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Published in:
Nursing History Review

DOI:
[10.1891/1062-8061.26.97](https://doi.org/10.1891/1062-8061.26.97)

Publication date:
2018

Document Version
Author accepted manuscript

[Link to publication in ResearchOnline](#)

Citation for published version (Harvard):

Greenlees, J 2018, 'To care and educate: the continuity within Queen's Nursing in Scotland, c. 1948-2000', *Nursing History Review*, vol. 26, no. 1, 7, pp. 97-110. <https://doi.org/10.1891/1062-8061.26.97>

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To care and educate: the continuity within Queen's nursing in Scotland, c. 1948-2000

Janet Greenlees

Home nursing has been practiced in some form or another for many years, but in Britain it was 1889 when it became formalized through the Queen's Nursing Institute (QNI). Financed by a gift from Queen Victoria, the QNI provided the training and administration of home nurses and the home nursing service for many local, voluntary District Nurse Associations (DNA). Although recruited by the QNI, local communities employed the nurse, providing her with a house, salary and often transport. In return, the nurse was expected to live in the community, nurse the sick and dying, provide maternity services and sometimes collect fees for services. The nurse reported to both the local committee and the QNI, with the latter ensuring the maintenance of high nursing standards. The Scottish Branch of the Institute, the Queen's Nursing Institute Scotland (QNIS), was formed in 1909, with a starting endowment of £400 from the overall income of the Queen's gift to the Institute of about £2000.¹ By the 1920s most areas of Scotland had established DNAs with the majority affiliated with the QNIS. Affiliation with the QNIS was desirable because these nurse recruits were specifically trained for district work rather than general nursing. Not only were they firmly grounded in hygiene practices, they quickly became a visible presence in the community, wearing a navy uniform with military style epaulettes.² This uniform identified their status as healthcare professionals, while their training and manner confirmed it.

After the introduction of the National Health Service (NHS) in 1948, the control of district nursing shifted from independent, voluntary organizations to local government. The state now paid Queens' Nurses' salaries rather than donations and community collections, but the QNIS continued to provide district nurse training until 1970 after a two year transfer to local authority responsibility, followed in the 1980s by the centralization of training under the

auspices of the UK Central Council for Nursing, Midwifery and Health Visiting (UKC). This move contributed to a more generalist ethos of nursing with a lack of specialist training in home nursing.³

In Scotland, Queen's trained nurses remained in practice until 2014 when the last one retired. Nevertheless, despite the centrality of the QNIS to district nursing and nurse training over the course of more than a century, the history of district nursing speaks little about the training and work of the Queens Nurses and how nurses viewed their role. Instead, it emphasizes nurses' efforts at negotiating and securing their place within NHS community care teams, while also fighting for autonomous professional standing, and the importance of technological change and geographical location to nursing practice.⁴ The administration of district nursing and associated legislation has also received attention.⁵ This article combines the institutional and training records of the QNIS with the oral testimony of retired Scottish Queen's Nurses who worked under the NHS between 1950 and 2000⁶ to determine the QNIS training and practice within the context of both the community in which they worked and the administrative demands of the NHS. It documents how throughout the structural and administrative changes to healthcare provision, the core elements of Queen's training and the nurses' perceptions about their practice remit remained consistent. Namely, Queen's district nurses were trained to provide holistic healthcare in the patient's home utilizing the current medical knowledge and implements available, while seeking to educate patients and their families about health and healthcare. Throughout, the Queen's Nurses considered themselves professionals, secure in their remit and confident in their abilities. All of this stemmed from their training. Firstly, this article considers how the Queen's training provided nurses with the self-confidence and skills to undertake nursing under any domestic setting. Secondly, it examines the continuities and changes in Queen's nursing practice under the NHS, focusing on the importance of the community context and the district nurse's relationships with her

patients and GPs. Lastly, this article analyzes the centrality of public health education to the work of the Queens' Nurses, their educational techniques and how the Queen's Nurses' successes in education stemmed from their training and relationships with patients.

