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Special Feature

The power of care: the Women's Hospital 1884–1914*

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The power of care: the Women's Hospital 1884–1914

The effectiveness of late-nineteenth-century nursing care should not be underestimated. The archive of patient records at Melbourne's Women's Hospital reveals a commitment to patient care that more often than not made the difference between life and death in the recovery from major surgery or post-partum infection. These records suggest the need to reassess the role of medical care in the mortality transition after 1850.

Key words: care, hospitals, mortality transition, nursing.

In June 1888, Mrs M. S., a housewife from Violet Town in northern Victoria, became pregnant. It must have been a joyous event for she had been married seven years and never conceived before. She appears to have been well nourished as a child for she had reached puberty at the age of 12, two years earlier than the average for her time; but like many nineteenth-century girls, her periods had been painful and troublesome. Now at 32, she was finally going to have a baby.

Everything seemed normal at first. In July she began vomiting in the mornings and had some early crampy pains. Before this she had never felt any tumour in her abdomen. At Christmas she felt her child quicken, but at the end of March 1889 the movements ceased. Since Christmas she had lost a little blood four or five times, at intervals of four to six weeks and lasting one to two days. About February she had some slight pains and some water came away from the vagina. Her baby never appeared.

It was now 8 June 1889, a year since she had conceived and she had just been admitted as a patient in the Infirmary. With its 25 beds, including only two for postoperative special nursing, the Infirmary's waiting list continued to grow. The backlog was aggravated by the slow recoveries still so common from abdominal surgery; and the longer sick women had to wait, the sicker they were by the time they reached the operating table, and the longer again it took them to be well enough to return to the normal wards. By the end of the year, 180 women would be awaiting a bed and four years later, it would be five hundred.[1] Mrs M. S. herself had been waiting too long, 3 months, since her baby had failed to appear.

She was examined by the Senior Resident Surgeon in the Infirmary, Dr R. H. Fetherston, son of Dr Gerald Fetherston, and he wrote up the case in the case book of her honorary gynaecologist, Dr Walter Balls-Headley. She reported no pain. Her general condition was 'slightly emaciated' and her abdomen was enlarged, containing a tumour of the size and shape of a 6½ months pregnancy. It felt rather hard, but fluctuated in places. Her vagina was discoloured and darkened, and they found a hard rounded mass in the first cul de sac, from which could be distinguished the foetal head. The cervix uteri was soft and displaced anteriorly behind the pubes. The condition of the fundus uteri could not be determined, but using a Hagar dilator, the cavity of the uterus was explored with the finger and found to be fairly normal. It was a case of abdominal pregnancy — extra-uterine gestation — where the embryo

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had burst through the fallopian tube and implanted itself within the abdominal cavity.

Twelve days later on 20 June, Dr Balls-Headley operated, assisted by Dr Rowan. An opening of about 5 inches was made and there was immediately a lot of bleeding from the incision. The cyst was reached and tapped, releasing some dark brown fluid — *liquor amnii*. Then the opening into the cyst was enlarged and found to be fairly thick — a quarter of an inch and leathery. The child's arm was opposite the opening and the placenta was inserted into the anterior and upper surface of the cyst in its upper portions. With some difficulty a foot was seized and the child thus delivered. It was a male, seeming about eight months at least, quite decomposed in parts but not malodorous. The placenta was removed in pieces by peeling it from the cyst. The umbilical cord had become macerated and was not intact but part attached to child and part to the placenta.

