8

Lady Dudley's District Nursing Scheme and the Congested Districts Board, 1903–1923

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This chapter outlines the attempts the Lady Dudley scheme made in tandem with the Congested Districts Board (CDB) to organize domiciliary medical care and to improve public health and sanitation in the West of Ireland from 1903 to 1923.[1] In the absence of egodocuments from officials or the native population, this chapter relies heavily on the scheme's and CDB's annual reports.[2] Although repetitious in nature, both sources—observations by nurses and CDB officials—provide us with an indication of medical, cultural, social, and economic circumstances in the West during this timeframe. The Dudley scheme's annual reports are of particular use because they incorporate detailed case notes and some interesting photographs of nurses interacting with patients.[3] This essay also attempts to tease out the relationship between medical care, the nurses, and the people.[4] Poverty and associated problems such as malnutrition and poor living conditions were a great challenge to practitioners of modern medicine during the period under review.

Lady Rachel Dudley (1876–1920, née Gurney) was the wife of William Humble Ward, third earl of Dudley, who was appointed lord lieutenant of Ireland in 1902.[5] The Dudleys had a holiday home in Connemara, an area of Galway whose inhabitants had endured particular distress throughout the nineteenth century. Although evidence of distress was still visible at the turn of the century, people were no longer

at "risk of starvation." However, Lady Dudley was particularly perturbed that in remote areas of the West no provision was made for nursing the sick poor in their own homes. In fact, outside of dispensaries and union (workhouse) hospitals, only four district nurses were working in the West, and they were maintained by external funding.[6] Two were supported by special funds (a Manchester Fund and the West of Ireland Association); the *Irish Homestead*[7] newspaper funded the third; and Queen Victoria's Jubilee Institute for Nurses (QVJIN) provided the other one, in Achill.[8]

To fully appreciate the role of the district nurse and the value of public health care in the West, it is necessary to give a brief overview of the Irish health-care system in the latter half of the nineteenth century.[9] Under the 1851 Medical Charities Act (14 and 15 Vic., c.68), Ireland was divided into 723 dispensary units. Each unit was managed by a committee composed of guardians and rate payers until the 1898 Local Government Act (61 and 62 Vic., c.37); after that, guardians were given sole authority).[10] Under this regime, the appointment of medical officers was unaccountable; it was done by election on an annual basis by poor-law guardians who more often than not served their own political agendas. This flaw in the system did not go unnoticed; a letter to the *Irish Times* in December 1903 criticized the election process and suggested that for the sick poor to be served more efficiently, appointments should be made by open competition.[11] Indeed, Ruth Barrington argues that the extent to which doctors (who from 1874 had the additional task of being medical officers for health) engaged in extracurricular activities was "to the detriment of their medical duties." She also highlights that local authorities were loath to increase tax rates, meaning the amount spent on health care for the poor remained the same year after year.[12] Further, local taxation was not an option in the West, where there were few "resident gentry or well-to-do inhabitants of the middle classes" to shoulder the burden, and without the wealthier classes it was impossible to raise voluntary contributions.[13] Several witnesses to local board government inquiries mooted ideas to locate "efficient nurses" in remote areas, but without serious consideration or funding, nothing came of the suggestions.[14]

