rooms in the Group, in the light of representations made by Staff interests, and decided that with effect from 1 January 1974 there should be an overall reduction of 5% on the non-negotiated meals (i.e. not including ASC meal).

The revised charges were put before the staff representatives on the Catering Working Group on Friday last and they agreed that this reduction should be effected on meat dishes only.

The revised charges are as follows:-

LUNCH

The 10½p range will be reduced to 9½p

" 14p     "     "     "     "     " 13p

" 18½p     "     "     "     "     " 17p

SUPPER

The 9p     "     "     "     "     " 8p

" 14p     "     "     "     "     " 13p

" 18p     "     "     "     "     " 17p

D.F. Thomas  
Acting Deputy Finance Officer



KCH  
NALGO  
1974

## NATIONAL HEALTH SERVICE IN CRISIS

A personal message to every nurse - Joint Nurses Action Committee KCH

Widespread unrest and disillusionment is growing in all our London hospitals and throughout the entire country. Nurses are rightly demanding a decent wage for a highly responsible job. Successive Labour and Conservative governments have played on the nurses meekness by telling them to wait and wait again and fob us off by public enquiries!

Meanwhile, hospital waiting lists number into 60,000 for our group alone. Those who do come in for treatment must be satisfied often with shoddy care through chronic staff shortages as highlighted recently in the I.T.V. programme about Kings College Hospital.

Are we nurses being honest with ourselves? We make up 70% of the staff workforce and yet we find our wages and condition in such deplorable mess. How much longer are we going to hide our pride behind Florence Nightingale's skirts of 1854? Can the nurses of K.C.H. in 1974 claim to be truly dedicated to their noble calling when, before their very eyes they see a steady deterioration of the National Health Service, but stand aloof and do nothing to halt this dangerous trend. It is up to us - nurses and all hospital workers to demand a living wage and an end to cuts in the NHS budget immediately. If this is not done further reductions in staff levels and services are inevitable and the well-off will be encouraged more and more to turn to private medicine, while the mass of people will have to be satisfied with a second rate 'poor-law' hospital service.

The public are sympathetic towards the nurses case, but unless we organise collectively behind our trade unions and associations to pursue the claim this sympathy is valueless. NALGO, NUPE, CO HSE, ancillary staffs, engineers and electricians are all pledged to support our claims. Dedication to the patients individually is insufficient if nurses don't recognise how their poor pay and conditions are fundamentally affecting the care of patients, through chronic understaffing etc. For nurses to stand idly by and not get involved in their very just claim is to be guilty of indifference to the sick and the aged and to the aims and ideals of our Health Service. The nurses are duty bound to stand up and be proudly counted.

# GENERAL MEETING

THURSDAY 30th MAY AT 4.45 pm

TO DISCUSS THE NURSES 55% CLAIM AND DECIDE ON ACTION

IN THE NURSES RECREATION ROOM : 1st FLOOR

All nurses are warmly welcomed and urged to attend

## A WORD OF WARNING

It has come to our attention that certain nursing officers are touring the wards and demanding to know which staff organisation or trade union nurses belong to. They have no right to do this and you are under no obligation to reply. The collective power of nurses is far stronger than the power of individual members of the middle management. All nurses who report cases of intimidation will be 100% protected by her union. Any attempt to intimidate any of our nurses may bring an immediate response from the major unions in the hospital.

\*\*\*\*\*

### Agencies.

At our 1st meeting on Monday 20th. May, the idea of a ban on working with agency nurses was discussed. In the light of our new campaign a letter will be sent to all agency nurses explaining why we urge them to come back in and join the staff in the NHS and fight for a better deal for us all together.

### LATEST NEWS - A public enquiry into nurses pay

Surely we are not going to be blackmailed into that one again. This enquiry may take months to complete, there is no guarantee at all that an acceptable pay award will be made. The situation with regard to nurses pay and conditions is perfectly clear NOW. We are tired of waiting.

AREN'T YOU?



Those faceless people at the DHSS ( Now called THE DEPARTMENT OF STEALTH AND TOTAL CSECURITY) have heard the message—— NURSES ARE " ANGRY".

Millions of T.V. Viewers have been told by our Consultants "PATIENTS ARE DYING".

The public, the press, the hospital administration offer their "SYMPATHY"

The only thing that will change the situation is Money.

Unless nurses are paid the rate for the job they will continue to leave the N.H.S.

On JUNE 6th. There is to be a NATIONAL DEMONSTRATION of Nurses.

1p.m. SPEAKERS CORNER MARCHING TO DOWNING STREET.

Over 10,000 nurses are expected to take part in this demonstration supported by all the organisations that represent nurses.

But what will happen when all the demonstrators have gone home and the press turn their attent to other things? we may be back where we started waiting for the miracle that will never happen

The hard fact is that we WILL NOT win our claim by asking politely. We tried that in 1971, 1972, 1973 and again in 1974.

If petitions, Demonstrations, Letters to newspapers do not work we have to be ready with real alternatives. In London close links are being made with other hospitals to co-ordinate a programme of positive action.

One of the biggest problems in London Hospitals is that of Agency Staff. Temps who earn more money often for less work and less responsibility. The Agencies who cash in on the desperate shortage of nurses do very little to earn the 12½% commission that the N.H.S. is forced to pay them. Agencies contribute nothing to the training of their nurses and Agency nurses often find themselves in unfamiliar wards in charge of patients they do not even know. It is NOT the fault of the Agency nurse but the system that allows this sort of LUNACY.

Hospital Administrators, Nursing Administrators, Medical staff feel as strongly as we do that something must be done to reverse this situation if there is to be any improvement in the standard of Nursing Care.

WE can wait no longer for Government legislation. IT WILL NOT COME.

Management will not make a stand on this issue. They have "BOSSES" of their own.

If N.H.S Nurses refused to work with Agency nurses then something WOULD HAVE TO BE DONE. Initially some wards would have to close. This would mean that non urgent cases may not be admitted and waiting lists would get longer. Some patients would be inconvenienced and in the short term some patients may suffer. BUT PATIENTS ARE SUFFERING NOW, and will CONTINUE to suffer unless something is done NOW.

LAST WEEK

DR. CRAM..... At "LEAST" one patient has died because of the shortage of trained staff  
DR. PARSONS..... Relatives are being bought in to nurse Renal Patients.

HOW MUCH WORSE CAN THE SITUATION GET? HOW MANY MORE PATIENTS WILL DIE?

NURSES MEETING.	NURSES REC. ROOM	K.C.H.
MONDAY 20th. MAY	4.45p.m.	

To Day

#### AGENDA

1. To discuss the NATIONAL DEMONSTRATION on JUNE 6th.
2. To elect a committee of nurses to co-ordinate an On going Campaign and to represent King's nurses in meetings with other hospitals.
3. To discuss the possibility of Banning work with Agency Nurses.
4. To receive alternative suggestions from the floor.
5. To get support from all other groups of hospital workers including Doctors, Ancillary Staffs, Administrators and all other groups. Remember Nurses are not the only ones who care about the patients and the future of the N.H.S.

These issues concern us all. If you are unable to attend make sure that at least one person from your ward or department is there to represent you.

For further information about what is going on in other hospitals contact  
NALGO Branch Secretary, KCH Ext. 2324.

TO ALL AGENCY NURSES.

Dear colleague,

we are writing to you to ask you to support our campaign for a fair and full settlement of our 55 per cent pay claim for nurses. The nurses in the King's group have been very involved in much of the action that has so far taken place to publicise our claim by leafletting, demonstrations and lobbying our M.P.'s. you will probably know that the nurses present at a meeting to discuss future action in this group of hospitals voted that we would not be prepared to work with agency nurses for very much longer. This is not a direct attack on you as individuals, we know that you work under the same stresses as we do. Because of staff shortages you work long hours of overtime in exasperating conditions. Like us you must be aware of the deteriorating nursing standards on the wards and like us you must care..

What we are fighting for is a realistic wage for all nurses, many nurses are forced to leave the health service and work for agencies because of poor pay especially in London where the cost of living is so high that it is almost impossible to live properly on the pay of the national health staff nurse, but if the present trend continues we are all going to suffer, you because you lose holiday pay, sickness benefit, superannuation rights, job security and promotion prospects, us because while one group of nurses are outside the health service, it is almost impossible to organise a united and determined campaign to improve our pay and conditions. The only people that really benefit are the agencies. If the present trend continues we shall all become virtually self employed, and we will lose all the protected conditions of service our organisations have fought for over the years.

The only way that we can change the situation is to change it together. It is in all our interests to protect our jobs and to improve conditions in our hospitals. This is the only way that we can hope to recruit and retain our staff, and the only way that we can insure that the patients that we care about are properly cared for.

There are plenty of vacancies on the staff and this hospital offers short term contracts. We are asking you to join us, and fight with us.

In a few weeks time we hope that all the nurses employed by this group, will be nurses employed by this hospital. If necessary we are prepared to force the management to close wards.

To achieve these ends ;

We will be refusing to work with agency nurses.

( The auxiliary workers will refuse to enter the wards on which they are employed.

We will also picket the agencies that employ you.

Our fight is not with you

If we win we all win, if we lose the people that will suffer the most will be our patients. If you care enough we hope you will join us.

We hope that you will reply to this letter, and ask you to address your reply to the Joint Action Committee.

c/o The NALGO Office,  
King's College Hospital.

Yours Sincerely,

L.

THE JOINT NURSES ACTION COMMITTEE.



ALL AGENCY NURSES WISH TO ACKNOWLEDGE  
 REPT OF YOUR CIRCULAR REQUESTING URGENT  
 TION TO JOIN THE STAFF OF THE ABOVE HOSPITAL  
 ORDER TO SUPPORT YOUR CLAIM FOR A 5% RISE  
 IN RESPONSE WE ASK YOU TO RECONSIDER  
 ACTUALLY YOUR PROPOSAL AS WE FIND THIS MOST  
 ADDRESSING FOR NURSES TO FIGHT AGAINST  
 NURSES IN ORDER TO ACHIEVE THE AIM FOR  
 RISE. WE ARE AFRAID THAT YOUR WAY OF  
 APPROACH TO THIS ISSUE IS THE ROAD TOWARDS  
 MASTER WHICH THE GOVERNMENT WILL VERY  
 MUCH WELCOME. MAY WE ADVISE YOU TO FIGHT  
 THE N.H.S. AND THE GOVERNMENT INSTEAD  
 OF CAUSING FRICTION AMONG NURSES. IT IS  
 MOST OBVIOUS THAT BY WORKING AGAINST  
 WILL NOT ONLY COMPLICATE MATTER

THE NALCO OFFICE  
 KINGS COLLEGE HOSPITAL  
 S.E. 5.

AGENCY NURSES  
 KINGS COLLEGE HOSPITAL  
 S.E. 5.  
 1st JUNE 1974.

BUT IT <sup>(2)</sup> WILL ONCE AGAIN PROVE TO  
THE PUBLIC AND THE GOVERNMENT - THAT LONG  
STANDING WEARINESS THAT NURSES SEEM TO  
SUFFER.

MAY WE REMIND YOU THAT WE ARE  
TRAINED STAFF AND FEW AUXILIARY NURSES  
AND WE DO NOT WISH TO BECOME PUPIL NURSES  
OR STUDENT NURSES AGAIN; WE DO NOT INTEND  
TO JOIN THE STAFF OF THE HOSPITAL TO ENSLAVE  
OURSELVES UNDER SUCH SEVERE HARDSHIP WITH  
THE PRESENT PAY SCALE.

WE ASSUME THAT ALL NURSES IN  
TRAINING DESERVE ALL THE RIGHT TO FIGHT FOR  
HIGHER PAY: MUCH THE SAME AS WE DO, BUT  
WE INSIST THAT ALL TRAINED NURSES SHOULD  
LEAVE THE N.H.S. UNTIL THE GOVERNMENT  
AGREES TO PAY US WHAT WE DESERVE FOR  
OUR LABOUR.

WE THE AGENCY NURSES HAVE PREFERRED  
TO LEAVE THE N.H.S. AND SACRIFICING  
OUR SUPERANNUATION RIGHTS, JOB SECURITY,  
PROMOTION, AND HOLIDAYS.

(3)

— WE CONCLUDE IN SAYING THAT  
WE HAVE OUR RIGHT OF TAKING STEPS  
AGAINST YOUR PROPOSAL OF BOYCOTTING  
AGENCY NURSES AND LOOK FORWARD  
TO SUCH A STEP.

WISHING YOU LUCK IN THIS FIGHT

YOURS SINCERELY,

AGENCY NURSES



~~Board of Governors King's College Hospital~~

~~Chairman: The Marquess of Normanby MBE~~

~~House Governor~~

~~and Acting Secretary: J.W. Collinson MA~~

# King's College Hospital Denmark Hill London SE5 9J

Telephone 01-274 6222

Extension 2322

10th June, 1974

Mr. P.S. Lam Man Chun,  
For the Joint Action Committee,  
c/o, Fisk and Cheere Ward,  
King's College Hospital.

Dear Mr. Lam Man Chun,

I have received a letter for the Joint Action Committee from Mrs. Prentice dated 7th June 1974 this morning, telling me that the Committee is prepared to extend the date of the period by which it is hoped that the number of Agency Nurses employed in the King's College Hospital Group would be reduced by 50%, provided the District Management Team gives an assurance in writing by the 14th June that this proposal is accepted.

The Joint Action Committee will appreciate the District Management Team's responsibility to meet its dual obligations, firstly, to patients and secondly, to the staff and that the District Management Team is anxious to reach a reasonable agreement with the staff as to how to protect the former.

I am still not clear about the action the Joint Action Committee proposes to take if it does not have this assurance from the District Management Team. In her letter, Mrs. Prentice says that the Joint Action Committee has a programme of action which will be implemented but there is no indication as to what form this will take. I am sure you will appreciate that the District Management Team would wish to know the alternative proposals, as any contingency plans would have to be based on the knowledge of the number of nurses prepared to take unofficial industrial action and the places in which they work.

At a meeting of district representatives of Trade Unions held in my office on the 3rd June, Mrs. Prentice informed the meeting that such information had already been collected by the Joint Action Committee and that, as is usual, it would be made available to Management in order that plans could be prepared. I have not yet had that additional information which will be essential if the District Management Team is to have all the necessary facts when it considers the original proposal of the Action Committee at its meeting on the 12th June 1974.

I have not yet had formal notification of the amended membership of the Joint Action Committee as I understand that representatives of additional Organisations have been added to those set out in Mrs. Prentice's letter to me of the 21st May 1974. Would you please let me have an up to date list of members of the Joint Action Committee with the Organisations they represent, for the meeting of the District Management Team. The District Management Team would wish to keep faith with the official Union representatives who have made their Organisations' position in this matter clear.

PTO

Would you, therefore, let me have the information requested above and the number of nursing staff by ward and department who, as stated in Mrs. Prentice's letters to me of the 23rd and 31st May 1974, will ban work with Agency Nurses, assuming that it is still the intention of the Joint Action Committee to implement that decision should the District Management Team be unable to agree to reduce the number of Agency Nurses working in the Group by 50%.

The District Management Team meets at 11.15 a.m. on the 12th June, 1974.

Yours sincerely,

Christie Brown

District Nursing Officer  
King's Health District (Teaching)



c/o Nalgo Office,  
The Joint Action Committee,  
Room 489,  
Kings College Hospital.

Miss I.C.S. Brown,  
District Nursing Officer,  
Kings' District (T).

11th June 1974.

Dear Miss Brown,

Thank you for your letter dated 10th June which we received yesterday afternoon. In reply to ~~you~~ letter the members of the Joint Action Committee and the organisations that they represent are;

S/N C. Bach NALGO. ✓  
S/N M. Quinn NUPE. ✓  
Sr. S. Waterman. NALGO. ✓  
S/N Lam Man Chun. NALGO. ✓  
Sr. S. Prentice. NALGO. ✓  
S/N Persallide. NUPE. ✓  
ST/N Hayton SNA. ✓  
ST/N S. Rutledge. NALGO. ✓  
ST/N J. Wall NALGO. ✓  
SEN P. Smith. NALGO. ✓  
MEDICAL STUDENT P. Byrne. MPU.  
P. Winston. AEWU.  
M. O'shea. T&GWU.  
C. Ramsey NUPE.  
CHARGE NURSE Mr. Aldridge. Chairman Local Branch COHSE.  
P. Part. NALGO..

Two ~~previous~~ <sup>the first one</sup> mass meetings have been held by the King's nursing staff. At one of these meetings members of the action committee were elected. At both of ~~these~~ meetings it was overwhelmingly decided by the King's nurses attending, to refuse to work with agency nurses. May we point out that one of the main reasons for the widespread disillusionment in the King's group is due to the large number of agency staff employed here. Permanent staff are continually leaving from the dual frustrations of daily trying to orientate this often casual labour, and the unnecessary suffering to patients from the lack of continuity in their care.

In response to the general feeling at these meetings The Joint Action Committee on behalf of the nurses in the interest of the patients felt a responsible form of action was needed and decided that in consideration of the problems facing the management, an initial reduction of agency staff would be better than an immediate ban. Further proposals of action to be taken if the agency staff are not reduced by 50 per cent within the time limit, are to be put <sup>be</sup> and decided upon by the mass meeting of nurses on Monday 17th June.

With regard to the nursing staff in the wards and departments prepared to take industrial action, we believe you <sup>have</sup> already ~~have~~ collected sufficient <sup>such</sup> information of the nurses in unions and organisations.

Yours sincerely,

On Behalf of the Joint Action Committee.



- (v) Lea Castle Mental Handicap Hospital,  
Kidderminster.

First Interview with Barbara Hibberd, Lea Castle  
Mental Handicap Hospital, Kidderminster, 1975.

At this mental handicap hospital, on the outskirts of Kidderminster, COHSE and NUPE have an unwritten membership agreement. COHSE specialises on nurses while NUPE 'looks after' ancillaries. It is (more or less) kept to - like every ceasefire, it is not perfect. Before, there was quite a bit of competition between them for the same membership groups. There is no Rcn to speak of at the hospital - one or two odd members in the administration and the training school. The union has full access to both in service training and the nurses' Training School.

Barbara Hibberd, the COHSE Branch Secretary, and a Ward Sister, said 'relations with management aren't bad'. There were problems with a former nurse administrator. There was 'phoney consultation' over a shift system. Management wanted to put in a scheme rejected by nurses 90 to 4. The shift management wanted 'didn't correspond with public transport' so 'the staff ran the hospital. Nobody used the hospital transport laid on for the new shifts and only one person went off sick' which was many less than usual. Barbara described that week as 'a very happy time' in which staff had 'a sense of comradeship'. The new Chief Nursing Officer for Mid-Worcestershire (late 72 or early 73), had just taken over - he was an outsider and was trying to make

an impact. He sent round a letter 'dismissing all staff'. The hospital was 99% organised. The hospital is fairly new and is the site of the Institute of Mental Subnormality.

There are approximately 290 nurses for approximately 500 patients. There used to be a JCC at the hospital but it fell through. She expresses her view that 'I'm not too keen on JCCs. Unions kept bringing things up and we got nowhere. Now they have bi-monthly meetings with the District Administrator between all unions and she says this is much better. She seems quite impressed by the District team and their approach to industrial relations.

Barbara has worked here for about 10 years and also been a County Councillor for the Labour Party for some 9 years. She emphasised that the union at Lea Castle 'can be very stroppy'. When the 1974 pay dispute was on they banned all admissions and this made Dr Simon, the Medical Director, 'uptight'. Branch meetings, however, are 'a dead loss'. The 2 shifts system: (1) 6.45 to 2.15, (2) 1.45 to 9.15, (3) plus one long day a week - are against them. Furthermore, the hospital wards are dispersed. There are some half dozen stewards across shifts and grades and it is through them that most of the branches work is done.

She is extremely critical of the unions nationally, not just about pay but about their lack of action on the threatened status of mental handicap nurses. She wasn't impressed by the proposed Scandinavian 'de-nursified' system saying 'it is the same as the GNC syllabus except for the training in judo'. She asked 'why aren't nurses' trade unions interested in the role of the nurse. If they don't concern themselves mental subnormality will disappear'. She was very worried about protecting the value of her qualifications, which the changes seemed to threaten, and other nurses expressed very similar fears to me. They had 'trained in good faith'. She wanted to see 'a new profession with a central role for the nurse in it. We're not hanging on to the name "nurse", because the work won't be any different'. She wanted nurses getting more opportunities for community work.

She felt that mental subnormality nurses had been 'avoiding these issues for too long'. Hostels in the community were 'being taken charge of by people who are not qualified. They often don't know how to handle them. The best hostels are those being run by nurses'. She said they took them in order to get accommodation. She felt that hostels were often more institutionalised than hospitals and that those patients 'who go from the ward to their own room in a hostel might think it was a punishment'. In all

this was the fear that nurses in hospitals might get landed with the rump of difficult cases. 'If hostel staff can't handle discipline they throw them back on the hospital', adding, however, that 'I haven't got it in for hostel staff'. She also mentioned that Dr Simon (the Medical Director) is sitting on the Jay Committee set up to look at reforms. A special conference on the issues had been called by the PNO. However she saw this as more something associated with 'the hierarchy than the grass roots' - which shows how one community of interest can cut across another, doesn't it,

The fact that facilities at Lea Castle are comparatively 'advanced' (in relation to the norm) sometimes makes it difficult to raise complaints with management. 'Local management say you've got more than other places and got more than your share'. Again, it seems that the response to union power is for district administrators to become increasingly involved in the 'industrial relations' management of nurses. (This also happened at Highcroft Hospital). Two things are therefore happening: (1) Trade unionism among nurses is increasing the tendency for power to shift away from hospital level (though it is also, of course, often a reaction to that phenomenon),

(2) Second, it erodes the power - or at least the traditional exclusive power of nurse managers over nurses as industrial trouble gives district administrators the chance to elbow in.

In service training exists for all nursing staff at Lea Castle, including Nursing Auxiliaries. They have done study blocks and I have records showing ward instructions they have completed. She thinks that this 'sometimes puts them a cut above the learner'. Many are married women with kids who perhaps are unable to take up full training. Of course, another thing which disrupts the supposed hierarchical differentiation between student nurse and auxiliary is that usually, the latter are 'established' members of the ward team while the former are a 'floating' or 'transient' population. Auxiliaries have to 'induce' new staff into the ward - a same relation, I've noticed, often exists between trained staff and doctors (see Scheff's article on asylum attendants).

The District Administrators name is Mr Stuart Dickens. The fact that they have good relations with him 'upset the Divisional Nursing Officer'. As a result of the unions activities 'the Nursing Officers come to the union for information'. COHSE also uses Dr Simon 'to get what we want'.

I was given a lift back to the station by Stan, a RMN doing a shortened Mental Subnormality Nursing training. He is a restless individual, says he really wants to be a social worker. He thinks psychiatric nursing 'has a cloth cap image'. At his previous hospital he was a COHSE member but set up an Rcn branch 'as an act of rebellion. I knew the Rcn was conservative but we students wanted something of our own'. He lived in for a year and didn't like it: 'It was work, club; work, club. Life revolved around the hospital. Many people left in the first year. 'They don't pay enough attention to selection'. It wasn't the geriatric nursing that was difficult, but the psychiatric nursing. 'It's easy. They sit in a chair and all you have to do is light their fags. But listening to someone who's really depressed for some time is a big strain. Many can't take it, especially those who've just left school'.

Second Interview with Barbara Hibberd COHSE Branch  
Secretary at Lea Castle Mental Handicap Hospital on  
8 May, 1975

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Barbara mentioned how she had used the Halsbury wage award to move out of hospital accommodation, and <sup>how</sup> one or two others had followed her example. That is, with their pay rise they had got mortgages, and as a result students were now getting hospital houses. As she put it to me: 'now I can mix with other people'. Presumably she was talking about the staff as much as the patients.

