An Oral History of District Nursing in the Outer Hebrides. A Heroic Service?

1940-1973
An Oral History of District Nursing in the Outer Hebrides 1940-1973

A Heroic Service?

A thesis submitted to The University of Manchester for the degree of

Doctor of Philosophy in Nursing

in the Faculty of Medical and Human Sciences.

2013

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and Social Work
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ABSTRACT

The study is an oral history of the work of district nurses in the Outer Hebrides of Scotland from 1940 until 1973. The rationale for the 1940 start date of the study is the decision to capture an insight into events in this remote part of Scotland before and during the introduction of the British National Health Service (NHS) and the creation of the welfare state. Nurse training was changing in the 1950s and from 1968 the Queen’s Nursing Institute was no longer the main body for the training of district nurses. The end of the study corresponds with the reorganisation of the NHS in 1974 which caused major changes to the way in which district nursing was managed and represented a radical break with the past. To create a picture of district nurses’ lives in the Outer Hebrides in the time under study, the study attempted to answer a number of key questions. What were perceived to be the main challenges to district nursing in the Outer Hebrides? What were perceived to be the advantages and constraints of district nursing in the Outer Hebrides? What did the nurses perceive to be their contributions to care? And how was the work of the district nurse affected and informed by the remoteness of the area and the particular culture?

To capture the lives and working practices of the district nurses I used an oral history approach. The main data collection method was as face to face interviewing. This was complemented by searching of local and national archives. Three main themes emerged from this study were the wide scope of nurses’ practice, the significance of their relationships and the unique nature of their role. Within the themes were concepts of self-sacrifice, resilience and autonomy. The challenges the nurses faced in their daily lives, from their surrounding environment and often urgent needs of patients were physically and mentally taxing. There was evidence of their resilience and strength of character when they did not flinch in difficult situations. Yet they described being ‘happy’ at work’ and relied on their faith.

The nurses worked long hours and were always available for the needs of the community where they practiced, which could be regarded as self-sacrifice. Most were lone practitioners and many worked on non-doctor islands where they were ‘first on call’. They were particularly confident in their midwifery practice, and worked autonomously. The relationship with the doctor was generally good but, on occasions, the nurses ignored what they knew was bad practice on the part of the doctor which may have been due to the culture of hierarchy prevalent at that time. On the other hand the nurses, when carrying out midwifery care, were assertive and not afraid to challenge the doctor if necessary. Most nurses were trained Queen’s nurses which was evidently influential and to some a prestigious qualification. They valued the periodic visits from the Queen’s Supervisors who had proved to be an advocate for them during the 1940s, and the only person who provided them with professional development

This thesis offers an insight into the daily lives of district nurses in the Outer Hebrides, which has never been studied before. It suggests that the service that these women provided could be described as ‘heroic’ although they would maintain that they were ‘doing their work’. As this study reveals, their work was often arduous and at times dangerous. However it is believed that the nurses’ personal and professional background prepared them for their role.
DECLARATION

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<tr>
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<th>Description</th>
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<tr>
<td>AIMS</td>
<td>Association for Improvement in Maternity Services</td>
</tr>
<tr>
<td>APH</td>
<td>Ante Partum Haemorrhage</td>
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<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>Ceilidh</td>
<td>Gaelic for concert</td>
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<tr>
<td>CMB</td>
<td>Central Midwives Board</td>
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<tr>
<td>FHN</td>
<td>Family Health Nurse</td>
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<tr>
<td>GNC</td>
<td>General Nursing Council</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HDCNS</td>
<td>Harris District Committee Nursing Service</td>
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<td>HIDB</td>
<td>Highlands and Islands Development Board</td>
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<td>HIMS</td>
<td>Highlands and Islands Medical Service</td>
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<tr>
<td>HV</td>
<td>Health Visitor</td>
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<tr>
<td>LNSSC</td>
<td>Lewis Nursing Services Sub Committee</td>
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<tr>
<td>LSA</td>
<td>Local Supervising Authority</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<td>QIDN</td>
<td>Queens Institute of District Nurses</td>
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<td>QNI</td>
<td>Queen’s Nursing Institute</td>
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<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
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<tr>
<td>RMN</td>
<td>Registered Mental Nurse</td>
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<tr>
<td>SCM</td>
<td>State Certified Midwife</td>
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<tr>
<td>SRN</td>
<td>State Certified Nurse</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>UKCC</td>
<td>United Kingdom Central Council for Nursing, Midwifery and Health Visiting</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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I would firstly like to thank my supervisory team Dr Christine Hallett and Dr Hannah Cooke. Their constant academic support and their encouragement for the last seven years have kept me going when at times I struggled. Dr Hallett will never know how much she encouraged me with her words on the feedback sheets ‘keep going you are nearly there’!

I am grateful for the financial support I received from the Wellcome Trust to allow me to travel out with the island. The Monica Bay Award, and a cheque received from a relative of a participant to assist with the study expenses, was appreciated.

Thanks go to my daughters Maryann, Kate and Aileen and my husband Allan who encouraged me, and understood when I was always busy and ‘in the office’. Special thanks to Aileen and Paul for being there when the computer technology failed and for Aileen’s proof reading. Thanks also to my five ‘Nessie nieces’ who helped their Auntie, by taking an interest and encouraging me in the study. Eunice and the library staff are owed thanks for searching for archives and various books. Also to my colleagues at the University of the Highlands and Islands who were always available to help with their computer expertise. This study has had a long and eventful family gestation spanning, retirement, illness, weddings, engagements and a baby.

I also owe thanks to my friend and former colleague Dr Annetta Smith who understood that I was close to the study topic and steered me from being subjective. Her advice and guidance were invaluable.

Finally my thanks go to the participants of the study. Their willingness and honesty in the collection of the data made it an enjoyable experience for me. They gave me their memories, some of which, I will never forget.
THE AUTHOR

Catherine Morrison has retired from nursing practice after an interesting and enjoyable career. She carried out her general nurse training in Glasgow, midwifery training outside Glasgow and district nurse training in Edinburgh. She worked in Stirling as a district nurse before going to Canada for 6 years. She returned to Glasgow to take up a post as a ward sister in the Neurological Institute Glasgow for a number of years. She then went to the Outer Hebrides where she was a district nurse before becoming a district nurse manager/teaching fellow with the University of Stirling from where she retired.

Because of living in a remote area, she carried out most of her academic development by distance learning, through the University of Robert Gordon and the University of Manchester. She won the RCN Community Nurse Award in 2008 for implementing an ‘out of hours’ community nursing service for the Lewis area of the Outer Hebrides. She works part time in the local University of the Highlands and Islands.

DEDICATION

This thesis is dedicated to my first grandson Angus Morrison Smith at whose birth I assisted in Alberta, Canada on the 26th June 2013.

‘It is a great honour to be a midwife’
Introduction

This introductory chapter presents the context of the study, by examining the geographical location and population of the Outer Hebrides, at the time under study. Consideration is also given to the remoteness and rurality of the area and how this factor may have impacted on the experience of inhabitants.

The socioeconomic characteristics of the islands under study such as travel, employment, housing, religion, language and social life are looked at to provide insight into the environment of the participants. The history of health care in the area, both past and present, is examined. Finally, the rationale and scope of study is discussed, including key questions that the study will seek to answer.

The study

This study is an oral history of district nurses in the Outer Hebrides from 1940-1973. The background to the topic of the study was generated by my interest in the history of the development of nursing in my own area of community practice. The study builds on an earlier oral history study that I carried out, which collected narratives from twenty retired district nurses. The study was completed in 2006 and funded by the Queen’s Nursing Institute, Scotland. The study reinforced my belief that there is an urgent need to collect district nurse’s testimonies about their lives and experiences. This is an area which Dingwall et al. maintained was ‘relatively neglected’. ¹ Dougall carried out an oral history study of district nurses in some areas in Scotland, from 1940-1999, (not the Outer

Hebrides) fourteen years later she supported this perspective, concluding that ‘many years later this area of research remains neglected’.\(^2\)

There are some similarities between the present study and the one conducted by Dougall. This study however contributes to the history of district nursing from a number of additional perspectives. Diverse geographical locations yield different results. The unique cultural aspects of living and working in the Outer Hebrides have not previously been investigated in relation to the history of district nursing.

From 1940 to 1973, (the time under study), transport links between islands on the Outer Hebrides and mainland Scotland were poor and many of the islands were not easily accessible. In some places roads were non-existent and communication was unreliable which would have presented challenges to the district nurses. The study specifically focuses on the work and lives of district nurses in remote and rural areas of the Outer Hebrides.

**Geographical location of the study**

As shown in Figure 1 the Outer Hebrides are an archipelago, off the North West coast of Great Britain, of 119 islands, 10 of which are now inhabited. Covering 160 miles, from the northernmost Butt of Lewis to the southern Isle of Barra, the islands in 2009 had a combined population of around 26,500 scattered throughout the small and large islands with the most densely populated being the town area of Stornoway in Lewis.\(^3\)


The Outer Hebrides, or the Western Isles as they are also known, has altered considerably since 1940-1973, the period under study. In the earlier dates under study, many of the small islands were not connected to the larger island, and the population was higher than in 2009. In Uist the first link was a bridge completed in 1942 from Benbecula to South Uist, and then a causeway from Benbecula to North Uist was opened in 1960, while the Baleshare causeway was opened in 1962. The bridge connecting Lewis with Great Bernera was opened in 1953 whereas it was not until 1997 that the Scalpay Bridge connected the island to the rest of Harris and Lewis. During most of the period of this study, the islands of Bernera, Berneray, Scalpay and Vatersay were only accessible by boat, whereas in the 21st century, causeways or bridges interlink them all.

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During the period from the 1940s to 1973, transport links between islands on the Outer Hebrides and to mainland Scotland were poor and many of the islands were not easily accessible. In some places roads were non-existent and communication was unreliable. This would have presented challenges to the district nurses. Major changes were also taking place at this time both socially and in the advancement of health care nationally which impacted on the delivery of nursing care. The study specifically focuses on the working lives of district nurses in remote and rural areas of the Outer Hebrides.
Figure 2: Map of the location of the Outer Hebrides in relation to mainland Scotland and with routes from Stornoway to Glasgow and Uist to Stornoway highlighted.

A journey can now be taken within the Outer Hebrides from the Butt of Lewis (the furthest northern part) to Barra (the most southern point) in one day. Connections by ferry, road and causeway make this possible whereas, fifty years ago, at the time under study, the journey could take a few days because of road conditions and lack of transport links.
Population of the Outer Hebrides

Figure 3 provides an overview of the population distribution in the Outer Hebrides in the 21st century. As can be seen, the main Island of Lewis has the highest population and in the smaller islands there is a sparse population.

Figure 3: Population and Map of the Outer Hebrides in 2001.²

| Population of the Outer Hebrides Island areas 2001 |
|-----------------|-----------------|
| Lewis           | 18,256          |
| Bernera         | 253             |
| Harris          | 1,662           |
| Berneray        | 136             |
| Scalpay         | 332             |
| North Uist      | 1,271           |
| Grimsay         | 201             |
| South Uist      | 1,818           |
| Benbecula       | 1,249           |
| Eriskay         | 133             |
| Barra           | 1,078           |
| Vatersay        | 94              |

There was a decline in the population at the beginning of the 20th century of all the Hebridean Islands. Some of this decline appears to have taken place during the Second World War. Morton, a reporter for a Scottish newspaper, wrote of the ‘Islands of sorrow’ in a pictorial article when he discovered that the island of Lewis had lost twenty times as many of its sons, per population, in the Second World War than any other part of Britain.\(^6\)

<table>
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<th>Population by Island area</th>
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<tr>
<td>(No census in 1941 due to the war)</td>
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<tr>
<td>1931</td>
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<tr>
<td>Lewis</td>
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<td>Harris</td>
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<tr>
<td>North Uist</td>
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<tr>
<td>Benbecula</td>
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<tr>
<td>South Uist</td>
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<td>Barra and Vatersay</td>
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Figure 4: Table showing population of Islands by area from 1931-1971\(^7\)

It was reported that other rural areas in Britain, apart from the Outer Hebrides and the Shetland Islands, saw an increase in population from 1960 attributed to immigration and a significantly higher number of births than deaths. Conversely in the Outer Hebrides people moved away and the population aged. It would appear although emigration of young people to the mainland was happening, internal migration from rural Lewis to the town of

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Stornoway was also occurring with young people seeking opportunities in the town area. The overall decline in population is obvious and is reflected in individual smaller islands such as Eriskay, Harris and Berneray.

In 1942 there was concern in Britain that complex changes were taking place in rural parts of the country, with changes in land utilisation and the movement of people to the cities. The Scott Report in 1942 was commissioned to review the situation nationally. It took, however, until 2005 for a major investigation and review of Scottish rural policies to take place. This was conducted by the Scottish Government and aimed at improving the economic competitiveness of rural Scotland.

There was also disquiet in Scotland in the early 20th century, about the economic sustainability of the Outer Hebridean areas of declining population. This was highlighted in 1938 when the Secretary of State for Scotland was asked in Parliament, if the islands of the Outer Hebrides were to be kept populated. The people of the Outer Hebrides knew of the depopulation of the neighbouring island of St Kilda due to illness, insufficient medical care and economic failure. The evacuation would undoubtedly have made the smaller island communities feel vulnerable to a similar fate.

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13 Various Authors (2005) The Decline and Fall of St Kilda: The Island Book Trust, Western Isles Enterprise pp.24-25.
Remote and Rural Areas

Remote and rural health care practice has been a challenge for Governments particularly in the United Kingdom and also the USA. In Canada and Australia it has been tackled effectively for many years according to Deaville. The reason for this was that ‘it has only been recently recognised in the UK that rural populations may have different needs, not necessarily met by urban health-care models’. There has always been debate about what is defined as a rural community and some agreed features suggested by the Department of Health in 1966, include; a scattered population, strong local networks and limited local employment. However the two definitions used subsequently by the Scottish Executive are the Randall Definition and the core Scottish Executive definition. The Randall definition of rural classification is based upon population density within a unitary authority. When the authority has a population of less than one person per hectare it is considered rural. The Scottish Executive defines rural as a settlement of less than 3,000 people therefore areas in the Outer Hebrides are defined as rural, along with 89% of Scotland’s landmass and 29% of its population.

The Scottish Executive Urban Rural classification clarifies the criteria for both urban and rural with a six fold breakdown of the classification from Large Urban comprising of settlements of over 125,000 people to Remote Rural areas with settlements of less than

3,000 people and with a drive time of over 30 minutes to a settlement of 10,000 or more. Therefore the Outer Hebrides with its many small islands and scattered villages is not only rural but remote according to the classification. Living in such an area can impact on many aspects of the inhabitants’ lives, such as transport, housing, service delivery, lifestyle and a sustainable economy. The Outer Hebrides are remote now and they were even more remote in the mid-20th century. For example if a person on the island of Scalpay in Harris at the time period of the study was requiring hospitalisation, the journey could involve a crossing on a fishing boat and at least a 2 hour drive on track roads, usually in a makeshift ambulance, at times accompanied by the district nurse from the area.

When looking at health care challenges in rural areas in the 21st century, challenges identified for health professionals were; isolation, responsibility, access to professional development and the broad work profile. Each of the nurses in this study faced the challenges identified. It is clear that the identified challenges faced by the 21st century health professionals were even more acute for the district nurse of the mid-20th century. Those challenges in the remote and rural areas of the Outer Hebrides will be investigated in the study.

**Travel**

In the 21st century travel throughout the islands is by bridges, causeways and waterways. A ferry journey of 3 hours duration takes residents of Lewis 48 miles to the nearest mainland town of Ullapool where they have to drive over 60 miles to the city of Inverness. From the furthermost area of Harris to the town of Stornoway, where the main hospital is situated, is

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a journey by car of one and a half hours. Because of difficulty of accessibility by road and
ferry the people of Uists and Barra do not always depend on their neighbours in Lewis for
medical care, as it is often easier for them to go directly to mainland Scottish cities such as
Glasgow or Edinburgh. The airports that serve the Outer Hebrides are in Stornoway,
Benbecula and Barra, the latter being the only beach airport in the world to handle
scheduled airline services. The first air link between Stornoway and Inverness was
started in 1934 while the first drive-on ferry started in 1960. Prior to this time, ships served
the islands.

In the Uists, the formation of bridges and causeways between islands, such as the Berneray
Causeway in 1999, has changed the way of life for the inhabitants who no longer have to
rely on a ferry service. Before the bridges were in place, a district nurse who was based on
a small island depended on the ferry/boat to transport patients to the larger island, for
transfer to hospital by road. In 1946, an ambulance was loaned from St Andrews
Ambulance and the Red Cross to the Harris areas, on condition that a nurse always
accompanied the patient in the vehicle. The expected time allowed for travel by ambulance
from Tarbert in Harris to Stornoway was five hours, and, Leverburgh to Stornoway, nine
hours.

The various transport links to the smaller islands have helped maintain a population in the
areas whereas previously other smaller Hebridean islands have become uninhabited due to
inaccessibility to services. One example is Scarp, off the west coast of Harris, which in
1951 had a population of seventy four. By 1968 the primary school and the Post office had

22 Harris Ambulance Committee Minute Book, 1946-1963: Hebridean Archives, Stornoway, R1215.
closed. The island’s infrastructure deteriorated and the population further decreased to twelve in 1971. The island subsequently became unpopulated, as services could no longer be sustained.23

The first usage recorded of the airline service for transport of a patient was in 1933 when a man who was injured was taken from Islay to Glasgow for surgery. While the patient was still recovering in hospital a Dr MacLeod from Uist read of the event in a newspaper. He then arranged to have a patient who was terminally ill in Glasgow, transferred back to his home in Uist, to spend his remaining days there. The flight took one hour and forty minutes from Glasgow to Uist whereas the patient would have spent a day travelling by land and sea. The flight signalled the first air ambulance to the Outer Hebrides and demonstrated the scope of aerial evacuation from, as well as to, hospital.24 Until 1993 an air ambulance service based in Glasgow, transported patients from the islands, to mainland hospitals for specialist treatment. In the 21st century it is a familiar sight in the islands to see the helicopter transporting seriously ill patients to the mainland hospitals.

Alongside the challenges of travel between islands there were also problems when travelling within islands. Lewis is mainly a blanket of moorland with many lochs and rivers whereas Harris is rocky and hilly.25 This has always had implications for the health workers in the different areas, as each terrain presented its own difficulties. For example some houses are difficult to access in the mountainous areas, whereas the flatter moorland areas are more densely populated and are easily accessed. Travel and transport, particularly

during the earlier time under study, may have been challenging for district nurses, especially in such rugged terrain.

**Employment**

In 1951 the Outer Hebrides was considered a problem region continuously losing population and with few employment opportunities. However Caird, who studied the changes in the Highlands and Islands of Scotland from 1951 to 1971, found that due to the efforts of the Highlands and Islands Development Board, established in 1965, (the first regional development agency in Britain with wide financial powers to provide grants and loans) employment was created. Fishing was also expanded and by 1971 there was a large fishing fleet based in the Outer Hebrides. However distance from markets and a poor road system did not favour industrial development within the area.  

Lack of employment during the time under study resulted in many young people leaving the islands for work. Caird suggested that agricultural labour was not attractive to the younger age group as they preferred a regular income. Young women, especially, found it difficult to obtain work, with many leaving the islands to seek employment. Further education centres were located in mainland Scotland and, while pupils from rural Lewis could find secondary education in Stornoway, the Uist and Barra pupils had to attend mainland schools in Inverness or Oban. Consequently areas without senior secondary

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schools suffered from absentees, in the 15-19 age groups in particular, and these were the largest group of emigrants in the 1960s.\textsuperscript{28}

At the time of the study it was common for most men to work as fishermen, crofters and weavers, while the main employers in the islands in the 21\textsuperscript{st} century are public services, followed by agriculture, fishing and fish farming. A number of weavers are scattered throughout the islands producing Harris Tweed for which there is an international demand. Tourism is also a major means of employment and consequently the district nurse of the 21\textsuperscript{st} century in the Outer Hebrides may often provide care for people of many nationalities, which was unheard of in the 1940s. Due to the advancement of telecommunications many cottage businesses thrive throughout the islands, such as creative industries. The capital of the Outer Hebrides, Stornoway, is typical of any small town and presents residents with employment in retail stores. Throughout the islands there are many historical sites and national nature reserves that attract tourists and contribute to the island’s economy.

Tourism, which was once a perfunctory and casual affair, emerged as a useful sector in the economy after the establishment of the Highland and Islands Development Board (HIDB) in 1964.\textsuperscript{29} Its main responsibility in the Outer Hebrides was executive authority over transport, industry and tourism.\textsuperscript{30} In 1991 the Highlands and Islands Enterprise replaced the HIDB and its responsibility was extended. One function was furthering the development of Scotland’s economy by maintaining and safeguarding employment.\textsuperscript{31}

\textsuperscript{28} Caird, B.J., (1972) Changes in the Highlands and Islands of Scotland.1951-1971:
Language

During the period under study the number of people who spoke the native Gaelic language in the Uist islands ranged from 93.7% in 1931 and 73.6% in 1971. In the town of Stornoway for the same period the figures were 70.7% and 51.3%, which reflected the fact that it had never been an area where the language was as dominant as in the smaller islands. The rural areas of Lewis saw the language being spoken by 95% in 1931 to 90.5% in 1971. It was also reported in 1961 that persons speaking only Gaelic, aged three and over, in the Outer Hebrides, totalled two hundred.32 Gaelic was the main language spoken during the time period under study. Children at school were taught in English in the mid-20th century although most spoke Gaelic as their first language.

Thus the Gaelic language was spoken by the majority of the islanders, and was a desired skill until 1970 for a district nurse relocating to the islands. In 1975 the local government made a commitment to give the Gaelic Language a high profile resulting in establishing its use for road signs and place names. However the language saw a decline in its use in the 80’s and 90’s. In the 2001 census, 70% of the population spoke Gaelic. In the 21st century it is still spoken by the older generation and is being actively encouraged in schools throughout the islands. Nurses in the study recalled communicating with their patients in Gaelic.

Housing

The type of housing in the islands has gone from the traditional ‘black-house’ of the early 20th century to the ecologically friendly houses of the 21st century. A few of the black-

houses were still being occupied in the early 60s in the remote areas. A Dr Doig provided a vivid description of a ‘black house’ when he came to Lewis in 1930. One house he described; ‘was constructed by local material such as flat stones and driftwood or spars from old ships, and straw from oats or barley for thatching. The smoke got through the thatch, soot adhering to it and the roof was stripped to the cabers each year and used as manure on the croft’.  

Prior to the Tuberculosis outbreak in the Western Isles in the 1930s when Dr Doig ‘led the fight against the disease’ a number of articles appeared in journals suggesting that reasons for the rarity of some diseases, including tuberculosis, at the time occurring in people who lived in black-houses, was that the peat smoke had ‘valuable antiseptic and protective properties’.  

As far back as the early 20th century after the Public Health Act of 1875 had been in place for over 30 years the need for installation of proper drainage, sewage and water supply was regarded as an unjustifiable expense. It was reported that there was even a suggestion by the Public Health Inspector that the burning of the fires in the black houses and the sea air admitted through the open and ill-fitting doors, counteracted any poisons within the house.  

The black house was a familiar sight in the Islands of the Outer Hebrides in the mid-20th century. The black-house usually had three apartments, two for the family and a third for the cattle. Most people however during the time under study lived in stone built houses

with the bigger houses being occupied by the minister and the doctor. District nurses in each area had a house in the village allocated to them for which they paid rent.

![Figure 5: A typical Black House (Taigh Dubh-Gaelic)](image)

**Figure 5:** A typical Black House (Taigh Dubh-Gaelic)

As in other areas of Britain, post war housing was a priority in the Outer Hebrides and council houses were built in the Outer Hebrides as was sheltered housing in the 1950s-1960s. Houses were also being built for district nurses in various geographical areas from the 1940s. Despite these developments, electricity and running water were not connected until the 1950s in many places in the Outer Hebrides. The kind of houses the district nurses lived in is studied in Chapter 5.

Religion

There are few communities in the United Kingdom, which have so closely integrated their
day-to-day life with their religious beliefs as those of the Outer Hebrides. The people of
Lewis, Harris and North Uist are Protestant Christians. There are seven churches in the
town of Stornoway with at least one in all the surrounding villages in Lewis, Harris and
North Uist. In South Uist and Barra the communities are predominately Roman Catholic.
The ‘Stornoway Sabbath’ as Sunday is known, is considered to be a day of rest. Only one
shop is open in the town and for only four hours. This would not have been accepted, or
even considered, at the time under study when there was strict adherence to the
community’s religious beliefs. However in 2009, the first ferry sailing service on a Sunday
started and an airline service commenced in 2010, despite protests from both religious and
other groups, who valued the island way of life.

The influence of religion in the Outer Hebrides particularly in Lewis cannot be
underestimated although the strict Sabbath observance was not confined to the Outer
Hebrides. Clark writes of religion in a north Yorkshire fishing village in the 1970s and
discusses many similarities to Lewis such as the strict sanctions on any kind of work on the
Sabbath. Although nurse’s work has always been considered a ‘work of necessity’ it was
still influenced by religion, as, during the time under study, the district nurses’ caseload
was reduced on a Sunday, and only essential work was carried out, as is noted in a later
chapter. It is likely that the nurses in the study were expected to attend church when work
permitted.

Social Life

As in other aspects of island living, people’s social lives have undergone a great deal of change. Television was introduced into the islands in 1971. According to Thompson this contributed to a decrease in the number of people attending the cinema that had been opened in the town of Stornoway in 1934.39 A mobile cinema provided an essential service to remote areas but after the advent of television this too was discontinued.

A study of Leisure and Society in Lewis published in 1975, shortly after the time period of this study, reveals that young people had an established pattern of weekend activities. This began in the town area of Stornoway at a ceilidh (concert) and then the young people toured the dances in the country areas throughout the night. It was noted in the study that excessive drinking was a problem, although it was suggested that it was not as extreme as amongst their predecessors. According to the report, in the 1970s the focus of spending among the 18-25 age groups tended to be for the purchase of a car. The study goes on to suggest that there was a low level of interest in organised leisure pursuits while middle aged and older women with cars spent time visiting friends.40

With the introduction of centres of academia in the town, such as the nursing campus of the University of Stirling and the University of the Highlands and Islands, the ease of travel to the islands, and greater cultural diversity, residents in the Outer Hebrides in the 21st century now have the opportunity for many aspects of culture and entertainment. Each locality throughout all the islands now have access to a wider range of culture and entertainment, has its own particular social calendar which can include summer shows,

night classes, or activities pertaining to health. This is in sharp contrast to the study period where transport or work commitments made socialising more restricted.\textsuperscript{41}

**Health Care in the Area**

In the 21\textsuperscript{st} century there is one district general hospital of 150 beds in the main town of Stornoway and a small cottage hospital in the Southern Islands. There are two large general medical practices in Stornoway and ten others scattered throughout the islands with a number of community nurses allocated to each practice. Other independent services such as Optometry, Dentistry, Community Pharmacy and complementary health care are provided mainly in the Stornoway area but are also located in Harris and the Uists. The Uist and Barra Hospital is located in Benbecula while St Brendan's is in Barra. There are close links between the community nursing services, allied health professionals, social work and the voluntary services within the islands. This is in contrast to the period under study when there was only a General Rural Hospital and a Tuberculosis Hospital in the town area of Stornoway, the latter being built to care for service men returning home with Tuberculosis (TB) after the First World War.\textsuperscript{42} This is interesting in view of the fact that the population was actually larger in the study period.

During the time of the study, the general practitioner (GP) and the district nurse provided most of the health care for the community of the Outer Hebrides. The GP generally ran his practice and had surgeries in his home. Matheson recalls seeing his father who was a GP in Stornoway in the 1940s, and the district nurse returning to the surgery after being out for a long period of time delivering a baby. At that time 90\% of babies were delivered at

home. In 1896 the Lewis Hospital starting with fifteen beds was opened in the town of Stornoway, and the Sanatorium with twenty-five beds, to treat people with Tuberculosis, was opened in 1920. Uist had a small cottage hospital, as did Barra at the time under study. People who required psychiatric services had to be transported to a mainland hospital for treatment.

The Sanatorium (as the TB Hospital was called) remained between the wars when TB was prevalent among fishermen and fisher girls of the Outer Hebrides, who worked by following the herring shoals around the coast of Britain returning home to spread the infection through entire families often with fatal results. (It was often necessary for people of the Outer Hebrides to travel to the mainland for employment. In the 21st century this pattern of working away from their home persists with many young people working in oil related industries.) After the Second World War with the introduction of anti-tuberculosis drugs the incidence of TB decreased and the hospital was used to treat all infectious diseases until 1975 when it was redeveloped as a geriatric hospital. It was closed when the Western Isles Hospital opened in 1993. It provided a range of acute specialities including the care of elderly and psychiatric patients.

One of the responsibilities given to local health authorities by the NHS Act of 1946 was to build health centres to provide multidisciplinary health care teams. Health centres emerged in the 1960s with only three in Scotland and thirty in England and Wales. By 1974 there were over five hundred in England, twenty-nine in Wales and fifty-nine in

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43 Matheson, A., *Memories of the Western Isle Health Service: Stornoway*, Matheson’s Private Collection, Stornoway.

44 MacLennan, C. M., ‘before 1975’ *A Century of District Nursing in a Hebridean Isle*: Used with permission of the Lochs Historical Society, Isle of Lewis.


Scotland. During the 1970s, after the reorganisation of health and social service, the numbers of health centres increased and they became the focus for health provision and teamwork.\(^{47}\) According to Rivett, in most geographical areas, the pattern of nursing in the community changed and the nurse and the GP shared the same practice population.\(^{48}\) In the Outer Hebrides change did not proceed as rapidly. The first health centre in the town of Stornoway was opened in 1977 some ten years after they were established in other parts of the country.\(^{49}\) Only one nurse who worked in the 1970s spoke of a team approach in community care which will be presented in a later chapter.\(^{50}\) Similarly the multidisciplinary team appear to have been slower to develop in the Outer Hebrides with one participant commenting that there was not a psychiatric nurse until the late 1970s.\(^{51}\)

Approximately fifty years ago there was one district nurse attached to each geographical area of the islands, many with no doctor in residence, and only a small boat for transport, for example in Scalpay, Harris. District nurses who worked in remote areas cared for all ages and stages of life, and were on ‘first call’ making the decision about whether to call for medical assistance. The ‘triple duty nurse’ as she was called, carried out general nursing, health visiting and midwifery. In most remote areas in Scotland, this type of nurse was the norm.\(^{52}\) This is consistent with Baly’s observation when she informs us that in the early part of the 20\(^{th}\) century the district nurses were ‘all-purpose health workers’.\(^{53}\)


\(^{49}\) Stornoway Gazette, February 26\(^{th}\) 1977, Stornoway library Archives.

\(^{50}\) Interview No18 Point 1950s-1970s

\(^{51}\) Interview No33 Scalpay 1960s-1970s


Outwardly change seems to be occurring in district nursing in the 21st century, with even the title being replaced by ‘community nurse’ throughout the country. A University Campus for nurse’s training is situated in Stornoway and nurses can carry out all their training locally with community health care theory and practice incorporated into the general training. Nurses have the choice to work in the community when they complete their training. This is in contrast to the participants’ experience. After completing their general and midwifery training they were expected to carry out further training before being employed as a district nurse. At the time under study, student nurses, if they wished, could do part of their general training in the Lewis Hospital and the remainder in a Glasgow hospital. For specialist training such as district nursing or health visiting it was necessary for nurses to travel to a mainland city. Most participants opted to do all of their training in mainland hospitals.

The study setting was remote with poor transport links throughout the islands and to the mainland of Scotland. Health care practice in remote areas has always presented a challenge nationally and internationally to governments. District nurses often worked alone on islands without a doctor or a bridge and, despite housing being made available for them, it was not until the mid-1950 that electricity was connected to the grid and piped water was available.

**Rationale for the study**

The lives and work of district nurses have not been studied in this location, during this timeframe, hence, I believe this study to be unique. Many nurses were lone health workers on islands, with the GP often living some distance away. A journey to the main hospital could involve boat and road travel. Most district nurses attended to all the health care in their geographical area and lived in the community. The study investigates the lives and
work of the district nurses. The rationale for choosing 1940 as the start date of the study stemmed from the various changes that took place during the 1940s such as the Second World War and the introduction of the NHS. Choosing 1973 as the date to end the study was due to the reorganisation of the Health service throughout Britain in 1974 that transformed the way in which district nursing was managed. This represented a radical break with the past when teamwork in community care replaced the lone worker in many areas and care became less localised and possibly less rooted in the community.

In the early part of the period under study the Second World War occurred, and the NHS was established in 1948. The period between 1940 and 1970 saw many changes in society and health. In 1940s diphtheria was rife in Scotland and in the 1950s there was a post war baby boom with the 1951 census recording the largest age group as the 0-4 years. In the late 1940s it was suggested that TB was killing someone every two hours in Scotland and in 1961, 43% of women and 59% of men smoked. The contraceptive pill was introduced in the 1960s and from a peak birth rate in the mid-60s there was a marked decline in the early 70s. It is clear that TB had an impact on the population of the Outer Hebrides as was discussed earlier in this chapter. The post war baby boom would also have impacted on the work load of district nurses as 90% of babies were delivered at home.

According to Leathard, from the introduction of the NHS in 1948, the two major issues, which dominated it for the next thirty years, were finance and effective organisation. Rivett maintained that the Labour government had attacked the NHS on expenditure. By 1952, there was considerable pressure on the new Conservative Minister of Health to get a tighter grip on costs, and an independent committee was appointed to examine NHS

54 Census Timeline (2009) www.scotlandsensus.gov.uk
expenditure. The Guillebaud Report of 1956 found no basis for the claim. According to White the report found the NHS to be working well and recommended that it should be given more funds in the future. However financial stringency throughout the 1950s meant that nurses pay fell from 68% to 60% of the national average from 1955-1960 resulting in the 1962 pay campaign for nurses.

In attempting to re-organise health care, the Salmon Report 1966 recommended a development structure for senior nursing staff, which affected hospital nurses more than community. It was one of a number of reports to introduce more managerial approaches to the NHS. According to Bellaby & Oribabor although it appeared to open an extended career hierarchy for nurses, it divided nursing between those committed to nursing and those involved in clinical nursing. The Mayston Report of 1969 proposed that the structure of community nursing should be based on geography, and not on function, and that a chief nursing officer would coordinate nursing service and communicate nursing matters to the Medical Officer of Health. Baly believed that, but for both reports, the reorganisation of the health service in 1974 would have been more traumatic than was the case. District nursing management, as a result of the 1974 reorganisation of health and social care, moved from the local authority to the control by health authorities.

The implications of the many changes that took place through the three decades under study would impact on the lives of health professionals everywhere in Britain. The study examines whether district nurses in the Outer Hebrides were affected by the changes and whether these changes affected them differently from nurses in other areas. How nurses were trained was also being transformed with the first University Diploma in Community Nursing being introduced in Manchester in 1959. District nurses in the Outer Hebrides at the period under study, were general trained registered nurses and usually midwives. They received further training on the mainland as Queen’s nurses before being allocated a geographical district. The Queen’s District nurse training was carried out at one of the Queen’s Nursing Institute training centres situated throughout the UK. When the training of district nurses moved into the higher educational Institutions the Queen’s Nursing Institute (QNI) discontinued training in 1968.

In 2000 the World Health Organisation (WHO) piloted the Family Health Nurse (FHN) training in the Highlands and Islands and the Outer Hebrides was chosen as one of the sites. This new community nurse was seen as multi-faceted, generic and included helping individuals, families and communities cope with illness and improve their health (WHO 1999). The claim that a new model of nursing was required was, according to Sweet and Dougall, recognition that something must have changed with district nursing. They suggested that the ‘new’ FHN model was reminiscent of the kind of relationships that district nurses in the past claimed to have had with their patients. This study seeks to

investigate the life of district nurses in the mid twentieth century in the Outer Hebrides. It will document the various events and experiences that shaped their personal and professional development. In doing so, it may cast some light on the ‘new model’ of nursing which is being implemented in some parts of Scotland.

**Conclusion**

It could be argued that district nursing in the Outer Hebrides between 1940 and 1973 was not different from that in other remote and rural areas of the UK. However the study will focus on a specific time and place, which has never been investigated before. Unique characteristics of the Outer Hebrides at the time under study included its diversity of terrain, combined with the culture of the Outer Hebrides, which in many respects was dictated, by its remoteness and religion. The place, the Outer Hebrides, has changed significantly since the time under study with travel and communication in the 21st century making the islands much more accessible. The time under study is significant, because of the changed geographical face of the place, combined with the various health developments that have occurred.

Some of the challenges nurses faced at the time of the study would include travel, and caring for people in a remote and rural setting. Transferring patients to the nearest hospital could involve travelling by various means of transport. Health care provision in the Outer Hebrides has adapted over time in an attempt to meet the needs of a remote community, which is a constant challenge. Other potential problems for the nurses would include housing and amenities which were inadequate and the effects of the extreme Hebridean weather.
District nursing has undergone vast changes in the last fifty years and the challenges of the nurse at the time under study would have been different from that of her counterparts in the 21st century. As well as the continual changes in the practice of nurses, it would be reasonable to suggest that patients’ needs have also altered, because of the accessibility of health care and the advances in technology. The challenges of providing health care in the geographical area at the time and place under study offer broader insights into the nature of nursing care.
Chapter 1 Background to the Study

1.1. Introduction

The study is an oral history of district nurses in the Outer Hebrides from 1940 to 1973. The literature to be reviewed in relation to the topic will be the key texts relating to the history of health care both in the UK and Scotland in the 19th and 20th centuries, including material on health and housing which are believed to be inextricably linked. Health care from the introduction of the NHS in 1948 and other contemporary reforms at the time under study will be discussed in relation to district nursing.

The implementation of the Highlands and Islands Medical Service (HIMS) and the ways in which it influenced health services in the Outer Hebrides will be discussed. Governments’ subsequent reforms to improve health including the National Insurance Act of 1946 and its implications for the Outer Hebrides will be considered. The history of district nursing locally and nationally will be examined, including a history of the Queen’s Nursing Institute (QNI). Midwifery practice will be considered, as all of the participants were midwives, and the majority were Queen’s Nurses. Reference will be made to the role of the health visitor and to the implications of their introduction to the community.

Introduction of district nursing in the Outer Hebrides will be discussed along with how district nursing in remote and rural areas developed nationally and internationally. Discussion will also take place as to whether progress in remote health care has occurred between the study period forty years ago, and the 21st century. Finally a connection between the Outer Hebrides model of district nursing in the early part of the 20th century, and the American nurse pioneer Mary Breckinridge, will be considered.
1.2. Healthcare Policy from the 19th Century

Public responsibility for health can be traced back as far as 1834 when the Poor Law Amendment Act was passed. According to Baly it was a significant event in health care when the state became responsible for the standards of health and the environment. The focus of the Act was uniquely English, and in other areas such as Scotland, issues such as the improvement of poor relief drove public health.¹ Baly believed that the Act influenced the whole design of the health and welfare services in the twentieth century.² The three main principles of the Law were those of less eligibility, the workhouse test and administrative centralisation and uniformity. This meant that the policy of subsidy for the poor was reversed in order to encourage the pauper to seek work. The ‘workhouse test’ was a way of putting the ‘less eligibility’ principle into practice. Paupers were given accommodation in workhouses where they were fed less than the poorest worker. The Government hoped that the ‘workhouse test’ would remove the poor from subsidy and restore the principle of work. This did not happen. A central board administered the Poor Law and had power to control practices.³ This was partly because of the large numbers of sick and disabled poor.

By 1861 there were over fifty thousand sick people in the workhouses.⁴ The parish workhouses had sick wards and it was necessary for the workhouses to admit the poor of the area, as many were dying in their own homes, unable to obtain medical help.⁵ The first Public Health Act of 1848 acknowledged the Government’s responsibility for health and

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created a General Board of Health to control the sanitary work of the local authorities.\(^6\)

According to Baly it achieved very few reforms, due to disputes over finance and difficulty in countering the vested interest of local managers of the Institutions.\(^7\)

The workhouse reforms were also interrupted by political upheavals in 1866 preceding the Metropolitan Poor Act (1867) which began to reorganise the pattern of the workhouses. By the end of 1867 the estimated repair costs of building work on hospitals had reached one million pounds.\(^8\) In the second half of the nineteenth century the Government again attempted to improve the health of the nation with the Public Health Act of 1875 which was the culmination of various Public Health Acts from 1848 onwards and included the Artisan’s Dwelling Act. The Act established compulsory Medical Officers of Health with power to impose health regulations upon a locality.\(^9\) This was at a time when district nursing associations were spreading throughout geographical areas in Britain, with Glasgow, in 1875, being the first location to train district nurses in Scotland.\(^10\) The 1875 Act was influential for health provision, as it controlled most of the public health legislation until 1936, and some until 1948.\(^11\)

The cholera outbreaks forced politicians to take public health issues seriously and impacted on Public Health legislation. Cholera was a major killer and it affected not only the working class but also the middle classes therefore the outcry for action was significant.\(^12\)

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\(^{10}\) Stocks, Mary, (1960) *A Hundred Years of District Nursing*: p.105.

\(^{11}\) Baly, M.E., *Nursing Social Change*, p104

According to Burrell and Gill the first cholera epidemic was believed to have reached Britain in 1831. Baly suggested that the Government’s responsibility to health was seen some years later during the 1854 cholera epidemic in Oxford. Dean and Bolton maintain that, when a nurse was called on to intervene, her ‘care’ was revealed as a crucial link in the fight against the ‘danger’ presented by the physical conditions of the poor in their own homes. Subsequently it was argued in Sir Acland’s memoirs, about the epidemic, that the provision of nurses to attend the poor in their own home was necessary. Florence Nightingale obtained one of her earliest nursing experiences caring for victims of the cholera epidemic in 1854 before she went to Crimea to nurse the Crimean War victims.

The Report on the Sanitary Conditions of the Labouring Population of Great Britain in 1842, which led to the Act being implemented, showed a strong link between the environment and health. The Report also noted that the mortality from fever was greater in Scottish cities than the most crowded area of England. It was not until 1855 that the civil registration of births and deaths was introduced and, for this reason, death rates and causes in the first half of the 19th century are patchy. Nevertheless the Sanitary Report concluded

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16 Baly, M. E., *Nursing and Social Change*, p.102
‘there is evidence to prove that the mortality from fever is greater in Glasgow, Edinburgh and Dundee than most crowded towns in England’.\textsuperscript{18}

Edwin Chadwick (1800-1890) the author of the Report was influential in taking forward the proposals of the Act in England, which were proper drainage, the removal of refuse, and the improvement in the supplies of water.\textsuperscript{19} The 1848 Public Health Act did not cover Scotland until 1886 therefore initiatives were carried out through the local authorities such as employing sanitary inspectors and medical officers of health.\textsuperscript{20}

In Scotland because of the cholera epidemics, a momentum for intervention was developed; with initiatives coming from the local authorities aided by the Burgh Police Act of 1861 and the Public Act (Scotland) of 1867. Police had the power to spend rates for a range of purposes including a considerable amount of cleaning. While Glasgow in the south of Scotland was attempting to improve their health by extracting water from Loch Katrine, the Outer Hebrides were struggling with land feuds and overcrowding.\textsuperscript{21} The Crofter’s Act of 1886 however gave the people rent for their land, and compensation for improvement to property. Subsequently the Medical Officer of Health commented that ‘much has been done to improve the dwellings and in Barra a skilled mason has been employed in building houses of an approved type’.\textsuperscript{22} Regardless of this comment it would appear that housing and health reform in the Outer Hebrides was slower than in parts of the rest of Scotland.

\textsuperscript{18} Chadwick, E., (1842) Report on the sanitary condition of the labouring population of Great Britain: London, HMSO.
1.3. Health and Housing

Housing was incorporated into the 1875 Public Health Act by adding the Artisan’s Dwelling Act, which allowed authorities to replace unsanitary housing, and was the forerunner of municipal housing.23 During the second part of the 19th century Britain, and particularly England, had begun to enjoy a period of increasing prosperity. However in Scotland conditions were much less satisfactory with a low wage economy and greater poverty. According to McCrae it was recognised that Scottish housing was a longstanding problem and the cause of illness and poor health. By the 1930s a housing programme was in place and raised the standard of living. Local authority surveys in Scotland showed that since 1919, 83% of houses were built under state aided schemes. In the larger cities of Scotland the contrast between the rich and poor was striking. As the population of Scotland grew between 1830 and 1930 there was a great need for affordable housing in towns and cities because of the poor housing conditions.24

A Report on the Sanitary Conditions of the Outer Hebrides in 1906 made for grim reading with every house in one geographical area being described as uninhabitable, with animals and people sharing the same rooms. It went on to suggest that many of the houses were a disgrace to civilisation.25 In the Outer Hebrides it is unclear when the first Medical Officer was appointed but it is recorded in the Stornoway Public Health Ledger that a Grant for a Medical Officer of Health and a sanitary inspector for the year 1918 was agreed.26

Conditions improved throughout Scotland in the first years of the 20th century and, by the

1940s, the local authorities in Scotland had built houses under state aided schemes, and a record number of contracts for housing had been approved.\textsuperscript{27} Improvement of housing was on the agenda of the Harris District Council frequently during the period from 1952 to 1972.\textsuperscript{28}

1.4. Twentieth Century Government Health Reforms

Many areas in the UK, in the early nineteenth century had voluntary hospitals funded by public donations. Poor Law Hospitals which were funded by the poor law authorities later became municipal hospitals. The latter were provided by the local authorities and used for the treatment of people with infectious diseases. Poor law Infirmarys developed after the Poor Law in 1834 and the nurses working in them cared mainly for the poor, chronically sick and the elderly. Voluntary hospital nurses on the other hand, cared for and attended primarily to the acute sick and the middle classes and remained independent until the 1948 National Health Service (NHS) Act brought them into the NHS.\textsuperscript{29}

According to Leathard, the state increased its responsibility for the provision of health care for the individual as a result of alarm at the poor physique of the volunteers for the Boer War of 1899-1902, which triggered action.\textsuperscript{30} Levitt and Wall also noted that the army’s Committee on Physical Deterioration reported that 48% of recruits had to be rejected on physical grounds and their recommendations were the basis for the establishment of the School Medical Service in 1907 and the introduction of School Medical Inspections.\textsuperscript{31}

\begin{thebibliography}{99}
\bibitem{27} McCrae, M., \textit{The National Health Service in Scotland Origins and Ideals 1900-1950}: pp. 91-94.
\bibitem{28} Minute Book 1952-1972 Harris District Council: Tasglann Stornoway Archives, R1.199.
\end{thebibliography}
related legislation in 1906 Education (Provision of Meals) Act were part of the Government’s reforms, as well as the introduction of the Old Age Pension in 1908.\textsuperscript{32}

An important Act which had implications in Britain was the National Insurance Act in 1911 which provided free care from GPs for certain groups of working people earning under £160 per year.\textsuperscript{33} The aim of the Act was to relieve poverty associated with sickness. McCrae and Leathard believed that the Act helped towards limiting poverty during the depression and high unemployment of the 1920s and 1930s. It gave workingmen a doctor, but not their wives and families, who still had to pay the doctor’s fees.\textsuperscript{34} The Act was the catalyst for the Dewar Report in 1912, which in turn changed the face of health care in the Highlands and Islands of Scotland and which is discussed in the next section of this chapter.\textsuperscript{35}

In 1929 the Local Governments Act marked the beginning of the end of the Poor Law. Responsibility for workhouses and infirmaries was transferred to the local authority and Medical Officer of Health, as were public health services. By the end of the 1940s there were one thousand and fifty local authority hospitals including some that specialised in infectious diseases and tuberculosis.\textsuperscript{36} The introduction of the welfare state in the post war period built on these earlier reforms.

\textsuperscript{32}Leathard, A., \textit{Health Care Provision Past, present and future}: p.2
\textsuperscript{33}Leathard, A., \textit{Health Care Provision Past, present and future}: p. 4 and Levitt, and Wall, A., \textit{The Reorganised National Health Service}: p. 3
\textsuperscript{34}Rivett, G., (1988) \textit{From Cradle to Grave}: London, Kings Fund, p.1
1.5. The Highlands and Islands Medical Services (HIMS)

In 1912 the Chancellor of the Exchequer appointed a Committee to consider ‘how far the provision of medical attention in districts situated in the Highlands and Islands of Scotland is inadequate and to advise on the best method of securing a satisfactory medical service therein’. The reason behind the investigation into health care in the remote areas was, that at the commencement of the National Health Insurance scheme in 1911 in Britain, it was realised that self-employed crofters and fishermen in the remote parts of the highlands had no status as insured persons. They received no wages and therefore could not pay into the Insurance scheme. The Committee set up to investigate how to resolve the problem became known as the Dewar Committee named after one of its members Sir John Dewar who was an MP for the Highlands of Scotland.

Among the problems the Dewar Committee found in the Highland and Islands of Scotland was that there were insufficient nurses, lack of organisation of nursing services, poor follow up and treatment of disease, and mismanagement at confinements. The enquiry found that in the Outer Hebrides, untrained crofter’s wives were attending each other at births and, in the area of Barvas in Lewis the doctor had reported the deaths of three mothers in twelve days. One of the committee maintained that this ‘was the result of deficiency in trained midwifery skills’. Lord Lovat, a witness before the Dewar Committee

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37 Highlands and Islands Medical Service Committee, (1912) (Dewar Committee) Report to the Lord Commissioner of His Majesty’s Treasury: Edinburgh, HMSO.
said ‘the medical salvation of the Highlands and Islands lies in organised nursing’. 39

According to McCrae this proved to be the case.40

One of the recommendations of the HIMS Committee Report was that ‘nursing be an integral part of the medical services’.41 To give an example of the difference a nurse could make to a community, the Report mentions a letter from the Nursing Association in Gigha, an inner Hebridean island where a Queen’s nurse was allocated. The secretary of the association spoke of the ‘feeling of quiet security it brought to the inhabitants to have the nurse living in their community’.42 At that time, there was concern, which was also noted in the HIMS Committee Report that there was a need for the provision of health education to the community, as well as addressing the School Medical Inspection Act of 1908. One of the Committee members, Dr Reardon, went as far as to say that ‘a nurse in many cases is far more essential than a doctor.43 The Report also mentioned nurses who were overworked and referred particularly to a district nurse Annie Maclean of Harris, in the Outer Hebrides (whose photograph is inside the back cover of this thesis).44

As a result of the Dewar Committee findings, in 1912 a treasury grant of £42,000 was donated by the Government to support the proposed new medical service, which was the equivalent to one shilling and sixpence for each member of the population. The first objective of the scheme was to provide GP services for every member of the community.

