been radiational fibrosis causing the dyspnoea you would have expected it to have appeared much earlier than this.

Dr. SUTTON: Yes.

FIBROSIS AFTER SUCCESSFUL TREATMENT

Dr. FLETCHER: Do you think that had you been successful with hormonal therapy in this case the fibrosis would have resolved?

Professor RUSSELL FRASER: Well, it was very extensive fibrosis. We find this problem in treating thyroid carcinoma disseminated throughout the lungs, where you wonder whether there will be more fibrosis after you have removed the carcinoma, and so more dyspnoea, than there was before. I think it is very difficult to tell.

Dr. FLETCHER: But in that case you are giving radioiodides which go into the deposits and cause local irradiation effects in the lung, don't they?

Professor RUSSELL FRASER: No, I think when you treat these thyroid cases what you get is an exchange of a disseminated tumour for disseminated fibrosis. Tumour would be replaced by fibrous tissue. I rather think the same would apply here; if this were effectively responding, you would get fibrous tissue remaining where the tumour was. Perhaps Professor Doniach would like to give us an answer on that? Supposing we had no tumour tissue here and just the same amount of fibrous tissue, would the patient be better off?

Professor DONIACH: I doubt it really, because it seemed to me that the ventilatory movement of the lung was tremendously restricted by the fibrous tissue and there were plenty of alveoli free of growth.

ANALOGY WITH THYROID CARCINOMAS

Professor RUSSELL FRASER: I can remember one or two of the thyroid cases where the total mass of tissue was much reduced and there was quite an improvement in the lung function; and then sometimes we gave one dose too many and the fibrous tissue reaction came on top of it and the dyspnoea was not improved by the last treatment, whereas it had been in the first instance.

Professor DONIACH: In the case of the thyroid, though, would you not be dealing with the shunting of blood through the deposits of tumour as another possible cause of dyspnoea?

Professor RUSSELL FRASER: Perhaps so, they are very vascular, aren't they?

Dr. FLETCHER: I don't see why that should cause dyspnoea. People with big shunts may not have much dyspnoea. They very often have a feeling of exercise restriction, but not so much dyspnoea. But when you give radioactive iodine you are actually irradiating the lung tissue together with the growth, aren't you?

Professor RUSSELL FRASER: Yes, oh, yes. But it is pretty local radiation as most of the radiation will only be in thyroid tissue. It doesn't go beyond a millimetre or two—most of the radiation from radio-iodine is β rays—and so would not reach beyond the carcinoma.

Dr. FLETCHER: And this has been true also in one other of your cases where there were large masses of growth which regressed on pituitary ablation and the dyspnoea improved considerably.

Professor RUSSELL FRASER: Yes, where we have had large masses, multiple nodules—not this histological

picture—undoubtedly the dyspnoea has improved. Quite often of course you have a pleural effusion in cases of breast carcinoma spreading to the lungs, and that has been improved. We have had one or two cases where pulmonary involvement has been the patient's problem and the dyspnoea has been dramatically improved; though I don't think we have had any experience of exactly this lesion where the x-ray looks normal and the dyspnoea is probably due to the lymphangitis and fibrosis.

We are grateful to Dr. J. P. Shillingford and Dr. B. E. Heard for assistance in preparing this report and to Mr. W. Brackenbury for the photographs.

THE CO-OP. NURSE AND THE NURSING SHORTAGE

BY

N. F. COGHILL, M.A., M.B., F.R.C.P.

Physician, West Middlesex Hospital, Isleworth, Middlesex

Everyone has heard of the "co-op. nurse" but few doctors know much about her history. Over 70 years ago the London teaching hospitals started to hire out their nurses for private work, and nurses' co-operation agencies started soon afterwards.¹

Inquiry reveals that many hospitals are now short of nurses, although the shortage is not "official." Questioned in the House of Commons last April, the Minister of Health seemed to imply that there was no shortage, but some of his figures referred to December, 1959.² Figures quoted more recently indicate a large rise in vacancies for hospital nurses and for unqualified nursing staff in hospitals.³ In answer to a recent question in Parliament the Minister of Health stated that there were nearly 20,000 known vacancies for hospital nurses in England and Wales on December 31, 1961.⁴

The shortage has been aggravated by the introduction of the 88-hour fortnight. For the same work 8% more nurses are needed. A shortage of hospital nurses is manifest, and is now to be further aggravated by the nurses' recent award of another week's paid holiday, by changes in the curriculum for student nurses,⁴ and as a result of the decision of the General Nursing Council to close training schools in hospitals of fewer than 300 beds.