On examining the cyst, which had been kept well out of the wound to prevent any fluid getting into the abdominal cavity, it was found to be intimately adherent to the transverse colon, the omentum, the small intestine and pelvic colon, so Balls-Headley could not attempt to remove it. (Had he attempted to do so, she could have haemorrhaged fatally.) It was not sutured to the wound, and the abdominal incision was closed, leaving a glass tube into the cyst. The sutures used were silver wire internally and horsehair for the skin.[2]

It was a textbook operation for extra-uterine pregnancy, faithfully carrying out the procedures recommended by Alfred Lewis Galabin — like Balls-Headley, a Cambridge man — in his *A Manual of Midwifery*,[3] published in 1886. The mortality rate for abdominal pregnancies was fearful at the time, over 50% for those left mainly to Nature, but a recent series of secondary abdominal sections had produced a mortality 10% lower. Surgery was an acceptable risk, and no one wished on Mrs S. the years of passing *per rectum* the disintegrating detritus of her only baby, let alone the constant risk of grave pelvic or systemic infection. Part of the success of the operation was to allow those parts of the placenta and sac which were adherent to abdominal organs to undergo decomposition over the recovery period.[3] The nursing care was going to be critical.

Mrs S. was carried to the special ward. The operation had taken 1½ hours and the deep anaesthesia required to relax the abdomen for surgery was in itself a threat to life. She was therefore 'very low' after the operation, but after about 3 hours, 'rallied very well indeed but still was weak'. She now complained of great pain in the abdomen, which continued for several hours and at last, as she was getting restless, she had a hypodermic injection of ¼ grain of morphia, which had to be repeated several times during the next few days.

A good deal of dark red bloody fluid was drawn off from the cyst which gradually was becoming scanty, and seemed rather foetid, and then the cyst was washed out with Mercuric chloride 1–3000 twice and three times a day. The patient in the first week was in a very low condition, enemata being given of egg, milk peptised, and champagne and brandy were given freely by the mouth. Champagne and brandy were standard postoperative care, as were the nourishing enemata. Saline infusion was known at the time, and would in fact be used, not very efficiently and with the wrong scientific understanding, in the great cholera epidemic that was to sweep Hamburg in 1892. Purging remained the basic treatment for cholera even in the late nineteenth century.[4]

Mrs S. was in a desperate state and had to be watched constantly. Her temperature rose each night to 101 to 102°, but fell back to normal each morning. Her pulse was 108–130, respirations 28–32. A good deal of flatus collected but was got rid of easily with enemas. Her condition on the fourth and fifth day was critical, her bowels acting involuntarily. To control the diarrhoea, 'a mixture of chalk and opium' was administered. Some sutures were removed from the upper part of the wound on the sixth day — it seemed to have closed, but the edges of the cyst wall were showing signs of sloughing and turning black. They were cast off after a couple of weeks or 10 days.

> *Second Week*: 28 June–4 July. The woman remains in the same low state, bowels acting (with mucus stools) very often; patient is low, restless, perspiring freely, tongue coated and side of abdomen sore. Temperature 101°–103° at night and 100–130 pulse. On thirteenth day some slight rigors probably due to small abscess forming in track of sutures which have been removed several days ago. The wound is being washed out frequently with Condy's solution, since the mucus diarrhoea it was feared was caused by Mercuric Chloride absorption; but its stopping had no effect on the diarrhoea. The sac remained adherent to abdominal wall. Treated with Quinine 16 grains a day, and diarrhoea much as before. She still received stimulants and nourishment, hot bottles, etc.
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> *Third week*: She gradually began to pick up and get a little stronger, appetite improved and diarrhoea stopped. There was still a good deal of discharge from the sac, which is carefully washed out every few hours. The patient gets a Hypodermic of water at night to break her of the morphia habit. She perspires very freely at night. Still getting Quinine 16–20 grains a day and also a good deal of stimulants. Her temperature hovered between 100°–102° at night.
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> *11 July to 2 August* (four to six weeks after the operation): The improvement continues and she gradually gets much stronger, wound and sac contracting up very well and drawing the skin of abdomen inwards; able to take solid

food. Sleeps well, temperature 100° at night. Pulse much better. Sides of sac adherent in places.

On 3 August (just over six weeks after the operation): At 8 pm, after a very good day, she got a severe pain in calf of left leg, which rapidly became swollen and oedematous. On calf and front and at the side of the thigh there can be seen some veins which have become blocked and obliterated. All around these veins the cuticle is rising up in blisters; in a few hours the four places look very red and angry; pain still severe and also into abdomen. The red places look as if they were going to slough under the blisters.

