

## Chapter 1

# The Emergence of the 21st Century Children's Nurse

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### **Introduction**

You will be reading this book because you are interested in current issues in children's nursing. Perhaps you wish to keep up to date with issues in nursing practice or perhaps you are learning how to be a children's nurse. In any case, your key orientation is likely to be your practice in a range of health care settings with children and young people (CYP), their families and others who are important to them. Why start this book with an account of the history of children's nursing? Answering this question is based on an appreciation that children's nursing is more than a job, it is a profession. As professional people, nurses have a sense of responsibility for their discipline because in a real sense it belongs to them. This includes how the discipline is developing, progressing and moving forward. Nurses increasingly direct their practice, for example, through analysis and application of the best available evidence and by developing and changing practice to maximise the quality of care which they and others deliver.

### **What is children's nursing?**

Following on from this, children's nursing is a professional activity which is focused on the delivery of care to CYP with a range of health care needs. It embraces the inclusion and involvement of families and significant others in that care, according to the needs and wishes of the CYP concerned. Childhood spans the most important period in our lives, incorporating birth and those babies born prematurely, infancy, being a toddler and then a young child, older children, early adolescence and the transition of young people into adulthood.

Children's nurses provide health care to CYP at home, at school, in primary care settings and in hospitals. Their practice is based on wide ranging skills and knowledge such as managing psychological as well as physical trauma, spirituality and care of the dying, and the science of maintaining body systems to sustain life. Children's nurses also work with adults in family units and other carer

settings and of course in collaboration with other disciplines. The role of a children's nurse, as it lies in juxtaposition between parent/carer and child, is one that is ancient in its history, professional in its continuous search for better care, and privileged beyond measure.

## **Why history?**

Children's nursing today encompasses a modern, caring discipline which embraces technical and scientific knowledge. It is also a discipline which has a long and interesting history, practiced over the centuries by women and men, by the rich and the poor and by the educated and uneducated (Evans 2004, Wyman 1984). It is important to have some appreciation of this colourful history because children's nurses can learn much that is useful today from the knowledge of good and poor practices recorded in history. In order to improve or develop children's nursing, for example, understanding from where it has come is as important as what is happening currently. It places today's practice into perspective and can even help to determine ways in which current practice can be improved. It can help you develop a plan for how you wish to develop children's nursing in your own lifetime. Perhaps, at no other time in modern history have we needed knowledge of the history of nursing as much as we do today. This chapter will aim to put the rest of the book into perspective for you.

## **Child health care before 1852**

The nursing care of children has taken place in every age and in every society (Cunningham 1995). For as long as there have been children there have been those who have been ill and who have been injured. It would be incorrect to assume that the care of children is necessarily better today than it was in the past. Instead, you might question notions of an increasing degree of human civilisation, of children having a harder time than today, and of historical cruelty (Jolley 2006b). Some authors have argued that the care of children has consistently improved as civilisation has developed (e.g. Aries 1962, DeMause 1974); however, it is important to consider the evidence carefully before accepting this argument (Jolley 2006b). On the other hand, the presence of war and famine in our own time offer testament to the way in which children are not always seen as a priority. Overall though, there is overwhelming evidence from history that parents and others tried hard to keep their children in good health (Hardyment 1995).

Little is known of nursing that must have taken place before Britain's medieval period. Nurses and those who cared for sick children rarely kept records of the activities and most of the documentation if any were lost. Some records remain from the great centres of civilisation in Greece (*ca.* 400 years BC), the Egyptian civilisation from the time of the Pharaohs and from the ancient

Arabian and Chinese literature (till 1931). It may be surmised however, that much of the great wisdom of the past is lost to us. We do know that the ancient Greek and Arabic texts (written by people such as Hippocrates and Rhazes) were still being used in the 16th century (till 1931, Ellis 2001). Some of the contemporary medical texts in this period still remain today, thanks to the fact that printing had become available. Nevertheless it should not be assumed that these early authors were 'doctors' and that they therefore belong to the history of medicine. Thomas Phaer's text of 1545 is as much about nursing as it is about medicine (Bowers 1999, Jolley 2006a). Perhaps, it is only from the 18th and 19th centuries that medicine and nursing begin to be considered separate disciplines as we know them today.

