

**"ESSENTIALLY A WOMAN'S WORK":
A HISTORY OF GENERAL NURSING IN NEW ZEALAND,
1830-1930**

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Abstract

At the time of the first European settlement of New Zealand, nursing was vaguely defined, an amorphous collection of domestic duties undertaken mostly by women, usually within the confines of the home. By 1930, it was regarded as a professional occupation, for which young single women undertook a specific course of training, passed examinations and were registered as properly qualified by the State. This thesis examines the ways in which nursing achieved this transition and the ideological foundations on which the new "profession" was built. It focuses on general nursing, rather than psychiatric nursing or midwifery, and it concentrates on the three- or four-year period of training which every nurse undertook within a hospital before entering the workforce as a trained nurse. At the same time, it includes a collective biography of the women who worked as nurses in New Zealand, both those untrained women who cared for family, friends and paying patients in their communities in the 19th century, and the the women who became New Zealand's "Nightingales", its first trained and registered nurses, in the period 1892-1930.

Nursing in this period remained "essentially a woman's work". Nursing reformers incorporated into trained female nursing ideologies of "womanliness". In order to achieve respectability for nursing, they shaped the "good nurse" as first and foremost a "good woman", pure, gentle, disciplined, self-sacrificing and unquestioningly obedient to male authority. The thesis examines both the positive and negative impacts of this philosophy. Nurses achieved a measure of professional recognition and a high degree of public approbation. On the other hand, because theirs was "woman's work", the formal education they received was minimal, and pay and working conditions were less than adequate. Nurses remained the "handmaidens" of doctors and the "servants" of hospital administrators. A new generation of nurses in the 1920s began to question the ideologies of the past, but nursing leaders remained committed to the "true spirit of nursing" and reforms were accordingly very limited in scope.

Abbreviations

AJHR	Appendices to the Journals of the House of Representatives
ATL	Alexander Turnbull Library
CHB	Canterbury Hospital Board
CMU	Canterbury Museum Library
CU	University of Canterbury Library
DNZB	Dictionary of New Zealand Biography
DUHO	Hocken Library, Dunedin
ES	Evening Star (Dunedin)
KT	Kai Tiaki (called the New Zealand Nursing Journal from 1930)
LT	Lyttelton Times
NA	National Archives, Wellington
NA (Christchurch)	National Archives, Christchurch
NCHB	North Canterbury Hospital Board
NERF	Nursing Education and Research Foundation
NZMJ	New Zealand Medical Journal

NZMJ	New Zealand Nursing Journal (called Kai Tiaki, 1908-1929)
NZPD	New Zealand Parliamentary Debates
NZTNA	New Zealand Trained Nurses' Association
ODT	Otago Daily Times, Dunedin
OHB	Otago Hospital Board
OW	Otago Witness, Dunedin

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Introduction

In 1986, the New Zealand Nursing Education and Research Foundation published a bibliography of printed sources on the history of nursing, *From candles to computers*, which contained over 3000 entries.¹ The sources listed covered most aspects of nursing and midwifery but did not include any general history of the development of nursing as an occupation for women in this country. The Foundation hoped that such a history might follow the publication of its bibliography and indeed a number of valuable studies have since appeared. Several excellent theses have been written, including Deborah Dunsford's study of the working conditions of nurses at Auckland's hospitals,² Alexandra McKegg's account of the backblocks nursing service and the Maori health nursing service,³ and Jan Rodgers' studies of nursing education in New Zealand and nurses who served during the South African and the first world wars.⁴ There are many local hospital histories and histories of schools of nursing available. Autobiographies and reminiscences of nurses abound and the *Dictionary of New Zealand biography* includes a large number of authoritative biographical essays on individual nurses. Several essays on other aspects of nursing have been published in volumes of conference papers and other collections.⁵ There is, however, still no general study which compares with those written by historians elsewhere in the western world. In England, Brian Abel-Smith's history of the nursing profession first

1 P. Sargison. *From candles to computers: a bibliography of printed sources on the history of nursing in New Zealand*. Wellington: NERF, 1986.

2 D. Dunsford, 'The privilege to serve others': the working conditions of general nurses in Auckland's public hospitals, 1908-1950, MA thesis, University of Auckland, 1994. Ms Dunsford's thesis includes in its first chapter a comprehensive and useful historiography of nursing history in New Zealand.

3 A. McKegg, 'Ministering angels': the government backblocks nursing service and the Maori health nurses, 1909-1939, MA thesis, University of Auckland, 1991.

4 J. Rodgers, Nursing education in New Zealand, 1883 to 1930: the persistence of the Nightingale ethos, MA thesis, Massey University, 1985; 'A paradox of power and marginality': New Zealand nurses' professional campaign during war, 1900-1920, PhD thesis, Massey University, 1994.

5 See for example, L. Bryder (ed.), *A healthy country: essays on the social history of medicine in New Zealand*, Wellington: Bridget Williams Books, 1991; N. Chick & J. Rodgers (eds.), *Looking back, moving forward*, Palmerston North: Massey University, 1997; L. Bryder & D. Dow (eds.), *New countries and old medicine: proceedings of an international conference on the history of medicine and health, 1994*, Auckland: Auckland Medical History Society, 1994.

appeared in 1960 and his work has since been expanded by writers like Celia Davies, Christopher Maggs, Anne Marie Rafferty and Martha Vicinus.⁶ In the United States, Charles Rosenberg, Barbara Melosh and Susan Reverby have led the way,⁷ while in Australia, several general studies of nursing in various states have been written.⁸ It is this gap in New Zealand nursing historiography which my thesis seeks to fill. While all the works cited above have influenced the shape and content of the thesis to some degree, those of Martha Vicinus and Susan Reverby have been particularly inspiring.

At the time of the first European settlement of New Zealand, nursing was vaguely defined and in no way a self-conscious or identifiable occupation. For the missionaries, it was a tool to be used in the 'civilisation' of the Maori people. Within the wider community, it was associated with women's domestic duties in the home - breastfeeding, childminding, the care of mother and infant before and after childbirth, and the care of the sick and infirm - although the demands of pioneer life meant that sometimes men also nursed. For most, it was a labour of love, part of a woman's duty to care for her family, but some women extended their care to others in the community, nursing friends and neighbours in times of need. Gradually some women who needed to earn a living, either because they had been widowed or for other reasons, began to charge for their nursing services. Such women, although often highly regarded within their communities, had no professional status, being classed with domestic servants in the 1874

6 B. Abel-Smith, *A history of the nursing profession*, London: Heinemann, 1960; C. Davies, *Gender and the professional predicament in nursing*, Buckingham: Open University Press, 1995; R. Dingwall et al., *An introduction to the social history of nursing*, London: Routledge, 1988; C. Maggs, *The origins of general nursing*, London: Croom Helm, 1983; J. Moore, *A zeal for responsibility: the struggle for professional nursing in Victorian England, 1868-1883*, Athens: University of Georgia Press, 1988; A.M. Rafferty et al. (eds), *Nursing history and the politics of welfare*, London: Routledge, 1997; M. Vicinus, *Independent women: work and community for single women, 1850-1920*, London: Virago, 1985.

7 B. Melosh, *The physician's hand: work culture and conflict in American nursing*, Philadelphia: Temple University Press, 1982; C. Rosenberg, *The care of strangers: the rise of America's hospital system*, New York: Basic Books, 1987; S. Reverby, *Ordered to care: the dilemma of American nursing, 1850-1945*, Cambridge University Press, 1987.

8 See for example, A. Hyslop, *Sovereign remedies: a history of Ballarat Base Hospital, 1850s to 1980s*, Sydney: Allen & Unwin, 1989; G. Strachan, *Labour of love: the history of the Nurses' Association in Queensland, 1860-1950*, Sydney: Allen & Unwin, 1996; R. Tremblath & D. Hellier, *All care and responsibility: a history of nursing in Victoria, 1850-1934*, Melbourne: Florence Nightingale Committee, 1987.

census.⁹ Hospital nurses who were employed in the institutions which began springing up in the 1850s and 1860s were older working-class men and women, often former patients. They attended the poorest and least respectable members of society and enjoyed a far from unsullied reputation. They were regarded, in Florence Nightingale's words, as "too old, too weak, too drunken, too dirty, too stolid, or too bad to do anything else".¹⁰

By 1930, however, nurses were no longer regarded as uncouth, immoral or belligerent. On the contrary, nursing was accepted as an occupation "which next to motherhood, is ... the highest ideal for women".¹¹ Nurses were young, single, professional women who underwent a specific period of training in the medical care of the sick, passed examinations and were registered as properly qualified by the State. Nurses had achieved a high level of respectability and public approbation. They were said to be "saintly women [who] were kind and gentle to all",¹² the manifestation of devotion to work in the spirit of service.¹³

This thesis attempts to explain how and why nursing was so transformed and the ideologies which shaped its development as respectable women's work. It suggests that the reformers overcame obstacles to respectability by linking the words "good nurse" with "good woman". The ideal woman in the nineteenth century western world embraced such virtues as modesty, chastity, temperance, humility, patience and piety within her "natural" environment, the home. Because her "nature" was specifically designed for motherhood, the ideal woman confined her interests to domestic responsibilities. She was not fitted for the public world of paid employment. Nursing reformers, however, saw an opening whereby women's "natural"

9 *Results of a census of the colony of New Zealand, 1 March 1874*, Wellington: Govt. Printer, 1875, pp. 155-156.

10 Quoted in Abel-Smith, p. 5.

11 Alice Holford, first matron of St. Helen's Hospital, Dunedin, P. Sargison, "Holford, Alice Hannah, 1867-1966", *DNZB, volume 3, 1901-1920*, p. 226

12 Letter to the editor by M. Bradley, *ODT*, 27 November 1916, OHB newspaper cutting books, v.11, p. 48.

13 Opening address by the Minister of Health to the matrons' conference, *ODT*, 15 June 1927, OHB newspaper cutting books, v.34, p. 12.

capacities for "social feeling", caring and service, already evident within the domestic sphere, might be expanded beyond the family into a wider field of service to humanity. Nursing, embedded as it was in women's private mothering and caring domestic duties could easily be enlarged to embrace "social motherliness", without in any way threatening the public roles of men.¹⁴ If "good nurses", like "good women", were pure, gentle, disciplined, self-sacrificing, subservient and unquestioningly obedient to male authority, then they could create a place for themselves within the public world of paid employment which was both respected and admired.

The thesis goes on to examine the consequences of the reformers' decision to utilise current ideologies on "womanliness" in order to create a respectable occupation for virtuous women. By constructing the "good nurse" as first and foremost a "good woman", nursing reformers were able to avoid offending the male prejudices which hampered the progress of other working women, like women doctors and lawyers. By the end of the nineteenth century, training programmes for single women had been successfully introduced in most New Zealand hospitals, attracting large numbers of middle-class women who had not previously been engaged in paid employment. In 1901, New Zealand became the first country in the world to establish state registration of nurses, which guaranteed them at least a basic nursing education and conferred on them considerable status.

The creation of an exclusively female community was also empowering for many of the first trained nurses. Martha Vicinus argues that no sense of "sisterhood" developed in nursing in England because it was too rigid and hierarchical,¹⁵ but within the smaller New Zealand nursing world, this was less true. At least until the 1920s, many nurses experienced a distinct female culture which one claimed, "makes even the most difficult task easy".¹⁶ Nurses were able to exclude all men from the profession, even

14 D. Riley, *'Am I that name?': feminism and the category of 'women' in history*, Basingstoke: Macmillan, 1988, pp. 44-66.

15 Vicinus, pp.111-112.

16 Annual report of Rose Muir, matron of Christchurch Hospital, NCHB minutes, 27 April 1921, p. 597.

during the war, because it was accepted that "no man nurse can adequately take the place of a trained woman".¹⁷

Some of the consequences of the reformers' decision to equate a "good nurse" with a "good woman" were less happy. By delineating nursing more as self-sacrificing service in the care of others than as employment by which women might earn a living, nurse leaders created a weapon for male doctors who were determined to pursue their own supremacy within hospital and health care hierarchies, and for male administrators who were determined to provide a hospital service at minimum cost to ratepayers.

In New Zealand doctors were largely responsible for the changes which resulted in the introduction of trained female nursing to hospitals and they were not prepared to relinquish this leadership to the new female authorities, the matrons. Matrons found themselves caught between their desire to establish their leadership in nursing matters and the ideologies on which trained nursing was premised, which demanded unquestioning loyalty and obedience to male superiors. It quickly became clear that without male support, matrons were unlikely to be successful within the hospital environment. Doctors remained in control of nurse training and, because they drew up the syllabus, gave the lectures, wrote the textbooks, and set and marked the examinations, were able to prescribe what knowledge they were prepared to share. The nurse's role remained that of assistant only, a faithful handmaiden serving her male lord. Doctors also prescribed what was "proper" work for nurses. Specialities like midwifery and anaesthetics, where nurses offered a genuine source of alternative care and thus were a real threat to medical domination, become battlegrounds in the war for supremacy in the provision of health care.

The ideologies which permitted doctors to retain their ascendancy over nurses also permitted hospital administrators to ignore for the most part claims from nurses for improved working conditions or higher pay.

¹⁷ A.A. Martin, *A surgeon in khaki*, quoted in *KT*, 9:2, April 1916, p. 106. Male orderlies did much of the menial work in military hospitals but under the supervision of nursing sisters who carried out most of medical nursing work.

Because nursing was "essentially a woman's work",¹⁸ closely allied to domestic caring and social service, nurses worked long hours with only brief holidays and for minimal pay in the years up to 1920. Hospital managers were also able to downplay the importance of nursing education because nursing was "natural" for women and training emphasised character rather than skill as the prime requisite of the trained nurse. "The womanly woman, who enters with the true spirit of compassion, leaves the hospital MORE sympathetic, MORE tolerant, MORE self-sacrificing than when she entered", noted Sister Cecilia McKenny in *Kai tiaki* in 1910.¹⁹ Accordingly, little time was allowed for study; the student nurse spent most of her days in work. She cleaned, polished, washed laundry and cooked meals for patients, as well as providing almost all their nursing care.

The post-war years brought some changes to nursing, but the ideological premises which had shaped the profession from its earliest days ensured that such changes remained minimal. Severe nursing shortages and the changing profile of the average student nurse compelled hospitals and the government to increase pay levels and offer weekly holidays to staff, while increasingly complex medical procedures and techniques required more emphasis to be given to scientific education programmes. Nevertheless, in the face of considerable social change, nursing leaders remained determined to preserve "the true spirit of nursing" as the primary focus of both training and practice. Nursing work was not "to be looked upon as a fee-producing necessity" but as a "strong sense of duty", in which only women of the highest ideals participated in a "spirit of sacrifice".²⁰ Only by reinforcing these ideals could nurses retain the approbation they had won as workers in the most womanly and therefore the most respectable of occupations.

The thesis also attempts to provide a collective biography of the first women nurses in New Zealand, both the untrained women who cared for

18 Isabella Fraser, matron of Dunedin Hospital, 1893-1911, quoted in J. Rodgers, "Fraser, Isabella, 1857-1932", *DNZB, volume 2, 1870-1900*, p. 155.

19 *KT*, 3:1, January 1910, p. 33.

20 Paper read at the Trained Nurses' Association conference, 1926, *KT*, 19:4, October 1926, pp.154-155; presidential address to the 1925 conference, *KT*, 18:4, October 1925, p.170.

family, friends and paying patients in their communities in the first years of European settlement, and the women who became New Zealand's "Nightingales", its first trained nurses, in the late nineteenth and early twentieth centuries. In the latter case, the focus has been primarily on nurses who trained at Dunedin and Christchurch Hospitals between 1892 and 1930, although some nurses from other regions are mentioned. Deborah Dunsford has studied nurses at Auckland Hospital in the period 1908-1950, but a comparative profile of nurses from other major training institutions, especially Wellington Hospital, is something which might usefully be considered by future researchers.

It did not prove possible within the confines of a single thesis to examine all the developments in nursing which occurred within the period 1830-1930. The thesis focuses on the history of general nursing and does not cover psychiatric nursing or midwifery. Psychiatric nursing, where male nurses continued to dominate, seldom overlapped with general nursing, while the history of midwifery in New Zealand has been described by Philippa Mein Smith in *Maternity in dispute* and Joan Donley in *Save the midwife*.²¹ A comparative study of power and gender relationships within midwifery and general nursing is another topic which might be pursued in the future. The general practitioner who saw "midwifery practice as a means of livelihood" resented the intrusion of independent trained midwives who "assumed medical functions" into his domain.²² Doctors preferred instead to work with general nurses, who also had maternity training. These women, thoroughly indoctrinated by schools of nursing in ideologies of subservience and obedience, worked happily under the direction of medical men and were always ready to call for medical assistance. By 1930, doctors had seized control of childbirth through medicalisation and hospitalisation, and independent midwifery had been replaced with maternity nurses who could not work without medical supervision.

21 P. Mein Smith, *Maternity in dispute, New Zealand, 1920-1939*, Wellington: Historical Branch, 1986; J. Donley, *Save the midwife*, Auckland: New Women's Press, 1986.

22 Letter from F. R. Riley, *NZMJ*, February 1930, p. 44.

The thesis focuses specifically on the three-year period of training in a hospital which every general nurse undertook to prepare her for her future career. It was during this period that the ideological prescriptions on which trained nursing was founded were instilled. No attempt has been made to investigate the ways in which these ideologies continued to shape the lives of nurses after graduation. Before the 1920s, few trained nurses remained in hospital positions, partly because hospital finances depended on the bulk of nursing care being carried out by poorly paid pupil nurses, and partly because nursing positions outside the hospital offered more flexibility. Before the war, many nurses worked privately, either in their patient's home or, in the postwar period, more often in a private hospital. Other nurses worked in the public health arena, with Plunket nursing and school nursing becoming very popular. District nursing, backblocks nursing, Maori health nursing, tuberculosis nursing and geriatric nursing offered other avenues of employment. Hester Maclean, assistant inspector of hospitals from 1906, continually urged her nurses to consider becoming involved in

all the schemes put forward for the betterment of the race in regard to health and living conditions... It is for nurses to show that the full qualification of a nurse makes a better health visitor, sanitary inspector, child-welfare worker, and so on, than any other woman with only partial qualifications.²³

Nurses in the 1920s and 1930s did take up these opportunities. It would be interesting to study at some later date the ways in which the gender ideologies on which their training was premised spread and changed in these new fields of endeavour.

By 1930, the first period of major nursing reform in New Zealand had ended. Changing social conditions and the widening range of employment opportunities available to young women in the 1930s greatly affected the attitudes and goals of student nurses. Mary Lambie, who became director of the Division of Nursing in 1931, took a more progressive attitude to modernising nursing, while the 1938 Social Security Act brought major

²³ Editorial, *KT*, 12:4, October 1919, p. 151. She expressed similar sentiments on several occasions, for example, *KT*, 4:4, October 1911, pp.142-143; *KT*, 13:1, January 1920, pp.7-8.

changes to the health system and greatly increased demand for hospital beds. New ideas and new ideologies were aired, but the basic premise established by the Nightingales remained. In the words of Ida Willis, nursing was

a vocation. We belonged in the same company of teachers and preachers, of healers and poets and those whose intangible rewards were far in excess of financial payments. We were among the healers. We were giving practical expression to that powerful urge in women to help, to save, to remedy, to comfort and soothe. The fulfilment of this urge was our reward.²⁴

24 L. Ida Willis, *A nurse remembers*, Lower Hutt: Wilson, 1968, p. 20.

Chapter 1

"Every woman is a Nurse": the origins of nursing in colonial New Zealand

Missionary nursing

Pakeha medicine, together with pakeha concepts of nursing, came to New Zealand with the missionaries, who hoped that healing work would facilitate conversion of the heathen. John Owens suggests that it was "put to the Maoris that if they were willing to accept the benefits of European technical skills, so also should they accept the missionary testimony concerning Jehovah".¹ The missionaries found early evidence of the value of pakeha medicine in impressing potential converts. When Thomas Kendall successfully treated the widow of an important chief for a painful eye condition, the operation "considerably enhanced [him] in the estimation of his new friends ...".² Medical mission work appears to have been increasingly valued over time: Eliza Stack noted after staying with William Williams that the demand for Williams' medical services "shows what an advantage it is to the missionary's flock when he is qualified to minister to the needs of their bodies as well as their souls".³ By 1842, Richard Taylor could record in his journal that

I could not help noticing today what an influence the dispensing of medicine gives the Missionary over the Natives. Those men come humbly asking for medicine who have been most opposed to us, and would not otherwise have condescended to have been seen near us.⁴

Ernest Dieffenbach, surgeon and naturalist to the New Zealand Company, castigated missionary medicine as an unprofessional system of

1 John Owens, "Missionary medicine and Maori health: the record of the Wesleyan mission to New Zealand before 1840", *Journal of the Polynesian Society*, 81:4, December 1972, p.420.

2 J.L. Nicholas, *Narrative of a voyage to New Zealand*, v.2 (1817), p.132, quoted in A. Drummond, "The New Zealand family doctor before 1840", *Northland magazine*, 7:2, April 1964, p.7.

3 J.W. & E. Stack, *Further Maoriland adventures of J.W. and E. Stack*, edited by A.H. Reed, Dunedin: Reed, 1938, pp.197-198.

4 Taylor's journal, 18 April 1842, *Church missionary record*, 15, January 1844, p.40.

"dispensing, bleeding and blistering".⁵ Certainly mustard plasters and "opening medicine" (laxatives), usually in the form of Epsom salts, formed a major part of the missionary's medical armoury. Epsom salts were ordered by the hundredweight, since most of the missionaries seemed to believe that almost any case of sickness could be relieved by a "simple dose of Aperient Medicine".⁶ James West Stack recalled that, even as a child, he had free access to the cask of Epsom salts, with instructions that

whenever a Maori came for medicine for an adult in my father's absence, to give a tablespoonful wrapped up in a piece of paper, or a teaspoonful if the dose was for a child, and direct them to take the medicine in a certain quantity of water.⁷

The missionaries used the very simplest of remedies. Marianne Williams often gave tea to her patients⁸ which, her husband Henry said, seemed to revive them.⁹ Jane Williams sent arrowroot and wine to the ailing,¹⁰ and Samuel Ironside relied "chiefly on the simple remedies as rhubarb, jalop, James and Dovers powders [opium], with Epsom salts for the men".¹¹ Eliza White placed her faith in "salts and abstinence", and also administered rhubarb vinegar for pain and sulphur ointment for sores.¹² George Selwyn's favourite restorative consisted of chocolate, flour, sugar and water, a "very nourishing and warm" prescription "most popular" with the natives,¹³ while Lady Martin, in the hospital she established in Auckland, used rosemary tea with treacle for coughs, elder shoots and

5 E. Dieffenbach, *Travels in New Zealand*, London, 1843, 2, pp.160-161, quoted in Owens, "Missionary medicine and Maori health", p.420.

6 J. Stack, J. Hobbs and W. White, Wesleyan Methodist Missionary Society, 20 May 1830, quoted in Owens, "Missionary medicine and Maori health", p.423.

7 J.W. Stack, *Early Maoriland adventures of J.W. Stack*, Dunedin: Reed, 1935, p.216.

8 A. Drummond, "Keep a brave heart", in Sister Mary Damian (comp.), *Growl you may but go you must*, Wellington: Reed, 1968, p.149.

9 Henry Williams, 21 December 1826, L.M. Rogers (ed.), *The early journals of Henry Williams*, Christchurch: Pegasus, 1961, p.31.

10 For example, on 7 June 1840, she sent arrowroot and wine to the relative of one of her Maori girls and on 10 October 1842 to the husband of Meriana Wiremu, F. Porter (ed.), *The Turanga journals*, Wellington: Victoria University Press, 1974, pp.116, 217.

11 Quoted in L.K. Gluckman, *Medical history of New Zealand prior to 1860*, Auckland: Whitcoulls, 1976, p.54.

12 R. Fry, *Out of the silence: Methodist women of Aotearoa, 1822-1985*, Christchurch: Methodist Publishing, 1987, p.26.

13 Gluckman, p.96.

broom for dropsy, poultices of seaweed for swollen joints and wild marshmallow for sores.¹⁴

The missionaries also became experienced midwives, although their services in this respect were given to each other, rather than to Maori patients. Almost all the women were the mothers of large families. Jane Hobbs had nine children as well as at least three miscarriages.¹⁵ Marianne Williams brought three children to New Zealand with her, and then bore eight more, while Jane's six daughters and three sons were all born in New Zealand. Although husbands did cope with childbirth from time to time,¹⁶ the women tried, as far as possible, to be with each other for their deliveries. Sarah Fairburn assisted Marianne Williams when her fourth child was born a few months after her 1823 arrival in New Zealand,¹⁷ Marianne reciprocating the service in 1830.¹⁸ Charlotte Brown was midwife to Jane Williams in 1831, just as Jane had been for her the year before.¹⁹ The women learned from their mistakes; Eliza White's second daughter was strangulated at birth by the umbilical cord in 1833 but when the same complication occurred a few weeks later with Jane Hobbs' son, her attendants knew what to do and the baby was safely delivered.²⁰

Because mission personnel were few and scattered, both men and women carried out "doctoring" and "nursing" tasks. Nevertheless, it was the

14 Mary Ann Martin, *Our Maoris*, London: Society for Promoting Christian Knowledge, 1884, p.74.

15 J. Owens, "Missionary medicine and Maori health", p.423.

16 F. Porter records the case of Charles Baker who delivered his wife of a large baby girl at Tolaga Bay. Despite severe pain, dreadful flooding and difficulty in removing the placenta, both mother and child survived, "All that the heart does bear", R. Glen (ed.). *Mission and moko: aspects of the work of the Church Missionary Society in New Zealand, 1814-1882*, Christchurch: Latimer Fellowship of New Zealand, 1992, pp. 146-147.

17 Letter, 7 January 1824, quoted in S. Woods, *Marianne Williams: a study of life in the Bay of Islands, N.Z., 1823-1879*, Eastgate, 1977, [no page].

18 Letter, 7 September 1830, quoted in S. Goldsbury, *Behind the picket fence: the lives of missionary wives in pre-colonial New Zealand*, MA thesis, Auckland University, 1986, p.66.

19 Letters of Marianne Williams, 7 September 1830 and 9 February 1831, quoted in Goldsbury, pp.65-66.

20 S. Coney, "Eliza White", C. Macdonald, M. Penfold & B. Williams (eds.), *The book of New Zealand women*, Wellington: Bridget Williams Books, 1991, pp.724-725.

women who were more likely to give hands-on nursing care. Nursing skills were regarded as part of a woman's "female knowledge" in the early nineteenth century,²¹ knowledge which was passed from mother to daughter. Sarah Fairburn, for example, was an experienced user of homeopathic medicines, a skill she passed on to her daughter, Elizabeth.²² Accordingly, missionary men acted as "doctors" while the women were the "nurses". John Butler prescribed medicine while his wife, Hannah "cook[ed] rice, tea and other nourishing things" for patients at the mission house.²³ Mary Ann Matthews and her sister, Matilda nursed the sick at their mission hospital in Kaitaia but their husbands took charge of the medicine chest and surgical instruments sent out from London.²⁴ When Dr Samuel Ford, who joined the Church Missionary Society in 1837, established a cottage hospital in Auckland, it was his wife whom the whaler J. Williams recorded as being "kind and affectionate to the sick, lame, halt and blind".²⁵ Furthermore, daughters, not sons, were generally the ones who assisted in nursing work. Jane Williams wrote in 1828 that "the elder ones are very useful in washing, ironing, sewing, and nursing...",²⁶ while Marianne's ten-year old daughter fed and poulticed a Maori woman suffering from a huge abscess and coped admirably when it burst and produced "a bason full of matter".²⁷

Male missionaries generally nursed only because there was no one else available, but an exception was George Selwyn, who arrived in New Zealand in 1842 as the first Anglican bishop. Selwyn "reverenced" hospital and nursing work, which he believed to be a part of the "doctrines and articles" of the Church of England and he desired "to live and die in conformity with the spirit and letter of them".²⁸ His own singular nursing

21 Eliza White's diary, October 1835, quoted in Goldsbury, p.41.

22 P. Sargison, "Elizabeth Colenso", *The book of New Zealand women*, p.145.

23 Journal of John Butler, 11 January 1820 and 28 February 1822, quoted in A. E. Woodhouse (ed.), *Tales of pioneer women*, Auckland: Whitcombe & Tombs, 1940, pp.5 & 7.

24 S.C. & L.J. Matthews, *Matthews of Kaitaia: the story of Joseph Matthews and the Kaitaia mission*, Dunedin: Reed, 1940, pp.103-104.

25 Quoted in Gluckman, p.58.

26 Jane Williams to L. Marsh, 27 March 1828, *Turanga journals*, p.28.

27 Marianne Williams' journal, quoted in Drummond, "The N.Z. family doctor before 1840", p.9.

28 Quoted by A.K. Davidson, *Selwyn's legacy: the College of St John the Evangelist, Te Waimate and Auckland, 1843-1992*, Auckland: The College, 1993, pp.63-64.

skills were universally acknowledged. "What an admirable nurse of the sick he was!" exclaimed G.H. Curteis. "There are those now living who can tell of his tenderness and patience in this capacity".²⁹ Helen Garrett suggests that he might have acquired this "great and unusual gift" at the bedside of his mother, a chronic invalid.³⁰ Selwyn included compulsory lectures on medicine and surgery in the syllabus of the missionary training course at St John's College, asking medical missionaries like Henry Butts and Christopher Davis to give them.³¹ He also gave priority to the building of a hospital at the site of the College, and appointed Dr Arthur Purchas as house surgeon.³² The hospital was to be staffed by a special order, the Brethren and Sisters of the Hospital of St John, who pledged themselves

to minister ... to all the wants of the sick of all classes, without respect of persons or reservation of service, in the hope of excluding all hireling assistance from a work which ought, if possible, to be entirely a labour of love.³³

Selwyn's order apparently never eventuated,³⁴ but nevertheless, he brought to New Zealand a vision of nursing similar to that already operating on the Continent. He was clearly aware of the work of both the Catholic Sisters of Charity in France, an order established specifically to nurse the poor, the Protestant Institution for Nursing Sisters set up in London by Elizabeth Fry, as well as that of the Deaconess Institution at Kaiserwerth.³⁵ The Kaiserwerth Institution was established by pastor Theodore Fliedner and his wife in 1833. Here women trained to become deaconesses, working in the Institution's hospital, orphanage, school and

29 J.H. Evans, *Churchman militant: George Augustus Selwyn, Bishop of New Zealand and Lichfield*, London: Allen & Unwin, 1964, p.239.

30 H. Garrett, *Te Manihera: the life and times of the pioneer missionary Robert Maunsell*, Auckland: Reed, 1991, p.127.

31 *Provincial College of St John the Evangelist, Tamaki, Auckland*, Auckland: Wilson & Horton, 1909, p.12.

32 Davidson, p.63.

33 H.W. Tucker, *Memoir of the life and episcopate of George Augustus Selwyn...*, London: W.W. Gardner, 1879, v.1, pp.208-210.

34 The rules appeared only in the 1847 Calendar of the College. The hospital was almost immediately overwhelmed by a typhus epidemic which struck the same year and when the Government hospital in Auckland was opened in 1847, Selwyn's institution was "relieved...of a large portion of the claims..." upon it. W.E.Limbrick, (ed.), *Bishop Selwyn in New Zealand, 1841-68*, Palmerston North, 1983, p.63; Davidson, p.64.

35 Mary Ann Martin referred to these organisations in a letter discussing Selwyn's hospital, Davidson, p.63.

penitentiary in a life devoted to prayer and dedicated service to others. Florence Nightingale spent several months at the Institution in 1851.³⁶ Selwyn's vision, like Fliedner's, emphasised both the spiritual and charitable dimensions of nursing which were to shape its development in the years to come. The changes in nursing initiated at Kaiserworth and later developed more fully by Florence Nightingale in England would eventually transform nursing in the colony, just as they did everywhere in the western world.

Florence Nightingale and the reform of nursing in England

The formal colonisation of the new colony of New Zealand which began in 1840 and the development of its pioneer settlements which continued over the next 40 years coincided with the beginnings of nursing reform in the Home Country. Florence Nightingale's work as superintendent of a female nursing establishment for the British army during the Crimean War from 1854 to 1856 gave impetus to her reforming zeal. On her return to England, and with funding from a grateful nation, she set out to transform nursing into a respectable womanly occupation which a well-bred woman might undertake with honour. She was able to capitalise on prevailing ideologies which acknowledged the duty of women to use their "mothering" qualities beyond the private, domestic circle. Social responsibility and service to the community in fields not too far removed from domestic labours would bring women's moral superiority into the public domain and benefit society as a whole.³⁷ Nursing, already perceived to be the duty of all women within the home, was clearly a suitable womanly occupation outside it.³⁸

In June 1860, the first group of 15 students enrolled at the Nightingale Training School for Nurses at St. Thomas's Hospital, London, embarking on a year-long course of formal study on the art of nursing. The

36 C. Woodham-Smith, *Florence Nightingale*, London: Fontana, 1964, pp.71-73.

37 R. Dingwall, A.M. Rafferty, C. Webster, *An introduction to the social history of nursing*, London: Routledge, 1988, p. 38; N. Boyd, *Josephine Butler, Octavia Hill, Florence Nightingale: three Victorian women who changed their world*, London: Macmillan, 1982, p. 246.

38 Boyd, pp.244-251.

programme emphasised good character as much as good skill. Nursing students were expected to demonstrate "obedience, discipline, self-control ... and the abnegation of self" within a service headed by both a master and a mistress. In this way, Nightingale sought to create the ideals of domestic family life within the hospital.³⁹ Nothing in the domestic sphere would be violated by women becoming nurses, because nurses would offer dedicated service based on loyalty and obedience to the "master", the doctor. Above all, their moral character would be unimpeachable. Nightingale nurses were to be asexual beings, their sexuality replaced by skill, discipline and motherly authority. The woman would be subsumed in the nurse.⁴⁰

To achieve this goal, nurses were required to undertake strict training in a hospital school under a moral preceptor, the matron, who would provide "constant, motherly, intangible supervision".⁴¹ "Rule, system and superintendence" through a female hierarchy would create a disciplined workforce able to impose the moral and environmental order within hospitals necessary for patients to become well. If nurses demonstrated all the characteristics prescribed for ideal womanhood - gentleness, kindness, submissiveness, obedience, patience, self-sacrifice and purity - then nursing would indeed be a worthy occupation which "good" women might honourably enter.