Doctors were also given financial assistance to buy their transport and housing. The

39 Highland and Islands Medical Services Committee:  p. 20.
41 Highland and Islands Medical Services Committee:  p.21.
43 Highlands and Islands Medical Service Committee; (Dewar Committee) (1912) Report to the Lord Commissioner of His Majesty’s Treasury:  Vol. 1, Edinburgh, HMSO. p.20.
44 Highlands and Islands Medical Service Committee, pp. 23 -25.
outbreak of the war in 1914 interrupted some of the plans as many medical and nursing personnel joined the armed forces. According to McCrae however, the HIMS revolutionised health care in the Highlands and Islands and general practice owed much of its success to the improvement in domiciliary nursing services.\(^{45}\)

District nursing services were also provided with grants from the HIMS to provide appropriate houses for nurses, and to pay 70% of expenditure to District Nursing Associations, who at that time were overseeing as well as funding some of the district nurses. Similarly in the rest of the UK, the implementation of the National Health Insurance Act opened up new opportunities for co-operation with bodies entrusted with statutory functions, since home nursing was part of the service to insured persons. However this was not a simple task as it was noted that ‘The Nursing of Insured Persons’ was an agenda item for the committee of the Queen’s Nursing Institute for many years after 1911.\(^{46}\) In the Highlands and Islands the grants received were being spent on staff and housing with three houses for doctors and nine for nurses completed before the HIMS plans were interrupted by the war in 1914.\(^{47}\)

A review of the HIMS was included in the Cathcart Report, (1936) drawn up by the Secretary of State for Scotland in 1933 to review the existing health services in Scotland, and make recommendations for, ‘any change in policy that may be necessary for the promotion of efficiency and economy’. The review concluded that the Highlands and Islands were now attracting medical men of a quality superior to the bulk of practitioners who found their way to the Highlands before the service was instituted. The Report went

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\(^{47}\) Cathcart Report (1936) *Committee on the Scottish Health Services Report*: Edinburgh, HMSO.
on to claim that the combination of doctor and nurse was ‘extraordinarily impressive’ and many of the doctors were saying that the practice in their areas would be impossible without the services of the nurse, with her work in health education being of particular value.  

It is clear from the tone of the Cathcart Report that district nurses were becoming valued members of the health care team and, in many remote areas in the Highlands and Islands of Scotland, were the only health professionals. By the time the National Health Service was implemented in 1948 the HIMS had been providing comprehensive care to the Highlands and Islands for 35 years. However it has been suggested that the importance of nursing to medical practice was not recognised for many years.

1.6. Health Care Policy 1948-1973

It would be naïve to think that organised health care only started in 1948 at the time of the introduction of the National Health Service (NHS) and that care was not being provided to the population of the UK prior to this. Rivett endorsed this view when he noted that the designers of the NHS did not start with a clean sheet of paper. Rather, the service was a rationalisation of what existed. He went on to suggest that it was the hospital services that were in most need of reorganisation as many were in ‘a muddle and at the end of their tether financially’.

In contrast, areas in Scotland in 1948 had already been successfully operating a comprehensive state health service from 1913 through the HIMS. The Secretary of State

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for Scotland introduced the NHS (Scotland) Bill in the House of Commons in 1946 by informing the House that the HIMS had provided the necessary pointers towards a comprehensive service for the whole country. According to McCrae half of Scotland’s landmass was already covered by state funded health system and was being run from Edinburgh. It is recorded that the war years had seen a state funded hospital building programme in Scotland on a scale unknown in Europe, which was incorporated into the new NHS.

Rivett claims that the main change that occurred when the NHS was created in July 1948 was the way people could obtain and pay for care. Instead of paying fees for their medical care they paid instead as taxpayers. For the first time hospitals, doctors, nurses, pharmacists, opticians and dentists were brought together under one umbrella organisation that was funded directly by the Ministry of Health and free for all at the point of delivery.

District nursing services including midwives and health visitors became the responsibility of the local health authority under the control of the Medical Officer of Health.

Health education had been pursued during war years but messages were now more concentrated on the dangers in the home, infectious diseases and accident prevention. In 1951 The British Medical Association (BMA) launched a magazine ‘Family Doctor’. The aim of which was the promotion of health. However some subjects were taboo, one being contraception. The birth rates were rising and demand for beds outstripped supply, therefore domiciliary births rose. Nevertheless the main complaint from mothers was that

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51 McCrae, M., *The National Health Service in Scotland Origins and Ideal*: p.1
52 NHS Scotland, Timeline (2008) NHS Scotland60@scotland.gsi.gov.uk.
there was lack of pain relief, as midwives in the community were not permitted to give the analgesic, Pethidine, until 1951.\textsuperscript{55} It had been approved by the Central Midwives Board (CMB) in 1948 and had been used in 75\% of hospitals from 1948. Training for the administration of premixed nitrous oxide and oxygen, which was an inhalational obstetric analgesia, was not taken up in many local authorities, as the equipment weighed twenty-two pounds, which would have made it difficult for one person to carry. Additionally the CMB rules stipulated that two midwives had to be present when ‘gas and air’ was administered and, with many geographical areas only having one midwife, it would have been futile to train them.\textsuperscript{56}

The NHS encountered many problems between 1948 and 1974 mainly due to conflict over funding, according to Levitt and Wall. They maintained that when charges for prescriptions were introduced in 1952 and the weekly NHS contribution was established, the idea of a free service for all was breached.\textsuperscript{57} Another problem was that the demand for NHS care rose very rapidly and resources were often insufficient to meet it. Rivett suggests that there was a perception that some people were getting something for nothing and that people were seeking free supplies of household remedies for which they had previously paid, such as aspirin, laxatives, first aid dressings and cotton wool. He went on to suggest that many people ‘were going round with two pairs of spectacles when one would have

\textsuperscript{56} McIntosh, T., (2012) \textit{A Social History of Maternity and Childbirth: key themes in maternity care}: London, Routledge, p.96.
\textsuperscript{57} Levitt, R., & Wall A., \textit{The Reorganised National Health Service}: London, Chapman and Hall, p 105.
done’. Webster however comments that there was no evidence of waste of resources and that the service was being economical in the delivery of its service.

Although no structural change in the NHS was recommended, one member of the Guillebaud Committee, (set up in 1953 to look at the costs of the NHS and referred to in the previous chapter) identified a weakness of the NHS as being its division into three parts, operated by three sets of bodies, and each financed differently. The GP services and hospital services were administered separately while community nursing and public health services remained under state control. One result however of the Guillebaud Report, was the publication in 1962 of ‘A Hospital Plan for England and Wales’, which Levitt and Wall believed, was the first major demonstration of planning in the NHS.

1.7. A General History of District Nursing

Nursing the sick and caring for them in their own home has been carried out since the beginning of human society. Until the late eighteenth century the lay nurse carried out many roles in the community such as handywoman, corpse washer or midwife and could be practising bleeding or blistering, among many other tasks. In 1840 Elizabeth Fry (1780-1845) founded a Protestant organisation that later became known as the ‘Institute of Nursing Sisters’ because she felt that ‘there was a necessity for a class of women to attend upon the sick different from the hireling nurses that are generally obtained’.

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The debate regarding the social class of nurses continued throughout the Victorian district nursing movement and had its roots in views about the social class and the role of working women. With the emancipation of women and their movement into paid occupations the training of district nurses became established. At this time a small number of women were entering the medical profession signifying a wider movement towards reform in the education of women. Florence Nightingale was ambiguous about the role of Elizabeth Garrett, the first female doctor. She asserted ‘Let women begin with the Profession (midwifery) which is undoubtedly theirs’. Yet she also suggested that ‘whether it is right or wrong that women should enter medicine, shall we not do more harm than good in shutting them out’. Although Nightingale’s argument may have been about her views on the professions of women, she also had an opinion regarding the qualities required to be a nurse. However, Dingwall et al maintained that Nightingale accepted that the district nurses would require a higher standard of character and skills, which would have the effect of excluding working class candidates.

It is difficult to discuss the history of district nursing without a mention of the notorious fictional characters of Sarah Gamp and her colleague Betsy Prig portrayed by Dickens. Their pictures have been widely publicised over the years to typify the nurses found in nineteenth century private nursing, and St Bartholomew Hospital London, respectively. Dickens described nurses ‘as those women who care for the sick by neglecting them, stealing from them and at times physically abusing them’. However Summers presents a

65 DN 150 (2008) Queen’s Nursing Institute, Edinburgh.(Published to Celebrate 150 years of District Nursing)
different view of Sarah Gamp, and the nurses she represented, when she claims ‘her character was destroyed, she was vilified, as no doctor ever was, for expecting to be paid for her work: her professional autonomy was undermined; most important of all, perhaps, her skills were denigrated or ignored. She had more expertise than many hospital nurses and in some cases as much as male medical practitioners’. If this view is to be believed a great deal of damage has been done to the history of nursing, which frequently portrays Sarah Gamp and her like, as the characters from which the profession developed.

Although District nursing is often said to have had its beginnings in Britain in 1859 when William Rathbone, a Liverpool philanthropist, was impressed by the care that the nurse Mrs Robinson gave to his wife when she was terminally ill, care had previously been provided in the home by Catholic societies and deaconesses in some European settings. This may have provided a model for district nursing. Abel Smith maintained that Britain owed the reform of nursing to the Protestant Institute of Deaconesses at Kaiserswerth Germany which influenced British nurses such as Florence Nightingale.

After Mr Rathbone’s wife’s death, he employed Mrs Robinson to go to the poorest districts where people could not afford care, to try to nurse people in their own homes. A month later Mrs Robinson returned distressed at the conditions she saw in the community, and had to be persuaded by Rathbone to continue, which she did for four years. It was clear that little could be achieved by one nurse so Rathbone enlisted the help of the Victorian

pioneer of nursing Florence Nightingale to set up a nursing school in the Royal Infirmary Liverpool.73

Once the nurses were district trained, Liverpool was divided into eighteen geographical districts and nurses were attached to an area to work with a ‘Lady Superintendent’ providing supervision.74 Members of wealthy families assisted with the funding of the nursing scheme, and were often voluntary members of the committees which ran the district nursing associations. By the late nineteenth century most of the superintendents were trained nurses.75 From Liverpool, district nursing spread to other industrial cities introduced in Manchester in 1864, Derby in 1865 and Leicester in 1867. The Glasgow Sick Poor Private Nursing Association was established in 1875 and in Dublin St Patrick’s Home for district nurses was founded in 1876. Glasgow in 1875 became the first location for district nurse training in Scotland.76

It would appear that historians tended to concentrate on hospital nursing more than district nursing, as literature on district nursing is sparse. Howse, who researched district nursing in Gloucestershire, commented that the two main texts on district nursing were written for special occasions in nursing, and were designed to emphasise its positive aspects.77 Stocks, who was not a nurse, was invited by the Queen’s Institute to become their historian and write about the first hundred years of district nursing. Similarly Baly, a nurse historian,

was invited on the occasion of the Queen’s Nursing Institute centenary to trace its history. In 2008 Sweet and Dougall sought to redress the balance with a comprehensive book on community nursing and primary health care which sought to look at the professional lives of the district nurses and the challenges they faced.

Two of the significant events in nursing history that impacted on all nurses were; the 1902 Midwives Act and the Nurses Registration Act of 1919, which introduced state registration of nurses and midwives. The Midwives Act however did not apply to Scotland, for which another Act was passed in 1915, when the Central Midwives Board for Scotland (CMB) was established to regulate the training and practice of midwives by regularly updating their rules. In the period when the Act only applied to England, midwives from Scotland went to London to sit the examination to be placed on the midwives roll.

The Nurse’s Registration Act was passed in 1919 allowing each UK country to set up its own General Nursing Council (GNC) with duties to compile a syllabus of subjects for examination and to compile a register of qualified nurses. With the introduction of the registration of nurses, Abel-Smith suggested that there was a time when a varied group of people were engaged in the practice of nursing. Ladies with ‘excellent instruction’ and servant girls with a minimum of training belonged to the same occupation and the standard of nurse training was also diverse. By 1925 the first state examinations for nurses were

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Fifteen years later when this study begins most nurses working in the community were not only registered but were also registered midwives and Queen’s nurses.

In anticipation of the implementation of the NHS in 1948, the Wood Report of 1947 was concerned mainly with the recruitment and training of nurses. There was an expectation that with the new structure there would be an increased demand for nurses. One of Wood’s proposals was that nurse training should be based on regional training Boards for each NHS region and that the training period should be reduced. The Royal College of Nurses (RCN), which had not been consulted by the working party, objected. Similar views were expressed by professional leaders including the GNC, in particular about the reduction of the general nurse training from three years to two. Another cause of conflict was that the district nursing training was no longer to be under the control of the GNC, which produced controversy and debate in the ensuing years. District nurses’ training was usually carried out after completion of general nurse training.

The introduction of the NHS in 1948 affected all nurses. Yet the White Paper outlining the proposals for the NHS only mentioned the district nurses, and noted that ‘a full home nursing service must be one of the aims of the new organisation and all who need nursing attention in their own homes will be able to obtain it without charge’. One participant of this study recalled payment being mandatory for her services, prior to the introduction of

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the NHS. Until the introduction of the NHS in 1948, district nursing was run and founded by local voluntary district nursing associations. Control was then transferred to local government under the direction of the Medical Officer for Health. In the Lewis Nursing Services Sub Committee Minute Book which recorded information regarding district nurses, such as their time off and transport problems, the last entry was 1947.

During the years after 1948 there was a significant change in the way district nurses worked. Patients were discharged to their homes more quickly and more acutely ill patients had to be cared for by the district staff. The work of the district nurse increased and radically changed during this period. Working conditions had gradually improved and the recommended working week was reduced from forty-eight hours in 1949 to forty in 1972. Holidays were also longer and by the mid-seventies nursing staff could no longer be dismissed when they married. Problems nevertheless continued with the provision of education to all nurses. The Platt Report of 1964 produced the document ‘Reform of Nursing Education’ in an attempt to improve the situation.

Although the Wood Report in 1947 and the Platt Reforms in 1964 proposing educational reform for nurses were widely debated, they failed to bring about the necessary legislation to change the educational programme. It was believed, that had the reforms been

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87 Interview No2 Brue 1940s-1950s
89 Lewis Nursing Services Sub-Committee (1940-1947) Minutes: NHS Western Isles Archives, Stornoway.
accepted, it would have brought about a greater emphasis on community nursing.\textsuperscript{94} The Briggs recommendations in 1972 were well received and were important to district nurses because, ‘it was the first Report to plan with the needs of the community as its base, rather than the service needs of the hospitals’.\textsuperscript{95} One of the Briggs committee’s terms of reference was ‘to review the role of the nurses and midwives in the hospital, and the community, and the education and training required for that role, to meet the needs of an integrated health service’.\textsuperscript{96} Although it is understandable that such a remit would result in some satisfaction among nurses whatever their role, Hallett & Cooke suggest that it led to a period of uncertainty during the 1970s. Legislation was not forthcoming until 1979 thus educational reform took longer to achieve.\textsuperscript{97}

In the 1960s nursing research that was being carried out reflected some of the issues of the day. One was the failure to retain staff therefore a study was carried out on the subject of ‘marriage and nursing’ which was described by Baly as significant because of its low response rate. This was due to the fact that once a nurse changed her name when married she was untraceable as there was not a ‘live register’ at the time. Another study ‘Feeling the Pulse’ was to gather information on which to base the future training of district nursing. The study revealed that a high proportion of nurses’ time was spent travelling and that nurses were often distracted by non-nursing duties.\textsuperscript{98} This research may have helped to stimulate awareness that organised primary health care teams, might be a more effective way of meeting the health needs of the population. However it was noted that reforms did

\textsuperscript{98} Hockey, L., (1966) \textit{Feeling the Pulse}: London, Queen’s Institute of District Nursing.
not take place until 1974 with the reorganisation of the health service. Until that time most
district nurses in the Outer Hebrides were trained district nurses with many being Queen’s
Nurses.

1.8. The Queen’s Nursing Institute

The Queen’s Nursing Institute was an important influence on district nursing in the Outer
Hebrides. With the recognition of the emerging district nursing service, Queen Victoria (on
the celebration of her Jubilee in 1887) provided a grant of £70,000 from the Queen
Victoria Women’s Jubilee Fund to be used for providing the ‘training, support,
maintenance and supply of nurses for the sick poor, as well as establishing training homes,
supervising centres, cooperating with other bodies and established branches as
necessary’. 99 A Royal Charter in 1889 constituted the Queen Victoria Jubilee Institute for
Nursing with a President and Council to take charge of the annual fund.

The early stages and organisation of the scheme were fraught with problems as debate
ensued in national and nursing press, as well as with the main people involved, namely
Florence Nightingale, William Rathbone and Mrs Dacre Craven (nee Florence Lees) who
published a Guide to District Nursing and Home Nursing in 1889. The debate centred on
how the grant should be used, whether another nursing organisation for nurses was
required, and the differing education of nurses. 100

Training of Queen’s Nurses included sanitary reform, health promotion, ventilation,
drainage, water supply, diet for the healthy and the sick, the feeding of infants and the care

Helm, p. 21.
of the newborn with some of these subjects unfamiliar to trained hospital nurses.\textsuperscript{101} It was also noted that nurses were also advised ‘to read Mrs Craven’s excellent manual’. Baly commented that ‘it is salutary to think that in 1890 a nurse was writing a standard textbook for nurses’.\textsuperscript{102} Considering that in the late nineteenth century nursing was still based on a medical model, it reveals Mrs Craven as a pioneer for district nursing. Mrs Craven was herself a trained nurse and carried out most of the investigative work for a report into district nursing in the London area in 1875. She was particularly scathing about the care that was being provided.\textsuperscript{103} As a result of the findings of the survey it was accepted that there was a need for superior educated, trained nurse superintendents to oversee the provision of nursing care.\textsuperscript{104} Baly maintained that Mrs Craven must be seen as the true originator of professional district nursing.\textsuperscript{105} Florence Nightingale was said to have described her as a ‘genius of nursing’.\textsuperscript{106}

A concern of Florence Nightingale was supervision of district nurses and she had recommended Miss Lees as the first ‘Superintendent General’.\textsuperscript{107} Florence Nightingale was concerned that once the nurse was on her district there was little inspection and supervision. However as time went on, despite objections at first by GPs, superintendents were employed, and inspected each Queen’s nurse periodically, until the Queen’s nursing training was discontinued in 1967.\textsuperscript{108}

\begin{thebibliography}{9}
   \bibitem{101} DN 150 (2008) QNIS Archives, Edinburgh.
   \bibitem{103} Bingham, S., (1979) \textit{Ministering Angels}: New Jersey, Medical Economic Company, p. 95.
   \bibitem{104} Stocks, M., (1960) \textit{A Hundred Years of District Nursing}: London, George Allen & Unwin Ltd, P.47.
   \bibitem{105} Baly, M.E., (1987) \textit{A History of The Queen’s Nursing Institute 100 years 1887-1987}: p. 37.
   \bibitem{106} Bingham, S., (1979) \textit{Ministering Angels}: p. 95.
   \bibitem{107} Stocks, M., (1960) \textit{A Hundred Years of District Nursing}: P.47
\end{thebibliography}
The Superintendent, who was sent from headquarters to carry out inspections on Queen’s nurses, was concerned with all aspects of the nurses, both on and off duty. Reports from the superintendents were concerned that the nurses should be neat, orderly and tactful with the nurse’s whole life an inspiration to orderly habits. This was in keeping with the Nightingale tradition as she maintained that ‘ward training was but half training’. The other half consisted of women being ‘trained in habits of order, cleanliness regularity and moral discipline’ with nurses’ rooms and homes subject to inspection.\(^\text{109}\) During the early part of the period under study, superintendents were well established and were concerned with the environment that the nurses lived in as well as the care that was given to patients.

The Queen Victoria Jubilee Institute for Nursing changed its name in 1928 and was known as The Queen’s Institute of District Nursing. In Scotland the history of Queen’s Nurses was similar to that of England with the District Nursing Associations becoming affiliated to the Queen’s Nursing Institute in 1889 when conditions were laid down for training and organisation of Queen’s Nurses.\(^\text{110}\) A Scottish Council was established whose president was Queen Victoria’s daughter Princess Louise. In Glasgow a sick Poor and Private Nursing Association was already in existence which had been founded by Mrs Mary Higgenbotham who is believed to be the pioneer of district nursing in Scotland.\(^\text{111}\)

Queen’s Nurse training initially was to be at an approved hospital for at least a year, then training in district nursing for six months, including the nursing of mothers and infants after childbirth. Nurses who worked in country districts required three months training in


midwifery. The first training school in Scotland was located in Glasgow and accepted nurses for Queen’s training with other geographical areas such as Edinburgh and Dundee becoming Queen’s nurse training branches. At the time under study nurses were required to complete their three year general training before being accepted in a Queen’s training centre. Most were also midwifery trained.

Examples of questions from the 1948-1958 Queen’s Nurse examination papers follow and indicate the kind of patients district nurses cared for:

1948 What help apart from your nursing care might you be able to obtain for a necessitous patient recovering from hemiplegia? From what sources could this help be obtained?

1950 For what kind of disease have you seen the following prescribed;

a) Streptomycin

b) Morphine. Describe the procedure when giving one of these in the patient’s home?

1952 You are called in to nurse a patient who has been discharged from hospital after two years treatment with poliomyelitis. He has paralysis of both his legs and is alone in the house from 8am until 5pm. Describe the plans you would make for his care?

1957 What would you do if called to the following emergencies?

a) A diabetic patient in a coma

b) A child with a cut hand that is bleeding badly

c) A man who has tried to commit suicide by putting his head in a gas oven

The examination papers would probably include medical and surgical problems that the nurse might encounter in her practice. The papers also provide awareness of the medical

conditions that were prevalent at the time period of the examinations. Further examples from the examination papers are included in Appendix 1.113

In the early part of the twentieth century the Queen’s Nursing Institute was developing throughout the UK and its prestige had spread abroad. Holland, Sweden and Canada contacted the UK to assist them in setting up training and a number of Queen’s nurses acted as advisors to countries that wished to start a system of district nurse training.114 Meanwhile, in the Outer Hebrides in 1912, the introduction of the Highlands and Islands Medical Services (HIMS) and the allocation of Queen’s Nurses had attracted the attention of Mary Breckinridge in the United States of America who was intending to introduce a community nursing service in Kentucky.

1.9 District Nursing in the Outer Hebrides

The first Lewis Hospital in Stornoway was opened in 1896 at a cost of £2,000, funded by the community, with a bed capacity of fifteen. There is no information that there were any qualified nurses in Lewis when the hospital was opened although there did exist a number of ‘knowledgeable women’ who assisted with midwifery. Before the opening of the Hospital a bequest of £1,000 from Lady Ashburton was the means of providing a district nurse and a ‘Bible woman’ to care for the sick in the town area of Stornoway. The Hospital itself was funded for 50 years from the local community and initially their own local general practitioner cared for the patients.115

‘Bible women’ were the initiative of Ellen Ranyard who, in London around 1857, was a missionary and social worker who believed in the importance of deepening people’s religious knowledge as well as caring for their health. After three months training in a general hospital, and then midwifery training, the ‘Bible woman nurse’ as she was then known, was allocated a district to work in.\textsuperscript{116} It would appear that the ‘Bible woman’ in Lewis was not nurse trained, but provided a similar function as those in London, mainly social work. As for the district nurse in the Lewis Hospital, her duties were carried out in the hospital, and the community.

The Second Report of the Lewis Hospital (1898) announced the first appointment of a Queen’s Nurse to the joint offices of the Hospital and the district, and, that the nurse was carrying out work in the town area of Stornoway, with the patients being supplied with clothing and food from the hospital when necessary.\textsuperscript{117} Training of nurses was introduced shortly after the hospital opened and with the addition of students the staff gradually increased. The training involved a year’s instruction supported by parish councils, and then it was increased to two years, followed by a period of midwifery training carried out in mainland hospitals.\textsuperscript{118} In 1899 the Lewis Hospital was reporting that a local candidate would train under the auspices of the Queen Victoria Jubilee Institute for Nursing.\textsuperscript{119}

The first appointment to a rural area was reported in 1895 with the nurse’s salary being paid by the Ladies Highland Association and the Lewis District Committee. According to

\textsuperscript{117} Lewis Hospital Report (1898) \textit{2nd Report of the Lewis Hospital}: NHS Western Isles Archives, Stornoway.
\textsuperscript{119} Lewis Hospital Report (1899) \textit{3rd Report of the Lewis Hospital}: NHS Western Isles Archives, Stornoway.
the Local Health Report, the advantages of the district nursing service became so apparent that new appointments were made and even before the HIMS was introduced in 1912, there were nine district nurses in Lewis. Although an application had been submitted for cars for nurses in some areas, the proposal was withdrawn due to financial constraints.  

In 1917 it was noted in the Report that there were thirteen district nurses working throughout the Island of Lewis with four of them being Queen’s Nurse trained. The Report goes on to say ‘it would be difficult to overestimate the service rendered by the district nurses, for example the mortality among the new-born has been greatly reduced and puerperal disease has also greatly diminished’. By 1934 there were nineteen district nurses, seventeen of these being Queen’s nurses with the ‘mode of conveyance used by district nurses being the bicycle, and two of the heaviest districts, Back and Gravir, provided with a motor cycle’. It was recognised that the bicycles were ‘not really satisfactory’ for the districts in Lewis. In Harris the Local Association’s reply to a nurse who requested a new bicycle was, ‘in view of the alleged defects of the cycle these dangerous hills should not be cycled’. In other words the blame for the broken bicycle was its misuse by the nurse.

The Lewis Hospital Report on the District nursing Service in 1947 indicated that there were 21 district nurses employed in Lewis. It also stated that ‘the district nurses service was one of the most efficient and harmoniously run parts of the County Councils’ Public Health Department’. The Report also noted that they were ‘keenly alive to the importance

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120 Report of Nursing Scheme 1917, 1918, 1934: NHS Western Isles Archives, Stornoway.
121 Brief General Report of the Medical Service Board’s Nursing Scheme for Lewis and Harris for the year 1917-1918: NHS Western Isles Archives, Stornoway.
122 Nursing in Lewis 1934: NHS Western Isles Archives, Stornoway.
of improving the service by the provision of telephones and cars. It was not until the 1950s, within the study time period, that there were cars and telephones for the use of district nurses in all areas of the Outer Hebrides. Certainly during the period under study there would have been no mobile phones. The means by which patients contacted the district nurse and the ways in which the nurse communicated with others is explored later in this thesis.

The Local Health Report which reported on the local district nursing service indicated that there were twenty one district nurses in Lewis with nineteen employed by the County Council, one by the Stornoway Burgh Association, which was independent of the County and one funded by the Glasgow and West Coast Mission. It also noted that the District Nursing Service calls for little comment, it is one of the most efficient and harmoniously run parts of the County Council Health Machine. That is probably due to the very democratic structure, which ensures that the people who receive the service are largely in control of it. The minutes of the Lewis Nursing Services Sub Committee show that it had a considerable amount of authority and was responsible for all appointments of district nurses, their salary, transport, housing and holidays.

The 1940s and 50s saw a great deal of progress for nurses’ welfare in the Outer Hebrides. Telephones were installed in most nurses’ cottages in the 1950s and many of them had cars with the first car being delivered in 1936. Nevertheless, the Sub Committee appeared to hold a great deal of control over the nurses as indicated in their notes of 1940; when they

126 Lewis Nursing services Sub-Committee (1940-1947) Minutes: NHS Western Isles Archives, Stornoway.
refused to allow nurses to attend a week’s refresher course in Tuberculosis, despite the Advisory Committee for Tuberculosis being willing to fund travelling expenses. One of the reasons given was that holiday arrangements had already been completed for most districts and nurses could only attend courses immediately before or after their annual leave.127

Notes of the Sub Committee for the 1940s also show the frequent turnover of staff. When a district nurse was required for a geographical area, the Queen’s Nursing Institute was contacted. They supplied a list of nurses available, which could be up to seven candidates, for the Local Association and Sub Committee to choose from. However in 1944, it was recorded that the number of nurses applying for district nurse training had been disappointing, and that had it not been for the married nurses continuing to work and others who had re-joined the service, the shortage would have been serious.128

1.10. Midwifery

We can date the beginning of the development of the registered midwives to the implementation of the Midwives Institute in 1886. The pioneer of midwifery, Dame Rosalind Paget and her uncle William Rathbone (the initiator of district nursing) gave advice and help in setting up of the Institute. The year after the start of the Midwives Institute it began to advance support for the registration of midwives.129

The Midwives Act of 1902 gave trained midwives status and protected the title of midwife and allowed the midwives to work independently of a doctor. It did not give the midwife the authority to issue any medical certificate, such as, for a stillbirth. Dame Rosalind Paget

127 Lewis Nursing services Sub-Committee (1940-1947) Minutes: 30th Sept 1940.
who was a leader of the Midwives Institute from 1855-1948 maintained that the clause was inserted to ‘make the medical practitioner happy’ as there was some antagonism from the medical profession regarding the training of midwives. Paget was not concerned about this issue as at the time there was no legal requirement to register stillbirths.130 The Act of 1902 did not apply to Scotland until 1916, when ironically, the Central Midwives Board for Scotland had the power to suspend midwives who broke the rules, which the English Board was unable to do until the Second Midwives Act of 1918.131

The Act required midwives to be trained with a diploma by examination and then become registered to practice. Over the next two decades there was the Third Midwives Act in 1926 followed by another Midwives Act 1936 which ensured that all women in Britain were entitled to care by well-trained midwives.132 The creation of the NHS in 1948 also made a difference to the quality of health care including midwifery provision. According to McIntosh, childbirth did not hold such a fear for women as a result of the development of antibiotics and blood transfusions.133 Although women’s experience of childbirth apparently improved because of the introduction of the NHS and other advancements in health care, Leap and Hunter who carried out an oral history of midwives who had practised during the 1940s and 1950s, suggest that the Midwives Acts had more impact on midwives’ lives, than the introduction of the NHS.134 The period from the 1940s until the 1960s has been referred to by McIntosh as the ‘golden age of district midwifery’, because midwives were competent and confident and due to their training worked as autonomous

professionals. The concept of a ‘golden age’ can fail to take into consideration the failings of a particular service. In this case the age was seen as ‘golden’ because midwives had more control of normal childbirth than either before or since. As can be seen in Chapter 8 there were drawbacks to working during the ‘golden age’.

The Central Midwives Board (CMB) for Scotland produced Rules for Midwives in 1939 and 1950, which would govern practice of the participants in this study. The Rules stipulated that all midwives should attend a refresher course at intervals of not more than seven years. Within the Rule Book were ‘Forms required under the Rules’ to be completed as Notification to the CMB. An example was ‘having laid out a dead body’ which asks for details of the deceased and the cause of death. The Form was then sent to the Local Supervising Authority (LSA). The midwife, after her attendance at a death, was in some circumstances not allowed to deliver a baby, for a period of forty-eight hours. As all of the nurses in the study carried out midwifery and general nursing, it questions whether the nurses were successful in adhering to this particular rule. They were also lone workers and would not be able to call on a colleague for help.

1.11. Introduction of Health Visitors in the Outer Hebrides

When health visitors (HVs) were introduced into the community the role of the district nurses inevitably changed in most areas. HVs initially came from a variety of backgrounds and were not necessarily nurses. They visited poor homes and taught the public about hygiene as early as 1862. The first recorded paid HV was appointed in 1867 and was

136 The Central Midwives Board for Scotland, Rules (1950) Royal College of Nursing Archives, /489/7/7 Edinburgh.
employed to assist the lady visitors, give advice and teach personal and household cleanliness.\textsuperscript{138} In the 21\textsuperscript{st} century to become a specialist public health nurse it is necessary to be a registered nurse or midwife and undertake forty-five weeks of theoretical study.\textsuperscript{139}

The five essentials in securing ‘the health of houses’ that Florence Nightingale taught and recorded in her ‘Notes on Nursing’ were pure air, pure water, efficient drainage, cleanliness and light which would have been important to the training of HVs.\textsuperscript{140} Other topics in the HVs’ curriculum were the management of the health of adults, women before and after confinement, and infants and children and by the end of the nineteenth century there were colleges offering training schemes.\textsuperscript{141} After the Maternity and Child Welfare Act in 1918 and Nurse Registration Act in 1919, the Board of Education laid down conditions for the appointment of health visitors, one being that the HV was a registered nurse. The Royal College of Nurses supported this requirement.\textsuperscript{142}

In the Outer Hebrides health visitors were not introduced until the 1970s. This caused problems under the NHS Qualification of Health Visitors Scotland Act (1974). All new nursing applicants involved in triple duty were required to have their health visitor certificate or gain an annual dispensation from the Secretary of State.\textsuperscript{143} As there was no guarantee that the application would be renewed every year there was uncertainty about the system. Other factors, such as the difficulty of triple duty nurses travelling to the mainland

\begin{thebibliography}{99}
\bibitem{143} Horne, J.L., (1971) \textit{Annual Report of The Medical Officer of Health}: Ross and Cromarty, Public Health Department, Dingwall.
\end{thebibliography}
to undertake the HV training, delayed the implementation of the 1974 Act in the Outer Hebrides. A health visitor survey was carried out in the Outer Hebrides in 1984 to examine the service which it states ‘had been in existence for eight years’ indicating that the first trained HV in the Outer Hebrides was employed around 1976. It reveals that there were nine HVs in Lewis and Harris, and three in the Uist and Barra areas.\textsuperscript{144} In 1972 at the later period of this study there were only three HVs employed in the Outer Hebrides.\textsuperscript{145} However the emergence of the health visitor in other areas caused concern to the Queen’s Institute.

The unease that the Queen’s Institute had regarding health visitors was concerned with the demarcation of boundaries. If district nurses were the main health professionals in the area who attended to ‘all ages and stages’ it is understandable that there was some controversy over the delineation of the district nurses role and the duties of the health visitors.\textsuperscript{146} It was suggested that resentment was felt because the health visitor sometimes visited the patient while the midwife was in attendance. Resentment may also have been due to the health visitor receiving higher pay with shorter working hours than the nurse midwife, who could be working day and night. White suggests another possible cause of this apparent discontent was that the Queen’s district nurses did not make allowances for the changing social climate after the introduction of the NHS and that this resulted in district nurses having little respect for the HV’s work in preventative health.\textsuperscript{147}

\textsuperscript{145} Horne, J.L., (1972) Annual Report of The Medical Officer of Health: Ross and Cromarty:
\textsuperscript{146} Baly, M.E., (1987) A History of The Queen’s Nursing Institute 100 years 1887-1987: London, Croom Helm, p.84.
1.12. Development of District Nursing in Remote and Rural Areas

District nursing spread rapidly in English speaking countries overseas when the Victorian Order for Canada was founded in 1897, while in Australia, the ‘Bush’ Nursing Association was set up in 1911. In New Zealand, an Act of 1909, allowed for visiting nurses in the rural areas, while in the United States of America, the National Organisation for Public Health Nursing was started in 1912 through the Boston district nursing association, which dated from 1886.\textsuperscript{148}

Remote area nursing in the Australian bush originated in Victoria with remote area nursing being carried out for more than 100 years following a similar model to that of the remote district nursing service in Britain. Some smaller geographical areas did not have access to home based nursing apart from what could be obtained privately. Queensland for example did not have an organised district nursing service until the 1960s.\textsuperscript{149} The idea of bush nursing is thought to have originated in Victoria, however it was suggested in 2000, that in terms of community expectation and isolation in nursing practice, remote area nursing has remained unchanged since the 1800s.\textsuperscript{150} Other types of nurses expanded their scope of practice and demanded the right to an advanced title, yet little changed for the remote area nurse in Australia. Until the 1972 Briggs Report, and the reorganisation of the Health Service, remote area nurses in the UK may have related to the Australian remote nurses’ experience. A report on community nursing in 2007 in Scotland, suggests that, with more emphasis on the kind of care people in the community should expect in the 21\textsuperscript{st} century,

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\textsuperscript{148} DN 150 (2008) QNIS Archives, Edinburgh. \\
\end{flushright}
nurses being educated in higher educational Institutions and the introduction of other
health services, nurses are obliged to expand their scope of practice.\textsuperscript{151} Thus they learn new
skills and acquire new knowledge whether working in an urban or remote area.

As has been noted, Canada founded its Victorian Order of Nursing in 1897. This was based
on the United Kingdom Queen’s Nursing Service and it is recorded that an experienced
Lady Superintendent was sent with the first nurses to the Klondike in 1898.\textsuperscript{152} It is
probable that the Canadian nurses were taking advice from the British Queen’s Nursing
system. Many areas in Canada are similar to Scotland’s remote and rural areas, with their
mountains, small islands and rugged terrain. Labrador, which is even more remote, is an
example where a nurse’s geographical area was the scattered hamlets of fishermen during
and after the Second World War. The nurse wrote of her experiences when she
experienced many trials and difficulties in the course of her work.\textsuperscript{153}

In common with the USA, Canada and Australia, which had been tackling the challenges
of remoteness for many years, other European countries such as Norway, Finland and
Denmark, also faced problems with remoteness. Elstad refers to a nurse from Norway in
the 1930s who quoted that, “when working in hospital responsibility is shared by many,
but district nursing in lonely places in the fjords—there one’s abilities are put to the test”.\textsuperscript{154}

Working in remote areas presented challenges for health professionals worldwide. In the
European countries development of district nursing was different. In rural Norway for
example, nurses were employed to care for the sick in their homes and do public health

Accessible and Integrated Care, Edinburgh, NES.
\textsuperscript{152} Mellor, R., (2008) Victorian Order of Nurses: Director of Canada Communications, Victorian Order of
Nurses.
\textsuperscript{153} See Banfill, B. J., (1953) Labrador Nurse: Canada, Ryerson Press.
\textsuperscript{154} Elstad, Ingunn, (2006) District Nursing between the local and the international, Northern Norway 1890-
work part time from the late 19th century onwards. In the late 1920s until the late 1930s they began to leave the rural areas for hospital work with better prospects of more holidays and time off.\textsuperscript{155} Despite the trials of remote area working for health professionals worldwide, even in the 21st century, a study in Australia found that nurses working in these areas reported a great deal of satisfaction with the scope and circumstance of their practice.\textsuperscript{156}

Nevertheless nurses working in remote and rural areas have always faced difficulties, different from their counterparts in urban areas, such as isolation and transport problems. Progress in health care in remote areas has been slow with 21st century nurses reporting that ‘locals regarded them as their own property’ and that they felt a commitment to their community which went beyond a professional remit.\textsuperscript{157} However research from 2000 has shown that the health professional, who, works and resides in the community, makes a valuable contribution to the social structure of remote areas as well as to health care.\textsuperscript{158}

It would appear that attempts have been made over the years to address the problems related to delivering health care in remote and rural areas. In 1995 a report into Health Care Services in Remote and Rural Areas of Scotland identified a range of work that nurses could undertake to meet the health needs of the remote communities.\textsuperscript{159} In 2000 in Scotland, with the initial introduction of the Family Health Nurse pilot training, in ten

\textsuperscript{159} Thomson, Thomas, Chair of Working Group, (1995) Health Care Services in Remote and Island Areas in Scotland: Edinburgh, HMSO.
remote areas of the Highlands and Islands of Scotland, there was optimism that ‘the skilled generalist nurse’ was the community nurse of the future.\(^{160}\) However despite nurses in the Outer Hebrides being part of the FHN pilot, the role did not progress in most areas in Scotland.

A report from the Rural and Rural Areas Resource Initiative (RARARI) in 2002 indicated that it was necessary to find ways of working to help isolated health professionals in Scotland and that good practice should be sought from countries such as Norway, Canada and Australia which have to deliver health over thinly scattered populations.\(^{161}\) This study is concerned with events that occurred over forty years ago in remote and rural areas, yet it is clear that in the 21\(^{\text{st}}\) century there are still problems with delivering health care in these geographical areas.

1.13. Frontier Nursing Service in Kentucky and the Outer Hebrides

Remote and rural nursing and midwifery services in the Highlands and Islands of Scotland in the 1920s came to the attention of an American nurse who was planning a district nursing service in the remote areas of Kentucky as was noted earlier in the chapter. Midwifery practice advanced more slowly in the United States of America than the rest of Europe. The first organised midwifery service in the USA was the Frontier Nursing Service in Kentucky in 1925, which Mary Breckinridge founded. She had to use British trained nurses for her service, as there were so few trained midwives in America.\(^{162}\) By the


time the first midwife was trained in America in 1932 Britain had been training midwives for over twenty years.\textsuperscript{163}

The success of the combination of the doctor and the nurses working together brought the American pioneer Mary Breckinridge to the Highlands and Islands of Scotland in 1924 to see at first-hand how this model worked before starting her own Frontier Nursing service in Kentucky. As well as the north of Scotland, Breckinridge travelled to the Outer Hebrides where she met with district nurses. She had experience of the ‘black houses’, which she described as ‘the warmest houses she found in Britain’. She met with the same Nurse Ann Maclean in Harris, referred to by the Dewar Committee (1912) ‘as the overworked nurse from Harris’.\textsuperscript{164} Breckinridge found ‘an exceptionally fine nurse living in a cottage hospital with a small operating room and accommodation for four to five patients’. Nurse Maclean provided midwifery and general nursing services for eighteen scattered villages. Breckinridge comments on the winds being so strong that nurse’s bicycles were useless and nurses had to walk miles over the moors to reach their patients.\textsuperscript{165}

The Queen’s Nurse model, where the district nurse was also a midwife, was of interest to Breckinridge. She also knew the rugged, in some cases road-less and mountainous areas of the Hebrides were similar to her own area in Kentucky, therefore the nursing model was one that she felt she could adapt for her proposed nursing service. The nurse/midwife role attracted Breckinridge, as she was appalled at the number of American women who died in

\textsuperscript{164} Highlands and Islands Medical Service Committee, (1912) (Dewar Committee) \textit{Report to the Lord Commissioner of His Majesty’s Treasury}: Vol. 1 and 11. Edinburgh, HMSO.
childbirth. Maternal death rates were four times as high as those looked after by the
Queen’s Nurses in Britain.\textsuperscript{166}

On returning to Kentucky Breckinridge put into practice what she had seen in Scotland and
started the Frontier Nursing Service where nurses were not only general and midwifery
trained but in some cases had been trained as a Queen’s District Nurse in Britain. Such was
her appreciation of all she found in Scotland that Ms Breckinridge invited Sir Leslie
Mackenzie, a member of the Scottish Health Board, to open her first Hospital in
Kentucky.\textsuperscript{167} Initially many of Mary Breckinridge’s nurses/midwives were trained in
Britain and she had many British nurses working in her service, as there was no training
for nurse midwifery in the United States.\textsuperscript{168} In addition one of the criteria for working in
the Kentucky nursing service was that the nurse was able to ride a horse, as that was their
means of transport. One of the first recruits was a Queens Nurse, Ann Mackinnon, from the
Isle of Skye in Scotland.\textsuperscript{169}

It is therefore ironic that an American nurse came over to the Outer Hebrides to gain
information about district nursing and over seventy years later in 2000 the Family Health
nurse, a new community nurse model, was piloted in the Outer Hebrides with some of the
theory underpinning the new role, originating from America. The Mary Breckinridge
Hospital which opened in Kentucky in 1975 had trained family nurses many years before
the WHO initiative which was referred to in the introduction as one of the driving forces
for this study.

\textsuperscript{167} Anonymous, Frontier Nursing in Kentucky (1928) \textit{The Lancet}, Vol. 212, Issue 5473, 21\textsuperscript{st} July, pp. 134.
\textsuperscript{168} Brooks, J., & Hallett, C., (2009) ‘Literary Angels’ The Portrayal of Employed Nurses in the Writings of
Female Nineteenth Century Authors: Presented at First Danish History of Nursing Conference, Aarhus
University.
\textsuperscript{169} Information received from; Macleod, Norman, (2013) \textit{Ann of Appalachia} Historian, Isle of Skye,
Scotland.(Paper presented in Skye to celebrate the Dewar Centenary )
1.14. Conclusion

District nursing has had a challenging journey from the caricature of Sarah Gamp of the 19th Century to the professional nurse of the 21st century. The literature review considered the history of district nursing in the context of wider health and social change in order to establish a foundation for the time period under study. An important influence in the care of the population of the Outer Hebrides was the implementation to the HIMS Services in 1912 where district nursing was recognised as being an integral part of the service. By 1936 The Cathcart Report reviewed the service and the value of the district nurse and doctor working together was described as being ‘extraordinarily impressive’.170

The introduction of the NHS in 1948 and subsequent legislation relating to nursing impacted on the district nurses development and practice. The health issues of the day such as poverty and social issues dictated their role. Literature shows district nurses of the past to be strong women, who were often highly regulated but autonomous practitioners. The development of the Queen’s district nurse training appeared to be steeped in a history of morality and religion with education a secondary requisite. Most participants in the study were Queen’s Nurses.

The history of district nursing in the remote area of the Outer Hebrides was similar to other remote areas both nationally and internationally. Evidence shows the experiences of working and living in remote areas, although challenging, may have had positive influences in the community. It could reasonably be expected that attempts to improve the health conditions in these remote areas will inevitably progress with improved transport and technology of the 21st century.

170 Cathcart Report (1936) Committee on the Scottish Health Services Report; Edinburgh, HMSO.
This following study explores who district nurses were in the Outer Hebrides between 1940 and 1973, what their role was, the challenges they faced as they cared for the people in their geographical districts, and their contribution to health care in the region.
Chapter 2 Research Design and Methods

2.1. Introduction

This chapter will look at the rationale and methods for carrying out the study using the oral history approach as a methodology. It will also consider the limitations of such an approach; for example the challenges to credibility, which potentially arise from distorted memory. Sampling and access to data and the justification for using purposive sampling will be discussed. The study investigates the lives and work of district nurses in the Outer Hebrides from 1940 to 1973. The year 1940 was chosen as the start date for the study due to the various changes that took place during the 1940s, such as the Second World War and the introduction of the NHS. Choosing 1973 as the date to end the study was due to the reorganisation of the Health Service throughout Britain in 1974, which transformed the way health care was delivered.

Most of the sources consulted are described, along with the challenges of missing material, and the variable quality of the documents accessed. Although the use of primary and secondary sources was important to link them with the interview content, the oral narratives provided the largest volume of data. The storage, confidentiality and interpretation of the interview data are discussed. Consideration is given to the identification of key themes that assisted in analysis and the necessity of being flexible and open to emerging themes. Links are made between archival material and the interview content in the thesis.

Ethical issues are addressed. The information leaflet for participants about the study (Appendix 2), the consent form (Appendix 3) for both the interview and retention of interviews in archives is presented. Included in the ethical section of the chapter is the
action that was to be taken in the event of problems arising during the interview, such as a participant becoming distressed on remembering significant events from their past. The thesis received ethical clearance from the Ethics Committee of the University of Manchester.

2.2. Scope and Rationale for the Study

The study, which is an oral history of district nurses who worked in the community in the Outer Hebrides from 1940s to 1973, involved semi structured oral history interviews with participants. The study explored social changes that have taken place during the time under study. Some of these included; housing, language, travel, challenges, religion, professional and social life and communication. The scope of district nursing and patterns of work were investigated along with boundaries of work. Sweet and Dougall’s study of 20th century nursing suggested that generally the district nurses’ concept of nursing involved the inclusion of non-nursing tasks.\(^1\) It is interesting to note that in a study conducted by Speed and Luker in 2004, district nurses were found to be carrying out non-nursing tasks such as shopping for patients.\(^2\) In contrast the findings of this study did not agree with either study.

As previously mentioned, this study is pertinent today as there is currently a great deal of focus on the reform of community nursing in Scotland. Since the pilot study of the FHN in 2000, the Scottish Executive has produced a plethora of documents relating to community nursing care.\(^3\) The completion of a major review suggested that all community nursing

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disciplines be merged and one generic community health nurse provide care for all. A two
year project piloted the ‘new’ community health nurse (CHN) role in three areas in
Scotland. The review of the proposed role indicates some misconception about previous
roles in the community and why they were changed. For example a number of participants
in the review believed that the previous roles of triple and double duty nurses were
abandoned because of concerns about the range of knowledge and skills required for each
discipline.

There now appears to be an increased specialisation of health personnel working in the
community in the Outer Hebrides. In addition to the allied health professionals, there are
nurses of many specialities. The community nurses can refer to the Macmillan nurse, the
multiple sclerosis nurse, the stoma nurse, the breast care nurse, the heart failure nurse, the
diabetic nurse, the tissue viability nurse and the practice nurse. In many rural areas, in the
Outer Hebrides, it has become the norm in 2013, when a call is requested for a doctor, that
a practice nurse attends. Although practice may be reminiscent of the time under study,
nurses at the time of the study did not have access to the services available at the present
time.

This study explored the working lives of district nurses, who worked broadly as the only
health professional in their geographical area. It may provide an understanding of the
effectiveness and value of this model of care. The perception of the nurses who delivered
the service in the past is also useful to create a clear picture of the origins of community

Community in Scotland, and Study of the Implementation of a New Community Health Nurse Role in
Accessible and Integrated Care, Edinburgh, NHS Education Scotland.
nursing and its influence on the present. The aim of the study was therefore to gain an insight into the day to day working and social lives of district nurses in the Outer Hebrides from 1940 to 1973.

The key questions the study sought to answer were:

- What were perceived to be the main challenges to district nursing in the Outer Hebrides?
- What were perceived to be advantages and constraints of district nursing in the Outer Hebrides?
- What did the nurses perceive as being their contributions to care in the Outer Hebrides?
- How was the work of the district nurse affected and informed by the remoteness of the area and the particular culture of the Outer Hebrides?

Some of the specific topics, which provided insight into the above questions, included the characteristic of the participants such as preparation for the role as a district nurse and social status and position within the community. The kind of work the nurse carried out, the challenges she encountered including, isolation, transport difficulties, accommodation and the number of hours she worked were explored. The relationship she had with others, the boundaries and scope of her nursing practice were included in the topics of the study to gain an understanding of the kind of women who nursed in the Outer Hebrides from 1940 to 1973, the kind of work they did, and the meaning they attributed to their work.

2.3. Oral History as an Approach

What makes oral history different from traditional historical work, it is suggested, is that it tells us not just what people did, but what they now think they did, and what they actually
believe is an historical fact.\textsuperscript{7} Moreover oral history allows people to offer their own interpretation of events along with drawing on other disciplines such as sociology, anthropology, psychology and linguistics.\textsuperscript{8} There are recognised limitations to carrying out oral history which will be discussed later in this chapter however this study used oral history as a methodology which allows the narrator the freedom to express ideas and thoughts which may not have been otherwise preserved in a written form.\textsuperscript{9}

Oral history has only become popular since the 1960s and its rise, according to one historian, ‘has been dramatic’.\textsuperscript{10} Oral History Societies sprung up internationally with the Scottish branch being founded in 1973.\textsuperscript{11} Oral history has responded to traditional historical critics by arguing that ‘narrative form, subjectivity, different credibility of memory, and the relationship between interviewee and the interviewer should be regarded as a strength rather that a weakness, a resource, rather than a problem’.\textsuperscript{12} It is also suggested that this type of methodology allows the narrator the freedom to express ideas and thoughts in a way that may not otherwise be preserved in written form and may give a sense of belonging to a place or time for the person or people involved.\textsuperscript{13}

It is necessary to question why one does oral history and to consider what is to be accomplished, as not everyone has enthusiasm for the subject. The value of history for

nurses, it is suggested, is that knowledge of the past, teaches nurses who they then are, and can learn from their experiences to influence their present day-to-day practice.\textsuperscript{14} It could be argued that it is not necessary to carry out oral history as this could be captured by written documentation. But an oral historian believes this methodology goes further as it produces a ‘history built around people, thrusts life into history itself and widens its scope’.\textsuperscript{15} However carrying out oral history can present major difficulties.\textsuperscript{16} For example oral history writers discuss the limitations of oral history particularly in relation to the fallibility of the memory of participants.\textsuperscript{17}

There is on-going debate within history as to whether memory can be trusted. Many oral historians have argued that both history from documentary sources and oral history are equally reliable.\textsuperscript{18} Portelli goes further to suggest that oral history is about how events were experienced rather than an exact account and claims there are no ‘false’ oral sources.\textsuperscript{19} Linking documentary material to substantiate the oral history can be a challenge if it is difficult to access the material or documentary sources are not available.