She mentioned how a News of the World reporter had got a job at Lea Castle for a couple of weeks as a Nursing Assistant and then wrote an article exposing conditions. He had also given a dossier to McCulloch the District Nursing Officer. This was about two years previously. He had accused one of the 'trainers' of brutality. Trainers are unqualified people who work from 8 am to 4.30 pm, take a group of mentally handicapped children and teach them social skills. They take the 'lower grade sub-normals', so the job does not have what is called 'educational content', ie supposed to be done by teachers. Some of these trainers work on the wards while others work in the school. The trainer was suspended and an enquiry was set up. He was represented by the trade union and was cleared eventually. However, he has since left and become an ambulance driver.



It was clear that the memory of this incident was a bitter one. She resented the fact that an outsider could come in and work for just a little while and then make a great many accusations. Shortly after that incident a charge nurse, who was a COHSE member, was prosecuted along with a nursing assistant. In this case it was a nurse that reported them. This seemed to carry more force. Barbara said that she herself reported the incident to the Union's Regional Secretary (who at the time was Geoff Baxter) with the recommendation that the Charge Nurse should not have the union's legal representation (the Nursing Assistant was not a COHSE member and had in any case, received two warnings previously). This was on the same ward where the News of the World reporter had worked, but the incident had occurred afterwards. 'The union had to take a stand. It involved physical violence on a blind patient. The membership was behind the union'.

Barbara felt that a lot of people joined the union for 'protection'. She claimed that recruitment increased around that time. People felt insecure when nurses were being prosecuted. Most of her work however is taken up with matters like pay queries, 'probably more than anything'. She sees herself 'in the role of welfare officer mostly. When people are in any sort of trouble,

perhaps in their private lives'. She has members in COHSE right up to the Principal Nursing Officer. She felt that management would sometimes try to use the unions to get the things that they could not. For example when the pay did not arrive. Thus the union can put the pressure on to get things that they cannot. She describes the Wages Department as very inefficient. She thinks that the union is very strong at Lea Castle. One sign of this is that 'Wendy Thornley (the Senior Nursing Officer) will think twice before she sends a memo out'. Nevertheless, she still thought that Dr Simon, the Medical Director and Chief Consultant 'still has a considerable say over what happens. He tends to get involved in things which aren't his pigeon, but largely because McCulloch (the Principal Nursing Officer (PNO) sits in the background'. The principal nursing officer is considered an extremely remote figure. 'I said to him last time I would take a photo of him and distribute it to staff so that they would know who he was. We only see him on Christmas morning'.

We talked next of issues. Unit nursing officers (ie no.7s) have complete Unit control over appointment and dismissal and make policy in the units. However they often feel that they do not have much sway with higher management. Barbara is a Ward Sister, yet because she is Branch Secretary she

finds that the Nursing Officers come to her for information. The Nursing Officers complain that 'number 8s' above them don't give them enough information, and she has privy to a lot of it. The Nursing Officers do not get on with the two 'Number 8s'. She described the 'Number 7s' (ie the Nursing Officers) as 'an unfortunate lot'. This issue had been raised with the District Management team, where the grouses of the number 7s had been made out. 'Unions have the opportunity to meet the PNO with fags handed out informally and the Nursing Officers don't'.

The Branch organisation is, to say the least, extremely informal. 'We don't have branch meetings. Nobody turns up until there is a crisis or a rumpus'. However she claimed that the union had a fairly effective steward system. The Branch Chairman is a rather portly charge nurse whose name is Rodgers but who is affectionately known as 'Podge'. The union tries to ensure that there are two stewards on each shift, one of whom is a charge nurse and the other a learner. Barbara said that Nursing Officers would not be welcome to come to meetings as 'people would be inhibited'. She tried to get an officers and sub-officers branch set up without success. She even tried to do this by combining the senior managers with those at another hospital but without success. Mr Rodgers works on Holly Ward. If an issue is boiling up they tend to go around the wards rather than

hold a Branch meeting. 'We only have a big meeting when there are big issues. People won't say anything in meetings. If people have complaints they ring us up'. An exception to this was the big dispute over the two shifts.

On relations with other unions, there is an informal understanding that COHSE only recruits nurses and NUPE only recruits ancillaries. 'COHSE speaks for nurses. If we go to a meeting together one puts the ancillary view and the other the nurses'. There were a few problems in the 1973 ancillary workers strike, especially over voluntary workers. 'We said that if ~~they~~ brought them in we would bring nurses out. We didn't do any of their jobs'. Thus at this hospital there seems to be quite a strong trade union culture and fairly good relations between COHSE and NUPE. It appears that there was quite a bit of solidarity between nurses and ancillary workers.

Since then of course the nurses have themselves been involved in industrial action. Both before and after Halsbury (when the pay award was being delayed because of problems with Government computers) the nurses banned all admissions and 'non-nursing duties'. They used this as an excuse also for bargaining over local issues. They claimed more domestics and overtime payments were demanded for when

nurses take patients on holiday. The management used to pay nurses 12 hours a day for it and now they get 16 hours payment. These are just some examples of how a national dispute can be used locally as well.

Membership statistics are as follows. At the hospital there are some 290 nurses, of whom 260 are in COHSE and about 10 in NUPE. This represents the very high level of organisation. This is all the more surprising, considering that it is a relatively new hospital, having only been opened in the mid 1960s. There is a considerable amount of confidence amongst the branch officials. If they take a decision on something 'we know that the members will back us up'. This had a powerful effect at union branch executive meetings. If it is a small thing the membership leave it to them. If there are big decisions to be made they send a letter around the ward and there are reports back at various stages of the negotiations. Thus even though there are not normal branch meetings very often there seems to be a continuous process of consultation with the membership.

Mrs Hibberd claimed that a lot of business had now gone to district level and to functional management. The union rarely dealt with the nursing side at that level. Instead Mrs Thornley was more or less in charge at the hospital. The union try to get her to push things with the District Administrator. The union claims to have made many positive

innovations, for example, on the security angle of paying out wages. 'We have come up with a lot of constructive ideas. We have sat up until two in the morning sometimes, working out a case'. She described the shift trouble as a landmark. 'It proved our ability'. This had occurred some three and a half years previously. At that time they 'threw out the Branch Secretary who had introduced a shift system supported by the union and not the nurses'. The Branch Secretary's name was one Canty, by then a senior nurse manager at EBH, via Chelmsley Hospital and is now a big wheel in the Royal College of Nursing. She said that there were 'a lot of internal problems'. Perhaps many of these were due to the fact that it was a relatively new hospital. Mrs Hibberd had occupied a union position since then. She said that Dr Simon had got very annoyed when the union had banned admissions pre- and post- Halsbury. He had claimed that the unions had no right to do so. 'We said that if he brought them in we would refuse to work with them'. They had tried to point out that they were fighting the Whitley Council not the doctors. She claimed that the unions' own machinery was falling down. She complained that they sent resolutions from COHSE's Regional Council without any effect.

She claimed that she had noticed some anti-ancillary sentiment. Trevor Woolley was the NUPE branch secretary and was a maintenance plumber. There was a JCC at the hospital but she described it as 'ineffectual. The basic problem was that the last hospital secretary didn't agree with it. The recommendations only came from the staff side. It should have been a two way thing'. Another dispute concerned the fact that nurses had to wait around after their shift had finished for their pay. She went to see McCulloch (the PNO) about it and claimed overtime. She said that she got on with him okay, 'the trouble is that he is not seen on the wards. It is a bit of a joke. When he came here on Christmas morning I had to introduce him to the staff'. She said that she had no problem with access. She dealt with Mrs. Thornley, but if she was not satisfied she could go across to see McCulloch. However she had never had to by-pass Thornley. The union amongst the nurses was very solid. 'At moments of crisis here, we have a solidarity which has to be seen to be believed'. She realised that she has had to be 'bloody-minded' on occasions but 'we are dealing with human beings - we are the people dealing with them not the Dr Simons and the Mrs Thornleys of this world'.

For example, she had taken up the issue of patients' clothing. She had come on duty and found that the night duty nurse had not dressed the patients because there were no clothes in the cupboard. She had phoned up the Hospital Management Committee, the Friends of the Hospital, and had got clothes for the patients by 2pm, that afternoon. She felt that certain things were necessary in relation to patients that 'outsiders' might not understand. 'If nurses clipped a patients ear, or during behaviour modification, when nurses at certain stages shout at patients sometimes, outsiders might misunderstand'. She also said that nurses are sometimes to blame for putting up with things, like staffing levels, which lead to violence. 'We are fortunate here. We are very patient oriented'. She said that when they take patients on their holidays, 'when we come back we are nervous wrecks'. She mentioned how one adult patient had been killed on a bike and the press had criticised the hospital, and a similar thing had happened when a Midland Red bus had run over a patient. However the union did not try to stop the patients from going out. She justified the occasional slapping of patients by saying that as they were supposed to act as parents, this was justified. She mentioned that some nurses had left the hospital and set up hostels with themselves as landladies. This so-called 'decantering'



is quite a lucrative business because they are able to claim the patients' social security money for payment.

Most of the nurses at the hospital are local although some are from overseas. The low level of overseas nurses is due to the fact that Lea Castle is a relatively prestigious hospital. There are more overseas nurses here than in the past. At one time it was thought that there was a colour bar. the nursing assistants and domestics, etc., all tend to be local. As far as charge nurses and sisters are concerned, some of them are local and others are 'passing through'. That is, they are building a career for themselves and working there temporarily. If people want to get on in the mental sub normality field it helps to work at the hospital. The balance had shifted recently to recruiting more mature students. However, most learners were local. They came from Kidderminster, Birmingham and places like that.

The union had access to the School to recruit for COHSE. In fact Dave Rowe, a clinical tutor in the School of Nursing, is the Branch Recruitment Officer. On the nursing assistants induction course he gives out forms to join the union as he is the in-service training officer. The principal tutor was not in the union but his wife was.

They do not bar anyone from membership because of their high rank. As we shall see a very important factor in the hospital is that a good number of husbands and wives work as nurses and live in. There is extremely good contact between people who live in. A couple of the stewards live in the nursing home. However there is a high turnover of staff, particularly of part time staff. But charge nurses and sisters, who do stay longer, act as effective recruiting agents. The Branch Recruitment Officer gets the students in. The social club is run by a different group of people from the union. She does not like going to the club 'because they still talk about hospital affairs. It's like always being on duty'.

COHSE are not members of the local Trades Council. 'We weren't deriving much benefit from it. We were excluded from it during the Industrial Relations Act (when COHSE registered nationally and were expelled from the TUC), and didn't bother afterwards'.

A couple of people in the Occupational Therapy Department are in COHSE and this is supposed to be a secret. Some laundry people wanted to transfer from NUPE but COHSE had said no. The reason why they had wanted to do this was because 'Trevor (the NUPE Branch Secretary), has a them and us approach to management and is a bit aggressive. I find I can do more, and be even dirtier, with a smile on my face'.

Lea Hospital, which is nearby, was built during the last war as a military hospital and then taken over for use as a Subnormality Hospital. Mr McCulloch is also the most senior nursing officer responsible for it. They tried to get the nurses at Lea Hospital interested in the union without a great deal of success. 'The nurses are much more submissive. They are a different lot from us'.

Lea Castle Hospital is stuck right in the middle of the countryside away from Kidderminster. It is very difficult for relatives to visit it, although there are coaches from Birmingham and Hereford. As I left to get my train back to Birmingham I saw a male patient crying because his girlfriend had been discharged and gone to live in a hostel. They had been separated. Stan gave me a lift to the station again. He felt that his job was very much concerned with social control. 'It's surprising the effect that the Hospital sticker has on the police when they stop you. They seem to think you are in a similar kind of occupation to them'. They therefore extend solidarity to you. He had been stopped in his car. He was drunk and his tax card was two months out of date, but they let him go. He thinks his job might have something to do with it.

22 May, 1975 Lea Castle, Interviews with:

Lesley a student nurse, Acting SNO, Mrs Radfield etc.,

Dave Crowe of COHSE and Trevor, Branch Secretary of NUPE

Dave works as a tutor in the school. He mentions all the unions to student nurses, but tells them that all nurses are in COHSE. He does not believe that JCCs are necessary. It's better to establish direct union links with management. A few of them are in the Rcn and some of these also have joint membership of COHSE.

Dave sometimes finds health service unionism difficult. 'Sometimes you have to defend one member against another. It's a funny situation'. He described the JCC as 'a bit of a farce. There was nothing done about the things that came up. It's much better to go across the office and have a chat'. He didn't feel that management play one union off against another. On industrial action there were joint meetings between COHSE and the few NUPE nurses on a shift.

He described the big fight over shifts as 'a managerial cock-up which did a great deal for the union. It was the first real test for the membership. It showed management that we could stand together. That's always a worry with nurses'.

During the 1973 Ancillary workers dispute, management brought in a great deal of voluntary labour. COHSE just asked its members to carry out normal duties. 'There was a little bit of friction but the conflict was really with management. There was an understanding beforehand that not many volunteers would be used'.

COHSE did not require ancillary workers to back nurses, 'but they were prepared to help'. He said that 'Nurses are in a difficult position. They're involved with direct patient care'. The unions are constantly raising the question of non-nursing duties. The new post of domestic superintendent had been created. 'In the past sisters used to run the domestics and some are unhappy about the change'. However Trevor felt that it helped 'to cut out an area of potential conflict with COHSE. You have one bloke to go to. But there is still the problem of sisters trying to tell domestics what to do'. Trevor felt that relations generally with management had improved considerably. 'since DHSS recognition and the introduction of the Industrial Relations Code of Practice'. But it depended on having a good shop stewards system. 'If you've got good stewards they can take things up at the time. In the past little things would blow up into big issues. This was especially the case, Dave thought, when the trouble over shifts was going on. Negotiations and discussions were continuous,

'Barbara (Hibberd) might be having two days off'. Trevor said that NUPE had 8 departmental stewards at the hospital. Both agreed that wages of nurses and ancillary workers were improving. However, NUPE had turned down the idea of bonus schemes at this hospital.

Dave felt that 'the change in nurses attitudes has come about through the increasing number of men'. However, he also thought that a different generation of student nurses was also important. 'Students play a big part now. They are a lot more questioning'. He was worried that the Jay Committee would be 'anti-nurse'. He was worried that 'nurses tend to shout when it's too late'. He wanted a unified mental handicap service separate from the NHS.

What did the students feel about COHSE. He admitted that 'a few students wanted to break because they felt it was associated with the charge nurses but this was not a major problem'. He put this down to a general problem COHSE had to face: 'the problem of just who's a manager and who's a worker'.

Next I left Trevor and Dave and went to talk to Mrs Radfield, the Acting SNO - a meeting arranged for me by Barbara. My first question concerned the effect of Salmon upon the hospital. She thought that the changes hadn't really affected

Lea Castle 'because we run the hospital on Salmon lines before Salmon. They were called Assisting Nursing Officers'.

She stated that by no means all of the students came from local labour markets. They come from quite a way off - because of the hospital's reputation. They haven't found recruitment difficult. So Lea Castle is not typical of mental handicap hospitals. 'In some hospitals they've not always had a training school for that long'.

She felt it was important for nurses to be aware of their entitlement. 'A lot of staff don't fill in their time sheets'. However, nurses were 'becoming sharper' about such things, because 'they are bringing up families. They often are very intelligent. They did some nursing in the past'. She was realistic about staff attitudes. 'Dedication has gone' she said, and appeared to accept the fact. One of the biggest changes was the fact that nurses no longer lived in.. As a result 'nurses react to the cost of living much more. They compare themselves with their neighbours'. Recruitment at the hospital was tied to the fortunes of the local carpet industry which was subject to economic fluctuations - this was especially true of nursing auxiliaries, especially if their husbands were made redundant.

I think she said that mental handicap hospitals cannot offer travelling allowances to the staff - this only applies to psychiatric hospitals. However special cheaper buses had been laid on by the local bus company. She deals very little with the unions. At present she was acting up for Mrs Thornley (who was on holiday). 'If I can't solve a problem I bring it to Mrs Thornley (the SNO). I use the union more as a guideline. I ring them up and ask them for advice. It's good to have someone local who's knowledgeable'. This seemed to indicate that she was uncertain with dealing with District Management or Finance and felt more happy asking the union.

There were 576 beds at the hospital. There were 474 patients with 30 on leave and 30 day patients. She thought 'relationships with the union are on the whole good'. However, 'you've got to have a certain amount of conflict'. She thought the adaptability of the hospital was good. 'Nursing Officers have considerable authority to staff wards and they have to work to a budget'.

Things work well even though problems arise. 'Nursing Officers often feel themselves to be just cogs in a large organisation. They are a bit out on a limb, unless they are continually asking for support from the SNO. They have to be able to



take a lot of buffeting from medical staff.

She herself is a member of COHSE. 'I can't participate.

Although I agree with what they're advocating'.

Industrial action, however, inevitably involved the Nursing Officer. When the pay dispute was on, the Branch took action, and the Nursing Officers had to give out drugs. Similarly, when they banned overtime (which has quite an effect in such hospitals) Nursing Officers had to work on wards much more. Similarly when they banned 'excess paperwork' - not the ordering of meals or ward reports but things like daily returns (statements of admissions, discharges, beds occupied etc., ) this made life difficult. She said, diplomatically, that she thought that industrial action 'is not always in the best interests of the patients. Unfortunately, a lot of action affects senior colleagues.' She particularly disapproved of the ban on day patients. 'Once industrial action gets taken, things are never the same again'.

She felt that involvement of unions was part and parcel of Lea Castle's progressive approach. 'In a hospital like this you have to bring in new ideas, so we consult the unions first over changes. This boosts morale for a

certain time, and then people start taking problems to the union. You tend to agree with your staff. You can't isolate yourself'. However, when there is industrial action the workload fell on senior staff, 'even though you agree with it' (ie the aims of the nurses in taking action).

Lesley was a student nurse I talked to. She said that many more lived in than out. There was a residents' committee of four at the nurses home, consisting of one representative for each floor. (3 female and 1 male floor). This had started up before Christmas. The major initiating issue had been the invasion of privacy by domestics. Furthermore Mrs Thornley (the SNO) had wanted a separate block for trained staff. Most of those in the home were learners. They hold a meeting once every 3 months. This is attended by the Home Sister. They had asked for new beds, and cigarette machines. The Home Sister had asked if they wanted contraceptive machines.

Lesley had been involved in an attempt to set up an Rcn branch 'but it crumbled. I did not renew my membership because it was not effective. The Principal Tutor was keen on the Rcn and got someone to speak to the block'.

Although one or two of them, like herself were keen, most joined because the Principal Tutor was keen on it. She complained that the students didn't have proper representation in COHSE. 'I am in COHSE. I was advised to join as an insurance'. She had been involved in industrial action. The union had instructed students not to act up, to do domestic duties, or give drugs. The Nursing Officers had encouraged them to follow union instructions, she claimed. She described the PNO, Mr McCulloch, as 'distant but that doesn't bother me. Mrs Thornley is pretty accessible'.

Her biggest complaint was that, 'what we're taught in school often doesn't relate to what we have to do on the wards. Other people don't cooperate with you'. For example, on Acorn Ward they had to rush to get the children ready for school. This didn't leave enough time to feed those patients who required it. 'We should slow down and let the patients be late so we could feed them'. However, the hospital had since set up 5 training wards and learners only work on these. Ward meetings are held. 'But there were only 3 students on the ward. You can't stand up to a ward full of people'. She had gone back to the school about it. The biggest problem was 'not getting cooperation from permanent staff. It's got to be a team effort'. It's not the problem of Sisters and Charge Nurses, but Nursing Assistants.

'They don't do it when sisters' around'. However, she was reluctant to say anything. 'You need them when patients attack you'. They were left on their own too much and 'I often feel that too much responsibility is put on us. I have come off some wards crying'. However, 'I don't mind now'.

Acorn Ward was again mentioned as a 'difficult' ward. The patients were hyper-active and noisy. 'They knew when the ward sister was off. Some wards aren't well covered'. Her original set had consisted of 12. Six of them had left. Some 'nearly had nervous breakdowns' because of the pressure, but others had been 'mainly personal'. She described this ward as good because you could go to the Sister, Mrs Hibberd, with any problems. She described her as 'fantastic'. The problem on Acorn was that 'the nursing staff and teaching staff wanted them in the classroom at a certain time'. It was better when classrooms were on the ward. She wasn't optimistic that much could be done about it. 'You just had to live with it, she said. 'Some wards work well but others are disastrous'. She has study days and occasional blocks. She thought that many of the staff at the hospital 'shouldn't be here'. I asked her whether changing wards so often bothered her. She was in her first year, but is now used to it. Not all

were bad. 'Some ward sisters ask you about your criticisms of the ward'. She wouldn't want to do anything unless she was confident of the backing of other staff - and she wasn't.

She was also worried about the Briggs proposals for reforming nurse education and the future of her qualification, describing it as 'a bit frightening'. She wanted the GNC 'to let us know where we stand. A lot of the hostels couldn't cope. A lot of people feel that psychologists, and so on, are taking over their jobs. If I was called a Care Assistant I would still be doing the same job and that's what I want'. However she felt that in relation to other nurses 'we have an inferior status because we're not nursing people back to health'. She told me that learners talk a lot among themselves about these kinds of issues. 'The pressure is now on to get other nursing qualifications because we're worried about the future of mental handicap nursing'. Again she repeated, 'the quality of staff is not all that good. There are only a few like Sister Hibberd. They're very institutionalised'.

She thought that 'medical staff aren't around that often', so weren't terribly involved in the ward. There had been a meeting on this ward (ie Mrs Hibberd's), to discuss the question of communication between teachers and nurses.

'It's all right here but on some wards there are awful relationships'. Psychologists were worse. 'They feel they can come in and dictate to nurses. The problems start when the ward sister or charge nurse isn't properly in charge'.

She was bothered that the Rcn were not interested in getting people to complain. The real problem was that 'people aren't prepared to give their time'. They would ask for things for students, but then some people would abuse them, and this was embarrassing.

Finally I talked to Beryl, a Nursing Officer, who states that she is fed up being an administrator, so gets directly involved in ward care a great deal. She said that there were considerable frictions between nursing and teaching staff. It was partly based on the fact that teachers had privileges not enjoyed by nurses - like extra holidays. But this created problems for nursing staff. The school was closed during normal school holidays and, during that period, (she claimed) children regressed. 'They have to start from scratch again at the beginning of term'. Teaching mainly consisted of an attempt to instill simple habits, etc. She felt there was need for teachers to be on shifts.

She said it was 'a good hospital materially' but the patients needed more attention. Too much of the care they had to

provide was custodial. 'The hierarchy have no concept of what is done in the ward situation'. The hospital runs its own school. Teachers used to be under the DHSS. 'Since the DES (Department of Education and Science) took over, teachers have become too academically oriented'. She didn't believe that was as important as habit training. There is a 2 hourly programme of toilet training on her block - but there are other things to do - like drugs and laundry which get in the way.

Interview with Dr Simon and other doctors at Lea Castle  
Hospital near Kidderminster, June 1975

We had a meeting over lunch in the staff common room. My impression is that the other doctors there, all junior to him are pretty deferential. He did most, if not all of the talking.

First Dr Simon emphasized that he approved of many things that the union were doing, for example over shortages of staff. Four years ago the group had found that it was short of money and had stopped recruitment of nurses. COHSE gave one months notice that they would stop taking day cases. It worked.

He realised that a great deal of industrial action was 'often for publicity effect'. However when there was a ban on admissions it had quite an impact. He said that 'I played along the first time' (that is before Halsbury) 'but not the second time when there was a delay in pay rises'.

He thus had an ambivalent attitude to industrial action. He stated that subnormality was a backwater and that industrial action could bring attention to its problems.