QNIS training

A QNIS Board carefully selected candidates for Queen's Nurse training, choosing candidates for both their personal characteristics and experience. Each applicant was required to "possess the qualities of tact, patience, discretion, adaptability, and common sense, with sound health and a real love of humanity."⁷ She had to be a registered hospital nurse and preferably also a midwife with a Central Midwife's Board (CMB) certificate. She could then practice double duty nursing, which was necessary in most rural communities, with the qualification of health visitor training a bonus enabling her to undertake triple duties. The careful selection of both personal and practical qualities was deemed necessary because the nurses went on to serve impoverished and sometimes isolated communities throughout Scotland where they needed the practical knowledge, communication skills, personal adaptability and self-confidence to tackle any situation they encountered. The Queen's method was founded on this principle of adaptability, which remained a constant throughout the duration of their Scottish training centers.⁸

A successful candidate for Scottish Queen's training undertook a six month course in district nursing until the NHS shortened the duration to four months for reasons of cost. The syllabus focused on the responsibilities and requirements of home nursing. In 1966, the nurse's responsibilities were five-fold, including: "Adapting hospital skills to nursing the sick in their own homes; being aware of the nursing and social needs of the patient and family; establishing and maintaining good human relationships; using every opportunity to educate the patient and his family in matters of health;" and "teaching relatives to care for the patient between the nurse's visits."⁹ While the technical details within Queen's training changed

over the years, the syllabus consistently sought to prepare the nurse for all eventualities on the district. It comprised three core sections: “Practical Care,” “Family Care” and the “Comprehensive Care of Prolonged Illness.” Specific lessons covered “Teaching the Family,” “The Effect of Sickness” (on individuals and families) and “Co-operation,” or the “Means of Communication” with GP’s, hospital staff, public health officials and voluntary staff.¹⁰

Alongside classroom training, candidates were required to gain practical experience with a qualified Queen’s Nurse “on the district.” In 1919 this was argued necessary because:

The District Nurse must know how to make use of the utensils she finds there, how to carry out her duties in limited space and with many interruptions, how to give simple instructions regarding cleanliness, ventilation, cooking, etc., in such a way that they will be understood and willingly carried out. Accustomed as she is to the routine and discipline of a hospital to which patients submit generally with little demur, the Nurse soon discovers that a different method is necessary to secure co-operation and goodwill in the home.... These things cannot be taught theoretically only, they must be learned practically, and with the guidance of experienced District Nurses.¹¹

By 1953, some local authorities were questioning the value of specialist district nurse training when the costs of this additional training could be saved by employing general nurses. Yet in a 1955 article in the *Lancet*, the medical profession confirmed that both the GP and the District Nurse needed specialist community practice training in order to ensure practitioner self-confidence, reporting that: “It is one thing to call and give directions about the care of a patient, and another to carry them out in any and every kind of home, whether clean or squalid, well equipped or bare of the simplest amenities.”¹² Such reassurance from the medical profession about the benefits of Queen’s training helped secure not only the continuation of specialist community nurse training, but that such education would still

comprise both classroom and practical experience. This training provided the individual self-confidence for candidates who had little prior experience with extreme poverty and for whom it was a shock.¹³ In 1966, shortly before the QNI handed training over to local authorities, it argued that:

Techniques are not an end in themselves but are used in the service of the patient and therefore must never be rigid or elaborate. They must be founded on sound principles and common sense and the nurse must use her initiative in adapting them to the various circumstances in which she works.¹⁴

The continuity within Queen's training throughout the twentieth century and the associated high expectations of the nurses translated into professionalism.