The leg was raised, poulticed and treated as an acute attack of 'Thrombosis'. Morphia had to be given freely again. This attack threw her back greatly and she seemed to lose courage; she got very weak and began to vomit again. Temperature up to 102° to 103° at night.

5 August (two days later): She was very low and almost in a dying state, urine passing involuntarily, and only kept alive by stimulants, hot bottles and great care.

She gradually got better and in a few days was much better and more cheerful. The veins that were sloughed by the thrombosis sloughed out and then left small ulcers which slowly healed.

10 August: Nurse Archer who has been nursing this case night and day since the operation (seven weeks ago), having refused relief, developed a slight attack of Pleuro Pneumonia at the apex of both lungs from a chill caught at night, completely broke down and had to be removed and kept in bed for some time. She left the case in a good condition and gaining strength rapidly, her care and attention were vital in the success of the case. From this time Mrs S. continued to improve and had no more bad symptoms. The wound (sac) gradually became closed and united forming one hard, firm cicatrise which still discharged a little pus on discharge from hospital. The temperature became normal and she put on flesh. The ulcers on the leg healed slowly.

21 September: Mrs S. is still doing very well.

1 October: Her temperature has been normal for some weeks. She is moving about a little. The wound is now only a sinus, but her leg swells a little when she walks and is painful if she is up too long.

On October 8th, four months after her operation, Mrs M. S. went home to Violet Town.

Mrs M. S. owed her life not only to her surgeon Dr Balls-Headley and to the Senior Resident, Dr 'Bertie' Fetherston, but also to Nurse Archer. Nurse Archer saved her life with 'great care': she became obsessed with the case, refusing all assistance. It was almost as though she willed Mrs M. S. to live. Yet it was unprofessional care, where the nurse transgressed the boundaries of the public and the private — the limits of proper professional detachment. Nurse Archer became too involved, she cared too much and compromised her own health. It hints, however, at a turning point in the professionalisation of nursing, in a transition from private care, of personal commitment between private individuals, to the universalised care of the universal patient. The American nursing historian, Susan M. Reverby, sees the defining dilemma of professional nursing as being 'ordered to care in a society that refuses to value caring'.[5] But just as significant is the awkwardness of being 'ordered to care' for strangers, strangers who might well be repellent in their behaviour, appearance or odour. 'Care' had to be regulated in order to be guaranteed. It could only be sustained and practised consistently if it was structured as a set of routines which had to be carried out on all patients, irrespective of who they were, and if nursing itself was constructed as a role. A hospital could not rely on raw human emotion and spontaneous relationships to guarantee appropriate care. If there had always been nurses in the past who cared too little, it seems there were also some who cared too much.

Finding this case in Dr Balls-Headley's case book for 1889 was a turning point in the writing of my history of the Royal Women's Hospital. Not that it was all that unusual in its detail of the postoperative care: there are many other such records for abdominal surgery in the case books and essentially the notes are little different from Richard Tracy's own published case notes for his first ovariotomy in 1864.[6] The case notes written up by Felix Meyer in 1884 when he was resident surgeon were even more systematic, with ruled columns for tabulated recordings of temperature, pulse and respirations at given times, therapies or 'remedies' prescribed, nourishment taken and general observations of the patient's condition and activities. What in fact was remarkable about this history was the story of Nurse Archer, the revelation of her extraordinary commitment to the care of this unfortunate woman. It hinted at an earlier world of nursing that was being displaced by modern routines and organisation.

This earlier world of nursing care was evident also in the relationship of the midwife to the woman she had attended in her confinement. The hospital maintained, at least until the early 1890s, the age-old commitment between parturient woman and her midwife in that the midwives could not go on leave until the women they had delivered had been discharged from the hospital. It was as though the private relationship of care was simply translated to the public setting of the charity hospital. And what was this saying about how these late nineteenth-century people conceived of care?

