An Oral History of District Nursing in Liverpool: Professional Identity, Community and Home.

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Abstract

This thesis, *An Oral History of District Nursing in Liverpool: Professional Identity, Community and Home,* examines district nursing in Liverpool between 1945 and 2000 through oral history interviews with retired district nurses. It analyses how the interviewees' recollections contribute to understandings of professional identity, community and home. The study is based on seven oral history interviews, conducted in person and remotely, using a semi structured approach that supported extended narrative and reflection on working lives. Interview testimony is placed in dialogue with documentary sources related to district nursing in Britain, including papers of the Queen's Nursing Institute held at the Wellcome Collection and government records at The National Archives. These materials are used to establish historical and institutional context, but they are not used to verify or arbitrate the truth of individual accounts. The analytical emphasis remains on what interviewees chose to narrate, how they narrated it, and what meanings they attached to practice in retrospect.

This thesis develops three connected arguments. First, it demonstrates that professional identity in district nursing was produced through negotiation rather than fixed status. Interviewees described professional identity as grounded in clinical judgement and responsibility, the management of relationships with patients, their families and healthcare professionals and respecting the domestic setting. Second, it argues that community functioned as both a geographical and relational space. Nurses remembered their practice as embedded in neighbourhood routines and local knowledge, while also being reshaped by organisational change and shifting expectations of community-based care across the second half of the twentieth century. Third, it argues that home functioned as a distinctive workplace that shaped the delivery of care and the organisation of nurses' labour. Working in patients' homes required continual negotiation of professional boundaries and personal intimacy, while nurses' own homes and domestic responsibilities were threaded through their recollections of working life. Methodologically, the thesis reflects on the selective and situated nature of memory, the intersubjective dynamics of the interview encounter, and the limits of representativeness within an intimate sample, emphasising depth of testimony and analytic insight.

By centring district nurses' testimonies and reading them alongside documentary sources of policy and professional regulation, the thesis contributes to histories of nursing and post-war healthcare. In doing so, it demonstrates how district nursing was shaped and understood through everyday practice in streets, clinics and homes, and through the gendered organisation of work and care.

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List of Abbreviations

ACTDN	Advisory Committee on the Training of District Nurses
COVID-19	Coronavirus disease 2019
DNA	District Nursing Association
GP	General Practitioner
HIV/AIDS	Human immunodeficiency virus / acquired immunodeficiency syndrome
LHA	Local Health Authority/Authorities
LJMU	Liverpool John Moores University
LMNNASP	London Metropolitan and National Nursing Association for the Sick Poor
LQVDNA	Liverpool Queen Victoria District Nursing Association
LTSHM	Liverpool Training School and Home for Nurses
MOH	Ministry of Health
MS	Teams Microsoft Teams
NHS	National Health Service
POA	Panel of Assessors
QIDN	Queen's Institute of District Nursing
QNI	Queen's Nursing Institute
QVJIN	Queen Victoria Jubilee Institute for Nurses
RCN	Royal College of Nursing
RGN	Registered General Nurse
SEN	State Enrolled Nurse
WRSC	William Rathbone Staff College

Chapter 1: Introduction

1.1 Introduction

I interviewed Mabel Williams in March 2022.[1] Mabel had agreed to take part in an interview with me after seeing a recruitment poster online, which invited retired district nurses who worked and or trained in Liverpool between 1945 to 2000 to take part in a project researching the history of their profession. Upon completion of her district nurse training in 1981, and until she moved into palliative care nursing in 1995, Mabel worked as a district nurse across Liverpool. This role took Mabel across the city, although her work in the areas of Old Swan and Dovecot formed her primary memories. Towards the end of our interview, when I asked Mabel how she felt district nursing, as a profession, changed throughout her career, she replied 'tremendously'.[2] When I asked her to elaborate, she stated:

> Tremendously really, yes. You know sort of from the calibre of the nursing staff to the patients that we were being asked to look after, from the changes in the NHS to the changes in attachments to GPs and changes in the community, yes. The whole thing just somersaulted really.[3]

This conversation with Mabel is an excerpt from a collection of oral history interviews conducted with seven retired district nurses who practiced in Liverpool between 1945 and 2000. Drawing on testimony collected from these interviews, this thesis explores how district nurses articulated their professional experiences and memories of district nursing in Liverpool between 1945 and 2000. Unsurprisingly, interviewees

[1] A pseudonym is used for all interviewees.
[2] Mabel Williams, interview with the author, conducted over Microsoft Teams, 8th March 2022.
[3] Mabel Williams, Interview, 8th March 2022.

expressed their memories of district nursing through a conveyance of a professional identity which was both personal to each interviewee but sits within a collective experience of district nursing in Liverpool. Central to my analysis is how their professional identities were articulated in the interview and remembered. This focus on the district nurse's perspective does not make the patient incidental, however. Where testimony centres the district nurse's professional experience, the patient has shaped that experience. The patient granted or refused entry to the home, set the terms on which care was given and acted as the figure around which professional identity, community and home were organised.

Furthermore, this research critically examines two key spatial domains that shaped district nursing practice, community and home. I argue that district nurses' testimonies reveal that community was not a fixed geographical entity but a complex social construct that was continuously negotiated and reimagined through professional practice. Similarly, home emerged throughout our interviews as a contested workspace where professional and private boundaries blurred, creating unique challenges and opportunities that significantly influenced nurses' professional identities and practices. By analysing these spatial dimensions through nurses' remembered experiences, this thesis contributes to our theoretical understanding of how healthcare professionals navigate and transform their working environments, while simultaneously being shaped by these spaces throughout the late twentieth century.

This research therefore pursues three primary objectives. The first objective is to analyse how district nurses construct their professional identities through oral history narratives, examining the ways in which their remembered experiences

reveal individualised conceptions of nursing practice. The second objective is to examine how district nurses conceptualised and engaged with community as a dynamic social construct, exploring the nuanced ways they navigated and defined the boundaries of their professional sphere. The third objective is to investigate how the home environment functioned as a distinctive workspace that shaped nursing practice and professional identity, considering the complex negotiation of professional and private boundaries that characterised district nursing during this period. By fulfilling these objectives, this thesis will have established an intricate history of district nursing in Liverpool during the period 1945–2000, built around the personal narratives of district nurses themselves.

Interviews were conducted both in-person and remotely over a 6-month period. I adopted a semi-structured approach to the questions for our interviews, understanding prior to embarking on the interview process that I wanted the interviewees to have the necessary space and time to recollect their memories in as relaxed forum as possible. The approach I took sat somewhere in between two approaches to oral history interviewing outlined by Paul Thomson; the first advocates for rigidly structured questions seen in box-ticking questionnaires, with the second allowing for a totally free conversation without direction or structure.[4] For me, the semi-structured approach meant that our conversations could be extensive and somewhat open-ended, but with some structure and direction. We covered biographical information such as place of birth and early education as well as each interviewee's motivation for entering the nursing profession and their

[4] Paul Thompson, *The Voice of the Past* (Oxford: Oxford University Press, 2000), 227.

journey to district nursing. This involved discussing both general and district nurse training as well as wider changes that were occurring in British society throughout the mid-to-late twentieth century. This meant our discussions aligned neatly with the thesis's focus on the nuanced and flexible understanding of community and the home, both of which were concepts undergoing considerable transformation during the period. Furthermore, I wanted to gauge how much the gendered understanding of district nursing as 'women's work' impacted the experiences of district nurses interviewed.[5] These conversations were not as explicit as I first imagined. However, as a category of historical analysis, gender played an important role throughout the interview process and subsequently the thesis.[6] Overall, each interviewee was able to provide a unique and engrossing narrative built around their memories of district nursing in Liverpool, which assisted with the rationale for research of the project.

Throughout this thesis, official records and documentary sources have been included as a way to work in tandem with that of the interview testimony, providing additional layers of information to conversations that were held. By utilising archival sources within the thesis, the historical tapestry of district nursing that has been threaded by way of conversations in the oral history interview can sit within a wider discussion relating to the transformation of district nursing as a profession. As well as information gathered from the oral history interview, this thesis has used archival sources related to the history of district nursing in Britain. This meant consulting documents created on behalf of Government committees, education and training

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[5] See Judith Canham, "Gender issues in district nursing: a review of the literature," *British Journal of Community Nursing* 8.4, (September 1999): 406–11

[6] See Joan Scott, "Gender: A Useful Category of Historical Analysis," *The American Historical Review* 95.5, (December 1986): 1053–75.

documents published by the NHS, or papers of the Queen's Nursing Institute (QNI).[7] The QNI is a registered charity dedicated to improving the quality of nursing care in the home and on the community. However, the organisation and its antecedents played an integral role in the history of district nursing in Britain. The influence of the organisation on the training, education, and development of district nursing in Liverpool and in Britain overall is discussed throughout the thesis.

Drawing together oral history and archival sources aligns with what Joanna Bornat has described as the 'more history' approach, where oral history adds to the historical record by illuminating perspectives and experiences absent from conventional documentary sources.[8] Archival sources therefore provided an integral perspective on district nursing in the mid to late twentieth century, helping place the perspective of the interviewees within a wider British experience. However, documentary sources were not to verify or fact-check the experiences discussed by the district nurses interviewed. Rather, they inform the historical setting of this thesis without driving its analytical focus. The oral history testimonies form the nucleus of the analysis and interpretation presented. A key asset embodied in the practice of oral history is the understanding that the researcher does not act in a way which requires an evidential process to interviewee's testimonies. The memory of the interviewee is paramount to the oral history interview, existing in what Lynn Abrams has referred to as a 'symbiotic relationship with the public memorialisation of the past', meaning we must always be aware that memories expressed in an

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[7] Queen's Nursing Institute Archive, Wellcome Collection, London.
[8] Joanna Bornat, "Reminiscence and oral history: parallel universes or shared endeavour?" *Ageing and Society* 21 (2001): 221.

interview exist within a field of memory work that is going on at many levels in our society.[9] Elsewhere Thompson has highlighted how there is a remarkable amount of personal and ordinary information that official records and documentary sources can provide, however 'it remains a very difficult task, requiring special ingenuity'.[10] The personal and everyday experience can be found in archives through letters and diaries, however at times individual, mundane, or everyday experiences can become lost or difficult to decipher in the official narrative. Archives of the QNI held at the Wellcome Institute and government records relating to district nursing held in the National Archives both provide a broader professional context for district nursing.[11] However, it is the lived experience, as expressed by the seven interviewees, that forms the interpretive core of this thesis.

By taking an approach which combines the oral history interview with archival research, this thesis asks two questions: How was district nursing in Liverpool remembered between 1945 and 2000? And how do these recollections contribute to our understanding of professional identity, community and home? What follows will be a summary of how each chapter answers the research questions driving the project. Each summary will help establish the key theoretical journey of the chapter and the approach to research that has been taken to fulfil the objectives of the project. Later in this introduction will include a section which discusses the key historiographical texts which have informed this research. As an independent theme of historical study, nursing history gained traction in the 1980s, propelled in key

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[9] Lynn Abrams, *Oral History Theory* (Oxon: Routledge, 2010), 79.
[10] Paul Thompson, "The Voice of the Past: Oral History" in *The Oral History Reader,* ed. by Robert Perks and Alastair Thomson (Oxford: Routledge, 2006), 27.
[11] The National Archives (TNA), Kew, London.

texts by Monica Baly, Celia Davies, Christopher Maggs, Robert Dingwall, Anne Marie Rafferty and Charles Webster.[12] Prior to these interventions, the historical study of nursing as a profession and key players within that profession sat more prominently within studies of women's history, that privileged its Victorian foundation, as evidenced in texts by scholars such as Martha Vicinus.[13] This thesis builds upon these approaches to provide a unique history of district nursing in Liverpool in the period 1945–2000. I have especially relied on the approach taken by cultural historians of women and gender, as I felt that this method would offer something vital and interesting to the historical record.

I chose oral history as the primary methodological approach to my research as I was confident in the method's potential and ability to reclaim the voices of district nurses in a manner which places their experience and accounts central to the project's analysis. Bridget Byrne has highlighted how oral history 'has been particularly attractive to researchers who want to explore voices and experiences, which they believe have been ignored, misrepresented or suppressed in the past'.[14] By establishing the historiographical conversations surrounding nursing history in this chapter, it will become more apparent why oral history was adopted as a methodological approach to uncovering district nursing history. Firstly however, it is important to discuss the history of district nursing prior to 1945. This will provide

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[12] See: Monica Baly, *Florence Nightingale and the Nursing Legacy* (London: Croom Helm, 1986); Celia Davies, *Rewriting Nursing History* (London: Croom Helm, 1980); Christopher Maggs, *The Origins of General Nursing* (London: Croom Helm, 1983); Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London: Routledge, 1988).
[13] Martha Vicinus, *Independent Women: Work and Community for Single Women 1850–1920* (Chicago: University of Chicago Press, 1988).
[14] Bridget Byrne, "Qualitative Interviewing," in *Researching Society and Culture*, ed. Clive Seale (London: Sage Publications Ltd), 210.

foundational knowledge of the district nurse role, assisting with understanding of how the role developed into a profession, while also highlighting the predominant focus of the origins of district nursing play within its historiography. Moreover, by discussing the origins of district nursing in nineteenth-century Liverpool, the true development of the profession towards the district nursing known by the interviewees can be truly understood.

1.2 History of the District Nurse Prior to 1945

This research was supported by the LJMU Vice-Chancellor's Bicentenary PhD Scholarship, created to commemorate 200 years of the university's educational history. Although Liverpool John Moores University was formally established in 1992, its origins can be traced back to 1823 with the founding of the Liverpool Mechanics' and Apprentices' Library. The Bicentenary Scholarship scheme was designed to explore the institutional histories and educational innovations that pre-date the university's formal foundation. As such, the topic of this PhD was pre-determined as part of the scholarship award, with a focus on exploring the social, political, and educational history of district nursing in Liverpool. District nursing has deep historical roots in the city, and within LJMU's institutional lineage, making it a fitting subject for this initiative. One of the first steps I undertook was to survey the broader history of district nursing in Liverpool, which began in the mid-nineteenth century when William Rathbone employed Nurse Mary Robinson to care for the sick poor in their homes, an act that laid the foundation for the district nursing profession and ultimately led to the establishment of the QNI. Engaging with this early history was

crucial in establishing an analytical framework for the study. In particular, tracing the organisation and training structures embedded within bodies such as the QNI helped illuminate how the professional identity of district nurses evolved, especially in the lead-up to the formation of the NHS. This contextual grounding provided a necessary backdrop for understanding the shifting dynamics of the role in the second half of the twentieth century.

In terms of the provenance of a district nursing profession, it is vital to understand the organisation and attitude towards healthcare in Britain in the nineteenth century. In this period, healthcare in Britain was shaped by the Poor Law Amendment Act of 1834 and subsequent legislation which reorganised the administration of poor relief and formalised the provision of medical care largely through the workhouse system. These laws created a system of healthcare for those unable to pay for care or who attended voluntary hospitals, such as those who were immobile due to serious health. The 'sick-poor', as they were commonly referred to, would seek treatment through local workhouses and infirmaries.[15] These workhouses were originally intended to house those unable to support themselves through employment but commonly became places to house the elderly, infirm and the sick. The standard of care varied widely throughout these institutions, and it was not uncommon for the more able-bodied members of the workhouses to care for those in need, with or without any training. Although a number of these public or voluntary hospitals had begun to offer nurse training programs, many of these

[15] Gwen Hardy, William Rathbone and the Early History of District Nursing: A Welfare Service 1859–1908 (Ormskirk: G.W&A Hesketh, 1981) 5.

graduates found employment in the private sector as private duty nurses for wealthy families. Wendy Marsden has found a similar pattern in Australia, where 'the wealthy hired private duty nurses while the poor attended to their own the best they could, only being admitted to hospitals as a last resort'.[16] This meant an incredibly varied approach to and understanding of healthcare.

Consequently, William Rathbone, a prominent Liverpool philanthropist, recognised the need to overhaul this approach to healthcare and was particularly interested in the idea of creating an organised home-nursing service. Mid-nineteenth Century Liverpool was a place of both extreme wealth and poverty, with an influx of immigration meaning the population ballooned to almost 400,000 in 1860 from just over 300,000 in 1851.[17] This had a detrimental effect on the quality of healthcare available for the city's inhabitants which was felt most strongly by the poorest who occupied slum dwellings. Rathbone had witnessed first-hand the benefits of nursing in the home after employing Mary Robinson, a trained nurse to look after his dying wife Lucreta in 1859. Hardy has written how Rathbone felt 'deeply grateful for the comfort which a good nurse had been to my wife' and how he thought 'what intense misery must be felt in the houses of the poor for the want of such care'.[18] Rathbone was a major proponent of the idea of a trained nursing service which could be deployed to tend the 'sick poor' in their homes. He therefore set out to create a system of home nursing in Liverpool and planned 18 districts where a 'district nurse'

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[16] Wendy Marsden, "Behind Closed Doors: The Public and Private Nexus of District Nursing, 1885–1956," *Health and History* 14, no. 2 (2012): 74.
[17] Jonathan Brown, Matthew Cocks, Chris Couch, David Shaw, and Olivier Sykes, "A City Profile of Liverpool," *Cities* 35, (December 2013): 300.
[18] Hardy, *William Rathbone and the Early History of District Nursing,* 5.

would be stationed. In these formative years, the district nurses were predominantly tasked with assisting with those affected by sickness and poverty in Liverpool.[19]

Meg Parkes and Sally Sheard have noted that during this period district nurses' work involved providing the sick with basics, such as nourishing food, clothing and bedding, 'as many of the poor had nothing'.[20] Building on Sheard's argument, Helen Sweet has stated that Rathbone's vision for district nursing was based on the provision of charity and often with religious undertones.[21] The focus in this literature paints district nurses as agents of moral and social reform, who would be equipped to mould their patients through health, hygiene and morality. This emphasis on district nursing operating within a moral and social as well as medical environment is further advocated by Rona Ferguson who has described early district nurses as 'mission women'.[22] Ferguson has noted that work completed by district nurses reflected the importance of the philanthropy to Victorian values.[23] She has argued that district nursing at this time adopted a class-based model where the district nurses would accept the role of visitor in the home of their patients, while maintaining the educative role in matters of health and hygiene.[24] The nature of the district nurse's role was therefore directly linked to the idea that the district nurse would be able to treat medical issues as well as social issues, supposedly

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[19] Hardy, *William Rathbone and the Early History of District Nursing,* 5.
[20] Meg Parkes and Sally Sheard, *Nursing in Liverpool Since 1862* (Lancaster: Scotforth Books 2012), 11.
[21] Helen Sweet and Rona Dougall, *Community Nursing and Primary Healthcare in Twentieth Century Britain* (New York: Routledge, 2012), 21.
[22] Rona Ferguson, "Recollections of Life 'On the District' in Scotland, 1940-1970," in *Oral History, Health and Welfare,* ed. by Joanna Bournat, Robert Perks, Paul Thompson and Jan Walmsley (London: Routledge, 1999), 140.
[23] Ferguson, "Recollections of Life 'On the District' in Scotland," 140.
[24] Ferguson, "Recollections of Life 'On the District' in Scotland," 140.

underscored by working-class behaviours. As it was only women who could become district nurses, there was an understanding that she would be able to imbue the poorest of society with the appropriate moral and social values. Vanessa Heggie has reiterated this point by arguing that in many cases women's direction to these professions was justified by a specific appeal to their femininity.[25] In other words, a foundational aspect of the role was the claim that middle-class women's natural tenderness and domestic role made would make them a natural district nurse. Eva Gamarnikow has argued that this identification of nursing with femininity was integral to shaping how a 'good nurse' was defined.[26] In her analysis of nursing writing from this period, Gamarnikow found that the qualities expected in a nurse were dominated by moral attributes such as patience, gentleness, endurance and unselfishness, with comparatively little said about skill, training or technical knowledge.[27] What qualified a district nurse for the role in the eyes of Rathbone and Nightingale then was therefore understood to rest on her character, which was taken to be a matter of femininity.

To further fulfil his aims Rathbone established the Liverpool Training School and Home for Nurses (LTSHM) in 1862. The School would be attached to the Royal Liverpool Infirmary and provide trained nurses for the infirmary and those to work outside of the hospital either in poor districts or for private families. The inclusion of private families echoes Marsden's earlier point about the role of private nurses in

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[25] Vanessa Heggie, "Health Visiting and District Nursing in Victorian Manchester; divergent and convergent vocations," *Women's History Review* 20.3 (2011): 404.
[26] Eva Gamarnikow "Sexual Division of Labour: The Case for Nursing," in *Feminism and Materialism: Women and Modes of Production,* ed. by Annette Kuhn and Annmarie Wolpe (London: Routledge, 1978) 97.
[27] Gamarnikow, "Sexual Division of Labour", 115.

attending the wealthiest families. In an 1862 prospectus, the School set out its three main objectives.[28] The first of these was to provide professional nurses for the Royal Infirmary. Here, the importance of education and training to the district nurse role becomes clear. Secondly, the School set out to provide district nurses who would attend the poor in their own homes in both a medical and social capacity. The class-based connotations to the role are also evident in the third objective, which was to provide trained sick nurses for private families. Distinguishing between district nurses for the poor and sick nurses for private families highlights how district nurses were understood to deal with health and social issues for the poorest in society, separate from trained sick nurses who would focus solely on health issues for the wealthy.

In the same year the LTSHM was established, Rathbone also established the Liverpool Queen Victoria District Nursing Association (LQVDNA). The LQVDNA was to be responsible for the organization and administration of Liverpool's district nurses, who were trained at the LTSHM and who would be supervised by a Lady Superintendent who was not a nurse. Instead, the Lady Superintendent was a voluntary member of a 'committee of ladies' who ran the LQVDNA.[29] Their responsibilities included arranging meetings with clergy and other prominent figures to explain the principles underpinning district nursing and enlist their support. A similar association was set up in Manchester and Salford as the Sick Poor and Private Nursing Institute, coming into being in 1864, followed by the Royal Derby and

[28] Hardy, *William Rathbone and the Early History of District Nursing*, 7.
[29] Sweet and Dougall, *Community Nursing and Primary Healthcare in Twentieth Century Britain*, 20.

Derbyshire Nursing and Sanitary Association and the Leicester District Nursing Association the following year. Others began to establish in Glasgow, York and Birmingham, with the London Metropolitan and National Nursing Association for the Sick Poor (LMNNASP) established in 1874.[30] The LMNNASP was founded according to the Liverpool model and was supported by both Rathbone and Florence Nightingale in line with the essential principle of providing trained nurses to work in the district who would treat their work along educational lines rather than as a craft.

Yet the institutional landscape of community health work in this period extended beyond district nursing with the distinction between district nurses and health visitors established early. Heggie's comparative study of Manchester has shown that both vocations grew out of the same Manchester and Salford Sanitary Association, yet diverged sharply in class, purpose and training.[31] Health visitors were upper working class paid agents focused on educating mothers in domestic hygiene and child rearing whilst district nurses were middle class trained professionals providing clinical care.[32] Despite extensive overlap in the homes they visited, the two organisations never collaborated.[33] Internationally, this separation took different forms. Jamie Lapeyre has shown that the community health workforce took different forms across Europe and North America, with health visitors, public health nurses and social workers emerging as distinct occupations according to

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[30] See also Stuart Wildman, "Local nursing associations in an age of nursing reform, 1860-1900." PhD diss., University of Birmingham, 2012.
[31] Heggie, "Health Visiting and District Nursing in Victorian Manchester; divergent and convergent vocations," 405-407.
[32] Heggie, "Health Visiting and District Nursing in Victorian Manchester; divergent and convergent vocations," 407.
[33] See also Buhler-Wilkerson, *No place like home* (John Hopkins UP, 2003) for a comparable analytic distinction in the US context.

national circumstance.[34] What distinguished the English arrangement was that the health visitor need not have been a nurse at all. In 1919 the Board of Education and the Ministry of Health established a two-year course for those without nursing qualifications alongside a one-year course for trained nurses, on the reasoning that health visiting was social and educational work for which hospital training was not designed.[35] Olive Baggallay, a visiting nurse in Battersea who studied public health nursing in North America in 1924, drew the contrast directly. In America, she observed, the impetus had come from nurses and their own organisations, whereas in England health visiting had developed through the Ministry of Health and legislation, and had been built up apart from the nursing profession as a whole.[36]

For Heggie, district nursing, more than health visiting, was the genuinely professionalised entry of middle-class women into paid medical work in the public sphere.[37] This point emphasizes the move away from the untrained nurses mentioned earlier and progression to nursing becoming viewed as a trained workforce. Throughout the developing landscape of district nursing initiatives however, the appointment of Lady Superintendents was unique to Liverpool. These women typically came from some of the city's wealthiest families and as noted by Hardy, had 'influence as well as affluence'.[38] These locally driven schemes would

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[34] Jaime Lapeyre, "'Some kindred form of medical social work': Defining the boundaries of social work, health visiting and public health nursing in Europe, 1918–25," in *Histories of Nursing Practice*, ed. Gerard M. Fealy, Christine E. Hallett and Susanne Malchau Dietz (Manchester: Manchester University Press, 2015), 144–58.
[35] Lapeyre, "Some kindred form of medical social work," 149–50.
[36] Lapeyre, "Some kindred form of medical social work," 156.
[37] Heggie, "Health Visiting and District Nursing in Victorian Manchester; divergent and convergent vocations," 415.
[38] Hardy, *William Rathbone and the Early History of District Nursing,* 7.

later become nationally linked through the formation of the Queen Victoria's Jubilee Institute for Nurses in 1887, which brought a formal structure and standardisation to the management and organisation of district nursing across Britain. However, with the exception of Liverpool, by the end of the nineteenth century the Lady Superintendent had shifted. In most other areas, they were now employed by their local associations and were themselves trained nurses.[39] Rathbone however had always advocated for a two-tiered model of involved. In 1879, he stated that 'it was most essential' that there were two classes of ladies engaged in district nursing, wealthy women with family ties who could become Lady Superintendents and younger women who would visit the poor in their own homes.[40]

Hardy has illustrated how it was especially important that the Lady Superintendent gained financial support since it was her role to provide for the nurse lodging.[41] Rathbone appealed to prosperous families in large towns to provide 'efficient ladies among their treasures' who would do incalculable good by undertaking the superintendence and supply of medical comforts in a district.[42] The Liverpool scheme embodied one of the key tenets of Rathbone's vision for district nursing, with Lady Superintendent supervising the social and moral reformation the district nurses were supposed to be engaged in. Indeed, Rathbone's son Herbert wrote in 1899 how the Lady Superintendent would prevent the 'work becoming too professional, and in keeping before the matrons and nurses the great social and

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[39] Sweet with Dougall, *Community Nursing and Primary Healthcare in Twentieth Century Britain*, 20.
[40] Hardy, *William Rathbone and the Early History of District Nursing,* 8.
[41] Hardy, *William Rathbone and the Early History of District Nursing,* 7.
[42] William Rathbone, *Organisation of District Nursing in Liverpool* (Liverpool: A. Holden, 1865) np.

moral reformation they are assisting'.[43] Other cities were quick to follow Liverpool's influence.

During this period, prominent nurse reformers were increasingly in agreement with the foundations set out by Rathbone and his vision for district nursing. Nightingale, according to Martha Vicinus, was the 'dominant ideological leader of reformed nursing'.[44] Nightingale promoted the idea that nursing would be an ideal career for educated single women of impeccable moral standards. She emphasized the need for educating and training for district, as well as hospital, nurses. This contrasted slightly with Rathbone's emphasis on district nursing being aligned with the provision of charity and philanthropy. The two nevertheless agreed fundamentally with the need for trained nurses to care for the sick poor in their homes. Interestingly, Sweet has pointed out how during this time there was increasing debate as to whether the district nurses should be recruited from the same class as the patients she was to nurse.[45] This was somewhat resolved, according to Sweet, in 1907 with the establishment of tighter regulation and uniformity of training standards throughout the organising bodies of district nurses.[46] For Nightingale, district nurses needed to be recruited from the class and gendered groups representational of the aspirational nature of the role, writing in 1897 how the success of district nursing 'depends almost entirely on the character of the

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[43] Herbert Rathbone, *A short history and description of District Nursing in Liverpool* (Liverpool: D. Marples & Co. 1899), 5.
[44] Martha Vicinus, *Independent Women: Work and Community for Single Women 1850–1920,* 85.
[45] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 22.
[46] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 22.

woman, for the excellence of the nursing may be the same in two opposite characters'.[47] District nurses were therefore preconceived to be middle-class women.

Through Nightingale's encouragement, the work of district nurses began to develop instruction on how to clean, wash and feed the sick and to ensure proper ventilation of the room. In addition, following Nightingale's intervention there was a push towards improving the skill, competence and status of the district nurses working in the associations throughout the country. Brian Abel-Smith has illustrated how Nightingale felt about the condition of nursing prior to reforms, quoting Nightingale expressing how nursing was generally done by those 'who were too old, too weak, too drunken, too dirty, too stupid or too bad to do anything else'.[48] In response to this concern, Sweet has argued that Nightingale pushed for regulation to improve the public image and professional status of district nurses.[49] Lynn McDonald's collation of Nightingale's writings on public health care underscores the significance of community-based and home nursing to Nightingale's wider vision, providing context for why she would lend her support to Rathbone's district nursing model.[50] Indeed, in a letter to Dr Farr on the importance of district nursing, Nightingale argued 'Till we have such district nursing in London we shall have done nothing, even when we have reformed all the hospitals and all the workhouses'.[51]

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[47] "Printed 'letters to nurses from Florence Nightingale' Jun 1897 and Feb 1898, reprinted for the nurses of the Liverpool QVDNA", 1913, SA/QNI/X.38/6, Queen's Nursing Institute, Wellcome Collection, London.
[48] Brain Abel-Smith, *A History of the Nursing Profession* (London: Heinemann Educational Books, 1960), 5.
[49] Sweet and Dougall, *Community Nursing and Primary Healthcare*, 22.
[50] Lynn McDonald, *Florence Nightingale on Public Health Care: Collected Works of Florence Nightingale, Volume 6*, Wilfried Laurier Press, 2006.
[51] Lynn McDonald, *Florence Nightingale on Public Health Care*, 7.

According to McDonald, Nightingale's work as a 'public health pioneer and reformer' was motivated and 'nourished' by her Christian faith, with hospitals acting as the last resort for those who fall ill.[52]

Nightingale's foundational role has been challenged, however.[53] For Damien Brennan, although Nightingale's achievements were significant, it would appear that her approach developed, refined, and reinforced a system in which nursing labour was directed by doctors, who operated from an emerging scientific medical paradigm, and built on a patriarchal model intent on excluding female-dominated providers of care.[54] Brennan has explained how from the mid-1800s, the medicalisation of health was becoming increasingly formalised across the western world, with the medical profession developing control over caring and health policy. This meant nursing was becoming increasingly embedded with an ethos of caregiving and rotated around duty, order and obedience, and constructed as 'women's work'.[55] Brennan has therefore argued that these perceived virtues remained attached to nursing for more than a century after Nightingale's interventions.[56] Indeed, as this thesis will show, the culture and ethos towards 'women's work' remained pivotal throughout the district nurse post-war history.

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[52] Lynn McDonald, *Florence Nightingale on Public Health Care: Collected Works of Florence Nightingale, Volume 6*, Wilfried Laurier Press, 2006, 6.
[53] For the fullest account, see Mark Bostridge, *Florence Nightingale: The Woman and Her Legend,* (Viking, 2008).
[54] Damien Brennan, "Commentary. The social construction of 'women's work': nursing labor and status," *Journal of Nursing Management* 13 (June 2005): 283.
[55] Brennan, "Commentary. The social construction of 'women's work': nursing labor and status," 282.
[56] Brennan, "Commentary. The social construction of 'women's work': nursing labor and status," 283.

Carol Helmstadter has similarly questioned Nightingale's status as the founder of modern nursing, going as far to propose that 'some of her contributions were damaging to the new profession'.[57] According to Helmstadter, when a 'radical left wing of new women' emerged in the 1890s, who rejected the Victorian view of women as 'purer' and 'subservient', Nightingale was shocked, dismissing them outright as 'unfeminine, hardened and selfish'.[58] For Helmstadter, Nightingale considered 'self-sacrificing devotion' an ideal of Victorian womanhood which should be an indispensable quality for nurses.[59] Helmstadter has argued that this attempt to 'produce religiously dedicated nurses' haunted the profession long after Nightingale's death, providing a justification for the long hours, harsh working conditions and low wages for nurses in the twentieth century. Overall, it is clear that Nightingale's gendered definition of nursing was limiting, certainly in the value that was placed on 'motherliness with religious commitment' above the kind of specialised professional knowledge that other nineteenth century professions such as architecture, accountancy or engineering used to define themselves.[60] However, rather than being necessarily destructive, Nightingale's reforms to the nursing profession should be understood as consolidating and synthesising values and virtues that already existed around women's work, while reshaping the organisation and management of nursing in ways that proved more enduring.[61]

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[57] Carol Helmstadter, "Florence Nightingale reconsidered as the founder of modern nursing," in *British Politics, Society and Empire, 1852-1945*, David Gutzke, 45.
[58] Helmstadter, "Florence Nightingale reconsidered as the founder of modern nursing," 58.
[59] Helmstadter, "Florence Nightingale reconsidered as the founder of modern nursing," 58.
[60] Helmstadter, "Florence Nightingale reconsidered as the founder of modern nursing," 58.
[61] See also Sioban Nelson and Anne Marie Rafferty (eds.), *Notes on Nightingale: The Influence and Legacy of a Nursing Icon* (Ithaca: Cornell University Press, 2011), for a collection reassessing Nightingale's contested legacy.

Turning to the organisational history of district nursing, in 1874, the LMNNASP set up a committee to be chaired by Rathbone to distribute a national questionnaire to the existing DNAs in the United Kingdom. The report was published in 1875 and reinforced the committee's conviction that there should be a regulated national institution responsible for training district nurses. A decade later, with the assistance of Queen Victoria's Jubilee Fund, the Queen Victoria Jubilee Institute for Nurses, (QVJIN) which was to ultimately become The Queen's Nursing Institute (QNI), was established. The QVJIN, and LQVDNA before it, are both direct antecedents to the QNI, operating at first as local and then national bodies responsible for the training and organisation of district nurses. Those who undertook training administrated on behalf of QVJIN-associated district nursing associations would be able to hold the title of Queen's Nurses. There were still district nursing associations throughout the country therefore not attached to the QVJIN, although the influence of the organisation cannot be understated. The QVJIN was granted a royal charter in 1889 and in 1890, Rosalind Paget (William Rathbone's niece), was appointed as the first Inspector General. Rathbone himself was awarded a prominent ambassadorial role, while Nightingale exerted considerable influence in an advisory capacity. According to Sweet, by the end of the nineteenth century there were 900 trained Queen's Nurses on the Institute's roll, with similar associations being set up across the British Empire in places such as Canada in 1897 and Australia in 1910.[62]

[62] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 25.

The international spread of district nursing-related associations sat within a wider movement of nursing internationalism. This took institutional form in 1899, when nurse leaders meeting in London proposed an International Council of Nurses, with its constitution adopted the following year.[63] Ethel Gordon Fenwick, who led the proposal, argued that nursing was international in character, and that nurses of all nations could therefore be asked and expected to join.[64] The organisation that followed drew on the model of the International Council of Women, from whose congress it had emerged, and was built upward from local associations through national nursing councils to the international body. What the Council offered was a structure through which claims to professional standing could be made collectively rather than nation by nation. Anne Marie Rafferty has drawn attention to the international dimension of this professional development, arguing that the reform of nurse education often occurred 'by analogy', with nurse leaders borrowing ideas and strategies from sources of authority they admired, including through intellectual and social exchange between nurse leaders across the international nursing world.[65]

Monica Baly's institutional history of the Queen's Nursing Institute frames the institute's development through the tension between its charitable origins and the emerging public-service framework. Baly has argued that the institute was 'wedded to the voluntary principle,' but as calls for state intervention grew in the twentieth century, it sought to 'preserve its voluntary and independent status, but to be

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[63] Barbara L. Brush and Joan E. Lynaugh, *Nurses of All Nations: A History of the International Council of Nurses, 1899–1999* (Philadelphia: Lippincott, 1999), 16–19.
[64] Brush and Lynaugh, *Nurses of All Nations*, 17.
[65] Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996), 7.

subsidised by the State for the services it provided'.[66] At the Liverpool Congress of 1909, the Institute's Honorary Secretary D.F. Pennant highlighted the scale of this dependency on charitable funding, noting that of the £108,000 spent on Queen's nurses in England and Wales, the Boards of Guardians contributed only 3.5%.[67]

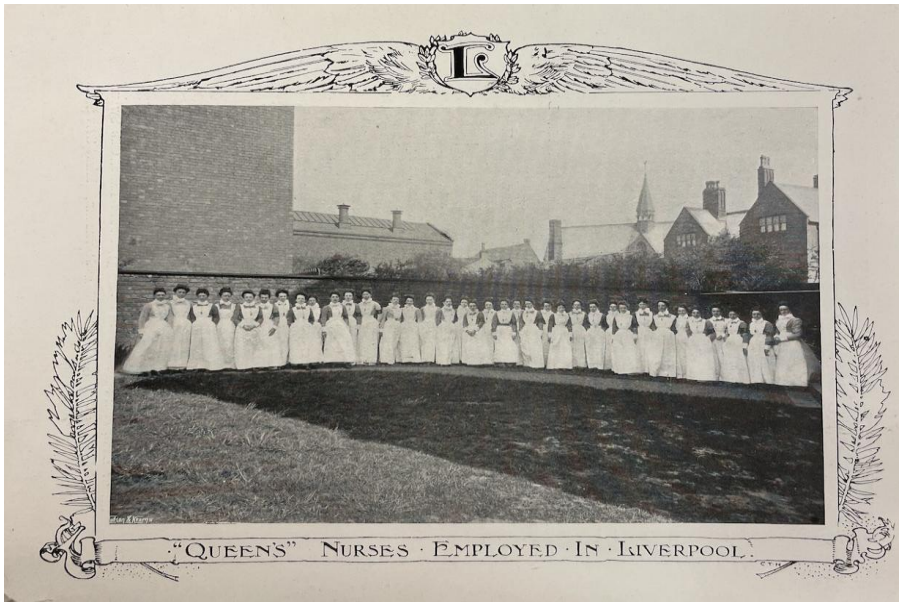

Figure 1: Queens' Nurses Deployed in Liverpool

Wellcome Collection, SA/QNI/X-38/1, 'Picture book 'Queen's Nurses', 1900

The vision propagated by Rathbone and Nurse Robinson was clearly successful, and meant that throughout Britain, and indeed the British Empire, district nursing was becoming increasingly ingrained within medical profession. In a booklet produced on behalf of the LQVDNA in 1900, it was noted that a 'Queen's Nurse is one who is engaged in nursing the sick poor in their own homes' with the title of

[66] Monica Baly, *A History of the Queen's Nursing Institute* (London: Routledge, 2024), 74.
[67] Baly, *A History of the Queen's Nursing Institute,* 74.

Queen's Nurse acting as a 'guarantee of thorough efficiency and good character'.[68] Figure 1 shows the Queen's Nurses of the LQVDNA in 1900 at the Central Home of the association at 1, Prince's Road Liverpool. The uniform shown in the image is typically Victorian, with its high collar and long sleeves, indicating the prestige and position afforded to the district nurse. Uniforms for district nurses across the country were not standardised. However, the QVJIN suggested that those associations affiliated with them should wear a style of dress with badges and armbands provided and to be worn by all Queen's Nurses.

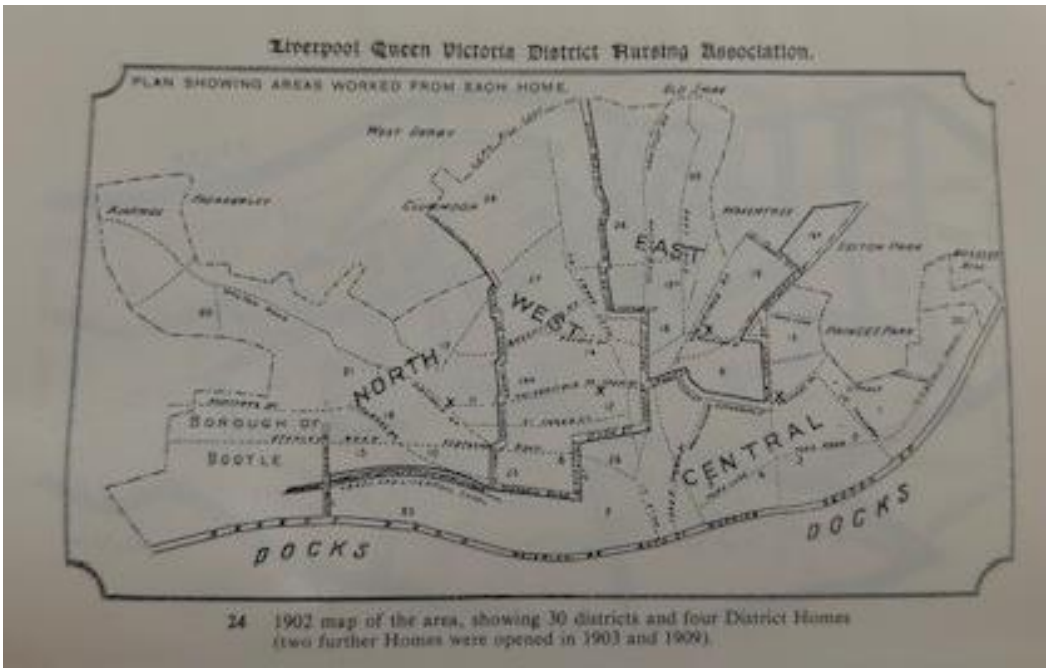

Figure 2: 1902 map of Liverpool Districts
Hardy, William Rathbone and the Early History of District Nursing, 20.

At the time of the booklet's publication there were 46 Queen's Nurses working in Late-Victorian Liverpool, residing in five homes across the city, each of which were 'presided over by matrons who are fully-trained nurses to whom are entrusted the

[68] "Picture book 'Queen's Nurses", 1900, SA/QNI/X.38/1, Queen's Nursing Institute, Wellcome Collection, London.

arrangements for the nursing of different areas of the City.'[69] Importantly, the whole of the city, as shown in Figure 2, was within the reach of an Queen's Nurse with 'not a street, alley, court or cellar where their services may not be obtained'.[70]

It was not just Liverpool where district nursing was growing in both number and influence. When it came to the start of the First World War in 1914, there were 2,100 Queen's Nurses nationally, with the number falling to 1989 by 1918.[71] Following the First World War, Sweet has noted how there was an acceleration with regards to governmental intervention in health and welfare provision which coincided with an increased awareness of the importance of professional status, in particular for the need for unity and status among trained nurses.[72] The College of Nursing, established in 1916, campaigned for pioneering professional status for nurses, resulting in the 1919 Nurses Act, which created a professional register for nurses for the first time. The register helped impose regulation of the nursing profession, meaning there was increasing importance placed on training and education. As discussed above, this was ingrained in district nursing since its inception, with the QVJIN setting well-established training standards throughout affiliated associations. In 1928 The QVJIN changed its name to the Queen's Institute of District Nursing (QIDN), which it was known as until 1973 when it became The Queen's Nursing Institute. Throughout the interwar period, in district nursing there

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[69] "Picture book 'Queen's Nurses", 1900, SA/QNI/X.38/1, Queen's Nursing Institute, Wellcome Collection, London.
[70] "Picture book 'Queen's Nurses", 1900, SA/QNI/X.38/1, Queen's Nursing Institute, Wellcome Collection, London.
[71] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 25.
[72] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 35. See also; Susan McGann, *The Battle of the Nurses* (London: Scutari Press, 1992), 48.

was a move away from the untrained, voluntary, Lady Superintendent-style management of DNA to a trained supervisor of nurses.

Consequently, this marked a move from a philanthropic ethos within district nursing to something more akin to professional status, no doubt spurred on by initiatives such as the General Nursing Register. Despite this shift toward professionalisation, significant class distinctions persisted within the nursing hierarchy. The transition from Lady Superintendents to trained supervisors did not necessarily democratise district nursing leadership, as these supervisory positions were still predominantly filled by women from middle and upper-middle-class backgrounds. The Queen's Nurses, with their distinctive training and higher status, often came from more privileged backgrounds than village nurses and other district nursing staff they supervised. Thus, while the interwar period saw important steps toward professional recognition, the underlying class structures that had characterised philanthropic nursing were often reproduced within the new professional framework. At the eve of the Second World War, there were just over 7,000 nurses on the Queen's Roll.

As indicated above, district nursing was an increasingly integral component of healthcare in Britain from its creation in 1859 up until the passing of the NHS Act in 1948. Its journey was certainly impacted by attitudes towards women's place in the home and healthcare from the nineteenth century, meaning that it sat within the realm of 'women's work' throughout its history. In later sections of this thesis, the professional organisation of district nursing and the implications of these values and virtues are covered in more detail, especially in Chapter 3. Now it is necessary to talk about the way historians have discussed this history of district nursing, highlighting

the prominence this stage of the profession's development holds within the literature. By acknowledging the nineteenth century eminence within the historiography, it will become clearer why the research in this thesis is necessary, largely due to the need to provide a twentieth-century history of the role and understand its journey and development into the profession we know of today.

1.3 District Nursing Historiography

Having introduced the historical roots of district nursing leading up to the period of study covered in this thesis, this section will now consider the historical scholarship surrounding district nursing. As well as providing the necessary context to this thesis this will help position my research as necessary due to the relative scarcity of the district nurse in histories of women, gender, or nursing more widely. This point is effectively mentioned by Carrie Howse, who has written how 'district nursing, if mentioned at all, is seen only as a footnote to the broader context of social history and philanthropy'.[73]

The first phase of district nursing historiography saw important work completed on the origins of district nursing, focusing primarily on the origin story of Rathbone enlisting Nurse Robinson to go out into the poorest areas of Liverpool to spread the message of district nursing. Moreover, there was a focus on highlighting the establishment of bodies such as the LQVDNA and its link with the QIDN. Not surprisingly then this work was commissioned by the QIDN and was spearheaded by

[73] Carrie Howse, "The Ultimate Destination of All Nursing': The Development of District Nursing in England, 1880–1925," *Nursing History Review* 15.1 (2007): 65.

Mary Stocks, with her work celebrating 100 years of district nursing in 1960.[74] Her work adopts a chronological overview of the role with an emphasis on figures such as Rathbone and Nightingale.[75] In her work, Stocks goes some way to document the expansion of district nursing as a response to social change throughout the twentieth century. Despite this, the main focus of her work was an examination into the complex nature of district nursing administration and the high standard of training required for the role. Published twenty-one years after Stocks, Gwen Hardy's work focused directly on Rathbone and the early years of district nursing was also commissioned by the QNI, as well as the Rathbone family. Like Stocks, Hardy presents a chronologically presented narrative of the profession.[76]

This scholarship provides a compelling overview of the provenance of district nursing on behalf of prominent reformers and nurse leaders but overlooks the everyday district nursing experience through the eyes of district nurses themselves. Consequently, the prevalence of leading figures in nursing in the literature presents an entirely top-down approach. This approach ignored the thousands of women (and later men) who were district nurses and whose experiences in the role shaped the profession's trajectory. Sue Hawkins has strongly advocated from an approach focused on 'nursing from below'. Hawkins here is emphasizing the importance for nursing historiography to be written from the point of view from the nurses working on the district and in hospitals rather than pioneering nurse leaders.[77] This approach

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[74] Mary Stocks, *A Hundred Years of District Nursing*, (London: George Alwin & Unwin, 1960).
[75] Mary Stocks, *A Hundred Years of District Nursing*, (London: George Alwin & Unwin, 1960).
[76] Hardy, *William Rathbone and the Early History of District Nursing.*
[77] Sue Hawkins, "From Maid to Matron: Nursing as a route to social advancement in nineteenth-century England" *Women's History Review* 19.1 (2010): 126–7.

was encouraged by the shift in nursing historiography that occurred from the 1970s onwards.

Subsequently, secondary literature during this period increasingly looked to the history of healthcare to examine diverse aspects of society such as disease, science, and government policy as well as social issues such as class, gender, and culture.[78] From the outset, this period represented a shift in focus for nursing history which was heavily influenced by the wider social history movement which saw an opportunity to develop the ideas of 'history from below'.[79] Sweet has noted that in terms of historical study, this meant a focus more on studies of patients and popular health care.[80] Feminist historians were also beginning to look at previously marginalized sectors of female healthcare such as midwifery and nursing.[81] This wider turn extended beyond nursing history into the broader social and political history of women in medicine. Rima Apple's edited collection *Women, Health and Medicine in America* exemplified a parallel development in US scholarship, situating the history of women's healthcare within the context of the women's health movement and broader women's movement of the 1970s.[82] For Apple, this scholarship sought to 'delineate the complex and dynamic relationships between

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[78] Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London: Rutledge, 1988); Celia Davies, *Rewriting Nursing History* (London: Croom Helm, 1980).
[79] On the emergence of 'history from below' as a historical practice, see E. P. Thompson, *The Making of the English Working Class* (London: Victor Gollancz, 1963); and Raphael Samuel, 'People's History,' *History Workshop Journal* 7.1 (1979): 153–161.
[80] Sweet, "Establishing Connections, Restoring Relationships: Exploring the Historiography of Nursing in Britain", *Gender & History* 19.3 (October 2007): 566.
[81] See: Annette Kuhn and Annmarie Wolpe, *Feminism and Materialism: Women and Modes of Production* (London: Routledge and Kegan Paul, 1978); Jean Donnison, *Midwives and Medical Men: History of Interprofessional Rivalries and Women's Rights* (London: Heinemann Educational, 1977).
[82] Rima D. Apple, ed., *Women, Health, and Medicine in America: A Historical Handbook* (New Brunswick, NJ: Rutgers University Press, 1990).

women (as patients and practitioners) and medicine (both practice and theory)', moving women from the 'periphery to the centre' of medical history.[83] Florence Melchior explains how the paradigmatic shift in women's and nursing history coincided with second wave feminism and women's studies movement that started looking at female labour and employment.[84] The culmination of this growing scholarly attention was exemplified in the 1980s, which Sioban Nelson described as an 'astonishing decade of revision and critique of the traditional nursing narrative'.[85] It was in this decade that care itself became an object of historical analysis rather than an assumed nursing virtue. Writing on American nursing, Susan Reverby has recast caring as historically produced and politically undervalued, a form of women's work obliged rather than chosen. [86] Within this scholarship, Celia Davies drew attention to the assumption that caring qualities were innate to women, noting that a woman doing nursing passed unremarked while a man in the same role was described not simply as a nurse but as a 'male nurse'.[87] Work in the 1980s was arguably inspired by Brian Abel-Smith's 1960 book *History of the Nursing Profession*, which provides a thorough and detailed historical examination of nursing in Britain.[88]

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[83] Apple, *Women, Health, and Medicine in America*, 15.
[84] Florence Melchior, "Feminist Approaches to Nursing History," *Western Journal of Nursing Research* 26, no.3 (2004): 343. See also; Christine Delphy, *Close to home: A materialist analysis of women's oppression,* transl. & ed. by D. Leonard (Amherst: University of Massachusetts Press 1970).
[85] Sioban Nelson, "The Fork in the Road: Nursing History Versus the History of Nursing?" *Nursing History Review* 10, (2002): 177.
[86] Susan Reverby, "A Caring Dilemma: Womanhood and Nursing in Historical Perspective," *Nursing Research* 36, no. 1 (1987): 5; See also Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (Cambridge: Cambridge University Press, 1987).
[87] Celia Davies, *Gender and the Professional Predicament in Nursing* (Buckingham: Open University Press, 1995), 2.
[88] Brian Abel-Smith, *History of the Nursing Profession,* 1960.

Although published during the same year as Stocks, Abel-Smith's focus was on the social and political history of nursing, rather than a chronological overview.

Building on the above interventions in the field, Nelson noted that the burgeoning nursing historiography was beginning to become informed by nurses who looked to academic historians in an attempt to inform their recovery of nursing history.[89] From the 1980s, prominent nurse historians such as Christopher Maggs, Celia Davies, and Monica Baly created historical works on nursing that reached outside of their profession.[90] Sweet has promoted similar ideas of nurses reaching outside of their profession in order to engage in a stimulating debate and discussion with historians beyond nursing and keep abreast of historiographical shifts.[91] However, the niche position that the district nurse played within the wider nursing historiography was certainly noticed when Christopher Maggs acknowledged in 1987 that he was 'still waiting for a scholarly account of district and home nursing in Great Britain'.[92] Even though Maggs did note that there were multiple authors looking at what he termed the 'Nightingale phenomenon' in that period, a history of district nursing from the perspective of non-elite district nurses is still very much needed and a foundational aim of this thesis. [93] This thesis therefore offers a valuable intervention to the field nearly four decades after Maggs' made his observation, and which includes discussion on Florence Nightingale, but who is by no means the primary focus.