These difficulties emphasize the need for hospitals to obtain nurses from all available sources. Memories of the important part that co-op. nurses played in the County Hospital Services have revived. Abel-Smith¹ states that before the last war many hospitals engaged co-op. nurses to supplement their staff.

The accompanying Table shows the number of student nurses entering the general training school of my own hospital in three different years and the number of co-op. nurses working on two dates in those years. It also

Nurses at the West Middlesex Hospital

Year	Student Nurses Entering	Agency Nurses			
		Working on		Employed During the Year	% Staying 3 Months or Longer
		Feb. 1	July 1		
1939	116	65	137	400	37
1944	76	155	131	273	62
1947	113	77	69	192	51

shows the total number of co-op. nurses employed at any time during those three years and the proportion staying three months or longer.

In view of the important part that agency nurses played in the hospital service before the National Health Service it is of interest to trace their recent history. The London County Council in 1947 and the Middlesex County Council in 1948 sought to restrict the remuneration paid to co-op. nurses by making it a condition of licensing the agencies that the nurses should be paid no more than was laid down in the Councils' approved scale of charges (according to the agencies, the Whitley Council rate). This oblique method of "squeezing" the agencies was challenged in the courts and the challenge succeeded, it being held that such restriction bore no relevance to the Councils' duty of securing the proper conduct of these agencies, and was therefore *ultra vires* the powers given to the Councils by the *Nurses Act*, 1943.⁵

In 1949 the Ministry took action which resulted in most co-op. nurses leaving N.H.S. hospitals. The reasons for this action, and its effects, seem never to have been adequately examined. In order to gather some current information about nursing agencies, especially in respect of their potentiality for the hospital service, questions were addressed to the principals of eleven nurses' co-operation agencies in and around London. I am most grateful to them for their ready help and co-operation in answering questions and in volunteering much interesting information.

Questions and Answers

What Happened in 1949 ?

It was a little difficult to be certain of what happened in 1949. It seems that at short notice agencies and hospital authorities were told that co-op. nurses working in N.H.S. hospitals must be transferred to the established staffs of their hospitals (and be paid at Whitley Council rates). As a result perhaps half the male nurses transferred to the permanent staffs of hospitals but the rest left. All agencies believed that between 25 and 90% of their women nurses left the hospitals. The agencies' finances became greatly strained. A number of nurses left agencies and attempted to do freelance nursing, a precarious means of livelihood. Many returned to Ireland; others took non-nursing posts in industry and were lost to the profession.

Two agencies used to run nurses' homes, one in Acton for 20 or more nurses working at the West Middlesex Hospital, and the other at Harlesden for nurses at several Middlesex County hospitals. Both were given up in 1949 as a result of the Ministry's action.

The feeling was that the Ministry made a determined attempt to induce nurses to leave agencies and join the permanent staffs of hospitals. The number of agency nurses that most hospitals were subsequently allowed to retain was greatly reduced. However, at least one ex-voluntary (non-teaching) hospital was mentioned as having resolutely resisted this policy and was said to have employed a good number of agency nurses ever since.

Have Fewer Nurses Joined Agencies since 1949 ?

Agencies advertise for nurses to join them and one has a recruiting office in Dublin. Six agencies reported some continuing shortage of nurses, but the others did not find this. Several stated that recently qualified nurses

formed an important source of recruitment. One principal obtained some of his staff from Eire, whither they returned, being taxed under Schedule D, before the end of the financial year. Another explanation for the shortage was that many nurses found private work uninteresting. The fact that many trained nurses went abroad for a time was put forward as another reason for shortage.

Would You be Able to Increase Your Supply to Hospitals if They were Allowed to Employ more Agency Nurses ?