Queen's training provided individual nurses with confidence within a medical hierarchy where the district nurse was accountable to three bodies: the QNIS who supervised their training and practice, the Medical Officer of Health (MOH) to whom all her records were sent and who produced an annual report on district nursing services (until the 1974 reorganization ended the MOsH role), and the district General Practitioner (GP) who was supposed to request new visits and specify treatments.¹⁵ Despite being poorly paid and at the bottom of this hierarchy, the retired Queen's nurses interviewed in 2013 and 2014 considered themselves professionals. Their Queen's training had taught them "that you were no doctor's handmaiden ... you were a professional in your own right."¹⁶ These nurses had the confidence to call the doctor and request specific medicines for patients, which many GPs provided because they trusted the nurse's judgment.¹⁷ The authority and self-confidence of the Queen's Nurses contrasted with the widespread the image of nurses being a doctors' handmaiden in the 1940s and 1950s. While this subservient stereotype remained at least into the 1960s, it was not understood by the retired Queen's Nurses.¹⁸ They saw their practice

skills and flexible approach to home healthcare, combined with self-confidence in their abilities as equating with professionalism rather than being separated from it.

The self-confidence and pride in having the ability to improvise and cope with any nursing situation was core to interviewees' memories about their training in the "Queen's Method" and remained consistent throughout both pre- and post-NHS Queen's district nursing. The "Queen's Method" was the label for the set of practices and procedures taught to minimize the transmission of germs in the household, but which had inbuilt flexibility. During the Great War Queen's Nurses used sphagnum moss and sawdust pads for dressings. This method remained in the 1943 QNI handbook,¹⁹ and the practice continued after the Second World War, particularly in rural Scotland. Running bars of soap along a bed was standard practice for drawing fleas away before tending patients.²⁰ Sterilization techniques were practical and included everything from utilizing various tins and containers to boil water, to placing rusty scissors in a kidney dish, pouring spirit over them, setting them on fire and then pouring Dettol [disinfectant] over them.²¹ Nurses collected biscuit tins from bakers and asked patients to save tins for nursing use. These tins would be lined with linen tea towels to hold swabs, cotton wool and sheets and baked in the oven for sterile use as dressings and incontinence pads.²² Such sterilization techniques remained in use after sterile packs were available from the NHS from 1967. The ready availability of sterile packs was inconsistent across Scotland and the transition to new treatment methods gradual. Nevertheless, because the nurses remembered the sterile packs being introduced it suggests their unique value in changing district nurse practice,²³ while at the same time, the nurses took pride in being able to maintain professional standards in any setting. Indeed, a nurse who worked on the Isle of Skye, remembered that "We were always told in Queen's that because of our training you could go to the desert and manage."²⁴

Queen's training was not merely learning operational skills. The Queen's Method also recognized the importance of relationship building between practitioner and patient. The Queen's Nurses were taught when visiting patients to always remember that they were a guest in someone's house, or an equal, not a superior. They were to provide healthcare in a non-judgmental manner. The Queen's Method also provided for relationship building during the time taken to sterilize equipment. Both the *1957 Outline of District Nursing Techniques* and the 1966 revised version, argued that while dressings were baking in the oven, "much time can be saved by planning to employ waiting time. Time spent in talking and listening to the patient is not wasted."²⁵ The retired nurses remembered how this time enabled them to get to know an entire family, growing relationships of mutual respect. A Queen's Nurse who worked in Edinburgh during the 1960s and 1970s explained, "People had a respect you know, for the district nurse and they would look after you. They had absolutely nothing, nothing, down in Granton and Leith, but what they had, you could have."²⁶ Similarly, a nurse who worked for thirty-five years in some of the poorest parts of Glasgow's East End from the late 1960s remembered: "Then they did have respect for nurses... they didn't touch our cars... but if other people went out they had cars, wheels stolen and other things... The people were the salt of the earth... you know we had a lovely relationship with them."²⁷ The Nurse could enter the home when the twentieth century health visitor could not, or as one Glasgow woman told her Queen's nurse, "You're a doer, they're a talker."²⁸