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[89] Sioban Nelson, "The Fork in the Road, 177.
[90] See: Monica Baly, *Florence Nightingale and the Nursing Legacy* (London: Croom Helm, 1986); Celia Davies, *Rewriting Nursing History* (London: Croom Helm, 1980); Christopher Maggs, *The Origins of General Nursing* (London: Croom Helm, 1983).
[91] Sweet, "Establishing Connections," 571.
[92] Christopher Maggs, *Nursing History: The State of the Art* (Kent: Aspen Publications, 1987), 6.
[93] Christopher Maggs, *Nursing History: The State of the Art,* 6.

The focus on Florence Nightingale by historians of nursing ties into what June Purvis aptly describes as a reliance on focussing on 'women worthies'.[94] Purvis states that Nightingale has been presented as the self-sacrificing 'Lady with the Lamp' who was able to overcome the barriers of her 'ladylike' statute to nurse men who were her social inferiors.[95] However, Francis Barry Smith goes further to suggest that Lady with the Lamp allegory is a significant barrier to the serious academic study of the history of nursing.[96] Linked with Purvis' concept of history focusing entirely on 'women worthies' without studying the everyday nurse and district nurse, saint-like portrayals of Nightingale fail to stimulate appropriate analysis and debate and are instead tied to a hagiographical telling of nursing. Indeed, Sweet has argued that this barrier is largely due to the imagery associated with nursing history emerging from the mid-to-late nineteenth century.[97] This imagery is centred around an almost saintly and virtuous portrayal of nurses, whose natural femininity was essential to cure the physically, as well as the socially, disadvantaged. This historiography presents the nursing profession as originating directly from Nightingale and leaders of the nurse reform movement, which fails to highlight the voices of the nurses themselves.[98] This has important implications for understanding who the district nurse is and what their experience might have been. This is further compounded by the inclusion of men in the profession in 1947. This is why this research advocates

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[94] June Purvis, *Women's History: Britain, 1850–1945: An Introduction* (London: Routledge 1997), 3
[95] Purvis, *Women's History: Britain,* 3.
[96] Francis Barry Smith, *Florence Nightingale, Reputation and Power* (London: Croom Helm, 1982).
[97] Sweet, "Establishing Connections," 570.
[98] See Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996), 1–20; Susan McGann, Anne Marie Rafferty, and Alistair Dingwall, eds., *Nursing History and the Politics of Welfare* (London: Routledge, 2009).

for an updated historical record which can cover the twentieth-century history of the role.

Nevertheless, there has been a limited, but significant, amount of secondary literature which attempts to examine the twentieth century trajectory of the district nurse's role. Julie Bliss has used the period 1948 to 1974 to explore the impact of policy changes by the NHS with reference to team working and collaboration.[99] This article provides a useful analysis of how policy changes have shaped the role. More recently, Catherine Morrison's oral history of district nursing in the Outer Hebrides between 1940 and 1973 has provided one of the few sustained studies of twentieth-century district nurses in their own words.[100] Morrison's case is shaped by the geographical remoteness and distinctive cultural and religious context of the Outer Hebrides at the time of study, conditions which she argued had not yet been investigated in relation to the history of district nursing.[101] This thesis contributes a sustained urban case focusing on Liverpool, as the founding site of organised district nursing, across the period 1945 to 2000. It examines how the profession's character was lived and reshaped in its original institutional home throughout the second half of the twentieth century. Taken together, the two studies extend the historiography beyond its nineteenth-century origin story.

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[99] Julie Bliss, "Teamwork and Collaboration: The Position of District Nursing 1948–1974," *International History of Nursing Journal* 6.1, (2001): 22–9.
[100] Catherine Morrison, "An Oral History of District Nursing in the Outer Hebrides. A Heroic Service? 1940-1974" (PhD diss., University of Manchester, 2014).
[101] Catherine Morrison, "An Oral History of District Nursing in the Outer Hebrides. A Heroic Service? 1940-1974" (PhD diss., University of Manchester, 2014), 17.

Even during periods where nursing history was full of stimulating debate, there is still a weighted favour with regards to the origin story rather than a discussion of its changing position in the twentieth century. One reason for this, as Sweet has pointed out, is that there has been a perception among the public that district nursing did not constitute proper nursing.[102] Drawing on the experience of district nurses from Lancashire, Sweet demonstrates how the authority and role of district nurse was questioned by community members. This Lancastrian district nurse was asked in one home whether she had ever worked in a hospital, and she replied:

> Yes. District nurses all have to do their training in hospital. And when you're in the community, you're actually being nursed by qualified nurses, whereas in the hospital, although they're supervised, you may be being nursed by a student nurse.[103]

As well as being a rare piece of oral testimony from a district nurse, this comment is significant as it highlights the varying public perception of district nurses versus their hospital counterparts. Sweet has argued that it is the continued existence of village nurse-midwives which contributed to this misperception in the public mind where community-based nursing was viewed as the provision of basic care that did not require the same skills as that of the acute sector.[104]

In more recent literature, Howse's study looked at the day-to-day duties and problems historically involved with nursing the sick poor in their homes.[105] Nonetheless, Howse continues to use Nightingale as a figurehead for her study and

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[102] Sweet, *Community Nursing*, 82
[103] Sweet, *Community Nursing*, 82.
[104] Sweet, *Community Nursing,* 82.
[105] Howse, "The Ultimate Destination of All Nursing", 65.

argues that historians should look at the organizational structure of the QNI as a way to understand her vision for the future of nursing.[106] Although Nightingale provides an important introduction into reforms of nursing, this is only one part of nursing and district nursing history. As indicated, a primary objective of this project is to fill in the absences of historiographical scholarship relating to everyday experiences of district nurses and the implications of our gendered understanding of the role for both female and male district nurses during the period 1945–2000. This will be completed using an updated period of study and without the constraints of the QNI or Nightingale driving the research.

1.4 Chapter Summaries

This chapter has introduced the rationale of study for this project, outlining the research questions which have driven and shaped the thesis. Contextual information pertaining to the history of district nursing has been provided in order to describe the environment of the profession at the start of the period chosen for study. Key texts which have informed the research have been discussed as a way to properly situate the research throughout the wider field. The final part of this introduction is therefore focused on explaining the structure and function of each of the thesis' chapters. This section is important as it will establish the framework adopted throughout the thesis, helping to better understand how the research questions have been fulfilled.

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[106] Howse, "The Ultimate Destination of All Nursing", 65.

Prior to embarking on the oral history interviews, I had a different idea as to how the thesis would be structured. Not envisioning the prominence that working 'on' the community would hold for the interviewees, my chapters were intended to focus on gender, class, and the home. However, as documented below, it would have been remiss not to include community as its own chapter. What emerged almost immediately during the interview process was that working in the home and working on the community were two important spatial remembrances to the district nurses interviewed. These were the two key spaces that were communicated in the memories of the participants. Home and community provided accessible language to help recollect their careers and verbalise their geographies of care. By focusing on each spatial theme in its own chapter, it became clearer how the thesis could utilise the language of the oral history interviewee to help establish a rich and extensive history of district nursing in Liverpool. Taken together, the district nurses' interviews therefore resolutely helped demonstrate the key drivers of their history for this thesis, with my approach shaped after the interview rather than before it.

The intricacies of this project's approach to oral history are outlined in the first chapter. This chapter provides extensive discussions on the practices and underpinnings of oral history. The form of delivering knowledge through voice and communication is something that could be said to be nearly as old as humanity itself, with Stephen Caunce illustrating how anything that people now living have been involved in can be a valid subject for oral history.[107] It is therefore essential that the history of oral history is surveyed. By exploring the historical foundation of

[107] Stephen Caunce, *Oral History and the Local Historian* (Essex: Longman Group UK, 1994), 4.

oral history, this chapter strengthens the cause of choice for oral history to uncover the history of district nursing in Liverpool. In addition, by including a discussion on the history of oral history, this chapter provides a theoretical journey of the thesis's method, helping to further clarify how this approach assists with fulfilling the research objectives of this project. Following this discussion, this chapter outlines the process of planning and preparing for the oral history interview, both of which were considerably disrupted due to the Covid-19 Pandemic and subsequently national lockdowns in 2020 and 2021. However, rather than curtailing the interview process, this meant that the oral history's methodological scope could be widened. As well as in-person interviews, remote interviews which occurred online were offered to participants, with four out of seven interviews taking place this way. The strengths and limitations of remote interviewing are discussed in this chapter, providing the opportunity to present key theoretical findings to a surely burgeoning aspect of oral history.

This chapter also covers the key epistemological frameworks which shaped the approach to oral history undertaken in this thesis. Memory drives the oral history interview, and its use has provided a considerable amount of discussion and contention for oral history practitioners. In order to understand the data delivered from the oral history interview, such as the personal recollections of the interviewee, it is essential that the form and structure of memory is understood. This is covered in this chapter, as well as the key debates and discussions surrounding key theoretical underpinnings of oral history such as intersubjectivity and composure. This chapter therefore serves as the methodological cornerstone, detailing the approach employed to uncover the history of district nursing in Liverpool. Vitally, this

chapter helps frame the oral history testimony and highlight its importance to this research.

The second chapter introduces the fundamental components of district nursing history by focusing on professional identity. Similar to the chapter on community, at first, I did not anticipate that this chapter would be necessary, as I expected to address the professional management and organisation of district nursing at multiple points throughout the thesis. However, it became clear when writing up how incredibly important the notion of professional identity was to the interviewees. Although not referred to directly, all of our discussions were being held in an environment that expressly focused on how the interviewees professionally identified as district nurses. This chapter, by focusing on the professional identity of the district nurse, will provide a broad foundational knowledge of district nursing. This, in turn, supports the personal, everyday narratives that were collected. Furthermore, it was clear that by discussing professional identity that the issue of gender and district nursing would evidently arise. The focus of this chapter is both on providing an overview of the historical management of district nursing through governmental interventions and also utilising the narratives of the interviewees to provide a richer understanding of the district nurse professional identity. Similar to the pre-1945 history of district nursing mentioned above, this chapter provides foundational knowledge of district nursing that adds layers to the oral history testimony.

A key component of this chapter is the use of governmental committee reports which are analysed to provide insight to how the district nurse was managed and organised through Local Health Authorities originally and then through various

departments bodies under the Ministry of Health. Alongside archival data analysis, oral history testimony provides a personal perspective on the professional identity of the district nurse. In order to provide detailed analysis on the professional trajectory of the district nurse, it was necessary to provide an extensive discussion on the relationship between the QNI and its antecedents and district nursing. The QNI was the primary professional body responsible for training district nurses for the majority of the twentieth century, and as such its impact on the professional identity of the district nurse role needs to be discussed.

The following chapter is concerned with the intersections between community and the district nurse. Community was stretched and adapted by each interviewee to represent a range of emotions, locations, and relationships. Community was a place the district nurses worked on, with interviewees talking about feeling proud of their work 'on the community'. Some spoke of their work on the community as being solitary, while others spoke of working within a wider team of GPs and nurses. Interviewees discussed their memories of various geographical locations and areas throughout Liverpool and the communities they encountered. Moreover, interviewees spoke of building relationships with the members of these diverse communities and the impact this had on their understanding and appreciation of their role. This chapter explores how the oral history interview itself and testimony which emerged unveiled a multifaceted representation of community. This chapter will provide a unique perspective on community through the language of district nurses, who looked at community through both professional and personal lenses. Professionally, community was used to discuss spaces involved with the delivery of care as well as being adopted in a way that assisted with recollections of key duties

and tasks involved in district nursing on the community. Personally, interviewees spoke of the relationships that were formed due to interactions occurring on the community. This chapter is incredibly useful in exploring the flexibility of the term community and includes analysis of how the study of community has been used in oral history projects to inform the approach undertaken in this thesis.

The final chapter investigates the relationship between home and the district nurse. Prior to starting the oral history interviews, the connection between the home and the district nurse was an area of analysis which I felt would be most useful to help understand the history of the district nurse role. The patient's home represented a primary characteristic of district nursing, linked to the idea that district nursing was nursing which occurred outside of the hospital. Indeed, as the second section of this introduction has shown, a key objective of William Rathbone was that district nurses would focus their work on the homes of the poorest in society. Home was the site that they would deliver care, which in turn would give them the teaching needed to serve a community group who might not have been able to receive car in the hospital or the workhouse. However, throughout the sixth chapter what became apparent is, similar to that of community, how nuanced and flexible understandings of the home were for the district nurses as a collective. A repeated analogy made by the district nurses I interviewed was that you were always the guest in the patient's home. This was something that connected all interviewees' understanding of the district nurse role. Each interviewee spoke about needing to make a holistic assessment prior to entering the homes of their patients, acknowledging the intricate relationship between people's home and their identity. Within this chapter, the dynamics involved in delivering care within the home are

explored in detail using the narratives collected by district nurses. What is also interesting about this chapter, again which was driven by the interview testimony, was the way language of the home was adopted in order to talk about the lives of the district nurses within their own home. The 'home' life of the interviewees, and how district nursing assisted, enabled, or hindered, was an important point of discussion and which is covered throughout this chapter. Overall, this chapter will shed light on the intertwined narratives of professional practice, gender roles and the evolving concept of home throughout the late twentieth century.

Chapter 2: Methodology

2.1 Introduction

This chapter will outline the methodological approach taken to fulfil the research aims and objectives of the thesis. Essential to this chapter will be the exploration of the key theoretical underpinnings of oral history and discussion of how these have been utilised in this thesis to provide a rich history of district nursing in Liverpool. Firstly, there will be an overview of the historical background of oral history as a tool to elucidate the historical reconstruction of past events. This will involve establishing the history of oral history, providing the necessary contextual information to inform understanding into how the oral tradition has developed. I will provide examples of oral history studies which have influenced the approach taken, which will in turn highlight the key benefits of the method. Further, I will consider oral history's journey from generational storytelling to a method of historical research. I will then discuss important emerging debates surrounding the method, indicating the current key debates within the field.

Following sections exploring the key themes surrounding oral history, I will explain how the method has been utilised in this project. This will involve discussion concerning the recruitment, selection, and the interview process with seven retired district nurses. Owing to the Covid-19 pandemic and subsequent restrictions that were put in place due to successive national lockdowns, adaptations to the planning and preparation of the interview processes were made. The median age of the interviewees meant that they were put in at risk categories, which meant I would

need to plan for both in-person and remote interviews. The processes, benefits, and difficulties of this approach will be discussed. Thirdly, I will move on to the epistemological frameworks that have shaped and structured the interview process and subsequent analysis. Crucial to this explanation will be a discussion concerning the representativeness of a sample size of seven interviewees. Following this, I will discuss how the interviews have contributed to our understanding of memory, intersubjectivity, and composure in the oral history interview. These are the key epistemological pillars of oral history that have emerged from the approach to research undertaken and discussed throughout this thesis.

It is important in this chapter that I discuss the parameters of using a selection of text and image-based archival sources to enrich the oral testimony gathered. While this chapter explores the theoretical and historiographical debates surrounding oral history, my own methodological stance is shaped by a commitment to oral testimony as more than a supplement to written sources. I have not sought to use interviews to fact-check or provide a definitive record of district nursing in Liverpool. Instead, I approach oral history as both method and object of analysis, where the processes of remembering, narrating and composing testimony are central to understanding professional identity, community, and home. In this sense, the oral history interviews are not treated as transparent windows into the past but as meaning-making practices, helping to reveal how district nurses framed their experiences in ways that were personally, culturally and historically significant. Finally, I will link back to the key strength of oral history as outlined by its earliest practitioners and discuss how the method has been used in this project to recover the lives of those hidden from history.

2.2 Oral History: A History

At its core, oral history represents a form of storytelling. If we go back to its earliest history, we see oral history represented in folklore or the sharing of familial traditions and experiences passed down generationally through speech. Alex Haley, whose groundbreaking works have encouraged Black Americans to explore their past through the popularisation of oral history, has referred to the figure of a 'griot' as a storyteller of a West African tribal community.[1] Haley has explained how, 'griots' were, 'in effect, walking, living archives of oral history'.[2] They would typically be older men, who would tell and pass down the stories they have been told since they were teenagers. In Haley's view, the stories are told 'in a narrative, oral history way, not verbatim' in the same way, generation to generation, across time since the forefathers of West African villages.[3] The figure of the 'griots' makes clear that oral narration, and the process of reconstructing historical events orally, has a long tradition across multiple cultures. This was especially important in periods were there was a reliance on eyewitness testimony of significant events to preserve generational traditions and stories.[4]

During the nineteenth century, there became increasing reliance within the academic community on archival research and documentary sources. This led to oral

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[1] Alex Haley, "Black History, Oral History and Genealogy", in *The Oral History Reader,* ed. by Robert Perk and Alistair Thomson (Oxford: Routledge, 2006), 14; See also: Alex Haley and Malcolm X, *Autobiography of Malcom X: As Told to Alex Haley* (New York: Grove Press, 1965) and Alex Haley, *Roots: The Saga of an American Family* (New York: Doubleday, 1976).
[2] Alex Haley, "Black History, Oral History and Genealogy", 14.
[3] Alex Haley, "Black History, Oral History and Genealogy", 20.
[4] Paul Thompson, *The Voice of the Past* (Oxford: Oxford University Press, 2000) 25.

testimony becoming marginalized outside of inter-generational storytelling and folklore and losing its significance as a way to recover the past.[5] In England, despite initial links, oral history and folklore studies have travelled down different paths. This has led Paul Thompson to argue that English folklore studies 'never escaped from the stigma of amateurism'.[6] In contrast, oral history began to be solidified as an academic approach, especially after the Second World War. Much of this was an outcome of technical advancements such as the increasing availability of portable tape recorders and the growing acceptance of its usefulness and validity as a historical method.[7] In 1948, Allan Nevins ushered in the framework of an oral history methodology by establishing the first oral history archives in Columbia University.[8] In Britain, this development grew parallel to an interest in recording the experience of 'ordinary' working people in the 1950s and 1960s.[9] Alistair Thompson has pointed out that oral history in this period was largely concerned with 'history from below' and fostered by politically committed social historians.[10] Within the history from below approach, increased attention is paid to the experiences of working-class and or marginalised individuals, exploring how economic and social structures can impact lives.

At its core, the history from below approach focuses on producing historical accounts from the perspective of ordinary people rather than of leaders. Although

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[5] Alistair Thomson, "Four Paradigm Transformations in Oral History," *The Oral History Review* 34.1, (Winter-Spring 2007): 51.
[6] Thompson, *The Voice of the Past*, 71–2.
[7] Thomson, "Four Paradigm Transformations in Oral History," 51.
[8] Brad Lucas, "Oral History's Turn: Archival Thinking and the Divine Views of the Interdialectic," *Issues in Writing* 17.1, (2008): 29.
[9] See; George Ewart Evans, *Ask the Fellows Who Cut the Hay* (London: Faber, 1956).
[10] Thompson, "Four Paradigm Transformations in Oral History," 52.

this research explores district nursing, it is doing so from the perspective of the district nurse, rather than the leading figures in the district nursing profession. It is the perspective of the district nurse, and their everyday testimony, that primarily shapes and informs this research, rather than exclusively the elite or nurse leaders. As the introduction has shown, in its first historiographical iteration, nursing history adopted a historical framework which sought to emphasise the professionalism of the role.[11] This meant focusing on the early twentieth century journey to registration, indicating the nursing profession's journey to professional recognition. The outcome was that there was a lack of focus on the everyday nurse and their lives and duties. This project is undertaking an approach first propagated by social historians of the 1970s and 80s who used oral history as the methodology to research the history of workers beyond the formal records of employers and trade unions.[12] Like social historians, many historians recovering the lives of women and Black, Indigenous, and People of Colour (BIPOC) have understood oral history to be the strongest vehicle to recover hidden histories, while empowering individuals to take part in creating their own histories. As such, from the 1970s there began movements to incorporate marginalised groups such as women, BIPOC and the LGBT community into the practice of oral history.[13]

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[11] Please see pages 15–19.
[12] Penny Summerfield, *Histories of the Self: Personal Narratives and Historical Practice* (Routledge, Oxford 2019), 106.
[13] See; Sharna Gluck and Daphne Patai, *Women's Words: The Feminist Practice of Oral History* (London: Routledge, 1991) and Susan H. Armitage, *Women's Oral History: The Frontiers Reader* (Lincoln: University of Nebraska Press, 2002). Gay Monitoring and Archive Project (GMAP), Hall-Carpenter Archives, British Library of Political and Economic Science, London School of Economics. On the early use of oral history within Black history see "Oral History and Black History," *Oral History* 8.1 (1980).

Despite this growing enthusiasm towards inclusivity within oral history, there were debates from the outset regarding the validity of memory amongst oral historians. At its core was the assertion that relying on memory to provide knowledge of historical experiences meant dealing with factors which could distort memory, such as physical deterioration or old age. Moreover, personal prejudices on behalf of the interviewer and/or interviewee and the influence of collective and retrospective versions of the past were argued to diminish the strengths of oral history. For example, Patrick O'Farrell wrote in 1979 that oral history was moving into 'the world of image, selective memory, later overlays, and utter subjectivity…and where will it lead us? Not into history, but into myth'.[14] Oral historians originally faced down these criticisms by developing processes to fact-check interview testimonies, while emphasising the use of documentary sources to assess the reliability of memory.

However, the tendency to transform oral history into just another historical source to find out 'how it really was' led to the neglect of other aspects and values of oral testimony.[15] In the 1980s, some oral historians began to turn criticisms of memory and the subjective nature of the interview into strengths of the craft, with the value of layered, individual memories increasingly highlighted as a strength to

[14] Patrick O'Farrell, "Oral History: Facts and Fiction," *Oral History Association of Australia Journal* 5, no.1, (1982–3): 9.
[15] Michael Frisch, Paula Hamilton and Alistair Thomson, "The Memory and History Debates: Some International Perspectives," *Oral History* 22.2, (Autumn 1994): 33.

the method.[16] This can be regarded as the cultural turn in oral history and represents how scholars began to look at the unreliability in oral history as a strength rather than a weakness. In 1989 Paul Thompson commented how there was a 'much more subtle appreciation of how every life story inextricably intertwines both objective and subjective evidence – of different, but equal value'.[17] Michael Frisch argued against the idea that oral history provides a sense of 'how it really was'.[18] For Frisch, successful oral history projects need to highlight memory as the 'the object, not merely the method of oral history'.[19] Here, Frisch was pointing out the importance of looking at how people remember and make sense of their past, rather than oral history acting solely as a quest for factual accounts.

Another important value oral history put forward by its formative practitioners was the method's ability to reclaim the voices of those who were hidden from history. In this sense, oral history provides an avenue for those not typically represented within the historical record to document their lives and experiences through the medium of recorded conversations. Paul Thompson has explained this denial as being down to the practice of history being essentially political until the twentieth century, primarily focused on struggles of power rather than documenting

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[16] See; Alessandro Portelli, "The Peculiarities of Oral History," *History Workshop Journal* 12, (Autumn 1981) 96–107; Popular Memory Group, "Popular Memory: Theory, Politics, Method," in *Making Histories: Studies in History Writing and Politics* , ed. by Richard Johnson, Gregor McLennan, Bill Schwartz, and David Sutton, (London: Hutchinson, 1982); Ronald J Grele, *Envelopes of Sound: The Art of Oral History* (New York: Praeger, 1985).
[17] Paul Thompson, "Editorial," *Oral History* 17.2 (1989): 2.
[18] Michael Frisch, *A Shared Authority: Essays on the Craft and Meaning of Oral and Public History* (New York: New York University Press, 1990) 188.
[19] Michael Frisch, *A Shared Authority,* 188.

the lives of individuals.[20] Barry Hazely has argued that the primary function of oral history is its ability to act as a medium via which voices which have previously been muted can become audible.[21] Here, Hazely argued that a key strength of the oral history process is the methods innate ability to uncover and promote the voices of those who may have previously been hidden from history. Penny Summerfield has echoed this uncovering ability/ recovery potentials of oral history, having classed the way the oral history interview introduces possibly overlooked voices to the historical record as a key strength the methodology.[22] This has been a consistent theme throughout oral history's development, especially since it became widely used by scholars in the 1970s and 1980s. As explained by Summerfield, during this period historians increasingly saw oral history as providing a voice to those hidden from history.[23] This became most evident when looking at the intersecting categories of workers, women, BIPOC and members of the LGBTQ+ community.[24] These are the individuals who had typically been denied a place in the historical record. Oral history therefore came to represent a way to incorporate the everyday experiences of individuals into the historical record they had previously been excluded from it.

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[20] Paul Thompson, "The Voice of the Past: Oral History" in *The Oral History Reader,* ed. by Robert Perks and Alastair Thomson (Oxford: Routledge, 2006) 26.
[21] Barry Hazely, "The Irish in Post-War England: Experience, Memory and Belonging in Personal Narratives of Migration 1945–69" (PhD diss., University of Manchester, 2012), 34.
[22] Penny Summerfield, *Histories of the Self: Personal Narratives and Historical Practice* (Oxford: Routledge, 2018) 106.
[23] Penny Summerfield, *Histories of the Self: Personal Narratives and Historical Practice,* 106.
[24] See: Joseph H. Cash and Herbert T. Hoover, *To Be an Indian: An Oral History* (Michigan: Holt, Rinehart and Winston, 1971); Alex Haley, *The Autobiography of Malcolm X* (New York: Grove Press, 1965); Alex Haley, *Roots: The Saga of an American Family* (New York: DoubleDay, 1976); Sherna Gluck, "What's So Special About Women? Women's Oral History", *Frontiers: A Journal of Women Studies* 2 (1977): 3–17.

Furthermore, some of the earliest proponents of the practice, such as Paul Thompson, argued history could become more democratic by focusing on consideration the lives of ordinary people.[25] According to Thompson, oral history can transform both the content and purpose of history, opening up new areas of inquiry and 'give back to the people who made and experienced history, through their own words'.[26] In a similar vein, this project is focused on introducing the voices of non-elite district nurses to the historical record, through their own words and experienced. To do this I embarked on a series of oral history interviews, with the intention of helping create a history of district nursing in Liverpool through the voice and recollection of district nurses in Liverpool. This approach has built on the work of Narelle Biedermann, who highlighted how oral history can play a significant role in retrieving and recording historical experiences of non-elite nurses who have limited record in historical documents.[27]

This section has established the formative paradigms within oral history's most recent past as a method of historical research. This was important as it establishes the key debates within the field and touches upon the key theoretical frameworks which structure the method is used and applied. By incorporating subjectivity and memory into its approach, oral history practitioners opened spaces to analyse and interpret findings outside of solely recovery history. Recognising that there are subjective factors which can influence the interview is now an accepted

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[25] Paul Thompson, "The Voice of the Past: Oral History." 26–7.
[26] Paul Thompson, "The Voice of the Past: Oral History." 26.
[27] Narelle Biedermann, "The voices of days gone by: Advocating the use of oral history in nursing," *Nursing Inquiry* 8.1 (2001): 61–2.

part of oral history. These frameworks will be discussed in more detail later in this chapter. It is now important to discuss the practicalities of how oral history has been deployed in my project. This will mean covering the process leading up to, during, and after the interview. Doing this will enable a clear understanding of the method and which will assist in understanding the themes which have been taken from each interview.

2.3 Interviewing: Preparation

Having examined oral history's practical and theoretical development as a methodological tool for research, this section will now outline the process of planning and preparing for the interviews involved in this project. The first and possibly most important factor to be decided was who would be interviewed. As mentioned above, it was important to me that I interviewed district nurses who would be able to provide insight into the everyday district nurse, rather than elite nurse-leaders. District nursing has always involved some form of training and qualifications building on from general nursing, so in a sense there is already a degree of professional advancement involved for the district nurse. Today, district nursing involves the requirement of taking a post-graduate qualification called the Specialist Practitioner Qualification. However, it was important that the district nurses I interviewed would be able to talk about and discuss the everyday nature of their role rather than the organisation and management of the profession at a larger scale.

After considerable thought it was decided that the recruitment criteria for interviewees would be district nurses who lived and/or trained in Liverpool from 1945–2000 and who no longer worked for the NHS. Focusing on a specific geographical area such as Liverpool meant that this research built on the advice of previous scholars of nursing history who argued that 'local studies are the most productive means of extending knowledge of district nursing as a service'.[28] Moreover, the link between Liverpool and district nursing history outlined in the Introduction provided an interesting opportunity in the interview to reflect on how the profession had changed over time.

Regarding the time period, it was felt that not only had daily life in Britain, and more specifically Liverpool, gone through unprecedented change during this time, but also district nursing had changed dramatically in the period 1945–2000. Firstly, the creation of the NHS meant a total overhaul to the management and organisation of district nursing. Secondly, this period offers a pivotal moment in attitudes towards gender and employment in Britain, with the introduction of male district nurses in 1947 specific to district nursing as well as an evolving attitude towards women and work. Thirdly, and perhaps more practically, it was decided that using 1945 as the starting year was the most realistic time a district nurse could have worked and be able to partake in the study. The choice to interview those who no longer worked for the NHS was informed by the understanding that, as the interviewees had not worked as a district nurse for a considerable amount of time,

[28] Enid Fox, "District nursing and the work of district nursing associations (DNAs) in England and Wales, 1900 – 1948" (PhD diss., University of London, 1993), 357.

there could be greater flexibility and opportunity for reflection in recalling memories. Interviewing those who no longer worked for the NHS also meant avoiding interviewing front line workers during the Covid-19 pandemic. Finally, in order to interview current NHS employees, especially during a pandemic, there would have rightly been more rigorous ethical applications necessary when time barriers were already in place to complete the research.

From the outset, there were considerable issues which impacted the availability of participants to contribute to the study. The Oral History Society, established in 1973 to promote the value and meaning of oral sources in history, advised in April 2020 that all interviewing should cease to occur owing to the UK national Covid-19 lockdowns.[29] This was adjusted in May 2020 to recommend that interviewing only occur in the most necessary circumstances.[30] Interviews were thought as of more urgent if they were specifically related to documenting the pandemic or for interviews on the topics of infectious diseases. During the 2021 national lockdown, it was advised that all face-to-face interviewing be postponed until further notice and for oral history interviews to occur only remotely and online.[31] In August 2021, this was then relaxed to allow for face-to-face interviewing to take place with all necessary health and safety precautions undertaken.[32] Ethical

[29] "Remote oral history interviewing," version 5 (4 April 2020), Oral History Society, accessed 6th April 2020, https://www.ohs.org.uk/covid-19-remote-recording/.
[30] "Remote oral history interviewing," version 6 (15 May 2020), Oral History Society, accessed 18th May 2020, https://www.ohs.org.uk/covid-19-remote-recording/.
[31] "Remote oral history interviewing," version 7 (8 February 2021), Oral History Society, accessed 8th February 2021, https://www.ohs.org.uk/covid-19-remote-recording/.
[32] "Recording oral history interviews in person during the Covid-19 pandemic: Approaching Risk Assessment," version 2 (23 August 2021), Oral History Society, accessed 23rd August 2021, https://www.ohs.org.uk/covid-19-risk-assessing/.

approval was granted in March 2021 for this project by the Liverpool John Moores University Research and Governance Committee (Reference: 21/NAH/004) on the basis that all interviewees be offered the option of either interviewing remotely or in-person in conjunction with a Covid-19 risk assessment, pre-empting advice from the Oral History Society.

The greatest issue that arose at this time, however, was how recruitment channels became limited. Understandably there were incredibly pressing matters evolving during this period which meant that planned in-person recruitment drives became unworkable. I decided to create two online profiles on X (formerly Twitter) and Facebook with the hope of contacting retired district nurses who met the recruitment criteria.[33] This approach was assisted by using existing networks of members of my supervisory team. As well as social media profiles I contacted the Queens Institute of District Nursing (QNI), whose influence on the district nursing role in England was covered in the previous chapter. Nevertheless, I was certain from the outset of this project that I did not intend to exclusively interview only those district nurses who had become Queen's Nurses. As the title of 'Queen's Nurse' is awarded by the Queen's Nursing Institute to those it feels have provided exemplary service within the community over the period of their employment, it was felt that to only interview Queen's Nurses could exclude those district nurses who had not been formally recognised for this. Therefore, when the QNI reached out to their members it was highlighted that the project was interested in any colleagues they knew who may not have been Queen's Nurses as well. In total there were ten

[33] X Profile: @DistrictPhD, Facebook: District Nurse Historian.

participants who provided consent for interviewing. However, due to unforeseen circumstances, the final number of interviewees for this project has been seven. Although I did not ask the interviewees where they had seen the call for participation, I know that Alan Carlise and Ethel Love both saw the project advertised in a QNI monthly newsletter. While I had originally thought the sample would be larger than what it was, the beneficial frameworks of working with an intimate sample size should not be dismissed and will be discussed in the later section on representativeness in more detail.

One of the earliest objectives for this project was to understand both male and female experiences of district nursing. As a profession typically gendered as 'women's work', I wanted to understand the experience of male district nurses.[34] I felt this approach would introduce new insight into gendered roles in the workplace and further our understanding of how we can break down gendered tropes around work and employment. Out of the seven interviewees there was one male participant. This resonated with the overall number of male nurses registered in the UK in 2022 which was 10.9%, and was much lower in the timeframe covered by my research, as well as in the experiences of my interviewees.[35] There was not a targeted recruitment drive for men who were district nurses, and the testimony provided by the male participant should still importantly be viewed in comparison to the experiences of the female participants. Moreover, this could be classed as a

[34] See Gerry Holloway, *Women and Work in Britain since 1840* (Oxford: Routledge, 2005).
[35] Bruce Forrest, "Men in nursing: smoke and mirrors," *British Journal of Nursing* 32.5 (March 2023): 234.

representative sample as the gendered characteristics of this sample are representative of the wider district nursing structure.

I had originally intended to undertake a targeted recruitment drive so that I would be able to interview an equal number of men and women who were district nurses. This tied in to how I wanted a more objective focus on the gendered experience of district nursing, using oral history interviews as a way to compare and contrast experiences. It was hoped this approach would provide insight into the understanding that district nursing was suited more towards women than men, helping contribute understanding into the experiences of male district nurses.

However, I am glad that this turned out not to be the case. After the interview process was complete, it soon became clear that the important stories to tell regarding the history of district nursing do not necessarily need to be separated by male experiences over female ones. As a profession mostly made up of women, it became clear that the female voices of district nursing deserved to be highlighted and explored. The subsequent testimony provided insights into wider structures of district nursing such as community and professional identity, helping to understand key factors of district nursing in Liverpool in the twentieth century. It was also interesting to hear memories of such a varied age group of participants, each with a degree of difference or overlap.

The participant ages ranged from 63 to 88 with nursing careers covering the latter-half of the twentieth century. Prior to agreeing to interview I asked each potential participant to fill in a questionnaire (See Appendix C). The questionnaire asked the potential participants where and when they completed their general and

district nursing training. There was also a question which asked for the area of Liverpool that they worked as district nurses in. As I was interested in hearing the reflections and recollections of the participants, I asked for their opinion on how both district nursing and Liverpool evolved during their careers. I chose to include this question on the preliminary survey for two reasons. Firstly, I wanted to make clear to the interviewees that not only was I interested in their district nurse histories, but also that I wanted to hear their thoughts and memories on how Liverpool as a city changed. It was therefore hoped that the interviewees would carry this into the interview. Secondly, as an outsider to district nursing, I was somewhat nervous about adopting the interviewer role. I therefore felt that if a foundational level of insight into the development of district nursing was provided prior to the interview, I would have a place to refer back to. This proved to be an incredibly useful exercise, as the interview participants provided some fascinating recollections which could be fed into the interview. Karen Walker, for example, wrote:

> When I listen to people working in community nursing now my feeling is that whilst it has radically changed I am not sure it has evolved into the community. I hear that home visits are less of a focus now than they were in general terms and more clinic-based work seem to be the main element. Specialist teams for End of Life and other clinical areas have developed and so this is not in the daily remit of standard community nurses. The number of trained community nurses has significantly decreased due to reduced funding for training. I feel there is a loss of recognition for the skill and knowledge required to provide

> high quality safe nursing in a person's home wherever in the community that may be.[36]

This quote suggests that there was an ease in which this participant talked immediately about the organisation of the role. This was something which she clearly felt was important in the role's evolution and could be mirrored when thinking about how she organised her memories of district nursing. Karen Walker ended up being the seventh and final district nurse I interviewed.

As well as these reflections, the questionnaire asked the participants which form of interview they would prefer, either remote via Microsoft Teams (MS Teams) or in-person. Out of the seven interviews, four occurred remotely and three occurred in-person. In the following sections, I will cover the process of remote and in-person interviewing.

2.4 Remote Interviewing

If we accept that the experience of the oral history interview influences the resulting data and testimony, the environment where the interview takes place is just as important to consider. Remote interviewing has commonly been an option for oral history practitioners, with interviews occurring over the telephone or even over email. Pioneering feminist oral historians Susan Armitage and Sherna Gluck's discussion on the developments of women's oral history occurred over email in 2002, with Gluck noting how the exchange was able to 'reproduce some of the spontaneity

[36] Karen Walker, Pre-interview survey, 2nd February 2022.

of the oral history interview'.[37] Owing to the Covid-19 pandemic, it was accepted that there would need to be some form of remote interviewing offered to participants. Remote interviewing technology has developed considerably from 2002. Nevertheless, the pandemic necessitated innovation when thinking about how to engage in data collection for this project. Separate to conducting interviews over email, options included telephone interviews, or for face-to-face interviews to occur remotely using end-to-end software such as zoom or Microsoft Teams. Choosing to offer the option to conduct the interview remotely meant I could interview in a safe and accessible environment for myself and the interviewee. After research into various interviewing software, it was agreed that interviews over MS Teams would be the preferred method. The option of telephone interviewing was offered to the participants; however, none opted for this.

Once it was decided that a virtual interview was an option for the interviewee, I wanted to understand the key strengths and limitations of the method. Scholarship on remote interviewing has commonly discussed the difficulties in building a rapport between the interviewer and interviewee in a remote interview, especially with vulnerable populations.[38] The rapport between the interviewer and interviewee is crucial to the oral history interview, and the inability to form a comfortable and at-ease relationship between the two is a concern before any interview. For this project, the questionnaire and interactions that occurred prior to the interview meant

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[37] Susan H. Armitage and Sherna Berger Gluck, "Reflections on Women's Oral History," in *The Oral History Reader*, ed. by Robert Perk and Alistair Thomson (Oxford: Routledge, 2006), 82.
[38] Alexandra Claudia Hess and Sarah Dodds, "Adapting research methodology during COVID-19: Lessons for transformative service research," *Journal of Service Management* 32.2 (2020): 203–17.

that there was already some connection between the interviewer and the interviewee. In addition, the questionnaire meant there was always something that I could refer to, on-screen, during the interview, although this rarely happened. As well as the difficulties establishing a conversational rapport with interviewees virtually, I was concerned with ensuring the technological process was streamlined and easy to understand as possible, both for the interviewer and interviewee. Prior to each interview I contacted the interviewee with an outline of how to access MS Teams and sign into the interview room. This was the only action needed on behalf of the interviewee, as it was decided that rather than send out recording device to record the audio, I would record the audio directly from MS Teams to a digital audio recorder. This way I could manage the recording all my end and avoid tasking the interviewee with further responsibility. This process also ensured a higher quality of recording rather than a secondary recording of the interview.

The benefits of a virtual oral history interview were, initially, difficult to fully appreciate as technological concerns loomed and the longing for the personal experience of the face-to-face interview took over. However, going forward I am confident that more oral historians will be able to utilise the method. For this project, at a time of restricted social networking and interaction, the virtual interview offered an opportunity to conduct important research within a safe environment.[39] I am confident that the benefit of the interviewees being in their home fostered a level of

[39] See: Mark Cave and Stephen M. Sloan, *Listening on the Edge: Oral History in the Aftermath of Crisis*. (Oxford: Oxford University Press, 2014); Malin Tureby and Kristen Wagrell, "Crisis Documentation in Oral History: Problematizing Collecting and Preserving Practices in a Digital World," *Oral History Review* 49.2 (August 2022): 346–76; Mary McDonald, Alyssa Puddicombe, Andrew Weymouth and Aubrey Williams "Methods for Collecting Oral Histories Amidst a Crisis," *The Serials Librarian* 81.2 (2021): 120–31.

ease in their approach to the interview. For each interview there was an introductory period of around five to ten minutes where we were able to introduce ourselves and make non-recorded and non-project-related conversation. This immediately created an open and conversational rapport just as there would be in a face-to-face interview. Each interviewee was told they could stop the recording at any moment if they wished for a break, although this only happened when I needed to change the battery in the recording device.

The first interview for this project was conducted remotely over Microsoft Teams on Monday 18th October 2021 with Cathy Earles. As stated previously, I spoke with Cathy the day prior to confirm the arrangements and provide a consent form. Cathy had only recently retired from working within the NHS and had worked as a district nurse for twenty years. Any concerns regarding the validity of the virtual oral history interview quickly subsided once our conversations began. The interview lasted just over 90 minutes and covered a wide span of topics, from the skillset required for district nursing to the election of different Prime Ministers and the impact they had on the NHS.[40] Owing to both of our positions facing a computer screen, I felt that the technological format of the interview would somehow remain prominent in our discussion, acting as a barrier to the interpersonal extras involved in an in-person interview. There were times when Cathy would call a family member to help with their tablet charger or request that a family member lower the volume of the television in a different room. Although I do not believe that these instances

[40] Cathy Earles, interview with the author, conducted over Microsoft Teams, 18th October 2021.

weakened or diluted the interview experience or subsequent testimony: it was apparent that we were conducting the interview in somewhat unknown conditions.[41]

Following Cathy's interview, I conducted a further three interviews remotely, meaning the majority of oral history interviews conducted for this project occurred over Microsoft Teams. I interviewed Julie Snowden on 21st January 2022, Mabel Williams on 8th March 2022 and Karen Walker on 14th March 2022, my final interview to take place. Having built up confidence from the first interview with Cathy, I felt considerably less nervous for the subsequent remote interviews. In fact, the second remote interview and fourth interview overall with Julie Snowden turned out to be the longest length interview, running to 94 minutes and which felt like a considerably detailed and extensive conversation. Of course, there are factors which much be considered when planning, conducting and analysing a remote oral history interview, which must be considered.

There are performances involved in an oral history interview, on part of both the interviewer and the interviewee, which have an impact on the final testimony.[42] As discussed by Katherine Waugh, within a remote atmosphere in which video and voice transmit digitally, it can be difficult for either party to read behavioural cues, therefore affecting conversations and ultimately impacting the final transcripts.[43] This is because nuances, performances and silences can be more difficult to gauge virtually. Moreover, sometimes an encouraging hand gesture or sigh of relief can

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[41] Cathy Earles, Interview, 18th October 2021.
[42] See; Lynn Abrams, *Oral History Theory*, 130–52.
[43] Katherine Waugh, "Failing to Connect? Methodological Reflections on Video-Call Interviewing during the Pandemic," *The Oral History Review* 50.1 (February 2023): 69.

easily be missed through the computer screen. Although this did not occur during my interviews, if an interviewee felt a particular sensitive emotion due to a topic of our conversations but did not present these emotions verbally on their face, it would have been extremely difficult for me to pick up a change in body language. This therefore would have meant I was prevented from acknowledging discomfort and pausing the interview. When you are conducting an interview in-person and sitting in close proximity, there are non-verbal expressions and body movements that shape and direct the interview, and which can alert either the interviewer or interviewee to the requirement to pause the interview. This means there is a strong reliance on the interviewee to orally express their emotions if they are feeling uncomfortable, which ultimately relies on necessary feelings of empowerment and rapport with the interviewer.[44]

Moreover, this heavy reliance on vocality and feeling strong enough to pause or stop the interview completely means that silences can be particular difficult to navigate. This is because the interviewer needs to consider what the expressed silences are for; thought or potentially discomfort. For Alexander Freund, silences are a constitutive part of oral history interviews, representing discomfort, reluctance, contemplation, and politeness.[45] However, during a remote interview it can be difficult to determine whether an individual had paused for thought or due to a feeling discomfort. This is because signals that might convey the purpose of silence,

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[44] Katherine Waugh, "Failing to Connect? Methodological Reflections on Video-Call Interviewing during the Pandemic," 69.
[45] Alexander Freund, "Towards an Ethics of Silence? Negotiating Off-the-Record Events and Identity in Oral History," in *Oral History Off the Record*, ed. by Anna Sheftel and Stacey Zembrzycki (New York: Palgrave Macmillan, 2013), 223.

such as body language, facial expressions and eye contact were harder to observe through a screen.[46] Of course, these are not necessarily inherent flaws of the remote interview. Rather, they are considerations that remind us that the oral history interview is an intersubjective experience, open to the influence of many different factors. The setting and modality of the interview has the opportunity to shape the subjective emotional encounter, with remote interviewing therefore producing its own unique testimony. It is now important to examine how these dynamics operated within the in-person interviews conducted for this project.

2.5 In-person interviewing

There are essential attributes which the successful interviewer must possess that cover both in-person and remote interviewing. Flexibility, an interest and respect for people as individuals, understanding and empathy, and a willingness to sit and listen are all listed as essential qualities of a successful interviewer by Paul Thompson.[47] This explains why I was prepared to have interviews decide if they wanted to be interviewed online or face to face. In this section, I will cover the practicalities and logistics of the in-person interview as well as providing a comparative discussion between in-person and remote interviewing which I argue will benefit future researchers. Out of the seven interviews conducted for this project, three were conducted in person. The first of these interviews was conducted in Birmingham, the second in Littlehampton, West Sussex, and the third in Liverpool. The interviewees

[46] Katherine Waugh, "Failing to Connect? Methodological Reflections on Video-Call Interviewing during the Pandemic," 70.
[47] Paul Thompson, *The Voice of the Past: Oral History*, 196.

in Birmingham and Littlehampton represented the oldest participants at that time. I decided to arrange interviews with these participants first as Donald Ritchie advised to start interviews with the 'oldest and most significant players' in your participant base.[48] Although there is no weight in this research to which interviewee was most significant, it was felt that for in-person interviews it would make sense to visit those more geographically distant early in the process. The interview in Birmingham was the second interview for this project and provided a great opportunity to provide an immediate reflection on a virtual interview conducted only two days prior. I arrived in Birmingham on Wednesday 20th October 2021 and made my way to the participant's house. I was provided with an incredibly warm and hospitable welcome by the participant, offered refreshments, and spoke with them and their spouse for around 20 minutes before the recording began. In comparison to the five minutes of introductions allotted for the virtual interview, this experience certainly encouraged a significant warming of relations between the interviewer and interviewee. The interview process lasted just over 2 hours, including 30 minutes for lunch provided by their spouse. Although I am confident that the testimony provided in-person and virtually are both equally rich and valuable, the experience of the interview itself offers contrasting analysis. The opportunity to sit with the interview and have lunch mid-way through the interview afforded us both an opportunity to reflect on how the interview had gone so far. This helped with the interviewer/interviewee rapport that we were able to build on for the latter half of the interview. For all interviews, both in-person and virtual, interviewees were told that they could pause, stop, or finish

[48] Donald Ritchie, *Doing Oral History* (Oxford: Oxford University Press, 2005), 35.

the interview at any time they felt comfortable. However, in the virtual context there was not the option of sharing a meal together and discussing topics not directly related to the interview during a break.

The next in-person interview was in Littlehampton on 8th November 2021. Prior to the interview I was asked if I had any dietary requirements so I was aware there would be another warm welcome. This interview similarly lasted just over two hours, with one hour of this recorded. As with the previous interview, I was made to feel incredibly welcome and at-home, with refreshments provided before, during and after the interview. It was important that the interviews combined a sense of structure, I was there to record the memories of the district nurse flexibly. For this interview, the participant felt the need to stop the recording and discuss topics that they preferred were 'off the record'. Donald Ritchie advises against allowing 'off the record 'conversations during an oral history interview, arguing interviewers should 'politely, but firmly decline to interrupt the interview'.[49] Ritchie has stated that this is because there is little value to be gained from hearing a story 'off the record'.[50] I disagree with this premise. In my eyes it was felt that offering the interviewee the chance to pause the recording and discuss something 'off the record' provided respect to which memories the participant chose to share. This not only helped foster a co-operative interview dynamic, but it also made clear which memories the district nurse privileged as integral to the story they wanted to tell. It can be said

[49] Donald Ritchie, *Doing Oral History*, 89.
[50] Donald Ritchie, *Doing Oral History*, 89.

that the pauses in the record provided examples of discomposure in the oral history interview.

Composure refers to the way an interviewee will compose a certain narrative deemed acceptable, while considering the intersubjective relationship between themselves and the interviewer. This interviewee decided to pause the recording as they felt this memory would not achieve coherence in their preferred telling of their career as a district nurse and I felt it was important to respect this. Although there were pauses and breaks in the virtual interviews conducted, the issue of off the record discussions were never brought up. I would argue this could be because of the presence of the computer screen fostering an idea of always being 'on', with the interviewees feeling there was not an environment to stop or pause the interview. Interestingly, this could also be because of the physical separation between myself and the interviewee during the remote interviewing process, resulting in the distance between the two of us feeling more pronounced.

Building on this idea of physicality, I would argue that the interpersonal dynamics between the interviewer and interviewee are more apparent during an in-person interview. Penny Summerfield lists the interviewer's style of dress, accent, tone of voice, demeanour, body language, and spoken and unspoken attitudes as signals which can shape the interview.[51] Throughout the interview process, I felt these were more pronounced and noticeable in-person rather than through a computer. I would therefore add environment to these intersubjectivities. As stated

[51] Penny Summerfield, "Dis/composing the subject: Intersubjectivities in oral history" in *Feminism and Autobiography: Texts, Theories, Methods,* ed. by Tess Cosslett, Celia Lury and Penny Summerfield (London: Routledge, 2000), 102.

by Valerie Yow, the place where the interview takes place makes a difference, with an interviewee presenting themselves differently in an office than they would at home.[52]

The third in-person and sixth interview overall was conducted on 22nd February 2022. This interview was the only interview not to take place in a home setting, and was conducted in a meeting room provided by Liverpool John Moores University. This interview lasted just over 90 minutes including a short break. The interviewee was accompanied by their daughter, who was also a nurse, and who waited outside. Whereas previously I had sat in the living room of the interviewee's home, for this interview we both sat at a table, across from each other with the recording device in the middle. This set up mirrors a traditional interviewing format and certainly felt more formal. However, this did not diminish the rapport between interviewee and I. Interestingly, this interview seemed to move in a less-directed format than previous, with multiple instances where the direction went off topic. However, this interview covered a great deal of technical information. I believe this was because of the more formal environment of the interview, where my position as a researcher looking for knowledge was more pronounced to the interviewee. In this instance, I was an outsider to district nursing, and the more formal environment of the interview reinforced this, allowing the interviewee to explain details and practices related to their memories of their district nurse role.

[52] Valerie Yow, *Recording Oral History: A practical guide for social scientists* (Sage Publications: California, 1994), 57.

This section has covered the practicalities and logistics of interviewing, both in-person and virtually. I have consciously chosen to highlight aspects of the in-person interview over the virtual interview, not because they were more detail-rich or important, but because I wanted to introduce what I argue are the main practicalities of interviewing. This is not to say that the virtual interviews all followed the same structure. There were certainly moments where discomposure was felt in virtual interviews, as well as an awareness of the intersubjective relationship between me and the interviewee. These are going to be covered in more detail throughout this chapter. What follows will be a discussion of the theories which underpinned the approach of oral history to this project. These are the key theories that have shaped both my approach to interviewing and subsequently the approach undertaken to analyse the testimony gathered from interviews.