Historians argue about the nature of oral history material, in particular in relation to whether it can be completely subjective or objective. Thompson maintains ‘it is questionable whether a fully subjective narrative interview could exist’. It has been

\begin{itemize}
\item \textsuperscript{15} Thompson, P., (2000) The Voice of the Past: Oxford, Oxford University Press, p.23
\end{itemize}
suggested that ‘subjective’ implies a partisan and partial point of view, less reliable, because it is subject to alteration over time. This means, he maintains, that some social historians have accused oral historians of ‘swallowing whole’ the stories that participants tell them and that a truer history must be based on statistical analysis and other objective data.\(^{20}\) According to Ritchie other authors who are sceptical about the validity of oral history data have also expressed concern over the accuracy of human memory.\(^{21}\) Tosh and Lang share this unease as they claim that memory may be overlaid with nostalgia, and is contaminated by many other sources, such as the media.

Nevertheless the researcher is challenged when it is maintained that the interviewer is an active participant, to ‘unpick the layers of memory, dig back into its darkness hoping to reach the hidden truth’.\(^{22}\) Hence the interviewer must take some responsibility for the data obtained. Nurses are ‘hidden from history’ as there are few documentary sources that relate to them. Therefore there is a greater need to tap into the collective memory, using oral history.

Lewenson & Hermann maintain that historical research enables nurses to explore their past and become critically aware of their professional identity and meaning.\(^{23}\) According to Nolan if nurses are conscious of the past they are in a much better place to mould their future, broaden their horizons and create a coherent sense of identity.\(^{24}\) It is possible to examine aspects of district nursing during the time under study by documentary evidence; however oral history permitted the researcher to take the analysis further, and allowed the

participants the scope to relate in their own voices their reflections, thus capturing their ‘lived’ experiences of nursing in the Outer Hebrides.

Although this is primarily an oral history study it is essential that the work is firmly grounded in documentary and printed/published primary sources which were of significant value. Documentary evidence is important in oral history work and my search for source material is discussed later in the chapter. Jenkins has argued that evidence should be referred to as, ‘traces of the past’ and are not evidence until they are used to support an argument. When examining written sources it is useful to check whether they are valid, credible and convey truth. The sources or ‘traces’ can be used to support a range of arguments and lines of interpretation. Within this study they are used together with oral evidence to construct a history.

2.4. Data Collection Methods

In the first phase of the study twenty retired nurses were interviewed, generating core data that provided the basis for further exploration. The interviews were transcribed verbatim, thematic analysis was undertaken and key themes identified which were then explored and developed further. Four of the participants previously interviewed were then re-interviewed to provide a greater breadth of information and to verify the impact of specific milestones in health care such as the introduction of the NHS in 1948. Additional interviews were also carried out.

Data were collected using multiple historical methods. Face to face interviews took place and interviews were tape recorded and transcribed. Archival material such as local newspapers, government documents and documents relating to rural nursing for the time period covered by the study were collected. Similar studies were referred to, such as those by Dougall in Scotland, and Madsen and Bradshaw in Queensland Australia, who studied the history of district nursing, and used similar data collection methods.\(^2^7\) Dougall’s study, which was an oral history of district nursing in Scotland from 1940-1999, was referred to, and although Dougall’s study did not include participants from the Outer Hebrides it was a valuable resource. Dougall’s study has been consulted throughout to compare and contrast findings.

2.5. Documents Consulted

Initially I emailed all the Local Historical Societies (eighteen at the start of the study) throughout the Outer Hebrides and requested any information regarding district nursing within the dates under study. Three of the societies replied while others had been in the process of updating their material. I then visited the sites, which indicated they might have material about district nursing, and gained access to some information. However, overall very little material was available through these sources. There were no electronic catalogues. When I requested access to the archives in the NHS Western Isles I was shown a cupboard in the NHS Board offices with various documents, which I hand searched, to identify material that was relevant to my study. The Lewis Nursing Service Sub-Committee of the Ross and Cromarty County Council 1933-1947 Minute Book, which I

reference in this thesis, was found, and has proved to be a valuable asset, in connecting the oral histories collected to the written evidence. The Minutes had information on nurses’ accommodation, transport and other topics found in the thesis.

In 2012-2013 archives from around the islands are in the process of being collected by ‘Tasglann’ the Hebridean archives in Stornoway in order to produce a central database, however this was not available at the beginning of this study. They have requested that all archival information from NHS Western Isles be included in their collection and it is hoped that all of the archival information stored in the NHS Western Isles will be transferred to the central Hebridean archives in the town of Stornoway where it will be accessible to all. It would appear that many of the ‘old’ health related documents have been discarded. Initially I was informed that there were no health connected archives in Uist but some have been found and sent to the archive centre where I have been able to access them. Locally NHS Western Isles, the local library and the Hebridean Arrives have provided information, which is included in the study.

The quality of the material sourced varied. Some letters from the 1940s were illegible while the Lewis and Harris Minute Book from 1938-1947 was clear, legible and complete, and proved to be a valuable resource. There were gaps where few resources were available such as the 1950s to 1960s yet a report from 1917 about nursing care was preserved and in good condition. I believe I am the first person to consult much of the material, notably the Minute Books. It is unfortunate that most records of local associations of nursing have not survived. Dougall also mentioned this in her thesis.\(^{28}\)

The Royal College of Nursing Archives, Edinburgh, holds records of all nurses trained at the Queen’s Institute of Nursing. I have visited the RCN to gain information regarding district nursing, midwifery and Queen’s Nursing. All of the information held by the RCN is electronically catalogued. The information in the Queen’s Nursing Institute Edinburgh on the Queen’s Nurses supervision while in training required to be searched by hand.

Resources were accessed at the RCN and the QNI and are included in the bibliography.

Secondary sources included a small private collection of historical health-related documents held by a local retired business man, Alexander Matheson.\(^{29}\) He has maintained an interest in all health issues since his long career as one of the pharmacists for the Outer Hebrides. His article ‘memories of the Western Isles Health Service’ although focused on some of his own experiences when his father was a GP at the start of the NHS, was valuable in highlighting specific dates regarding health care in the Outer Hebrides at the time of this study.\(^{30}\) District nursing and Queen’s History publications were consulted such as those by Mary Stocks,\(^{31}\) Monica Baly,\(^{32}\) Reference was also made to Helen Sweet, Rhona Dougall \(^{33}\) and Tania McIntosh.\(^{34}\) These were valuable secondary resources, though some were celebratory rather than critical in focus. Theses consulted included Dougall, Fox, Denny, and Damant.\(^{35}\)

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\(^{29}\) Matheson, A., Private collection, Newton, Stornoway.

\(^{30}\) Matheson, A., *Memories of the Western Isles Health Service*: Private collection, Newton, Stornoway.


2.6. Existing oral history transcripts

Some of the data used in this thesis were collected by the author in 2005, as part of a small scale study funded by the Queen’s Nursing Institute. The work yielded some interesting information but analysis of findings was superficial. The study provided the impetus for this study and the earlier data were supplemented with new material in order to permit more extensive as well as more detailed interpretative work. For the original study I interviewed twenty retired nurses in the Outer Hebrides whose ages ranged from 74-97 years which generated core data providing the basis for further exploration, and a report of the findings was submitted to the QNI. The present study drew upon the extensive original manuscripts collected for that earlier work.

Limitations of the small scale study were addressed in this study, such as inadequate data analysis. Some of the emerging themes that were identified in the initial study were, the kind of transport used by the district nurse, the impact of inclement weather on practice, contact with other professionals and patients, the hours on duty, balancing home and professional life and the clinical role of the district nurse. The study participants also raised topics that had not been included in the schedule such as the impact of their travel to the mainland UK for training and their personal lives. These topics and others identified were included within this study’s schedule.

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2.7. Sampling and access

Study participants consisted of retired district nurses of all ages who had been employed in various geographical locations of the Outer Hebrides at the time under study and were willing to participate. Since there were already core data of twenty interviews from the original study it was initially difficult to be specific about the final sample size. A further ten interviews were subsequently conducted, four participants were re-interviewed and two narratives were received resulting in a total of 36 transcripts. Contained within the sample were extracts from a narrative by a nurse who worked in the Ness area in the 1940s to 1950s, which was received from the Ness historical society. Interview No 35 Ness, 1946-1960s, Interview received from Ness Historical Society and used with permission.


Dates of when and where nurses worked, their age and their qualifications are included in Appendix 4.

Recruitment of the sample involved a purposive sampling approach as it is based on the belief that the researcher’s knowledge about the population can be used to address the needs of the study. I was aware of the location of many of the participants because of my previous employment as a district nurse in the Outer Hebrides. I chose participants who were knowledgeable about their practice as district nurses before they retired. Whilst I recognise this kind of sampling has the potential to be subjective, it is considered appropriate to address the aims of the study in a relatively small geographical area.
Additionally it is suggested that purposive sampling is a key feature of historical research when the researcher seeks individuals on the basis of their personal knowledge of the subject who can contribute to the depth and breadth of the study.\textsuperscript{40} Snowballing was also utilised to recruit the sample. This approach is the selection of participants through referral from earlier participants.\textsuperscript{41} The islands are relatively small and informal contacts assisted in identifying who was available and appropriate to be included in the study. Initial contact was made by letter.

District nurses who worked during the decades under study volunteered to participate in the study and information was provided initially by telephone. After discussion about the purpose of the study, issues such as the involvement of the participants, the approximate time the interview would take were discussed. Written consent from all the participants was obtained (Appendix 3). Consent was also obtained for a Deposit Agreement to preserve the interviews and transcriptions permanently in an archive (Appendix 5). No participant refused consent for either the interviews or for the deposit agreement. All participants received the Participation Information Leaflet, (Appendix 2) which sought to answer any questions participants may have had regarding the study. Interviews were carried out in the participant’s home at a time and date that was mutually convenient.

2.8. Interview technique

Each interview was tape recorded face to face and transcribed verbatim. A semi-structured interview schedule was used (Appendix 6). It was necessary to address the same core areas


with all participants, yet, be aware that interviewees have their own experience that no questionnaire can anticipate.\textsuperscript{42} Oral history is a subject in its own right and its interview technique allows researchers to investigate memories in particular subjects.\textsuperscript{43} In this study I was investigating memories of retired district nurses who had worked in the Outer Hebrides.

During the interview I intended to take written notes, as one of the limitations of the first study was that, on one occasion, the tape recorder was faulty and there was no note to identify the part of the interview that was omitted. Researchers advise the use of notes as a backup in the event of malfunction of the recorder and that it also helps the interviewer to formulate new questions as the interview progresses. As well as writing notes for accuracy, it is suggested, that it is useful as a reflective tool, which can be applied to question the interview style and approach. Subsequently the schedule can then be adapted, the interviewing technique changed, or for example, the position of the tape recorder altered.\textsuperscript{44} I had therefore intended that my notes would supplement each transcribed interview. However I found when I was interviewing that my writing was inhibiting the flow of the interview and I only wrote a few notes. I also gained confidence in the use of the tape recorder over time.\textsuperscript{45}

Interviews were carried out in the participant’s own homes. It is recommended that interviews last no longer than 2 hours. If the interviewee is tired it is advisable to stop the interview on a relaxed note, and then the respondent will wish to repeat the experience,

\textsuperscript{45} A Phillips Voice tracer with integrated microphone was used.
which can be continued at a later date.\textsuperscript{46} I feel that the structure of the schedule and the sequencing of questions allowed for easy transition from each life event. Topics could stand alone, and it did not detract from the study should a further visit have been necessary. Participants were given the opportunity to stop the interview at any time and were advised that they could withdraw from the study whenever they liked. No participant stopped the interview for any reason.

As already discussed, memory of events can be problematic when the majority of participants are elderly. To assist in recall, prompts such as the date of the opening of a local bridge, or landmarks in health (for example the birth of the NHS) were mentioned. The majority of participants did not require a prompt and frequently provided significant dates themselves despite their average age being 79 years.

When administering the schedule I was alert to the challenges associated with this procedure, such as developing a rapport with the interviewee, being aware of the room acoustics, problems associated with distraction for instance a loud television nearby.\textsuperscript{47} It was also necessary to be flexible and respectful regarding the time and place for the interviews; for example, because of the religious culture on the islands I did not conduct interviews on Sundays to avoid offending participants.

2.9. Rigour

Constructing the schedule can be a challenge to reduce the introduction of bias such as social desirability. Responses to questions can be coloured for various reasons and it has been suggested that people can be economical with the truth to make their response more


socially desirable. Lydeard maintains that prestige bias, social desirability and practical/ethical standards are all different names for the same phenomenon. Answers can be exaggerated to support or object to particular causes. A particular challenge when interviewing an older population is that memory distortion can generate responses that will be viewed favourably by the interviewer or are consistent with prevailing social views. In the initial study I found that some participants were reluctant to complain about their working conditions such as the lack of time off. It appeared as if they perceived it was their duty to work long hours and that is was socially wrong to complain. Questions were therefore constructed in such a manner that there was no right or wrong answer. It is necessary for the interviewer to be impartial at all times.

There is no simple answer to social desirability bias apart from research awareness and filtering questions in such a way that a negative response is acceptable. Impressing upon the interviewee the necessity of accuracy and reinforcing that there is no right or wrong answer can be helpful. An example was when participants were asked about their professional development. If a respondent indicated they were unable to attend courses or meet with other professionals it was made clear that I was not questioning the interviewee’s professional competence.

As a retired Hebridean district nurse I had to reflect on my own background and experiences and to the extent that they could have affected the data collection and analysis. I believed that they could be positive in sensitising me to issues that participants may not

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be aware of but it could also have been negative in introducing bias. According to Hammersley, bias is by no means straightforward in meaning and it can be ambiguous. The term he suggests may be used in a conscious of unconscious way on the part of the researcher to produce data, which are in line with his or her commitments. Patten, in relation to bias, reminds the interviewer of the need to be reflexive which involves being self-aware and undertaking an on-going examination of one own perspective. It was necessary for me to reflect on my own experiences and accept the participant’s responses regardless of my own background.

Interviewer bias must be acknowledged and controlled yet there is a limit to the extent it can be resolved. The study requires the interviewer to be familiar with the topic, which can be a disadvantage, as there may be a tendency to anticipate how the interviewee will respond. Researchers are advised to clear their vision from their prior knowledge and adopt a perspective of ‘unknowing’, in which they listen with ‘the third ear’ free if possible for any prejudice or bias. Decentring oneself takes practice and is a challenge to achieve. The interviewer is reminded that they must have a willingness to ‘sit quietly and listen’ and that they are there to learn which assists in minimising bias. As well as listening attentively, time must be allowed for an interviewee to answer.

As this was an open-ended interview what may seem unimportant to the participant may be of particular value to the interviewer and to the study. One of the advantages of an

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interview schedule is that the researcher can identify circumstances when the question has not been fully understood, and any misunderstandings can be clarified. Conversely, as discussed, there may be the introduction of bias, which is a limitation of questionnaires and schedules when an interview is being conducted.\(^{59}\)

According to Thompson, how questions are asked of participants can raise strong feelings among oral historians. The use of a schedule he suggests can produce rigidity in the research and may reduce the responses to short answers. However he maintains that some topics make advance planning of questions essential.\(^{60}\) The planning of topics was necessary for this study to prevent any themes being omitted. Whatever tool is used for the research, the researcher has a responsibility to ensure that it is prepared, constructed and administered to address the aims of the study. Many writers remind us that ‘oral history is a joint product shaped by both parties’.\(^{61}\)

Historical work, it is claimed, always contains within itself threats to rigour as the accuracy of the sources and the quality of interpretation is open to question. One way to ensure that the study is rigorous is to be clear about what questions are underpinning it and that they can be flexible.\(^{62}\) Indeed Lummis suggests that the validation of oral evidence is the degree to which the interview yields reliable information, and the degree to which the individual experience is typical of its time and place.\(^{63}\) During interviews I was flexible and led the informant when appropriate. Open questions assisted in giving the participants a voice to

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help in producing a credible interview. The use of a purposive approach in sampling also addressed the questions of the study.

2.10. Interview Schedule

Although this is an historical study I have also been guided by research literature on qualitative interviewing. An exploratory semi structured interview schedule (Appendix 6) was used for the interviews with questions related to the key questions of the study. Themes identified in the initial research were further explored. However I was open to emerging themes when specific events of each decade were investigated. Buck discusses the use of frameworks in historical research to capture and make sense of the past.64 I found this to be a useful tool for both the collection and analysis of data as it provided a structure, yet was not rigid, as I attempted to look at relevant health, social and cultural policy.

In the study, a great deal of demographic and background information was obtained which is often gained at the beginning of the interview. Some researchers advise against starting an interview with demographic information, as it is maintained that the interviewee needs to become active, and should not be conditioned into giving short answers at the beginning of the session.65 I believe I confused some of the participants I interviewed in the earlier part of the preliminary study, by asking questions at the beginning of the interview that I already knew, for example, their name and age. Subsequently demographic information was collected at the end of the interview. Because of the historical nature of the study, the

material being presented directed me. Each participant was encouraged to relate narratives of experiences and incidents that occurred while in practice.

The quality of the information obtained in an interview is largely dependent on the interviewer, which clearly indicates that the interviewer has a great deal of responsibility to ensure that it is a success. Oral history writers suggest that the place where the interview is conducted, the clarity of the interviewer, the reliability of equipment, the organisation of the interview and the ability of the interviewer to probe appropriately, will assist the interviewee to feel that a connection has been established in which communication is flowing two ways.66 One of the advantages of interviewing is that it allows the participant’s perspective to be presented and explored to gain their story. A clear understanding of the implications of the study and its value was communicated to all who participated, before, and after, the interview. According to writers who examined oral history the importance of listening must not be underestimated. They maintain that ‘oral history cannot work unless the researcher learns how to listen which is the key to successful oral history’.67

The interview guide was in the form of a semi structured schedule, a tool for data collection, administered face to face (Appendix 6). Within this thesis the guide was not a tool of social survey, but provided a structure to an oral history study. Rather than give a strict format, its purpose was to guide the interview. A survey will usually stick to the questionnaire whereas in oral history the interviewer must be willing to abandon the

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prepared questions to follow the interviewee into unexpected topics. The schedule was therefore utilised as a prompt to ensure various topics were not omitted while I attempted to explore and understand phenomena during the time period being examined. It is also noted that the guide can also provide a framework that allows the interviewer to sequence questions, and decide which information requires further exploration, as well as help to utilise the limited time of an interview. According to Thompson interview schedule should be carefully prepared, constructed and administered to ensure it addresses the questions the study seeks to answer. This requires care taken with the structure, wording and format of the schedule. Informed consent had been obtained, and a full explanation about the study given to the participants before the interview.

It can be valuable to pre-test the guide and the interviewing approach as research has shown us that participants often interpret questions differently to the investigator. The wording of the questions requires that they are clear and non-ambiguous. The value of piloting is also emphasised by researchers when they suggest that in addition to providing clarity of questioning, it can also check on potential interviewer mistakes or omissions. In the initial study, some participants discussed the difficulty of travelling to their training school, in the mainland of Scotland or England. This topic had not been included in the initial interview schedule but it was added to the later schedule to address this subject.

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carried out three further pilot interviews to determine whether the interview schedule had moved forward to address study questions.

In wording questions for the interview schedule, the need for the researcher to consider the clarity of questions, the ability of participants to give information and the risk of bias and sensitivity is highlighted.\(^\text{73}\) Caution is recommended as we all interpret words differently, which I discovered when some participants answered questions by using Gaelic words or phrases. Paton has suggested that using words that make sense to the interviewee reflects the participant’s world and improves the quality of data.\(^\text{74}\) I believe that an understanding of the Gaelic language by the researcher assisted in clarity and understanding of both the delivery of the schedule and the data analysis.

In preparation of the schedule the sequence of questions must allow for smooth transition hence the schedule begins with the nurse’s training and ends with her leaving nursing. Open ended questions were used throughout the schedule as it is recommended that open ended questions permit the participants to take whatever direction they want, to express what they have to say.\(^\text{75}\) Prompts are included within the schedule if a topic has not been discussed. Probes such as: Can you give me an example? Could you tell me more about that? These were used to clarify answers or encourage the interviewee to expand on the discussed topics. This approach was generally successful and allowed participants the opportunity to develop themes that were pertinent to the study.


2.11. Interpretation of Interview data

An interpretive approach was applied to the oral testimonies to enable understanding and create the history. Each interview was transcribed verbatim to place the data in context and make connections between topics and other information collected. Rafferty warns of the contingencies that historians deal with that include conflicting stories, missing pieces, personal and professional bias, and ideology, which can apply to any interview data when the participant has his or her own subjective view of events. During the interview participants were invited to recall events chronologically, telling the story from the beginning of the decades until the end. This assisted in relating the history of district nurses, their lives, their work, and their development over the three decades.

Data were analysed and interpreted by identifying key ideas and emerging themes and linking archival information acquired with interview content. Codes were applied to emerging themes, while each line of data was scrutinised for common topics or words used, to capture the lives of district nurses in the Outer Hebrides at the time under study. Interpretation begins to emerge, it is maintained, when all sources have been collated and read carefully which also involves the historian being aware of their own pre-existing assumptions.

2.12. Ethics

The participants were fully informed about the interview and its purpose (Appendix 2). Written informed consent was necessary to conduct the interview and due to the historical

nature of the study, participants were also required to give written consent for interviews and transcripts to be stored in archives permanently (Appendix 5). All data were held in a secure and confidential location. If the informant wished to be interviewed but did not agree to be identified they were assured of anonymity. Similarly, if any participant did not wish their interview to be stored in an archive, the data would have been destroyed at the end of the study. However, all participants were content for data to be stored. Most of the participants requested to remain anonymous therefore a decision was taken to anonymise all interviews.

Lewenson and Herrmann’s ethical Guidelines and Standards for the Nurse Historian, was valuable and provided information about the responsibilities of historians to ‘assure professional accountability and competence’. Examples identified are, that the historians have a responsibility not only to the participants, but to the sources, to accurately report all information relevant to the subject. The participants have a right to privacy and the historian must demonstrate sensitivity in the use of confidential information.78

Patten advises caution when interviewing, as the information given can produce unexpected or emotional revelations. An ethical framework was therefore necessary to deal with any unexpected or emotional revelations.79 Bornat recalls an incident when an elderly informant became emotional and she ‘didn’t know what to do with the emotion’ She reminds us that historians can neglect the significance of an interview in the life of an older

person. However such concerns can also be a reminder of the social purpose of oral history. Bornat also refers to the similarity of the oral history to reminiscence therapy in a care setting and suggests that, in response to painful emotions that, the context and circumstances should be considered. To address this potential problem, a trained counsellor, who is also a district nurse, agreed to be available, should any participants feel they required support after the interview. This assisted in addressing an Ethical Guideline that ‘sensitivity is demonstrated’. One participant, while remembering an incident that occurred over thirty years before, which she had never spoken about since, stated that she ‘was shaking as she thinks of it’. She declined the offer of further support after the interview.

With the area under study being relatively small, anonymity was a problem when participants recalled experiences that occurred to patients who may still be alive. Reassurance was given that patients would not be identified. Ethical clearance was obtained for the study from the University of Manchester Ethics Committee.

2.13. Conclusion

Carrying out oral history methodology allows the participants to express their story in their own way. It is clear that there are many pitfalls to be avoided, for the result of the process to be credible. The importance of the tool for administering the semi structured interview schedule was paramount to allow for a smooth transition of the interview, therefore care

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83 Interview No.20 Back 1940s-1950s
was taken in its construction. I was aware of my responsibility to the study, when preparing constructing and administering the interview. Many oral historians document potential problems that can occur during interviews.

Literature makes it obvious, that specific skills are necessary for successful interviewing. The interviewer must build a rapport with the participant, to allow the study to be a joint production of both parties. As most of the participants were elderly I was flexible and accommodating. However I attempted to be aware of my own preconceptions, as they could have influenced the study. I was prepared to be led by the informant to answer the study questions, and open to discuss emerging topics, to gain rich data.

The interpretation of data required meticulous analysis to capture a more detailed picture of how district nurses in the Outer Hebrides from 1940 to 1973 lived. In data analysis I consulted theory to assist in ensuring that the data were placed in a logical manner. Accessing local archives and document related to the study was a challenge. There were no electronic resources and the quality of some the material was disappointing. Letters about nursing from the 1940s were illegible. Nevertheless a few resources such as the Lewis and Harris Minute Book were invaluable to connect the various issues, highlighted by the participants, to be verified.

The necessity of ethical consideration cannot be underestimated, as it provides protection for the informant as well as the researcher in the event of ethical dilemmas, which can occur during historical enquiry. Most of the interviews ran smoothly. All of the participants were willing volunteers and the researcher was prepared for any unexpected events. Although a strategy was in place to address any emotive issues that could have arisen during interview it was not required. It is believed that the study has been successful
in capturing the experiences of the nurses of the Outer Hebrides whose voice had never been heard before.
Chapter 3. Professional Background

3.1. Introduction

The purpose of this chapter is to offer a clear, contextual background to the work of district nurses in the Outer Hebrides from 1940 to 1973. Their professional background such as the memories of travelling to their training hospitals from their home in the Outer Hebrides will be recounted. The influence of their hospital training is also described. Because the majority of the participants were trained as Queen’s Nurses their opinion of the training and its value to them is explored with their narratives.

Participants address how they kept their professional skills and practice up to date in a remote area. To gain further insight into the experience of nurses of the Outer Hebrides, at the time under study, their age, qualifications, geographical areas of work and dates when they worked are included in Appendix 4.

3.2. Travel to training hospital

Most of the participants interviewed originated from the islands and remembered travelling to their training hospital on the Scottish mainland. For some it was the first time away from home and also the first time on a boat, train or bus. Many nurses commented on the trauma of leaving home, often for the first time, to go to their training hospital. The nurses described accounts of long and arduous journeys. Figure 2, provides an illustration of the distance nurses travelled. The following nurse gives an account of her journey in 1952 from her home to her training hospital in Glasgow:
The bus was at 2 o’clock from my home [Harris] and I got to Stornoway about 7pm and the Loch Seaforth [ferry] didn’t leave until midnight. When I started my training it was January and lo and behold it was stormy and the Loch Seaforth couldn’t sail. I had to phone the Victoria [Glasgow Hospital] and speak to the Matron and I felt, she must have thought I was in the back of beyond somewhere. I had to go back home, 5 hours back. Luckily it sailed the next day. It was a very stormy crossing and in those days on the Loch Seaforth, the luggage was on the deck and the sea was coming over it. I remember getting to the nurse’s home, and I was the last one to get in. That was awful you know. I felt terrible and when I opened my case, all the sea water had come through, and all my text books that I had to read and all my clothes were ruined. *You had bought your textbook before you got there?* Oh yes. You got a list of everything you had to have, grey cardigan, your shoes, and all the books you had to read. That was my start. I was sharing a room with a girl from Dundee and she had been to a pre nursing school and of course I hadn’t. I was so homesick and I couldn’t sleep because of the tram cars going up the side of the hospital and down the other side! 1

This young woman described a daunting experience travelling to the mainland and claimed that ‘she had never been off the island’. The tenacity of this young woman was evident, when even with the five-hour journey back to her home in Harris, and the return again the next day she was not deterred. The time her journey took to return home from the town of Stornoway is an indication of the remoteness of the area she lived in. For the following nurse, her experience of her journey to Glasgow remained with her forever:

The ferry, the Loch Ness, left Stornoway at 12 midnight and it was reeling. I wakened with a fright at the sound of bells ringing. Someone said that it was the cattle that had got loose and the noise was to waken the crew. We took the train from Mallaig and I smelled for the first time coal and oil. I wasn’t used to the smells. When we got to Crianlarich the train started to go backwards but a lady on the train told me that it was alright as the engine was on the other end. 2

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1 Interview No 28 Harris 1950s-1970s
2 Interview No 3 Brue & Relief in Lewis 1940s- 1960s
All the new experiences that the participants had, such as the smells and the noise of the traffic remained in their memory, such was the impact these encounters had on them.

Another nurse who travelled by plane for the first time from Uist was disappointed when she landed at the airport:

*Had you been to the mainland before?* No, that was my first time and I went by plane and I was so disappointed because the first thing I saw in Renfrew Airport, was a seagull and I was so disappointed because I had been used to seeing so many of them here.³

The accounts of these young women from the Outer Hebrides suggest that it must have been difficult for some of them to adapt to the new culture of big cities. They saw, heard and even smelled new phenomena that they could only have imagined as their experience took place in the 1940s and 1950s, before television was widely available. One participant had read about trains but had never experienced rail travel before:

I left Scalpay Pier [Harris] at 9am and it was 7 o’clock the next morning before we arrived in Glasgow. We got the boat to Kyle of Lochash, a train to Inverness and then a train to Glasgow *Had you been on train before?* No I had never seen a train. *How did that feel?* Very natural, I think reading about it, you sort of knew. I was sick on the ferry and I didn’t like it, but there were a lot of soldiers, sailors and airmen travelling. The trains were packed and it was good fun so the time passed very quickly. Of course it was war time.⁴

Despite challenges such as a twenty four hour journey for at least one participant, some being sick on the journey and having clothes and books ruined by sea water, the participants appear to have accepted the challenges that their journey presented. Thus we

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³ Interview No 22 Uist 1940s-1970s
⁴ Interview No 32 Scalpay 1940s-1950s
could infer that these participants were resilient women, which is defined as the ability to ‘spring back’ after an episode of difficulty.\(^5\) The ability to cope with resilience has been the subject of research for over twenty years. Various scales have been developed to determine the qualities that enable people to thrive in the face of adversity.\(^6\) Wagnild & Young defined resilience as ‘a personality characteristic that moderates the effect of stress and promotes adaptation’.\(^7\) Resnick and Inguito suggest other characteristics associated with resilience include positive interpersonal relationships, a willingness to extend oneself to others, high self-esteem and a sense of purpose of life.\(^8\) Jacelon, who reviewed literature on resilience, found that resilient people have a strong sense of self, independence and a positive outlook.\(^9\) The resilience of district nurses of the Outer Hebrides will become clearer as the picture of their lives emerges.

### 3.3. Participants’ Training

Most participants left their island home to undertake often four to five years training in mainland hospitals. The length of the general nurse training was expected to take three to four years depending on the hospital. The duration of the midwifery training at the time of the study was usually one year and the Queen’s nurse training four months. Some participants carried out further training such as sick children’s and tropical disease nursing courses. Some aspects of the nurses’ training participants recalled as being hard work and long hours. Their training and work was remembered by the following participants:

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At that time, 1944, the war was still on and … there were restrictions on the number of staff so it meant it was a hard life, a hard working day but we thoroughly enjoyed it. We had a day off a week and we were happy doing what we were doing and nobody moaned about money or anything then.

We had three months in the preliminary training school but at the weekends we were in the wards. I think we had a half day on Sunday. It would either be in the morning or afternoon. My first ward was a burns unit. The Glasgow men have quite a sense of humour and when they saw me coming every time they used to say ‘here she comes, the wee highland teuchter’. [Slang term for someone from the highlands of Scotland] I was small in stature.

When we were accepted for our training we were sent our acceptance letter, instructions as to what to bring as well as regulations that we had to be healthy and that the training would last four years.12 We were in PTS [Preliminary Training School] first and then we went to the wards. They signed you on then, like a contract for 4 years and then you got a month’s holiday. And you didn’t get a holiday until then. We were up at 6.30 and in bed by 10pm.13 It was hard work and with a war being on we had people sign on who wouldn’t normally have. Titled people, the Queen mother’s niece was two classes ahead of me but they never finished their training. They just went back to their castles that had been used as hospitals. There were eighteen of us at the start and at the end of four years, nine finished. My father always said to me ‘whatever you start you must finish’.14

A typical set of ‘Instructions to Probationers on Entry’ (Appendix 7) dictate what they were required to bring with them. Material and instructions for making their uniform dresses were included which the participant stated ‘had to be nine inches off the ground’. The timetable (Appendix 8) reveals that probationers had to ‘rise’ at 6.15 am to be in the wards for 7.15 am. They were then off duty at 8.30pm. The timetable shows that the probationers worked long hours and the participant described the work as hard. It is unsurprising that the participant

10 Interview No 22 Uist 1940s-1970s
11 Interview No 24 Ness 1940s-1960s
12 The Royal Infirmary (1939) Training School for Nurses: Letters re Information about Nurse Training, Authors Personal Archives, Stornoway.
13 The Royal Infirmary, Timetable for Nurses and Probationers 1940-1944: Authors Personal Archives Stornoway.
14 Interview No 29 Stornoway & Relief 1940s-1960s
mentioned the high rate of attrition at the time; therefore the participants who all completed their training could be considered survivors.

According to White, the Ministry of Health recognised at the time that there was a nursing crisis and that they would become responsible for the nursing service in the new NHS (1948). A working group was set up to look at recruitment and training of nurses and produced the Wood Report that was published in 1947. \(^{15}\) Although the Report recommended structural changes in the delivery of nurse’s education most of the profession’s leaders rejected its recommendations at the time. \(^{16}\)

Notwithstanding the hard work in the wards, the long hours or the teasing of the nurse by the patients, participants persevered and completed their training with some of them carrying out extra training after completing their general training as is noted in Appendix 4. One participant carried out tropical diseases training in London and another completed her mental health training. Participants were mobile as most of them moved from their general training school to a different school, often in a different town, to carry out midwifery, and then moved again to complete their district training. One participant moved to a nursing home in Surrey to work after she finished her training in Glasgow and Ayr, before moving to Canada to work for a number of years. \(^{17}\)

There was a contemporary social theory current in the 1960s that there was a group of nurses who engaged in ‘touristry in nursing’. That is, when nurses constantly changed geographical areas to work and used their work as a means to other unrelated ends such as to see the sights

\(^{17}\) Interview No 24 Ness 1940s-1960s
and sample the social life of an area. I would suggest this reflected contemporary concern about retention in nursing, particularly at a time of full employment, when nurse recruitment was seen as a seller’s market. Touristry in nursing was also thought to reflect the gendered nature of nursing and the fact that many nurses’ careers would be terminated by marriage. It would be reasonable to suggest that some of the nurses from the Outer Hebrides could be considered part of this ‘touristry group’. For the majority of the nurses in this study, travel to mainland hospitals and further training in various hospitals throughout the country was a necessity, to gain the required qualifications before returning to their home area to work. However, because of the fluctuating economy and necessity of mainland work, as well as accessing specialist health services, a culture of travel exists in the Outer Hebrides as was noted in a previous chapter.

Figure 6: Lewis prizewinning nurses at the end of their general nurses training in Glasgow, 1950s.

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19 From ‘Back in the Day’ Archives, Stornoway Gazette Office, & Library, Stornoway.
Of the thirty two participants only three were not Queen’s Nurses. (Chapter 1 provides information regarding the history of Queen’s Nursing). One of the three who worked for some time as a district nurse stated that ‘district midwifery was not her forte and that she liked medical hospital work’. Another participant was unable to carry out district training, as she was caring for her elderly parents. The Queen’s nurse training was held in high esteem, not only by patients, but, by others as will be discussed in the next section.

3.4. Queen’s Nurses

From the 1940s onwards there was concern about the future and duration of the Queen’s nurse training. In the 1940s to mid-1950s the Lancet included articles about both. The training course in 1948 involved a six month residential course but was reduced in later years depending on the qualifications of the nurse. By 1960 a four months training was in place. Topics covered in the Queen’s Nurse training included sociology, public health, nutrition, dietetics, psychology, hygiene, house planning, sanitation and tuberculosis. Questions from Queen’s Nurse examination papers from 1948-1958 are included in Appendix 1. The scope of health issues incorporated in the examinations indicates the wide range of knowledge that was expected of the nurse at that time.

Participants interviewed were very proud of their Queen’s Nurse training as the following participant stated:

20 Interview No 29 Stornoway & Relief 1940s-1960s
21 Interview No 14 Harris 1960s-1970s
25 District Nursing 150 Questions from the Queen’s Nurse examination papers 1948-1958 QNIS Archives Castle Terrace Edinburgh.
We were always told in Queen’s that because of our training you could go to the desert and manage.26

A participant expressed that she received a level of preferential treatment because she was a Queen’s nurse:

I took very ill in Clydebank and I was three months in the Glasgow Western Hospital. If you were a Queen’s nurse you were the ‘bee’s knees’. I was treated as a private patient in the corner of the ward. I remember the sister and I discussing the pay and mine was even better than hers. I remember telling her it was seventeen pounds and something, and that was in the1940s.27

Participants gave the impression that it was prestigious to be a Queen’s Nurse. The nurse was given the privileges of a private patient and her salary was more that her counterpart in a hospital setting. Before the current approach to the banding of nurses salaries according to the role they carry out, and also before the ‘clinical grading’ schemes were implemented, (Department of Health 1988, Review Body for Nursing Staff, Midwives, Health visitors and Professions Allied to Medicine 1988) qualifications had a greater impact on nurses’ pay. Thus district nurses with their added qualifications were often on a higher salary than their colleagues working in hospital. According to an account record from the 1947 Nursing Salaries in the Northern Regional Health Board, which included the Outer Hebrides, only one nurse received a salary of seventeen pounds, while other salaries were considerably lower, although there was no indication of their qualifications.28 The record specifies they were all trained nurses, which might imply that one had an extra qualification. In the following narrative the nurse attempts to

26 Interview No. 12, 1950s-1980s Uig Back Bernera
27 Interview No 1 Scalpay 1940s-1950s.
28 Northern Regional Hospital Board (1947) Western Isles NHS Archives Stornoway.
clarify the difference between the professional practices of a non-Queen’s and Queen’s Nurse:

I had to demonstrate in front of a whole crowd of nurses how to do a wound dressing a la Queens. (Laughter) … I don’t know why I was picked out of all these people! What was different about the Queen’s dressing? Well you see everything had to be as clean as possible. You went in, folded your coat; put it on a chair with something underneath it. We trained as the Queens, it was very strict. The mothers were told about stuff for the baby, clothes, what they had to get. They got antenatal care and then you went back again and you did the delivery but they [mothers] knew the Queen’s nurses. We wanted it done in a proper manner. There were other nurses too, not Queens. Queens were different? We were different so when they would find out, they would notify us and I would get a call in the middle of the night to go to a woman’s house [for a maternity case] and I would get there and they would have nothing.  

The nurse who had to demonstrate the Queen’s Nurse technique of carrying out a wound dressing worked in Harris until the 1970s which was likely when this event would have taken place. Her experience, when she maintains that Queen’s nurses were different, inasmuch as mothers notified them instead of their own midwife appears to have taken place in the 1950s on the mainland, after her completion of Queen’s Nurse training. The surgical dressing technique, which the nurse was probably demonstrating is included in the booklet in Appendix 9. The QNI District Nursing Techniques Handbook maintains that instruction should always be ‘clear, concise and comprehensive taking nothing for granted and leaving nothing to chance’.  

Such was the demand for Queen’s nurses in the late 1940s there was a waiting list to carry out the training. It would be reasonable to suggest that the reason for this demand may have been due to the reduction of nurses in training during the war years as was commented on in

29 Interview No 28 Harris 1950s–1970s
QNI’s Annual Report of 1944. ‘The number of district nurses applying for training has been disappointing. Had it not been for the number of nurses who have re-joined district work as well as the married nurses who have continued in the service, the shortage of district nurses would have been serious’.  

White maintained that the national shortage of nurses threatened the government’s plans for the National Health Service. Subsequently in the period from 1939 to 1949, a series of reports and investigations into nursing were carried out.

In an attempt to address the shortage of nurses in the Outer Hebrides during the period from 1940 to 1944 it is recorded in the LNSSC minutes that the procedure for the appointment of a district nurse had been changed. At that time the LNSSC provided the local Nursing Association with the names of prospective district nurse candidates and the Association would choose who they thought was suitable for their area. Because of the shortage of nurses the LNSSC agreed that in some cases they would appoint the nurse directly ‘in case the nurse might accept another appointment before the next meeting of the Association’. Clearly they were pre-empting any chance of the nurse being appointed elsewhere.

Most of the participants carried out their Queen’s training in Edinburgh but the following nurse recalled that she was unable to do so:

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34 Lewis Nursing Services Sub-Committee (1940-1947) Minutes: NHS Western Isles Archives, Stornoway, May 1945.
35 Lewis Nursing Services Sub-Committee (1940-1947) Minutes: NHS Western Isles Archives, Stornoway, May 1945.
I applied to Edinburgh to do my Queen’s district nursing and came home. One of my sisters took ill and was taken to hospital and that delayed the date that I was given for my Queen’s training in Edinburgh. I got word asking would I go to Ayr. They didn’t have enough places for pupils [in Edinburgh]. I didn’t mind. I didn’t know where it was! I knew Edinburgh, that was why I wanted Edinburgh but I decided I wanted to get through my district training so I decided to go to Ayr and that was in 1952, November 1952 to March 1953, 6 months. What happened was, if you did your district training in Ayr they always kept their own nurses if they trained there, but I was called ‘an Edinburgh nurse’ because it was Edinburgh that sent me. I didn’t apply to Ayr and sometimes that happened. I did enjoy Ayr and I was surprised.36

Queen’s Nurses, as has already been referred to in Chapter 1, were trained in various places in Scotland. The majority of the participants were trained in Edinburgh but some were trained in Aberdeen, Glasgow, Edinburgh, Dundee as well as Ayr.

The 1944 minutes of the LNSSC indicate that most nurses who applied for posts were Queen’s Nurse trained. One applicant was not Queen’s trained and there was controversy over the proposed appointment. She was appointed but in most instances, the minutes of the LNSSC reveal that if there was a Queen’s Nurse and a non-Queen’s Nurse applying for a post the outcome was the appointment of the Queen’s Nurse.37 The nurse who was appointed was one of the participants in the study and was not a Queen’s Nurse. She recalled the reason for her being appointed was, that ‘the other applicant had been working abroad as a missionary and did not have much experience of the island, whereas she had been working as a relief district nurse in the area’.38

36 Interview No 16 Scalpay 1950s-1970s
37 Lewis Nursing Service Sub Committee of the Council for Ross and Cromarty 1933-1947 Western Isles Health Board Archives, November 1946.
38 Interview No 29 Stornoway & Relief 1946-1960s
However by 1946 it was recorded in the minutes of the LNSSC that there were six applicants for a district nurse post and of the six only two were Queen’s Nurses’. It suggests that there was not a shortage of nurses in the Outer Hebrides in 1946. It would be expected that the number of trained district nurses available would be reduced in the late 1940s and 1950s. This might explain why after a period of shortage of Queen’s Nurses there was a waiting list to carry out the training, as the nurse noted, who had to train in Ayr despite applying to Edinburgh.

By the 1950s it would appear that, in the Outer Hebrides, there was a shortage of trained district nurses. One participant recalls that when she was appointed in 1955 four nurses ‘were shipped off to Aberdeen to carry out a Queen’s District nursing course’. After gaining district nurse posts without Queen’s Nurse training, in some cases, the local Health Board seconded the nurses from their posts as the participants explain:

I got married in 1958 and I stopped working, but I did a lot of relief, then in 1966 I got a District so I felt that I had to do district training and went to Edinburgh. They sent me. [Local Authority]  

The reason I did Queens was, when I applied for the district I was told I would have to do my Queen’s training, otherwise I probably wouldn’t have done it.

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39 Lewis Nursing services Sub-Committee (1940-1947) Minutes: NHS Western Isles Archives, Stornoway, January 1946.
40 Interview No 16 Scalpay 1950s-1970s
41 Interview No 4 Lochs 1950s-1967
42 Interview No 17 Lochs 1950s-1970s
43 Interview No 6 Breasclete 1940s-1950s
It was after I got married that we did some district training, about three or four of us who hadn’t got our Queen’s nurse went to Aberdeen for an intensive course and we got a certificate from there. Was that after you had started on district? Oh yes, years after I had started.44

The Local Authority would have paid the QNI for the nurse’s training at a cost of approximately £90.45 In addition travel costs would have been needed and payment for relief staff. It seems likely that the expenditure was intended to address the shortage of trained nurses in the community.

During their training Queen’s Nurses were given ten driving lessons. It was reported by the QIDN in the 1953 minutes, that two nurses’ driving were so unsatisfactory that further lessons were recommended, and if they were not ready for their test, they should continue their driving lessons in the area to which they were appointed.46 The following nurse suggests that the lessons may not have been completely free, but it may have been that they were bonded by their training, including their driving lessons:

We got our driving lessons in Edinburgh. With Queens? Yes, that was included in our training, so many driving lessons. I sat my test in Greenock and I got through the first time. I went on contract to Greenock, you had to do a year’s contract or else you had to pay £30 which you didn’t have as a salary then. I’m glad I did it and I wouldn’t give it up until I finished it all [training]. I would never think of getting married. You weren’t allowed to work then if you got married. I stopped in 1953 because I intended to get married.47

A similar concern about paying for training if it was not completed was highlighted in the minutes of a Queen’s Nursing Finance committee meeting in 1953. Arising from the

44 Interview No 18 Stornoway & Point 1950s-1970s
46 QIDN (1953) Scottish Branch, Minutes of Nursing Committee 20th October, RCN Archives Edinburgh.
47 Interview No 23 Uist 1940s-1970s.
minutes was a request that a ‘penalty of thirty five pounds be imposed on a nurse for failure to complete her period of service under contract in respect of district nurse training’. The matter was being taken up with the woman’s solicitor.\(^{48}\) The previous extract also indicates that the nurse would not even think of getting married, as she would have to repay the money to QNI if she did not honour her year’s contract. Marriage and the problems that it created for nurses are discussed in the next chapter.

3.5. Skills update

Most nurses who worked on district in the Outer Hebrides at the time of the study felt they had received a thorough initial district nurses training. However the following participants’ response when asked how they kept their practice up to date provides an insight into their access to continuing professional development and updating after their Queen’s Nurses training:

No we had no lectures or anything. I was on a refresher course once. \(^{49}\)

No, there was no such thing.\(^ {50}\)

Yes we had in the 70’s and 80’s.\(^ {51}\)

I got the Nursing Times and Nursing Mirror and was there a Journal called the Standard? Did you ever go on courses? Yes. We had to go on refresher course ever 5 years for our Midwifery. Were you supervised? Not every year. I was 3 years in Taynault and had one supervision during that time. No, I never had supervision here.\(^ {52}\)

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\(^{48}\) Queen’s District Nursing, *Minutes of Meeting of the Finance Committee* 14\(^{th}\) February 1956, Edinburgh.

\(^{49}\) Interview No 8 Carloway 1950s-1960s

\(^{50}\) Interview No 10 Point 1960s-1970s

\(^{51}\) Interview No 13 Uig 1957-1970s

\(^{52}\) Interview No 22 Uist 1940s-1970s
I remember getting Nursing Mirror and the Nursing Times.\textsuperscript{53}

Yes, I went to Elsie Inglis Hospital in Edinburgh [midwifery refresher]. \textit{How did you keep up to date?} There were plenty of magazines and I would go up to Stornoway and get supplies and have a chat with the Nursing Officer there and you got to know things that way.\textsuperscript{54}

In the 1940s 50s and 60s, apart from the statutory refresher midwifery course, which each midwife carried out every five years after passing the Central Midwives Board examination,\textsuperscript{55} it is not apparent that there was any other formal skills updating. Most participants were familiar with nursing journals and claimed that they read them to keep their skills up to date. In the early 1970s, a participant spoke of demonstrating her Queen’s Nurse dressing technique,\textsuperscript{56} suggesting that the nurses were receiving some practical training at this time.

With the reorganisation of the Health services in 1974 and the recommendation of the Briggs Report (1972) that ‘an element of further education must be built into the system’, nurses and management saw the necessity of continuous updating of skills.\textsuperscript{57} According to Levitt and Wall, the profession broadly welcomed the Briggs Report, but it was not until the 1979 Nurses Act, and the establishment of the UKCC, that sections of the report were implemented.\textsuperscript{58}

\textbf{3.6. Conclusion}

The findings from the participant’s narratives reveal that for some, travel to their training hospital was an experience remembered vividly. They appeared to adapt and cope with the

\textsuperscript{53} Interview No 25 Lochs 1950s-1970s
\textsuperscript{54} Interview No 28 Tarbert, Scalpay 1950s-1970s
\textsuperscript{56} Interview No 28 Harris 1950s-1970s
\textsuperscript{57} Briggs, ASA, (1972) \textit{Report on the Committee on Nursing}: London HMSO.
experiences of new places, and living away from their home in unfamiliar surroundings.
The traits identified by some researchers as ‘resilience’ were evident in some of the participant’s experiences when they recovered quickly from some harrowing journeys before they even had begun their training.

Training as a nurse was acknowledged as hard work particularly during the war years, and at a time of attrition, but participants persisted. In addition, the rules during training, identified by a participant appeared daunting, yet participants persevered and all completed their course. Most of them completed general, midwifery and Queen’s district training, often in different geographical locations from each other and in different institutions, before returning to the Outer Hebrides.

The district nurse training, particularly their Queen’s training was believed by participants to have had a positive effect on their professional life. Some participants alleged that it equipped them for any eventuality that they faced in their working lives. It seems it was prestigious to be a Queen’s Nurse and it was believed by many participants that their practice was different from those who did not have the additional training.

The scope of health issues included in the Queen’s District Nurse examination papers suggests that their knowledge base was wide and relevant to the health issues of the time. Their midwifery training required that they had the ability to cope alone with medical situations as will be discussed in later chapters. Professional development was ad hoc, and apart from midwifery refresher courses, nurses themselves had sole responsibility. The participants’ accounts of the challenges of travel to an unknown environment and the hard work required during their training present a picture of the participants as determined and knowledgeable women. They believed that their background and training may have given
them the confidence and knowledge to prepare them for the challenges of working in remote areas in the Outer Hebrides.
Chapter 4 Image and Cultural Background

4.1. Introduction

Issues relating to the ways in which the nurses’ culture and lifestyle impacted on the image they had of themselves will be considered in this chapter. Their attitude to their uniform, what they carried in their professional bag and the equipment they had available for their practice will be described. Examination of the image of the district nurses at the time under study reveals how steeped they were in the culture of the community in which they worked.

To create a picture of the district nurses at the time under study, the culture such as the Gaelic language, which most of them spoke, and their opinion on marriage and the district nurse, was explored within the participant’s testimonies. The culture/faith in the Outer Hebrides at the time under study was different from many lowland areas of Scotland, and participants provide recall of its effect on their work.

4.2. Nurses Uniform

Uniforms for nurses have been part of the nurse’s image since the Victorian times when some uniforms were reminiscent of the parlour maid dresses with stiff white aprons and starched white collars. By the 1940s the traditional uniform was a symbol of nursing’s traditional authority and social standing. Participants took pride in the wearing their uniform especially those who were Queen’s trained. Part of their assessment during their training was concerned with their appearance in uniform. Examples of comments included

in the ‘Inspection Reports are include in Appendix 13. Nurses recalled aspects of their uniform such as its warmth, their hat and badge:

I had my district uniform and there were clips on it on the shoulders. I had a skip cap. *Did it ever blow away?* Yes sometimes.

Navy blue dress and a coat, something like your baseball cap nowadays, with a skip hat. *Was it warm?* Yes, it was warm, but it rained so much in this area, there was more or less no way of escaping that. I was brought up in a place where there were lots of hills and valleys for shelter. When I came to this area the only shelter you could find was beside a house.

You could have your own style of hat which ever. I had quite a nice one, but you had to wear the bonnet with the brooch if you were a Queen’s, if not you could have you registration badge or your midwifery badge. The hat I had was the kind that we still wear in Church, flattish one with a brim. It was like a pudding bowl, more or less.