There was an eclectic mix of unqualified and traditional medical practitioners in the West, most notably "handy women," who acted as midwives, or "wise women," who advised on all ailments from ulcers to abscesses. In urban areas, chemists were prescribing for all matters and acting as dentists. According to official reports to Parliament, bonesetters, cancer curers, and individuals who were described as "spectacle quacks" were also in operation.[15] Regardless of the three medical officers in the Dunfanaghy Union in 1909, it was found that the local shopkeeper prescribed and sold drugs and recommended various acids for dermatological conditions, "often to the disfigurement of the patient."[16] By 1900, people who resorted to formal medical health-care institutional options were limited to district hospitals and union hospitals, but the former were considered an adjunct to the "poor house," and this stigma meant that the majority of sick poor "preferred to die at home rather than enter an institution."[17] Generally speaking, medical care was inextricably linked to the poor-law system, which in the popular mindset was a euphemism for the "workhouse," an institution that aspiring smallholders despised. A sick person could avail himself or herself of treatment at dispensaries, smaller units manned by a medical officer, if a person held a black ticket or in the home if he or she held a red ticket; both types of tickets were obtained from the local poor-law guardian. Barrington also notes the dispensary system was notoriously corrupt in that guardians doled out tickets to rich and poor alike in exchange for votes.[18] This corruption did little to inspire confidence. From a professional perspective, Nurse Bridget N. Hedderman noted the people of Aran perceived the dispensary "as a kind of guillotine or deathtrap."[19] In a report to Dublin Castle in April 1889 on the "alleged distress in Donegal," William Lawson Micks,[20] in his capacity as a local government board inspector, also noted the reluctance to engage with formal systems of poor relief. He cites relatively low indoor and outdoor relief statistics, stating that the "tenacity with which country people cling to their homes is so well known that nothing short of the most acute suffering and utter despair will compel families to run the risk of abandoning their houses even temporarily and to become inmates of the workhouse."[21]

In addition to the medical system's apparent shortcomings and the people's unwillingness to engage in it, not all areas had the benefit of a medical officer. Some congested districts—those districts with living conditions so poor that they could not support the people who lived in them—were so remote that the delay in obtaining medical assistance cost lives; this was especially true in the case of the islands. Nurse Hedderman wrote how her appointment to Aran located her nine miles away from the nearest doctor, "a situation not without risk as there was no special concession for me: laws that applied to nurses on the mainland were equally applicable here."[22] That the people were slow to engage with official medical care meant that the real delay in seeking medical assistance was much longer than normal, so patients were usually on death's door by the time doctors and nurses intervened. Monsignor Walker of Burtonport wrote how it was "impossible for the dispensary doctor to reach the island [either Arranmore, Rutland, or Inisfree] in stormy weather, and consequently the sick are left to the mercy of the winds and waves; and the sad cases of deaths which occurred in such circumstances have been the source of the greatest pain and anxiety to myself and the resident priest on the Island for a long time."[23] Many congested-district residents were very impoverished and could not afford the doctor's fee. For the majority, when they were ill, it was a case of "trusting to chance," and as a result many people died, especially women in childbirth.[24] Midwifery services were not prioritized. Laurence Geary notes that in 1851 there were no midwives in Munster or Connaught and only three in Leinster and four in Ulster, and the situation did not improve until nursing and midwifery and its training were formalized in 1919 with a registration act.[25] Distinctions between "trained" and "qualified" were crucial to the debate on nursing as a profession or vocation. Union hospitals were not fully exploited as maternity services in the West, and therefore union hospital nurses' ability to aid the birthing process in a meaningful way was questioned.[26] Lady Dudley noticed that where the boards of guardians could not provide maternity nurses, situations were pitiful; instead, "the people assist each other," and the poor supported the destitute. These areas could not afford to raise the

monies necessary to employ a nurse, so external funding was of the utmost importance in the provision of domiciliary health care.[27]

Inspired by the high level of social inequity, Lady Dudley wrote a series of letters that appeared in Irish newspapers throughout 1902 and 1903, highlighting the lack of proper health care in the West, and from this attention a subscription fund evolved. This money was used to start the "Dudley scheme for the establishment of district nurses in the poorest parts of Ireland" in 1903. A few areas were selected for a pilot medical scheme to start "cottage" dispensaries in the more remote parts of the West or those areas farthest away from existing health-care provision. Lady Dudley's actions were not unusual and must be viewed in the wider context of philanthropy and social consciousness of the time.[28] To ensure that the nurses were trained in medicine, surgery, and midwifery, the Dudley scheme liaised closely with bodies associated with the QVJIN. This institute emanated from a public fund that was collected in 1897 in honor of Queen Victoria's Golden Jubilee and was subsequently used to fund training as well as district nursing schemes.[29] There were two affiliated training institutions in Ireland: Catholic nurses were trained at St. Laurence's, and Protestant nurses were trained at St. Patrick's Training House, both in Dublin.[30] It was envisaged that the Dudley nurses would be stationed on their own; to this end, supplementary district training was given.