## Monastic and religious nursing orders

Many of us are familiar with the ruined monasteries and abbeys in the British towns and countryside. From the 4th and 5th centuries until the dissolution of the monasteries by Henry VIII, some of these large institutions provided a degree of nursing for the traveller and for those in the local community (Evans 2004). Baly (1995) pointed out that some of the religious orders such as those of St. Benedict and St. Augustine tended to provide a service to the community, while others such as the Carthusians and Cistercians were more enclosed. A number of these orders provided a service to specific groups of people, for example, the St. Antonines provided care to the mentally ill (Mackintosh 1997). However, there is little evidence of the provision of children's nursing by the monasteries and it is therefore likely that most of the care they provided was to adult travellers and to pilgrims.

There were also military orders which came about at the time of the Crusades. One of these orders, the Knights of St. John of Jerusalem provided hospital care. The ruins of their hospitals can still be found today in Malta and in Rhodes (Baly 1995). Again, however, most of their patients would have been travellers and there is very little indication that they provided care to sick children. The Knights of St. John of Jerusalem live on in the UK today as the St. John's Ambulance Brigade and members wear the badge of the order (a Maltese Cross) on their uniform.

So it can be surmised that the monastic movement did not make a sizable contribution to the history of children's nursing. There existed no institutionalised discipline that focused its work on the needs of sick children. Of course, one should not conclude from this that children did not receive nursing and medical treatment. Instead, that medical and nursing knowledge which existed at the time is likely to have been common knowledge and delivered by the child's family. What advice that was available would probably have been acquired from local people, those with experience of the particular disorder and, where such contacts existed, from those who were better educated. In this way, nursing knowledge was much more a part of the *common understanding* than is the case today.

Families consequently provided the main care and treatment for sick children. They would have *known* how to do this and would not necessarily have been dependent on people with greater knowledge. Today, families still provide much of the health care required by their CYP but they have a range of expert care providers available such as those found in today's hospitals. This notion of *expert* is quite modern. Experts can, of course, be very useful but their introduction into society has removed a significant part of the traditional role of the family particularly in health care and education.

It is also interesting that it was largely men who worked as nurses in the monastic and military models of health care that were prevalent until the dissolution of the monasteries in the reign of Henry VIII.

With the passing of the monastic movement, health care was largely un-institutionalised and became the responsibility of the individual family. On the whole, general hospitals did not begin to develop until the 18th century (Evans 2004) and these did relatively little work with children. However, the general hospitals of the 18th and 19th centuries were working to a very different model and were institutional in the separation of Medicine and Nursing. In the days of the monasteries, the distinction between care and treatment had been relatively indistinct. In the mid-19th century, however, Florence Nightingale built on separate models of nursing and medicine at a time when roles of men and women were particularly distinct. So, Nursing became an almost exclusively female activity and Medicine almost exclusively male. This model was so integrated with societal notions of the proper roles of men and women that it did not begin to be overturned until the middle of the 20th century, and then only very slowly.

Today, it is accepted that women have much to offer in Medicine and men have much to offer in Nursing. It cannot now be doubted that health care would be impoverished without the respective contribution of men and women in today's health care professions.

## The Renaissance

Medicine and nursing have not always been scientific disciplines. In common with his peers, Thomas Phaer (1510–1560) believed that God had endowed nature with healing powers (Jolley 2006a). This did not just apply to drugs obtained from plants and so on but also to a range of other materials. Phaer recommends the use of an amulet (a charm) for the treatment of childhood epilepsy:

I fynde that manye thynges have a naturall vertue agaynste the fallyng evell, not of any quality elemental but by a singlar propertie, or rather an influence of heaven, whyche almyghtye God hath gyven into thynges here in earth ... These (red coral, sapphires or stones from a swallows stomach), or one of them, hanged about the necke o the childe saveth and preserveth it from the sayde syckenes (p. 41).

It is not surprising that many of the children Phaer cared for had diseases we would recognise today. Here he informs his reader of how to recognise the dangerous condition of epiglottitis:

[It is a] daungerous syckenes bothe in yonge and olde, called in Latyne angina. It is an inflammation of the necke with swellying and great peyne. Somtyme it lyeth in the verye throte upon the wesent pipe, and then it is excedyng perillous for it stoppeth the breath and straguleth the pacient anone ... The signes are apparaunt to syght, and besydes that the chylde can not crye, nether swallowe downe hys meat and drynke wythout payne (p. 54).

Phaer also writes about the care of the child with the lethal condition of Small Pox; his treatment seems particularly holistic and caring. Firstly, he declares that there is no effective treatment and cautions against the use of treatment that may make the child worse:

The best and most sure helpe in this case is not to meddle wyth any kynde of medicines, but to let nature woorke her operation (p. 61).