Eight agencies stated that they could supply hospitals with more nurses if the demand increased. One principal was prepared to supply more to hospitals but "wouldn't wish to put too many eggs in one basket" in view of his experience in 1949. Two principals mentioned that young nurses especially liked hospital work as there they had a communal life with young colleagues and avoided the alleged tedium of private nursing.

Are Agency Nurses in Hospitals Employed Mainly on Day or Night Duty ?

Two principals thought that about half their nurses worked on day duty and half on night duty. Eight agencies found the demand from hospitals was mainly for night nurses. One principal thought that the cream of hospital work was given to the permanent staff and the rest to temporary nurses. He had argued this point with matrons, who had evinced a fear of their permanent staff leaving to join agencies. One principal was particularly concerned about the length of night duty for the agency nurses, and sometimes had to remove a nurse from a hospital which had declined to change her to day duty on the request of the agency on her behalf.

Do Hospitals Show any Particular Attitudes towards Agency Nurses ?

Opinions varied. Two principals thought that their nurses were treated exactly like the hospitals' own permanent staff. Two thought that most, although not all, matrons and senior nursing staff had a reasonable attitude towards agency nurses. One of these principals had, however, inserted a clause in the nurses' contracts stating that they could not join a hospital's permanent staff. Its legal validity was doubtful, but it was designed to protect the nurses from unwanted pressure by matrons.

One principal said that, although some hospitals welcomed agency nurses, many regarded them "as a necessary evil." Two others thought that hospitals were variable in their attitudes to their nurses, about one-half welcoming them.

One experienced principal said that many matrons let his girls know plainly that they regarded them as stopgaps they would prefer to do without. Many agency nurses received less courtesy than the permanent staff. The fact that they had gone into private practice was held against them. Hospital management committees were unaccommodating in respect of seniority increments and would usually allow only half the time a nurse had spent in an agency to count for these if she subsequently joined a hospital's permanent staff, even if the nurse had been working in a hospital while an agency nurse; and then only on representation from the agency. Of one particular hospital he wrote:

"Should a nurse be off sick even for one day she must commence again as from scratch." This generally causes hardship, as she loses any accrued benefit of off-duty, etc."

What are the Conditions of Employment ?

Agencies have been licensed by the London County Council since 1921.* Formal licensing of agencies by all counties was introduced under the Nurses Act 1943. Licences have to be applied for yearly. The licensing regulations are detailed and comprehensive, and are said to be strictly enforced.

The fees that nurses' co-operation agencies may take from nurses are fixed by the licensing authorities. The fee allowed by the L.C.C is 10% of the nurse's salary if the agency has only office facilities, and 12½% if the agency offers extra facilities—for example, if it undertakes to pay the nurse before the agency has received any payment from the employer, or if it runs a hostel. Such a hostel may provide storage for luggage, cooking facilities (for food bought and cooked by the nurse), and a rent-free room for any nurse on the agency's books who wants to use it, whether she is in work or not.† The Middlesex County Council allows a rate of "up to 12½%."‡ It is said that one or two agencies in the North have been known to charge a little more than this.

Agencies usually allow nurses to choose their own style of uniform, merely laying down broad limits for it. The nurses are said to like this arrangement.

Nurses in an agency can usually take their holidays when they like, provided they notify their employers and the agency well in advance. Compassionate leave can be granted quickly. In these cases the agency sends another nurse to the hospital as replacement.

When a nurse leaves a hospital assignment, provided her work and behaviour have been satisfactory, commonly no special references or reports are rendered by the matron. One principal wrote: "In the case of every assignment we send a printed card to be returned to us to indicate date of leaving, etc., and quality of nurse—regrettably not many hospitals return these." A nurse who finds a hospital post uncongenial can leave it at any time, with at the most 48 hours' notice. The agency simply replaces her if required. Hospitals may terminate the employment of agency nurses virtually without notice. Some agencies require a nurse to give a month's notice before leaving the agency. Others assume that the end of each assignment constitutes the completion of contract.

Agencies generally try, in the words of one of them, "to marry the girls with the jobs." It is, after all, in their interests to keep their nurses happy.

What is the Usual Remuneration of an Agency Nurse ?