The uniforms the nurses wore were probably cumbersome in the summer, and the hat created problems in the wind, but most participants persevered and always wore their full uniform. Nurses reported how the Hebridean weather affected the wearing of their uniform:

But half the time in the winter your hat wouldn't stay on and I also had to wear an anorak.

If it was windy and wet and cold, we just dressed in Wellingtons and trousers, because if you had Wellingtons on you couldn’t see the trousers. *You always wore your hat?* Yes and you had a summer coat and a tweed winter coat and they were very cosy and the summer coats were light.

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2 QIDN (1953,1955,&1962) Inspection Reports, Castle Terrace Edinburgh (Appendix 13)
3 Interview No 2 1940s-1950s Carloway
4 Interview No 3 Arnol, Brue Barvas 1940s-1960s
5 Interview No 4 Lochs 1950s-1967
6 Interview No 14 Tarbert and Scalpay 1960s -1970s
7 Interview No 21 Uist1960s
The participant who wore trousers was required to go on horseback to a nearby island, which was part of her practice area, and it would certainly be more suitable to wear trousers than a dress. Trousers were not part of the uniform at the time. Hats were a problem but because the nurses felt they were not in complete uniform without it and they seemed to take pride in wearing it:

You never went out without a hat. I was always dressed in full uniform. Being on my own district it meant a lot when you were in uniform.  

Most of the participants maintained that they were proud of their uniform. It was suggested by Dickson in 1958 that if nurses did not have a hospital uniform that pride would be lost and it would discourage the competitive spirit that prevailed between nursing hospitals at that time. She went on to maintain that it gave the wearer authority, self-confidence and a sense of discipline. Hallam dismissed that view when she contends that uniforms displayed ‘the fragmented historical identity of a professional driven by issues of class and status. It is possible that the nurses in the study whose uniforms were part of their identity depended on it to symbolise the status they appeared to have within the community. Nurses who currently prefer the uniform of ‘scrubs’, may indicate, that they want to discard their historical image. In the 21st century the national uniform has been introduced. It is unknown as yet if it will influence the image of nursing.

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8 Interview No 8 Carloway 1950s-1960s  
The participants of the study spoke about their fondness for the uniform including the hospital badge. It was important to most of them as the following nurse recalls:

I can’t remember being off sick when training but if you missed through sickness you had to make up your time before you could claim your hospital badge. The hospital badge was very important to show off pinned to your apron.  

Figure 7: A Queen’s Nurse with her car in the 1950s Ness.\textsuperscript{11}

\textsuperscript{11} Photograph used with permission from the Ness Historical Society Ness, Isle of Lewis.
\textsuperscript{12} Interview No16 Scalpay 1950s-1970s
There was one nurse who felt that the meaning of her badge indicated that the service supported the patient too much at the expense of the nurse:

The patients always, that’s what our badge stood for and we were reminded of it every day and it was wrong! The pelican bird. You only got it after four years. Nine out of the eighteen in my class got it. I’m telling you the pelican takes blood out of its own breast to feed its own. It was the patient, the patient and that’s all very well but your welfare was also…The pendulum has swung too far now. It was too far the other way back then but it’s too far the other way now! 13

The nurse did not seem impressed that the patients always came first and that very little thought was given to the concerns of the nurse. She is inferring that there is too much consideration given to the nurses today, and not enough for the patient. The Pelican badge was chosen by the participant’s Royal Infirmary training hospital, to represent the charity and self-sacrifice of nurses, pelicans being known to feed their young from their own blood. Nurses trained in the hospital are referred to as ‘pelicans’. 14

![The Pelican badge](image)

**Figure 8:** The Pelican badge. 15

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13 Interview No 29 Stornoway 1940s-1960s
A study about the perception of nurse’s uniforms found that nurses are judged primarily by what they wear.\textsuperscript{16} It goes on to assert that if nurses want to improve the public’s professional image of them that they should be reminded that how they dress makes a statement as to how they are perceived as professionals. Participants considered that wearing the uniform was important and they regarded it as a significant part of their training. It helped them to appear professional, which the nurses had been taught was necessary for the public’s impression of them. Some saw the nurse’s uniform as proof of her competence and a reassurance to the patient.\textsuperscript{17} Nurses identified the bag they carried as part of their uniform.

4.3. Contents of Nurses’ Bag

The contents of the bag, usually a Gladstone bag, that nurses carried, has been described as ‘part of the imagery of district nursing; a container of secret powers and instruments of healing’.\textsuperscript{18} Contents of the midwifery bag were itemised in most maternity textbooks such as Myles, A Textbook for Midwives.\textsuperscript{19} One nurse described the contents of her bag:

\begin{flushleft}
\end{flushleft}
I had this black bag and there was nothing in it but the forceps and a syringe. There was no throw away syringes then, you boiled them. I went to the Nursing Officer and asked her for some bandages and cotton wool and things for my bag because if I met something on the road, an accident, I had nothing in the bag. I was going around with that bag and anyone would think that there were an awful lot of wonders in it. She said Oh no, you can’t have that, but I will give you some lint and she would give you lint ‘till the cows come home’. What am I was going to do with it, I don’t know. She didn’t give me a bandage, a triangular bandage if somebody had hurt themselves or cotton wool to clean anything up, not a thing. Why? It was just because that was what was done in those days. Then when I became a Nursing Officer, there was a cupboard full of stuff and the nurses were given whatever they needed, gloves and everything that was necessary for their work. That was one thing that I saw to.20

In the extract the nurse was annoyed because of the lack of equipment in her bag. However she rectified this when she became a nursing officer, which must have been after 1970. The Salmon Report of 1966 introduced a new organisational structure for nursing and midwifery in the UK and defined the role of the Nursing Officer. The person will ‘act as a consultant in nursing practice and develop new ideas and methods’.21 The nurse who became a nursing officer was ensuring she was changing practice for the district nurses such as making certain they had enough equipment to carry out their practice. The nurse’s bag was part of her uniform as the following participant explains:

I always carried my bag. Was it heavy? No, it was just the black bag, I never found it heavy. When the doctor came, he was walking with me. There was no road then in the island, not for a vehicle anyway and I carried the doctor’s case for him too, because he was older. You had your own as well as his? Oh no, I didn’t carry my own when he was there. I only carried my own for confinements.22

20 Interview No 10 Point 1960s-1970s
22 Interview No 1 Scalpay 1940s-1950s
The nurse described assisting the doctor with his bag, as he was elderly. The nurse did not carry her own bag, which she maintained was not heavy probably due to how few items were in it. However the midwifery bag for confinements would have been heavy especially if the nurse had to walk a distance as the following participant who worked in the 1940s stated:

*Was your bag heavy? Oh walking kept us very active you know. Did you have gas and air with you? Oh yes we had. Yes, it was very heavy, but we were young and we were so keen. You know when you are keen on your work that makes the world of difference.*

The maternity bag, as well as the gas and air bag would have been heavy, yet very few nurses complained about this or any part of their work despite the challenges of their working environment. (Nurses noted that since they found enjoyment in their work, many of the situations such as carrying a heavy bag were accepted.) Many nurses in the 1940s and 1950s rode a bicycle, which must have been difficult to balance a bag on. The nurses who rode bicycles were asked if it had been difficult trying to balance the bag:

*Yes, I think I could set it on the bike, I could get the bag on the bike some way or other; I didn’t have it on my shoulder like they would have now.*

Similarly the nurses who had to go to the smaller islands such as Scarp, on a small boat, over difficult terrain and sometimes against the winter elements, would have needed the strength to manage to carry the maternity bag, and perhaps another one with gas and air. Other chapters in the thesis give examples of relatives carrying the nurse’s bag when they were hurrying to a confinement.

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23 Interview No 5 Shawbost 1940s
24 Interview No 9 Ness, Harris 1940s-1950s
Nurses’ bags have been transformed over the years with canvas lightweight shoulder bags replacing the familiar pictures of the Gladstone nurse’s bags of the 20th century. For the nurses in the study the contents of the bag were described as being inadequate for their practice. Conversely present day nurses are able to carry some emergency drugs, like adrenaline, in case they encounter a patient with anaphylactic shock. Most items are now disposable which is in stark contrast to the nurses of the study who indicate in the next section that they had to boil glass syringes and sterilise dressings in the patient’s oven.

4.4. Equipment

To possess a thermometer was not part of the nurse’s equipment at the earlier time of the study in the 1940s and 1950s as the following nurse describes:

The most important equipment that you carried was your thermometer and that was in your pocket. At first you had no thermometer but latterly it was so great that you had one.25

The nurse who did not have a thermometer worked from the 1960s, indicating that all nurses before that time did not possess one. Yet, in the ‘midwifery contents bag’ described in a Midwifery Textbook it stated that a low reading thermometer was recommended.26 Another nurse reflected on the difficulty of not having a sphygmomanometer (blood pressure monitor) when she attended a home confinement and complications arose:

After the delivery, the baby was fine and the mother seemed fine; the doctor had just gone downstairs and going to his car when she had a fit, so fortunately he was there. Her blood pressure must have shot up. In those days we didn’t have a sphygmomanometer, we just had to rely on her going to the doctor. We didn’t have a sphyg in the 1950s.27

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25 Interview No 33 Scalpay 1950s-1970s
27 Interview No 13 Uig 1957-1970s
Assessment of a patients’ condition, without equipment, may have been difficult for the nurses. The lack of equipment at the time period of the study was evident as nurses complained of being short of supplies. At the earlier time under study any equipment necessary for patients would be stored in the nurse’s cottage. The following participants responded when asked about the equipment available to them:

I had cod liver oil and orange juice. *Did patients have to buy that?* No.²⁸ [The availability of cod liver oil and orange juice is referred to in a later chapter].

When I was in Edinburgh we were putting the dressings in the oven in the milk tins, I’m not sure we had the packs, they started by 1967. I vaguely remember sitting rolling balls [cotton wool] to sterilise them. *In the patient’s oven?* But of course, yes and you made some swabs and things like that, sanitary pads, and the doctor invariably thought it was for his nose as a mask.²⁹

A description of how nurses sterilised the dressings is included in the Queen’s Nursing Technique Book states ‘dressings are baked for one hour in a moderately hot oven. Dressings will be a golden cream colour if properly baked’.³⁰ This ‘sterilisation procedure’ would have been a time consuming task but, the nurse was also reminded in the textbook that, ‘much time can be saved by planning to employ waiting time. Time spent in talking and listening to the patient is not wasted’.³¹

Nurses described being practical and making use of what was available at the time. The nurse, in the following extract, asking the young mother how she coped indicates how

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²⁸ Interview No 2 Carloway 1940s-1950s
²⁹ Interview No 4 Lochs 1950s-1967
³⁰ Queen’s Institute of District Nursing (1957) Outline of District Nursing Techniques: RCN Archives c/479, folder 21, p. 37.
³¹ Queen’s Institute of District Nursing (1957) Outline of District Nursing Techniques: RCN Archives c/479, folder 21, p. 5.
difficult it would have been even to wash clothes perhaps without running water or electricity. Although electricity came to many places of the islands in the late 1950s it took some time before all geographical areas were connected to the electricity grid. Likewise running water gradually became available and, in some places outside wells were functioning into the 1960s, as was noted in a previous chapter. The following participant describes how she managed patients who were incontinent:

You could get quite good rubber sheeting, which you could borrow from the nursing service and you kept probably a couple. You got worn sheets that you could tear down, but invariably you would have big long washing lines outside the house. It was amazing how the people just coped. Mind you, you learnt as you went by. I remember asking one young mother “How on earth do you manage?” “I just do the tops and the bottoms of the sheets and the necks of the things.” We had the inevitable bedpans and bottles. There was a room that was really like a surgery and these things were kept in there. Various bits and pieces we had.32

The ‘bits and pieces’ described by the previous nurse may be explained by the following participant:

There were no commodes, but there were bedpans. People were kept in bed a lot more then. The doctor would put people to bed if they had a bad cold or flu, an old person would have to go to bed. We did have mackintoshes and drawsheets and old sheets. That was all really. There were no pads.33

The above nurse worked in the 1940s-1950s when there was little available yet she acknowledged the need for bedpans as patients were being put on bed rest for what would

32 Interview No 4 Lochs 1950s-1967
33 Interview No 9 Ness Harris 1940s-1950s
seem like minor ailments. Another participant relates what equipment was available to her to attend to her patients:

We kept rubber sheeting and that sort of thing. After the war people didn’t have all that much, like linen, so you were forever getting old sheets from somebody and keeping these for draw sheets. It was hard work, because incontinence pads hadn’t come into force then and even to keep their skin [intact] meant all these visits.34

The nurses who did not have continence pads described having to undertake a great deal more work and visits to protect their patients’ skin. The importance of keeping their patients’ skin intact was regarded as a matter of professional pride as is noted in a later chapter when a participant maintained that even if the patient died and the body was dressed ‘you took pride that the skin was whole’.35

Nurses who worked in the remote areas of the island described that it was their responsibility to go to the town area to collect equipment. They appeared to accept that this duty was carried out in their own time:

We just had to phone to get our dressings and things from Stornoway. We would go over maybe on our half day and get them.36

According to the participant’s responses, it would appear that the nurse’s life was their work and collecting equipment was another accepted part of it. For nurses working in or near the town area it seems to have been easier to access resources as following nurse explains:

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34 Interview No 18 Stornoway, Point 1950s-1970s
35 Interview No16 Scalpay 1950s-1970s.
36 Interview No 6 Carloway 1940s-1950s
You had the daily visit bag, with dressings or whatever you needed. We were quite well stocked; we had no problem with stock.  

The extract from a nurse who worked in the town area is in contrast to the nurses in the more rural areas who narrated that they had limited access to equipment. Nevertheless there are similarities with all district nurses who worked at the time under study with the kind of uniform they had, the bag they carried and the equipment available. The findings indicate that the amount of equipment available for the nurse was dependent on the geographical area of the nurse’s practice. Although the nurses of the Outer Hebrides had a bag and this, informed part of their identity, the contents was not always fit for purpose.

4.5. Gaelic Language

The majority of people in the Outer Hebrides spoke Gaelic at the time under study as was noted in the Introduction. Earlier in the century the Dewar Report stated ‘that a good knowledge of Gaelic was preferable for nurses working in Gaelic speaking districts’. The findings from the study show different attitudes towards Gaelic. The following nurse describes her experience with the language:

I had been born in Barvas, so I knew the weather and I knew Gaelic, but not to speak fluently, because I only took it when I went to Stornoway to school. But my word I had to learn it because there was a lot of Gaelic in those days.

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37 Interview No 18 Stornoway, Point 1950s-1970s  
38 Highlands and Islands Medical Service Committee (1912) (Dewar Committee) Report to the Lord Commissioner of His Majesty’s Treasury: Vol. 1 p.18, Edinburgh, HMSO.  
39 Interview No 4 Lochs 1950s-1967
The nurse was working from 1960s-1970s when the language was spoken by over 90% of the population in rural areas.\textsuperscript{40} It is understandable that patients would prefer to communicate in what was effectively their first language. Although a large number of people spoke Gaelic the following nurse did not perceive it a problem if a nurse did not speak it:

They all spoke English, but some preferred speaking Gaelic, the older ones. \textit{How would nurses manage without Gaelic} They would have managed fine, because every house spoke English.\textsuperscript{41}

Contrary to the previous nurse commenting that everyone spoke English the nurse in the following extract relates what happened when she had a patient who only spoke Gaelic and was visited by a doctor:

I remember a doctor came, a relief. He wanted to learn Gaelic and he thought it was going to dead easy! I had a lady who could only speak Gaelic so I said to him, how about giving her a visit. I said to the old lady there was a new doctor coming and he wanted to learn Gaelic. So off he went. I didn’t see him afterwards. I called on her the next day and asked her how he got on and she said “he was bad enough when he was talking in English but he was ten times worse when he was talking in Gaelic”!\textsuperscript{42}

The nurse who maintained that everyone spoke English practiced in Uist where only 73% of the population spoke Gaelic in 1971 in contrast to the rural areas in Lewis where 90% spoke the language as is noted in the Introduction. \textsuperscript{43} It was also reported that 30% of the population in some rural areas of Lewis could speak only Gaelic. One nurse who worked in

\textsuperscript{40} Census Scotland, Gaelic Report 1951, 1961, &1971.
\textsuperscript{41} Interview No 28 Harris/Scalpay 1950s-1970s
\textsuperscript{42} Interview No 28 Harris/Scalpay 1950s-1970s
the 1950s recalled an incident when an obstetric difficulty arose and at a time when English was not commonly spoken in the islands:

There were twins in Scalpay, before my time, and there was a retained placenta. They sent the husband for the doctor and he asked the nurse ‘what will I say to the doctor’ He was told to say Thùr shin a chlann ach dhur shin ach a chlann (Gaelic) (We got the children but we got nothing but the children). They were clever.

The nurse appears to be using the Gaelic language to relay a message to the doctor without alarming the husband. The culture of the islands and of the nurses at the time of the study was in contrast to 21st century health care where openness of health issues is the norm. The incident conformed to the nurses training when they were instructed to care for relatives as ‘failure to extend this consideration and care may cause anxiety and suffering for the patient’. By conveying her message in Gaelic that the babies were born, but there were still problems, this nurse described caring for the patient and relative by preventing them anxiety.

As Gaelic was the first language of most of the participants and many of them carried out their training in Edinburgh one of the extracts from Dougall’s study could have involved some of nurses in this study. One of the participants in Dougall’s study commented that when she was carrying out Queen’s training in Castle Terrace in Edinburgh that “I heard this language going on… it was Gaelic. There were a lot of highland girls and they were talking in Gaelic”. It may not be surprising that these women spoke their own language

44 Interview No 1 Scalpay 1940s-1950s
when they met, as it was a part of their culture and natural to communicate in their mother tongue.

The findings from the study did not indicate that there was any disadvantage for a nurse who did not speak Gaelic, yet, it suggests that it was very helpful to have a working knowledge of the language.

4.6. Marriage

A theme that was prevalent in many interviews was that the nurses were disappointed that they had to leave work after they had married. Most of the district nurses were highly qualified yet many of them only worked for a short period. However some of them did return to work until after the mid-1960s when married women were asked to provide relief work due to a shortage of nurses. All of the participants who worked at the earlier part of the study were unmarried at that time. By the late 1960s many district nurses in the Outer Hebrides were married. The following nurses gave their opinion on marriage and the nurse:

The nurse for the Bayble district was married but she just refused to resign, and she just kept on until she retired. It was a jolly bad thing that you had to leave your job because you were married, but that is quite true.47

Yes when you got married that was the rule. Before you got married, you gave in your notice, three months’ notice. A husband wasn’t supposed to live in the cottage.48

In 1957 I was there, until I got married and I left then. Everybody left then when they got married.49

47 Interview No 18 Point & Stornoway 1950s-1970s
48 Interview No 3 Brue 1940s-1960s
49 Interview No 8 Carloway 1950s-1960s
One nurse recalled a colleague who had refused to resign when she got married which was obviously unusual. The participant clearly did not agree that nurses should resign when they married. The other two nurses accepted the practice that nurses left their employment when they married. Undoubtedly most participants interviewed would have liked to continue working after they married. According to the minutes of the LNSSC in the 1940s some nurses were allowed to carry on working during the war, because others had to go to the services.\textsuperscript{50} When the war was over many married district nurses then had to resign. It is interesting that a nurse refused to resign despite being married. In the minutes of a rural district nurse committee in 1954 a discussion took place between the members about the appointment of married nurses. The conclusion they came to was that single nurses should be appointed but ‘where a married nurse is better qualified she should be appointed if her domestic situation did not make the appointment inadvisable’.\textsuperscript{51}

By the 1960s debate continued as to how to resolve the national nursing shortage. The formal or informal ‘marriage bar ‘which applied to public bodies and some private firms before 1939, had to be relaxed during the war, and was not reinstated because of post war labour shortage.\textsuperscript{52}

The following participants described how the position for married women changed:

\textsuperscript{50} Lewis Nursing Services Sub-Committee (1940-1947) NHS Western Isles Archives, Stornoway31\textsuperscript{st} March 1942.
A couple of years after I got married it all changed. They couldn’t get nurses so they had to take married nurses then. And it was good because young people weren’t going in for district. That is how I was relieving after I got married.\footnote{Interview No 6, Breasclete, 1940s-1960s}

When I was relieving on the district, and sometimes it was for three months at a time. I was a married woman. There were no married women on the district at that time, [1950s] but it lessened a bit and they had a few married women.\footnote{Interview No 29 Stornoway & Island Relief, 1940s-1960s}

\textit{When did your husband go with you to the cottage? In 1964.} \footnote{Interview No 19 Lochs 1950s-1970s}

Many nurses who were married were asked to return to work in the late 1960s to relieve the permanent staff which some of the participants noted. Despite the general shortage of nurses an article written by a doctor in 1966 indicated that not everyone was in support of married women working. He questioned whether the married nurse would be financially better of working, whether it was morally right for her to leave her children, if she would be able to attend a refresher course on her return and whether she would be accepted by her younger colleagues. His rhetorical reply to each of his own questions was ‘probably not’.\footnote{Girdwood, R. H., (1966) Some Problems of Nursing Today: \textit{British Medical Journal}, 4\textsuperscript{th} June, p.1411.}

Figure 9: Some nurses married in uniform during the war years. The above participant commented that 'she knew she could not work on district after she had married'.

4.7. Influence of Culture

When participants discussed what they did in their social life very few of them appeared to have outside interests apart from attending church. It was evident that religion played an important role in many of their lives. A nurse, who complained about not having time off to attend church, did not stay long on the island, illustrating the importance of their faith, as is noted in the next chapter. When some nurses discussed their faith, they connected their feelings about that faith to their nursing role, their faith and work appeared to be intertwined as the following relate:

I was dedicated to my work, I lived for my patients and my nursing and I was never one for dancing, going to concerts or anything like that. I was quite happy to work. I felt it was from the Lord.

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58 Interview No 30 Glasgow 1940s
I took off my uniform when I retired and went down on my knees and thanked the Lord. I dealt with an awful lot, things could have happened but thank the Lord it was uneventful.  

The last extract was from a nurse who had worked for approximately 30 years in a remote area and was responsible for schools, health visiting, midwifery, and general nursing. However the following nurse when asked if she relied on her faith had a different response from the others:

No! I think I was so confident. I can’t say that I did. You always tried to do what was right whatever faith you were working with. I may have asked if I was doing the right thing but that was it! But I was very happy. It was a lovely time. Socially we were looked up to in the village, you, the policeman and the headmaster, the postman, the minister and the nurse were all in the same category. We used to get invited out to a lot of things. I used to play a lot of badminton and you had the occasional wedding you went to and they also had a post-office club that we went to and we played table tennis and badminton there. If you wanted to go further afield we went over to Carinish [next village] to dances and debates.

The sentiment of the district nurse about being so confident that she did not rely on faith was different from most of the other participants’ response. The Outer Hebrides at the time under study was, as indicated in Chapter 1 known for its religious values therefore it is unsurprising that most of the nurses were part of this culture. The previous extract was from a nurse in Uist and described a difference from the Lewis and Harris nurse’s social life where most of them indicated that they did not have a social life. The participant was also describing being happy which was typical of many comments from other informants regardless of the sometimes difficult work and the many challenges they faced.

59 Interview No 1 Scalpay Non Dr Island 1950s
60 Interview No 17 Lochs 1950s -1970s
61 Interview No 21 Uist 1960s
4.8. Attitude to Work

Participants were asked about their attitude to their work, which is described in the following extracts from the interviews:

We were happy enough to get on with our work and nobody bothered us. We had a nursing superintendent come out once or twice a year and did a round with you and checked your cottage to see that everything was in order, but that was all.  

It was really quite a happy job, I really quite liked it.

I was very keen on my work all the time until I had to leave it. I loved going round the patients. I think I was born like that, but this is where I am now, an old granny.

There was satisfaction that is the word I want, satisfaction and you saw somebody that was ill doing a recovery.

Regardless of whether nurses worked in a rural area, town area or islands with no doctor, all of them responded that they enjoyed their work and appear to have had satisfaction in their work. They believed that they did not have the same concerns as the nurses of today:

We weren’t bothered about litigation or anything, which you have to be so careful about now. But again you had to be careful what you said and where you said it, because there were houses where you had to watch what you did, but they weren’t the norm. There was no fear of litigation or that sort of thing. Things have changed and people have got to know more.

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62 Interview No 18 Stornoway, Point 1950s-1970s
63 Interview No 10 Point 1960s-1970s
64 Interview No 5 Shawbost 1940s
65 Interview No 33 Scalpay 1950s-1970s
66 Interview No 18 Stornoway, Point 1950s-1970s
Participants described the enjoyment that their work gave them:

How daring I was, I never thought of anything in the middle of the night, but if it were now I wouldn’t go. There wasn’t the same fear? There wasn’t, not that I was made that way, but I just didn’t feel any. Oh I was happy, I was very happy. I was there nearly eleven years. It was my job and I was quite happy in it.67

When asked about their life most participants did not mention the difficulties that they faced daily when they were working, or complain about the obstacles they encountered, while carrying out their duties. The following two extracts from participants summarises how much their work meant to them:

It was a fulfilling time, because you know I learned a lot and I loved my work, I enjoyed it and every day was new and it was lovely. I don’t really think I disliked any of it. I liked it all.68

How did you manage to have any time to yourself? You just got used to it. Living in a rural area, you just worked and slept. It was your life.69

Most participants seem to be accepting of their life and work balance. However a theme identified in an American study, which examined letters that had been received from nurses from 1900 to 2005, was of self-sacrifice versus self-care. Achieving a balance between caring for patients and caring for oneself was reflected in many letters received. It was maintained that the search has continued for a balance between the desire to serve people and the need for self-care into the 21st century.70 Although the nurses worked day and night at times most of them did not complain about their working time. Whether it was their faith that

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67 Interview No 20 Back 1940s-1950s
68 Interview No 21 Uist 1960s
69 Interview No 17 Lochs 1950s-1970s
sustained them, the culture at the time or their evident love of their work is unknown. Apart from the nurse who did not enjoy working on an island without a doctor which is discussed in a later chapter, and the participant who expressed some discontent about her pelican hospital badge, which she suggested supported the patient at the expense of the nurse, there were no other examples of nurses who were dissatisfied with their work.

4.9. Conclusion

The participants’ obvious pride in wearing their uniform including their badge could have stemmed from their general training, which would have addressed the necessity of wearing a uniform. Queen’s Nurse training went further by including in their supervision the way the nurse appeared in her uniform. Whether the uniform gave the nurses a feeling of authority, self-confidence and a sense of discipline, as suggested, is possible. The contents of the nurse’s bags varied, as did the equipment available, with the probability of the nurses in the town area having more access to stores, than their more remote area colleagues.

Participants recalled that the Gaelic language was part of the culture, yet, most participants did not believe that it was essential to speak it to practice as a nurse. However, it is likely that many of the community would be more comfortable communicating in their native language. Knowledge of the language spoken in the area may also have assisted to integrate the nurse into the community.

Because district nurses were required on most occasions, to leave their work when they married, all participants considered this to be unfair. Apart from one nurse, who was reported to have refused to leave, all the others accepted that they could not be married while working. An exception was that for the duration of the war years some nurses were allowed to remain in post. Most of the participants did not agree with the ‘ruling’ and during the latter part of the study time period the rules were relaxed because of the shortage of nurses
Findings revealed that despite the many challenges that the nurses faced they described that they were happy and had satisfaction in their work. They also maintained that they ‘loved’ their work which may have assisted them overlooking the negative aspects such as the long hours of work.

Culture and faith in the Outer Hebrides played a large part in the nurses’ lives and work at the time of the study and both appeared intertwined. Nevertheless there was a difference between the cultures of the islands. On the Island of Lewis participants did not appear to have any social life, while their counterparts in Uist enjoyed various activities. The image that the participants describe of their pride in their uniform, strength to carry their bags, their faith, the love of their work and speaking the language of most of the population would have instilled confidence in the patients of the Outer Hebrides. The picture that the nurses’ background portrays would appear to be one that was immersed in the culture of the community in which they worked.
Chapter 5 Working Conditions

5.1. Introduction

To capture the working conditions of the district nurses in the Outer Hebrides from 1940 to 1973 this chapter will present interview data around topics such as the nurses’ accommodation and their patients’ accommodation. In addition, the nurses’ mode of transport, the impact of weather on their practice, the number of hours district nurses worked and the on call arrangements will be described. In order to appreciate the nurses’ commitment to their patients and their character, it is important to uncover the challenges and the experiences they encountered.

From the data presented it will be evident that key themes emerged throughout the chapter and included the challenges of remote and rural working, working on islands without bridges and causeways and the impact of the Hebridean weather and terrain on the nurses’ practice.

5.2. Nurses’ Accommodation

The minutes of the Lewis Nursing Service Sub Committee (LNSSC) recorded that discussion often took place regarding nurses’ accommodation between 1933 and 1947. Although each geographical area had their own District Nursing Associations all decisions made locally were required to be confirmed by the larger committee that met every two months in the main town of Stornoway.

The type of housing at the time and place under study was varied, and depended upon the time frame when the nurse was in post. In the earlier period of the 1940s the LNSSC minutes noted that ‘repairs to the nurse’s cottage were an on-going agenda

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1 Lewis Nursing Services Sub-Committee (1940-1947) Minutes: NHS Western Isles Archives, Stornoway March 1939,April 1940, May 1942,March 1945.
topic for discussion’. Seven years previously (1933) in the minutes of the Harris District Committee Nursing Service (HDCNS) district nurse’s housing was discussed. Repairs at that time presented to the committee as being necessary for nurses’ homes were ‘windows requiring hinges and the cottage and surroundings were damp’. The committee deferred consideration of the repairs. An example of a request to the LNSSC, in the 1940s, was the ‘installation of a sanitary convenience’, which the committee agreed upon, providing the nurses paid an increase in their rent.

In 1946 at the committee meeting, Ranges (cooking fireplaces) in the nurses’ cottages were described as being in a ‘hopeless condition’ and this was to be brought to the attention of the County Council. At the same meeting it was stated that ‘in view of the numerous complaints from the nurses regarding the state of their cottages, a survey should be carried out, with a view to the necessary repairs to being carried out, as little attention had been given to the houses referred to during the war years’.

The nurses’ housing had improved by the 1960s and 70s, the latter part of the study. This was evident in the findings, as most complaints about nurse’s accommodation occurred in the 1940s and 1950s. Most people at the earlier time of the study lived in stone houses, while the bigger houses belonged to ministers, doctors and schoolmasters. The condition of the houses that were allocated to the district nurses differed from area to area as the following participants explain:

2 Harris District Committee Nursing Service 1933-1946, Stornoway Archives, 2011/006.
3 Lewis Nursing Service Sub Committee of the County Council 1933-1947 Western Isles Health Board Archives, October 1942.
4 Lewis Nursing Service Sub Committee of the County Council 1933-1947 Western Isles Health Board Archives, January 1946.
Bare necessities! I thought it was terrible. When I came there in 1956 there wasn’t a flush toilet inside the house. There was a well outside the cottage, and it was away down deep and you had to put a pail on a string and get water. 

The cottage was just awful. The stove in the living room wasn’t working, the oven was broken and I had to do with a wee primus stove and no electricity, Tilley lamps. But the cottage was making me awfully unhappy, and if I did complain the answer I would get was, “well they are going to build a new cottage.” But when! There was no time specified. So I was there carrying on in the old cottage and it was very uncomfortable.

Electricity came to the islands in the 1950s but outlying areas were supplied later than the town areas. Most of the Island of Harris was connected to the electrical supply in 1954. Toilet facilities in some of the nurses’ houses were also a problem, which a previous participant noted, and many others who worked in the 1940s-50s mentioned:

In the first house, there was a bath and a sink in the kitchen and it was really a disgrace, there was no toilet. It was an outside toilet, a dry toilet. It was terrible.

Although this scenario that was described occurred in the 1940s, it is likely that the nurse had been accustomed to inside toilets elsewhere, or she would not have complained. Two participants had made similar complaints to the Queens Nursing supervisor about the conditions of their houses:

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6 Interview No12 Uig 1950s-1970s
7 Interview No 5 Shawbost 1940s
9 Interview No 3 Brue 1940s-1960s
Our supervisor came once a year to see that everything was in order, but I was always emphasising to her—“can you expect the district nurse to go out and teach hygiene when she can’t have it in her own cottage?” It was an Elsan that we had, no toilet and a big bath in the kitchen, with two big taps but no water, what the bath was for to this day I don’t know! Someone local said to me, “Oh well it would do fine for dipping the sheep.”

In the kitchen of the cottage there was a huge bath for which I could never understand its purpose. Apart from having no running water, no electricity to heat the water, if we got some, and with people constantly at the door, it wouldn’t be an option to use the bath.

Even though the first nurse described the conditions in her own house she still managed to find humour in the situation. She also stated to the supervisor the inconsistency of living in unhygienic conditions and teaching patients about hygiene.

In the LNSSC minutes there was frequent input from a Miss Weir, described as the’ Inspectress of the Queen’s Institute of District Nursing’. In 1942 she informed the Committee that repairs which were supposed to have been carried out some 5 years previously had not been completed. The response from the committee was that any complaints of this nature would be lodged with the proper quarter as soon as they were received. Miss Weir then suggested to the committee that the rents for the nurses’ cottages should therefore be reduced (because the repairs had not been carried out) to £10 per year which the committee agreed upon. It is not clear how much rent the

10 Interview No 5, Shawbost 1940s
11 Interview No 5, Shawbost 1940s
12 Lewis Nursing Service Sub Committee of the County Council for Ross and Cromarty 1933-1947 Western Isles Health Board Archives, October 1941.
nurses were paying at the time. Their salary is noted as being £185 per annum in the 1940s, and had remained unchanged since 1934.\footnote{Nursing in Lewis (1934) Authors Personal Archive collection, Stornoway.}

In the minutes of the LNSSC Miss Weir comes over as a formidable woman, whose priority was the welfare of the patients and nurses. She acted as an important advocate for the nurses. Other incidents within the minutes refer to Miss Weir and will be mentioned later in this chapter. Considering that the committee consisted of six to seven men her influence on nursing matters during the 1940s was evident. The minutes indicate that she did not attend the full meeting. However she was invited to speak by the Chairman and then had to leave the meeting. It was likely that Miss Weir had received many complaints from the nurses such as the following:

> It was shocking. A woman came round once to see the houses and she said the nurses away from here had much better houses, she was disgusted. You see there was no electricity and it was a coal or peat fire we had. Sometimes when I would come home I would try to light a fire but before I started there would be another call.\footnote{Interview No 3 Brue1940s}

Some district nurses revealed housing as inadequate in the 1940s and 1950s. The ‘basics’ were lacking in many of the houses. Without running water or inside toilets as well as the potential problems of inadequate cooking facilities nurses uncovered the challenges they faced to keep their house warm, collect water, warm it and use it for cooking and washing. Most nurses had open fires that had to be lit and kept stoked with coal or peat, making this a chore of necessity when they returned home from work. However not all nurses experienced poor housing conditions. A few nurses were happy
with their houses suggesting that some geographical areas were better equipped than others:

I had a nice cottage down by the bridge there, it was lovely, it had a bathroom, a sitting room and bedroom and a kitchen.\(^\text{16}\)

This was in sharp contrast to the nurse working five years previously who described being disgruntled about her accommodation.\(^\text{17}\) The nurse who recounted being happy with her accommodation worked in the 1950s but lived on a non-doctor Island which might suggest that conditions were better for the nurse on this island Some of the smaller islands were known as being more affluent that the others due to the income from the thriving fishing industry at the time.\(^\text{18}\) The area she worked in may therefore have influenced the nurse’s satisfaction with her accommodation. Another participant who also worked on a non-doctor island recalled an unusual problem she had and how the solution came through the kindness of the community:

I remember going into town and going to a shop and said “Someone told me I was to get material for curtains for the cottage as there was nothing on the windows”. They just gave me the material and I thought what am I going to do with this material? And who came into the shop but Mrs X and she made them for me.\(^\text{19}\)

In addition to her work, the nurses other chores would include finding fuel, water and lighting. Making curtains for a house that they paid rent for would have been

\(^{16}\) Interview No 1 Scalpay Harris 1940-1950s

\(^{17}\) Interview No 3 Brue1940s-1950s


\(^{19}\) Interview No 26 Barvas, Bernera &Back, 1940s-1970s
an extra task. No other participant recalled having to make curtains for the nurse’s house. The following participant describes a problem she had in her nurse’s house:

I had rats to keep me company and I phoned home and my father told me, if you have a stick just give it a rattle and they will soon go away. I soon got used to it. The house had been empty for a few months and it was since then. [the rats had appeared] The wind got to it quite a bit, I wasn’t used to it. Was it frightening? At first it was with being on my own.20

The nurse indicated that it was very unpleasant being alone and knowing that there were rats in her home, yet this nurse was resourceful and found a solution. In the 1950s an article in the Queen’s Nursing magazine described how a house should be built for a district nurse. ‘The house should be soundly built with a view to economy of maintenance. The appearance should be neat and unpretentious and particular care should be taken to make the house look at home in its surroundings’. The article continues; ‘the aim must always be to visualise the arduous life of the District Nurse with its long and irregular hours, and provide a dwelling which will make housework as light and pleasant as possible’.21 It would appear that it was many years later before the district nurses in the Outer Hebrides were provided with bespoke nurses’ houses.

Before they set out for a day’s work, in the 1940s and 1950s nurses’ recalled lighting a lamp for light, boiling water after they had fetched it from a well and making food on a fire or range that had to be fuelled with peat or coal. Furthermore, many walked to their patients (as is discussed later in the chapter). As well as adapting and coping with substandard nurse’s accommodation, nurses also found themselves delivering care in patient’s homes that were also of poor standard.

20 Interview No 16, Harris & Scalpay 1950s-1970s
21 DN150. QNI Archives, Castle Terrace, Edinburgh.
5.3. Patients’ Accommodation

In the 1950s in Scotland the housing situation was worse than in England with over a million of the population ‘denied a reasonable home life through having to endure overcrowding, squalor and lack of sanitation’.\(^{22}\) The Outer Hebrides would have had similar problems. From 1952-1972 it is recorded in the Harris District Council Minute book that housing was frequently on the agenda during that period and that a housing programme was under way in 1961.\(^{23}\) It is likely that comparable programmes were in place in other geographical areas of the Outer Hebrides.

Until the 1950s most houses in the Outer Hebrides were not connected to the electricity grid or a supply of running water, which would mean that nurse’s preparation for some tasks, would take longer. In some houses even boiling water could necessitate firstly going to the well as one participant recalled:

We got the water from the well.\(^{24}\)

Before the nurse carried out care for her patients, she would in most cases, require water and some form of lighting and heating. Some nurses narrated that other householders would provide these essentials but if the patient was on their own this duty would fall to the nurse. The black houses as described in the Introduction were a challenge to the nurses when they had to deal with the animals and the patients. The following participant explains how she found an animal a welcome distraction when she attended to a patient in a black house:

\(^{23}\) Harris District Council Minute Book: 952-1972, R1, 199, Stornoway Archives, Stornoway.
\(^{24}\) Interview No 13 Uig 1957-1970s
I was called out to a young girl. She was running around at that stage maybe two or three years old and she fell into a pan of hot soup. They had taken the pan off the fire and the wee one was running around and she fell into it. She burnt the whole of her back and word came for the nurse of course. When I saw the mess that she was in, she didn’t want anyone to go near her. But they had got a young calf in the house. It was a black house and the calf was in part of the house, as they were in those days, and she wanted the calf. Her grandfather said, right, we’ll take up the calf and that is how I managed to dress her wounds. By her patting the calf and I was dressing her burn at the same time, taking her attention away from what she was suffering. She was really badly burnt, but she healed up through time, but I was going there every day for a while.  

The incident that the nurse remembered, although described as very traumatic for all concerned, was helped by the presence of the calf, which distracted the girl. It also assisted the nurse in carrying out what must have been a very painful procedure. It is unlikely that the nurse carried analgesics to assist in alleviating the child’s pain.

Regardless of the kind of accommodation that nurses worked in, the patient’s relatives appeared to look after the nurse, particularly when the patient was in labour, and the nurse had to stay with her for a prolonged period. Chapter 6 expands on the relationship the nurse had with the community where she worked. The nurse in the next extract describes a particular incident:

One thing that stands out in my mind was in a black house. There was no heating in the room that the patient was in, and the old lady, her mother, used to come up with a griddle full of hot cinders and stick it in front of me on the floor and ‘that should keep the nurse warm and so will it keep the baby when it arrives’ she would say. From time to time she was coming up with the griddle full of hot cinders from the stove. “Did you ever hear that?” On a pancake griddle? Yes, and she had so many of the cinders and she put it in the centre of the floor in the bedroom. When she saw that the cinders were turning dark, she was going back and replacing them with other ones. That was very funny for me; I had never seen anything like it. The old lady was not going to be beat, she was afraid that 

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25 Interview No 5 Shawbost 1940s
we were cold, but in a situation like that of course, you are not cold, you are sweating.\textsuperscript{26}

According to participants people at the time appeared to adapt to conditions as they were, and used what resources were available. Peat for fuel would have been plentiful and the old lady in the scenario was looking after the woman in labour and the nurse. She was also preparing warmth for the imminent new baby.

By the 1960s nearly all the black houses in the islands had disappeared and housing had improved. Nevertheless the black houses made an impact on the nurses who had to care for patients living in them. One participant described a black house:

The animals stayed in the building. The black houses were built so that the animals didn’t come back up where the humans were staying and the animals were in what they called the kitchen. The next room was where the people sat and ate and lived. Now the next department again was the sleeping quarters. At the most there were three beds and all their possessions were in their beds. Women who had a baby weren’t allowed to walk for ten days, so I just lifted them out of bed and carried them to a chest on the other side of the room.\textsuperscript{27}

The nurse described carrying out her practice, regardless of the surroundings, with very little fuss. The nurse had been taught that that the women should not walk for ten days after having a baby.\textsuperscript{28} That did not mean the nurse could not move her.

Mary Breckenridge, who is referred to in Chapter 1.12, commended the black houses, despite its unusual accommodation. She maintained in 1924 they were ‘the warmest houses in Britain’.\textsuperscript{29}

\textsuperscript{26} Interview No 5 Shawbost 1940s
\textsuperscript{27} Interview No 3 Brue 1940s-1960s
\textsuperscript{28} See Myles, M.F., (1972) A Textbook for Midwives: Edinburgh and London, Churchill Livingstone, p. 460, Midwives were taught to keep patients in bed for ten days after a confinement.
Nurses seemed to accept their working conditions. When they compared their patient’s homes on the islands to other geographical areas they had worked in, it was generally noted by them that there was little obvious poverty in the islands. The islanders were in many ways self-sufficient with their own peat for fuel, and food was easily accessible by fishing or agriculture. The following participant compared the poverty in Clydebank, on the mainland during the war, with her home island:

I was in Clydebank after the blitz, and there was just single ends there and no street lighting or anything and coming to Scalpay was just like going to Buckingham Palace compared to what I experienced in Clydebank, with towels and basins and everything that you needed. But here, they were maybe not as modern as they are now, but there were always plenty of peat fires and I couldn’t say that they were short of anything. They were quite well off, there was good fishing in those days and it was quite a prosperous Island in my day. I don’t think there was sanitation then or the water, no it was a good while after that that the water went round the Island. We had to go to the wells if I remember right, but otherwise it was quite easy. In Clydebank, you couldn’t get babies clothes or anything, it was so poor, five hundred killed in the one night there with the bombing.  

The stark contrast between where the nurse worked in Clydebank, during the war years, and the island was evident. She had witnessed extreme poverty and need in Clydebank. Yet, when she came home there did not appear to be a shortage of any essentials. As noted earlier in this section many of the people in the islands were self-reliant and their relative definition of poverty would be different from some other parts of the UK where there would inevitably be a higher minimum standard. Saith & Stewart maintain that despite the necessity to eradicate poverty there is little agreement on the definition. They believe that while the monetary approach to the measurement of poverty is most

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30 Interview No 1 Scalpay Harris 1940s Non Dr Island
commonly used, that different definitions of poverty span different spheres of concerns, and may not easily be measured.\textsuperscript{31} Nevertheless there were other challenges for the nurses as they carried out their everyday work particularly in the long dark winter months. The following extracts gives insight into how nurses coped without adequate heating and light:

\textit{Did the area have electricity?} No. \textit{How did you manage?} Not good - it was very dark and gloomy. \textit{You would have had a torch?} Yes, I always carried a torch. \textit{Was there running water and toilet?} No.\textsuperscript{32}

\textit{You had no electricity?} Oh there were lamps in every house, but sometimes you just couldn’t go next door to borrow paraffin and they used candles, but they had a bright peat fire. \textit{You had a torch with you?} Oh yes, you had to have a torch, but sometimes batteries were very scarce. But storing up batteries, you know that they wear out, they wear out even if you are not using them.\textsuperscript{33}

\textit{Was it cold in some houses?} Going back we invariably had the sick person in a bed downstairs and there would be a peat fire and some of them still had a bed in the kitchen. The heating wasn’t bad. \textit{What about lighting?} I think they all had Tilley’s [lamps].\textsuperscript{34}

\textit{Would there be lights.} Oh no, but I didn’t feel afraid, I think maybe now if I was going to be in the cities.\textsuperscript{35}

I started here in 1952 and we got electricity in 1953 and running water.\textsuperscript{36}

These nurses described that they were fearless and prepared for any eventualities. They recounted challenges in their working life with many homes inadequately equipped to

\textsuperscript{32}Interview No 2 Carloway 1940s-1950s
\textsuperscript{33}Interview No 3 1940s-1960s Arnol, Brue Barvas
\textsuperscript{34}Interview No 4 Lochs 1950-1967
\textsuperscript{35}Interview No 6 Carloway 1940s-1950s
\textsuperscript{36}Interview No 8 Carloway 1950s-1960s
carry out care such as a confinement. The following nurse describes her caring approach to her patients:

*After a baby was born, what did you do with the waste?* Well we knew to pack things up and take them home and burn them in our own fire. You had to be merciful, one person looking after kids coming home from school and all that. She mightn’t manage to get things burned in the fire. *Were there many animals around?* I was good at chasing them out. Rats were the only thing in the city, but definitely not here.

The participant who spoke of the rats in the city was not aware of the nurse who had to contend with them in her own home, on the island, as noted earlier in the chapter. The discomforts of the nurses’ own accommodation and the challenges of some of their patient’s homes do not appear to have deterred the nurses from carrying out their duties. Another area of life, which presented problems, was the mode of transport they used or in some cases the lack of transport.

5.4. Transport

Kynaston refers to the main mode of transport for workers in Britain from the 1940s to the 1960s. In the 1940s 17.2% of the population walked to work, 19.6% used a bicycle and only 6% had a car. In the next decade and up until 1960, 13.4% walked to work, 16% used a bicycle and 16.3% had a car.\(^{37}\) In 1963 a car factory was opened in Scotland (the first built in Scotland for thirty years) designed to reach an output of 150,000 cars a year, to meet the transport demand.\(^{38}\) The nurses working in the Outer Hebrides were likely to have been later in accessing cars than their counterparts on the mainland. Transporting cars to the islands would have been difficult, involving a five hour drive.

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from a mainland city like Glasgow, then a ferry crossing. Nevertheless, it was reported that a nurse had a car in 1937 which is discussed later in this chapter.

Nurses walked, used bicycles, motorcycles and cars to carry out their duties in the 1930s to 40s, as was noted in the minutes of the LNSSC. One nurse in Bernera had bought her own motorcycle in 1942 and an application was submitted from her to receive an allowance for it. Some nurses never learned to drive. Examples of the type of transport that the nurses used are included in the extracts that follow:

My two feet was my transport around the Island.  

He (husband) would drive me around, the car was there but I couldn’t use it. In some areas I was known as Barbara Moore [a well-known walker at the time] because of all the walking I did in the area.

*When did you get your own car?* I didn’t pass my driving test until 1975, but I could take the nurses’ car out before then if I had a co-driver with me. I had to hire a car both day and night.

This participant either walked or relied on a driver for nearly ten years. Another participant described driving without a licence, with the knowledge of the police:

It was 1960 when I got word that my application for a district was successful in spite of the fact that I didn’t have my driving licence, but of course the roads weren’t as bad then as they are now. *How did you get around?* Oh I could do so much driving; I could manage on my own. But I hadn’t’ passed my test. *You were driving on your own?* Yes. The policeman sent me a message with this man that ‘he knows that I don’t have my driving licence but I am all right as long as I keep out of his way’. Now sometimes at the end of the road there, once a month the police used to stop people but I never happened to come across them. Anyway I got a driving test at the beginning of September and I passed alright first time.

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39 Interview No 1 Scalpay Harris 1940s-1950s Non Dr Island
40 Interview No 31 Brue 1940s-1950s
41 Interview No 14 Scalpay & Tarbert 1960s-1980s.
42 Interview No 29 Stornoway 1940s-1960s
District nurses were vital members of the community and may have been trusted by the police who turned a ‘blind eye’ to the nurse without a driving licence. Nurses indicated that they were aware of the responsibility of using a car belonging to their employing authority. In most areas the nurse who had a County or later a Health Board car was not allowed to give lifts to people or take the car out of their own geographical area. In the following two instances the nurses used their own judgement about the best and quickest transport for a patient even if it meant disobeying the rules:

I got a call that a woman who had come here, a visitor who was haemorrhaging … had come up from Wales the night before and she was an APH, [Ante partum haemorrhage] I just phoned them in maty [Hospital maternity] and I said I am just going to take her right over and I put her in the nurse’s car. You weren’t supposed to, but I said to myself if they say anything to me about using the nurse’s car, that’s better than dicing with this woman’s life. She wasn’t too bad so I packed her into the car and took her to hospital.\footnote{Interview No 12 Uig & Bernera 1950-1970s}

It was a breech and we thought she had better go to hospital and it was in a bus we went to hospital. I accompanied her. She was in labour and she was in a rattly bus. \textit{Did everything go alright? Yes.}\footnote{Interview No 7 Ness, & Carloway 1940s-1950s}
In the first extract it was evident that the nurse did not hesitate in doing what was necessary for her patients regardless of the consequences to herself. She knew that using the car to transport a patient was against the rules. The other nurse who went with the patient in the bus stated in her interview that she never had a car and used a bike or walked round her area. She was prepared to improvise if necessary to safely transport her patient to hospital. Part of the culture of the mid-20th century was that nurses had a ‘duty of care’ for patients and the patient had a right to expect that no avoidable harm would be done. The nurses in both instances were ensuring that no harm would come to the patient.

One nurse recalls her experience when learning to ride a bicycle:

45 From ‘Back in the Day’ Archives, Stornoway Gazette, Stornoway.
I never rode a bicycle until I went to Ayr and I had to because buses weren’t taking you out to your own district and it was a bit far to walk from where the nurse’s home was. I was trying my hardest; the people got to know me down on the sea-front in Ayr. The policemen in Ayr got to know me because I couldn’t do a right hand signal They made me come off my bicycle if I didn’t do that right hand signal. You see there were no bikes in Scalpay, there were no roads in Scalpay and there were no cars there. That is what people have got to remember.47

The nurse describes comparing her own home in a small island, with Ayr, a small town, where there were roads, and various forms of transport. She however describes persevering despite the difficulties.