Phaer suggests some medicine to soothe pain: rose or fennel water to soothe the eyes and rose water for the child to gargle with where he or she has oral pain. He was obviously as much concerned with the child's discomfort as he was with providing treatment for the disease. In this regard, indeed Phaer was Britain's first children's nurse.

The majority of this early literature is not specifically focussed on the care of children. Since Phaer did much of his work with sick children, he was almost certainly exceptional in this respect. In fact the first organisation of paediatricians (in the UK) did not become established until 1928 (Forfar *et al.* 1989) and of paediatric surgeons until 1954 (Dunn 2006). Some forms of nursing were controlled by law as early as the 16th century (Bowers 1999) but for the most part there existed no separate organisation of children's nurses until the children's hospitals began to be built from 1852. A register specifically for children's nurses was opened in 1919 and the first national organisation of children's nurses, the Association of British Paediatric Nurses, was established between 1936 and 1938 (Duncombe 1979).

## **The 17th and 18th centuries**

Even during the 17th and 18th centuries there were no hospitals for sick children in Britain, nor was there a formal discipline of children's nursing. However, there were two non-hospital-based models of child care in operation before the mid-19th century; they are the foundling hospitals and the children's dispensaries, which have been seen as precursors to modern children's nursing.

## The foundling hospitals

A 'foundling' is an abandoned child (a small thing found). It is sadly the case that in the 18th century many people could not afford to keep their babies and this was especially the case in the rapidly growing cities. Young mothers were often caught in a web of poverty, poor housing and lack of family support. Industrialisation had spawned large, unhealthy towns in which the poor often vainly sought escape from the traditional ways of countryside living. This resulted in the breakdown of the extended family and the support that this had once provided. For the first time in history, people found themselves without the support of their family and local community.

Thomas Coram (1668–1751) was a businessman and shipbuilder who from lowly beginnings had developed trade with New England. Coram was saddened to see the number of dead and dying babies abandoned in the streets of London. He worked for many years to get an official approval and sufficient funding for his 'Darling Project', the opening of the first 'hospital' for foundlings in Britain. His business in New England was eventually to falter, largely because of Coram's relatively poor social position and of the lawless nature of the new American states. In his old age, he saw the opening of the London Foundling Hospital as his most proud achievement. Indeed Wagner (2004, p. 1) suggests that:

Coram is rightly acclaimed for having forced society, rather against its will, to interest itself in the fate of its youngest, most defenceless, destitute and abandoned citizens.

Coram was, according to Wagner (2004, p. 4), a man of *startling integrity in a corrupted age*. It was indeed this awakening of society to its responsibility towards defenceless children that was to see the development of first the children's dispensaries and later the children's hospitals with which we are familiar today. Arton (1992) suggests that the foundling hospitals, the first of which was opened by Thomas Coram in 1741, were the first real children's hospitals in Britain. It is probably better to consider these as orphanages rather than children's hospitals but they did employ people to care for the children and it is known that many of these children were sick. The main reason for not including the foundling hospitals as part of the history of children's nursing is that the (nursing) staff were never professionally organised. In this way there was never to be a 'discipline' of foundling hospital staff.

The aim of the foundling hospitals was to recover abandoned children and to provide them with accommodation, food and a Christian education. Moreover, the development of the foundling hospitals was noteworthy for two reasons. The first is that some foundling hospitals did in time become children's hospitals. This is the case with what is now Alder Hey Hospital, Liverpool and with L'Hôpital des Enfants Malades (the hospital for sick children) in Paris. It was the existence of L'Hôpital des Enfants Malades that made envious physicians in this country to establish children's hospitals here, in particular Charles West to establish Great Ormond Street Hospital (GOS) in London. However, perhaps the most important reason to consider the foundling hospitals seriously is that

they highlight the moment when society accepted responsibility for children in need of care. It was this very awakening that enabled the notion of a hospital for children to be embraced by British society during the 18th century.

### The children's dispensaries

George Armstrong (1781) opened the first children's dispensary in 1769 in Red Lion Square, London (Jolley 2007a). The dispensary was rather like hospital outpatient department. Here, working parents (the 'deserving poor') could bring their sick children to obtain advice and medicine from apothecaries (pharmacists) and physicians (though usually the former). Armstrong himself had undergone medical training but was not licensed as a medical practitioner because of his social background (Jolley 2007a). This did not stop him writing two important texts on the treatment of sick children (Armstrong 1771, 1777) in which he took the opportunity to promote his own dispensary.