Salaries evidently vary only slightly between agencies. A common agency salary now is about £10 a week for a State-registered nurse. Some may earn more if they have other qualifications. There are seldom increments for seniority. The agency's fee of 10–12½% is deducted from this. Additional payments are made for expenses, which may amount to £2–3 a week if the nurse is non-resident (laundry, travelling, residence, etc.). Fifteen years ago this rate of pay was much higher than that for qualified nurses on hospitals' permanent staffs. Nowadays the difference is smaller: about £2 10s. a

week for junior staff nurses, falling to about nothing for senior staff nurses.

When an agency nurse is not working because of sickness or holidays, or because there is no post available, or for any other reason, he/she is not paid. Furthermore, agencies make no superannuation payments, and if a nurse wishes to remain eligible for pension she must pay the employers' share of the superannuation contribution as well as her own. Many do this. These are the main reasons why agency nurses have been paid higher salaries.

Do Nurses Have a Greater Sense of Freedom Working in a Co-operation Agency ?

It seemed likely that discipline varied between agencies. All felt that nurses enjoyed greater freedom working as agency employees, and that this was a powerful inducement for them to join an agency.

Discussion

Prior to 1949 co-op. nurses were a valuable pillar of the nursing service in many hospitals, particularly the non-teaching ones. They were found to be necessary even when the hospital had a large nurse-training school. In fact, they eased the burden of the student nurse. It is evident that in 1949 the Minister sought to force agency nurses to join the permanent staffs of hospitals. In this he was largely unsuccessful, and the chief result of his action was seriously to deplete the non-teaching hospitals of trained nurses.

The motives for his action are not entirely clear. There was a feeling that agencies mulcted the nurses of a large proportion of their salary in fees. This was true at one time,⁶ and as recently as the 'thirties one agency charged its nurses 15–20% of their salaries.⁷ Some at least of these agencies provided rent-free accommodation for their nurses when they were not working. However, fees paid by nurses to agencies have been fixed by the licensing authorities in London since 1921, and in the country as a whole since 1943. As at the inception of the Health Service gross salaries of co-op. nurses were rather higher than those of nurses on the established staffs of hospitals it is possible that economy was one of the main reasons for the Ministry's action.

Since 1949, at my hospital, we have usually had fewer than 20 co-op. nurses on the staff (including 10 to 12 midwives). The co-op. nurses are greatly missed, for since 1950 our total number of nurses has fallen from 777 to about 560. There is reason to believe that other hospitals have been similarly affected. Such a reduction in numbers, first of agency nurses and later of others, leads to an increasing load on the rest of the nursing staff. If the work of a hospital is too heavy it militates against recruitment and is an important cause of wastage of nurses, student and qualified.⁸

There has always been a shortage of nurses. It will probably be difficult in the future to raise much further the recruitment level of student nurses. The reasons for this have been suggested.⁷ Now that there are so many things a young woman can do, enough girls will simply not be available to provide all the student nurses we want. This would be so even if nursing were more attractive (which it could be). If hospitals are to keep themselves reasonably staffed they must tap all sources of nurses.

⁸Although our available beds have fallen by about 11% since 1945 the volume of work has increased.

*London County Council (General Powers) Act 1921.

†Information obtained partly from the Chief Officer of the Public Control Department, London County Council.

‡Information from the Clerk to the Middlesex County Council.

The Ministry has been extremely reluctant to allow more agency nurses in hospitals, even to facilitate the introduction of the 88-hour fortnight for the permanent staff. Interest in the nurse's welfare, or concern for economy, cannot now be the whole answer to the Ministry's attitude. Are other pressures at work?

Several agencies felt, rightly or wrongly, that there were some who would like to get rid of them altogether. One medical adviser of an old-established agency and a principal of another large agency both spoke of what they called the "absurdity and vindictiveness of many Ministry Acts and regulations of that period" (1949), and felt that "organized nursing bodies" were behind them (but could not produce any direct evidence for this belief). Among the agencies there was certainly a feeling, whether justified or not, that almost every man's hand was against them.

There seems no doubt that agency nurses are often regarded by matrons and sisters in a different light from their permanent staff. This attitude is shared by some lay administrators. "Blacklegs" is an epithet applied to them.