2.6 Representativeness

According to its earliest sceptics, oral history as a methodology was inherently flawed due to its inability to be representative of larger populations.[53] In response to this, oral historians such as Elizabeth Roberts and Paul Thompson undertook large-scale projects with a 'representative' sample size.[54] It was argued that due to the size of their sample, they would be able to provide historically accurate

[53] For discussion of these criticisms see Brian Harrison, "Oral History and Recent Political History," *Oral History* 1.3 (1972): 30–48; Alistair Thomson, "Unreliable Memories? The use and abuse of Oral History," in *Historical Controversies and historians*, ed. William Lamont (London: University College Press, 1998), 23–34.
[54] Elizabeth Roberts, *A Woman's Place: An Oral History of Working-Class Women 1890–1940* (Oxford: Blackwell, 2005) and Paul Thompson, *The Edwardians: The Remaking of British Society* (Bloomington: Indiana University Press, 1975).

representations of their chosen participants. This links back to the earliest concerns regarding memory and the positivist approach to oral history, rooted in the search for facts that can reinforce testimony. However, as Alessandro Portelli has pointed out, sources – oral or otherwise – are never entirely objective, with written sources just as much open to interpretation by the reader as audio sources to the listener.[55] Building on this idea of sources as inherently subjective, Portelli argued that oral testimony is never the same twice, as the same interviewer could get a different version or narrative from the same interviewee at different times.[56] It is therefore essential to understand how each interview could be unrepresentative, open to interpretation by anybody who studied it. Oral testimony invites us to consider a range of values, beliefs, emotions, and narratives each representative of personal and social histories. These are positive functions of all sources. In this way, I would argue it is not possible to obtain a statistically representative sample of any population of the past, no matter the size of the sample. This is more pronounced when dealing with the individual memory construction process involved in the oral history interview. As illustrated by Penny Summerfield, there are major complications in attempting to collect truly comprehensive data on any social group for a range of factors.[57]

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[55] Alessandro Portelli, "What Makes Oral History Different?" in *The Oral History Reader,* ed. by Robert Perks and Alastair Thomson (Oxford: Routledge, 2006), 38–9.
[56] Alessandro Portelli, "What Makes Oral History Different?" 39.
[57] Penny Summerfield, "Oral History as an Autobiographical Practice," *Miranda* 12.12 (March 2016): 7.

Writing about the creation of Mass Observation Project in Britain in 1937, Annebella Pollen has noted how its founders were grounded in the belief that 'the press and the government repeatedly made claims on behalf of the "man on the street" but never tried to access his views.'[58] In response, The Mass Observation movement tried to establish a more imaginative and democratic means of documenting and understanding patterns of popular experience and focused on producing a representative portrayal of the "man on the street". However, there were debates from the onset to how far you could generalise the material found in Mass Observation and how far it was truly representative. For James Thomas, the huge amount of data provided by the mass observation collectors meant that it was too difficult to find the personal or truly representative experience of the "man on the street". Concerns lay with the size of the sample being too large, with Thomas pointing out how 'if the sample were smaller, it is doubtful whether criticisms would be so persistent'.[59]

Thus, I argue that the concept of a truly representative sample can be inherently problematic. This is because there is great value to be found in studying the personal narratives of individuals that can be omitted through the question for a uniformed, representative sample. This links back to the original objectives of the earliest oral history practitioners that is to shed light on the individual narrators who tell our past by creating stories and narratives, rather than the method merely being

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[58] Annebella Pollen, "Research Methodology in Mass Observation Past and Present: 'Scientifically, about as valuable as a chimpanzee's tea party at the zoo?" *History Workshop Journal* 75.1 (2013): 213.
[59] James Thomas, *Diana's Mourning: A People's History* (Cardiff: University of Wales Press, 2002), 37.

a 'quest for facts'. If we look to the documentary or written sources, it would be fair to argue that these can never be fully representative of the subjects they discuss either. Historically, the selection of record creators is problematic as not everybody wrote diaries, letters, or memoirs. An even smaller few would have created governmental or media records. Historians have however used such material to compare the profile of the authors with the characteristics of the larger population, exalting the 'representativeness of their sample of personal testimony'.[60]

In the preliminary stages of the project, it was my intention to conduct interviews with 10–15 district nurses. I planned for this sample size as I felt that the larger the sample, the more representative these participants experiences would be of district nursing. However, due to issues with recruitment outlined earlier in this chapter, it became apparent that I would be working with a smaller sample than originally planned. This led me to think about the intention of the project. Rather than focusing on how each interview would establish representativeness of district nursing, the interview would provide the opportunity to highlight the experiences of each individual district nurse, while still offering the potential to look for commonalities. The personal focus was exemplified further once the interviews were completed. Each interview contained intimate and rich testimony which helped to truly understand the experience of each district nurse. For example, Dorris Smeethe spoke at length about the relationships they formed with patients which took them outside of the typical nurse-patient dichotomy when they were asked to attend or

[60] Penny Summerfield, *Histories of the Self: Personal Narratives and Historical Practice* (London: Routledge, 2018), 138.

even speak at the funerals of their patients.[61] Although not necessarily the typical district nurse experience, the testimony was representative of this narrator's district nursing history.

In addition, there was a horizon of possibilities as to what these interviews could tell us, with the potential to tell us about evolving trends and attitudes towards home, community and gender. There must be awareness, however, of over-reaching in terms of generalisations and tying the experiences of these seven district nurses to all district nurses in Britain between 1945 and 2000. I am conscious that this group is not inclusive of all district nursing experience in this period, and that each account is informed by specific discourses and individual memories, as well as a personal construction of their role. I was able to devote considerable time to each testimony without a distracting commitment to ensuring that the experiences of these narrators where either typical of atypical of the district nursing profession in the period. Rather than being representative of all district nursing in twentieth-century Britain, this research uses oral history testimony to further our understanding of district nursing in Liverpool, as well as contributing to our knowledge of home, community and professional identity.

The sample for this research has been made up of seven retired district nurses, who worked and/or trained in Liverpool between 1945 and 2000. I interviewed six women and one man who were born between 1933 and 1958. One participant began their nurse training in 1951, one in 1969 and five between 1971

[61] Dorris Smeethe, Interview with the author, Liverpool, 22nd February 2022.

and 1978. Two began their district nurse training in the 1950s with the rest undertaking training between 1980 and 1988. Each interviewee moved from district nursing to a different role within the NHS, except for the male district nurse, whose career saw him become Principal of a nursing training school in Liverpool. This district nurse then became part of a government body who advised on the development of district nurse training, before being ordained as an Anglican Minister in 1990 and then becoming a Bishop in 2010. Although this experience might not be a benchmark for a wider representative sample of all male district nurses, this testimony deserves to be studied. Timothy McMurry has pointed out that there is evidence of male nurses entering positions of leadership and earning more over their female counterparts.[62] This participant represents *an* experience of district nursing as a man during the period discussed. I do not believe this needs to be the universal or benchmark representation of male district nursing, as there is something to be said about the luminosity of the single case. This approach is supported in Daniel James 'work in *Doña María's Story*.[63] James uses the life of María Roldan as a vehicle to explore the characteristics and contradictions of working-class women's lives in Argentina. [64]

For this project, rather than look to archival sources to determine the validity of the testimony provided by interviewees, I adopted the approach to correspond with what the narrators discussed in the interview with nationally produced sources,

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[62] Timothy McMurry, "The Image of Male Nurses and Nursing Leadership Mobility," *Nursing Forum* 46.1 (2011): 22–8.
[63] Daniel James, *Doña María's Story: Life History, Memory, and Political Identity* (Durham, NC and London: Duke University Press, 2000).
[64] Daniel James, *Doña María's Story: Life History, Memory, and Political Identity* (Durham, NC and London: Duke University Press, 2000).

such as training manuals, newspaper articles and organisational leaflets. This is intended to act as a companion to the oral testimony, rather than as evidential. This approach is informed by Jane Humphries, who used a 'benchmark to normal standards' to examine how representative the testimony in working-class autobiographies was to the wider working-class population.[65] In my research, where a district nurse has mentioned a development to a particular training method, I have been able to look to the archive to enrich this discussion. This became apparent after the first few interviews, where the idea of working in the patient's home emerged as a prominent theme of discussion. A recurring theme throughout the interviewee's memories, I looked to the national archives for training manuals, where again the idea of being a visitor in the home of the patient was central.[66]

An area which I believe does deserve more representation within the sample of interviewees for this project is race. Unfortunately, I was unable to work with any participants who were not White British, and this has certainly limited the scope of this project. The absence of BIPOC participants in this study may have been because of the scope of networks I engaged with for recruitment, something which I regret not targeting more prolifically from the onset. It is a point that I consider more fully in the thesis's conclusion.

This section has aimed to establish reasoning for the importance of the sample of interviews collected for this project. It has discussed the limits of both a

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[65] Jane Humphries, *Childhood and Child Labor in the British Industrial Revolution* (Cambridge: Cambridge University Press, 2010), 11.
[66] Queen's Nursing Institute, *Advertisements for District Nursing, 1955,* SA/QNI/P.7/32, Wellcome Collection, London.

large and small sample in the hope of addressing anxieties about the number of interviews. Each of the seven interviewees felt an impulse to express their memories of district nursing and I am committed to exploring how each narrative intertwines with wider historical lenses of study. The strengths and weaknesses of using memory as the foundation of oral history will now be discussed.

2.7 Memory

Oral history provides access to information that may not be available through conventional sources. Central to the oral history interview is the recollection of memories on behalf of the interviewee. Mahua Sarkar has stated that 'the peculiar strength of oral histories lies not in their capacity to provide new facts, but in their ability to provide valuable insights into the meaning's subjects attach to particular events or processes'.[67] Current scholarship in oral history emphasises that it is important not to reject accounts reliant on memory and memory-making, but rather to embrace the shaping of testimony in a combined approach with factual information, considering wider historical knowledge. This is the post-positivist approach to oral history mentioned earlier in Section 2.6. The pairing of oral testimony with documentary sources is not a process based on providing proof or evidence to the memories discussed in the oral history interview, however. Rather, this approach has been adopted in this project to enrich the memories, rather than to prove factual information. The evolution of memory within oral history has been

[67] Mahua Sarkar, "Between Craft and Method: Meaning and Inter-Subjectivity in Oral History Analysis," *Journal of Historical Sociology* 25.4 (2012): 583.

noted as representing a shift from a focus on individuals who could provide historians with facts, to one concerned with meanings and subjectivities. Ronald Grele describes this shift as indicating a 'concern with data to a concern with text'.[68]

This debate concerning the reliability of memory within an oral history study can be better understood by considering the function of memory and how and what individuals choose to remember. There are varying factors which contribute to how individuals chose to construct memories, such as the amount of emotion attached to an event and the significance of the event in relation to surrounding environments. By way of illustration, Corinna Peniston-Bird shows we must deeply consider the weight of importance we place on reliability in the oral history interview.[69] Peniston-Bird provides the example of differing memories recalled of the same event by both her grandmother and her mother, with her grandmother repeating 'frozen narratives' which may have been repeated due to their well-received first retelling. Frozen narratives indicate personal experiences which are memorised due to their significance to the individual and are then continuously repeated. Peniston-Bird has advised against focusing on the differing accounts or inaccuracies in testimony, pointing out how individuals commonly exaggerate, reinterpret, confuse, or even

[68] Ron Grele, 'The History of Oral History', Columbia University, 30 June 2010. https://www.youtube.com/watch?v=voPIGiv3sIQ (accessed September 2022).
[69] Corinna Peniston-Bird, "Oral History: The Sound of Memory," in *History Beyond the Text: A Student's Guide to Approaching Alternative Sources*, ed. by Sarah Barber and Corinna Peniston-Bird (New York: Routledge, 2009), 109.

lie.[70] Similarly, Alessandro Portelli commits to the idea that 'errors, inventions, and myths lead us through and beyond facts to their meanings.'[71]

For my research, I have infused this approach throughout the interview analysis in order to respect the memories of each individual interviewee. The truth that is provided through these constructed narratives is the narrative that matters for the individual. This is to say that it is the task of the oral historian is to interpret and analyse the meaning of the narrative and understand why certain memories are constructed in a certain way. For example, when Alan Carlise spoke about an international meeting of nurses he attended in Montreal in 1969, I never felt the urge to verify this fact or date.[72] It was important enough to this study that he felt this trip reflected an integral part of his district nursing career. As oral history cannot and should not act as a quest to solely create a depository of facts, the oral historian must look at memory and ensure the interviewee has agency in producing their own important perspective. The impact on this project is that each of the memories presented by the interviewee is regarded as truthful to their understanding. This then can contribute to our understanding of what each can recall of their lives within and outside of district nursing. Some interviewees privileged certain memories over others, and my analysis focused on understanding why particular experiences foregrounded in their recollections.

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[70] Peniston-Bird, "Oral History: The Sound of Memory", 109.
[71] Alessandro Portelli, *The Death of Luigi Trastuilli and Other Stories*: *Form and Meaning in Oral History* (Albany: State of New York University Press, 1991), 2.
[72] Alan Carlise, Interview, Birmingham, 28th October 2021.

Similarly, there were shared memories. Each interviewee, for instance, discussed at length the position of the home in undertaking their role, and how it was essential that as district nurses, they understood they were visitors in the home of the patients. This directed my research to begin thinking about why the home had such a large presence in everyone's memories. Some interviewees recalled specific memories that could not be matched to the wider sample, such as the interviewee who spoke emotively about working with patients diagnosed with HIV/AIDS. This interviewee recalled how patients chose to share:

> …[s]tories about how they'd told their parents that they were gay, how they told their parents that they were positive, how they told their families, their partners. All of that gave – for me – as a nurse it gave me a whole different perspective on community.[73]

This particular memory was privileged by this district nurse and represents a different perspective to memories of other community nurses. Although this may not be a universal experience of district nursing, it is valid in helping us widen our understanding about delivering care in the community during period. To refer back to the debate about representativeness, this unique memory provided by this interviewee is representative of a key moment in their district nursing career. Thinking about memory in this way helps us confront assumptions about objectivity within history and what can or cannot be recalled. In terms of what this tells us about the testimony gathered for this project, it provides understanding into a

[73] Karen Walker, Interview with the author, conducted over Microsoft Teams, 14th March 2022.

horizon of other historical possibilities other than the history of district nursing, for example that of the experience of HIV/AIDS within a community care setting.

Thus, memory plays an integral component to the methodological approach taken for this research. As Michael Frisch has argued, 'what matters to history is what we are able to remember and what role this memory places in our lives'.[74] The environment in which memories are retold and discussed has also been an integral underpinning to the methodological approach to this project. The process of the oral history interview, the retelling of memories on behalf of the interviewee and the analysis of these memories conducted by the interviewer, is based upon a relationship between the two individuals. As mentioned earlier, there are aspects which shape this relationship, such as the interviewer's style of dress, accent, tone of voice, demeanour, body language, and spoken and unspoken attitudes. I will now discuss in more detail the theory of intersubjectivity within the oral history interview, and the impact this has had on this research.

2.8 Intersubjectivity

The oral history interview represents a conversation between two individuals. Typically, within this conversation there is an interviewee who is responding to questions posed by an interviewer, who subsequently analyses and interprets the responses. This analysis forms the product of the interview. As both actors bring

[74] Michael Frisch, *A Shared Authority: Essays on the Craft and Meaning of Oral and Public History* (Albany: State University of New York Press, 1990), 15.

something of themselves to the process, it can be said that the product is shaped by two subjectivities. Here, subjectivities refer to the factors which make up an individual's sense of self. Lynn Abrams classifies these as being shaped by 'experience, perception, language, and culture – in other words an individual's emotional baggage'.[75] Subjectivities can fit within structuralist understandings, such as those shaped by the structures evident in society such as social class, race and gender. Modern definitions, such as that put forward by Helen Callaway, however, emphasise the contingency within subjectivity, arguing it is fluid and never fixed.[76] This approach is useful when thinking about the oral history interview, where interviewees may draw upon a range of ideas and subjects in order to construct a narrative of memory that is acceptable to them at that given moment of interview. The interviewer's subjectivity may also change, such as when interviewing a different person.[77] If we accept that the product of the interview is shaped by the interview itself, it is important to understand the structures within the interview that shape the product.

Intersubjectivity therefore describes the interaction between the two subjectivities of interviewer and interviewee. To understand intersubjectivity is to accept that we need to understand how memories and stories have been constructed, the devices and conventions used, and the way in which the narrative ultimately is to be read.[78] As suggested by Penny Summerfield, 'the process of the

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[75] Lynn Abrams, *Oral History Theory* (Oxford: Routledge, 2010), 54.
[76] Helen Callaway, "Ethnography and Experience: Gender Implications in Fieldwork and Texts," in *Anthropology and Autobiography,* ed. by Helen Callaway and Judith Oakley (London: Routledge, 1992), 37.
[77] Lynn Abrams, *Oral History Theory,* 56.
[78] Daniel James, *Doña María's Story,* 158.

production of memory is always dialogic or intersubjective in the sense that it is a product of the relationship between a narrator and a recipient subject, an audience.'[79] In its simplest form, intersubjectivity reflects the acknowledgment that the interview process effects the final outcome. My *intersubjectivity* as a non-district nurse would have affected how interviewee's constructed and retold their histories. This section will therefore cover the intersubjective encounters within the interview process and how I believe this impacted the project.

Intersubjectivity touches on the complex relationships involved within the interview process and is a useful conceptual framework to understand how memory narratives are composed. It is also linked with how dis/composure is experienced in the interview. Certainly, there are factors which affect the interview output which also have an impact on how interviewees are able to compose their narratives. Following this section there will be a discussion in greater detail on the process of composing memory narratives acceptable to the interviewee and how I felt this emerged in the interview process. The oral history interview allows the interviewer to become part of the research process and assist in the production of a primary source, which can be somewhat unusual for a historian. As argued by Lynn Abrams, 'neutrality is not an option because we are part of the story'.[80] It therefore becomes necessary to understand how the subjectivities of the interviewer and interviewee shape the interview process. Julie Cruikshank and Tatiana Argounova-Law, for instance, found that in their work with communities in the Yukon Territory, their

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[79] Penny Summerfield, *Reconstructing Women's Wartime Lives: Discourse and Subjectivity in oral histories of the Second World War,* 15.
[80] Abrams, *Oral History Theory,* 58.

outsider status allowed interviewees to view the researchers as people who could help extend their testimony to broader audiences, as proxies for the outside world.[81] As interviewers, it is therefore important to self-reflect on our own subjectivities and the contribution these can make to our interview and subsequent analysis. This was something that I felt was crucial to my approach to interviewing. For this research, one of the most prominent subjectivities shaping the interview outcome was my outsider status as a non-district nurse. Amy Tooth-Murphy has offered useful insight into the strengths and weaknesses of insider/outsider dynamics in oral history.[82] In her work, she reflected on feeling like an insider when interviewing older women who shared her same-sex sexuality, while in other projects she occupied more of an outsider role.[83] Tooth-Murphy has argued that acknowledging intersubjectivity enables us to:

> 'understand the oral history interview as an encounter taking place between two unique individuals at a unique moment in time…and pushes the oral historian to consider their own role in the creation of the interview.'[84]

Her reflections highlight how the interviewer's position can shape testimony in different ways, a point that resonates with my own experience.

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[81] Julie Cruikshank and Tatiana Argounova-Low, "'On' and 'Off' the Record in Shifting Times and Circumstances," in *Oral History Off the Record*, ed. by Anna Sheftel and Stacey Zembrzycki (New York: Palgrave Macmillan, 2013), 51.
[82] Amy Tooth Murphy, "Listening in, Listening out: Intersubjectivity and the impact of insider and outsider status in oral history interviews," *Oral History Journal* 48.1 (Spring 2020): 34–44
[83] Amy Tooth Murphy, "Listening in, Listening out: Intersubjectivity and the impact of insider and outsider status in oral history interviews," 35.
[84] Amy Tooth Murphy, "Listening in, Listening out: Intersubjectivity and the impact of insider and outsider status in oral history interviews," 35.

My own positionality inevitably shaped the interview process. As a male researcher with no professional experience of nursing, I occupied an outsider status in relation to my participants. At times this was certainly productive, as it promoted interviewees to expand on technical aspects of district nursing practice that might otherwise have gone unexplained. At other times, my position may have contributed to moments of hesitation or discomposure, particularly when I asked about gendered assumptions within nursing. I was conscious that questions about male nurses, for example, could be inflected by my identity as a man, and I reflected carefully on how participants responded. To mitigate these dynamics, I worked to establish rapport first through the preliminary questionnaire, then through conversational introductions in the interview itself as well as sensitivity to silences or shifts in tone. These intersubjective dynamics are not peripheral but central to oral history. The testimony is always co-constructed between the interviewer and interviewer, reactive to the surrounding environment and the individual characteristics of each party. One example of how my outsider status shaped the direction and therefore testimony of the interview was when I asked participants to explain specific procedures or terminology, such as the following exchange with Cathy:

> Cathy: And then we went to work in the department called the CSSD, which was the Central Sterile Supply Department, and that was where they would make up the dressing packs, and they would put them through the autoclave and they would erm, make up saline and dextrose, and put that through an autoclave as well…
>
> James: Sorry could you just explain what an autoclave is?

Cathy: An autoclave is a machine which I think, just kills all the bacteria.[85]

In one way, my outsider status meant that I was able to ask for a detailed explanation of certain terms, assisting with my overall understanding of important technical and medical aspects of the role. However, at times this may have held the interviewee back, made them pause and consider their explanation, thereby stifling a naturally flowing conversation.

The boundaries between intersubjectivities can therefore become blurred in the oral history interview. In her PhD thesis which studied a group of North-West women's narratives of World War Two, Patricia Phillips discussed how her insider status afforded her a privileged but sensitive position with her participants.[86] The participants involved in Phillips' interviews were friends and neighbours of her mother, meaning Phillips' came to the interviews not as an unknown academic but a 'neighbour's daughter who was doing some research about the war'.[87] There was a prior relationship and knowing between Phillips' and her interviewees which reflected an insider subjectivity. So, although Phillips was an outsider in terms of the interview topics to be covered, there were parts of the interview process which meant her particular presence meant she became an insider. Even prior to the interview taking place, there was interaction and communication with the interviewees which meant I had, even on a limited level, displayed traits of my subjective self which could be read by the interviewees and inform their understanding and approach of the

[85] Cathy Earles, Interview, 18th October 2021.
[86] Patricia Phillips, "Lives Less Ordinary: North-West Women's Narratives of World War Two" (PhD diss., University of Manchester, 2009), 29.
[87] Phillips, "Lives Less Ordinary", 29.

interview. This then would have contributed to how the interviewee perceived me and when it came to the interview itself impacted the construction and performance of their memory retelling.

In order to understand how subjectivities react to create an intersubjective relationship, it is important to understand the performance involved within the oral history interview. Judith Butler has argued that gender, a subjectivity mentioned earlier, is a performative act.[88] By this, Butler contends that our identity as a man or woman is unstable, and as there is no true form of maleness and femaleness.[89] Instead, we can look to gender as a performance that draws on culture and discourses around us to help us create our gender scripts. If we apply this theory to the oral history interview, we can understand the 'self', and what we convey of ourselves, is unstable, performative, and drawn heavily upon culture. Building on this, it is important to understand how individuals can perform in the interview, as this performance can be based on behaviours which are felt by the interviewee and interviewer to mimic appropriate styles. The performance in the interview and the intersubjective relationship between interviewer and interviewee is much more than what might seem face-value, imbued with influences on how we should or could behave in the situation. This is prominent when we look to outside influences, such as that in art or literature, and the effect this can have on the interview.

As well as the relationship between the interviewer and interviewee for the production of discourse, it is important to consider how the interviewee may draw

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[88] Judith Butler, "Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory," *Theatre Journal* 40.4 (Dec. 1988): 520.
[89] Butler, "Performative Acts and Gender Constitution," 528.

upon examples from wider culture. In their work collecting oral histories of the British Home Guard during the Second World War, Penny Summerfield and Corinna Peniston-Bird provide an extensive evidence base for personal recollections becoming influenced by popular culture.[90] This term is referred to as the 'cultural circuit'.[91] The cultural circuit notes how local and personal stories are developed and portrayed in generalised cultural depictions in film, television, fiction, newspapers, and other popular cultural vehicles. These experiences are then 'crystallised' in popular imagination. These cultural depictions then shape local and personal experiences. Summerfield and Peniston-Bird use the example of the popular BBC TV show *Dad's Army*, depicting male members of the home guard. In their interviews with actual members of the home guard, similarities and comparisons with *Dad's Army* occurred. The idea that memories can be malleable and shaped in conjunction with cultural constructions does not mean however that it should be understood as a peril of the methodology. Instead, oral historians indicate that the cultural circuit can tell us much more than just how it was.[92] Memories retold through oral history can point to wider cultural trends and how and why certain memories are prevalent, through the narrative presented on behalf of the interviewee. Emphasising further, Summerfield has argued that historians must understand the 'cultural ingredients' that comprise the accounts of a remembered past.[93]

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[90] Corinna Peniston-Bird and Penny Summerfield (eds.), *Contesting Home Defence: Men, Women and the Home Guard in the Second World War*.
[91] Corinna Peniston-Bird and Penny Summerfield (eds.), *Contesting Home Defence: Men, Women and the Home Guard in the Second World War.*
[92] See Alistair Thomson, *Anzac Memories: Living with the Legend* (Oxford: Oxford University Press, 1995).
[93] Penny Summerfield, 'Culture and Composure: Creating Narratives of the Gendered Self in Oral History Interviews,' *Cultural and Social History* 1.1, (2004): 67.

It is this relationship between the self and memory that has influenced the approach to oral history throughout this project. As already mentioned, if we look at the testimony provided through the oral history interview as not merely a depository of factual information, but as a horizon of possibilities that can shape our understand of the historical self, we are able to better understand individual narratives of history. It is essential however to consider how these memories are composed. To do this we need to understand that individuals compose memories which reflect their personal narrative. Interviewees must also feel that these memories sit within their preferred understanding of 'self' in a way which they feel composed, or a sense of personal equilibrium.[94] This is the duality which makes up the concept of composure within oral history, and which will now be discussed.

2.9 Composure

Having discussed the narratives produced within the oral history interview, memory, and the structure within which the discourse is created, intersubjectivity, it is now important to discuss the process of composing this discourse on behalf of the interviewee. The construction of our memories is not deterministic. Its shape, form and content are determined by the need for the narrator to construct a memory with which they can feel comfortable with at that moment. In order to produce a memory comfortable to oneself the story may also cohere with larger cultural understandings that should be taken into consideration.[95] This process has been termed composure

[94] Penny Summerfield, "Culture and Composure," 70.
[95] Abrams, *Oral History Theory*, 66

and was originally coined by Graham Dawson to explain how people tell stories about their lives while drawing upon imagined forms embedded in culture.[96] Dawson's *Soldier Heroes* explored the compulsion to re-tell stories of soldiering in order to reinforce masculine tropes. Dawson has explained how 'the cultural importance of storytelling lies not only in the stories we are told … but also in those we ourselves tell, or compose'.[97] Elsewhere, Justin Willis has argued that the manner in which interviewees edit their memories, as well as discussing their past selectively, provides evidence that they present alternative versions of themselves/their selves in accordance with changing circumstances. The edits and composure of certain memories can therefore provide important clues to the complexities of lived experience.[98]

Within any edit or composition there are items which are not included. Silences can reflect moments when the interviewee feels a personal discomfort in sustaining a particular narrative of their memories, which may not align with the performance intended for the interview. This is referred to as discomposure. There is risk within the oral history interview of the interviewee feeling unable to tell a comfortable story about the self, resulting in a state of discomposure, evident in confusion, distress, and silence. The manner in which women compose a narrative is particularly complicated when we talk about silence and discomposure. If we look to feminist theory, it is argued that discourses of femininity are multiple and

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[96] Abrams, *Oral History Theory,* 66.
[97] Graham Dawson, *Soldier Heroes: British Adventure, Empire and the Imagining of Masculinities* (London: Routledge, 1994) 22.
[98] See Justin Willis, "Two Lives of Mpamizo: Understanding Dissonance in Oral History," *History in Africa* 23 (1996): 319–32.

contradictory. These discourses place women within a disadvantaged position due to their framing within male norms of action and control.[99] In terms of the oral history interview, where memories confirm to a norm of femininity, such as nursing, women may find it easier to compose socially accepted narratives. According to Kathryn Anderson and Dana Jack, however, when these experiences deviate from societal norms, it can be more difficult for interviewees to compose a narrative that brings them personal equilibrium.[100]

In terms of instances within the interviews where discomposure might have occurred, I would argue that this generally occurred when I would ask questions concerning the visibility of male district nurses. When I asked Ethel Love to talk about the male nurses she trained with, she replied: 'I shouldn't really say this… but they were quite feminine anyway. They were lovely lads. They were nice lads.'[101] The start of this reply instantly shows that the interviewee felt that this narrative did not align with the sense of composure necessary for the interview. This could have even because of the intersubjective effect I had on the interview as a male-presenting individual, or it could link with what Anderson and Jack discussed regarding discourse which deviates from societal norms.[102] Regardless of the reason, it is essential to understand how dis/composure can affect the interview testimony.

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[99] Penny Summerfield, "Culture and Composure," 70.
[100] Kathryn Anderson and Dana Jack, "Learning to Listen: Interview Techniques and Analyses," in *Women's Words: The Feminist Practice of Oral History,* ed. by Sherna Berger Gluck and Daphne Patai (London: Routledge, 1991), 14.
[101] Ethel Love, interview conducted with author, Littlehampton, 8th November 2021.
[102] Anderson and Jack, "Learning to Listen: Interview Techniques and Analyses," 15.

A useful way to highlight the composure of acceptable memory narratives is the recollection process adopted by the male district nurse interviewed for this project. In literal terms, they had composed a narrative acceptable to themselves through the process of creating a document that he provided me prior to the interview. The interviewee was working on a memoir and had prepared the chapter on his district nursing career to accompany our interview. I would argue here that we have a literal embodiment of the dual aspect of composure. There was a composed narrative created which the interviewee felt provided personal equilibrium to his district nursing career and ended up assisting his performance throughout the interview. Although this document was not something that the interviewee referred to through the interview, it was part of a collection of documents which the interviewee felt provided a sense of composure to his district nurse identity. By providing me with these documents prior to the interview, not only was the interviewee acting incredibly helpful, keenly aware that I would find any information he had useful. The documents also acted as a literal embodiment of how he conceptualised his district nursing career, an act of composure which he felt necessary to provide. This is interesting, as the interviewee had somewhat created his own personal archive, which he felt acted as a satisfactory way to reconstruct his career history.

2.10 Working with the archive

To clarify, I am discussing here the process of creating a narrative within the oral history interview that is acceptable to the interviewee. If we refer back to the earlier

discussion on intersubjectivity, I discussed the effect that the interview has on the creation of discourse. This is not the only contingent within the oral history interview. The process of composing an acceptable narrative is important to understand, as it points to wider social and cultural behaviours which are deemed normative. As historians, we can look to oral history interviews as a vital source in providing insight and knowledge into these behaviours. In order to assist this process, composing an acceptable narrative which produces a rich and extensive history of district nursing, I felt that it was necessary to introduce archival research into the project. This was so that the important moments of composure which the interviewees undertook could sit within a wider piece of research, centring their narratives but by no means as an attempt to fact-check these carefully crafted narratives.

I chose to integrate archival text and image-based sources into this project following the conclusion of the oral history interviews. Prior to any interviews taking place, however, I visited the Liverpool Central Library Archives to study an existing collection of interviews with nurses. These were conducted as part of a Wellcome-funded research project titled 'History of Nursing in an English Urban Region', recorded between 1991 and 1995.[103] Out of 74 interviews deposited there are only three with district nurses who worked in the Liverpool area, totalling an interview time of over five hours. Again, this indicates the limited scope of regional district nursing research. This was a useful approach, and the interviews provided a wealth

[103] Nursing Oral History Collection, *History of Nursing in an English Urban Region, 1991–1995,* 610 NUR, Liverpool Central Library Archives, Liverpool.

of interesting data which furthered my understanding of district nursing history. However, I felt that it would have been more insightful to listen and study these interviews with a corresponding document which shed light on the wider picture that was occurring in district nursing during the period discussed.

I was concerned that this exercise would imply that the interview testimony might not be able to sit on its own, and that the archival sources were needed to provide a degree of legitimacy to district nurses' memories. However, I adopted the approach which, rather than using the text and image-based archives to fact check the interview testimony, I would apply archival data to the analysis to enrich the transcript. To do this, I visited the Wellcome Collection, Royal College of Nursing, and National Archives.[104] I searched for sources which spoke to the history of district nursing, largely through documents and collections relating to the QNI. In this way I performed a degree of methodological triangulation, searching for overarching themes and discussions which occurred in the oral history interview and cross-referencing these with archival sources. I want to reiterate that this was by no means done to validate interview testimony. An example of this was the frequent claim by the interviewees that they were guests in the home of their patients.[105] I wanted to look in the archives, and training documents in particular, to assuage whether this was something that was a wider sentiment within the profession, developing Summerfield's argument about the 'cultural circuit' discussed earlier. This

[104] Wellcome Collection, *Queen's Nursing Institute Archives (SA/QNI)*, London; Royal College of Nursing Archives, London; The National Archives, Kew.
[105] Julie Snowden, interview with the author, conducted over Microsoft teams, 21st January 2022; Mabel Williams, interview with the author, conducted over Microsoft teams, 8th March 2022; Karen Walker, interview with the author, conducted over Microsoft teams, 14th March 2022.

then would situate the experiences of the interviewees within a wider experience of district nursing in Britain at that time. The recurrence of this language across both oral testimony and archive sources demonstrated how deeply the idea of 'guest hood' was embedded with the identity of district nurses. Consulting archives therefore did not serve to fact-check oral testimony, but to situate it within a wider professional discourse spanning decades. In this way, archival material acted as a supporting layer that contextualised and deepened the oral histories, enriching the analytical scope of the thesis.

2.11 Conclusion

This chapter has outlined the methodological approach taken in this thesis and situated it within the wider practice and development of oral history. By tracing oral history's journey from folklore and history from below to its engagement with memory, intersubjectivity and composure, I have established the theoretical framework guiding this research. At the same time, I have reflected on the practical challenges of interviewing during the Covid-19 pandemic, the ethical considerations involved in working with older participants, and the implications of conducting interviews both virtually and in person. Although originally planned to be all in-person, I am glad that the interviews took place through a combination with remote interviewing. I believe future oral history practitioners will be able to study the approach taken in this thesis and others similar when beginning to think how to navigate the remote interviewing process. Oral history was uniquely suited to this project because it allowed me to access the lived experiences of district nurses

whose voices are largely absent from the written record. Semi-structured interviews created space for interviewees to shape the direction of their stories, while a small and intimate sample enabled depth and richness. From the outset, I deliberately kept interviews as open-ended and conversational as possible, which allowed participants to prioritise the memories and themes most meaningful to them.

The analytical positioning developed in this chapter rests on several key methodological commitments. I felt it was necessary include discussion on the representativeness of a sample of seven interviewees, namely as this was something which I originally could have restricted key analytical interventions, but which turned out to make the interview testimony that much more appreciated. Representativeness is treated not as a statistical benchmark but as a recognition of the value of individual narratives. Memory is understood less as a repository of facts than as a process of meaning-making. Intersubjectivity highlights how testimonies were co-constructed through my encounters with participants, while composure draws attention to how narrators shaped their accounts to maintain coherence and equilibrium. Finally, archival sources were used not to validate testimony but to situate it within a wider professional and cultural discourse. Taken together, these themes reflect an approach that sees oral history not only as a method but as an object of analysis in its own right. By centring the voices of seven retired district nurses, this chapter sets out the methodological foundations for the subsequent analysis of professional identity, community, and home. In doing so, it highlights how oral history contributes not only to nursing history but also to broader methodological debates about memory, subjectivity, and the democratic potential of history-telling. The next chapter applies this methodological framework to explore

how district nurses constructed and understood their professional identities in post-war Liverpool.

Chapter 3: Professional Identity

3.1 Introduction

District nurses were a distinct branch of the nursing workforce in post-war Britain, responsible for delivering clinical care in patients' homes and communities. They were trained, regulated and increasingly professionalised, yet their work remained closely tied to traditions of community care, volunteerism, and gendered expectations of service. As this thesis explores, district nursing cannot be separated from the community and the home, the places in which it was practiced. Yet to grasp how these themes were remembered by district nurses themselves, it is first necessary to examine how they understood their professional identity. Professional identity represents the identification of an individual with their profession. It encompasses the markers and attributes that signify one's association with their professional role, acting as an individualistic articulation of professionalism. For Valerie Fournier, professionalism is the byproduct of a set of normative identities that both discipline and enable the social actors concerned by it.[1] In this identification of professionalism, specific behaviours associated with a role help to construct a professional identity which provides the individual with autonomy and

[1] Valerie Fournier, "The Appeal to 'Professionalism' as a Disciplinary Mechanism," *The Sociological Review* 47.2 (May 1999): 286.

authority.[2] Professionalism can therefore embody one's association with a professional role, which in turn helps to create a professional identity.

As the original scope of this research was the social, educational, and political history of district nursing, I felt that discussions on employment and the transformation of employment practices associated with district nursing between 1945 and 2000 would provide the necessary insight and understanding into the professional history of the district nurse. These conversations were expected to focus on the evolution of practices and behaviours associated with being a district nurse, such as how the district nurse spoke about the training for their role or professional organisations they were members of. It was believed that these discussions would have helped contribute to a wider understanding of 'the' district nurse's professional identity. However, when it became clear that the number of interviewees would be smaller than originally expected, I began to think more about the personal and individual expressions of professional identity. What emerged was that in order to understand how interviewees spoke about topics such as home, community and gender, it was necessary to examine how they communicated an identity associated with their professional status as a district nurse. Each of these concepts were discussed within the sphere of the individual interviewee's professional history and therefore intersected with how each interviewee communicated their own professional identity as a district nurse. This chapter will highlight key moments from our conversations which contributed to each district nurse's expression of professional identity. Moreover, I will explore the key markers,

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[2] Fournier, "The Appeal to 'Professionalism', 282.

attributes, and values which interviewees identified with their profession, integrating these recollections within analysis of the broader district nursing profession during the period.

In analysing professional identity, this chapter focuses on several interrelated themes. First, training and regulation, which shaped the formal boundaries of the profession and provided markers of legitimacy. Second, autonomy and responsibility, as district nurses frequently described themselves as working independently in patients' homes, making decisions without immediate supervision. Third, gender, since professional identity was constructed within a nursing culture that remained strongly feminised, even as men entered the profession. Finally, the relational and moral dimensions of practice, where professional values were expressed through care, duty and responsibility to patients and families. These themes overlap with the wider themes discussed in the thesis relating to community, home, and gendered labour. By foregrounding professional identity here, the analysis establishes the framework through which these broader themes can be understood in subsequent chapters.

In approaching these questions, oral history interviews form the centre of analysis. The testimonies of retired district nurses provide direct insight into how professional identity was remembered and expressed. As the seven district nurses existed within a wider landscape of district nursing, it is important to understand the systems of knowledge and behaviours of the district nursing profession they were situated within. In order to contextualise the interviewees' testimonies with the profession of district nursing in Britain between 1945 to 2000, I analysed archives of the Queen's Nursing Institute held at the Wellcome Collection in London, Royal

College of Nursing Archives, London and the National Archives at Kew.[3] Materials including images, training manuals, meeting minutes, industry journals and more were studied to help establish the testimony gathered from interviewees within the wider district nursing professional landscape.

By combining analysis of oral history interviews with archival materials, this chapter is able to produce a multifaceted examination into the professional identity of the district nurse in Britain. As mentioned in the methodology chapter, archival sources have not been consulted to fact check or evidence memories that were discussed by interviewees. Instead, I looked to archival sources to, firstly, provide necessary context and data pertaining to the district nurse role between 1945–2000. Secondly, this contextual use of archives allowed for a richer reading of oral history interview testimony, revealing how individual recollections both intersected with and diverged from official discourses of professional identity. As an outsider to the district nursing profession, I felt it was important that the district nursing profession outside of Liverpool was explored. This was so there would be necessary insight into the professional environment of the district nursing profession that was recalled by interviewees.

Moreover, as the primary professional organisation associated with district nursing for much of the period, the archives of the QNI felt like appropriate sources to contrast with the more intimate narratives of professional identity conveyed by those interviewed. Consequently, interesting links were discovered between the

[3] Wellcome Collection, *Queen's Nursing Institute Archives (SA/QNI)*, London; Royal College of Nursing Archives, London; The National Archives, Kew.

archival portrayal of district nursing and the interviewees' testimonies through a collection of materials relating specifically to the history of district nursing in Liverpool. Integrating these records within the personal narratives of the district nurses allows for a deeper understanding into the nature and experiences of district nursing in Liverpool. This approach will demonstrate how the professional identity of the district nurse has been imagined, developed, and implemented through a combination of personal experiences, governmental management and public-focused discourse.

This chapter is organised into three sections that examine the construction, development and expression of a district nurse professional identity between 1945 and 2000. To begin with, the first section provides a historical overview of the professional landscape of district nursing in the decades following the introduction of the NHS in 1948. It examines the tensions between voluntary and statutory forms of regulation, the declining influence of the Queen's Nursing Institute, and the establishment of the Panel of Assessors in 1959. This section draws on archival materials to explore how the district nursing profession was institutionally framed as well as how this framing contributed to the formation of a professional identity. This section is crucial in establishing the professional organisation of district nursing just before the testimony of the interviewees is able to provide more of an individualistic expression of district nursing professional identities.

The second section focuses on training and early career development, utilising the oral history testimony of interviewees to examine how professional identity was shaped through education, personal background, and early experiences in practice. The careers of Alan Carlise and Ethel Love, who trained in the 1950s and 1960s, are

considered alongside those of Cathy Earles, Dorris Smeethe, and Mabel Williams, who trained at Walton Hospital in the 1970s. This section also introduces the training histories of interviewees Julie Snowden and Karen Walker. Their accounts are contextualised within broader transformations in district nurse training, including policy interventions such as the Briggs Report and the 1979 Nurses, Midwives and Health Visitors Act. In the third section that follows I explore how district nurses articulated and embodied professional identity through their day-to-day work. Drawing primarily on interview testimony, this section highlights how nurses navigated the values, practices, and ethical demands of the role.

3.2 Constructing the District Nurse Professional Identity

This section will examine the institutional landscape that framed district nursing practice between 1945 and 1959. This section is necessary as, although the oral history testimony gathered for this project does not provide a first-hand experience of district nursing during the period 1945 to 1959, there is a need to understand requisite contextual information pertaining to the district nursing profession. Indeed, this period ushered in a foundational template to understand both the district nursing profession and its professional identities which I argue remained in some capacity with the role throughout the late twentieth century. Moreover, it was at this time that there was a development in the organisation, management and implementation of healthcare in the United Kingdom which affected the district nursing profession on a similar scale of breadth and importance to that of William Rathbone and Nurse Robinson's intervention in 1859. This was the establishing of

the National Health Service (NHS) on 5th July 1948. The creation of the NHS and the impact this had on the organisation of the district nursing profession will be examined in this section, principally the relationship between the Queen's Nursing Institute (QNI) and the role's development. It is also important in this section to explore key values an attributes of the district nurse professional identity that were prevalent during this time. This will include examining the gendered understanding of the district nurse role as well as exploring how the role retained associations with attributes such as charity and volunteerism that first emerged in the nineteenth century.

DNA, the QNI, and the NHS

The district nursing profession was subject to the transformative changes that occurred in Britain in the immediate aftermath of the Second World War. During this time, the profession was in a transitory state between the modernising and standardised approach to healthcare promoted by the NHS and the longstanding, regionalised traditions of the QNI. Prior to the introduction of the NHS, district nursing services had been managed and delivered by voluntary or charitable institutions organised through local District Nursing Associations (DNA).[4] Some associations ran their own district nursing services, while the majority outsourced this to the QNI. In 1948, there were 2,716 county and district nursing associations

[4] Pauline Allen, Donna Bramwell, Kath Checkland, and Jolanta Shields, *Community Nursing Services in England: An Historical Policy Analysis* (Palgrave Macmillan, 2022), 10.

affiliated to the QNI, employing a total of 8,294 district nurses.[5] The 1946 National Health Service Act came into effect 5th July 1948 and gave Local Health Authorities (LHA) the responsibility for providing 'the attendance of nurses on persons who require nursing in their own homes'.[6] The Act specified that this could be done by making arrangements with local DNA, which could be affiliated to the QNI, or by employing the nurses directly. This created an opportunity for LHA to devise their own district nursing standards, training, and education. In January 1948, a document was sent to nursing staff employed by the Liverpool Queen Victoria District Nursing Association (LQVDNA) which stated that the ultimate future of the Queen's Nursing Institute following the introduction of the NHS was 'not yet known'.[7] However, it was explained that for district nurses themselves, 'the changeover will affect you very little because your duties will be the same as at present.'[8] In Liverpool, the LQVDNA was awarded responsibility for the management of the city's district nursing service. The LQVDNA, as well as being affiliated with the QNI, held the influential position of being the first DNA, dating back to 1862. The majority of LHA however, 75 out of 146, opted for direct employment of district nurses.[9] As a result of this, the voluntary sector of district nursing provision, which the QNI was at the forefront of, began to contract. Possibly

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[5] Helen Sweet, "District Nursing in England and Wales c. 1919–1979 in the context of the Community Health Team"(PhD diss., Oxford Brookes University, 2003), 110.
[6] United Kingdom Parliament, National Health Service Act 1946, Parliamentary Archives, HL/PO/PU/1/1946/9&10G6c81.
[7] "Information re the introduction of the National Health Service", 1948, SA/QNI/X.38/7, Queen's Nursing Institute, Wellcome Collection, London.
[8] "Information re the introduction of the National Health Service", 1948, SA/QNI/X.38/7.
[9] Roger Ottewill and Ann Wall, *The Growth and Development of Community Health Services* (Sunderland: Business Education Publishers, 1990), 149.

owing to its long-standing history with the QNI, the LQVDNA remained responsible for the training and organisation of district nursing in Liverpool until 1959.

This realignment of responsibility for the district nursing service became a site of tension between the government and the QNI. On the QNI side in particular, there were concerns with how the district nurse would best operate within the NHS while abiding by the rigorous training and educational standards ingrained in the profession for over 80 years. Moreover, according to Mary Stocks, there was some trepidation regarding the creation of a nationalised health service in and of itself.[10] Stocks argued that there was some nervousness regarding the supposed socialistic implications of the NHS, writing '[t]he new service was to be a bright jewel in the crown of an admittedly socialist government, and very many leading personalities in district nursing had little sympathy with socialism in general'.[11] In a membership meeting in 1947, Mrs Brooke, a member of the QNI Council, asked '[w]hat will be the future of training of the district nurse? I wonder sometimes if we realise that there is a risk that the Queen's Nurse may become a historical figure?'.[12] For Sheila Gibson, the introduction of the NHS meant the relationship between the statutory and voluntary sectors had irreversibly changed.[13] Gibson has illustrated how, now that the State was in a position to provide a more comprehensive and funded service, the voluntary service might be seen as redundant, not least as fundraising efforts became increasingly difficult.[14] In an attempt to overcome these concerns,

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[10] Mary Stocks, *A Hundred Years of District Nursing* (London: Allen and Unwin, 1960), 171.
[11] Mary Stocks, A Hundred Years of District Nursing, 171.
[12] 'QIDN Report of a Public Meeting, 10, 1947' quoted in Sheila Gibson, "A History of the Panel of Assessors for District Nurse Training 1959–1983," (PhD diss., University of Surrey, 1993), 88.
[13] Gibson, "A History of the Panel of Assessors for District Nurse Training 1959–1983," 110.
[14] Gibson, "A History of the Panel of Assessors for District Nurse Training 1959–1983," 110.

the QNI worked to promote the benefits of affiliation between LHA and the Institute. As a voluntary organisation, the QNI placed a huge degree of importance on creating a regulated system of training for district nursing, corresponding with a key tenet of professionalism identified by Anthony Giddens.[15] Furthermore, they made a significant commitment to aligning the professional identity of the district nurse with their core values, one of which was research. From the onset of the NHS, the QNI were committed to delivering research programmes designed to 'obtain information from which to determine the future role and education of the district nurse and the relationship of district nursing to other community services.[16] It is evident, therefore, that there was a willing determination by the QNI to play an integral role in helping to design the professional identity of the district nurse within the NHS and remain integral to the profession's organisation and management.

According to Lisbeth Hockey, when the National Health Service Act was implemented in 1948, district nursing services were professionally organised through a fragmented and complex administrative structure which made the task of organisation 'even more formidable'.[17] The professionalism within district nursing was largely emphasised through a long-standing commitment to training and education. It was therefore important for both the QNI and the NHS to produce a national syllabus of training for district nursing that could be managed by all DNA, whether affiliated or not. This approach would help unify the district nurse around a

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[15] Anthony Giddens, *Sociology* (Cambridge: Polity Press, 2021)*,* 358.
[16] Ottewill and Wall, *The Growth and Development of Community Health Services*, 149.
[17] "The family care team: philosophy, problems, possibilities by Lisbeth Hockey," 1971, SA/QNI/P.7/67, Queen's Nursing Institute, Wellcome Collection, London. Lisbeth Hockey, n.p.

set of professional values throughout the various regional DNA. The government, however, were reluctant to formally commit to the QNI national training scheme, recognising that some LHA produced training advice was not entirely in line with the Institute's policy or practice. If the government were to formally commit to the QNI national training scheme, they would be required to apply standards throughout LHA, an expensive and time-consuming process. Recognising the struggle between the state and QNI, Dorothy Goodwin, the organisation's education officer, wrote in 1957 that 'one of the things we have to keep in front of the student is that the service is to people and not to organisations. The State, the Local Health Authority, the hospital are abstractions. They are not living things. It is the people within their frameworks who are living and we service people not things'.[18] This reflected the concern within the QNI that if district nursing became too attached to the State or an LHA, their standing as the primary organisation responsible for district nurse management and organisation could be diminished. A reason for this could be that even though the state had considerably larger resources, pressure could be put on the profession to undertake training or education that might not be in line with QNI standards, but which might be more economically viable. This tension had a confusing effect on the professional identity of the district nurse, as the regulating body, a key tenet of professionalism, was in flux.

[18] "Changing Concepts in Nursing Education", December 1957, SA/QNI/N10/3, Wellcome Collection, London, Dorothy Goodwin, 185.

Panel of Assessors

In order to address some of the issues regarding the regulation and training of district nursing, a Working Party was set up under the chairmanship of Sir Fredrick Armer in 1953. The Working Party was tasked to consider what training it is desirable that registered and enrolled nurses respectively should undertake prior to their employment on home nursing duties, and the means by which such training should be provided. Out of the seventeen members of the Working Party, five were nurses, two of which were 'qualified and experienced' district nurses.[19] This was an intervention which represents a shift in policy making decisions towards a more unified national approach to district nurse regulation. The QNI contributed considerable evidence to the Working Party, with a notable intervention in its suggestion of a central training body for district nurses. The QNI argued that a central district nursing body should be responsible for drawing up the syllabus of training, setting examination papers, conducting examinations, and approving centres of district nurse training. At that point, most specialist district nurse training was provided by the QNI, although training was not standardised or compulsory. Organisations such as the Raynard Mission however also offered some specialised home nursing training.

The Working Party published The Armer Report in 1955. The report recommended district nurse training to be reduced to between three and four months, at odds with the advice of the QNI. The report also argued that due to the

[19] Sir Frederick Armer, Report of the working party on the training of district nurses, 1955 quoted in Allen, Bramwell, Checkland and Shields, *Community Nursing Services in England: An Historical Policy Analysis,* 11.

improvement of the general standard of housing within the country, six months training was no longer required.[20] Following the recommendations of a Working Party which reported to Iain Macleod, Minister of Health in 1955, the Armer report pushed for the creation of a non-statutory permanent advisory committee to formulate district nursing training. The committee would 'advise the Minister on matters relating to district nurse training and in particular on the approval of schemes of district nurse training and examination submitted by local health authorities.[21] The Advisory Committee on the Training of District Nurses (ACTDN), set up in 1957, consisted of twelve members, including members from the Queen's Institute, local authorities and other health-associated organisations. The ACTDN met monthly and in 1959 produced the Ingalls Report. The report included an approved syllabus for district nurse training and recommended the establishment of a permanent panel of assessors in a supervisory role. The report was published in accordance with the recommendations first set out in the Armer Report and was chaired by Dr Ingalls. In the report, the work of the district nurse was out outlined as 'caring for people with infectious diseases, pain relief, treating wounds, and the prevention of accidents within the home.'[22] Although a broad summary of the work of the district nurse, this a useful indication of governmental understanding into the primary work of the district nurse, which would therefore impact the professional

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[20] Sir Frederick Armer, Report of the working party on the training of district nurses, 1955 quoted in Allen, Bramwell, Checkland and Shields, *Community Nursing Services in England: An Historical Policy Analysis,* 11.
[21] Sir Frederick Armer, Report of the working party on the training of district nurses, 1955, quoted in Allen, Bramwell, Checkland and Shields, *Community Nursing Services in England: An Historical Policy Analysis,* 11.
[22] D.H Ingall, Training of district nurses report of the advisory committee, 1959, quoted in Allen, Bramwell, Checkland and Shields, *Community Nursing Services in England: An Historical Policy Analysis,* 11.

identity entwined with the role. In what could be understood as a shift away from the professional identity espoused by the QNI, there is limited reference in Dr Ingall's words to the district nurse's responsibility to improvise hospital-based tasks within the home, removing that institutional connection. The report advised for 4 months training, operated by LHA, but which carried a national certificate issued by the MOH. In response, the QNI reduced the length of training they provided from 6 to 4 months. Sally Sheard and Meg Parkes have argued this decision disadvantaged district nurses for a considerable time during a period of changing health needs and provision.[23] In 1959, the Minister for Health, Derek Walker-Smith MP, accepted the recommendations of the Ingalls Report. He also approved the establishment of the Advisory Committee of the Training of District Nurses Panel of Assessors, often shortened to the Panel of Assessors and renamed Panel of Assessors for District Nurse Training in 1971.