Armstrong was influential in propagating the then novel idea that children's diseases could be treated successfully. The prevailing belief was that children were too difficult to treat and that (rightly) most treatments of the day were too powerful for children. In one of his texts on paediatric medicine, Armstrong (1777, p. vii) refers to:

the absurd notion, which has too long, and too universally prevailed, that there is little or nothing to be done in the complaints of children has prevented many parents from applying to physicians for advice.

Armstrong's accounts of the diseases of children are likely to have prompted the medical fraternity that there might be good purpose in developing a new discipline of medicine for children.

Armstrong's dispensary and those that followed provide an important building block in the history of children's nursing. This was a charity-based model of health care which pre-dated the children's hospitals, which provided treatment to sick children. Armstrong spoke out against hospitals as being inappropriate for young children because of the risk of cross-infection and because of the needs of children for their parents. In practice, however, Armstrong was simply trying to promote his own dispensary. This was an endeavour that would eventually fail. Queues of ragged children waiting to see an apothecary simply failed to inspire the wealthy middle- and upper-class benefactors whose financial support was so necessary (Jolley 2007a). The children's dispensaries declined about the time that Charles West was founding the first children's hospital in 1852.

Charles West had worked in a dispensary (the Universal Dispensary in Waterloo Bridge Road, London). However he had learned an important lesson from his work in the dispensaries: health care for children was expensive and therefore required proper funding. To achieve this it was necessary to have the support of the most influential members of society. These people would not only give money, they would give credibility to the scheme and then more money

would follow. The hospital provided a romantic image of children's health care that the dispensaries had always lacked. The provision of civilised, educated and humane nursing was an essential element to this romantic image.

The co-dependency of medicine and nursing was now also understood, so paediatric medicine would from now on take an active interest in the development of paediatric nursing. The dispensaries would fail but would spawn the hugely successful children's hospitals. The first children's hospital was opened in Great Ormond Street, London, in 1852. By the end of the same century a children's hospital had been built in almost every large town in Britain; many of these hospitals remain today.

Florence Nightingale's modernisation of nursing was hugely influential in the hospital movement and was based on the traditional Victorian division of labour between men and women and a further division of labour which separated classes of female kind (Mackintosh 1997). It was also dependent on the Victorian notion of 'family' with the male as head and female as carer (Evans 2004). As in the middle-class Victorian household, caring was seen as a simple activity but one which required obedience to the doctor's orders. Nurses needed to be reliable, kind, honest and with enough wit to follow orders. For this reason and from this point forward women were to dominate nursing, military obedience was replaced by the discipline of the household servant and planning and problem solving was left to (male) physicians and surgeons. At least this model allowed for the nursing of sick children. Based on such a model children's hospitals were founded and children's nursing as a discipline was born.

### ***From 1852 to 1918: The romantic years***

What makes the beginning of hospital nursing different from the informal care of sick children that had taken place before is that children's nurses began to see themselves as an occupational and later a professional entity. They began to work as an occupational unit and with an overall sense of responsibility, not only for the children for whom they were caring but for the discipline of children's nursing as a whole. This is still very much the case today, with children's nurses as members of a profession and carrying responsibilities not only to the CYP entrusted to their care but also to the wider profession. In this way, children's nurses have cultivated a responsibility to study, to improve their collective understanding and application of nursing, to conduct and/or implement research and to publish ideas about how they can continue to improve what they do.

This sense of responsibility to CYP and their families is evident from the beginning. Charles West established a set of 'rules' for the GOS. These rules were copied by every other children's hospital because GOS was used as a template for hospitals that developed after it. West's rules for nurses can easily be misunderstood today. Nurses were to be kind, respectful and honourable. They were to show respect for physicians and always recognise that the physician had a better knowledge of medicine than did the nurse (West 1854). However,



all professional groups have rules that define their professional status. What matters here is that nurses accepted these rules for themselves; they accepted 'standards' both of practice and of their relationship with physicians. This relationship was mutually respectful and employed the middle-class values of the day. Physicians such as Charles West now understood that they needed nurses and so began an unusually cooperative relationship between two professional groups and one that is still very much in existence today.