One example of this was threats of strike action that had occurred in the past over the bad laundry service. The first time he had agreed to stopping admissions. Those that were urgent were the subject of consultation between the union and the doctors. However, the second time he had said no to banning admissions. 'It isn't as if one is penalising one individual child, but in two cases it had led to families breaking up'. He was therefore, angry about the second industrial action and was worried that these kinds of things were making his job harder.

There were 'reasonable relationships in the hospital but we are often functioning at danger level. One student nurse is in charge of 20 patients at weekends'. He described the Health Service as 'the only industry which runs on the work of apprentices'. He felt that the union ought to take a more active interest in these kinds of things and ask me rhetorically why they hadn't. 'Why haven't they talked about the syllabus'. He really wanted to see more professionalism amongst nurses. In the subnormality field 'the nurse-doctor dependency relationship is greater'. That's one way of putting it! He wanted to see the nurses getting together and forming a 'professional association'.

He felt the syllabus of training was quite good but that it was interpreted differently. The Swedish system seems to be receiving a great deal of attention. However he too said that it was different in only one respect in that it includes training in judo. He was also very critical of some of the consultants in his own profession whom he said, 'wouldn't discharge people'. They were basically custodially-minded.

There was a great emphasis at this hospital in training people in behaviour modification. However because of its leading position they tend to lose staff who go and get promotion elsewhere. Some ex-nurses at the hospital were also setting themselves up as nurse therapists.

#### Interview with Mrs Thornley SNO at Lea Castle Hospital

This interview was held on the same day as the one with Dr Simon and was in many ways more satisfactory and more revealing. She talked very freely and tried to be helpful in every way to my research.

The procedure adopted at the hospital was that initial negotiations always came through her. 'We have got a good working relationship. We come to a compromise most

often'. If not it was then passed onto Mr Cullogh. It then becomes his decision. Thus it is clear that she takes an 'industrial relations approach' to the union which is not always that common in the Health Service. Perhaps that was one reason why she was ready to talk to me. An example of this was the claim for extra pay for taking patients on holidays. This had to go up to the district staff because 'I have no control over the budget'. Whether it terminates with her therefore, depends largely on the subject matter. It tends to if it involves the patients, then she deals with it. Things like shifts have to go up. If there is a major industrial action then the district administrator is involved because it 'affects the whole service'.

One of the biggest disputes at the hospital concerned shifts. It happened at a time when she was not working at the hospital. It concerned the change over from a 42 to a 40 hours week which was negotiated nationally. Four shifts were suggested and one had a long changeover period. People did not want to lose the long day and they liked the advantages of a long changeover. The increased staff would lead to more patient activities but it was felt by the staff that it would cause them domestic problems. One rearranged shift was suggested initially. The unions were then asked to submit their own versions, and a working party

was set up with the SNO as chairman. The management chose the members rather than them being elected by the staff. After this four schemes were submitted to the vote of the staff. The first three had come out of the proposals of the management working party. The fourth was the one requested by other staff. The advantage of the latter one was that it wouldn't involve any days off and would enable husband and wife teams to arrange their shifts. The ballot took place in January 1972 and the vote was firmly for the one recommended by the staff. After a long battle on February 14 there was a final agreement on shifts.

Although she was away for two years, she had worked previously at the hospital. She said that there had always been a strong branch of COHSE and NUPE at the hospital. She is a member of the Rcn 'but that doesn't affect my attitude. Most people here are trained so they have to belong to a union. I joined the Rcn when I was a student doing my SRN. It is not very well publicised in this area'. Talks on membership organisations are now included in induction courses and members of staff are advised to join something. The student section of the Rcn hasn't really got off the ground in the hospital.

One feature of the hospital that she noticed was that 'sisters and chargenurses here are not aloof from the other grades. This creates a completely different atmosphere. They are trying to create a home and trying to teach them ordinary everyday things. In the general field it is more structured and people are more conscious of status between grades. People are all friends from the beginning. They get enrolled in COHSE right from the beginning'.

At this hospital there is a grade different from nursing auxiliaries called trainers. They work from Monday to Friday. They get about the same wages as nursing auxiliaries but without increments. They have no career structure and come under the workshop manager who is not a nurse, and is responsible to the hospital secretary. There are about four trainers in the hospital. Half of them work in the workshops and half of them in the wards. Those trainers on the wards look after those who are badly handicapped or are too disruptive to be allowed into the patient workshops. Before the trainers came on they never had enough nurses to do the work that needed to be done. I don't think they are aware of changes and difficulties. I have talked to them but they don't seem particularly worried. She felt that there were too many

conflicting views in mental subnormality. 'People are thinking of their own speciality'. It depended on whether the hospital was old or new. In a new hospital like Lea Castle, she claimed, patients came in for assessment and training and custodialism was at a minimum.

Virtually all the nursing auxiliaries are recruited locally. Learners come from a bit wider afield. The recruitment of auxiliaries is very much tied to the fortunes of the local carpet industry at Kidderminster. When there is a slump in the carpet industry the hospital does well in terms of recruitment and when orders pick they do badly. She is conscious of having to compete for labour with the carpet factories who made all sorts of arrangements for the women who work there, like allowing them choice over hours and things like twilight shifts. 'We have to be fairly flexible'. There is a 15 hours minimum week. And part-time staff can work evenings, early mornings, and weekends.

There are two full time and one part time physiotherapist in the hospital for some 90 severely physically handicapped patients. There is thus a limit to what they can do. There are 570 beds at the hospital of which 500 are in use. In terms of full time equivalents there are 298 staff. There are 37 charge nurses and ward sisters, 25 SENs, 20 staff nurses and 68 learners.

She too recognised that industrial action was mainly aimed at 'publicising the fight' but she was concerned about the effect on patients. 'Stopping day patients didn't affect the general public. They don't care a twopenny happeny damn. But it does affect a man who has to care for a kid bigger and heavier than you, who has to get him up and go to work himself'. The other patients who were affected were those who were due to go on holidays. This affected about 20 people. 'Nobody was put in jeopardy in the hospital'. She was aware too that 'they did use it (industrial action over national pay issues) as a lever to get local things'. She believed that the Industrial Relations Act had given unions - at least in hospitals - 'more power to their elbow. Unions are very influential here. They are consulted now'.

Interview with Mr Rodgers, COHSE Branch Chairman at  
Lea Castle on 5 June, 1975

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He talked first about the 1972 shift dispute saying it was 'the first big meeting with all staff and the first bit meeting with the HMC. I think 4 shifts were put forward. The staff one got 119 and I think 1 vote between the other three!'. He talked about how the thing was run: 'Everyone was responsible for the wards they worked on. From each ward plans went up to the Branch Executive. The Office didn't know who was on which wards. The CNO said that we would be breaking our contracts and that they would not pay for part of the shifts'. However, they ignored him, as well as the bus laid on by management. They had wanted a shift system with a big overlap, whereas the unions had wanted a different one because husbands and wives worked opposite shifts. After a week, the union won. The management went back to the old system, while negotiations proceeded on a new shift system. 'Certain people' were dropped out of the negotiating team of the management side. The Regional Secretary came in and signed a new agreement with the Group Secretary. 'We gave way on certain points but not the essentials'.



As the Branch Chairman said, 'This made the union. We discovered that if we backed each other up, we could achieve things'. The CNO had said that he would throw out the staff scheme, to a Sisters/Charge Nurse meeting, regardless of how people voted. Mr Rodgers said, ironically, 'he was a great help to us in putting the union on its feet'.

Before they go into meetings with management, he and Barbara discuss tactics. One adopts a 'militant' stance, the other a 'moderate' one. During the last pay dispute they switched roles 'and threw them'. They believe that COHSE had the measure of the management because they were a more stable and permanent group. 'They are not so mature as negotiators. The administrators keep changing'. 'We are also fortunate in having the support of Dr Simon and have informal meetings with him. Now they are prepared to give concessions and to tap the union for suggestions'. They have negotiated arrangements for the payment of weekly staff on Thursdays. They are seeking to negotiate a local agreement upon the implementation of the new holiday entitlements under Halsbury. They have negotiated 16 hours daily payment for when they take patients away on holiday.

'When we have industrial action on, for example, in May 1974 over Halsbury, we have used it to get things locally, like more domestics and an increase in the establishment of nurses. When we reach agreements on things, we put out a bulletin, which management prints. It's great when there's an industrial dispute. They treat you like kings'. The union had been provided with an office and a phone. 'They ask us for information on Whitley Council matters'. At the end of all this he said, 'it's not a them and us situation'. But he went on to say, 'we never inform them first of the action we're taking but the press. We want them to come to us'.

The COHSE Branch took action before Halsbury, and also after it - over delays in payment. Dr Simon 'went up the pole' when they banned admissions after Halsbury and non-nursing duties. 'We said we would agree to certain provisions if he kept quiet about it. He's crafty. He tries to get round each of us on our own'.

The kinds of things the office phone him up on, concern advice on Whitley Council things. 'There is a lot of informal bargaining. This was the case for the claim on 16 hours payment for taking patients on holidays. We very rarely keep minutes'.

When all but emergency admissions were banned, the cases that Dr Simon wanted to admit went through the union first. One thing that they refused to do also was to act-up as Nursing Officers, even though the Salmon Report advocated it. The problem is that it is always for less than a week so they don't get paid, even though over a year it will be a considerable amount. They banned overtime, but they allowed patients' holidays to go ahead. The reason was 'we wouldn't want to let the patients suffer'. When an issue comes up they take it first to Mrs Thornley. If it is not resolved, Mr Wicks, the District Nursing Officer, is brought in.

He said that he wasn't bothered about Conference of COHSE when I asked if the branch put resolutions. 'One branch can't influence the union but we can affect our own working conditions. The wider union wasn't very involved in Lea Castle. 'The last time we had the Regional Secretary here was at a meeting in 1972. They leave Lea Castle alone. They heard about our action through the papers'.

Members use the internal phone as their main method of communication with branch officials. 'People ring us up with all sorts of problems, often outside the scope of the

union'. However pay queries are the commonest items, especially on weekly and monthly pay days. 'Management make all sorts of blunders which the unions sort out'. Pay arrived late often and they sorted this out by insisting on overtime pay for those who had to wait.

At the time I talked to him he had applied for a Nursing Officers job. If he got it, he would have to give up his Chairmanship of COHSE. He was already an acting Nursing Officer. Mobility among nurses, both upwards and geographically, appears to be a problem for unions like COHSE in filling Branch positions.

There had been a threatened total walkout by ancillary workers in the 1973 dispute, over the use of voluntary workers. Their use had been encouraged by Dr Simon. The unions brought in a personnel officer from the District, 'who told Simon he couldn't do it'. People often phone him up. The message is sometimes 'Mr Wicks wants a chat, but I always say I'm too busy'.

He is Chairman of the hospital football team and was previously the Secretary of the Entertainments Committee. He is on the Executive of the Hospital's Tenants Committee. On NUPE he said that he and Trevor (the NUPE Branch Secretary) 'support each other'. He has a phone with a direct line out, 'so they can't listen in'.

Discussion with Student Nurses at Lea Castle Hospital  
Summer 1975.

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This was put on for me by the school, through Dave Crowe. The group was, in fact, too big to manage a proper discussion. A mixture of men and women.

The majority were in COHSE although some were in the Rcn. One ex-member of the Rcn said they were 'conned into it at the time. The Rcn were doing more at the time' - thus the local activities of organisations may be pretty important in stimulating membership. Most of them joined for protection. 'I pay my dues and then forget about it, but if there were more meetings I would go along' was one typical response. Few saw the union as an avenue which they would contact immediately if they had a problem. 'I use the union as a last resort if I can't get things sorted out' was a typical remark.

Most of the student nurses said they identified more with the ward staff than with student nurses in other hospitals and students in general nursing. 'General nurses look down on mental subnormality nurses. They don't realise what our job entails. They don't know enough about it'. There wasn't much support for the idea of a separate

negotiating body for students - like a Students Council or Union - 'it wouldn't have enough weight', someone said. Some of them were going on afterwards to do (psychiatric nursing) RMN. For some this was largely because of the uncertainty surrounding the future of mental handicap nursing, but others wanted to do it anyway.

By no means all of them were sympathetic to taking industrial action though they'd all obeyed union instructions. One disapproved of the fact that a window, smashed by a patient, had been left unrepaired; because of the paper work strike, a requisition had not been put in. Another said that laundry that had been left in a corridor was a fire hazard. Some saw industrial action as pointless - 'we're just making it harder for ourselves'.

The idea that mental handicap was an inferior branch of nursing and their own emphasis upon it as something worthwhile, came across strongly. One said that when general nurses did their training they changed their views. 'When they come here they're impressed. They didn't think we were so competent'.

They thought generally that nurses were 'apathetic'. Four of those present were on the Residents Committee of the Nurses Home, but weren't optimistic about doing much. On prompting, they thought the idea of a student section of COHSE was a good idea, but there wasn't much enthusiasm. The Branch Executive Committee of COHSE was, however, involved in a disciplinary case of a student.

They were quite critical of some wards. They perceive them of consisting 'of four factions: teachers, trainers, physios, and nurses'. They are not happy about the fact that they have no jurisdiction over children under 16 years, between 9am - 4pm because they were in school. There was some resentment against trainers. 'Trainers are unqualified. Yet they deal with the kids and we do the menial jobs', one said. 'They're off bank holidays' was one complaint. Relationships with teachers often required tact. 'We can go into the classroom, but we have to ask'. Teachers are in the National Union of Teachers, while trainers are in NUPE.

To cope with some of the students' frustrations five training wards had been set up and in those the students took over the trainers role. (Behaviour modification regimes are

very popular at this hospital). To cope with the threat posed by the teachers, these nurses (as did others I talked to) articulated an anti-academic ideology.

'Education is more than formal learning' was a typical remark of this kind. They felt they were better at handling the human side. 'Kids, when frustrated, can bang their heads against the wall'.

Most claimed to be committed to their job - though it appears quite a few drop out. 'It's hard to give it up, once you get into it', one said. 'You get really attached to the kids. It's not dedication' said another - dedication implying that you suffer because of your work. Others liked the place and wouldn't think of working in a general hospital. 'It's a relaxed atmosphere'. According to them, the aim of industrial action had been 'for publicity reasons'. Yet it had a real effect. 'Simon was practically in tears about day patients' one said. The problems of working on Acorn Ward came up as in my other interview with a student. 'The main action to be taken with difficult patients is to put them in side rooms, but this has to be written up by a consultant'. They were aware of the Social structure within wards. 'Each ward has a King Rat. They have their own society'.



The commitment of some of them was again apparent. 'The kids have a lot to give us' said one. 'It's difficult to explain', said another. Many of them were scornful of public attitudes to mental handicap nurses. They felt there were two sets of attitudes. One was that nurses had halos - were perfect; 'wonderful'. The other was paraphrased as 'you're wasting you're time - why don't you shoot the lot of them'. Both distorted the facts. 'We are not wasting our time. We're trying to improve their condition. There is no line between the vegetable and the fairly alert'.

Afterwards I talked to Dave Crowe, the COHSE Clinical Instructor. He said that trainers were originally brought in as play therapists for kids. They 'are now part of the hospital community'. There was much talk about consistency 'but you can't get it with nurses shifts and days off. But trainers do provide it. They are in 5 days a week - and charge nurses have latched on to this'.

Nurses are jealous of some of the favourable conditions of trainers, eg the fact that they can get double time. This also applies to relations between nurses and teachers.

The teachers got considerably improved conditions when the

DES took over in 1971. Dave was proud of Lea Castle training school. 'We are training the next generation of mental subnormality nurses'. They would have an impact when they went elsewhere. He thought the commitment of the group I talked to was high 'even though they've experienced the stresses and strains of the ward situation'.

Interview with Dave Crowe at Lea Castle  
19 July, 1975

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Dave who now works in the School of Nursing has been on the Branch Executive for 3 years. He used to be a Charge Nurse and was more active in the union then. He left for a spell to work in a private home. He's always been involved in the union. He's worked in the school for 2½ years. 'I'm not in contact with the ward situation, but I have a better chance of recruitment. I talk to students in the school'.

He felt that there were certain paradoxes about the hospitals. 'Branch meetings are pretty useless' and as a result, he was 'surprised at the response to initiatives the union has undertaken. The hospital appears apathetic on the outside'. He thought that one disadvantage of deduction of dues from wages 'is that collectors don't get round the wards'. Most learners join 'but one or two strongly object. I strongly advise but don't pressurize them'. He emphasises the importance of 'protection'. The Rcn had been originally very active among students but it didn't seek to negotiate for them. They put on one or two social events. Some students have complained that

COHSE may be alright for ward staff but doesn't do much for students. 'I told them all you've got to do is to take 20 or 30 students to the AGM and you take over the union'. They didn't, however.

He was opposed to the Briggs proposals (for a unified basic training for all nurses) saying 'it is like having carpenters and electricians on the same course'. He wanted to retain a separate Registered Mental Subnormality Nurses (RMNS) qualification. The COHSE branch, he said, 'takes a haphazard approach'. Branch meetings are only held if there's a crisis, 'instead of getting together, once a month and waffling over coffee'. When the Industrial Relations Act was in operation he believes that management could have 'got them' for not following 'proper' procedures.

He has taken up one case of a student disciplined - who had received a final warning. He represented the nurse in front of Mrs Thornley. There could have been a conflict with his role as clinical instructor in the school - but disciplinary decisions are taken higher up, by tutors. 'I advised him on his rights and he decided that he wanted to resign. The case was strong against him'.

He is optimistic about the introduction of training wards. 'I hope to be able to intervene more in the ward situation'. He felt it would also 'assist students to speak their mind more'. The new generation of staff were more questioning and this was a good thing. 'In the depression, discipline was easy. At one hospital 25 years ago, the nurses were lined up outside the Chief Male Nurse's Office. The same Chief never talked to me until I was a staff nurse. We used to call him "Mr Gestapo". He was 6 foot one and straight as a board, with his keys behind his back. We used to get a phone call that he's on his way and it would create panic'.

He talked of what he called 'this conflict: between the trade union and the Florence Nightingale image. We want to help people. It would be a national catastrophe if we take strike action. But we've taken a lot of abuse in the past. They think "they're nurses, they'll never go on strike"'. It was because of this that they felt they had to take action. The Industrial Relations Act of 1971 had provided considerable recognition for unions in hospitals - an official status. He was very much in favour of expanding nurses' roles and having greater say over patient

care. 'The allocation of beds should be a nursing rather than a medical responsibility. Nurses should be able to say with their present nursing staff, how much nursing care they can provide'.

There was a resentment against Teachers by many nurses. 'There is a feeling that they have the kids while we mop the floor. There is fear of an educational takeover. It's a mixed-up business at the moment, subnormality nursing'. Nurses at Lea Castle do their own follow ups: '...though we should go to the social workers officially. A Charge Nurse can sort it out better than a social worker'. The hospital was going to appoint a couple of community nurses whose job would be to go into people's homes to do behaviour modification - particularly to teach parents how to do it. Behaviour modification was the technique which nurses were latching on to. It was also leading to renewed interest in mental handicap. 'The thing which annoys most nurses is that we were left on our own. EEGs (Electro-Encephalograms), physios, etc., weren't heard of'. However, the increased participation of specialist professionals created new problems. 'There are too many tribes. It's getting people together and

getting unity'. He wanted to see beds decrease but staff establishment remain the same. That was how 'we can change the atmosphere. They shouldn't necessarily close down all the hospitals. They've got all the facilities and expertise. He was pessimistic about social attitudes changing dramatically, saying, 'society will tolerate but not accept subnormals'. When I queried this he asked me how many friends of mine were subnormals.

He was very angry about the News of the World reporter who worked at the hospital. 'He came in undercover and went out undercover. People were really angry. He's lucky he did, otherwise he'd have been lynched'. He was angry about the way that nurses were scapegoated. He said that the Ely Report (on accusations of patients' ill-treatment in a mental handicap hospital), had criticised the Hospital Management Committee and the medical staff - but only male nurses were disciplined and sent to gaol.

(vi) Hatton Psychiatric Hospital, Warwick



First Interview with Pat O'Shea, Warwick Hospital  
25 March, 1975

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There are 850 patients at this psychiatric hospital and 400 nursing staff. There are about 7 consultants and 12 junior doctors. Most of the nurses are in COHSE and most of the ancillaries in NUPE. The Branch Secretary of COHSE is a middle-aged Charge Nurse and also on COHSE's NEC (he has since been deposed). There is no officers' branch because of lack of numbers and it is not a live issue. There are a number of Nursing Officer members but they are not active. He reckoned that 85-90% of nurses were in the union. There are very few Rcn members - only about  $\frac{1}{2}$  dozen he thought, and no student section.

He thought that junior staff had little awareness or knowledge of union procedures 'and may not understand national issues'. He thought this was particularly true of overseas nurses, of whom there were many at the hospital. The long day was still operational at the hospital and travelling to and from the hospital was difficult. Since they were unable to hold branch meetings in working hours, meetings were poorly attended.

Pat's wife was also present at the interview (but didn't get much of a look-in). She works as a ward sister at the hospital. She felt there wasn't much social life at the hospital. Students were different because they had their own culture.

Pat said that although normally meetings can't be held during working hours, they were during the industrial dispute. Normally however 'it creates difficulties with management' - something he appears studiously to avoid. Not more than 20 people ever attend. Section meetings are held for some groups, like engineering workers, but not nursing staff. I asked him how much time is spent on union business. Most of it is for affairs outside the hospital. He takes 10-12 days off a year to attend NEC and Regional Councils, and 'that is all the time that's needed'. Fortunately he does not work on a busy ward. However, he has no special arrangements with management to do union business. He's worried that this means him being 'obliged to them'.

There has been a COHSE Branch at Central since 1937 and minutes go back to about 1950. He gave the impression that it was an uphill struggle to get things done by management, a situation to which he appeared to be largely

resigned. 'It takes a very long time to get changes'. Simple things couldn't be done, even though the union had pressed for them. He recalled that 15 years ago (!) the union had tried to get the hospital to employ a barber, because there was a shortage of nursing staff. 'They made some excuse, saying the patients preferred having the job done by staff who knew them'.

He felt that inter-staff relations were much better than in the general field because the staff were 'long stay' (the words he used!). 'There is more friendliness and familiarity'. However, 'this has changed lately. The portering and domestics are so overloaded with overseas people that it causes friction with permanent staff' (my emphasis). They have induction courses 'but many of the women have a poor education, which no course can overcome. At least students and pupils must have a basic knowledge before they are taken on'. The union had proposed to the Hospital Management Committee that they employ an interpreter but they said that there were 'too many dialects'.

In terms of recruiting new staff he said that with students he looked for 'a key person in a set' who would get the others in. Of the older nurses, many of them were married women, 'and their husbands encourage them to join'.

The tutors in the training school are COHSE members. However, the SNO and the tutors don't invite him to give a talk on the union. He feels he cannot ask to give a talk unless the students themselves pressurize their tutors for it.

There is a sort of a Joint Consultative Committee at the hospital, but it isn't much used. He thinks the staff side is largely to blame for it not functioning. In the first instance it is too big. Although all were union representatives he didn't think that they were 'generally well informed'. If management were opposed to a certain line of action, 'they would try to sway their grades of staff their way'. eg Matrons - nurses, and catering manager - the catering staff. He recalled that 6-8 years ago they had put to the JCC that the road past the staff houses should be properly surfaced. It was 'like a track'. Management claimed that it was not their responsibility but that of the local Council. However the real reason was cost and the fact that it was not seen as a priority. However, the representatives on the JCC were taken in by Management's arguments and failed to back Pat up. So he blames them rather than management.