A nurse on the island of Uist was adaptable when it came to travelling to her patients who were located in small islands that were part of her geographical area. The following extract reveals the versatility of nurses to adapt to different forms of transport often in the space of one day. The extract is fairly long; however it provides an illustration of a district nurse in the 1950s, who, although she had a car, still had to use other means of transport:

My first car was a Ford Anglia and then when I got the very first Mini that came to the island it caused a lot of excitement, people seeing a new car. I got that in my second year, (1960). I also had to ride a horse, because of covering for the nurse in the next district’s day off. One of her areas was the Island of Balisher that could be reached by boat and by walking. So I used to ride on a horse because it was easier than walking. *Had you ridden a horse before?* Oh heavens yes! I had a pony at home. Oh yes, we also had to learn to ride a bicycle and not be sea-sick in a boat, you had to be a seasoned mariner. *Did you have causeways or bridges then?* Oh no. Well I used to row myself across in a boat and then get a bicycle at the Post Office and just rode around, and it was a man’s bicycle too. *You wore dresses?* Oh we wore dresses, and hats. We coped, but we would have a saddle on the horse so that it was quite easy to get onto. A huge big horse it was. *And your bag?* Yes, I also had a wee corgi that went with me and he used to be beside me. *Your horse, your bag,*

47 Interview No 33 1950s-1970s Scalpay
your corgi and your bike? Yes, but it didn’t bother us because that was the way of life and we accepted it.\cite{48}

This extract provides a vivid picture of the nurse on her big horse, wearing a dress, riding side saddle, her bag in hand and her dog running along beside her. She would have tied her horse to a pole (there weren’t many trees on the islands) then row the boat to the destination island. She would then have collected a bicycle from the post office and do her rounds before returning as she came.

\textbf{Figure 11:} Photograph of three district nurses at the pier in Uist which includes the participant who rode on a horse for some of her visits. The dog may have belonged to the nurse. (It is likely that this photograph was taken in the 1950s when there was a district nurse assigned to three geographical areas in Uist)

The nurse worked in Uist and the culture of Uist may have been different from the Island of Lewis and Harris as I have not found any evidence that nurses on any of the

\cite{48} Interview No 21 Uist 1960s
other islands used horses. The following photograph of a doctor in Uist on horseback from the 1940s indicating that horses were used as one means of transport on specific islands.  

Figure 12: Dr Macleod, Uist, on horseback.  

Some nurses whose remit included small islands were fortunate enough to have a man who organised the boat trip for them and rowed them across to the islands. The nurse who worked in Harris, including Scarp, (an island off Harris which was uninhabited in 1971 as noted in the Introduction) as part of her geographical responsibility, recalls her journeys there:

49 Macleod, J. A., (2008) Uist Health Care. Pre and Post NHS, Extract from a talk delivered as part of the 60th Anniversary of the NHS. (Includes photographs which are courtesy of Mrs MacLeod’s (Dr John’s Widow’s) collection, Uist).

50 Dr Macleod Uist 1940, Courtesy of Mrs Macleod (Dr Macleod’s Widow) Uist.
Went over to Scarp on a wee boat, because there is no harbour, they had to draw up the boats on the shingle. They just had small boats.\textsuperscript{51}

These nurses present a picture of women who accepted the terrain of their geographical areas and appeared to utilise whatever means of transport was necessary for the good of their patients. The following extract, although long, describes a situation which resulted in the nurse transporting the patient by helicopter to hospital:

I knew that there was this family in the lighthouse, but I didn’t know at that time that she was expecting a baby. I got a call, and I left here quite confident, because I had been a number of times out at the lighthouse. It was a foggy misty morning and you can get the car out, there is a beacon light out there, but you have to leave it there and walk the rest. I got my bag and was quite confident that I knew the road well. But being so misty I missed the telegraph poles which you always followed and I soon discovered that I wasn’t on the right track and I was a big frightened. I knew that it was a southerly wind that had been blowing as my husband had said to me when I left,” don’t think of calling a boat out to the lighthouse, because a boat won’t land there because of the wind”. I knew it was a southerly wind and when I stood still, I thought no, the southerly wind should be in my face going out. I had the sense to know that I wasn’t on the right track. So I turned back to the car and got a hold of the telegraph poles and followed them. When I got there this patient was 3 ½ months pregnant and bleeding quite a bit. I phoned the doctor and I said to the doctor that the moor was very, very boggy. No way could I arrange a stretcher to take her the 3 miles to the ambulance to the end of the road. Well he said the only other way is to get there by helicopter. The doctor came down and ordered a helicopter and that day it meant that I was away from home from the back of 8 o’clock until 2 or 3 in the afternoon. I couldn’t leave the patient by the time the helicopter was ordered and everything. The doctor said you have got to accompany the patient; there was nobody on the helicopter at that time that would be responsible. I went in the helicopter. \textit{How did you feel about that?} It was horrible, the noise. The doctor had arranged with the health board in Stornoway, he would get somebody to get a car at the hospital to take me back home [Would have taken 2 hours].\textsuperscript{52}

Despite the foggy weather the nurse managed to work out the direction to the lighthouse by being aware of the wind direction and following the telegraph poles as

\textsuperscript{51} Interview No 9 Scalpay Harris\textsuperscript{1950s Non Dr Island}

\textsuperscript{52} Interview No 16 Scalpay \textsuperscript{1950s-1960s Non Dr Island}
markers. The nurse did not enjoy the helicopter experience but she did not refuse to transport the patient. Not only were the nurses adaptable to all transport situations, during the war years they were independent. They had to rely on their own skill to repair and maintain their transport as the following extract describes:

Oh yes, I always had a torch. A small one for my pocket and a big one in the car too- and the punctures you got in those days. They couldn’t buy tyres in those days. In the war years I could change my wheel; I could mend my puncture and put the wheel back on. I did it umpteen times. Yes, I could do everything, and I had to. There was no one about and the men were all away (at war). There were only women in the houses apart from the men on leave and they left a maternity case every time.53

Men were away at the war in the 1940s and car maintenance for the nurses who had cars was their own responsibility as there was no one else to carry out repairs. The last comment referred to the number of pregnant women that there were after men returned from their war leave, which would impact on the workload of the nurses. Not many nurses in the Outer Hebrides had cars in the 1940s but for those few who did it would appear that maintenance was an extra challenge.

The LNSSC minutes show that in 1944 there were only three cars on the main Island of Lewis in Back, Gravir and Leurbost.54 The nurse in Shawbost was very excited when she got her car in 1947:

When I got the car there was a temptation to go, [to the town] but I had to watch that there was nothing on the go then you know. I was very happy then.55

53 Interview No 20 Back 1940s-1950s
54 Lewis Nursing Service Sub Committee of the County Council for Ross and Cromarty 1933-1947 Western Isles Health Board Archives, 21st September, 1944.
55 Interview No 5 Shawbost
In May 1947, the LNSSC minutes reports that a car had been delivered to the Bragar area that was part of the Shawbost nurse’s remit. The local Nursing Association had paid their 30% proportion of the cost of the car, which was £92.4.2. The Department of Health had paid their 70% grant of £215. Also in the minutes was a request for a replacement car for the nurse in the Lochs as ‘it was over ten years old and in a very bad state’. There is confirmation in the 1937 minutes of the LNSSC that a Ford 8 car had been delivered for the district nurse in Lochs area. The nurse applied for a week’s leave to learn to drive, as ‘she is unable to spare time for driving lessons while on duty’. The committee agreed to the request.\textsuperscript{56} It is interesting to note that in 1937 there was a nurse who had a car yet in the 1950s some nurses did not or could not drive.

For remote nurses who also worked in the community in other countries and in the early 20\textsuperscript{th} Century travel to their patients could be difficult and fraught with danger at times. For example Banfill, who worked as a nurse in Labrador, recalled her experience when she had a team of dogs as transport to visit her patients. Both the doctor and she were catapulted out of the travelling box when the dogs went over a ridge in the snow. Neither was hurt.\textsuperscript{57}

In Kentucky, when Mary Breckenridge started her Frontier Nursing Service, one of the skills required for the nurse was that she could ride a horse.\textsuperscript{58} Considering Breckenridge described the terrain in the Outer Hebrides as similar to Kentucky it would undoubtedly have presented a challenge for her nurses to work on horseback.

\textsuperscript{56} Lewis Nursing Service Sub Committee of the County Council for Ross and Cromarty 1933-1947 May 1947.
\textsuperscript{57} Banfill, B.J., (1953) \textit{Labrador Nurse}: Canada, Ryerson Press, pp.54-57.
over the mountainous land. It has been noted in this chapter that one nurse in Uist travelled to patients on horseback. In the neighbouring Islands of Lewis and Harris with its more mountainous terrain it would be difficult to reach patients on horseback.

The challenges described by the nurses such as their personal and working environment and the transport they used had an effect on the nurse’s practice. Each of these components of their working life improved over time, with the advancement of socio economic conditions, however little can be done to change the Hebridean weather that had an impact on the nurses’ day- to- day activities.

5.5. Impact of Weather on Practice

Weather conditions impacted on district nurses’ work in rural areas whereas housing conditions and poverty were more likely to be influencing factors in the city. In the Hebrides the weather is known for the wind and rain that is whipped up and can often exceed one hundred miles an hour lasting sometimes an average of twelve hours a day. However the sea is warmed by the North Atlantic drift giving the islands often milder winters. (With the year round swells of the sea, modern tourist can enjoy surfing and windsurfing). Breckinridge, who visited the islands in 1933, commented on the weather; ‘the winds were so terrible that bicycles were almost useless and the nurses had to walk miles over the moors to reach their patients’. The following participants describe how the weather impacted on their lives:

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The weather had a tremendous impact. Gales that was another thing! In an easterly wind the ferry couldn’t move out. If there was a real howling gale, you would be loathing getting aboard a ferry or boat. Sometimes, they just couldn’t move. The weather had tremendous impact here, especially gales and ice and snow.  

The husband of the lady in labour came for me. It was a wet, windy evening and by the time we arrived at the house, he had no car either, I was so wet, I had to remove some of my clothes and borrow some of the woman’s.

Most of the participants interviewed stated that they were adaptable and determined to reach their patients. They indicated that they would never refuse to go to a patient regardless of the availability of transport or severity of the weather. A study participant wrote about an experience that his niece had:

A birth crisis arose at the Uisinish lighthouse [Uist] during stormy weather. There were two ways to the Lighthouse, either by five miles across a rarely used track over the hill or by open boat. The lighthouse keepers naturally chose the boat as the only option. Apparently my aunt was terrified during the very rough crossing so much so that she would not go again on an open boat and ‘even the MacBrayne ferry was viewed with mistrust’.  

The nurse did not refuse to attend the patient in the lighthouse and her uncle stated that ‘the journey was worthwhile as there was a new healthy baby at the lighthouse’. It is interesting that the same nurse who was so terrified of the stormy weather safely delivered undiagnosed triplets at a patient’s home in 1952. Photographs of the nurse, taking the mother and babies into the air ambulance for transporting to a mainland hospital, were in the local newspapers in Uist after the delivery. Three years later, the

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63 Interview No 14 Scalpay 1960s-1970s Non Dr Island  
64 Interview No 5 Shawbost 1940s  
65 Interview No 36 information from Roland Stroud (2009) Re; Kate Macleod, District Nurse, South Uist 1940s- 1961.  
66 Interview No 36 information from Roland Stroud (2009) Re; Kate Macleod.
nurse and the triplets were presented to the Queen during her visit to Uist. (Appendix 10) It would appear that the nurses would face any peril for their patients, although their own lives might be in danger.

A participant also spoke of sometimes having to stay for long periods in patient’s homes and overnight because of inclement weather:

Oh yes for a night and a day too, you couldn’t get out if the weather was bad. I remember the first January I was there, I had a friend who had come down to stay with me and I was called to Scarp. I was there all night and she went away. What could you do? You had to stay until the weather got better.67

The weather had an element of control over the nurses’ lives. The following nurse describes using an opportunity in severe weather to continue to provide a service for their patients during a severe snow storm in 1954:

The snow was so deep in places-I wore Wellingtons, oilskins and carried a walking stick. Men from the various villages I visited would take my arm and help me along from one house to the next. There were no snowploughs in those days. Some of the young men were on their way home on leave [National Service] at that time and they had got stuck in the snow. They phoned the cottage to tell me they intended walking home to Ness [26 miles]. I took my opportunity and asked them to call at the doctors on their way so they could collect some penicillin, codeine, and other medicines for me before my stock would run out. The boys dutifully brought me a large sack containing everything I required.68

This nurse describes how the snow did not deter her from acquiring her supplies. At a later time period in the 1950s, another participant remembered when the snow prevented her from reaching her patient and she had to get her husband to row her across the Loch:

67 Interview No 9 Scalpay Harris 1940s-1950s
68 Interview No 35 Catherine Mackay (1946-1960s) District Nursing in Ness: Permission of Ness Historical Society Isle of Lewis.
The weather was so bad I had to get my husband to row me across the Loch to a maternity case. It was a fishing village and people used boats for their livelihood. 69

Husbands (when nurses eventually were allowed to be married and remain in work) were very useful as can be seen in Chapter 6. The following participant, who had a car, did not have any option but to walk in the snow, when she was summoned to a patient:

I had to walk from the cottage at 2 o’clock in the morning when two women came for me, and the three of us had to walk. I couldn’t get the car out with the snow. Through the snow, we walked carrying the maternity case taking turns about with it, and trying to make it as quickly as possible. It was her third or fourth baby. 70

This nurse who was wakened in the middle of the night, and then had to walk in the snow to the patient and deliver her baby, was the same nurse who recalls, in a later chapter, being ‘dead tired’ at times. 71 She also said ‘I was a healthy person’. It would have been essential to be healthy to cope mentally and physically with all the challenges that the nurses described that their environment and their practice presented.

Another problem that the nurses contended with was their lack of time off duty.

5.6. On-call/Holidays
Nurses who worked at the earlier time period of the study clearly had very little time off and were even dependent on ‘finding’ someone to relieve them. When trying to establish how many hours nurses worked, the responses indicated that in the 1940s and 50s and early 60s they could work for as long as year, without an official day off. In the

69 Interview No 17 Lochs 1950s-1970s
70 Interview No 20 Back 1940s-1950s
71 Interview No 20, Back, 1940s-1950s.
1940s not only did nurses’ work without days off, they at times, had to find their own holiday relief as the following nurses’ recall:

I worked round the clock sometimes. Time off, there wasn’t such a thing. The only time you got off was for your holidays in the summer and the last holiday I had there I went to Ness to get a replacement. She was up in years, but someone said to me; “Well I think she would help you out.” When I arrived there she was unloading a load of peats and she said; “What do you want me for?” I said; “To give me holidays.” “Oh well a ‘gràidh (my dear) as long as you have no maternity I’ll be over.” You had to find your own relief? Yes, definitely, there was no replacement and no days off except if you did take it.\footnote{Interview No 5 Shawbost 1940s}

It is not clear why the relief nurse did not want to do the maternity caseload but it may have been, as she was older (‘she was up in years’) she had lost her confidence in carrying out midwifery care. The same nurse who had to find her own relief spoke of going out one evening when she was on call:

I can recall going to see my father[10 miles from her base]. Before I left I went round to see that there was nothing wrong in the area. There was one lady who was expecting and I called on her especially, just before I left I said to her “I’m going to Crossbost and if you need me there is a phone in the Post Office there and phone and I’ll get the message. I didn’t get any, I didn’t stay too long, about 2 hours or so. I had got the car by then, and probably I was showing off with it. When I appeared in Shawbost all the houses there were lit up and I thought that’s funny! And as soon as I got into the cottage, there was a man behind me with a car telling me that I was needed in Shawbost. “They need you there and come right now.” So I did and that was the last delivery I had, a girl and she weighed 11lbs. A big baby and I was glad I was there. Everything went fine.\footnote{Interview No 5 Shawbost 1940s}
The nurse made preparations before she left the village to ensure that she could be contacted by phone. The community expected her to be available at all times. In the scenario it would seem that the community, with their lamps lit, were on the lookout for the nurse’s arrival. It was the 1940s, and there would be no electricity, which would indicate that the news of the imminent arrival of the baby had spread and perhaps the family had gone looking for the nurse in various houses. The area was one of the first where the nurse had a car and probably her referring to ‘showing off’ was her going away from the area for a short time. She could not have walked to see her father because of the distance and the time it would take.

Nurses indicated that they were aware of the needs of the community and their duty to be accessible for them. However the amount of time off for the nurses may well have been different from their counterparts working on the mainland in the 1940s as this participant recalled:

At that time the district nurses were run by a committee. I had to report to the schoolmaster’s wife who was in charge then. I had been working in Galashiels, [the borders of Scotland] and we had a day off every week but there were no set hours of course. Here you were on call all the time and I wasn’t allowed a day off in Lionel, apart from my holidays. Did you have any outside life? No outside life at all, in fact I had difficulty getting to church sometimes. I was doing my visits and in Lionel - the prayer meeting was on a Thursday morning at midday and it just lasted an hour and I did the visits that needed to be done in that area. Some days I couldn’t go of course, but when I could arrange my visits I went to the prayer meeting. But the first time I went the schoolmaster’s wife objected to my having gone. Why? I was supposed to be on duty and she objected to my going, and I told her that any place I was in I always had a half day or time off for any of these things.74

74 Interview No 7 Ness 1940s -1950s
Religion was important to the nurses of the Islands and for many of them in Lewis their only social activity was attending church. It is interesting that this nurse who objecting to having no time off was only in the area for three years and she then went to the mainland to work because of the ‘difficulties she was having with the off duty’. She returned to the Island after she married and worked as a relief nurse. Most nurses nevertheless accepted the limited time off as normal practice. The following participant recalls her lack of time off duty:

I remember working here a whole year without a day off, a whole year. It must have gone over a year. And do you know the superintendent in Inverness she was quite appalled at the time. She couldn’t find anyone to cover me and she said, just take so many hours off when you can and that’s just the way it went. You couldn’t really be off call when there was no one else there but yourself. And you were quite happy doing it as long as you were able to do it.75

This nurse did not complain about the lack of time off and accepted it as part of her job. Another participant had a similar story to relate about her working hours when asked about the number of hours she worked:

I couldn’t tell you that because I tended to be on all the time. We only got a holiday once a year. Two weeks holiday in my time. Nobody relieved us. Maybe there would be days when you were slack, when you didn’t have much.76

Some of the participants had been relief nurses themselves. They too did not have much time off even in the 1960s as this participant explains:

75 Interview No 22 Uist 1950s -1970s
76 Interview No 1 Scalpay 1940s-1950s Non Dr Island
It was a bone of contention, the full time district nurses had to have their
day off and there was no thought to giving the relief a day off. It was the
same with holidays, there wasn’t any sensible consideration there for
holidays, but all the time I was part time, I wasn’t full time.\textsuperscript{77}

The same participant worked full time, prior to her relief post, and described her
working time in the early 1960s:

You came in and had a bite of lunch or something but you were maybe
called out shortly, you sat there on call. You couldn’t say that your day
was over really, sometimes you were not called out at all, but then
sometimes you were. That was the position. There wasn’t a set day off at
all. You worked full time. Yes we didn’t even have a day off. On call 24
hours and we did triple duties.\textsuperscript{78}

By the 1960s nurses were getting a day off and relief was often from the neighbouring
area which this participant remembered when asked about her time off duty:

We had a day off a week. We were on call apart from that day and on call
for the next district when the other nurse had the day off, but apart from
that I was on call all week except for my day off.\textsuperscript{79}

The amount of time off the nurses were allowed increased, and by the 1960s most
nurses had an official day off once a week that was in contrast to the nurses of the
1940s and 1950s who worked long hours without days off. In the early 1970s when the
reorganisation of Health Service was in progress, a nurse who worked in the town areas
noted the change in her time off:

\textsuperscript{77} Interview No 12 Uig 1950s-1970s
\textsuperscript{78} Interview No 12 Uig 1950s-1970s
\textsuperscript{79} Interview No10 Point/Stornoway 1960s-1970s.
It was when 1974 reorganisation came, about that time. Now previous to that you didn’t know where everybody was on call, but after reorganisation we were able to work on a rota and it worked very well. How we did it was, we were allowed two days off a week, but prior to that you got off what you could take off. You could have worked a long time without days off. There was always one person on call, we tried to work it out that you could at least be off the evening before your day off. There was always somebody on. There were so many returns [visits] then because there were no carers, so whoever was on call did the return visit and that was counted unsocial hours so it worked fine.  

Nurses recalled seeing changes in their working conditions in the 1970s when they had more time for themselves and were no longer tied to the district. The changes would have had implications for the community and how they perceived the ‘new’ working arrangement’. One of the nurses voiced concern about the changes in nurses’ time off” in comparison to when she worked from the 1960s:

There isn’t a nurse that people can send for. I shudder at the thought of Bernera being without a full time midwife. There is no proper coverage. When I see at the weekend here, you say to yourself that there isn’t a nurse west of Garynahine. I mean that is 2 days every week and multiply that by 52 and it is 104 days. If you were called out during the night it was usually attending somebody who would be ill. It was a great comfort for the people to know that the district nurse was there, the district nurse could always be sent for.

The participant perceived that the service had not been improved by nurses getting so much time off and was concerned about the impact on the community. As would be expected on the islands where religion was of importance Sunday was usually a quieter day for the nurses and they only carried out essential work as the following participant recalled when asked if Sunday was a day off:

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80 Interview No 18 Stornoway and Point areas 1950s-1970s
81 Interview No 12 Uig 1950s-1970s
People were very good, but we had visits to do. They wouldn’t send for you on Sunday unless it was really necessary.\(^\text{82}\)

An article written by the Area Nursing Officer for the Island of Lewis, ‘not dated, but before 1973’, describes how she viewed the district nurses. ‘They had to have the courage and physical strength to face the black moorland walks in the night, exhausting battles with wind and rain and journeys in small boats across stormy seas’. She maintained that they were heroic’.\(^\text{83}\) Nurses described facing obstacles with courage and resilience, which were characteristics that they also revealed in the previous chapter.

### 5.7. Conclusion

The working conditions of nurses from 1940 until 1973 were harsh, and would in many ways be considered unacceptable today. Although nurses complained about their own accommodation and, at times, their time off, they seemed to prioritise their patients’ needs over their own. Regardless of the kind of house that their patients lived in, the nurses carried out their practice. Even the apparently negative impact of having animals living in the house was turned to the nurse’s and the patient’s advantage. One child found comfort from a calf in the room while the nurse was dressing her wound.

Every effort was made by the nurses to reach their patients, whatever the weather; perhaps sometimes to the detriment of their own health and safety. For example the nurse who went on the boat to her patient in stormy weather was subsequently unable to feel comfortable travelling on a boat. As well as boat travel these women were resilient and were willing to

\(^{82}\) Interview No 6 Carloway & Breasclete 1940s-1950s  
\(^{83}\) MacLennan, Catherine. \textit{A Century of District Nursing in a Hebridean Isle}: Courtesy of the Balallan Historical Society, Isle of Lewis, ‘before 1973’.
use any mean of transport, whether by bus, car, helicopter or horse to ensure their patients were treated.

It clearly required physical strength and courage on the part of the nurses to cope with the dark walks in the night in all weathers. They were able to manage the long hours on duty and for some, long periods without days off and holidays. The district nurses contribution to care in the Outer Hebrides in light of the working environment was their total commitment to their patients notwithstanding the many obstacles they faced.
Chapter 6 Relationships

6.1. Introduction

Although nursing in the community has changed considerably it is suggested that there has been little exploration of what it means to work within the community from the perspective of the nurses themselves.¹ In this chapter nurses described the relationships that were important to them, for example, (when working on a non-doctor island) with the men who operated the ferry.

The nurse on the Outer Hebrides was dependent on many people to assist her in carrying out her role. Not only did she have a working relationship with the doctor she was also required to liaise with her district nurse supervisor and others in the community. In some areas health visitors were being introduced but relationships between district nurses and health visitors could be strained. This chapter therefore presents narratives from nurses’ relationships with patients, the wider community, participants’ husbands, and professional relationships including Queen’s Nursing Supervisors and health visitors.

6.2. Patients

In the days before mobile telephones and when telephones were not in all of the nurses’ houses, patients were resourceful when they required contacting the nurse. Generally the community knew where the nurse was and participants spoke of leaving a notice on their window, informing people what time they would return, if they had to leave the village for any reason, such as, to assist her colleague in the next area.² One participant recalled an

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² Interview No 2 Carloway 1940s-1950s
incident when a patient’s relative was waiting for her at her house when she thought she 
had finished her work for the day:

Just as I came home after being in Shawbost at another confinement a man was 
standing at the cottage door and he said “nurse I have been waiting for you”. I 
said “I can't be everywhere,” “Well,” he said, “Give me your bag, my wife told 
me not to wait a minute talking.” I said “What are you going to do with the 
bag?” “You’ll be lighter when you start running.” he said to me, “You can run 
and, I’ll carry your bag.” So he did and we were on time and everything went 
fine.3

When patients were looking for the nurse, whether during the day or night, they managed 
to find her. The weight of the nurses’ midwifery bag has already been referred to in 
Chapter 4. As is evident from the accounts, little consideration was given to the nurse’s 
own time or privacy. The nurse was asked how patients contacted her:

By phone or sometimes they came to the bedroom window and knocked. In 1953 
there was a phone in the cottage, but it was a nuisance too. It was the only phone 
in the village and I was being told time and again to ‘leave the door open 
because we have to get to the phone if we need a doctor’. People would be using 
the phone in your house? Yes, it was a nuisance in a way and they would come 
in and say “Can I use your phone?” and you didn’t like to refuse people.4 

Participants were of a generation where they would not offend anyone even though it was 
inconvenient to be interrupted in their home by members of the community. When the 
nurse was ‘off duty’ it was possible to locate her. The following participants recall how 
patients contacted them:

I remember going out with my father to cut peats and put on one of my brother’s 
boiler suits. A man came for me as a cow had stood on a woman’s leg. I had to 
go in my boiler suit, but that was my half day. They knew where you were? My 
mother’s house was in the middle of the village and they could see if my car was 
there and if it wasn’t there, she would know where I was.5

3 Interview No 5 Shawbost 1940s 
4 Interview No 5 Shawbost 1940s 
5 Interview No 8 Carloway-1950s-1960s
Patients were also aware of where nurses were, especially when they were walking around their district. Many patients’ relatives walked a distance to contact the nurse and then travel back with her to the patient as was recalled:

They had to walk. These two women walked from Tong and back again [probably 8 miles]. It was usually the man that came for me, if there was a man in the house. He came and knocked at the door and at the window if I didn’t hear the door.6

In the late 1960s and early 1970s most communities in the Outer Hebrides could still contact the nurse quite easily. Until the reorganisation of the Health Service in 1974, the communities considered that the district nurse belonged to them. The participants, accounts suggests that there was little regard to the nurses’ time off or whether it was day or night; they were bound by the community’s need of their service.

6.3. The Community

District nurses at the time of the study may have been lone workers, but could call on the assistance of various people in the community, from their neighbour, the minister, police, husbands, relatives of patients and ferrymen. The following are examples of extracts from interviews showing the importance of the nurse’s relationship with others:

When there was snow and you couldn’t get the car out of the garage, usually somebody would come and there was always a good neighbour and the minister was good. One or two mornings I went out and they were pushing it, the car wouldn’t start even without the snow sometimes. The garage would be open and there was the neighbour and the minister and they would be trying to start the car pushing it in and out of the road, which was very nice.7

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6 Interview No 20 Back 1940s-1050s
7 Interview No 11 Uig 1960s-1970s
It was clearly reassuring for the nurse who had car problems or was hampered by weather to have the willing assistance of the minister and the neighbour. Participants spoke of the kindness of the community and the following three participants recount how the community were looking after them:

Oh yes, everybody looked after you. There wasn’t a house that I couldn’t go into at any time.8

Calum kept some peats for me and I was using them. The people were good to me; I had my own peat [fuel] stack.9

I used to give an old lady an injection. This particular day, a cold horrible raw day I went out and on my way back, she was at the gate [of her house] Come in here I’m going to speak to you……” “Well I can’t stay just now, someone is waiting for me”. I said. “Let her wait, there is not a lot you can do.” So in I went in and the table was set- “sit there and take a cup of tea, take your time, you’re going there like a hare. Sit! Anyway what kind of shoes have you got on there, why have you not got right shoes on?” All about my welfare! “Why have you not got a scarf on your neck?” She came with a scarf stinking of mothballs and wrapped it round my neck.10

The nurse described how this woman demonstrated concern for her welfare. The woman seemed aware that the nurse was not looking after her own health. On occasion the vigilant and caring community may also have prevented a tragedy that could have had dire consequences for the nurse, as the following participant remembered:

The car just skidded off the road into a loch. I must say it wasn’t a deep loch, but you know it could have sunk down. One of the men working on the road had seen the car opposite his house on the road and when it didn’t appear again on the next hill he knew something must have happened. So he came with a squad of men, but by the time they came I had managed to free myself. I sat there wondering what was going to happen to me, but these boys managed to get me, and the car out.11

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8 Interview No 11 Uig 1960s-1970s
9 Interview No 26 Back, Barvas & Bernera Relief 1950s-1970s
10 Interview No 18 Point Stornoway 1950s-1970s
11 Interview No 14 Scalpay/Tarbert1960s-1970s
The nurse had managed to free herself from the car but had still to get out of the loch, which would have been difficult with the ice and cold. The observation and action of the community for the nurse may well have saved her life. The relationship between the nurse and community was clearly a reciprocal one. Although the participants described they were at the community’s beck and call, the community in turn looked after their wellbeing. Clark who worked in a North Yorkshire village maintained that village life produced a certain type of social network characterised by mutual bonds of interdependence and support.\textsuperscript{12} The community would know one another and many may have been related.

The importance of neighbours and relatives assistance for providing care is also indicated in the following extracts:

\textit{Did the doctor come for the delivery?} No. You did it yourself. There was always some woman around that would help, a neighbour, a good neighbour, nearly always.\textsuperscript{13}

But I always felt that the relatives do the caring most of the time and they can be on edge sometimes. Maybe if you were a few minutes late they would be there waiting. You had to remember that they had the caring and that if they were irritable, they had reason to be. You had to take that sometimes. Take it in your stride and not react.\textsuperscript{14}

Working alone particularly at the delivery of a baby could have caused the nurse concern but it would appear that there was always someone in the community to help. For example in the previous extract the nurse pays tribute to the relatives. Although she may have been

\textsuperscript{13} Interview No 8 Carloway 1950s-1960s
\textsuperscript{14} Interview No 14 Scalpay, Tarbert 1960s-1980s
busy and not well received by relatives if she was later than expected, she empathised with them, and accepted any rebuke as understandable.

Nurses who worked on an island without a bridge depended on the ferrymen day and night to take them on or off the island. It was the responsibility of the nurse to arrange transport for the doctor, if he was required, and also to transport a patient to hospital. The nurse had also to organise her own transport back on to the island, if she visited patients in surrounding areas, or if she had to go to the hospital with a patient. On one island a participant had a unique way of contacting the ferryman while another participant described how she travelled without payment:

Suley [the ferryman] would be there and he told me that if he wasn’t there I was to pick up a stone and throw it on the tank beside his house night or day even three in the morning and he would hear it. *He got up and took the ferry out?* Yes, I used it often. I had to get back to the cottage on the island and that was when I needed the stone. *It must have been a big tank?* Yes his house was just beside it.  

I had to phone from the hospital to tell the ferry boys that I was leaving and they would time it for the ferry to meet me but they met me free of charge. 

The same nurse who praised the service of the ferrymen spoke of the assistance she received from the community:

I got two of the boys; one of them had a wee van, and asked them to come with me to the clinic to get a stretcher and a few crepe bandages and splints. The boys went with me and carried the stretcher with the woman into her car. I just went to the nearest house and while I was phoning the doctor, I phoned the ferry boys, who were home for lunch and asked them if they would take the ferry before its time and that was that.

15 Interview No 26 Back, Barvas & Bernera 1950s-1970s  
16 Interview 33 Scalpay 1950s -1970s  
17 Interview No 16 Scalpay 1950s- 1970s
It is obvious that on an island with neither doctor nor bridge, the community assisted the nurse to provide care. However another participant who worked on the same island described why she was reluctant to contact the ferrymen, especially at night, to transport a doctor to see a patient:

The main thing was that we were dependent on a ferry, sometimes in the winter the last ferry would be at 6 o’clock at night. If I had to get the doctor, it wasn’t just the doctor you were getting it was the ferry as well. It put the onus on you. I felt it was far too much really because you had to consider the relatives. You were called maybe to an old woman and in your opinion, I mean she didn’t really need to see a doctor but the relatives were all worried and it was their right that a doctor should see their mother. So you had to weigh all this up and then weigh the ferrymen and their reaction to be got out of their bed and you hated to do it.  

This was the only participant who was apprehensive about calling the ferrymen. This is the same nurse who in a later chapter comments that she was glad to leave the non-doctor island, as she disliked the extra responsibility. Interestingly she was also the only nurse who worked on a non-doctor island who was not trained as a Queen’s Nurse. Her worry about being called out in a non-doctor island may have been due to her lack of training which will be explored further in Chapter 8.

The relationship with the community was identified as a source of support yet tensions were acknowledged as some of the participants noted. They found that it was necessary to maintain a professional relationship with the community as the following extract explains:

I didn’t make any friends in the area; well not close friends that I could go to at any time. It wouldn’t be wise to.

18 Interview No 14 Tarbert, Scalpay 1960s-1970s
19 Interview No 20 Back 1940s-1950s
Despite in a previous extract a nurse stating that she could go to any house in the village, it was clear from the extracts, that the nurses did not have close relationships with the people in the area they worked. McGarry also found that some thirty years after the end date of this study, district nurses continued to have problems being part of the community and maintaining their professionalism. He suggests that one of the reasons for retaining the professional distance involves notions surrounding respect for the nurse as a professional.

6.4. Participants’ Husbands

Participants also described how their husbands were an important help to them after nurses were ‘allowed’ to marry. There were exceptions to the ‘rule’ as one nurse was ‘allowed to carry on working as her husband was working at sea’. Nurses, who married in the 1940s and the 1950s, usually had to leave their work. In the late 1950s and 1960s the ‘rule’ was being relaxed particularly in remote areas where it was difficult to recruit district nurses. One participant perceived that boyfriends were accepted before husbands as the following extract reveals:

The husbands weren’t approved by that time but the boyfriends were. You see I was older, I was 36 by the time that I got married and there were no children about. It was quite annoying for him [husband] if he thought that we were going to go somewhere and then he had to trail out in the snow. If you did have a delivery, after four hours wait, your husband usually got a whisky.

Many of the husbands acted as chauffeurs, especially in the winter when the roads could be dangerous, as was previously noted. It would appear that the husband, as well as driving the nurse to her patient, waited until the delivery was over and celebrated with the family.

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20 Interview No 11 Uig 1960s-1970s
22 Interview No 2 Carloway 1940s -1950s
23 Interview No 4 Lochs 1950s-1967s
However in the extract from the nurse employed in 1955, husbands did not seem to be accepted at that time. Another participant echoed the usefulness of husbands:

A husband wasn’t supposed to live in the cottage. There couldn’t have been anything more useful at the time! To help you start the car in the morning.  

One husband who was present during a participant’s interview spoke of a call out his wife received to a patient in labour during a northeast gale when the roads were blocked with snow. He had rowed his wife across the Loch to reach the patient. He also spoke of accompanying her on all night calls as well as having her meals ready when she came home after work. The nurse worked in the 1960s and it was then becoming more acceptable to have husbands staying with the nurse either in the cottage or in their own home.

6.5. General Practitioners (GPs)

Nurses and doctors have always worked closely together to complement each other’s care of patients, but they have at times had difficulty understanding each other’s role, or being able to work effectively with each other. Florence Nightingale wrote that the chief qualities doctors expected from nurses were ‘devotion and obedience’. Even when the NHS was set up in 1948 the British Medical Association (BMA) wanted ‘more nurses of adequate skill and a capacity to follow doctor’s orders’. Many doctors wanted the devoted

24 Interview No 11 Uig 1960s-1970s
25 Interview No17 Lochs 1950s-1970s
assistant and handmaiden who had been available before the war years. From the 20th century, and before, doctors dictated the nurse’s role and had input into the delivery of their training. One participant remembered, during her nurse training in the 1940s, receiving most of her theoretical training from the doctors. It is therefore not surprising that within the nurse-doctor relationship almost all the power was weighted in the favour of the doctors, leaving nurses in a subservient role.

Stein’s well-known study of the doctor-nurse game, involved the nurse making recommendations to the doctor about clinical issues, yet appearing passive. The game, by the use of indirect communication by the nurse, supported and protected a structure where the physician was in clear authority. The power relationship between the nurse and the doctor is complex. Sociological explanations, feminist theories and economic explanations have been explored to uncover the attitudes presented by both the doctor and the nurse.

Stein also agreed that the relationship between doctor and nurse was more complex than might be first imagined. He observed that if doctors were going to make decisions based on the best knowledge possible they could not afford to ignore nursing knowledge.

The model of the doctor and the district nurse working together in the mid 1920’s was recognised as a model to be replicated by Mary Breckinridge in Kentucky. It is surprising to find that, only 20 years later, not all nurses had a close working relationship with the

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29 Interview No 29 1950s-1960s Tolsta, Stornoway
doctor as some participants recalled. Nevertheless, they did not hesitate to contact the doctor if they thought it was necessary:

I sent for the doctor because when I was examining for the foetal heartbeat, I felt that it wasn’t quite right. He came and he wasn’t in a good mood either and the first thing I told him was that I had brought him because I had two patients in labour and that I wasn’t happy with the foetal heart. He examined the mother and he said that there was nothing wrong as far as he could see. I said, ‘you will have to stay here because I’m going down to see what the other labouring woman is doing’. I came back and shortly after that the child was delivered and it was blue. *Was he there at the time?* He was there I made him stay. *Did the doctor mind staying?* I didn’t ask him and I didn’t care, but I don’t think he liked it…..oh I didn’t care, no way’ If he had left me then there would have been… I told him straight to the point, no way. Oh he had to come; he jolly well had to come, because I certainly didn’t send for a doctor without a reason.  

The extract demonstrates how the nurse describes putting her patient’s wellbeing before upsetting the doctor. Her behaviour suggested that there was no subservience to the doctor in this situation. Both the doctor and the nurse had their work to do and the nurse had responsibility to the patient and notably she was in control of the situation. The notion of Stein’s ‘doctor nurses game’ that the ‘subservience of nurses was only an appearance and that nurses were in fact involved in decision making processes about care’ 36 is clear in this scenario. In this narrative the nurse who called for the doctor did not even make a ‘show’ of subservience. She told the doctor exactly what she wanted him to do.

Another participant who had delivered a baby that died stated that ‘she had been glad when the GP had come immediately when she sent for him’. She recalled a conversation she had with a relief nurse shortly after the incident:

35 Interview No 10 Point 1960s-1970s  
A relief nurse came to do my holidays. Just straight out of district training and I’d left her a note of four patients due their babies before I came back. I gave her the doctors’ phone number and I said, don’t hesitate to call them at any time; they will be more than willing to help. “Och,” she said, “I can’t be fussed with doctors”. I said “nurse, you won’t be very long in this job when you realise that they are the very best friends you’ve got.” She had the confidence of youth but experience teaches you.\(^{37}\)

The nurse indicates that she had valued the doctor’s immediate response in an emergency and also placed value on her own experience.

If a nurse needed to contact a GP and no phone was nearby, she had to be imaginative when she gave someone a message to be relayed to the GP, so that he would understand the urgency of the messages. The following participant managed both:

A first baby and I was with her, it was during the night and there were no phones of course, and the foetal heart started to be irregular and she still had a ring of cervix, so I had to send the husband to the telephone box with a note just saying FH, [foetal heart] because I didn’t want to worry the husband. The doctor came and she had to have a forceps. The baby was okay.\(^{38}\)

The experience with relaying the message to the doctor is similar to the extract in Chapter 4 which was spoken in Gaelic, to prevent upsetting the relatives. The nurses were caring for the family as a whole and tried to avoid causing alarm. Findings from the study give accounts of the district nurses as confident women who took their responsibilities seriously and put the needs of their patients first, which sometimes resulted in conflict with the GP. The nurse, who had called the doctor about her concern at the confinement, gave the impression of being confident in her own knowledge and clinical expertise.

\(^{37}\) Interview No 18 Point/Stornoway 1950s-1970s.

\(^{38}\) Interview No 13 Back 1960s-1970s
Communication with the GP was essential in remote areas and the majority of informants spoke of a trusting relationship with the GP and their dependency on them especially when they were working alone on a small island. Participants were asked how they contacted the GP:

We had the phone, that was easy and the doctor was always ready to come. It was a fishing boat that would go out for him.\textsuperscript{39}

\textit{Did you meet with the GP?} Oh yes all the time, we worked together, very closely.\textsuperscript{40} [When on the doctor area]

On the phone mostly, and of course at that time if the GP came down to see a patient day or night, we had to meet him, he didn’t take his car across. We had to go the patient with him. When I first went onto the district you see I didn’t realise that the onus was on me to try and persuade the doctor to come down. I used to think well I’ll tell him the symptoms, I’ll tell him what I think and that it is up to him to make the decision. The doctor we had then was nearing retirement, elderly and he wouldn’t always come unless you actually asked him. Oh I learned I had to!\textsuperscript{41} [When on the non-doctor island]

The last participant recalled that she had difficulty calling the GP and initially described how the onus was on the doctor about whether to visit the patient. The participant then reveals that she learned that she was the one to make the decision about whether the doctor was necessary. This aspect of practice will be explored in the Chapter 8.

It was expected that there would have been less contact with the GP on the non-doctor island than on the larger island. The following participants, who worked on the main Island of Lewis, complained that it was not always easy to contact the doctor and that communication

\textsuperscript{39} Interview No1 Scalpay Non Dr Island 1940s-1950s
\textsuperscript{40} Interview No 14 Scalpay and Tarbert 1960s-1970s
\textsuperscript{41} Interview No 14 Scalpay and Tarbert 1960s-1970s
with them was not always good. One participant recalled having problems contacting the doctor on a Sunday:

He was a churchman and I couldn’t take him out of the pulpit on Sunday as he was preaching. He would never say where he was but his housekeeper knew.42

The doctor wasn’t keen on going out at night unless it was really desperate; he would come if there was a complication.45

I worked with GPs who were often not available. It could be trying that way.44

If I was worried about a patient, I phoned the GP. There wasn’t much communication between the doctors and the nurses at all.45

One participant spoke about the doctor who had an unusual routine after a baby was born:

He liked alcohol and after a confinement he always toasted the baby’s health, wealth and happiness. On one occasion he pushed me so that the table with the bottle of whisky was hidden from the mother; He then helped himself to more.46

The nurses describe being complicit in the doctor’s actions whether he was preaching and not available or drinking whisky in a patient’s home. The nurse, at the confinement who did not allow the doctor to leave the patient, referred to earlier in the section, did not appear to be subservient to the doctor.47 However it is likely that some of the nurses in the study, who were trained within the medical model of nursing, in the 1940s and 1950s still retained the attitude of the ‘doctor’s handmaiden’ which the Briggs Report identified as the

42 Interview No 8 Carloway 1950s
43 Interview No 11 Uig 1960s-1970s
44 Interview No 12 Uig 1950s-1970s
45 Interview No10 Point 1960s-1970s
46 Interview No31 Brue 1940s-1950s
47 Interview No 10 Point 1960s-1970s
public perception of nursing. 48 Although the nurses described the bad practice of the doctors they did not appear to have challenged their behaviour.

6.6. Colleagues

Most nurses at the time of the study did not have nurse colleagues but depended mainly on the GP and the community as already noted. By the mid-1970s a wider range of health and social care workers became available. 49 Only one participant had experience with working in a team and she worked in the town area of Stornoway in the late 1970s after health care reorganisation. 50 Participants recalled having very little contact with colleagues, apart from when they relieved one another, or when they needed help, during a busy period as the following extracts explain:

Did your colleague relieve you when you were off? Yes, she would, they would send for her when I was off and they would send for me when she was off. There would be a note on the door. 51

Well there were no phones. If I was needed in the nurses’ area, due to maybe having two maternity patients going at the same time or her being off ill, I got a telegram. 52

The nurses described how they depended on colleagues when busy with more than one midwifery confinement at the same time. It would take forward planning to have time to send a telegram to the nurse’s colleague that more than one birth was imminent. One

50 Interview No 18 Point, Stornoway, 1950s-1970s
51 Interview No 6 Carloway 1940s-1950s
52 Interview No 3 Shawbost 1940s -1960s
participant recalled only knowing the nurse in the next area as a friend and not a colleague:

*Did you meet with other nurse colleagues?* Well I was friendly with them anyway and in actual fact the nurse in the next area and I trained in Queen’s together, so I got to know her.53

In the 1970s when staff meetings were convened, the heavy workload did not allow the nurses to attend as the following participant relates:

*Did you meet with your nursing colleagues?* Oh it was so heavy, it was so busy, you didn’t have time then, because there was no hospital accommodation and all the nursing work was done at home and we had ill people. But we used to have staff meetings, occasionally when time allowed.54

On the other hand the contact with the nurse’s Supervisors was mandatory as is shown in the following section.

6.7. Superintendent of Nurses

The inspection of Queen’s nurses was carried out by a superintendent, or ‘Inspectress’, as she is referred to in the minutes of the LNSSC 55 and was as discussed in Chapter 1. Superintendents periodically inspected each Queen’s nurse by accompanying the nurse to see patients and observing how various procedures were carried out. They also listened to the nurses’ concerns, and before the introduction of the NHS, conveyed any problems to the Local Nursing Association.56 During the Queen’s Nurse training the nurse was regularly accompanied and assessed by the superintendent. Comments were documented about the nurses’ appearance in uniform, their relationship with patients and their clinical

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53 Interview No 10 Point 1960s-1970s
54 Interview No 18 Point 1950s -1970s
55 Lewis Nursing Services Sub-Committee (1940-1947) *Minutes*: NHS Western Isles Archives, Stornoway, October 1941.
skills. Examples of the Inspection Reports comments included; ‘Miss M is ‘absolutely dependable, gentle, kind and one of the most faithful women I have ever had’ (1947). ‘Miss M looks neat and smart in uniform and her books and cards are well kept’ (1953). Miss M being tall and slim, is extremely smart in uniform, she has a frank and pleasant manner’ (1966). Other examples are included in Appendix 13. Participants spoke of the visits from the superintendent and one remembered two amusing incidents when she was carrying out her Queen’s district nurse training in Edinburgh:

The war was still on anyway and food was terribly, terribly scarce. This nurse went with the superintendent. She attended to the patient and when they were leaving the patient said “Oh nurse, your breakfast is in the oven.” So when we went back for lunch that day we were all called to the superintendent’s office and she reprimanded the three of us for taking food in a patient’s house.58

The superintendent knew which nurses were allocated to each patient therefore all the nurses who had visited this particular patient were reprimanded for eating in a patient’s home, a practice not viewed as acceptable. This participant, who trained in the 1940s, remembered that food was scarce, and having breakfast in the home of a patient with diabetes, was accepted as normal so much so, that the other nurses were ‘envious of the nurses who had diabetics’.59 The same participant had another encounter with the superintendent this time she was praised for caring for a patient:

The superintendent said “there has been a message from the nursing home to thank you for your prompt attention [she had diagnosed a lady with an ectopic pregnancy] and they have sent you a gift of five pounds, but you can’t have it, you are not allowed to take money. You can accept a pair of stockings or a box of handkerchiefs” Five pounds were like fifty today. So that was no food, no money.60

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58 Interview No 1 Scalpay 1940s-1950s
59 Interview No 1 Scalpay 19402-1950s
60 Interview No 1 Scalpay
The participant expressed her frustration at being unable to eat in a patient’s home and not being permitted to accept the money, which was given as a gift. This situation may have seemed unfair to the nurse as, during the war years, they were short of food and money, but professionally she may have seen the point of not accepting gifts.

Superintendents were also assigned to the nurse’s geographical areas and carried out supervision regularly. It would seem that every area was supervised differently as the following participant indicated:

A woman came here, a Miss Weir. [Her name is mentioned regularly in the LNSSC minutes during the 1940s] I never forgot her, from England, a supervisor. She came round with you to do cases. Now I wasn’t Queen’s trained but she came round with everyone periodically about every year and then she told you what you shouldn’t do and she said you don’t do that and that was a help and she looked at your books. She was very helpful. Oh the committee they were very involved like the board of management. Just a few men and women and they were the ones that decided if you got, say a bicycle.61

The above nurse’s appointment is documented in the LNSSC minutes of 1946 where she is described as ‘aged 26, SRN, SCM and unemployed’.62 The nurse appeared pleased to have the superintendent giving her advice about her practice but she commented more negatively on the local nursing committee who made decisions about nurses’ working conditions. Nurses who worked around the 1950s continued to receive visits from the superintendent while a participant who worked at the same time thought that since she was carrying out relief work, the superintendent did not visit so often:

61 Interview No 29 Back, Stornoway areas 1950s-1960s
62 Lewis Nursing Service Sub Committee of the County Council for Ross and Cromarty Minutes 1933-1947 Western Isles Health Board Archives, November 1946.
Oh yes, they were coming but I think more to the permanent ones. I remember Miss Clyne. She used to come to the house from Inverness. She would come to the house to see me but she never went out on Supervision.63

I had a superintendent coming from Edinburgh yearly at that time and we had to go round to see one or two patients with her just to see that everything was done according to the rules.64

Miss Clyne is mentioned in the minutes of the Queen’s Nursing Institute in 1956 as being responsible for ‘5 nurses in 5 areas’.65 The Nursing Mirror (1948) included an article where the editor accompanied Miss Clyne, the superintendent, on her rounds to Uist to see the district nurses. The article describes Miss Clyne as the County superintendent who looked after the professional and personal interests of the district nurses. It mentioned that the nurses were ‘one of the strong links in this successful HIMS’.66 Chapter 2.4 discusses the HIMS. It is likely that it was the same Miss Clyne who visited the nurse some ten years later. It is also possible that Miss Clyne supervised the following nurse who worked in Uist:

She (the superintendent) checked you did everything as it should be done. Did she watch you do it? Oh yes, She watched you doing everything. And the dressing, and the injections, I did one that was going to be difficult, and I was glad of that later on because it’s quite difficult sometimes.67

The Queen’s Nurse Training was discontinued in 1967. It was evident that the inspection was routine in the 1940s and early 1950s and nurses appeared to value the advice and

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63 Interview No 22 Uist 1950s-1970s
64 Interview No 20 Back 1940s-1950s
65 Queen’s Institute of District Nursing, Scottish Branch, 17th April 1956, RCN Archives Edinburgh.
67 Interview No 27 Uist 1950s-1960s
support of the superintendents. With only the visits from the superintendent to ensure nursing standards were maintained, most nurses were working autonomously.