Queen's Practice and Professionalism

To Queen's Nurses, nursing practice combined healthcare provision with the practicalities of helping impoverished patients. Not wanting to ask patients to spend money, nurses used drawers and cardboard boxes for cradles. They collected and saved spare bedding and baby clothes in case poor families needed them. Yet, the nurses did not consider this charity work, but rather charitable, practical and helpful, with nurses willing to go beyond their remit of

responsibility in order to help people. Nurses helped people locate specific household items from organizations like the Red Cross, the Women's Royal Voluntary Service, the Salvation Army, the Churches and the Society of St Vincent de Paul. Yet the poor were "never called poor because there was no such thing as poor because we were all in the same boat."²⁹ Helping people was entwined within the remit of holistic care. The nurses' held the attitude that "if you accept people for what they are they'll accept you and you can have mutual respect."³⁰ Mutual respect created a sense of community which was possible because the Queen's Nurse was embedded within the community.

When Queen's Nurses were assigned to a community, they almost always resided in it, making them a visible, recognizable source of help. In urban areas, several Queens Nurses lived together in a house with a nursing supervisor and where supplies were stored. In isolated rural communities, the local authorities provided the nurse with a house. The entire community knew the nurse's house. This meant the nurse could be called on for advice at any time, day or night, without bothering the doctor. An Ayrshire nurse remembered how:

You were just on call for everything and you would just offer everything and they would come over not to bother the doctor...they would just come to you...you were available to go whenever you were needed and you'd probably be out the whole night at a confinement and still had to carry on with your normal duties the next day.³¹

Similarly, an Aberdeenshire nurse recounted how:

You always answered the door ... I can remember 12 o'clock at night... I would be away home for my weekend off and when I came back on a Sunday night, they would see my light up and ... sure enough there would be somebody at my back door or front door... We were just waiting for you to return Nurse.³²

While not a publicized “open door” policy, such accessibility was expected of the Queen’s Nurses because they were part of the community. With their distinctive uniform, they were instantly recognizable. When they were called, “We just went. Morning, noon and night, you know.”³³ This instant availability applied to urban nurses too, where nurses were often on foot or bicycle until the 1970s, making the district nurse both visible and approachable.³⁴ However, patient referrals did not just come from individuals and their families. The community policeman and neighbors also contacted the nurse when concerned about someone’s wellbeing.³⁵ Health and welfare were entwined within the community with the Queen’s Nurse at the core.

The Queen’s Nurse remained a trusted, approachable healthcare professional throughout the many twentieth century changes in transportation and state healthcare provision. These included the rapid development of communication technologies, transportation changes - which saw nurses making greater use of cars rather than being more visible walking, cycling or on buses - and NHS initiatives such as specialist clinics. From the early 1970s, the district nurse became “group attached,” or worked from general practice (GP) surgeries and health centers, rather than a “nurse’s house.” In cities, merely being based in the doctor’s surgery raised the nurse’s profile amongst the other health practitioners based in the surgery, including doctors, midwives, health visitors and social workers. It enabled the development of closer working relationships with these practitioners because healthcare was delivered between the community healthcare team. The retired nurses remembered how these relationships enhanced their healthcare delivery. However, in rural areas a team approach to healthcare provision already existed. District nurses traditionally worked closely with GPs, sometimes dividing home visits between them,³⁶ suggesting greater autonomy amongst rural nurses. This meant the Queen’s Nurses were simultaneously agents of the community in which they worked, agents of the state which employed them, agents for the individual and

agents for the QNIS. Yet as historian Rona Ferguson found in her study of the impact of the NHS on Queen's nursing, the familiarity of the Queen's Nurse as a member of the local community who was both knowledgeable about medical matters, but also approachable and separate from the doctor, represented a key difference between Queen's nursing and NHS nursing.³⁷

The NHS underwent many reforms during the latter half of the twentieth century with advancing health care technology, shifting providers of district nurse education, changing inter-professional work relationships and nurses being based in GP surgeries. In the surgeries, these reforms led to inevitable changes to some functions of Queen's Nurses, which were reflected in the oral histories. Nurses discussed clinics they introduced, their thoughts about working in a General Practice and the benefits and challenges posed by modern pharmaceuticals. Yet the nurses also clearly remembered the continued importance of their relationships with patients, with the psychotherapeutic side of Queen's nursing recognized by other practitioners based at the same GP surgery.³⁸ The surgery practitioners may have even encouraged these relationships to help bridge gaps in health and social care.