He is sore about the state of hospital houses. They are not properly maintained and some had been built 80 years ago. He had taken it up with the Hospital Secretary without getting very far. On issues that now come up, he goes to the Head of Department and doesn't use the JCC. The problem was that 'union members don't always want to take up the issues and recommendations of the union'. For example, instead of working through the union, they wanted to set up a tenants' association. This they did, but he claims that 'the two leaders of the association were given nice houses and the committees disbanded. They were outmanoeuvred. They were easy prey for management'. Housing is still not very good, and this does not help the hospital compete for staff.

The other forum at which staff issues can be raised are at non union staff meetings between ward staff and senior nursing management. There are meetings for Sisters and Charge Nurses, and also for SENs/Staff Nurses and Deputy Charge Nurses. He is able to raise things there. As always, 'they have a policy of dragging out things so long that you give up in the end'.

He made the interesting comment that the Halsbury award had been oriented to the needs of full-time staff and hadn't done much for part-timers.

As an NEC member he often knows more, and knows it earlier than local management, eg, on changes in Bank Holiday entitlement and Sunday night working. However, they don't ask him because 'they are reluctant to admit that any one else knows more than them'. So they don't approach him. This is true of Nursing Officers and the Finance Department. This is 'often to my advantage'. He is able to explain mistakes that they have made, eg on nights in lieu.

He felt that the COHSE unions in the West Midlands were pretty 'placid'. They are 'more militant in the North'. In the Midlands: 'they don't want to get involved. You get worried that you'd be left high and dry. The members are reluctant to oppose management. Even if it were the union's policy they might vote against it, for example at Charge Nurses Meetings'.

At the 1974 Leamington demonstration for higher pay, 'the Charge Nurses and Sisters didn't support it, mainly the learners'. They 'made excuses about not going to meetings, but if the Hospital Secretary and Matron were there,

they'd be breaking their necks to go'. The fear that they have is they won't be shortlisted for promotion, 'so they keep out of it. Management is under no obligation to give reasons. The union should have someone on the interviewing panel'. At this point Pat's wife came into the conversation (although Pat wasn't too pleased about it). 'Management at the top don't want very bright people coming up. They want good "yes men"'. Pat agreed, saying 'they don't select the right people. They did not consult the staff who knew people's weak points'.

Just as Pat was resigned about the union and the lack of collective cohesion among the work force, so he was fatalistic about his job. He was entering his 50s. 'Work in mental hospitals is depressing and monotonous, which younger people don't want. You've gone beyond the stage when you notice it. All I'm interested in is getting it done smoothly and getting the money at the end of the week. A lot of women won't admit that and say they're doing it for the sake of helping people'. Pat felt that the work was getting less interesting because of the increased amount of geriatric nursing. He was also clearly worried about the increasing number of overseas nurses. His views were clearly racist, but racism often has roots in real

social experience and in Pat's case this appeared to have two sources. (1) They brought their own culture with them which didn't fit into the established cultural patterns and forms of association that had grown up among long serving staff. (However a similar thing happened in the 1930s when a wave of unemployed dislodged the pattern of recruitment from local agricultural labourers.) The 'influx' of immigrant labour into the mental hospitals therefore has precedents, though the scale is probably greater - especially in isolated rural hospitals, like Central, which does not have easily accessible local labour markets that it can tap. He claimed that in Central 70% were from overseas. 'They can't speak English and they're immature. The men are 20 years of age and more, yet they act as boys of 13 years of age. They are very timid'. He also claimed that 'white people are more anxious to help patients than nurses from overseas'. This clashed with his earlier admission that he viewed his job in purely instrumental terms. Some other remarks of his suggested a concern that the ward culture wasn't being transmitted to overseas nurses. 'On a ward you do tend to create favourites. People from overseas don't do this as much. This is due to their different cultural backgrounds'.



(2) If Pat was hostile to black nurses because he perceived them as threatening to the long established white culture at the hospital (even though, as an Irishman, he was himself an immigrant), there were other reasons. These were more material than cultural. He perceived that there was an association between the fact that nursing had low status and pay and was associated with a high amount of immigrant labour. He went beyond this to seeing a causal relationship between the widespread immigrant labour and the low status of nursing rather than the other way round, ie immigrants do nursing because it is a low status job.

I asked him if he thought of promotion. He said that he hadn't applied for any jobs except the Charge Nurse job he has. 'If I were promoted I would have to give up union affairs'. He has spent 15 years in the same job.

He was also despairing about the fact that 'the members won't query the situation of employing so many overseas staff. Senior staff cover up the fact that it's pissing off present staff. Trained staff (ie nurses) have to face the problems while doctors and consultants can avoid it'. When consultants introduced changes they did not

consults nurses. He also was not impressed by the quality of doctors. 'They used to say that mental hospitals were full of medical failures'. He felt that in many respects the job in psychiatric hospitals, for both nurses and doctors, was easier. However, his wife thought that, 'there is more job satisfaction in general. In psychiatric hospitals, with 60-80 patients on a ward you can't give them individual care. For nurses of lower grades it's more difficult' (ie than for their counterparts in general).

Then Pat mused on the qualities required of a nurse in psychiatry. 'If you're easily irritated it's no good. You have to face awkward patients hour after hour'. Discussion of 'quality' led him naturally and unconsciously back to the subject of black nurses. 'Overseas nurses have no outside interests, only with friends in the hospital. In mental hospitals you need outside interests'. We thus moved on to social life. Pat's wife suggested that 'male nurses feel more secure in mental hospitals. It's more of a men's world'. Pat said that 75% of staff lived away from the hospital. The Sports and Social Club was not used much. The only real social life in the hospital was among overseas nurses, many of whom lived in. They played music and cooked food in the nurses home. Pat

bemoaned the fact that in the past, the hospital had good football and cricket teams. Although overseas nurses use the social club, each group tends to pick its own tables'. Pat's wife said, 'it's great on a ward if there's only a couple on, but when there's too many they form a clique. They pretend not to understand. They get out of doing things that way'.

Pat said that, under the admissions policy, everyone took the GNC admission test. 'The PNO at Central took batches of overseas nurses under pressure from the Ministry. Many claimed GCEs but they found they hadn't got them when they arrived. So they made everyone take the GNC test. But some of those with GCEs couldn't pass it because of cultural factors'. Those who failed their GNC tests became pupil rather than student nurses. However, he felt that personality was as important a requirement for the job as education. 'The present theory is to put the most educated into administration and technical jobs. They don't need them to do basic care. So they get SENs to do it. But the GNC brought in job descriptions and exempted them from non-nursing duties. So these tasks have been off-loaded from SENs onto students'. At the present time they were increasing the numbers of domestics. '...but the language problem makes them difficult to supervise. They are also slow-moving, for example the Pakistanis. The students

complain that they're doing too much routine work. Once you've done something seven or eight times you've learnt how to do it, they say'. For example, changing patients. This was one thing they had come to the union about. Since then, a policy had been adopted of moving them around wards more and giving them experience of different types of work. However, there was a limit, he felt, to the extent to which non-nursing duties could be eliminated. 'If a patient knocks a jug over in the middle of the night you can't wait until the next morning to get it cleared up'. In such circumstances job descriptions didn't make any difference. This meant there are two problems: (1) lines of demarcation, and (2) the question of cover at different times of the day, public holidays and weekends. 'Job descriptions lead to squabbles between students and trained staff and domestics and nurses'. In theory they're supposed to eliminate them!

He felt that it was okay for domestics to have a separate supervisor, 'but it depends on a supervisor's quality. If a ward's bad and dirty, it's no good saying it's not my problem. There has to be good communication. But the supervisor will get out of it by saying "look Mary, the sister's complaining that so and so's wrong. I'm satisfied with it but the Charge Nurse isn't". The question has

been raised at Charge Nurses' and Sisters' meetings but they (ie Charge Nurses and Sisters) didn't know what to do. They don't know the procedure. They say they never see the supervisor. They get nurses to do it rather than complain'. (He may have a rather elitist attitude to other Charge Nurses and Sisters. They don't know the procedures while he (of course) does).

On interunion relations, he spoke of 'a need to be diplomatic. If there's a bad worker there's a chance of a clash. When they send a relief the problems arise. You can't expect the same standard. If a domestic and a sister are members of the same union you listen to the story and try to establish (a) whose job it is and (b) what led up to it'. In the past at the hospital everyone belonged to COHSE, but after COHSE registered under the 1971 Industrial Relations Act 'NUPE felt no compunction in poaching'. (This could be important, COHSE registered largely because of fears that they would be upstaged by the Rcn. However, they could have miscalculated, and, as a result have lost a lot of members to NUPE, particularly among ancillary workers).

The Branch structure at COHSE is as follows:

Branch Secretary, Pat O'Shea	Charge Nurse
Chairman	an SEN

and the Branch Executive consists of

- 2 Student Nurses
- 1 Painter (also a Steward)
- 1 part-time Staff Nurse

In addition there are 2 Shop Stewards

- 1 Porter
- 1 Staff Nurse

There are no overseas workers in any union position at the hospital.

I asked what the union does about those who worked on nights. He stated that, 'I wait for the member to approach me'. In other words he makes no special efforts to get in touch with staff who work awkward hours. 'If nursing staff have a problem they approach me direct'. In other words there is no proper shop steward system for nurses - although ancillary staff do use their steward. His whole approach was not to act unless members wanted him to. 'It's up to the individual.

I don't act unless I'm approached. I don't act on hearsay. If a problem affects all the workers in the grade, I tell the person to approach the Branch meeting'. I asked about what kind of relationship he had with the COHSE full-timer. His reply was 'I'm so experienced I don't have to bother'. He uses COHSE Regional Council to find out what's happening within other branches. Members at regional level resort to the Regional Secretary rather than the NEC member. 'The Regional Secretary gives assistance to inexperienced members'.

Although members will pay subs, they won't do much else. 'Since the industrial action things have gone back to apathy as before' (perhaps to an extent because he did not try to build on it, eg by getting some of those involved to become shop stewards etc., - perhaps his approach caused a self-fulfilling prophecy? 'We knew we wouldn't get an interim award (ie from the Government) but used it (a) to get closer relations with the DHSS and (b) to build membership'. That's a significant statement from a NEC member, on COHSE motives for taking industrial action. He claimed that during the 1973 Ancillary Workers dispute COHSE had not wanted to take industrial action at the hospital but that NUPE had been keen on it. Seven bus drivers - very important at a hospital like Warwick - in

ferrying staff to and from work - went out for a week. The NUPE Branch Secretary is a hospital bus driver. The catering staff wouldn't come out, but the laundry, he said, stayed away Friday and came back on Saturday to work double time.

The local hospital managements response to the strike was to hire some buses from a non-union coach hire firm - 2 private vans and nurses came in to work. He felt that COHSE could not have ordered nursing staff not to use the transport 'and there was also very little liaison between NUPE and COHSE'. There was nothing like a Joint Trade Union Committee and the only place they were likely to meet the hospitals JCC - had fallen into disuse.

How many discipline cases had he handled? He said that there had been eight that he had 'taken' - implying that there were others with which he had not been involved. One was under Section 112 of the Mental Health Act which forbids male staff from having sexual relations with patients - but doesn't apply to female nurses. A porter had a relationship with an adolescent patient. He was asked to leave and did so. There had been two such cases with male members that had got to Court 'but female staff backed them up'. He



always advises people to elect to go for trial by jury.  
'Now with the increases in pay they won't get legal aid,  
so it's vital that they're in a union'.

A rather depressing interview, but perhaps typical of the  
'traditional' pattern of COHSE activity (or non-activity)  
in mental hospitals? In support of this view is the fact  
that I was directed to the hospital by COHSE's Assistant  
Regional Secretary who thought it was 'typical of rural  
mental hospitals'.

Second Interview with Pat O'Shea, COHSE Branch Secretary  
at the Central Hospital Warwick held on the 3 June, 1975

Pat lives in a row of hospital houses close to the huge and forbidding hospital. He started by complaining about the difficulties of organisation that he faces. At the time of the interview he was one of the regions representatives on the NEC of the union. Pupils and student nurses finish at 2 pm. He felt that it was difficult to hold meetings in people's own time and that it was difficult to hold it in the lunch hour. People only get half an hour and these are staggered anyway. It wasn't like a factory where everybody went to the canteen. The hospital did take some action during the nurses dispute. People took an hour or so off in the afternoon when time was slack, banned overtime and transfers of staff from one ward to another. Much of the action however seems to have been of a token kind. Bill Gardiner, the principal tutor, is a COHSE member. He wanted to give access to the union at the school but was reluctant to ask the head of nursing for permission.

Pat, as in the first interview, appeared to be pretty demoralised about the union. He felt that it was extremely difficult to get very far. He complained about the

parochialism of the members saying that they 'were more concerned about the colour of their belts (ie on their uniforms) than new government legislation'. Branch meetings when they were held were often inquorate. Therefore the majority of things were dealt with by him on a day to day basis. In the past it has been an immense struggle to get even small things done.

In the past there were a lot of non-nursing duties. Parties accompanied by nurses went out potato picking, working in the dairy, and so on. The hospital farm sold all their produce. Now this has been replaced by concentrated occupational therapy. He wasn't sure whether this was a good thing. The emphasis was now on rehabilitation. Retired nurses work in industrial therapy and the occupational therapy department. Students have to do six weeks there. Nurses assess the patients' reaction to this course of treatment. There was friction at one time between the nurses and the occupational therapists. However they now have helpers working in the department rather than nurses. There was a dispute about whether the head of the occupational therapy department should be a nurse or an occupational therapist. There is also friction over who orders materials.

There are seven consultants in the hospital. He claims it is impossible to disagree with them over things like diagnosis and treatment. He says that they are 'neutral' over the issue of industrial action. This was very different from the past when the hospital was ruled sternly by a Medical Superintendent who had considerable say in which staff were taken on. For example he was very keen on cricket and he employed a trained nurse whose sole job was to keep the cricket field in order. Another Medical Superintendent wanted to make the hospital completely self supporting by agriculture. The reason for this was that the Medical Superintendent and other doctors lived in and got free food. Pat says they were 'living off the fat of the land'. The power wielded in the past by the Medical Superintendent was summed up in a little anecdote. Pat said that about 25 years ago one nurse had a quarrel with the Medical Superintendent who then sacked him. The nurse said 'I will appeal to the committee'. The reply of the Medical Superintendent was: 'don't be silly, I am the committee'.

Until 15 years ago there were no domestics or porters on the male side. All the male patients were expected to do the work. He also reiterated his strong feelings about overseas nurses and doctors, believing that their recruitment

should always involve a language test. He felt that the qualifications ought to be raised and that wards at night ought to be staffed by trained staff. To do this however he agreed would be 'putting many members out of a job' (ie the untrained members who work on nights). His opinion of overseas doctors was very low. 'A good nurse with general and psychiatric training is better than one of those doctors'. Senior staff were not choosy about who they take on as nurses. However he felt that nobody could be enthusiastic about looking after geriatric patients. The work was 'basically drudgery' and he did not feel terribly involved in it.

Interview with Mrs Bennett, SNO at Central Hospital  
Warwick, 1975

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Mrs Bennett was a Senior Nursing Officer but also acting as Principal Nursing Officer until someone else took over. She described the union at the hospital as 'very helpful and considerate. It's because of his (ie Pat O'Shea's) personality. We have a happy working relationship with COHSE'. She was herself, however, a Rcn member 'for legal protection'. She was the SNO in charge at the time of the 1974 pay dispute. There is an Rcn branch at the hospital.

However, though she was full of praise for Pat, she was not at all sympathetic to unions generally. Her husband was in the building industry and disapproved of closed shops. 'One's job should not be controlled by having to belong to a union' she told me.

I asked her how long issues took to settle. She said it depends. If something involved finance however, it would have to be taken higher than the hospital level. She felt that reorganisation in 1974 had 'caused frustration generally' and uncertainty at Divisional Nursing Officer levels. 'Ward staff are sceptical of the results. Under the old set-up, you had a House Committee genuinely interested

in your domain. There is now no body of persons exclusively concerned with the hospital'. There has been a 'shift of power away from the hospital, and discretion has declined at the hospital. Since reorganisation in 1974 decision making has been removed even farther still'. She was less able to influence the District Management Team than the old House Committee.

We talked next of recruitment. 'There is a general shortage of trained staff'. One reason was the isolated geographical position of the hospital. There are also accommodation difficulties: (1) Staff houses are in short supply. (2)

Property in the area is difficult to get and also pretty expensive. 'All hospitals can hope to do is to train their own and retain them'. However she didn't want to hold staff back from developing themselves. They go away for experience and she hopes that they will come back later.

The recent growth of unemployment had increased the intake of learners, and hence a decline in overseas candidates seemed likely. She has been at the hospital for 13½ years and 'it's the first time we've been up to full establishment'. However, the present slump was different from the 1930s when there was a flood of recruits into the asylums. The

same advantages over external jobs - like pensions - 'are not so true today'. She didn't think there was much solidarity in the hospital 'because there's been a decline in it in society at large. People are more materialistic'. The family tradition in mental nursing, 'is still there to some extent, but they apply elsewhere. They don't want to get a job at the same hospital where their mum's an SNO'. The hospitals were also changing because promotion 'is much more competitive than it was'. Also, 'we are bringing fresh blood in'.

She disagreed with my suggestion that overseas learners were 'hospital bound'. She thought that: 'They have a wider experience. They have a social life away from the area with other overseas nurses'. That is, they go away for their days off. They have a 'sleeping-out' book just in case there's a fire in the nurses home, and they leave an address for contacting.

All staff work long days. Learners do 2 days although Nursing Officers work to a different system. I asked why this was so, when official policy was to phase them out. 'The staff are not over keen on changing the system. The unions' not keen. I'm not sure why'. She thought that



travel problems and the isolation of the hospital might have something to do with it. In addition, because of it, the staff have alternate weekends off. 'The new system has to have these advantages and staff would have to come in more days a week'. Many staff were married women and didn't want to. 'Are stresses greater during the long day, or when staff have to come in more often?', she asked. Another reason why the staff wanted the long day retained was the fact that 'many want to work part-time jobs outside' to supplement poor wages.

She thought that as a result of Salmon 'people felt uncertain. The Matron took over 2 sides. The male Nursing Officers were apprehensive about their new boss' (- interesting that they thought it would lead to female domination of male sides). At this place, prior to Salmon, there was joint administration of the training school. Since then, however, 'there are many more men in senior jobs. Women can't move around so easily. Women couldn't force men to move in order that they could advance their careers, but women nurses have to follow the men wherever they go'. Furthermore, 'part-timers can't get promotion above deputy sisters. At the higher administrative

levels it wouldn't be fair to promote part-timers over full-timers. If you want promotion you have to put up with minor inconveniences' (sic). It was clear that she had missed out herself because her husband was rooted to the area and she felt she could not apply for jobs up and down the country.

There are Sisters/Charge Nurse meetings bi-monthly and unit meetings held by unit Nursing Officers. Units had been set up with 'a cross section of patients' but there were two sections for geriatrics alone.

Finally she told me that the nurses home was in the process of modernisation.

(vii) Chelmsley Mental Handicap Hospital,  
Birmingham

Chelmsley Hospital, 13 March, 1975

Mr Hastings is a Nursing Officer who has worked here, at this mental handicap hospital on the outskirts of Birmingham, since 1935. He was originally an agricultural labourer. When he left school at 14 he worked until he was 19 on a farm 'and never got a day off, only a long lunch hour on a Sunday. I came to work at the hospital for 56 hours a week and thought it was relatively easy'. Conditions weren't easy, however. Nurses had to sleep in 'on call' for two nights a week - they had a bed in the ward. 'Charge nurses didn't necessarily work on the wards. One was a bricklayer'.

When the union was started up at the hospital in the 1930s, he remembers, the Medical Superintendent 'victimised the instigators of the union by sending them off the wards to work painting the staff houses'. Chelmsley wasn't originally a hospital, but a boys home, before it was 'made up into a mental deficiency institution'.

He recalled the battles that had gone on in the hierarchy over the years. The stock of the Medical Superintendent had declined and that of lay management increased. The Chief Clerk (ie the Group Secretary) was able to exploit the conflict which existed between the Chief Male Nurse and the Matron. There was 'petty competition' between them. The

Matron had the ear of the Chief Clerk and controlled the Training School. One of the biggest fights between the union and management at that hospital had been over pensions.

Next I talked to Wilf Shaw, the COHSE Branch Secretary - and a much younger man! 'I don't think militancy is necessary. You can get more by gentle persuasion than thumping the table'. He has done the job for 2 years and has taken membership from 60 or 70 to around the 350 odd mark. He works on 'an easy ward. Most patients go out during the day', enabling him to devote much of his time to union business. He was shifted from a more difficult ward 'expressly for that purpose'. There are 5 unions at the hospital. They are currently talking with management about clocking on and the time allowed before money is docked off. This affects part-time nurses as well as ancillary nuses. In early February there had been an investigation at Chelmsley and other hospitals by the Fraud Squad concerning food rackets.

The Nursing Auxiliaries have their own steward. In the maternity hospital next door a Nursing Auxiliary represents all staff. He believed that the quality demanded of a steward was 'the right kind of attitudes towards working

people'. He was very much concerned to protect the interests of long serving staff. He claimed that hospital statistics showed that most sickness occurred in the first 5 years of service, 'yet many of the older ones are being cut off', (ie pressured to retire).

Although a lot of power has been removed from the hospital level, Nursing Officers do have some power to spend small amounts - such as issuing maintenance chits. The problem he thinks is more at ward rather than Nursing Officer level. 'Ward Sisters say what right have you got to interfere'. However, staff had complained about getting bad backs on wards which had an upstairs and no lift'.

Interview with Wilf Shaw, COHSE Branch Secretary  
at Chelmsley Hospital, 12 June, 1975

Chelmsley Mental Handicap Hospital is on the fringe of Chelmsley Housing estate in Birmingham - a massive and barren urban environment. It is also next door to Marston Green Maternity Hospital. So Chelmsley Hospital used to be out in the country until, after the second war, Birmingham crept up to it. It is part of Warwickshire AHA, not Birmingham.

There are some 390 COHSE members at the hospital. 320 of these are nurses (including some from the maternity hospital next door). Wilf Shaw claims virtually a 100% membership at the hospital. He took all of NUPE and some Nalgo admin. and clerical members who were dissatisfied with the new grading structure. Their hours had gone down but their responsibility increased. He was taking this up with management since they need regrading. NUPE don't even have a Branch Secretary at the hospital now. In this hospital, at least COHSE lives up to its claims of being an 'industrial' union.

Most of the increase in membership had been very recent. They had started from a nursing base of some 66 odd members two years previously and increased very rapidly. There were now 15 shop stewards. Four covered nurses: a Charge Nurse, Nursing Auxiliary, SEN and a student. The rest covered admin. and clerical, domestics, ancillaries and craftsmen. There is a separate Officers and Sub-Officers Section at this Hospital. Their Secretary is Mr Hale, a Nursing Officer. Wilf works on a ward - more or less a hostel - where the workload is light. Management put him there deliberately, so he could specialise on union affairs.

The general staffing situation of the hospital had eased considerably with the building of the estate. (These notes will appear rather disjointed because of the way Wilf flitted from subject to subject!). Wilf tends to represent the interests of long serving members. He is himself in his 40s. One result of reorganisation was that a great many items of policy dropped out of the sky from area level. One of these which antagonised Wilf and quite a few others was an absolute limit of 70 for retirement - except in very exceptional circumstances. Soon afterwards



2 long serving members came up for review and the District Nursing Officer (DNO) sent them a letter asking them to retire within 6 months because they were around 70 years old.

Wilf went to the Principal Nursing Officer (PNO) and complained that no proper review had been carried out, that it was 'a one-man decision' by Mr Murphy (the DNO), based at Nuneaton. Wilf wrote to him saying his Branch felt these were both exceptional cases. The cases were then handed over to personnel and a proper review done.

Another matter causing anxiety were complaints about ill-treatment. One of the friends (a relative) had complained that too much punishment was going on and unruly boys being put on sedation. Wilf had threatened to bring in the COHSE Regional Officer.