Why should this be so? Medical experience shows that the average agency nurse is no different from others. In an agency a nurse suffers the drawbacks of casual employment, or non-pensionable work, holidays and sick-leave without pay, the possibility of a cool reception in hospital, the likelihood of night work only, or, as the only alternative, private work for which she has less interest. She has the prospect of being discriminated against in respect of her salary if she rejoins the permanent staff of a hospital. Nowadays she gets only a little higher salary to offset these disadvantages, and then only in her earlier years. Why are nurses of all ages prepared to adopt this kind of work rather than stay in hospitals? Is it because they feel freer in an agency? One of the advantages of working in an agency is that if a nurse is unhappy in her work a transfer can easily be arranged, without fear of adverse comments in subsequent references. Hospitals should ask themselves why nurses are so keen to work outside them.

A common complaint by matrons is that agency nurses often stay only a short time, and that they are in short supply. If hospitals always treated co-op. nurses on an equal footing with their permanent staff in respect of night work and a welcoming attitude these nurses might be more willing to go to hospitals and to stay in them longer.

Ministerial withdrawal of agency nurses from hospitals obviously led to a reduction in the number of nurses entering agencies, but recruitment seems to have improved since then. It was difficult to assess the agencies' assertion that they could supply more nurses to hospitals at once. It seems likely that this might be so to a limited extent, but only if the conditions of work for agency nurses in hospitals were closer to those of the established staff. Under these conditions a demand (from hospitals) might be expected to increase the supply.

I do not believe it would be practicable for hospitals to rely on agencies for a large proportion of their staff, although this suggestion has been made by one agency. However, employment of some agency nurses seems to provide a degree of flexibility in nurse staffing not always present with a completely permanent staff. They used to constitute a valuable reserve for a hospital caught

with an influenzal epidemic among the staff, at holiday times, or when there was a sudden increase in admissions (which in the old County Council days could not be sent elsewhere). If another ward had to be opened suddenly agency nurses were the immediate answer. I was informed that the Ministry itself once thought of organizing a mobile group of nurses to go where needed at short notice.

Now that the salaries of co-op. and hospital nurses are not very different the argument that employing both kinds of nurse in a hospital leads to ill-feeling has little weight. Co-op. nurses are employed without the need for advertising. Considerable sums, running well into four figures, are expended annually by individual hospitals advertising for staff nurses. This is due partly to the high turnover of these nurses, which may be further evidence of dissatisfaction with hospital conditions. There seems to be no reason why co-op. nurses should not be employed more generally. The Ministry should review its policy and employ them in the numbers needed to relieve the strain on existing hospital staff, and to enable some badly needed wards to be reopened.

In the long run measures must be taken to make life more attractive for permanent hospital staff. Various courses are now open to the qualified nurse. She may join a co-op., try freelance private nursing, do district nursing or health visiting, be a district midwife, work in local authority clinics, do industrial nursing, or work abroad. She may even engage, as all too many do, in work quite other than nursing.

It is in the hands of the medical and nursing professions and of the administrative hospital authorities to make the necessary changes in hospital life and atmosphere to enable the hospital to compete on an equal footing with all the counter-attractions there now are for nurses.

I thank Mr. Francis Barnes, barrister-at-law, for advice about the court case referred to.

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In an article in *Western Mail* (March 6), "The Return of an Old Enemy," Mr. G. Penrhyn Jones traces the history of smallpox in Wales. The disease was firmly entrenched there by the eighteenth century and attacked rich and poor alike. Advertisements for servants often contained the phrase, "Must have had the Smallpox." There were severe outbreaks in Carmarthen in 1722-3; south-west Wales (1729)—Sir John Phillips noting that in Carmarthen "the smallpox very mortal there among the Children"; in Pembrokeshire (1732); Anglesey (1747 and 1752); Cardiganshire (1759 and 1763); Carmarthenshire (1791); the Dolgellau-Llanfachraeth district (1791 and 1802); the industrial valleys of South Wales, particularly in the neighbourhood of Merthyr (1837-8); as well as sporadic outbreaks elsewhere. There was a serious epidemic throughout England and Wales in 1871-2, and in Cardiff a special smallpox ship was anchored outside the harbour for isolating those suffering from the disease. This was the last major epidemic in Wales, and by the twentieth century smallpox had ceased to be a major cause of disease and death, though localized outbreaks continued to occur.