Within a few years, Nightingale-trained nurses had spread her ideas about nursing into many parts of the world.⁴² In 1866, Sir Henry Parkes, governor of New South Wales, asked Nightingale to send trained nurses to the Sydney Infirmary to reform nursing there. Lucy Osburn and five others arrived in March 1868 and established a school which trained the

³⁹ Quoted in M. Poovey, *Uneven developments: the ideological work of gender in mid-Victorian England*, London: Virago, 1989, p. 180.

⁴⁰ J. Achterberg, *Woman as healer*, Boston: Shambhala, 1991, p. 160-161; Reverby, *Ordered to care: the dilemma of American nursing, 1850-1945*, Cambridge University Press, 1987, p. 43.

⁴¹ Poovey, p. 190.

⁴² Between 1860 and 1893, Nightingale nursing spread to Canada, Australia, Scotland, Ireland, Sweden, Germany, India, Holland, the United States and Japan, as well as New Zealand, L. Russell, *From Nightingale to now: nurse education in Australia*, Sydney: W.B.Saunders/Balliere Tindall, 1990, p.9.

nurses who became matrons of other Australian hospitals.⁴³ In 1873, the first schools offering nurse training based on Nightingale principles were opened in the United States.⁴⁴ Miss Pringle, one of Nightingale's favourite nurses, brought her reforms to the Edinburgh Royal Infirmary, which in turn trained the first matrons of the Launceston and Royal Adelaide Hospitals.⁴⁵

Nightingale nursing reforms were much slower to reach New Zealand. There were a few trained nurses among the early immigrants. Margaret Sievwright, who arrived in New Zealand in the 1870s, had trained in England under the Nightingale system.⁴⁶ Mary Tattershall, who had worked in the Crimea, was briefly matron of Timaru Hospital in 1865,⁴⁷ and Mrs Sarah Dalton was appointed to Nelson Hospital in 1868, after the Hospital Committee decided that "the system of nursing in the present Hospital much needed improvement, and that the best way to improve it would be to get from England a trained nurse".⁴⁸ In 1877, however, she was apparently the only trained nurse working in a New Zealand hospital. As the Minister of Immigration advised the Agent General in London

The general opinion of the medical officers to hospitals seems to be that for the men in colonial hospitals, and for the class of patients generally located there, male attendants and wardsmen are more suitable ...⁴⁹

In most instances, the early settlers who began arriving in the colony in large numbers after 1840 expected to be nursed at home by the women of their families when they were ill.

43 *ibid*, pp.10-11; R. Trembath and D. Hellier, *All care and responsibility: a history of nursing in Victoria, 1850-1934*, Melbourne: Florence Nightingale Committee, 1987, pp.17-18.

44 Russell, p. 9; Reverby, pp.60-61.

45 Russell, p. 11.

46 E.M. Simpson, "Margaret Home Sievwright, 1844-1905", *DNZB, volume 2, 1870-1900*, p.463.

47 C. Macdonald, *A woman of good character*, Wellington: Allen & Unwin, 1990, p.111.

48 Report of the Hospital Committee, Nelson Provincial Council gazette, 30 April 1868, p.112.

49 Quoted in S. Orchard, "More 'women of good character'", N. Chick and J. Rodgers (eds.), *Looking back, moving forward*, Palmerston North: Massey University, 1997, p. 13.

Nursing within the family

In the 1840s and 1850s, "nursing" remained an ill-defined term linked to a variety of women's duties - breastfeeding, the care of young children, the care of mother and baby after childbirth, the care of the sick and infirm. It was not an identifiable or self-conscious occupation.⁵⁰ Susan Reverby notes that in mid-19th century America, nursing tasks almost always took place in the home and were part of women's "duty to care" for those they loved, not wage-earning work. "Caring and sacrifice" were a "poignant manifestation of female virtue".⁵¹ "Obligation and love, not the need to work, were to bind the nurse to her patient. Caring was to be an unpaid labor of love".⁵² In the new colony of New Zealand, a place of scattered settlements, no hospitals and few people, nursing was almost entirely a domestic and womanly duty.

Colonial women were obliged to look to their own resources when it came to childbirth and the nursing of the sick because it was often impossible to hire expert medical help. Doctors were few and far between, especially outside the main towns, and many families lived thirty or more miles from a medical practitioner. Few people could afford to pay for him to make such an expensive and time-consuming journey. Furthermore, as Michael Belgrave has pointed out, doctors were often incompetent. He notes that

The most socially successful doctors, such as John Logan Campbell in Auckland or David Monro of Nelson, did not practise medicine at all. Those who did treat patients often had little but their pretensions to distinguish them from chemists, teeth-pullers and itinerant drug vendors.⁵³

Certainly Jane Maria Atkinson had little time for her family's practitioner, whose ignorance she believed turned her daughter's "indisposition into a severe illness"⁵⁴ and who, with his colleagues, allowed scarlet fever and

50 Dingwall, Rafferty, & Webster, p. 4.

51 Reverby, p. 11.

52 S. Reverby, "A caring dilemma: womanhood and nursing in historical perspective", *Nursing research*, 36:1, January/February 1987, p. 6.

53 M. Belgrave, "Medicine and the rise of the health professions in New Zealand, 1860-1939", L. Bryder (ed.), *A health country: essays on the social history of medicine in New Zealand*, Wellington: Bridget Williams Books, 1991, p.7.

54 F. Porter, *Born to New Zealand: a biography of Jane Maria Atkinson*, Wellington: Allen & Unwin/Port Nicholson Press, 1980, p.224.

dysentery to cut a swathe through New Plymouth's children in 1865. "I have less & less faith in medical science", she wrote at that time, "& feel sometimes that it is all chance work".⁵⁵

Nor was it usually possible to obtain the services of an experienced nurse. The proportion of women who came to the colony specifically to work as nurses was small. In her study of 4,028 single women coming to Canterbury in the 1850s and 1860s, Charlotte Macdonald found only 67 women who gave their occupation as nurse (1.7%) and a further 93 who were recorded as specialist domestic servants (2.3%). This latter group included monthly nurses, but also nursemaids, laundrymaids, parlourmaids and ladies' maids.⁵⁶ Other sources confirm these findings. Even as late as the mid-1880s, there were only 97 nurses among the 1,744 female immigrants who came into the country over an two-and-a-half year period (5.5%).⁵⁷ The majority of women who gave their occupation as "nurse" were young, aged between 14 and 25,⁵⁸ and so were probably nursemaids, rather than midwives or monthly nurses. And of those who did come to New Zealand expecting to care for the sick, many looked for hospital positions, rather than private nursing work.⁵⁹ Mrs Nurse, who advertised in the *Lyttelton times* in 1854, seeking to obtain positions as "NURSE, which she thoroughly understands having had long experience", was a rarity.⁶⁰

55 *ibid*, p.218.

56 Macdonald, p. 49.

57 Trades and occupations of immigrants, January 1884-June 1886, AJHR, D-5A, 1886, p.2; S. Orchard, "More 'women of good character', pp.5-16 discusses this issue, and provides information on some of the women who gave their occupation as "nurse" in shipping records.

58 There were for example, eight nurses on the Westmeath which came to Auckland in 1883, seven of whom were under 26. The eighth was the matron, Amelia Crisp, a trained nurse who became matron of Auckland Hospital, J. Rodgers, *Nursing education in New Zealand, 1883 to 1930: the persistence of the Nightingale ethos*, MA thesis, Massey University, 1985, p.10.

59 Mary Tattershall for example, who had nursed in the Crimea, was appointed matron of Timaru Hospital, and Sarah Dalton came to Nelson to nurse in the hospital there. Ann Clive, another Crimea nurse, intended to establish her own hospital although financial obstacles prevented her from doing so, Macdonald, pp.111-112.

60 *LT*, 27 May 1854, p.11.

Ability to nurse the sick was therefore regarded as a requisite skill of the pioneer wife. Jane Maria Atkinson approved of her prospective sister-in-law, Jane Skinner because she was a "capital nurse", as well as being able to make "unexceptional pies & puddings".⁶¹ Almost every woman in the colony could expect to spend some part of her life caring for the infirmities and illnesses of members of her family. Husbands could prove troublesome, as Sarah Courage found after hers suffered a coaching accident. "I had a lot of trouble to keep him quiet," she wailed, "men are such obstreporous creatures."⁶² Gretta Hyde of Cheviot Station recalled "how bravely Mother fought her way through that troublesome time ... " when her father was desperately ill with pneumonia and a doctor unobtainable,⁶³ while Jane Deans remembered the pain of nursing her dying husband, who "would have no one but myself to attend upon him ..." and for whom she could do so little.⁶⁴

It was the illnesses of children, however, which brought the greatest stress to colonial women. Eliza Godfrey (later Mrs Prichard)'s account of nursing her first husband and five children, all stricken with diphtheria, is traumatic. Two daughters died, followed by her husband and then her only son. "How I lived through it I do not know," she wrote. " ... I knew my dear ones were no more for this world. I felt turned to stone and could not move".⁶⁵ Rebecca Dawber, whose elder daughter had previously choked to death, despaired when another child fell victim to typhoid. From Wednesday to Sunday she nursed the child day and night, dozing on a sofa by the crib when possible but remaining fully dressed. "I have such a nervous dread of losing this darling too", she confided in her diary. " ... I think if I were to, I should soon follow ... ".⁶⁶

61 Porter, *Born to New Zealand*, pp.83-84.

62 S. Courage, *'Lights and shadows' of colonial life: 26 years in Canterbury*, Christchurch: Whitcombe & Tombs, 1897, p.179.

63 Gretta Hyde, *Memories of early Cheviot*, pp.29-30, CMU.

64 Jane Deans, *Letters to my grandchildren*, Christchurch: Canterbury Publishing Company, 1923, p.14.

65 Eliza Prichard, *Memories of early Marlborough: the Godfrey family and the Woodbourne Estate*, Rotorua: Morning Post, 1940, pp.19-22.

66 Diary, 13 July-7 August 1881, A. R. Dawber (comp.), *Robert and Rebecca Dawber*, Akaroa?, 1968, pp.240-242.

For women like Mrs Dawber, sick nursing could, at least at first, prove daunting. Lady Barker admitted that she "knew quite as little of medicine as my husband did of law". Her "jumbled up remedies", she said, consisted largely of "mustard by the pound and brandy by the quart".⁶⁷ Other women, however, found skills they did not know they had. Catherine Chapman's husband greatly regretted that he had not brought his splendid medicine chest out from England, but at that time, he said, "I was not aware of what a dab Kate is at doctoring". Her gift for home nursing not only prevented their children from falling victim to epidemics and childish ailments, but was also much appreciated by their neighbours, who "had great faith in Kate's remedies".⁶⁸ Many women, like Amelia Clotworthy of Whareora, learned to make and use simple remedies⁶⁹ and they also sought help from medical guidebooks and manuals. Ellen Tripp brought back from England in 1863 a copy of *How to nurse sick children*,⁷⁰ Evelyn Hosken obtained good results by following the advice of Professors Kirk and Kuhne⁷¹ while the Richmonds and Atkinsons depended on *Bull's hints* for guidance.⁷² Seriously concerned to perform their nursing duties well, women flocked to hear lectures on the subject, such as those given by Mrs Bernard Moore in Christchurch in 1882,⁷³ and by the St John Ambulance Association when it was established in 1885.⁷⁴

67 Mary Ann Barker, *Station life in New Zealand*, London: Macmillan, 1870, p.268.

68 B. Smedley, *Homewood and its families*, Wellington: Mallinson Rendel, 1980, pp.138-139.

69 Mrs Clotworthy was famous for her cough medicine, which combined treacle, liquorice, brown sugar, laudanum, anniseed, peppermint, brandy and water, F. Keene, *And his wife: women of Whangarei*, Whangarei, 1991, p.28.

70 B. Harper, *The kettle on the fuschia: the story of Orari Gorge*, Wellington: Reed, 1967, p.49.

71 E. Hosken, *Life on a five pound note*, Timaru, 1964, p.61. Louis Kuhne published several medical guidebooks. Mrs Hosken probably used either *The new science of healing, or, The doctrine of the oneness of all diseases*, translated by Dr T. Baker, Leipzig, 1892, or *The rearing of children: a handbook of warning and advice to parents and children*. English ed., translated from the 20th rev. German ed., by C.C. Potts, London, 1906. Professor's Kirk's book may have been John Kirk's *Health*, new ed., edited by E.B. Kirk, London, 1904.

72 Porter, *Born to New Zealand*, p.207. Mrs Porter identifies this work as Thomas Bull's *Hints to Mothers, for the management of health during the period of pregnancy, and in the lying-in room; with an exposure of popular errors in connection with those subjects*, London, 1837. Thirteen editions had appeared by 1876, p.384, n.31.

73 *LT*, 12 June 1882, p.4d, 17 June 1882, p.5a, 21 June 1882, p.4f, 22 June 1882, p.4, 24 June 1882, p.6b.

74 R. Wright-St Clair, *The Order of St John in New Zealand*, Wellington: Priory in New Zealand of Order, 1977, pp.22, 25 and other references.

Like the male missionaries, settler husbands seldom did much hands-on nursing. Athur Atkinson proved himself a "dear old clever fidgety nurse" when he cared for his wife after their eldest daughter was stillborn in 1856, and was both nurse and midwife at the time of Maria's last confinement in 1864. He also helped nurse his sister Alice who was dying of tuberculosis.⁷⁵ Most men, however, preferred to confine their medical attentions to "doctoring" rather than "nursing". Their duties, according to Edward Jerningham Wakefield's *Handbook for New Zealand* (1848) were to "learn how to bleed, set a broken or dislocated limb and bind wounds. If he can even learn how to amputate a limb so much the better".⁷⁶

Missionary women sometimes expected their servants to provide nursing services. The nursing work in Lady Martin's hospital was, for example, apparently done by her servant companion, Mrs Elizabeth Smith.⁷⁷ Servants in colonial New Zealand were, however, in extremely short supply and are not often mentioned as additional sick nurses, although Charlotte Godley found her former lady's maid, Mary Powles, a "capital nurse" after the birth of her daughter in 1852.⁷⁸ Sometimes, servants were nursed by their mistresses. When Frances Caverhill's cook fell sick, she nursed him for a week, applying "hot bags of hops" to his inflamed side and gradually bringing him back to normal with "broth", "a walk", "a little wine" and finally "a little beer".⁷⁹ Catherine Chapman was said to be "much fatigued" in 1848 after she had nursed the bailiff and the cowman, four of the children, the cook, the nurse and the nursemaid through an influenza epidemic,⁸⁰ while, according to a former station worker, Ella Tripp, a daughter of Orari Station, looked after any sick stationhands "better than a nurse ... I can't tell you how good she was to us men".⁸¹

75 Porter, *Born to New Zealand*, pp.89, 173, 175, 210.

76 E.J. Wakefield, *The handbook for New Zealand*, London: J.W. Parker, 1848, p.440. "Bleeding" and vaccination were also the province of male missionaries, J. Woon to Rev. Waterhouse, 4 March 1837, quoted in Goldsbury, p.70.

77 R. Dalziel, "Mary Ann Martin", *DNZB, volume 1, 1769-1869*, p.275.

78 C. Godley, *Letters from early New Zealand*, Plymouth: Bowering Press, 1936, p.333.

79 W.J. Gardner, *The Amuri: a county history*, Culverden: Amuri County Council, 1956, p.183.

80 Smedley, p.138.

81 Harper, p.144.

Additional help with sick nursing came in the first instance from other female relatives of the family. Charles Turner was "at my wit's end to know what to do" with his desperately ill pregnant wife in the lonely Rai Valley in Marlborough and was very thankful when her sister was able to care for her until her confinement.⁸² Charlotte Gawen's grandmother and aunt looked after her when she and a sister were ill with scarlet fever, while another sister and a brother had chickenpox,⁸³ and Mrs Harper came from Christchurch to nurse her daughter Janet when she became seriously ill during a visit to her sister, Ellen Tripp at Orari.⁸⁴

If no relative was available, friends and neighbours would help on a basis of mutual aid. When Whangaroa was first settled, two women, one with ten children and the other with 12, nursed each other turn and turn about.⁸⁵ Eliza Godfrey was supported by several women friends during the diphtheria epidemic which decimated her family, and Jane Deans' friend, Mrs Gebbie came to assist her towards the end of John Deans' illness, while other friends sat with him at night.⁸⁶

For some women, however, nursing and midwifery became an occupation which extended well beyond answering the occasional call for help from a neighbour, yet remained short of being recognised paid labour. Such women were known within their local communities to have both an aptitude for nursing and to be generally willing to give nursing help when required. Three such women lived on the Taieri Plains near Dunedin in the early days of settlement there. Agnes Allan settled near Mosgiel with her farmer husband and seven children in 1850. A small, wiry woman, she delivered many babies in the district, vaccinated children and was always sent for at times of sickness, services she continued well into old age. She

82 P. Neal (comp.), *London to lonely Rai*, Nelson, 1969, p.83.

83 Charlotte Gawen, *My first 21 years, 1897-1918*, pp.43-44. Typescript, CMU.

84 Ellen Tripp, *My early days*, Christchurch: Lyttelton Times, 1916, p.19.

85 *Brave days: pioneer women of New Zealand*, Dunedin: Reed for Women's Division of Federated Farmers, 1939, p.36.

86 Deans, p.14.

is remembered as "a mother in Israel" by her neighbours.⁸⁷ Over the hill on the Brighton side of the Taieri, another farmer's wife, Mary Cuddie, also spent a great deal of her time "ministering aid to the sick and distressed" and "giving comfort to the sick and dying",⁸⁸ while Mrs McDiarmid near Taieri Mouth "was the good Samaritan [who] from mere love of humanity and a noble, unselfish heart, ... trudged to many women in trouble, absolutely refusing any payment for her services."⁸⁹

Refusal to accept payment was often noted in accounts of the work done by such women. Mrs John McGregor of Waipu, who continued to nurse maternity cases until her death in 1883, aged over 80, "never asked for a fee, and willingly gave of her best without considering it".⁹⁰ Mary Pennell of Paeroa did her good deeds "not for money ... being able to help was ample reward".⁹¹ Margaret Home Sievwright helped "the bad and degenerate and poor and unloved ... in cases of sickness for miles around people (some of whom she hardly knew) would come to her to minister to them".⁹² For these women nursing was perceived to be still a "duty", a labour of love to others less fortunate than themselves. Like the missionary wives, they followed in the footsteps of Christ the healer. Agnes Allan was a deeply religious Scots Presbyterian,⁹³ Mary Cuddie a "good, Christian woman" who gave "the spiritual advice of one who ... enjoyed the benefits and consolation of true religion".⁹⁴ Mrs Elizabeth Pedley of Mosston was a "faithful church worker" who sought no reward but the respect of the community and the title of "Mother of Mosston".⁹⁵

87 Thayer, M. (comp.) *The Taieri Allans and their decendants*, Dunedin, 1990, p.66.

88 Obituary, *OW*, 20 June 1889, p.14b.

89 R.V. Fulton, *Medical practice in Otago and Southland in the early days*, 2nd ed., Dunedin: ODT, 1922, p.216.

90 Memories of Miss B. Sutherland, N.R. McKenzie, *The Gael fares forth*, Auckland: Whitcombe & Tombs, 1935, p.121.

91 I. Hawkins, "Nurse Mary Pennell", *Ohinemuri regional historical journal*, October 1968, pp.18-19.

92 Meta Sievwright to Mrs Daldy, 22 June 1905, MS 94, Daldy letters, 1903-5, Auckland Institute and Museum.

93 *The Taieri Allans*, p.62. Her husband was the first elder of the East Taieri Presbyterian Church and a member of the Otago Presbytery.

94 Obituary, *OW*, 20 June 1889, p.14b.

95 C. Palmer, "Elizabeth Pedley, the mother of Mosston", in E. Feist & H.F. Richardson, *Bush, people and pasture: the story of Waitotara County*, edited by P. Melody, Wanganui: Waitotara County Centennial Committee, 1983, p.244.

Nursing was thus firmly established in colonial New Zealand as one of the many tasks carried out by women as part of their "duty to care" for their loved ones. Although the exigencies of pioneer life meant that men occasionally, from necessity, undertook nursing work, nursing was perceived as "natural" for women. Some women also offered their nursing services outside the home, among friends, family, and even sometimes among strangers, but such services were given not to earn a living, but as part of the charitable and humanitarian work expected of all "good" women. "Good" women, at this time, were not numbered among those who entered paid employment.

Chapter 2

"Wonderful women with practical knowledge of nursing": the emergence of nursing as an occupation

By the 1870s, colonial New Zealand was already undergoing rapid social change. Erik Olssen has described the shift from a pre-industrial or frontier society to a modern one as ongoing, but notes that the changes, including urbanisation, developing bureaucracies, and the dramatic fall in fertility rates probably affected women more than any other category of people. As work became more specialised, wider occupational opportunities emerged and women began to move from largely domestic service positions to others in emerging organisations like factories, offices and schools.¹ This changing environment also allowed nursing to emerge as a distinct occupation, rather than as a labour of love.

For many women who shared their nursing skills with friends, neighbours and others, nursing remained a humanitarian service to the community, for which they did not expect financial reward. As settlements expanded, however, a few neighbourhood nurses who needed to find paid work were able, as Reverby says, to trade on their household or community experiences and enter the ranks of those who nursed for a living.² As Reverby says,

Nursing, as women's domestic labor structured by duty and custom, was very slowly supplemented by nursing, as women's paid labor shaped by market forces and cultural changes ... Women's obligations and work were transformed by the expanding industrial economy and changing cultural assumptions ... Duty began to take on new meanings ... [and] nursing could be added to the list of tasks that could be passed onto another woman to perform ... money, not just love, obligation, or charity, could tie a nurse to her patients. Caring as love could be separated, for some, from caring as labor.³

1 E. Olssen, "Women, work and family, 1880-1926", *Women in New Zealand society*, edited by P. Bunkle and B. Hughes, Auckland: Allen & Unwin, 1980, pp. 159-167.

2 Reverby, *Ordered to care*, p.11.

3 *ibid*, pp.11-13.

Gradually, nurses and midwives began to appear in trade directories like the *Southern provinces almanac* which listed only one nurse in its 1867 volume but six in 1871 and 14 in 1877. In the 1874 New Zealand census, 259 nurses were listed in the domestic service section, as well as 43 midwives, who were listed with doctors and chemists.⁴ Nursing, for a few, had become work, not duty.

Nursing as an occupation remained ill-defined. There were several kinds of "nurses". Midwives attended a woman in labour, delivered the child and perhaps stayed on for a day or two. Monthly nurses might assist with the delivery but remained for several weeks to care for mother and infant and to help with housekeeping. Other women came to look after the sick and infirm. All these activities continued to take place within the home. There continued to be a good deal of overlap between the different functions, with many women performing all of them. Douglas McKain, for example, sometimes acted as midwife to her patients but also stayed for six weeks or more after the delivery. Fan Blanch normally stayed for one or two weeks after the birth,⁵ while Lizzie Heath informed her sister in 1868 that she was going to take care of herself after only one week: "No one in this country thinks of keeping to their room more than a week", she said, "the poorer classes 4 days".⁶ Most nurses did a great deal of housework and looked after other children as well as their nursing duties. Janet Taine's nurse "saw to everything, cooked and saw that the children were neat before they went to school, she made some jam too ...".⁷ Mrs Holtham would sit by her patient with a pile of mending and darning for the family,⁸ Mrs Henderson "washed mountains of clothes" for Jane Maria Atkinson,⁹ and Mrs Klaus of Tai Tapu even saw to the engagement of a suitable

4 *Results of a census of the colony of New Zealand, 1 March 1874*, Wellington: Govt Printer, 1875, pp.155-156.

5 J. Bassett. "Fan Blanch", *The book of New Zealand women*, p.89.

6 Lizzie Heath to her sister, 8 July 1868, Letters from Charles Heath of Kaipara and his wife Lizzie to their family in England, 1865-1875, MS papers 0939, ATL.

7 Janet Taine to her mother-in-law, 9 March 1891, Taine family papers, 1826-1932. MS papers 0587-07, ATL.

8 *Brave days*, p.143.

9 Porter, *Born to New Zealand*, p.214.

nursemaid to look after Mrs Peryman's prematurely born daughter in 1867.¹⁰

Michael Belgrave, in his study of the health professions in nineteenth century New Zealand, has noted the dearth of information available on the women who entered the occupation of nurse. He suggests that "This informal market for medicine was provided mostly by married women whose occupations are not recorded on street directories, in electoral roles [sic] or in the census, and whose part-time profession was closely linked to their roles as housewives". Later historical records, he continues, have paid scant attention to the work of these women, who have been largely ignored by historians and have "received little but contempt from an historiography serving the interests of both professionalised medicine and professionalised nursing".¹¹

Certainly several different pictures of the nineteenth century nurse survive. Some commentators regarded them with contempt. Ewen Alison, a member of the House of Representatives for Waitemata at the time of the debate on the Midwives' Bill in 1904, called them "untrained, uneducated and often inexperienced women" who caused untold deaths among mothers and babies through their incompetence.¹² Wellington gynaecologist Dr Kenneth Pacey agreed that many were incompetent, dirty and dangerous, although he added, "Attendance at many births, intelligent observation and instruction from doctors with whom they worked, gave them a rugged efficiency".¹³ According to Dr Agnes Bennett, they wore their oldest and dirtiest clothes for deliveries and regarded "childbed fever" as a normal risk of pregnancy,¹⁴ but nursing leader Amelia Bagley admitted that

10 L.J. Trask, *Elizabeth of Lavington*, Wellington, 1976, p.24.

11 M. Belgrave, "Medicine and the rise of the health professions in New Zealand, 1860-1939", L. Bryder (ed.), *A healthy country: essays on the social history of medicine in New Zealand*, Wellington: Bridget Williams Books, 1991, pp.11-12.

12 NZPD, 1 July 1904, 128, pp.87-88.

13 C. & C. Manson, *Doctor Agnes Bennett*, Christchurch: Whitcombe & Tombs, 1960, p.48.

14 *ibid*, p.60.

Though in many instances undesirable, we must give her her just tribute. Many of these women have done excellent work according to their lights, often exhibiting the real nurse's spirit in much unselfish work.¹⁵

For many local historians, however, the nineteenth century nurse was little less than a saint. She was the woman who never failed to answer a call, who travelled long journeys through rain, hail or storm both day and night to serve the needs of her patients.¹⁶ It was due to her attentions that "so many fine families were reared, so many of our splendid pioneer women came safely through the perils of maternity and are spared to us to-day, healthy, vigorous and buxom ...".¹⁷

It is clear from these accounts that within their communities, nineteenth century nurses commanded considerable respect, their names enduring not only in the minds of countless grateful patients but also in more public memorials. Mary Pennell of Paeroa, for example, is remembered by the maternity ward bearing her name at the local hospital in the district.¹⁸

While Belgrave correctly points out the invisibility of many pioneer nurses in New Zealand, it has been possible, through a range of sources, to identify a number of them. Street directories have yielded some data. Although nurses and midwives were seldom listed in the trades sections of these volumes and almost never advertised in them,¹⁹ a number do appear in the actual street listings. By going through the *Southern provinces almanac*, a directory covering Christchurch and rural areas in the province of Canterbury from 1867 until 1888, I was able to identify 40 women who described themselves as nurses or midwives during this

15 *KT*, 3:1, January 1910, p.35.

16 See for example, McKenzie, *The Gael fares forth*, pp.121-122; O.Gillespie, *South Canterbury: a record of settlement*, 2nd ed., Timaru: South Canterbury Centennial History Committee, 1971, p.212; C. Palmer, "Elizabeth Pedley, the mother of Mosston", in Feist and Richardson, pp.244-245.

17 Fulton, p.231.

18 Hawkins, "Nurse Mary Pennell", p.18.

19 Belgrave, p.11 cites an advertisement by Mrs M.H.Smart, monthly nurse of Nelson, which appears in *Lucas's Nelson almanac for Nelson*, 1867, p.xxxiv. I found no other advertisements in the almanacs I checked, although some nurses did advertise in the newspapers. Mrs Nurse of Lyttelton, for example, advertised in the *LT* on 27 May 1854, p.11 and Mrs Bradshaw advertised her availability as an experienced monthly nurse in a Reefton newspaper on 29 May 1872, apparently the first nurse to advertise in the district, R. Jones (ed.), *Women of Westland and their families*, Greymouth, 1977, p.11.

period. *Stone's Otago and Southland directories* are among the few which include listings for nurses and midwives in their trades sections. Accordingly, these volumes were checked for the years 1884 to 1900 and again in 1907 (after the publication of the first midwives' register). The names of one hundred and forty five women and one man were found who were listed as either nurses or midwives in the city of Dunedin.

In order to shed further light on the lives of the women, information has been added from other sources, in particular the electoral rolls. I have tried to discover what occupations the women gave themselves on the electoral rolls, whether they were living with husbands or were independent (either widowed or separated), and what their husbands' occupations were. For the women in the *Southern provinces almanac*, this was often difficult. Not only were the women themselves not on the rolls (the period covered being before 1893) but often the men's occupations were not given. In some cases, however the gap could be filled with information from the *Wise's New Zealand post office directories* or from other almanacs and directories. Using these sources, I was able to tentatively identify 17 of the 40 nurses in the *Southern provinces almanac*, and 54 of the 145 nurses in *Stone's*.

Street directories and electoral rolls clearly have limitations as source materials. Only a proportion of women working as nurses are listed in them,²⁰ usually only those seeking some financial reward for their labour. It was often possible to identify only those with uncommon names, particularly when the original directory listing gave no Christian name. It was not always possible to establish which of two or more men living at the same address as the "nurse" was her husband.²¹ And omissions and mistakes, as well as the inevitable mobility of individuals, mean that the directories are not necessarily accurate guides to the length of time a woman worked as a nurse. To counter these drawbacks, it was necessary

20 The 1893 Dunedin electoral roll, for example lists at least three nurses who are not in the *Stone's directories*, Jean Mackie Allan and Selina Margaret Goldman of Great King Street, and Agnes Milne of Albany Street.

21 Mary Ann Cook, for example lived with Austin and Lawrence Cook, both clerks. Mrs James John Sims lived with two men of that name, presumably a husband and a son. One was a contractor, the other a soapmaker.

to augment the data with a study of individual women for whom biographical information is available.

The most obvious characteristic of the nurses listed in both the *Southern provinces almanac* and in *Stone's* is that they are almost all women. Gilbert Laurensen, who is listed in the 1886 *Stone's* as a gentleman's nurse, is the sole exception. As we have seen, nursing was viewed as "natural" for women, closely linked with their loving duty and with domestic work. Just as men in the home saw their medical role as one of "doctoring", rather than nursing, so too did men among the wider community. John Sinclair, the carpenter at Cheviot Station had charge of the medicine box, pulled teeth, vaccinated children, stitched up cuts and splinted broken limbs but "To maternity cases, [he] turned a deaf ear and a blind eye! They were left to Providence and the capable hands of certain courageous women on the station".²² It was John's wife, Margaret for whom "caring for the sick was 'part of the day's work'", and it was she who nursed her employer's brother after a heart attack and the head groom after a serious illness.²³

The second most obvious characteristic of the nurses listed in the directories is that they are, with only four exceptions, married women. The single women all come from the *Stone's* list and three of them appear from 1894 onwards, after the introduction of hospital nursing training programmes for single women. Misses Emily Rigg, Margaret Sinclair and Mary Stuart were almost certainly hospital nurses, who established themselves as private nurses after completing their training. The exception is Miss Margaret Fleming of Melville Street, later Swan Street, Dunedin who is listed as a nurse in the directory for the entire period of the survey (1884-1907) but who does not appear to have become either a registered nurse or a registered midwife.

The women who are remembered as nurses within their local communities were almost invariably married women. At a time when nursing credentials

²² Gretta Hyde, *Memories of early Cheviot*, pp.4, 15, 16, 20, 32.

²³ *ibid*, pp.12-13.

could only come after long years of practical experience in nursing family or friends, few single women were likely to qualify. Childbirth in particular was not something a young single woman could be expected to know about, nor was it considered proper for her to do so. Alice Holford was 35 years old and a trained nurse when she decided to go to Sydney to train as a midwife in 1902, but she was still an unmarried woman. Accordingly, many people were shocked and appalled at her choice of career, ostracising her socially.²⁴ Only an eccentric single woman like Selina Sutherland who had studied medicine privately in Scotland, wore short skirts, men's hats and coats, and was not afraid to stand up to the establishment could overcome such obstacles. She is fondly remembered in the Wairarapa for her skilful nursing and midwifery in the community during the 1860s and 1870s, but she had to contend with unco-operative medical authorities and her behaviour was disapproved by some.²⁵

Perhaps the next obvious characteristic of the nurses named in the directories is that there is none who is clearly Maori. Maori women healers in the nineteenth century played an important role in attending to the health needs of their own people but were seldom consulted by the new white settlers. One of the few recorded instances of such a consultation is that noted by Florence Keene in her account of the life of Agnes Pollock of Whangarei. Keene claims that, in the absence of any other white woman, Mrs Pollock's neighbour William Carruth asked a local Maori woman, Tangihua, to attend her in her confinement, and that, after some debate, Tangihua did so.²⁶ Another Maori woman, Mere Mathieson, who was the daughter of a pakeha whaler and a Ngati Tanewai woman, worked as a nurse and midwife in the Hawera district in the late nineteenth century, caring for both Maori and European patients,²⁷ but on the whole Maori women seem to have confined their healing services to their own people.

24 Adelheid Wassner's memories of Alice Holford, in her Drafts and papers regarding research into obstetrical nursing services in Dunedin Hospital. Arch.41.91, DUHO: folder on Alice Holford.

25 K.A.Simpson, "Selina Sutherland", *DNZB, volume 2, 1870-1900*, pp.491-492; J.C. Jessop, *Selina M. Sutherland*, Melbourne, 1958; F. Fyfe, *Fiesty [sic] wee Selina: a tale from Masterton of the 1870s*, Greytown, 1992; Manson, *Pioneer parade*, pp.183-185.

26 F. Keene, *And his wife*, p.105.

27 C. Clement & J. Johnston (eds.), *Women of south Taranaki*, Hawera: Suffrage Centennial Local History Group, 1993, p.191.