Meanwhile, the CDB had been operating in eighty-four districts along the western seaboard in the counties of Donegal, Leitrim, Sligo, Roscommon, Mayo, Galway, Kerry, and West Cork since 1891.[31] Although the board was relatively well funded, health care did not fall under its remit; the board was expected to improve living standards in the designated districts through the development of agriculture, fisheries, existing cottage-based industries, and the creation of markets. It was not directly responsible for people's health issues, but it could not ignore the appalling living conditions. One nurse commented how a house she visited "was a most wretched one, with practically nothing in it. The patient was lying on a bit of grass on the floor, with no covering except an old skirt and jacket she had on. There was no under-clothing, bed or bedclothing. . . . It was the most pitiable state of

affairs that anyone could imagine, and I shall not forget my experience of that day for some time."[32] The board's first systematic attempt to deal with health fell under the rubric of sanitation issues; for this, the Parish Committee Scheme was founded in 1897.[33] In short, the board delegated authority to local committees to fund and supervise improvement works on houses. The Parish Scheme's initial aim was to remove animals out of the family dwelling and to move the cesspool from immediately outside the door to an allotted twenty feet away from the house. That same year the CDB agreed to pay the wages of a Jubilee nurse stationed at Achill Island, County Mayo.[34] Strictly speaking, the board was not permitted to spend its money employing a nurse, but it continued to do so until 1 May 1899; after that, the costs were paid out of the Achill Disaster Fund.[35]

Once the initial expenses of furnishing a house and equipping the nurse with a bicycle and the necessary medical stores (which amounted to £55) were paid, the Dudley committee, which was established to support district nurses, estimated that it cost between £108 and £112 per annum to place a nurse in a rural area.[36] Where suitably furnished houses were available, the initial outlay was reduced to between £90 and £100 per annum, but accommodation suitable for a trained nurse was usually unavailable in the selected poor districts.[37] In October 1904, the committee approached the CDB for help in finding accommodation in the congested districts of Ballycroy, County Mayo; Glengariff, County Cork; and Arranmore Island, County Donegal. The board agreed either to purchase or to build cottages at the specified locations on the condition that the committee paid the interest on the capital sum.[38] In 1906, the board provided cottages for nurses at Annagry, County Donegal; Dooks and Caherdaniel, County Kerry; and Bealadangan, County Galway.[39] It was not difficult to convince the CDB to get involved because it had always been concerned with people's health but had been curtailed by legislation. Aside from home-improvement schemes, the board had been running small coffee stalls for fishermen at Teelin and Malinbeg since 1894, and in later years similar stalls were opened at Downings Bay and Kincasslagh. These stalls were designed to combat what the CDB felt was excessive alcohol consumption among fishermen and

employed women at six shillings a week to sell coffee at a penny per cup.[40] Because the board was separate from any particular political ministry, people accepted its help a little more readily than they would help from government agencies, so an affiliation to the board served the Dudley committee well. Indeed, the Dudley committee admitted that without CDB support it would not have been able to operate in the congested districts and "would have been compelled most reluctantly to move the nurses, who were doing excellent work, elsewhere."[41] The accounts of the Dudley committee, in table 8.1, make clear the extent to which the committee was financially dependent on the CDB.

Once established, the Dudley committee was overwhelmed with appeals for nurses from both overworked doctors and local clergy, who were frustrated by the lack of facilities, but one of the stipulations for

Table 8.1
Location and Year in Which the CDB Houses Were Built

Location of CDB House	County	Year
Geesala, Ballycroy	Mayo	1904
Glengariff	Cork	1904
Arranmore	Donegal	1904
Anagry	Donegal	1906
Caherdaniel	Kerry	1906
Dooks	Kerry	1906
Spiddal	Galway	1908
West Cove	Kerry	1908
Derrybeg	Donegal	1909
Achill	Mayo	1909
Pulathomas	Mayo	1908
Bealadangan	Galway	1909
Roundstone	Galway	1911
Kiltimagh	Mayo	1911
*Tory Is	Donegal	1911