The Panel of Assessors (POA) had seven members, drawn from the ACTDN and included wider nursing and education representatives, but none from the QNI. The QNI had originally sought to change its charitable status by making a bid to become the Central Committee for District Nurse Training, with a renewed call for a statutory qualification for training in district nursing. This would have required legislation however, and the government opted for the creation of the POA. Although originally established to act in an advisory and supervisory manner, the POA would have considerable impact on shaping the professional identity of the

[23] Meg Parkes and Sally Sheard, *Nursing in Liverpool Since 1862* (Lancaster: Scotforth Books, 2012), 71.

district nurse, during this period and onwards. When it was first established, the work of the POA was seen as a continuation of the work carried out by the ACTDN, meaning there were no precise terms of reference or remit outlined. Sheila Gibson has provided five terms of reference which usefully outline the key responsibilities of the panel.[24] Firstly, the POA would advise on the suitability of schemes of district nurse training submitted by training authorities. This was an acknowledgement of the increasing responsibilities that were placed on regional LHA in designing training schemes operating outside the sphere of the QNI.

Secondly, the POA would advise the MOH on the extent that, once approved, the standard of each individual training scheme was being maintained. One of the main advantages promoted by the QNI was their ability to implement exemplary training standards, with those who had undertaken QNI training awarded the prestigious Queen's Nurse title. With the POA now advising the MOH on training standards, it is hard to ignore how the professional identity of the district nurse was moulded away from the QNI ideal. Thirdly, the POA would advise on the need for changes to examination question papers set by the LOH, following a moderation process. This term of reference, as well as the previous two, solidify the importance in regulated training and education of a professional identity argued by Giddens.[25] The final two advisory responsibilities outlined by Gibson cover the POA advising on moderation of exam scripts, both for those who obtained borderline grades and those who should pass.[26] During this period, it seems there was a key focus on

[24] Gibson, "A History of the Panel of Assessors for District Nurse Training 1959–1983," 119–20.
[25] Giddens, *Sociology*, 358.
[26] Gibson, "A History of the Panel of Assessors for District Nurse Training 1959–1983," 110.

maintaining the advisory nature of the POA, in contrast to creating a body with the status of an independent training body argued for by the QNI. There were therefore concentrated efforts on behalf of the QNI to reinforce their position as the leading organisation tasked with the training and regulation of district nursing. This was done largely by emphasising the core values of district nursing associated with delivering care within the home.

District Nursing, Nursing in the Home, and Gender

The manner in which home was interwoven in the oral history with district nurses will be covered extensively in Chapter 5. However, it is necessary to briefly include here the foundational relationship between the home and district nursing and how this impacted the professional remit of the district nurse during this period. When the NHS was created, the broadest definition of district nursing was the provision of nursing care in the home, with services managed totally separate to those within a hospital setting.[27] This lead to a perception among the public that district nursing did not 'constitute proper nursing' and was instead an extension of home care delivered by an untrained nurse.[28] Adding to this misunderstanding of the district nurse role, Elizabeth Roberts has highlighted how discernible changes in attitudes to welfare provision which took place during the inter-war period created a belief within the working classes that they 'would be better cared for in hospital'.[29] The confusion

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[27] Allen, Bramwell, Checkland, and Shields, *Community Nursing Services in England: An Historical Policy Analysis,* 12.
[28] Sweet and Dougall, *Community*, 82.
[29] Elizabeth Roberts, "The Recipients' View of Welfare," in *Oral History, Health and Welfare,* ed. by Joanna Bournat, Robert Perks, Paul Thompson and Jan Walmsley (London: Routledge, 2000), 224.

surrounding the actual remit of the district nurse meant groups such as the QNI were increasingly at odds to emphasise what they believed to be the true professional nature of the role, advocating mainly for a unified approach to training and regulation across DNA who were and were not affiliated with the organisation.

The training provided by the QNI was for six months, on top of the three years of training needed to become a state registered nurse. Sheila Gibson has noted how the curriculum within training advocated by the QNI was largely focused on how traditional nursing tasks could be undertaken in the home, with a strong focus on improvising equipment from items that might be found in the home.[30] This is emphasised by Pauline Allen, Donna Bramwell, Kath Checkland, and Jolanta Shields, who argued that training and recruitment manuals produced by the QNI suggested that during this period district nursing was understood as providing nursing services within a home setting, with a strong emphasis on improvisation of skills learnt in the hospital.[31] This is shown in recruitment pamphlets produced by the QNI, such as Figure 3, which portrayed a professional identity of the district nurse which rested on the nurse's ability to improvise hospital-based tasks within the home.[32] In the image, we see a district nurse treating a patient in their home, with medical apparatus conveying the hospital-adjacent environment the district nurse would be delivering care within. Showing the district nurse in the process of delivering care, with her pristine uniform and hat, in front of a window to the

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[30] Gibson, "A History of the Panel of Assessors for District Nurse Training 1959–1983," 86.
[31] Allen, Bramwell, Checkland, and Shields, *Community Nursing Services in England: An Historical Policy Analysis*, 14.
[32] "The Training and Work of District Nurses", November 1949, DV 11/149, The National Archives, London, np.

patient's home garden, indicates a clear intersection between the hospital and the home.

It's clear that during this period, the professional identity of the district nurse was heavily rooted in the delivery of care that would be provided in the home. The QNI were focused on conveying a professional identity of the district nurse who could use hospital-based skills within a home context, rather than home nursing being understood as a separate strand of nursing. It was hoped that this approach would help the QNI leverage their position, utilising decades of experience at the forefront of district nurse training. During the first years of the NHS however, as healthcare providers struggled to make sense of their remit or their organisation, there was little explicit advice provided which delineated the role and function of community nursing services, with 'nursing in the home' assumed to be a self-evident category of activity.[33] For Allen, Bramwell, Checkland, and Shields, in order to understand the activities of the district nurse during this period, it is best to consider the training which was provided, at this time delivered primarily by the QNI.[34]

[33] Allen, Bramwell, Checkland, and Shields, *Community Nursing Services in England: An Historical Policy Analysis*, 11.
[34] Allen, Bramwell, Checkland, and Shields, *Community Nursing Services in England: An Historical Policy Analysis*, 11.

Figure 3: Nursing Patients in Their Home

The National Archives, DV11/149, 'The Training and Work of District Nurses', 1949

In the same recruitment pamphlet as Figure 1, it was argued that district nurse training had to be designed to 'help nurses adapt hospital methods to nursing in the homes, and to give them an understanding of the social and health needs of the patient and his family'.[35] This represented an acknowledgment of the burgeoning professional lens placed over the district nurse, but which resonated with the idea that there needed to be an understanding to both health and social needs of the patient in a quasi-maternal manner. This is because we see the district nurse adapting hospital training methods in the home but with a holistic approach to the social and health care needs of the patient and their family. Moreover, the pamphlet goes on to state '(the training) develops in the nurse a feeling of personal interest in

[35] "The Training and Work of District Nurses", November 1949, DV 11/149, The National Archives, London, np.

the patients and their families she visits, and she acquires a sense of real and personal responsibility for their welfare'.[36] The mentioning of personal responsibility and welfare here points to an established understanding that the district nurse was performing some aspect of moral duty in their role, rooting the professional identity in values of volunteerism and philanthropy, that was targeted in the home of the patient.

The connection between the district nurse and the home is integral to the role to this day, as the interview testimony will later show in chapter 6. However, during this post-World War Two period there were still associations with the district nursing role which reflected a continuation of nineteenth-century ideals. Indeed, Rona Ferguson and Helen Sweet have both argued that when the NHS was first implemented in Britain, the district nurse occupied what has been stereotypically represented as a vocational, maternal, or semi-domestic role working outside of a hospital institution.[37] To me, this period acts as the point where district nursing began to merge into the profession we know it today, largely brought on by the creation of the NHS and the start of the QNI's repositioning as an advisory rather than managing body which shaped the professional identity of the district nurse. The historic connection between district nursing and volunteerism had a definite impact on the professional identity of the district nurse. Heggie has highlighted how voluntary work in healthcare undertaken by Victorian and Edwardian women created

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[36] "The Training and Work of District Nurses", November 1949, DV 11/149.
[37] Helen Sweet and Rona Ferguson, "District Nursing History", in *District Nursing: Providing Care in a Supportive Context*, ed. by Jane Cantrell, Jane Harris, and Sally Lawton (London: Churchill Livingstone, 2004), 82.

tensions between inherently female skills and professionalism.[38] It is clear that there was tension between the supposedly-inherently feminine skills of 'tenderness and domesticity' that were associated with district nursing, and the fact the role was becoming imbued with its own professional markers and attributes.[39]

The professional identity of the district nurse was shaped by gendered codes that reproduced nineteenth-century ideals of femininity and duty, demonstrating how older cultural expectations continued to inform the profession in the post-war period, despite broader attempts towards modernisation. District nurses acted as both maternal and semi-domestic figures, while also solidifying their burgeoning professionalism. This dual role echoed remarks made by Herbert Rathbone, William Rathbone's nephew. Writing in 1899, Herbert Rathbone pointed to how '[t]he friendly and sympathetic interest of the lady superintendents is most important, as they assist in preventing the work from becoming too professional, and in keeping before the matrons and nurses the great social and moral reformation they are assisting'.[40] The point made here is that the Lady Superintendent, a key actor within the QNI's formulation of the district nursing profession, assisted with preventing the district nurse from becoming 'too professional'.[41] Reiterating the point made by Ferguson and Sweet, in this way, even half a century after this discussion in 1945, the district nurse was still imbued with a domesticated and singularly feminised understanding. In her work on the historical shaping of the division of labour in

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[38] Heggie, "Health Visiting and District Nursing in Victorian Manchester; divergent and convergent vocations," 403.
[39] Heggie, "Health Visiting and District Nursing in Victorian Manchester; divergent and convergent vocations," 403.
[40] Gwen Hardy, *William Rathbone and the Early History of District Nursing,* 8.
[41] Gwen Hardy, *William Rathbone and the Early History of District Nursing,* 8.

health care, Ann Witz has shown how strands of nineteenth-century patriarchal culture influenced the professionalising projects of medicine, nursing and midwifery.[42] This culture was evident in district nursing at the onset of the NHS. This was represented through a clear gendered dichotomy which represented women's work as caring, in contrast to the male-dominated understanding of medicine as curing. For Helen Sweet, this effectively reinforced the idea that work in the female, domestic sphere, was of lower status.[43] District nursing then, was seen as vocational, maternal, and semi-domestic, with a professional identity situated within gendered constructs. However, the contraction of the QNI's influence certainly coincided with an examination into the professional remit of the district nurse, especially to do with the gendered understanding of the role.

Gender was, and still is, deeply embedded into the design, structure and functioning of the professions, which Celia Davies refers to as the masculinity of organisational life.[44] This is to say that the structures of organisations and professions are built in a way which strongly rest on the understanding of masculinity and femininity as accepted cultural codes of life, where for example, men may be able to carry out work labelled 'managerial' and women could do the work labelled 'clerical'.[45] In district nursing, the dichotomy between professional and duty demonstrates this. The Beveridge Plan, 1942, which laid the blueprint for the NHS and the welfare state, set out the structure for postwar society based upon

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[42] Ann Witz, *Professions and Patriarchy* (London: Routledge, 1992).
[43] Sweet with Dougall, Community Nursing and Primary Healthcare in Twentieth Century Britain, 176.
[44] Celia Davies, *Gender and the Professional Predicament in Nursing* (Buckingham: Open University Press, 1995), 43–65.
[45] Celia Davies, *Gender and the Professional Predicament in Nursing,* 45.

gendered divisions. Beveridge had at its heart, a specific model of the family based upon the economic contribution of men and the financial dependency of women.[46] Actors within the welfare state, in this instance district nurses, first saw their professional identity absorbed into this model. This gendered model was evident in the way district nursing roles were structured around assumptions of women's domestic responsibilities, with community-based practice often positioned as vocational and semi-domestic work rather than as equivalent in status to hospital nursing.

These gendered social and institutional foundations, along with policy intervention, significantly influenced how district nursing training evolved in the post-war period. As training programs developed through the 1950s and beyond, they navigated complex societal expectations while simultaneously working to establish district nursing as a discipline with its own distinct knowledge base, practices, and professional standards. The training experiences of district nurses during this period reveal how educational pathways shaped interviewees' understanding of their role and professional identity within the evolving healthcare system. These experiences demonstrate how training programs integrated clinical expertise, specialised knowledge, and professional values to prepare nurses for autonomous practice in community settings. The following section examines how interviewees' experiences of their educational journeys contributed to the formation of their professional identities as district nurses.

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[46] Anne Kelly and Anthea Symonds, *The Social Construction of Community Nursing* (London: Red Globe Press, 2003), 44.

3.3 Becoming a District Nurse

The post-war period saw a growing emphasis on education and training as the means through which the professional identity of the district nurse was negotiated and refined. National debates over training standards, the restructuring of professional qualifications and individual nurses' recollections of their educational experiences reveal how identity was shaped not only by what nurses learned but by what that learning signified about their place within the profession. As Keith Macdonald has demonstrated, the regulation of training and education is an essential part of control of entry for professions.[47] Carol Hall has described developments in nursing education during this time as being 'complemented by peaks and troughs fuelled by political influences of subsequent governments'.[48] Consequently, the process of becoming a district nurse underwent significant transformation between the 1950s and 1970s, reflecting broader shifts in nursing education and professional identity formation combined with four Conservative and three Labour governments, with ideological shifts in both parties. Moreover, this period marked the beginning of an ongoing acknowledgment of the need for nursing in the UK to move towards academic learning and not simply training.[49] During this period, district nursing witnessed important changes in its educational frameworks, regulatory structures, and professional recognition as it adapted to the evolving

[47] Keith Macdonald, *The Sociology of the Professions* (Sage, 1995), 78–9.
[48] Carol Hall, 'Professional Identity in Nursing' in *Professional Identity in the Caring Professions,* ed. by Roger Ellis and Elaine Hogard (Taylor & Francis, 2020).
[49] *Professional Identity in the Caring Professions*, 33.

healthcare landscape within the NHS. According to David Clarke and Georgina Willets, beginning in the 1960s there was a deliberate move in the UK to establish nursing as a professional occupation, with the transformation of educational preparation seen as the defining event towards professional status.[50]

Joanne Cecil and Calum McHale have argued that, in essence, professional identity is the result of a complex consolidation of one's own personal values and beliefs with taught or observed professional values and beliefs.[51] It is therefore vital to understand the training and observed values discussed by interviewees. It is necessary to reiterate here that district nursing is a post-registration profession, meaning one needed to have qualified as a nurse before undertaking further training and education to become a district nurse. Training with the QNI carried additional significance, as it conferred the title of Queen's Nurse, a recognised marker of professional identity within the field. When the QNI ceased providing district nurse training in 1968 the title of Queen's Nurse was afforded to those deemed by the organisation to have made a significant contribution in their career. Following the removal of the QNI as the organisation solely responsible for district nurse training, there were wider profession-based shifts which occurred to both general and district nurse training. These shifts were the result of through government interventions such as the Briggs Report and the Nurse, Midwives and Health Visitors Act.

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[50] David Clarke and Georgina Willets, 'Constructing nurses' professional identity through social identity theory,' *International Journal of Nursing Practice* 20 (2014): 165.
[51] Joanne E. Cecil and Calum T. McHale, "Observing Identity," in *Professional Identity in the Caring Professions: Meaning, Measurement and Mastery*, ed. Roger Ellis and Elaine Hogard (Abingdon: Routledge, 2020), 354.

The transition from QNI training impacted broader professional standards and coincided with a significant change in the district nursing identity, especially around gender. While professional consolidation was occurring at an institutional level, individual practitioners were navigating complex personal and social values about who could properly embody the district nurse role. The historical foundation of district nursing as a feminised profession created tensions with emerging notions of nursing professionalism, particularly as men began to enter the field. Though male district nurses were officially introduced in 1947, the deeply ingrained gender expectations surrounding care work continued to shape both institutional structures and individual career paths in the decades that followed. This tension was not confined to Britain. Christine Williams, writing on men working in female-dominated professions in the United States, found the same structural dynamic at work. Men in nursing and comparable occupations tended to be moved towards senior and managerial roles, a pattern she termed the 'glass escalator'.[52] What was distinctive about the Liverpool case was not the existence of these expectations, but where they were encountered, since the district nurse met them in the patient's home rather than on the hospital ward.

[52] Christine L. Williams, "The Glass Escalator," *Social Problems* 39, no. 3 (1992): 253–67, cited in Sharon Whiting, "A Space of Their Own: Manchester's Early Critical Care Nurses, 1967–2000" (PhD diss., University of Manchester, 2024), 222.

Post-NHS Training

This tension between the singularly feminine construction of the district nurse role, rooted in its nineteenth century provenance, and the emerging acceptance of professionalism within nursing continued following the introduction of male district nurses in 1947. This nuanced reading of gender was illustrated by the only male district nurse interviewed for this project, Alan Carlise. According to Alan, he had always 'wanted to do something in caring.'[53] Born in Birmingham, 1932, Alan left school at 14 to become an apprentice tool maker, recalling how his father said '[g]et a trade under your belt son and you'll never be out of work.'[54] When he was 17, and after becoming a practicing Christian, Alan remembered how he went to see his local hospital in Selly Oak, Birmingham, to enquire about working as a porter, however the only job on offer was a ward orderly, whose main duties were 'making beds, scrubbing loose floors, cleaning out sputum [sic] cups, urinals, scrubbing bed pans'.[55] Alan did this for six months, until he 'found out men could be nurses'.[56] The implication here is that a role in nursing did not seem available or open to Alan, even though he had always wanted to do something in caring. The timing here is important, as this was three years after the introduction of the first male *district* nurse.

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[53] Alan Carlise, Interview with the author, 28th October 2021.
[54] Alan Carlise, Interview, 28th October 2021.
[55] Alan Carlise, Interview, 28th October 2021.
[56] Alan Carlise, Interview, 28th October 2021.

However, there had never been a specific law stating that men could not work as nurses. According to Joan Evans, men's participation in nursing was common until Florence Nightingale firmly established nursing as a woman's profession.[57] Evans argued that Nightingale encouraged the view that women who entered nursing were only doing what came naturally to them, with men assuming the 'dominant' role as physicians.[58] For Evans, this belief propagated the view that nursing was unskilled and of low value in comparison to men's occupations, further painting nursing as an extension of women's domestic role.[59] Men in nursing therefore tended to largely be found in institutions focused on psychological treatment and between 1921 and 1938 a total of 435 male nurses were registered (on a separate register) to 97,028 general female nurses.[60] Men were present in the nursing profession then, yet the tension between nursing's association with care and prevailing gendered codes meant that it was rarely articulated as a viable career path for men. In Alan's case, this silence around male nursing careers created a sense that the role was not open to him, even though he had always expressed an interest in 'doing something in caring'.[61]

Alan began his general nurse training in 1950 but unfortunately, after six months he suffered an infection with hepatitis after an incident with an infected patient and

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[57] Joan Evans, "Men nurses: A historical and feminist perspective," *Journal of Advanced Nursing* 47.3 (August 2004): 322.
[58] Evans, "Men nurses: A historical and feminist perspective," 323.
[59] Evans, "Men nurses: A historical and feminist perspective," 323.
[60] Carolyn Mackintosh, "A historical study of men in nursing,", *Journal of Advanced Nursing* 26.2 (August 1997): 234.
[61] Alan Carlise, Interview, 28th October 2021.

needed to be confined to hospital for three months. Alan went on to qualify in general nurse training in 1953, becoming a ward sister after three months, a move he described as very unusual for the time.[62] Alan recalled an anecdote about when he enquired to the matron about the ward sister role and she looked at him, shocked, and said '[c]ome to the window, turn your face, can you grow a moustache?'.[63] Alan explained to me that, you would not question this, and returned with a moustache.[64] Six months later, Alan was the senior on duty in a 500 bedded hospital three nights out of the four he worked. The request that Alan grow a moustache reflected wider cultural codes in which facial hair operated as a visible marker of masculinity, maturity, and authority. As Alun Withey has argued, beards and moustaches were historically imbued with meanings that extended beyond appearance as they could be regarded as outward signs of vigour and health, even linked to bodily vitality and moral character.[65] In a context where nursing was widely regarded as women's work, facial hair could thus provide a symbolic means of reinforcing Alan's professional authority as a male nurse.

However, this was not to last long, as two years later when Alan got married, he found that they could not afford to live on his salary alone, and he actually went into to work in industrial heating. Alan returned to nursing and began his district nursing career in 1959, but it's important here to highlight how his nursing salary was not enough to fulfil the breadwinner role expected of him during this period.

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[62] Alan Carlise, Interview, 28th October 2021.
[63] Alan Carlise, Interview, 28th October 2021.
[64] Alan Carlise, Interview, 28th October 2021.
[65] Alun Withey, *Concerning Beards: Facial Hair, Health and Practice in England, 1650–1900* (London: Bloomsbury Academic, 2021), 63.

The breadwinner status referred to the societal expectation that male workers should earn sufficient wages to financially support their entire household, including a non-working wife and children. This reinforced traditional gender roles that positioned men as economic providers and women as homemakers. Moreover, there were instances in our interview, the unusualness of his promotion and need to grow a moustache for example, which were indicators of the male district nursing professional identity communicated by Alan.

Recalling his re-entry into nursing, Alan explained that he had worked for an oil heating company in Newcastle-upon-Tyne for four years, living in a house with his family that the company helped him pay for.[66] Although Alan had made roots in Newcastle, finding a 'very good church' and making some friends, he still had a desire to get back into nursing.[67] It was clear in our conversation that Alan's lifelong desire to do something 'in caring' had propelled his desire to work in nursing. Nevertheless, Alan went on to explain how (financially) nursing alone would not be able to accommodate the breadwinner status afforded to his gender. On beginning his career as a district nurse, Alan spoke about how he 'looked around the nursing press, and the only thing on offer was a male district nurse in Birmingham with an offer of training. Unfortunately, it was £7 a week, £350 a year.'[68] The average wage for a male manual worker in 1959 was £13 2s 11d, around £13.15 a week.[69] According to Alan, they had made some money in business with a house to sell, and

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[66]Alan Carlise, Interview, 28th October 2021.
[67]Alan Carlise, Interview, 28th October 2021.
[68]Alan Carlise, Interview, 28th October 2021.
[69] "50 Years of Men 1954–2004", *The Guardian*, June 27, 2004. https://www.theguardian.com/world/2004/jun/27/gender

as there would be a house provided by the Local Health Authority at 18 shillings and 6 pence a week, his family were able to move in 1959 and start a new life.[70] Despite this, Alan had to find a second job, approved by the council, as a lecturer in health education. Alan's wife did not work, and he said that the extra income of nine guineas a week 'almost doubled my salary.'[71]

It is interesting to compare Alan's testimony, in which he offered a reflection of his own professional identity at this time, with another district nurse interviewed and who trained and worked in a similar period. Ethel Love was born in Aigburth, Liverpool in 1934. When I asked at the beginning of our interview if Ethel had a desire to go into nursing, she explained that she 'always knew in my heart I'd like to do nursing.'[72] Ethel explained how she first went into nursing to follow in her sister's footsteps, who had 'gone into the profession a year before' and who Ethel described was a 'very bright girl'.[73] This familial influence suggests how personal relationships could shape entry into the profession, creating expectations and comparisons that might influence one's developing professional identity. Ethel recalled that her first three months of training were 'gruelling', with 'lots of exams and learning'.[74] I followed this up with a question on whether she had always known she wanted to get into district nursing too, and Ethel replied '[n]o, not at all. I didn't know a thing about it'.[75] When I asked Ethel if she remembered seeing district nurses in the community when she was growing up, she said that she did not, although 'you did

[70]Alan Carlise, Interview, 28th October 2021.
[71]Alan Carlise, Interview, 28th October 2021.
[72] Ethel Love, Interview, 8th November 2021.
[73] Ethel Love, Interview, 8th November 2021.
[74] Ethel Love, Interview, 8th November 2021.
[75] Ethel Love, Interview, 8th November 2021.

see the odd midwife with her little bag going in a house.'[76] Here is evidence of Ethel's understanding of the professional connection between district nurses and midwives due to their placement working on the community. According to Sweet, community health legislation was considerable and notable from the 1960s.[77] Sweet has asserted that this period marked an intensive reassessment of community healthcare, with numerous official studies, inquiries and reports which resulted in a stream of changes in policy towards community healthcare.[78] Ethel's sister, who was two years older, also went into nursing after the end of the Second World War. Ethel described how the two sisters 'did not look a bit alike' and Ethel 'couldn't beat' her older sister in nursing exams.[79]

Ethel began her nurse training at the Preliminary Training School (PTS) at Sefton General Hospital when she was 17 in 1951, recalling how her first three months were contained intensive academic study.[80] Describing her training, Ethel said:

> We started at eight in the morning until five at night, cramming anatomy, physiology, hygiene and practical work into our heads. We learned about natural wells, how the plumbing in the house worked, and I don't know what use that was to us but we did, we even visited the local sewage works and local tips. Also, every type of plaster to relieve pain and congestion. Belladonna mustard plasters were still used. We had to learn how to clean sick people's rooms and damp dust and change fuses and clean spittoons.[81]

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[76] Ethel Love, Interview, 8th November 2021.
[77] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 205.
[78] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 205.
[79] Ethel Love, Interview, 8th November 2021.
[80] Ethel Love, Interview, 8th November 2021.
[81] Ethel Love, Interview, 8th November 2021.

This broad summary of Ethel's nurse training came at the very start of our interview, after I had asked Ethel to introduce herself and tell me about her life and where she was brought up. This could be described as a part of Ethel's life story, which Lynn Abrams has described as a narrative device used by an individual to make sense of a life or certain experiences in the past.[82] A life story is offered by an interviewee as a way to achieve coherence, both in the sense of telling a coherent story and in the sense of telling a story that conforms to the expectations of the listener.[83] Abrams has argued that a life story is a fluid retelling of one's life history, which can contain facts, but which also has another purpose.[84] According to Abrams, the meaning of a life story is to tell the listener what kind of person the narrator wants to be seen as and is related to consciousness, self and the way that self is told is told or presented.[85] Similar to composure, where an individual creates a comfortable sense of self by aligning a memory with publicly available discourses, the life story creates an acceptable narrative on behalf of the interviewee. In this moment, Ethel was producing an acceptable life story surrounding her nurse training, one which emphasised the rigour, breadth, and practical immersion of her early education. By recalling long days 'cramming' anatomy and physiology alongside learning about plumbing, sewage systems and domestic maintenance, she evoked a vision of nurse training as both exhaustive and socially useful.[86] This retelling presented her younger self as disciplined, adaptable, and embedded in a professional culture that

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[82] Lynn Abrams, *Oral History Theory* (Oxon: Routledge, 2010), 40.
[83] Abrams, *Oral History Theory*, 40.
[84] Abrams, *Oral History Theory*, 40.
[85] Abrams, *Oral History Theory*, 40.
[86] Ethel Love, Interview, 8th November 2021.

valued technical knowledge and domestic competence in equal measure. The fact that this came at the very start of our interview offers insight into what Ethel felt was integral to the recollection of her professional history.

Later on in the interview, when we were on the topic of her nurse training between 1951 and 1954, Ethel mentioned how she lived in a nursing home attached to Sefton General Hospital for the first 'three or four' months, before moving into 'big houses'.[87] Following this, Ethel took the decision to move back home, where she remembered how she rode every day to Sefton General on her bicycle, where she had a locker at the hospital where she would change into her uniform.[88] Ethel lit up when talking about her uniform, mentioning how '[w]e had a green dress, a white apron, always had to have the nurse's cap and we always had to have black lace up shoes'.[89] I asked Ethel if she remembered these items vividly, and she replied '[o]h yes, I do. Black stockings was [sic] a must. The dresses were calf length. They couldn't be short'.[90] According to Julia Hallam, donning a nurses' uniform is a process that exposes a private world of unwritten professional codes and rules, 'many of which are expressed in the complex signification of the uniform itself.[91] Although led by my questioning, this was an instance where Ethel was communicating the professional codes that she embedded in the recollection of her nurse training. The professional codes of uniform can be understood as attributes of

[87] Ethel Love, Interview, 8th November 2021.
[88] Ethel Love, Interview, 8th November 2021.
[89] Ethel Love, Interview, 8th November 2021.
[90] Ethel Love, Interview, 8th November 2021.
[91] Julia Hallam, *Nursing the Image: Media, Culture and Professional* Identity (London: Routledge, 2000), 51.

a professional identity, and it is therefore important to understand how gender can interact with these recollections.

When I spoke with Alan on the topic of working in the home as a district nurse, he made the connection between relationships with the patient and the uniform he was wearing, explaining how:

> '[o]f course, as a male nurse, we had a peak cap on and epaulettes and a search suit and a gladstone bag. So, if you were new and you didn't say anything they showed you the electric meter or the gas meter.'[92]

Here, Alan is referencing how his uniform provided a distortion of his professional identity, reinforcing Hallam's point on the complex professional codes and rules embedded within uniform. An apparent cultural reading of the uniform was gender, where patients were more familiar with Ethel's uniform than Alan's. The contrast between Ethel's and Alan's response to uniform points to the way the district nursing uniform encoded a set of gendered expectations about who the role belonged to and what it was doing. Jane Brooks and Anne Marie Rafferty have argued that a central function of the nurse's uniform was to set boundaries, marking the wearer out as a nurse and granting permission to deal with strangers in intimate ways that would otherwise be unavailable.[93] Although Brooks and Rafferty write of hospital nursing in an earlier period, the boundary-setting work they describe applies directly to the district nurse arriving, in uniform, at a stranger's door.[94] The uniform regulated the

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[92] Alan Carlise, Interview, 28th October 2021.
[93] Jane Brooks and Anne Marie Rafferty, "Dress and Distinction in Nursing, 1860–1939: 'A Corporate (as well as Corporeal) Armour of Probity and Purity'," *Women's History Review* 16, no. 1 (2007): 52.
[94] See also Christina Bates, *A Cultural History of the Nurse's Uniform* (Gatineau: Canadian Museum of Civilization, 2012), on the longer cultural history of nursing dress.

boundary even when the precise role was unclear, allowing the nurse, and others, to recognise their status. For Ethel, the recognisable female figure in a calf-length dress and starched apron, this worked as intended. She was legible, and the legibility carried authority into the patient's home. For Alan, wearing a uniform built around the female figure, the same function broke down. The patient reached past the professional code to the nearest available reading and saw the man from the gas board. What Ethel's uniform conferred without effort, Alan's withheld. The uniform's authority depended on a cultural expectation that the district nurse was female, and Alan's presence in it exposed that expectation by failing to meet it.[95]

Alan went on to explain how, while he had no problems with this misreading of his district nursing role, the patients could be embarrassed when he would reply 'I think that's an antique meter, I would really take care of that, could I see the patient[?]'[96] Alan then decided to visit his nurse superintendent to ask for a £27 a year allowance he could spend on 'ordinary clothes' as he 'wanted to be an ordinary person'.[97] Alan was explicit that his uniform, the material marker of his profession, prevented him from being recognised as a district nurse and making the appropriate first impression with patients. This negative experience reveals how the district nursing uniform might fail to effectively signal professional authority when worn by a male district nurse. This is in quite the contrast with Ethel who lit up when talking

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[95] See also Anthea Symonds, "Angels and Interfering Busybodies: The Social Construction of Two Occupations," Sociology of Health and Illness 13, no. 2 (1991): 249–64, on the dual cultural framing of the community nurse as moral authority and domestic intruder: on gender and authority in medicine more broadly, Rosemary Pringle, *Sex and Medicine: Gender, Power, and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998).
[96] Alan Carlise, Interview, 28th October 2021.
[97] Alan Carlise, Interview, 28th October 2021.

through the pieces of uniform she recalled of when she was training to be a nurse. The stark difference between Alan's discomfort and Ethel's enthusiasm highlights how uniform acts as a material embodiment of professional identity. Moreover, it can also reinforce gendered expectations in district nursing. For Ethel, the uniform symbolized achievement and professional belonging, while for Alan, it represented a barrier to professional recognition and legitimacy because it did not have the accepted cultural meaning needed to express his identity.

Hallam has identified that by the 1960s, nursing publications produced by the Department of Health and Social Security were 'working in antithesis to the feminised images of nursing' that were previously depicted in nursing recruitment literature.[98] The result of this was, according to Hallam that men were far more career-motivated rather than vocationally orientated in their outlook to nursing.[99] This somewhat corresponds with the professional trajectory outlined by Alan. As mentioned above, Alan began his career in district nursing in 1959 after finding a recruitment advertisement in the nursing press.[100] He was working both as a district nurse and as lecturer in health education, before receiving an appointment to open a small new hospital in Birmingham. According to Alan, this was 'more of a research unit for elderly people' with 150 beds.[101] Moreover, Alan explained that 'I was fortunate enough to get it because I was a district nurse basically, and I knew the social services side of it.'[102] Alan's knowledge of 'the social services side of it' points

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[98] Hallam, *Nursing the Image,* 113.
[99] Hallam, *Nursing the Image*, 113.
[100] Alan Carlise, Interview, 28th October 2021.
[101] Alan Carlise, Interview, 28th October 2021.
[102] Alan Carlise, Interview, 28th October 2021.

to the wider institutional landscape that district nurses worked alongside, discussed in Chapter 4. .

Alan was then promoted to assistant matron in charge of the hospital, before going on to run it himself. Alan was then elected to the Royal College of Nursing in 1963, working on the finance committee and ultimately becoming the Midlands Area Organiser.[103] His work for the Royal College of Nursing is interesting as men were only admitted to the General Nursing Register in 1960. It was in January 1967 that Alan received a letter informing him about the vacant post of Principal of the William Rathbone Staff College (WRSC), and after visiting the college he was given the role.[104] It was this role that brought Alan to Liverpool. His career development marks him out from the female district nurses interviewed for this project. Instead, Alan's professional identity rested on an upward trajectory that involved his wider nursing career. His desire to go into a caring position at a young age arguably pushed him into nursing, but it was his male identity that seems to have helped enter technical and managerial posts in nursing.

Consequently, there was an emphasis on promotion and progression with Alan's communication of his professional identity, which marked him out from other interviews with female district nurses. On his work at WRSC, Alan remembered that when he accepted the position of principal, he: 'went there (Liverpool), I met their board, and immediately it looked to me that we were living in the present, which is

[103] Alan Carlise, Interview, 28th October 2021.
[104] Alan Carlise, Interview, 28th October 2021.

fine, but education should be living in the present and taking people into the future.'[105]

Alan explained how he wanted the training delivered at WRSC to maintain complete focus on the patient, stating:

> [I]n the teaching that we did in William Rathbone it was to say top management could be completely out of things, completely out. Middle management absolutely distracted by so many things, and it was really to try and get all this rubbish out, so they only concentrated on the essential, which was the patient.

Although the College offered courses in management for nurses, Alan's experience as a district nurse provided him with the background to identify that there should always be a focus on the needs of the patient within nurse training courses.[106]

Even as his account stressed promotion and progression, Alan continued to locate the purpose of district nursing in the patient rather than the management of services. Sharon Whiting has found that the men in her study of critical care nurses positioned themselves in different ways in relation to the technical work of the specialism, which was strongly associated with technology and masculinity.[107] Some were drawn to that association, while others foregrounded patient care over it. One described himself as 'hopeless mechanically', valuing instead the 'one-to-one care' that the work allowed.[108] Whiting reads these positions against the structural

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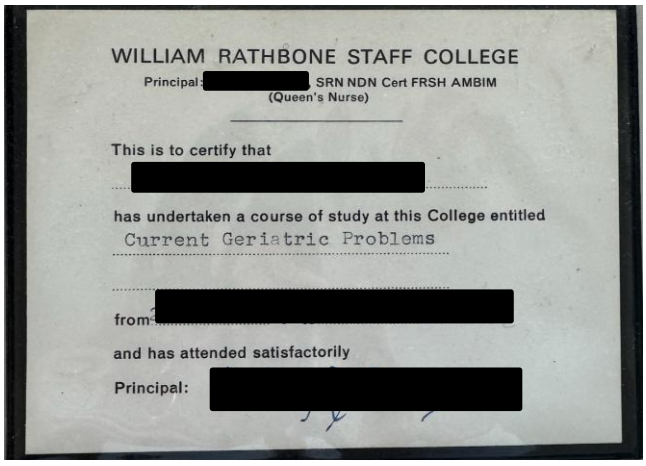
[105]Alan Carlise, Interview, 28th October 2021.
[106]Alan Carlise, Interview, 28th October 2021.
[107] Sharon Whiting, "A Space of Their Own: Manchester's Early Critical Care Nurses, 1967–2000" (PhD diss., University of Manchester, 2024), 227.
[108] Whiting, "A Space of Their Own: Manchester's Early Critical Care Nurses, 1967–2000", 229.

advantages that have tended to move men in nursing towards management and senior grades, representing the 'glass escalator' mentioned earlier.[109] Alan's testimony stands in a similar relation to those advantages. He had moved into senior and educational roles, but he held to care as the organising principle of district nursing rather than setting it aside as his responsibilities, for example as Principal of the WRSC, grew.


WILLIAM RATHBONE STAFF COLLEGE

Principal: [redacted] SRN NDN Cert FRSH AMBIM
(Queen's Nurse)

This is to certify that

[redacted]

has undertaken a course of study at this College entitled

Current Geriatric Problems

from [redacted]

and has attended satisfactorily

Principal: [redacted]

Figure 4: Certificate of attendance from William Rathbone Staff College for course entitled 'Current Geriatric Problems', dated [22nd January to 9th April 1969].

Provided by Ethel Love.

Alan's principal role meant that Ethel and Alan overlapped with one another. In 1969 Ethel completed a course at the WRSC and was granted a 'Certificate in the Theory and Practice of District Nursing', shown in Figure 4. Ethel proudly displayed and referenced the certificate within our interview, which Abrams has described is a way to aid recall for certain people, places or experiences that interviewees feel will be

[109] Christine L. Williams, "The Glass Escalator," *Social Problems* 39, no. 3 (1992): 253–67, cited in Whiting, "A Space of Their Own," 222.

important to the interviewer. [110] In this instance, Ethel recalled how she underwent a written exam for this certificate, most of which had been covered on her general nurse training 'so not too difficult'.[111] This discussion is evidence of the importance the qualification was to Ethel. Moreover, it is evidence of the increasing training and education that was involved with district nurse role. Gained in 1969, Ethel had been working as a district nurse for 6 years by this point. After becoming a State Registered Nurse in 1955, Ethel 'more or less went straight into midwifery', which involved a one-year training course based in the midwifery unit at Sefton General Hospital, which Ethel found 'intense'.[112] Similarly to Alan, Ethel got married soon after finishing her training when she was 22 and went on to have two children, both girls. Ethel explained that she decided to go into district nursing 'because I could work my home as well as the nursing job'.[113] Elaborating further, Ethel stated that the district nursing role was more convenient for her family life, as 'the hours were good and we could get home at lunch time'.[114]

Ethel's first identification with the district nursing profession was therefore based on the flexibility the role could offer to her family life, inside of the home and outside of work. The gendered relationship between the female district nurse and the home both as a site of care and domesticity will be explored in greater detail in the chapter on Home. However I wanted to mention here how Ethel's conveyance of her professional identity was intertwined with how the role could be managed

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[110] Abrams, *Oral History Theory*, 84.
[111] Ethel Love, Interview, 8th November 2021.
[112] Ethel Love, Interview, 8th November 2021.
[113] Ethel Love, Interview, 8th November 2021.
[114] Ethel Love, Interview, 8th November 2021.

alongside the period's gendered expectations of duty. Laura Paterson and Eve Worth have coined the term 'organisational labour' to describe the strategies that women put in place to combine paid employment with motherhood and domesticity between 1960 and 1990.[115] Ethel's experience therefore points to the wider expectations of women during this period and help to clarify the contrast in professional identity espoused by her and Alan. The professional identities espoused in these two interviews were not mutually exclusive however and as we see with later interviewees there were nuanced ways that professional identity was communicated that did not sit neatly within gendered expectations.

In 1968 the QNI passed responsibilities for the training and examination of district nurses to local authorities. Sweet has described this move as reflecting the position of the QNI that they no longer felt able to effectively argue their case for their position as the primary provider of district nurse training across the UK.[116] In Liverpool, this decision meant that LHA would manage all district nursing services, reporting directly to the Ministry of Health who would in turn be advised on matters relating to district nursing by the POA. One of the last district nurses to undertake training run by the QNI in Liverpool was Angela Hogg in 1967. Angela Hogg regarded the influence of the QNI as being beneficial, stating '[i]t was very procedure-orientated, it gave one finesse in practice'.[117] To me, Hogg's use of the word 'finesse' ties back to the standards and training which were supposedly

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[115]Laura Paterson and Eve Worth, 'How is she going to manage with the children? Organisational, Labour, Working and Mothering in Britain, c. 1960–1990,' *Past & Present* 246.15 (December 2020): 318.
[116] Sweet and Dougall, *Community Nursing and Primary Healthcare,* 90.
[117] Angela Hogg, quoted in Meg Parkes and Sally Sheard, *Nursing in Liverpool Since 1862* (Lancaster: Scotforth Books, 2012), 73.

embedded in the QNI tradition of training, providing the inclination that these were skills related to a professional identity and finetuned over a century nearly. Moreover, it is clear that professional identity espoused by the QNI created an air of pride and confidence for the district nurses who undertook their training. Angela Hogg goes on to say the QNI uniform provided an air of authority when entering the homes of the patients, indicating the importance of appearing professional through external markers such as uniform and which was no doubt strengthened through the ethos of the QNI.[118]

As the QNI withdrew from the provision of training and education for district nurses, responsibility for shaping and managing the district nurse's professional identity transferred to government oversight. Nevertheless, the long-standing commitment the QNI had made towards the training and education of the district nurse highlights the importance of training in both the organisation and management of a profession. Indeed, Giddens has outlined how a profession must have a degree of autonomous regulation and control, with accountability to a self-regulating body which emphasises standardised training, qualifications, and registration to a professional identity.[119] This is because a key component in establishing a professional identity is an emphasis on knowledge as a 'core generating trait'.[120] The fulfilment of district nursing as a profession which produces an agreeable identity for those involved is based on the generation of knowledge in

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[118] Angela Hogg, quoted in Meg Parkes and Sally Sheard, *Nursing in Liverpool Since 1862,* (Lancaster: Scotforth Books, 2012) 73.
[119] Anthony Giddens, *Sociology* (Cambridge: Polity Press, 2021), 358.
[120] See Keith Macdonald, *The Sociology of the Professions* (Sage, 1995), 157.

the form of training and education. The QNI, as the primary self-regulating body associated with district nursing until the creation of the NHS, was integral in propagating the standards of district nursing that they believed matched their outlook for the district nurse's professional identity. The fulfilment of district nursing as a profession which produces an agreeable identity for those involved is based on the generation of knowledge in the form of training and education. The QNI, as the primary self-regulating body associated with district nursing until the creation of the NHS, was integral in propagating the standards of district nursing that they believed matched their vision for the district nurse's professional identity.

1970s and 1980s Training

The place of policy in this oral history of district nursing requires some justification, given that the interviewees themselves rarely spoke of it directly. Michael Traynor has argued that those who work in the health service operate within a highly politicised setting, whether or not they experience it as such, and that policy is characteristically made by one group of people while its effects fall on those who may have had no part in its formation.[121] For district nurses, the training structures, regulatory bodies and service boundaries within which they practised were largely determined elsewhere, in government committees, professional associations and legislation, yet they impacted the everyday conditions of their work. Traynor further noted that policy frequently produces unintended consequences, particularly where it operates in complex settings.[122] Understood in these terms, the relative silence of

[121] Michael Traynor, *Nursing in Context: Policy, Politics, Profession,* (Bloomsbury, 2013), 127.
[122] Traynor, *Nursing in Context,* 127.

interviewees on questions of policy is not necessarily evidence of its irrelevance, but a reminder that the district nurse worked in an environment they did not design and did not always have cause to articulate. It is for this reason that the policy and training context examined in this section matters to an account of professional identities. Even where it sits beneath the surface of testimony.

Progressing into the 1970s, it is evident that the landscape of nurse training continued to evolve, with increasing emphasis on academic preparation alongside practical skills. The Government were looking for ways in which to restructure the entire nursing profession within the NHS, with the POA beginning to see their influence wane throughout the 1970s. In April 1970, a committee, chaired by Professor Asa Briggs, was set up to review the role of nurses and midwives in the hospital and the community. Professor Briggs was a prominent historian who specialised on the Victorian era of Britain, which is an interesting nod to the hold that Victorian values had over nursing during this period. As well as Briggs, the Committee included Nursing Professor Margaret Scott-Wright, members of the RCN, ward sisters, and experts in public health. There were, however, no district nurses on the committee. Abigail Beach and Celia Davies have argued this is evidence that the committee was weak on its primary care remit, with district nurses expressing concern that their work was not being discussed with sufficient adequate expertise.[123] Similarly, this exclusion further reflects broader issues of professional marginalisation facing district nurses, who were struggling to assert their distinctive

[123] Abigail Beach and Celia Davies, Interpreting Professional Self-Regulation: A History of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (Oxford: Routledge, 2000), 5.

expertise within nursing's professional hierarchy. The predominantly female nursing workforce faced particular challenges in gaining representation in policy discussions, highlighting how gender dynamics intersected with professional identity formation during this period. The absence of district nurse voices on the committee reinforced existing power imbalances that privileged hospital-based care models over community-based practice.

The terms of reference for the committee were 'to review the role of the nurse and the midwife in the hospital and the community and the education and training required for the role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service'. [124] In the absence of any members of the committee who were district nurses, Briggs relied on contributions from the QNI. In January 1971, the QNI established their own working party to assist in gathering evidence to contribute to the Committee on Nursing. In terms of their position, the QNI described themselves as a 'voluntary organisation (who) has continued its practice of providing courses for special needs where there are no statutory provisions available. It has an extensive educational programme, the priority being to provide refresher courses for district nurses in order to keep them up to date with modern medical and nursing techniques'.[125] The report of the Committee on Nursing was published in October 1972. The view of the report was that nurses were understood as either the 'lady with the lamp' or the 'ministering

[124] SA/QNI/P.1/24 – Queen's Institute of District Nurses (QIDN) evidence to the Asa Briggs Committee (Committee on Nursing) January 1971, n.p.
[125] SA/QNI/P.1/24 – Queen's Institute of District Nurses (QIDN) evidence to the Asa Briggs Committee (Committee on Nursing) January 1971, 2.

angel,' imagery which had been inherited from the nineteenth-century origins of the role.[126]

The Briggs Report recommended major changes to the model of nursing in Britain, laying the foundations for the 1979 Nurses, Midwives and Health Visitor Act, the first major legislative re-organisation of the wider nursing profession. Among its recommendations, the report considered whether the existing distinction between health visitors and district nurses should be replaced by a single category of 'community nurse'.[127] It also recommended the abolition of the separate statutory training body for health visiting, the Council for the Education and Training of Health Visitors, with its powers to be transferred to a proposed central nursing and midwifery council.[128] Moreover, Beach and Davies have argued that, although it can be firmly associated with the creation of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), the first national independent regulator for nurses, midwives and health visitors, there is limited discussion of professional regulation within the report.[129] The committee's attention, however, lay principally with the nature and purpose of nurse training and the management of limited nursing and midwifery resources. As Beach and Davies have noted, reform of

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[126] A. Briggs (1972) Report of the Committee on Nursing, Professor Asa Briggs, (Chairman), Information found in Bradshaw, 'An historical perspective on the treatment of vocation in the Briggs Report (1972)', *Journal of Clinical Nursing*, 3461.
[127] PRO, MH165/160, CN (71), ninth meeting of Briggs Committee, 12–13 March 1971 quoted in Beach and Davies *Interpreting Professional Self-Regulation: A History of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting,* 7.
[128] PRO, MH165/160, CN (71), ninth meeting of Briggs Committee, 12–13 March 1971 quoted in Beach and Davies *Interpreting Professional Self-Regulation: A History of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting,* 7.
[129] Beach and Davies *Interpreting Professional Self-Regulation: A History of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting,* 3.

the existing statutory and training bodies, deemed the 'organisational framework', was addressed only briefly.[130] The RCN broadly welcomed the report's proposals on nurse education, though not without reservation. Susan McGann, Anne Crowther and Rona Dougall have noted that the College wanted further education to take place outside the hospital for school leavers entering through cadet schemes, rather than within it.[131] Its principal criticism, however, was that the report paid little attention to what it termed the 'professional issue', the expanding role of nurses and their widening responsibilities.[132] For the College, then, the primary concern was less the structure of training than the future shape of the nursing role. Nevertheless, although the focus of the report was on training and resources, its longer consequence for district nursing was a gradual reshaping of the role.

For Sweet and Dougall, by 1979 district nurses had become 'like their hospital counterparts' more closely associated with the medical model and the team aspect of health care, losing much of their communitarian image.[133] They continue that, 'due to changes in hospital policy, particularly relating to reductions in inpatient length of stay, the job was becoming more demanding in knowledge of medical and surgical advances as a nursing science.'[134] Taken together with the regulatory restructuring set out above, these shifts suggest that district nursing underwent a period of medicalisation during the 1970s, as the role, in policy at least, was

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[130] Beach and Davies *Interpreting Professional Self-Regulation: A History of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting,* 3.
[131] Susan McGann, Anne Crowther & Rona Dougall, *A History of the Royal College of Nursing 1916-90,* (Manchester: Manchester University Press), 240.
[132] McGann, Crowther & Dougall, *A History of the Royal College of Nursing 1916-90,* 240.
[133] Helen Sweet and Rona Dougall, *Community Nursing and Primary Healthcare in Twentieth Century Britain* (New York: Routledge, 2012), 163.
[134] Sweet and Dougall, *Community Nursing and Primary Healthcare in Twentieth Century Britain*, 163.

beginning to draw closer to a medical model. Yet the testimony examined in this thesis complicated this picture, since the relational and observational dimensions of the work persisted alongside its increasingly technical demands. None of the interviewees referred to the Briggs report directly, yet the changes it set in motion concerning training, regulation and the boundaries of district nursing formed the environment within which the majority of them trained and qualified. The experiences of those who entered nursing during this transitional period illustrate both the continuity of certain professional values and the emerging importance of formal academic qualifications. The individual journeys of nurses who trained during this era provide valuable insights into how professional identity formation adapted to these changing educational standards, and it is their experiences that this chapter now turns.