The Queen's Nurse and Health Education

Together, the Queen's Nurse's community visibility and availability, her non-judgmental manner and her holistic healthcare enabled her to engage in public health education. The centrality of health education to the Queen's Method remained prominent in the nurse's memories. "...When we were in training it was dinned into us that we were also educators."³⁹ Their responsibilities included "actually teaching the whole family."⁴⁰ The continuity of education being core to the Queen's remit clearly illustrates a growing conflict between the authority of the QNIS and that of the state. The 1956 Jamieson Report had sought to separate the role of the district nurse and health visitor, arguing that the District Nurse should not use

her skills as a “highly trained health educator and social advisor.” While the QNI’s 1970 report on *Nursing in the Community* switched the language of health education to simply advising the patient and family on matters of “diet, rest, fresh air and prevention of accidents,”⁴¹ the oral histories reveal how the Queen’s Nurses remained committed to their broader remit of educating patients in all matters of health and hygiene into the twentieth-first century. In practice, they ignored the state separation of nurse and health visitor responsibility.

The Queen’s Nurse’s health education was practical, informal and constrained by both the poverty they encountered and traditional healthcare advice networks. The rapid growth of medical and pharmaceutical knowledge during the twentieth century meant that not only was the nurse expected to learn the new drugs, dosages and possible side effects, she also had to teach skeptical patients that certain methods were designed for particular illnesses in individual patients and were not for collective or multiple use. In addition, while nurses taught patients basic care for cuts, sterilization techniques and advised on public health matters, the latter had to be approached with care. Throughout the twentieth century family members were a regular source for health advice in Scotland, creating boundaries of authority, particularly through a family matriarch. Elderly female family members held respect and authority in their family and often the local community, with the matriarch passing on her knowledge to younger members.⁴² For example, patients took off the nurse’s dressings, to instead use the Grandmother’s recommended Germolene. This meant that the nurse not only had to convince the patient, but the entire family, that Germolene could “actually burn the area further down... and cause more distress to the skin.”⁴³ Such self-medication was common, but so was combining home remedies with those of the nurse. Nurses found that patients combined herbal and pharmaceutical medicines and shared medicines. Nurses had to work hard “trying to get them to understand that’s for one person it

might not work with you and then trying to use home remedies that someone made up... Old Granny So-and-So said to use this... different things.”⁴⁴ Securing behavior change was a slow, difficult process, requiring patience in order to teach the entire family. Moreover, change could not be demanded, merely suggested.

The core technique behind the Queen’s health education was the nurse inviting her patients to become part of the healthcare team and work together to cure a particular illness. This included suggesting “experimental” treatments, or testing the nurse’s suggestion. Experiments involved trying the Queen’s dressing or using prescription medicine alone, rather than combining it with herbal remedies – just to see what happened. Herbal remedies were popular, inexpensive and regularly recommended by family and friends. Even in the latter years of the twentieth century many patients did not realize that combining herbal remedies with pharmaceutical drugs could cause an adverse reaction. For example, some patients mixed herbal remedies with Warfarin for Atrial Fibrillation. In order to try and stabilize the patient, the nurse suggested using only Warfarin “for a fortnight and see how your bloods do?... and they would start to become stable mostly and they would say ‘Aye, I knew that, Nurse, but Mrs. So-and-So said that she had used it so I thought that I’d use it, you know’...”⁴⁵ Education through experimental demonstration was a slow process. Yet nurses believed that their successes in patient behavior change resulted from the district nurse viewing health as a patient-practitioner partnership.