A number of European women, however, continued the work of the missionaries by using their nursing skills to assist their Maori neighbours. One of the best known of these women was Agnes McDonald of Horowhenua, whose work among local Maori was of critical importance during the scrofula and influenza epidemics of the 1860s. Mrs McDonald apparently found an effective treatment for scrofula, using iodine, and was authorised by the Native Minister, Donald McLean, to make up a medicine chest at government expense and replenish it each time she visited Wellington.²⁸ Mary Jane Berry of Waipa was also a respected figure within the Maori community, who named her "Mata Pere" and successfully petitioned the government for medicine so "she could help those who were diseased, or sick in other ways ...".²⁹ Agnes Robertson, too, was "loved and respected" by the Maori population of Hastings for the work she did among them.³⁰ At a time when Maori and settler often faced each other over a great divide, these women provided an important link between the tangata whenua and the immigrants and did something to bridge the gap between missionary medical work among the Maori in the early part of the century and the first government attempts to address Maori health issues towards the end.

It has not been possible to establish the ages of any of the women listed as nurses in the directory surveys, but it is evident from other sources that many of the women who worked as nurses in colonial New Zealand were older women. The frequent epithet of "Granny" given to local midwives is an indication of advanced years and many later accounts also refer to the "good old dames" who nursed colonial women.³¹ Women like Douglas McKain, Fan Blanch and Agnes Allan were all well over 50 when they began nursing work. As Reverby has said, with no formal apprenticeship, women needed to claim some years of familial service to the sick to be accepted as a nurse, while the exposure to naked bodies, especially of men, was deemed neither shocking nor arousing to older, motherly

28 A.J. Dreaver, "Agnes McDonald, Hector McDonald", *DNZB, volume 1, 1769-1869*, p.246.

29 *Women of Waipa*, Te Awamutu: Business and Professional Women's Club, 1993, p.50.

30 M. Boyd, *City of the plains*, Wellington: Victoria University Press for Hastings City Council, 1984, p.216.

31 Fulton, p.231.

women.³² Nevertheless, in a pioneer society with fewer elderly women than in Europe, it was also necessary for younger women to nurse at times. Sarah Higgins and Mary Cuddie may have been only in their 30s when they began nursing, while early widowhood meant that Susannah Cullen began nursing in her 40s. Single woman Selina Sutherland was only 26 when she arrived in the Wairarapa and began to nurse her neighbours.³³

Belgrave has suggested that most nineteenth century nurses were housewives who worked on a part-time basis and the directory analyses seem to confirm this, at least to some extent. Of the 17 women identified from the *Southern provinces almanac* list, 15 appear to have been wives and mothers, while 30 of the 54 women identified in the later survey also seem to have been living with their husbands. Many of these women are recorded in the electoral rolls not as nurses or midwives but as housekeepers, housewives or under the ubiquitous descriptor, "domestic duties". It seems likely, therefore, that these women worked as nurses to supplement family income as the need arose.

Sarah Higgins' experiences of paid employment, including nursing, provide an excellent example of the way colonial women used their varied skills in different ways and at different times according to changing family needs and circumstances. Mrs Higgins first acquired caring skills when as a young girl, she helped a neighbour with her baby. She followed this experience with 14 months in service as a nursemaid. In the early years of her marriage to sawyer and small farmer Sydney Higgins, she combined the rearing of her 11 children with farm work, dairying and sewing. As her daughters grew up and were able to take over some of her household duties, she "went out nursing", at first working with the local doctor, Thomas Oldham, and then on her own. She claimed to have "nursed over 350 babies into this world". When her daughters married and left home,

32 Reverby, *Ordered to care*, p.20.

33 K.A. Simpson, "Selina Sutherland", *DNZB, volume 2, 1870-1900*, p.492. M. S. Shaw & E. Farrant, *The Taieri Plain : tales of the years that are gone*, Dunedin: Otago Centennial History Publications, 1949, p. 192 suggest that several local midwives were relatively young. Mrs McDiarmid, for example, was said to take her own young baby with her when she attended cases.

however, she found that nursing "took me away too much", so instead she took in invalid boarders, nursing them in her own home. She also delivered the babies of her daughters and daughters-in-law and did much to help rear her grandchildren.³⁴

Other women also combined nursing with housekeeping and other work. Mary Cuddie nursed when her children were young but after she was widowed in 1871, she devoted her energies to managing the family farm and in later life, she opened a store in Mosgiel.³⁵ Mrs Alexander Jenkins of Otikerama near Matura combined the rearing of 15 children with nursing work, dressmaking, farming and cooking. Later, she opened a maternity home in Winton and ended her working life as postmistress in Timpany's Siding.³⁶

Nevertheless, for increasing numbers of women, nursing provided more than just an occasional foray into the realms of paid employment. Only two of the 17 women identified in the *Southern provinces almanac* survey, Mrs Pratt of Doyleston, later Leeston, and Mrs Scaife of Brookside appear to have been widows and presumably supporting themselves with their nursing work.³⁷ However, out of the 54 *Stone's* nurses identified, 20 (nearly 40%) do not appear to be wives, although several, like Agnes Forrest, Elizabeth Garshore, Sarah Ann Hall and Jane Rainton were apparently mothers, living in the same house with adult daughters.³⁸

34 K. Orr, "Sarah Higgins", *DNZB, volume 1, 1769-1869*, p.188; A. Drummond (ed.), *Married and gone to New Zealand*, Hamilton: Paul's Book Arcade, 1960, pp.93-94; S. Higgins, *Autobiography*, 1920?, MS Papers 1146, ATL; autobiography also published in C. Brereton, *Vanguard of the south: Nelson, New Zealand*, Wellington: Reed, 1952, pp.215-228.

35 Janet Angus, "Mary Cuddie", *DNZB, volume 1, 1769-1869*, p.97; G. Griffiths (ed.), *The advance guard*, Dunedin: ODT, 1973-1974, v.2, pp.151-178.

36 *Brave days*, p.300.

37 There are references to Mrs Pratt "who is to nurse" her sister Fanny Bridge during pregnancy and childbirth in the letters of Mary Ann Hastings of Southbridge, Bridge Family, *Letters from Canterbury, New Zealand, 1867 to 1871*, Worcester: W. Leicester, 1872, p.14.

38 Agnes Forrest is listed on the electoral roll at the same address as Ada, Agnes and Catherine Forrest, all "domestic duties". Elizabeth Garshore lived with Mary (domestic duties) and Agnes (tailoress), Sarah Ann Hall with Frances (tailoress) and Jane Rainton with Elizabeth (domestic duties).

These women may have been supporting themselves and their families entirely by nursing.

Susan Reverby notes in her study of nineteenth century nurses in America that

Shifts in a woman's marital status often preceded her entry into nursing. Marriage to a very poor man, divorce or abandonment, or widowhood were often preconditions of nursing. Widowhood, in particular, appears to have been an important, if cruel, pathway into nursing.³⁹

A similar pattern seems to have operated in colonial New Zealand. Jane Hinkley in her study of pioneer widows in Otago found that there were far more widows than widowers in New Zealand. Widows did not tend to remarry quickly, if at all, and unlike widowers, could not send their children away to be cared for by relatives. These women seem as a matter of course to have worked outside the home in order to remain independent.⁴⁰

Biographical sources on colonial nurses confirm these findings. Some women came to New Zealand as widows. Douglas McKain emigrated in 1840, three years after the death of her husband, accompanied by five of her 13 children. She established herself as a general nurse and midwife in Wellington, working in this capacity and making an excellent living for some 20 years.⁴¹ Mrs Klaus of Tai Tapu was also a widow when she arrived in 1862 with a party of German colonists, one of whom employed her as a housekeeper. After his marriage, she moved into her own cottage and supported herself by nursing among her neighbours. In later life, she was appointed matron of the Old Men's Home in Napier.⁴² Other widows became nurses after living some years in the colony with their husbands and families. Fan Blanch of Drummond began her battle for independence after her elderly husband's death in 1909, gradually establishing a

39 Reverby, *Ordered to care*, pp.15-16.

40 Jane Hinkley, *Pioneer widows of Otago, 1870-1900: a case study of independent women*, postgraduate diploma long essay, Otago University, 1990, pp.2-3, 40.

41 M. Patrick, "Douglas Mary McKain", *DNZB, volume 1, 1769-1869*, p.252.

42 Trask, pp.21-24, 41.

reputation for maternity nursing in the eastern Southland region,⁴³ while Mrs Pauling of Ashburton also engaged in practice as a nurse after being widowed and leaving her Mayfield farm.⁴⁴ Susannah Cullen of Maungaturoto, the mother of 12 children, was widowed in her early 40s and became the family breadwinner as a nurse and midwife in the district,⁴⁵ while Mary Player, who had used her nursing skills to augment the family's modest income during her husband's life, was left penniless and homeless when he died in 1905. With seven children to care for, she took on full-time case nursing, often living in, while her elder daughters minded their younger siblings.⁴⁶

Other married women found they needed paid work, not just to augment the male breadwinner's earnings but to replace them when times were tough. Grace Hirst's husband, a Taranaki trader and later a small farmer, was a bad businessman and often in debt, so it was Grace who, through her nursing and midwifery work, was the mainstay of the family, providing both its emotional and financial support.⁴⁷ Beth Jones was the local midwife at Kakahu Bush from the 1870s. Her husband John was seldom successful in his attempts to earn a living and was twice declared bankrupt.⁴⁸ Rangiora midwife Eliza Thompson's husband Arthur became seriously ill after their marriage, so Eliza took over responsibility for the family, running a small holding and doing craft work as well as nursing.⁴⁹ Mrs A.M. Johnson of Auckland told Premier Seddon that she had an invalid husband and 11 children for whom she was the "sole support".⁵⁰

The number of years in which women appeared in the directories confirms that, while some women worked as nurses for relatively short periods,

43 J. Bassett, "Fan Blanch", *The book of New Zealand women*, pp.88-89.

44 Obituary, *Press*, 20 November 1902, p.6g.

45 *A new earth: pioneer women of New Zealand*, Wellington: National Council of Women, 1975, pp.36-37.

46 G. Rainbow, "Mary Player", *The book of New Zealand women*, pp.522-523.

47 R. Dalziel, "Grace Hirst", *DNZB, volume 1. 1769-1869*, pp.193-194.

48 A. Rebecca (ed.), *Notable South Canterbury women*, Timaru: Aoraki Women's Resource Centre, 1993, pp.70-72.

49 P.J. Wood (ed.), *Women of the Waimakariri*, Rangiora: Waimakariri District Women's Suffrage Centennial Committee, 1993, pp.21-24.

50 Letter to Seddon, 1904, Seddon Papers, 2/34, NA.

intermittent with other duties, others made a much longer commitment to their nursing "careers".

Career Duration of 19th Century "Nurses"			
Rural Districts			
<i>Years</i>		<i>No</i>	<i>%</i>
	1-2 years	9	23%
	3-5 years	15	38%
	6-10 years	12	30%
	Over 10 years	4	10%
	total	40	100%
<small>Source: Southern provinces almanac</small>			
Dunedin City			
<small>(included 1 man)</small>			
<i>Years</i>		<i>No</i>	<i>%</i>
	1-2 years	69	48%
	3-5 years	23	16%
	6-10 years	25	17%
	11-15 years	14	10%
	16-20 years	8	6%
	over 20 years	5	3%
	total	144	100%
<small>Source: Stone's Otago and Southland Directories</small>			

It is evident that about a quarter of the first group of nurses and just under a half of the second group seem to have worked for only a year or two. Nevertheless, well over half the first group of women nursed for between three and ten years, while about a third of the second group did so, and 10% of the first group and 16% of the second group nursed for over ten years. These figures are probably understated because of the mobility of the 19th century colonial population. Many women may have moved to another district and continued nursing there.

Those who were widows or otherwise independent were often among the longest-serving women. Mrs Eliza Brading of Mornington, for example appears for 17 years, Mrs Georgina Bowers of Leith Street and Mrs Agnes Forrest of Grange Street for 14 years, Mrs Jane Batholomew of Leith Street for 16 years, Mrs Sarah Gill of Mornington for 22 years and Mrs Mary Simpson of Caversham for 20 years. However, this was not always the case. Three of the five nurses who are listed for ten years or more in

the *Southern provinces almanac* (Mrs Day and Mrs Reilly of Timaru and Mrs Crow of Doyleston) have identifiable husbands, while Mrs Catherine Cardno of Caversham, whose husband William was a ropemaker, is listed as a nurse in *Stone's* for almost the entire period of the survey, from 1887 until 1907. Mrs Ellen Dickinson of Roslyn, whose husband John was a blacksmith, and Mrs Susan Harold, whose husband John kept the Ravensbourne Hotel, are both listed for 16 years.

Many other women gave a lifetime to nursing work. Mrs Holtham of Patea apparently worked as a maternity nurse for 45 years,⁵¹ and Margaret McNicol delivered her last baby at the age of 75.⁵² Some women literally died on the job. Mary McKay of Southland tripped and fell when travelling to a case, dying of exposure⁵³ and Mrs McGregor of Waipu was over 80 when she died while attending Mrs William McDonald.⁵⁴

As Charlotte Macdonald has noted, there was a wide variation in the amount and type of payment made to women who worked as nurses and midwives.⁵⁵ As we have already seen, many nurses undoubtedly worked without financial reward. Some women like Margaret McNicol seem to have charged their patients sometimes but not others.⁵⁶ Sarah Greenwood noted in a letter that during the birth of her son, she "was very comfortably attended by Mesdames Hogan and Bere; the former lady ... [being] delighted to be paid in old clothes ...".⁵⁷ For those who did receive money, the amount seems to have depended on the class of patient being nursed. Douglas McKain, who worked among the wives of the wealthy in Wellington, seems to have charged a fee of £2-£7, according to the length of time she attended the patient. Mrs Duncan and Mrs Penny paid £2 in

51 *Brave days*, p.143.

52 *Women of Westland, 1860-1960*, edited by V. Hawker, V. Corbett & R. Jones, Greymouth, 1959, p.37.

53 S. Natusch, *On the edge of the bush: women in early Southland*, Invercargill: International Women's Year Committee Southland Branch, 1976, pp.75-76.

54 Memories of Mrs Kenneth McDonald, McKenzie, *The Gael fares forth*, p.122.

55 Macdonald, *A woman of good character*, p.166.

56 *Women of Westland*, p.37.

57 Sarah Greenwood to D. Greenwood, Greenwood family papers, 1803-1942, MS Papers 98/14, ATL.

1852, Governor Eyre £6-10/-. In 1856, Mrs Varham was charged four guineas for each of two visits in October and December, while in 1859 Mrs Loxley and Mrs Barnes paid six guineas for their confinements and nursing. Mrs McKain had received £42 from Mrs Loxley after an earlier confinement, when she attended her for nearly eleven months (1 March 1855-29 January 1856).⁵⁸ Rebecca Dawber mentions similar figures being charged by nurses in Christchurch at the time of her arrival in 1870. Mrs Wells, a monthly nurse, charged 6 guineas a month, Mrs Brown 30/- for the confinement and £1 per week for nursing.⁵⁹ In 1881, she engaged Mrs Langlois to nurse her stepdaughter at two guineas a week.⁶⁰ Janet Taine paid her monthly nurse 25/- per week in 1891, although she knew the woman, who was a family friend, had charged others two guineas a week.⁶¹ At the other end of the scale, however, Mary Harriet Power's descendants remember her earning only 2/6 for each confinement⁶² and Mrs McSweeney, the Irish midwife in Timaru who attended Mrs Eliza Vincent's births, was apparently content with "the small sum of a dollar [10/-] per week".⁶³

For some women, the practice of nursing within the community enabled them to become businesswomen in a more formal way. Sarah Sommerville of Caversham appears as a nurse in *Stone's* from 1890 until 1895. From 1910, she is recorded as the proprietress of the Cairnsmore House Maternity Home in Invercargill. Other pioneer nurses also went on to open maternity hospitals. Mary Ann Young (later Towers) had a home in Wanganui in the 1870s and later started the first nursing home in the Normanby district.⁶⁴ Mrs Goodison, a well known Northland nurse, opened a hospital in Ponsonby in 1900 for surgical and maternity patients⁶⁵ and Hawera midwife Florence Gomer, who delivered Daisy Basham's son in 1905, opened a maternity home in the town in 1914.⁶⁶

58 Douglas McKain, *Diary, 1841-1872*, Micro MS 41, ATL.

59 Rebecca Dawber's diary, 25 June and 22 July 1870, *Robert and Rebecca Dawber*, pp.191-192.

60 *Diary*, 19 May 1881, *ibid*, p.238.

61 Janet Taine to her mother-in-law, 9 March 1891, Taine family papers, ATL.

62 Macdonald, p.166.

63 Hosken, *Turn back the clock*, p.18.

64 *Women of South Taranaki*, p.308.

65 J. Rattray, *Great days in New Zealand nursing*, Wellington: Reed, 1961, p.22.

66 *Women of South Taranaki*, p.115.

It has usually been assumed that women who nursed outside their own homes had working class backgrounds. Indeed, it is often implied that they came from the lowest strata of society. Susan Reverby found, however, that the majority of the nineteenth century nurses in Boston whom she studied were the daughters of skilled artisans - blacksmiths, masons, shoemakers, mechanics and carpenters - with the rest coming largely from farming families.⁶⁷ A study of the occupations of nurses' husbands in this survey reveals a startlingly similar result. Of the 15 husbands identified from the *Southern provinces almanac* list, it has been possible to find occupations for only six. The other nine were recorded on the electoral rolls as leaseholders (1), freeholders (3) or householders (2) or in three cases, as nothing. It seems likely, given the rural nature of the directory, that at least some of these men were farmers. The six with occupations included a bricklayer, a storeman, a carpenter, a farmer, a blacksmith and (possibly) a postmaster. Some 30 husbands have been identified from the *Stone's* list, with 23 of these urban dwellers being skilled tradesmen - bootmakers, soapmakers, ropemakers, blacksmiths, tinsmiths, compositors, printers, firemen, woodcarvers, bakers/cooks, miners and butchers. There were only five unskilled workers (three labourers, one gardener and one janitor), the others being clerks and a hotelkeeper.

It seems clear from biographical sources that many nurses in rural areas were married to farmers, usually small holders, or to those engaged in other rural occupations like sawmilling or bullock-driving. Sarah Higgins, Grace Hirst, Fan Blanch, Mary Cuddie and Eliza Vincent were all the wives of small farmers, while Mrs Frame of Pukaki was married to a bullock-driver. Agnes Bosley of Normanby, Mary Batchelor (formerly Mrs Sloper) of Glentui and Christina Prouse of Whiteman's Valley were sawyers' wives. Sawmilling districts were never free of accidents and the need for women to develop nursing skills was compelling. Tina Prouse prepared herself for the frequent emergencies by studying medical books and having plenty of first aid equipment on hand, including a set of surgical needles.⁶⁸

67 Reverby, *Ordered to care*, pp.16-17.

68 M. Macgregor, *Petticoat pioneers: North Island women of the colonial era: book 2*, Wellington: Reed, 1975, pp.191-199.

Whalers' wives also found plenty of demand for nursing expertise. Sarah Dougherty, wife of Port Underwood whaler Daniel Dougherty, found her husband's young men were constantly in need of first aid and was "thankful for her practical backwoods upbringing" in Canada, which had given her the necessary skills. It was she who nursed the survivors of the Wairau Affray in 1843.⁶⁹ Caroline Mayhew of the Bay of Islands was another whaler's wife who delivered the babies of other whaling wives and once nursed her husband's entire crew through a smallpox epidemic.⁷⁰

Women who ran accommodation houses and hotels also developed nursing and midwifery skills, like Mrs Harold of Ravensbourne who is listed as a nurse in *Stone's*. Some of the best known nurses in colonial New Zealand were accommodation house keepers. Sarah Ann Cripps of the Whareama accommodation house was "the best loved woman from Wellington to Ahuriri".⁷¹ Georgina Burgess of the Burke's Pass hotel left "an enduring record of her unselfish work and devotion",⁷² as did Agnes Harrold, a Stewart Island hotelier,⁷³ and Horowhenua accommodation house keeper Agnes McDonald.⁷⁴ Frances Turton of Ashburton was the wife of William Turton, a sawyer at the time of their marriage and later the local ferryman and accommodation house keeper.⁷⁵ Elizabeth Mackay of Wakapuaka ran the Black Bull Hotel there,⁷⁶ while sick people in Naseby were nursed by the wife of the hotel proprietor before the hospital was built.⁷⁷ In isolated settlements, hotels were often the focal point of the

69 H. Manson, "Sarah Dougherty", *DNZB, volume 1, 1769-1869*, pp.112-113; C.& C. Manson, *The story of a New Zealand family: the beginnings*, Whatamongo Bay: Cape Catley, 1974.

70 Manson, *op cit*, p.74.

71 G.H. Sutherland, "Sarah Ann Cripps", *DNZB, volume 1, 1769-1869*, p.95.

72 O. Gillespie, *South Canterbury*, p.212.

73 M. Barlow, "Agnes Harrold", *DNZB, volume 1 1769-1869*, p.178.

74 A.J.Dreaver, "Agnes McDonald, Hector McDonald", *DNZB, volume 1 1769-1869*, p.246.

75 J. Brown, *Ashburton, New Zealand: its pioneers and its history, 1853-1939*, Dunedin: Reed, 1940, pp.237, 261.

76 M. Lash, *Nelson notables, 1840-1940: a dictionary of regional biography*, Nelson Historical Society, 1992, p.100.

77 *Tales of pioneer women*, p.293.

community and the women who ran them were well known and popular figures, usually capable and caring, with an innate understanding of people. Nursing was a logical progression from their other caring duties.

The circumstances of war inspired a number of women to enter nursing work. Sarah Fielding acted as a soldiers' nurse and a midwife to soldiers' wives in Tauranga in the 1860s, later running a maternity home in the town.⁷⁸ Mrs Lee of Taranaki nursed typhoid patients in a temporary hospital there during the war of 1860,⁷⁹ at the same time as Harriet Richards began her nursing work. Harriet's skills were much in demand during her first marriage to accommodation house keeper Andrew Smith, and when she married Dr George Richards, she was able to nurse many difficult cases at their home.⁸⁰

Susan Reverby has suggested that nursing work was too closely associated with domestic service to become the occupation of more genteel women in need of paid work.⁸¹ Nevertheless, there were women who worked as nurses in New Zealand whose backgrounds were not working class, although they often married skilled working class men. Several of these women were also trained nurses. Ann Clive was the daughter of a railway inspector but had eschewed genteel life to nurse in England and then with Florence Nightingale in the Crimea. When she arrived in New Zealand, she worked as a domestic servant before her marriage to William Evans, a schoolmaster turned house painter. After his early death, Mrs Evans supported herself and her children with nursing and midwifery work in Taranaki, one of her patients being Maori leader Titokowaru.⁸² Isabella Graham of the West Coast was also a trained nurse, having completed a course at Melbourne Hospital before emigrating to New Zealand in the mid 1860s. The daughter of a doctor, she was brought up by her uncle, another doctor. In 1869 she married

78 *New Zealand herstory 1982*, compiled by Tauranga Women's Centre, Dunedin: McIndoe, 1981, p.44.

79 *KT*, 5:2, April 1912, p.19.

80 *Women of South Taranaki*, pp.246-247.

81 Reverby, *Ordered to care*, p.15.

82 C. Macdonald, "Ann Evans", *DNZB, volume 1, 1769-1869*, p.117.

goldminer David Graham who later worked as a grocer, baker and ferryman.⁸³ Whaler's wife Caroline Mayhew was also a doctor's daughter, while Grace Hirst's father was a paper manufacturer. Agnes Robertson of Hastings was the daughter of a British officer, her first husband also being in the army. In New Zealand, however, she married blacksmith William Robertson.⁸⁴

Ann Clive Evans and Isabella Graham were among the few pioneer nurses in New Zealand to have had any formal training. The *Southern Provinces almanac* lists only three women who claimed that they held midwifery diplomas, Mesdames Hill, Nicoll and Ross, all of Christchurch. Of the 145 women listed in *Stone's*, only Mrs Catherine Cardno is known to have trained in midwifery, at the Aberdeen Lying-In Hospital.⁸⁵ Other women apparently had some experience of nursing before landing in New Zealand. Sarah Symmans of Otakeho was believed to have been one of Florence Nightingale's nurses in the Crimea,⁸⁶ while Mrs Klaus of Tai Tapu had worked in a London hospital.⁸⁷ Mrs Mary Booth used her London hospital experience when she became an alternative health practitioner, attending to female patients in her husband's Massage Institute in Dunedin.⁸⁸

Most pioneer nurses in New Zealand acquired their nursing skills through observation and long practical experience in caring for others, usually family members. Skills were passed from one woman to another, mother to daughter, friend to friend. Ann Alison Corbett Harlin, one of Florence Nightingale's nurses, named her daughter, later Mrs Florence Gomer, after her mentor and trained her to continue her work in Taranaki.⁸⁹

83 C. Dann, "Isabella Graham", *The book of New Zealand women*, pp.249-250; A. Graham & J. Wilson, *Uncle Alec and the Grahams of Franz Josef*, Dunedin: McIndoe, 1983, p.17; P. Graham, *Peter Graham: an autobiography*, edited by H.B. Hewett, Wellington: Reed, 1965, p.10.

84 M. Boyd, *City of the plains*, p.216.

85 New Zealand gazette, 25 April 1907, p.1343.

86 *Women of South Taranaki*, p.276.

87 Trask, p.21.

88 *Cyclopaedia of New Zealand*, volume 4, Christchurch: Cyclopaedia Co., 1906, pp.254-255.

89 *Women of South Taranaki*, p.115.

Sarah Dougherty's daughter, Ellen, became the first trained matron of Palmerston North Hospital, while Eliza Vincent taught her daughter Eliza, later Mrs Hosken, the nursing skills which enabled her as a married woman to deal competently with accidents and illness on her isolated Mackenzie Country sheep station.⁹⁰ Inga Jacobsen's 12 children were delivered by a local midwife who took care to pass on her skills,⁹¹ and Margaret McNicol's first patient was a maternity nurse who taught her what to do.⁹²

Undoubtedly some of the women who worked as nurses and midwives in colonial New Zealand were less than adequate attendants. Women who had been accustomed to the skilled service available in Europe tended to be particularly critical of colonial nurses. German immigrant Anna Dierks noted in her diary after the birth of her child in March 1890 that her strength was not returning because she lacked proper care. "The midwife meant well and was very good in her business but did not understand how to take care of patients in the German manner", she said.⁹³ Jane Maria Atkinson thought Mrs Wakefield, "who had attended most of the Richmond-Atkinson births, a poor nurse, but she was honest and Maria knew of no better one",⁹⁴ while Mrs Hobhouse was appalled by the woman who was her monthly nurse. She noted that her

turn of thought and mode of expression is what I should not even have imagined but for the help of Dickens and my slight acquaintance with him. I often wonder as I hear her speak ... how she can have thought of such ingeniously vulgar things as she says.

Mrs Hobhouse found the woman useful in a domestic capacity but "rather wearisome" and was glad she was soon to leave.⁹⁵ Patty Adams' monthly nurse was "rough" but very kind. She left after some weeks because she assured Mrs Adams she could no longer continue without a drink.⁹⁶

90 Hosken, *Life on a five pound note*, pp.61-65.

91 *Women of Waipa*, p.33.

92 *Women of Westland*, p.37.

93 Anna Dierks, *Diary, 1875-1893*, MS Papers 2326/1, ATL.

94 Porter, *Born to New Zealand*, p.210.

95 Letter, 30 August 1862, M. Hobhouse, *The selected letters of Mary Hobhouse*, edited by S. Tunnicliff, Wellington: Daphne Brasell Associates, 1992, pp.93-94.

96 M. Adams, *Martha*, Blenheim, 1978, p.7.

Alcohol was a problem for a number of nurses. Mr T. Beaufort told Premier Richard Seddon in 1904 that his wife had recently been delivered of her nineteenth child, with a midwife in attendance who was not "free from the demon drink". She had that day come to wash and change the baby but instead "puked all over it". C. H. Hyett had had great difficulty in obtaining the services of any midwife at all and the one he engaged was "utterly incompetent", causing a healthy baby to become weak and ill.⁹⁷

Yet the enduring impression of colonial nurses is one of cheerful and kindly competence and of, as Joan Donley says, their "almost evangelical attention to cleanliness".⁹⁸ Doctors like Robert Fulton claimed that this was because doctors chose to instruct some women. They "carefully taught the most intelligent the why and wherefore of personal cleanliness, and later the need for antiseptics".⁹⁹ Many colonial nurses undoubtedly did learn from doctors, either relatives or those they worked with. Caroline Mayhew "let it be assumed that her long experience helping her doctor-father and doctor-uncle ... had qualified her as someone whose word should be taken as law".¹⁰⁰ Agnes McDonald of Horowhenua was raised in the household of her a uncle, a Glasgow doctor, and as a young woman assisted him in his dispensary.¹⁰¹ Other women, like Sarah Higgins, worked closely with local doctors, gaining experience by working on their cases before beginning midwifery practice on their own.¹⁰²

Yet doctors themselves, as became evident during the debate on puerperal sepsis in the 1920's, often knew little about asperis and the spread of infection. New Zealand's first nurses learned through experience and used practical common sense to develop their own techniques. Agnes

97 T. Beaufort to Seddon, 24 May 1904, Seddon Papers, 2/34. NA. Hyett to Seddon, 1904, *ibid*.

98 J. Donley, *Save the midwife*, Auckland: New Women's Press, 1986, p.28.

99 Fulton, p.231.

100 Manson, *The story of a New Zealand family*, p.81.

101 A.J. Dreaver, "McDonald, Agnes, McDonald, Hector", *DNZB, volume 1, 1769-1869*, p.246.

102 K. Orr, "Sarah Higgins", *DNZB, volume 1, 1769-1869*, p.188.

Harrold used raspberry leaf and tansy tea during childbirth, had the woman kneel for delivery, kept the baby warm, then sponged the mother before returning her to a clean bed and feeding her with thin gruel sprinkled with nutmeg.¹⁰³ Mrs Sarah Parsons of the Rai Valley advised Matilda Turner not to exert herself for a fortnight but not to lie in bed as this would weaken her. She was to get dressed, sit with her feet up, eat nutritious food and drink tea, cocoa and milk rather than beer or ale.¹⁰⁴ Records of the work of many nurses claim that they seldom lost either a mother or a baby. Mary McNicol delivered 101 babies and lost only one, when a doctor failed to respond to her call.¹⁰⁵ Lizzie Lean of Dunedin delivered over 1000 babies on her own without loss,¹⁰⁶ and Sarah Higgins over 350,¹⁰⁷ while Mrs Goodison nursed nearly 2000 maternity cases successfully at her hospital.¹⁰⁸ The skill these women brought to their nursing work was remembered for years after their deaths, with local people paying tribute to their midwives as Tom Telford did to Granny Cripps; she was, he said, "our beloved friend".¹⁰⁹

As doctors strove to secure their place at the top of the medical market, however, they became, as Belgrave has shown, less willing to tolerate the pretensions of possible competitors, including nurses.¹¹⁰ Even as early as 1840, Constance Brandon could report to her sister that the "widow woman" who was her monthly nurse was "always at daggers drawn" with the doctor,¹¹¹ while anxious young men eager to establish themselves no doubt resented being told by the midwife Mrs Chaney that they were "beardless boys" who knew nothing about childbirth - especially as her claim was probably justified.¹¹² Many early nurses undertook tasks which doctors increasingly saw as solely their own. Georgina Burgess and

103 M. Barlow, "Agnes Harrold", *DNZB, volume 1, 1769-1869*, p.178.

104 *London to lonely Rai*, p.87.

105 *Women of Westland*, p.37.

106 Donley, p.27.

107 Brereton, p.227.

108 Rattray, p.22.

109 Manson, *Pioneer parade*, p.183.

110 Belgrave, pp.7-24.

111 Constance Brandon to her sister, December 1840, Brandon Family_Papers, 1831-c.1929, MS Papers 2549/1, ATL.

112 Macmillan, p.341.

Agnes Harrold, for example, were both regarded as "unofficial doctors" who would diagnose and prescribe treatment for their patients if necessary,¹¹³ while Ann Evans was known as "Ann the Doctor" within her community.¹¹⁴

As far as doctors were concerned, the chief drawback of the untrained nurse was that, without the indoctrination provided by hospital training, her willing subservience could not be guaranteed. Nor could the doctor be assured that she would always "follow out his instructions implicitly" and without question.¹¹⁵ While most were "deferential to the doctor when he was in attendance", others assumed sole responsibility for patients and "who then so autocratic, and so implicitly obeyed as the 'howdie?'"¹¹⁶

As the era of trained nursing dawned, the aspiring professional nurse and her medical allies ensured that the days of the colonial nurse were numbered. Nevertheless, her legacy could not be ignored by the reformers. Not only did she continue to compete with her trained colleagues for many years to come, offering services which many younger nurses declined to see as part of their job, but she also left a more lasting bequest. Although nursing for some colonial nurses was indeed an occupation rather than a duty, most remain forever identified with self-sacrificing and virtuous womanhood. They were perceived, whether rightly or not, as serving their fellows for the love of mankind and the good of their souls. Accordingly, they engendered an expectation which would remain at the heart of many nursing conflicts in the years to come: "real" nurses worked not for money, but for love.

113 N. Crawford, "Georgina Jane Burgess", *DNZB, volume 1, 1769-1869*, p.54; M. Barlow, "Agnes Harrold", *ibid*, p.178.

114C. Macdonald, "Ann Evans", *ibid*, p.117.

115 A. Osborne Knight, "The family doctor", *Brett's colonists' guide*, edited by T.W. Leys, Auckland, 1902, p.671.

116 Fulton, p.231.

Chapter 3

"Suitable work for respectable women": the transition to trained female nurses, 1880-1901

David Thomson has argued that "New Zealand created a grudging and miserly public relief system by the standards of its own day", emphasising self-reliance and family responsibility for those in need.¹ Certainly most settlers expected to be nursed at home in times of illness by relatives, friends or paid attendants. Some settlers, however, mainly men, were denied this form of care because of poverty, old age or isolation. They were obliged to seek nursing care from a variety of attendants, both male and female, who staffed the colony's nascent hospitals.

The first hospitals in the colony were established in the 1840s and by 1881, there were 36 institutions around the country.² Most were very small and were staffed by married couples, the husband acting as steward, gardener, dispenser and warder to the male patients, while his wife cooked, cleaned, washed and nursed the few female patients. The larger institutions, however, gradually acquired a subordinate staff of warders or nurses or both. Auckland, Dunedin and the West Coast hospitals were staffed mainly by mainly men, while Christchurch Hospital employed mainly women. Most attendants were older people from the working classes, many being ex-patients. Although there were some who were undoubtedly kindly and cheerful, it was often difficult to attract suitable staff "on account of the oftentimes irksome and disagreeable duties they had to perform".³ Violence, drunkenness and laziness were often cited as the causes of staff dismissals. Working conditions were poor, with long hours, low pay, cramped accommodation and poor food. Although some

1 D. Thomson, "Who will care for me?: family responsibilities in nineteenth century New Zealand", *Landfall in the southern seas*, Auckland: NZ Society of Genealogists, 1997, p. 119.