Mabel Williams was born in Waterloo, Liverpool in June 1953. Mabel had two brothers, neither of who were 'in nursing or caring' she explained to me.[135] Mabel decided that she wanted to go into nursing in her last year at school, achieving enough O-Levels to attend a pre-nursing training course at the Mabel Fletcher Vocational College in Liverpool.[136] Mabel told me that she was 'really, really, really keen' for a career in nursing, but was 'shot down a few times' by neighbours who thought she did not have the 'right academic qualification(s)' for the role.[137] This was 1969 when Mabel was 16, emphasising the burgeoning academic approach associated with nursing. On her pre-nursing course, Mabel was able to redo any

[135] Mabel Williams, Interview, 8th March 2022.
[136] Mabel Williams, Interview, 8th March 2022.
[137] Mabel Williams, Interview, 8th March 2022.

necessary O-Levels and partake in placements within a nursing setting.[138] Mabel also had a mentor in each of the placements and felt that 'considering it was many years ago, it was very well organised' and 'it was a very good course, very good introduction to nursing'.[139]

Similarly, Cathy Earles was born in Anfield, Liverpool in 1953. Unlike Mabel, Cathy came from a family who had a 'thing about nursing', as both her mother and aunt were nurses.[140] Cathy remembered wanting to become a nurse when she was 14, specifically recalling how people had 'so much respect' for her Aunt Sylvia, who Cathy described as her role model.[141] Cathy's mother would talk about how Sylvia had 'letters after her name' as she was a qualified nurse.[142] This discussion was at the very start of our interview, and it was clear to see how Cathy's admiration for her Aunt Sylvia was emboldened due to the qualification her aunt was able to achieve by way of her nurse training. Cathy left school at 16 in 1969, 'with five good O-Levels' and became a Cadet Nurse at Walton Hospital.[143] During the 1960s and 1970s hospitals ran training courses for perspective nurses to work across departments, in a trainee role observing a skilled practitioner. When I asked Cathy what working as a cadet nurse would entail, she immediately brought up the uniform she wore, saying:

> Yeah, so the great thing was you got a uniform, and I remember having a yellow uniform, with a white starched collar and cuffs, and you didn't go

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[138] Mabel Williams, Interview, 8th March 2022.
[139] Mabel Williams, Interview, 8th March 2022.
[140] Cathy Earles, Interview, 18th October 2021.
[141] Cathy Earles, Interview, 18th October 2021.
[142] Cathy Earles, Interview, 18th October 2021.
[143] Cathy Earles, Interview, 18th October 2021.

> anywhere near patients, but what you did was they put you, there was like six of us, and they would rotate us through different departments, so the first job I had was a reception, on the reception desk at a clinic, accident and emergency, where people where coming back to have dressings changed.[144]

The perspective of pre-nurse training offered by Cathy presents an insightful narrative into what she felt were pivotal moments in her education. The instant recollection of her uniform and subsequent description conveys something she could have pride in, the 'white starched collar and cuffs' ties into a visual personification of the emerging professional identity offered through this training. Joanne Cecil and Calum McHale have described the concept of professional identity as 'complex, with multiple constituent components', and Cathy's discussion indicated the components which evidence the professional identity through her pre-nurse training. [145] Cathy's uniform afforded her a status which she felt was 'a great thing'.[146] For Brooks and Rafferty, uniform played a central role in the formation and maintenance of a professional identity for nurses, providing a visible guarantee of professional standing and moral character 'from the earliest years of The Nightingale Training School to the late twentieth century'.[147] Cathy's description of her uniform, with its starched collar and cuffs, evokes that sense of credibility and purpose. That this happened early in her training indicates how the uniform worked as a marker of entry into a profession. Uniform then should be understood as a key marker that those entering a profession internalise. When would-be professionals are undergoing

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[144] Cathy Earles, Interview, 18th October 2021.
[145] Joanne E. Cecil and Calum T. McHale, 'Oberserving Identity: Measuring professional identity empirically in the healthcare professions' in *Professional Identity in the Caring Professions*, 354.
[146] Cathy Earles, Interview, 18th October 2021.
[147] Jane Brooks and Anne Marie Rafferty, "Dress and Distinction in Nursing, 1860–1939: 'A Corporate (as well as Corporeal) Armour of Probity and Purity'," *Women's History Review* 16, no. 1 (2007): 44.

training, they are beginning the process of internalising characteristics, values, norms and beliefs associated with that profession. Cecil and McHale have discussed how this formation can contribute to a more successful transition from study to the workplace.[148]

Training and education therefore became integral in shaping professional identities. Both Mabel and Cathy underwent a pre-nursing course between the ages of 16-18, which they both described as being beneficial for their subsequent nurse and district nurse training. Similarly, both Cathy and Mabel attended the School of Nursing at Walton General Hospital during 1971 to 1975, although made no mention of knowing each other in our interviews. By the mid-1970s nursing was beginning to move toward the longer, university-based training, bearing more similarity to the medical model with post-registrational specialisation (including district nursing and community specialisms) becoming the trend. Professional nursing skills were becoming more defined, identified with technical expertise and associated with formally acquired knowledge.[149]

For Cathy, training at Walton General Hospital was 'like an apprenticeship, on the wards working as part of the staff.[150] When I asked Mabel how her training was, and if she felt her pre-training course had prepared her sufficiently, she replied:

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[148] Joanne E. Cecil and Calum T. McHale, 'Oberserving Identity: Measuring professional identity empirically in the healthcare professions' in *Professional Identity in the Caring Professions*, 354.
[149] Sweet and Dougall, *Community Nursing and Primary Healthcare in Twentieth Century Britain*, 163.
[150] Cathy Earles, Interview, 18th October 2021.

> 'Yes. I thoroughly enjoyed it. I had lots of great experiences. I worked in loads of different wards and departments so felt I had a really good introduction to training and then good experiences during the training was.'[151]

Mabel told me how Ear Nose and Throat (ENT) was a specialism that particularly stood out from her training, because 'it was a quick turnover, so you met lots of patients'.[152] The patient interaction, and ability to be immersed on the wards like you were 'part of the staff' were aspects of Cathy and Mabel's training that they recalled the most positively.

Similar to both Cathy and Mabel, Dorris Smeethe undertook a pre-nurse training course between the ages of 14 and 16 at Mabel Fletcher Vocational College in Wavertree, which she found more appealing than traditional schooling.[153] This vocational pathway reflects the growing formalisation of nursing preparation during this period. When she was 17, in 1964, Dorris was offered a place to study ophthalmic nursing at St Paul's Eye Hospital, however she would have had to 'live-in', which Dorris 'wasn't fussy on doing' so chose not to. I chose not to press Dorris on the reasons why she 'wasn't fussy' about living-in, however it could be a sign of Dorris seeking greater personal independence. Unlike earlier generations , who often accepted residential training as part of the professional pathway, it was becoming more common for trainee nurses to view the rigid supervision and lack of privacy in nurses' homes as unnecessarily restrictive.[154] During the 1960s, and

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[151] Mabel Williams, Interview, 8th March 2022.
[152] Mabel Williams, Interview, 8th March 2022.
[153] Dorris Smeethe, Interview, 22nd February 2022.
[154] See Susan McGann, *The Battle of the Nurses: A Study of Eight Women Who Influenced the Development of Professional Nursing, 1880–1930* (London: Scutari Press, 1992), 120–45; and Celia Davies, *Rewriting Nursing History* (London: Croom Helm, 1980), 83–90.

certainly by the 1970s, this practice was becoming less universal as younger nurses like Dorris sought greater personal independence, reflecting broader social changes in women's expectations.

Following her decision not to attend training at St Paul's, Dorris went into hairdressing, although 'she still wanted to do nursing but didn't want to be a cadet'.[155] Dorris then explained that she 'got married young, at 21, had two children' before getting a job in 'school health'. When I asked Dorris to expand on this, she explained: '[y]ou had school nurses, who looked after the children, and they had auxiliary nurses who helped them. We used to go in with the doctor and the nurse to get the children, get their arms ready for injections… We did vision tests.'[156] This role was based in a community clinic and Dorris did this between 1971 and 1978, 'mainly because of the school holidays off, and it fitted in with the children'.[157]

However, Dorris's father died in 1978, and with her mother retiring 'wanted to work on the district half-days to see to family things'.[158] She then worked as a district auxiliary nurse, going out to work with district nurses who had undergone the requisite pre- and post-nursing training qualifications. Encouraged by her employer, Dorris pursued her State Enrolled Nurse (SEN) qualification, training at Walton Hospital from May 1981 to 1983. Dorris described the SEN training as more 'practical work', with less 'academic work' compared to Registered General Nurse (RGN) training, which involved four weeks in school and eight weeks on wards,

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[155] Dorris Smeethe, Interview, 22nd February 2022.
[156] Dorris Smeethe, Interview, 22nd February 2022.
[157] Dorris Smeethe, Interview, 22nd February 2022.
[158] Dorris Smeethe, Interview, 22nd February 2022.

gaining experience in various clinical areas. The two-tier system of nursing qualifications in the 1970s and 1980s offered distinct career pathways through either the State Enrolled Nurse (SEN) or Registered General Nurse (RGN). The SEN qualification required a two-year training program focusing primarily on practical nursing skills and was often more accessible to those with fewer formal academic qualifications. In contrast, the three-year RGN training involved more theoretical content and was increasingly emphasising academic knowledge, reflecting nursing's evolving professional status. This division created a professional hierarchy within nursing, with RGNs typically having greater career advancement opportunities, though many district nursing teams relied on both qualifications working complementarily in community settings. Dorris is the only interviewee who underwent SEN training, meaning it is a useful point to understand how entry to district nursing can be varied.

For Dorris, the SEN offered practical training that served her well. She recalled it warmly as 'good' and 'hard work', valuing how the 'practical nurses were a good help to the qualified nurses', explaining how it 'stood me in more stead' for the district nursing that followed.[159] When discussion touched on the idea of a two-tier system, it was in institutional and economic terms, covering grading disputes, the funding she could not secure and the protected title she could not claim as an SEN 'community nurse'.[160] What did not surface was the more personal register that the qualification could carry. Sharon Whiting has shown that the SEN grade was felt by

[159] Dorris Smeethe, Interview, 22nd February 2022.
[160] Dorris Smeethe, Interview, 22nd February 2022.

some of her interviewees as a mark of a lesser standing, recalled in the language of being 'looked down on' or 'only the enrolled nurse', on Part 2 of the register rather than Part 1.[161] That hierarchical representation is largely absent from Dorris's testimony, even as she recounts the structural inequities of the grade in detail. As discussed in the methodology chapter, silences in oral history can mark moments of discomposure, where an experience is hard to compose into a comfortable story about the self. Anderson and Jack note that this is more likely where an experience departs from accepted norms.[162]

This absence may also reflect the shape of the interview itself. Unaware at the time of the SEN/SRN hierarchy that Whiting's interviewees describe, and of the specific language of being 'looked down on' that accompanied it, I did not ask Dorris directly about these dynamics. Dorris was therefore never prompted toward the register in which other studies locate this feeling, and her not raising it unprompted cannot be read as equivalent to its absence. The interview is a co-constructed account, and my own lack of prior knowledge of the hierarchy is itself part of why this dimension remained unspoken. Dorris was able to compose a technical structure to her retelling of the SEN role, however how she felt about what others described as a lesser grade was absent. Her near silence on this more personal dimension is striking because our conversation was incredibly open and wide-ranging. I would argue that this indicates, at least in part, how Dorris understood the enrolled grade as a matter of pay and progression to be navigated, and converted out. But the

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[161] Sharon Whiting, "A Space of Their Own: Manchester's Early Critical Care Nurses, 1967–2000" (PhD diss., University of Manchester, 2024), 214.
[162] Anderson and Jack, "Learning to Listen: Interview Techniques and Analyses," 15.

silence may equally reflect the limits of what this interview, shaped by my own unfamiliarity with the hierarchy at the time, was able to elicit.

After qualifying as an SEN, and having worked in other healthcare settings, Dorris aimed to work on the district and undertook the State Enrolled District Nurse examination. Her district nurse training took place at Woolton Manor, which she characterised a school-like environment similar to university.[163] The training involved a month of intensive learning followed by practical experience with a mentor. Dorris specifically recalled her mentor, Barbara Hennesey, teaching her practical skills like tracheostomy care, with a significant part of the training focused on the differentiation between being in the hospital and being at home.[164] Both Julie Snowden and Mabel Williams also completed their post-registration district nurse training at Woolton Manor, in 1980 and 1981 respectively. It's worth noting that throughout the interviews, participants tended to provide more detailed accounts of their general nurse training compared to their district nursing preparation. This emphasis could partly be attributed to methodological factors such as interviewer prompting, as I was generally more focused on exploring the everyday experiences of their district nursing career and the impact this had on their professional identity. This relative silence regarding their district nurse training may also reflect the historically shorter duration and perceived status of this specialist qualification during the 1970s and 1980s. Typically lasting only between six months to a year, district nurse training at the time was often viewed as supplementary to the more

[163] Dorris Smeethe, Interview, 22nd February 2022.
[164] Dorris Smeethe, Interview, 22nd February 2022.

substantial and formative three-year general nursing training. The brevity with which participants discussed their district nursing training could suggest either that this specialised education was less formative to their professional identity than their initial nurse training, or that the concentrated nature of district nursing courses in this period provided fewer memorable milestones for recollection. These narrative choices within the oral history interview reveal not just what was experienced, but what was deemed significant enough to recount, a distinction that itself provides insight into how professional identities were constructed and understood by practitioners. This became clear when hearing about Cathy Earles's district nurse training, which she recalled was six months and which I would now presume was completed at Woolton Manor. However, I did not press any further questions on the location of this course, which Cathy noted was 'actually very good'.[165]

Nevertheless, some interviewees did provide valuable insights into their district nurse training, particularly evident in the reflections shared by Julie Snowden. Julie began her district nurse training, also at Woolton Manor in October 1979, having completed her general nurse training at Broadgreen Hospital from 1972 to 1976 and then midwifery training at Fazakerley Hospital from 1977 to 1978. Julie explained that 'the expectation was if you wanted to get a sister's positing in a hospital or work on the community that you would have to have a second qualification, so off I went to Fazakerley'.[166] This expectation of successive qualification reflected a wider model of nursing career progression, in which nurses

[165] Cathy Earles, Interview, 18th October 2021.
[166] Julie Snowden, Interview, 21st January 2022.

accumulated qualifications across branches of nursing as a route to advancement. Stephanie Kirby's study of the London County Council nursing service describes exactly such a pathway, in which nurses trained across fever, general and midwifery nursing and were supported by the institution in doing so, retaining status and pension rights as they progressed.[167] Julie's way of retelling her progression through different training environments represented not just the acquisition of technical skills, but the building of a specialised professional identity.

Each training phase served as a mode of progression where Julie was able to learn the values, practices, and behaviours that would assist in her becoming a district nurse. This was evident when discussing the training programme at Woolton Manor, which Julie described as not being 'particularly long,' but 'really good in being very clear about cultures and practices around community nursing'.[168] For Julie, the programme was 'quite interesting in that it started with history and then it went through everything that you would think about, where does district nursing sit within health? Where does it sit within social care?'.[169] Julie's recollection highlights how the district nurse training curriculum deliberately cultivated a professional identity that encompassed both clinical skills and a broader understanding of the district nurse's position within healthcare systems. By framing district nursing within both its historical traditions and contemporary healthcare structures, the training helped Julie develop a coherent sense of professional belonging.

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[167] Stephanie Kirby, "Splendid Scope for Public Service: Leading the London County Council Nursing Service, 1929–1948," *Nursing History Review* 14 (2006), 40-41.
[168] Julie Snowden, Interview, 21st January 2022.
[169] Julie Snowden, Interview, 21st January 2022.

While Julie's experience highlights her personal content and wider approach of district nurse training at Woolton Manor in the late 1970s, other interviewees' pathways into nursing reveal how early exposure to community care concepts often began much earlier in their professional development. Similar to all other interviewees (except for Alan), Karen Walker completed a pre-nursing training course, however Karen's was when she left school at 16 in 1972. Karen completed her course at a local technical college in Widnes and described the course as encompassing 'quite a few areas that were related to nursing, one of which was nursing in the home'.[170] Karen told me how, towards the end of this course, she applied to four different hospitals to complete her nurse training, and after an interview for each, was offered a place at four different hospitals.[171] This multiple acceptance was a formative moment in Karen's professional journey, one that validated her academic capabilities and reinforced her sense of belonging within the nursing profession. The way Karen highlighted this achievement in our interview demonstrates how these early academic successes contributed to a durable professional identity rooted in competence and achievement.

Karen then accepted a place at Broadgreen Hospital where she completed her Registered General Nurse (RGN) training between 1976 and 1980. Unlike all other interviewees, Karen lived in a student nursing home for the full three-year duration of her course, for the first year in Wavertree House, followed by the Robert Davis

[170] Karen Walker, Interview, 14th March 2022.
[171] Karen Walker, Interview, 14th March 2022.

Nurses' Home for the remaining two years.[172] When I asked Karen what that experience was like, she described it as 'fantastic', saying,

> I suppose what I look back on it and think is we were part of that hospital. We were absolutely part of that hospital. We were trained by that hospital, with the standards and the protocols, and everything about us was Broadgreen trained. So, when you were qualified, you were a Broadgreen nurse. If you stayed at Broadgreen, it was embedded into you that that's what you were.[173]

This reflection illustrates how training and education can serve as a powerful mechanism for shaping professional identity. For Karen in particular, the location of her RGN training explicitly framed her subsequent nursing identity. Karen's emphasis on being 'absolutely part of that hospital' and the repetition of 'Broadgreen trained' suggests that training constituted an initiation into a specific professional culture with distinct values and practices.[174] The phrase 'embedded into you' is particularly revealing, suggesting a transformation process whereby the institution's standards and protocols became internalised as part of her professional self. This institutional imprinting demonstrates how training environments functioned as formative spaces where professional identity was actively constructed through immersion in organisational culture.

Nevertheless, once Karen had undertaken a community placement in 1978, she was certain she wanted to go into district nursing, although it was not until 1988 that she began her district nurse training, nearly 12 years after starting her nursing

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[172] Karen Walker, Interview, 14th March 2022.
[173] Karen Walker, Interview, 14th March 2022.
[174] Karen Walker, Interview, 14th March 2022.

career. Karen applied for and was successful in gaining a place on a district nurse training course ran by the University of Liverpool in September 1988, at the age of 30. Although Karen's training was largely completed in the University of Liverpool campus, she did complete certain parts of her training at Woolton Manor, highlighting the centrality of the location to the provision of district nurse training in Liverpool.

Similar to Julie, Karen explained how she undertook some training on William Rathbone and the history of district nursing, stating how she was 'extremely proud because I trained to be a district nurse in the city where district nursing originated and we were proud to be Liverpool district nurses.'[175] This connection to place and history in Karen's narrative reveals how specialised training cultivated professional identity through historical lineage and geographical significance. By emphasising her pride in training in the birthplace of district nursing, Karen demonstrates how educational programs strategically incorporated historical consciousness to foster professional belonging. Her identification as a 'Liverpool district nurse' suggests that training successfully instilled not just technical competence but a sense of participating in a distinct professional tradition with local roots and historical legitimacy (outlined in Chapter 1).[176]

[175] Karen Walker, Interview, 14th March 2022.
[176] Karen Walker, Interview, 14th March 2022.

Discussing the nature of training, Karen explained how it would primarily be based on practical work, with another qualified district nurse teaching the students.[177] Karen told me how she 'absolutely loved' the training, which was everything she 'expected it to be'.[178] This was because she was able to 'get to know the people you looked after as human beings, with a life, with a family, with surroundings, with a background, with support, or lack of it, whichever it was'.[179] Karen's description of getting to know her patients aligns with what Shaun Speed and Karen Luker have termed 'personal and aesthetic knowing,' an understanding of the patient's whole circumstances build through sustained, direct contact, which they identify as central to district nursing.[180] Speed and Luker have argued that this mode of knowing came under pressure as primary care was reorganised over the closing decades of the twentieth century, with a more distanced 'knowing about' the patient, or knowing by proxy, increasingly taking its place.[181] For Karen then, this ability of being able to get to know patients outside of the hospital setting was a positive function of not just her district nurse training but subsequent practice. In addition, Karen's account gives the patient a rounded presence, with a life, a family and a background. This stands somewhat in contrast to the policy that shaped her training. Where Karen's testimony treats the patient as a participant in care, the Briggs report addressed the patient as the recipient of a service, framed through the needs of an integrated health service. The passivity that can attach to the patient is in this sense a feature

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[177] Karen Walker, Interview, 14th March 2022.
[178] Karen Walker, Interview, 14th March 2022.
[179] Karen Walker, Interview, 14th March 2022.
[180] Shaun Speed and Karen A. Luker, "Changes in Patterns of Knowing the Patient: The Case of British District Nurses," *International Journal of Nursing Studies* 41, no. 8 (2004): 926.
[181] Speed and Luker, "Changes in Patterns of Knowing the Patient," 926;

of the policy record rather than of district nursing as the interviewees described it.[182] This reading of the patient was not confined to British policy. Karen Buhler-Wilkerson has shown that American home care statisticians described the typical mid-century patient in similarly administrative terms, defined by diagnosis, visit frequency and compliance rather than by voice.[183]

Throughout this section, I have shown how training and education served as foundational experiences in shaping district nurses' professional identities. From their initial nursing training to specialised district nurse training, these educational pathways provided a framework for understanding their professional role and purpose. The interviewees' testimony reveals how training institutions imprinted their values and approaches onto nurses, creating a sense of belonging based on professional tradition. As we move from examining how district nurses' identities were formed through training to exploring how these identities were enacted and reinforced in practice, we see a transition from theoretical preparation to lived experience. The following section will explore how the daily work of district nursing further developed the interviewee's sense of professional identity.

3.4 Professional Identity in Practice

In order to effectively understand the professional identities of the district nurse that were espoused by the interviewees, it is crucial to examine how the practice of district nursing was recollected. In this section, I explore how district nurses

[182] Asa Briggs, *Report of the Committee on Nursing* (London: HMSO, 1972), 11–12.
[183] Buhler-Wilkerson, *No Place Like Home,* 196.

articulated and embodied their professional identity through the everyday realities of their work. Drawing primarily on oral history testimony, I analyse how nurses navigated the values, practices, and ethical demands inherent to their roles, demonstrating how professional identity was continuously shaped and reshaped by these daily interactions. As district nurses moved between patients' homes, navigating diverse social environments and responding to complex healthcare needs, they developed nuanced understandings of their professional boundaries, responsibilities, and values. These understandings were tested and refined through critical incidents that demanded both technical competence and emotional intelligence. Through these narratives, this section underscores how professional identity was both personally felt and publicly performed, shaped by individual experiences and collective understandings of what it meant to be a district nurse.

Interviewees understood and communicated their professional identity through a complex construction shaped by specific tasks, intricate relationships and autonomous decision-making. These constructions were inextricably shaped by their remit outside of the hospital. Later in the chapter focused on Home, the pivotal relationship the home played on the work of the district nurse is discussed in greater detail. Here however, it is important to discuss how interviewees spoke of the tasks involved in this care, and how it helped create an acceptable conveyance of professional identity.

Suzanne Gordon and Sioban Nelson have argued that nurses, when asked to describe or justify their work, too often fall back on a traditional caring discourse

which they have deemed a 'virtue script'.[184] Within this discourse, the nurse is presented above all as a good and compassionate figure. The knowledge and skill that caring actually demands are not denied, but they tend to go unspoken, folded into character rather than recognised as expertise. For Gordon and Nelson then, the concern is not with caring language as such, but with the way it can sentimentalise what is in fact complex and highly skilled work.[185] This concern belongs to a longer engagement within the history of nursing with the ethics of care. Reverby's account of American nursing, discussed above, treated care not as a natural attribute but as a historically shaped obligation, and although her frame is drawn from the United States before 1945, that insistence travels to the post-war British context studied here.[186] Gordon and Nelson's account of the virtue script returns to this same problem, questioning how a caring discourse can obscure the skill that nursing work in fact demands.[187] Grace Clement has argued that care and autonomy need not be opposed, but can be held together within an ethics of care.[188]

However, the interviewees for this thesis did not draw on such a 'virtue script'. Although interviewees spoke readily of care, compassion and relationship, they did not present these in place of clinical competence. Rather, they treated relational attentiveness and technical skill as inseparable aspects of the same professional identity. This is evidenced in greater detail below in the material

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[184] Suzanne Gordon and Sioban Nelson, *The Complexities of Care: Nursing Reconsidered*. (New York: Cornell University Press, 2006), 13.
[185] Gordon and Nelson, *The Complexities of Care. Nursing Reconsidered*, 13.
[186] Reverby, "A Caring Dilemma," 5.
[187] Gordon and Nelson, *The Complexities of Care: Nursing Reconsidered*, 13.
[188] Grace Clement, *Care, Autonomy, and Justice: Feminism and the Ethic of Care* (Boulder, CO: Westview Press, 1996).

covering the importance of relationship building in the clinical aspect of the bed bath. In this sense, the interviewees invoked a caring discourse without performing its defining move. They declined to set care against expertise, instead understanding the two as mutually constitutive. This way of holding care and skill together was only one part of how interviewees expressed their professional identities. Their accounts returned just as often to the independence that their work offered them.

Autonomy and Responsibility

One of the most consistent themes to emerge from the oral history interviews was the sense of autonomy and responsibility that interviewees associated with their professional identity. In later chapters, autonomy will be examined in relation to how district nurses worked within communities and entered patients' homes. Here however, autonomy is considered as a defining marker of professional identity. Oral history interviews repeatedly highlighted that to be a district nurse meant being recognised as someone who could act independently, exercise judgement and carry responsibility without immediate oversight.[189] Autonomy was remembered not simply as a feature of practice, but as central to how district nurses understood themselves as professionals. Julie Snowden recalled that even during the week of her district nursing placement she undertook as part of her general nurse training she recognised this, explaining how '[f]rom the week I'd done as a student on the

[189] See also Rona Ferguson, "Autonomy, Tension and Trade-off: Attitudes to Doctors in the History of District Nursing," *International History of Nursing Journal* 6, no. 1 (2001): 10. and Shaun Speed and Karen A. Luker, "Getting a Visit: How District Nurses and General Practitioners 'Organise' Each Other in Primary Care," *Sociology of Health & Illness* 28, no. 7 (2006): 883–902.

district I saw it as a job where I would have some more autonomy and that I would need to build my skills'.[190] For Julie, autonomy was not simply remembered as a feature of practice but as central to how district nurses understood themselves as professionals.

Unlike hospital nurses, who worked within visible hierarchies overseen by ward sisters and consultants, district nurses often entered patients' homes alone, assessed conditions, and made decisions about treatment or referral without immediate oversight. This independence was central to how nurses defined themselves as professionals. Indeed, Alan Carlise told me how he envisaged the future identity of the district nurse as that of a 'coordinator of all services to the patient' who examined needs, allocated resources and managed a team of nurses and assistants.[191] His vision extended beyond clinical tasks to include aspects of social work, positioning the district nurse as the manager of a whole team and underscoring how autonomy was remembered as integral to professional identity.[192]

Interviewees' recollections of autonomy and independence consistently carried with them an emphasis on responsibility, where professional identity in practice was tied to the expectation that district nurses would make clinical and diagnostic judgements on their own. Alan's vision of the district nurse as the 'coordinator of all services to the patient' emphasised the comprehensive clinical assessment and intervention planning that he felt was crucial to the district nurse's professional identity. When Alan spoke of performing a bed bath on a patient for

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[190] Julie Snowden, Interview, 21st January 2022.
[191] Alan Carlise, Interview, 28th October 2021.
[192] Alan Carlise, Interview, 28th October 2021.

example, he would simultaneously observe minute changes in the patient, noting skin colour, clamminess, and temperature.[193] In contrast, Mabel Williams told me how these routine tasks were opportunities for relationship building, using the extended time required for certain procedures to develop deeper connections with patients.[194] The repetitive nature of treatments like leg ulcer dressings created recurring touchpoints that gradually built familiarity and trust. Rather than rushing through brief interventions like insulin injections, Mabel deliberately maintained space for communication and connection even when she might have been constrained by time. This approach was reinforced by Julie, who explained to me how 'giving somebody a bed bath is more complex than taking stitches out', elaborating on how:

> That is the time when you can really talk to somebody because it takes a while. When you really talk to somebody to find out how they are, how they're feeling, what their problems are, blah-blah-blah. I don't think we value that enough now.[195]

These reflections reveal an understanding of how clinical procedures functioned simultaneously as technical interventions and interpersonal opportunities. Both Mabel and Julie's testimonies suggest that relationship-building was not separate from clinical care but embedded within it. The intimate, time-consuming nature of procedures like bed baths created natural contexts for meaningful conversation. Moreover, the consistency between Mabel and Julie's accounts suggests that this approach to integrating clinical and interpersonal dimensions was a shared

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[193] Alan Carlise, Interview, 28th October 2021.
[194] Mabel Williams, Interview, 8th March 2022.
[195] Mabel Williams, Interview, 8th March 2022.

professional practice within Liverpool's district nursing community. For both nurses, these interactive care moments were central to how they conceptualised their professional role and ultimately to how they recalled their district nursing careers, revealing the centrality of interpersonal dimensions in their professional identities.

This kind of intimate bodily work has been analysed by Jocalyn Lawler, whose account of nursing as 'somological' practice treats the body as something nurses come to know through practical experience, integrating the patient as both object and subject.[196] Lawler has argued there is a paradox in how such work is regarded however, as bodily care was historically assigned low status and associated with the 'dirty' and junior tasks, yet nurses held it to be profoundly important to the patient's wellbeing and recovery.[197] The value that Julie, Mabel and Alan placed on the bed bath and other tasks that brought them into direct contact with the patient's body aligns with this second understanding of what Lawler refers to as somology. Further, it was also, as Alan's attentiveness to skin colour and temperature suggests, a site of clinical observation, the principle Lawler regards as 'fundamental' to contemporary nursing.[198] In addition, this integration of clinical and interpersonal care reflects what Lawler has described as the expert nurse's tendency to acknowledge the patient as a person as well as a body, drawing together various dimensions of care into a composite and integrative view shaped by the particular patient and situation.[199]

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[196] Jocalyn Lawler, *Behind the Screens: Nursing, Somology and the Problem of the Body,* (Sydney: Sydney University Press, 2006), 5.
[197] Lawler, *Behind the Screens,* 33-34.
[198] Lawler, *Behind the Screens,* 65.
[199] Lawler, *Behind the Screens,* 25.

This integrated approach to clinical care and interpersonal communication fostered relationships that evolved beyond unidirectional professional encounters into more reciprocal exchanges. Mabel indicated a reciprocal nature of relationship-building resulting from this approach, noting that '[t]hey [patients] knew everything about you, your dog, and everything. All above board, all [that] they can know about you'.[200] This statement reveals how responsibility extended beyond clinical and diagnostic tasks to include the careful management of professional boundaries. Nurses described a calibrated form of self-disclosure that allowed patients to know something of their lives beyond the role, while still preserving professional identity. Such reciprocity was remembered as part of the responsibility of sustaining trust, reinforcing the sense that professional practice required judgement not only in treatment but also in relationships.

These recollections show that autonomy and responsibility were remembered as central to the professional identity of the district nurse. Independence meant being trusted to exercise clinical judgement, while responsibility extended into the ways routine care created space for observation, conversation and reciprocal trust. Professional practice was therefore understood as both technically skilled and relationally attentive, qualities that together defined what it meant to be a district nurse for the interviewees.

[200] Mabel Williams, Interview, 8th March 2022.

3.5 Conclusion

This chapter has examined how district nurses between 1945 and 2000 remembered and articulated their professional identity. Drawing together testimony and archival sources, it has shown that professional identity was constructed through a combination of institutional frameworks, educational pathways, and the lived realities of practice. Training and regulation provided the formal boundaries of the profession, but interviewees consistently recalled that professional identity was not defined purely by qualification. It was embedded in the responsibilities and values they carried into their everyday practice.

Gender remained central to this construction. As the testimonies of Alan Carlise and Ethel Love illustrate, district nursing was shaped by cultural codes of femininity and domesticity even as male district nurses entered the profession. Uniforms, expectations of duty and the compatibility of district nurse work with family responsibilities revealed the persistence of gendered structures in the post-war period. Yet nurses also remembered their identities in terms of autonomy and responsibility, presenting themselves as independent practitioners trusted to act without oversight. Autonomy was remembered as both an enabling and demanding marker of professional legitimacy and accountability. The recollections offered by Julie Snowden and Mabel Williams highlight how professional identity was forged through the integration of clinical skill and interpersonal attentiveness. Routine procedures were remembered not only as technical interventions but as opportunities for observation, conversation and trust-building. Responsibility therefore encompassed diagnostic judgement, relational sensitivity and the careful

management of professional boundaries. These qualities were central to how district nurses defined themselves and were remembered as integral to the practice of their profession.

Taken together, these findings demonstrate that professional identity was not a fixed or abstract status but a lived and narrated experience. It was shaped by the intersection of institutional authority, gendered expectations, clinical responsibility and interpersonal practice. Oral history testimony revealed how district nurses composed their identities in ways that reflected pride in autonomy, recognition of responsibility and commitment to values of care and duty. By examining professional identity in this way, this chapter established a foundation for the thesis as a whole. The ways in which district nurses understood themselves as professionals shaped how they worked with patients' families, colleagues in the community, and how they negotiated the particular dynamics of providing care within patients' homes. Professional identity therefore forms the entry point for the chapters that follow, where community and home are examined as the spaces in which these identities were enacted.

Chapter 4: Community

4.1 Introduction

When I asked Karen Walker if she had always wanted to go into nursing, she replied that '[y]es, from the age of about nine, all I ever wanted to do was to be a nurse,'.[1] Elaborating, Karen explained how '[w]hen I was a little girl, my mum used to play with me a lot, and all I ever wanted to play with my mum was nurses. And just from that very time, I remember thinking, "I'm going to be a nurse. That's what I wanted to be"'.[2] Although Karen told me that she initially envisioned a career as a theatre sister, when it came to her nurse training, and undertaking her 'community placement', she decided on a different route.[3] According to Karen, 'Once I'd done my community placement, no, that was it. My mind was made up. This is what I want to do. I want to go and nurse people in the community.'[4] The dual reference to 'community placement' as a professional training environment and nursing people 'in the community' as spatial and interpersonal practice demonstrates the layered meanings this concept held for interviewees. In addition, Karen's narrative is not only a recollection of childhood aspiration but an oral history performance in which memory, career trajectory and professional identity are woven together in a composed and coherent story. This testimony captures the multidimensional nature of community that emerged across my interviews with district nurses who practiced

[1] Karen Walker, Interview, 14th March, 2022.
[2] Karen Walker, Interview, 14th March 2022.
[3] Karen Walker, Interview, 14th March 2022.
[4] Karen Walker, Interview, 14th March 2022.

in Liverpool between 1960 and 2000 and will form the basis of this chapter's concept of community.

For Alistair Thomson, community oral history is 'the mainstream of British oral history', with a vibrant and radical tradition.[5] Thomson's understanding of community history is that it is 'about a particular community, however defined, created in partnership with members of that community, and for the benefits of that community'.[6] Although typically referring to a group of individuals defined by shared experiences within a geographically defined locale, community can also refer to a shared social identity. In this respect, we can talk about members of the LGBTQIA+ community, people from minoritized ethnic backgrounds, or members of an occupational community such as district nurses. Karen's testimony exemplified this fluid conceptualisation of community. Karen's narrative transitioned between community as a category of her professional identity when discussing her 'community placement' to then conceptualising community as a geographical professional domain, discussing her desire to nurse 'people in the community.[7] These dimensions of community were not separate, but interconnected aspects of Karen's foundational understanding of her district nursing career. This layered understanding of community appeared across interviews, which I argue highlights its centrality to how district nurses constructed their professional identities and

[5] Alistair Thomson, "Oral History and Community History: Personal and Critical Reflections on Twenty-Five Years of Continuity and Change," *Oral History* 36.1 (2008): 95.
[6] Thomson, "Oral History and Community History: Personal and Critical Reflections on Twenty-Five Years of Continuity and Change," 97.
[7] Karen Walker, Interview, 14th March 2022.

understood their role. Within the interviews, community represented the space between the houses that interviewees delivered care in. Community also came to represent people, such as patients and other nurses, that district nurses interacted with in their work.

This chapter will show how interviewees revealed that community functioned across three distinct yet interconnected dimensions. First, there was the community which reflected the specialised professional domain with distinct practices and terminology. Second, there was the community of social relationships with patients and colleagues. Third, there was the community of mid-to-late twentieth century Liverpool, with its urban territories and communal characteristics. This chapter will examine these layered portrayals to understand how community was embedded within the recollections offered by district nurses in our interviews. To begin with, I will explore the linguistic evocation of a professional community, examining how district nurses adopted certain language and phrases to articulate their roles and responsibilities within the districts they worked on. A consistent pattern which emerged across the interviews was the distinctive way that district nurses described their professional relationship to community, alternating between working 'on' and '"in" the community'.

The following section investigates the interpersonal dimensions of community through district nurses' accounts of patient interactions and relationships. The people that made up the communities that were mentioned by interviewees covered patients and their extended families, as well as in some cases wider members of local communities in Liverpool such as clergymen. Owing to their shared experience as district nurses, interviewees articulated their own community, so in this section I

examine communal identifiers such as their uniform and practice-related commonalities. This will help illustrate the shared characteristics of a district nursing community that emerged from the oral history interviews. The third and final section focuses on the spatial conveyance of community offered by interviewees. As district nurses who worked across Liverpool, interviewees provided interesting and insightful perspectives on the experience and concept of community in the city. Topics ranged from experiences within areas of the city they encountered while working as district nurses as well as musings on the city itself. Liverpool underwent considerable social and economic changes throughout the latter half of the twentieth century, and discussions with interviewees provided insight into how these changes were recollected. Owing to the predesigned structure of the project associated with telling a history district nursing in Liverpool, it felt it was important to understand the relationship between the district nurses as a public-facing healthcare providers and the city they lived and worked in. Furthermore, this approach allows for an updated companion to histories of district nursing which had predominantly focused on the role's origins in the nineteenth-century city.

4.2 The Professional Community

When beginning this research, I anticipated that 'community' would primarily function as a geographical or social concept that would illustrate Liverpool's local history during the late-twentieth century. Specifically, I felt the use of 'community' as a point of analysis or theoretical direction was primarily going to assist with an understanding of communities in Liverpool that the district nurses worked and lived

in during their career. For example, I would ask interviewees whether they felt visible within the communities they worked in, focusing on the communal or social formation of 'community'. However, what quickly became apparent was how district nurses employed 'community' as a specialised professional term with multiple dimensions. Throughout the oral history interviews, district nurses employed specific terminology to articulate their professional identities and relationships to community.

This section examines how these linguistic patterns reveal not only individual professional positioning but also broader historical shifts in how district nursing was conceptualised in Liverpool during the mid-to-late twentieth century. By analysing how interviewees alternated between working 'on' and 'in' the community, as well how they spoke of feeling reluctant going 'into' the community, we can understand how language functioned as a crucial tool for articulating a specialised professional identity tied to both place and practice. These shared linguistic patterns also reveal how district nurses in Liverpool, despite their individual experiences, formed an occupational community bound by common understandings of their professional role. This occurred during a time when community was increasingly woven into the fabric of the district nursing profession.

The term 'community' was increasingly associated with district nursing from the 1950s onwards, formalised through political interventions into the management of health services in the Salmon and Mayston reports. These interventions foresaw the community as becoming increasingly important as a geographical environment of care. A 1969 *Nursing Times* article, written on behalf of the Royal College of Nursing, provided evidence of this new focus towards community nursing, when it

noted that 'district nursing is the nursing of the sick in the community'.[8] Within the article, roles are discussed which involved nursing on the community, with the district nursing service described as being 'operated by highly skilled nurses, who can discern the needs of the patient and initiate appropriate action.'[9] It was noted that 'a nurse operating at this level must not only be highly skilled in nursing procedures but must in addition have insight into human relations and have some skills of management, counselling and teaching.'[10] The article also mentioned nurses on the community who were not district nurses, such as domiciliary and auxiliary nurses.[11] The inclusion of non-district nurses working on the community reflects the diversity of nursing roles within community settings, with the use of 'highly skilled' indicating the advanced training required of the district nurse role to work on the community.

This is useful as it highlights how there has and is currently a clear demarcation between the identity and work of the district and the community nurse. In a 2013 Department of Health document, district nurses were defined as 'qualified nurses with a graduate level education and specialist practitioner qualification recordable with the Nursing and Midwifery Council.'[12] For the Royal College of Nursing, the work of the district nurse should be the 'planning, provision and evaluation of appropriate programs of nursing care, particularly for people discharged from hospital and patients with complex needs; long term conditions,

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[8] SA/QNI/P.7/61 "The future of district nurse training 1969", *Nursing Times,* March 20, 1969.
[9] SA/QNI/P.7/61 "The future of district nurse training 1969".
[10] SA/QNI/P.7/61 "The future of district nurse training 1969".
[11] SA/QNI/P.7/61 "The future of district nurse training 1969".
[12] Department of Health, "Care in local communities: A new vision and model for district nursing" (Department of Health, 2013).

those who have a disability, are frail, or those at the end of their life'.[13] Community nursing, on the other hand, can be understood in broader terms, with Pauline Allen, Donna Bramwell, Kathleen Checkland and Jolanta Shields having noted that 'community nursing encompasses a diverse range of nurses and support workers who work in the community, including district nurses, intermediate care nurses, community matrons and hospital at home nurses.'[14] Moreover, Baker *et al* have highlighted the wide range of practitioners 'community nursing' could encompass, noting district nurses, health visitors, health-authority employed treatment nurses, community midwives, community psychiatric nurses, practice-employed nurses and school health service nurses.[15] That these roles shared community jurisdiction did not mean they shared an institutional home.

The district nurse did not work in isolation, but alongside a network of health and social welfare services that met the patient in the home while occupying distinct institutional remits. Under the tripartite structure established by the 1946 NHS Act, health provision was divided between local authorities, executive councils and hospital boards, with district nursing sitting alongside maternity, child and environmental health within the local-authority arm.[16] Social welfare provision sat apart from this structure, administered separately from the health services the district nurse belonged to. The district nurse and the social worker might visit the

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[13] Royal College of Nursing, "District nursing: Harnessing the potential. The RCN's UK Position on District Nursing" (London, 2013).
[14] Pauline Allen, Donna Bramwell, Kathleen Checkland and Jolanta Shields, *Community Nursing Services in England*, 5.
[15] G. Baker, J. M. Bevan *et al*, *Community Nursing: Research and Recent Developments* (London: Croom Helm, 1987), 1.
[16] Allen, Bramwell, Checkland, and Shields, *Community Nursing Services in England: An Historical Policy Analysis*, 9.

same patient, but they belonged to different services, with different training, lines of accountability and definitions of need. This kind of institutional fragmentation was not particular to Liverpool. Rima Apple has shown that community nurses in Depression-era Wisconsin worked within a similarly crowded field of overlapping agencies, county nurses, school nurses, industrial nurses, and voluntary organisations such as the Red Cross and the Wisconsin Anti-Tuberculosis Association, each responsible for a distinct client group or task within the same community.[17] In Rock County, for example, a dispute arose in 1931 when a voluntary tuberculosis organisation attempted to take over follow-up visits to discharged patients that had traditionally been the county nurse's responsibility, and the matter had to be settled through a county health committee rather than through any established line of authority.[18]The institutional details differed from Liverpool's tripartite arrangement, but the underlying condition, several services meeting the same patient without a shared institutional home, recurred wherever community health provision developed piecemeal across multiple agencies.

Where the district nurse's domain was acknowledged as the clinical care of the patient, social services carried responsibility for welfare and social provision. As discussed later in the chapter on Home however, this boundary was rarely clean at the point of care, since the needs of a patient within their own home seldom divided neatly into the clinical and the social. This was true even within nursing's own

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[17] Rima D. Apple, "'Community healthcare': Struggles and conflicts of an emerging public health system in the United States, 1915–45," in *Histories of Nursing Practice*, ed. Gerard M. Fealy, Christine E. Hallett and Susanne Malchau Dietz (Manchester: Manchester University Press, 2015), 163–64

[18] Apple, "'Community healthcare'," 175–77.

recognised remit. Bathing, for example, was a task that neither service clearly owned. The home help service, built around a model of housework, traditionally stopped short of intimate personal care, while the district nursing service recognised bathing as part of its professional remit but was reluctant to treat it as a distinct, guaranteed service.[19] Responsibility for such tasks was worked out informally on the community, case by case, rather than settled by policy, in what Twigg has termed a 'grey area' of provision.[20]

The increased use and variation of the term 'community' could be explained due to the shift that was occurring in healthcare in a political and public level during the mid-twentieth, explained by Susan Carr as having a 'strong community and primary healthcare focus'.[21] Thus, to properly analyse the interviewee's placed-based associations with community, it is important build on the work of Gary Hickey, who has discussed how there is a difficulty in researching nursing work 'on the community', due to the manner in how 'the community' can be defined.[22] Accordingly, 'the community' can be linked to a particular type of specialist practice, such as district nursing, whilst also being understood as any environment classed as a non-hospital setting.[23] Interestingly, Hickey highlighted how differences in interpretation of 'the community' were most noticeable between nurses within

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[19] Julia Twigg, "Deconstructing the 'Social Bath': Help with Bathing at Home for Older and Disabled People," *Journal of Social Policy* 26, no. 2 (1997): 215.
[20] Twigg, "Deconstructing the 'Social Bath'," 215.
[21] Susan M.Carr, 'Nursing in the Community - Impact of Context on the Practice Agenda', *Journal of Clinical Nursing* 10 (2001), 330.
[22] Gary Hickey, "Using questionnaires to ask nurses about working in the community: problems of definition," *Health and Social Care in the Community* 8.1 (2000): 70.
[23] Hickey, "Using questionnaires to ask nurses about working in the community: problems of definition," 71.

different branches.[24] For example, adult and child nurses, typically based within the hospital, referred to district nurses and health visitors as working on 'the community'.[25] Mental health nurses, in comparison, referred to psychiatric nursing on the community or jobs based in community health centres. [26] Hickey has outlined three strands of nursing-work on the community, which are useful in helping frame the interview testimony of district nurses in this project. The three distinct locations of work 'on the community' are:

1) Visiting or providing care for people in their own homes (district nurses);
2) Settings in which care is provided to people who visit it but do not stay as inpatients (nursing in a GP practice);
3) Settings in which people live together in the community (residential care homes).[27]

Thus, 'community nursing' can broadly be understood as an umbrella term that describes a branch of nursing which occurs outside of the hospital. Within that branch of nursing, there are district nurses as well as a range of other healthcare professionals such as health visitors and community midwives.

This framework resonates with how interviewees positioned their professional work on the community. Mabel Walker, for example, spoke about how her district

[24] Hickey, "Using questionnaires to ask nurses about working in the community: problems of definition," 71.
[25] Hickey, "Using questionnaires to ask nurses about working in the community: problems of definition," 71.
[26] Hickey, "Using questionnaires to ask nurses about working in the community: problems of definition," 71.
[27] Hickey, "Using questionnaires to ask nurses about working in the community: problems of definition," 71.

nurse training meant that she was 'adapting our nursing experience into the community, which we knew was going to be entirely different'.[28] Again, similar to the study discussed by Hickey above, we are seeing the nuance and flexibility involved with terms such as 'community' and 'district'. What connects both is an awareness that nursing on the community would necessitate a different approach to that of the hospital. Elsewhere, Julie Snowden for example provided an interprofessional understanding of nursing on the community, recalling how she spent three months working as 'a community midwife' prior to becoming a district nurse.[29] This reflection demonstrates how experiential learning on the community helped interviewees identify their preferred professional positioning within community healthcare.

As a result, interviewees were able to elaborate on the multiple professional identities which encompassed community nursing to help reinforce their district nurse identity. The distinction between district nursing and broader community healthcare roles became particularly evident when interviewees discussed their experiences working within community health structures such as Health Centres. Upon completion of her district nurse training in 1989, Karen Walker began work as a district nurse in Speke. Karen explained to me how she was 'attached' to Speke Health Centre, one of five qualified district nurses working there.[30] Unpacking the idea of being 'attached' to a health centre, Karen described how each district nurse

[28] Mabel Williams, Interview, 8th March 2022.
[29] Julie Snowden, Interview, 21st January 2022.
[30] For more information on the introduction of district nurses being attached to health centres please see Chapter 1, Section 3.

worked for a GP practice, which also included 'community nurses who worked with you on the team, but (who) weren't qualified as a district nurse.'[31] Furthermore, within that health centre, there would be 'enrolled nurses, and registered nurses, who weren't district nurse qualified, and then auxiliary nurses'.[32] Karen's testimony reflects how, within the increased prominence of nursing on the community, district nurse's positioned themselves within hierarchies of professional expertise. As discussed in Chapter 3, professional identity for district nurses rested heavily on the autonomy and expertise required of the role. In Karen's discussion of Speke Health Centre, these claims are expressed not only through her account of tasks and responsibilities, but through the act of naming and ordering colleagues. Her interview testimony therefore provides insights into how district nurses narrated their place within evolving health structures, situating themselves within hierarchies of community practice that were both professional and linguistic.

In her discussion pertaining to the organisation of community health, Karen provided a clearly demarcated hierarchy of nurses using terms such as 'qualified', 'enrolled', and 'registered'.[33] These terms help position the district nurse as central to delivering care on the community. Here, community means the community of healthcare providers, indicating the inter-professional nature of these relationships. The continued mention that it was district nurses who were qualified in comparison to community nurses who were not highlights the importance that interviewees placed on their training and education. In addition, throughout our interviews,

[31] Karen Walker, Interview, 14th March 2022.
[32] Karen Walker, Interview, 14th March 2022.
[33] Karen Walker, Interview, 14th March 2022.

district nurses naturally shifted between undertaking their work 'on' or 'in' the community, a choice that both differentiated individual experiences and unified them through shared professional terminology. This pattern of expression reveals how deeply the concept of community was embedded in their professional identity, serving as both a physical workspace and a framework for understanding their role.

On/In the Community

Looking at the interview testimony and archival sources together, it is clear that during the mid-to-late twentieth that community nursing emerged as an increasingly inclusive professional category that encompassed multiple nursing disciplines, while still maintaining important distinctions. Within our interviews, district nurses consistently articulated their specialised identity within this broader environment, positioning themselves as qualified practitioners with specific training that distinguished them from other community-based healthcare workers. For district nurses interviewed, placement within the community rested on their completion of further specialist training, which Cathy Earles, Julie Snowden, Dorris Smeethe, and Mabel Williams completed for Liverpool Health Authority at Woolton Manor between 1979 and 1981. According to Stephen Barley and John Van Maanen, occupational communities are created not just due to working in the same geographical location, but due to being engaged in the 'same sort of work'.[34] This shared training experience at Woolton Manor likely functioned as a crucial site for professional

[34] Stephen Barley and John Van Maanen, "Occupational communities: Culture and control in organisations", *Research in Organizational Behaviour* 6 (1984): 287.

socialisation, where nurses developed not only clinical skills but also common linguistic frameworks for understanding their role in community settings.

Discussions about district nursing and community focused not only on the tasks, duties and responsibilities that helped define the role but also on how nurses understood and described the environment in which they practiced. For example, when I asked Ethel Lowe what a typical day involved in her role, she replied '[w]ell you had your bed bound patients. Initially we would have to give them a bath, a quick bath, treat their bed sores, if any, make sure they were comfortable'.[35] Whilst interviewees frequently recounted the practical aspects of district nursing, as Ethel did, it became increasingly clear that equal emphasis was placed on the location of care delivery. The setting in which district nurses worked was a fundamental aspect of how their professional identity was communicated, shaping how they described their role and experiences. Therefore, a shared professional identity was articulated through distinctive patterns of language that revealed a complex relationship to community, such as when interviewees alternated between describing themselves as working 'on' and 'in' the community. Their adoption of phrases associated with community to reference their workplaces reveals how language functioned as a crucial tool for articulating professional identity, interconnected to both community and place.

[35] Ethel Love, Interview, 8th November 2021.

Throughout the oral history interviews, district nurses spoke consistently on the work they undertook 'on' the community, which at times encapsulated its own environment, or was used to differentiate or highlight nursing outside of the hospital in a similar vein as discussed by Hickey.[36] This was clear when Julie Snowden discussed her experience working as midwife. When describing her transition from midwifery to district nursing, Julie described how she had spent 'three months on the community as a community midwife'.[37] Here, Julie positioned the community as a professional territory where different healthcare disciplines operated. By situating her midwifery experience 'on the community' Julie established community as a professional landscape that was navigated and occupied by various healthcare professionals. However, Julie made clear what she felt distinguished the work between the district nurse and the midwife on the community. For Julie, although she 'enjoyed midwifery', the fact that she wasn't 'looking after sick people' directed her into district nursing.[38]

Later in our interview, Julie described what her expectation of district nursing on the community would entail, describing how she:

> expected to go on the community and have a caseload that was mine, that I would be responsible for, that I would develop a rapport with patients and their families and be part of that process, that I would be promoting independence rather than dependence, and that I would spend my time developing relationships with other people who were part of the team looking after them,

[36] Hickey, "Using questionnaires to ask nurses about working in the community: problems of definition," 71.
[37] Julie Snowden, Interview, 21st January 2022.
[38] Julie Snowden, Interview, 21st January 2022.