However, we must also acknowledge that the Queen’s Nurses were not always successful with their efforts at health education. Individual mindsets, the challenges of poverty and addiction prevented some people from engaging with the nurses. Nevertheless, a Glasgow nurse with over thirty years working in some of the most socio-economically deprived areas of Glasgow, where people faced multiple life challenges, reckoned that she had about a 65 percent success rate in securing health behavior change through her informal

methods.⁴⁶ While it is impossible to either confirm the figure or to specifically identify the contributors to her high success rates, she was the community district nurse, recognized by many and visible in the community as a non-judgmental professional. Moreover, along with her Queen's colleagues, she was willing to learn from her patients.

Indeed, health education was reciprocal, with nurses learning many successful treatments from their patients. For example, one nurse remembered learning how Robin's Starch Powder helped heal "excoriated areas," while Boric Acid cured fungal infections and could be purchased from the local hardware store.⁴⁷ Putting a bar of soap in bed prevented cramps and worked better than quinine.⁴⁸ Another nurse remembered a patient applying a cabbage leaf to a varicose ulcer because she had read about it in a book. To the nurse's surprise, it worked!⁴⁹ Throughout all forms of health education, the patient was an active, equal participant in their healthcare, with the education and respect reciprocal.

Conclusion

Hallett, Madsen, Pateman and Bradshaw have argued that both British and Australian community nurses relinquished their focus on providing holistic nursing care between 1960 and 2000.⁵⁰ Yet, both the training and practice of the Scottish Queen's Nurses highlight their continued adherence to a belief in their own autonomy. They were able to address the needs of their patients as they saw fit, even under the various changes under the NHS. The Queen's Nurse sought to retain their emphasis on holistic provision, but adapted their techniques to meet the ever changing medical and technical environment in which they worked. They utilized the new scientific methods and taught their patients the benefits of both technology and medical science. More broadly, they sought to meet individual patient needs as best they could, whether through home visits, social care, charitable works or establishing community clinics for pain management, methadone or antenatal care.⁵¹ While clinics grew in number towards the end of the twentieth century, they also kept care in the community. This

prevented nurses from having to encourage patients to attend hospitals when fear of institutions and travel costs made it difficult.⁵² Clinics also provided the efficiencies and integrated care expected of practice working. In other words, as Julie Fairman and Patricia D'Antonio have argued, technology is a process that needs to be understood in its social context.⁵³ Tools, skills and knowledge were combined to construct a particular product or in the case of the Queen's Nurses, time efficiencies (or scientific management), indicators of professionalism and responsibility. Yet the Queen's Nurses did not view technological change and scientific proficiency as necessarily separate from holistic care. Rather, these were entwined. The new technologies, medicines and medical supplies enhanced nursing care but did not necessarily replace improvisation or cheap alternatives like Boric Acid.

Just like retired Queen's Nurses who worked in the early years of the NHS remembered the ethos of the Queen's Method and how the Queen's Nurses' remit provided the crucial difference between district nursing of the past and that of today,⁵⁴ so too did the Queen's Nurses working in the latter years of the twentieth century hold similar memories. The organizational and structural changes in the NHS did not alter the Queen's Nurse's understanding of their own remit. Instead, they consistently placed the home at the center of their healthcare ethos. Home nursing encouraged positive patient-practitioner relationships. This, in turn, helped secure behavioral change. This does not imply that health behavior change cannot occur in other environments, but rather that the Queen's nurses both understood and demonstrated the home environment and patient practitioner relations to be important to their successes in healthcare delivery and public health education – something to which twenty-first century healthcare is slowly returning.

Acknowledgements: My thanks to Dr. Alexandra Flucker for her assistance collecting the oral histories of Queen's Nurses working in different parts of Scotland. This research was funded by grants from the Queen's Institute of Nursing Scotland (QNIS EHNIQ01) and the Wellcome Trust (102830/Z/13/Z).