What did nurses and the resident doctors actually do when they cared for very sick patients? The records reveal a routine of intense activity. The major task of postoperative care was assisting the patient in her journey

through the valley of death that was infection in the pre-antibiotic age. If the old joke ran: 'the operation was a success but unfortunately the patient died', it had more than a measure of truth. Major surgery was divided into two distinct phases: the operation itself and all the attendant risks of collapse and haemorrhage; and the recovery which almost inevitably involved a prolonged struggle with wound infection as well as the recovery from the trauma of surgery. By the time the Women's Hospital was founded in 1856, postoperative care required not merely the nourishment of the patient, the cleansing of wounds and the management of elimination, but also observations and increasingly measurements of the patient's condition in description of her skin — pallor, sweating, hot or cold and so on; of her movements; of her bowel and bladder eliminations; of her sleeping; of her speech and comprehension; mood and emotional expression. Added to that was a growing list of measurements of temperature, pulse and respirations. By the 1890s, the laboratory began to play a growing role, analysing urine for blood, albumin and deposits; followed by bacterial smears and blood itself. Some historians have perceived a quantum change in the hospitals' use of such technologies and medical records in the first decades of the twentieth century;[7] but seen in the longer context of medical record making from the 1860s, there is a more striking continuity, where new technologies are incorporated into an existing routine of patient observation.

What did change was the narrative mode. Tracy was a born story teller and his case histories are narratives par excellence; 'Bertie' Fetherston's account of Mrs M. S. and Nurse Archer is a gripping, even enthralling tale, which brings us to the precipice with Mrs M. S. and then thankfully has a happy ending. Many of the case histories of the 1880s are rich narratives, with traces of the patient's voice and the doctor's own emotional response. Felix Meyer as resident surgeon, recording the condition of a 17-year-old girl dying of miliary tuberculosis, noted her body's 'mawkish odour' and the one lovely thing left about her — her long dark lashes.[8] As nosologies became more scientific, the notes became more cryptic and symbolic, but still the bare bones of the nursing history is a compelling narrative of the patient's perilous journey.

Perhaps the real question to explore, however, is how few patients died. Even during the 1880s when the hospital was at its most septic and overcrowded, it is striking how many patients survived major abdominal surgery. There are many remarkable recoveries from major trauma in both the surgery itself and the subsequent wound infection. And of those who died, many were receiving surgery too late — they had advanced malignancies or tuberculosis, they were wasted and anaemic, they had heart or kidney disease as a result of rheumatic fever — very common among the hospital's patients into the 1940s. Tracy's low death rate for ovariotomy in the 1860s came in part from his careful selection of patients who were likely survive anyway, and from his pre-operative care where women were admitted to hospital to be fed and rested before surgery — a preparation which might take weeks.

There were, of course, no blood transfusions and without the technology to maintain fluid and nourishment intravenously, postoperative care involved careful coaxing to suck ice, sip champagne and other stimulants as well as beef tea and broth. The other mode of delivering nourishment was by nutrient enemas — the delivery of milk, egg and brandy *per rectum*. Therefore perhaps the most critical task of all was the feeding of patients. All this required an intense, intimate relationship between nurse and patient: heads had to be cradled and coaxing, encouraging words had to be uttered with sips of drinks, small spoonfuls of food. The nurse had to be able to read signs in patients too sick to communicate, she had to interpret mutterings, soothe tears and terrors. Patients became hysterical, irrational, violent and psychotic. They became despairing, certain that death approached, distraught at leaving their families motherless, fearful of Purgatory, hopeful of Heaven. Nursing was a human relationship of extraordinary intimacy and psychological intensity: a great struggle of the will to life against the terrifying power of disease and death.