> so GPs, social workers, home helps, as we had then and health visiting, those sorts of people.[39]

This testimony illustrates how language associated with community functioned as a key marker of professional identity for district nurses in our interviews. For her the phrase 'on the community' was not merely a geographical descriptor but a professional signifier that distinguished Julie's work from her hospital-based roles, reinforcing the autonomy and patient-centred nature of district nursing.[40] Julie's emphasis on 'having a caseload that was mine' and 'developing a rapport with patients and their families' underscored the responsibility and continuity of care that defined her district nursing practice on the community.[41]

Julie's example goes someway to explain the frequency and overlapping use of the term 'on the community' throughout the wider interview process. Working 'on the community' helped interviewees formulate and structure the recollection of their careers. Nevertheless, interviewees were still able to recognise that within the community nursing environment there were individuals such as auxiliary nurses who occupied community-oriented medical spaces. This language of community is therefore explained as broad, fluid, and inclusive, with interviewees recognising that they would be part of a multidisciplinary team working on the community. As Julie's quote above indicates she was aware of this wider medical team when she references the multidisciplinary collaboration with GPs, social workers, and health

[39] Julie Snowden, Interview, 21st January 2022.
[40] Julie Snowden, Interview, 21st January 2022.
[41] Julie Snowden, Interview, 21st January 2022.

visitors reflected an interprofessional understanding of community healthcare, positioning district nurses as integral coordinators within a broader system of care.[42]

Thus, the linguistic framing of working 'on the community' functioned as both a practical description of place-based healthcare and a professional identity tied to independence, relational care, and embeddedness within the wider healthcare network. There were also instances where working 'on the community' or 'on the district' were used interchangeably. Julie, for example, described her role as a chief nurse as one of her best jobs, explaining how she felt this role had the most impact.[43] However, she then went on to say 'actually, in terms of direct patient impact, probably my community nursing was best out of them'.[44] Prior to this, Julie used the term, 'district nursing' to note how she had 'done a broad range of things over my career, not just district nursing'.[45] Here, we see how Julie was able to

[42] Julie Snowden, Interview, 21st January 2022.
[43] Julie Snowden, Interview, 21st January 2022.
[44] Julie Snowden, Interview, 21st January 2022.
[45] Julie Snowden, Interview, 21st January 2022.

alternate between 'district' and 'community' nursing when referring to the same phase of her career.[46]

Figure 5: District nurse carrying a Gladstone bag,
Wellcome Collection, SA/QNI/P6/2, 'Queen's Institute of District Nursing', 1962.

This terminological fluidity contrasted with the more consistent language used by interviewees who trained and practiced in earlier decades. When discussing her equipment, Ethel Lowe (aged 87 at the time of our interview) specifically described her Gladstone Bag (Figure 5) as 'a symbol of the district nurse', employing terminology that explicitly connected her professional identity to historical traditions within the occupation.[47] Similarly, Alan Carlise (aged 88 at the time of our interview),

[46] Julie Snowden, Interview, 21st January 2022.
[47] Interview with Ethel.

when discussing training he organised as principal of the William Rathbone Staff College, spoke about how it benefitted 'particularly district nurses working in that community'.[48] For these practitioners who began their careers in the late 1950s and early 1960s, the term 'district nurse' appeared to carry significant professional meaning and was used more commonly when discussing professional identity and practice.

The contrast between interviewees use of 'district nurse' and other interviewees more fluid alternation between 'district' and 'community' nursing suggests a generational shift in professional self-identification. It appears that the term 'district nursing' remained firmly rooted in tradition and history, carrying particular resonance for those who trained during the pre-NHS or early NHS period. Meanwhile, 'community nursing' emerged as a broader, perhaps more modern umbrella term that reflected policy shifts toward integrated community care from the 1970s onward. Linguistic choices made by the interviewees therefore reflected deeper shifts in how nurses conceptualised their professional identity, both personally and in relation to changing healthcare structures and policies. The fluidity was further embodied by the interchangeable nature of working 'on' or 'in' the community.

Whereas 'on the community' reflected a more professionally rooted domain of care, 'in the community' came to convey a sense of immersion and belonging. This was certainly the case for Mabel Williams, who when I asked whether she felt a

[48] Alan Carlise, Interview, 28th October 2021.

prominence within the community, and whether this was an important aspect of her role, replied:

> Yes I think so definitely. That's what makes you stay in the job I think. That's what makes you stay in the position, because it's quite a privilege really I think. You are not always going to get that in a busy surgical ward or whatever. I think if that's the way you want to take your career forward then that's what I think kept me in the community.[49]

Mabel's linguistic choice of 'in the community' rather than 'on the community' in this quote revealed how to her, community was conceptualised as an environment that offered meaningful relationships as well as professional fulfilment.[50] Her comparison to 'a busy surgical ward' highlights how being 'in the community' represented a distinctive form of nursing practice characterised by privileged access to patient's lives and sustained relationships.[51] Moreover, her phrase 'it's quite a privilege really' suggests an understanding of community practice as offering special access to intimate spaces and relationships that hospital-based nursing did not provide.[52]

Although practicing much earlier than Mabel, a similar sentiment was also echoed by Ethel Love, who described her district nursing role as something 'that just seemed second nature to you'.[53] Ethel then added 'You did get well known in the community'.[54] Ethel's use of 'in the community' suggested an integration of the district nurse into community structures, so much so that 'you did get well known'.[55]

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[49] Mabel Williams, Interview, 8th March 2022.
[50] Mabel Williams, Interview, 8th March 2022.
[51] Mabel Williams, Interview, 8th March 2022.
[52] Mabel Williams, Interview, 8th March 2022.
[53] Ethel Love, Interview, 8th November 2021.
[54] Ethel Love, Interview, 8th November 2021.
[55] Ethel Love, Interview, 8th November 2021.

This quote articulates how Ethel's conceiving of community was rooted in a more traditional, place-based manner, where her 'well known' status reflects deeper social integration rather than professional positioning. Practicing in the late 1950s and early 1960s, Ethel's experience represents a period when district nurses often remained in the same geographical area for extended periods, becoming recognised figures within neighbourhood social networks. Her description of the role becoming 'second nature' suggests a naturalised professional identity that blended seamlessly with community life.[56] This signifies an embedded identity within communities that transcended a clinical relationship for the district nurse, similar to how Mabel described her work 'in the community' versus her experience of working on a 'busy surgical ward'.[57]

Karen Walker's testimony further illuminates how being 'in the community' was adopted by interviewees to describe their approaches to patient care. Speaking about the differences in delivering treatment for HIV/AIDS patients in the community versus in hospital, Karen explained '[w]hereas, in the community, we were far more used to saying to people, 'Well, what is it do you want? What do you need? How can we work with you? And so, we did support them very different, very differently in the community.'[58] Karen's emphasis on being 'in the community' positions this environment as enabling a more patient-centred, collaborative approach to care. Moreover, the phrase 'we were far more used to' suggests that community practice cultivated habits and orientations toward patients that privileged their autonomy and

[56] Ethel Love, Interview, 8th November 2021.
[57] Mabel Williams, Interview, 8th March 2022.
[58] Karen Walker, Interview, 14th March 2022.

preferences.[59] This patient-centred approach represents another way in which community as a professional environment shaped distinctive nursing practices and values. By contrasting community-based care with hospital approaches, Karen highlights how being 'in the community' fostered a professional identity characterised by flexibility, responsiveness, and partnership with patients.[60]

Cathy Earles articulated an alternative understanding of this community-based professional identity, when she observed:

> You had more autonomy in the community anyway, to begin with, because you haven't got a doctor to call. You're not surrounded by other health care professionals, you're on your own. And you've got to be able, you've got to be confident, and you've got to be able to be confident in decision making.[61]

Cathy's emphasis on being 'on your own' is in contrast to Julie's earlier framing of working 'on the community' and acts as a rejection to the participation within an interprofessional network of care. While Julie emphasised collaboration with GPs, social workers, and health visitors as central to her practice 'on the community', Cathy foregrounded the solitary nature of community work and the self-reliance it demanded.[62] This contrast reveals the variation in experience of district nursing in the community, with some interviewee's perceiving it as a collaborative professional domain while others experienced it as a space of professional isolation that demanded independent judgment.

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[59] Karen Walker, Interview, 14th March 2022.
[60] Karen Walker, Interview, 14th March 2022.
[61] Cathy Earles, Interview, 18th October 2021.
[62] Julie Snowden, Interview, 21st January 2022.

Interviewees adopted these phrases as a way to reference a geographical space associated with their role, like when Mabel Williams explained that she thought about a career in district nursing after 'a couple of very good friends had moved on to the community'.[63] Mabel also described to me how 'in the community, you went straight to the sister role'.[64] The shift in Mabel's language, from colleagues who 'moved on to the community' to describing her own experience 'in the community' illustrated a dual positioning of community. Community was both a professional destination and an immersive environment of practice. On the other hand, the word 'community' was utilised to describe a certain branch of nursing for the interviewees, such as when Julie Snowden was discussing her district nurse training and explained '[t]hat programme, whilst wasn't particular long, was really good in being very clear about cultures and practices around community nursing.'[65]

Concerned Discussion of Community

While interviewees predominantly expressed a positive association with their community practice, especially through the phrasing 'in the community', Cathy Earles provided a counternarrative that revealed the professional anxieties that some nurses could experience. Cathy's testimony is useful due to the insight it provides into how community could be experienced as a site of professional displacement

[63] Mabel Williams, interview with the author, conducted over Microsoft Teams, 8th March 2022.
[64] Mabel Williams, Interview, 8th March 2022.
[65] Julie Snowden, interview with the author, conducted over Microsoft Teams, 21st January 2022.

rather than enhancement, providing an opportunity to explore an alternative communication of community practice. Cathy, who started her district nurse training at Woolton Manor in 1979, worked first as an A&E nurse. However, she began looking for a new role because of the long and demanding hours involved on the A&E ward.[66] Cathy recalled how, her Aunty Sandra, a district nurse, recommended district nursing to her, saying: '[s]o Sandra, said to me, why don't you try district nursing? You know, you're out and about, you've got set hours, so you'll have every other weekend off'.[67] The idea of being 'out and about' which Cathy's Aunty Sandra espoused is indicative of the mobile nature involved within the district nurse role.[68]

Moreover, Aunty Sandra's description positioned community nursing as attractive primarily for its practical advantages rather than its professional content, focusing on benefits like being 'out and about' and having predictable hours.[69] When I asked Cathy whether she felt nervous or anxious about the solitary working that could be involved with this mobility, she responded that:

> I didn't even think about it to be honest with you. But when I started, I just thought, what have I done?! It was just so different. And I just thought, I felt like I was a cross between a home-help and the Red Cross. It was just crazy. And I just thought, all the knowledge and skills I had, [sic] weren't being put to good use.[70]

Cathy's stark assessment of her initial experience of community nursing revealed the contrast between professional expectations and workplace realities that district

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[66] Cathy Earles, Interview, 18th October 2021.
[67] Cathy Earles, Interview, 18th October 2021.
[68] Cathy Earles, Interview, 18th October 2021.
[69] Cathy Earles, Interview, 18th October 2021.
[70] Cathy Earles, Interview, 18th October 2021.

nurses may have encountered whilst on the community. The comparison of her role to being a cross between 'a home-help and the Red Cross' articulates a concern about professional deskilling, indicating a misunderstanding to what nursing on the community could involve.[71] Within this concern was the fear that one might be expected to undertake tasks and duties that did not necessarily correlate with the qualification and professional position the district nursing qualification afforded. Cathy's comparison also gestures toward the institutional landscape discussed earlier in this chapter, in which tasks such as bathing sat uneasily between the district nurse's clinical remit and the home help's domestic one. Her further reference to the Red Cross points to the voluntary sector's place within this landscape.

Cathy's testimony therefore demonstrated how working on the community could be experienced as professional displacement rather than enhancement for district nurses, particularly by those who had developed a specialised expertise in a hospital setting. Moreover, her statement indicates that early-career district nurses may have struggled with role clarity, particularly when their highly developed clinical skills were not immediately transferable to the day-to-day demands of community care. Cathy's reflection illuminates the complex professional recalibration district nurses underwent as they transitioned from institutional settings to community practice, revealing how interviewees navigated the tension between clinical expertise and the broader social dimensions of working on the community.

[71] Cathy Earles, Interview, 18th October 2021.

Cathy elaborated on the disjuncture on her professional identity her placement on the community caused when we discussed the wider community nursing team.[72] For Cathy, one of her main concerns about working on the community was that 'there was no skill mix'.[73] I asked Cathy to elaborate on this, and she explained

> 'So in accident and emergency, you had a team, and you had sisters and charge nurses, then you had staff nurses, then you had enrolled nurses, and then you had students. And you had health-care assistants as well. When I went into the community, everybody was the same grade. So I was sitting in this office, and everybody was like a sister, so there was nobody to delegate anything to. And I was given, this huge file, and told, OK there are your patients.'[74]

This comparison reveals how community practice disrupted Cathy's understanding of professional identity as embedded within visible hierarchies. Whilst working in a hospital environment, Cathy recalled how identity and responsibility were structured through a grading system, with sisters and charge nurses, then staff nurses, then enrolled nurses and students.[75] This layering created a clear chain of command in which responsibilities could be passed through the hierarchical workflow, with professional identity demarcated through a visible hierarchy that positioned nurses at different levels of authority and expertise. The community environment, with a professional structure where 'everybody was the same grade' rendered these familiar markers of professional status invisible.[76] Cathy's description of managing

[72] Cathy Earles, Interview, 18th October 2021.
[73] Cathy Earles, Interview, 18th October 2021.
[74] Cathy Earles, Interview, 18th October 2021.
[75] Cathy Earles, Interview, 18th October 2021.
[76] Cathy Earles, Interview, 18th October 2021.

'this huge file' of patients with no support staff 'to delegate anything to' highlights how community nursing may have challenged hospital-based understandings of teamwork and appropriate delegation of responsibilities.[77]

Moreover, it is interesting that Cathy uses the phrase 'into' the community rather than 'on' or 'in' the community as other interviewees did. Going 'into' the community seems to be entering somewhere less familiar, whilst 'on' and 'in' the community indicates a more comfortable and familiar geographical location. In addition, going 'into' the community suggests crossing a boundary into an unfamiliar space, while working 'on' and 'in' suggests a more established professional positioning. This linguistic distinction reveals how Cathy experienced community as a site of professional disruption rather than belonging, at least initially. As discussed in the methodology chapter, the oral history interview is not a quest to find one true factual interpretation or compare contrasting testimony with the aim of falsifying another. Each interviewee told their own truth that is important to understand and a significant contribution to the history of district nursing. With regards to the above passage, firstly, it is interesting to see how Cathy has compared the solitude of being on the community, where 'everybody was on the same grade', with the environment of the accident and emergency ward, where you had a team with sisters, charge nurses and staff nurses.[78] In contrast, Mabel Williams spoke of wanting to work on the community because a couple of her close friends had moved 'onto the community and they were telling me of posts coming up'.[79] Mabel's friends told her

[77] Cathy Earles, Interview, 18th October 2021.
[78] Cathy Earles, Interview, 18th October 2021.
[79] Mabel Williams, Interview, 8th March 2022.

that the community was being run 'like a ward', which suggests a more communal and close-knit description of community than discussed by Cathy.[80]

The contrast between Cathy's and Mary's accounts reveals that community was not a monolithic professional space but rather a contested terrain that could be experienced very differently depending on a multitude of factors, such as prior professional socialisation, workplace context, and individual expectations. This heterogeneity challenges simplistic narratives about community nursing and highlights the complex ways in which nurses negotiated their professional identities as they moved between institutional and community settings. Despite her initial concerns, Cathy's narrative ultimately reveals how she actively reshaped her professional environments rather than simply adapting to them.

When I asked Cathy about a pinnacle moment in her career, and whether there were moments in her career as a district nurse that stand out the most, she explained that:

> Well one of the things I did as well, was, you know when I said when I came back into district nursing, I said that it was, there was no skill mix, and I brought this up at my interview. So they said to me that, about a year after being in post, they contacted me and said we want you to do this course, at, University of Liverpool, to become an educator of district nurses. So, for example, when they are doing the SPQ course, and they come into the community, they have to have like a mentor, so I, back in the day they call them practical work-teachers, and I was a practical work teacher.[81]

[80] Mabel Williams, Interview, 8th March 2022.
[81] Cathy Earles, Interview, 18th October 2021.

This expansion of her role to being both a district nurse and educator represented a significant shift in Cathy's relationship to community practice. Cathy was advised that by becoming a practical work-teacher, she would 'get one student from University of Liverpool, who would be with me for that year in practice'.[82] This positioned Cathy as an agent of change within the community nursing environment she had initially found displacing. Cathy told me how she was able to guide students 'from not really knowing much about the community, to getting right in,' demonstrating how she came to occupy a bridging role between institutional and community-based conceptions of nursing expertise.[83] Rather than remaining alienated by the perceived lack of skill mix, she became instrumental in shaping how new district nurses understood and navigated community practice.

Cathy observed that by the end of their training, students were 'like a fully-fledged member of the team! They could do everything' suggesting a developing appreciation for the distinctive skill set required in community practice.[84] This evolution in her perspective reveals how professional identity in community nursing was not static but developed through engagement with the specific demands and opportunities of community-based care. Her journey from feeling deskilled to becoming an educator whose advance skills and knowledge helped others acquire community nursing expertise illustrates the complex processes of professional adaptation and growth that characterised district nurses' experiences. This educational aspect of Cathy's career connects to broader patterns of how district

[82] Cathy Earles, Interview, 18th October 2021.
[83] Cathy Earles, Interview, 18th October 2021.
[84] Cathy Earles, Interview, 18th October 2021.

nurses combined their professional and interpersonal identities within community settings, which will be explored in the next section on interpersonal dimensions of community.

It is also important to recognise how the form of questioning I adopted shaped the memories that were articulated. When I asked Cathy to reflect on what she considered the 'pinnacle' of her career, her response centred not on emotional attachment to earlier forms of practice but on her role as a practical work-teacher. This framing invited evaluation and retrospective ordering of experience, encouraging Cathy to foreground memories associated with expertise, recognition and professional authority. While Cathy does not express nostalgia in an overt sense, the recollection of the 'pinnacle' of her career shows how reflective questioning encouraged district nurses to retrospectively identify moments of professional significance. In Karen's case, similar reflection was shaped by a sense that valued aspects of community nursing had been diminished over time, generating nostalgia for earlier forms of community care. When I asked Karen whether she would still be visiting patients and delivering care in her role in Speke Health Centre, Karen responded how '[i]t was meant to be, in theory, it was meant to be an oversight role, but in practice, that didn't work.'[85] For Karen, delivering care was what she loved most about district nursing, as she 'never really seen myself moving away from delivering care'.[86] This was because, according to Karen, what was most rewarding was that she saw patients for months and sometimes years at a time.[87]

[85] Karen Walker, Interview, 14th March 2022.
[86] Karen Walker, Interview, 14th March 2022.
[87] Karen Walker, Interview, 14th March 2022.

This is Karen explaining the relationships she was able to build with patients while working on the community, expressing a longing for direct patient care. This tells us that for district nurses like Karen, working on the community offered the opportunity of building close relationships with patients, emphasising a close-knit and familial nature of community. This nostalgic framing positions direct-patient relationships as the essence of district nursing that could at times become eroded through wider professional-organisational changes.

As Kirsi-Maria Hytönen has noted, 'nostalgia is a longing for the past, the safe and familiar world where things are better. Nostalgic narration has been compared to a search for a lost paradise.'[88] Nostalgia can refer to the construction of memories which elicit a feeling of safety and familiarity within an oral history interview, in a similar to manner to composure which was discussed in the methodology chapter. In the context of district nursing, this nostalgia often centred on the relational aspects of community practice that nurses feared were being diminished through organisational changes and evolving professional structures. Karen exemplified this nostalgic framing when she contrasted with her past experiences with contemporary practice. Karen explained to me that working in a team, whether that was in a Health Centre or when she was attached to a GP, made 'such a difference' to her practice, because she didn't 'have to worry about certain things'.[89] However, she positioned this testimony in contrast to modern district nursing, which she said 'had changed so much' as she did not 'suppose, these days, people have that luxury of

[88] Kirsi-Maria Hytönen, "Hardworking women: nostalgia and women's memories of paid work in Finland in the 1940s," *Oral History* 41.2 (2013): 96.
[89] Karen Walker, Interview, 14th March 2022.

being in a team, a regular team'.[90] Karen's characterisation of team-based practice as a 'luxury' that has been lost illustrates how nostalgia functions in oral history, transforming past professional arrangements into romanticised experiences that appear ideal when viewed from a present perceived as lacking.[91] While such nostalgia might romanticise earlier forms of practice, it also reveals what former and retired district nurses themselves valued most about community work, which was the opportunity to build sustained relationships and to become embedded within community life. Having examined how district nurses constructed their professional identities through specific language around community practice, I will now turn to how these professional identities shaped their relationships with the people who inhabited those community spaces. The interpersonal dimensions of district nursing reveal how professional boundaries were negotiated in daily practice through interactions with patients, families, and colleagues.

4.3 Interpersonal Community

Having established how district nurses linguistically constructed their professional identity through community-related terminology, I will now turn to examining how they experienced and articulated the interpersonal dimensions of community in their everyday practice. We can develop a more comprehensive understanding of how

[90] Karen Walker, Interview, 14th March 2022.
[91] Karen Walker, Interview, 14th March 2022.

district nurses both shaped and were shaped by the communities they worked on by analysing their accounts of relationships with patients, families, and local institutions.

The interpersonal dimension of community emerged as a cornerstone of professional identity across all interviews conducted for this research. These relationships formed a crucial component of how interviewees recalled their district nursing career, revealing how they navigated complex social terrain in their delivery of care on the community. Interviewees demonstrated how they were able to build meaningful connections with patients, families and local community members that influenced how they practiced district nursing. By examining these relationships, we are better able to understand how district nurses functioned simultaneously as healthcare professionals and community members, developing nuanced cultural competencies that allowed them to work effectively across diverse neighbourhoods and communities in Liverpool. This analysis reveals district nurses not merely as providers of technical care but as skilled relationship-builders whose effectiveness depended on their ability to establish trust, demonstrate cultural sensitivity, and adapt their practice to varied social contexts. Their accounts of patient interactions across different religious, cultural, and socioeconomic communities provide valuable insights into both the professional practice of district nursing and the changing social landscape of Liverpool during this period.

While shared training and professional development provided a foundation of belonging among district nurses, their identity was also shaped by the relationships they developed beyond the profession. These relationships were not confined to individual patients within he home, which will be discussed Chapter 5, but extended to wider networks of recognition and visibility within neighbourhoods, cultural

communities and during times of crisis. To understood interpersonal community in this broader sense, it is useful to first consider the professional community of district nurses themselves.

Professional Community Identity

Beyond their integration into Liverpool's neighbourhoods, district nurses participated in their own distinct professional community, bound together by shared experiences, practices, and visual identifiers. This professional community provided a foundation of collective identity that both supported and informed their work with patients. As Ken Blakemore has observed, healthcare professionals develop distinct cultural values that influence their approaches to care delivery.[92] For district nurses, this professional culture was manifested through several key communal identifiers. The professional community that emerged from these interviews was grounded in shared educational experiences and generational perspectives. All but one of the interviewees, Alan Carlise, completed their district nurse training in Liverpool, creating a common foundation of local knowledge and practice approaches. The temporal clustering of their training, with four of the seven interviewees completing their district nurse qualification between 1979 and 1989, and four of the seven completing training at Woolton Hall Manor, suggests exposure to similar pedagogical approaches. This shared educational timeline coincided with significant developments in community healthcare policy and practice in Britain, outlined in the

[92] Ken Blakemore, "Working with minority ethnic communities", in *The Social Construction of Community Care,* ed. by Anne Kelly and Anthea Symonds (London: Macmillan Press, 1998), 261.

previous chapter, which created a generational cohort with common reference points and experiences. Furthermore, the age proximity of interviewees, five were between 63 and 74 years old at the time of interview, meant they were reflecting on their careers from a broadly comparable temporal vantage point. These shared educational and generational characteristics contributed to the formation of a distinct professional community with common understandings, values, and approaches to district nursing practice.

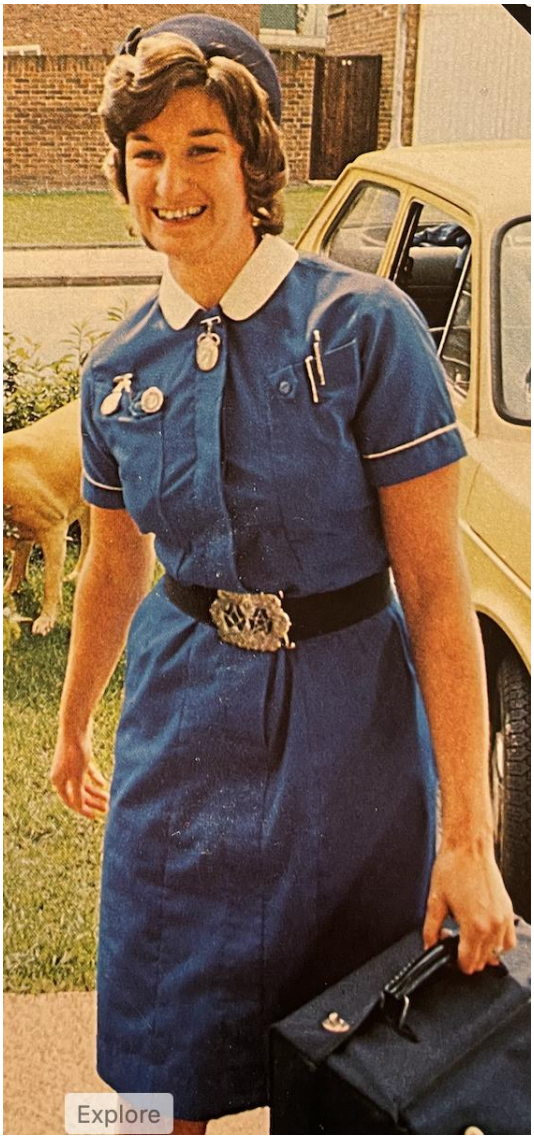

Figure 6: District Nurse – Cover of Nursing and Midwifery in the Community
Wellcome Collection, SA/QNI/P.7/68, 'Picture book ''Nursing and midwifery in the community', 1974

Figure 7: District Nurse – Fletchers Advertisement
Wellcome Collection, Journal of District Nursing, July 1987, p.10.

The uniform represented perhaps the most visible marker of membership in the district nursing community. While previous sections have considered how the uniform mediated interactions with patients and the public, it also served as a powerful symbol of professional belonging among nurses themselves. Cathy's observation that 'the uniform gave you a whole lot of protection' suggests not only practical security but also the psychological protection derived from visible

membership in a recognised professional group.[93] The district nursing uniform was also communally represented in archival sources. Figure 6, taken from a 1974 recruitment booklet titled *Nursing and Midwifery in the Community*, depicts a district nurse in full uniform standing by her car, holding onto her Gladstone bag. The image was used to attract new entrants into community nursing, presenting the nurse as both approachable and professional. Similarly, Figure 7, an illustration from a Fletcher's medical equipment advertisement published in the *Journal of District Nursing* in July 1987 uses similar imagery of the smart uniform, belt, cap and Gladstone bag. Moreover, the visual cue of the car in both images acts as a symbol of mobility and autonomy, key markers of the district nurse professional identity.

The recurrence of these visual motifs across different types of sources, one recruitment-focused and the other commercial, highlights the uniform's role as a recognisable emblem of district nursing. Both images reinforce the impression of a distinctive professional community, bound together by dress, equipment, and the expectation of mobility. Moreover, there is a shared emotional connection with both district nurses smiling. That these depictions remained so consistent across the 1970s and the 1980s suggests that uniform functioned not only as practical attire but as a visual shorthand for belonging to the district nursing profession, a marker of membership that was readily legible both within and beyond the occupational community. The uniform created an immediate visual bond between district nurses, distinguishing them from other healthcare providers and signalling their shared

[93] Cathy Earles, Interview, 18th October 2021.

professional identity. This visual distinction reinforced district nurses' sense of themselves as a distinct community within the broader healthcare landscape.

The development of specialised language and terminology also marked membership in the district nursing community. Throughout their interviews, district nurses employed phrases and conceptual frameworks that reflected their shared professional culture. As an interviewer who was not trained within district nursing, I often became aware of how this language both connected the nurses to one another whilst excluding me from full understanding. Terms such as 'caseload,' 'clinical practice teacher' or 'syringe driver' we used with an assumed familiarity that signalled insider knowledge.[94] This intersubjective position, shaped by my status as an outsider to the profession, revealed how linguistic practices reinforced belonging within the district nursing community while simultaneously delineating its boundaries to those beyond it.

Similarly, the distinction between working 'on the community' and 'in the community' discussed earlier, exemplified how linguistic practices served as markers of professional belonging. These shared linguistic patterns created cognitive frameworks that influenced how district nurses conceptualised their work and reinforced their sense of participation in a distinct professional community. The collective navigation of professional challenges further strengthened community bonds among district nurses. Their shared experiences of adapting to diverse cultural contexts, managing complex patient relationships, and balancing clinical

[94] Interview with Julie Snowden; Interview with Dorris Smeethe.

requirements with community integration created common narratives that reinforced their professional identity. While shared professional identifiers and practices bound district nurses together as a cohesive professional community, their effectiveness ultimately depended on how successfully they integrated into the diverse neighbourhood communities they served, creating a dynamic interplay between professional belonging and community integration.

Community Integration

The process by which district nurses became integrated into the communities they served represented a fundamental aspect of their professional practice. Unlike institutional nursing, district nursing required practitioners to insert themselves into established community structures and dynamics, developing relationships that facilitated effective care delivery while respecting existing social frameworks. Moreover, interviewees explained to me how a degree of geographical consistency allowed greater integration within the communities they worked in. Mabel Williams explained to me how:

> The other thing that was really good, and I suppose, I retired five years ago so I haven't had any contact with DNs since then, but I think we had a small cohort of patients that we looked after. We weren't sent all over the place. Just like they are now. We were in teams, and the patients got to know you and them.[95]

[95] Mabel Williams, Interview, 8th March 2022.

Mabel's comparison to contemporary practices suggests that geographic consistency was not incidental but a deliberate approach to facilitate relationship building within the community. This geographic structure created the foundation for deeper interpersonal connections that transcended clinical interactions. Significantly, Mabel elaborated on how these relationships developed through everyday nursing tasks, even those considered routine or laborious. After describing how 'leg ulceration and treating patients with leg ulcerations' were more 'laborious tasks,' Mabel elaborated on the importance of patient communication.[96] She acknowledged that these procedures 'would take a lot longer than giving somebody an insulin injection'.[97] Despite this time pressure, Mabel emphasised that she 'still had to have the time, still liked to have the time to communicate with the patient'.[98] This communication was essential to ensure patients did not feel the nurse was 'just running in to do their insulin'.[99]

However, in order to facilitate this interpersonal relationship building, interviewees explained how they would need to possess a nuanced understanding of family dynamics and community contexts. Cathy Earles' reflection on her practice reveals the complex interpersonal navigation required when working within patients' homes and family systems:

> It's one of the things, you've got to do, as a community-based nurse, you've got to build up that rapport with the family. Because they can ask you to leave, if they want to. You know, they could not even let you in, if you upset them.

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[96] Mabel Williams, Interview, 8th March 2022.
[97] Mabel Williams, Interview, 8th March 2022.
[98] Mabel Williams, Interview, 8th March 2022.
[99] Mabel Williams, Interview, 8th March 2022.

> You had to very much, had to be very much, very, very, I mean this is what nurses should be like anyway, but not judgmental.[100]

Here, Cathy is able to illustrate the delicate balance district nurses maintained between building trusting relationships and fulfilling professional responsibilities. Her mentioning that families could 'ask you to leave' highlights the conditional nature of access in community settings.[101] This reality necessitated sophisticated interpersonal strategies that balanced rapport-building with professional assessment. In addition, Cathy's emphasis on being 'not judgmental' reveals how she cultivated an approach that prioritised understanding over criticism, creating the foundations for trust that enabled effective care delivery.[102]

While maintaining these carefully constructed relationships, interviewees spoke about developing observational skills that allowed them to identify potential health and welfare concerns. As Cathy further explained:

> But at the same time, you'd be on the lookout for, things like child abuse, or mums not coping with young babies, prop feeding instead of holding the baby to feed a young baby with a bottle, just propping them. And you know, I'd go back and have a word with the health visitor, who would go out, not say that I'd mentioned it, but just go out. And that was why working with health visitors was so important, because there were things that you had to report, like that you know.[103]

This excerpt demonstrates how district nurses functioned within interconnected community healthcare networks, strategically navigating professional responsibilities

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[100] Cathy Earles, Interview, 18th October 2021.
[101] Cathy Earles, Interview, 18th October 2021.
[102] Cathy Earles, Interview, 18th October 2021.
[103] Cathy Earles, Interview, 18th October 2021.

without compromising their established relationships. Cathy's example of identifying potential child welfare concerns while still maintaining family access reveal the sophisticated approach that distinguished effective district nursing practice. By channelling concerns through appropriate colleagues like health visitors, district nurses could ensure intervention while preserving the trust they had carefully cultivated within families. This approach required an innate understanding of community structures, professional boundaries, and interpersonal dynamics that far exceeded the clinical skills taught in formal nursing education.

As already mentioned, the connections fostered by district nurses while on the community went beyond individual patient relationships. Interviewees articulated how interpersonal relationship building encompassed families, neighbourhood settings and broader community health networks. According to Julie, when she first began district nursing in 1981, 'everybody knew where the district nurses were based,' establishing a recognised physical presence for the district nurse that extended beyond individual home visits.[104] Julie discussed the importance of this, telling me:

> I personally, think that that link between the actual community, a district nurse and people's homes and district nursing and where they fit within that is absolutely essential because my job as a district nurse was not just about a single patient. It was about a family and a community.[105]

Julie's perspective reveals how district nurses conceptualised their role as inherently embedded within multi-faceted community systems, rather than limited to singular

[104] Julie Snowden, Interview, 21st January 2022.
[105] Julie Snowden, Interview, 21st January 2022.

clinical encounters.[106] Julie then elaborated on the contrast between clinic-based and home-based district nurse, stating: 'the way you deal with a patient in a clinic is very different from the way you deal with a patient in their own home'.[107] According to Julie, she got to the stage where 'we started to separate that out a bit and it became not quite district nursing, it became something else – a kind of hybrid of hospital nursing just in a clinic'.[108] This highlighted how the setting itself fundamentally altered the interpersonal dynamics of nursing practice, underscoring the manner in which physical context of care delivery shaped the possibilities for relationship building and community integration.

Significantly, the expansive community role of district nurses extended beyond individual patient care to include participation in broader public health initiatives. Julie's recollection that 'if you look at when there would be outbreaks in schools and stuff, we were often part of that process' reveals how district nurses functioned as integrated components of community-wide health infrastructure.[109] This involvement in school outbreaks demonstrates how district nurses' integration into community structures positioned them to respond to collective health challenges, not just individual care needs. As recognised and trusted healthcare figures within neighbourhoods, district nurses could effectively bridge institutional public health responses and local community contexts due to their visible communal integration.

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[106] Julie Snowden, Interview, 21st January 2022.
[107] Julie Snowden, Interview, 21st January 2022.
[108] Julie Snowden, Interview, 21st January 2022.
[109] Julie Snowden, Interview, 21st January 2022.

The visibility of district nurses within community spaces further reinforced their integration into neighbourhood life. Dorris Smeethe captured this recognition when she noted that community members 'would buy you sweets in the shop.'[110] The recollection of these everyday interactions in public spaces reflect how deeply nurses had integrated into the fabric of community life, becoming familiar figures worthy of acknowledgment and appreciation rather than anonymous healthcare providers. Moreover, this observation captures the subtle yet significant ways that community integration manifested beyond clinical settings, creating networks of recognition and reciprocity that enhanced nurses' effectiveness and community standing. The persistence of this memory in Dorris's professional recollection indicates that these everyday acknowledgments constituted important affirmations of her community integration. That Dorris chose this example to illustrate her community presence rather than more formal or clinical aspects of her role, reveals how deeply the social dimensions of district nursing were intertwined with professional identity and practice.

Communities in Crisis

The emergence of HIV/AIDS in the 1980s represented one of the most acute crises faced by community health services in late twentieth-century Britain. For district nurses, it demanded a reorientation of practice as they confronted new medical uncertainties and worked with groups stigmatised both socially and politically. Oral

[110] Dorris Smeethe, Interview, 22nd February 2022.

history interview testimony highlights how nurses remembered this period as one in which professional boundaries were redrawn, and new forms of community were forged. Several interviewees reflected on Liverpool's response to the epidemic, but it was Karen Walker's recollections, no doubt shaped by her role as the city's HIV/AIDS-specialist nurse, that captured most powerfully the challenges and transformations of the crisis.

A reflexive consideration of these interviews highlights the intersubjective nature of oral history, in which the interests and questions of the interviewer inevitably shaped what is recalled and how it is narrated. My own focus on HIV/AIDS influenced the direction of discussion, leading participants to provide particular emphasis to this episode when narrating their work on the community. Given the stigma that surrounded HIV/AIDS during the 1980s and 1990s, and the continuing emotional weight it carries in memory, testimony elicited through direction questioning cannot be separated from the context of its production.[111] This does not lessen the historical value of the material but rather underlines that meaning is co-created in the interview encounter. The prominence of Karen Walker's testimony, in particular, should therefore be read both as a reflection of her own career trajectory and as a product of our shared focus during the interview.

The first documented cases of AIDS in the UK were identified in the early 1980s, with the first case reported in December 1981.[112] By the middle of the

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[111] See Virginia Berridge, *AIDS in the UK: The Making of Policy, 1981–1994* (Oxford: Oxford University Press, 1996); José Catalán, Barbara Hedge, and Damien Ridge, *HIV in the UK: Voices from the Epidemic* (London: Routledge, 2021).
[112] E. J. Adams, P. M. Copas, G. Fenton *et al.*, "HIV in Gay and Bisexual Men in the United Kingdom," *International Journal of STD & AIDS* 21.8 (2010): 546–52.

decade, the epidemic was established across major urban centres, including Liverpool, reflecting the national pattern. During this early period, public understanding of HIV/AIDS was fraught with fear, with press coverage in particular stoking an increase in prejudice, intolerance, and discrimination.[113] The Conservative government's 1986 'Don't Die of Ignorance' campaign remains emblematic of this climate, raising awareness of the risk of HIV transmission while heightening public anxiety.[114]

By the end of 1987, around 2,500 people in the UK were known to be HIV positive, and 610 had died, half of those deaths occurring in that year alone.[115] Matt Cook has identified 1986-1987 as the moment that the British response shifted from 'policy from below,' driven by community activism, to a climate of 'wartime emergency,' met by a government public-health campaign and a marked escalation in hostile tabloid coverage.[116] Liverpool, like other major urban centres, was caught up in this national climate even as its own response developed distinctive local features, discussed below.[117]

Against this backdrop, community health practitioners, and district nurses in particular, were often among the first professionals to build sustained relationships with people living with HIV/AIDS. Unlike hospital settings, where patients might be

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[113] See; Raphaela Van Oers, 'Stigma, Prejudice, and Sympathy: British Press Coverage of HIV/AIDS in the 1980s', PhD Thesis, McGill University, 2022.
[114] Department of Health, *AIDS: Don't Die of Ignorance* (London: HMSO, 1986).
[115] Matt Cook, "'Archives of Feeling': The AIDS Crisis in Britain 1987," *History Workshop Journal* 83, no. 1 (2017): 52
[116] Cook, "'Archives of Feeling': The AIDS Crisis in Britain 1987," 54
[117] See also the National HIV Story Trust (hivstory.org.uk), a video oral history archive of testimony from people who lived through the UK HIV/AIDS pandemic, developed in partnership with organisations including the Royal College of Nursing's History of Nursing Forum.

admitted for acute episodes of illness, community nurses provided care over time, often within the privacy of the home. This positioned them at the frontline of the crisis. Ian Hicken and Tony Butterworth have supported this view, showing how district nurses carried responsibility for coordinating care packages, liaising across services and provided palliative support when other health services lacked capacity.[118] Tommy Dickinson, Nathan Appasamy, Lee P. Pritchard and Laura Savidge have argued that when treatment occurred in the hospital, fear of transmission and a lack of clinical knowledge meant patients living with HIV/AIDS were often isolated and in some recollections treated to 'theatrical shows of infection control' with full gowning, multiple gloves and visors involved in routine contact.[119]

The RCN recognised the resulting strain on care as early as February 1985, publishing guidelines acknowledging that 'AIDS has highlighted serious deficiencies in the ability of some nurses to meet the psychological needs of their patients'.[120] Dickinson, Appasamy, Pritchard and Savidge draw on nurses own accounts from the period to show that this tension was being worked out in practice rather than simply followed as policy.[121] In one account, a nurse, having gowned up for a bed bath, recalled removing her gloves afterwards and noticing that her patient was crying, and going back to comfort him even though this meant she 'knew I would have to

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[118] Ian Hicken and Tony Butterworth, "AIDS and Community Nursing Care," *International Journal of Palliative Nursing* 2.1 (1996): 15–21.
[119] Tommy Dickinson, Nathan Appasamy, Lee P. Pritchard, and Laura Savidge, "Nursing a Plague: Nurses' Perspectives on Their Work during the United Kingdom HIV/AIDS Crisis, 1981–96," in *Histories of HIV/AIDS in Western Europe: New and Regional Perspectives*, ed. Janet Weston and Hannah J. Elizabeth (Manchester: Manchester University Press, 2022), 114.
[120] Dickinson, Appasamy, Pritchard and Savidge, "Nursing a Plague: Nurses' Perspectives on Their Work during the United Kingdom HIV/AIDS Crisis, 1981–96," 114.
[121] Dickinson, Appasamy, Pritchard and Savidge, "Nursing a Plague: Nurses' Perspectives on Their Work during the United Kingdom HIV/AIDS Crisis, 1981–96," 115.

put another pair of gloves on'. [122] These national tensions between caution, stigma and care took particular local forms in Liverpool.

For the district nurses interviewed, the arrival of HIV/AIDS in Liverpool was remembered through both institutional change and personal encounters with patients. Their accounts positioned the epidemic within the city's distinctive social landscape, where new public health initiatives intersected with entrenched stigma and the intimate relationships district nurses developed on the community. When developing those relationships on the community, interviewees were able to recall particular neighbourhoods as sites of concern regarding HIV/AIDS, linking the epidemic to wider anxieties about mobility, housing and social change in the city. According to Cathy Earles, public health officials were particularly concerned about areas such as Princes Park, Toxteth, which had 'very much a transient population and which highlighted as areas where there might be a prominence of HIV/AIDS.'[123] At the beginning of the crisis in the early 1980s, Cathy was asked to complete a six-month course at Liverpool John Moores University to prepare her for managing HIV/AIDS patients.[124] This additional training indicates an attempt to equip district nurses with knowledge to manage a condition that was poorly understood yet highly stigmatised. Cathy's testimony demonstrates both the uncertainty of the early years of the epidemic and the ways in which district nurses were drawn into emerging systems of expertise owing to their position within community health.

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[122] Dickinson, Appasamy, Pritchard and Savidge, "Nursing a Plague: Nurses' Perspectives on Their Work during the United Kingdom HIV/AIDS Crisis, 1981–96," 115-116.
[123] Cathy Earles, Interview, 18th October 2021.
[124] Cathy Earles, Interview, 18th October 2021.

Cathy also recalled how Liverpool established a dedicated HIV/AIDS team, which she described as 'quite unique' at the time.[125] Cathy emphasised that this team bore overall responsibility for HIV/AIDS patients, meaning that district nurses like herself were only involved in specific areas of care.[126] Her role, she explained, 'didn't really change that much,' as the specialist team would typically coordinate treatment and refer to district nurses for targeted tasks.[127] For example, Cathy described being called in at the end of life, when she might be asked to set up and maintain a syringe driver for symptom control.[128] This account is significant because it illustrates how professional identity was reshaped through collaboration with emerging specialist services on the community. District nurses had to position themselves within new professional hierarchies, sometimes ceding responsibility to specialist teams while maintaining a crucial role in ongoing patient management.

Whereas Cathy was able to reveal the structural and medical dimensions of Liverpool's response to HIV/AIDS, Dorris Smeethe's memories highlighted the interpersonal dynamics of care evident during the crisis. Dorris told me of her work in a Genitourinary Medicine (GUM) clinic in Liverpool City Centre, where patients often entered discreetly 'via the back door'.[129] Dorris told me that patients were registered by number rather than name, a standard practice in GUM clinics that reflected the longstanding stigma surrounding sexually transmitted infections.[130] In the context of HIV/AIDS, however, this anonymity took on an added weight,

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[125] Cathy Earles, Interview, 18th October 2021.
[126] Cathy Earles, Interview, 18th October 2021.
[127] Cathy Earles, Interview, 18th October 2021.
[128] Cathy Earles, Interview, 18th October 2021.
[129] Dorris Smeethe, Interview, 22nd February 2022.
[130] Dorris Smeethe, Interview, 22nd February 2022.

reinforcing the sense of secrecy and marginalisation that patients experienced. Yet, Dorris was able to illustrate how these relationships could extend beyond the treatment she provided at the clinic, such as when she moved to New Brighton and some of the patients she treated were there waiting to help her move in.[131] This moment of personal support reveals how trust and reciprocity developed even within systems that otherwise fostered anonymity and fear. For Dorris, this memory illustrated how community was expressed between the district nurse and their patients, even under time of considerable crisis. Together, Cathy and Dorris's testimonies highlight two dimensions of the HIV/AIDS crisis in Liverpool. First, the institutional innovation through specialist services and training, and second, the fragile but enduring interpersonal bonds that developed within clinical and community contexts.

Karen Walker in particular was able to provide insight into the treatment of communities in crisis. Karen and I were discussing the breadth of patients on community that she would treat as a district nurse when I asked her whether she felt that she was a visible part of the communities she was working in. I asked this question to understand whether, similar to how Dorris Smeethe described how members of the community would buy her sweets if they saw her in the shop, Karen felt a prominence in the communities she worked.[132] Karen replied:

> Yes absolutely. You always felt as though, again, like I say, you welcomed into that community, whatever it was, and when I moved on from district nursing, I became a community nurse with HIV and AIDS, as a specialist nurse. So, a lot

[131] Dorris Smeethe, Interview, 22nd February 2022.
[132] Dorris Smeethe, Interview, 22nd February 2022.

> of the people that I met doing that job were from the gay community, and I got to know them very well, their families, as part of that.[133]

Echoing Dorris' experience of community recognition, Karen immediately began discussing her work in the community with those suffering from HIV/AIDS, specifically talking about working with those 'from the gay community'.[134] This is interesting as Karen elects to talk about her work with a community in crisis in order to effectively convey the importance of her role within communities. Karen explained how, after six years working as a district nurse between 1988 and 1994 she had nursed a number of patients who were suffering from AIDS-related illnesses.[135] Karen then began covering 'for somebody who was an HIV/AIDS specialist while she was off on maternity leave', and after they decided not to return, was offered the only HIV/AIDS specialist post in Liverpool.[136] Within this role, Karen advised that she '[t]hen came into contact with people from across the city, really, who were – I met some of the most wonderful brave people that I'd ever had the honour to look after. Fantastic, they were fantastic'.[137] Karen became emotive during this discussion, her heartfelt reflection revealing several important dimensions of community nursing during the HIV/AIDS crisis.

Karen's own framing of this work as an 'honour,' and her insistence on her patients' bravery rather than on her own experience of death can be set against a wider history of how testimony about AIDS-related death has developed. In his

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[133] Karen Walker, Interview, 14th March 2022.
[134] Karen Walker, Interview, 14th March 2022.
[135] Karen Walker, Interview, 14th March 2022.
[136] Karen Walker, Interview, 14th March 2022.
[137] Karen Walker, Interview, 14th March 2022.

study of British responses to the crisis, Matt Cook reads the written testimony of one Mass Observation correspondent who, after a friend's death from AIDS, described how he cried, twice but did not say how he felt.[138] Cook suggests a complex knot of emotions such as grief, isolation, perhaps even fear might have fuelled those tears, but is careful to call this reading 'emotional guesswork,' noting the difficulty in attempting to recover feelings of people in the past.[139] I would argue that is even more difficult when emotions are perpetuated by trauma. Cook connects this reticence to the pressure felt by those closest to the epidemic to keep grief, anger and shame out of view in a hostile climate.[140] Nursing historians have traced a related pattern in their analysis of trauma and emotion. Christine Hallet has argued that First World War nurses engaged in a practice of 'self-containment,' subordinating 'their own emotional and physical needs to those of their patients'.[141] Katherine Roberts, writing on British nurses during the Second World War, describes a wartime 'emotional community' governed by 'strict feeling rules' that left 'a very limited range of acceptable emotional expressions,' in which nurses' 'emotional efforts were continually directed outside of themselves' with their 'emotional needs sacrificed for the sake of their patients'.[142] Karen did not describe her own work in this language of reticence. However, this historiography identifies how the expression of feeling around serious illness, trauma and death is historically and

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[138] Cook, "'Archives of Feeling': The AIDS Crisis in Britain 1987," 52.
[139] Cook, "'Archives of Feeling': The AIDS Crisis in Britain 1987," 52.
[140] Cook, "'Archives of Feeling': The AIDS Crisis in Britain 1987," 52.
[141] Christine E. Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009), 194 quoted in Katherine B. Roberts, "A Duty to Care: The Emotional Community of British Nurses on Active Service during the Second World War" (PhD diss., University of Manchester, 2023), 26–27.
[142] Katherine B. Roberts, "A Duty to Care: The Emotional Community of British Nurses on Active Service during the Second World War" (PhD diss., University of Manchester, 2023) 13–14, 29.

socially conditioned, with attention often directed outward toward the patient rather than inward toward the self. This is a useful way to read an account like Karen's which foregrounds the courage of patients so consistently. Rather than meaning that death was unfelt, it reflects a wider pattern, shown to occur across crises and periods, in which this kind of reticence is itself a form of testimony.[143]

Karen's description of patients as 'wonderful brave people' stands in stark contrast to the fear and stigmatisation that often-characterised societal attitudes toward those with HIV/AIDS during this period. By framing her work as an 'honour,' she inverted the traditional healthcare power dynamic, positioning herself as privileged to care for these patients rather than presenting them as passive recipients of treatment.[144] This reframing is significant not only as an account of nursing practice but also as a form of oral history composure, in which memory, identity and affect are woven together to construct a narrative of professional life. Additionally, Karen was able to get to know members of this community, and their families, 'very well', an indication of the relationships district nurses were able to form, even during incredibly distressing times.[145] Karen's testimony illustrates how district nurses extended the ethos of community care into contexts of acute crisis. Her relationships with patients and their families 'from the gay community' reflect a professional identity grounded in recognition and solidarity, where care was not merely clinical but also social and emotional.[146] In remembering her career, Karen

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[143] See also Christy Watson, *The Language of Kindness: A Nurse's Story* (London: Chatto and Windus, 2018), for a contemporary nurse's reflective memoir on the emotional weight of patient deaths.
[144] Karen Walker, Interview, 14th March 2022.
[145] Karen Walker, Interview, 14th March 2022.
[146] Karen Walker, Interview, 14th March 2022.

chose to highlight these encounters, suggesting that they remained some of the most meaningful and transformative experiences of her working life.

This selection of testimonies demonstrates how district nurses recalled their role during the HIV/AIDS epidemic as simultaneously medical and interpersonal. Cathy's account of training and specialist teams shows how professional responsibilities were reshaped by new organisational structures. Dorris's memory of the clinic reveals how interpersonal trust could be forged even in conditions of anonymity and stigma. Karen's reflections capture the emotional intensity of building relationships with stigmatised communities and show how such experiences became integral to her narrative of professional identity. Taken together, these oral histories illuminate how community in crisis was experienced and remembered by district nurses in Liverpool. They reveal how neighbourhoods, clinics and patient relationships became sites where stigma and solidarity intersected, and where professional practice was redefined in response to unprecedented challenges. By threading their voices into the history of HIV/AIDS in the city, we see how district nurses constructed meaning around their work not only through technical care but also through their capacity to foster relationships in the most difficult circumstances.