In two letters to the Times, Sir James Paget, one of the founding fathers of modern medicine, writes of nurses, that they were:

kind, loving, holistic, but simple people whom men would do well to emulate'. And that 'There were no such nurses ... especially for children, as women' Men (doctors), however clever, were apt to be too studious, to treat their patients as different cases, the singularity of which occupied all their attention. But it was not so with women (nurses). Their skill was subordinate to their love, and men would do well to emulate them in their gentleness, their tenderness, and their watchfulness (Paget 1874).

Of course nursing was a very new discipline at this time, its members were recruited largely from the servant classes. Nevertheless, and much to the credit of these early nurses, they won the respect of some of the most well regarded physicians and surgeons in the country (Jolley 2007b).

The needs of children for their parents and for play and respect for children as children were well understood and soon became integrated in the nurses' practice (Jolley 2006c). Cruelty, even overt unkindness, to CYP was not tolerated in this period. Records from Yorkhill hospital show that nurses were dismissed if they hit a child (Yorkhill Hospitals Archive 1916–1932) and were also dismissed if they showed an inability to keep children happy and to communicate effectively with them as children. At the end of the 19th century Catherine Wood (Wood 1888, Jolley 2006c), Lady Superintendent of GOS, gave an account of children's nursing that seems perfectly relevant today:

Order and discipline there must be, or the children will not be happy; but the Ward that is tidied up to perfection, in which the little ones look like well drilled soldiers, when the home look of liberty is absent, and nothing is out of its place, is hardly suggestive of the happy heart of a child. Toys and games are as much part of the treatment as physic, and the ceaseless chatter and careless distribution of the toys are surely consistent with a well-ordered children's Ward. As a convalescent, a child requires nearly as much attention as one in bed, and because the heart of a child is set on mischief, certainly as much looking after. Some of the older children may make themselves of use in the Ward; but also they may be a great deal of trouble, so that from first to last the sick child is some person's care (p. 508).

Over and above the actual skilled Nursing, it is necessary to develop in the Nurse the mother's instinct, the grand self-sacrifice and self-forgetfulness that are the outcome of the mother's love; we want each Nurse to gather her little

ones into her arms with the resolve that she will spend and be spent for them. They are hers, and for a time they will look to her for a mother's love and a mother's care. They must be more than cases to her, or they will not thrive as they might in her care. Let us put into the arms of a young Nurse some poor little neglected babe. It is to be her charge by day, and she is to do her best with it; her pride will be aroused, especially if some other young Nurse also has a case, and a generous rivalry between the two will be to the manifest advantage of the babes. Suppose that this babe improves in the marvellous way that babes do, with love and intelligent care, then that Nurse will have learnt a lesson in the care of young infants that will abide by her always (p. 509).

This first period in children's nursing's history was a romantic one. There are many reasons for this but here it is sufficient to note that the natural inclination of young women drawn as they were to nursing, to be creatures with a kind disposition and intent on bringing hope and happiness to the lives of hospitalised children. At the same time these nurses accepted for themselves a code of behaviour that was professional in its orientation and put the welfare of the child before their own.

### ***1919–1959: Science and professionalism, faltering care***

Nursing has never been independent of wider society. The period between 1852 and 1920 was heavily influenced by Victorian romanticism, the strength of the Christian church and by a new awakening that society possessed a responsibility to care for the weak. British society around World War I subsequently began to undergo change. World War I had demonstrated a lack of young men fit enough to go to battle, the notion of fixed social positions began to change and people were seen to be capable of improving themselves and climbing the social ladder. At the same time there began to be a new understanding of childhood that was behaviourist in its orientation (Watson 1928) and which complied with the way that 'science' was intruding into everyday life.

Science had already explained the origins of life itself (Darwin 1872) and it was considered that in time, science would provide all the answers to man's problems. Science would cure disease, organise nursing (Ashdown 1927) and tell us how to bring up our children (Hardyment 1995). In particular, child care was now seen as a scientific process; like behaviourism itself, our dealings with children would be objective, systematic and regularised. There would be one known way of managing children which if it worked for one child must be applied to all children. Children were no longer to be understood as individuals but as examples of a whole. In addition, behaviourism dictated that emotional and romantic notions of childhood were dangerously unscientific and therefore wrong. There was to be no room for emotionality; to the increasingly influential behaviourists, children simply did not possess social, emotional and psychological needs (see Watson 1928, Jolley 2007c).