¹ Royal College of Nursing Archives (RCN) QNI/F/05 *The Story of the Queen's Nurses in Scotland* (Edinburgh: QNIS, c. 1920), 1-2.

² Rona Ferguson, "Whose Nurse? The Doctor, the District and the NHS," in *The NHS in Scotland: The Legacy of the Past and the Prospect of the Future*, ed. Chris Nottingham (Aldershot: Ashgate, 2000), 22.

³ Rona Dougall, "Perceptions of Change: An Oral History of District Nursing in Scotland, 1940-1999" (PhD diss., Glasgow Caledonian University, 2002), esp. 59.

⁴ Helen Sweet with Rona Dougall, *Community Nursing and Primary Healthcare in Twentieth-Century Britain* (London: Routledge, 2008); Dougall, "Perceptions of Change"; Rona Ferguson, "Recollections of Life 'On the District' in Scotland, 1940-1970," in *Oral History, Health and Welfare*, eds. J. Bornat, R. Perks, P. Thompson and J. Walmsley. (London: Routledge, 1999); Catherine Morrison, "An Oral History of District Nursing in the Outer Hebrides, 1940-1973: A Heroic Service?" (PhD diss., University of Manchester, 2013); and C. E. Hallett, W. Madsen, B. Pateman, J. Bradshaw, "'Time Enough! Or Not Enough Time!': An Oral History Investigation of Some British and Australian Community Nurses' Responses to Demands for 'Efficiency' in Health Care, 1960-2000," *Nursing History Review* 20 (2012): 136-61, doi. 10.1891/1062-8061.20.136.

⁵ C. R. Kratz, "District Nursing," *Nursing, Midwifery and Health Visiting since 1900*, eds. Peta Allen and Moya Jolley (London:Faber and Faber, 1982); Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London: Routledge, 1988).

⁶ During 2013-14 Dr. Alexandra Flucker and I interviewed sixteen retired Scottish Queen's Nurses who had worked in various parts of Scotland. Permission was obtained to publish from all interviewees, although some participants wished to remain anonymous. These interviews have since been deposited in the Royal College of Nursing Archives, Edinburgh. The corresponding archive numbers have been used in this article to aid future researchers.

⁷ RCN/QNI, *Handbook for Queen's Nurses*, 3rd ed. (London: QNI, 1943), 22.

⁸ RCN, QNI/I/2, *General Principles of District Nursing Practice* (Queen's Institute of District Nursing, 1966), 10-11.

⁹ *General Principles of District Nursing Practice*, 5.

¹⁰ RCN QNI/1/8 *District Nurse Training* (Edinburgh: Queen's Institute of District Nursing, Scottish Branch, c. 1960); *District Nursing, 150 Questions from the Queen's Nurse Examination Papers, 1948-58*.

¹¹ RCN QNI/F/32, *The Story of the Queen's Nurses in Scotland* (n. p., c. 1919), 2-3.

¹² "Training the District Nurse," *The Lancet* Sept. 10 (1955): 543, doi. 10.1016/S0140-6736(55)93287-6.

¹³ RCN QNIS, Interviews T/HHI/1 trained and worked in Glasgow mid-1950s and 1970s; T/HHI/11, trained in 1962, worked in Glasgow and East Kilbride, 1960s; T/HHI/12, trained and worked in Glasgow, 1968-2000s; T/HHI/15, trained 1968, worked in Glasgow.

¹⁴ RCN QNI/1/2 *General Principles of District Nursing Practice* (Queen's Institute of District Nursing, 1966), 5.

¹⁵ Ferguson, "Whose Nurse?," 22-23.