2 Hospital returns for 1881, AJHR, H-23, 1882.

3 Annual report of the Provincial Surgeon, Wellington Provincial Council, *Votes & proceedings*, 1872, p. 26.

attendants stayed for many years and acquired considerable experience and expertise, high staff turnover characterised most institutions. The institutions themselves were often unruly and uncouth places, horrifying to the more genteel, although working class patients found the surroundings congenial.⁴ Many patients stayed for years.⁵

Nevertheless, nineteenth century New Zealand hospitals made every effort to keep up with both medical and management innovations from Great Britain. One such innovation was the substitution of trained female nurses for untrained male or female attendants, a reform which began in Britain when Florence Nightingale opened her training school at St Thomas's Hospital in London in 1860. Many of those involved in hospitals in New Zealand saw this change as inevitable. In 1877, for example, a commission on the management of Auckland Hospital noted it was "abundantly clear" that female nurses were more efficient and that the new system was "a vast improvement on the old state of affairs where wardsmen were employed".⁶ It was not until 1883, however, that Wellington Hospital established the country's first nurse training school, under the matronship of ex-Crimean War nurse, Mrs F.M. Moore. The new regime, with nursing tasks being carried out by probationers (pupil nurses) "from a higher order of society", was hailed as very successful by the Inspector of Hospitals, Dr G.W. Grabham, who declared that "a foundation is here being laid for a considerable permanent benefit to the colony".⁷ Nevertheless, the transition period at Wellington Hospital was far from smooth. Within a year Mrs Moore and all but one of her probationers had resigned in protest at the dismissal of the Medical Superintendent, Dr

4 Domestic servant Mary Taylor (later Mary Lee) had a "ripping time" in Dunedin Hospital in 1888, M. Lee, *The not so poor: an autobiography*, edited by Annabel Cooper, Auckland: Auckland University Press, 1992, pp.65-69. However, missionary J. W. Stack was disgusted by life in Wellington Hospital in the 1870s, when he was admitted with erysipilas, J.W. Stack, *Parochial experiences, Maori and English*, pp.60-72. Typescript, DUHO.

5 In 1887, Duncan MacGregor, the Inspector of Hospitals, reported that Westland Hospital had had two patients for over seven years, another two for over three years and two more for over two years, AJHR, 1887 (1), H-19, p. 24. On other occasions he complained that hospitals were refuges for the improvident and homeless, the incurable and destitute, AJHR, 1887 (1), H-19, p.17 and 1889, H-3, pp.3, 16.

6 Report of the Auckland Hospital Commissioners, AJHR, 1877, H-15, p. 2.

7 AJHR, 1884/I, H-7A, p. 20.

Hammond.⁸ Other hospitals began to appoint female nurses during the 1880s,⁹ but systematic training programmes did not necessarily follow. A trained English nurse, Miss Annie Crisp, was appointed to Auckland Hospital in 1883 along with a staff of women nurses, but no formal training was begun until 1889. Again, the transition engendered a period of intense friction, punctuated by several commissions of inquiry.¹⁰

During the 1880s, Grabham and his successor, Dr Duncan MacGregor, constantly urged nursing reform on the other two large hospitals at Dunedin and Christchurch.¹¹ Dunedin Hospital acknowledged in 1887-8 that "[s]ooner or later the substitution of female nurses for wardmen must be carried out".¹² Nevertheless, neither hospital was prepared to act quickly and the transition in these hospitals, just as in Auckland and Wellington, proved to be a long and often bitter process which took several years to resolve. This chapter examines the conflicts at the two institutions, which were shaped by a number of contemporary ideological debates about gender, class and power. Social changes led to discussions on women's role in the workplace but expanding work opportunities for women also sharpened class differences. At the same time, administrators and medical men were locked in a struggle for control of the colony's rapidly growing hospitals, which were perceived to be a source of both economic and social power within the community. Acceptance of trained female nurses and womanly authority in the person of a nursing superintendent or matron became enmeshed in this power struggle in ways which helped secure nursing's subordinate place in hospital hierarchies for decades to come.

British and American nursing historians have identified several changes which stimulated the demand for better nursing within hospitals in Europe

8 *New Zealand mail*, 24 November 1883, p. 15 and supplement, p. 1.

9 Duncan MacGregor commented favourably on the appointment of female nurses at New Plymouth Hospital under Matron Blackley in 1887, *AJHR*, 1887/I, H-19, p. 16 and at Thames Hospital in 1888, *AJHR*, 1888, H-9, p. 13.

10 D. Scott (ed.), *The story of Auckland Hospital*, Auckland: Royal Australasian College of Physicians, 1977, pp. 20-24.

11 See for example, Grabham, *AJHR*, 1885, H-18, p. 1 and MacGregor, *AJHR*, 1887/I, H-19, p. 5.

12 Dunedin Hospital annual report, 1887-8, p. 5.

and America, notably advances in medical science which led to different ways of practising medicine, and social and demographic transformations which impelled women reformers to seek a respectable occupation for single middle-class women requiring work. In both Britain and the United States, the experiences of war further highlighted the need for change.¹³ Neither social changes nor the New Zealand wars of the 1860's had the same impact in New Zealand. In 1871, when Britain had a surplus female population of over half a million, there were twice as many men between the ages of 21 and 65 in the colony as there were women. Consequently almost all women married and only a very small proportion joined the paid workforce.¹⁴ Although this gradually changed over the next two decades, with an excess of women over men in the 21-40 age bracket first appearing in Christchurch and Dunedin in the 1880s,¹⁵ the incidence of marriage remained very high and there was less pressure than in England or America from single women desperate for new forms of work.

Nor were there in the colony large numbers of leisured women able to devote themselves to social reform. The absence of a well-defined "spinster-culture" in New Zealand meant womanly influence on social issues was rather more limited than in Britain. The perennial shortage of domestic servants kept most women extremely busy with housework, child care and home nursing, helping on farms and in businesses. Those who did participate in welfare work were invariably an urban-based social elite, highly selective about the objects of their charity.¹⁶ There is little evidence to suggest that these women interested themselves in nursing reform in the 1880s. The experience of war did not stimulate interest in health reform as it had elsewhere either. The New Zealand wars of the 1860s tended to be brief, localised outbreaks. Moreover, they were fought on the

13 Dingwall, Rafferty & Webster, pp. 19-34; Rosenberg, *The care of strangers*, pp. 215-219; Reverby, *Ordered to care*, pp. 43-49; Abel-Smith, *A history of the nursing profession*, pp. 17-20.

14 R. Dalziel, "The colonial helpmeet: women's role and the vote in nineteenth century New Zealand", in B. Brookes, C. Macdonald & M. Tennant (eds.), *Women in history: essays on European women in New Zealand*, Wellington: Allen & Unwin, 1986, p. 58.

15 E. Olssen, "Women, work and family, 1880-1926", p. 160.

16 M. Tennant, "Beyond benevolence: welfare organisations", in Anne Else (ed.) *Women together: a history of women's organisations in New Zealand*, Wellington: Historical Branch, Daphne Brasell Associates, 1993, p. 110; Dalziel, "The colonial helpmeet", pp. 60-61.

settler side largely by British troops, whose medical needs were met by their own military surgeons and male orderlies.¹⁷ While the settlers who were forced to seek refuge in crowded and insanitary stockades in nascent towns like New Plymouth and Onehunga were often ravaged by epidemics of infectious diseases, women's responses remained charitably rather than medically oriented.¹⁸

Nursing reform in New Zealand was driven chiefly by individual members of the medical profession. In the absence of either hereditary or, in the early days, landed elites in the colony, many New Zealand doctors had already achieved distinction as social and political leaders within the country.¹⁹ In small pioneer communities where other health workers such as midwives and chemists were few and seldom worked full-time, they were also able to establish a unique hold on the provision of medical care to the new settlers. New Zealand families were far more likely to have access to a general practitioner than their counterparts in England or America.²⁰ Doctors were quick to organise themselves, founding the New Zealand Medical Association in 1886 and launching the *New Zealand medical journal* the following year. They were thus able to speak with considerable authority and rapidly became influential in the public health arena.²¹ Doctors were determined to extend their domination of the health sector within the hospital system. New Zealand was swift to implement both antisepsis and the reforms in abdominal surgery which followed.²² Surgical advances fostered a belief that hospitals were places of cure

17 R. Wright-St Clair, "Medical services in the Waikato war", *Auckland-Waikato historical journal*, 43, 1983, pp. 28-35.

18 M. Tennant, "Beyond benevolence: welfare organisations", in Anne Else (ed.), *Women together: a history of women's organisations in New Zealand*, Wellington: Daphne Brasell Associates/Historical Branch, 1993, pp. 109, 121; Porter, *Born to New Zealand*, pp. 138-142, 217-19.

19 Dr Isaac Featherstone, for example, was the first superintendent of Wellington Province and Dr John Logan Campbell was a notable Auckland businessman and financier.

20 M. Belgrave, "Medicine and the rise of the health professions in New Zealand, 1860-1939", pp.7-24; B. Brookes, "Reproductive rights: the debate over abortion and birth control in the 1930s", in Brookes, Macdonald & Tennant (eds.), *Women in history*, p. 133.

21 D. Dow, *Safeguarding the public health: a history of the New Zealand Department of Health*, Wellington: Victoria University Press, 1995, pp. 39-40.

22 D. Dow, "Springs of charity?: the development of the New Zealand hospital system, 1876-1910", in L. Bryder (ed.), *A healthy country*, p. 63 and *Safeguarding the public health*, p. 40.

rather than homes for the sick. Colonial hospitals were not the marginal institutions which they were in Britain and the United States at this time. In New Zealand, patients were expected to meet as much of the cost of their hospitalisation as they could afford,²³ and chronic and incurable patients were increasingly discouraged because they impaired "the efficiency of the hospitals by crowding out sufferers from illness who might benefit from treatment".²⁴ Thus hospital treatment came to be "seen as a right, not as a last, humiliating resort" rather more quickly than in Britain.²⁵ Hospitals were therefore important social institutions and were regarded by doctors anxious to establish reputations as crucial, either for private practice or for specialisation. House surgeons used hospital appointments as platforms from which to launch practices while honorary staff positions were also keenly sought by practitioners keen to advance their medical careers. By the 1880s, the honorary medical staff of Dunedin Hospital was a relatively cohesive body which held regular meetings and was willing to make far-reaching decisions. The group included both surgeons and physicians, an ophthalmic surgeon, a dermatologist and a gynaecologist. Later a children's specialist and a pathologist were added.²⁶

It was these doctors who sought subordinates able to offer a different type of patient care from that offered by the untrained nurse or warder. As diseases became better understood, doctors required reliable observers to identify when particular things were happening so that appropriate interventions might be made.²⁷ Dr A.C. De Renzi of Christchurch spoke for many practitioners when he declared that

At the present day such important advances have been made in medical and surgical treatment that a very large amount of technical skill and knowledge is required of a professional nurse ... in the great majority of cases of serious illness it is upon the nurse that the success, or otherwise of the treatment adopted almost entirely depends.²⁸

23 Dow, "Springs of charity?", p. 45.

24 Dr Grabham, *AJHR*, 1885, H-18, p. 2.

25 M. Tennant, *Paupers and providers: charitable aid in New Zealand*, Wellington: Allen & Unwin, 1993, p. 31.

26 J. Angus, *A history of the Otago Hospital Board and its predecessors*, Dunedin: Otago Hospital Board, 1984, pp. 79-80.

27 Dingwall, Rafferty & Webster, p. 23.

28 Dr De Renzi at the presentation of certificates to the first trained nurses at Christchurch Hospital, *Press*, 25 August 1892, p. 3. Dr J.H. Murray-Aynsley of Christchurch Hospital also referred to advances in surgery which required corresponding advances in nursing education, *Press*, 27 June 1895, p. 3.

In the words of Dr Colquhoun of Dunedin, doctors needed to be sure that their instructions were being implicitly carried out night and day and only a thoroughly trained and disciplined staff of nurses could give them this assurance.²⁹

Dunedin Hospital was the largest hospital in New Zealand in 1881. It contained 177 beds, with a daily occupancy rate of 120. The hospital was staffed by six male warders, one night warder and one assistant night warder, two nurses, one night nurse and one midwife.³⁰ Pupil nurses (called probationers) began to work at the hospital in a very haphazard way from 1882 but only a few were appointed, they worked only in the female wards, no trained matron was appointed and no formal training programme instigated. The honorary medical staff requested nursing reform every year from 1884 onwards but the trustees remained dilatory. In January 1889, exasperated by the lack of progress, Dr F.C. Batchelor, a gynaecologist on the honorary staff and a lecturer at the Medical School, tried another approach. A former patient, William Gay, was encouraged to write to the newspapers, describing the defective state of nursing within the hospital.³¹ Gay's letter received "instant and general [public] credence", provoking an uproar in the editorial and letters columns of the daily press.³² Batchelor then attacked the trustees at their next meeting, demanding reforms in terms which even he admitted were "very strong".³³ The trustees, however, continued to procrastinate. It was not until December that a subcommittee was appointed to investigate the issue³⁴ and not until April 1890 that the House Committee's report approving trained female nurses was accepted.³⁵ The new system was still not in place when the commission of inquiry into Dunedin Hospital sat in August 1890, so witnesses could assert that the unsanitary condition of the

29 *ODT*, 1 March 1889, p. 4i.

30 Hospital returns for 1881, *AJHR*, 1882, H-23.

31 William Gay to the editor, 31 January 1889, *ODT*, p. 3c and *OW*, 31 January 1889, p. 22b-c.

32 Editorial, *OW*, 7 February 1889, p. 21d-e.

33 Report of the Commission of Inquiry into Dunedin Hospital, *AJHR*, 1891, H-1 p. 12.

34 Dunedin Hospital Trustees minute book, 29 December 1889.

35 *ibid*, 30 April 1890.

hospital, which precipitated the inquiry, was in part due to bad nursing.³⁶ It was not until 1892 that a trained matron, Miss Edith Mawe, finally took up her post, the nurses' home being opened and wardsmen retired the same year.³⁷

Events at Christchurch Hospital followed a different pattern. This hospital was the smallest of the four metropolitan institutions in 1881, with a bed capacity of 110 but a daily occupancy rate of only 65. Apart from the head wardsmen, Richard Brown, whose duties were more those of an assistant medical officer than a nurse, the staff was entirely female, consisting of three day nurses, three night nurses and three assistant nurses.³⁸ Later, two wardsmen were appointed to nurse male venereal patients. The first trained matron, Miss Paton, who had worked in a London hospital, took up her post in 1885, but a training school was not established until 1891 and, even then, probationers remained few. No attempt was made to displace the older untrained nurses who retained their positions as ward sisters. Friction developed between the two groups, which worsened considerably after the appointment of two reformers in 1893. These were the matron, Miss Sibylla Maude, a Christchurch woman who had trained as a "lady-probationer" at Middlesex Hospital in London, and the house surgeon, Dr J.H. Murray-Aynsley. In January 1895 these tensions erupted when an anonymous letter appeared in the *Christchurch star*, accusing hospital authorities of mismanagement, cruelty, discrimination and incompetence.³⁹ The hospital board, which was, according to Duncan MacGregor, "afraid to do their duty" and seeking someone else to "bell the cat for them",⁴⁰ asked MacGregor to hold an inquiry, which was ultimately conducted by his deputy, Grace Neill, the first woman public servant in New Zealand. MacGregor and Neill advised that the older nurses and Brown had to go; they had used their position to form a cabal which paralysed the authority of the matron and the house surgeon, creating an

36 See for example Dr Batchelor's evidence in his address to the trustees, *ODT*, 28 February 1889, p. 3a and in the report of the commission of inquiry, *AJHR*, 1891, H-1 p. 60.

37 Dunedin Hospital Trustees minute book, 18 July 1892; *AJHR*, 1892, H-3, p. 10.

38 Hospital returns for 1881, *AJHR*, 1882, H-23.

39 *Christchurch star*, 22 January 1895, p. 3f.

40 *Press*, 28 June 1895, p. 3d.

intolerable situation.⁴¹ The dismissals which followed, however, precipitated a spate of public meetings and outraged letters to the press, followed by a deputation to local cabinet minister, William Reeves, decrying the "Star-chamber justice" of Mrs Neill's inquiry,⁴² and the "cruel and heartless" dismissal of long-serving staff.⁴³ The board, "shuffling and shifting",⁴⁴ reinstated the nurses and was finally persuaded by Reeves to seek a commission of inquiry, which was held in June/July 1895. It was not until the commission's report came down firmly in favour of reform that the hospital's remaining untrained nurses either resigned or were retired, a nurses' home was opened and the transition to trained female nurses completed.

The superiority of female nurses over male warders was not an especially contentious issue in the 1880s. Florence Nightingale's work was widely appreciated and most agreed with William Gay's assertion that

As a rule men are naturally incapable of nursing so well as women ... they are wanting in that sympathy, that quiet and gentle authority, and that almost intuitive perception of a patient's wants which women manifest in the presence of disease.⁴⁵

While not everyone concurred in Mrs Neill's condemnation of warders as "a relic of barbarism",⁴⁶ it was generally accepted that even at their best, "they can never be what women are".⁴⁷

Why then did the transition to trained female nurses cause such conflict within the Dunedin and Christchurch Hospitals? A number of issues were involved, several of which have already been traversed by British and American nursing historians. These include economic factors and the

41 *Press*, 28 March 1895, p. 6b.

42 *Press*, 8 April 1895, p. 6a.

43 *LT*, 4 April 1895, p. 4e.

44 *Press*, 28 June 1895, p. 3e.

45 William Gay's letter to the editor, *OW*, 31 January 1889, p. 22b.

46 Evidence to the Christchurch Hospital commission of inquiry, *Press*, 27 June 1895, p. 3.

47 Editorial, *ODT*, 31 January 1889, p. 2d.

gender and class ideologies which shaped attitudes to women's work. Most important of all, however, was an issue which has been less fully analysed elsewhere. This was the struggle for power which characterised colonial hospitals at this time, as administrators, doctors and matrons jostled for supremacy within the rapidly growing empires these institutions represented.

Economic issues were clearly of some importance to boards of trustees considering trained female nurses. Dingwall argues that in England "probationers turned out to be a cheap source of labour for the hospitals", who could also become a source of revenue when they were hired out for private duty. This did much to persuade hospital governors of the benefits of the scheme.⁴⁸ It was just as obvious to New Zealand officials that women nurses would cost less than male warders. The author of a letter in the *Press* in 1878 pointed out that the ten wardsmen who staffed Dunedin Hospital cost £610 a year. Christchurch, he suggested, could, by employing women, have better nurses for £350, including a good salary for a trained lady superintendent.⁴⁹ In 1889, Dr W.S. Roberts of Dunedin pointed out that the hospital could pay two nurses and one probationer for the price of one wardman.⁵⁰ This was a significant saving at a time when rising patient numbers and new medical techniques required an increasing hospital staff. Nevertheless, economic concerns also served to delay reforms, because the prospect of cheap salaries was offset by the cost of the special accommodation believed essential to guarantee the moral probity of probationer nurses. Both Christchurch and Dunedin administrators accepted that a nurses' home was pivotal for the employment of young women from the middle classes who, furthermore, required moral disciplining and supervision away from tempting proximity to men.⁵¹ The Dunedin Hospital trustees were, however, worried not only by the cost of building a nurses' home, "a far larger outlay than [they] contemplated ...",⁵² but also by on-going maintenance expenses, which they understood had meant "a considerable increase in the yearly

48 Dingwall, Webster & Rafferty, p. 59.

49 *Press*, 16 October 1878, p. 5h.

50 *ODT*, 7 March 1889, p. 3c.

51 Dunedin Hospital Trustees minute book, 3 April 1889.

52 Dunedin Hospital annual report, 1887-8, p.5.

expenditure ... " at Wellington and Hobart hospitals.⁵³ Even Dr Batchelor acknowledged financial difficulties were at least partly responsible for Dunedin's failure to reform its nursing system; "That has been the whole difficulty", he admitted: "at least they have always given us to understand so".⁵⁴

The differing ideologies which shaped people's attitudes to women, work and class also served to hamper the transition to trained female nursing. Generally speaking, colonial New Zealand was not unsympathetic to the widening of opportunities for women. The first girls' secondary school was opened in 1871 and in 1874, Kate Edgar enrolled at Auckland University College, graduating with a BA from the University of New Zealand three years later. In 1877, primary education was made compulsory for both sexes and women were recognised as eligible to vote for and sit on school committees and education boards. The 1880s brought women eligibility to sit on liquor advisory committees and charitable aid boards and a guarantee of property rights for married women. A women's suffrage bill came before parliament as early as 1878 and after a vigorous campaign by women throughout the country, suffrage was achieved in 1893, nearly a quarter of a century before British and American women were granted the same right. Raewyn Dalziel has, however, argued persuasively that the early success of women in gaining political rights in this country was related less to recognition of women's equality in society than to their achievements within the home and family as guardians of moral health and welfare. Women did not seek to undermine their traditional role but to bring their special qualities as upholders of moral values and social purity to bear on public as well as private life.⁵⁵ Attitudes to women and work were therefore mixed. Many agreed with the first secretary of the Labour Department, Edward Tregear, that, while "the abnormal ... conditions of life in the nineteenth century made it imperative that women should earn

53 Dunedin Hospital Trustees minute book, 16 June 1886.

54 Batchelor's evidence to the commission of inquiry, AJHR (1891) H-1 p. 91. Rosenberg, *The care of strangers*, p. 219 discusses similar economic concerns experienced by American hospitals in introducing trained female nurses and A. Hyslop, *Sovereign remedies: a history of Ballarat Base Hospital, 1850s to 1980s*. Sydney: Allen & Unwin, 1989, p. 159 records the economic worries of Ballarat Hospital's board.

55 Dalziel, "The colonial helpmeet", pp. 55-68; D. Page, "Introduction", *The suffragists: the women who fought for the vote*, Wellington: Bridget Williams Books, 1993, pp. 17-18.

their own bread ... the fact should be regarded as a necessary evil".⁵⁶ A woman's work experience should not adversely affect her special functions in life as a wife and mother. Nursing was well suited to this purpose. It "tended to produce the highest form of womanhood", noted *Daybreak*, a feminist periodical aimed at working women, because it allowed women's "natural instincts" to be given free rein in the service of others.⁵⁷ The Premier, Richard Seddon, believed nurses made "excellent wives" because they were trained "to the duties and responsibilities of maternity".⁵⁸ It was a job which a respectable woman might usefully undertake.

Ideologically, then, New Zealand was receptive to the moralisation of nursing as propounded by Florence Nightingale. Reformers accepted Nightingale's maxim that nurses should be women of good character, who would accept a training grounded on discipline, subservience and unquestioning obedience to authority.⁵⁹ The new "model" nurse would be "from a class very much superior to the old-fashioned hospital nurse of former times"⁶⁰ and would pursue her calling "from other than pecuniary motives".⁶¹ Most important, her moral character would be above suspicion, her motives denoted by "purity" rather than "uncleanliness" of mind.⁶² In the words of Susan Reverby, respectability was the trait which was to separate the trained nurse from her predecessors. Disorder, dirt and immorality would be replaced by obedience, submission and loyalty.⁶³

Just as in Britain and Australia, however, there was "a discrepancy between the dominant ideology of nursing - the self-sacrificing lady officer,

56 AJHR, 1897, H-6 p. ix.

57 *Daybreak*, 6 July 1895, p. 2.

58 Seddon in the debate on the Midwives' Bill, NZPD, 128, 1 July 1904, p. 71.

59 Reverby, *Ordered to care*, p. 41.

60 MacGregor, AJHR, 1887/I, H-19 p. 23.

61 Grabham, AJHR, 1884/I, H-7A p. 20.

62 Dr Colquhoun of Dunedin declared that objections to men being nursed by women arose not from "purity of mind" but from "uncleanliness", *ODT*, 1 March 1889, p. 4i.

63 Reverby, *Ordered to care*, pp. 41-49.

extolled by reformers - and the realities of recruitment".⁶⁴ English-trained doctors like Grabham and MacGregor might have expected the "lady-probationer" scheme which operated in England to be instituted in colonial hospitals but New Zealand hospital boards soon found it was not a viable option. Although both Dunedin and Christchurch Hospitals flirted briefly with the notion, Dunedin appointing a Miss Stenhouse to work in the wards in 1882 in a voluntary capacity,⁶⁵ and Christchurch appointing a Miss Buckley as acting matron and then honorary nurse in 1889,⁶⁶ most female nurses in the 1880s continued to come from the servant classes. Christchurch Hospital appointed several women nurses who first worked as housemaids in the institution, including Nurse Christina Cameron who was to become the centre of the storm of controversy leading to the 1895 royal commission.⁶⁷ The commissioners referred disparagingly to Cameron as being no different from a housemaid in their report.⁶⁸ Even ex-patients were still occasionally employed in a nursing capacity.⁶⁹

In the eyes of the reformers, the problem with these women nurses at Christchurch Hospital was not that they were inefficient but that they did not exhibit the class or the character required of a trained nurse. As both R.H. Wood, the board chairman, and Dr MacGregor said, the untrained nurses lacked the "education and refinement" which would enable them to profit from training.⁷⁰ They were disloyal to the matron⁷¹ and insubordinate in refusing to obey her commands,⁷² but most important,

64 Vicinus, *Independent women*, p. 97; G. Strachan, "Sacred office, trade or profession?: the dilemma of nurses' involvement in industrial activities in Queensland, 1900 to 1950", in R. Francis & B. Sceates (eds.), *Women, work and the labour movement in Australia and Aotearoa/New Zealand*, Sydney: Australian Society for the Study of Labour History, 1991, pp. 147-148.

65 Angus, *A history of the Otago Hospital Board*, p. 84.

66 F.O. Bennett, *Hospital on the Avon*, Christchurch: North Canterbury Hospital Board, 1962, p. 95.

67 NCHB House Committee minutes, 19 January 1886, p. 38 and 17 April 1888, p. 304. Cameron's appointment, 1 November 1887, p. 261; she became a head nurse on 18 October 1889, pp. 431-432 (CH 293/223, NA, Christchurch).

68 Report of the commission, AJHR, 1895, H-18, p. 5.

69 See for example, NCHB minutes, 5 October 1886, p. 134.

70 MacGregor, AJHR, 1891, H-7, p. 5; R.H. Wood's evidence to the commission of inquiry, *Press*, 29 June 1895, p. 10c.

71 Miss Maude's evidence to the commission of inquiry concerning Nurse Elizabeth Medlam, *Press*, 2 July 1895, p. 5f.

72 R.H. Wood referring to Miss Steele's complaints during his evidence to the commission, *Press*, 29 June 1895, p. 10b.

their conduct towards both doctors and patients was unseemly. Nurse Cameron and Nurse Elizabeth Henry behaved reprehensibly with patients in the hospital's gardens, Nurse Cameron ultimately being dismissed for "undue familiarity" with a patient by whom she became pregnant and later married.⁷³ Mrs Neill found Dr McBean Stewart's use of nurses' christian names very peculiar,⁷⁴ while Miss Charlotte Steele, matron from 1890 until 1893, believed attendants who enjoyed "nocturnal reunions" with the house surgeon in the ward kitchens to chat and drink tea were unfit to be nurses.⁷⁵ Such women might be "kind and attentive", said Dr W.H. Symes, but they were "very deficient in discipline".⁷⁶

Similarly, warder Richard Brown was unsatisfactory not so much because he was male, but because he was a man with whom no respectable woman would wish to associate.⁷⁷ Worse still, he told probationer nurses who attended "delicate" male operations that they were "unwomanly", the very notion nursing reformers most desired to quash. Accordingly, the hospital's commissioners recommended his dismissal in no uncertain terms:

The coarseness which could impute indelicacy of mind to a young woman in the performance of her duties unfits him for any work which might require his presence among the nurses in the wards ...⁷⁸

In fact, both Christchurch and Dunedin hospitals continued to employ men, first for venereal cases and later, to nurse patients suffering from delirium tremens. No "respectable young woman" or "lady nurse" should attend

73 *Press*, 27 June 1895, p. 3; AJHR, 1895, H-18, p. 11.

74 Mrs Neill's evidence to the commission, *Press*, 27 June 1895, p. 3.

75 Wood's evidence, *Press*, 29 June 1895, p. 10b.

76 Dr Symes' evidence to the commission, *Press*, 28 June 1895, p. 3e.

77 R.H. Wood's evidence at the commission of inquiry, *Press*, 29 June 1895, p. 10b-c. Wood, whose daughter was a probationer nurse at the hospital, suggested "women with any respect" would not like Brown and that he was not a man with whom he would like his daughters to associate.

78 AJHR, 1895, H-18, p. 10. See Brown's evidence to the commission, *Press*, 12 June 1895, p. 6c and the reaction of probationers to his comments, 22 June 1895, p. 7a and 3 July 1895, p. 3d. A letter to the *LT*, 5 August 1895, p. 2b-c suggested that Brown was dismissed principally because he dared to express himself with regard to young women attending delicate operations.

such cases, it was said.⁷⁹ Such views contrasted starkly with the suggestion made in 1895 that the older nurses at Christchurch Hospital should be offered alternative positions at a proposed venereal ward in Addington, a revealing indication of the perceived character failings which sealed their fate.⁸⁰

Problems of recruitment were further exacerbated by confusion about the importance of training for women nurses. In Victoria, Australia, just as in Christchurch, male warders were replaced by female nurses in hospitals before the large-scale influx of probationers in the 1890s, possibly because authorities did not fully understand Nightingale's premise that practical training as well as character was essential in the making of the true nurse.⁸¹ It seems likely, however, that attitudes towards the value of women's education also influenced hospital boards in their decisions about training for nurses. Many people believed that nursing was a "natural" occupation for women, and that systematic training could not compensate for a "kind womanly heart and sympathetic disposition".⁸² Dunedin Hospital, therefore, did not even appoint a matron to teach the probationers until 1892, while neither Miss Paton nor Miss Boys of Christchurch Hospital was encouraged to open a training school.⁸³ When a programme was set up in Christchurch under Miss Steele in 1890, the board showed its contempt for the education provided by insisting that certificates of competence be granted not only to the probationers who had attended lectures and passed examinations but also to the untrained nurses whose qualifications were based on experience only.⁸⁴

The attitudes of the reformers delayed the transition to trained female nursing, particularly in Christchurch. Their ideologies concerning women's

79 See for example, Dunedin Hospital Trustees minute book, 30 April 1890; *Press*, 14 May 1900, p. 3e-f, 24 May 1900, p. 3f, 1 February 1901, p. 4f, editorial, 24 October 1907, p. 6c.

80 *Press*, 13 April 1895, p. 8e; editorial, p. 4f.

81 Trembath & Hellier, *All care and responsibility*, p. 16.

82 *Daybreak*, 27 April 1895, p. 4.

83 The editors of the *NZMJ*, 4, 1890-1, p. 56 mourned the resignation of Miss Boys, noting that it was "a thousand pities that no Nursing Training School is started". They regretted that the Board had not made use of the matron's "ability and talents".

84 Presentation of certificates, *Press*, 25 August 1892, p. 3.

work were not necessarily shared by the women who were active in the working class trade union movement of the 1880s and 1890s. Christchurch's response to the introduction of trained female nurses demonstrated the sharp class differences between women which emerged as occupational opportunities expanded.⁸⁵ As the hospital's commissioners pointed out, "education and refinement" were thought to mean "fine ladyism",⁸⁶ and this caused an upsurge of "class prejudice and petty jealousy".⁸⁷ The older untrained nurses were said to have made "sneering remarks" about the "broken down ladies" who had joined the nursing ranks at the hospital,⁸⁸ while others accused these young women of being "a set of haughty incapables, who in their ignorance imagine that they are of a superior class".⁸⁹ Trade unionists T.E. Taylor and Aileen Garmson orchestrated widespread public protest against the injustices done to their "helpless and persecuted sisters", who were being cruelly shunted aside because they lacked culture and social distinction.⁹⁰ Until these concerns were worked through, the transition could not proceed smoothly.

The most important reason for the conflicts which arose over the transition to trained female nursing in Dunedin and Christchurch, however, centred on issues of power. The question of nursing became entangled in the power struggles occurring within hospitals at this time. Most nursing histories have focused on the confrontations which occurred between the new matrons who desired to establish autonomous nursing departments and the men within both the medical profession and the lay administration who saw themselves as being displaced.⁹¹ These conflicts also occurred in New Zealand hospitals but, in keeping with the dominant role which

85 M. Nolan, 'Miss Hardgraft and Mrs Grumble': employment organisations, in Anne Else (ed.), *Women together*, p. 197.

86 Report of the commission, AJHR, 1895, H-18 p. 11.

87 *Daybreak*, 27 April 1895, p. 4.

88 All the probationers at Christchurch Hospital gave evidence to this effect at the royal commission hearings, *Press*, 20 June 1895, p. 3f, 22 June, p. 4g, 25 June, p. 7a, 26 June, p. 3d, 3 July, p. 3d.

89 *Daybreak*, 11 May 1895, p.3.

90 *Press*, 8 April 1895, p. 6a; 18 September 1895, p. 2e.

91 See for example, Abel-Smith, pp.24-29 and A. Bashford, "Frances Gillam Holden and the Children's Hospital dispute: woman's sphere, feminism and nursing", *Women's history review*, 2, 1993, pp. 319-330.

doctors took in pushing for trained female nurses, they were less important in hampering the transition period than disputes between doctors and administrators and between the doctors themselves.