4.4 Spatial Community

This section examines the spatial dimensions of community as conveyed through district nurses' testimonies about Liverpool's changing urban landscape between 1960 and 2000. District nurses occupied a distinctive position from which to observe the city's transformation, their mobility across neighbourhoods affording them

insights typically inaccessible to nurses confined to institutional settings. As they navigated Liverpool's communities, district nurses witnessed firsthand the effects of deindustrialisation, housing policies, demographic shifts, and socioeconomic disparities on community structures and health outcomes. Their observations of specific localities, from Cathy Earle's detailed mapping of Princes Boulevard's cultural divisions and reflections on high-crime areas where her uniform provided protection, revealed how district nurses developed sophisticated geographical knowledge informed their practice.[147] Liverpool during this time underwent a considerable upheaval, with Jon Burden having noted that between 1970 and 2000 Liverpool was a 'city of challenge', marred by de-industrialization which was turning the city into 'a graphic illustration of urban dereliction'.[148] By examining how district nurses navigated, interpreted, and responded to these spatial transformations, this section contributes to both the history of healthcare provision in Liverpool and broader understandings of how urban change affects community cohesion and wellbeing.

Mapping the City through Memory

The spatial memory of Liverpool, as articulated by the district nurses interviewed, reveals how geography defined both the boundaries and intimacy of community care. Rather than recalling the city as a sprawling metropolis, interviewees described it as a mosaic of closely observed neighbourhoods, structured through distinctive

[147] Cathy Earles, Interview, 18th October 2021.
[148] Jon Murden, 'City of Change and Challenge, Liverpool since 1945', in *Liverpool 800,* ed. by Jon Belchem (Liverpool University Press, 2006), 428.

catchment areas, health centres, and general practices. These testimonies suggest that for district nurses, community was fundamentally contained and a recognisable spatial unit, experienced not in abstract but through the daily rhythms of familiar streets and institutions.

Spatial segmentation was therefore integral to their professional practice. District nurses worked within zones that were often attached to a GP surgery or health centre, reinforcing their visibility and knowledge within the locality. Cathy Earles, for example, recalled being attached to practices across South Liverpool, Toxteth, and Dingle, where she told me how there was 'a boulevard called Princes Boulevard, and one side is very multicultural, and the other side was very much white working class. And white protestant working class'.[149] For Cathy, navigating this line required cultural awareness and sensitivity, revealing how geography carried social as well as physical significance. For Julie Snowden, locality took on a more personal dimension. She worked for 16 years in Anfield, 'working on streets that I had played in as a child'.[150] This continuity created a powerful sense of belonging and trust, with neighbours stopping her on the street to request visits on behalf of local residents who might not have been on her caseload.[151] Similarly, Dorris Smeethe recalled covering Long Lane, Muirhead Avenue, Mill Bank, and West Derby village, her workload structured by both geographical attachment and group assignment to specific doctors.[152] Mabel Williams, working from Old Swan Health

[149] Cathy Earles, Interview, 18th October 2021.
[150] Julie Snowden, Interview, 21st January 2022.
[151] Julie Snowden, Interview, 21st January 2022.
[152] Dorris Smeethe, Interview, 22nd February 2022.

Centre, described how GPs were zoned within a five-mile radius, ensuring her rounds took place within a relatively small and stable area.[153] These insights illustrate how community was experienced through bounded geographies that structured both professional identity and interpersonal connection.

This localised stability was disrupted by night and twilight services however, which dissolved the familiar boundaries of practice and extended coverage across the city. Dorris remembered her night duties stretching from Bootle to Crosby, Speke, and Netherley, transforming her role from local caregiver to mobile practitioner across an unfamiliar terrain.[154] Mabel described such shifts as 'scary,' precisely because they required visiting patients she did not know, without the continuity and recognition that characterised her daily rounds. Their testimony demonstrates how geography shaped professional identity. Stability and containment fostered intimacy, while city-wide expansion produced distance and uncertainty.[155]

Mobility was therefore central to how nurses constructed their spatial understanding of community, but this mobility was always anchored in specific medical space. Earlier in the period, transport was limited. Ethel Love recalled cycling through Garston, Aigburth, and Wavertree in the 1960s, navigating tramlines that posed daily hazards for her route.[156] By the 1970s and 1980s, cars had become essential for meeting the demands of larger caseloads (as seen in Figure 6 and 7). Anchoring this movement were the city's health institutions, which provided

[153] Mabel Williams, Interview, 8th March 2022.
[154] Dorris Smeethe, Interview, 22nd February 2022.
[155] Mabel Williams, Interview, 8th March 2022.
[156] Ethel Love, Interview, 8th November 2021.

organisational and emotional bases for nurses' work. Ethel recalled her central office on Rose Lane as a vital hub that mitigated the isolating nature of home visits.[157] Training sites also formed part of this geography. Walton Hospital, the Mabel Fletcher Technical College on Picton Road, and Woolton Manor were repeatedly invoked as places that not only trained them but tied their professional identity to the city's medical landscape.

Taken together, these oral histories reveal that district nursing was fundamentally shaped by community as geography. Nurses' testimonies consistently mapped care onto neighbourhoods, streets, and institutions, showing that holistic practice depended upon recognising the physical and social geographies in which patients lived. They were not only a guest in the patient's home was also a guest in the broader geography of Liverpool. By recalling boundaries such as Princes Boulevard, by contrasting affluent Mossley Hill with impoverished districts, or by reflecting on the loss of stability in the 1990s, nurses revealed how the geography of care was inseparable from the geography of the city itself.

Urban Decline, Housing and Health

District nurses' testimonies also positioned their work within the broader urban transformations that reshaped Liverpool in the second half of the twentieth

[157] Ethel Love, Interview, 8th November 2021.

century.[158] For the nurses interviewed, community was not only a set of relationships or professional attachments, but a material and geographical reality that framed health itself. Interviewees recalled contrasts between areas of affluence and deprivation, the consequences of slum clearance and rehousing, and the visible scars of urban decline. Their testimony demonstrates how housing and urban space were remembered as determinants of both health outcomes and community cohesion.

Several interviewees recalled the stark contrasts of wealth and poverty within their caseloads. For example, Karen Walker described moving between Mossley Hill, with its comfortable homes and professional families, and neighbouring districts marked by 'extreme poverty'.[159] Ethel Love remembered visiting families who were 'very poor,' sometimes unable to offer her a cup of tea without borrowing crockery from neighbours, or still living without indoor sanitation.[160] Ethel Love also told me how, in the 1960s, many of her patients had no indoor bath and relied on outside toilets.[161] Dorris Smeethe similarly recalled homes with only a single gas fire and families boiling water in kettles.[162] These recollections of deprivation resonate with wider perceptions of Liverpool during the 1970s and 1980s as a city of dereliction and decline, frequently depicted in political and media discourse as emblematic of

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[158] See also Aaron P. Andrews, *Decline and the City: The Urban Crisis in Liverpool, c. 1968–86* (PhD Thesis, University of Leicester, 2018); Jonathan Brown, Matthew Cocks, Chris Couch, David Shaw, and Olivier Sykes, "A City Profile of Liverpool," *Cities* 35, (December 2013): 350–60; Christopher Wildman, "Urban Transformation in Liverpool and Manchester, 1919–1939," *Transactions of the Historic Society of Lancashire and Cheshire* 161 (2012): 107–31.
[159] Karen Walker, Interview, 14th March 2022.
[160] Ethel Love, Interview, 8th November 2021.
[161] Ethel Love, Interview, 8th November 2021.
[162] Dorris Smeethe, Interview, 22nd February 2022.

Britain's urban crisis.[163] These testimonies underline that for district nurses, geography indexed inequality. They remembered community as a stratified landscape where the boundaries of their rounds were also the boundaries of deprivation.

Others reflected on how urban planning fractured the networks that had sustained patients and practitioners alike. Julie Snowden emphasised that the demolition of terraced housing and the move to high-rise flats in the late 1970s and 1980s undermined the close-knit bonds of working-class neighbourhoods.[164] She observed that such housing 'was not conducive' to social interaction, leaving elderly and vulnerable residents without the neighbourly support that had once been integral to community life.[165] For district nurses, this meant greater patient isolation and increased reliance on formal care. Oral history here captures not only the medical but also the social consequences of rehousing, showing how nurses interpreted the decline of locality as a decline in resilience. These reflections echo what Colette Fagan has noted about the gendered reliance on local networks, with women often sustaining the very forms of neighbourly care that were eroded by rehousing.[166]

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[163] Philip Boland, "The Construction of Images of People and Place: Labelling Liverpool and Stereotyping Scousers," *Cities* 25.6 (2008): 355–369; David Hall, "Images of the City," in *Reinventing the City? Liverpool in Comparative Perspective*, ed. by Ronaldo Munck (Liverpool: Liverpool University Press, 2003), 45–65.
[164] Julie Snowden, Interview, 21st January 2022.
[165] Julie Snowden, Interview, 21st January 2022.
[166] Colette Fagan, "Gendered Perspectives on Access to Employment in Liverpool," in *Reinventing the City? Liverpool in Comparative Perspective*, ed. by Ronaldo Munck (Liverpool: Liverpool University Press, 2003), 139–60.

Elsewhere, Cathy Earles described the dangers of working in Toxteth and the Dingle during the 1980s, where she treated patients who had been stabbed or shot.[167] She remembered sitting behind cars during 'drug deals' on Granby Street, a stark reminder of how the urban geography itself produced caseloads of violence and trauma.[168] These experiences underline how district nurses' understanding of community was inseparable from the dangers and inequalities embedded in the city's space.

Together, these recollections show how district nurses remembered urban decline not as background to their work but as its defining context. For them, community health was fundamentally conditioned by the material and social landscape of Liverpool. The demolition of familiar streets, the construction of high-rises, and the persistence of poverty reshaped the boundaries of community, and district nurses remembered themselves as witnesses to, and participants in, this transformation. They interpreted poverty, sanitation, redevelopment and violence not as background conditions but as active determinants of health. Their oral histories reveal a sophisticated diagnostic capacity rooted in place, where the nurse's clinical expertise was always mediated by the material environment. By situating community health in relation to urban decline, poor housing and fractured neighbourhoods, these testimonies illuminate how district nursing embodied a form of social medicine, adapting professional practice to the constraints and vulnerabilities of the city itself.

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[167] Cathy Earles, Interview, 18th October 2021.
[168] Cathy Earles, Interview, 18th October 2021.

4.5 Conclusion

The recollections of Liverpool's district nurses show that community was never a fixed or singular entity. It was instead constructed and reconstructed through practice, relationships, and geography. Across their testimonies, community emerged in multiple dimensions such as a professional framework, a set of interpersonal bonds, and as a spatial landscape shaped by the wider forces of urban change. Working on the community, district nurses positioned themselves as members of a professional body whose practices were distinct from institutional medicine. Uniforms, training sites, and shared linguistic markers such as the distinction between working 'on' and 'in' the community created a sense of collective belonging. Oral history testimony highlighted how this professional community was both supportive and sometimes disorientating. The absence of hospital hierarchies unsettled some, while the shared identity of being a district nurse provided protection, recognition, and solidarity in uncertain settings.

Working with the community, nurses remembered the everyday negotiations of building relationships with patients, families, and local networks. Cathy Earles's insistence on the importance of not being judgmental, or Dorris Smeethe's memories of patients discreetly accessing the GUM clinic 'through the back door,' reveal how trust was hard won but deeply valued. Karen Walker's testimony, particularly her recollections of caring for HIV/AIDS patients, shows most vividly how crisis could redefine community. In her memory, these encounters were not only professionally

demanding but personally transformative, highlighting the compassion and advocacy that became central to her understanding of district nursing.

Spatial community added a further layer to this understanding. Nurses' testimony mapped Liverpool onto their daily rounds, showing how geography conditioned health and wellbeing. Cathy Earle recalled boundaries such as Princes Boulevard that carried cultural significance, while Julie Snowden and others remembered how rehousing and high-rise flats disrupted established neighbourhoods. Testimonies of poverty, outside toilets, single gas fires, and borrowed crockery, spoke not just of deprivation but of the uneven landscape of the city. For district nurses, community was therefore inseparable from the material realities of housing, urban decline, and the reputations of particular areas. In their accounts, Liverpool was remembered as a stratified city of contrasts, where affluence and deprivation existed side by side, and where community health was always conditioned by place.

Taken together, these testimonies highlight the flexibility and adaptability of district nursing. Community was not a backdrop to their work but its defining framework. Liverpool district nurses recalled navigating professional hierarchies, negotiating relationships marked by stigma or trust, and adapting to urban environments that were undergoing profound change. Their oral histories reveal community as a lived and felt category, grounded in the streets they walked, the families they visited, and the crises they encountered. For the history of nursing more broadly, this perspective complicates any simple narrative of community care as an extension of hospital practice. Instead, it shows that district nurses developed their own epistemology of place, rooted in mobility, visibility, and intimate

knowledge of local geographies. For the history of Liverpool, their testimony provides an ethnographic account of how urban decline, poverty, and stigma were experienced at the level of everyday healthcare. For oral history, it demonstrates how memory of community is mediated through both pride and pain, as nurses composed narratives that balanced professional identity with personal reflection.

This chapter has therefore shown that community was not a single sphere of practice but a set of interlocking domains: professional, interpersonal, and spatial. District nurses' testimony demonstrates how these domains intersected, shaping their identity and defining their work. As the following chapter will explore, the concept of home added another crucial dimension to this story. If community was the framework within which nurses moved and belonged, home was the intimate setting where those relationships unfolded, requiring new forms of negotiation and adaptation. Together, community and home reveal how district nursing was constructed as both a social and spatial practice, grounded in the lived realities of district nurses in Liverpool between 1945 and 2000.

Chapter 5: Home

5.1 Introduction

This chapter examines how district nurses in Liverpool conceptualised home as central element of both their professional and personal identity. For those district nurses interviewed, home represented more than a location where care was delivered. It signified a space where the boundaries between the personal and professional blurred. The home was both the intimate environment of the patient and the professional realm of the district nurse. Working in a patient's home required acknowledgment of this intersection and an awareness and understanding of how to effectively navigate the delivery of care. Home is therefore a critical concept for understanding district nursing, operating dually as a physical space where care is administered whilst also underpinning a theoretical evocation of professional and personal identity. Interviewee's descriptions offer valuable insights into how the concept of home is deeply woven into the fabric of the district nursing profession.

This duality of home, both as a tangible site of care and as a construct shaping professional and personal identities, aligns with broader understandings of the home as complex site. Home is therefore much more than bricks and mortar. This chapter will show that in the interviewees' recollections home became a space where boundaries of care, gender and professional identity were continuously negotiated assisting with them feeling a sense of homeliness and belonging.

The first section of this chapter will focus on the home as a site of care delivery, highlighting how district nurses articulated aspects of their professional identity whilst discussing their work in their patients' houses. This section considers how the spatial dynamics of the patients' house influenced key practices and routines for the district nurse. This approach will assist in understanding how the physical structure of a house and its rooms and contents can be reconstructed and adapted around the delivery of care. Following this, the next section will explore how district nurses discussed navigating the power dynamic which emerged from working within the of the patient's home. Whilst discussing their work in the home, interviewees provided rich accounts of the district nurse-patient relationship, stressing the centrality of the home in influencing interactions. Beginning with the complex navigation of power dynamics within the home discussed by interviewees, I will then move on to discuss how relationship building was conveyed as central element to their professional identity. This section will unpack how this relationship unfolded, focusing on how the intersection of the home as a private dwelling and the home as a place of work enabled a nuanced professional element for the district nurses interviewed. The testimony of each interviewee will be central to analysis in this section, helping to convey how each utilised the home as a space to deliver care. Their narratives highlight how the domestic setting shaped interpersonal relationships, deepened the emotional labour involved in caregiving, and influenced nurses' perceptions of home as a space of care and connection.

The final section will explore how interviewees spoke about managing their own homes and families alongside their professional responsibilities. In particular, I will examine how the concept of 'working' one's own home, a term coined by Ethel

Love, one of my interviewees, to describe the way district nursing allowed her to manage her own domestic duties, highlighted prevalent attitudes toward gender, domesticity, and labour during this period.[1] In this section, I extend this potentate imaginary to examine how district nurses balanced domestic responsibilities with professional duties, using language that reveals the gendered nature of home and labour during this period. By analysing how interviewees articulated their dual roles as professional caregivers and wives, mothers, sisters and also husband and fathers, this section will provide insight into how district nurses negotiated their personal and professional identities.

I will position the exploration of the personal home discussed by interviewees within broader analysis which considers how the language used by interviewees captures broader attitudes toward privacy, domestic life, and changing gender roles in mid-to-late twentieth-century Britain. This will involve exploring ways in which societal expectations regarding women's roles at work and at home intersected with the experiences of district nurses. Additionally, this section will consider how varied understandings of home, both a private space and a site of women's work, redefined professional identities and responsibilities, for the district nurses interviewed. By situating the experiences of the interviewees within a wider analysis of gender roles, this section will reiterate the nuanced construction of home, especially in relation to gender, work and professional identity.

[1] Ethel Love, Interview, 8th November 2021.

Examining the home as both a space of professional empowerment and familial responsibility is crucial for understanding the lived realities of district nurses in Liverpool between 1945 and 2000. By exploring this intersection, this chapter provides a deeper understanding of how district nurses' identities were formed and expressed within and outside the domestic sphere, revealing the complex interplay between space, identity, and gender in the practice of district nursing. The first section, then, will begin with establishing the predominant theoretical discourse surrounding home and district nursing by investigating how the home was articulated as a site for the delivery of care by interviewees.

5.2 Home as the Site of Care Delivery

District nurses' accounts of delivering care within patients' homes reveal how the domestic environment shaped both their professional practice and identity, highlighting the complex interplay between private space and medical care. The intrinsic relationship between home and the work of the district nurse was continuously emphasised by the interviewees, and it was clear that home represented much more than a location of employment. It was a fundamental element that shaped daily practices, professional identities and relationships with patients. Home in this instance was dynamic, constantly evolving and individual to each interviewee. By understanding how the interviewees articulated home as more than just a site where they delivered care, this section provides the framework to sufficiently understand what I argue is a foundational element of district nursing: that is how the concept of home underpins key attributes and markers of the district

nursing professional identity, whilst also defining how care is delivered by the district nurse.

In this thesis, home is understood not simply as a physical dwelling but as a layered and contested concept. It encompassed, for interviewees, the material structures of patients' houses. Their rooms, furnishings and routines, as well as the intimate associations of privacy, family life and belonging. As Shelly Mallet has emphasised, home should be understood as a multidimensional concept – encompassing place(s), space(s), feelings, practices and an active state of being in the world.[2] Similarly, Tracy Bhamra, Kerstin Elder Mackley, Val Mitchell, Roxana Morosanu and Sarah Pink have argued that home does not necessarily refer to a fixed dwelling or family residence, but rather to the ongoing and contingent process of feeling at home.[3] In addition, Jane Brooks has shown how nurses in active service in the Second World War worked to construct an idea of home for their solider-patients, decorating wards, growing gardens and marking Christmas and birthdays so that men recovering from injury would feel close to a place of safety worth returning to.[4] This imagining is of home as a space that nurses created for someone else, a deliberate and gendered act of domestic labour serving morale and the war effort. Interestingly, in this study the district nurse did not explicitly construct home as a space *for* the patient. Rather, they entered a home that already existed and had to navigate their place in it. What both concepts of home here share is an

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[2] Shelley Mallet, "Understanding Home: A Critical Review of the Literature", *The Sociological Review* 52.1 (2004) 63
[3] Tracy Bhamra, Kerstin Elder Mackley, Val Mitchell, Roxana Morosanu and Sarah Pink, *Making Homes: Ethnography and Design* (London: Routledge, 2017), 12.
[4] Jane Brooks, *Negotiating Nursing: British Army Sisters and Soldiers in the Second World War* (Manchester: Manchester University Press, 2018), 61-67.

understanding that home was never a neutral backdrop. It was something that had to be actively managed, whether built from nothing in a war-related hospital or negotiated, room by room, in a patient's house in Liverpool.

This negotiation shaped the district nurse's experience of home in this study. Entering the home meant working within a space that was simultaneously a private domestic refuge, a site of family life, and once care was introduced, a setting of medical practice. What happened to the home during medical care, then, was a reconfiguration of its meanings. A space defined by privacy and familiarity became a workplace, where the boundaries between domestic and professional life were blurred. To examine the complexity of these definitions, it is important to acknowledge what Jan Angus, Isabel Dyck, Pia Kontos and Patricia McKeever have deemed the paradoxical nature of home in the context of long-term healthcare. [5] For them, when home becomes a site for long-term care, like it did for many of the patients discussed by interviewees, home is transformed into a 'workspace of caregiving'.[6] Care is provided within spaces which are designed for other purposes, and when a private space is entered by a health professional, who in turn is attempting to control that space, the home ironically becomes its most 'public'.[7] This shift challenges the meaning of home and blurs the boundaries between public and

[5] Jan Angus, Isabel Dyck, Pia Kontos, and Patricia McKeever, "The home as a site for long-term care: meanings and management of bodies and spaces", *Health & Place* 11, (2005): 181.
[6] Angus, Dyck, Kontos and McKeever, "The home as a site for long-term care: meanings and management of bodies and spaces," 181.
[7] Angus, Dyck, Kontos and McKeever, "The home as a site for long-term care: meanings and management of bodies and spaces," 181.

private spaces, with interviewees acknowledging how important it was that they understood this complex blurring.

Holistic Care

In order to effectively navigate this blurred positioning of the home, interviewees adopted language which signalled a comprehensive approach to patient care. The transformation of a house into a workspace of care meant that the district nurse needed to assess both the patient and the domestic setting they were situated in. As mentioned above, the home being designed for other purposes meant the district nurse needed to constantly adapt their process of delivering care. Terms such as 'holistic' were repeatedly used by interviewees to indicate a process of delivering care that went beyond addressing just the immediate physical health needs of the patient. In nursing literature, holistic care is commonly defined as an approach grounded in the philosophy of holism, which understands individuals as integrated beings whose physical, psychological, social and spiritual dimensions are interconnected.[8] The term was associated with the nursing profession from the 1970s through theorists such as Martha Rogers, who understood the person as a unified whole existing in continuous interaction with their environment, and Myra Levine, who defined the nurse's role as seeing each patient as a whole rather than through the reductionist lens of medicine.[9] McEvoy and Duffy have suggested that

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[8] Louise McEvoy and Anne Duffy, "Holistic Practice: A Concept Analysis", *Nurse Education in Practice* 8, no.6 (2008) 415.
[9] Martha E. Rogers, *An Introduction to the Theoretical Basis of Nursing* (Philadelphia: F.A. Davis, 1970); Myra Levine, "Holistic Nursing," *Nursing Clinics of North America* 6, no. 2 (1971): 253–64, both cited in McEvoy and Duffy, "Holistic Practice," 415.

holism may have described what nurses were already doing, and that the theorists gave a name to an existing approach rather than introducing a new one.[10] Within this context, holistic care came to represent an integration of multiple aspects of healthcare delivery that being within the home of the patient necessitated.

Each interviewee had a memory of how the process of being in the home shaped their approach to delivering care. Cathy Earles, for example, in the first interview conducted for the study, described how the district nurse had to be 'part-dietician, part-physiotherapist, and part-occupational therapist'.[11] I asked whether Cathy would describe this as holistic and she responded 'absolutely'.[12] In this way, holistic care became patient-centred but adaptable, allowing for a seamless integration of broader medical interventions with practical advice on managing multiple aspects of health. Working holistically within the patient's home demonstrated an awareness of what the home could tell the district nurse about their patient. The various roles described by Cathy evidence how the nurse might need to ask questions about daily routines, habits, and relationships, which required a level of intimacy and trust that was facilitated by being in the home environment. This is because the home environment positioned the district nurse into the private dwelling of the patient, allowing but also requiring the need to integrate multiple aspects of care delivery.

Other interviewees spoke about delivering holistic care as a way to evidence a broader assessment of the patient's needs. When I asked Mabel Williams, who

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[10] McEvoy and Duffy, "Holistic Practice," 415.
[11] Cathy Earles, Interview, 14th March 2022.
[12] Cathy Earles, Interview, 14th March 2022.

completed her district nurse training in 1981, what the term 'holistic care' meant to her, she replied that: '[y]ou've got to have that holistic approach because otherwise then you are just treating the patient for what their treatment is and you are not seeing any further. You are not looking at the wider picture.' Similar to how Cathy spoke of the wider medical remit needed by the district nurse, Mabel conveys an understanding of holistic care that demonstrated a need to look at the 'wider' picture. For Mabel, being in the patient's home meant:

> You can pick up anything that is a miss in any area in the patient's journey. Whether it might be something socially, whether it might be something psychologically, whether it just might be something on the day that doesn't feel right, you know what I mean? You weren't just going to do that task.[13]

Mabel explained how on her visits to patients' houses, there were the clinical nursing tasks that needed completing, as well as a broader social/psychological assessment that would need to be done on the patient's behalf.

For Mabel and Cathy, being within the domestic sphere of the patient meant that the district nurse was afforded the opportunity to think in a more holistic way concerning the delivery of care. By adopting the word 'holistic', interviewees were emphasising an interconnectedness of the patient's physical, psychological, emotional and social needs. Being in the home made these visible. This links back to the earlier point about the blurring between the public and private that underpins the district nurse role. Both Cathy and Mabel advised how this blurring necessitated a need to

[13] Mabel Williams, Interview, 8th March 2022.

undertake a broader, more holistic assessment of the patient's health. Interestingly, Mabel positions her holistic assessment of the patient's needs against the idea of 'just going to do a task'.[14] This could be read as a recognition that there would not be just one approach to delivering care, as being in the home of the patient required the integration of multiple processes.

This positioning of working holistically in opposition to in a task-focused way was also pointed out by Julie Snowden. Julie, who trained and worked as a district nurse at a similar time to Cathy and Mabel in the 1980s, advised that she was trained to look at things in a 'holistic way'.[15] This came following a discussion on how district nurses 'now' are incredibly task orientated, whereas she had the time to talk to patients and find out, 'how they are, how they're feeling, what their problems are'.[16] Here then, Julie is emphasising how she was trained to think holistically about the needs of the patient in a way which incorporated a much broader health and social care perspective within a home setting. For Julie, a task orientated approach might mean the district nurse is going to take stitches out, rather than undertaking a broader and more holistic assessment of the patient.[17] To me, this represents the dynamic and evolving position of the home as a workspace of caregiving, outlining the requirement of the district nurse to think broadly about the patient's needs. Rather than a singular task-focused approach to treating patients, interviewees spoke about interactions in a manner which became imbued with an

[14] Mabel Williams, Interview, 8th March 2022.
[15] Julie Snowden, Interview, 21st January 2022.
[16] Julie Snowden, Interview, 21st January 2022.
[17] Julie Snowden, Interview, 21st January 2022.

acknowledgement of the home and its complexities, indicating difficulties and opportunities through navigation.

Complexity of Homecare

As previously mentioned, some interviewees focused on conveying the work of the district nurse as holistic rather than in a singularly task-focused way. To me, a holistic perspective meant moving beyond a purely task-orientated approach, to instead understanding the patient within the complex context of their spatial environment. This is useful as it aids in awareness of the complexities of what home can mean. It is useful to highlight some examples here to help better understand how working holistically was communicated by interviewees in relation to health-focused interactions with patients in the home. Firstly, Julie discussed with me an instance with a patient she had looked after 'for many years,' who could only access the ground floor of her house, which had no heating and an outside toilet.[18] The patient had severe leg ulcers, and Julie made an assessment that she needed to elevate her legs. This represented a medical task that Julie needed to undertake in delivering care to her patient. However, Julie explained to me that the patient had a dog, described as 'her only companion' which would sleep on the only bed in the house, whilst the patient slept in a deck chair.[19] Julie emphasised to me a knowingness that the patient adored the dog, and Julie therefore needed to find a

[18] Julie Snowden, Interview, 21st January 2022.
[19] Julie Snowden, Interview, 21st January 2022.

solution that took this into consideration.[20] On the other hand, when a social worker visited the patient and suggested that they find someone to look after the dog while the patient slept in the bed, Julie said the patient was 'absolutely broken-hearted because she thought they were going to take her dog'.[21] This sentiment aligns with Deborah Wells' analysis of the human-animal relationship, which emphasises the emotional and psychological benefits of companion animals, particularly their capacity to reduce loneliness and provide comfort in care settings.[22] In this context, Julie communicated an acknowledgement of the patients' needs without a task-orientated focus on the district nursing task at hand.

Thinking holistically in this way meant that Julie recognised how various aspects of a patient's life were interconnected, and their health and overall wellbeing did not just rest on the task Julie was undertaking. Julie's patient's health was affected both by their physical condition and the emotional connection to their dog. Julie put it like this:

> You see, for me, that's the difference. The difference is when we assess a patient in hospital, we say: 'What are the medical requirements or their care requirements to get this patient from a to b?' When you assess somebody at home, the things that I think are important might be in no way important to them. So, my thought that she needed to sleep in her bed wasn't important to her. Her dog being comfortable was important to her.[23]

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[20] Julie Snowden, Interview, 21st January 2022.
[21] Julie Snowden, Interview, 21st January 2022.
[22] Deborah L. Wells, 'The Effects of Animals on Human Health and Well-being', *Journal of Social Issues* 65.3 (2009), 528-529.
[23] Julie Snowden, Interview, 21st January 2022.

This is a useful example of how Julie illustrated the complexities and opportunities of delivering holistic care. While her professional training informed her medical assessment that the patient's legs needed elevating, the domestic setting required her to also consider the patient's emotional attachment to her pet. The patient's emotional attachment to her dog, which Julie identified as 'her only companion', exemplified how care delivery in the home demanded attention to both medical and personal priorities.[24] This illustrates the nuanced relationship between district nursing and home, where the act of care extends beyond medical intervention to encompass the patient's broader well-being.

Julie's reflection underscores how delivering care in a patient's home required an approach that accounted for what mattered most to the patient, not just what was medically advisable. As Julie said, when making an assessment on how to undertake your duty of care, you are working *with* the patient in *their* home, meaning you have to take into account what is important to them.[25] The home as a geographical and social space of care enabled her to think beyond isolated clinical tasks, integrating physical, social, and emotional needs into her assessment. Overall, Julie's example underscores the nuanced and often contested nature of the home as a site of care, where professional expertise must be mediated through the patient's lived reality.

The complexities of delivering holistic care within the home environment were similarly evident in Dorris Smeethe's testimony. Like Julie, Dorris provided an

[24] Julie Snowden, Interview, 21st January 2022.
[25] Julie Snowden, Interview, 21st January 2022.

example where a health-based interaction required broader consideration of the domestic and social environment. While we were discussing how observations were inherent to the district nurse role, Dorris mentioned how 'people got stuff for Mother's Day, smellies, off their daughters, and they put them in the bathroom and they'd still be there next Mother's Day untouched'.[26] Here, Dorris is highlighting how her observations would extend beyond health assessments, and how being invited into spaces such as the bathroom provided an opportunity for the nurse to gain a broader perspective into the lives of their patient. Later, Dorris explained how she would suggest using these products when bathing her patients, because '[y]ou don't want them [patient's family] to think "God, she's never used them up."'[27] In this example, Dorris explained how she noticed something which could have caused hurt or offence to a family member of her patient. In an attempt to avoid this, Dorris went out of her way to try use the products and avoid anything that might affect her patient's wellbeing. This is evidence of needing to think holistically about the needs of the patient that extends beyond a medical assessment, but which is entwined in the location of care.

This point was made to highlight the opportunities afforded to the district nurse to broadly assess their patients in their own homes. However, this also meant that the nurse's role expanded beyond strictly medical tasks, as they became a part of the patient's domestic space and routines. To effectively integrate multiple aspects of health care, nurses needed to address physical, social, and emotional

[26] Dorris Smeethe, Interview, 22nd February 2022.
[27] Dorris Smeethe, Interview, 22nd February 2022.

needs which became intrinsically linked to operating within the personal sphere of the patient's home life. Holistic in this instance therefore represented comprehensive assessment of the patients' needs within the home. Further, this conception of holistic care required an understanding of the patient's family dynamic, support systems, and living conditions.

Each interviewee's discussion of navigating the complexity of homecare also reflected a retrospective positioning of district nursing within an evolving professional discourse. Their emphasis on recognising the interconnectedness of patient priorities within the home illuminates a professional ethos centred around holistic care. By framing their experiences through this lens, their testimony not only reveals the complexities of delivering care in the home but also contributes to our understanding of how district nurses constructed and maintained their professional identity. The ability to adapt care to the specific social and material conditions of the home, whether by recognising the significance of a family pet or ensuring sensitivity to familial relationships, was fundamental to the professional identity of each interviewee. The district nurses that were interviewed underscored that this capacity for negotiation and responsiveness was not just a practical necessity, but a defining feature of district nursing.

5.3 A Guest in the Home of the Patient

Having established how district nurses spoke about delivering complex, holistic care within the home, it is clear that this required careful navigation of professional boundaries and domestic spaces. The ability to provide comprehensive care rested

not only on medical expertise, but on understanding one's position within the patient's private domain. Interviewees frequently emphasised their status as 'guests' in patients' homes, suggesting this mindset was crucial for effective care delivery. This positioning raises important questions about how district nurses managed complex power dynamics between home actors, such as the patient, family members, and themselves, while also maintaining their professional authority. The following section examines how interviewees articulated their role as guests, exploring how this status influenced their ability to deliver the holistic care that has been described. Their accounts reveal sophisticated strategies for balancing professional responsibilities with respect for patients' domestic authority, demonstrating how the concept of being a guest became fundamental to district nursing practice.

Interviewees often spoke about tackling or circumventing power dynamics that could have arisen by way of delivering care. For the district nurse to be able to enter the houses of their patients, invited but not necessarily welcomed, they communicated the importance of developing a trusting relationship with the patients and their families. This ties back to the interconnected nature of holistic care discussed earlier, as the district nurse would need to assess environmental and social factors within the home. The authority the district nurse holds within the home has been illustrated by Lis Cook, who has argued that the district nurse has traditionally been at the centre of health-care provision for those patients who

remained at or were discharged to their own home.[28] This concept, placing the district nurse in a position of authority in a space where they would not necessarily be in charge, differentiates them from nurses in a hospital setting. This was communicated through language associated with being a guest in the homes of their patients, an idea that was not mirrored when patients are in hospitals because in this medical transaction, the patient was the guest. This blurring of formal and informal care was not unique to Liverpool. Karen Buhler-Wilkerson has traced a comparable story in the United States, beginning with the Ladies Benevolent Society of Charleston, a charitable group of women who from 1813 visited the sick poor in their own homes, in the absence of family or the means to pay for care.[29] The uncertain status of home care that this origin established persisted throughout the twentieth century. Writing of the 1990s, Buhler-Wilkerson has noted that policymakers still could not agree on a basic definition, torn between home care as a formal service and an informal one, a medical intervention and a domestic one, overall uncertain within a wider system of health care.[30] This tension surrounding the organisational function of the district nurse role was then felt through the patient/guest dichotomy.

This idea that the district nurses were on the patient's home territory was echoed frequently throughout the interview process. When I asked Mabel, for example, if she felt nervous about going into the patient's home as a district nurse,

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[28] Lis Cook, "Demography and Social Change" in *District Nursing: Providing Care in a Supportive Context*, ed. by Jane Cantrell, Jane Harris, and Sally Lawton (London: Churchill Livingstone, 2004), 35.
[29] Karen Buhler-Wilkerson, *No Place Like Home: A History of Nursing and Home Care in the United States* (Baltimore: Johns Hopkins University Press, 2001), 1.
[30] Buhler-Wilkerson, *No Place Like Home*, 205–207.

she responded '[y]es, I think you were nervous. You always had to remember that like I said you were a guest in that patient's home. But you were giving them the treatment they required.'[31] This notion of being a guest in the home of the patient was further reinforced by Julie Snowden.[32] Julie tied the skills she felt district nurses needed to the ability to not only acknowledge the status of being a guest in the patient's home, but to ensure that this acknowledgment informed relationship-building, because '[w]hen you go into somebody's home as a district nurse, you are the guest. Therefore, the art of really good district nursing is that ability to develop a wonderful relationship with a patient and their family'.[33] According to Julie, this 'doesn't happen with everybody', but it is essential to be able to understand what is important to each patient.[34] By explaining what the 'art' of really good district nursing was, Julie was reflecting the key skills and training afforded to the district nursing professional identity. For Julie, the foundation of *really* good district nursing rests on the district nurse recognising the intricate relationships that the district nurse encountered when delivering care within the home. These relationships needed to reciprocal and developed beyond the patient, the medical actor at the centre of their care.

A district nurses' authority did not always translate to ease of access. Julie McGarry has argued that district nursing was characterised by the unique nurse-patient relationship within the home, referring explicitly to being a 'guest in the

[31] Mabel Williams, Interview, 8th March 2022.
[32] Julie Snowden, Interview, 21st January 2022
[33] Julie Snowden, Interview, 21st January 2022.
[34] Julie Snowden, Interview, 21st January 2022.

patient's home' similar to the interviewees.[35] According to McGarry, the location of care being the patient's home meant that the patient adopted a position of control.[36] This was largely due to the perceived jurisdiction of the home space and the understanding of the district nurse as an outsider.[37] This was especially the case when a district nurse may have disrupted a gendered expectation with regards to the provision of care. This idea has already been introduced in Chapter 3 when Alan Carlise discussed how his uniform was often misread by patients and their family. This highlighted how – unlike in the hospital, where Alan's uniform signified authority and conferred a sense of professional legitimacy – in the home it was something that patients could engage with, question, and even challenge. His experience introduced another complexity of delivering care within the home, that of the interplay between professional identity and expected gender norms. While in the hospital setting, Alan's gender and attire aligned with embedded assumptions about male authority in medicine. However, within the home, these markers did not elicit the same recognition. Instead, his presence as a male nurse disrupted conventional expectations of caregiving, especially within the home.

When I interviewed Alan, I was able to ask him whether he found nursing to be especially different in the home versus the hospital because of his varied career path. I was wondering whether he felt he had a different relationship with the patient because of being in their home. Alan responded that '[y]ou have to have a

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[35] Julie McGarry, 'The Essence of 'Community' Within Community Nursing: A District Nursing Perspective', *Health and Social Care in the Community* 11.5 (2003) 425.
[36] Julie McGarry, 'The Essence of 'Community' Within Community Nursing: A District Nursing Perspective', 425.
[37] Julie McGarry, 'The Essence of 'Community' Within Community Nursing: A District Nursing Perspective', 425.

different relationship because you're in on their territory, and you're there by invitation. At any time, they could tell you to get out and you do get one or two extraordinary experiences where they won't have you'.[38] Here, Alan highlighted how the district nurse could be told to leave the home at any time, underscoring how the space of home is contingent on the patient's consent. The reaction of patients suggested that male nurses in domestic settings had to actively negotiate their role, with Alan recalling in our interview how his uniform reinforced an unexpectedness related to his role. Alan's recounting of these moments, framed with humour, indicated the social and relational aspects of care in the home. Rather than asserting authority outright, he navigated these encounters by using humour as a strategy to diffuse discomfort and establish rapport with patients. His account underscored how district nurses continually adjusted their approach in response to delivering care within the houses of their patients.

Alan did go on to convey a sense of discomfort in relation to his uniform and entry into his patient's homes. Alan stated that:

> In the end, I went to see the nursing superintendent and I said, 'Look, can I use my £27 a year allowance on ordinary clothes? I want to be an ordinary person'. And she thought that was quite novel, took it to the health committee, and I got approval.[39]

[38] Alan Carlise, Interview, 28th October 2021.
[39] Alan Carlise, Interview, 28th October 2021.

Earlier in the interview, Alan had explained how he laughed off the mistaken assumption that he was a gas reader, a presumption shaped by both his uniform and gender. However, he still felt compelled to raise the issue with the nursing superintendent and eventually requested to wear 'ordinary' clothes. Building on this, Alan went on to explain:

> So, I used ordinary clothes. My problem was by then I had four children. I had a Bedford van with windows, it was a deluxe version, 12 seats, with green down the side…and it was exactly the same as the doctor's, so they didn't know if I was the doctor or not. And the GP said, 'I don't mind what you call yourself as long as you get the work done.'[40]

Alan's use of the word 'ordinary' to describe his non-uniform clothing is interesting, redefining an attribute of nursing that other interviewees called a 'symbol' of their profession.[41] In relation to his work in the home, Alan's choice to wear 'ordinary' clothing indicates a rejection of an overarching district nursing identifier, whilst also demonstrating a desire to integrate into the home space. Alan could have felt this assisted with building relationships through a shared understanding of everyday life rather than through the formal distance of a professional encounter. This builds on Joe Moran's description of the home as a place where the mundane everydayness of life happens.[42] For Alan then, factors such as your uniform or even the vehicle you were driving, became material visualisations of your professional identity, which became part of a complex navigation of care he needed to undergo. When

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[40] Alan Carlise, Interview, 28th October 2021.
[41] Ethel Love, Interview, 8th November 2021.
[42] Joe Moran, "Housing, memory and everyday life in contemporary Britain", *Cultural Studies* 18.4 (2004), pp. 607–27.

discussing his work within the home, Alan used his rejection of these signifiers to reflect how his gender provided a transgression to what the patients were expecting from a district nurse. In order to combat this, Alan went to lengths to provide a sense of composure to the patient's he was visiting. As he was operating as a guest in their homes, his decision to abandon his uniform revealed an acute awareness of the power dynamic that was altered in this space. Whereas in hospital settings uniform symbolised authority and professional standing, in the home it could just as easily strip him of authority leading to patients mistaken him for a gasman or other everyday visitor. By adopting 'ordinary' clothing, Alan sought to renegotiate this ambiguity. This wasn't to assert traditional professional dominance, but to create a rapport that restored his legitimacy on different terms. This suggests that establishing trust and rapport was more important in a domestic setting than relying on the traditional markers of authority associated with the nursing profession. This challenges the idea of uniform as a symbol of authority for men when compared to how patients interacted with him when he was wearing his 'ordinary clothes'.[43]

Alan's recollections emphasise how district nurses had to adjust their approach to the domestic setting, recognising that care work in the home required more than clinical expertise, or what interviewees described as working in a task-focused way.[44] It demanded relationship-building and effective communication. Alan's account of modifying material markers of authority reflected a broader theme in interviewees' testimonies. It reflected how district nurses understood themselves as guests in the

[43] Alan Carlise, Interview, 28th October 2021.
[44] Julie Snowden, Interview, 21st January 2022.

home, and their ability to form connections with both patients and their families was central to their role. This emphasis on relationships was embedded in the very nature of delivering holistic care, which required an understanding of the patient's social and familial environment alongside their medical needs.

Alan's understanding of working within the home contrasted with work in a hospital setting, where patients are often seen as guests within the institution, expected to comply with the staff's direction. As Julie Snowden explained:

> I saw it [district nursing] as a job where I would have more autonomy and that I would need to build my skills because when you work in a hospital, there are always people around you. There's always somebody on the end of a phone. Plus, the patient is a guest in your house.[45]

For Julie, district nursing offered a sense of autonomy precisely because it required navigating care without the support structures that were perceived to be in place in the hospital. Interestingly, the phrase 'the patient is a guest in *your* house,' utilises language of home in a way which frames the hospital as an extension of the domestic space.[46] This reinforces the centrality of a multiple home imagery within the interview, suggesting that for the district nurses interviewed, institutional and domestic care environments were intrinsically imbued with complex relational dynamics associated with home.

[45] Julie Snowden, Interview, 21st January 2022.
[46] Julie Snowden, Interview, 21st January 2022.

Homespace relationships

Interviewees frequently employed emotive language when describing their interactions with patients in their homes. This language revealed the emotional labour inherent in caregiving, highlighting how relationship-building influenced the district nurse's perception of the home as a space of care and connection. This was touched upon earlier, when Julie Snowden mentioned how the 'art of really good district nursing is that ability to develop a wonderful relationship with a patient and their family'.[47] Expanding on this, Julie explained how '[t]he art of being a district nurse was always about good quality care, but it was actually also about how you build a relationship with somebody to enable them to let you know what is important to them'.[48] This demonstrates the strong connection that was necessary between the district nurse and the patient. The relationship rested not just on the district nurse gaining entry into the patient's home, but also on their ability to utilise domestic space when building and maintaining strong-enough connections to be able to enter and remain in the home. This connection enabled the patient to feel comfortable enough to inform the district nurse what was important to them. Julie's distinction between good quality care and relationship building indicates a duality of district nursing that I argue is tied up with the interconnectedness of holistic care interviewees emphasised in our interviewees. In this instance, holistic meant offering both quality care, in a medical sense, as well as a broader social assessment of the patient, their family and their domestic environment.

[47] Julie Snowden, Interview, 21st January 2022.
[48] Julie Snowden, Interview, 21st January 2022.

Interviewees reinforced how the broader domestic environment of the home required a nuanced assessment of relationship building with both the patient and their family. For Cathy Earles, it was 'an absolute pleasure' to witness the informal care provided by families to the patients. When working in 'less affluent' areas, Cathy described how:

> You'd have a small house, that was originally a two up or two down, so not very much room, and you'd go in through the front door and you couldn't open the front door properly because there'd be a hospital bed in the living room. You know, and all life would be going on, everybody would be carrying on and all the family members worked out a rota for themselves to look after the patient.[49]

The way Cathy described how the family went about modifying the home space in order to accommodate the needs of the patient helps better understand how the district nurse would be working with not just the patient, but also their family. As previously mentioned, for this relationship to work interviewees advised that they would need to recognise their place as a guest in the home of the patient, and one that was distinct from closer family members. This is implicit in Cathy's testimony, where she highlighted the navigation required, not just of her approach to care, but of the home's spatial structures which for this family saw the restriction of household space in an already 'small house'.[50]

The need for flexibility and responsiveness within the domestic setting was reflected in how interviewees discussed the diverse social backgrounds of their

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[49] Cathy Earles, Interview, 14th March 2022.
[50] Cathy Earles, Interview, 14th March 2022.

patients too. Karen Walker, for example, explained how she treated patients of 'all kinds of backgrounds', describing those living in Mossley Hill and Woolton as being extremely wealthy.[51] Karen explained how '[s]ome of those patients were extremely wealthy, lived in big houses, had lots of ability to be supported, and so, you had to deal with whatever their surroundings were, whatever their setup was.' Though these were wealthy patients, with more expansive environments, Karen still emphasised the need to 'deal with whatever their surroundings were'.[52] This indicates the adaptive navigation required for homecare, regardless of economic circumstances. However, Karen did go on to explain some of the challenges that she faced navigating the diverse social and domestic conditions of her patients, all of whom she could see in one day. When discussing visiting a patient from an 'affluent background,' Karen shared how they could have 'lots of family support, and the best of everything'.[53] According to Karen, the patient, or their family, could have purchased their own equipment with 'everything there for you to handle…things that the NHS couldn't supply, they would get hold of'.[54] It was not only equipment. Karen noted the she would be 'fortunate enough' to work in a larger domestic rooms, such as a 'big bedroom, and all kinds of beds that did all kinds of things to help what you did for them'.[55] Karen explained how 'you, obviously were able to deliver the care in a completely different way'.[56] Here, Karen is providing an example of how the

[51] Karen Walker, Interview, 14th March 2022.
[52] Karen Walker, Interview, 14th March 2022.
[53] Karen Walker, Interview, 14th March 2022.
[54] Karen Walker, Interview, 14th March 2022.
[55] Karen Walker, Interview, 14th March 2022.
[56] Karen Walker, Interview, 14th March 2022.

physical structure and amenities of the home could directly impact the provision of care a district nurse could provide.

In contrast, Karen discussed what would happen on a visit to a patient of 'a fairly average background'.[57] In this patient's house, 'a lot of the equipment they would have, would be what we had supplied', and Karen reported that she would be 'nursing in hospital beds, with hoists that had been provided to lift them and move them'.[58] Her account shows that district nursing could be shaped less by the layout of individual rooms than by the specialist medical equipment that could be installed and used within them. Beds, hoists, and other apparatus transformed domestic interiors into sites of medical practice, but they also required the nurse to adapt their work around placement and availability. Noting the spatial structures of these spaces, Karen described the patients as living in 'an average house where you might have to adapt the space, and you might have to adapt the room'.[59] Karen's reflection highlights how important such equipment was to the provision of care. It not only enabled nursing tasks but also dictated how care could be delivered within the home. In this way, the adaptation required of district nurses was not simply to the space of the room but to the integration of medical technologies into the domestic environment. Similar to Cathy, Karen would have to assess the space within the home and decide how this might affect her delivery of care.

[57] Karen Walker, Interview, 14th March 2022.
[58] Karen Walker, Interview, 14th March 2022.
[59] Karen Walker, Interview, 14th March 2022.

Like Cathy, Karen went on to indicate how important it was to build relationships with the patient's family, and how important this was to her delivery of care, stating:

> But again, you had to do that with the cooperation of the family, and everybody that was around them. So, you couldn't just go in and say, 'I want that there, or I need these here'. You'd have to do it in such a way where you'd have to say, 'Look, for the patient's safety, and for their comfort and their wellbeing, is there any way that we can move things around, to try and make that easier? Can we work with you? And they would.[60]

Within this excerpt, it is evident how far cooperation and collaboration were rooted in Karen's approach to district nursing. For Karen, then it was essential that you worked not just with the family, but 'everybody that was around them'.[61] The opportunity to complete this comprehensive, holistic care was intrinsically linked to working within the home environment, with Karen advising how she would only be able to ensure the comfort and wellbeing of her patients through relationship building with multiple actors within the home. Although Karen was the medically trained professional, being in the home space of the patient and their family required an acknowledgement of a unique set of power dynamics.

Not all the homes district nurses visited were domestic ideals. A patient's surroundings could challenge the type of care district nurses could provide. Karen illustrated to me how 'on the same day, with one list of patients, you would then go to somewhere where they had nothing to sit on, the house would be filthy.'[62] Karen

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[60] Karen Walker, Interview, 14th March 2022.
[61] Karen Walker, Interview, 14th March 2022.
[62] Karen Walker, Interview, 14th March 2022.

provided an example of one patient who suffered with leg ulcers, which took 'about 45 minutes to dress because you had to soak them – but you had to soak them from where she sat in this chair, 24 hours a day'.[63] Karen described how she would spend a great deal of time cleaning the patient, making her 'as clean and comfortable as you could'.[64] However, Karen would visit the next day and the patient would be exactly as she left 'in this filthy house'.[65] The patient's own perspective on this care is not recorded. She is not quoted or given a voice in Karen's retelling. What stands in her place is a description of her surroundings. The home, not the patient, is made visible and becomes the object of scrutiny and feeling. Describing the house in this way may have offered Karen a means of registering her discomfort without directly judging the patient who lived within it, the home absorbing a scrutiny that the patient herself was spared. Even so, what this testimony does tell us is the condition of the patient, and her home, on Karen's return. This indicates the patient was maintaining both her own care and her home in a way that was consistent to her. The patient may have been unable or unwilling to sustain the standard of care that Karen had established. The patient's ordering of her home persisted, which Karen had to continue to work within rather than overriding. Moreover, the use of the word 'filthy' by Karen to describe dirty homes is drastic and emotive, going some way to explain some of the conditions the patients might have lived in, with Karen advising how 'hard it was' to see them in that condition.[66]

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[63] Karen Walker, Interview, 14th March 2022.
[64] Karen Walker, Interview, 14th March 2022.
[65] Karen Walker, Interview, 14th March 2022.
[66] Karen Walker, Interview, 14th March 2022.

The word 'filthy' also positions district nursing work in relation to domestic disorder. Julia Twigg has noted that nursing is hierarchically structured so that 'as staff progress, they move away from the basic bodywork of bedpans and sponge baths towards high-tech, skilled interventions; progressing from dirty work on bodies to clean work on machines'.[67] This hierarchy is striking when placed alongside Karen's testimony. As an experienced district nurse, she occupied a senior position within community nursing, yet her daily practice in patients' homes still involved exactly the kinds of intimate, physical, and often messy tasks that hospital hierarchies relegated to the least senior staff.