Physical intimacy reinforced emotional intimacy. Nurses were touching patients constantly. The hospital usually had only one special nurse during the 1880s and 1890s, so the special nurse slept with the patient in the special ward. They shared a total life. They were a couple. Faces, hands and bodies had to be sponged and wiped through days, even weeks of high, swinging temperatures. Backs were rubbed and powdered. Hot bottles were constantly refilled and strategically placed. Delirious patients had to be kept still lest the drainage tubes from their suppurating wounds — at first glass, later rubber — became dislodged. Managing bladders and bowels was equally difficult. Catheters were rigid and difficult to insert; opium was the only sure way to control diarrhoea and conversely, coping with the costiveness of most patients, especially those on opiates, called for massive enemas. The surgical repair of damaged perineums and fistulae created particular difficulties with nursing care, because well before germ theory it was known empirically that faecal contamination of the wound would be disastrous. As it was, still in the 1860s these

operations had to be performed on conscious, kneeling patients. Afterwards their bowels were confined with opium, a catheter was inserted permanently if they could tolerate it, and patients had to remain lying on their side for at least two weeks. The syringing of wounds and of vaginas to control infection was difficult, messy, exhausting work. A 'long hot douche' involved syringing the vagina with 6 to 8 pints of hot water at 120°F; in 1894 a patient died when an ill-trained nurse douched her with boiling mercuric solution.[9] The use of opiates meant that many patients became temporary addicts who had to be broken of their addiction once the pain was bearable. Many patients were alcohol dependent and only the generous prescription of stimulants avoided attacks of *delirium tremens*.

On 2 May 1884, Mrs A. of Windsor was admitted for surgery from Dr Walter Balls-Headley for an ovarian cyst. Felix Meyer wrote the notes and for the first 6 days they record his visits to her ward and his observations. He was living in and he observed her around the clock. She was a healthy woman of 38, who had married late and had three children in very quick succession. She was also better off than most of the hospital's patients. Dr Balls-Headley was an exceptionally neat surgeon and she made a fine recovery with only the odd day with an elevated temperature. Her devoted husband promised the hospital 20 guineas to be paid in small monthly instalments:

> I have great pleasure in expressing my sincere thanks for the great and assiduous care my wife received during her severe illness from Dr Balls-Headly [sic] who was unremitting in his attention and so skilfully performed the dangerous operation; from Dr Meyer, who spared no trouble and who showed me, as well as Mrs A., so much personal kindness; from Nurse Martha who did her arduous duty with so much kindheartedness and from Mrs Cousens for her kind and motherly attention.[10]

Mrs J. O'C. of North Carlton was a more earthy patient and she told Dr Meyer a lot about herself: she had had rheumatic fever 10 years ago (incidentally at the time of a puerperal fever and erysipelas epidemic in Melbourne). She had lived in town for the last 17 years, coming to Melbourne just as people were trailing back in numbers from the gold fields. She had reached menarche at 18, so had been poorly nourished in her youth, but her appetite had 'always been good'. Meyer noted that she was of 'bilious temperament, melancholy look and sallow complexion'. She was a less promising candidate for abdominal surgery than Mrs A. She came in for an ovarian tumour, but they discovered that at the age of 48, after bearing four children between the ages of 24 and 29, she also had a complete uterine prolapse, a procedentia. Her ovarian tumour yielded 50 pints of fluid. She also was a patient during the height of the summer and the hospital staff had great difficulty in preventing patients from becoming distressed with the heat. Her wound became infected and had to be surgically drained a second time, which brought on a haemorrhage and later large clots. The nurse and the resident were syringing her uterus frequently using a catheter through the opening. She was gravely ill for nearly 6 weeks, but by the end Felix Meyer reported that she was 'eating heartily. Takes two bottles of stout a day. Hasn't got her bill yet. Doesn't walk much'; (her procidentia was still untreated). She was discharged to the Lady McCulloch Convalescent Home.[11]

While it is easy — and ahistorical — to find things done to patients which were pointless or even dangerous, what is significant is the quality of the care and its attentiveness. While the study of therapies and nosologies is vital, so also is the study of the most basic techniques of nursing and medical care. And perhaps the most significant changes that came to it were necessary reforms to practice and hospital organisation. Antisepsis and asepsis constrained the physical intimacy of nursing; as it would in the 1950s in the hospital nurseries in the fight against golden *Staphylococcus*. The regulation of nurses' working hours into defined shifts, with regular time off duty, unavoidably intruded upon the special relationship between nurse and patient. Nonetheless, the most valuable thing that doctors and nurses could give the sick was constant, dedicated, basic care.