* Temporary residence.
Sources: CDB, *Seventeenth Annual Report* (Dublin: CDB, 1908), 34; CDB, *Eighteenth Annual Report* (Dublin: CDB, 1909), 25; Lady Dudley's Scheme, *Third Annual Report* (Dublin: n.p., 1906), 11–12; CDB, *Twentieth Annual Report* (Dublin: CDB, 1912), 31.

establishing a district nurse was that the area needed to collect as many subscriptions (donations) as possible.[42] In this regard, the people were granted active agency in the care of their communities. Following this subscription process, the committee provided the deficit funds for the maintenance of the nurse. There were a few exceptions to this rule; for example, in Roscommon a local committee had enough funds to maintain its own Jubilee nurse.[43] In Lissadell, County Sligo, Sir Josslyn Gore Booth guaranteed the costs from 1912 until 1921.[44] The *Irish Homestead* newspaper provided funding for two nurses from 1901 in Foxford and later at Pulathomas until 1907, when it approached the Dudley committee to take over.[45] When the CDB bought Tory Island in 1903, conditions were very primitive; there was a population of "355 persons, separated by 8 miles of sea from the nearest doctor." The board negotiated with other bodies, such as the Commissioners of Irish Lights and the Guardians of Dunfanaghy Poor Law Union, to maintain a nurse on Tory Island, and even the impoverished islanders made subscriptions voluntarily in support of the service.[46] In this instance, the board agreed to pay £12 a year toward the cost of providing a qualified nurse.[47]

Funding was an issue that required careful consideration because the expense involved in supplying a nurse was substantial. Table 8.2 shows the cost of providing nineteen nurses in 1909–10. As the table highlights, salary payment was the largest expense, but accommodation costs would have been much higher were it not for the CDB, which provided fifteen of the nineteen nurses' homes by 1912.[48] Despite the fact that most of the nurses used bicycles, traveling costs remained higher than rents and taxes owing to some patients' remote location. The committee relied heavily on subscriptions, and although Lady Dudley moved to Australia in September 1908, she continued to support the Irish initiative from there.[49] She arranged for Sir Ernest Shackleton, who had sojourned at her home in Australia, to give a lecture in Dublin on his return from the *Nimrod* Antarctic expedition, and it raised £315 for the scheme.[50] That year the CDB gave £50 to the Dudley scheme and continued this grant in aid of the scheme until the board's dissolution in 1923.[51]

The district nurse was theoretically supposed to work alongside and under the direction of the local dispensary doctor, but the Dudley

Table 8.2
Budget, Lady Dudley's Scheme, 1910

Receipts	Pounds (£)	Shillings (s)	Pence (d)	Expenditure	Pounds (£)	Shilling (s)	Pence (d)
Cash at Bank of Ireland	781	8	10	Nurses Salaries	1,806	6	11
Deposit	502	0	2	Rents and taxes	119	4	11
Cash in secretary's hands	3	18	6	Furnishings and repairs	113	6	2
Donations	190	14	3	Medical appliances, stores, and nourishments	77	19	8
Subscriptions*	1,688	19	5	Traveling expenses	232	8	7
Dividends and income tax refunds	363	3	7	Sundries	105	1	9
Collecting boxes	10	11	5	Management salaries	125	0	0
Annagry Christmas tree	1	1	0	Printing and stationery	57	9	8
Leyden fund	24	0	0	Sundry expenses, including postage	48	13	1
Spiddal fund		10	0	Traveling and inspection	32	1	0
Nurse's stoves	8	11	0	Annagry Christmas tree	1	1	0
Emergency cases	13	9	8	Leyden fund	32	10	9
Interest on deposit account	8	19	1	Nurse's stoves	8	11	0
Shackleton lecture	315	12	6	Emergency cases	9	13	1
				Investments	509	9	0
				Balance in bank	645	3	9
Total	3,944	0	4		3,944	0	4