There was a much higher degree of social conformity than is the case today. People were much more likely to follow orders, to respect their elders and

'betters' and to do what they were told. Government policy began to be applied more closely to people's everyday lives. More hospitals were built, more special schools. This was the age of the scout movement and where military uniformity complied so well with scientific notions of objective and systematic approaches. It should not then surprise you that this was also the age of the eugenics movement (Galton 1905) which aimed to purify the Anglo-Saxon race at the expense of children less worthy in colour, handicap and breeding. Of course the Nazis took eugenics to its horrific conclusion but the degree to which eugenic principles were influential in this country should not be underestimated (see Welshman 1997).

Children's nursing became a 'harder' discipline that largely excluded parents from the care of the hospitalised child (Jolley 2007c). The Nurses Act of 1919 gave children's nurses the status of State Registration (Lindsay 2001). Nurses began to see themselves as 'professionals' and if not scientists themselves they worked intimately with Medicine which was, of course, 'science'. This effectively alienated them from parents who were seen as emotional and uneducated. Parents were often blamed for causing the child's illness by providing an inadequate diet and insufficient fresh air. Parents, especially mothers, were considered too emotional and therefore unable to provide the care needed by the child (Jolley 2004).

The most well understood effect of this period is the way in which parents were able to visit their child in hospital only for perhaps half an hour a week and in some cases not at all. Once children were separated from their parents in this way, they would initially cry but would eventually '*settle in*', meaning that they would become quieter and more compliant. So it was that wards were full of bed-ridden children, separated from their families often for months at a time. Jolley (2004) provides some accounts from now-elderly people looking back on what it was like to be a child in hospital during this period. Some of the children's stories from this period are quite harrowing but they provide an important lesson for us today:

If you want me to actually choose one thing, I think it was the powerlessness. I wasn't anything. I had no-one on my side to protect me, I was just there to be done to. Yes, I think that was it, the powerlessness ... So all I have thoughts on now is ... that they didn't really care. I think that they were getting on with their jobs. The fact that we were kids who (there must have been others who were as unhappy as I was). I don't think they cared a hoot what our feelings were, they were into bodies, not feelings ... I was completely and utterly isolated. It's like sticking a naked child in a pen with a load of farmyard chickens. You've got nothing to protect yourself with at all ... (p. 136).

Here, a nurse describes the way in which *science* did not actually involve thinking and problem solving but which instead was simply what existed in the literature of the day (Jolley 2004, p. 102):

We went in to the theatre with them and then we brought them back into the anaesthetic room, we brought them round, then we took them back to the ward and we looked after them in the ward. That's how it was in the textbooks and we did it. You wouldn't deviate from that because it was what

worked fine and the patient was recovered as a result of it. So you know we never questioned how anything could be done differently because everything was right.

These nurses were not uncaring as they cared (Jolley 2006b). They took much pride in their work and it was especially rewarding when they were able to 'nurture a child better' (Jolley 2004). Nurses were clear about their contribution to the child's recovery and that their role was every bit as important, even more important than was that of the physician or surgeon (Jolley 2007b). Nor should it be considered that these nurses were ignorant of child psychology or of the child's social needs (Jolley 2007c). Nurses possessed the understanding of their day and this was essentially behaviourist. They were well educated and well trained, they did understand the science but the science was flawed. The truth, not understood at the time, is that children are individuals with individual needs for understanding, affection and love.

### ***1959 to the present day: A refocus on CYP and family care***

World War II brought significant changes to British society which was to have a direct impact on children's nursing. In time, parents would once again be welcomed into children's wards and would play an active part in their child's care. That care would also become more closely orientated to the CYP's needs as an individual and to the CYP's social and psychological needs.

World War II brought separation on a massive scale, not only through the armed conflict itself but through the mass evacuation of children from the towns and cities into the countryside (Titmuss 1950, Cleary *et al.* 1986, Macnicol 1986). This social exercise taught Britons everywhere that existing science and behaviourism did not provide a full explanation of children's needs as children. Instead it was clear that children did indeed have emotional needs, they needed their parents and their parents needed them. This was the love that is naturally present between parent and child and which behaviourism had ignored.

At the same time, war propaganda machine had told Britons that they were different from the German enemy because Britons were free and Britain was a democracy. The National Health Service, instituted in 1946, had put health care into the public domain. The hospitals now 'belonged' to the people. These changes empowered the British public to demand what they wanted from the National Health Service and for parents and carers, what they wanted was more access to their hospitalised sick children.