The status of the matron was not an issue during the immediate transition period at Dunedin Hospital because at that time a trained matron had not been appointed. Dunedin Hospital's trustees were, however, determined to retain control over the doctors who served the institution. It seems clear that trained nursing was considerably delayed in Dunedin because of the trustees' "decided objection to their being placed in the position of appearing to do under coercion what they were perfectly willing and prepared to do of their free will at the first possible opportunity".⁹² The trustees' defence of the warders reflected their belief that they "ought not to allow the medical profession to rule them",⁹³ rather than any real faith in the quality of male nursing. The doctors, on the other hand, felt that all reform could "safely be left to the honorary medical staff" and were prepared to seize upon any cause which would advance their claim to a larger voice in hospital management.⁹⁴

In Christchurch, it was the trustees' failure to allow either the matron or the resident medical officer to exercise any independent authority which exacerbated friction. Neither Miss Paton nor Miss Boys made any serious attempt to install herself as a superintendent of the nursing staff. Miss Paton seems to have confined herself largely to domestic management,⁹⁵ while Miss Boys was the daughter of a board member, which undoubtedly assisted her in her relations with the administration. Miss Steele, appointed in 1890 and Miss Maude, who followed in 1893, adopted a very different approach to nursing matters, which the board found less

92 Dunedin Hospital Trustees minute book, 3 April 1889.

93 Trustee Mr Mackenzie, quoted in an unnamed newspaper cutting, 1 August 1889, Otago Hospital Board Records, Box 3, item 14.

94 William Gay's letter to the press which sparked the Dunedin controversy, *OW*, 31 January 1889, p. 22b. Dr Colquhoun of the honorary medical staff acknowledged that it was he who advised Gay to publicise nursing problems (*ODT*, 1 March 1889, p.4i), and it seems likely that he also had a hand in drafting the letter.

95 This certainly involved her in several disputes with the house steward and the head cook. See for example, Minutes of the House Committee, 30 March 1886, pp. 63-64.

acceptable. Within a week of taking up her post, Miss Steele had entered into the first of many arguments with the House Committee over reorganising the nursing staff, changing the hours of duty, introducing a uniform and selecting and appointing suitable probationers.⁹⁶ The board opposed all these measures and insisted on referring every proposal either to the house surgeon or the honorary staff or both, relying on jealousies between these doctors and the matron to prevent any action being taken. Miss Maude fared little better. When Mrs Neill insisted in her report that the matron and the house surgeon should have complete control over the nursing staff, the board firmly rejected her advice.⁹⁷ Members continued to permit aggrieved nursing staff to approach them directly with complaints, a step which the commissioners declared would "hardly be credited in some hospitals",⁹⁸ and which MacGregor called "preposterous".⁹⁹ Accordingly, the matron felt unable to enforce discipline among the older nurses, so, as the *Lyttelton times* said, "what was a small and easily managed grievance [grew] into a scandalum magnum".¹⁰⁰

The boards' power games were possible because neither the medical staff nor the doctors and matrons presented a united front. Conflict between matrons and doctors was perhaps the lesser issue at this time. Nevertheless, professional women were certainly perceived by some doctors as a threat. Dr W. Stenhouse of Dunedin made noises about "high flown matrons" and difficult female nurses,¹⁰¹ while Christchurch Hospital's house surgeon Dr De Renzi did his best to thwart Matron Steele, encouraging both the older nurses and the trustees to defy her orders. R.H. Wood told the royal commission that he knew De Renzi and Steele were at loggerheads,¹⁰² while De Renzi himself admitted that although the matron had told him she was unable to carry out her duties because of friction between the older and younger nurses, he took no

96 House Committee minutes, 6 August 1890, p. 492, 20 August, p. 495, 27 August, p. 497, 10 December, pp. 517-518.

97 *Press*, 28 March 1895, p. 6b.

98 Report of the commission of inquiry, AJHR, 1895, H-18, p. 10.

99 MacGregor's evidence to the commission, *Press*, 28 June 1895, p. 3d.

100 *LT*, 24 April 1895, p. 4g.

101 *ODT*, 7 March 1889, p. 3.

102 *Press*, 2 July 1895, p. 5f.

action because he "utterly disbelieved" her.¹⁰³ Dr Murray-Aynsley, on the other hand, was very supportive of nursing reform and of Miss Maude's position, but this concord served only to make the board and the honorary staff more suspicious of the potential challenge to their power.

At both hospitals, medical jealousies were rife. The *Otago daily times* declared of Dunedin's medical men that "a more angular and cantankerous set of men it would be hard to meet".¹⁰⁴ The presence of the Medical School exacerbated friction between doctors there. As Professor Lindo Ferguson said later, the request for trained nurses at the hospital was seen as an unreasonable suggestion emanating from the designing section of the honorary staff known as the "university clique".¹⁰⁵ The university lecturers on the staff, Drs Batchelor, Ferguson, W.S. Roberts and H.W. Maunsell all supported trained female nurses, while Drs W. Brown, J. Macdonald, W. Stenhouse, M. Coughtrey and Jeffcoat expressed reservations.¹⁰⁶ That these reservations stemmed from concerns about power as much as conviction is evident in Dr Coughtrey's changing opinions on the subject. When he addressed the first graduation of New Zealand medical students in 1887, Coughtrey, at that time a lecturer, described nursing by warders as "simply execrable",¹⁰⁷ yet in 1890, when he had been removed from the medical school, he supported the male staff and advocated training for both male and female nurses.¹⁰⁸

Christchurch's medical suspicions revolved around the balance of power between the resident and visiting staff. It was revealed on the first day of the commission of inquiry into the hospital that the author of the anonymous letter which had sparked the controversy was Dr McBean Stewart, lately retired after 12 years as a visiting surgeon at the hospital and recently elected to the honorary consulting staff. He was supported by

103 *ibid.*

104 Editorial, *ODT*, 5 January 1877, quoted in Angus, p. 79.

105 *ES*, 17 December 1914, OHB newspaper cuttings, v.8, p. 147.

106 Report of a meeting of the honorary medical staff, *ODT*, 7 March 1889, p. 3. Jeffcoat and Coughtrey did not join the staff until 1890 and so were not at this meeting.

107 *NZMJ*, 1, 1887-8, p. 144.

108 *AJHR*, 1891, H-1, p. 245.

the former house surgeon, Dr De Renzi, who had left the hospital under a cloud. It seems clear that Stewart's and De Renzi's advocacy of the untrained nurses at the hospital stemmed less from genuine concern about their fate than from their determination to undermine the position of the new house surgeon, Dr Murray-Aynsley. This was part of an ongoing campaign which finally succeeded in April 1896, when Stewart and his supporters had Murray-Aynsley dismissed for negligence.¹⁰⁹

Nursing reform in New Zealand arose from the same medical advances which precipitated change in Europe and North America in the latter part of the nineteenth century. It was shaped by similar ideological beliefs about women's work and education which opened the way for the devising of a "respectable" occupation for the daughters of the middle classes. The reform campaign differed somewhat from those elsewhere in that it was both driven and shaped by male administrators, particularly medical men whose principal concern was to create a disciplined and subservient workforce which would not impose any threat to their own domination of the health system. As early as 1889, one disgruntled displaced nurse was able to perceive clearly what this male hierarchy required of the reformed nurse:

It seems to me that a good, decent, regular, working, eight-hour nursing automaton, guaranteed to go for three years, to be wound up every Sunday morning, is the only perfect machine likely to please the susceptibilities of this very particular doctor. They are cheap, cleanly, give little trouble and can always be trusted to carry out commands.¹¹⁰

¹⁰⁹ *Press*, 23 April 1896, p. 3; editorial, *LT*, 24 April 1896, p. 4f. By this time Stewart had been elected to the hospital board. One of his supporters, Dr Lomax-Smith brought the charges which resulted in Murray-Aynsley's dismissal.

¹¹⁰ Letter to the editor, *ODT*, 14 March 1889, p. 4d.

Chapter 4

"All power over nursing [should be] put into the hands of one female trained head": the role of the matron in New Zealand hospitals

The Appointment of Matron ... is a very important duty ... The success or non-success of a training-school largely depends on the matron. She should be appointed not solely for her nursing qualifications, but for an all-round knowledge of administration, both domestic and institutional. She must be possessed of tact and judgment, have some organizing ability, and be a good judge of character. Her duty ... demands a very clear head and a strict sense of justice. She must be careful and methodical, and keep books accurately entered up. She must be possessed of a kindly, sympathetic disposition, but tempered with sufficient firmness to deal with those who may impose upon it ... A matron, once appointed with due care, should then be acknowledged as supreme in her own part of the administration of a hospital ... What is the use of paying an expert and not reaping the benefit?¹

The above analysis of the role of the matron in a hospital, published in 1911, appeared to accept the principle upon which Florence Nightingale had founded her nursing service. Nightingale believed that

The whole reform in nursing ... has consisted in this; to take all power over the nursing out of the hands of men and put it into the hands of one female trained head and make her responsible for everything (regarding internal management and discipline) being carried out.²

She sought to establish within her hospitals a female hierarchy which was equal to but separate from that of the men. Nurses would not directly challenge the authority of doctors because the matron would control a separate arena of concern and would hold independent responsibility for the work of the female staff.³

1 Report of the Hospitals Conference, AJHR, 1911, H-31, pp. 193-194.

2 Nightingale to Mary Jones, head of St John's House, 1867, quoted in Moore, *A zeal for responsibility*, p. 5.

3 Reverby, *Ordered to care*, p. 42

In New Zealand, such an independent role for the matron failed to materialise. The power struggles which characterised the period of transition from untrained to trained female nursing continued, hospitals becoming battlegrounds on which various authorities fought for supremacy. Jealousy among residential medical staff, honorary medical staff and hospital administrators remained rife, as each group jostled for control and domination. This situation was fraught with difficulties for the new challenger to power in the field, the matron. Constrained both by her gender and by the principles of subordination and obedience which formed the basis of her new profession, it behoved her to walk warily in the jungle of conflicting power-seekers which confronted her. Matrons sought to follow the Nightingale prescription by establishing absolute authority over nurses, their training and the domestic management of the hospital, but soon found they were regarded suspiciously by hospital secretaries, resident medical officers, other doctors and especially by board members. In the end, it became evident that only by allying themselves with the ultimate victor in the power struggle, the hospital medical superintendent, was it possible for matrons to achieve any degree of professional independence. This alliance did not give matrons the self-determination over nursing matters which had been envisaged by Nightingale and did allow doctors a great deal of influence in nursing matters. Nevertheless, such a professional alliance was infinitely more acceptable to nursing leaders than the continual lay interference in nursing matters which characterised hospitals in the prewar years.

Almost all of New Zealand's first professional matrons were English- or Scottish-trained, although some, like Edith Mawe and Isabella Fraser, respectively first and second trained matrons of Dunedin Hospital, had also worked in Australia. These women, accustomed to the Nightingale system in Britain, found that their role in the much smaller New Zealand hospitals was very differently defined. Matrons in these institutions were expected to act variously as nurses, housekeepers, cooks, laundresses, home sisters, tutor sisters, house surgeons, dispensers and anaesthetists, depending on the demands of the moment.⁴ Many undertook clerical

⁴ Comments on these roles can be found, for example, in Dr Falconer's eulogy to Miss Fraser, *NZNJ*, 25:6, 16 January 1933, p.315; reports on hospitals like Kumara and Waihi by the Inspector-General, *AJHR*, 1896, H-22, p.15 & 1912, H-31, p.117; and reports in the *Journal of the Department of Public Health*, eg Tauramaramui Hospital, 3:4, April

work, gardening and the preserving of fruit and vegetables.⁵ The matron of one small hospital was responsible for maintaining the acetylene gas plant, while another both used and serviced the x-ray machine.⁶ Male administrators and medical men were prepared to make use of their matrons' multiple skills when it suited them to do so. When Cecelia McKenny of Wanganui Hospital, for example, sought to be relieved of her clerical duties so that she could concentrate on her nursing responsibilities, the board refused, adding that it also expected her "to exercise more care in future in the making of her returns".⁷ Many matrons continued to act as dispensers well into the 1920s.⁸ The New Zealand Trained Nurses' Association believed this practice to be a menace to patient safety and unfair to nurses, but the Department of Health and doctors generally, although they refused to permit nurses to undertake any training in pharmacy, continued to make use of their services because it was impossible to find trained chemists to work in small rural institutions.⁹

Nevertheless, boards of trustees and their male staff remained deeply suspicious of any threat to their own hegemony. Within a week of her arrival at Dunedin Hospital in March 1892, Miss Mawe was informed that although the administration would confirm her appointment of a housemaid this time, in future all appointments must be submitted to the

1920, p.134.

5 See for example, reports on Wairoa Hospital, *KT*, 2:3, July 1909, p.121 and G. Conly, *A case history: the Hawke's Bay Hospital Board, 1876-1989*, Napier: Hawke's Bay Area health Board, 1992, p.151; report on Otaki Hospital, *KT*, 17:2, April 1924, p.82.

6 *KT*, 3:2, April 1910, p.69; *AJHR*, H-31, 1914, p.90.

7 R. Wright-St Clair, *Caring for the people: a history of the Wanganui Hospital Board*, Wanganui: Centennial Celebrations Committee, 1987, p.29.

8 In 1930, the Trained Nurses' Association notified the Department of Health that nurses were still dispensing medicines in at least ten public hospitals, Secretary of the NZ Trained Nurses' Association to the Department of Health, 21 November 1930, H1 21/10, NA.

9 In 1909, Dr E.D. McKellar proposed that some registered nurses be given formal training in hospital pharmacy, *KT*, 2:3, July 1909, pp.106-107. The government was prepared to consider the idea (see Massey in the debate of the Hospitals and Charitable Institutions Bill, *NZPD*, 22 October 1909, p.524) but it was rejected by doctors, pharmacists and hospital boards, eg *NZMJ*, 7:30, May 1909, p.51, OHB Trustees minutes, 16 June 1909, p.205.

Hospital Committee for prior approval. Similarly, rules for the laundry and plumbing work at the Nurses' Home could not be instigated without the Committee's consent, nor could stationery or anything else be ordered.¹⁰ In August Miss Mawe was informed that a housekeeper was to be appointed and that

In order to prevent friction and the overlapping of duties in future, the Matron will confine herself entirely to the duties of nursing and the management of the Home ... She will also be pleased to consider Mr Burns [the hospital secretary] the representative of the Trustees in everything connected with the Hospital ...¹¹

The matron was not granted a free hand in nursing matters either. On 6 April 1892 she was empowered to engage nurses "residing in this Hospital District" as probationers, but a week later, she was told to refer the details to the chairman of the Hospital Committee for his prior approval. By August, her recommendations were regularly being rejected and consideration of the rules she had drawn up for the Nurses' Home was postponed. At the same time she was given instructions on the kinds of work nurses might undertake on the Sabbath and her refusal to sign certificates for nurses not trained under her supervision was disregarded (the certificates were issued under the signatures of the examining doctor and the chairman of the board).¹² Not surprisingly, by December Miss Mawe had had enough and submitted her resignation.¹³ She had survived in her post for less than a year.

Miss Mawe's experiences with hospital trustees were by no means unique. Miss Crisp, Auckland Hospital's first trained matron, was not permitted to have control over linen or bedding although she was given authority to dismiss probationers.¹⁴ Miss Paton, the first trained matron of Christchurch Hospital, endured two years of constant friction with the head cook, the head laundress and the steward on issues relating to their

10 OHB House Committee minutes, 9 March, 16 March, 27 July, 16 November 1892.

11 *ibid*, 13 August 1892.

12 *ibid*, 6 April, 13 April, 3 August, 10 August, 17 August 1892.

13 *ibid*, 7 December 1892.

14 M.B. Brown, 'The Auckland School of Nursing, 1883-1990: the rise and the fall', MA thesis, Auckland, 1991, p.41.

respective authority.¹⁵ Her successor, Miss Steele's refusal to sign certificates for untrained nurses was disregarded.¹⁶ At Invercargill Hospital, conflict between the matron and the secretary caused years of turmoil. The first matron, Miss Helen McKay, resigned after a few months, leaving the staff in disarray.¹⁷ Miss Blackley, first matron of New Plymouth Hospital, found that "Control appears to be divided between myself and the ladies' committee, some of whom take upon themselves the duties of reproving and instructing the nurses and servants".¹⁸ At Te Waikato Sanatorium, Matron Rochfort was described by the resident medical officer in 1903 as "a gem", who successfully managed nursing and housekeeping duties, as well as book-keeping, the organisation of the internal economy, a large amount of correspondence and supervision of the farm and garden. The house steward appointed to assist with some of these matters, however, was determined to assert his authority. He would not be a mere clerk to the matron, he told Dr Makgill, but would be the boss. Poor Miss Rochfort, added Makgill, had found her difficulties doubled instead of halved, but the "real question" was whether "he or the Matron is to be paramount power up there". Few male administrators were prepared to allow a mere woman to assume such a position.¹⁹

Gradually, matrons were permitted to assume control of the domestic management of hospitals. It suited contemporary gender ideologies to have a female in charge of housekeeping matters; hospital inspector MacGregor, for example, was staggered to learn in 1905 that the house steward, rather than matron of Auckland Hospital was responsible for the patients' food. Not only did her knowledge of the requirements of the different wards mean the matron could do the job perfectly satisfactorily, he said, but it was much more the province of a woman than a man to superintend the cooking and serving of food.²⁰ In the early years of

15 See for example, CHB House Committee, 23 March 1886, pp.60-61, 15 June 1886, p.100, 1 March 1887, p.179, 17 March 1887, pp.185-186.

16 *ibid*, 31 October 1892, pp.57-58.

17 AJHR, H-22, 1896, p.15; 1898, p.19; 1900, p.12.

18 A.B. Scanlan, *Hospital on the hill: a centennial history of the New Plymouth Hospital, 1867-1967*, New Plymouth: Taranaki Hospital Board, 1967, p.29.

19 Letters from J. Hislop to Dr Mason, 26 August 1903, and Dr Makgill to Dr Mason, 29 December 1903 and 4 January 1904 in B. Mayo, Research material on Te Waikato Sanatorium, Acc.89-265, WTU.

20 Report of the Auckland Hospital Commission, AJHR, 1905, H-22A, pp. 6, 51, 70-71.

trained female nurses, some hospitals employed both a matron and a housekeeper.²¹ It was far cheaper, however, (and less divisive) to have one female head within the institution and by the late 1890s, most matrons were expected to fulfil both roles. It soon became evident that "No mortal woman can do the work of the matron and housekeeper conscientiously".²² The chairman of the Christchurch Hospital Board suggested as early as 1898 that the matron's workload should be lightened by a rotation of ward sisters to preside over domestic management under her supervision.²³ By the turn of the century, this arrangement had been formalised with the appointment by the major hospitals of submatrons to supervise domestic duties.²⁴ From this time onwards, apart from constant exhortations to improve economy and avoid waste,²⁵ administrators generally were prepared to leave domestic issues to the control of the matron without undue interference. The domestic power of matrons thus remained unchallenged until the appointment of trained dietitians in the 1930s.²⁶

21 Christchurch Hospital, for example, appointed a housekeeper in 1895, after the royal commission into the hospital suggested that Miss Maude was "somewhat deficient" in her housekeeping skills and needed assistance in this area. When she resigned a year later, the position was quietly dropped and the new matron, Miss Eileen Johnstone, was expected to carry out both nursing and domestic responsibilities, AJHR, H-18, 1895, p.13; *Press*, 26 September 1895, p.3c, 20 August 1896, p.3f.

22 Letter to editor, *Press*, 14 March 1898, p.3c. When the first trained matron of Timaru Hospital was appointed in 1903, her responsibilities encompassing all those previously divided between the matron and the steward, the *Timaru herald* commented that the new appointee would need to be a "cast iron specimen" who would certainly die of exhaustion if she remained long in the service of the board, J.C. McKenzie, *A history of Timaru Hospital*, Christchurch: Pegasus, 1974, p.69.

23 *Press*, 28 July 1898, p.6e.

24 Sister Griffiths became Christchurch Hospital's first submatron in 1902. *Press*, 26 June 1902, p.5a & 28 August 1902, p.5e. Sister Veitch was Dunedin Hospital's first submatron, OHB Trustees minutes, 19 August & 16 September 1903, v.3, pp.356-7, 362. Later second and then third assistant matrons were appointed as hospitals and their staffs grew and the matron's duties became more complex and demanding. Christchurch Hospital, for example, appointed a second assistant matron in 1919 and a third in 1920, NCHB Hospital Committee minutes, 21 January 1919, p.403, NCHB minutes, 26 May 1920, p.3.

25 See for example, the Inspector-General's regular comments on this aspect of the matron's work in his annual reports, AJHR, H-22, 1909, pp.29, 42; 1910, p.26; 1911, H-31, pp.94, 101. In 1908, he suggested that a question on hospital economics should be included in the state examination, 1908, H-22, p.3.

26 Nursing leaders were reluctant to yield control of domestic matters to another person, and dietitians fought a long battle to secure their status in hospital hierarchies. The first dietitians in the main hospitals remained under the control of the matron. Their uncertain position and the implacable hostility of nurses meant none lasted long. They were then replaced by nurses who took up positions as dietary sisters. It was not until the late 1930s that training courses were established and dietitians became firmly established in hospital kitchens. See D. Crooks, *A history: New Zealand Dietetic Association (Inc.) and dietetics in New Zealand*, Wellington: New Zealand Dietetic Association, 1993, pp.2-4;

Control over nursing issues was another matter. Certainly, in a few institutions, matrons were granted independent authority in nursing affairs. When Miss Stewart of Thames Hospital retired in 1910, for example, she noted that in the 20 years she had served the hospital, there had been absolutely no unpleasantness between the staff and the board at all. As Hester Maclean pointed out, the Thames Hospital board was, unlike so many, "content to leave the medical and nursing matters entirely in the hands of the doctor and the matron and had not thought it wise to interfere except when specifically requested to do so".²⁷ Similarly, the Waihi Hospital Board, after forcing the resignation of the first trained matron, appointed Miss Janet Macgregor to the post and "evidently decided to give their officers the fullest scope possible". In 1911, Valentine reported that

This Hospital furnishes a classical instance of what can be done by a Board recognizing that they have good officers and letting them alone. The credit, therefore, is as much due to the Board as to the officers.²⁸

Unfortunately, few other boards qualified for such plaudits. In both nursing and medical matters, the majority continued to maintain their right to interfere and make decisions for many years. Hospital trustees were determined to assert their authority and to retain their claim to ultimate power over their employees, both medical and nursing. As Wellington Hospital Board member, Mr F.T. Moore, exclaimed during a dispute with the matron, Frances Payne in 1912, he was determined to demonstrate that "I, for one, am not afraid of the matron, or any other woman".²⁹ Hospital boards, said one Christchurch member bitterly in the same period, were too much directed and controlled by their paid officials.³⁰ "So long as I am on the board", reiterated a New Plymouth member, "the board is going to rule".³¹

KT, 20:3, July 1927, p.143, 21:2, April 1928, p.63, 22:2, April 1929, p.54.

²⁷ *KT*, 4:1, January 1911, p.35.

²⁸ *AJHR*, 1906, H-22, p.31; 1911, H-31, p.98.

²⁹ *ES*, OHB newspaper cuttings, v.10, p.128.

³⁰ *LT*, 16 March 1911, p.3b.

³¹ Scanlan, p.56.

Boards were particularly keen to maintain firm control over staff appointments and dismissals. Although some of the earliest trained matrons were granted sole power to appoint probationers to the nursing staff, boards quickly realised that such a concession represented a major loss of control. By 1892, the matron of Christchurch Hospital was told firmly that she must adhere strictly to the rules and submit the names of all prospective probationer nurses to the Hospital Committee for approval.³² In Dunedin, although applications were screened by the matron, appointments had to be approved by the Committee, which regularly set aside her recommendations. In 1897, it was formally resolved that the matron and the chairman of the Committee should jointly select probationers,³³ but the board continued in many instances to reject the women chosen.³⁴ Auckland Hospital's by-laws specified that all appointments were to be made by the board, the matron to submit the names of suitable persons for approval.³⁵

The Inspectors-General, Dr MacGregor and Dr Valintine, continually pressed boards to allow matrons a free hand in the selection of their staff.³⁶ "Most Hospital Boards hold their Matron responsible for the efficiency of her staff", said Valintine in 1911, "but some do not allow her the selection of the raw material".³⁷ They deplored the system whereby medical staff and board members granted individual nurses personal testimonials, rather than the hospital giving a single certificate of competence signed by both matron and board chairman.³⁸ Nursing leaders agreed. As laymen, board members were not competent to judge a nurse's professional qualifications, they declared.³⁹

32 CHB House Committee minutes, 14 December 1892, p.79.

33 OHB House Committee minutes, 6 October 1897; confirmed 26 October 1898.

34 The matron's recommendations were rejected, for example, on 7 March 1900, 30 March 1904 and 20 April 1904.

35 F. Rauch, 'The history of the Auckland Hospital and Auckland Hospital and Charitable Aid Board, 1847-1914', MA thesis, Auckland, 1933, p.155.

36 See for example the annual reports on Reefton Hospital, AJHR, H-22, 1908, p.44 and on Waikato Hospital, AJHR, 1906, H-22, p.32.

37 Report of the Hospitals Conference, AJHR, H-31, 1911, p.194.

38 AJHR, 1905, H-22, p.9.

39 *KT*, 6:1, January 1913, p.5.

Matrons learned through bitter experience that in order to minimise board interference, an alliance with the hospital's medical head was indispensable. In 1899, for example, when Christchurch Hospital became embroiled in a dispute over the dismissal of a nurse for disciplinary reasons, the house surgeon, Dr Fox, informed the chairman that he "would not allow a layman to interfere" behind the backs of himself and the matron. As head of the hospital, he said, it was his right to control the nurses and "to place the nurses in whatever position he liked". The dispute led to the chairman's resignation after a unanimous resolution by the board.⁴⁰ Matron and medical superintendent had gained control of the nursing staff; and if the matron had simply replaced one controller with another, then this professional alliance was infinitely more acceptable than the lay interference which had preceded it.

Accordingly, by 1914, matrons in larger hospitals were allowed to select their own staff, provided it was done in conjunction with the medical superintendent. The Otago Hospital Board granted this right as early as 1910.⁴¹ Yet board members had still not finally conceded defeat. In 1916, the board set out once again "to prove its own importance", by refusing to accept the matron's recommendation that two probationers, having completed their three month trials, were not suitable for appointment to the permanent nursing staff. Margaret Myles, the matron, saw no alternative but to resign if the board had so demonstrably lost confidence in her judgement. "It is a hateful business," she wrote to Hester Maclean, "but far too serious to put to one side and say nothing".⁴² Both Dr Valentine in the Department of Hospitals and Dr Ferguson, the medical superintendent agreed. Dr Ferguson urged Dr Valentine to scotch any suggestion of "resuming the old system of selection by the Board". The careful selection of experts was needed, he said. "I warn you that interference in a professional training of which it knows nothing by a lay board is incurring a serious responsibility". The honorary medical staff gave their unanimous support to Miss Myles. Doctors had to be able to trust in the nursing staff's qualifications, they said, and interference with the supervision of the

40 *Press*, 11 May 1899, pp.5g, 6a-b.

41 OHB minutes, 5 September 1910, p.429.

42 Miss Myles to Miss Maclean, 20 February 1916, H1 89/3/2, NA.

subordinates of the medical superintendent and the matron would lead to "anarchy". Valintine concurred. The matron might make mistakes occasionally in selecting her staff, said Valintine's report on the case, but there was "no other authority which has the experience and opportunity combined to undertake this most onerous and anxious duty".

Against the united professional front imposed by nursing and medical leaders, the lay board stood little chance. Board members continued to mutter that they "had asserted [the board's] rights and taken the proper course". The matron, they added, had been "impudent" and the nurses who supported her had used language unsuitable for servants of the board. In the end, however, they were glad to accept Valintine's suggestion that in time of war, the hospital could not afford the disruption of losing a competent matron, and his tactful compromise motion which maintained everyone's dignity. Miss Myles was persuaded by a letter from the Minister of Health to set aside her personal feelings of insult and remain at her post; one of the nurses concerned was appointed while the other was not.⁴³

The importance of medical and nursing unity in defeating board interference was demonstrated in a similar case in New Plymouth. Once again, the board at this hospital refused to accept the matron's and medical superintendent's recommendation that a nurse should be dismissed for incompetence. The medical staff promptly resigned, and the matron and nurses threatened to do so, both parties expressing a clear determination that interference on medical issues would not be tolerated. Such interference, they said, was a menace to discipline and an incentive to insubordination, as well as a vote of no confidence in the executive. Faced with such intransigence, the board withdrew. All the members resigned and the new chairman requested the doctors to return. Matron, medical superintendent and chairman continued to work in harmony for the next decade and no further problems occurred.⁴⁴

43 Reports on this incident appear in OHB newspaper cuttings, v.10, February-April 1916, pp.39, 51-52, 61-71, 83-88, 91-92, 96-97, 100. Correspondence and newspaper reports for the period 18 February-4 June 1916 are also found in H1 89/3/2, NA. Valintine's report on the case is published in *KT*, 9:2, April 1916, pp.68-69, 99-100.

44 Scanlan, pp.58-59.

The Department of Public Health and Hospitals in 1916 took steps to ensure that such cases could not occur again. Regulations were passed which made the three month probationary period of nurse training compulsory, and stated that probationers must be recommended as suitable for training by the matron at the end of this period before being accepted onto the permanent staff. These regulations were designed, said Maclean, "to recognise the matron of a training school in her expert knowledge, and give her her due authority and position". They had been made necessary by recent events.⁴⁵

The same regulations also introduced measures which curbed board authority with regard to the dismissal of nurses in training. Nursing leaders had never claimed that matrons should have the ultimate power of dismissal over their subordinates. "As a matter of proper discipline and justice both to matron and nurses, the extreme step of dismissal should rest only in the hands of the governing body", said Maclean, although she added that the matron must always be able to remove by suspension any disturbing element from the staff.⁴⁶ "The nursing profession has its ethical side, so unlike any other", and no matron could uphold and maintain discipline without powers to remove those who proved themselves unworthy, physically, morally or temperamentally, for their work. Any such suspensions, however, should be reported at once to the medical superintendent, who would then report to the board, where final action could be taken after full representation of the trainee's case.⁴⁷ However, an incident at Gisborne Hospital in 1916 convinced Maclean that boards could not necessarily be trusted to act justly on dismissals. The hospital's non-New Zealand trained matron, Miss Tait, of whom Maclean wholly disapproved, dismissed a trainee for reasons which Maclean considered quite unjustified. The nurse was given no right of appeal by the board, and Maclean was unable to have her reinstated.⁴⁸ Accordingly, the 1916

45 New Zealand gazette, 24 July 1916, p.2578; *KT*, 9:3, July 1916, p.159.

46 *KT*, 1:2, April 1908, p.30.

47 *KT*, 4:2, April 1911, p.45; *Journal of the Department of Public Health*, 1:17, November/December 1918.

48 *KT*, 9:2, April 1916, pp.111-112; 11:4, October 1918, p.217; H. Maclean, *Nursing in New Zealand: history and reminiscences*, Wellington: Tolan Printing, 1932, pp.75-76.

regulations provided that the training of a nurse could only be terminated if the Registrar of Nurses (who was also the Inspector-General of Hospitals) was notified and his consent obtained.⁴⁹

Hospital boards were infuriated by the "autocratic interference with the domestic working of the institution" imposed by the 1916 regulations. They demanded at the next hospitals conference that "full authority be given to every board to control their own nursing staff during training".⁵⁰ But at least in this respect, the days of board control were over. Matrons, by clinging to the coat-tails of the medical profession, had gained the upper hand.

By uniting with medical officers, matrons also secured the right to appoint and promote sisters. Initially, boards kept this power firmly within their own control. The Otago Hospital Committee refused to consider Miss Mawe's nomination for a sistership in 1892, telling her that "the Committee will be glad if she [could] see her way to appoint one of our present nurses to the charge of the surgical ward".⁵¹ The Christchurch board decided that appointments should be made by order of seniority only; a motion to provide for merit appointments in 1905 was lost.⁵² Both boards continued to interfere in sister appointments, the matrons' recommendations being regularly turned down. Sisters were largely responsible for training student nurses and were thus key figures in ensuring that the ideals of nursing were handed on to each group of new recruits. Maclean recognised that matrons must be able to secure women with the right personal qualifications for these positions. Accordingly, she sought medical support to counter board control. At the 1911 Hospitals' Conference, she recommended that promotions to sisterships be handled jointly by matron and medical superintendent. Since the work of charge nurses was vital to doctors as well as nurses, no sister should be appointed without the concurrence of both officials regarding her suitability.⁵³ Accordingly, in

49 *KT*, 9:3, July 1916, p.159.

50 *Ashburton guardian*, 4 September 1916, OHB newspaper cuttings, v.10, pp.196-197; *ES*, 25 January 1917, p.75, *ibid*, v.11, p.75.

51 OHB House Committee minutes, v.2, 6 April 1892.

52 *Press*, 20 October 1896, p.3e; CHB minutes, 28 June 1905, p.12.

53 Report of the Hospitals Conference, AJHR, 1911, H-31, p.194.

Christchurch Hospital's new by-laws in 1910, the matron was given the power to appoint and promote sisters, subject to approval from the medical superintendent and the Hospital Committee, such promotions to be according to merit rather than length of service.⁵⁴

The power which doctors acquired over nurses by supporting and encouraging the transition to trained female nursing was thus augmented by the needs of matrons for professional support in countering hospital board control of nursing issues. Yet even with medical support, it behoved matrons to tread warily in their relationships with administrators, because hospital boards could appoint and dismiss matrons at will. Matrons who alienated their male superiors for any reason could easily find themselves without a job, and in the years before 1914, frequently did so.

Department of Hospitals officials often expressed concern at the unsuitability of matron appointments. The bitter feuding at Wairau Hospital, for example, was, in Grace Neill's view, caused by the appointment of unsatisfactory matrons and the rejection of first-class candidates.⁵⁵ To solve this problem, Neill's successor, Hester Maclean, proposed that she, as the person most familiar with senior nurses throughout New Zealand, was the best person to appraise applicants' qualifications for matronships and advise boards accordingly. Dr Valentine agreed and in 1908, a clause was inserted into the Hospitals and Charitable Aid Bill which provided for government supervision of all public hospital matron and medical superintendent appointments. Written approval from the Minister of Health would be required before such appointments could be confirmed. Needless to say, boards displayed considerable opposition to this proposal.⁵⁶ They were, as Maclean noted with some restraint, "very jealous of any interference",⁵⁷ and so the clause failed to survive when the bill was debated in parliament. The Act decreed that boards had to inform the Inspector-General of proposed

⁵⁴ *Christchurch Hospital by-laws, 1910*, nos. 110, 111, 166.

⁵⁵ AJHR, 1905, H-22, p. 6.

⁵⁶ See for example, the response of the Christchurch board, *Press*, 26 March 1908, p.8h and CHB minutes, 6 May 1908, p.139.