This has much wider historical relevance than the history of a particular hospital, or even of nursing and hospital practice in general. Thomas McKeown's *The Modern Rise of Population* struck a receptive academic audience in the late 1970s when he argued that the mortality decline was well under way before medical science could intervene in human disease and death and before the sanitary movement could take effect.[12,13] The advance of medical science had not made the crucial difference in the modern growth of population that began in the second half of the eighteenth century. The only satisfactory driving cause, he argued, had to be the increase in food production that came in the wake of the agricultural revolution. It is an argument that rages still, despite the evidence of declining nutrition among the British poor in the first phase of industrialisation when measured by declining mean height. Why, then, were there more people and why were people not dying? The demographic historians increasingly argue that because of the political and economic stability of the eighteenth century after the upheavals of the sixteenth and seventeenth, people began marrying younger and having more babies. Therefore while death

rates remained high, there were simply more babies to survive to adulthood and food supplies, if not distribution to the growing hordes of urban poor, grew to match the growth in population. The debate has also swung back and forth about how the people's health and its changes can be measured, and the effects of vaccination against small-pox, and of better nutrition after the 1850s on tuberculosis rates, and of municipal socialism in England in gradually bringing piped water, gas and sewerage disposal to industrial cities.[14]

Little attention has been paid, however, to what doctors and nurses could do for individual patients. It is too easy to say that they had no remedies against the major infectious diseases of the day; that they did not understand the rehydration of adults and especially infants suffering diarrhoeal disease; that they had only small-pox vaccination; and that they permitted the tubercular to remain living with their families in cramped, ill-ventilated hovels. Moreover, their surgery was good as far as it went, but over a whole population, only a small proportion underwent major surgery in their lifetimes. It is still the received wisdom among most historians of women's health that doctors were bad for women in childbirth, and midwives preferable because they 'did not interfere', i.e., women who engaged doctors instead of midwives were doomed to unnecessary forceps deliveries and infection. These debates are not confined to the arcane groves of academe; they penetrate deep into the community, journalists believe them, young women absorb them as students, and thus they feed distrust of 'medicalisation' as some sort of imposition of the unnatural and oppressive upon the healthy processes of the natural.

However, the historian James Riley has amassed a vast database of medical and work absence records from British friendly societies in the second half of the nineteenth century. He argues that these records attest to increasing morbidity amidst declining mortality: that is, if fewer were dying prematurely because they survived major illnesses, then there had to be more weakened, sickly but living people: *Sick, Not Dead* is the title of his latest book.[15,16] Riley's critics have protested that these illness episodes were defined by the workers themselves and that there may have been generational differences in their tolerance of sickness and disability, i.e., community mores and financial pressures forced working men in the 1860s to tolerate pain or sickness that their sons and grandsons would later absent themselves for.[17] Riley argues that what may be more significant is that medical interventions in sickness and injury were becoming more effective: that is, medical carers were better at keeping people alive in the 1890s than they had been in the 1850s.[15,16] The evidence he advances for this is tentative, relying on an optimistic reading of another historian's study of the medical marketplace rather than on any form of patient records. However, preliminary work on the remarkable collection of over 14 000 infirmary case records from 1884 to 1935 in the Royal Women's Hospital archives suggests that this may well be a fruitful line of inquiry.[18] Doctors were improving their therapies and surgical techniques steadily from the 1860s and the rate of improvement accelerated in 1880s. The coming of antisepsis and asepsis, while far from perfectly practised, cleaned up if not actually sterilised hospitals and some private practices. The development of vulcanised rubber, despite its high costs, made an impact on hospital technologies and procedures. Anaesthesia improved: methylene mixture, for instance, replaced chloroform and ether at the Women's Hospital in the 1880s. The advance of abdominal surgery enabled doctors to observe the processes and effects of pelvic infection in the living: they could now see what they had once described from external palpation as 'prolapsed ovaries' to be salpingitis for instance. Above all, the emergence of nursing as a profession with formal training and standards of practice surely had a significant effect on the survival rate of people with grave infections.