There is a North Warwickshire District Consultative Committee, the minutes of which are supposed to be confidential - but they distribute them anyway with the blessing of the DNO. The representative for COHSE is a Ward Sister at Weston Hospital (a nearby mental handicap hospital). Wilf is her deputy on the Committee. It recently met for the first time and talked of a number of things:

- (1) Expenditure for the District - though not in great detail;

- (2) Staff Transport - which management wanted to cut back.
- (3) Staff uniforms; allowances and suits, etc.,
- (4) Nominations for the Area Consultative Committee, one management tier further up.
- (5) Carry over of annual leave.
- (6) Circulars from the DHSS.

I asked how he had increased membership so rapidly. 'I built up the branch by talking to people and winning one or two cases, and by stimulating their interest'. He won a pay entitlement of £50 for a nurse who hadn't had her proper incremental payment. People got irritated by delays when inflation was rampant. Branch meetings are held regularly but they are not very well attended.

'Most of the work is done by the shop stewards'. The Senior Nursing Officer (SNO) at the hospital, Mr Kitson, is also a COHSE member. Wilf claimed, 'many of the issues don't get to Branch meetings. Stewards often resolve things themselves, but sometimes they come across sticky problems.'

The most difficult cases are ones involving complaints about treatment, as at the Annexe and hostel, 'when both sides are union members'. One tricky case was in the Annexe (outside the hospital) where a charge nurse's wife, who worked as an ancillary worker, constantly shouted at patients, until a nursing auxiliary and SEN complained. All were members of COHSE. The nurses resented having an ancillary worker ordering them around. However, 'what's at the root of it is the fact that the Charge Nurse's knocking off one of the two complainents'. The Charge Nurse and his wife live on the premises and he has transferred some of his authority to her. There are 12 elderly men and women patients there. It's a problem he doesn't like to deal with: 'I'd rather hand it over to personnel'.

NUPE used to recruit next door at Marston Green Maternity Hospital but weren't very efficient at it. COHSE has quite a few domestics and nursing auxiliaries in membership but not midwives. The steward is a painter and decorator and he plans to set up a separate branch if the union continues to grow there. He told me: 'the Matrons' left but her ghost is still there. Nurses are frightened still.

In the past management got away with murder. Nurses were forced to do overtime without pay and have no choice of their days off'. Now that's changed. A lot now are also part-time, working 4 hours in the evening.

Four stewards from the hospital are on training courses: 1 domestic, 1 porter, 1 painter and a nursing auxiliary. The domestic doesn't get a full shift's pay in lieu because she works only 4 hours in the evening. The Branch Chairman Jack Edmonds is a trainer (which is an ancillary not a nursing grade). He works in Industrial Therapy and has been working in the hospital for 20 years. He started off as a cook. He has also been a Nursing Assistant. He worked in occupation therapy doing 'simple bloody jobs, like making paper bags. I advanced to making polishing mops. When Industrial Therapy was set up, I changed from Nursing Assistant to Trainer'. Now they make curlers, light fittings and so on. Nursing staff had said it wasn't their job to supervise this work. There is friction between the wards and Industrial Therapy. Patients arrive late because they are kept on the wards to do the washing up. How much do they earn? Jack said, 'the kids get pocket money,' and then he checked himself: 'I'm not supposed to call them that'. As for the Afrikaaner and their black

servants; for the old-style mental handicap nurse, their charges are always children, regardless of age.

Wilf reckoned that management were pretty inflexible over holidays. 'Many women want the industrial fortnight with their husbands and they go sick. They then (ie management) turn around and say they're short of staff. The word hospital derives from the word hospitality but it's the last thing you see here'. Wilf had a strong antagonism towards management. He says he spends some 20 to 25 hours a week on union business. He hasn't been doing the job long but he gives the air of someone who is quite pleased at the way he's doing it. He is a very friendly man, with an empathetic rather than an expert approach to union business. He associates himself strongly with the staff on the ground: porters, domestics and nurses. They're the ones with commonsense, and a human approach to things - unlike in his eyes, management.

It was when Pat McGinty, by then moved to East Birmingham Hospital, was responsible for the hospital that he'd been shifted to his previous ward. Before, 'I was on a rough ward'. This made it difficult for him to cope but he'd worked it out now. One sign of this is that 'you know information before management. I let the pay office at District know the advance information I get through COHSE'.

On recruitment, most is done by stewards. He has not yet given a talk to students on the union at the Training School. However, he does speak on in-service training courses. There has been a committee set up for students. His approach to building the union was: 'I chip away and I find I'm getting somewhere. I'm beginning to have real influence'.

Interviews at Chelmsley Mental Handicap Hospital  
18 June, 1975

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Wilf Shaw - Branch Secretary COHSE. There was quite considerable friction between the PNO Pat McGinty and COHSE. He had tried to get rid of the SNO who had been at the hospital some years. 'He wanted to get rid of Mr Kitson. He said "you've been here too long, I'm moving you. You'll be in charge of in-service training". He assumed everyone was happy. The District Nursing Officer, Mr Murphy thought so, but the PNO had lied to him'. There was considerable loyalty to Kitson and hostility to McGinty, who was regarded as an opportunist. 'Mr Kitson's the Matron here. He was told what to do by a high flyer who'd been appointed from the outside and had a bad reputation. He was a bit authoritarian - fond of banging the table'.

At the same time that the hospital was buzzing with resentment over this issue, there was trouble on nights. The hospital had no central mess room. This brought in 60 members from NUPE. To get a meal people had to walk from the wards along an unlit drive to the Marston Green Maternity Hospital dining room. The union had increased its stock by getting lighting, bleeps for wards and cover at nights. The union was growing before McGinty

whizzed in from outside. 'It's good to be in a union for a hundred years and not want it, than to not be in it and want it for five seconds'.

However, the trouble with Mr McGinty had built the union. 'It's the first time the union has dug its heels in. Meetings took place over Mr Kitson's grievance with Mr McGinty, which lasted hours. 'Then he lost his rag and walked out on the meeting saying, "these bloody people won't let me do me job"'. (There were two reasons, I reckon, for widespread support of Kitson. (1) They were fond of him as 'one of them', and felt he'd been shabbily treated. (2) Many of the long-standing members felt insecure and threatened. If McGinty could do it to the ex-Chief Male Nurse, what chance had they? (3) Fear of change among staff who had become more than a bit institutionalised.)

Wilf took over the branch from a woman who had let it go into decline. 'She said she objected to trade unions. She's now in the Rcn'. The branch only had 66 members. He had started from scratch and was proud at how he'd coped. 'She didn't give me a piece of paper'. He had a strong solidarity with other grades and not just nurses.



'I'm interested in the lower dog' (ie ancillary workers). At the same time he felt insecure at threats to the professional status of mental subnormality nurses: 'They're trying to take my qualification off me'. His wife used to be bothered by the amount of work involved, but since he'd moved to this ward, the pressure was less intense.

He resumed his tale of the McGinty Saga. There had been a Charge Nurses' and Sisters' meeting at which he had banged the table. He'd demanded apologies from people who were not present because it was their holiday or day off. Most people put this down to his own sense of personal insecurity. He had since moved to East Birmingham Hospital.

When Mr Kitson had been moved sideways by McGinty all COHSE members - nurses and ancillaries - had threatened an immediate walk out. Mr Kitson had said 'it's my turn tomorrow and yours the next day. If you get the old ones out, you can get all your mates and friends in!'. That was his explanation of McGinty's actions. McGinty was being succeeded by Mrs Hendry from the middle of August. There had been exchanges of letters over the affair between McGinty and Albert Spanswick, the General Secretary of COHSE, with the former wanting to use the latter as a

policeman over the members.

I got the impression that this hospital was a backwater, where few changes had occurred before Mr McGinty came.

'When you've had patients for years you know them in and out. If someone at the top tries to introduce changes it upsets the patients'. He had wanted to swop staff between wards. To put all the high dependency patients together which would lead to them having 'no motivation from the better patients'. It also leads to the staff on those wards becoming custodial, said Wilf. 'He introduced changes without consultation'.

The majority of staff were younger but there were some 'old stagers' retired nurses who had come back part-time.

There were 'a stream of people going through'. He was pleased that they were making inroads into Nalgo. 'Other hospitals with fewer patients get higher clerical rates'.

A psychiatrist had even approached the union about his incremental position. He was not a COHSE member, but he has known doctors to be members.

Next I interviewed an ex-Charge Nurse who had worked at the hospital many years. The place had originally been an

orphanage from the 1880s. It was closed down in 1933/4 and re-opened as a Mental Handicap Hospital in 1937. At that time Chelmsley was a division of Coleshill Hall. Power in the hospital used to be very centralised, at the other hospital, which dated from 1930. 'They were the supreme command. No one could move: nursing, farms, gardens or workshops'.

He used to be in NUPE but was now a COHSE member. He used to work in a hospital in Staffordshire. The union there was seeking to compare rates of pay at different hospitals. They were warned by the Superintendent. 'The Superintendent said we shouldn't be in the union. He told us: "be careful, the committee doesn't like it". I used to meet the Area Secretary in a car outside the hospital. He couldn't come in. I left soon afterwards. I was single and I wasn't all that bothered when the Superintendent warned them'. Then he came to Chelmsley in the late 1930s.

He said that Chelmsley had 'moved with the times'. When he first came there were no night staff to speak of. The Charge Nurse used to go round now and again, 'but they looked after themselves after 8 o'clock'. The war had broken out before the hospital was 'in full swing'. The farm was now leased out. 'We used to get all our milk from the farm'. The growth of Chelmsley Wood Housing

Estate made the staffing situation better, especially for domestics and nursing auxiliaries. 'The Medical Superintendent used to say that the only way to get staff was to build barracks'.

The administrative set up has changed a few times. They went in with East Birmingham, then Solihull, and are finally part of the North Warwickshire District. Being a cog in a big administrative machine 'leads to problems of communication'.

In the past it was a nurse who looked after the Matron's stores: she got one day off a month. An Assistant Matron got  $\frac{1}{2}$  day off a week. A storekeeper only got 1 day a month. 'I came to work here originally as a tailor instructor. The Medical Superintendent didn't like brass buttons (ie on male nurses uniforms). We had braid trousers and jackets and peak caps. He didn't like this kind of thing. He employed everyone as a nurse.' It was he who gave staff their lectures in the school: 'In his first lecture he said "never repeat outside what goes on inside"'. He told me that if I had tried to visit the hospital to do research in the old days, 'they wouldn't have let you in. They would have said "there's a stranger up the drive". They used to have gates and stop everyone'.

During the war, 'a certain proportion went to the forces and then the Medical Superintendent said "no more". Things got a bit lax during the war, so rules got ignored'. Things didn't alter much as a result of the new NHS - not at first. In fact they were left even more to their own resources. 'Before then (1948) we had the Board of Control come round. It was more regular before the War'. A number of male nurses from Chelmsley went into the Royal Army Medical Corps, and after the war went and did general training.

Competition for jobs at the hospital was considerable in the 1930s. 'They had a hundred on the waiting list and closed the books. You had to have a contact on the inside. If you had another qualification, if you could play the piano or were a tailor you stood a better chance. A number of people here were musicians in silent movies who became displaced by the talkies. We had a really good band here of professional musicians!. They used to have pageants and all the staff contributed their various skills. In addition they also recruited from local agricultural labour markets. 'They could be choosy, then'.

Originally they didn't have domestics on wards. He remembers 'swinging bumpers on a hot day'. What domestics they had came from Ireland and looked after the female nurses homes. There were no male residences then. 'We used to have to cycle for miles. We were in lodgings. You had to be on the mark. You wouldn't go sloping past the Medical Superintendent. You felt you had to pull yourself up straight'.

It was his impression (contrary to what someone else said) that the Matron and Chief Male Nurse got on okay. 'They commanded considerable respect. The Matron ran the whole place to start with, then brought in the Chief Male Nurse. The Matron took charge of the school. She was more in contact with the Committee and the Medical Superintendent.' He mentioned the family tradition in the field and how 'village life centred around the hospital'.

Wilf Shaw felt that the League of Friends had done a good job. However, there was one instance where a boy had absconded from a ward and his parent (a member of the League of Friends) accused the Charge Nurse of being cruel. At first she wouldn't see the union, but then did so. There was a meeting between the SNO, the union, the woman and the

Charge Nurse concerned. The union offered to farm out the issue to outside the hospital. 'Then she apologised and that was the end of it'.

Then he mentioned how Mr O'Toole, the former Chief Male Nurse before McGinty, 'never took things out of a ward's hands'. McGinty often did so. When Mr McGinty left, 'they sent round a collection tin for him. I told them to fuck off. The Domestic Supervisor - who's a bastard - sang "For he's a jolly good fellow"'.

Mr Kitson, Senior Nursing Officer (acting PNO) says he has a good relationship with the union. He involves union reps on all issues in consultation with Nursing Officer - for example over leave entitlements. He thinks that the union's 'a damn good thing because of the power of District Management'.

He used to be the Branch Chairman for a spell after the War at Chelmsley. However, 'it's nothing compared with now. The big change was "in the grass roots". The shopfloor is more involved. In the past you led rather than involved the membership'. Attitudes had also changed in the health service, 'you can question things more, now'. He declared

his philosophy as 'I'm in favour of whatever nurses should get'. He had used the union to press a claim for himself. He wanted more money in relation to another Nursing Officer because he went round the wards. During the Halsbury dispute, 'I didn't interfere'.

The hospital is now part of the Mental Subnormality Sector of North Warwickshire. The SNOs in the District have fortnightly meetings with the District Nursing Officer, who is a Mental Subnormality Nurse (Mr Murphy). There are 500 beds at Chelmsley - the nursing staff are 202 days and 65 nights. Many of the people are severely handicapped at the hospital. He didn't think nurses were resistant to change. In the past the hospital had every facility - like laundry - but no longer. The Medical Superintendent was 'the gaffer'. If you'd gone to see the one at St Margarets (at the other side of Birmingham), you'd think he was the chief of police'. However, Dr Stevens was on the more progressive side, he wanted a nurse for everything'. On work gangs, nurses had to sign to take patients off the wards. Not now. He said there were no patients on 'Sections' at Chelmsley - they went to Coleshill (ie compulsory admissions).



Trainers, teachers and nurses cooperated well together. There was a Social Education School at the hospital. Nurses were beginning to have more say. There is now a nurse representative on the Professional Executive Committee. The Matron at one time earned around twice as much money as the Chief Male Nurse - she was in charge of the training school. Chelmsley had appointed a PNO from 1970, just after EBH. There had been a Matron from 1937.

They managed to get highly skilled people. 'We've a draughtsman on a Dobel steam car' (ie the boiler house).. 'He worked at a steam wagon works. The works manager shifted him and he went on short time'. Many of Mr Kitson's relatives are in nursing. The proportion of male to female nurses is about 1/3.

The hospital previously had difficulties in recruitment because of competition with local factories. So there are a lot of part-timers, because they're easier to get. There is a waiting list at the moment for staff. There are some overseas nurses in training.

He described Mr McGinty as 'a dogmatic sort of a person. He used to say "I want this" and "I want that"'. He came from Lea Castle. 'He couldn't delegate. He was like an old Matron. He never used to trust his subordinates. He didn't work Salmon. If someone came up to him on the ward and asked for time off, he would give it, and not let the SNO know. People tended to be a bit scared of him. He used to be in the Chief Male Nurses Association. He wanted to move me out of Chelmsley. He tried to get me earlier to EBH. He shifted SNOs around. He hadn't reckoned on the staff reaction. People come to me with all sorts of worries. Husbands and wives come up here. I've been here 38 years. I'm father round here to the patients. They become part of the buildings. The people that you argue and fight with keep you going'.

After the threatened walkout it was Mr McGinty and not he who moved. 'Though he claimed that he chose EBH after having been offered the Divisional job. But he didn't get on with Mr Murphy, the District Nursing Officer'.

Jack Edmonds, COHSE Steward and Trainer

Jack works in the workshop. There are 6 trainers and 12 nurses plus a Deputy Manager. There is no Whitley workshop manager grade. There is no career structure Jack complains; there are also 'too many bosses'. On Daffodil Ward (another workshop) there are more nurses. They are mainly lower grades and need more nursing care. In the workshop the work is more skilled and there are more day patients. Nurses in the workshop work a five day week and this causes some controversy. Learners attend for 6 weeks. 'There is some friction with the wards. They like to send behaviour problems and keep the useful ones'. The older charge nurses were more difficult. 'You don't get the cooperation from them'.

All ancillary workers (including trainers) joined the 5 day strike in 1973. He was on the picket. 'It was bloody cold that. The Hospital Secretary arranged for tea and coffee to be distributed. He was a decent bloke'. However, the nursing staff were less cooperative. Some of the nurses worked in the laundry, 'but they were so upset at the amount of work they had to clear that many of them said they wouldn't do it again'. Only Wilf Shaw was helpful.

All the work done in the workshop is contract work, lamp brackets, kettle fittings, hair curlers. Because of the lack of work, to keep patients going, things were sometimes done twice!. But the Nursing Officer stopped that. Instead they go for more walks, or dances. As a trainer he resents the fact the Nursing Assistants take over when the SEN and NO is off, 'even though she hasn't been here as long as many trainers'. If there's a behaviour problem, they phone the ward. 'They don't come, and you take them, and you find them sitting them around'. He thought that the strike over McGinty would have been solidly supported by all staff. It wasn't loyalty to Mr Kitson but 'the principle'. Mr McGinty moved people around and never consulted anyone.

(viii) New Cross Hospital, Wolverhampton

Interview with Ken Forbes in June 1975 at  
New Cross Hospital, Wolverhampton

Mr Forbes is Branch Secretary of the biggest Health Service branch in Nalgo. It has 2000 members of which 800 are nurses. That includes radiographers, physiotherapists, speech therapists, admin and clerical works officers, building, medical lab technicians, medical photographers, dental workers, and so on. In fact it has every grade except ancillary workers. He sees branch meetings as the occasion for educating members of different grades on each others problems. This 'has a beneficial effect' especially since they were 'dealing with the most bureaucratic body in the whole of Western Europe' (ie the National Health Service). He claimed that the DHSS was 'ignorant of how the NHS works. They operate in a theoretical vacuum. They phone up one AHA and take it as the viewpoint of the service. They have a bureaucratic mind and can't see the way that staff are so interdependent and the information from the grass roots is simply not there. So many of them have no knowledge of the day to day work of the service'.

He is the head of the Fire Security Service in the area and his branch covers Wolverhampton, Sandwell, Dudley and Walsall. All are single district areas. There are sub-branch groups for each authority. He admits that they could do with a branch organiser really. The sub groups meet with the members and the branch as a whole has an annual meeting. 'But I find that departmental representatives take most interest'. They get information straight from Head Office and the branch. Among nurses he has a departmental rep in Admission Block and day and night representatives in the geriatric block. In all, the branch has 180 departmental representatives, including 40 staff representatives. It has membership in all hospitals in the district and there are members in every clinic. The membership includes district nurses, SENs, and TB visitors. He claimed that 'the Rcn will never be a union. It is inadequate in its representative role, though it does have a role. They are considerably handicapped in negotiations even though they are better than they used to be'. He described them as having 'many old fashioned members'. They have a few members on the ground in this area 'but are not very active'. Lots of people never joined because <sup>of</sup> one, the high fees, and two, the remoteness, and three, their limited scope'. He claimed that 'most Rcn reps don't know their onions'.

He was very conscious of his expertise in dealing with national agreements and detailed matters like the geriatric lead, back pay, and enhanced payments. He contrasted this with the ignorance of nursing management. 'In the majority of cases the nursing administration don't understand what you are talking about'. He very much saw his job as enforcing the rules that were made nationally, that were not always followed at local level. There were a considerable number of errors in pay packets and delayed holidays. These could not be resolved at nursing officer level. 'I tell them to go to the head of department first'. On discipline he said that they had a distinct procedure. On the question of working rotas, he believed that the staff should be consulted first before any change. 'I warned them not to interfere without consulting the unions first. It is in their own interest to consult us'. He felt that the hierarchy opposed unions because it did not want its prerogatives challenged. He had noticed a change in the Health Service: 'you can't push nursing staff around like you used to. The days when the nurse grovelled before the matron are gone. There has been a change from below'. However, he said that a very substantial number of the senior nurses in the branch were Nalgo members. This included tutorial staff, area nurses, and divisional



nursing officers. The SNOs and divisional nursing officers were in Nalgo 'because it seems more professional'. He also thought that Nalgo members were 'a cut above those of other unions. When I compare the people from my department there is no comparison in intelligence. NUPE and COHSE branch officials have to rely more on their full timers than we do'. There were some COHSE members in the psychiatric wing. There were also some NUPE nurses who 'want to come across'. Nalgo lost some members to NUPE at one stage 'but they are coming back. We have got a far more enlightened leadership in NALGO. We are not strike happy. Only when we are pushed beyond the limits of patience'. He cited as an example the community nurses who threatened to withdraw their cars because petrol allowances didn't cover costs under the NSH, when they transferred from local authorities. 'If there are problems which affect district nurses we will call them together and then report back to the branch'.

He felt that they had 'a good system of communication and that the potential for nursing membership in Nalgo was not recognised nationally. He felt that too many Nalgo branches were 'pedestrian. You have to get a reputation for fighting for your membership'. The question of contact with membership

was resolved by leaving as many questions to be settled at sub-group level as possible. He said that there had been a steady growth in membership each year of about 500 to 600. Most of the union's members were women. This leads to problems of retaining members due to turnover of staff. Men leave the hospital and go elsewhere but tend to stay in Nalگو more than women. In 1973 branch membership was 1100. By 1975 it had grown to over 2000.

'People are less reluctant to join unions now than ever before. If you treat them as intelligent they will join. They see that they have fallen behind'. People 'suddenly come alive when they see some group upgraded. There have been big improvements in medical records here. You keep feeding information to them and through communications they become more aware of not only their own problems but those of others'.

Nevertheless communications were difficult where staff were engaged in 24 hour duties and there was a big part time membership. It also makes administration and rotas more complex: thus the problems of nurses are essentially different from those of other staff. 'No other section of the service is quite like it and it is the largest single working group'. The turnover is very high especially of nursing auxiliaries. 'Nevertheless even though many leave

they will also come back again'. One of his major jobs is to keep a check of the membership. Every month he gets computer sheets. Pupil nurses and students move about so much that it is very difficult to keep track on them. They are regularly moved around from ward to ward. 'It is very difficult to talk to them but if you get them in they tend to stay!.

He was very proud of the fact that one of Nalgo's big selling lines was their immediate legal cover. 'It doesn't matter who is in the right or wrong'. He felt that 'unions will fight for their members much more. No nurse is carpeted here before she has a chance to take Nalgo along. They don't make written statements without contacting the union'. There was an incident on one ward where a senior nurse had wanted every nurse on the ward to write out statements. A couple of years ago there had been an incident where a male black nurse in a psychiatric unit was accused of sexual interference with a female patient. This particular patient, according to the branch secretary, had an obsession herself with coloured men. She tried to get two black male nurses to have sex with her. They said no and she complained. 'They came to me and I immediately put an embargo on statements. This gets known among the nursing fraternity'.

Another case had concerned a sister and a cardiac arrest on a child. 'She tried to resuscitate the child and clearly it appeared to the parents that she was being very rough with the child. They complained. Nobody can anticipate when it might happen'.