Research published by Bowlby and Robinson (Bowlby 1944a, b, Alsop-Shields and Mohay 2001) demonstrated that children needed their parents. Had it not been for World War II it is unlikely that nurses or the public would have taken notice of this research but it was instead exactly what they wanted to hear. The government was also keen to respond and published the Platt Report (Ministry

of Health 1959) while at the same time the National Association for the Welfare of Children in Hospital (NAWCH) was formed to pressure hospitals to implement the Platt Report recommendations (Siddle 1991). The Platt Report recommended a move to what we would now call 'family-centred care'. This has been defined by Shields (Shields *et al.* 2006) as:

... a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognized as care recipients (p. 1318).

This was a revolutionary change; children's nursing was still an inflexible organisation and it resisted the move to family-centred care (Duncombe 1979). Nevertheless social pressure, voiced largely through NAWCH, was unrelenting and inexorable. Today we can see the fruits of these labours in every children's ward in the land and in today's government policy (DH 2003, 2004) and in English law (DH 1989). Parents do not only visit their CYP every day, they often stay all day and all night too. Parents and other members of the CYP's family are not just 'visitors' but are active members of the care team and with whom children's nurses work compassionately, cooperatively and intimately.

Anne Casey's model of children's nursing (Casey 1988) illustrates this process well. Children's nursing has come to be a 'cooperation' of nursing, parenthood and childhood. Three essential elements in a professional activity designed to comfort and treat sick and injured children and to promote child health. In this model there is a new awareness, there is a new awareness of children that each child is an individual with individual needs and each an essential and inseparable part of a family.

## **Conclusion**

Today, science and professionalism are both important aspects of children's nursing. However history has taught us that science is not static but that even though it is imperfect it continues to improve; nursing science today is characterised by a continuous struggle to discover better ways of delivering care. Professionalism too, has been redefined by history. It is now characterised by protecting the CYP in situations where other interests are legion and pressing and it is to accept the responsibility of making the profession better and more informed for children everywhere and for tomorrow.

Today there is room once again for Victorian romanticism (Jolley 2006c); CYP are important, childhood is important. Sick children deserve respect, protection and indeed affection. It is not possible to properly respect the individuality of a child without gaining a sense of affection for the human being that that endeavour reveals. So it is that children's nursing today employs ancient values, values that give the discipline depth and integrity. Indeed, it is not an exaggeration to

say that it is such care as this, of the weakest and most defenceless members of society that defines civilisation itself (Jolley 2006b).

## Further Reading

There are not many texts on nursing history; most modern historical studies are published in the nursing journals. For an informal introduction to children's nursing history you may wish to look at Jolley's series of short articles in Paediatric Nursing from 2006, some of which are referenced at the end of this chapter.

## References

- Altop-Shields L and Mohay H (2001). John Bowlby and James Robertson: Theorists, scientists and crusaders for improvements in the care of children in hospital. *Journal of Advanced Nursing*, 35(1), 50–58.
- Aries P (1962). *Centuries of Childhood*. London: Cape.
- Armstrong G (1771). *An essay on the diseases most fatal to infants. To which are added rules to be observed in the nursing of sick children: With a particular view to those who are brought up by hand ...*. London: T. Cadell.
- Armstrong G (1777). *An account of the diseases most incident to children, from their birth till the age of puberty; with a successful method of treating them. To which is added, an essay on nursing, also a general account of the Dispensary for the Infant Poor, from its first institution in 1769 to the present time*. London: T. Cadell.
- Arton ME (1992). *The Development of Sick Children's Nursing, 1919–1939. History*. MPhil Thesis (unpublished), University of Bath.
- Ashdown AM (1927). *A Complete System of Nursing*. London: Waverley Book Company Ltd.
- Baly ME (1995). *Nursing and Social Change*. London: Routledge.
- Bowers R (1999). *Thomas Phaer and the Boke of Chylidren*. London: Arizona State University.
- Bowlby J (1944a). Forty-four juvenile thieves: Their characters and home life (I). *International Journal of Psychoanalysis*, 25, 19–53.
- Bowlby J (1944b). Forty-four juvenile thieves: Their characters and home life (II). *International Journal of Psychoanalysis*, 25, 107–127.
- Casey A (1988). A partnership with child and family. *Senior Nurse*, 8(4), 8–9.
- Cleary J, Gray P, Rowlandson PH, Sainsbury CPQ and Davies MM (1986). Parental involvement in the lives of children in hospital. *Archives of Diseases in Childhood*, 61, 779–787.
- Cunningham H (1995). *Children and Childhood in Western Society Since 1500*. London: Longman.
- Darwin C (1872). *The Origin of the Species by Means of Natural Selection*. London: Murray.
- DeMause L (1974). *The Evolution of Childhood. The History of Childhood: The Evolution of Parent Child Relationships as a Factor in History*. London: Souvenir Press.
- Department of Health (DH) (1989). *Children Act 1989*. London: DH.
- Department of Health (DH) (2003). *Getting the Right Start: National Service Framework for Children. Part I: Standard for Hospital Services*. London: DH.