⁵⁷ Maclean, p.74.

appointments and could not confirm them until 21 days after such notification, but they remained free to ignore any advice which the Inspector-General might offer during this time.⁵⁸ In the following years, Auckland and Gisborne Hospitals, among others, rejected Miss Maclean's advice, with such disastrous results that further regulation was imposed in 1916. At this point, the government insisted that if a hospital wished to operate as a training school - and no major hospital could afford not to - then the appointment of the matron had to be approved by the Registrar of Nurses.⁵⁹ It was not until the 1925 Nurses' and Midwives' Act, however, that the Registrar (by then the director of the Division of Nursing within the Department of Health) secured an absolute power of veto over matrons' appointments.

Government officials were far less successful in preventing matrons from being ignominiously dismissed from their positions for any reason which boards might choose to contrive. Such dismissals were so common that Maclean declared in 1924

there is no doubt many fine women well suited for the position of matron, knowing of instances of unfairness, consider positions under hospital boards as insecure and hesitate to take up these onerous posts.⁶⁰

On this occasion, Maclean was expressing her indignation at the dismissal of Miss Polden, the matron of Thames Hospital, simply because she did not hold midwifery qualifications. Since the sister-in-charge of the maternity annexe at the hospital was naturally fully qualified in this field, said Maclean, it was quite unnecessary for the matron to be similarly qualified. Six years later, Miss Stevenson of Taumarunui Hospital was dismissed in precisely the same circumstances, Maclean again noting the precarious nature of the hospital matron's position:

Too often it is that matrons, who have not the same access to Boards as either secretaries or medical superintendents (although they should have the same privilege of representation) are condemned unheard and regarded

58 NZPD, 147, 22 October 1909, p.522.

59 *KT*, 9:3, July 1916, p.159.

60 Editorial, *KT*, 17:1, January 1924.

unfavourably, due often merely to some personal feeling or incompatibility of temperament, and therefore lack of coordination with other responsible officers.⁶¹

Miss Stevenson refused to accept her dismissal and was able to secure reinstatement after gaining support from Jessie Bicknell, Maclean's successor as director of the division of nursing within the Department of Health. In many cases, however, matrons felt too humiliated or too intimidated to take such a step. In a profession in which moral probity, self-sacrificing service and dutiful submission to male authority provided the grounds on which its public acceptance was secured, it was difficult for nurse leaders to challenge any questioning of their actions. As Maclean suggested, the "pride of a refined woman" too often prevented them from taking steps against boards which would bring so much unwelcome publicity. Such women, she added, "in spite of latter day movements, do not care to fight for themselves" and still needed protection.⁶²

Many such cases occurred over the years. Isabella Fraser of Dunedin Hospital resigned in mortification in 1910 when her administration became the subject of a public outcry. She was, said Miss Maclean, "too deeply hurt" by the accusation that she treated her nurses cruelly to return to her position, even when requested to do so. As several commentators noted, she accepted criticism of the whole system of hospital administration as a reflection upon herself, while the men who were equally responsible (the medical staff and the board members) were only too happy to have her carry more than her share of the burden.⁶³ Miss Jean Todd of Timaru Hospital, "an upright Christian woman", was accused of dishonesty in 1915, refused the right to appear before the board, and resigned, heartbroken. Her innocence in the matter was not established until 1924, when it was discovered that the hospital secretary had been stealing from the board for years but by that time, Miss Todd was an invalid, her career

61 *KT*, 23:2, March 1930, p.112.

62 *KT*, 7:2, April 1914, p.74.

63 *AJHR*, 1911, H-31, pp.78, 90; F. Mulrennan, *Dunedin Hospital: an account of the period 1851-1900*, MA thesis, University of Otago, 1974, p. 101; letter from "Ditto" to the editor, *ODT*, 14 December 1910, *OHB newspaper cuttings*, v.2, p.128; M. H. Murray, "Fraser, Isabella, 1857-1932", *DNZB, volume 2, 1870-1900*, pp.154-155.

ruined.⁶⁴ Both Miss Ewart of Christchurch Hospital in 1908 and Miss Gosling of Nelson Hospital in 1913 were dismissed after requesting increased salaries. The Christchurch board simply seized the opportunity to get rid of a matron who was perceived to be no longer efficient (having refused to accept Mrs Neill's advice to this effect some years earlier), while the Nelson board took the opportunity to lay charges of extravagant administration at the matron's door.⁶⁵ Mabel Thurston of Christchurch Hospital was doubly injured by hospital boards. In 1918, having been granted leave for the duration of the war - she was the matron-in-chief of the British-based New Zealand Army Nursing Service - her appointment was abruptly terminated, the board citing adverse effects on both the hospital and the acting matron as excuses for their action. Neither the public outcry or pressure from government ministers could force them to alter their stance.⁶⁶ Then, in 1924, having being appointed to the matronship of Dunedin Hospital, Miss Thurston was further humiliated by public debate as to whether she fitted the criteria with regard to age which had been set by the board at a maximum of 50 (in fact she was 55). It was, as one writer suggested, "a most discourteous and amazing way to treat any matron". Miss Thurston declined to provide the certificates requested and withdrew her application forthwith.⁶⁷

Once again, a close alliance with medical authorities was essential if matrons were to survive these attacks on their positions. Medical support could sometimes prevent boards from acting against matrons. In New Plymouth in 1916, for example, during a dispute with nurses over pay and working conditions, the board chairman denied any previous knowledge of the complaints. The matron, Miss Elizabeth Browne, informed the board that she and her assistant had pointed out the inadequacies of nursing accommodation to the chairman many times. The chairman promptly threatened to resign, saying he could not possibly work with the matron. Only wholehearted medical backing enabled Miss Browne to overcome

64 *KT*, 9:1, January 1916, pp.45-6.; 9:2, April 1916, p.108; McKenzie, pp.120-122; *South Canterbury women: an inventory of memorials and tributes to women*, Timaru, 1995, pp.156-157.

65 *LT*, 24 July 1908, p.3b, 31 July, p.6d; CHB minutes, 28 May 1908, p.142, 24 June, p.146; *KT*, 6:3, July 1913, p.106.

66 J. Rodgers, "Thurston, Mabel, 1869-1960", *DNZB, volume 3, 1901-1920*, p. 533.

67 Correspondence and newspaper reports, 12-27 September 1924, H1 89/3/2, NA.

this "misunderstanding" and secure a new nurses' home, as well as improved pay and annual leave. Even so, she resigned her position the following year, moving to Te Waikato Sanatorium.⁶⁸ Similarly, Rose Muir of Christchurch Hospital was able to survive what she regarded as continuous attacks on her administration with regard to working conditions from Mrs Elizabeth McCombs of the North Canterbury Hospital Board in the late 1920s, because of the steadfast support of Dr Walter Fox, the medical superintendent. At the time of the inquiry into the death of Nurse Helen Jones from military tuberculosis in 1928, when Muir was accused of callousness and neglect, she was again actively supported by both Fox and the Director-General of Health. This support enabled her to overcome her feeling of "persecution" and the temptation to resign, even though the Board's resolution clearing her on the matter gave her "no comfort or sense of security".⁶⁹

Medical support for matrons developed gradually as doctors became convinced that their interests were best served by such an alliance and that these nursing leaders were unlikely to challenge medical supremacy within the hospital environment. Isabella Fraser, for example, second trained matron at Dunedin Hospital, was the "possessor of much tact ... with the officers above her".⁷⁰ Imbued with the traditions and ideals of Nightingale, she was "keen in her loyalty to the medical profession".⁷¹ Conflict was thus reduced and Miss Fraser was able to carve out areas of responsibility for her position which were not perceived to threaten any male bastions. Like all matrons, she accepted that the medical superintendent would always speak on her behalf when nursing issues were considered by hospital committees or the board.⁷² Indeed, Miss Fraser became so accustomed to speaking through the medical superintendent that even her farewell speech was given by him.⁷³

68 Scanlan, pp.56-57.

69 Muir to Jessie Bicknell, 31 July 1928, CH 426/26a, NA (Christchurch); P. Sargison, "Muir, Rose Caroline, 1884-1970", *DNZB, volume 4, 1921-1940*, pp. 361-362.

70 Quoted in Rodgers, "A paradox of power and marginality", p.35.

71 Obituary, *NZNJ*, 25:6, 16 January 1933, p.314.

72 No matron in New Zealand had direct access to the board, all reports being submitted via the senior doctor in charge. In Christchurch, this arrangement was first formulated in 1896, *Press*, 23 January 1896, p.2g and 27 February, p.5f.

73 *ODT*, 22 April 1911, p.11. This was extremely common. Although some nurses would speak on their own behalf, many senior nurses usually did so through a doctor on public occasions. Miss Ewart, for example, gave her farewell speech through Archdeacon Averill in 1908, *LT*, 31 July 1908, p.3a, and Rose Muir gave hers through Dr J. Guthrie in

As medical techniques became more specialised, doctors accepted that "all [their] work might be for naught if the nursing service failed to carry out [their] instructions and render routine general care".⁷⁴ As long as nurses accepted the premise that "to every patient the doctor stands first and the nurse next in relation to their welfare",⁷⁵ they were prepared to offer the support necessary to ensure the nursing service met their needs. If, however, matrons threatened medical supremacy, such support was not forthcoming. At Wanganui Hospital in 1899, for example, MacGregor blamed the matron and nurses for the friction which existed between them and the resident medical officer. In fact, he added tartly

our system of female nursing, if it is to be kept within anything like bounds ... as regards ... the pretensions of individual matrons and nurses, will require a much stronger and less sentimental handling than most of our Boards seem able to apply to it ... The grievances of nurses, which in New Zealand are really very hard to discover, figure far too much in the newspapers.⁷⁶

Other doctors agreed with him, the honorary staff at Wanganui Hospital resigning en masse in 1903, insulted and offended because the board consulted only the matron and the resident medical officer on hospital matters, rather than themselves.⁷⁷ Rivalries between the honorary staff and resident medical staff also influenced the case of Miss Todd in Timaru in 1915. When Miss Todd was dismissed without a hearing, the honorary staff immediately resigned, ostensibly in her support. In fact, their resignation had more to do with their own longstanding dispute with the board over remuneration and the employment of stipendiary medical staff. Once the threat of being replaced by paid resident staff diminished, they

1936, *KT*, 29:4, July 1936, p.146. The local branches of New Zealand Trained Nurses' Association was also led by doctors for many years. Neither the Wellington nor the Dunedin branches elected women presidents until the absence of doctors during the first world war forced them to do so.

74 Dr MacEachern, quoted in *KT*, 15:2, April 1926, p.66.

75 *ibid.*

76 *AJHR*, 1899, H-22, p.30.

77 *NZMJ*, 3, 1903, pp.102-104.

returned to work, anxious to win public sympathy which would "be useful when the next Board election occurred". The private interview which Miss Todd had had with Dr Valintine was deemed sufficient to have given her a fair hearing; nothing more could be done. As the *Timaru herald* wryly noted, "the Matron's grievance, magnified by them, had always been the smallest real factor in the quarrel".⁷⁸

The case of Auckland Hospital in the years before the first world war is particularly illuminating with regard to the position of matron and nurses in conflicts between resident medical officers, honorary visiting staff and hospital administrators. It demonstrates both the limitations imposed on matronly control by male power struggles and the importance of securing medical support for matronly survival.

The problems which occurred at Auckland Hospital reflected the failure of its board to establish a workable system of management for the institution. As each disaster led to yet another commission of inquiry, the board alternated between vesting power with the resident medical officer or with the honorary medical staff, the matron being caught somewhere in the middle. The doctors involved were bitterly jealous of each other and refused to co-operate in any way. Each group blamed the other for any errors; sometimes both blamed the matron and nurses. Until the Inspector-General intervened in 1912, vesting the medical superintendent with sole responsibility for the administration of the hospital and making all other officers responsible to him, no permanent solution could be found.

The first crisis at the hospital occurred in 1890, when a probationer nurse, Margarita Arnaboldi, who had been in training for only nine months, spoke to Duncan MacGregor during his annual visit of inspection. She accused the resident medical officer, Dr Floyd Collins, of mismanaging and neglecting the treatment of two patients to such a degree that both died. The uproar which ensued resulted in a commission of inquiry which found

⁷⁸ *NZMJ*, 15:66, April 1916, p.91. This report is quite frank about the doctors' motives in the dispute and reports gleefully that the board found the power of the British Medical Association too much for them. *Timaru herald* report, quoted in McKenzie, p.120.

that Collins' handling of the cases had in some instances been ill-judged and that he should have called upon the expertise of the consulting surgeons much earlier. In commenting on the inquiry, the medical profession was caught in something of a dilemma. Delighted though the honorary staff were to be given such a useful stick with which to attack the "uncontrolled" actions of the resident medical officer and his "almost absolute power", they were also extremely reluctant to condone the actions of a junior nurse who greatly "exceeded her capability in expressing an opinion on surgical matters". Dr Mirback noted gravely in an addendum to the commissioners' report that the precedent set by Miss Arnaboldi in taking this action "is a bad one, and her act tends to be subversive of necessary discipline; and espionage by subordinates is quite destructive of confidence on the part of responsible officials, and of the respect due to them by their assistants". Collins himself was considerably more forceful:

Probationer Arnaboldi has broken the golden rule which is supposed to be a nurse's first lesson in all hospitals. I refer to the rule, which enjoins strict obedience and strict silence. The teaching of silence refers ... to the very thing probationer Arnaboldi has been guilty of, namely, criticism of those in authority over her.

He believed, probably rightly, that Arnaboldi had been prompted to the action by others, who were motivated by a "persistent malignity" towards his position. Collins, it was said, had been given far too much responsibility, and was the victim of "unskilful and inadequate administration", expected to cope with a large number of patients almost single-handed. It was time for the honorary staff to take on a much larger role.⁷⁹

Dr Collins, the charges against him having been dismissed (Arnaboldi was censured for her conduct), remained at the hospital until 1895 but the honorary staff took over the medical management.⁸⁰ During this period, the hospital continued to be beset by petty grievances between the

⁷⁹ *NZMJ*, 4, 1890-1, pp.119, 125-129, 185-187, 207-227.

⁸⁰ The following account is based on D. Scott (ed.), *The story of Auckland Hospital, 1847-1977*, Auckland, 1977, pp. 20-24, as well as the other sources footnoted below.

doctors, as well as between the staff and the board, and according to MacGregor, the nurses were lax, insubordinate and undisciplined, the matron having little authority or status.⁸¹ In 1895, however, Dr Baldwin was appointed as medical superintendent and two years later, Mrs Wootten became matron. A calmer period followed, but once again the jealousies of the honorary staff intervened. Dr Baldwin resigned, apparently on account of "unpleasantness" with the staff, who "harrassed [him] in every way",⁸² and the board yielded to pressure, appointing two junior doctors to work under the supervision of the visiting medical men. During this period, Mrs Wootton was left in full control of the nursing staff, and "no friction whatever occurred".⁸³

The peace could not last. Concerned that no experienced doctors were immediately available to patients, the board again decided to appoint a medical superintendent. Dr Clive Collins took up this position in 1903 and was given authority to attend all meetings of the honorary staff and to act as their intermediary with the board. Intense friction developed, which led to the resignation of most of the visiting staff, and an avowal on the part of Collins to get rid of the matron, who, he claimed, "is trying to set the nurses against me".⁸⁴ The royal commission which resulted from Collins' prolonged campaign to denigrate both the honorary staff and the nurses led to his resignation.

It was Mrs Wootten's resignation in 1910 (on account of poor health as a result of the long strain imposed by her demanding position)⁸⁵ which precipitated the final crisis. Mrs Wootten was replaced as matron briefly by Miss Dora Peiper, a Invercargill-trained nurse, who resigned a few months later to marry.⁸⁶ The new matron was Miss Hannah Griffiths, an English-trained nurse with no New Zealand hospital experience. Her appointment was opposed by Hester Maclean, who refused to give her approval when

81 AJHR, 1896, H-22, p.5.

82 Report of the Auckland Hospital Commission, AHJR, 1905, H-22A, pp.63, 101.

83 *ibid*, p.51.

84 *ibid*, p.23.

85 Obituary, *KT*, 9:4, October 1916, p.243. A year after her resignation from Auckland Hospital, Mrs Wootten was appointed matron of Balmain Hospital in Sydney.

86 *KT*, 3:2, April 1910, p.87; 4:2, April 1911, p.88.

the board notified her of its choice, as they were required to do. The board, however, declined to change its decision and the hospital was once again plunged into unending wrangling and debate between the matron, the acting medical superintendent, Dr Maguire, and the honorary staff, led by the irascible Dr Pabst. Within months, the submatron and almost all the sisters issued an ultimatum to the board, declaring that "we cannot with justice, either to the institution or ourselves, continue to carry out our duties under the management of the present lady superintendent".⁸⁷ In less than a year, they, along with several staff nurses, had all resigned, the chairman of the board had been ousted, and immediate action was demanded in order to prevent internal chaos. In a series of very public and very abusive board meetings, the nurses accused the matron of holding them up to popular ridicule, the medical staff accused her of impertinence and insolence and Dr Pabst called her untruthful, provocative, incompetent, and inexperienced. Miss Griffiths in turn asserted that there was "nothing in the bylaws to indicate that the members of the medical staff [were] her superiors" and that she was not paid "to be at the beck and call of the honorary staff". She had tried to carry out Dr Pabst's exacting demands, despite his "uncompromising attitude", but these frequently clashed with the duties laid down for her by Dr Maguire and the board. She regarded herself as a "servant of the board" although she was unclear as to whether she was responsible to it or to Dr Maguire. Every obstacle had been put in her way and she had found her position an exceptionally difficult one.⁸⁸

On 15 May 1912, "in much distress", Miss Griffiths resigned, believing she could no longer serve with dignity.⁸⁹ Her position was indeed untenable, for she had alienated the support of both nursing leaders and the medical profession. Miss Maclean was unwilling to come to the aid of a woman whom she believed should never have been appointed, and was even prepared to condone the usually unforgiveable disloyalty of the hospital's senior nurses, in order to ram home to the board that her advice on the

⁸⁷ *KT*, 4:3, July 1911, p.120.

⁸⁸ *ODT*, 19 April 1912, OHB newspaper cuttings, v.4, p.14; 6 May 1912, *ibid*, p.27; 13 May 1912, p.30; 14 May 1912, pp.31-32; 15 May 1912, pp.33.

⁸⁹ *ODT*, 16 May 1912, OHB newspaper cuttings, v.4, pp.36-37.

selection of the matron should have been heeded.⁹⁰ The medical profession would not tolerate a nursing leader who refused to acknowledge her subordinate position. In fact, Dr Pabst continued to campaign against her after her resignation.⁹¹ The board believed she had never neglected her work or her patients and gave her a testimonial for faithful service,⁹² but during her tenure allowed her to thrash about unaided in a sea of uncertainty as to her role and place within the institution's management. Unwilling to concede authority to either the medical superintendent or the honorary staff, the board tried to placate both and expected the matron to do the same. This challenge proved impossible.

In September 1912, Dr Valintine resolved to settle Auckland Hospital's problems once and for all. Other major hospitals had already established a system whereby the medical superintendent was vested with complete control of the hospital's management, the secretary and the matron being responsible to him for their own departments.⁹³ Valintine recommended that Auckland adopt the same system, with the Hospital Committee (including members of the honorary staff) taking over much of the board's work.⁹⁴ This system, said Maclean, would enable the matron to "look to the medical superintendent for guidance and help" in the nursing department, and thus obviate the need for her to cope with interference from the honorary staff or the lay administration.⁹⁵ At the same time, the larger hospitals created the position of "lady superintendent" for the matron, granting her responsibility for supervising nursing duties and training at all the institutions under the board's control (cottage hospitals, old age homes and sanatoria).⁹⁶ This brought all nurses under the matron's immediate control and enabled her to establish uniformity in discipline and training standards.

90 *KT*, 5:3, July 1912, p.73.

91 *ODT*, 9 August 1912, OHB newspaper cuttings, v.4, pp.113-114; *Dominion*, 21 August 1912, *ibid*, p.127

92 *ODT*, 31 May 1912, *ibid*, p.58.

93 Dunedin Hospital, for example, established this system in 1910, *ODT*, 6 December 1910.

94 *ODT*, 11 September 1912, OHB newspaper cuttings, v.4, p.141; *ES*, 18 September 1912, *ibid*, p.148; *ODT*, 22 November 1912.

95 *KT*, 5:4, October 1912, p.108.

96 See for example, NCHB minutes, 18 August 1910, p.66.

An alliance between matron and medical superintendent was thus cemented in place and became the foundation stone on which many matrons were able to build successful careers. Miss Frances Payne of Wellington Hospital, bolstered by the unswerving support of Dr Ewart and his successor, was the only matron of a major hospital who was able to deal with discontent among her nurses in the years before 1914 without a public scandal.⁹⁷ At the same time as Miss Griffiths was being destroyed in Auckland and Miss Fraser was resigning in Dunedin, Payne was able to survive unscathed from what was described as "the most painful episode" in the hospital's history, a hostile and embittered personal attack by a board member, whose daughter was one of her nurses.⁹⁸ In the postwar years, Rose Muir of Christchurch Hospital was able to implement changes in nurse training and education well ahead of her contemporaries because she and Dr Fox shared a similar vision which enabled them to present a united front to the board.⁹⁹ As long as matrons accepted medical supremacy and did not openly threaten male power, they were able to secure a measure of control over many nursing issues. The willingness of nursing authorities to defer to male superiors, however, came at a heavy cost. Subservience to men gave respectability to a "womanly" occupation, but as far as training and working conditions were concerned, nurses were very often short-changed.

97 NZPD, 148, 1 December 1909, p.491.

98 *ES*, 14 August 1912, OHB newspaper cuttings, v.4, pp.127-128.

99 P. Sargison, "Muir, Rose Caroline, 1884-1970", *DNZB, volume 4, 1921-1940*, pp. 361-362.

Chapter 5

"More a question of character than of acquirement": nurse training before World War 1

The Nurses' Registration Act (1901) required nurses to undergo three years of practical and theoretical training in a hospital before they could sit the state registration examination. It also laid down some specific requirements for that training which were expanded by regulations.¹ This training was inevitably shaped by the ideologies on which the reformed occupation of "nurse" was premised. The first and overpowering concern was to maintain respectability. Moral character and personal qualities were more important than intellect. It was important also to maintain "womanliness"; sympathy, gentleness and kindness were more important than scientific understanding or the ability to pass examinations. Because the "good" nurse was to be first and foremost a "good" woman, training focused on domestic management. Cleaning, polishing, washing and cookery were a woman's most valued skills, and training in these would fit the nurse for her "real" purpose in life, as a wife and mother.

Training was also shaped by the pragmatic requirements of hospitals for a cheap source of labour. Endowments for training schools such as those proposed by Nightingale were out of the question in New Zealand.² Hospitals were concerned chiefly about the welfare and care of their patients, not about the education of nursing staff. Training thus consisted largely of work, not study.

Doctors had been the major instigators of the introduction of trained female nursing. They were concerned to maintain their influence over the new workforce so that their own expectations of its value could be met. From the first, therefore, training was shaped and controlled by the

¹ Regulations on hospital training schools for nurses, New Zealand gazette, 2, 23 December 1908, p.3313.

² J. Rodgers, Nursing education in New Zealand, 1883 to 1930: the persistence of the Nightingale ethos, MA thesis, Massey University, 1985, p.95.

medical profession which assumed responsibility for all aspects of the course. They had ultimate control over the selection of probationers, designed the syllabus, gave the lectures, set and marked the examinations, headed the registration board and for many years were also a major influence within the Trained Nurses' Association. Doctors were concerned to preserve their own professional monopoly by limiting the knowledge they were prepared to share. They sought a "handmaiden", not an assistant of equal status. Many doctors had very conservative views on women's education. Dr Frederick Truby King, for example, believed a woman's place was in the home and that paid work led to "a life of discontent, ill-health and possible mental collapse".³ Dr Batchelor, the power behind the introduction of trained female nursing in Dunedin, declared that occupations which necessitated "excessively heavy mental tax and nervous strain" were damaging to women's future reproductive abilities.⁴ In 1911, a committee of the British Medical Association (NZ Branch), representing the views expressed at a recent conference of the organisation, called on the Minister of Education to point out the failings of women's education. They suggested that a system which emphasised stress of mental effort, competition and strain paid insufficient attention to ensuring normal, orderly and well-balanced development and complete fitness for maternity. A woman's future happiness, they concluded, depended on an education which gave them the body, mind, morals and inclination for home life and motherhood.⁵

Within these very considerable constraints, nurses sought to put in place their own agenda for professional recognition and status. Grace Neill was successful in establishing the world's first state registration system for nurses in 1901, by which a national system of examination and certification was inaugurated. A professional journal, *Kai tiaki*, began publication in 1908 and a professional organisation, the New Zealand Trained Nurses' Association, was founded in 1909. Nurses were able to resist demands for training schools to be established in private hospitals,

3 P. Sargison, "Babies for Empire: Anne Patrick (1881-1937), first director of Plunket nursing", *Notable women in New Zealand health*, Auckland: Longman Paul, 1993, p.41; B. Brookes, "King, Frederic Truby, 1858-1938", *DNZB, volume 2, 1870-1900*, p.258.

4 "The education of women: Dr Batchelor's remarks challenged by Dr Siedeberg", newspaper cutting, June 1909, E.H. Siedeberg McKinnon papers, MS 665/4, DUHO.

5 *NZMJ*, 9:37, February 1911, pp.52-53.

though not in small public hospitals, and fought a successful battle against state regulation of the trained nurses's working day. Such successes were, however, only partial. The demands of both the medical profession and hospital administrators left little room for either independent female leadership in nursing or for nursing control over training policies and practices. Perhaps even more significant, however, was the reluctance of nurses themselves to challenge prevailing gender orders and ideologies. Nurses accepted that their claim to professionalism and public respectability rested ultimately on their willingness to work within the boundaries dictated by both the male hierarchy and the wider public. To receive an accolade as the "most noble profession" in the world was in the end worth the sacrificing of self-determination.

Early training programmes

When female probationer nurses first began to work in New Zealand's public hospitals, they were not necessarily given any formal course of training at all. Isabella Fraser, one of the first five probationers at Dunedin Hospital, began working there in 1888. She recalled in 1926 that she and her fellow probationers were engaged on the understanding that in return for their long hours of work in the wards, they would receive instruction in the art of nursing. After a short time, however, " ... the nurses realised that while they were fulfilling up to the limit all their part of the conditions the Hospital Trustees were not fulfilling theirs, and were giving no lectures or training at all". The nurses sought the support of the house steward, Andrew Burns, who put their case to the authorities. The hospital's resident medical officers, Drs Copeland and Barclay, agreed to give lectures, an examination was held at the end of 1889 and the first certificates were granted in December.⁶

⁶ "Pioneer nurses: hospital 40 years ago: some vivid reminiscences", *Dunedin Hospital diamond jubilee, 1851-1926*, Dunedin: ODT, 1926, pp.12-13; Dunedin Hospital annual report, 1889-1890, p.5; OHB House Committee minutes, v.1, 28 May, 11 June, 2 July 1889 (lectures being given and form of certificate approved); OHB Hospital Trustees minutes, 20 December 1889 (Dr William Brown presents the results of the examinations which he conducted).

In Auckland, the first certificates were not granted until the middle of 1891, although probationers had been employed since the mid-1880s.⁷ The Colonial Secretary, on being requested by Auckland's Hospital Committee for permission to introduce a nursing course in 1884, declared that he "did not see the necessity for such a course".⁸ He and many other hospital authorities subscribed to the view that nursing was a "natural" occupation for women and that systematic training could not compensate for a "kind womanly heart and sympathetic disposition".⁹ Dunedin Hospital did not even appoint a qualified matron to supervise the nurses' training until 1892. Isabella Fraser described the previous matron, Mrs Janet Burton, as "just a housekeeper" who snorted, "A' didna' hae ony lectures and A' got on all right! ... Lecters! ... A' never heard o' sic a thing!" when asked to approach the authorities about formal training.¹⁰ Christchurch Hospital, although it appointed its first trained matron in 1885, waited until 1890 to offer a training programme.

Dunedin Hospital's 1890 by-laws specified that the duties of the honorary staff included responsibility for lectures to nurses and the conduct of examinations.¹¹ By 1893, the annual report claimed that a systematic course of instruction was being offered by the medical staff,¹² and the same year the matron introduced monthly reports prepared by the head nurses and herself on each nurse pupil.¹³ Nevertheless, academic achievement remained a low priority. The Otago Hospital trustees in 1894 resolved to give letters to four nurses who had failed the final examinations twice, stating that they had served their time, had given keen attention to their duties and were of irreproachable character. These qualities were clearly seen as infinitely more worthwhile than any formal qualification.¹⁴ Grace Neill acknowledged in 1899 that the value of a

7 Rauch, *The history of the Auckland Hospital and Auckland Hospital and Charitable Aid Board, 1847-1914*, pp. 80-81; M. Brown, *The Auckland School of Nursing, 1883-1990*, p. 47.

8 Brown, p.40.

9 *Daybreak*, 27 April 1895, p.4.

10 "Pioneer nurses", pp.13-14.

11 Dunedin Hospital, *By-laws*, Dunedin, 1890, p.11.

12 Dunedin Hospital annual report, 1892-3, p.5.

13 OHB House Committee minutes, 5 October 1892 and 29 March 1893.

14 OHB Hospital Trustees minutes, v.2, 15 August 1894.

hospital certificate was very low. Certificates and badges were sometimes given out by hospital authorities when little or no training had been given and no examination at all had been passed.¹⁵ As Flora Cameron wrote in her later tribute to Neill,

It was only in the larger hospitals that it had been found possible to give any systematic training to nurses or to provide any satisfactory way of testing and certifying their efficiency by examination. In many hospitals not only were probationers not properly taught but there was a positive tendency which was encouraged on the score of expense, to have as many probationers as possible, who received no pay ... and often no regular instruction.¹⁶

It was for these reasons that Neill introduced state registration but even after the Nurses Registration Act was passed in 1901, exploitation continued. In 1905, Dr MacGregor noted in his annual report on Auckland Hospital that "of late years the proper training of nurses has been almost entirely neglected".¹⁷ The matron in her evidence to the Auckland Hospital Commission the same year stated that in 1904, the nurses had received only six lectures by the senior medical officer, Dr Collins.¹⁸ As late as 1918, Hester Maclean bemoaned the fact that small hospitals in particular solved their staffing problems by opening a nursing training school, without any consideration or appreciation of their responsibilities towards the young women they engaged as probationers.¹⁹

Small training schools

The economic benefits of employing student nurses were a major incentive for hospitals to establish training schools. Many smaller hospitals, like Coromandel and Whangarei, employed probationers even though they offered no training.²⁰ Others, like Wairoa Hospital, employed

15 Grace Neill's address to the International Council of Women, "The professional training and status of nurses", quoted in J.O.C. Neill, *Grace Neill: the story of a noble woman*, Christchurch: Peryer, 1961, p.44.

16 F. Cameron, "A tribute to a great woman", in Neill, p.83.

17 AJHR, 1905, H-22, p.5.

18 Auckland Hospital Commission, AJHR, 1905, H-22A, p.51.

19 H. Maclean, "Training of nurses in small hospitals", *Journal of the Department of Public Health*, 1:13, July 1918, pp.212-214.

20 AJHR, H-22, 1906, p.10 (Coromandel); p.37 (Whangarei).

probationers with the intention of offering training, although they had none of the necessary prerequisites; in 1910, when the hospital mooted its training school proposal, the matron was neither certificated nor registered.²¹ As Mary Webb pointed out in 1908, it was absurd to consider that three years in a hospital with only a few beds, usually filled with chronics, could provide any woman with an adequate education in all aspects of nursing.²² Hospitals faced with the costs of employing only registered staff, however, were confronted with a real dilemma. Waipawa Hospital, for example, was roundly criticised by Dr Valintine for not opening a training school, and thus incurring the unnecessary expense of high salaries for its six trained nurses and matron.²³ As Hester Maclean pointed out on several occasions, hospitals were established primarily to care for the sick and "the least costly way of carrying out this work is by establishing a training school for nurses ... so that a minimum number of nurses demanding the pay of qualified nurses is required".²⁴ In these circumstances, small hospitals could hardly be blamed for using whatever means were at their disposal in order to obtain an affordable staff.

Role of doctors in training

From the first, nurse training in New Zealand was firmly controlled by the medical profession. Having largely been responsible for the instigation of a trained female nursing workforce, doctors sought to retain their pre-eminence in shaping the role of their new assistants. Training programmes were thus very dependent on medical encouragement and support, and Dr MacGregor made it clear in his reports that he considered the attitude of the medical superintendent in the hospital to nurse training to be at least as important as that of the matron. At Waikato Hospital, for example, he was enthusiastic about the quality of nursing training offered from a very early date. "The nursing is careful and intelligent and shows that good results have attended the systematic instruction which Dr Kenny has made a feature of his work", he wrote in his 1892 report, repeating the accolade

21 AJHR, H-22, 1910, p.29.

22 *KT*, 1:4, October 1908, p.99.

23 AJHR, H-22, 1909, p.29 and H-31, 1911, p.100.

24 *Journal of the Department of Public Health*, 1:13, July 1918, p.212. See also editorial, *KT*, 1:2, April 1909, pp.41-44.

several times again in following years.²⁵ Similarly, Dr Ewart of Wellington Hospital was much praised for his outstanding teaching of the nurses.²⁶ When approving the appointment of Dr Falconer to Dunedin Hospital in 1906, MacGregor hoped that "his professional enthusiasm will be reflected in the training and teaching of the nurses".²⁷ Dr Murray-Aynsley of Christchurch Hospital was congratulated on the efficient work he did in training and organising the nursing staff, even although the board was in the process of dismissing him.²⁸ At Timaru Hospital, on the other hand, training programmes were much hampered by power struggles between the medical staff and the board, which resulted in doctors refusing to become involved in nurse training. Dr Bowe was dismissed when he declared that the rules contained no reference to any requirement for medical staff to teach nurses, while his successors chose to take umbrage at the nurses' habit of noting their arrival and departure times in the ward book. They could not possibly give lectures to women permitted to indulge in a practice so "offensive" and "degrading" to medical status. The board agreed that such records should not be kept but in the end decided to appoint a resident medical officer, in the hope that he might prove more obliging.²⁹ Nurse training at Auckland Hospital also became caught up in the power struggles of administrators and doctors in a year of "turmoil and confusion" when training programmes virtually disappeared, ultimately resulting in a commission of inquiry into the institution.³⁰

Eventually, hospitals appointed and paid doctors specifically to teach nurses, rather than expecting all the resident and honorary staff to undertake this duty gratuitously. Dunedin Hospital introduced this policy in 1908, when it appointed Dr Williams as lecturer in medicine and Dr O'Neill as lecturer in surgery.³¹ Auckland Hospital followed in 1913 when the honorary staff declared that the claims on their time were quite onerous enough without the addition of arduous lecturing duties.³²

25 AJHR, 1892, H-3, p.25; 1894, p.24; 1895, p.25; 1896, p.26; 1897, p.25.

26 AJHR, H-22, 1900, p.29; 1901, p.31; 1905, p.34.

27 AJHR, H-22, 1906, p.11.

28 *Press*, 9 April 1896, p.3e.