In the home, the domestic environment drew her back into the fundamental bodywork of cleaning, washing, and dressing wounds, work which carried little prestige but was essential to her professional identity. This was echoed by Julie Swowden and discussed in the section on 'Autonomy and Responsibility' in the 'Professional Identity' chapter, who advised that 'giving somebody a bed bath is more complex than taking stitches out'.[68] Elaborating, Karen emphasised how:

> You had to go in and just look after them the best you could. And you couldn't make reference to the surroundings that you were in, and say they weren't suitable. You couldn't say, 'I'm not going to that house because it's too dirty'. You had to do it.[69]

It was clear throughout our interview that if there was a safeguarding or health-related issue related to the cleanliness of her patients that Karen would have

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[67] Julia Twigg, "Carework as a Form of Bodywork", *Ageing & Society* 20.4 (2000): 390.
[68] Julie Snowden, Interview, 21st January 2022.
[69] Karen Walker, Interview, 14th March 2022.

stepped in, and work with the patient and their family to find a solution. In this instance however, Karen is making clear how the patient's domestic environment was something did not have any power over neither did her role permit her to intervene even if she was focussed on holistic care. Consequently, she, like many other district nurses in this period, had to work around the dirt and the filth. Indeed, Karen explained how in these instances, she had to acknowledge that 'it was their home', with the patient 'often looked after by family' who 'all lived in the same way and treated things the same way.'[70]

Karen's account of working around conditions she could not change, alongside family who provided the day-to-day care, reflects a wider change in district nursing that Shaun Speed and Karen Luker have documented. They argue that the reorganisation of primary care over the closing decades of the twentieth century pulled the district nurse away from 'personal and aesthetic knowing' of the patient, which they argue is the understanding of a patient's whole circumstances that came only through sustained, direct contact.[71] Here is another example of how important it was for the district nurse to observe and work within the structures of the home, and how the patients and their family might have already been utilising the space.

[70] Karen Walker, Interview, 14th March 2022.
[71] Shaun Speed and Karen A. Luker "Getting a Visit: How District Nurses and General Practitioners 'Organise' Each Other in Primary Care." *Sociology of Health & Illness* 28.7 (2006): 927.

The Patient's Family

District nurses acknowledged that family members were a part of the caring process in the patient's homes. Hence, they had to respect these caring dynamics. As Dorris Smeethe explained, you would have to ask the patient whether you could perform tasks and duties sometimes, as well as gain permission 'from the family as well'.[72] For Dorris, this 'had to be a holistic thing'.[73] By this, Dorris is emphasising the collaborative nature of delivering care within the home, ensuring acknowledgement of the social and familial dynamics already in place. Julie Snowden was able to articulate this in greater detail, explaining to me how at times she would 'get into all sorts of trouble' because she 'used to spend loads of time talking to families.'[74] When I asked Julie if this meant building relationships, she replied 'Yes. Yes, but that was because unless I knew what the buttons were that were going to be pressed that could cause pressure in the family, I couldn't prevent it, I couldn't mitigate it. I couldn't mitigate that risk'.[75]

For Julie, an innate part of her district nursing role extended to understanding the external familial relationships between the patient's family and holistically assessing how this might affect her delivery of care. The discussion of the family members with professional terms such as 'mitigate' highlight how integral this was to her professional identity. Providing an example, Julie said '[s]o, it was really important to know that, for Joe, who looks after Molly, the ability to get out to his

[72] Dorris Smeethe, Interview, 22nd February 2022.
[73] Dorris Smeethe, Interview, 22nd February 2022.
[74] Julie Snowden, Interview, 21st January 2022.
[75] Julie Snowden, Interview, 21st January 2022.

football match on a Saturday at Anfield was really important. So, we had to make sure there was somebody around to look after all'.[76] Through this example, Julie demonstrated how professional care extended beyond the patient to include an assessment of family caregivers, whose ongoing involvement formed a critical part of the care environment she was required to navigate.

District nurses were also expected to understand and accommodate complicated familial relationships. Another example provided by Julie was that "[y]ou had to know that John doesn't talk to Fred because of, well, whatever and therefore don't try and talk to them together'.[77] In this example, Julie makes clear that the nature of the disagreement between family members was not important. However, what was important was the impact this might have on the care she could offer the patient. Julie explained that 'you've got to know these things to manage family dynamics'.[78] In order to understand these familial relationships, Julie had to collaborate with her patients, and their families, in a way which encouraged trust and rapport. This was intrinsically tied to operating within the domestic sphere.

The collaboration between the district nurse and the patient and their family was based on the trust and rapport the district nurse was able to gain. When I asked Karen how important it was that the district nursing recognised the position of being in the patient's home, she replied that it was 'crucial'.[79] Similar to other interviewees' representation, Karen advised that 'you always had to see yourself as a visitor to

[76] Julie Snowden, Interview, 21st January 2022.
[77] Julie Snowden, Interview, 21st January 2022.
[78] Julie Snowden, Interview, 21st January 2022.
[79] Karen Walker, Interview, 14th March 2022.

that person's home. You were the visitor'.[80] The word 'visitor', rather than guest, suggests a more formal relationship, emphasising the importance of respecting professional boundaries in order to gain trust within the home. Karen expanded on this point, describing how

> You were there to conduct that care because if you didn't build that relationship with that patient, and that family, the chances were that you wouldn't get to know everything about that patient, or they may even develop, I suppose, a barrier towards you.[81]

For Karen then, acknowledging her status as a visitor allowed her to build relationships with their patients, providing the opportunity to gather the necessary information about the patient. Karen also pointed out how this would prevent barriers developing between the district nurse and the patient.[82] Although Karen said that she did not think she was ever in a situation 'where somebody refused to let me care for a person,' she did go on to say that 'there were times when people didn't want to let you in'.[83]

Karen usefully elucidated the difficulties that district nurses could face in establishing a relationship when working with the patient, and their families, within a domestic setting. Karen explained to me how at times she would 'struggle to get access to a house', describing how she 'have to keep going back, you'd have to keep trying to contact them, to make sure that you did get in to see people'.[84]The

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[80] Karen Walker, Interview, 14th March 2022.
[81] Karen Walker, Interview, 14th March 2022.
[82] Karen Walker, Interview, 14th March 2022.
[83] Karen Walker, Interview, 14th March 2022.
[84] Karen Walker, Interview, 14th March 2022.

struggle to gain access to the patient's home, as described by Karen, corresponds with what Twigg has described as the crossing of boundaries involved in domiciliary care.[85] According to Twigg, the entry into the home by a care worker represents not just a crossing between the public and private, but also an 'intrusion into the private world of values, rationalities and temporal structures that belong to formal care provision'.[86] The difficulties faced by Karen in gaining entry into her patient's home should therefore be understood not only as a resistance to this public-private boundary crossing, but also as a reaction to the authority she embodied as a professional caregiver.

For some patients and their families, authority figures, whether medical professionals, social workers, or other state representatives, had played complex and sometimes negative roles in their lives. The district nurse's status as a caregiver could not override the authoritative standing she carried into the home. Holistic caregiving might have been perceived not simply as the offer of medical treatment but as the opening up of the household to judgement, surveillance, or external interference, dynamics observed by Sue Peckover and Megan Aston in their work examining other community health roles.[87] Reiterating how district nurses spoke of acknowledging their guest/visitor status, Twigg has explained how 'they [care workers] accept that they are in some measure bound by the norms of being a guest,' with some patients being 'very guarded about their space'.[88] District nurses

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[85] Julia Twigg, *Bathing – The Body and Community Care* (London: Routledge, 2000), 77.
[86] Twigg, *Bathing – The Body and Community Care*, 77.
[87] Sue Peckover and Megan Aston, "Examining the Social Construction of Surveillance: A Critical Issue for Health Visitors and Public Health Nurses Working with Mothers and Children," *Journal of Clinical Nursing* 27, no. 1–2 (2018): 379–389.
[88] Twigg, *Bathing – The Body and Community Care*, 79.

therefore had to negotiate access carefully, often drawing on the wider multidisciplinary team to build trust and alleviate anxieties.

When I asked Karen how she would navigate this guarding of space on behalf of the patient and their families, she explained that:

> You would have to work with the GP, work with other members of the team, and you'd have to try and find out what the concerns of the family were, or the patient were, why they didn't want you to come in, what their experience had been, to try and overcome that, and get yourself into that household.

This indicated another layer of holistic care provided by the district nurse in order to fulfil their duties within the homes of the patient. It required an awareness of the difficulties that one might face dealing with a patient and their family within the home. Moreover, it highlights the importance of working as part of the multi-disciplinary team, discussed in the previous chapter. Karen's testimony conveys an innate dedication and commitment to working *with* the patient and their family in order to alleviate any concerns regarding entry into the home.

For Twigg, the privacy and protection afforded to the home depends on the capacity to exclude, reinforcing the privileged status of being a guest/visitor.[89] Elaborating further, Twigg argued that by restricting access to certain people at certain times, the home provides the ability to maintain a 'socially appropriate front stage,' concealing ways that life may fall short of the domestic ideal.[90] In the example provided by Cathy earlier, it is clear that the domestic ideal was disrupted

[89] Twigg, *Bathing – The Body and Community Care*, 79.
[90] Twigg, *Bathing – The Body and Community Care*, 78.

by the creation of an institutional, ward-like environment with a hospital bed and rota. This can represent the public face of care. Cathy had to navigate, in a literal sense, through this and work through the disturbance it caused to the patient, the family and the domestic environment. This can therefore explain why some patients were reluctant not just to build relationships with district nurses, but to allow them entry in the first instance.

Consequently, some district nurses articulated their creation of relational strategies to gain access. Karen went on to explain that she 'always felt that what made it work was when you didn't overstep the mark, that you always remembered that you were being invited into this house, even if it wasn't for the very best reasons, and you became very familiar with some families.'[91] Karen was explicit in acknowledging the importance of relationship building in working through difficulties with patients and their families. For Karen, not overstepping the mark, and remembering the guest/visitor status afforded by being invited into the home, was an intrinsic component to her district nursing care. When discussing the positives this could bring for the district nurse-patient relationship, Karen said:

> I mean, there was always tea and cake and Christmas cards, and Christmas gifts, and all of that. They got to know you, and that was what you were always, and you had to maintain that position of, I'm still a visitor here, and I cannot and should not ever overstep the mark. And it's a feeling that in this family, I'm just here to care for this person and that person's interests.[92]

[91] Karen Walker, Interview, 14th March 2022.
[92] Karen Walker, Interview, 14th March 2022.

This testimony illustrates how everyday tokens of hospitality were welcomed as signs of trust, but for Karen they also reinforced the delicate balance between relational closeness and the professional authority she sought to uphold as a visitor in the home.

Within our interview, Karen presented her navigation of the home space in a way which emphasised an innate understanding, and commitment, to the professionality rooted in her guest/visitor status. For Karen, working within the home meant that 'you were part of their life, and particularly those with chronic illness, you were part of their whole day to day managing and living'.[93] This representation of the district nurse becoming part of their patient's 'whole day' goes some way to describe the commitment that the interviewees had to working with their patients, appreciating the opportunity to treat within the home. However, Karen underscored this emotive portrayal of connecting with her patients, and being part of their *whole* life, with a degree of professionalism, explaining how 'you had to be, you had to be, but alongside this, still being the professional, and still maintaining that level of trust and distance between you and that family.'[94]

Gift Giving

When interviewees were able to successfully acknowledge and navigate the interconnected provision of care that was required within the home, they spoke fondly of the relationships that they were able to build with patients and their

[93] Karen Walker, Interview, 14th March 2022.
[94] Karen Walker, Interview, 14th March 2022.

families. A closeness no doubt linked to the trust and rapport building performed by the district nurse. As indicated by Karen above, district nurses could be offered tea and cake, even Christmas cards and gifts.[95] The nature of gift giving between patient and nurse was generally frowned upon, however. Janice Morse has argued this dated back to Florence Nightingale, who listed 'not accepting the most trifling fee or bribe from patients or friends' as one of the virtues an 'honest' nurse must have.[96]

Nevertheless, the district nurses I interviewed spoke about receiving gifts from their patients, which indicated the privileged position they held due to the relationships they formed in the home. Mabel Williams illustrated to me the types of gifts she might receive, which she was allowed to keep 'at that time'.[97] According to Mabel, 'chocolates and biscuits and things like that you get all the time' with these items generally shared with other district nurses working within the same community.[98] However Mabel did recall how she was given an object that she described as more 'personal', stating:

> I don't think, I never recall being given anything personal. In fact, the only thing I was ever given, and I'd asked if I could keep it was a fob watch, which was a lovely thing to be given. I was allowed to keep it. There was no problem. I don't know how it would be now, these days, but I was allowed to keep it.[99]

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[95] Karen Walker, Interview, 14th March 2022.
[96] Janice Morse, 'The Structure and Function of Gift Giving in the Patient-Nurse Relationship,' *Western Journal of Nursing Research* 13.5, (1991), 597.
[97] Mabel Williams, Interview, 14th March 2022.
[98] Mabel Williams, Interview, 8th March 2022.
[99] Mabel Williams, Interview, 8th March 2022.

The emphasis on Mabel being allowed to keep this gift indicates the complex nature of gift giving within the nursing profession, where presents from patients often required approval. However, while Mabel perceived the gift as a token of individual gratitude, the object itself carried an unmistakably professional symbolism. The fob watch was not an intimate keepsake but a core marker of the nursing role, a tool worn on the uniform and widely recognised as a symbol of clinical discipline, time-keeping, and professional identity.

Similarly, it is also evidence of the type of connection that Mabel was able to form with one of her patients. The gifting of something as personal as a fob watch indicates just how integrated the district nurse could become into the lives of their patients. It also signifies the gratitude that patients would feel towards the district nurse. Sophie Chevalier outlined how a gift is located within a social relationship, charged by the dynamic exchanges among individuals. [100] On this occasion, the fob watch was used to convey a sense gratitude through the district nurse-patient exchange. The fact that this gift was a fob watch is all the more striking. Described by Stephen Riddell as once a 'symbol of all that was good about nursing,' the fob watch emphasises just how grateful Mabel's patient was.[101] Here the gift simultaneously affirmed the nurse's personal qualities and her professional authority while highlighting how gestures of intimacy were mediated through objects that carried wider occupational meaning.

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[100] Sophie Chevalier, "The Cultural Construction of Domestic Space in France and Great Britain," *Signs* 27.3 (Spring 2002), 852.
[101] Stephen Riddel, "If the cap fits: does nursing need to rebrand its image?" *Nursing Times,* 11th May 2012, 13.

Similarly, Ethel Love explained to me how, on occasion, she could 'go home with a bottle of sherry,' which fit 'just nicely' in her Gladstone bag.[102] This followed a discussion concerning the patients that Ethel would visit, whom she described as 'lovely' and who respected the nurses, meaning she would feel at ease whilst in their home. Whilst the practice of gift-giving was not the sole identifier of a relationship between the district nurse and their patient and family within the home, it underscores the importance of adopting an approach to holistic care that allowed connections to form. Understanding these gift exchanges as tokens of appreciation reflects the deep connections that nurses formed with their patients and families, highlighting the unique and privileged position they held in within the home.

Interviewees were able to convey the integral nature of building relationships with patients and their families within the home outside of gift giving too. By explaining how they were able to form relationships with patients and their families, district nurses emphasised the degree that their work extended beyond medical treatment of their patients. The connections that were formed did not just enable the district nurses to conduct a holistic assessment of the patient's needs, it also impacted the recollection of their profession. Dorris Smeethe, for example, recalled how when she would use gifts from family members in the bath on her patients' she felt she became 'involved' with the family, which she said was 'nice'.[103]

Building on this relationship with her patients and her family, she explained how at times she would attend funerals, which of course was difficult, however she felt she

[102] Ethel Love, Interview, 8th November 2021.
[103] Dorris Smeethe, Interview, 22nd February 2022.

had to be there 'for the family'.[104] The emotive recollection of attending the funerals of her patients is evidence as to how close the connection between the district nurse and the patient could be. In order for this connection to develop, Dorris advised that 'people have to feel that they're able to…communicate. Good communication. They've got to be able to be able to talk to you.'[105] Communication was a key tenet of Dorris's ability to perform her district nursing duties, and the professional identity she conveyed in our interview, which was enabled through the relationship building which occurred in the home.

What is clear from the interviewee testimony is how personal the provision of care needed to be in the home. The memories articulated by interviewees with regards to being a guest/visitor in the homes of their patients underscored the deeply personal nature of holistic care in their understanding of district nursing. Interviewees repeatedly emphasised that delivering care in the home required an acute awareness of their position as both a professional authority and a guest/visitor in the patient's home. The ability to build trust and rapport with both patients and their families emerged as a defining feature of providing holistic care, shaping how nurses adapted their approach to the unique social, cultural, and material conditions of each household. Care was not simply a clinical task but an act of negotiation between professional expertise and the domestic and emotional realities of the patient's home environment. The provision of this care was shaped by both social and spatial structures, as interviewees explained the adaptation that was required

[104] Dorris Smeethe, Interview, 22nd February 2022.
[105] Dorris Smeethe, Interview, 22nd February 2022.

from affluent homes with ample resources to households where the provision of care was shaped more by spatial constraints and material deprivation.

Crucially, interviewees articulated how their ability to form meaningful relationships with patients and their families was not a byproduct but integral to their professional identity. This relational aspect of care was demonstrated in the exchanges that took place within the home, through symbolic acts of gift-giving, which, despite being discouraged within the profession, emerged as gestures of appreciation and trust. The personal nature of district nursing was also reflected in moments of emotional connection, as some nurses described attending the funerals of former patients, an act that underscored the depth of their relationships and the emotional labour embedded in their work.

Building on this discussion of home as a site of care and relationship-building, the next section will consider how interviewees spoke about their own personal, domestic lives in relation to their professional roles. While district nurses worked within the private homes of their patients, they also spoke about managing their own households and familial responsibilities. By exploring how district nurses articulated the relationship between home, work, and gendered expectations, the following section will situate these personal narratives within the broader social and cultural constructions of women's work and family life in the mid-to-late twentieth century.

5.4 Communicating the Personal and Professional Home

This section examines how interviewees articulated their dual roles as caregivers within their professional practice and also their home, highlighting how their experiences intersected with broader cultural understandings of home, professional identity and gender. Important historiographical interventions into the study of the home have indicated the relationship between the home and the development of key social changes in mid-twentieth century Britain.[106] For Claire Langhammer, these interventions have shown how significant social, cultural and economic developments, such as changes in the nature of work, were largely informed by the nature and status of the British home.[107] Throughout the interview process, female district nurses who were wives, mothers, daughters and sisters drew on language and meanings of home to discuss both their professional practice and their domestic duties, highlighting how personal and professional experiences were narrated through shared cultural understandings of home.

For some, district nursing providing the opportunity to work more flexibly, resulting in a greater ability to care for children, spouses and family members. Their language revealed not only how they conceptualised the home as a site of care delivery for their patients, but also how district nursing assisted with the management of their domestic lives. By analysing these narratives, we can understand that the home was not simply a backdrop for personal life, but a

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[106] See Judy Giles, *Women, Identity and Private Life in Britain, 1900–50* (Basingstoke, 1995); Alison Light, *Forever England. Femininity, Literature and Conservatism between the Wars* (London, 1991); Wendy Webster, *Imagining Home: Gender, 'Race' and National Identity, 1945–64* (London, 1998).
[107] Claire Langhammer, 'The Meanings of Home in Postwar Britain', *Journal of Contemporary History,* 40.2 (2005), 342.

dynamic space that both reflected and influenced the personal and professional lives of district nurses interviewed. Their testimonies suggest that the concept of home influenced both professional identity and familial responsibilities, thereby shaping the recollections in complex way. To begin with, I examine how conversations with district nurses highlighted their ability to use discussions of home to reflect on their personal and professional life.

'I could work my home'

District nurses' testimonies repeatedly positioned the home as both metaphor and material space, shaping how they remembered their working lives. The home was where they practised professionally, but it was also the anchor against which they measured the compatibility of their careers with family obligations. Their recollections reveal professional identities negotiated at the intersection of domestic responsibility and occupational autonomy. It was Ethel Love who first introduced the concept of being able to 'work her home and nursing job'.[108] By this point I had only interviewed Cathy Earles and Alan Carlise, and I had to travel a considerable amount to conduct the interview. Ethel began her district nursing career in 1953, aged 29 and married with two children. Following the Second World War, the number of married women entering the workforce increased from 10.1% in 1940 to 22.2% ten years later in 1950.[109] Thus Ethel was part of a burgeoning married-woman

[108] Ethel Love, Interview, 8th November 2021.
[109] Office of Population Censuses and Surveys, *Census 1951: England and Wales. Occupations Tables* (London: HMSO, 1956); Arthur Marwick, *British Society since 1945* (London: Penguin, 2003), 89–92.

workforce. Ethel explained to me that she took a district nursing role because it was 'convenient' for her family life, as the hours 'were good' and she could get home at lunch time.[110] The domestic responsibilities that working women were expected to undertake around their careers is evident in this retelling, articulated by Ethel as being able to 'work my home as well as the nursing job'.[111] In this instance, home is embodied by Ethel as a metaphor for the labour she would undertake as a wife and mother.

This could represent the double burden placed on women discussed by Katherine Holden who has noted that, despite major cultural and economic shifts during the twentieth century, the nature and meaning of work for most women in Britain continued to be linked with their positions within household, family and kinship networks.[112] It is necessary to include this as, although Ethel explained how her district nursing role assisted with her domestic responsibilities, there still remained a sense of professional autonomy associated with her role. [113] Ethel's role provided her with the means to manage her home life, communicating that district nursing was conductive to fulfilling both professional and personal obligations, providing evidence of the duality involved. Dorris Smeethe also highlighted the pull of family accommodation, recalling how she initially sought work as a district nursing auxiliary so she could work 'half days to see to family things'.[114]

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[110] Ethel Love, Interview, 8th November 2021.
[111] Ethel Love, Interview, 8th November 2021.
[112] Katherine Holden, "Family, Caring and Unpaid Work" in *Women in Twentieth-Century Britain: Social, Cultural and Political Change,* ed. By Ina Zweiniger-Bargielowska (London: Routledge, 2014), 134.
[113] Ethel Love, Interview, 8th November 2021.
[114] Dorris Smeethe, Interview, 22nd February 2022.

Similarly, Julie Snowden reflected how 'the district was a good place to work in terms of flexibility, because it was a little bit more flexible than being on a ward'.[115] Expanding on this, Julie said

> For instance, when my son was born, I went back to work full time when he was six weeks old because, at that time, people couldn't afford to stay at home… So when my son was home, I went back to work and my colleagues were excellent because I was a zombie.[116]

Julie's experience reflects the limited maternity protections available to healthcare workers during this period. While the Employment Protection Act of 1975 had established the right to return to work after childbirth, paid maternity leave was extremely restricted, with many women receiving only a fraction of their normal income during their absence. Julie explicitly describes how 'people couldn't afford to stay at home', highlighting what were felt were inadequate maternity provisions within the National Health Service and broader employment legislation.[117] Julie's return to work just six weeks after childbirth highlights the significant gap between policy and the economic realities facing nursing professionals. Her colleagues' support underscores how informal workplace accommodations often had to compensate for the structural limitations in formal maternity protections, creating networks of mutual support among predominantly female district nursing teams.

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[115] Julie Snowden, Interview, 21st January 2022.
[116] Julie Snowden, Interview, 21st January 2022.
[117] Julie Snowden, Interview, 21st January 2022.

Yet this apparent flexibility was double-edged. While district nursing was remembered as affording scope for family accommodation, it also blurred temporal boundaries. Mabel Williams observed that the workload meant the role was 'never an 8:30am to 5:00pm day,' particularly when complex cases required follow-up with GPs late into the evening.[118] Julie Snowden also recalled periods when she would begin at 8:30 in the morning and not return until 8:30 at night, emphasising that 'district nursing is never closed.'[119] These recollections complicate the image of a profession compatible with domestic life. They show that the very ethos of holistic care that made the work meaningful also demanded extended hours. Flexibility often meant self-imposed flexibility, with nurses choosing to stretch the boundaries of their day in order to meet the perceived needs of their patients.

Furthermore, within this testimony, the flexibility within district nursing is not necessarily explicitly tied to domestic responsibilities but economic factors. Julie had an 'excellent' community of colleagues who could assist with her while returning to work so soon after giving birth, but there is not the same home management association that was implicit in Ethel's recollection because, by the time she trained to be a district nurse, her children were slightly older. However, Julie did go on to say that:

> When my son started school, it was good because I could work in a different way. I could work flexibly, which I was able to do. Plus, occasionally, if we weren't busy, I could go and pick him up from school and take him to his

[118] Mabel Williams, Interview, 8th March 2022.
[119] Julie Snowden, Interview, 21st January 2022.

> gran's to drop him off and stuff like that, staying there and going out and getting him.[120]

The management and organisation that Julie would have to undertake to manage both her childcare and work duties is evident in this excerpt. Moreover, inherent in Julie's testimony is what Laura Paterson and Eve Worth have described as 'organisational labour'.[121] Paterson and Worth adopted the term 'organisational labour' to discuss the strategies that women put in place to combine paid employment with motherhood and domesticity.[122] Paterson and Worth have highlighted how the onus was on women to make work, domesticity and caring fit into their lives, which was only possible by the organisational labour they undertook within the home and family.[123] Ethel Love's coining of the term 'working the home' succinctly encapsulates what Paterson and Worth present, highlighting a predominant understanding of women's work in this period.

For many interviewees, district nursing was remembered as distinct from hospital work precisely because of the flexibility it appeared to offer. The contrast is important. Whereas hospital nursing was structured by rigid shift patterns, district nursing allowed greater scope for autonomy. Yet that autonomy was gendered: it was justified and valued because it enabled women to meet domestic obligations.

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[120] Julie Snowden, Interview, 21st January 2022.
[121] Laura Paterson and Eve Worth, "How is she going to manage with the children? Organisational Labour, working and mothering in Britain, c. 1960-1990," *Past and Present* 246.15 (December 2020), 318.
[122] Paterson and Worth, "How is she going to manage with the children?", 318.
[123] Paterson and Worth, "How is she going to manage with the children?", 318.

This double positioning, as both professionals and household managers, complicates any simple separation between the personal and the professional. The home, in their recollections, was simultaneously a workplace, a site of domestic labour, and a metaphor for negotiating gendered expectations. The professional identity of district nurses was therefore inseparable from their domestic roles, and their narratives reflect the blurred boundaries between the two.

Crucially, these accounts should not only be read as practical descriptions but as narratives of composure. As Lynn Abrams argues, women's oral histories often frame memories through cultural scripts of respectability, particularly around motherhood and domesticity.[124] By emphasising their ability to 'work the home,' interviewees aligned their recollections with broader ideals of the competent, respectable working mother. The act of remembering itself was structured by these cultural expectations. Thus, interviewees were not only recounting strategies of balance; they were performing narratives that reconciled professional pride with feminine domesticity.

Taken together, these accounts complicate the division between personal and professional spheres. In communicating their ability to 'work the home' nurses articulated professional identities defined by the intertwining of domestic obligations and paid employment. The home was not simply the backdrop to their lives as district nurses, but a structuring force that shaped how they remembered, narrated, and valued their careers. These testimonies illuminate the gendered expectations

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[124] Lynn Abrams, *Oral History Theory* (London: Routledge, 2010), 77–82

embedded within district nursing and underscore the centrality of home as both material and symbolic space in their professional identities.

5.5 Conclusion

This chapter has examined the complex relationship between district nursing and the home environment through the lens of oral history testimony. The home emerged as a multifaceted space within interviewees' narratives, simultaneously a site of professional practice, a boundary to be negotiated, and a space that shaped the nature of care delivery in profound ways. District nurses operated at the intersection of public healthcare provision and private domestic space, creating a unique professional dynamic that distinguished their practice from hospital-based nursing. Through careful analysis of interviewees' testimonies, I have demonstrated how the home was not merely a backdrop to district nursing work but a constitutive element of professional identity and practice that evolved significantly throughout the period 1945–2000.

The home, as described by district nurses in this study, represented a site of professional autonomy where nurses exercised independent clinical judgment away from the direct supervision present in hospital settings. This autonomy was particularly valued by interviewees, who frequently contrasted their experiences in district nursing with previous hospital work. Yet this autonomy came with significant responsibility, as nurses navigated unfamiliar environments, adapted to varying domestic circumstances, and made critical decisions with limited immediate support. The testimony district nurses interviewed for this study highlighted how the privacy

of the home setting fostered intimate nurse-patient relationships that transcended purely clinical interactions. These relationships often developed over extended periods, with district nurses becoming integrated into the fabric of patients' domestic lives in ways that hospital nurses typically could not.

Interviewees consistently articulated how the home environment necessitated a distinct approach to nursing practice. Unlike the standardised hospital environment, where space was designed specifically for healthcare delivery, district nurses entered spaces primarily designed for domestic living. This required significant adaptability, as nurses transformed structures within the home into sites for intensive care. The narratives presented in this chapter reveal how district nurses developed specialised skills in improvisation and resource management to overcome the limitations of domestic spaces.

Adding another layer of complexity to the concept of home is my own experience as an interviewer entering the houses of the district nurses I interviewed. Two of my interviews were conducted in the houses of district nurses, Alan Carlise and Ethel Love, both who lived a considerable distance away from Liverpool. I argue that conducting the interview in Alan and Ethel's home had an impact on the interview and its subsequent testimony. In both Alan and Ethel's home I was offered hot drinks and snacks, as well as space for conversations both prior to and following the interview. For me, the act of being in the home of the interviewee afforded a greater sense of co-operation and collaboration, which affected how my intersubjective self was conveyed. The intersubjective nature of interviewing is outlined in more detail in the earlier chapter on methodology; however, it is useful

to reference now as it underlines the necessity of understanding the implications of home to this study.

Moreover, as Lynn Abrams has highlighted, oral history interviews are shaped by the space in which they are conducted, with the interviewer navigating the power structure within the interviewee's personal domain.[125] My entry into the houses of the interviewees replicated the district nurse's own negotiation of space and power they made whilst delivering care in a patient's home. However, whereas the interviewees were the experts entering the homes of the patients, I was an outsider, invited into the home to discuss their district nursing career. By this invitation, I was afforded a shared authority, coined by Michael Frisch to describe the negotiation and control throughout the construction of the interview narrative.[126] The interview as a process as well as the subsequent narrative was therefore shaped by the environment of the interviewee's home. Although I only entered the homes of two interviews, the four interviews conducted remotely meant both I and the district nurses were in our own homes. These remote interviews were a direct consequence of the COVID-19 pandemic and the social distancing measures implemented during 2020–22. This unprecedented situation created a unique methodological context wherein both the researcher and participants were simultaneously confined to and speaking from their domestic spaces. There is no doubt that this offered a sense of comfortability for the interview, with interviewees making references to certain artefacts in certain rooms which they associated with their district nursing careers.

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[125] Lynn Abrams, *Oral History Theory*, (Routledge, 2010) 166.
[126] Michael Frisch, A Shared Authority: Essays on the Craft and Meaning of Oral and Public History, (State University of New York Press, 1990).

The pandemic context may have also heightened interviewees' awareness of the relationship between home and healthcare work, as COVID-19 had dramatically blurred professional and domestic boundaries for many healthcare workers. Several interviewees drew explicit parallels between their experiences of navigating public health concerns during their careers and the contemporary pandemic situation. I argue that being at home made these references more explicit for the interviewees, even remotely. This chapter has therefore built on this assertation of home as a complex and dynamic environment, examining how the home interspersed interviewing and analysis.

Chapter 6: Conclusion

In September 2023, I delivered a keynote address at the *Nursing Times Careers Live* event in Manchester. Speaking to a multidisciplinary audience of nurses, I attempted to present a conclusive history of district nursing. From William Rathbone, Nurse Robinson, and its Victorian origins through to contemporary practice. The presentation traced the evolution of the philanthropic nursing initiatives of the 1860s, through the professional consolidation following state registration in 1919, to the current challenges facing community healthcare provision. During the Q and A session, a newly qualified nurse working in/on the community asked whether a separate qualification for home-nursing should exist alongside district nursing. This role would be separate but equal to the district nurse, working within the home without necessarily being tied down to the historical frameworks I had communicated in my address. This question highlighted the ongoing questions about the professional boundaries of district nursing, such as what the role encompasses, where its jurisdiction lies, and how the concept of nursing in the home relates to broader community practice. It became evident that the complex journey of the service, with overlapping charitable, municipal, and NHS jurisdictions, continue to influence contemporary discussions about training pathways and professional identity.

This thesis has explored the history of district nursing in Liverpool between 1945 and 2000 through the memories of retired nurses whose working lives were rooted in the everyday practices of care. By adopting an oral history approach, it has sought to recover experiences often absent from the official record and to

understand how nurses themselves recalled their professional and personal identities. The central aim has been to illuminate the ways in which district nurses navigated the intersections of professional identity, community, and home, and in doing so to situate their work within broader social, cultural, and historical transformations. The focus on district nursing was established through the design of this doctoral project, which held the initial title of 'From Home Nurses to Specialist Practitioners: A Social, Political and Educational History of District Nursing in Liverpool'. While the project design fixed the geographical scope, the approach taken in this thesis has been to use oral history to broaden the historiography of nursing beyond its traditional emphasis on hospital-based training and the reforming legacy of Florence Nightingale. Within existing scholarship, the voices of district nurses have remained underexplored, despite their central role in the provision of community health. By foregrounding these voices, this thesis has revealed a provision of care that was both autonomous and embedded, shaped not only by medical knowledge but also by reciprocal relationships with patients, families, and neighbourhoods. It demonstrates that to understand district nursing in the second half of the twentieth century, attention must be paid to the community context in which it was delivered, and to the ways in which nurses organised their working lives around both the demands of their profession and the responsibilities of home.

In charting these experiences, the study has also aimed to contribute to wider debates in social and cultural history. It has shown how oral history can expand the historical record by accessing memory, subjectivity, and emotion, thereby providing insight into forms of labour and identity that are often difficult to capture through conventional sources. Moreover, it has highlighted the importance of Liverpool's

distinctive urban and social geography in shaping both health outcomes and nursing practice. By situating the testimonies of district nurses within these broader contexts, this thesis has offered a historical account that is at once local and national, personal and professional.

Key Findings and Arguments

Professional Identity

One of the central concerns of this thesis has been the professional identity of district nurses, and how it was shaped by the competing demands of autonomy, responsibility, and respectability. The oral testimonies reveal that district nursing was remembered as a profession marked by responsibility, adaptability, and professional judgement exercised in the relatively unstructured setting of the home. Interviewees recalled making decisions independently, often without immediate supervision. However, these decisions were rarely understood in opposition to wider structures of accountability. Instead, district nurses positioned themselves as trusted practitioners whose authority derived from their ability to act responsibly within both the professional frameworks of general practice and the expectations of the communities they served.

Professional identity was also closely tied to the ways in which district nurses understood and enacted authority. Interviewees emphasised the responsibility they carried for patient outcomes but also reflected on the collaborative nature of their work with general practitioners and other healthcare providers. While clinical decisions often required negotiation across professional boundaries, district nurses

described how their sustained presence in the home gave them a particular kind of expertise, one which was grounded in intimate knowledge of patients' circumstances and the ability to make practical judgements when they arose. This authority was not always formally acknowledged within professional hierarchies, yet it was integral to how the district nurses interviewed remembered their role.

Gender and professionalism further shaped the contours of this professional self-understanding. For many district nurses, authority rested not only on their medical skill but also on the projection of moral character. Oral testimonies recalled how uniform and conduct shaped public perceptions, and how being known within the community required district nurses to embody standards of respectability as well as clinical competence. This emphasis on character aligns with broader observations in the historiography of nursing, where the cultivation of respectability and discipline has been shown to underpin professional authority.

In addition, oral testimonies suggested that professional identity was negotiated through reciprocal relationships. District nurses were remembered as both carers and community figures, known personally by patients and often subject to informal scrutiny from neighbours and families. While professional boundaries were maintained, nurses allowed aspects of their personal lives to be visible, a strategy that fostered trust but also demanded careful navigation. This calibrated self-disclosure illustrates how professional identity in district nursing was constructed not in isolation but through embeddedness in the social fabric of everyday life.

Taken together, these recollections reveal that the professional identity of district nurses in Liverpool was not a fixed or uniform construct but a dynamic interplay of

autonomy and accountability, authority and respectability, expertise and community integration. By drawing attention to these negotiations, this thesis highlights how district nurses contributed to the shaping of professional practice in the community, while also illuminating broader questions about women's work, authority, and respectability in twentieth-century Britain.

Community

A second key theme running through this thesis has been the ways in which district nurses understood and worked with the concept of community. For interviewees, community was not simply an abstract notion but a lived reality that shaped both their daily practice and their professional identity. Testimonies emphasised the immediacy of place. Streets, estates, and neighbourhoods were remembered as integral to how care was delivered and experienced. District nursing was situated within Liverpool's distinctive urban geography, which encompassed areas of entrenched poverty alongside districts of relative affluence. Moving between these contrasting settings was recalled as a defining aspect of the role, requiring adaptability and reinforcing the sense that health outcomes were inseparable from social and material conditions.

The memories of district nurses underline that community was both a geographical and a relational space. Interviewees consistently described how their work extended beyond the individual patient to encompass families, neighbours, and the broader social networks that sustained or complicated care. This meant negotiating not only medical needs but also domestic circumstances, poverty, and

housing conditions. In some cases, district nurses recalled providing emotional support alongside clinical interventions, recognising that the two could not be neatly separated in the context of community healthcare. Such recollections highlight how district nursing blurred the boundaries between professional expertise and social embeddedness.

Relationships with patients and their families lay at the heart of this construction of community. District nurses were remembered as figures of continuity and trust, whose repeated presence in the home distinguished them from other healthcare professionals. Testimonies suggest that care was often reciprocal. While district nurses provided medical and emotional support, they were also drawn into patients' lives in ways that required careful navigation of personal and professional boundaries. Being known within the community meant that district nurses carried reputations that could enhance trust but also subjected them to informal scrutiny. This embeddedness reinforced the importance of moral authority and respectability as components of professional identity.

Community was also framed by the institutional and policy changes that reshaped health provision in the second half of the twentieth century. District nurses recalled the shifting responsibilities between local authorities and the NHS, as well as the challenges of coordinating with general practitioners, hospitals, and other community-based services. These structural transformations were experienced on the ground as part of everyday practice. District nurses had to adapt to new bureaucratic expectations while maintaining the personalised relationships that defined their work. In this sense, interviewees located their professional identity

within both the micro-scale of neighbourhood interactions and the macro-scale of health system reforms.

Taken together, the oral histories reveal that community was not a backdrop to district nursing but a central element of the profession itself. It was through their engagement with communities, both as places and as networks of people, that district nurses forged professional identities, negotiated authority, and enacted care. By situating community as a centre of district nursing practice, this thesis underscores how the profession cannot be understood in isolation from the social and geographical contexts in which it operated. In doing so, it contributes not only to the history of nursing but also to broader understandings of how community, health, and social change were interwoven in post-war Britain.

Home

The final theme developed in this thesis has been the significance of home, both as a site of care and as a framework that shaped the working lives of district nurses. Interviewees consistently described the home as the distinctive setting of their practice. Unlike hospital environments, which were marked by institutional hierarchies and standardised routines, the home required district nurses to adapt their skills to diverse circumstances. Testimonies recalled visits to houses that ranged from comfortable, well-equipped spaces to dwellings that lacked basic sanitation. This variation reinforced the sense that health and illness were inseparable from domestic environments. District nurses remembered themselves not only as clinicians but also as witnesses to the material conditions of everyday

life, which informed their understanding of patients' needs and the forms of care they could provide.

The home also shaped the rhythms of district nursing work. Interviewees emphasised how their professional responsibilities were intertwined with domestic commitments, particularly in relation to family life. The ability to fit paid employment around household responsibilities was remembered as a key factor in choosing district nursing as a career. Some recalled the convenience of working hours that allowed them to be present for children returning from school, while others valued the flexibility of part-time arrangements. Yet these memories were often accompanied by accounts of the workload extending beyond official hours, as patients' needs and unexpected demands disrupted the neat boundaries between professional and private time. The home, therefore, was remembered as both an enabler and a constraint, offering the possibility of balance but also exposing the pressures of dual responsibility.

Interviewees also reflected on the emotional dimensions of working within patients' homes. Entering domestic spaces involved negotiating boundaries between professional authority and personal intimacy. District nurses recalled the importance of respect for household norms, which shaped how they were received and how they conducted their work. Some described being welcomed as part of the family, while others remembered tensions arising when their authority as health professionals conflicted with the preferences of patients or relatives. These encounters underscored the need for sensitivity, tact, and the careful presentation of self. The authority of district nurses rested not only on clinical expertise but also on their ability to manage relationships within the intimate space of the home.

At the same time, district nurses' own homes featured in their recollections of professional life. Oral testimony highlighted how interviewees positioned themselves as both nurses and family members, balancing the competing claims of work and domestic labour. Memories of returning home between visits, or of structuring the day around school hours and household tasks, suggest that the boundary between professional and private life was permeable. This interplay shaped how district nurses remembered their identity, not as separate roles but as overlapping commitments. The capacity to harmonise work and family life was often presented as a defining feature of district nursing, yet it also revealed the extent to which women's professional opportunities remained conditioned by domestic responsibilities.

The theme of home, therefore, illuminates the dual character of district nursing as both a professional practice and a form of domestic negotiation. Homes were the settings in which care was delivered, but it also contained the spaces that framed the daily organisation of work and family life for the nurses themselves. By exploring these dynamics, this thesis has demonstrated that home cannot be understood as an external backdrop to community healthcare but as an integral element of professional identity. The interweaving of home, community, and professional responsibility offers a fuller understanding of district nursing in the second half of the twentieth century and highlights the distinctive character of a profession that was at once clinical, relational, and domestic.

Methodological Reflections

The methodological framework of this thesis has been central to its findings. By employing oral history interviews with retired district nurses, it has been possible to recover experiences and perspectives that are largely absent from the archival record. Oral history has allowed for a focus on memory and subjectivity, offering insights into how interviewees recalled and explained the significance of their work. This approach has not only generated new empirical material but has also shaped the interpretive strategies through which the history of district nursing has been written here.

The testimonies revealed the ways in which memory operates in relation to both personal experience and broader cultural scripts. Interviewees often framed their recollections in terms of respectability, domestic responsibility, and professional commitment, narratives that were shaped as much by contemporary understandings of womanhood as by the events themselves. This reflects what oral historians have described as composure, the process by which individuals construct coherent life stories that align with socially acceptable identities.[1] Recognising this process has been vital in interpreting the interviews, ensuring that memories are not taken as transparent records but understood as situated narratives that reveal how the district nurses interviewed wished to represent themselves and their profession.

[1] Penny Summerfield, Reconstructing Women's Wartime Lives: Discourse and Subjectivity in Oral Histories of the Second World War (Manchester: Manchester University Press, 1998), 17–21. See also Graham Dawson, Soldier Heroes: British Adventure, Empire and the Imagining of Masculinities (London: Routledge, 1994), and Lynn Abrams, Oral History Theory (London: Routledge, 2010).

Equally important has been the intersubjective character of the interviews. The conversations were not neutral transactions, but exchanges shaped by the relationship between interviewer and interviewee. Conducting interviews in the homes of district nurses heightened this dimension, as the setting itself carried resonances of domesticity, intimacy, and authority. Entering the personal spaces of interviewees echoed, in some respects, the district nurses' own professional practice of entering patients' homes. This parallel underscored the power dynamics at play, an important reminder to the researcher of the need for sensitivity and reflexivity in interpreting testimony. The interviews were thus co-productions, shaped by dialogue, environment, and the expectations of both parties.

Oral history also highlighted the limits of representativeness. The number of interviews conducted for this study was necessarily small, and those who agreed to participate were a self-selecting group. Their testimonies cannot be assumed to represent the full diversity of district nursing experiences in Liverpool between 1945 and 2000. Yet this does not diminish their historical value. Rather, the partiality of memory has been treated as an analytical resource, illuminating how district nurses chose to narrate their working lives and what themes they prioritised or silenced. Paying attention to absences and silences has been as important as attending to what was spoken, since both reveal the cultural and personal frameworks within which memories are constructed.

The methodological approach has also required a balance between oral testimony and archival context. Archival sources provided essential background on institutional structures, policy developments, and the administrative frameworks

within which district nurses operated.[2] However, they could not capture the affective dimensions of practice, the negotiations of identity, or the daily realities of entering patients' homes. Oral history therefore offered a necessary corrective and supplement, allowing the history of district nursing to be written from the perspective of those who performed the work. This aligns with the tradition of history from below, in which the voices of ordinary practitioners' challenge narratives dominated by institutional or elite perspectives.

Reflecting on the use of oral history in this thesis also underscores its potential to reshape the historiography of nursing more broadly. By centring the experiences of district nurses, this study demonstrates the value of listening to practitioners whose contributions has often been marginalised. Oral testimony reveals not only what district nurses did but how they made sense of their work, how they negotiated authority, and how they integrated professional and domestic responsibilities. These insights are critical to understanding nursing as a lived practice, not merely as a professional structure or institutional development.

In summary, the methodological reflections of this thesis highlight the interpretive richness of oral history, while also acknowledging its challenges. Memory is selective, composure shapes narratives, and intersubjectivity complicates the boundary between researcher and participant. Yet precisely because of these qualities, oral history provides access to the ways in which district nurses understood their work and identities. By embedding these testimonies within broader social and

[2] Wellcome Collection, *Queen's Nursing Institute Archives (SA/QNI)*, London; Royal College of Nursing Archives, London; The National Archives, Kew.

historical contexts, this thesis has demonstrated how oral history can both expand and deepen the study of nursing history.

Contribution to Knowledge

This thesis makes several contributions to the historiography of nursing, to the history of women's work, and to broader understandings of community, home, and healthcare in post-war Britain. Its primary contribution has been to bring the voices of district nurses to the centre of historical analysis. While the history of nursing has often privileged institutional narratives, particularly the legacy of Florence Nightingale and the professionalisation of hospital nursing, the testimonies of district nurses reveal a parallel history grounded in community-based practice. By examining their experiences between 1945 and 2000, this study has highlighted a profession that was at once autonomous, relational, and embedded within the everyday lives of families and communities.

In doing so, the thesis broadens the focus of nursing historiography beyond hospitals and training schools to encompass the less visible but equally vital spaces of homes, neighbourhoods, and local health systems. It demonstrates that district nurses were not marginal figures but central actors in the delivery of healthcare, responsible for clinical decision-making, emotional labour, and the negotiation of authority within patients' homes. Rather than positioning district nursing as secondary to hospital-based practice, this study demonstrates that it represented a parallel strand of professional identity, one defined by autonomy, community relationships, and the intimate settings of patients' homes.

The research also contributes to the history of women's work by revealing how district nurses managed the intersections of employment, domestic responsibility, and community service. Testimonies underscore the strategies women used to reconcile professional roles with family commitments, showing how district nursing was often chosen for its compatibility with home life while simultaneously demanding significant personal sacrifice. This duality highlights the extent to which women's labour in the caring professions was shaped by cultural expectations of respectability, motherhood, and service. While the profession remained overwhelmingly female, the inclusion of a small number of men, such as Alan, offers a reminder that these gendered expectations were not universally shared. His account suggests that male district nurses navigated a different, but still gendered, set of assumptions about authority, professionalism and care that were often defined in relation to, rather than within, the norms of feminine respectability that shaped their female colleagues' experiences. By situating these findings within the broader history of women's employment, the thesis contributes to debates about the gendered character of professional work and the ways in which women, and in some cases men, exercised agency within the constraints of domestic and cultural norms.

At the same time, the thesis adds to social and cultural histories of twentieth-century Britain by situating healthcare within the lived realities of Liverpool's urban communities. District nurses' testimonies illuminate the social determinants of health, from poor housing and sanitation to the effects of slum clearance and rehousing schemes. In doing so, they offer a perspective on public health that foregrounds the voices of practitioners embedded in these communities, rather than the perspectives of policymakers or administrators. This local focus contributes to a

richer understanding of how national health policies were experienced at the level of the neighbourhood and the household.

Methodologically, the thesis demonstrates the value of oral history for expanding the historical record and accessing dimensions of practice that are otherwise difficult to capture. By foregrounding memory, subjectivity, and intersubjectivity, it shows how oral history can provide not only empirical detail but also insight into how practitioners represented and interpreted their own lives. This contributes to ongoing debates about the role of oral history in the study of professions and in histories of healthcare. Taken together, these contributions position the thesis as a corrective to dominant narratives in nursing history, a case study in the gendered character of professional work, and an exploration of the relationship between healthcare and community in twentieth-century Britain. By situating the testimonies of district nurses at the centre of analysis, it has revealed a profession that cannot be understood solely through institutional or professional frameworks but must be seen in relation to home, community, and the lived experiences of those who practised it.

Limitations

The scope and methods of this study inevitably imposed certain limitations, which must be acknowledged in reflecting on its findings. The most obvious is the small scale of the oral history collection. Seven interviews cannot capture the full diversity of experiences among district nurses in Liverpool between 1945 and 2000. The interviewees represent a self-selecting group who were willing to share their

memories, and their perspectives may not reflect those of colleagues who did not participate. While this restricts the breadth of the study, it also underscores the depth of insight that oral history can provide, allowing detailed exploration of the lives and identities of those who were interviewed.

The retrospective nature of oral history also raises challenges. Memories were shaped by the passage of time and by the cultural scripts available to interviewees, particularly around themes of respectability, motherhood, and professionalism. Testimonies should not be read as transparent accounts of past events but as narratives constructed in the present. This partiality, however, is not a weakness so much as a feature of oral history that can itself be analysed. Attending to silences, omissions, and moments of composure has been as revealing as what was explicitly remembered.

One further limitation concerns the absence of participants from Black, Asian, or minority ethnic backgrounds. All interviewees in this study identified as White-British, which inevitably narrows the perspectives represented. This gap reflects the limitations of the recruitment networks accessed during the project, and it restricts the extent to which the findings can capture the experiences of a more diverse workforce. Given Liverpool's longstanding connections to migration and multicultural communities, the absence of these voices is significant and highlights an important direction for future research.

Finally, the focus on Liverpool provided a rich and distinctive case study but inevitably limits the scope of the conclusions that can be drawn. The city's social and economic context, marked by extremes of poverty and affluence, as well as its

history of urban transformation, shaped the practice of district nursing in ways that may not be directly comparable to other parts of Britain. This does not diminish the value of the study but points to the need for further comparative research in order to situate these findings within a broader national context.

Future Research

The findings of this thesis suggest several avenues for further research. The absence of participants from Black, Asian, or minority ethnic backgrounds highlights the need for studies that explore the experiences of district nurses from more diverse communities. Liverpool's long history as a port city with strong ties to migration makes this an especially important area for future enquiry. Oral histories with BIPOC practitioners would provide a richer understanding of how race and ethnicity shaped experiences of community healthcare and professional identity in the post-war period.

There is also scope for comparative work across different geographical contexts. While Liverpool offers a distinctive case study, district nursing in other British cities and rural areas may have followed different trajectories, shaped by local demographics, health needs, and institutional structures. Comparative studies would allow for a more nuanced understanding of both regional variation and shared national patterns in community healthcare. Further research might also extend beyond district nursing to examine the histories of other community health professions, such as health visitors, midwives, and practice nurses. Oral history approaches could reveal both commonalities and differences in how these

practitioners understood their roles, negotiated professional authority, and interacted with families and communities.

Finally, there is potential for connecting historical research on district nursing to contemporary debates about community health and the future of the NHS. The challenges of integrating professional expertise, community relationships, and home-based care remain pressing today, and historical perspectives can provide valuable insight into the continuities and changes that shape current practice.

Final Synthesis

This thesis has examined the history of district nursing in Liverpool between 1945 and 2000, focusing on the intersecting themes of professional identity, community, and home. Through the oral testimonies of retired district nurses, it has shown how these practitioners remembered their work as both clinical and relational, grounded in professional responsibility yet inseparable from the social and domestic contexts in which care was delivered.

The study has argued that district nursing cannot be understood solely through the lens of institutional histories of the NHS or professional reform. Instead, it must be seen as a practice embedded in homes and communities, shaped by local geographies and by the personal circumstances of those who carried it out. By foregrounding oral history, the thesis has captured how district nurses themselves recalled the significance of their work, offering perspectives that extend beyond what can be recovered from policy documents or administrative records. In doing so, the thesis has highlighted the value of listening to the voices of practitioners whose

contributions have often been overlooked. The memories of district nurses not only enrich our understanding of community healthcare but also speak to broader questions about women's work, professional authority, and the relationship between health and society in post-war Britain.

The oral histories presented here demonstrate that district nursing was not a marginal or secondary form of practice, but a profession defined by its integration of clinical expertise, community relationships, and domestic negotiation. In centring the testimonies of district nurses, this thesis highlights how professional identity, community, and home were interwoven in shaping both healthcare and women's work in post-war Britain.

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