6.8. Health Visitors

Only three nurses in the study worked with health visitors and although the latter were well established in the mainland of Scotland it was not until after the reorganisation of the health service in 1974 that they were employed in the Outer Hebrides. A review of Health Visiting in the Islands was carried out in 1984 stating ‘It is now 8 years since this service [HV] was introduced.\(^68\) At the time period described in this study there were no health visitors. Nevertheless some nurses did comment on their introduction around 1976. The following nurse recalled working in the 1960s:

That’s right there were no Health Visitors then, and we had the Health Visiting to do as well.\(^69\)

Two participants commented on their experience when health visitors were introduced into the community:

Maybe I was a bit peeved that they were only writing things down. They weren’t hands on as we were used to doing. You just got into it and that was that and I probably resented that a wee bit. And I also thought what a waste of time just putting it on paper. Just do something about it and that’s it!\(^70\)

I was never as glad as when we got a Health visitor because she did the whole of Harris and Scalpay. I was really glad because she took a load off me, and she was a very pleasant person and got on well. But people were a bit wary, the patients.\(^71\)


\(^{69}\) Interview No 10 Point 1960s-1970s

\(^{70}\) Interview No22 Uist 1950s-1970s

\(^{71}\) Interview No 28 Tarbert, Scalpay 1950s-1970s
The first comment from a participant confirms that there was no health visitor employed before the mid-1970s. Some resentment that was expressed about the introduction of the health visitor by the second participant was similar to the reaction in many other geographical areas. Baly suggested that some resentment may have been due to the health visitor visiting the patient at the same time as the nurse or that the HV was well paid and worked shorter hours. Whatever the reason some participants who worked with the health visitor welcomed her.

Health visitors were not part of the nurses’ lives in the Outer Hebrides until the 1970s. Most of the nurses in the study carried out what was known as ‘triple duties’ which included general nursing, midwifery and the duties of a health visitor. This could consist of child development, immunisations and school inspection that will be discussed further in the next chapter.

6.9. Conclusion

Relationships that participants described when they worked as district nurses illustrated the support mechanisms they were able to draw upon to provide a service to the community. The community contacted the nurse when she was at her home, out on her rounds, and during her time off. She was accessible to the community day and night and they appeared to know, most of the time, where she was and how to contact her. The community’s awareness of the nurses location at all times may have saved the life of the nurse who skidded into the loch.

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The nurse, who recalled that she had the phone in her house, was inconvenienced by people using it at any time, irrespective of the nurse’s right of privacy. The community behaved as if they owned the nurse and her time.

This close relationship appeared to be inter-dependent, as members of the community were described as assisting the nurse, and she depended on them particularly in a non-doctor island, when everyone relied on boats for transport. The reciprocity between the nurse and the community would be unthinkable in the 21st century where island communities are so varied and people are less dependent on each other. Nevertheless it could be argued that the community’s expectation of the nurse at the time of the study was both demanding and excessive.

When it was permitted for nurses to be married, their husbands acted as chauffeurs, ferrymen, car mechanics and housekeepers during their wives long and unpredictable hours. Only one participant’s husband complained that his plans were disrupted because of his wife’s employment. Participants concluded that husbands were helpful and one maintained that ‘there was nothing more useful than a husband at the time’.

Most participants had a good working relationship with the GPs but some only saw the GP when he was contacted to deal with complex medical needs. This relationship may have been difficult for the nurse if she did not have a working relationship with him, and then, depended on his medical expertise within a clinical situation. It is likely that, at the time of the study, medicine would have the prominence in the health hierarchy. Despite the nurses disapproval of the actions of some of the GPs who appeared to behave unprofessionally the situation was accepted.
The power relationship between the doctor and the nurse may have contributed to her acceptance of circumstances that she disliked. Yet, the nurses describe being confident in their own skills and claimed a ‘de facto’ independence that allowed them to behave autonomously, even, at times to dictate the practice of the doctor.

Health visitors were not employed in the Outer Hebrides until after the 1970s therefore only a few participants had experience of working with them. One participant resented the health visitor while the other observed a decrease in her workload resulting in her positive attitude towards them. With so few district nurses being involved with health visitors, at the time of the study, evidence about their relationship with them is sparse.

These nurses of the Outer Hebrides only had the community and infrequent communication with the superintendent for support. GPs were not always reliable. Contact with nursing colleagues occurred only in an emergency, and health visitors were not employed in the area until the late 1970s. A good relationship with the community was therefore vital as the nurse was dependent on them to assist her in her work as well as for transport.
Chapter 7 Scope of practice

7.1. Introduction

The previous chapters focused on the background and character of the women who worked as district nurses and the challenges they faced in the Outer Hebrides from 1940 to 1973. This chapter will explore the nurses’ caseload and their professional practice. Consideration will be given to the extent that their background and knowledge equipped them for their diverse practice.

Within this chapter, general nursing care, unconventional care, school nursing, caring for an ethnic group and the perceived boundaries of the scope of the nurse’s practice will be described and discussed. Because a large part of the nurse’s practice was midwifery, the complexities of that role will be explored in a separate chapter.

At the time of the study, district nurses were neglected by the GNC, who did not provide clear guidance on scope of practice; and analysis from this study suggests that they found themselves pushing the boundaries of their practice. The scope of practice of the district nurses was varied and at times unpredictable.

In 1992 the United Kingdom Central Council for Nursing and Midwifery (UKCC) published ‘The scope of professional practice’, which stated that practice must be limited only to the individual’s own knowledge and competence. The underpinning principles emphasised individual and professional, specifically nurses, are required to:

- Uphold the interest of the patient,
- Recognise the limits of their own knowledge;
- Keep knowledge, skills and competence up to date,
- Ensure standards of care are not compromised by new developments,
• Acknowledge their own accountability for all actions and avoid inappropriate delegation.¹

Some fifty years earlier the study participants relied on their training and background to determine their scope of practice. Although Queen’s Nurses received instruction, during their training, about many topics of care as was referred to in previous chapters, they relied on general nursing textbooks, and a range of journal articles to keep their skills updated.² McIntosh suggested that in the 1970s the only textbook dedicated to district nursing was Craven Dacre’s ‘A Guide to District Nurses and Home Nursing’ that had been published in 1889.³

An observational study of district nursing from 1972-1974 questioned the knowledge base of district nursing. Its findings suggested that professional artistry remained hidden, and ‘a better understanding of the district nurses knowledge must be vigorously pursued’.⁴ Recognition of professional artistry has been described by Schon as ‘the application of scientific theory and technique to the instrumental problems of practice.’⁵ In district nursing this could involve, for example, being able to evaluate the level of glucose in the urine, which is knowledge that is derived from basic sciences such as physiology, and then advising the patient about the management of their diabetes. Thus, also included, was having a good understanding of human behaviour and motivations.⁶ It is likely that district nurses, at the time of the study, possessed not only professional artistry but also other knowledge, to effectively manage their scope of practice. Nurses’ knowledge during the

time period of the study was based on experience, biomedical knowledge (such as anatomy and physiology and medical conditions) and skill in nursing procedures.

The nature of nursing knowledge has been explored extensively since the time period of this study. Knowledge in practice and the concept of professional knowledge both in the community and in general nursing has been investigated by nursing scholars. Because Carper’s description of ‘knowing in nursing’ was carried out at the later period of the study, it is a useful tool to apply to the nurses who worked at that time, in an attempt to understand their knowledge base. Carper’s well-known fundamental patterns of knowing are categorised as; empirics, the science of nursing; aesthetics, the art of nursing, personal knowledge, the component of personal knowledge in nursing; and ethics, the components of moral knowledge in nursing.

The term ‘science of nursing’ was seldom used in literature until the late 1950s. Since then there has been an increasing importance placed on the development of empirical knowledge. However, Bishop & Scudder questions whether nursing can be described as an art because rather than creating beauty or pursuing truth it seeks to foster healing, health and wellbeing. Additionally the primary characteristic of nursing is the moral component. This leads them to suggest that nursing is a practice, which can sometimes involve

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applying science and at other times artistic and creative care.\textsuperscript{10} The type of knowledge that the nurses in the study depended on in their everyday working lives form part of the content of this chapter.

### 7.2. General Nursing Care

To gain an understanding of the participants’ scope of practice they were asked about the needs of their patients. Most of the participants intimated that it was the patient confined to bed (or dependent on others) who had priority on visits, second only to a midwifery patient, who was always the first priority. The following participant noted the changes that took place in the number of patients she saw and the reason she visited them while she was in post between 1957 and the late 1970s:

At the beginning when I started in 1957 I didn’t have so many [patients]. They were all GNC’s [general nursing care], bathing, injections and dressings. By the time, near the end of my nursing I had more of a caseload. We called in to see people and advised them and saw elderly people. We didn’t have midwifery; they all seemed to go to hospital. \textit{You had midwifery initially?} Yes. I went to see terminally ill patients first. Of course if we had a mother who had come out of hospital, I would go and see her first. We were on I suppose 24 hours. \textit{When did your day start?} After nine usually. In the last few years [late 1970s] we used to meet the doctor in the surgery every week and discuss the week’s work. \textit{And you finished?} Different times different days. Five I suppose. Sometimes earlier, sometimes busy, and sometimes not so busy. I remember going out for more than a year every night to somebody who was bedridden and he didn’t have much help- every night at nine o’clock. Maybe in between times of course I had terminally ill people or people with strokes; I had to visit them quite often. If people were bed ridden, we would have to go to visit them first and wash them and dress them and get them up, and there was plenty of that.\textsuperscript{11}

General nursing care (GNC) which the participant referred to was described by the QNI as;

‘the professional care given by a nurse to a patient in degree according to his necessity, to

\textsuperscript{10} Bishop, A. H., & Scudder, J. R., (1997) Nursing as a Practice; Rather Than an Art or Science: \textit{Nursing Outlook}, Vol. 45, No 2, pp.82-85.

\textsuperscript{11} Interview No 13 Back, Uig 1957-1970s
meet some of his basic needs includes, washing and attention to details of toilet, bed making, with special consideration for his comfort and the prevention of bedsore or deformity, arrangement of the room and his accessories for his convenience, advice on nutrition and hygiene generally and relief of pain (under doctors direction).\(^\text{12}\) Included in Appendix 9 is further information from the QNI booklet regarding GNC.\(^\text{13}\) Health care has changed considerably since the earlier time of the study which was echoed by one of the participants when asked about how she prioritised her caseload in the 1950s -1960s:

I would go to an old lady who was on her own or somebody who was ill and near the end of their days and that could go on for quite a while. Also people were inclined to stay in bed more, older people. I remember going to one lady very frequently, she was bedridden, but I don’t think she would be bedridden the way things are today.\(^\text{14}\)

Although there are similarities in the geographical areas where the nurses worked each participant had a unique story to relate regarding her caseload:

When I started there was a man very ill with chest cancer and I had to go to him daily and work a drain. He was my first patient and the rest were just ordinary. \textit{What was ordinary?} General nursing care. If people were bed ridden they had to be washed, toenails cut, no podiatrist on the island. You really did what was necessary, changing beds, that sort of thing. \textit{What about the care of terminally ill patients?} I usually stayed with them if it was at night. I dressed up the body. \textit{You stayed all night with them?} If necessary, yes. Well if they were elderly and there was nobody else with them.\(^\text{15}\)

It is likely that the care this nurse carried out could be viewed as ‘therapeutic use of self’, a phrase popular in the literature in the 1970s.\(^\text{16}\) Conway suggests that the ‘personal

\(^{14}\) Interview No 25 Lochs 1950s-1960s
\(^{15}\) Interview No 21 Uist 1960s
knowledge’ component of Carper’s framework is concerned with interpersonal processes and involves interactions, relationships and transactions.\textsuperscript{17}

The same participant (in the following section) recalled being asked by the doctor to stay all night with a lady who was pregnant and had been bleeding.\textsuperscript{18} She accepted the request as normal, which may indicate that it was a regular occurrence. The sense of obligation that is the moral component of Carper’s framework of knowing would have been influential.\textsuperscript{19} Nurses worked in and knew the community and felt a responsibility towards it.

A nurse, who provided holiday relief to a nurse in a non-doctor island during the 1960s and at the same time period as the previous nurse, described her caseload in the non-doctor island when she was first on call. She compared her experience when she worked in the larger island with a doctor available:

I would say about ten patients and most of it was maybe somebody bedridden, general nursing care, diabetics and leg ulcers, we had a lot of that. The caseload wasn’t heavy in itself; it was more the other side of it being called out. We had lots of night calls and then as I say diagnosing and wondering if we needed to send for the doctor and that was the major part of the work. I would go out in the morning, never went out earlier than ten, because people weren’t ready for you, and then I would come home for lunch and maybe I would have a call or two in the afternoon and sometimes not, but you had to stay by the phone in case you were wanted, the workload was not heavy really. I was there for 20 years. Tarbert was a heavy, heavy district and the places are so far apart. I would do mileage of sometimes 100 miles a day. The doctors got first call there all the time, whereas in Scalpay it was the nurse. Nobody ever phoned the doctor.

\textsuperscript{18} Interview No 21 Uist 1960s
This nurse was adamant that she wouldn’t go back to the non-doctor island to work where she had been first on call, is the same nurse who described not feeling confident and was also reluctant to contact the ferrymen and the doctor as noted in the previous chapter.\textsuperscript{21}

Part of the nurse’s duties on the non-doctor island was the distribution of medicines to patients as the participant described:

I was sent over to give relief. It was the ferry in those days. And the doctor used to go over once a week to do a surgery on the island and he would go back to Tarbert [mainland], sort out all the tablets in a box, put them on the ferry the next day to Scalpay and the nurse had to deliver all the tablets. And it so happened that I arrived the day after the doctor had been, so he had gone back to Tarbert and the box came. I was down at the ferry, [to collect the box of medicines]. When I got back to the house I opened the box. Lo and behold a bottle of Aludrox [a white chalky liquid medicine] had broken in the box. Can you imagine all these tablets with labels and my first day there! I thought this is not right! I phoned the Surgery in Tarbert and spoke to the receptionist, who was the doctor’s wife and told her what had happened. I told her that some of the bottles I can’t make out the labels, some have no labels and I don’t know the patients So between the two of us, I don’t know how long we spent, sorting it all out and then I had to go round all these people and pray I was giving out the right tablets.\textsuperscript{22}

Nurses were taught about the administration of medicines during their training and were aware ‘never to give medicines from unlabeled bottles or other containers’. Also that misappropriation of drugs was viewed very seriously as had been taught during their training.\textsuperscript{23} The nurse was concerned that she gave the correct

\textsuperscript{20} Interview No14, Tarbert, and Scalpay 1960s-1970s.
\textsuperscript{21} Interview No 14 Tarbert and Scalpay 1960s-1970s
\textsuperscript{22} Interview No 28 Tarbert and Scalpay 1960s-1970s
medication to the patients; however she describes being determined to sort out the medication on her first day working in an unfamiliar area. Thus the reality of working life did not always match up with what the nurse has been taught during her training.

Nurses had to be adaptable and when an outbreak of whooping cough affected the children on one of the non-doctor islands in 1951 a participant recalled the effect on her caseload:

There were four or five elderly people in their eighties who needed general nursing care and who died in my time and we had to do the last offices and everything like that and I was on the go all the time. There was the GNC’s and there were confinements and you had to follow up after the birth because there was no health visitor. Another thing when I was on the island before the injections for the whooping cough came, the school was closed, all the children were down with whooping cough and I had to be out night and day. I’ll always remember that year. I had to get up once or twice. There was epistaxis [nose bleeds] and the cough was bad. Did anyone die? No thank God, nobody died, that’s what I always thank God for, that nobody died while I was here, in my care anyway.24

Triple duty nursing, describes the role of most of the nurses in the study and was carried out mainly in rural areas when one person undertook the work of the district nurse, midwife and health visitor.25 The scope of practice of the district nurse who was carrying out triple duty nursing was wide-ranging and involved all ages of the population. After the reorganization of the health service in 1973 and the introduction of health visitors only a few triple duty nurses were employed in rural areas. The author is aware that triple duty nurses were still employed in rural areas in the Outer Hebrides in the 1980s. The district nurse’s practice would have been comparable

24 Interview No 1 Scalpay 1950s
whether working in the city or a remote area but the remote nurse faced challenges associated with the remoteness. Dougall maintains that the main difference between the city nurse and the remote nurse was that the city nurses were never far from a GP or a hospital and had the benefit of accessible transport.²⁶

7.3. Unconventional practice

Nurses felt they were well trained but often faced unusual situations which their training had not prepared them for, and sometimes they provided care that today could not be considered ‘evidenced based’. Improvisation was sometimes necessary. This section will look at some of the unusual incidents that nurses recalled and the ways in which they used their initiative and knowledge to deal with them. The first extract describes how a nurse attempted to overcome the absence of sterile instruments. The participant had left her instruments at a previous midwifery confinement when she was called to another and was ‘wanted in a hurry’.²⁷

I had delivered the baby and when I looked to get my scissors to cut the cord, the scissors were still left in the last house. I asked “Have you got scissors here” and some tinker wifey came with a pair of scissors. They were rusty! So I got the kidney dish and I set fire to it first, you know with spirit and then I poured Dettol [disinfectant] on it and I thought here goes, and nothing happened, not a thing.²⁸

This is an example of the nurse describing using her initiative and experiential knowledge to improvise. She was obviously worried that she could have introduced infection but she did everything she knew to minimise the possibility and was relieved as she said ‘nothing happened’.

²⁷ Interview No. 1 Dalmuir and Scalpay 1950s
²⁸ Interview No. 1 Dalmuir and Scalpay 1950s
When participants were asked what equipment or treatment they kept in their cottage most of them replied that they only had cod liver oil and orange juice for distributing to mothers. It was reported in the LNSSC notes in 1944, that the Ministry of Food, who provided the cod liver oil and orange juice, were instructing district nurses to ‘impress upon mothers the benefits which would accrue to them and their offspring by taking more of the oil and juices offered particularly during their period of pregnancy’. A nurse found an innovative way of administering the cod liver oil, which the Ministry of Food could not have envisaged:

The child was so under nourished, so what I did was, I used to soak cotton wool in cod liver oil. [And apply to the skin] What was that supposed to do? It was the vitamins in the cod liver oil that were being absorbed by the skin. Now the doctor didn’t know this and when he did his monthly visit he came along to the cottage and said in surprise, “That baby is still alive.” I said “Oh yes, the baby is improving.” “Well,” he said, “I noticed, but she has got an awful fishy smell.” He didn’t know what I had been doing. Obviously it helped because the baby couldn’t take anything by mouth. It had what we would call ‘marasmus’ at one time, undernourished dry skin. That was the word that was used and we used to get quite a lot of babies like that. I don’t remember ever using it in hospital, but it was just a case of I can’t give him by mouth so will try if he absorbs it through the skin.

‘Merasmic’, as the nurse identified the baby, is described in the 1967 At Risk Register as intra uterine growth retardation. The nurse was improvising in carrying out this ‘treatment’ on the baby who was not thriving. She chose not to inform the doctor about what she did, indicating that this was probably not an accepted treatment at the time. It is suggested that the relative isolation of the district nurses in some areas increased the

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29 Lewis Nursing Service Sub Committee of the County Council for Ross and Cromarty 1933-1947 Western Isles Health Board Archives December 1944.
30 Interview No 3 Brue 1940s-1960s
possibility that they might develop idiosyncratic practices that were not based on contemporary procedures.\textsuperscript{32} In addition procedures at the time would frequently have been based on custom and practice rather than research evidence. Most of the district nurses relied on nursing journals to update their skills, as is noted in Chapter 3. Nevertheless it is unlikely that the technique used was evidence based. Yet the nurse believed that she had saved the baby’s life. The same nurse used a poultice of cattle feed as a treatment:

They had no oatmeal in the house, “Have you got any cattle feed?” “I stayed up all night making the poultices. \textit{What did you mix it with?} Hot water, but it was a never ending job, I mean it would only stay minutes and you had to have another one to put on. \textit{How were you heating it?} I would stand over the fire, and you would know in twenty minutes you would need to change it. We used poultices for any infections of the skin. But then penicillin came.\textsuperscript{33}

This participant contributed to a book about ‘Traditional Plant Lore’ where she referred to the incident with the cattle feed. She described how the patient she applied the poultice to, was a ten year old boy with pneumonia and the most seriously ill patient that she remembered. She explained in the book how the poultice was placed between sheets and placed on the boys back and chest changing them every twenty minutes. She also made the child drink as much as he could to allow him to sweat.\textsuperscript{34} The participant, stated in the book, that ‘she stayed up all night making poultices and the child survived’.\textsuperscript{35}

\textsuperscript{33} Interview No 31 Brue 1940s-1960s
\textsuperscript{34} Barker, A., (2011) \textit{Remembered Remedies, Traditional Scottish Plant Lore}: Birlinn Limited, Edinburgh
\textsuperscript{35} Interview No 3a Brue 1940s.
Nurse’s textbooks from the 1950s and 1960s include poultices as a treatment mainly for infections of the skin.\textsuperscript{36} They could be prepared using, for example, linseed, kaolin, charcoal, starch or even sometimes ice.\textsuperscript{37} There was no reference to oatmeal poultices in the nursing textbooks, or evidence that oatmeal was therapeutic when taken orally.

However this nurse described the use of oatmeal as a treatment:

> There was one patient that I was quite worried about, but the doctor was very good and we got the bleeding stopped and he told me to stay with the patient for the rest of the night, which I did. \textit{How did you stop the bleeding?} I don’t remember but the woman had to have warm gruel, she had to drink it – hot water and oatmeal, quite liquidly. \textit{Was that because of the bleeding she was given this?} The doctor just ordered it.\textsuperscript{38}

Accepting that the doctor knew what he was doing the nurse did not question him which might indicate that this ‘treatment’ may have been used before. Walsh & Ford suggest that prior to 1970s, nursing had little research tradition and no professional knowledge unique to nursing therefore, the nursing care was based on what the doctor thought or tradition.\textsuperscript{39}

They go on to say that the subservience of the nurse was sometimes a stumbling block to evidence based practice which may have been why the nurse did not question the doctor.

However this study indicates that nurses did, sometimes, improvise their own ‘cures’ and that their own experiential knowledge was of value alongside medical prescription and traditional practice.


\textsuperscript{38} Interview No 21 Uist 1960s

Although there was no evidence found in nursing textbooks regarding the therapeutic oral administration of oatmeal as a medicinal treatment, the tradition of its use in the Outer Hebrides, may be over two hundred years old. As far back as the 1700s when Martin wrote about his visit to the Island of Lewis, oatmeal was recognised as having therapeutic properties. Martin mentions ‘Brochan’ as being oatmeal and boiled water, which he maintained the people used as a diuretic, a sedative and as a common cure for coughs.\textsuperscript{40} This remedy may have continued to be used in the Outer Hebrides. Beth who wrote about traditional medicines in the Highlands and Islands also found that oatmeal was often resorted to as a medicinal therapy and the gruel was used as a sedative and a diuretic.\textsuperscript{41}

Castor oil was also recognised as part of the treatment for a mother after she had her baby as well as other accepted routines as a participant remembers:

I was at a confinement and the patient’s mother was in the house and after everything had been settled and the woman was relaxing in the bed, I said to the mother, she can have cup of tea now. She said “Will it not kill her?” They weren’t supposed to take any food or anything. You were supposed to give the mother castor oil [a purgative] for 3 days after the confinement and they were not allowed food or to get up from bed until after that.\textsuperscript{42}

The comment was probably made in the 1940s, but by the late 1950s the Myles Midwifery textbook was advocating that women be ambulated on the first day of the puerperium, and, ‘may also have a shower six hours after delivery’. It is interesting to note that in the textbook it emphasises in bold lettering that ‘the practice (ambulating on the 1\textsuperscript{st} day)

\begin{thebibliography}{9}
\bibitem{40} Robson, M., eds., (2003) \textit{Curiosities of Art and Nature; A Description of the Western Islands of Scotland: The Isle of Lewis}, Islands Book Trust, p.23.
\bibitem{41} Beth, Mary, (1995) \textit{Healing Threads Traditional Medicines of the Highlands and Islands}: Edinburgh, Polygon.
\bibitem{42} Interview No 3 1940s-1960s Brue & Relief
\end{thebibliography}
appears to have no immediate deleterious effect’.\textsuperscript{43} The textbook also confirms that it is customary to give a laxative thirty-six hours after delivery. Therefore the ‘nurse’s experiential knowledge was revealed and by her giving the woman food after she had delivered her baby, it could be suggested that the art of nursing was demonstrated, by persuading the family to ignore the prevailing cultural understanding of childbirth in order to feed the patient.

7.4. Schools

In addition to general nursing and unconventional care that the nurses provided to the community, their remit extended to caring for school children. The 1907 Education (Administration Provisions) Act required authorities to provide for the medical inspection of children making the Board of Education a health authority. In this way the School Health Service emerged.\textsuperscript{44} Subsequently the number of health visitors required to assist in the school service rose, in England and Wales between 1914 and 1918, from six hundred to over two thousand.\textsuperscript{45} Medical inspection of children continued until 1959 when the Ministry of Health no longer required a specific number of health checks on school children.\textsuperscript{46} However school checks continued in most geographical areas and if there was no health visitor the district nurse carried out the role.

Schools were part of the remit of district nurses until health visitors were introduced in the 1970s in the Outer Hebrides.\textsuperscript{47} In Barvas (an area in the west of Lewis) School records reveal that district nurses visited schools for a variety of reasons. For example in June 1940

\textsuperscript{43} Myles, M., F., (1972) \textit{A Textbook for Midwives}: Edinburgh and London, Churchill Livingstone.
\textsuperscript{47} Western Isles Health Board, Health Board Working Group (1984) \textit{Health Visiting Survey}: WIHB Archives.
it is recorded that ‘the district nurses examined the children and a consignment of gas masks (50) that had been delivered was to be looked after by the nurse’.\textsuperscript{48} Her monthly visits are documented, as well as her visits to the school with the GP, ‘who examined and inspected the children’. It is recorded that a child was excluded from school on account of a skin infection.\textsuperscript{49}

The school records of 1942 and 1943 also reveal that Miss Weir, the superintendent of the district nurses, carried out her half yearly visits. Examples of why she visited the school are recorded as; ‘to address the pupils on how to prevent colds’, and spent time talking to classes on ‘the laws of health and kindred subjects’.\textsuperscript{50} It is likely that it was the same Miss Weir, who featured in the Lewis Sub Committee minutes until 1947, advocating for nurse’s working conditions in Chapter 5, and who also supervised at least one of the participants.\textsuperscript{51} Participants were asked about their input to the schools:

The schools were very interesting, because I went to each school once a month checking heads, nails and bits and pieces. The Medical Officer came so many times a year and the children got their immunisations when she came \textit{Did you give them their injections?} No she did, I just got the people in because she had a list of the people.\textsuperscript{52}

I had to do schools, I had ten schools to look after and check once a month. There was a school in every village. There were a lot of children then in all the schools. \textsuperscript{53}

\textsuperscript{48} Smith, P., School Records for Barvas 1940s, Private Collection, Barvas, Isle of Lewis.
\textsuperscript{49} Smith, P., School Records for Barvas 1940s
\textsuperscript{50} Smith, P., School Records for Barvas 1940s
\textsuperscript{51} Lewis Nursing Services Sub-Committee (1940-1947) \textit{Minutes}: NHS Western Isles Archives, Stornoway and Interview No 29 Stornoway and Relief 1950s-1960s
\textsuperscript{52} Interview No 21 Uist 1960s
\textsuperscript{53} Interview No 9 Ness, Tarbert & Scarp 1946-1950s
In the 1950s ‘baby boom’ the population increased and when they moved into school they strained the resources.\(^{54}\) In the Outer Hebrides there was a school in each village, and the increase of pupils would have impacted on the nurse’s caseload. If the nurse had to visit schools at least once a month, accompany the doctor and possibly the superintendent every six months from the 1940s until the 1960s, this would involve a considerable amount of work when they already had a caseload of general nursing and midwifery care.

7.5. Travellers (‘Tinkers’)

One aspect of practice, which many of the participants’ recalled with some affection, was caring for travellers (tinkers) at various camps in and around Stornoway as well as on the mainland of Scotland. While it is said that the Scottish travellers or tinkers are descendent of vagrants and victims of the great famine or the Highland Clearances, it is forgotten, according to Oakley, that the early ‘Egyptians’ (gypsies) were recorded in Scotland. She maintains that the term ‘traveller’ does not imply a ‘drop out’ from the sedentary society but full membership of an ethnic group. Often Scottish and Irish travellers tend to adopt the terminology ‘gypsy’. They are sometimes labelled ‘tinkers’ and although they use this term among themselves they more often use the less pejorative term ‘traveller’.\(^{55}\) Similarly in Whyte’s book about her life as a traveller the only time the word ‘tinker’ was used was in a derogatory way.\(^{56}\)

In the Outer Hebrides, tinkers were known in Gaelic as the Ceàrdan (the craftsmen) and lived in different locations around the main town of Stornoway. Anecdotal evidence suggests that some lived in tents, some in caravans while others were in small houses or  


huts usually on the outskirts of the villages. A participant who was carrying out her training with the Queen’s Institute in the 1940s and was on placement in the central area of Scotland recalled the following scenario:

The superintendent, she had been a Queen’s nurse herself, said “You know the tinkers were here booking a nurse today, I believe that the tinkers always have a retained placenta!” [A concern for the midwife that the patient might haemorrhage] In those days if the patient needed sheets, the midwife has to sign what was necessary because everything was rationed. So I went up to see, there were a few tents, but it was a lovely place, there was a stream running down. This was her sixth child and I said we must get a bed in here and she said “Yes, we are going to put in a bed and you will need sheets.” So I signed what we called a ‘dock’, [for the bed and sheets]. The baby came, there wasn’t a retained placenta, but there was quite a lot of bleeding and I had to phone for the doctor to go and have a look at her. But after that, every day I went out on the tram car, [post natal visit] there was this little man, he was in the Registration Office and I always sat beside him. This day he was laughing his head off and I said “what is so funny about today”? He said “the tinker was in yesterday and called the baby after you”. In those days you got a lot from the Red Cross in America, clothing, food, milk and everything. Another nurse and I went out one night to them with a bundle of clothing for the children and we thought we would get clothing coupons from them in exchange. They lived on their wits, and what we had when we came home was sweetie coupons! When I went out there, you know the grey army blankets that I gave her, well there were posts in the ground and covered with grey army blankets [making tents].

The nurse placed the order for the sheets and blankets and was surprised that they were not returned but used as tents. Although the nurse maintained that the tinkers ‘lived on their wits’ it could have been out of necessity. They very seldom stayed in one place for long and life must have been difficult, particularly with children to care for. However by naming the baby after the nurse they demonstrated that they were happy with her treatment of them. Nurses often provided ante-natal care to the tinker

57 Interview No 1 Scalpay 1940s-1950s
expectant mothers in the periphery of the town of Stornoway. One nurse’s empathy towards the tinkers, and the conditions they lived in, is illustrated in the following extract:

We had an unmarried girl in the tinker’s encampment out in Marybank, [outskirts of Stornoway] a lovely girl, and she wanted to be confined at home. They had a hut so the other nurse said fine. We happened to have had the decorators decorating the nurse’s cottage and we had rolls of wallpaper left over, so all this went out to the hut and she got the men to paper it. Psychedelic, but at least it was clean and it was fine and we had everything in order. The nurse got them to tidy up around the house and it was just fine. One particular afternoon, this lassie came to my door, weeping and crying. “I’ve been at the doctor and he says that I have to go into hospital.” “He says that I’ll be better in hospital, but I don’t want to go.” I said “Leave it at the moment, when the other nurse comes she’ll speak to the doctor and don’t you worry about it, it will be fine, come and I’ll make you a cup of tea and I’ll take you home.” So I told my colleague, and off she went to the surgery and she said to the doctor “What are you doing to the girl, what is wrong with her?” He said “nothing, but why should you have to work in these conditions, when she can get a hospital bed”. “If that is all that is wrong leave her at home, because I’ve gone to a lot of work to get the place ready.” “What if you are going to be there for two nights or more”, he said, she said, “We’ll just have to cross that bridge when we come to it.” So anyway that was fine. The girl went into labour and delivered very quickly with no problem. One or two days after the baby was born, I happened to be in [the nurses’ house] in a morning, and I saw my colleague coming and she was pot black from top to toe and she wore a peaked cap and I said to her “What on earth happened”, “I fell at the tinkers encampment” “Did you hurt yourself”, “No, but look at the mess”. Two doors down I saw the doctor’s car., I went chasing, I said to him “Come, quickly, nurse has fallen” “Where did you fall?” he asked her, she said “I fell out at the tinker’s encampment” “Serves you right I told you not to go”. These were the sort of things you couldn’t do nowadays. We were younger then, you were ready to take anything on. You had the confidence to do it.¹⁵⁸

The doctor was trying to protect the nurses from the conditions around the patient’s house but the nurse described how she waived him in consideration of the patient’s wishes. The

¹⁵⁸ Interview No 18 Point & Stornoway 1950s-70s
fact that the nurses had instructed the men to prepare and decorate the house added to their argument and made them more determined. The incident appears have taken place in the early 70’s when district nurses began to work in teams and had colleagues for support. Whyte (2003) who wrote of her life as a travelling person throughout Scotland from the 1920s believed that by the 1950s most travellers had settled into houses. She maintained that compulsory schooling for children after the war caused them ‘much vexation and misery’ when they had to live in a house for most of the year.  

It is difficult to imagine the conditions that nurses at the time of the study worked under and the challenges they faced carrying out their work as this participant relates:

I was on my knees on the earth floor, delivering with the ceàrdan [Gaelic tinkers] I used to go on my knees to deliver her. She was lying flat on the earth. She didn’t go into the bed? There wasn’t a bed. It was in a house though? It was a tent- they lived in tents. What did you do for water? It came from the river. Everything went fine. I remember the last time I was there during the night and it was doctor and oh he was getting so tired he went away to get a flask of tea for us and when he came back he sent her to hospital. He was fed up sitting up there during the night. She got on fine, but I had to deliver on my own. [The nurse would go into the hospital to deliver the baby] Why was the doctor at the patient’s home? Well I always sent for the doctor for the delivery, they all booked the doctor. Were they at the delivery often? No I was mostly on my own, but the patients liked to have the doctor booked.

The extract indicates that although the doctor did not have the patience to wait for the delivery, the nurse still had to be on hand to deliver the baby when she went into hospital. One can understand why this same nurse who was referred to in Chapter 5 and in Chapter 8 complained of feeling ‘so tired that she was afraid she would fall asleep at the wheel of

60 Interview No 20 Back 1940s-1950s
If she had a few overnight deliveries, and had to carry out her daily work as well, it would have been exhausting. Most of the tinkers were confined at home as the following participant remembers:

We had tinkers encampment too and they were mostly all confined at home. It was amazing the effort they went to have everything in order. It was fine. The tinkers always had heating. There were no social workers or anything, but they survived and the children were always well looked after. They had their own way of working. Anything you used a jug, or something, all that was put aside and was boiled. They were very fussy about that sort of thing. But the Tong Road seemed to be a better class, because I remember going there to do a post natal visit. I hadn’t delivered her. But they always had fresh clothes for the baby every day, and she is saying to me, “I’m sorry nurse; nobody came in to do the ironing.” “I said that is not important, that doesn’t matter”.

It is clear from Whyte’s book that tinkers, or travelling folk as they were latterly known, had to cope with a great deal of ignorance and prejudice from the community. What the nurse’s perception or experience of the tinkers was is unknown, but she indicates surprise at the cleanliness of the house and that the mother had someone ‘coming in’ to carry out her ironing. It is also clear from all the extracts that the tinkers looked after themselves and their children. They were also kind to the nurse who cared for them as the following participant describes:

I remember the tinkers at Tong Bridge In Back. It would have been 1957 or 1958 and I was called. The doctor came in to tell me that there was an unbooked patient at Tong Bridge in labour, so I had to go there. It was her first baby, and I was there most of the night and the baby was born early morning fine. The doctor came to see her since she wasn’t booked and stayed until the baby was born. They treated me very well, but you could

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61 Interview No 20 Back 1940s-1950s
62 Interview No 18 Point, Stornoway 1950s-1970s
hardly move, everybody came in to see the baby. It was a hut they were in. There were two rooms and I remember there was a youngish woman there and she made a meal for me. I didn’t like to refuse it, I was hungry really. The food was alright, it was a fry up and I remember onions being there anyway and I couldn’t take onions for a long time after that. They treated you very well.\textsuperscript{64}

Tinkers were a stigmatised group in society and Goffman suggests that nurses can be considered ‘the wise’ in relation to a stigmatised group of people such as the travelling people. For example nurses can be intimately privy to the secret life of the individual or group therefore become sympathetic and to an extent act as their advocate.\textsuperscript{65} Although the nurse did not enjoy the food she accepted it as the family were showing their appreciation of her care and may have been treating her as ‘the wise’.

The tinkers were described by the nurses as a close knit people who celebrated the birth of a baby. The house was full of people yet they had the time and the means to give the nurse a meal. At that time in the town of Stornoway and the surrounding areas nurses appeared to be working closely with the doctor. They mentioned that they called him for most of the deliveries even though he seldom attended. One participant remembered an unusual way that the doctor was useful:

Extraordinary things like going to a tinker’s tent, and no lights, until the doctor’s car lights came up and shone in.\textsuperscript{66}

\textsuperscript{64} Interview No13 Back & Uig 1957-1970s
\textsuperscript{66} Interview No 4 1950s-1967 Lochs
Whether the nurse cared for the patient in a tent, a shed, on a bed or the floor it was accepted as normal. The tinkers, who may have been lacking in material possessions, were described empathetically by the district nurses. The tinker’s cleanliness, care of the baby clothes and their kindness to the nurses may have given them a different perspective of the kind of people they perceived them to be. Nevertheless even in the 21st century there are striking limitations in the health of the travelling people when compared to other ethnic minorities. In 2007 in England it was found that travelling people were more likely to have long term illness and a higher that average problem of miscarriage and premature death of offspring. Reports of the Confidential Enquiries into Maternal Deaths covering the period 1997-1997 identified travellers as having the highest maternal death rate among all ethnic groups. If the travellers in the 21st century have health problems it is possible that there were similarities some fifty years ago. The supervisor who cautioned the nurse that the ‘tinkers have retained placentas’ may well have experienced problems with them at confinements.

7.6. Boundaries of care

It has long been recognised that a nurse’s work is flexible. It has been argued that much of healthcare provision required flexibility to allow it to operate and it is often nurses who fulfil

70 Interview No 1 Scalpay 1940s-1950s
this function whether in hospital or community.\textsuperscript{72} Two studies of community care, carried out some fifty years after this study, found that in practice, nurses worked beyond the boundaries of their occupation if no other services were available.\textsuperscript{73} Carper’s moral component of knowing, ‘which guides the ethical conduct of nurses and is based on the primary principle of obligation embodied in the concepts of service to people’,\textsuperscript{74} was a significant element of these nurses’ practice.

For the nurse at the time of the study it is questionable whether the nurse had clear boundaries of care. The NMC defines clear standards of professional boundaries as relating to personal versus professional relationships and focusing on ‘receiving gifts from patients and maintaining clear sexual boundaries with people in your care’. Legislation is in place in the 21\textsuperscript{st} Century by the NMC to protect patients from harm when a nurse crosses the professional boundary of care.\textsuperscript{75}

It would appear that professional ‘crossing the line’ only came under public scrutiny in the decades since the reorganisation of the Health Service in 1974. Speed & Luker maintain that in the past district nurses undertook aspects of patient care that some felt was beyond the professional boundaries of their role. They assert that the reason for this was because the district nurse knew the patients in their own homes. The nurses were aware of the problems that would not have been seen by hospital staff or GPs. Consequently her knowledge of her

\textsuperscript{72} Allan, D., & Lyne, P., (1997) Nurses flexible working practices; some ethnographic insights into clinical effectiveness: \textit{Clinical Effectiveness in Nursing}, 1, 3, pp.131-140.


patients created a moral obligation to provide care.\footnote{Speed, S., Luker, K. A., (2004) Changes in patterns of knowing the patient: the case of British district nurses; \textit{International Journal of Nursing Studies}, 41, pp. 921-931.} This section will consider circumstances where nurses undertook what would be regarded today as non-nursing care. These incidents raise questions about the clarity of district nurses’ role boundaries during the time of the study.

In other remote areas such as Australia where nurses were lone workers there was some concern among the doctors about the blurring of boundaries between the nurse and doctor. Yuginovich asserts that nurses in remote areas in Australia were mostly invisible for most of the last two centuries and that remote area nursing was not recognised as a different type of nursing by the authorities.\footnote{Yuginovich, T., (2002) \textit{Silence- Not so Golden}, \textit{Collegian}, Vol.9 No 3 p. 22-27.} She discusses that the ‘silence’ of remote area nurses about undertaking tasks normally performed by doctors threatened the Australian Medical Association, who declared that some tasks carried out by nurses were beyond their ability. The remote area nurses justified their practice and, due to the absence of doctors and the needs of the community, continued carrying out the roles that would normally have been performed by doctors in other settings.\footnote{Yuginovich, T., (2002) \textit{Silence- Not so Golden}, p. 22-27.} There may have been similarities with the remote nurses of Australia and nurses in this study particularly in the non-doctor islands, however most participants appeared to recognise their own professional limitations.

While most of the nurses in the study carried out triple duties, they referred to the various roles, which at a later date, would have been the remit of other health professionals. The following extract describes how the participant carried out multiple roles:

\begin{quote}
In the days when we were on the district you did triple duties. I remember once counting the amount of duties that I had done in 24 hours. I had done the health visitors job, by that time if there was a health visitor she wasn’t
\end{quote}
available. I did my own job, and I did the chiropodists job. I remember in the Care Unit this old lady she was ill and I went and did the return visit there. I went to bed and I think about 1 o’clock in the morning the phone rang and this was a man with retention of urine and it was a terrible night. There was snow on the road, it was terrible and I went in to see him and I phoned the doctor. When I was in the Western Hospital I had done a lot of urological work. The doctor said that the roads were bad, so I said I’ll pass a catheter, which I did. I had done it dozens of times in the Western, but when I came back that was the doctor’s job. I came back home, went to bed and I wasn’t in bed for an hour when somebody rang that the old lady had died. Now today that is the undertaker’s job that was really the true position in those days. 79

The previous extract is likely to have occurred in the 1970s, when there were care units in many villages on the islands, and prior to health visitors being employed in every area. The nurse was confident in her ability to carry out a male catheterisation, which at the time, she maintained, was the responsibility of the doctor.

Another response regarding the boundaries of care was from a participant who accepted the various roles she carried out as meeting the needs of her patient:

Did you ever do anything that wasn’t nursing? No you didn’t have to. Sometimes you made a spot of creamola [pudding] or something like that. Why would you be doing that? Well you might have an old couple and the bodach [old man] in those days- the stoves weren’t all that good. It would probably be his only chance to get out of the house to go to the well to fill the pails and the calleach [old lady] had been sprogged up [washed and changed]. She’d been bathed and all the rest of it and I knew he would have to do the washing. There was water in the house? Not necessarily so.

The same participant continued:

This lad came from hospital and they decided he needed daily baths after a rectal operation. There were five houses in that street and none of them had baths. You got a big tin bath, whether it was for bathing babies or other things. I remember distinctly, it must have been about 1970 because at that time we were finding out things that we hadn’t found out before. They had a tap outside the house. You would take the water and boil it

79 Interview No 12 Uig & Relief. 1950s-1970s
inside and fill your bath? Well they usually had good big peat fires but I still remember when we had to measure the water, so as not to be extravagant. Did you do domestic chores? No, definitely not.\textsuperscript{80}

Despite making the pudding for the old lady, and allowing the husband time to collect water, the nurse did not consider this a domestic chore. The nurse showed consideration for the man by giving him time away from his wife, which may have eased his difficulties. In particular she gave him time to collect water. The Queen’s Nurse magazines, from 1946-1957, included ‘Invalid Recipes’ which many district nurses at that time may have made, and given the recipes to their patients.\textsuperscript{81} A copy of some of the recipes is included in Appendix 11. Nurses therefore had the knowledge to look after their patient’s nutrition. Making the patients’ pudding may well have been considered within her remit at the time. A copy of a participant’s General Nursing Certificate from 1950 states that, ‘she had attended a course of instruction in Sick-Room Cookery’ (Appendix 12).\textsuperscript{82} If the nurses were taught to manage the patient’s nutrition they would consider it within their scope of practice.

In the second part of the scenario a great deal of work was involved in heating and even measuring the water yet it was not considered a domestic chore. With the development of social care services after the 1970s home helps carried out household tasks and it would be the role of the auxiliary nurse or carer to bath patients.

Participants did however carry out some unconventional care as revealed in the following extracts:

What about household chores? No, but there was somebody who was quite ill and they had a lovely garden so I just went and did the garden,

\begin{flushright}
\textsuperscript{80} Interview No 4 Lochs 1950s-1967
\textsuperscript{81} DN 150 Invalid Recipes QNIS Archives Edinburgh (Appendix 11).
\textsuperscript{82} Interview No 1 Scalpay 1950s
\end{flushright}
but that was off my own bat, I wasn’t asked to do it, but you know you
got involved. *Was it because you were a nurse that you were doing it?*
No, just as a friend.\(^{83}\)

One of his lambs got a broken leg and he asked if we had any bandages I
could put on the lamb’s leg, which I did.\(^{84}\)

No nobody asked you to do that, but I have seen me going to old people
and make them a cup of tea and do things like that, but that was a
voluntary thing, people didn’t ask you to do that, but I have done plenty
of that and the bodachs [old men] often said “fill my pipe”.\(^{85}\)

It would appear that the nurses could be involved in many different tasks, but they
suggested that they were not expected to go beyond their nursing duty. On one occasion
the relief nurse was annoyed with the permanent nurse whom she felt had gone beyond the
boundary of nursing:

I used to take the shopping with me in the morning. *Would people ask
you?* No, very few, as a matter of fact I think that was the only one and
maybe I offered to do it myself, I rather think I must have. *Did you ever
light a fire?* No I never had to do anything like that. Oh I washed clothes
for one, but it was the permanent nurse here that started it and I did it
when I was relieving. One Christmas day I came with a pile of urine
soaked bedclothes and he [son] was looking forward to his Christmas
dinner and here was me coming home with this smelly load! He was
standing up against the wall and how disappointed he was. Everybody
else is having a Christmas dinner and what are we going to get! They
were big flannelette sheets too. Nobody would do it nowadays. *You had
to wash them before Christmas Dinner?* That’s right.\(^{86}\)
The nurse describes the impact on her family life of having to wash the bed linen of a patient on Christmas day. The permanent nurse had set a precedent and although the nurse was not happy with the situation she continued to wash the clothing. The narrative reveals the priority the nurse gave to her work. Setting a precedent, according to Speed & Luker, could lead to some patients receiving 'extra' care whilst others did not. They suggested that it might explain why some research findings have suggested that the district nursing service was variable and open to personal interpretation by practitioners. In many ways the service of the district nurses of the study was open to individual interpretation as the nurses were lone workers and had to use their own discretion. It is surprising, that the studies referred to carried out from the 1990s, would still find district nursing practice open to personal interpretation, when skill mix and research based practice were prominent in district nursing.

Dougall in her study of district nurses, (which did not include nurses from the Outer Hebrides) found that non nursing tasks were influenced by the rural-urban split when the rural nurses were more likely to help with domestic chores than the city nurse. However in this study most participants, responded that they were never asked to do any household chores or carry out what may have been considered non- nursing duties, such as shopping for patients. Some nurses commented that they had made a cup of tea for a patient, who lived alone, but had never been asked to do so. Participants however indicated when they

worked on the mainland where they perceived there was more poverty than on the islands, they were asked to carry out non-nursing care, as the following nurse describes:

Were you asked to do household chores like light a fire? They would, if they couldn’t do it. I have often done that and also run to the shops if there was nothing in. Now, that was in Glasgow. In Uist would you do that? No, oh no. There is a difference? In Uist you would never do that. Oh no, you would probably make them feel -does she think we can’t do it- but in Glasgow you could run out to the corner shop if the husband was working. Oh yes. I found more poverty in Glasgow, whether the food was there or not they would give you what they had.90

The participant maintained that the people in the Outer Hebrides she was caring for would be offended if the nurse carried out non-nursing tasks. It must be remembered that in the islands the community support was apparent at the time under study as was referred to in Chapter 6. The people of the islands were also self-sufficient, with their own livestock and fuel. Therefore compared to the industrial areas of Glasgow and Edinburgh where many of the nurses trained the level of poverty was relative. It is suggested that because urban nurses encountered more poor home conditions and poverty they were more likely to be involved in non-nursing tasks.91

Dougall indicated that the performing of non-nursing tasks was highlighted in her interviews and was considered to be ‘a defining characteristic of district nursing’.92 Within this study non-nursing tasks was not an issue with the participants, as what may be perceived as a boundary of care today, was accepted as part of the nurses’ role at the time, as the following respondent remembered:

90 Interview No 27 1950s-1960s Uist
I used to do quite a lot of physiotherapy with the stroke patients until they were quite mobile. We had to do bed bathing, general nursing care, washing people, as I say cutting toe nails, and cutting patient’s hair, nowadays they don’t do that.\(^93\)

There were no community physiotherapists in the 1960s in the Outer Hebrides therefore the nurse considered it part of her role. Similarly there would be no chiropodist or carers to carry out the personal care. As has been noted in section 2, in many areas particularly the non-doctor islands, the nurse also distributed the medicines.\(^94\)

Nursing textbooks up until the 1970s included treatments for various conditions including physiotherapy where this would be appropriate. Male catheterisation procedure was also included in the textbook, which indicates it was part of the nurses’ training.\(^95\) Nurses did read these textbooks as has been confirmed by their comments in the interviews.

When a wider range of health professionals were introduced to the islands with the reorganisation of health care in 1974 some dissatisfaction about role boundaries was evident as was noted in Chapter 6 regarding the relationship with health visitors. Although the following incident occurred in the late 1970s it indicates that problems with boundaries between the roles of the health professionals were beginning to appear:

> When I think of the psychiatric nurse [in the late 1970s] fighting because he would never come down here and I would tell him, “Do you realise that I am doing your work, two nights during the week I have been up doing your work and you never budge from your home”. \(\text{This was with}\)

\(^{93}\) Interview No 21 Uist 1960s  
\(^{94}\) Interview No 28 Scalpay, Tarbert 1960s-1970s  
psychiatric patients? Not so much the psychiatric as the alcohol, there was quite a few. That would keep you busy too.96

In the next chapter, when decision making is discussed, one nurse in the 1960s did not hesitate to attend to a call out to ‘a man who went berserk’ which she suggested may have been due to overindulgence of alcohol.97 Yet, some ten years later with the introduction of different kinds of health professionals, new boundaries of care within nursing were beginning to be apparent, as was evidenced in this scenario.

Speed & Luker’s study questioned whether the changes in working pattern had changed the relationship the nurse had with her patients. Their conclusion was that ‘the direct involvement of district nurses in personally knowing patients has been replaced by knowing about or by proxy’. The study carried out in 2000, over thirty years from the time period of this study, interviewed district nurses and found that many of them were carrying out non-nursing duties such as shopping and lighting a fire.98 Although nurses in this study did not carry out many of the tasks identified in Speed & Luker’s study, the people of the community, as was noted in Chapter 6, supported each other. Nurses in this study accepted ‘other’ roles as their own as there was no one else to do them hence they did not consider this as a contravention of boundaries.

7.7. Conclusion

The district nurses cared for all people across the communities. Mothers and babies were part of their caseload, as were schoolchildren, ethnic groups such as the travellers and anyone else in the community who needed their care. The nurse’s practice may have been

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96 Interview No 32 Scalpay 1940s-1970s
97 Interview No 13 Uig 1957-1970s
similar to her counterpart in a city, though somewhat extended, but her support network was very different and much more informal. The knowledge nurses relied on to address their patients’ needs would of necessity be extensive, yet the moral component of their knowledge is apparent, and it was the moral component that could influence them if they had to cross the boundaries of their work.

Some nurses carried out unconventional treatments, which could have been part of the culture at the time. This may also have been a response to limited resources and a need to improvise. Care decisions were not obviously underpinned by evidence based practice at the time of the study.