29 McKenzie, *A history of Timaru Hospital*, p.69; *Press*, 21 June 1899, p.5d.

30 AJHR, 1905, H-22, p.5; Report of the Auckland Hospital Commission, H-22A, 1905.

31 OHB Trustees minutes, 6 February 1908, p.25 and 18 February 1908.

32 *ODT*, 1 July 1913, OHB newspaper cuttings, v.6, p.32 and 30 September 1913, *ibid*, p.125.

It was doctors who decided what nurses should learn. The Auckland Hospital Medical Committee proclaimed in 1913 that "The medical profession has played a prominent part in this evolution of a new profession. It has freely and gratuitously planned and directed the general scheme of training".³³ Although matrons might prepare initial drafts of syllabi, these were always referred to the medical staff for approval before being submitted to the hospital board. In 1895 at Dunedin Hospital, the medical staff decided that the two lectures included by Matron Fraser on eye, ear and throat diseases were unnecessary, so they were deleted.³⁴ Christchurch Hospital held over approval of the matron's proposed syllabus in 1902 until the medical staff authorised acceptance,³⁵ and in 1912, MacGregor reported that the honorary staff at Auckland Hospital had revised both the theoretical and practical courses of teaching considered necessary for the nurses.³⁶

Doctors were also the examiners of nurses' written and practical work at both hospital and state level.³⁷ The arrangements made for the nurses' studies and examinations, claimed the Auckland Hospital Medical Committee, were "in the interests of the discipline and efficiency" of nursing staff, but even more important, were in accordance with medical views.³⁸

Medical views delineated a very definite subordinate place in the health care system for nurses. As Cath James, who trained at New Plymouth Hospital remembered, the first principal to be inculcated was that "nurses did not diagnose".³⁹ The doctors emphasised in their lectures, said

33 *KT*, October 1913, p.147, quoted in Rodgers, *Nursing_education in New Zealand, 1883 to 1930*, p.41.

34 OHB House Committee minutes, 11 September and 23 October 1895.

35 NCHB House Committee minutes, 6 March 1902, p.87.

36 *AJHR*, 1912, H-31, p.114.

37 At Christchurch Hospital, for example, paid medical examiners were first appointed in 1898, *Press*, 25 August 1898, p.2f and 29 September, p.6a, the trustees having established that this was the practice at most other hospitals.

38 Rodgers, *op cit*, p.32.

39 NERF oral history tapes, no.61, ATL.

Sophie Reyburn (nee Palmer) of Auckland Hospital, what nurses were expected to do in various cases, not what doctors would do; "that was made very plain to us, you served the doctor's diagnosis".⁴⁰ Dr Barclay of Waimate Hospital underlined this point in an address to nurses in 1912. Doctors look to nurses, he said, for "loyal co-operation and support" even in a case of misdiagnosis which might cause public condemnation. "No one but the nurses and doctor can appreciate the difficulties, and herein lies the essence of that bond we call LOYALTY".⁴¹ Visiting hospital administrator Dr MacEachern, who came to New Zealand in 1926 at the invitation of the British Medical Association (New Zealand Branch), described the nurse's role very clearly:

To every patient the doctor stands first and the nurse next ...
The doctor makes the diagnosis, treats the condition, and leaves the necessary orders to be followed in his absence. However, all his work might be for naught if the nursing service failed to carry out these instructions and render routine general care.⁴²

In their teaching and examining roles, doctors consistently sought to reinforce these views, that nursing was a necessary but lesser occupation, which humbly served the needs of male medical superiors. This was achieved by reducing the theoretical aspects of nursing courses to a minimum, while emphasising the importance of practical care and the domestic chores associated with general nursing. As early as 1888, in a review of a textbook on fever nursing, the medical reviewer deplored the author's construction of the nurse as "a ministering angel of the most scientific pattern", to the extent that "the physician has somehow been ... forgotten". Too many pages were given up to useless definitions of words which had no bearing on practical nursing, he continued. Detailed information did not necessarily lead the nurse to carry out her duties any more intelligently. The book encouraged nurses to assume "undue responsibility" and even worse, encouraged her to criticise the physician if his treatment differed from the text. These statements were quite out of place in a book on nursing. The best nurses, he concluded, were those

40 *ibid*, tape no.109.

41 *KT*, 5:2, April 1912, p.28.

42 *KT*, 15:2, April 1926, p.66.

"who recognise most fully the line which separates their duty from that of the doctor".⁴³

Similar reviews of other textbooks appear in later editions of the *New Zealand medical journal*. In 1908, a reviewer questioned the amount of space given to the pathology and diagnosis of each complaint in another book on fever nursing, suggesting that the patient would be better served "if the nurse's mind was directed more to the skilful arrangement of his pillows and the preparation of his food rather than to other matters which really belong to the physician". The information given was valuable, he added, but only if the nurse "does not try to learn too much".⁴⁴ The same year, another reviewer commented that most books for nurses tried to teach too much, when all nurses needed was common sense and a little less learning.⁴⁵ Dr Faulke was even more blunt when he commented on the inflexibility of nursing rules regarding sterilisation. "Such hard and fast rules must tend to restrict the little thinking that a conscientious nurse should consider comes within her scope legitimately", he wrote.⁴⁶

State examiners followed the same line, and doctors who set papers requiring considerable theoretical knowledge were criticised for having asked questions more suited to medical students than nurses. One such examiner defended himself by pointing out that he expected answers of quite a different type and standard from those which a medical student would give.⁴⁷ In 1914, Dr George Home, the state examiner for medical nursing, contributed a lengthy article to *Kai tiaki*, in which he advocated a scheme whereby written examinations for nurses would be secondary to marks based on practical ward work over three years. Very capable practical nurses often failed the examinations, he said, and "the practical nurse is the desirable one!" This system would enable her to attain the

43 *NZMJ*, 1, 1887-8, pp.292-293: review of J.C. Wilson, *Fever nursing*, Edinburgh: J. Young, 1888.

44 Review of *Practical fever nursing* (1907) by Edward Register, *NZMJ*, 6, February 1908, p.57.

45 G.H. Hoxie, *The practice of medicine for nurses*, Melbourne, 1908, *NZMJ*, 7:28, November 1908, p.74.

46 *ibid*, 7:30, May 1909, p.7.

47 See for example, *KT*, 8:3, July 1915, pp.150-151.

position "to which her special kind of ability should entitle her". Most commentators, both nursing and medical, agreed that the practical nurse was preferable, though regretfully they acknowledged the impracticability of the proposal and the impossibility of establishing uniform standards suitable for state registration. Nevertheless, Hester Maclean reiterated the importance of the hospital certificate, which did take account of practical ward work, saying that it was this certificate, rather than the state registration badge, which was the true measure of the nurse. Ultimately, it was made compulsory for nurses to receive their hospital certificates before being eligible to sit the state examinations.⁴⁸

The limitations imposed by medical men on the work which nurses might legitimately be permitted to undertake are illuminated by the debates which surrounded the issue of nurse anaesthetists. Anaesthesiology was clearly an area of expertise outside the normal boundaries of nursing work. It involved medical and scientific knowledge which, as far as doctors were concerned, was beyond the scope of any nursing curriculum. Yet the small and scattered nature of New Zealand's hospital service meant that in many cases, there was no second doctor available to act as anaesthetist for the surgeon. In the early days of trained nursing, this was true even in the metropolitan hospitals. Miss Steele and Miss Maude, both matrons of Christchurch Hospital during the 1890s, acted as anaesthetists during their tenure. The work was carried out in a manner which, according to Dr Hacon, "reflected great credit" on them. The report of the commission of inquiry into Christchurch Hospital in 1895 intimated that "tuition in the administration of anaesthetics" formed a part of nurses' training at the institution. Nevertheless, Dr Hacon was not entirely convinced that nurse anaesthetists were desirable. Although he was not prepared to say the "new woman" should not administer anaesthetics or indeed do anything else, he suggested it should only be done by a woman in a doctor's presence. In fact, he concluded, he would really prefer a second medical

48 *KT*, 7:1, January 1914, pp.26-27; 7:3, July 1914, pp.129-130. At the first council meeting of the NZ Trained Nurses' Association, it was argued by several delegates that the hospital certificate was a better guarantee of proficiency than state registration because some nurses were brilliant in theory but very inferior in ward work. A recommendation was made to the Registrar of Nurses that no nurse might sit the state examination before passing her hospital tests, Minutes of the NZTNA Council, 17 November 1909, CH 303/22a, NA (Christchurch).

officer to be appointed for the task.⁴⁹ By the turn of the century, doctors were available in larger hospitals to act as anaesthetists, but this was not the case in country institutions. In these hospitals, matrons continued to administer anaesthetics as a routine part of their work, well into the 1920s.⁵⁰ While doctors remained as half-hearted as Dr Hacon in their support for this practice, there was generally little publicity or comment about it.

The first world war, however, brought the whole issue out into the open in ways which doctors perceived to be a direct threat to their position. Both the American and British army medical services regularly trained and employed nurses as anaesthetists at casualty clearing stations and in army hospitals at the front. Seven New Zealand army nursing sisters received this training,⁵¹ the surgeons, according to Hester Maclean, being "much pleased with their skill and care in this responsible work".⁵² One of the nurses reported in *Kai tiaki* that the surgeons preferred nurse anaesthetists, because males were "much more interested in watching the operation than in paying attention to the anaesthetic".⁵³ Accordingly, Hester Maclean believed that with the experienced sisters returning to New Zealand and available for hospital positions in this country, it was time to advance the whole concept of nurse anaesthetists by establishing formal regulations for a postgraduate training programme and a certificate which would give recognised status to its holders.⁵⁴ In July 1919, she informed Dr Valintine that the matron of Wellington Hospital, with the support of the acting medical superintendent, proposed recommending the appointment of Sister Blanche Huddlestone, lately returned from France, as Sister Anaesthetist at the hospital.⁵⁵

49 Evidence to the Royal Commission of Inquiry into the Management of Christchurch Hospital, *Press*, 11 June 1895, p.4c; 12 June, p.4c-d; 18 June, p.3d; 20 June, p.3d; 28 June, p.3f. Report of the Royal Commission of Inquiry, AJHR, 1895, H-18, p.7.

50 *KT*, 10:4, October 1917, p.229.

51 Sisters Blanche Huddlestone, Ellen Schaw, Jean Porteous, Margaret Davies, Maud Atkinson, Hilda Steele and Susan Nicholas. See Rodgers, "A paradox of power and marginality", p.194n.38.

52 H. Maclean, "New Zealand army nurses", in H.T.B. Drew (ed.), *The war effort of New Zealand*, Auckland: Whitcombe & Tombs, 1923, pp.99-101.

53 *KT*, 12:3, July 1919, p.118. Hester Maclean had made a similar comment the previous year, *KT*, 11:2, April 1918, p.62.

54 Memorandum from Maclean, 4 July 1918, H1 21/10, NA.

55 Maclean to Valintine, 4 July 1919, H1 21/10, NA.

The Health Department, initially supportive of the proposal,⁵⁶ was speedily brought to a realisation of its error by members of the medical profession. Dr Frengley minuted that a nurse anaesthetist system could not be allowed "to prevent junior house surgeons gaining experience in this important branch of their professional work."⁵⁷ Doctors in other hospitals had similar concerns. While those in smaller rural institutions expressed some interest in the idea, many doctors in larger hospitals reacted angrily. Dr Hugh Douglas, medical superintendent at Waikato Hospital, declared he was "absolutely opposed" to persons with "meagre training" undertaking such responsible work, except under very special circumstances where the services of a doctor could not be secured. He would never allow a member of his own family to be so treated. Nurses could never take full responsibility for a patient and therefore should never anaesthetise. An emergency wartime measure would not be a good thing in peace time when there was no difficulty in obtaining doctor anaesthetists.⁵⁸ Auckland doctors "did not take kindly to the suggestion", while in Wairarapa, doctors believed the "responsibilities ... were ... more than a Nurse should be asked to undertake". In Otago, it was agreed that nurses could be trained to use ether (though not chloroform) for employment in outlying districts, where a second doctor was not available. However, there was not sufficient clinical material for such training at Dunedin Hospital, because too many medical students required cases for themselves.⁵⁹ By 1923, the New Zealand Branch of the British Medical Association had firmly declared that the practice of nurses giving anaesthetics was "derogatory to the profession and a danger to the public". No nurse should be permitted to undertake such work except under the strict supervision of a doctor.⁶⁰

56 AJHR, 1920, H-31, pp.10-11.

57 Minute, 4 July 1919, H1 21/10, NA.

58 *Waikato times*, 10 October 1919, *Journal of the Department of Public Health*, 2:11, November 1919, p.338; reply to departmental circular no.424, August- October 1919, H1 21/10, NA.

59 Responses to departmental circular no.424, H1 21/10, NA.

60 *NZMJ*, February 1923, p.61.

Nurses themselves quickly withdrew from a situation so fraught with the likelihood of seriously upsetting their medical superiors. Within days of Maclean's proposed appointment of Sister Huddleston to Wellington Hospital, she reported that Huddleston did "not wish to incur the displeasure and consequent adverse criticism of medical men who she hears do not approve of a nurse giving anaesthetics and thereby encroaching on their own ground". Within a month, Maclean was forced to inform those few hospitals who did express interest in sister anaesthetists that none was prepared to apply for the positions. Sister Porteous was willing to go to Picton Hospital, but when the board learned that she would be appointed as assistant matron, and that they would still require a second surgeon for major operations, it decided not to proceed. Within a year, Dr Makgill in the Health Department admitted sourly that "sister Anaesthetists are all very well for large British Hospitals but not for small country Hospitals in New Zealand apparently". In January 1922, the idea was "respectably buried" until further notice.⁶¹ New Zealand nurses were not prepared to challenge doctors by seeking advancement in a field which medical men regarded as their own. Anaesthetics remains a specialisation outside the compass of New Zealand nurses to this day.

State registration of nurses

New Zealand nurses were prepared to accept the role of handmaiden to medical authority because by doing so, their new profession gained acceptance as a "womanly" and therefore respectable occupation. As long as their superiority was acknowledged, doctors were prepared to support the professional aspirations of nurses, aspirations which achieved a major success in 1901, when New Zealand became the first country in the world to pass legislation requiring state registration of its nurses. The Nurses' Registration Act appointed a Registrar (the Inspector-General of Hospitals) to record and publish at regular intervals the names of all duly qualified nurses in New Zealand. In order to register, nurses had to be 23 years old, to have undergone three years' systematic training in a hospital in practical and theoretical nursing, and to have passed an independent state

⁶¹ Correspondence, July 1919-July 1925, between the Department, hospital boards and the British Medical Association, H1 21/10, NA.

examination (although some provision was made for experienced women already working as nurses without having had formal training). In future all hospitals and state institutions were to give preference to registered nurses in making appointments. The register of trained nurses would inform doctors and private patients requiring nursing assistance of the names of those women who were trained to a nationally set standard, although it did not interfere with the rights of individuals to employ whomsoever they wanted.⁶²

Grace Neill, actively supported by Duncan MacGregor, was the prime architect of state registration in New Zealand, and as such has been honoured by later generations of nurses as the founding mother of the profession.⁶³ Neill was a very independent woman, a widow, who had originally trained as a nurse in England despite considerable opposition from her family. After the death of her doctor husband, she chose to support herself and her son in Australia rather than return to her comfortable English home. She pursued several careers, as a journalist, a businesswoman and a government official, before becoming New Zealand's first woman factory inspector in 1894. A year later, Dr MacGregor secured her transfer to the Department of Hospitals and Charitable Institutions, where he wanted "an able and experienced woman" to assist with the "numerous and delicate" questions affecting women in the areas of health and welfare. The management of obstreperous nurses was part of this brief.⁶⁴

Neill and MacGregor, "feeling the necessity for some co-ordination and a standard of training among ... hospital nurses", at first hoped that professional status might be sought, as it had been in England and Australia, through the formation of a professional nurses' association. They opened negotiations with the Royal British Nurses' Association (to

62 The Nurses' Registration Act, New Zealand statutes, 1901, no.12, pp.22-24.

63 See for example, her obituaries in *KT*, 15:4, October 1926, p.169 and *ODT*, 24 August 1926, *OHB* newspaper cuttings, v.31, p.42; "An appreciation", by Hester Maclean, *KT*, 16:2, April 1927, pp.71-72; foreword by William Young in H. Maclean, *Nursing in New Zealand*, p.9; F.J. Cameron, "A tribute to a great woman", in Neill, pp.70-97.

64 M. Tennant, "Neill, Elizabeth Grace, 1846-1926", *DNZB*, volume 2, 1870-1900, pp.347-348.

which some New Zealand nurses already belonged), with a view to establishing a colonial branch in New Zealand.⁶⁵ However, Neill found when she visited England in 1899, that membership of the Association was so wide it provided no guarantee at all of either efficiency, professional qualification or moral character. The Matrons' Council, of which Neill was made an honorary member, was the most effective nursing organisation in the country, she decided, and it was working strenuously, along with American nursing groups, to secure state registration for properly trained nurses. Neill was convinced that "nothing short of this will ever secure for any country efficient and trustworthy nurses".⁶⁶ On her return to New Zealand, Neill campaigned vigorously for registration, gaining the support not only of MacGregor, but also of the premier, Richard Seddon.

State registration was not achieved in either Britain or the United States until after the first world war (although several American states introduced the measure shortly after New Zealand did so),⁶⁷ and in both countries was the subject of much heated and bitter argument. In New Zealand, however, state registered nurses came into being with relatively little debate, either publicly or in parliament. Christchurch newspapers on the whole took very little interest in the measure. The *Lyttelton times* declared when the new parliamentary session opened in July 1901 that there were "no proposals of unusual importance or striking novelty" to be laid before it, an editorial on the proposed measures described in the speech from the throne making no reference at all to the nurses' bill.⁶⁸ When the bill was introduced, the *Press* was strongly in favour, quoting Dr MacGregor's supporting memorandum at length,⁶⁹ while the *Lyttelton times* also believed the measure was a necessary one, so that miserly hospital boards could be prevented from the indiscriminate employment of cheap untrained nurses.⁷⁰ No dissenting voices were heard in the letters columns. Only a few members of parliament spoke against the bill during

65 D. MacGregor, "Our hospital system", 79/032/12/2, ATL.

66 F. Cameron, "A tribute to a great woman", p.81.

67 North Carolina, New York, Illinois, Virginia and New Jersey, AJHR, 1903, H-22, p.2.

68 *LT*, 2 July 1901, p.4d; 3 July 1901, p.4d-e.

69 Editorial, *Press*, 15 August 1901, p.4.

70 *LT*, 1 August 1901, p.4e.

the brief debate on it. Some of the medical profession were ambivalent, but the New Zealand branch of the British Medical Association welcomed both the introduction of the bill and its subsequent passing, adding that certification was in the interests of doctors, nurses and the public.⁷¹ Hospital boards appear to have reacted positively,⁷² and from the beginning, the act was found to work smoothly and effectively. There was no compulsion to register, said Neill,

except that of enlightened self-interest on the part of the nurses themselves and it is becoming daily more apparent that by the silent pressure of this law the nursing profession of New Zealand will be effectively organized.⁷³

By 1910, 882 nurses' names appeared on the register, 112 having been added the previous year.⁷⁴

Registration was accepted in New Zealand for several reasons. First, it fitted well with Liberal Party ideologies and principles. David Hamer has described the Liberal government's approach to social problems as one of "pragmatic interventionism". The state's role was to serve the people and state intervention was seen not in a doctrinaire light but as a peculiarly New Zealand way of dealing with problematic situations. Measures which catered for the interests of particular sections of the community were acceptable if they promoted self-reliance as well as the interests of the community as a whole, and particularly if they were perceived to protect the colony from "Old World evils". New Zealand was proud to lead the world in social reform and maintain its reputation as "a progressive and enlightened country".⁷⁵ Nurses' registration would protect public interests by preventing the "swamping" of the profession with Old World "Sairey Gamps" and "Betsy Prigs": untrained or poorly trained women who held no certificates and could pass no examination but added "a new and very real, as well as costly, terror to illness and death" through their

71 Editorial, *NZMJ*, 1, 1900-1, pp.41, 115-116.

72 The South Canterbury board, for example, agreed that registration would raise the status of nurses and lessen the number of inferior nurses, *Press*, 22 August 1901, p.5a.

73 *AJHR*, 1903, H-22, pp.2-3; 1904, p.2.

74 *AJHR*, H-22, 1910, p.4.

75 D. Hamer, *The New Zealand Liberals: the years of power, 1890-1912*, Auckland University Press, 1988, pp.40, 45-46, 54-55, 59-61.

ignorance.⁷⁶ It seemed reasonable to most people that the State should license those who attended the sick, just as they did others who carried out important public work: surveyors, dentists, seamen, dairy operators and factory managers.⁷⁷ State registration, as Neill insisted, had "no patronage, benevolence or spoon-feeding about it". Each nurse had to prove her worthiness and pay for her certificate of efficiency.⁷⁸ And as one doctor noted in later years, the colony seemed "specially suitable for experimental legislation. Here new-fangled ideas had a less deleterious effect than they they would have in an older country".⁷⁹

The need for a list of trained nurses available for private nursing had also already been established. As early as 1888, the St John Association in Christchurch had devised a register, which listed the names of nurses approved by medical men as being competent. Nurses paid a small fee in order to be listed and doctors and members of the public did likewise in order to obtain the names of suitable nurses. The rules were revised in 1891 and by 1895, there were 41 on the register, all "professional nurses ... qualified to serve in accouchement, medical and surgical cases". The register was still in existence in 1902.⁸⁰ Various branches of the British Medical Association were also involved in drawing up lists of suitable nurses for the benefit of their members. Auckland doctors founded a directory in 1891, which in 1894 was limited to trained nurses only, but not widely supported by them,⁸¹ and Dunedin doctors followed in 1895.⁸² In 1900, a chemist in Christchurch set up a free nurses' register "to fill a long-felt want".⁸³ The same year, an editorial in the *New Zealand medical journal* expressed surprise that in a "progressive colony" like New Zealand no effort had been made to organise nursing. An association like that in New South Wales, it suggested, to which only nurses with recognised

76 MacGregor, "Our hospital system", p.3.

77 W. Hall-Jones in the debate on registration, NZPD, 117, 15 August 1901, p.387.

78 Neill, quoted in Maclean, p.25.

79 Letter from Dr P.W. Hislop, NZMJ, 6:26, May 1908, p.44.

80 G.W. Rice, *St John in Christchurch, 1885-1987: ambulances and first aid*, Christchurch: Order of St John, 1994, pp.44-46; *Press*, 13 October 1891, p.6g; 14 October 1902, p.6e & 15 October, p.5c.

81 NZMJ, 4, 1890-1, pp.124, 199-200, 295; 5, 1892, pp.79, 284; 7, 1894, p.241; 9, 1896, p.241.

82 NZMJ, 8, 1895, p.270.

83 Advertisement, Hoben & Cole, *Press*, 16 January 1900, p.4d.

qualifications could belong, would allow doctors to obtain the services of properly trained and efficient assistants, and would also protect the public against the ministrations of the "pseudo-nurse".⁸⁴

The outbreak of war in South Africa in 1899 further reinforced the need for a reliable list of nurses who could be certified as having been adequately trained. New Zealand nurses were keen to travel to the veldt to care for soldiers,⁸⁵ and the government, as well as nursing leaders, were concerned that their professional reputation should not be marred by inappropriate behaviour or lack of skill. The *New Zealand medical journal* was horrified to hear that nurses were said to be rushing to South Africa in the hope of securing wealthy husbands,⁸⁶ while Grace Neill deplored the political influence which enabled many of these "so-called nurses" to obtain positions with the services. The registration act was passed during the war, she wrote later, to ensure that "for future public service in an emergency there would be a body of qualified women nurses ready to be called on by the Government".⁸⁷ In introducing the bill to the Legislative Council, W.C. Walker pointed out that the experiences of war had shown hospital training served "much wider purposes and ... a very much wider good" than just for New Zealanders; registration, he said, would ensure that the New Zealand hospital nurse "shall never be known but by the hallmark of real professional perfection" all over the world.⁸⁸

The need for some uniformity in training and independent examination of candidates had also been expressed by certain hospital officials. Waikato Hospital officials, conscious of the disadvantages suffered by nurses

84 Editorials, *NZMJ*, 1, 1900-1, pp.34, 252.

85 S. Kendall and D. Corbett list six Christchurch and seven Dunedin nurses who served in the war and were paid for by Imperial War Department or by public subscription. They add that many other nurses (at least 31) also went to South Africa, either by paying their own way or by joining an English nursing service, *New Zealand military nursing: a history of the Royal New Zealand Nursing Corps, Boer War to present day*, Auckland, 1990, pp.5-11. Jan Rodgers quotes S. Gray, (*The South African War, 1899-1902*, Auckland, 1993) who estimates that 32 New Zealand nurses served either with the British Army Nursing Service or in a private capacity, 'A paradox of power and marginality', p.1,n.2.

86 *NZMJ*, 1, 1900-1, p.322.

87 *KT*, 8:1, January 1915, p.30.

88 *NZPD*, 116, 9 July 1901, p.179.

trained in small hospitals such as their own, suggested in 1892 that a central board of examiners be established for Auckland Province which would examine all nurses from the region (Auckland, Waikato, Gisborne, Coromandel and Thames). The certificates obtained would give these nurses much higher standing throughout the country. The Auckland Branch of the British Medical Association took up the proposal, setting up a committee to facilitate it, but it seems to have foundered on the rocks of hospital boards' jealous determination to maintain their own identities. Nevertheless, it is clear that some authorities at least were aware of the need for a single standard to be maintained in a small country where most training institutions offered very limited clinical experience and few formal teaching programmes.⁸⁹

Perhaps most significant in causing the smooth passage of registration in New Zealand, however, was the approach taken by Neill and MacGregor in pressing the necessity of legislation. They were careful at all times to emphasise the "womanliness" of trained nursing, the importance of discipline and self-sacrificing service, and its subordination to male medical authority. Neill made this clear in her address to a congress of the International Council of Women in London in 1899, where she was principal speaker in the Nursing Section. Nursing, she said, needed to be placed on a "straight-forward professional footing", and governed by the same disciplines and rules of training considered needful for men. Nurses must show the same devotion to duty as doctors, always remembering however, that

the habitual thinking of others first, and self last, is the main characteristic of a good nurse ... It cannot be too strongly impressed upon a probationer that the main function of a nurse is to serve - to serve others.

Womanly sympathy and gentleness, unvarying courtesy and thoughtfulness, and "above all, discipline, obedience and ethics of nursing" were the ideals which Neill sought to restore through state registration, which would filter out "women of low repute" from the profession.⁹⁰

⁸⁹ NZMJ, 5, 1892, pp. 69, 80, 82; R. Wright-St Clair, *From cottage to regional base hospital: Waikato Hospital, 1887-1987*, Hamilton: Waikato Hospital Board, 1987, p.24.

⁹⁰ Neill's address to the ICW, Neill, pp.38-45; Neill, quoted in Maclean, p.24.

MacGregor reiterated these views in presenting his case for registration. In its early years, he said, trained nursing had attracted educated women "filled with the enthusiasm of humanity", who "devoted themselves" to a noble career where self-denial and discipline ruled. Now, "Love of nursing work is only one among many ordinary motives. The question has become one of wage-earning, like typewriting, teaching, domestic work, etc." The ideals of nursing were threatened both by improving working conditions (which impinged on professionalism) and by the "marriage question" (expectations of imminent marriage affected women's attitude to their work). Steps must be taken to combat these evils and restore Nightingale's ideals of self-sacrificing service and professional dedication to duty.⁹¹

Members of parliament were thus reassured that state registered nurses would not threaten accepted gender ideologies. Registration, like suffrage before it, would grant morally superior women the right to exert a beneficial influence on society, in this case by 'civilising' the rough male hospital environment and bringing to it new standards of cleanliness, order and propriety. They would not, as they feared, be "spoiled by having to pass an undue examination in theoretical knowledge", when inborn practical sympathy and tenderness were the hallmarks of the "real" nurse.⁹² Indeed, one of the major amendments to the bill saw the number of lectures required for the course reduced from 25 to 12.⁹³ Nor was it considered necessary that the matron of a training hospital be herself a certificated nurse.⁹⁴ The "haughty women" who, according to Mr Thomas Mackenzie, did not trouble to give patients the same attention and care which "homely elderly women" nurses had always accorded them, would not be encouraged.⁹⁵ Instead, respectable young women would pursue highly commendable lives devoted to "practical Christianity" through

91 MacGregor, "Our hospital system, pp.1-2.

92 T. Kelly, NZPD, 116, 9 July 1901, p.180-181; H. Fisher, 117, 15 August, p.394.

93 NZPD, 117, 20 August 1901, p.490.

94 NZPD, 116, 16 July 1901, p.366; 118, p.203: debate on uncertificated matrons. This change was made to protect existing staff. A number of small rural hospitals retained untrained married couples in charge of their institutions for several years, and one at least (Cromwell) returned to this system after having a trained matron for a year, much to MacGregor's annoyance, AJHR, 1904, H-22, p.8; 1905, p.9; 1906, p.11. By 1910, virtually all hospitals in the country employed a trained matron.

95 NZPD, 117, 15 August, 1901, pp.390-391.

nursing, rather than behind convent walls.⁹⁶ Women were accordingly not seeking to attain a working role perceived as inappropriate for their sex. Doctors secured access to efficient assistants (which they did not, however, have to employ in private practice if they chose not to), while retaining total control over the whole process. They defined the syllabus, gave the lectures, set and marked the examinations, and (in the person of the Inspector-General of Hospitals), managed the state register. Nurses thus did not achieve autonomy within their profession, but as Grace Neill's successor, Hester Maclean noted in 1918, they appeared to have no desire for more direct control of their own affairs.⁹⁷ Maclean herself came to believe that "to allow [the medical profession] to have the monopoly of control is a great mistake, and lowering to the status and independence of nurses".⁹⁸ Accordingly she fought for and achieved greater nurse control through the 1925 Nurses and Midwives Registration Act, which provided for a nurse majority on the registration council. Nevertheless, she acknowledged that medical representation was still important. By accepting subordination to medical hierarchies, nurses had acquired a professional status which served them well. They were able to exclude men and unsuitable women, to eliminate "unearnest girls, and [attract] ... 'high-minded noble-hearted girls' of the right sort".⁹⁹ In this way they secured the respectability of nursing and public acceptance of it as worthwhile women's work.

Practical training and domestic work

It suited both doctors and hospital administrators that nurse training should include a great deal of practical nursing care and domestic work. Almost all reminiscences of the prewar period comment on how strenuous this work was. Patients were bedridden for a long time, and required everything to be done for them, while cleaning, polishing, washing and scrubbing were exhausting.¹⁰⁰

96 Mr Scotland, NZPD, 116, 9 July 1901, p.180.

97 *KT*, 11:3, July 1918, p.148.

98 Editorial, *KT*, 16:2, April 1923, p.49.

99 Dr Chapple, one of the supporters of the bill, *KT*, v.5,no.4, October 1912, p.127.

100 See for example, M. Thorp, *The long, long trail: an autobiography*, Hastings: Hart Printing, 1971, p.34; Greta Fraser, quoted in C. Lind, *Step by step: the history of nursing education in Southland*, Invercargill: Southland Hospital Nurses' Reunion Committee, 1991, p. 26; Sophie Mandeno, quoted in M. Murray, *Always on duty: a history of the Otago Branch of the New Zealand Nurses' Association, 1907-1989*, Unpublished

Christchurch Hospital's 1910 by-laws specified that the nurse must learn dressings of all types, fomentations, poultices, the management of helpless patients, the prevention of bed sores, bandaging, bedmaking, ventilation, hygiene, diet and the management of the convalescent. Strict and accurate observations of all bodily functions were vital in providing the doctor with the information he required for diagnosis and prescription: temperatures, pulse, respiration, expectorations, skin, appetite, sleep, the state of wounds, and the effects of diet, medicines and stimulants.¹⁰¹ Particular attention was expected to be paid to developing careful observation skills. Pupils must be taught "OBSERVATION above all things", decreed Nurse Maude, in an impassioned plea for the continuation of practical rather than theoretical training, "to use eyes, nose, and sense of touch in their daily routine in the wards."¹⁰² State examiners concurred with this emphasis. They commented regularly on any "carelessness and want of attention to detail" demonstrated in examination answers, for these were "traits of character which are grave faults in a nurse".¹⁰³ No one expected nurses to understand chemical physiology, said one examiner, but they should supplement their limited theoretical knowledge by cultivating "habits of more accurate observation".¹⁰⁴

The paramount need of hospital authorities for economy, however, meant that at least in her first year, most of the nurse's time was devoted to domestic rather than nursing duties. Before trained female nursing was introduced, hospitals employed servants to carry out cleaning tasks in the

typescript, 1990.

101 *Christchurch Hospital by-laws, 1910*, p.7. Rodgers, *Nursing education in New Zealand*, pp.56-57 gives almost exactly the same outline for Wellington Hospital and notes that it "was almost a replica of the duties of the probationers who received the English Nightingale training".

102 *KT*, 6:1, January 1913, p.13.

103 *KT*, 8:1, January 1915, p.6; see also 3:4, October 1910, p.144: if candidates betray careless and superficiality in their answers, they probably exhibit the same characteristics in the performance of their nursing duties.

104 *KT*, 4:1, January 1911, p.11.

wards, so that the nurses could devote their time to the patients.¹⁰⁵ As the period of nurse training was extended, however, it was found to be far cheaper to use probationers for this work, so that the first year of training was given over largely to "sweeping, polishing and dusting".¹⁰⁶ Jessie Torrance, who trained in Dunedin from 1903, recalled some of the less appealing aspects of the work. In the men's medical ward, she said, the only place for the men to smoke was in the lavatories, the floor serving as a spittoon.