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- ¹⁶ RCN QNIS, T/HHI/15.
- ¹⁷ RCN QNIS, Interviews T/HHI/15; T/HHI/11; T/HHI/8, trained c. 1960.
- ¹⁸ Morrison, “Oral History,” 203.
- ¹⁹ RCN QNI *Handbook for Queen’s Nurses*, 3rd ed. (London: QNI, 1943), 42-43.
- ²⁰ RCN Interview T/HHI/15
- ²¹ Catherine Morrison Collection, Interview No. 1, Scalpay, 1950s, 221.
- ²² Incontinence pads from Morrison, “Oral History,” 144-45.
- ²³ Dougall, “Perceptions,” 137.
- ²⁴ Interview No. 12, 1950s-1980s, Back Bernera, Uig. Catherine Morrison collection, also cited in Morrison, “Oral History,” 123.
- ²⁵ *Outline of District Nursing Techniques*, 1957, 37; These guidelines remained core to Queen’s training throughout its duration, being those taught to our interviewees. This technique is also listed in RCN, QNI/I/2, *General Principles of District Nursing Practice* (Queen’s Institute of District Nursing, 1966), 10-11. The *General Principles of District Nursing Practice* is the updated version of the *Outline of District Nursing Techniques*.
- ²⁶ T/HHI/9 trained in Edinburgh, 1968; worked Morningside, Edinburgh.
- ²⁷ T/HHI/12.
- ²⁸ T/HHI/15.
- ²⁹ T/HHI/15.
- ³⁰ RCN T/HHI/12. And similar memories are found in: T/HHI/15; T/HHI/11; T/HHI/6, trained Edinburgh, 1968; worked in Edinburgh.
- ³¹ RCN T/HHI/13, Queen’s Nurse, Ayrshire, early 1960s.
- ³² RCN, T/HHI/4, Queen’s Nurse, Aberdeenshire, mid 1960s.
- ³³ RCN, T/HHI/11.
- ³⁴ Eg. T/HHI/4, Queen’s Nurse, Aberdeenshire, mid-1960s; T/HHI/15; T/HHI/12.

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- ³⁵ RCN, QNIS, T/HHI/12.
- ³⁶ T/HHI/13. Queen's Nurse in Argyll from the late 1960s to early 1970s.
- ³⁷ Ferguson, "Whose Nurse?," 27
- ³⁸ RCN QNI/F/11 Letters from GP's to the QNI Superintendent about District Nurse practice attachments, 1966-67.
- ³⁹ RCN, T/HHI/11.
- ⁴⁰ RCN, T/HHI/1, "Well, you see when you're going into a house, you're actually teaching the whole family."
- ⁴¹ *Nursing in the Community* (London: Queen's Institute of District Nursing, 1970), 6.
- ⁴² RCN, T/HHI/15.
- ⁴³ RCN, T/HHI/12; T/HHI/10, Trained c. 1955 and who nursed in the East End of Glasgow (Carntyne, Barlornock, Easterhouses, Cranhill) in the late 1950s and early 1960s, told similar stories about how "you could get people who were maybe using Germolene or something, you know, which they would've thought that was an ideal remedy for something like a carbuncle or a boil or... something."
- ⁴⁴ RCN, T/HHI/12.
- ⁴⁵ RCN, T/HHI/12.
- ⁴⁶ RCN, T/HHI/12.
- ⁴⁷ RCN, T/HHI/12.
- ⁴⁸ RCN, T/HHI/15.
- ⁴⁹ RCN, T/HHI/8, trained Edinburgh 1961, worked in Musselburgh and on Skye.
- ⁵⁰ Hallett, et. al, "Time Enough!"
- ⁵¹ RCN, T/HHI/12; T/HHI/15; T/HHI/11.
- ⁵² RCN, T/HHI/12; T/HHI/15; T/HHI/11.

⁵³ Julie Fairman and Patricia D'Antonio, "Virtual Power: Gendering the Nurse-Technology Relationship" *Nursing Inquiry*, 6 (1999), 180, doi. 10.1046/j.1440-1800.1999.00032.x.

⁵⁴ Dougall, "Perceptions of Change."