Perhaps the most telling evidence so far is the impact teaching hospitals like the Women's Hospital in Melbourne and those in London had on maternal mortality. Once the Women's Hospital adopted antiseptic midwifery at the end of 1887, death from puerperal infection acquired during a delivery conducted on the premises or by the hospital's extern midwifery service became rare. Similarly in London, Lara Marks has found the women of the East End slums, especially the desperately poor recent Jewish immigrants from Poland and Russia, to have had a lower maternal mortality for most years between 1880 and 1940 than the women of the West End.[19] The women of the West End engaged private doctors, private nurses and used small private establishments, which, as in Australia, were hives of infection. The women of the East End were served by teaching hospitals which ran extern midwifery for the healthy with hospital back-up in emergencies, while high-risk patients were confined in the hospital. Lara Marks is convinced that it was the use of midwives which led to East London's lower intervention rates and lower infection; yet maternal mortality was highest in Britain in remote or impoverished rural and mining areas where there were few doctors, even fewer hospitals and where unqualified midwives delivered most babies. The critical difference in London, as in Melbourne, was between private practice,

which was driven by the profit motive and patient demands for relief, and teaching hospital practice where midwives were trained and salaried doctors oversaw standards and handled complicated cases. That is, maternal mortality was reduced before the introduction of sulphonamides in places where advanced medical practice was allowed full rein. The public patient had to do as she was told; she could not demand chloroform and quick relief; her distressed relatives could not hound the doctor from the minute he crossed the threshold; the doctor was just down the corridor when he attended to another patient, not five miles away. If too many general practitioners took the easy way out and applied the forceps too soon and too often, this did not mean that all doctors did so and that such practices were universal.

What we must not discount also, is the spread of knowledge of better care of the sick into the lay community's home nursing. The historian Anne Hardy, in her study of infectious disease and the rise of preventive medicine in England from 1856 to 1900, reminds us how little people regarded sickness. The very poor could not afford to stay home and nurse others; they tended to ignore infectious disease in the family so that soon everyone was infected; or they concealed its presence for fear of being 'sent away' to hospital where they might 'die among strangers'; infectious corpses were kept in open coffins in homes for days before funerals. People put up with the most atrocious symptoms for years before seeking medical help: 'There is a great deal of carelessness touching human life, and a great want of common sense or serious thought in the preserving of it; much is left to chance: there is a fatalism, a stolid indifference on the matter, pervading English society' remarked one observer.[20] The better health of East End Jews which so puzzled contempories, given that their poverty was every bit as appalling as that of their Cockney neighbours, may well be explained by their better care of the sick and of young children, perhaps for fear of the working days that would be lost if Jewish mourning laws were to be observed: to the very poor, days without work meant days without food.[21] Better care of the sick was part of the better care of the self that grew with the rise of the culture of respectability among the regularly employed poor in the nineteenth century; and compulsory schooling after 1872, even if it taught little of reading, writing and arithmetic, did teach some, girls in particular, about hand washing and order.

What mattered most in the sickroom or the hospital ward was cleanliness and care. The translation into the secular sphere of the Christian duty to attend the sick — the secularisation of the vocation to care as Sioban Nelson has been showing[22] — transformed nursing from the lowest and dirtiest form of personal service to a profession. But while care could be professionalised, broken into defined tasks and routines, enhanced by technology and reified, it remained a moral commitment and a human relationship. And perhaps its greatest healing power was the power of care.

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