* Including interest on Irish Women's Memorial Fund given by the QVJFN.
Source: Lady Dudley's Scheme, Seventh Annual Report (Dublin: n.p., 1910), 22–23.

nurses worked mainly on their own initiative. More often than not, nurses were called because the doctor was unavailable; Nurse Brady, based in Annagry, County Donegal, commented after one case that "[t]he doctor had not yet arrived. . . . I thought at the time I should certainly lose him [the patient]. I do not know what these poor things would have done without the nurse's services[;] several times this month it has been impossible to get a doctor, the latter having so much to do."[52] The absence of a doctor was a regular occurrence. In a letter to the Dudley fund, Father Anthony Timlin wrote, "Short a time as your nurse has been here, she has been the means of saving the life of a poor woman. The doctor was from home when sent for, and were it not for the nurse it is generally believed the poor woman would have been lost to her weak little family."[53] In areas where nurses, unlike doctors, were accepted unequivocally, they had a twofold position, that of health-care provider and educator; one priest noted how "she [the nurse] acts the part of instructress in matters of hygiene, cookery and cleanliness; and as the poor are apt and anxious to learn, we expect great after good as the result of her services."[54] Nurses were nearly always female; they were perceived as maternal figures, and the remit of those engaged in the public health-care setting was broadly defined. On entering a household, a nurse was expected to conduct domestic duties, such as cooking and cleaning as well as caring for children.

As a result of CDB initiatives, many significant improvements occurred in living standards (through the parish committee schemes), but the CDB was a self-help agency, and it did not receive a unanimous response from the people. As a consequence, many substandard, unsanitary dwellings remained in use in parts of the West. When Nurse De Largy was relocated to Foxford (following a four-year stint in Dooks, County Kerry), she was deeply upset by the level of destitution there; she remarked how her first case "was rather a shock. Half the room was little more than a dung heap. At the other side was a big turf fire pouring smoke into the room (for there was no chimney) and round it were a man and woman, five children, a dog, a calf, a donkey and four or five fowls."[55] In this instance, the patient was a baby with chronic

pneumonia, and, according to De Largy, the pneumonia was caused directly by the poor living conditions. The very design of this type of cabin was not conducive to good health, being damp and poorly ventilated and lacking a chimney. These conditions led to a high number of respiratory diseases, and the risk factor was exacerbated by cohabitation with animals. Poor housing stock and families living in clusters also aided the spread of fever and disease.[56]

Despite the high levels of training, Dudley nurses had much to reconcile given the poor reputation that assistant nurses had in workhouses.[57] An obvious social and cultural gulf existed between the two classes—the educated nurses and the poor local people—and the resident population initially challenged the authority of female health-care providers. That the nurses lived in sturdy houses, wore uniforms, and used bicycles and on occasions motorcars meant that they were visibly a different class from the resident women, and a reluctance to engage was apparent particularly among the women of the congested districts. Hedderman found that "the men's conversion to modern methods is much more pronounced than the women's. . . . The women cling to their ancient beliefs with a tenacity which is hard to credit."[58] Unsurprisingly, perhaps the biggest obstacles to advancing better practice were the extent to which folk medicine was used and the power held by local handy women and bonesetters. Nurse Hedderman noted on the Aran Islands, "Until recently our islanders knew nothing of modern nursing. . . . [T]hey adopted ways as old-world and quackish as they were unscientific."[59] The prevalence of ethnomedicinal practice, faith healing, and other less expensive forms of self-medication using patent medicines also worked against proponents of scientific medicine.[60] Mrs. Hazell of Cashel House, County Galway, remarked how the people were "most ignorant and allow sick people to eat and do most unheard of things. It is against ignorance of this sort the nurses have to fight and they will no doubt bring wisdom and cleanliness to many homes."[61] When Nurse Rosina Hayes attended a maternity case in Carna, she found that the only reason she was called was that the local "handy woman" was drunk and was unable to deliver the child. The expectant mother explained that she had not called for medical assistance in the