I put to him an argument which was originally made to me by a senior official in the Royal College of Midwives. She had said that non nursing trade unionists did not understand the complex medical arguments which often surround disciplinary cases. I asked him to comment on this. He called this 'out and out professional arrogance. The RCM set themselves up as prosecutors, jury and judge. You can't play all three with the best will in the world. I will defy anyone in those associations to outmanoeuvre me'. He cited the case of a woman who had complained about a midwife and he had 'got her off' (ie the midwife). He also felt that you can be more objective because 'you are outside the situation'. Problems arise when there is no consultation. 'That is what they don't like really'. Meaning the professional associations. 'They are very circumspect when they are dealing with me. They are not dealing with the unintelligent average NUPE or COHSE

steward who can't keep an intelligent conversation for more than five minutes'. This was not the first time in the interview that his status hang-ups were put on view. But with generosity he added 'it is not their fault. Rather in Nalگو we have had managerial experience. We represent different grades. Domestics and kitchen staff aren't people who understand Whitleyism and write letters. If you have got a loud mouthed kitchen porter, his colleagues appoint him as a shop steward, but he might not be able to write his own name'. On the other hand 'when I go into discuss management matters with the Area Administrator he knows that I know as much as him'. Then he partially contradicted himself by saying that many senior administrators were more there by luck than by ability.

He has more contact with nursing staff than with admin and clerical. 'During the nursing auxiliaries induction week I get most of them in Nalگو'. With them the approach is different than with trained staff. 'I use charm and humour'. The appeal is 'less the professional advice and services that the union offers'. He lectures all student nurses on fire prevention and this also gives him an opportunity to recruit. Tutors are all Nalگو members from the Director of Nursing Education downwards. He talks to learners 'by informal

arrangement with the school'. He describes himself as 'probably the best-known figure in Wolverhampton Area Health Authority'. Because of his position as Fire Prevention Officer he has considerable mobility. 'I have more contact with every member of staff than any other member of the authority'. He also has similar recruitment arrangements in other authorities. Departmental reps deal with members problems at lunch hour.

He was very much in favour of deduction of contributions at source. 'In the past people built up arrears and dropped out more easily. When there is an increase in subs DOCAS people don't notice so much or don't lose the will to remain members'. As a result 'the departmental reps have time to deal with problems much more<sup>than</sup> in the past. There is not the same physical contact but it is easier to get reps. However some are used to the pocket money', (ie the percentage of members subs they receive). There were still about six members who insisted on paying their dues directly to the union. 'Maybe they don't want management to know'.

He talked a little about his union responsibilities. When people phone me up I say 'god not another piffling issue'. He claimed to take his responsibilities seriously. 'If

you do your job properly you establish a rapport with your colleagues'. He felt it was important to establish a sweet bargaining relationship with management. 'You catch more bees with sugar than vinegar. I know the people in management and whether you can get them by charm or a kick up the backside. You can settle most things by a quiet word with the head of department. There are two sides to every question. I won't defend an individual who is in the wrong, but usually there is enough in it to recommend leniency'. He is recognised as an important figure in the union. 'If I can't go further I go to London'. He started off the branch in 1968. The branch employs its own part time secretary who is employed by the Area Health Authority. She works from an office at home, her bedroom. 'There's no real problems about facilities'.

He is very active in the union nationally especially at Conference. He uses it to provoke replies from the platform. 'I have considerable contact with the press and I am a well known local magistrate'. He is a Tory trade unionist and one of the 'hanging and flogging' brigade. He is a member of the National Industrial Tribunal as a TUC nominee and is on the National Health Service National Staff Commission. From this he gets considerable information and has considerable authority.

He has, in his own words, 'vast experience'. He is extremely 'skilled at interpreting documents'. He is also good at singing his own praises, it appears.

He expects 60 new applications for membership by the next branch meeting. He describes 50 new members a month as 'a bad month'. He sees the role of the branch as giving the lead to the departmental representatives. Meetings are held in different hospitals throughout the area in rotation.



Interviews with Full-Time Officials of  
Nurses' Organisations.

Interview with Nick Grant, Research Officer, COHSE

When I visited, the union was in the middle of expansion. Nick's office was in a hut and the size of headquarters was being doubled. He talked of the pressure the union was under. It's resources were stretched in two directions: due to the enormous increase in membership and because of the complexity of tasks it faced (changes in the NHS, new labour legislation enquiries, etc.) It had to present evidence on this and that. Further, seeking to rival the professional associations in new fields also demanded they be on their toes. The union was seeking to use a computer to get more information on the membership. While it had to expand its officer and professional staff, in the meantime, it was seeking to draw on the experience and knowledge of the membership in the interim period.

He claimed that the NEC was not very well organised. It meets only quarterly. He described them as 'a lot of rotting fodder. They have not highly developed their decision-making functions'. The President (Vickerstaff, who has since died) dominates the NEC. However, there are signs of more determination from new members - who are getting through to COHSE's Regional Councils. Already some NEC members have been thrown off the NEC - in the North West and Newcastle (this has since also happened in the Midlands - how general

is it?) He said that 'the attitude of the NEC has changed considerably'. There were more officers, now - COHSE was becoming a dynamic organisation.

There is not now - as reported by Clegg and Chester - much arbitration in the NHS. COHSE still has ambitions towards being an industrial union - it has one consultant in membership! There is a heavy emphasis upon recruitment now. Regions have been given a limited period in which to submit plans of recruitment campaigns.

As a result of the Ancillary workers' strike in 1973 he claims 'we lost some - gained some'. My impression though is that they took a hammering in quite a few places.

However, he says that 'militancy makes for growth'.

Through the dispute the NEC refused requests (by Spanswick?) to end the dispute. Albert had been a nurse until 1959.

When the Enquiry was set up he put it to the NEC that they should end industrial action, but they refused. Albert did have some problems in the transition period taking over from Frank Lynch. (Before Lynch the General Secretary was Cliff Comer.... He was responsible for moving Headquarters from Manchester because he lived in the Banstead area).

The previous election had been in 1969 when membership had only just risen. Albert did act as General Secretary-elect for a year before Frank Lynch stepped down. Nick said that 'Albert was very loyal to Frank, who kept decisions to

himself. Albert is a better manager'. He believes that NUPE took no action in the nurses dispute because they did not have the membership among nurses that they claim, and it would have shown. However, that's only part of the story.

I asked why COHSE had not taken action on the private practice dispute. Nick said a motion got through conference opposed to all private practice in and out of the NHS. However, this did not imply a desire to take action. 'Private practice is often accepted as normal. We don't want to issue instructions to members when they're not interested'. COHSE was worried that any action taken would be 'localised and not unified'. It was 'a new area for unions'. It was easier in NUPE because 'they're officer dominated' ie members would obey instructions. 'It's more of a manual union. It has a different character'. In many hospitals, anyway, there weren't any pay beds. Action was being taken here and there, though, eg in Shotley Bridge (Newcastle - a centre of consultant action). It seems that COHSE's policy of militancy over pay and caution over pay beds - limiting action to political lobbying helped increase nursing members. I had heard that NUPE lost nurses as a result of the actions some members of their union took.

Day spent with Bob Loftus, COHSE Assistant Regional  
Secretary for the Midlands on 5 June, 1974

Bob showed me a clipping from the Daily Express for 5 June, 1974. This reported Charlie Donnett of the GMWU as hinting that NUPE and COHSE were mainly concerned with gaining membership. Donnett was quoted as saying 'it is disgusting to hear them screeching at each other like tarts fighting over the last of the big spenders'. The report also said that the Rcn would not back any members who were disciplined because they took industrial action. Bob and I were on our way to Bromsgrove to visit Barnsley Hall Hospital for mentally handicapped people. He had been called in on a disciplinary case of a pupil nurse who had been accused of hitting an elderly patient the previous Sunday. It was a fellow member of COHSE, a porter, who had reported the incident. The pupil nurse, who was male, had been called to management's office and faced with an inquisition. He was dismissed on the Monday and given twenty eight days notice. After he was dismissed he was told he could have had someone in with him and had a right of appeal. He admitted striking the patient. A doctor examined the patient and found no injuries.

On the way to the hospital Bob told me that Bill Griffiths of NUPE had previously been a COHSE officer twenty eight years ago. However he had quarrelled with the union's finance officer, who was Bob Farthing. He went over to NUPE and took a lot of ambulance men with him. Bob said that if he had stayed in COHSE he would have most likely have been General Secretary by now.

This kind of disciplinary case is one in which the regional officers are called in to deal. I was allowed to attend the interview which Bob had with the member. The Branch Secretary was also present. He was appealing to the AHA. However, he had been told that if he appealed or went to the union, management would call in the police. He had received a letter which stated 'if you wish to appeal against this decision, please let me have your appeal, in writing, as soon as possible and I will put it before the DNO for her consideration'. Bob pointed out that they had followed the wrong procedure. The nurse should have been suspended pending an inquiry for seven days, and the receiving of statements for witnesses. If it was a police matter the police should have been called in straight away.

There were many mitigating circumstances. There were only four staff on the ward and the pupil was under considerable pressure. It was a 35 bed ward of psycho-geriatric patients. The member was told by Bob not to make any statement. There was only one statement made by the porter. The nurse accused had not seen the statement. Bob said that the union would insist on seeing the statement and he was told not to sign anything. Bob also wrote out a letter of appeal for the nurse. He told him that there was a fifty-fifty chance that his appeal would be successful. (Bob later told me that it was).

In the car, Bob told me that discipline problems only form about 1% of the cases dealt with by the region. There were about 6 or 7 a year. However, he felt that he was 'dealing with the tip of the iceberg of serious problems' as a union officer. His most time-consuming job was dealing with bonus schemes for ancillary workers. After that, industrial injuries and appeal hearings, of which he did two a month, were most important. 90% of these, he said, were back injuries amongst nurses and sometimes domestics or porters. A few of the cases were assaults on staff.

One or two of the cases involved the GNC. He mentioned one, who was a male nurse, who took a vaginal swab from a patient when she had complained of vaginal pain. In the morning she said she was alright and he threw the swab away. Questions were asked later and the male nurse was accused and later dismissed. He was disciplined by the GNC and accused of (a) sexual assault and (b) lack of professional judgement for not having taken a chaperone with him. He was found not guilty under (a) but nevertheless crossed off the Nurses Register for (b). In the Barnsley Hall case, Bob said that the porter who made the accusation, the member accused, and the Principal Nursing Officer were all members of COHSE. How then does he sort out things in such circumstances? 'I take the view that the member accused is the most important and to hell with everyone else'.

We were on our way to Dean Hill Hospital at Ross-on-Wye, a small mental handicap hospital with 95% membership in COHSE. This was in the middle of the 1974 Pay Dispute. A skeleton staff was being left on the wards while there was a one-hour walkout. There were no problems with the SNO. Some 50 staff work at the hospital although only about 14 were on the demonstration. Some nurses were apparently reluctant to parade through the streets. It was a very dignified procession in fine weather. When



Bob arrived he was treated as a celebrity. The local vicar was also in attendance. It was not like other rowdy nurses demonstrations that I have attended. One male nurse carried a sign saying 'give us this day our daily bread'. The demonstration set off to march round the streets of the small country town. It was slowed down by a male nurse at the back with a bad foot and a limp. Those nurses whom I talked to said that they were doing it to support the union. 'We only demonstrate with great reluctance'. Three or four of them had dual membership between COHSE and the Rcn. These were mostly the senior grades. Some of the male nurses told me that they took other jobs in their spare time. The senior staff were backing the demonstration and the Deputy Chief Male Nurse was on the demonstration. It was as much a show of union loyalty as anything.

Bob claimed in the car, that about 100 wards were closed in the country. If you work on an average of 30 beds a ward that's about 3,000 beds closed as a result of the dispute. He also felt that the number was likely to be 60/40 in favour of psychiatric beds. I asked whether there had been many threats of victimisation in the dispute. Apparently a consultant at All Saints Psychiatric Hospital, Birmingham had told the local COHSE executive

member that any nurses on his wards taking industrial action would be reported to the GNC. There was a meeting of the staff at the hospital at 11.00 am and on the 5 June they threatened a strike if any member was intimidated. At Dudley Road General Hospital, the ancillary workers supported the nurses because they had received support during their strike. The situation was the opposite at the Birmingham General Hospital. In the ancillary workers dispute 'nursing staff literally threw cold water on their efforts'. Bob claimed that the Rcn kept people on its books for a considerable length of time after they had lapsed in membership. He said that he had left the Rcn in 1964 yet still received communications from them.

Although most of the demonstrations have been by day staff, there have been some activities by night staff. There was one midnight demonstration to Longbridge from Northfield Psychiatric Hospital by the night staff, in pouring rain. They were threatened by police for shouting slogans late at night. There were some twenty of them.

Another demonstration I attended with Bob was at Leamington Spa on 6 June. It departed at midday from the Royal Midlands Counties Home. There were representatives from all the hospitals in the area, psychiatric and general.

There were representatives from NUPE, COHSE, and the Rcn. A report by the Runnymede Trust by Simon Jenkins in the 1960s called 'Here to live: a Study of Race Relations in an English Town' has a section which deals with Leamington Spa hospital. It reports that the hospitals in the area 'lean really heavily on immigrant labour'. Yet in the Autumn of 1970 there was no coloured doctor in the Warneford Hospital, even though approximately one third of the nurses were from overseas. Most were **young** West Indian ~~women~~ who were recruited direct from the West Indies. (West Indian nurses were very evident on the demonstration I attended). It also reported '20% of cleaners are Indian women who started to take jobs when, in the words of a superintendent, "the Italians and Spaniards just weren't coming forward any more"'.

Interview with Bob Loftus and Ted Hassle of COHSE  
West Midlands Office, 9 April, 1975

I later accompanied Bob Loftus on a visit to St Wulstan's Psychiatric Hospital which is threatened with closure. It nestles in just below the Malvern hills. It is a rather unusual place. The whole emphasis is on 'rehabilitation'. The place is run as a factory with patients clocking on and off and the nurses act as foremen. The place has bit contracts with outside firms and does CSSD work. The place is completely industrialised and patients are psychiatric and mental handicap. The Regional Planning Committee wanted it to be closed down. The West Midlands RHA had a policy at that time of picking off a number of small hospitals. High View Hospital at Exhall was another at the same time. The local MP, Michael Spicer, had raised St. Wulstans in the House.

On the way Bob gave me a few snippets of information. Since the dispute of 1974 COHSE had been having monthly meetings with officials of the DHSS. Increasing numbers of women members were getting to Regional Council and onto the Regional Executive. There was a 14 person executive of which 2 were now women.

Ted Hassle is the new Regional Secretary of COHSE, replacing Geoff Baxter. He is an ex-telephonist at Stoke who entered the NHS in 1945. He complained that the growth of big hospitals had brought an 'impersonal' atmosphere in the health service. He complained that there were not 'real negotiations' at local level in the NHS as there were in Local Authorities.

These contrasts were being highlighted by the fact that ambulancemen were coming into the NHS with widely differing pay and conditions and the Ambulancemens' Council was having a difficult job getting a national pay structure established. In Birmingham they had got a £5 expenses allowance which was not allowed nationally. It was the way they had got round incomes policy in the past. Other local authorities had been stricter. Arising from the McCarthy report on ambulance work, Heath had intervened in the Council and prevented an agreement being struck. They had to go back to the Green Book to see 'what could be wrung out of it'. Similarly with standby allowance. In 1948 Ambulancemen had gone into LAS and stayed there till 1974. The restrictions on them that follow membership of the NHS bargaining structure were making them increasingly frustrated.

Ted spoke a little of developments in Consultation since 1974. In the absence of guidance from above, AHAs were going their own way. In Lincoln they were setting up a two-tier system of general and sectional meetings, based on the Whitley distinction at national level between functional and general Councils. He was himself in favour of a single annual pay round in the NHS, instead of at several times in the year. This would 'simplify the system'. (At that time McCarthy was carrying out a review of the system). Birmingham's response had been to set up a 'Staff Panel' with Bill Griffiths as Chairman. COHSE, NUPE and Nalgo claimed 2 seats a piece, while there was 1 between the RCM and Rcn and 1 for the rest. Ted felt that 'JCCs failed in the past because too many grades were represented on one Committee'. By no means all areas in the Region had yet set up Committees. A circular had been due from the General Council on Joint Consultation - then postponed from December 1973 to June 1975. Ted passed the general remark that 'a good Branch Secretary, is one who knows everything and is easy to find'.

Bob felt the Industrial Relations Act had been very important in hospitals. Even though it was bad, 'certain parts were good'. (1) Industrial tribunals were an outside body which unions could use. (2) The Industrial Relations Code gave unions a lever. 'You could go to an authority and

quote it at them'. It wasn't needed now because 'it had created a dynamic'. However, 'industrial relations is an atmosphere, and environment and people. Both sides have got to create it not the Government'.

Ted felt that 'it's been easier for full-time officers to settle matters since then'. He talked a little about industrial action. 'A full-time officer tries to be nowhere near action when it takes place. Sometimes the idea of a hostile rank and file is laid on for management. Minor things put together can set things off'. Full-time officers are not always in control of such situations. 'When a crowd of domestics walks out it can be a hairy situation. If women decide on strike action they can be far more militant than any men'.

Bob Loftus agreed with this sentiment. 'That's why the nurses' campaign was so successful, because the women became more militant'. Ted felt that this made it sometimes difficult to control them. 'They get more emotional. Men usually accept the imposition of rules. Women don't - it's either right or its wrong. They're not interested in the rules. Men will abide by the rulebook. Mental nurses (ie men) are militant in the context of what they can do.

They're militants who know the rules. They're pushed from the back by militants who don't know the rules'. Bob said that men and women had different attitudes about pay packets. 'Men look at it as something to be divided up. A woman looks at it in terms of the fact that she's now paying 80p for some steak. She thinks of items rather than the total. The housewife and the student nurse are worried about the price of tights. They don't give a damn about the Whitley Council'. Most, however, join the union for 'protection'. Ken thought that women hadn't created a dynamic for making complaints. It depended on having someone (presumably a male branch secretary) 'who knows about things'.

Bob said: 'The silent majority are only silent because they're uninformed, until they know the truth'. Bob also said (as an Irishman): 'The English are basically Conservative. They tend to go for the status quo until they have to stand up and be counted? (This was at the time of the EEC referendum and Bob predicted that people would vote to stay in because of Conservatism, just as they would have voted to stay out, for the same reason).



Bob felt that what COHSE did at that time 'reflected the will of nurses. It was the right man, doing the right thing at the right time. Albert (Spanswick) stuck his neck out, uncertain of the support he would get. He didn't expect such a massive response'. For its first 60 years COHSE had a minority of nurses. 'Now it has become the leader and overtaken the Rcn. But we don't want recruitment for its own sake, but only to provide services. We weren't opportunistic in 1974. The membership did it'.

He talked of the Birmingham COHSE demo when parts of the demo wanted to go different ways. 'The officials wanted to go via the route agreed with the police. The membership were worried that they were sending them via the back streets. The members wanted to disrupt the traffic'. Ken thought that this was due to the militancy of the women and the fact that they're less bound by procedures. 'Men use orthodox channels' he said. (Certainly when I remember the marches I attended - it was always the women who led the chanting).

In the long run, the fact that COHSE had more nurses in training than the Rcn, would have considerable consequences.

'Most of the new conditions are due to COHSE' claimed Bob and he mentioned special duty payments, overtime payments, even though 'COHSE has never ignored the professional side'. He felt that there were changes in the Rcn on the professional front towards managerialism. 'In the past the Rcn has been dominated by its educational side. In the past Matrons had to have College Certificates. Now they have to have Management Certificates which are organised separate from the Rcn'.

Within the year 9 new branches had been formed in the Region. The numbers in the Regional Branch (ie individuals at hospitals with no branch or members of the hierarchy) had been 200 the previous year, but had now declined to only 21. Between 1974 and 1975 COHSE put on some 10,000 new members in the West Midlands Region alone.

Interview with Tony Nicholls and Bill Griffiths,  
NUPE Officers at Birmingham

I talked first to Tony. I had had some trouble getting in contact with him. His secretary acts as a buffer between him and the outside world. He gave me his home telephone number saying that I should use it if I wanted to get in touch with him. He talked a little of the problems in getting the regional JCC set up. The Chairman of it is to be Bill Griffiths. Nalگو wanted the thing to be based upon representatives for each grade. This would of course give Nalگو more members than any other union because it had the widest spread of membership. NUPE has massive membership among ancillaries but it is largely focussed upon them so that it could loose out in any constitution based on those criteria. He repeated what virtually every experienced activist in the NHS knows: that JCCs are not respected by the membership, because management manipulated them. 'People prefer to take up things with their steward'.

He stated that it was very difficult to remain in touch with the nurse membership. 'The turnover amongst them is huge because many marry. Many work part time. Many are black workers with very low morale. 60% of NUPE's membership are part time. It is only really deduction at

source which has helped to boost nursing membership'. We talked a little about the special officer that NUPE had appointed for nurses. He emphasised that she was not a National Nursing Officer but simply a Recruiting Officer. She was used simply to address meetings on nurses and get people into the union. She had a very specialised function. 'She was reputed to be quite good'. She was an area officer and came from Wales. However, she had domestic problems and had to give the job up. He stated that the nursing membership wanted the newsheet that NUPE produced called News for the Working Nurse to be permanently available. However he reported that 'this would set a precedent for other grades'.

At this point Bill Griffiths, the Chairman of the Staff side of the Nurses and Midwives Whitley Council, and Chief Regional Official in the West Midlands, walked in and sat down. He told me about a survey by the Whitley Council of the Nursing membership in 1963 which indicated that the Rcn had 50 to 60,000 members, and that there were some 38,000 in COHSE, and other unions. The HVA and the RCM, however, were able to achieve a higher density amongst their recruiting field. In 1971 the Briggs committee conducted an investigation (Bill was on that committee). It found that one in two nurses were in membership of some organisation in hospitals.

However two out of three community nurses were members of an organisation. Since that date a much higher density of hospital nursing membership had been achieved. He cast doubt on the Whitley Survey of 1963, stating that the figures were then 'probably inflated'. Perhaps by some 6,000 or so. He felt that there were still dividing lines between the Colleges and the trade unions. He criticised trade unions: 'They have not taken any great interest in professional aspects, procedures and education'.

Bill was very pro-Briggs. He reported that Briggs had recommended central funding for the implementation of the report but Barbara Castle was against it. He felt that the recommendations would relieve staffing problems in psychiatric and mental handicap fields'. He reported that on the Whitley Council NUPE is no more anxious than the Rcn to increase the number of seats allocated to COHSE. 'The number of seats is not important except for prestige'. There is a negotiating committee which consisted of one from each of the organisations which is 'very effective'. I got the impression that Bill Griffiths has enormous respect for the senior people in the Rcn.

Bill is also alarmed at the tendency for industrial action to increase. 'I go to first line management courses and find a surprising degree of aggressiveness with respect

to industrial action. It is no longer felt to be evil. Nurses had seen the hypocrisy of the medical profession in condemning ancillaries in 1973, and now Consultants are doing the same thing'. (The first line management courses he speaks of are those given to ward sisters and charge nurses). He spoke approvingly of the great increase in steward education that was being sponsored by the West Midlands RHA. 'This was a rarity five years ago, now fifty per cent of regions are doing it. We can now talk about industrial action. It is no longer a frightening thing'. He felt that 'the College are going through a revolution. There have been big changes since Goddard left and Hall took over. They are much broader minded now. They have seen the light'. He clearly sympathised with many of the views of the Rcn. He stated that 'nurses have a 24 hour responsibility. If industrial action takes place they are saddled with it. This has caused bad feeling where nurses have been called black-legs'.

Bill was very keen to increase the in-service training of nursing auxiliaries and claimed this was 'not dilution of labour'. Career prospects are very limited for them.

Briggs would encourage them to take training without loss of pay. The problem is that many of them are of a mature age. They want facilities over a longer period of time, or

part time, or courses which exclude school holidays'. Many of them have come out of the Ward Orderly grades which were governed by the Ancillary Staffs Council. They therefore feel a closer link with ancillary workers.