Most participants did not express the same concerns about the boundaries of practice as was evident in contemporary literature. Because the nurses in the study were mostly lone workers they recalled that they carried out care that today would be the remit of other professionals. There was no one else to provide the care and they perceived they had the knowledge in most areas of care. Many participants were adamant that they did not carry out care that was not nursing. Hence what they considered as appropriate nursing work was encompassed within very wide boundaries.

These district nurses of the Outer Hebrides described addressing their scope of practice confidently and competently with their focus on providing the best service they knew for their patients. The knowledge underpinning their ability to address their scope of practice would undoubtedly be empirical, biomedical, aesthetic, personal and ethical. However the

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ethical component may have been highly influential in their provision of care to the community.

The only obvious concern regarding boundaries of care at the time of the study was with the doctor, with whom the nurses worked closely and, in most cases, had a good working relationship. To conclude that the district nurses at the time of the study did not cross acceptable boundaries of care is reasonable. However this assumption could only hold, if the boundaries of care are set very wide. The nurses were obviously well trained, assertive and competent women who knew their limitations. Despite, being at times called upon to diagnose on the non-doctor islands, the majority of them did not indicate that they were carrying out work that was not nursing care. Their patients required to be washed, fed and treated, and being the only health professional available at the time, the nurses appeared to accept it, as part of their scope of practice.
Chapter 8 Autonomy and clinical decision making

8.1. Introduction

Nurses had to act autonomously and make decisions for themselves, which required little support or supervision because they were involved in care that was sometimes unpredictable and urgent. This occurred most often in relation to midwifery therefore this chapter’s first focus will be on midwifery practice, and the nurse’s perceived autonomy. The second section considers clinical decision making in general and midwifery care.

What midwives did, how they did it, and how they planned their practice is impossible to reconstruct with complete accuracy from remaining evidence. However women’s birth stories are a source of rich data that can illuminate contemporary midwifery practice.¹ Likewise documenting the unique testimonies of midwives provides insight into the social and professional norms of the time and locality.² This section therefore also seeks to provide an understanding of the midwives role and responsibility at the time of the study and in a remote setting.

8.2. Autonomy and midwifery practice

Midwifery care was a large part of all the participants’ work and most of them stated they enjoyed this part of their role. As was noted in Chapter 1, the 1940s -1960s were referred to as the’ golden age of midwifery’ because midwives were competent and confident and worked as autonomous professionals.³ At the time of this study from the 1940s until the late 1960s most births in the Outer Hebrides were confined at home. In the 1970s the

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number of home births had decreased considerably and the role of the district nurse changed. The Annual Report of the Medical Officer of Health for 1972 indicates that only eight home births were carried out in Lewis and that ‘in the last decade births were considered to be an Institutional event’. 4

After the 1970s mothers could still request a home birth despite the Peel Report which stated ‘we consider that the resources of modern medicine should be available to all mothers to allow for 100% hospital delivery’. 5 In response to the Report, the Association for Improvement in Maternity Services (AIMS) campaigned for the right of a woman to decide where to give birth. 6 An added impetus to the campaign was the result of an analysis of mortality rates of births at home and in hospital. It was shown that planned home births for normal women were safer than hospital births provided experienced midwives who knew the mothers cared for them. 7 Midwives advocating the provision of home births argued, along with the statistician who carried out the research, that home births were safe. 8 Nevertheless home births have reduced nationally since the 1970s.

Many of the participants had experience of managing women with complex midwifery deliveries. Of the thirty two participants, five had experienced the delivery of a still born baby, two delivered a breech presentation, two delivered twins, one delivered triplets, two

cared for a woman with an ante partum haemorrhage and another managed a woman with a post-partum haemorrhage.

In the Stornoway Hospital, in the 1960s, there were five midwifery beds and in some narratives, participants indicated that this was inadequate. Some district nurses, who were all midwives at that time, indicated that they had to spend time in the hospital to update their skills. They were also required to go into the hospital with the mother and deliver the baby if it necessitated hospital admission. An example of this situation is described in Chapter 7.4 when the nurse was asked by the doctor to transfer the patient to hospital as the labour was prolonged. The following extract is from the nurse who was working in the hospital when the patient was admitted:

I was doing night duty in the Lewis Hospital and this doctor came in. He said, “I need a bed.” I said, “I don’t have a bed for you.” We only had 5 beds and we had a patient in the labour room bed, there were no beds, but a single room that the surgeon wants for a patient that is coming in tomorrow for sectioning. “Give me that bed,” he said, “but he’ll kill me if I give you that one”. Well he said, “Come with me and see where the midwife is working. She is out in a tent [tinkers camp] and the Tilley [Lamp] had gone out and there is no paraffin and the rain is coming in. The trainee doctor is sitting on a sink pail ready to go through the floor anytime.” “Well I said if I take this patient off the labour room bed I’ll have to put her on a trolley, is that lassy nearly?” [Near delivery] “She is quite near.” I said, “Bring her in.” The nurse, I’ll always remember her coming with her wellingtons on in the middle of the night. She got the patient onto the labour bed; got her delivered and the next morning she went home.10

The extract describes an event that took place near the town of Stornoway where midwives had easy access to the hospital if required. It is likely that this incident occurred in the

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9 Interview No 20 Back 1940s-1950s
10 Interview No 18 Point & Stornoway 1950s-1970s
latter time frame of the study as no other participant indicated that they ‘worked’ in the hospital.

8.2. a. Still Births

The conditions that nurses worked in were often challenging and they dealt with them as they thought best at the time. The following narrative demonstrates an incident when the nurse had to cope with the delivery of still born babies:

I had two still born babies. One was quite unexpected but the other one was expected. How did that affect you? One of them had hydrocephalus, [enlargement of the baby’s head] and had been dead in the womb for quite a long time and before the doctor could get the forceps on, what a carry on we had. I was giving the anaesthetic. You gave the anaesthetic? Of course, the doctor was there to watch all the time. We just couldn’t get them [forceps] on and the whole bed went to the floor, just think of that. The bed collapsed. I’ll never forget that, mind you it wasn’t to the floor until now. You were on the floor? I’m shaking now when I think of it. We were all on the floor but not too far down, it was quite a low bed, and the poor doctor was just relieving at the time. It was a horrible child. It was hard trying to hide it all. What do you mean hide it? Well I didn’t want to let her see it. She didn’t see the baby? No she didn’t see the baby. She wouldn’t want to see the baby it was better for her not to see that, the huge head. Was the other still born unexpected? It wasn’t expected, the doctor was there, not with everyone. They were over [births] by the time the doctor arrived quite often.11

In the late 1940s when this incident took place there would be no debriefing for the nurse after the still birth. It shows the considerable strength of character required of these women as they were expected to cope with any situation. Confidentiality was important to the nurses and it may have been that the nurse had not spoken of the first incident since it happened, some 50 years before, as she told of ‘shaking as she thought about it’. One of the participants in Reid’s study had a similar experience when a ‘grossly deformed’ baby

11 Interview No 20 Back 1940s-1950s
was taken from the mother and she didn’t see him again. The participant stated ‘women were very accepting of the care they got and did not question’. Bolton suggests that nurses have to ‘mask’ their feelings of abhorrence in order to help mothers come to terms with foetal abnormalities. The nurse’s attitude towards protecting the mother from seeing the dead baby may also indicate the culture at the time towards abnormalities in children. Fryde, who had a child with severe learning difficulties in the 1940s, encountered such prejudice towards children with learning difficulties that she was instrumental in founding what is today known as the Royal Society for Mentally Handicapped Children and Adults (MENCAP). Another participant spoke of her experience with a patient who had a stillbirth:

I always remember the lady who had three boys and her husband coming home. [Working away from home] She sent me a very worried message. I couldn’t get a foetal heart and when the baby was born I discovered that her waters had gone some time before and the baby was dead and it was a girl and that really shattered me. It must have been dead at least a couple of days, but she hadn’t gone into labour and then she realised when she started labour that there was something wrong. It had a very short cord, which was another thing that wouldn’t happen I don’t suppose today. I found it very sad. How did you deal with that? Well it was a trainee doctor that came out and she was distressed, so the boss [doctor] came and knowing the family he said, “Did you have no idea about this?” and she said “Well I couldn’t feel the baby the last couple of days, but it was so far down.” I always remember that there was some question that they would like a post mortem and the husband heard this somewhere. When I went back to do the return visit they were leaving from the house, a bunch of men with a tiny little coffin and I found that quite awful.

Like the previous participant this nurse was a lone worker and did not have colleagues to share her experience. Her response when asked about how she dealt with the baby’s death


\[14\] Interview No 4 Lochs1950s-1967s
was to consider the others who were involved. The same participant was obviously recognised for her expertise in midwifery when she worked in another area of Scotland and recalled:

> When I was in Grangemouth, I got to the stage when the doctors used to say to their assistants, “If the nurse phones for you, tell her you will be a while, and by the time you arrive she’ll have done something.”

Although one of the nurses described being ‘shattered’ at the outcome of the birth there was no suggestion in her oral testimony that she held herself responsible.

**8.2. b. Haemorrhage and retained placentas**

The nurses described being confident in their own ability and but were aware of the complexities associated with birth, particularly when they worked alone in remote areas and did not have a hospital nearby. As was shown in a previous chapter the nurses knew when and how to contact the doctor and did not hesitate to do so when it was necessary. One nurse recounted her experience when she was working on the mainland of Scotland.

The patient suffered a post-partum haemorrhage:

> I had one haemorrhage in Dalmuir. She went off to Rottenrow Hospital. I said to the superintendent “That’s me finished.” “Why” she asked? “Because the patient had a haemorrhage.” “Who’s afraid of the haemorrhage?” she asked “I am,” I said “and I’m finished.”

Despite her frightening experience the nurse did not ‘finish’ but continued with her career including maternity care. Another participant, who worked on a non-doctor island in the 1950s, also recalled a harrowing experience:

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15 Interview No 4 Lochs 1950-19670s
16 Interview No 1 Scalpay 1950s
I had a lady with a retained placenta and I sent for the doctor and he came and it was quite a bad day and the fishing boat came. I shall always remember the herring scales and the smell! We put like a stretcher on the boat and had the patient there and you know she was sea sick and with the sea sickness more clots would come away and it was terrible. Doctor and I were there and the crew and her father and her husband. At the pier there was just an improvised ambulance. It was an old bus improvised and the doctor was in touch with the hospital all the time. When we arrived at the hospital I put my face to her face and she was quite pulseless then. She was put onto the trolley and she was to go to theatre. The blood transfusion was started right away and about half a pint of the bottle that was there then went in. She came round and asked for the bed pan and the placenta beautifully came away in the bed. She was home in two or three days. 

*What a relief?* I can assure you. I think if there was an answer to prayer ever, then it was that day, because we were all in an awful state and that is one case that I will always remember, praise the Lord.17

The extract reveals the clinical emergencies that district nurses in the remote islands encountered and the limited services available to deal with them. It illustrates the variable and often urgent nature of the work the nurses carried out and how they played a pivotal role in managing the care and treatment of patients. The acceptance of this situation as part of her work was evident. The emotional turmoil of the journey and the severity of the woman’s condition are described as alarming for all involved. The story demonstrates the nurse’s strength of character and her reliance on her faith when she ‘praised the Lord’. Despite the worry about complications in midwifery the same nurse stated in the interview ‘although I say it myself maternity was my best, I liked it very much’.18

A nurse describes her experience with an ante natal patient who had a haemorrhage, which she found alarming:

17 Interview No 34. Scalpay 1950s
18 Interview No 34. Scalpay 1950s
It was her third baby and she had lost the first two. She had a bad obstetric history. We had a trainee doctor and he was called out and before he phoned me he had got her ready and put her into the ambulance ready for going to hospital. It took me about 10 minutes to get out of bed and get my bags. What time was this? About 5 o’clock in the morning and she was lying in the ambulance then. Of course once I got in, the ambulance just set off. I didn’t have time to examine her, but I stood beside her and felt her contractions and you know this we hadn’t gone far when she started having expulsive contractions. I told the ambulance driver to stop while the baby was being born. It was a hair raising experience. Having lost two babies already! Anyway the baby was born and the placenta came out and after a while she started bleeding. That was really a frightening experience and he [ambulance driver] just put his foot on the accelerator and we got her into hospital. I packed her vagina to stem the bleeding. The baby was alright, it was really quite alarming. I blamed the trainee, because he should have known how far on she was. Perhaps I should have just put my foot down and said I am going to examine her before I take her off, but I took it that he had done that. I was a trained midwife, but delivering a baby in the back of an ambulance with a bad obstetric history too! That was one really scary experience I had.19

Even though the outcome for the patient and baby was positive, the nurse was able to reflect on what had happened and what she should have done, instead of accepting the trainee doctor’s word about the patient’s condition. The Myles Textbook for Midwives describes the method for packing the vagina and maintains that ‘only in remote areas will the midwife have to cope with traumatic haemorrhage alone’.20 The situation was an obstetric emergency and the nurse revealed that she had the knowledge to cope with it successfully.

8.2. c. Complex foetal presentations

In Chapter 5 reference is made to the nurse who transported the pregnant mother with a breech presentation to hospital in a ‘rattley bus’21 and the woman who had an ante

19 Interview No 14 Scalpay & Tarbert1960-1970s
21 Interview No 8 Carloway 1950s -1960s
partum haemorrhage who the nurse escorted to hospital in her car. The nurses give
the impression of being knowledgeable and conscious of the urgency, when
difficulties arose for their patients, as the following participant described:

She seemed to be in second stage, but she wasn’t having second stage
pain and eventually we realised there is something wrong. So I examined
her and it was a hand. It was the worst experience I have ever had. The
doctor was in the kitchen with the husband. He gave her a quarter of
Morphine and we went off to Stornoway. [Hospital about 50 miles away]
I was terrified that her pain might start, but it didn’t. She slept most of the
time. Was the doctor there? No just myself. You got an Ambulance? No
just a car. He was a good driver and the doctor must have gone to the post
office and telephoned the hospital and we were expected. We went in, she
was almost asleep. The pains had gone fortunately for her. The doctor
and the Sister were waiting. The Sister turned the baby so quickly into a
breech and delivered it, a girl, a lovely girl. I was so sorry it was stillborn.
But then Sister started shouting, “Fundus, fundus this woman is starting
to haemorrhage” and we managed to stop it. How? We rubbed up the
fundus. Yes, it was bad. I didn’t actually deliver a stillborn except that
one at the hospital. I was crying on the way back home-it was a bad
experience, very bad.

It must be remembered that most of the nurses would have been in their twenties or early
thirties at that time and were lone workers with no one to share their experiences. The
nurse’s journey back to her home would have taken her about two hours and she would
have immediately gone back on duty probably without discussing the incident with
anyone. The nurse described providing all the medical care she and the doctor could in the
circumstances.

A participant recounted her experience when delivering a breech baby when she was
concerned about complications:

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22 Interview No 12 Bernera, Uig & Back1950s-1970s
23 Interview No 9 Ness, Scalpay & Tarbert 1940s-1960s
The day I delivered a breech I sent the husband to tell the doctor to come and that it was urgent, because I was afraid of complications. *How did the delivery go?* Fine, I panicked maybe to begin with; you always tried to keep yourself so that the patient wouldn’t notice that you were too worried. But to me my faith meant a lot to me. I don’t think I would have gone through my nursing from the first day I left home until today without my faith. To me I felt that I could lift my head and see Maggie Myles’s book [Midwifery text book] on the wall, and even the pages were turning, with each thing that I did to deliver the baby and the baby was delivered. I was cutting the cord when the doctor appeared outside the door and everything was okay.  

The participant described how she used her skill, knowledge and faith to gain a successful outcome. The nurses had limited life experience as most of them were single, and apart from their training on the mainland had not travelled much. They described coping with difficult cases and most of them did not mention taking time off duty for illness. The nurses on the non-doctor islands did mention that they had extra worry.

### 8.2. d. Twins

Before the introduction of diagnostic scans, nurses and doctors relied on their own examination of the mothers to diagnose multiple pregnancies. At times the diagnosis of twins was uncertain as the following participant recalls:

I had a set of twins one was born on the Tuesday afternoon and the other was born on the Wednesday morning, they were okay. I was with her all that time. *Were you worried?* Well I had the doctor coming in and out. I had managed to get a hold of him. I had examined her in the morning and I felt a foot, so I sent her husband to get the doctor. I didn’t want to start delivering a breech on my own, but that was what it was, it was twins. We didn’t know they were there. *Were they both okay?* Yes.

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24 Interview No 16 Scalpay 1950s -1970s.
25 Interview No 8 Carloway 1950s-1960s
This event was seemingly uneventful for the nurse as she went on to say she had delivered another set of twins and ‘they were fine’. Multiple births, if there were no complications, as the following nurse described were exciting:

I had twins in Shawbost when I was there, twin boys. It was very exciting, because the lady had boys and she wanted girls. Her mother was with her in the house and when the babies arrived; we had a good idea it was going to be twins, and I had notified the doctor. The first baby arrived and the doctor then came and said, another boy and the daughter said “Oh don’t tell me” and the caileach (old lady) was so amused, she said “Be quiet, you should be thankful that they are alive.” She was annoyed at the daughter complaining when they are alive and well.26

The accounts suggest that none of the stillborn babies mentioned by the participants were injured at the delivery by poor midwifery care. It would appear that most stillbirths were due to circumstances out-with the nurses’ or the patients’ control. A review of the risks of home births for low risk mothers in comparison to hospital births concluded that planned home births are no less safe than hospital births.27

Loudon who looked at maternal and infant mortality from 1900 to 1960 found that there was not a close link between the two. Levels of neonatal mortality Loudon suggests were caused by factors that cannot be understood.28 Many neonatal deaths, the study found, were due to maternal or foetal pathology, which did not put the mother’s life at risk.29 According to Gardner, the Scottish rate of still birth in the last twenty five years has fallen to less than half, since registration begun in 1939. He maintained that although there has been an improvement in all geographical areas the Northern Region

26 Interview No 5 Shawbost 1940s-1950s
(which includes the islands of the northwest and many sparsely populated areas some with long distances from hospitals) had maintained the best experience. He suggested that the reason for this finding might be in part, the excellent biological condition of the people\textsuperscript{30} A similar reason was given by a nurse in the next section who suggested that because of mothers’ physical fitness they did not require pain relief.\textsuperscript{31}

Nurses had obstacles to consider, when patients had to travel to get to the hospital for treatment of obstetric emergencies, for example, the distances, inadequate transport and poor road conditions. Roads have now improved and help can come quickly, even by helicopter, yet midwifery emergencies will always occur in remote areas. Although this chapter has focused on emergencies one nurse put home deliveries in perspective:

Having deliveries at home were so common and it was a natural thing to happen\textsuperscript{32}

### 8.2. e. Pain in labour

In the 1960s and 70s various publications advocated the relief of pain in childbirth by various methods related to the mothers attitude and confidence during labour.\textsuperscript{33} Sheila Kitzinger, a well-known writer regarding pain in childbirth during the latter part of the study, stressed the value of antenatal preparation for birth and the importance of the environment surrounding the birth. She maintained that the environment where the birth


\textsuperscript{31} Interview No 9 Ness Tarbert, Harris 1940s-1950s

\textsuperscript{32} Interview No 4 Lochs 1950s-1967s

took place could either reduce or contribute to the perception of pain. Most of the participants interviewed did not consider pain as an issue in labour. Many suggested that pain was something that the media has introduced into midwifery in the last twenty years. Participants were asked about pain relief for women in labour:

I never used drugs What about pain? I went to Raigmore Hospital for the gas and air training, but I don’t think I ever used it much here. Is there a difference now when women are having babies? I think it is ridiculous. They all go to hospital. Of course there must be two midwives and a doctor and I can’t understand it. I was trained. But before that, women went round delivering babies and they were good too. I think that practical experience teaches far more. Certainly you need the theory, but I believe in practical experience and that is why I can’t understand nurses now when they start going to universities, I believe in practical experience in the wards.

This nurse as well as discussing pain relief in labour took the opportunity in the interview to give her opinion on her own midwifery training and the current university trained nurses. She did not agree that women had to go to hospital for confinement and was of the strong opinion that practical experience was paramount for training nurses. Although the nurse stated that she had received training for ‘gas and air’ she had never used it. The following nurses did not consider pain in labour a problem:

The doctor was always available to help if there were any problems. Was he there at deliveries? Not very often. Does that mean that the ladies didn’t have painkillers? No. Did the women complain? Och no! No there was nothing of the kind. What about the afterbirth? It was left to nature’s way.

35 Interview No 1 Scalpay Harris 1950s
36 Interview No 7 Ness and Relief 1940s-1950s
Did they have pain relief? No. Eventually we got some gas and air. When did that come in? I would say 1948 or 1949. But before that there was no pain relief? No pain relief, but the women were strong. I think on the whole, because they were fit, they worked hard, croft work and taking home peats, they were very fit really. Did that help? I think it did help the labour.37

Pain relief in labour for the mother was not a concern for the nurses. They did not expect the women to complain and one of the reasons that a participant gave was because the women were strong, fit and accustomed to hard work. Despite their general attitude towards pain they were prepared, by carrying out further training for using ‘Nitrous Oxide and Oxygen’ which was an inhalational analgesia.38 Some Local Authorities felt that the equipment was too difficult to transport (it weighed twenty two pounds) and according to the rules there had to be two midwives present before it could be used as was noted in Chapter 1.39

Myles Midwifery Textbook that all Scottish midwives were familiar with from the 1950s - 1970s asserts that the midwife’s personality and attitude plays an important part in the behaviour of the woman in labour.40 Similarly it was believed the environment of the birth can have an effect on the pain.41 It is possible that the combination of the physical and emotional strength of the women of the islands as observed by the midwives, and their confident approach, could have had an effect on the mother’s perception of pain. However there is no evidence about the mothers’ perception of pain in labour at this time.

37 Interview No 9 Ness Tarbert 1940s-1950s
8.2. f. Last offices and maternity care

The nurses identified problems about ‘laying out of a dead body’ and then being required to attend maternity care, which was not permitted by the Local Supervising Authority (LSA), an organisation set up in 1915 in Scotland, under the Midwives Act of 1902, and consolidated in subsequent Acts of 1918, 1926, and 1936. The LSA’s role was to exercise general supervision of midwives and a requirement was to notify them of various circumstances related to midwifery. One such situation was after the laying out of a dead body.42 Participants spoke of the problems related to this required notification:

As time went on we worked it out. If you had a hospital discharge, mother and baby, you didn’t do them for a day or two days because you were like the lepers of old, you were contaminated. Once you touched a body, you were contaminated. You didn’t care for babies for two days? That’s right.43

I don’t know what happens now. If somebody died in a house, would you send for the nurse? That is what I had to do; you weren’t supposed to do it [attend a death] if you had a maternity case but I never liked to refuse.44

You had to go out if they died at night. You did terminal care? If I did I had to report it and had to be off duty from babies for forty eight hours, I tried to avoid that if I could.45

It is understandable that a lone worker would have problems if she had to attend to terminally ill patients and also attend at births. From the responses of the nurses, they tried to avoid ‘touching a body’ as they would then have to notify the LSA and would not be allowed to attend to a birth or care for a baby. Undoubtedly the reason they could not touch

43 Interview No 4 Lochs 1950-1967
44 Interview No 8 Carloway 1950s-1960s
45 Interview No 29 Back 1950s-1960s
a mother or baby after attending dead body (for 48 hours) was due to the belief about
infection risk. Chapter 1 discusses the history of nursing, and this potential dilemma for the
nurse is referred to, and questions, whether nurses were successful in adhering to the rules
regarding babies and death. Participants gave the impression that they attempted to avoid
this situation occurring if possible.

8.3. Decision making

Accounts that the nurses provide of their practice suggest that they considered themselves
to be autonomous practitioners as midwives. Skår’s study suggested that to gain
autonomous practice nurses must be competent, and have the courage to take charge, in
situation where they are responsible. Skår found that to be knowledgeable and confident,
was the coherent meaning of autonomy in nursing practice, and that nurses who work
alone with a patient is forced to take charge of situations. According to Holden
autonomous nursing practice is not possible without personal and professional
responsibility. The nurses in the study were lone workers and describe taking personal
and professional responsibility.

Decision making is a key element of community nurses assessment in practice, and often
the challenges they face are different, from those of their hospital colleagues. Along
with challenges of the assessment of patients, the nurse in the remote area of the Outer
Hebrides faced problems of accessibility to medical services, as well as difficulties of
transport. Each area was geographically different and some nurses worked more


pp.398-403.
decision making as they relate to community nursing assessment practice: Journal of Advanced Nursing 24,
pp. 24-30.
autonomously than others especially if the doctor was not easily accessible. A study by Luker & Kendrick looked at the sources that influence the clinical decisions of community nurses in the 1990s.\textsuperscript{50} The study which was carried out prior to the nurse prescribing initiative, twenty years after this study, is of value to understand the knowledge that nurses later perceived underpinned their decision making. The findings suggested that the nurses’ practice was based on experiential knowledge, and that on the whole, the district nurses were not positively disposed to research.

If district nurse practice is heavily influenced by experiential knowledge, it is suggested that decision making improves as the nurse gains experience of nursing patients within a specific speciality and, with experience, nurses gain a sense of saliency in relation to decision making.\textsuperscript{51} The nurse in the previous section, who commented on nurse education, strongly believed in the primacy of experience to teach nurses.\textsuperscript{52} The nurses carried out decision making on a daily basis however it is doubtful that their knowledge to make clinical decisions was confined to experiential knowledge, for example participants mentioned the importance of their nursing textbooks.

On the non-doctor islands where the nurse was first on call, and had to diagnose, they made decisions. All participants in this study were trained midwives as well as nurses and the following narrative gives the response from one when asked if she ever made any clinical decisions:

\begin{flushleft}
52 Interview No 1 Sculapay Harris 1950s
\end{flushleft}
Yes, I did the antenatal as it was laid down; I was very fussy about it, because there were home deliveries then. You had to be very careful because you were the one who was going to be landed in the middle of the thing.53

The nurse was aware of her responsibilities and because of the guidance which, as she said was ‘laid down’, she was determined to carry out her care meticulously. This knowledge was not essentially experiential, although part of it may have been, but knowledge dependent on the competencies skills and behaviour that midwifery training provided. For one participant the Midwives Rules was forever in her mind, as she had to write them out in verse during her training in 1939 (Appendix 14).54

Another participant describes an unusual visit when she had to make a decision whether to attend a patient:

I had one unusual call out. A man who had gone berserk and they were trying to calm him down. He must have had drink. It was during the night, I didn’t refuse to go. I think probably it should have been a police case. When I got there he had calmed down. He was saying that he was going to commit suicide. I think it was the effects of drink.55

This nurse had made the decision to attend to the ‘call out’ yet in the interview she responded to being asked about who made the decisions about patients as being between the doctor and herself:

Probably the two of us [doctor and nurse] the nursing care decision of course I made.56

53 Interview No 10 Point 1960s-1970s
54 Interview No 34 1940s Glasgow ‘Rules for Midwifery’ (Appendix14).
55 Interview No 13 Uig 1950s-1970s
56 Interview No 13 Uig 1950s-1970s
The nurse’s own personal knowledge of the community may have been a factor in her attending to the patient. She also stated that ‘the patient had phoned the doctor but “I don’t think he wanted to get involved”’. It was ironic that the doctor did not attend the patient, however the nurse defended him by saying that he did not want to be involved and that ‘she had phoned him and it ended up ok’. The following participant received a call that would have required knowledge from various sources:

I was called to a person who had shot himself. Was that difficult? I suppose, but you were sort of able to cope with anything and everything at that age. I think it is part of the courage of youth again. [Participant mentioned this before] What did you do? I couldn’t touch him until the police came so I had to pacify everyone around. There were quite a few people. And then the doctor came and he couldn’t touch him either as we still had to wait for the police. You knew not to touch him? Oh yes you were told that in lectures at Queen’s.

The nurse knew before she went to the patient what had happened but it did not deter her from making the decision to attend the call. She was confident and she stated that her knowledge stemmed from her Queen’s Nurse Training. The courage to deal with the situation she maintained was ‘because of her youth’.

For nurses who worked on the non-doctor islands it was not only the nursing care that they had to make decisions about. The following participant recounted a clinical decision she made:

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57 Interview No 13
58 To avoid identifying its location the participant requested this incident remain anonymous.
I remember one night called to an elderly lady with severe pain that I took to be cholecystitis. She had a history of this. There was a howling gale, the boats couldn’t get out, the ferry wasn’t running and really she needed to see the doctor, so he asked me to visit the patient. He prescribed her morphine. We kept these dangerous drugs in a locked cupboard in the clinic, I gave it to her. It was a terrible worry until he got down the next day.59

Although the nurse diagnosed the patient’s problem she was not confident and needed the reassurance from the doctor. Whether her decision was influenced by experiential knowledge or medical/practice knowledge is unknown. Nurses on the non-doctor islands had the added responsibility of being on first call, accessing the ferry as well as transport if the patient had to be hospitalised. When midwifery was involved however, the nurses then took the responsibility for making decisions and did not depend on the doctor as the following participant explains:

Largely, because you were a practitioner in your own right when you were a midwife and the doctor probably didn’t see a person until she was seven months pregnant. He would probably know the string of babies she had before that or if she was a primigravida [first baby] he would have a peep and see just how well she was. Did you decide if they should be moved to hospital? Oh no, if you got into trouble, you called the doctor. If you knew that somebody had started in labour, maybe a young one, you would give the doctor a ring and say, “I might have to call you later in the night”, but if not the baby was delivered normally and you phoned when you came back home.60

In their role as a midwife the women had no qualms about making independent decisions, but when carrying out nursing work they recalled often referring to the doctor. It was unusual for the GP to contradict the nurse or vice versa but in the following participant’s experience she did not hesitate to make the decision for her patient:

59 Interview No 14 Scalpay& Tarbert 1960s- 1970s
60 Interview No 4 Lochs 1950s-1970s
When I got to the house they had been working on it and there was no outside light and I got in only to find this girl in labour. She had never told us, never had any antenatal care and this was her second. She didn’t want to go into hospital. She didn’t tell anyone and there was nothing in the house. I knew she was well established in labour just by looking at her. So I examined her and she was dilated and there was no way we could have made it to Stornoway 60 miles in the night! So the doctor came in and says she’ll have to go hospital. And I said there was no way she could go to Stornoway. I was not delivering in an ambulance halfway there in this weather. We’ll either lose the baby or both. It has to be a home confinement. And he hummed and hawed and I said there was nothing else for it. You were quite assertive? I was. The ambulance was at the door waiting to take her away and I said ‘no, she can’t go’ so that was it. I tried my best in the house but there was nothing ready and the house was in a boorach [messy] as they were working on the house. A safe delivery of a girl.61

The nurse overruled the doctor by not allowing the patient to be sent to hospital and appeared to make the decision based on her midwifery knowledge, her personal knowledge of the area and for the safety of the mother and baby. She was asked how confident she felt making decisions:

*You diagnosed and decided if they needed a doctor?* Yes, I did. It was quite a responsibility on an island. You had to decide, say just now if you thought you needed hospital or a doctor and a ferry had to be called out. You had all those decisions but I quite enjoyed my stay. *Did you feel confident to deal with them?* Well, I suppose, yes I did.

The perception one gets of some of the nurses interviewed was that they were resourceful and had the ability to make decisions and deal with any type of problem or emergency. In most areas the nurse was the ‘first on call’ and had to make the decision as to whether to send for the doctor or treat the patient herself. The next extract is from a participant who describes the reason for the calls she received:

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61 Interview No 28 Scalpay & Tarbert 1950s-1970s
It was busy and it was really a big district. There were very few things that you weren’t called to even if you had to send for a doctor. They would call you first? Yes, call the nurse first. Were there many accidents? Not a lot. Of course there weren’t the cars for that. There was very little traffic on the road for which I was thankful.  

Although there were few accidents to attend it was expected that the nurses would be called out to whatever ailment or injury presented itself on the district. The nurse would contact the doctor after she had assessed the situation. One nurse spoke of making decisions and how glad she was when she moved to the town area to work where she could easily access a doctor: 

There was this baby and he wasn’t well and I kept phoning the doctor and it was late at night. I phoned him and I thought surely he’ll come now and you know this he didn’t. He didn’t come until morning and by then that baby had to be rushed away. These were the terrible decisions. Clinical decisions you had to make? Yes, I had to make them on the spot. I think we took a lot of the doctor’s work on. I must admit when I got a temporary job in Stornoway on the district, I thought I was in heaven, there wasn’t the same worry. There was a lot more nursing and heavy nursing, but not the worry of ferries and doctors. It was wonderful for me. 

This nurse was the only participant who appeared to have concerns working on a non-doctor island and communicating with the doctor. 

Unknown circumstances did not deter these informed women from attending to patients or relatives. Their knowledge of the area and the people may have helped them to cope with difficult situations. They appeared resilient and continued with their work after some difficult experiences and responded at times to calls without considering the personal consequences. 

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62 Interview No 20 Back 1940s-1950s
63 Interview No 14 Scalpay & Tarbert 1950s-1970s
8.4. Conclusion

Some of the complexities of midwifery that the participants experienced were clinical emergencies. Several did not have a positive outcome such as when a baby died. The effect of traumatic experiences on the nurses is unknown, yet one participant some fifty years after the event, was ‘shaking’ as she thought of it. Confidentiality was important to the nurses, and they did not have colleagues with whom they could share their experiences.

The responsibility to mothers and the babies was immense and in the obstetric emergencies the nurses accepted the responsibility. At times they indicated they were afraid and anxious about a situation, particularly in midwifery, yet seemed to portray confidence that may have come from their knowledge of what to do in any given situation. Queen’s Nurse training was acknowledged by some participants as being highly relevant to their practice and some attributed this training to their ability to manage any situation.

The participant’s role as midwives revealed them as being competent and making decisions, which is suggested as the criteria for being an autonomous practitioner. Their accounts describe then as taking personal and professional responsibility for their practice without regard to their own wellbeing. Their resilience and strength of character in the face of setbacks was evident.

Some nurses were more confident than others in making decisions and this may have been due to a difference in their knowledge base. While the Queen’s Nurse was confident in her ability, the other nurse was constantly worried about making decisions. It could be suggested that she did not have the ‘extra’ district nurse training to provide her with the knowledge and confidence she needed. Most participants, especially Queen’s Nurses,

indicated that they were confident and competent to make decisions. They describe acting autonomously and making clinical decisions in urgent and complex situation. It is likely that their decision making knowledge stemmed from various sources but that their training and their experience were particularly significant.
Chapter 9 Discussion and Conclusions

9.1. Introduction

The study reported here used oral testimony, supplemented by archival sources to explore the lives, work and challenges faced by the district nurses who were mainly lone workers and practised in the Outer Hebrides from 1940 to 1973. Although other parts of Britain by the 1960s were developing increasing specialisation within health care, the data reveal that this was not the case in the Outer Hebrides. The first health centre employing a multidisciplinary team was not opened until 1977.¹ There is evidence in the narratives that, even in the early 1970s, only a few nurses worked with nurse colleagues therefore the majority, for the duration of the time of the study, were lone workers whose only professional relationship would have been with doctors.

All participants in the study were retired district nurses, with ages ranging from 75 to 97 years who had worked in the Outer Hebrides at the time of the study time period. A total of thirty four interview transcripts were obtained. Included in the transcripts was one that was obtained from a nurse who was from the Outer Hebrides and had worked as district midwife in Glasgow during the time period of the study. Other data included information from a relative of a district nurse who worked at the time of the study, and one interview with a district nurse that was received from a historical society.

Participants were all trained general nurses and midwives, the majority had been trained as Queen’s Nurses. Included in some of the nurse’s further training was sick children’s nursing, tropical disease training and mental health nurse training. The further training the

¹ Stornoway Gazette, (1977) £2500, 000 Centre Opening Marks New Health Era for Lewis: Stornoway Library Archives, Vol LV1, 26th February.
nurses received on top of their general training equipped them for the unusually isolated and, at times, pressured nature of their role. Apart from the statutory midwifery refresher course every four years, most participants stated that their skills were updated only by reading nursing journals and when they had periodical Queen’s supervisory visits.

The setting of the study was remote, with some areas more isolated than others. This specific time period, place and topic have not been studied before. The time period of 1940 to 1973 was significant, as the way health care was delivered changed with the introduction of the NHS in 1948 and, in the period leading up to the reorganisation of health care in 1974. The geographical area itself was unique with its diversity of terrain and remoteness, combined with the unique culture of the Outer Hebrides. During the time under study the culture of the islands was influenced by its remoteness and the particular form of religious observance practised by the people. All participants spoke Gaelic, and although they intimated that they communicated to their patients in the language, they did not think it was necessary to be a Gaelic speaker in order to work as a nurse in the Outer Hebrides. These views contrasted with the views of the Dewar Report, which twenty years earlier had recommended all nurses in Gaelic-speaking areas should have a good working knowledge of the language.²

District nursing formed a major aspect of the participants’ past and allowed them an opinion on district nursing in the present day in comparison to when they worked. It is also probable that the nurses were filtering their past memories through their present experiences. Society has changed in the islands and communities are no longer interdependent on each other to the same degree as in the past. District nursing likewise has

² Highlands and Islands Medical Service Committee (Dewar Committee) (1912), Report to the Lord Commissioner of His Majesty’s Treasury: Vol, 1 & 11. Edinburgh, HMSO.
undergone changes in the last fifty years creating a shift in the entire culture of community nursing. Even the term ‘district nurse’ is a misnomer today as nurses who work in the community are referred to as ‘community nurses’, and are not necessarily attached to a particular ‘district’.

Three important themes emerged from this study, the wide scope of the nurses’ practice, the significance of the relationships that they had in their work, and the unique nature of their role. Many of the participants maintained that their work was their life. They enjoyed their work and found it satisfying, despite its many challenges, such as isolation, travel, inadequate accommodation, long working hours, inclement weather and coping alone with medical emergencies. The characteristics of the nurses and the challenges they faced suggests that they may, on some level, have been influenced by an idea of their service as a ‘heroic’ one even though they never overtly claimed that this was the case. This chapter opens with a summary of the study and its findings. It goes on to consider certain key elements of the study including the scope of the nurses’ practice, significant relationships they had, including the unique nature of their role. Finally it comments on the implications of the study for the future of district nursing, the limitations of the study and recommendations for further research.

9.2. Summary of the Study and its Findings

The key questions that the study attempted to answer were:

- What were perceived by district nurses as the main challenges to district nursing in the Outer Hebrides?

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What were perceived as the advantages and constraints of district nursing in the Outer Hebrides?

What did the nurses perceive as being their contribution to care in the Outer Hebrides?

How was the work of the district nurse affected and informed by the remoteness of the area and the particular culture of the Outer Hebrides?

The main challenges that the district nurses perceived were described as, the inadequacy of their own and their patient’s accommodation, transport (sometimes the lack of it), the inclement weather and the long hours of work. Working conditions were an enduring challenge for the nurses. Running water and electricity were not accessible in the Outer Hebrides until the late 1950s, and even later in the more remote areas.4

The nurse’s inadequate accommodation was reported as a source of concern for nurses, and for the Queen’s Supervisor of Nurses, who advocated for the nurses with the local nursing authority. Although their own and their patients accommodation was a challenge, on one occasion the ‘black house’ with animals was an asset to the nurse and a child who required treatment.5

Various forms of transport were used by the nurses to reach patients. These included, walking, cycling, horseback, cars, boat, bus and on one occasion a helicopter. In the 1950s some nurses could not drive, although there were cars available in some areas. During the war years, some nurses became competent in repairing their cars, as there were so few men in the community because most inhabitants with engineering skills had joined the war effort overseas.

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5 Interview No 5 Shawbost 1940s, Chapter 5 p.146
A major challenge, which had an impact on the nurse’s travel, was the Hebridean weather. One participant was so emotionally damaged by a journey to attend a patient, that she could no longer travel on a boat, after a stormy and potentially dangerous boat crossing to reach a patient.⁶

Working conditions were a constraint. Nurses worked long hours and could be on call for long periods of time though most of them did not complain about this. Only one participant expressed annoyance that she did not get time off and left the island to return at a later date when working conditions improved. Another participant recalled being on duty and on call for a year without a day off. Nurses also described how they were required to access their own holiday cover from another geographical area. However one nurse who recalled the on call arrangement at the time of the study, expressed concern over the 21st century district nurses ‘who cannot be contacted in an emergency’.⁷ She did not consider the consequences of nurses today working long hours as a problem, in comparison to her perception of the communities in the present day being without the ‘comfort of a district nurse’.

The main advantage of working as a district nurse in the Outer Hebrides at the time of this study recounted by most participants was that they gained satisfaction and fulfilment from their work. Most nurses also described being happy carrying out their work despite the challenges they faced. It was reported that working in an autonomous role as a midwife also gave particular work satisfaction.

The contribution that the nurses made to care in their geographical area was, according to their testimonies, one of self-sacrifice and commitment. They were always available for

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⁶ Interview No 36 Uist 1940s-1960s Chapter 5.p. 182
⁷ Interview No12 Uig, Back & Bernera 1950s-1970s Chapter 5. p. 189
the community where they worked. In return the particular culture at the time saw the community supporting the nurse in her everyday work.

The remoteness of their areas of work impacted on their everyday lives. Their ability to reach patients, the potential problems of travel, accessing medical assistance and equipment led them on many occasion to demonstrate their ability to improvise. They were not deterred by the lack of equipment. The 'little black bag and its mystique’ which Damant describes as part of the imagery of district nursing, ‘a container of secret powers and instruments,’ was described as a disappointment for the nurses because of its limited contents and therefore limited utility for the nurses. There was evidence that the lack of colleagues to provide support for nurses in remote areas may have had a lasting effect on some of the nurses, particularly the nurse who had never spoken of an incident since it had occurred, some fifty years previously.9

Faith played a key part in the nurses’ lives. The Outer Hebrides at the time of the study was known for its strict religious beliefs and this was evident in the nurses’ testimony. Most described the importance and dependence on their faith, and the study found that there was a difference in culture between the mainly Protestant north islands, and the mainly Catholic southern island nurses. The nurses in Lewis and Harris did not seem to socialise with the community; indeed, some deliberately chose not to mix socially, whereas in Uist the nurses give the impression of being an integral part of the community. There are a number of possible explanations for this difference but one might be that the Uist nurses, who were originally from the geographical area, had been part of the community before

9 Interview No 20 Back 1940s-1950s, Chapter 8 p.234
and after their training. In Lewis, the larger island, nurses did not have the same personal and historical connection.

Most participants viewed their Queen’s Nurse training as having a positive effect on their practice. The scope of health issues included in the Queen’s Nursing examination papers in Appendix 1 indicates that they had an extended knowledge base. Furthermore, this knowledge was associated with a particular form of skills training which represented an in depth understanding that they believed made them resilient, when faced with challenges of practice. Nevertheless it would be naïve to suggest that they only relied on the knowledge from their nurse training to carry out their daily work. This thesis argues that the nurses’ island origins, their experiences of travel, adapting to life on the mainland of Scotland, and their training, all played a part in producing the confident and resilient nurses described in the findings. They were also women who at times appeared self-sacrificing in the stories they relate about their service to the community in which they worked.

9.3. Scope of Practice
The breadth of the nurses’ practice was wide and included people of all ages and stages of life. The remit of most of the nurses in the study included triple duty care involving general, midwifery, school nursing and health visiting. When one considers the caseload and the working hours of the nurses it is not surprising that one nurse commented that ‘she was afraid she would fall asleep at the wheel of her car’. Aldridge suggested that when nurses are tired or struggling with their motivation that they have their routine to fall back on.\textsuperscript{10} Nurses in the study described returning to work immediately after dealing with

difficult situations and when tired. They may have been relying on their routine to enable them to continue with the work.

Some of the practice carried out by a few of the nurses may have been idiosyncratic or even steeped in ritual and culture; nevertheless participants believed that it did not harm their patients. Research-based practice was not topical until 1972 when Briggs emphasised the need for research as ‘insufficient attention is paid to research as a continuing activity’. Nurses in the study appeared to rely significantly on experiential knowledge. Their practice had a strong ethical dimension. The moral component of their practice was seen on many occasions when for example some of the nurses stayed with patients overnight ‘if there was no one else’. This moral element of care, according to Griffin, is grounded on a nurse’s perception and judgement of the patient’s need at a particular time. The nurses reported that the overnight care of the patients only occurred when there was a need.

The only ethnic minorities that the participant claimed they cared for were the ‘travelling people’ and their comments indicate that this was a new area of care for them. They were empathetic towards the ‘tinkers’, and their perceived lack of resources. Moreover they recalled that their view of ‘tinkers’ was that they were ‘kind and clean people’. The realities of their encounters with them may have changed the nurses’ attitude towards the tinkers, as they have always been a stigmatised group. It is probable that the nurses were aware of the inequalities in health of this ethnic group of people, which has persisted into

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12 Interview No 23 Uist 1950s-1970s.
the 21st century. Goffman’s idea of the nurse being ‘the wise’, in relation to a stigmatised group, therefore being trusted, probably resulted in the tinkers feeling ‘neither shame nor exerting self-control as they knew they would be seen as an ordinary other’. Nurses did not appear judgemental towards the tinkers and delivered their babies in unusual places such as a tent, shed and a bed on the floor.

Schools at the time of the study had a high pupil roll because of the ‘baby boom’ of the 1950s. Nurses regularly attended schools to carry out health checks. This was in addition to their general, midwifery caseload and child development assessments. Apart from the nurse who had her sick children’s certificate, the extent of knowledge the other nurses had of child development is unknown. However children’s medical conditions were included in nurses’ medical and surgical textbooks from the 1950s. Both were almost certainly a part of their required instruction during their training.

Midwifery practice was a large part of the nurse’s role that was similar to many other district nurses in geographical areas in the Britain at the time. Nurses practised at a time referred to as ‘the golden age of midwifery’. When describing their experiences they recalled that they were competent and confident with the care they provided and only consulted a doctor for obstetric emergencies. They described coping with obstetric emergencies and in spite of some setbacks and distressing experiences they displayed resilience. After the nurse had dealt with the complications of midwifery whether in the

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patients’ home or at the local hospital she then had to return to her lone area of work where
she continued on duty. She did not have a colleague to discuss her problems with. While I
was interviewing a participant, she spoke of a distressing experience she had had fifty
years previously. It was the first time she had spoken of the incident. The nurses described
confidentiality in their practice as being essential, therefore this nurse had not confided in
anyone about her experience. It could be argued that the ‘golden age of midwifery’ may
have had a negative impact on many of the nurse’s personal and social lives. Although
nurses worked autonomously and competently it is unknown how the long hours and the
difficult situations they managed, affected their lives. McIntosh suggests that it was the
sense that midwives’ had of their own position and status which had perhaps given rise to
this period as a ‘golden age’, however it came at the expense of women.20 It was
particularly in their midwifery practice that the nurses described themselves as being
autonomous practitioners. Skär’s study into the meaning of autonomy in nursing concluded
that to gain autonomous practice nurses must be competent and have the courage to take
charge of situations where they are responsible.21 Mantzoukas & Watkinson suggest that
the relationship with patients is also essential in developing autonomous practice.22
Evidence in this study revealed that nurses had the courage to deal with any situation,
whether in midwifery or general care, and their relationship with their patients would
identify them as working autonomously.

There may be evidence that there was some blurring of boundaries within the nurse/doctor
relationship and, on rare occasions, between the nurse/domestic worker boundaries.

20 McIntosh, T., (2012) A Social History of Maternity and Childbirth: key themes in maternity care:
Routledge, London, p. 83
22 Mantzoukas, S., & Watkinson, S., (2007) Review of advanced nursing practice; the international literature
and developing generic features: Journal of Clinical Nursing, 16, pp. 28-37.
However district nurses’ boundaries were less clear cut at the time of the study than they became at a later period. There was also no evidence that ‘boundary crossing’ was considered to be a pressing concern at the time of this study. This is because ‘boundaries’ were not an issue, as nursing practice, was needs led. According to Gerrish and Griffiths, community nurses worked beyond the boundaries of their occupational role if no other services were available.\(^\text{23}\) Discussions about the boundaries of nursing only became prominent in the literature after the 1970s.\(^\text{24}\)

Nurses in the study described themselves as well trained. They also presented themselves as confident and assertive women who appeared to know the limitations of their practice. They did not indicate that they carried out work that was not perceived as nursing care at the time. Furthermore they expressed that any other work that they carried out which may not have been regarded as nursing care, such as shopping or housework, was carried out only when they worked in the urban areas of the mainland. Some of the care they delivered at the time of the study would today be provided by another health professional. There was no one else at the time to carry out the care required for their patients, such as physiotherapy therefore they considered it within their scope of practice. Only one participant claimed she had carried out what she considered as ‘non-nursing’. She was


annoyed with a colleague, who had set a precedent by carrying out non-nursing care by washing a patient’s bed clothes.25

The findings are in contrast to Dougall’s study where she found that almost all participants in her study spoke of non-nursing care as a feature of the past and not the present. She goes on to suggest that the rural nurse was more likely to find that she was helping with household chores if she was stranded in a patient’s home.26 There was limited evidence in the study that this occurred in the Outer Hebrides.

Most nurses were trained Queen’s Nurses which they highlighted as being influential to their knowledge base and their ability to make decisions and manage. On the non-doctor islands where the nurses was first on call and were expected to diagnose, they made decisions such as, about the patient, the necessity to call the doctor or the ferrymen. The participants described unusual call outs where they may have been in danger because of the nature of the call out or the inclement weather. Nevertheless they were not deterred from attending the patient and taking charge in a crisis when the doctor was not present.

9.4. Significant Relationships

The nurses reported that members of the community had high expectations of them assuming that their whole lives belonged to the community day and night. Nurses described having no privacy in their own home and that they were always contactable and visible. The community appeared to be dependent on the nurse for dealing with any health issues or emergencies. In return the community were also depicted in the study as looking after the nurses’ wellbeing; for example, by providing her with fuel for her fire, transport and on one occasion, warmth (the nurse was given a scarf). They also looked after her

25 Interview No 22 Uist 1950s-1974, Chapter 7 p.225
safety and were available when she required them for assistance in her work, whether when delivering a baby or helping her manage an accident.²⁷

However it could be argued that the expectations of the community outweighed their contributions to the nurses’ work and welfare. ‘Subordinating ones own interests and desires to those of others’ are deemed self-sacrifice²⁸ yet, for most of the participants this did not seem to be their view of the relationship. According to Pask, a self-sacrificing attitude allows nurses to act for the good of their patients, while suffering the effects of other influences on them.²⁹ Some of the participants spoke of the effects of this ‘self-sacrifice’ such as tiredness³⁰ and the consequences after a traumatic journey to a patient, when the nurse could no longer travel by ferry.³¹ Yet, nurses spoke only of the assistance they received from the community and commented on their help. ‘The people were good to me’ and ‘everyone looked after you’,³² were evidence of the community’s regard for the nurse. However one nurse commented that, at the time period of the study, more consideration was given to the patient than the nurse. She claimed that the ‘pendulum has swung too far today and the concern is now for the nurse and not the patient’.³³

For married nurses, another relationship that she considered valuable to her work was with their husbands. Nurses were not ‘allowed’ to marry and live with their husbands until the 1960’s and many participants expressed being unhappy regarding this ‘rule’. This ‘marriage ban’ was relaxed during the war (1939-1945) and then again in 1960s when

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²⁷ Interview No 31 Scalpay 1950s-1990s, Chapter 6 p.178; Interview No 18 Point Stornoway 1950s Chapter 6 p. 176; Interview No 9 Bernera 1950s-1970s Chapter 6 p.175
³⁰ Interview No 20 Back 1940s-1950s
³¹ Transcript No 36 Uist 1940s-1960s
³² Interview No 11 Uig 1960s-1970s
³³ Interview No 29 Stornoway1940s-1960s
there were shortages of nurses. When nurses were allowed to marry, some of them spoke of the assistance their husbands gave them in their work, especially in providing transport during inclement weather. The role of the husband was described to be that of an assistant to the nurse. Some of them drove the nurse to her patients, while others rowed them across the lochs to patients, and many accompanied their wives on night calls. These men were in many ways unpaid support workers for their wives.