first instance because the neighboring women said the handy woman was "lucky."[62] In another instance, Nurse Brannagan found it difficult to convince the women of Derrybeg to follow her instructions regarding "measley children," and they continued to fill them with "horrid whiskey" and "piled dirty clothes" on them.[63] An anonymous account in 1908, five years after the induction of the Dudley scheme, noted a case of a young boy who had broken his leg, and his parents sent for a bonesetter. The child was in severe pain, and only after the priest's intervention would they allow the nurse to tend to him. Under no circumstances would they allow the child to see the doctor, despite the nurse's repeated efforts to get them to do so. In this instance, the nurse was perceived as the bridge between the people, the clergy, and the doctor. More accounts highlight how the people were happy to adopt a hybrid approach to medical health care that embraced modern medical practice but did not abandon traditional remedies. The following story illustrates this point:

> Had been attending a case of ulcerated leg for some days. I called unexpectedly one evening and found the patient had been treating her leg in an extraordinary manner. I discovered a large piece of moss, with earth attached to it, laced on the open sore, with the earthen side next it. I naturally felt quite irate and asked why my treatment had been abandoned. I received a long explanation of the virtues attached to the moss cure, and was told an old woman prescribed it. . . . [S]uperstition was, of course, at the back of all this. I merely relate this as an instance of some of the difficulties a nurse has to meet in dealing with patients of this class.[64]

Among the nurses, there was little tolerance of ethnomedical practices; its persistence reminded them of the social gulf that existed between them and their patients. Ethnocentric tones were probably inadvertent, but the discourses on the body that can be gleaned from these reports are almost that of redemption, sanitation, and reclamation from all that was ill about rural western society.

It took a while before the nurses won their localities' trust and respect; with it, they began to have a profound impact on health care and on raising levels of cleanliness. In stark contrast, the lesser-trained

nurses in union hospitals were not viewed in the same favorable light; one Limerick child described them as not being "right nurses," but "oul wans wud dirty necks an yallah sthrings to their caps."[65] Maria Luddy cites cases whereby lay women carried out work in lieu of maintenance in institutions, but more significantly she highlights that from the 1860s the religious orders, such as the Sisters of Mercy, were making efforts to take control of union hospitals, and they subsequently supported and perpetuated "the existence of a cheap welfare system."[66]

On the strength of the Dudley scheme's success, the Vice Regal Commission on Poor Law Reform in Ireland recommended more "cottage hospitals" for remote districts of the Northwest, to be "attended by the dispensary doctor and with a fully trained Nurse of the Jubilee class."[67] A party of Parliament members who visited the West in 1906 reported how "deeply impressed" they were "with the value of the work of Lady Dudley's nurses in these districts. They say that the elevating and refining influences of such devoted women cannot be overstated, and they are rewarded by the gratitude and affection of the people to whom they minister."[68] In August 1907, the report of the Vice Regal Commission on Poor Law Reform described the scheme as "a remarkable and unquestionable success." In 1909, the commission proposed that a complete overhaul of the system be made, that doctors be paid out of parliamentary funds, and "that the hospitals should be taken completely out of the Poor Law." This proposal was rejected in favor of a "transfer of all infirmaries and hospitals to the County Public Assistance Authority, which would co-ordinate the medical institutions of their area, and organize an outdoor service, including the Medical Dispensary Service and the appointment of nurses for nursing in the homes of the necessitous."[69] But this proposal did not go into effect, nor did it entice the government to invest directly in district nursing schemes.

Before long, it became obvious to the Dudley committee that working in the congested districts was very physically demanding for the Jubilee nurses. Travel to patients often included cycling, hiking over hills, traversing fields, sometimes paddling in boats— often in darkness. Nurses were expected to conduct all medical and educational duties; they were exposed to infectious disease and, because of the abject poverty