'Many stay as Ward Orderlies because with their pay and special payments they are better off. When nursing auxiliaries were introduced, many Ward Orderlies were encouraged to become "nurses". They swopped over until they picked up their first wage packet. Then they clamoured to come back as Ward Orderlies'. He felt that Briggs would have more to offer them because the Certificate level would not be so high to aim at. The present entry requirements are very stiff and Briggs wanted them to be more flexible. 'There is a need to offer them the chance to take training. Many of them have a wealth of experience'. He said that there had been a 'big fight with the hierarchy' over the Report, who wanted two streams based on different ability at entry. They threatened a minority report and Bill claimed that he was very central in determining the unified recommendations of the Report.

On the whole he was in favour of the Salmon Report which he described as 'very necessary' because it was 'based on nursing management by nurses. It could be argued that this should be done by somebody else. This would be fatal'.

However, the problem was that 'it didn't create a career structure on the clinical side. It stole some of the best nurses from clinical areas. To get more money they had to go into administration'. He wanted to develop the consultant role of ward sisters. He felt that the borderlines between medicine and nursing were especially hazy in areas such as intensive care, and cardiac care units.

He felt that community nurses were a different breed from other nurses. 'They work as individuals and this is one of the attractions'. He was in favour of them being attached to group practices because they then might become part of a multi-disciplinary team. 'It is difficult to make contact with them. To get them into unions you have to pick them up early in the hospital'. Briggs could change things in this respect leading to more movement between the hospital and the community. This had happened in midwifery already. 'It will make it easier for them to join unions as they come into the hospital, and as nurses go out'. The integration of services will increase the possibilities of organising them. There has to be a rapid increase in community nurses and this can only be achieved by the community drawing on the services of the hospital nurses much more.



Interview with Miss Cowie of Rcn Labour Relations  
Department

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At the time of this interview, in 1975, Miss Cowie was Betty Newstead's deputy. She succeeded her, when Betty retired, not long afterwards. She thus became the head of the Rcn's 'Labour Relations' activities.

She claimed that the Rcn had already decided to implement a steward scheme at the time of the 1971 Industrial Relations Act, even though the latter, and registration, 'speeded it up'. The Rcn had previously passed a resolution in favour of 'an obvious College presence at local level'. The previous system was the appointment of someone known as a "key member", who had no formal training. Their main responsibility appears to have been putting up Rcn notices sent out from HQ. That is, they acted pretty much as communication agents of the centre, with very little role in the localities. The reorganisation of this system was undertaken jointly by the Labour Relations Department and the Rcn's Area Officers (of whom there were 6, plus one each for Scotland, Northern Ireland and Wales). She wanted them to be:

- elected
- trained
- to be no higher than ward sisters.

She saw their functions as threefold:

- recruitment
- public relations
- representative.

She stated them to me in that order (in both cases).

Perhaps it indicates some rank order.

The Rcn's course for stewards lasts for 2 days. On the first day they are told about the College, they receive a 'run down' about the organisations on the Whitley Council. They are taught how to 'solve problems', and of 'ways of appealing to the membership'. On the second day, there is more discussion of the details of Whitleyism. The advantages of being a member of a staff side organisation is emphasised, and they go through the handbook. They talk also about grievance procedure, even though she finds that not all of them are convinced of the need for such machinery. Cases of negligence are also discussed. Although the Rcn has its own courses, it encourages stewards to attend day release courses in technical colleges.

Branches - at that time, it has subsequently changed - were centred on a geographical area, and cover all nurses in the different fields. Stewards, however, were not

accountable to Branches. Although I did not ask (I must do when I go back) this must be because Branches are often dominated by senior people. They work directly to Area Organisers, and they are also accountable to their workplace constituency. As indicated, there is an election procedure. The former 'key members' often used to be senior, eg a hospital matron, so these are ineligible. (However I know of cases where Nursing Officers are acting as stewards). Turnover of staff, especially in London, often makes it difficult to recruit stewards. Managerial grades problems are dealt with separately. As Miss Cowie said, 'SNOs wouldn't like their problems to be dealt with by an SEN'. She also said, 'the use of the word "steward" raised a few eyebrows'. There was a debate inside the Rcn about the appropriate name. 'Representatives' was thought inappropriate, because this is what delegates to local conferences were called. At the time, 'some members didn't want the Rcn to undertake such work, although there is little opposition now'.

She seemed quite happy about the way the steward scheme was working in hospitals, but felt 'in the community it is a lot more difficult'. The problems are often to do with pay and conditions, and malpractice or negligence, whereas

in hospitals, 'interstaff problems' are more common. On pay, this was because before reorganisation, there was more variation in community nurses' pay. They might be paid on NMC scales or the Local Authorities NJC (APT&C). There were thus wide disparities, eg between neighbouring London Boroughs. When reorganisation brought community services into an integrated NHS, 'the nurses met together, the anomalies became known and this caused great dissatisfaction.' On malpractice, community nurses feel insecure: 'there are no witnesses so it is very difficult'.

I asked which were the most and least active groups in the Rcn. Without hesitation, she said students were the most active, often organising around regulations in the nurses' home, but also generally in the Rcn. The least active were ward sisters and staff nurses. They were also difficult to recruit and she was at a loss to know why. She felt that perhaps they were dispersed through the hospital. Students formed 'a unit'. There was a noticeable drop-off in membership among students when they completed their training. They often failed to transfer to full membership. (Perhaps expense has something to do with it. I think also that many move their place of location on completion of training. In any case they leave the student collectivity which

cemented membership. In psychiatric hospitals, however, students make a permanent not a temporary commitment to unions, because they don't have a student category. Don't forget also the importance of union access to check-off).

The Rcn is very much, in Turner's terms, a 'closed' organisation. However, over the years it has gradually opened the doors a little wider. It let male nurses in from 1961, student nurses in 1968 and SENs in 1970.

Nursing auxiliaries are still excluded. However, all these groups - including the last - have had their own organisations which have expressly had the desire to be members of the Rcn. In fact they could largely be regarded as satellites of them. Once they gained acceptance they often attained the status of specialist sections within the Rcn. However, there has never been a male nurses section within the Rcn, and the SEN Section, Miss Cowie said, was 'crumbling' because its members could join other sections.

She explained the greater activity of students as due to their special status and problems. They also have many collective problems. She liked there to be, if possible, in each hospital, one steward each for students

and trained staff. However if only one steward was possible, she preferred that it be a trained member of staff. Once again, the idea that representatives can act for people above their own hierarchical situation, is a repellant one for members of professional organisations, (and is not necessarily fully accepted within unions).

The militancy on pay was symptomatic of some deeper discontents, and this was especially true at senior levels. She saw trade union and professional functions as complementary: 'If conditions are better so are professional standards. The Rcn was always concerned with pay and conditions. But in the past it meant emancipation for women to do nursing', and they tolerated inferior conditions as a result. However, there was more to it than that. 'This was in the past, when hospitals weren't governed by the State so resources were very limited'. Even immediately after the creation of the NHS opportunities were very limited. She complained that in the past many nurses were 'labelled as troublemakers for claiming their rights under Whitley', ie nationally negotiated rates and allowances.

Interview with Mrs Gibbs in 1975 - Area Organiser of  
Rcn for Birmingham

Mrs Gibbs has the air of someone who has had industrial relations functions thrust upon her, and was unclear about what they might entail. She seemed to be in her 50s and not far off retirement. She seemed to be hazy about the structure of Whitleyism.

She put the membership problem of the Rcn down to the fact that student nurses fail to join the Rcn permanently once they complete training. Two factors were important. The cost was prohibitive, and many went off to do their midwifery training. As to which organisation nurses joined, she believed it was 'often a case of who gets there first. The majority of schools let trade unions in to talk to nurses'. (I doubt that). She complained that 'a lot of union officials are not nurses but porters and this creates problems' - something commonly stated to me by cadres of professional associations.

She emphasised how militant community nurses were becoming as a result of reorganisation. Because of the equalisation of conditions that was occurring, some were gaining while others losing. However, mileage allowances were generally poorer in the NHS. They really penalise district nurses and standards would fall if they used the buses. 'They

were given £20 but this made them more angry'. Some local authorities gave nurses cars and others provided a low interest loan. It is an interesting commentary on the NHS that a transfer to it led to a deterioration of conditions.

She felt that there had been some increase in membership lately, but wasn't sure where it came from. 'Possibly many are trained staff'. She agreed that the image of the Rcn: 'old ladies in flowery hats', was not a good one. 'The media are not interested in us. The membership say the Rcn doesn't project itself enough'. One place where the Rcn have made gains is at Highcroft Hospital. Since the strike, a new branch had been formed there by disgruntled nurses and it already had 31 members. However, she did say that the Rcn had come under considerable pressure to be more militant over pay, particularly from the Birmingham and Manchester areas, was her impression. It was also often from men, and she felt that the massive rates increases in the Midland area may have added fuel to this pressure. None were asking for strike action, but apart from calls for marches, there were some calls to take industrial action, such as bans on 'non-nursing duties'



and a paperwork strike (such as refusing to fill in the daily statistical returns made from the wards). The College could not contemplate taking industrial action where students were concerned. If they lost more than 21 days out of their 3 year training, they are supposed to make it up, under GNC regulations. There was a lot of unrest in the NHS, she agreed, but by no means was it restricted to pay. 'A lot of unrest is due to one word: "change"'.

As far as Salmon was concerned, she felt that the Nursing Officer was the "weak point - not the grade but the people who fill them". She also decried the tendency towards larger hospitals. 'In a smaller hospital there are more close relations between all staff'. She didn't believe that senior staff knew how to deal with personnel matters. She would like to see more 'counselling'.

She emphasised how the Rcn was also an educational body, receiving funds from the DHSS and the DES. It does its own tutor course, and only the Rcn offers an occupational health certificate (though it is not mandatory for practising in this field). You don't have to be a member of the Rcn to attend these courses, but you get a reduction

if you do. This applies also to many of the Conferences on nursing practice. (This could be said to encourage a certain instrumentality. I know of at least two cases where nurses have said to me they joined the Rcn in order to take courses more easily).

Finally, she believed that Salmon had led to 'people at the top becoming apprehensive because their juniors know so much', something which other nurses have also said to me.

First Interview with Peter Mellor, Rcn, Birmingham  
20 February, 1975

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We talked first of the code on patient violence. Peter said that COHSE had wanted to become part of the Liaison Committee on Patient Violence. There seems to be some mystery why they aren't on it. He believed very much in professionalism. In mental handicap people are defining their own occupations. Doctors could disappear. He felt that it could be the first area of nursing to truly professionalize. He referred to the behaviour therapy at the Maudsley Hospital. The patients were referred by the psychiatrists but the nurse decided the course of treatment. But, I asked, would they still be nurses? He replied that they could be part of a 'new caring profession' the core of which would be nurses. It would also be based on a statutory qualification. Briggs was flexible in that it kept three separate trainings. The Rcn had called for a new national committee on mental handicap. It disagreed with the split between Social Services and Health that had occurred since reorganisation. Social workers could be included in management teams with an equal power with doctors.

He talked of the reorganisation in the Rcn and the resistance to change. The Tavistock Report was not seen as truly independent. However, the Rcn was growing. He claimed (rather doubtfully I think) that the majority of learners in psychiatric hospitals were in the Rcn. They were less successful than COHSE in getting in qualified staff. Subs were less now than COHSE's, taken over the year. Because of the College's Royal Charter there was a need for a more complicated membership form and they didn't yet have deduction at source. At Highcroft Hospital a new Rcn branch had been set up as a result of the dispute, formed out of nurses who were opposed to the unions strike action. The Area Group Secretary of the Highcroft Hospital Rcn branch is Mr A Williams who is a Nursing Officer. He also claimed that there were some Rcn membership in the Special Hospitals. George Moss the PNO (T) was in the Rcn because Rampton was a training school. Peter, who is a psychiatric nurse, claimed that in some ways psychiatric nursing was more professional than general nursing because it had qualifications initiated by doctors, long before other branches of nursing. However, there was, of course, a large proportion of untrained nurses in psychiatric hospitals. In 1972 the DHSS had issued a paper on staffing standards to be achieved by 1974. The supposed standard is one nurse to three patients. In hospitals with training

schools it is presumed that 40% auxiliary nurses are acceptable. In hospitals without training schools this can be as high as 60%. These figures exclude those nurses in administration, including only those on the wards. He wondered if the Briggs Report would attract more trained personnel. He believed that hospitals take the easy way out by employing more auxiliaries and don't try to make the training more attractive.

He talked about relationships with occupational therapists who were 'taking over nursing roles' especially as these were expanding in areas like psychodrama. Nurses had always done these things informally. In general however 'the major problem is the nurse-doctor problem'. It is the doctor who initiates the expansion of Occupational Therapy rather than creating a more expanded role for nurses. He said 'there is a lack of appreciation of doctors by nurses'. He expressed the division of labour between doctors and nurses in psychiatric hospital as follows: 'nurses are involved in the public lives of patients and doctors in the private lives of patients'. He believed that nursing had a distinct identity and that it was related to the general affairs of patients. 'Nurses are not just mini-doctors. If this is not recognised then

doctors will jealously guard their prerogatives'. He did not believe in there being 'strictly medical or nursing decisions but multi-disciplinary decisions'. He spoke of the decline of the medical superintendent at these hospitals. 'People had to go to him sometimes to ask for permission to marry'. The power of the psychiatrist was very great in law and it depended on how different psychiatrists interpreted their role. He spoke of the need to erode old relationships. Nurses were more than reporters back, they needed to carry out things as well.

It was difficult at the moment to recruit men to psychiatric nursing. However increasing unemployment may mean increased recruitment. They have always been there, but only recently on mixed wards. His impression was that of the female nurses in psychiatric hospitals, a greater proportion of them were married than in the general field. This tended to limit their mobility. Female applicants weren't forthcoming for senior posts. With the ending of the divided male and female hierarchies came an increased professional status for men. He felt that since reorganisation the administrative nurses in the psychiatric field were much more in contact with clinical practice and policy decisions

than in the general field, where the PNO is a specialised administrator because of highly specialised nursing functions. He felt there was less social distance generally in the psychiatric hospitals and so closer relationships formed between staff of different levels. He claimed that legislation to implement Briggs was just around the corner. This did not appear until 1979, so it was a very long corner, stretching from 1975. It would be interesting to do some research on these delays.

Second Interview with Peter Mellor of the Rcn Birmingham,  
8 May, 1975

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We talked first of the new personnel posts in nursing since the 1974 reorganisation. The Nursing and Midwives Council is, he says, apparently willing to have the posts open to non nurses, but lay administrators are the most worried about outside competition. Nurses were quite keen that people from the Polytechnics, the GNC and the DHSS should come in, though at present they are excluded. Peter felt that many of the new personnel jobs might be 'sterile' especially at area level. The people filling them have little experience even though courses are being run in various places. There are essentially two problems. The first is that nurse managers do not accept them often and secondly, the personnel departments have no defined place. The district administrators accept them even less. Because it is being said that there is one tier too many. District administrators are 'fighting to establish themselves and defending the territory they have got'. Thus the fear of job security is at the moment affecting personnel functions at the moment particularly. Many are not very much concerned with industrial relations. Some of them at area level are setting up JSCCs. However they are 'involved



in the mechanics of setting them up'. Not many of them are actually taking decisions in this sphere.

We talked next of the Tavistock Report on the Rcn.

Peter said that the aim was 'how to affect the situation of the quality of the job'. In the past the Rcn rep. came from management, largely matrons, 'and spread downwards to the clinical nurse'. He stated that there was very little that the Rcn could do if they were faced with 'one dogmatic member such as an area nursing officer'. In saying this he had a particular case in mind. He believes he is entitled to mediate 'to see that the College fulfills its objectives'. However he tends to intervene in an informal rather than a formal fashion.

The obvious tendency is for the Centres (proposed by the Tavistock Report) to be established at district levels. However, in some rural areas, like Lincolnshire, this is a very large unit and makes communication difficult. However if an issue covers more than one Centre, they are getting together on it.

Peter felt that stewards' authority was fairly clearly defined. For example, in defining 'at what stage an issue should be passed over to a College Officer'. However, in addition to using their steward any individual members of the Rcn can apparently approach the Council. Therefore

individuals did not necessarily have to go through the Rcn's regional officers. However, 'HQ' now passes many things back. They only deal with legal matters and things like that. Nowadays however many more problems come direct to the Area Officer. Comparing the Rcn and trade unions he said 'there is no difference in labour relations already. The difference is in professional matters'. (Again I thought this to be an exaggeration, though a real convergence seems to have taken place). He claimed that the reorganisation of the Rcn was being speeded up and the financial crisis which the Rcn was facing would speed up the decentralisation of the organisation. He felt that the most influential person in bringing about the changes was Betty Newstead. He felt 'she has been more influential perhaps in the changes than Catherine Hall'. Mrs Gibbs intervened in the conversation and added that there had been a 'wind of change from the membership'. In the last 10 years there had been much more changeover of staff than in the Rcn. She felt that 'much of this has been brought about by men members. The Rcn is no longer an organisation of old ladies in flowery hats'. However it was not really a question of broad changes in the membership but of more active individuals coming along. 'Nurses are right of centre, but are rapidly moving towards the centre'. She felt that if the private practice affair

had really spread, the majority of nurses would have sided with the consultants 'out of loyalty to them rather than the background issues'.

Because of the centrality of the Students Section in the Rcn, it faces a greater problem of membership turnover than unions. Peter described the Student Section as 'a separate body who see membership of the Student Section as different from membership of the Rcn'. They have to fill in a new form to become full members of the college.

Peter felt that nurses would eventually win equal status with doctors and this was his objective. However he felt that it was in the psychiatric and mental handicap fields that the most changes in the traditional relationships between patients and doctors would come. 'It will come there first and spread to other parts of nursing later. In mental handicap the role of nurses is questioned, but that of doctors even more so'. I asked whether he believed that the health service ought to make it easier for nurses to become doctors. He felt that the problem was that this would be taking experienced nurses out of the service. He thought that some medical schools discriminated against nurses for that reason.

Interview with Steve Johnson, National Health Officer  
in Nalgo, 28 May, 1975

Steve is one of three organisers for Health and Staff and works under Audrey Prime. He works on the Nurses and Midwives and Professional and Technical 'A' Whitley Councils. A lot of his work involves individual appeals. Lots of things that affect nurses comes from the General Council which Nalgo is strong on: London weighting etc. Nalgo once held the chair of the Nurses and Midwives Council and its influence in the nursing field depends on the general prestige and size of the union. He talked of the recent dispute concerning TB visitors which the Labour Government had refused to allow to be referred to ACAS. He had argued for a Special Conference embracing all the organisations concerned but with little success.

He claimed that there was little polarization on the Nurses and Midwives Council these days. He complained that the TUC unions did not give the support expected for a minimum wage. NUPE holds back, he says. It is NUPE's policy that there should be a 35 hours week for nurses, yet NUPE has not pushed for a reduction of hours. The Nurses and Midwives Council as a whole does not, of course, negotiate nurses pay. It is devolved to a negotiating committee of 10. This consists of one each

from the ASHM, COHSE, HVA, Nalgo, GMWU-7 NUPE, RCM, and three from the Rcn. Steve said that Nalgo often got more help from organisations like the RCM and the HVA than other unions. As a white collar union it was more concerned with 'comparisons' than 'differentials'. He claimed that Nalgo was more the 'maverick union' on the Whitley Council than COHSE. He stated that Nalgo didn't like 'the recent claim let alone the settlement'. Nalgo had wanted new threshold agreements (ie automatic inflation agreements) but the Council had agreed with management side simply to monitor the Retail Price Index. He complained that it was not Whitleyism but the inertia from the unions on the staff side. The GMWU say nothing. COHSE and NUPE have influence but COHSE 'is not the militant nurses union it likes to appear in public'. He believed that Nalgo were more insistent on the Council. He said that the Staff Side had prepared a claim for Halsbury that was thrown back. Nalgo put 64 amendments of which two or three got through. However all organisations then put their separate evidence to the committee. When the next claim after Halsbury came around, Nalgo said that it should be 30% on consolidated thresholds and reductions in hours. It wasn't COHSE's claim, it was drafted by the Rcn, he said. He believed that the unions on the NMC should at least cooperate on the lines of TUC policy.

On the redistribution of seats he stated that Nalgo was opposed to COHSE's claim for more seats. He claimed that influence on the Council was due to more than mere numbers. Nalgo's seats had been cut down in 1963. He again emphasised the greater unity of the professional organisations in comparison to the unions. The professional organisations on the NMC caucus together but the unions do not. The basis exists for it with the TUC Health Services Committee of which Nalgo holds the chairpersonship. Nalgo is strongly represented among TB visitors, blood-donor attendants, health visitors and community nurses. As far as its nursing membership is concerned there is not much in the psychiatric sector although quite a large presence in the community. He put this down to members who 'wanted to take a half step away from the Rcn.' However Nalgo had lost some members because of its strong opposition to private practice. It was Nalgo's resolution to the TUC in 1973 which had been adopted.

He complained that the media do not notice Nalgo. Industrial action can be taken without a ballot but it has to be approved by an Emergency Committee of the National Executive. Their policy is to pay full strike pay. He believed that industrial action was necessary to 'prevent a decline in the service'. He cited as an example the recent dispute over TB visitors. He believed that the present consultants action over contracts would change

attitudes in the Health Service. With doctors taking industrial action the barriers against other staff doing so would be lowered.

He referred again to the attempt to call a national Staff Side meeting of all affected TB nurses. This would amount to some 1200 nurses. The Rcn said no, as did the other professional associations, because they were frightened that it might lead to a call for industrial action. Nalgo was therefore left with no option but to call a meeting of its own members on the question.

He next referred to the ban on working with agency nurses, saying that it posed a number of dilemmas. At King's College Hospital, nurses had refused to work with agency nurses and this had led to wards being closed (see Case Study of Kings College, Nalgo).

He was deeply worried about the decline in the Health Service. He felt that there were two threats to the central funding of the Health Service. The first was the future possibility of regional funding and devolution. The second were the harmonisation objectives of EEC membership which implied an increase in insurance funding and a decline in exchequer-funding. The major problems

facing Health Service staff concerned not just wages and the cost of living but internal problems like under-manning and under-financing. 'The dilution of the service needs to be prevented'. The union has an official parliamentary connection through their legal department even though they are not affiliated to the Labour Party, and they have influence through the TUCs Health Service Committee. They also have individual contacts through MPs and the Socialist Medical Association. He manages to find out things which he then creates a rumpus about, for example one consultant in an eye hospital was shipping donated corneas to the Middle East for profit. He also found out that blood donated by the public was being given to private hospitals.

I got the impression that he would like to devote more resources to recruiting nurses. However it was already being said that they got too much priority in the organisation in relation to their weight. He agreed with me that if Nalgo had taken more initiatives they might have swept the board with nurses, at least in the general hospitals.



Rank and File Conference for Nurses held in Manchester  
on 1 June, 1974

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Considering the amount of militancy among nurses the Conference was poorly attended. It was held in the Manchester Students Union building. The usual doctrine splits were apparent. The International Marxist Group (IMG) wanted to attach a wider set of demands, such as the abolition of private practice. This was opposed by the International Socialists (IS) because this 'couldn't be done through the Whitley Council'. The IS were also voting against the IMG demand for a sliding scale of wages, although at this stage their policy on this issue was not all that clear, and some were voting for it. The meeting was chaired by an IS nurse called Pam Dennard from London. The CP were also present. They were arguing for unity between the unions at national level and were not in favour of attacks upon trade union leadership.