The remoteness of the area and the time period intensified the kind of support that the nurses required. With no electricity in many places, water drawn from wells, inadequate roads, inclement weather the assistance of the husband was invaluable. One participant remarked, ‘there couldn’t have been anything more useful at the time’. \(^{34}\) In light of the support of the community and the husbands, (when they were eventually allowed to live with the nurses) it could be argued that, without their assistance, the nurses’ practice would have been more difficult. If the support was essential for the nurse, it raises the question of whether the local authority was relying on the good will of the community, to assist in providing health care.

Queen’s Nursing Supervisors were influential in the nurses’ lives. Regular visits were made to the nurses where discussion took place about the nurses’ conditions of work and practice. They were the only colleague nurses had, who supported them both clinically, and as an advocate, to improve their working and living conditions. The superintendent regularly presented the concerns of the nurses to the local nursing committees as well as providing them with a report on the practice of the nurses. The nurses expressed that they valued the supervisors support and advice about their practice. Apart from their midwifery refresher course and reading nursing journals, the superintendent was the only person

\(^{34}\) Interview No 11 Uig 1950s-1970s
providing supervision of the nurses’ practice. In the later time period of the study there is evidence from one nurse that there was a professional development day where she demonstrated her wound dressing technique ‘a la Queen’s’ to her colleagues.35

The professional relationship between the nurse and doctor varied. Some had a good working relationship with him, whereas, others rarely saw the doctor unless a patient had complications. Incidents where the doctor behaved in an unprofessional manner were recalled yet this was accepted by the nurses, giving the impression that the medical model of hierarchy, where the nurses was subservient to the doctor, prevailed at that time.36 Yet instances remembered by participants, particularly when practising midwifery, suggested that the nurses could be assertive, overruling the doctor’s decisions when they believed they were acting in the patient’s best interest. It would appear that the relationship between the doctor and the nurse was important, as she was in some ways, dependent on him as a colleague.

The relationship with the health visitor was not captured in detail by this study as only two participants worked with health visitors in the 1970s. While one welcomed her as ‘someone to lighten her work load’37 the other resented her arrival in her area.38 This is a surprising reaction, as most nurses were lone workers without colleagues nearby. The nurses described that the only contact they had with their nurse colleagues was when they contacted them to provide assistance with their caseload or for holiday relief.

Some nurses, who worked before the introduction of the NHS, remembered the relationship with the local Nursing Association. They recalled the tension that could arise

35 Interview No 28 Harris 1950s-1960s, Chapter 3 p.105
37 Interview No 22 Uist 1950s-1970s, Chapter 6 p.194
38 Interview No 28 Harris 1950s-1960s, Chapter 6 p.194
when their opinion differed from a member of the local Association. One participant described how she left her employment because of a disagreement with the local authority regarding off duty.\textsuperscript{39}

With so few colleagues to support them, the remote nurses indicated that the most important professional relationship they had was with the doctors who they relied on especially in obstetric emergencies.

\textbf{9.5. Unique Nature of the Role: A ‘heroic service’?}

The findings from this study reveal that the role of the district nurses in the area was unique. The challenges they encountered included a nurse transporting a mother with a retained placenta on a stormy night in a fishing boat, and alone for a further two hour road journey.\textsuperscript{40} Another nurse managed a complex foetal mal presentation competently without medical aid, and continued afterwards with her everyday work.\textsuperscript{41} A nurse, ‘although terrified’, opted to travel in an open boat in stormy weather to reach her patient quickly, rather than walk on a rarely used track road.\textsuperscript{42} These nurses revealed themselves as remarkably brave, resilient people of courage and strength of character. Other nurses braved the inclement weather to reach patients regardless of their own safety displaying courage and bravery. The conditions in which they carried out their work were unique and it is likely that not many members of the public would be willing to continue carrying out this kind of ‘work’ after some of the harrowing and distressful experiences described by the participants.

\textsuperscript{39} Interview No 7 Ness 1940s, Chapter 5 p.167
\textsuperscript{40} Interview No 1 Scalpay 1950s, Chapter 8 p.237
\textsuperscript{41} Interview No 9 Harris 1950s, Chapter 8 p.239
\textsuperscript{42} Transcript No 36 Uist 1940s-1950s, Chapter 5 p.162
The definition of heroism is of ‘someone who commits acts of remarkable bravery or shows an admirable quality such as great courage or strength of character’. Examples of nursing heroines are identified as Edith Cavell who was a British nurse in World War 1, Mary Breckinridge the American nurse who pioneered the nursing service in Kentucky and Vivian Bullwinkel an Australian nurse during the Second World War. Mortimer who writes of the courage of the nurses of World War Two maintains that ‘they were the very definition of heroism’.

The concept of heroes varies across different cultures. Seale presents the possibility that there is a ‘heroic script’ that, he suggests, is applicable to some people who are dying. The script for heroic death depicts the dying person struggling sometimes against the inner self to know the truth and when clarified, there is an opportunity to display great courage in the face of death. Similarly Featherstone suggests that the heroic life is generally masculine and is filled with moments when adversary is overcome by acts of courage and self-sacrifice. The idea that a ‘heroic script’ could be applied to the district nurses in this study is credible, when looking at the personal characteristics they displayed when faced with the challenges and demands of their work.

It has been suggested that heroines of the past were women ‘who faced enormous obstacles but squared themselves off against them and responded with integrity and courage’. Some of the participants recalled that, even in difficult situations, they were ‘doing their

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job’ and it is unlikely that they would consider their work as heroic. This study identified some characteristics portrayed by the participants which may mark them out as ‘heroines’. They did not recoil when they were called upon to carry out work which was physically and mentally taxing. They regarded it as ‘their work’ and despite being a lone worker with no peer support, their resilience and strength of character were evident.

A Harris Poll (2001) cited attributes for naming someone as a hero. One of the reasons from three quarters of the respondents was ‘not giving up until the goal is accomplished’. Another measure of heroism was ‘doing what is right regardless of personal consequences’.50 Participants in this study might meet the criteria to be considered heroines. They also managed to stay ‘level headed in a crisis’ which was another characteristic identified by the Poll. Additionally, most participants would ‘not expect personal recognition’, another recognised characteristic, to name someone a ‘hero’.

Hallett suggests that nursing work by its very nature is potentially heroic because effective nurses engage with the physical damage and emotional distress of patients.51 The nurses of the Outer Hebrides described engaging in both. They also showed a care and concern for others and courage in the face of danger.

9.6. The future of district nursing

As part of the World Health Organisation’s policy for health, the Outer Hebrides was one of the areas that piloted the Family Health Nurse (FHN) training in 2000. This new community nurse was seen as multifaceted and her role included helping individuals,

families and communities cope with illness and improve health. The claim that a new model of nursing was required was recognition that something must have changed within district nursing. It was also suggested that the ‘new’ FHN role was reminiscent of the kind of relationships that district nurses in the past claimed to have had with their patients. The role of the FHN was described as that of a ‘skilled generalist nurse’. The nurses in the study could be considered as having been ‘skilled generalists’, along with carrying out the role of midwives, and health visitors, yet it is difficult to perceive how the modern day FHN practice can compare.

One of the roles of the FHN is stated as ‘to enable empowerment of communities by motivating them to take responsibility for their own health’. Evidence from the study reveals that, the community were dependent on the nurse. Yet it is claimed that the modern FHN would reduce the community’s dependency on her. However, communities and their health needs have changed since the time of this study. Communities are now less isolated, have easier access of travel, improved infrastructure and access to health information via the internet. Additionally, nurse education is adapting to meet the health needs of communities by the introduction of specialist nurses. District nurses now work with colleagues such as health visitors and other health professionals who practice their own specialist care. Therefore, health care can be accessed readily.

It could be argued that with the changes in travel and communication, the legislation surrounding nursing practice, including the working hours of the present day nurses, the

proposed ‘alternative community health model’ would bear little resemblance to the nurses’ practice in this study. The evaluation of the FHN indicated that the course had prepared nurses to work in remote and rural health care. Whether nursing care for the communities should be provided by the ‘multifaceted’ FHN, or by a new Community Health Nurse (CHN) with health professional teams for support, will continue to be debated in the 21st century. The nurses of this study and their practice were particular to the time and place and cannot be replicated however present day nurses can learn from their unique circumstances.

9.7. Strengths and Limitations

One of the strengths of the study was its access to key participants. This was due to the willingness of all those participants who were approached to be part of the study. Although the ages of participants ranged from 74-97 years their narratives appear to have been a faithful account of their lives as district nurses. Very few nurses required prompts (from the Interview Guide) to assist with specific dates and times. Archival sources accessed frequently linked and corroborated the information gained from the narratives. Accessing the minutes of the LNSC was invaluable, in connecting the narratives to the archive source.

Another strength, which may also nevertheless be perceived as a limitation, was that some of the participants were known to me. This may have resulted in their speaking less freely about issues that might have seemed sensitive to them. As all participants’ spoke Gaelic and I have a working knowledge of the language, I considered this understanding a

strength in enhancing the interviews. My understanding of the various comments that were recounted in Gaelic during the interviews improved the ‘flow of the interview’. I was aware that my knowledge of some of the participants, and the topic being studied, could also be considered by some historians a limitation of the study which is discussed in Chapter 2. To address this potential problem, throughout the study I reflected on my own experiences, and accepted the participants’ responses, regardless of my own background. I kept brief reflective notes on all interviews and spent time discussing interview transcripts with my supervisors, focussing, in particular on ways in which I might, inadvertently have led, or steered participants.

Another perceived limitation was that all participants originated from the Outer Hebrides and were familiar with the area and culture. Some nurses, who may have worked at the time under study, and were not islanders, had moved away from the islands for various reasons, such as, returning to their own home area on the mainland. A few who remained on the island were not suitable to participate in the study because of ill health. Because all nurses were from the islands, this gave similarity to some of the data, which, although it provided credibility, may also have shaped the responses in particular ways. Several of the participants were reluctant to relate incidents that had occurred during their working lives, because of working in a small community, where, people could still have been identified by relatives. Confidentiality was important to the nurses and even though their experiences had occurred forty years previously, they did not always narrate the ‘whole story’.

Access to local primary sources was a limitation of the study. Archives in the Outer Hebrides, for the last number of years, were being collated and transferred to a central location; hence many of them were not available until the latter part of the study. Archives related to health care in Uist, Barra, Harris and outlying areas of Lewis were transported, to a central location within the library, in the town of Stornoway. It is possible that the
sample is representative of the nurses at the time but also possible that it is biased towards participants who originated in the Outer Hebrides. However it is impossible to be sure as statistics for the time do not seem to exist despite an extensive search.

9.8. Recommendations for future research
The study highlights the need for further research into community nursing particularly into the period after the reorganisation of the health services in 1974. For example the time period of transition from a lone worker to a health team approach may have been slower in the Outer Hebrides than in other geographical areas. How nurses and the communities reacted to the changes in community nursing care after the reorganisation requires investigation to determine whether the health care teams were perceived as more effective than the lone worker.

Another area worthy of study is the Scottish Queen’s Nursing Archives held in Edinburgh. It is clear that the Queen’s training and the input of superintendents were influential in the nurses’ lives. Further analysis of the training and the role of the superintendents may deepen our understanding of the Queen’s Nurse training in relation to other training programmes.

9.9. Conclusions
This study offers insight into the day to day working and social lives of the district nurses in the Outer Hebrides in the mid-20th century, an area not previously studied. There are similarities to other work such as Dougall and Damant (which was expected), such as the district nurses contact with their superintendent 59 and the importance to the nurses of

wearing a uniform on duty. However, as was shown, nursing in remote areas brought different challenges.

The findings from this study highlighted what was important to the participants of the study when they worked as district nurses in the Outer Hebrides. The narratives described the working conditions and the kind of practice that the nurses carried out. It reveals the nurses as women whose life was their work and who were happy and fulfilled carrying out their role. Their Queen’s Nurse training was evidently significant in their working lives and despite the infrequent contact with the superintendent she appeared influential in their lives. Conditions and challenges of work, which nurses in the study tolerated, would not be acceptable today. It could be argued however that because of the nurses’ background, their training and the strength of character they displayed, they were prepared for the challenges that the work and the environment presented.

The nurse in remote islands functioned as an autonomous practitioner. Dougall suggests that a corollary of this autonomy may be isolation. However as the nurses were the first health professionals on call they described many occasions when they worked autonomously. Within midwifery practice the participants described themselves as autonomous practitioners and appeared confident in their role. On occasions they challenged the doctor. Nevertheless the findings reveal that there were instances when nurses accepted what could be described as bad practice by the doctor leading to the conclusion that a culture of medical hierarchy was prevalent at the time.

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There was no evidence that nurses considered that they were ‘boundary crossing’ whether professionally or in other ways. Their scope of practice was wide and they carried out many aspects of care. Most were adamant that they did not carry out non-nursing tasks although one participant reluctantly did on one occasion.

Findings revealed that the community’s expectation was that the nurses were always available to meet the health needs of the local population. The consequence of this ‘self-sacrifice’ was evident resulting, for example, in one nurse being tired (she was afraid she would fall asleep at the wheel of her car) and another subsequently being unable to travel on a ferry. The nurses however mainly commented on the support they received from the community. It would appear that this support outweighed the physical and emotional cost to the nurses who indicated that their work was their life.

Relationships with nurse’s colleagues were limited to the nurse’s reliance on them for relief and when the caseload was excessive. Generally nurses had a good working relationship with doctors but their contact with them varied depending on the area.

Having a husband living with the nurses appeared to be an advantage for some participants, although a few expressed a conflict of priorities when patient life came before family life. This situation may well have been similar to other professionals who serve the community such as the clergy, the vet or the doctor.

What prepared the nurses to make decisions particularly in midwifery was, according to participants, their training. In their role as midwives the women described having no qualm about making independent decisions, but, in carrying out general nursing, they referred to the doctor. The study shows that participants felt so confident and autonomous in their midwifery practice that they would contradict the doctor if they believed it was necessary for the good of the patient.
Queen’s Nurse training was also depicted as influential in the nurses’ decision making and their perceived ability to cope in any situation. The perception one gets from some of the nurses accounts is that they were resourceful and had the ability to make decisions and deal with any type of problem or emergency. One participant maintained that, when she carried out her Queen’s training, she was told that because of it ‘you could go to the desert and manage’. Only one nurse, who was not a Queen’s Nurse, indicated that she did not feel confident making decisions. It is possible that the lack of Queen’s training meant that she did not have the confidence and knowledge that she believed she needed. Most nurses indicated that they were confident and competent to make decisions and implement them. It is likely that their knowledge to make decisions stemmed from various sources but that their training background and experience were particularly significant to them.

Findings regarding the unique nature of the nurses in the study, leads one to conclude that they demonstrated characteristics that could identify them as ‘heroes’. It is unlikely that they would agree with this theory as they insisted that they were only doing their work. However it is suggested that the work could not be carried out by most members of the public (regardless of training) and that they were resilient and courageous women.

The term ‘heroism’ has already been associated with the nurses of the Outer Hebrides. MacLennan, who was a Nursing Officer in the Outer Hebrides before the 1970s, suggested it could be applied to the district nurses of the 1940s. She commented ‘they had to have the courage and the physical strength to face the black moors walks at night, exhausting battles with wind and rain, and journeys by small boats across stormy seas. It was the way help

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63 Interview No 12 Uig, Bernera & Back 1950s-1970s
must come to save the patient, it was given without hesitation.’ 64 This description is reinforced by the many accounts of nurses in this study who demonstrated true heroism by committing acts of bravery on a daily basis and showed both admirable quality and strength of character. It has been a privilege to share the narratives of this study and capture the history of their truly heroic service.

64 MacLennan, C. M., A Century of District Nursing in a Hebridean Isle ‘Date Unknown but before 1973’ Permission of the Kinloch Historical Society.
Bibliography

Unpublished primary sources
The testimony of the following participants was used in this thesis (Most participants wished to remain anonymous) Most participants were interviewed in their own home.

Oral Testimony

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Transcripts received

- No 35 Ness (Used with permission from the Ness Historical Society)
- No 36 Uist (Information received and used with permission from Mr Stroud (uncle of deceased district nurse who worked in Uist) Received 09/08

Historical Society


Interview No 36 with permission of the Ness historical Society, Isle of Lewis

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Appendix 1 Examination Questions for Queen’s Nurses

Questions from Queen’s Nurse examination papers 1948-1958

24 June 1948

What help, apart from your nursing care, might you be able to obtain for a necssessful patient recovering from hemiplegia? From what sources could this help be obtained?

8 June 1950

For what type of disease have you seen the following prescribed: (a) streptomycin (b) morphia? Describe the procedure when giving one of these in the patient’s home.

12 June 1952

What part can the district nurse play in the National Campaign against accidents in the home? Give examples of some of the commoner home accidents and show how these might have been prevented.

You are called in to nurse a patient recently discharged from hospital after two years treatment for poliomyelitis. He has paralysis of both his legs, and is alone in the house from 8 am until 5 pm. Describe the plans you would make for his care...?

9 February 1956

A young miner suffering from paraplegia following a severe spinal injury is brought home after months in hospital. Describe your nursing care, and the social care that he would need to make his life happier and fuller.

10 May 1956

What advice would a district nurse give to a wife whose husband has pulmonary tuberculosis and is being nursed at home pending his admission to hospital? They have two small children at home.

19 May 1957

The doctor has just asked you to visit immediately a man who has just had a cerebral thrombosis. You arrive to find the patient semi-conscious in the kitchen, fully clothed, and his wife and married son very upset. What would you do for this patient? What equipment would be needed and how would you obtain this?

What would you do if called to the following emergencies?
- a: diabetic patient in a coma
- b: a child with a cut hand that is bleeding badly
- c: a man who has tried to commit suicide by putting his head in a gas oven.

Discuss the responsibilities of a district nurse in regard to:
- Dangerous drugs
- Care of nursing equipment
- The house, furniture and car provided by the Local Health Authority for her own use
- Her own health.

January 23 1958 (New Syllabus)

You are nursing a man of fifty years who is recovering from a cerebral thrombosis which has caused some left side paralysis. How can you assist this patient to overcome his disabilities and what other services may you enquire to help him?
Appendix 2 Information Leaflet for Participants

An oral history of community nursing in the Outer Hebrides of Scotland from 1940-1973

The purpose of the study

The purpose of the study is to collect memories of former community nurses who have worked in the Outer Hebrides. I would like to know what challenges you faced in an island community and what were the benefits of working in this geographical area. I would like to find out what your working conditions were what your role as a district nurse involved and the boundaries of your work.

Why have I been invited? You have worked as a district nurse in the community in one of the decades that I am studying.

What would be your part in the study? I would like to invite you to take part in the research study. Before you decide you need to understand what it is about and what your part would be. Please take time to read through the following information carefully. Talk to others about the study if you wish. If you agree to take part I would like you to take part in an interview in which you will be asked about your memories of district nursing.

When and where will the interview take place? The interview will be arranged for a time and place acceptable to you. This would normally be where you live. You can have a relative or friend present during the interview if you would like this. You can withdraw your consent for the interview at any time. There is no time limit for the interview. This will depend on you. You might want to stop the interview for a rest, or ask for the interview to continue on another occasion. It is absolutely fine for you to state your wishes to the interviewer and this will be respected.

The conduct of the study

Do I have to take part? It is up to you to decide. Read this information sheet carefully, and if you have any questions please contact me. I will ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason and your decision will be respected.

What will happen if I agree to take part? You will be invited to be interviewed. This interview will be arranged for a time and place acceptable to you. This would normally be where you live. Following the making of arrangements, you will be contacted 2 days before the interview to check that it is still convenient for the interview to take place.

How long will the interview last? As a guide, it is anticipated the interview will last between 1 to 1.5 hours, however, there is no time limit for the interview. This is in your control.
Will the interview be recorded? I would like to record the interview using a digital audio recorder. The recording, with your consent, will form part of an audio archive which will be deposited in the oral history collection at the Royal College of Nursing’s Archive in Edinburgh. The interview could proceed without being recorded however this would make it more difficult for the interviewer to note what you say.

Who will be the interviewer? The interviewer will be the researcher Catherine Morrison. I have been a community nurse for over 20 years in the islands and senior community nurse for Lewis and Harris as well as a part time academic in the University of Stirling.

Who is overseeing the project? The senior supervisor of the project is Dr Christine Hallett, Reader in Nursing History, School of Nursing, Midwifery and Social Work, University Place, University of Manchester, Oxford Road, Manchester M13 9PL; Tel No: 0161 275 2000; email: Christine.Hallett@manchester.ac.uk

Will the interview be confidential? Any recording of the interview will only be listened to by those directly involved in the study, and anyone else you authorise. Parts of the interview, in written form, may be reproduced anonymously as part of the research thesis. I will ask you to complete a “deposit agreement” on which you can tell us your wishes about the storage and future use of your interview. Unless you wish it, your name will not be associated with any audio or written transcript.

Who will keep the information after the interview and where will it be stored? The interview will be immediately downloaded onto a computer which can only be accessed by the interviewer. Once collected, data will be transferred onto a CD as well as a backup disc made. Notes made during the interview will be created into a Word File. Transcripts will only be printed when necessary and will be stored in a secure place by the interviewer.

Who is organising the study and funding the research? The study has been approved by the University of Manchester and the research is not funded.

Who has reviewed the study? The study has been reviewed and approved by the University of Manchester’s Committee on the Ethics of Research on Human Beings. This is an independent group of people from University of Manchester and exists to protect your safety, rights, wellbeing and dignity.

Further information and contact details
For general and specific information about the project or advice about participation contact Catherine Morrison who can be contacted on 01851703503, 07979032768 or email: Catherine_3jd@hotmail.com.uk
If you are unhappy about any aspect of the project contact the senior supervisor of the
project Dr Christine Hallett, Reader in Nursing History, School of Nursing, Midwifery and
Social Work, University Place, University of Manchester, Oxford Road, Manchester M13
9PL; Tel No :- 0161 275 2000; email: Christine.Hallett@manchester.ac.uk
Appendix 3- Consent Form

Title of project: An oral history of community nursing in the Outer Hebrides of Scotland: 1940-1973

Catherine Morrison has explained to me the nature of the research and what I would be asked to do as a volunteer. She has given me my own copy of the interview information sheets, which I have read.

Having had a period to consider my decision since seeing the information about the study, I consent to take part as a volunteer and I understand that I am free to withdraw at any time without giving any reason and without detriment to myself. I understand that I can be accompanied during the interview by a person of my choosing. I agree that the venue for the interview will be at a place and time acceptable to me. I confirm that I worked as a district nurse during the time under study.

If I have any concerns about the study or the conduct of the interview I know that I can contact Christine Hallett, Reader in Nursing History, School of Nursing and Midwifery, University of Manchester on 0161 27520000 to express my concerns.

Signed.......................... Date..........................

NAME (Print)...........................................................................................................

Address for correspondence..................................

..............................................................................................................................

Telephone number (including STD code) .........................

Witnessed.......................... Date..........................

NAME (Print)..........................................................................................................

Please return one copy of your completed form to:

Catherine Morrison

I confirm that I have fully explained the purpose and nature of the study

Signed.................................................. Date..........................

NAME (Print)..........................................................................................
### Appendix 4- Information about participants

<table>
<thead>
<tr>
<th>Interview</th>
<th>Age</th>
<th>Time Period worked</th>
<th>Area Worked</th>
<th>Qualifications</th>
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<td>1940s</td>
<td>Shawbost</td>
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<td>No.6</td>
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<td>1940-1950s</td>
<td>Breasclete</td>
<td>SRN,SCM,QN</td>
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<td>No.7</td>
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<td>1940s-1950s</td>
<td>Ness</td>
<td>SRN,SCM,QN</td>
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<td>No.8</td>
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<td>Carloway</td>
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<td>Harris</td>
<td>SRN,SCM,QN</td>
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<td>No.11</td>
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<td>1960s-1970s</td>
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<td>MN, SRN,SCN,QN</td>
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<td>No.12</td>
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<td>Harris</td>
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### Abbreviations

<table>
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<th>Description</th>
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<tr>
<td>SRN</td>
<td>State Registered Nurse</td>
</tr>
<tr>
<td>SCM</td>
<td>State Certified Midwife</td>
</tr>
<tr>
<td>QN</td>
<td>Queens Nurse</td>
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<tr>
<td>SCCN</td>
<td>State Certified Children’s Nurse</td>
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<tr>
<td>MN</td>
<td>Mental Health Nurse</td>
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</tbody>
</table>

All participants were born in the Outer Hebrides and spoke or had an understanding of the Gaelic language.
Appendix 5 Deposit Instructions

An oral History of Community Nursing in the Outer Hebrides of Scotland
1940-1973

Clearance Note and Deposit Instructions

The purpose of this “deposit agreement” is to ensure that the storage and future use of your interview is in strict accordance with your wishes.

Under the 1988 copyright Act your written permission is required for any future use to be made of your contribution.

This does not restrict any use you may wish to make of your interview but does allow us to ensure that it is preserved as a permanent public record and resource for use in research, publications, education, and broadcasting.

<table>
<thead>
<tr>
<th>I agree to my interview being used for:</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>research purposes</td>
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<td>educational purposes</td>
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<td>reference in radio or television broadcasts</td>
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<td>reference in publications</td>
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<td>I agree to my name being mentioned</td>
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</table>

Do you wish to apply any time restrictions before your contribution is released

Please state number of years (up to a maximum of 30)

Are you willing to give your copyright to the University of Manchester

Signed …………………………….      Print Name …………………………..

Address .................................................................

..........................................................................Post Code ..............

Telephone No......................................................

Date of Recording. ....../....../2008

Place of Recording .........................

Signature of Project Worker ..........................................................

Date ....../....../2008

Note: After the completion of this project the master copy of your interview will be stored at the Royal College of Nursing Archives, 42 South Oswald Road, Edinburgh, EH9 2HH
Appendix 6 Nurse Interviewing Schedule

Nurse Interviewing Guide

Training

Can you tell me about your training to become a District Nurse?
Where and when did you do your general nurses training?
When and where did you carry out district nurse training?
What age were you when you started training
Had you been on the mainland before you went to carry out your training?
Can you describe to me the journey you took to where you trained?
If you had never been to the mainland before how did you feel the first few days away from home?
Was there anyone you knew with you?
Why did you pick this particular hospital for your training?

District Working Conditions

Can you tell me about the first district area you were employed in the Outer Hebrides?
 Were you interviewed for the post?
 What kind of accommodation did you have?
 What transport did you use?
 What did the area look like – remote, town etc.?
 Who were your colleagues?
 How did the patients contact you?
 How did you liaise with the GP and others?
 How many hours did you work a day? Holidays /? On call
 What kind of Uniform did you wear- ? Suitable for inclement weather
 How did you balance your work and home life?

Professional development

Can you tell me how you kept your practice up to date?
 ? Journals
 ? Courses
 Meeting with colleagues/senior nurse

Role of the district nurse

Can you tell me about your day to day practice and contact with patients?
 What size was your caseload?
 Did you share the caseload with another nurse?
 What were the main reasons for visits? Frequency of visits
 How often did you visit?
 What equipment did you use?
 What was the impact on the nursing care provide on e.g. inadequate heating, lighting, sanitation or animals.

Boundaries of Practice

Did you ever carry out ‘non nursing’ chores?
E.g. lighting a fire, making food, shopping, washing clothes
Was there clear boundaries about what you did and what other professionals did e.g. GP, Physiotherapist, and Health Visitor
Were there tasks that you would not do?
? Expectations of patients

**Prompts**
Before and after NHS
Marriage while in post
Effect of contraceptive pill/Abortion law
Involvement in vaccinations
Management of labour-? Analgesics
Health Visitors

I am sure you have many good and bad memories of your time as a district nurse. Can you now tell me any stories that you remember about incidents that happened while you were a district nurse

**Biographical section** at the end of the interview to avoid closed questions at the beginning
Date and place of birth
Why Nursing?
Any other questions that have not already been answered, or, topics that have been raised that need to be explored.

**Any distress noted in the participant during interview- Yes    No**

If yes, would the participant wish to be contacted by a colleague (who is trained counsellor and district nurse) to discuss any issues, that have been brought to light in the course of the interview.
Appendix 7 Instructions to Probationers

THE ROYAL INFIRMARY,

EDINBURGH, 3rd July 1939.

TRAINING SCHOOL FOR NURSES.

Miss...

DEAR MADAM,

In reply to your letter of enquiry the next date of entry will be on...

Probationers should not be under nineteen or over thirty-one years of age on entry. Candidates must be well educated.

Candidates must be in good health, and without defect of sight or hearing, and not under 5 feet 2 inches in height. In accepting candidates preference is given to those of superior education.

The course is for four years, and includes a three months' probationary period; seven weeks of this time is spent in the Preliminary Training School where the pupil probationers are under the supervision of a Sister who devotes her whole time to teaching them prior to entering the wards. A fee of five guineas is payable before admission to this training.

No agreement is signed until after the full three months' trial.

During the course of their training probationers receive instruction both practical and by means of lectures. They are prepared for the State Examinations and their work is supervised by a Sister Tutor. In the case of candidates who have a certificate of previous training and have passed a State Examination, a concession is made in the length of training.

Probationers receive £20 the first year, £25 the second, £30 the third and £40 the fourth, and are provided with board, lodging and a certain amount of indoor uniform material and laundry.

A personal interview is indispensable. Office hours, 11-1 daily, excepting Saturday. Candidates are requested to come on Tuesday or Thursday morning.

I remain,

Yours truly,

[Signature]

Lady Superintendent of Nurses

Received from and used with permission from participant No. 29
### I. Staff Nurses and Assistant Day Nurses

<table>
<thead>
<tr>
<th>RISE (6:30 a.m.)</th>
<th>BREAKFAST (7 a.m.)</th>
<th>WARDS (7:15 a.m.)</th>
<th>LUNCH (9:10 a.m. or 9:35 a.m.)</th>
<th>DINNER (2 or 2:30 p.m.)</th>
<th>TEA (4:30, 5, or 5:30 p.m.)</th>
<th>RECREATION (2:30 to 6 or from 6 p.m.)</th>
<th>OFF DUTY (8:30 p.m.)</th>
<th>SUPPER (8:35 p.m.)</th>
<th>BED (10 p.m.)</th>
<th>Lights out 10:30</th>
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One Day and One Half-day off Duty each Month. Staff Nurses and Assistant Day Nurses are required occasionally to take times off as in Table III.

### II. Night Nurses

<table>
<thead>
<tr>
<th>RISE (7:30 p.m.)</th>
<th>TEA (8 p.m.)</th>
<th>WARDS (8:30 p.m.)</th>
<th>OFF DUTY (8 a.m.)</th>
<th>DINNER (8:50 a.m.)</th>
<th>RECREATION (8:40 to 11:50 a.m. or 4:30 to 8:30 a.m.)</th>
<th>BED (9 a.m. or 11:30 a.m.)</th>
<th>Every Third Night off Duty each Month</th>
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On Fridays and on alternate Sundays Night Nurses go to bed at 9 a.m. and may rise at 4 p.m.

Nurses wishing to Sleep out of Hospital for nights off, or on the night before a day off duty, receive permission on request.

### III. Probationers

| RISE (6:15 a.m.) | BREAKFAST (6:45 a.m.) | WARDS (7:15 a.m.) | LUNCH (9:10 or 9:35 a.m.) | RECREATION (10 to 1 p.m. or 2:20 to 6 p.m.) | DINNER (9 or 2:30 p.m.) | TEA (4:30, 5, or 5:30 p.m.) | OFF DUTY (8:30 p.m.) | SUPPER (8:35 p.m.) | BED (10 p.m.) | Lights out 10:30 |
|-----------------|----------------------|-------------------|----------------------------|---------------------------------|------------------------|-----------------|-------------------|-----------------|-----------------|-------------|----------------|
|                 |                      |                   |                            |                                 |                        |                 |                   |                 |                 |             |                |

One Day and One Half-day off Duty each Month.

### Sunday Hours

10 to 1:30, or 2 to 10 p.m. alternately. (Every fourth Sunday Nurses do not go on duty until 1:30 p.m.)

All times off Duty are subject to exigencies.

Punctual observance of the above Time-Tables is required, and permission for alteration of any of the hours, or absence from meals, may be had from the Lady Superintendent of Nurses.
DEAR MADAM,

I shall expect you here on the evening of the 22nd June 1940 before 6 p.m. if possible.

I enclose copies of regulations as to uniform, etc., and I am sending you material for two uniform dresses, receipt of which you are kindly requested to acknowledge to me.

The uniform material is supplied before entry on condition that any probationer leaving within the first six months refunds the cost of the material, or else leaves the made-up uniform.

Letters and parcels should be addressed to Nurses' Home, Royal Infirmary, Edinburgh, 3.

Please instruct your taxi-driver to set you down at Archibald Place.

I remain,

Yours truly,

[Signature]

Lady Superintendent of Nurses.

ROYAL INFIRMARY,

EDINBURGH, 3... 33... 1... 1940.

TRAINING SCHOOL FOR NURSES.

DEAR MADAM,

We have decided to accept your application, and shall be pleased to offer you a vacancy in the Preliminary Training School on June 22nd 1940.

Please confirm your acceptance of this vacancy and give the address to which you wish your uniform sent.

Copies of regulations as to uniform, etc., and material for two uniform dresses, will be sent a month prior to entry.

The fee for the Preliminary Training School (£5, 5/-) should be forwarded at least 14 days before entry.*

You are required to be re-vaccinated, if this has not been done within two years.

Should any unforeseen circumstances arise to prevent you from accepting this vacancy, you are requested to notify me immediately.

I remain,

Yours truly,

[Signature]

Lady Superintendent of Nurses.

*Cheques and Money Orders to be made payable to the Treasurer, and sent to the Lady Superintendent of Nurses.
where the hot water supply is limited, when
this may be poured into the nurse’s hand
basin instead). The contents may be cooled by pouring
cold boiled water over them.
The nurse then removes the saucepan con-
tents on to the table handling only the outside
surfaces of the bowls and lifting these in such
a manner that the instruments are untouched
by hand.
The lotions are prepared and the bottles re-
corded. Then the lid is removed from the
dressing tin without contamination of the
contents.
The hands are thoroughly washed and dried on
a clean towel. No wounds or dressings will
be touched by hand.
The dressings are prepared with the use of a
pair of forceps, which should then be placed
lightly inside the dressing tin in case more
dressings are needed.
The dirty dressings are removed from the wound
with the second pair of forceps and placed in
the paper bag prepared for this and the
dirty forceps are put into a jar of Dettol or
other receptacle placed distinctly apart from
the other bowls (so that they will not be used
again by mistake).
The wound is cleaned—the swab is wrung out
by the deft use of two pairs of forceps, one
in each hand. Care is taken not to let a
swab which has mopped the surrounding area
touch the actual wound, or vice versa.
The clean dressings are applied, both pairs of
forceps being used. Then the bandage is put
on.
Note: If ointment has to be spread, the list
or gauze should be laid on a suitable surface,
e.g., marble, or enamel, or a mackintosh
mopped with pure Dettol, or a boiled dinner
plate—and a boiled spatula used. Fomenta-
tions must be balled in a wringer in a sauce-
pan and applied covered with protective
covering, e.g., Jacenet and wool.

The instruments are cleaned, using a swab held
by a pair of forceps. They are then rinsed
over the pail with water from the bottle and
placed in the saucepan to boil (together with
the bottle and cork for boiled water—if used).
The soiled dressings are wrapped up for burning
and taken out, together with the saucepan,
which is put on to boil.
The nurse now cleans away into the special
container—the patient’s washbowl, soap and
towel, lotion bottles and small bowls (after
rinsing and drying them on the bowl cloth).
The dressing tins are replenished and the dress-
ing towels replaced for baking.
The nurse brings in the saucepan, removes the
lid—employing bag technique—she wipes,
dries and replaces the instruments in the
nursing bag.
She packs the table cover (if used) for baking;
empties the hand basin, wipes it and puts it
away—also the saucepan. She sees that the
bucket is emptied down the w.c. or outside
drain.
Finally the nurse writes the report and gives
advice and directions to the patient and/or
relations.

GENERAL NURSING CARE
This term implies the professional care given by
a nurse to a patient in degree according to his
necessity, to meet some of his basic needs and
includes:
Washing and attention to details of toilet.
Bed-making, with special consideration for his
comfort and the prevention of bedsores or
deformity.
Arrangement of the room and accessories for
his convenience.
Advice on nutrition and hygiene generally.
Relief of pain (under the doctor’s direction).
The help of the patient’s friends is enlisted.
Such activity relieves some of their anxiety and
at the same time they learn what to do between the nurse’s visits. Their assistance may also be really needed by the nurse if the patient is very helpless. When requested, relatives usually prepare hot water, collect necessary equipment, and keep it separate for the patient’s use only.

In some instances the patient may be alone and the nurse will then have to heat the water on arrival, and the fire may need mending or the oil or primus stove lighting.

If possible the furniture is so arranged that a table is kept beside the bed at the patient’s right hand for easy working.

Procedure
The nurse’s outdoor clothes are left outside the sick room whenever possible.

The patient is greeted and asked how he feels—and slept.

The bedside table is cleared, and protected with thick folds of paper or a towel, unless the surface is of marble or enameled.

The equipment is arranged as follows:
on the table—patient’s basin; soap-dish; 2 flannels; 2 towels; surgical spirit; talcum powder; tooth brush and paste; mug of mouthwash and receiver (or mouth tray, swab and spatula if necessary); hair brush and comb and shoulder cape; if no bathroom, nurse’s basin, soap and towel.
on the floor (on newspaper)—kettle of hot water; jug of cold water, slop pail. Also newspaper for soiled linen and for soiled dressings, etc.

The nurse washes her hands and if necessary takes the patient’s temperature and records it.
The window and, if necessary, the door are closed.
The top clothing is removed from the bed and placed folded on a chair at the foot, leaving the patient well covered with one or two blankets.
The night attire is removed and placed with the top sheet on a chair or horse near the fire.

The patient is washed and the nurse, using really hot water, works with smooth speed:
Protects all bedding from damp by the careful use of towels;
Pays special attention to axillae, groins, both hips and other pressure points, as necessary;
Attends to finger and toe nails;
Avoids exposure of the patient;
Controls the patient’s position throughout, according to his condition, helpless patients being turned by using the draw sheet as a sling;
Clothes are then replaced: if the patient can sit forward, when he is washed down to the waist, if not, after the washing is finished.
The bed is made:
The under sheet being removed and shaken out;
The draw mackintosh mopped with disinfectant and well dried and powdered.
The patient is made comfortable with the use of blanket and foot rests or bed cradle if necessary.

For incontinent patients measures for protecting pressure areas and the bedding may include the use of urinals or rubber bedpans, and absorbent padding.
The top clothes are left sufficiently loose to allow free movement.

Having well washed her hands, the nurse attends to the patient’s mouth:
Allowing the patient who is able to clean his own teeth with a tooth brush and paste and then rinse with a mouthwash;
Cleansing any dentures in a separate bowl;
Using a mouth tray, spatula, and swabs for really ill patients, and teaching their relatives to repeat this process at frequent intervals between her visits. Peroxide 1-4 with water, with soda bicarbonate 1 drachm to a tumbler, is very cleansing for a mouthwash, followed by soothing lotion—e.g., glycerine and borax and lemon.
Appendix 10 Triplets being transported to hospital in Glasgow from Uist.

Triplets being transported to a mainland hospital the day after their birth in 1950. District nurse and hospital nurse (Nun) assisting.

Triplets who were born at home in Uist 3 years previously being presented to the Queen along with the Queen’s Nurse who delivered them. (Pictures received from Roland Stroud and used with his permission). See Chapter 5.4. p.178.
Appendix 11 Recipes

Recipes from the Queen’s Nurses’ Magazine

1946-1957

Hot Potato Dogs | 1946
6 medium well-scrubbed potatoes
6 sausages (skinned)

Remove a centimetre core, using an apple corer, from the centre of each potato, and stuff the cavity with sausage meat. Bake the potatoes in their jackets in the usual way. Serve hot.

Pricenutts of Tripe | 1946
Tripe is often available, and if the patient likes it, it is very suitable for an invalid.
½ lb dressed tripe
½ oz margarine
½ pint milk and stock
1 dessertspoonful chopped parsley
Small onion
½ oz flour
Seasoning

Wash and cut up tripe. Cover with water and bring to boil. Drain, Cover with stock or fresh water. Add salt and onion, bring to a boil. Cook very gently until tender. Strain.

To make the sauce, melt margarine, add flour, and blend over the heat and gradually add ½ pint liquid. Bring to boil, stirring all the time and cook for three minutes. Season. Reheat tripe in the sauce, and lastly add parsley.

Corned Beef and Raisin Sandwiches | 1946
4 oz corned beef – cooked
2 oz seedless raisins
1 tablespoonful mayonnaise

Bread and margarine

Poach boiling water over raisins, allow to stand for 15 minutes, drain and chop. Mix with corn beef and mayonnaise. Spread between buttered slices of bread, cut into lovely shapes and serve garnished with parsley.

Junktet | 1946
Warm ½ pint milk to blood heat. Pour into a glass dish and stir in 1 teaspoonful of essence of vanilla and teaspooonful of sugar. Get in a warm place. This is a good stand by as it is so quickly made. Children like it sprinkled with grated chocolate.

Apples in Hiding | 1946
Peel and core 3 or 4 apples; cut into quarters. Drop into a Yorkshire pudding batter just before putting into the oven. Serve, very hot, with sugar or golden syrup.

Potato éclairs | 1948
1 ½ oz flour
½ oz margarine
1/8 pint water
1 reconstituted egg
3 tablespoonfuls mashed potato
Seasoning

Melt the margarine in the water and bring to the boil. Remove from the gas, add the flour immediately and beat until the mixture thickens. Beat in the eggs, and if necessary and a little extra water to make the mixture quite soft. Beat in the mashed potato, put the mixture into a forcing bag with a half-inch metal and force onto a greased baking sheet. Bake in a moderately hot oven for about 35 minutes. Sift over and serve with a savoury mixture.

A New Way with Rabbit | 1948
1 dressed rabbit
1 pint water

2 oz fat
½ pint vinegaret
3 oz sugar
2 teaspoonful salt
1 teaspoonful pickling spice
2 tablespoonfuls flour

Cut the rabbit into serving pieces. Mix together vinegar, water, sugar, onion, seasoning and spice and pour over the rabbit. Soak for 36-48 hours. Drain and wipe dry. Heat the cooke, put in the rabbit, fry the rabbit pieces till golden brown, and ½ pint of the pickling liquid. Bring up to pressure, cook for 15 minutes and cool normally (i.e. allow pressure to come down without putting under the tap). Thicken the gravy with flour.

Cheddar Dumplings | 1952
Melt in a frying pan: 2 teaspoonfuls fat. When hot, add to this: 2 teaspoonfuls onion, 1 medium chopped onion, ½ teaspoon salt, shake of pepper. Toss for ten minutes till golden brown and serve hot.

Benito Sweet | 1956
3 egg whites
1 egg yolk
Juice of 1 ½ lemons
Grated rind of 1 lemon
¼ oz gelatine
½ pint water

Dissolve gelatine in water. Add sugar, beaten yolk, juice and rind of lemons. Whip whites of egg until stiff, fold in all the other ingredients whilst still warm. Pour into decorative glass dish and decorate with whipped cream and slices of crystallized orange and lemon when cold.

Ginger Beer | 1956
4 quarts water
1 teaspoonful ground ginger
½ oz yeast
2 lemons
1 lb sugar

Peel the lemon rind very thinly and add to the water with the juice, sugar and ginger mixed together. Bring to the boil, cool and when lukewarm, ferment for 24 hours with the yeast. Take off the skin and remove the lemon rind. This is an easily made drink with a slight kick, and a favourite of the children.

Gooseberry Sherbet | 1956
1 lb gooseberries
1 lemon
1 quart water
4 oz sugar

Cook the gooseberries in the water until very soft. Put grated lemon rind and sugar in a jug and strain the boiling liquid onto it. When cold strain through muslin. A delicious drink for hot days.

Country Chop Suet | 1956
5 rashers streaky bacon
3-4 onions
5-6 stalks of celery
2 oz mushrooms
½ oz coriander
⅛ pint water
Salt, pepper
1 teaspoonful soy sauce
1 small or half a large cabbage (shredded)
8 oz cooked spaghetti

Kromeskies | 1953
6 oz mixed white meal
5 oz thick brown or tomato sauce
Seasoning

DN 150. Queen’s Nursing Institute, Edinburgh
Appendix 12 Nurses Certificate for Sick Room Cookery

Received from and used with permission from the participant No1
### Appendix 13 Inspection Reports

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<th>Roll No.</th>
<th>29235</th>
<th>Exam. Result</th>
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**District Training**

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<th>CIN No.</th>
<th>22717</th>
<th>Exam. Result</th>
<th>49</th>
<th>Grade No.</th>
<th>6332</th>
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</thead>
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<tr>
<td>Dental Training</td>
<td>Royal Infirmary, Glasgow: 15/9/48 - 30/4/52</td>
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**District Training**

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<th>CIN No.</th>
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<th>Grade No.</th>
<th>6332</th>
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<td>Medical Training</td>
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**Report of Superintendent for Scotland:**

"Miss _______ appears to take a long time to settle down to actual nursing duties, the preparations being unduly prolonged. The nursing care of the patients is fairly good, and she is patient and considerate with them. The technique is cumbersome and lacks careful planning. Educationally she is weak. Her manner is quiet and pleasant and she is accepted gladly everywhere," W. McMahon, Inspector, 20/1/54.

"______ is a smart, capable person. Her work was well done and her technique very satisfactory. All patients received good and conscientious attention of which they were most appreciative. She should be a satisfactory Queen's Nurse in any type of area. Miss looks neat and smart in uniform and her books and cards are well kept." M.C. Ormiston, Glasgow D.N.A., 22/1/54.

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**Notes:**

- **Health Visitor Training**
- **District Training**
- **Hospital Training**

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Queens Nursing Institute Archives, Castle Terrace, Edinburgh
Appendix 14 Midwives Rules in Verse (1939)

Appendix 14 Midwives Rules in Verse

1. Every patient must be seen
2. Every midwife must be clean
3. Keep her tools - bag in order
4. Wash her hands - arms in water
5. Instruments are disinfected
6. Report infection when suspected
7. Stay beside her losing patient
8. Swab is care on four occasions
9. Examine only as needed
10. Never leave unless requested
11. Clean the bloody mess away
12. Until the 10th day you must not
13. Leave the normal rules of labour
14. Write the T.P.R. on paper
15. Immediately the head is born
16. Bake the baby in hot warm
17. If no movement - baby makes
18. Reel at once resuscitate
19. If the baby's end you guess
20. Tell the Daed to guard itself
21. Mind how she del the shell

22. Unless you do it in yourself
23. Administration applications notify
24. So rules 18, 19 & 19 don't forget
25. Or you'll be staked
26. Rules 24 you must caution
to labour lying in a home
Midwives Rules in Verse (1939) Typed Version

1. Every patient must be seen
2. Every midwife must be clean
3. Keep her tools and bag in order
4. Wash her hands and arms in water
5. Instruments be disinfected
6. Report infection when suspected
7. Stay beside her losing patient
8. Swab with care on four occasions
9. Examine only as directed
10. Nothing burn unless inspected
11. Clean the bloody mess away
12. Until the 10th day you must stay
13. Learn the normal rules of labour
14. Write the TPR on paper
15. Immediately the head is born
16. Bathe the eyes in lotion warm
17. If no movement baby wakes
18. Then at once resuscitate
19. If the baby’s kind you guess
20. Tell the dad its going west
21. Never leave her on the shelf
22. Unless you do her in yourself
23. Administrations, Application notify in Registrations
24. So Rules 20, 19, 18 don’t forget or you’ll be slated
25. Rule 25 you must conform to Labour lying in at Home
Figure 13: Back page Nurse Ruadh (Gaelic for red) Probably had red hair

Annie Maclean, Nurse Ruadh, was born to 12 Crowlista in 1872 and served as district nurse in Uig before taking up the post in Tarbert, where she worked until her death in 1940, and was much loved. The following is from the Stornoway Gazette:

It was with deep regret that we learned of the death at Tarbert, Harris, of Annie Maclean, known in Uig and Harris as the Nurse Ruadh. Born at Crowlista 68 years ago, the youngest daughter of the late Mr and Mrs Peter Maclean, she entered the nursing profession and in due course qualified to take up duties as a district nurse. About 1906 she was appointed district nurse for West Uig, and at that time, and for many years after, this district comprised all the territory west of a line between Kinlochroad and Ard Bheag. It was indeed a very difficult district, when roads were bad and almost the only means of travel was on foot. To many villages there were no roads at all, a condition which greatly added to the difficulties of promptly attending to those in need. Nevertheless, Nurse Maclean was ready in all weathers and at all hours of the day or night to do her utmost in alleviating every case of sickness or pain to which she was called. [Annie is the overworked nurse mentioned by Dr Ross in his Dewar Commission testimony in 1912.]

She had a most cheerful disposition and this virtue was in very many cases of greater value to the patient than the doctor’s prescription. She was always happy and cracked jokes which drew, temporarily at least, the patient’s thoughts from his or her own suffering.

In 1915 she took up duties at Tarbert, where the geographical difficulties confronting her were even more formidable than at Uig. Here, again, by her unusual characteristics and willingness to help, she greatly endeared herself to the inhabitants of her district. She took great pleasure in her work and despite advancing years remained tireless and active. She worked under Dr Ross for the long period of thirty-three years, which we feel is a record. Her death, attributed to a bad fall received early in September, is mourned by a very wide circle of friends in Uig, Harris and elsewhere, who feel the poor for her passing, and the sympathy of Uig and Harris goes out to her surviving brothers and sister.
The Harris Nursing Committee wrote in sympathy:

6 February 1940

John Maclean
12 Crowlista
Uig, Lewis

Dear Mr Maclean

At a recent Meeting of the Harris Nursing Committee, sympathetic reference was made to the death of the late Nurse Maclean, your sister, who for nearly a quarter of a century served the Committee as District Nurse at Tarbert. It was agreed to record in the Minutes the deep regret of the members, and their great sense of loss in the death of so faithful and efficient a nurse. The Committee being conscious of the unique place Nurse Maclean had in the affection of the people she served, agreed to take steps to have expression given to the people’s appreciation of her services and their personal attachment to her by raising over her grave a memorial to her in the form of a gravestone. I am therefore instructed to ask if you or her other relatives have any objection to this cause. There will be no difficult in meeting the cost of this memorial which will be met by the willing subscriptions from these whom she served as well. In your reply will you kindly inform me who is responsible for winding up her estate in order that the salary due to her at her death may be paid into it.

Let me express to you and all the relatives the deep sympathy of the members including myself in your sore bereavement.

With kind regards
Yours sincerely
John Macleod
Int. Clerk