they witnessed, psychologically disturbing situations. On arrival, nurses had to deal with issues of health, malnutrition, and sanitation; in every respect, the nurses were overworked. It was also found that the nurses' diligence was expended often to their detriment, and that in most cases for ethical and moral reasons they willingly risked life and limb. Both Nurse De Largy, stationed in Dooks from 1907, and Nurse Ellen Donald, who was in Derrybeg in 1909, contracted typhus while performing their duties.[70] Nurse Hedderman, who was stationed on Aran, later recounted "the hardships connected with maternity work, in one of the loneliest and most isolated districts in the West of Ireland."[71] Like many other Victorian institutions, the committee in charge of the Dudley scheme was patriarchal and felt "responsible for their [the nurses'] appointment and regard the wellbeing [*sic*] of their nurses as a sacred trust."[72] Two nurses (Leyden and Trinham) were "forced to resign on account of ill-health" because of "the hard and trying conditions of their lives with constant exposure to weather[,] long hours of work and incessant anxiety and responsibility."[73] By 1910, the committee had recognized the "arduous nature of their duties," and in 1913 it was decided to put a maximum limit of three years on the amount of time nurses could spend in the congested districts.[74]

From 1913 to 1923, the Dudley committee operated smoothly but did not expand because from the outset efforts were hampered by financial problems. Following the implementation of the 1911 National Insurance Act, costs increased, and that year the QVJIN decreed that each of the affiliated societies should pay £40 toward the training of each nurse.[75] During the Second World War, financial limitations meant a drain on funds and left a mere twenty-three nurses in twenty-one districts.[76] In 1916, the committee even scaled its annual report down to a one-page document to cut back on printing costs.[77] The situation improved slightly after Lady Dudley's tragic drowning while she was on holiday in Connemara in 1920. Lady Mayo collected £40,000 in the United States as a memorial.[78] This money was used to sustain the current number of nurses, though the Dudley scheme failed to expand; its optimum number of nurses was twenty-one, a relatively small number considering the fact that there were eighty-four congested districts.

Although this low number was in part owing to the lack of funds, the few women applying to the Jubilee nursing schemes was a more pressing issue. It was most difficult to entice Catholic women into the scheme, despite its scope for upward mobility.[79] Nationalist and sectarian issues also prevented Catholic women from entering the Jubilee training institutes because the latter were perceived as Anglophile institutions (despite the fact that the Catholic nurses were trained at St. Laurence's separately from Protestant Jubilee nurses). The fallout was that some areas lost their nurses; for example, in 1914 the position in Pulathomas was vacant for more than a year.[80] In addition, the lack of participation of Irish-speaking women posed communication problems, and the committee later introduced remunerative incentives for nurses to become proficient in the Irish language.[81] As Barrington remarks, "[T]he service was uneven and depended entirely on local initiative," and in the grander scheme only 21 of Ireland's 174 district nurses in 1917 were employed under the Dudley scheme.[82] Although Barrington is very critical of the scheme, she is careful to note how invaluable the service was to the sick poor living in remote districts. Albeit a small-scale operation, the relationship between the CDB and the Dudley committee was a very practical and productive one. At the last CDB meeting held on 29 May 1923, it was decided that all CDB property would be presented as gifts to the respective communities. In other words, the Dudley committee and the district nursing scheme had the benefit of the houses free.[83] The Dudley scheme subsequently enjoyed good relations with the Irish government, and it continued until 1974, after which the respective health boards reemployed the Dudley nurses.[84]

The long tradition of local authorities using local clergy, benevolent landlords' charities, and programs such as the Dudley scheme as a panacea for its own shortfalls in the provision of health care and sanitation in remote rural districts was difficult to redress, and this situation did not change in independent Ireland. In the 1927, the *Report of the Commission on the Relief of the Sick and Destitute Poor Including the Insane Poor,* the existence and "extraordinarily good work" of the Jubilee nurses were acknowledged, but no alternative system proposed. Indeed, the report took the continuance of the scheme for granted.[85]

Although the provision of privately funded schemes alleviated local authorities' huge burden of responsibility, it also allowed them the bad habit of not budgeting sufficiently for health care in general, not to mention domiciliary health care. In this political climate, where local authorities effectively ignored their responsibilities regarding health-care provision, voluntary initiatives such as the Dudley scheme were absolute necessities.