The meeting started by receiving reports of action by the various delegates present. Salford Royal Infirmary reported that NAG (Nurses Action Group) meetings had been held. A brief 'strike' had been held on a Monday and they had received support from the local Labour movement. More strikes were on the way. The delegate from Springfield Hospital, Manchester, was putting a CP line,

was clearly from COHSE, and said that they had held a two hour strike on the Wednesday and had marched to Crumpsall Hospital. They were also refusing to do 'non-nursing duties'. They had received support for the claim from senior nursing administrators. Since this is probably a psychiatric hospital one would expect that the senior nurses would also be COHSE members. Leeds NUPE reported that a joint meeting had been held with COHSE, but that it had not been possible to get a joint action group going. A demonstration was being held that very day and was being opposed by NUPE. The delegate also reported that Doncaster busmen had come out for four hours in support of the nurses. In Bristol a JAC (Joint Action Committee) had been in existence for three weeks composed of NUPE, COHSE, and ASTMS. There had been walk-outs in both the general and psychiatric hospitals and rolling strikes, which were now up to three hours in duration. These actions had been fully supported by NUPE in the locality. There had been 'tremendous support' from the working class in the area. Support had been given from the Trades Councils but the Action Committee was contacting trade unions one by one. The student union at the University provided free leaflets and so on. They were running a bulletin. Busmen in the area were reputed to be giving free rides to nurses. It

was said that there might be a strike at Rio Tinto. There had been an attempt to victimise two nurses for taking part in activities and a work to rule was continuing. They were building for the 6 June national demonstration. Lowestoft reported next. There had been marches in Ipswich and the Trades Council had pledged their support. The action in Norwich had started with canteen boycotts. Nurses were joining trade unions in large numbers. Walk-outs were being organised and so on. In Glasgow there had been a demonstration of 3000 nurses and walk-outs were planned. The Fire Brigades Union had pledged to undertake strike action for nurses if they were called upon to do so. In Edinburgh there had been a small march. However the unions were acting independently rather than together. NUPE was doing nothing. COHSE was acting under pressure. There was a NAG (Nurses Action Group) consisting of some 50 members and covering eight hospitals. In Dundee it was also reported that COHSE and NUPE would not work together. Here, too, there was a NAG although it was reported that 'people are demoralised with trade unions'. A paper was being produced. In Leicester there was some hope that NUPE and COHSE could work together. The Trades Council was calling for sympathy strikes on Monday afternoon for nurses and factories were coming out. The local mental hospital was running an overtime ban.

In London the scene was a little bit more complicated. There was a London Coordinating Committee covering some 23 hospitals. In Buddenbrooks, the unions were said to be cooperating. Many nurses had joined unions and there were only a few left in the Rcn. Shop stewards had been appointed for nurses. There had been attempts to threaten student nurses and ancillary workers with a loss of money if they supported the actions being taken. In Harrow nurses were attempting to bring out building workers on the 6 June. There was a ban of routine admissions and they were involving nurses who weren't members of trade unions. At Claybury mental hospital there was considerable hostility between NUPE and COHSE. There was an attempt to form an inter-union committee which NUPE walked out of. They were trying to get NUPE stewards at branch meetings to support action however. Friern Hospital (a mental hospital at Barnet) was organised by COHSE. Two thirds of the nurses were following the NEC's line. This was an overtime ban and only emergency admissions allowed. Consultants had threatened to admit patients under sections of the 1959 Mental Health Act in order to get round the ban. However staff had threatened a total strike and had vetted emergency admissions. It was reported also that ancillary workers at this hospital

were hostile because nurses had not supported them in the strike the previous year. However, ambulance men were joining nurses' demonstrations. They were working together with Whittington Hospital nurses. The Outpatients Department and three wards had been closed.

When it came to resolutions there was quite a lot of argument. However, relatively few people supported the IMG line. They became effectively isolated from the meeting. A number of resolutions were passed. These included resolutions which called on NUPE members to pressurise their unions to take industrial action at their firms; calling on other trade unions to take industrial action and strikes; the setting up of Area Action Committees to coordinate action. There was some debate about whether nurses' action groups should run the campaign or whether action should rather be through individual trade union channels. A clear line on this did not emerge from the conference.

Additional Documentary Material.

Nurses Demonstration in Epsom, Friday, 17 March, 1974  
late afternoon.

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Attended by 300 or more nurses from general and psychiatric hospitals in the vicinity. Most if not all were probably off-duty and the numbers on the march were slightly disappointing, considering the high concentration of hospitals in the Epsom area, and the blazing sunshine.

The march itself was high spirited and noisy. There was quite a bit of chanting eg 'What do we want?' - 'More pay!' 'What do we get,' - 'Nothing!' I talked to a couple of male nurses on the march: one from a general hospital and one from a psychiatric hospital. Both favoured industrial action. Student nurses seemed to feel most bitter about increases in meal prices, brought in before they received their Phase III wage increases. A nursing tutor I spoke to wanted action and supported the demonstration but was worried about the lack of a united approach to the campaign for more pay (COHSE had attacked Rcn's plan, and NUPE had attacked COHSE for going it alone both on their claim and Industrial action).

The march ended with a short rally and a speech by a COHSE Regional Official and a local Rcn representative. The COHSE speaker outlined the unions policy: industrial action

if £100M was not on the table by Monday, 20 May. He argued for a strategy of disruption rather than strikes: eg overtime bans, a ban on new private patients, paperwork strike, a ban on cold surgery. The Rcn representative displayed his lack of experience. He incorrectly declared that strikes by nurses were illegal under the Industrial Relations Act's Code of Practice. A student nurse showed her lack of experience, by announcing that there were 310 people on the march. It seemed she had actually counted them! A seasoned militant tends to make rather generous estimates, knowing that the press tends to underestimate numbers.

More seriously, the COHSE officials were able to put considerable pressure on the Rcn and Student Section officials. The initial impetus for the demonstration had seemed to come from the student nurses, and members of the Rcn's Student Section had taken the lead in organising it. The central office of the Rcn, however, had declined to offer a speaker for the demonstration. After the rally the COHSE officials argued to them that

- (a) it was necessary to take further action quickly;
- (b) that the Rcn policy (of contracting out) was not only wrong in principle, but bad practically (because of



the problems of student nurses, black workers, superannuation rights, unfair dismissal etc.,). Furthermore that it was projected too far ahead.

The local Rcn leadership was clearly worried that COHSE would be able to wrest the initiative from them. They talked among themselves: sample comment: 'If we don't do something, we won't have much to offer'. Meaning that although they had initiated the campaign and led it up to now, the official Rcn policy of contracting out provided no basis for taking the campaign forward at this point. They had whetted the nurses' appetite for militant action, what would they do next?

COHSE claimed 3 Rcn stewards were leaving and joining them. I was unable to verify this, though.

Letter to me from Mrs M R Harrison in 1978

During the 1974 pay dispute, there was a very active Action Committee here in Liverpool. Originally the action committee was composed of members of the Confederation of Health Service Employees in the Southern and Eastern hospital districts. I was appointed Public Relations Officer! and therefore had a more or less free hand in contacting the local press and other trade unions. We had a great deal of success in gaining support not only from other hospitals, but also from other trade unions. However the committee began to crumble following a condemnation of our activities from the officials in the Confederation of Health Service Employees. We were advised not to contact local trade unions or local Labour Parties, as the Confederation believed in 'going it alone'. Following this a group of members left the original committee and linked with another action committee operating from Rainhill Hospital and mainly composed of members of the National Union of Public Employees, we were slandered by COHSE for this unity with NUPE.

The 'second' action committee ie. COHSE/NUPE flourished and we spent a good deal of time speaking at union meetings, trades councils and local Labour Parties. The action committee was organised with a secretary, treasurer and

executive committee. Donations to our campaign funds came from all sections of the Labour movements. To give just one or two examples, we received £50 from one miners' branch. £100 from the Merseyside dockers, small donations of £5 and less from Labour Parties and Labour Party Youth sections. Demonstrations were held in Liverpool attended by representatives from all health service unions and speakers usually included MPs.

I believe the action committees which grew during this period were a very natural outcome of the events leading to the campaign, nurses were at the end of their tether and the official unions were slow to take any real action. Only when the rank and file members of COHSE NUPE put pressure on the union leaderships did they actually initiate activity. Experiences of response from other trade unions was immensely gratifying, however the attitude of the health service unions particularly my own union, COHSE left a lot to be desired. While we as rank and file members fighting for a decent living wage, saw the importance of united action of all health workers and other trade unions, COHSE rejected this unity and we were ostracized.

After the Halsbury Committee reported, and the recommendations accepted, it was decided to maintain the committee on a very loose basis, perhaps holding meetings 2 or 3 times a

year. However many members left the area and the committee ceased to function. There was no actual formal disbandment, but the treasurer called a final meeting in relation to the small amount of money left in the action fund. This money eventually was distributed to charities, trades councils, and strike funds.

I hope this information may be of some use to you. I would be happy to provide more if necessary. As a keen trade unionist one of the subjects dear to me is industrial relations and I envy you your task.

# NURSES UNITED

We have seen ~~such~~ spontaneous, and very variable levels of action throughout hospitals in London. The need was obvious - to attempt to get the action directed and channelled to achieve the greatest affect. Thus on 20th May at a meeting at Guy's the London Nurses Action Committee was elected. We are an inter-union committee and thus far we have 23 hospitals with a nurse on the committee. We are not setting up yet another organisation but doing at district level what should be happening at hospital level, that is the formation of inter-union action groups.

We have decided that one of the most urgent needs is to unify around a claim which really meets the needs of nurses. The present claim of 55% is the result of a claim which was presented to the full Whitley Council in Jan '72 as 25%, snowballed through Jan '73 as 40%, and to Jan '74 as 55%. Interim offers of 8½%, £1+4%, and laterly 7% appeared and disappeared, with increases in canteen prices and 'living in' rates. If we're lucky we might get a percentage of our current monetary claim, which will disappear as fast as our previous increases with yet further increases in 'board and lodging'. What we need is a much more comprehensive claim and one which will assist the lower grades of staff most. The claim outlined below is one which we feel will answer the most immediate problems and begin to attract people into the NHS.

## THE CLAIM

1. £30 basic for nursing auxillaries at 18. The same cash increase for all other grades, ie approx. £12.
2. 40 hour week, inclusive of meal breaks and 30 mins changing time per shift. Time and half Saturdays, Double Time Sundays, Double Time Night Duty, Triple Time Bank Holidays.
3. Canteen prices to be returned to pre-April '74 levels.
4. Same rent for all grades of staff living in, set at £1 per room. No compulsory living in. Accomodation to be run by elected committees of residents, and should be freely available for all who want it.
5. Present staffing levels laid down but not acted upon, must be acted upon. No staff cutbacks through closures of wards or hospitals. Unqualified staff are not meant to take charge of wards, this must be acted upon.
6. No agency nurses in the NHS.
7. No private practice in the NHS.
8. Increase in London Weighting Allowance to £500.
9. A sliding scale of wages, that is a 1% increase in wages whenever there is a 1% increase in the price index.

WE MUST DEMAND THAT NO MONEY FROM THE CURRENT NHS BUDGET BE DIVERTED FOR PAY INCREASES. THE £111 MILLION CUTBACK UNDER THE LAST GOVERNMENT MUST BE RETURNED TO THE NHS. THERE MUST BE INCREASED EXPENDITURE ON THE NHS.

ANY OFFER TO BE DECIDED ON BY MASS MEETINGS OF ALL NURSES, ORGANISED BY ELECTED NURSES REPRESENTATIVES.

This is not a pious claim but one which must be acted upon. It must be brought up as a resolution at your union branch to be sent to the unions' National Executive Committee so that their reps on the Staff Side of the Whitley Council can press for its adoption as the claim. It should also be pushed through your professional organisation if you don't belong to a Trade Union. It has also become necessary that you demand that your NEC back the action being taken by rank and file nurses as we do not accept that an enquiry will give us the satisfaction that we want NOW.

FOR FURTHER INFORMATION PLEASE CONTACT:

Chairman, London Nurses Action Committee,  
Pam Denard, 93 Prince George Road, N16.  
Telephone 249/1648.

## FAIR PLAY FOR NURSES CAMPAIGN

(1974)

A meeting was held at St. George's Hospital, Hyde Park, on Monday, 20th May, at which Police Officers from the Ceremonials Department were present. The following points arose:—

1. Stewards should wear a white armband with the letter "S" on it.
2. There will be banners on the wall on the Victoria Embankment with areas of the country marked on them. Please assemble your party by the appropriate area banner.
3. Coaches can pick up in Park Lane, northbound near Speakers Corner, preferably at 5 p.m.—not before!
4. Coaches should have a sign, not less than 3 feet long, on the *side* saying where they are from, so they can be found easily.
5. Large banners should be on stout poles, and have holes cut in the vowels of words, otherwise they will put up too much wind resistance and may break!
6. Stewards are needed only to keep the marchers in order. Don't try to deal with any trouble—leave it to the Police. If help is needed, ask Police (mostly Inspectors) who have radios.
7. We will march six abreast. We will be broken into groups of about 1,500 to allow traffic across. The Police stress that they are not trying to be awkward, but they have to keep the traffic moving!
8. The "lead banner" will be from Mayday Hospital. The Police ask that you don't get in front of it, so that they know what's happening!
9. The route will be: Victoria Embankment — Bridge Street — Parliament Square — Whitehall — Trafalgar Square — Cockspur Street — Pall Mall — Lower Regent Street — Piccadilly Circus — Regent Street — Oxford Street — Hyde Park.
10. The delegation with the petitions will go to No. 10 via Richmond Terrace while the march is in progress, and will rejoin the march—hopefully—as it goes up Whitehall.
11. Uniform.—There are strong views for and against. We can't really be dogmatic about it.
12. A point of interest: June 6th is the anniversary of "D" Day.
13. Any questions? Ring Di Dawe 01-656 1355.



# NATIONAL RANK AND FILE NURSES CONFERENCE MANCHESTER

## Keep up the action

OPEN TO ALL NURSES **JUNE 1st**

1.30pm — 5pm in the Main Debating Hall of the Manchester University Union, Oxford Road, Manchester 13 Short bus ride from Picadilly Station

### CASTLES IN THE AIR?

What does Castle's enquiry mean to us? Above all it means that two weeks of massive unprecedented action by rank and file nurses have succeeded where 26 years of polite negotiations in London have failed. It is tremendous victory, but it would be a catastrophe to put the brakes on now, just when we're beginning to get somewhere.

The enquiry guarantees nothing to us, but it gets the negotiators off the hook and gives them the excuse to call off our action. It also means that the RCN will regain its domination of events round the table. If we take the pressure off them, they will revert to their old habits.

### WHAT ARE WE DEMANDING?

The fact that our unions and the RCN have been washing their dirty linen in public has not seriously damaged our campaign at grassroots level. But the fact that we are not fighting for a common set of demands could be disastrous when negotiations start. Whatever the unions and the RCN are demanding, one thing is certain, none of their demands have been democratically discussed or agreed by us. Just as certainly, whatever offer is made by the Government will not be put to us for agreement or rejection.

So far our united determination has brought us out of the Victorian era, now we must agree on common goals. If we don't unite round a clear set of popular demands on cash, conditions, agency labour, staffing levels, private practice—and step up the fight for them, then we could be left high and dry by events.

### WHAT IS THIS CONFERENCE?

The conference will concentrate on formulating a programme of demands to meet the needs and wishes of rank and file working nurses. It will outline a national plan of action to push these demands loud and clear during Castle's enquiry. We'll need to elect a national committee to co-ordinate our decisions. We cannot afford complacency having come so far so quickly after so many years of being ignored.

It has been called by nurses who are rank and file trade unionists and Hospital Worker supporters. It has already been fully backed by the Manchester Nurses Action Group.

We want nurses from all unions and other bodies, from action groups, co-ordinating committees, union branches and sections, and any individuals committed to the fight. The conference will be open and democratic, with no full time union or RCN officers present.

**TOTAL VICTORY IS WITHIN OUR GRASP—IT IS OUR UNITY WHICH WILL DECIDE THE OUTCOME. IF WE MEAN REAL BUSINESS, THEN WE MUST STEP UP THE ACTION DURING THE ENQUIRY—NOT WAIT PASSIVELY FOR MORE PROMISES**

If you agree with the main points here, then be in Manchester on Saturday, and be there in strength. We have nothing to lose and everything to gain

Read the Hospital Worker Nurses special issue. Written and edited entirely by working nurses in the trade unions, it contains articles on what our demands should be, how to fight for them and win, plus news and letters about the fight from all over the country. There is no other paper which represents the interests of the rank and file nurse. Rush orders to the Business Manager, 8 Beverstone Road, London SW2. 3p each plus 3p postage, orders for more than 10 copies post free.

Conference sponsored by Hospital Worker and the National Rank and File Delegate Conference Organising Committee

For more details about the conference arrangements, transport etc. ring Wendy 01-274 2405



AFTER THE MARCH - WHAT NEXT ?

WHY ARE WE HERE? Nurses are marching because they are sick of starvation wages, Victorian conditions, and, above all, the standard of patient care, which they see crumbling around their ears.

In spite of our ingrained fears about taking action, in spite of attempts by hospital managements to victimise active nurses, in spite of the publicity-seeking squabbles between our so-called leaders, ordinary working nurses are showing magnificent unity, ingenuity and determination.

MILITANCY VERSUS WHITLEYISM. During our 26 years of submissiveness in the Health Service, we have had public sympathy and repeated government concern - that got us nothing. All the top-level talks by our "expert negotiators" on the Whitley Council got us nothing. Our wages are still falling behind the rising cost of living.

This is no accident. The Whitley Council is dominated by the Royal College, with its preponderance of higher nursing grades, who are mostly interested in status and professional standards. And the union representatives have failed to mobilise their members to fight for better pay, and are often too divorced from working nurses to know what they want.

RANK AND FILE MILITANCY IN HOSPITALS HAS DONE MORE FOR NURSES IN A FEW WEEKS THAN YEARS OF NEGOTIATIONS !!!

BUT WHAT ABOUT THE INQUIRY? Why do we need an inquiry? The facts about nurses' wages are well-known - we don't need any more talk, we need CASH NOW. The only purpose of the inquiry is to con us back to the wards, while the same old negotiators along with Barbara Castle, fiddle a special case agreement.

But nurses aren't a special case. We are only one of the many groups of health workers on poverty wages, while NHS money is creamed off by drug companies, property firms and consultants using OUR health service facilities to get fat private fees.

They say we're a special case because we are taking action. Like the miners did.

But the reason the miners got such a huge settlement was because they kept up solid industrial action before, during and after their inquiry.

HOW DO WE GET WHAT WE WANT ? If the inquiry agrees to our demands, well and good. But experience shows that it will only do that if we KEEP UP THE PRESSURE. Only by stepping up our action will it be clear that we mean business.

It's taken us years to build up this level of confidence and organisation. Nurses have been joining unions in droves because they saw that they could do something. If we allow matters to be taken out of our hands now, to produce a shabby compromise, all this will be wasted.

WHAT ARE WE DEMANDING ? Not 55% - why should working nurses waste their energy fighting for a demand which brings more for the nursing management?

We want

a £30 minimum wage, and £12 increase for all grades

a 35 hour week. Double time for weekends and night work

canteen prices back to pre-April levels. No further increases

A rent-freeze for resident staff. Same rent for all grades. No compulsory living in and an end to petty rules.

staffing levels to be published and adhered to. Acting up pay for unqualified staff running wards.

No agency nurses in the NHS

No private practice in the NHS

funds for our claim from OUTSIDE the NHS and social services budget

mass meetings of nurses in hospitals to decide on acceptance of offer

a sliding scale of wages. 60p for every 1% rise in the cost of living index, to be computed by the TUC

Nurses action groups up and down the country have already supported these

WHAT MUST WE DO ? Rank and file nurses must build up strong union organisation in hospitals - this gives us automatic links with millions of other workers who can support us. We must form elected local action committees of nurses from all the unions. And we must STEP UP THE ACTION - bans on agency nurses, private patient bans, bans on routine admissions and ultimately strike action, a few hours at first, then half days and days. COHSE nurses are already doing this - the rest of us must act with them. We must go out to factories and other workers and demand their support - it's their Health Service that's falling apart.

NATIONAL LINK UP Last weekend, rank and file nurses from all over the country met in Manchester to try and achieve some national coordination. The delegates all agreed on these policies and a National Coordinating Committee was set up. If we are to achieve national unity, we must support and enlarge this committee, which can then coordinate action all over the country. If you would like further details of its activities, contact PAM DENARD, Coordinating Committee Chairman, 93 Prince George Rd, London W16 ( 01 249 1648 )

P&P HOSPITAL WORKER, 8 Beverstone Rd, London SW 2

*Handwritten notes:*  
M. J. ...  
...  
...  
...  
...

We are going through with the struggle in spite of parliamentary enquiries and in spite of the RCN. In spite of the fact that because most of us are women, the government never thought we would do anything except explain to each other.

As nurses we are constantly reminded that we must behave in a professional way. But conducting ourselves in a professional way hasn't got us anywhere in the past. It's professional about low pay?

To be a professional nurse is to be a professional mother. That's why we don't get paid anything. They expect mothers and nurses to do it all for love. The only way we'll ever get anything is to recognise that we are all WORKERS. We have to organise to fight for what we need, like every other worker.

They have used the blackmail against us that patients will suffer if we strike. But patients are suffering BECAUSE WE GET LOW WAGES. Because of low wages we are understaffed and overworked. Many of us have to go home and do another job for our families after a day's work or a 12-hour nightshift on the wards. In that job at home, we face the same blackmail: don't let anyone else suffer, suffer yourself, in silence.

We are trained as women to accept hardship and to obey orders. We are trained as nurses to fit into the hospital system, not to question anything. We are trained to accept no pay as housewives and low pay when we work outside of the home. We are trained to let all decisions be made by the person one step above. But now we are not prepared to leave decisions about our pay and conditions to anybody. We are the only ones QUALIFIED to decide.

In the past we have been divided against each other and against ourselves. They use race and nationality to divide us. They use rank and status to divide us. They

use uniform to divide us. And they use wages to divide us. Those who get a pittance more are afraid of losing it by joining with those who get less. But we have nothing to lose by joining together and everything to gain.

We refuse to be divided any longer, by the administration of hospitals or unions or so-called professional bodies. All of us need more money, less work and more time for ourselves. No hospital can run without all its workers. If the kitchen stops, everything stops. Therefore we are all entitled to equal pay. Those of us with the lowest wages must get the biggest rise.

And all of us must get a big rise! No one counts the work that women do, in our homes, in travelling to work, especially for weekend duty, as well as the hours we spend in hospitals, factories offices, schools ... Whether we are serving people or serving machines, it's not so different, it's a job. WE NEED TO BE PAID FOR ALL THE WORK WE DO. WE NEED THE MONEY AND THE TIME TO DO MORE THAN JUST KEEP OURSELVES ALIVE TO WORK ANOTHER DAY.

No hospital worker must be threatened with loss of job, loss of training, or with deportation - as is happening with hospital workers from other countries. Black nurses face this threat as well as the extra degradation and insults they normally are forced to undergo. THERE MUST BE NO VICTIMISATION FOR STRUGGLING FOR WHAT IS RIGHTFULLY OURS.

Although we have been forbidden to use our voice and our power, now that we have begun to act, every day more becomes possible. WE WANT WAGES FOR ALL THE WORK WE WOMEN DO, FREE TIME AWAY FROM THAT WORK. The days of blackmail and "professional" submission are over. We're going to look after our own health now!

Nurses from the POWER OF WOMEN COLLECTIVE -

WAGES FOR HOUSEWORK

Telephone: 263-2622 or 459-1150

(1974)

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33. See, for example, J. Beardshaw Conscientious objectors at Work, London: Social Audit (1981).

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- (7) See Royal Commission on the Poor Law, Volume III, (Minority Report), London: HMSO (1909), Cmnd.4499.
- (8) Bain, Growth of White Collar Unionism, p.73
- (9) *ibid*, Chapter 4
- (10) In the interwar period, they could not become State Registered Nurses, but could only join a reserved register. See Abel-Smith, History of Nursing Profession, Chapter 6.
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