- Department of Health (DH) (2004). *Every Child Matters: Change for Children in Health Services*. London: DH.
- Duncombe MA (1979). *A Brief History of the Association of British Paediatric Nurses, 1938–1975*. London: Association of British Paediatric Nurses.
- Dunn PM (2006). Sir Denis Browne (1892–1927): The father of paediatric surgery in Britain. *Archives of Diseases in Childhood*, 89(Suppl 1), A54–A55.
- Ellis H (2001). *A History of Surgery*. London: Greenwich Medical Media Limited.
- Evans J (2004). Men nurses: A historical and feminist perspective. *Journal of Advanced Nursing*, 47(3), 321–328.
- Forfar JO, Jackson ADM and Laurance BM (1989). *The British Paediatric Association, 1928–1988*. London: The Royal College of Child Health and Paediatrics.
- Galton F (1905). *Eugenics, Its Definition, Scope and Aims*. London: Sociological Society of London.
- Hardyment C (1995). *Perfect Parents: Baby Care Advice, Past and Present*. Oxford: Oxford University Press.
- Jolley J (2004). *A Social History of Paediatric Nursing, 1920–1970*. History. PhD Thesis, University of Hull.
- Jolley J (2006a). The first paediatrician. *Paediatric Nursing*, 18(7), 12.
- Jolley J (2006b). The progress of care. *Paediatric Nursing*, 18(8), 12.
- Jolley J (2006c). A mother's love. *Paediatric Nursing*, 18(5), 13.
- Jolley J (2007a). Ahead of his time. *Paediatric Nursing*, 19(3), 12.
- Jolley J (2007b). Lost causes and new hope. *Paediatric Nursing*, 19(2), 12.
- Jolley J (2007c). Separation and psychological trauma: A paradox examined. *Paediatric Nursing*, 19(3), 22–25.
- Lindsay B (2001). An atmosphere of recognition and respect? Sick children's nurses and medical men, 1880–1930. *International History of Nursing Journal*, 6(1), 4–9.
- Mackintosh C (1997). A historical study of men in nursing. *Journal of Advanced Nursing*, 26(2), 232.
- Macnicol J (1986). *The Evacuation of Schoolchildren. War and Social Change: British Society in the Second World War*, pp. 3–31. Manchester: H Smith.
- Ministry of Health (1959). *The Report of the Committee on the Welfare of Children in Hospital (the Platt Report)*. HMSO, London.
- Paget J (1874). Letter. *The Times*. London, p. 10.
- Shields L, Pratt J and Hunter J (2006). Family centred care: A review of qualitative studies. *Journal of Clinical Nursing*, 15, 1317–1323.
- Siddle J (1991). A voice for children NAWCH – the National Association for the Welfare of Children in Hospital. *British Journal of Theatre Nursing*, 1(6), 4–5.
- Still GF (1931). *The History of Paediatrics: The Progress of the Study of Disease of Children Up to the End of the XVIIIth Century*. London: Royal College of Paediatrics and Child Health.
- Titmuss R (1950). *Problems of Social Policy*. London: Longmans.
- Wagner G (2004). *Thomas Coram, Gent, 1668–1751*. Woodbridge: Boydell Press.
- Watson JB (1928). *Psychological Care of the Infant and Child*. London: Allen and Unwin.
- Welshman J (1997). Eugenics and public health in Britain, 1900–40: Scenes from provincial life. *Urban History*, 24(1), 56–75.
- West C (1854). *How to Nurse Sick Children*. London: Longman.
- Wood C (1888). The training of nurses for sick children. *Nursing Record*, 1, 507–510.
- Wyman AL (1984). The surgeoness: The female practitioner of surgery, 1400–1800. *Medical History*, 28, 22–41.
- Yorkhill Hospitals Archive (1916–1932). Nurses Register 1916–1932. YH8/1/4, Glasgow.