To wash those places out was the evening pro's work. Kneeling was impossible. We put the bucket on the floor, tucked in our skirts to the knees, and washed away, bending down, trying hard to keep our mind on anything than on what we were doing.¹⁰⁷

At times, especially in smaller hospitals, where it was difficult to find domestic staff, nurses could even be called on to work in the kitchen and the laundry. It was standard practice everywhere for nurse pupils to prepare afternoon tea and supper for patients in the ward kitchens and to wash the dishes afterwards, while laundry was given a preliminary wash in the wards before being despatched to the laundry for further cleaning.¹⁰⁸ In Whangarei in 1909, two probationers were doing all the cooking and washing,¹⁰⁹ while in 1918, "Nurse S." of Palmerston North Hospital was commandeered to the kitchen after the cook was dismissed, the Board actually giving consideration to paying her at the cook's, not the nursing rate (£40 rather than £25 per year).¹¹⁰

105 Dunedin Hospital appointed permanent cleaners in 1887, OHB Trustees minutes, 25 February 1887; Christchurch followed in 1890, *Press*, 9 January 1890, p.3f.

106 G. Boyd, "Summary of nursing in Dunedin Hospital, 1866-1966", p.3, reprinted in Murray, *Always on duty*.

107 *KT*, 20:3, July 1927, p.132.

108 Emily Hodges, for example, commented on washing all the laundry in the ward in order to get it ready to go to the laundry, NERF oral history project, tape 12, ATL.

109 *AJHR*, 1909, H-22, p.37.

110 Palmerston North Hospital Board minutes, 2 February 1918, quoted in Rodgers, *Nursing education in New Zealand*, p.37. In Stratford Hospital in 1920, the nurses were relieving in the kitchen, *Journal of the Department of Public Health*, 3:10, October 1920, p.265, and the following year, a similar situation occurred at Oamaru Hospital, *ibid*, 4:4, April 1921.

That nurses should work in a domestic capacity was scarcely questioned in the years before the war. In 1908, for example, Dunedin Hospital's board members gave only perfunctory consideration to a proposal to employ wardsmails again, justifying its decision by saying that it did not matter to the public whether extra nurses were appointed for the new wards, or whether wardsmails were engaged, "as its interests will be equally well attended to in either case". While it might seem desirable to the layman for nurses to be relieved of some of the burden of domestic work, added Dr Batchelor, probationers were not much use elsewhere, and it was fitting that they should do such work. The local press was fully aware of the real motives behind the decision. "We hope they were not influenced ... merely by motives of economy", noted a journalist severely, but obviously wardsmails could not be obtained for the "trifling pecuniary consideration allowed a probationer nurse".¹¹¹ Nevertheless, when a group of nurses at Dunedin Hospital complained that "they had more scrubbing & cleaning to do than nursing" and "that they had neglected patients through having been otherwise occupied", Matron Fraser was appalled. Extra nurses had been appointed in lieu of wardsmails, she said, and "a nurse who would neglect a patient for other work ... should be dispensed with as unfit for such a responsible position". All nurses needed to know how to clean utensils and the sickroom because these skills were required of the private nurse.¹¹² The Department of Hospitals agreed. Domestic training was necessary to test endurance and to emphasise the extreme importance of cleanliness and neatness. Hester Maclean, in investigating complaints about the physical work nurses were being asked to perform at Dunedin Hospital in 1910, did not think they were called upon to do anything which required special strength or endurance. She did agree, however, there was no need to scrub floors three times each day or blacklead the stoves. Furthermore, she added severely, all scrubbing and polishing on Sundays should be absolutely forbidden.¹¹³ Domestic work should not, she said, be "unduly pressed ... We may lay it down as a general rule that young women training as nurses should not be given work to do which can be well done by porters and wardsmails".¹¹⁴ These functionaries, however, had to be paid at much higher rates than nurses

111 Unnamed Dunedin newspaper, OHB newspaper cuttings, February 1908, v.1, p.4.

112 OHB Trustees minutes, 4 September 1907, v.3, pp.568-570.

113 Maclean's report, ODT, 2 December 1910, OHB newspaper cuttings, v.2, pp.84-85.

114 KT, 5:3, July 1912, p.66.

and it was both cheaper and easier for boards to continue to engage nursing staff for such tasks.

The emphasis on domestic skills was reinforced by the only major change made to the training syllabus in the years before the first world war, the introduction of a compulsory course in invalid cookery. This change was promoted because the vast majority of nurses who left the hospital at the end of their training became private nurses, caring for patients in their own homes. As early as 1896, Dr Stewart at Christchurch Hospital recommended to the board that all probationers be taught "sick cookery",¹¹⁵ and the course was approved for third year nurses in 1898, "provided there was no cost to the Board".¹¹⁶ The house surgeon arranged for a teacher who gave instruction to those nurses who desired to learn cooking skills at their own expense.¹¹⁷ Another attempt was made to have the course made compulsory in 1902,¹¹⁸ and Dr W. Young brought the matter onto the national stage in 1908 when, as state examiner, he commented on the very poor answers in the state medical examination on diet and cookery and urged that "It is reasonable to expect of a well-trained nurse that she should know how to prepare her patients' food in the most palatable and digestible form".¹¹⁹ Hester Maclean commented that the matter was already under consideration and the following year, the new regulations and syllabus were issued. Invalid cookery was to be taught by a certificated teacher either at the hospital or in a local technical school, the course to be limited to invalid diet only and be practical as well as theoretical.¹²⁰ Auckland Hospital's course, carried out at the Newton Manual Training School, included 18 two-and-a-half hour lessons with lectures, demonstrations and practical work on drinks, jellies, soups, fish, poultry, eggs, custards and puddings, the serving of food, its functions, nutrition and digestion for the sick, the convalescent,

115 *Press*, 24 September 1896, p.2f. The Hospital Committee decided not to proceed with the proposal at that time, after considering the house surgeon's report, 24 December 1896, p.3c.

116 NCHB minutes, 22 June 1898, p.49; *Press*, 23 June 1898, p.3f.

117 NCHB minutes, 21 December 1898, p.80.

118 *Press*, 27 February 1902, p.4g, 26 June 1902, p.4g, 24 July 1902, p.3d.

119 *KT*, 1:1, January 1908, pp.9-10.

120 *KT*, 2:1, January 1909, p.3.

children and infants. An examination was held at the end of the course, which was also open to staff nurses and sisters.¹²¹

By accepting that domestic duties were also a nurse's duties, nurses fulfilled the desires and expectations of their male superiors who were necessary allies in their pursuit of professional status and acceptance. The linking of nursing and domestic work also helped nursing to conform to the ideological parameters essential for respectable women's work. As long as nurses undertook womanly tasks which could easily be transposed to the private domestic environment of marriage and family, the occupation of 'nurse' could be accepted as both honourable and admirable.

Lectures and examinations

With its emphasis on practical skills, character training, discipline and duty, the theoretical content of nurse training before the first world war was minimal. The "education" of the nurse was not allowed in any way to encroach on her work in the wards. Lectures were always attended in the nurse's own time and as Louise Renouf of Napier Hospital found, after an 11 or 12 hour day, "naturally we were jaded when it came to evening lectures".¹²² Greta Fraser in Invercargill remembered going to bed at 7am after night duty, getting up again at 11am to attend a lecture and then returning to bed.¹²³ As Ida Willis said, the fundamental notion that patient care came first was so deeply implanted that no nurse ever forgot it.¹²⁴ Hospital authorities were inevitably concerned principally about meeting the needs of their patients, and even Dr MacGregor, a staunch supporter of trained female nursing, was anxious not to alienate them by pressing the educational needs of nurses too hard. In 1897, for example, he remarked that as the nursing was particularly heavy at Auckland Hospital in the summer and autumn, lectures should be confined to the winter months.¹²⁵

121 *KT*, 2:2, April 1909, p.72.

122 G. Conly, *A case history*, p.36.

123 Lind, p.27.

124 Willis, *A nurse remembers*, p.19.

125 *AJHR*, 1897, H-22, p.4.

Lectures were kept to a minimum at any time. In 1890, nurses were required to attend no more than one lecture a week at Dunedin Hospital, with both the preliminary and the advanced courses comprising 13 lectures.¹²⁶ By 1901, Auckland Hospital officially offered about 12 lectures each on anatomy and physiology to first year nurses, together with ten on basic nursing etiquette, given by the matron. Second year nurses received 12 lectures each on medical and surgical nursing, with a further ten from the matron, while third year students received about 26 on special aspects of nursing like ophthalmic, fever and obstetric nursing.¹²⁷ Yet as the Auckland Hospital Commission of 1905 revealed, practice did not necessarily follow prescription. From 1902 until 1904, fewer lectures were given each year, with only six being offered by the resident medical officer in 1904. The matron's lectures revolved around cleanliness, "which was the chief point to be observed".¹²⁸ The Nurses' Registration Act (1901) specified that nurses should receive at least 12 lectures in each of the three years of training,¹²⁹ only half those originally proposed by Grace Neill. As Legislative Councillor T. Kelly commented in his speech,

... we want them to be effectually trained to attend the sick, to have some general knowledge of sanitary matters and the practical work which good nursing involves; but we do not want to give them too technical a training ... good nurses should not be spoiled by having to pass an undue examination in theoretical knowledge when their real practical work was nursing.¹³⁰

That nursing education should involve a practical rather than theoretical emphasis remained an ongoing concern for many years. In 1909 during the debate on the Hospital and Charitable Institutions Bill, for example, Legislative Councillor Jenkinson reiterated Kelly's concerns, declaring that nursing examinations had become increasingly difficult, and were now at a level which a fourth year medical student might fail. This meant nurses

126 *Dunedin Hospital by-laws, 1890*, nos.257-261, pp.30-31.

127 "Syllabus of instruction to be given to probationer nurses", reprinted in Brown, appendix 5.

128 AJHR, 1905, H-22A, p.51.

129 Nurses' Registration Act, New Zealand statutes, 1901, no.12, para.6, p.23.

130 NZPD, 116, 9 July 1901, pp.180-181.

profession for women demanded nothing less than absolute purity of purpose and uprightness among its members. Accordingly, while most hospitals preferred candidates to hold the Standard 6 proficiency qualification,¹³⁶ this was by no means as essential as that "her moral character should be above reproach".¹³⁷ In interviewing a prospective nurse, said Hester Maclean, mental ability should be judged but "her bearing, manner and general address would largely indicate whether or not she is likely to be a successful nurse".¹³⁸ Nurses should approach their work from the highest motives of desire to help suffering humanity, she added, although she reluctantly acknowledged this desire "may of course be, and usually is, combined with the necessity for earning an independence".¹³⁹ Above all, in the words of the author of *The gentle art of nursing the sick*, extracts from which were published in the *Lyttelton times* in 1895, the nurse must "have a large share of the quality of 'womanliness'... nursing is, if anything is, a calling, a religion".¹⁴⁰ Such 'womanliness' encompassed a good knowledge of cookery and housework,¹⁴¹ and unimpeachable moral virtue. It was, said Maclean severely, the matron's responsibility to see that "no unfit person is received as a pupil nurse".¹⁴²

Prospective nurses had to supply references as to their moral character,¹⁴³ and during the training which followed, every effort was made to ensure that only "women of good character" became trained nurses. Discipline, both on the ward and off-duty was absolutely essential for the smooth running of the hospital and the efficient care of patients. "Nurses in training are like the private soldiers in an army - without

136 About half the nurses who trained at Dunedin Hospital between 1910 and 1918 had a secondary education. Eleven reached matriculation level, but most attended secondary school for only one or two years. The other half had attended primary school, 37 having been awarded proficiency. Eighteen did not reach this standard.

137 Address to 1911 Hospital Boards conference by Hester Maclean, *KT*, 5:3, July 1912, p.65.

138 *AJHR*, 1911, H-31, p.194.

139 Editorial, *KT*, 4:2, April 1911, p.43.

140 *LT*, 3 June 1895, p.4g.

141 *Christchurch Hospital by-laws, 1910*, section 182, p.7.

142 Editorial, *KT*, 4:2, April 1911, p.44.

143 See for example, *Auckland Hospital by-laws, 1893*, printed in Brown, appendix 4; *Dunedin Hospital by-laws, 1890*, p.30.

discipline and strict obedience to superior officers there is nothing but rout and defeat ahead of them".¹⁴⁴ Both doctors and nurse leaders emphasised that loyalty, respectful deference to authority, especially medical authority, and unquestioning obedience to orders were the essence of the good nurse. *Kai tiaki* published numerous exhortations along these lines, constantly reminding its readers that medical acceptance of professional nursing depended on continued faithful subservience, while public accolades depended on an unblemished reputation for moral probity and respectability.¹⁴⁵ Reports on nurses in training, made by senior nurses as pupils passed through their hands, focussed not on skill and intelligence, but on behaviour and attitude. Good nurses were praised for being respectful, quiet, obedient, punctual, neat and clean, trustworthy, helpful, kind and attentive. Less satisfactory students were noisy, abrupt and mechanical, boisterous, "dashing & bold", unmethodical, unreliable, untidy and "indifferent in carrying out orders". A nurse who was careless and slow in her work could be excused because she was "always very respectful". Another who was anxious and untidy was also "very willing, with an excellent manner, quiet and respectful". A third nurse, however, although also careful and willing, was not satisfactory because she resented correction, while a fourth was a good all-round nurse but had an objectionable and quite uncontrolled laugh which made her unsuitable for hospital work.¹⁴⁶ The primary duty of the probationer nurse, as set down in by-laws, was to "Be obedient, sober, honest, truthful, punctual, quiet and orderly, cleanly and neat, patient, cheerful and kindly".¹⁴⁷

Uniform

The nurse's uniform was designed to convey discipline and asexuality. In the 1890s, washable cotton uniforms replaced the serge dresses worn by

¹⁴⁴ *KT*, 5:3, July 1912, p.66.

¹⁴⁵ See for example, A. Holford, "Loyalty and unity", *KT*, 1:1, January 1908, pp.21-22; S. Maude, "Hospital etiquette", 1:2, April 1908, p.36; Sister Cecelia, "The nurse and womanly sympathy", 3:1, January 1910, p.33; H. Clifford Barclay, "Discipline and etiquette", 5:2, April 1912, pp.12-14.

¹⁴⁶ Comments taken from reports on nurses in training at Dunedin Hospital between 1910 and 1918, Dunedin Hospital School of Nursing records, DUHO.

¹⁴⁷ *Christchurch Hospital by-laws, 1910*, no.174. This by-law was one which formed part of the Department of Hospitals' model by-laws and is replicated in most hospital rules of the period.

the earliest nurses, pupil nurses initially having to pay for them themselves.¹⁴⁸ By 1910, uniforms were provided by the hospital authorities after the probation period, although shoes, stockings, collars, and cuffs remained the responsibility of each nurse. The uniform covered the nurse from top to toe. Long sleeves, high, stiff collars and huge, enveloping aprons removed any hint of sexuality and emphasised service. Hair was pulled firmly under the cap or veil. Jewellery and other adornment was strictly forbidden.¹⁴⁹ Thick stockings (Hana Anaru remembered being reprimanded for wearing silk stockings at Napier Hospital in the 1920s)¹⁵⁰ and low-heeled black shoes (called "maid's shoes" by one nurse)¹⁵¹ completed an outfit which had to convey modesty and respectability above all else. Nurses were encouraged to wear their uniforms at all times, even as evening dress,¹⁵² emphasising that the woman was submerged in the nurse. One nursing examiner even suggested in 1912 that a percentage of marks ought to be granted to candidates who wore the uniform properly, since propriety in nursing dress was essential to efficiency.¹⁵³

The role of ward sisters and matrons in training

Responsibility for instilling a sense of duty into pupil nurses belonged to the ward sister, who was perceived to be the nurse's most important teacher. Nurse training centred chiefly on practical work in the hospital ward under her guidance. "Sisters must be good teachers and must see that each probationer gets her proper share of instruction in all nursing points", said Nurse Maude.¹⁵⁴ Ward sisters were expected to be both models and mentors for the younger staff. The title 'Sister', with its significant religious connotations, was indicative of the dedicated commitment to self-sacrificing service which these women were expected

148 At Waikato Hospital, for example, the board raised no objection to the introduction of uniforms, provided it was done at the nurses' own expense, Wright-St. Clair, *From cottage to regional base hospital*, p. 14.

149 *Christchurch Hospital by-laws, 1910*, no.202.

150 Hana Anaru reminiscences, NERF oral history tape, no.268/2, ATL.

151 Louise Renouf, trained Napier 1900, quoted Conly, p. 36.

152 *KT*, 2:1, January 1909, p. 4.

153 *KT*, 5:3, July 1912, p. 85.

154 *KT*, 6:1, January 1913, p. 13.

to make.¹⁵⁵ At Christchurch Hospital, Matron Mabel Thurston underlined the nun-like devotion of the role when she conceived the idea of calling the sisters by their Christian names. Rose Muir became Sister Rose, Theresa Butler became Sister Theresa. Just as in a religious order, those whose names were considered unsuitable were given another.¹⁵⁶

At first, ward sisters were rotated from ward to ward, each woman also taking a turn as night superintendent and theatre sister, but gradually, more permanent appointments were made. Dunedin Hospital appointed Sister James as permanent sister in the Outpatients' Department in 1905¹⁵⁷ and Nurse Kelly as permanent night sister in 1908. The same year, it was recommended that ward sisters be retained in charge of a particular ward for at least a year.¹⁵⁸ By the mid-1910s, it was not uncommon for sisters to remain in a particular ward for years. Sister Dulas Jones, for example, became sister-in-charge of ward 7 at Christchurch Hospital in 1918 and remained there for 30 years, "a strict disciplinarian but much loved by her staff".¹⁵⁹

Matrons were also expected to play a large part in training, particularly in establishing a high moral and ethical tone within the training school. Christchurch Hospital's 1910 by-laws urged the matron "by the maintenance of a wholesome discipline [to] impress upon [the nurses] a high sense of the responsibilities devolving upon them, thus securing to the institution an efficient and reliable nursing staff".¹⁶⁰ Matrons who were strict in instilling the "highest ideals" of nursing earned the praise of nursing and medical authorities. Dora Peiper of Auckland Hospital provided excellent technical training to her nurses, but "her great desire

155 The title was first introduced in Dunedin Hospital in 1904. Previously the term 'charge nurse' had been employed, OHB House Committee minutes, 9 March 1904, p. 315.

156 Reminiscences of Jean Erwin, trained 1911-1914, Historical questionnaire, CH293/87a, NA (Christchurch).

157 OHB House Committee minutes, 6 December 1905.

158 *ibid*, 19 August 1908, p. 101. OHB Trustees minutes, 20 May 1908, p. 68. Sister Kelly's appointment, 16 September 1908, p. 109. Christchurch Hospital appointed a permanent night sister in 1912, NCHB minute book, 30 January, 24 and 28 February 1912.

159 Obituary, *Press*, 24 December 1965, p. 2.

160 *Christchurch Hospital by-laws, 1910*, no.90.

has ever been to raise the ethical standard of the profession".¹⁶¹ Miss Stewart of Gisborne Hospital was much beloved by her nurses "to whom she has endeavoured to impart the true spirit of nursing".¹⁶² Frances Payne of Wellington Hospital was regarded as one of the greatest matrons of the prewar years. She was, said Hester Maclean, "strict to a degree and intolerant of anybody who did otherwise than strive to uphold the ideals of nursing and the honour of the school". She established such a high standard of efficiency, loyalty, moral tone and discipline in nurse training that her school produced more future matrons than any other. A certificate signed by her was regarded as "the hall-mark of efficiency". Her wonderful disciplinary powers and vigilant supervision of law and order enriched the lives of her students with self-control, self-reliance, service before self and devotion to duty.¹⁶³

Weak matrons were those who failed to instil discipline. The matron of Ashburton Hospital in 1905 was "extremely kind" and very popular but "soft". The nurses did as they liked and grave irregularities occurred.¹⁶⁴ Miss Mary Ewart of Christchurch Hospital was lax about discipline and a poor teacher, said Grace Neill, who recommended her dismissal in 1906.¹⁶⁵

Many nurses commented on the excellent training given by matrons and ward sisters. Mary Lambie, later director of the division of nursing within the Department of Health, believed the lectures she received at Christchurch Hospital from 1911 were well-planned and that the matron, Miss Thurston was a good teacher who knew how to get the best from her pupils and spur them on to success. Some, if not all the sisters were

¹⁶¹ *KT*, 4:3, July 1911, p. 118.

¹⁶² *KT*, 2:2, April 1909, p. 69.

¹⁶³ Reports on Miss Payne's retirement, *KT*, 9:4, 4 October 1916, pp.221-222, 10:3, July 1917, p. 179. Reports on the unveiling of a tablet in her memory, *ODT*, 29 November 1926, *OHB* newspaper cuttings, v.32, p. 29, *KT*, 20:1, January 1927, p. 28. Maclean, p.240. The Inspector-General also commented regularly in his annual reports on the excellence of her training programmes, *AJHR*, 1903, H-22, p. 31, 1906, H-22, p.35. Among the matrons trained by Payne were Ellen Dougherty of Palmerston North, Mabel Thurston of Christchurch and Bertha Nurse of the NZ Army Nursing Service.

¹⁶⁴ *AJHR*, 1905, H-22, p.4.

¹⁶⁵ *AJHR*, 1906, H-22, p. 9; *CHB* minutes, 26 September 1906, p. 72.

excellent teachers and very able clinical nurses who set a high standard and a good example to pupil nurses.¹⁶⁶ Ida Willis felt Miss Payne and Dr Ewart of Wellington Hospital were teachers of the finest calibre, while the sisters were wise, upright women and firm disciplinarians imbued with a determination to send out efficient, dependable nurses. They demanded nothing less than perfection and often became lifelong friends.¹⁶⁷

Nurses' homes and the maintenance of discipline

Hospital discipline was not confined to work on the wards. As Miss Thurston of Christchurch Hospital declared, "The training of a nurse is not all due to ward work, but greatly to the influence and discipline in the Nurses' Home - the discipline contingent on community life".¹⁶⁸

The maintenance of wholesome discipline within the Home, declared the by-laws of Christchurch Hospital, would "impress [on nurses] a high sense of the responsibilities devolving upon them".¹⁶⁹ Accordingly, rules were strict. In the early years, nurses in training were not allowed to be absent from the Home without special permission after 8pm.¹⁷⁰ By 1910, however, many hospitals had extended this time until 10pm, with lights out by 11pm, except for the probationary period of three months, when nurses were still expected to be in by 8.30pm.¹⁷¹ One late leave until 11pm a fortnight (or in some hospitals a month) was permitted (although not

166 M. Lambie, *My story: memoirs of a New Zealand nurse*, Christchurch: Peryer, 1956, pp.7-8. Miss Lambie reiterated these views when she completed the historical questionnaire sent out to early nurses during the 1962 Christchurch Hospital nurses' reunion, CH 293/87a, NA (Christchurch). She recorded her "appreciation for the outstanding care and tuition given by the Matron and Ward Sisters". Amy Copland recalled Miss Thurston's "bribe" before the state examinations. If any nurse topped the list, she could choose any ward she wanted when appointed a sister, NERF oral history project, tape 154, ATL.

167 Willis, p.19-20. Edna Pengelly also remembered Miss Payne as a woman who set very high standards, which at the time, not all her nurses appreciated, E.Pengelly, *Nursing in peace and war*, Wellington: Tombs, 1956, p.15.

168 Letter from Miss Thurston to Miss Maclean, written after her retirement from nursing, *KT*, 23:4, July 1930, p.208.

169 *Christchurch Hospital by-laws, 1910*.

170 *Auckland Hospital's 1901 rules*, D. Dunsford, 'The privilege to serve others', p.34.

171 This was still true when Marjorie Chambers trained at Christchurch Hospital in the late 1930s, M. Chambers, *My life in nursing: Christchurch Hospital, 1936-1966*, Tauranga: Moana Press, 1988, p.9. Nor did all hospitals extend hours. Nurses at Timaru Hospital in 1910 still had to be in by 9pm, causing one nurse to exclaim that "We will never get married at this rate!", McKenzie, *A history of Timaru Hospital*, p.114.

usually in the first year of training and never after afternoon duty) and occasionally a later dance leave might be granted. Trained nurses and ward sisters were similarly not permitted to be absent without leave after 10pm, with even the sub-matron at Christchurch Hospital thus restricted.¹⁷² Visiting hours were few and male visitors in particular were not encouraged.¹⁷³

These rules were devised on both health grounds - nurses working strenuously for long hours every day required adequate rest - and to enforce moral probity. Within the Home itself, nurses were expected to be quiet, tidy and punctual to all meals. Precedence for seniors was always maintained, junior nurses being expected to achieve effacement of self in order to display respect for authority. They had to stand in the presence of seniors and open doors for them. In general, friendships between younger and older nurses were not encouraged, but within the small cohorts of nurses at this time, this was less rigidly enforced than in the post-war period. Mary Lambie, for example, maintained a friendship with her first ward sister, Emily Hodges, all her life.¹⁷⁴ Nevertheless, if junior nurses passed sisters, the matron or doctors in corridors, they were expected to stand aside and press themselves unobtrusively against the walls. Orders and messages were passed through a hierarchical line. Junior staff did not address senior nursing or medical staff directly but via the person who was their immediate superior. If they did address doctors, it was always as "Sir".¹⁷⁵ One doctor even apparently insisted that nurses bow to him when he passed,¹⁷⁶ while a nurse at Auckland Hospital who made a joke about a doctor's lecture was found by a disciplinary committee to have committed "an act of deadly insult ... and terrible insubordination". She

172 *Christchurch Hospital by-laws, 1910*, nos.104 & 113.

173 A.L. Macdonald & C. Tulloch, *Wellington Hospital: educating nurses for more than a century*, Wellington: Wellington Hospital Nurses' Reunion Committee, 1991, p.9; *Dunedin Hospital by-laws, 1910*, p.8; *Christchurch Hospital by-laws, 1910*; Thorp, p.30.

174 Emily Hodges' reminiscences, NERF oral history tapes, no.12. Edith Edwards, however, who was a staff nurse at Christchurch Hospital while Miss Lambie was training, had little to do with Lambie; "you know, you keep to your own", she remembered, NERF oral history tape, no.11, ATL.

175 Macdonald & Tulloch, p.27; New Plymouth School of Nursing Old Girls' Association, *Silver jubilee, 1957-1982: 'service before self'*, New Plymouth, 1982, p.21.

176 Wright-St Clair, *The early history of Waikato Hospital*, p.14, on Dr Kenny, medical superintendent in the 1890s.

was dismissed forthwith.¹⁷⁷ Such nursing etiquette was always one of the first lectures given during probationary training by the matron and it was firmly instilled by all senior nurses, including the Home Sisters, who were first appointed to maintain discipline and control in nurses' homes in the larger hospitals about 1910.¹⁷⁸

Punishment for transgressions of discipline were severe. Nurses who came into the Home late were reprimanded and eventually dismissed if caught several times. Nurses who refused to obey orders unquestioningly were unlikely to be retained, while nurses who committed the ultimate sin of disloyalty by publicly criticising hospital, matron or medical staff were punished by instant dismissal. The sister who allowed herself to be interviewed by a reporter from the *Otago daily times* in 1911 about dissatisfaction among nurses at the hospital suffered this fate. "I recommend that this nurse be informed that your Board has no further use for her services", advised Dr Valintine, adding that a "spirit of loyalty [is] regarded as one of the chief characteristics of an honourable calling".¹⁷⁹

Although it was universally acknowledged that nursing discipline was tough in the pre-war years, few nurses of the period seem to have questioned it. Sophia Reyburn was horrified to find she had to be in at 9pm when she arrived at Auckland Hospital in 1915, having been accustomed to attending dances and parties, but "you had to obey the rules", she said.¹⁸⁰ Marian Thorp, who trained at Wellington Hospital from 1908 recalled "we were a law-abiding lot on the whole".¹⁸¹ Only six of the reports on Dunedin nurses in the pre-war period contain major disciplinary

177 Editorial, *Press*, 7 May 1895, p.4.

178 The matron of Dunedin Hospital recommended the appointment of a Home Sister in 1908 and one was appointed early in 1910, OHB Trustees minutes, 17 June, 15 July, 19 August 1908, 21 December 1909. Christchurch Hospital's first Home Sister was appointed in 1911, NCHB Hospital Committee minute book, 17 August 1911, v.2, p.1.

179 *ODT*, 2 December 1910, OHB newspaper cuttings, v.1, p.82. Public pressure on the board, which focused on the fact that the reporter had been admitted to the ward by a doctor who had suggested he interview Sister Woodward, ultimately led to her reinstatement, although she was assigned to work in the Fever Hospital, not the main hospital.

180 NERF oral history tapes, no. 109, ATL.

181 Thorp, p.32.

criticisms and few nurses were dismissed for disciplinary reasons at this time. The furore at the hospital in 1910, when dissatisfaction with working conditions led to in a media campaign which resulted in the resignation of the matron, Miss Fraser, does not appear to have been supported by the majority of nurses. It is, of course, always difficult to establish the real views of the rank-and-file when the threat of dismissal is in the air,¹⁸² but the *Otago daily times* itself, which orchestrated the campaign, acknowledged that discipline among a large staff of nurses was essential and that the matron had to be firm as well as sympathetic. The esteem in which she was held by those who served under her showed her to be an "exceptional woman".¹⁸³ Pre-war nurses in New Zealand on the whole accepted that discipline and obedience were essential elements in shoring up the respectability of their profession and behaved accordingly.

Conclusion

Nurse training in the first years of the 20th century was constrained by both ideology and practical interests. Few nurses wanted to challenge the authority of doctors, particularly after Hester Maclean replaced Grace Neill as assistant inspector of hospitals in the Department of Hospitals and Charitable Institutions in 1906. Maclean had, according to her friends Neill and Dr Agnes Bennett "too lofty an opinion of the male."¹⁸⁴ She enjoyed a warm and harmonious relationship with her superior in the department, Dr Thomas Valintine,¹⁸⁵ and used her editorship of *Kai tiaki* to promote the importance of maintaining submissiveness to "those whose assistants we are, without whom we are helpless, and to whom we hope and believe we are helpful ...".¹⁸⁶ Educational articles in *Kai tiaki* were inevitably written by doctors who were also prominent on the councils of the first

¹⁸² Fourteen nurses wrote to the paper, disassociating themselves from the claims which had been made about nursing dissatisfaction. Fifty-four nurses signed a letter, begging the matron to reconsider her resignation (the total number of nurses at the time being about 60), *ODT*, 4 November 1910, OHB newspaper cuttings, v.1, pp. 51, 54-55.

¹⁸³ *ODT*, 4 November 1910, OHB newspaper cuttings, v.1, p.51.

¹⁸⁴ Neill to Bennett, 2 March 1920, Agnes Bennett papers, folder 211, MS Papers 1346, ATL.

¹⁸⁵ She wrote in her autobiography that "no relationship of chief and subordinate could have been happier", Maclean, pp. 40, 54.

¹⁸⁶ Editorial, *KT*, 1:1, January 1908, p. 1.

branches of the Trained Nurses' Association.¹⁸⁷ Nursing leaders needed the support of medical men and believed that their goals of respectability and professional acceptance were best served by allowing them to dominate and shape nursing educational programmes. "Good" women obeyed their men and "good" nurses could do no less.

¹⁸⁷ Doctors served as presidents of the Dunedin, Christchurch and Wellington branches of the Association until well into the war years. The Christchurch branch still had three medical advisers in 1929, although none served on the council, Canterbury Trained Nurses' Association minutebook, 22 November 1928, CU.

Chapter 6

Southern "Nightingales": the first trained nurses in New Zealand, ca.1885-1918

Who were the women who became New Zealand's "Nightingales", its first trained nurses? Often little is known since biographical information is available only for a few outstanding individuals. Yet these nurses formed the backbone of the nursing profession in New Zealand. It was they who transformed nursing as an occupation in the early years, while at a later period, their leadership, both inside and outside hospitals and training schools, shaped its future development. The ideals and life experiences which these women brought to nursing informed debates over training, working conditions, salaries and professionalism for decades to come and are central to our understanding of nursing as an occupation in the years up to 1930.

New Zealand's Nightingales trained in an era when middle-class, well-educated women embraced with enthusiasm a form of paid employment which was both womanly and altruistic, but which also offered professional status, opportunities for travel and war service, and the possibility of a lifelong career. These women embodied Nightingale's legacy of the ideal nurse. Unquestioningly obedient to authority, they found their utmost satisfaction in rendering service, asking for little in return except the privilege of passing on the lamp, "that spirit of service which alone maintains its undimmed fire!"¹

When training programmes for nurses were first introduced in Victorian England, it was social class and education which was supposed to distinguish the new nurse from her untrained predecessor. Nevertheless, Nightingale herself emphasised that a nurse's moral character and personal qualities were as important as class and education in making the

¹ Cecilia McKenny, matron of Wanganui Hospital, who trained at Wellington Hospital from 1898 to 1901, *K7*, 17:4, October 1924, p.144.

ideal nurse. From an early stage, the Nightingale School at St Thomas's acknowledged that its best candidates were "the daughters of small farmers who have been used to household work - and well-educated domestic servants".² By the turn of the century, nursing authorities admitted that the profession was "mixed as to rank".³ England's rigid class system quickly engendered a two-class nurse training programme. Small numbers of middle-class women became "lady-probationers", who paid for a special training course which destined them for the more senior nursing positions. Working class women were given different training and filled the rank-and-file nursing positions, both inside and outside the hospital.⁴ In the United States, the status of the training school tended to determine the social class of its nurse pupils. At the more prestigious schools in New York, urban upper-middle women trained as nurses, while in Boston, most nurses came from the middle and working classes.⁵ By the 1910s, all American nursing schools were finding it increasingly difficult to attract educated and respectable middle class women and more and more nurses came from lower middle and working class backgrounds, often from rural rather than urban areas.⁶

New Zealand's first trained nurses were a rather different group. They have generally been assumed to have come from the well-to-do middle classes. In his 1884 annual report to parliament, the Inspector of Hospitals, Dr G.W. Grabham declared Wellington Hospital's new probationer nurses were "from a higher order of society", and were taking "the greatest possible interest in their calling, which they have chosen from other than pecuniary motives only".⁷ The perception that nursing was henceforth to be an occupation which was the sole prerogative of "the daughters or relations of well-to-do people", women of "culture and social distinction" or "education and refinement",⁸ as we have seen, did much to

2 Florence Nightingale, quoted in S. Reverby, *Ordered to care*, p.79; Abel-Smith, pp.21-22.

3 C. Maggs, *The origins of general nursing*, London: Croom Helm, 1983, p.73.

4 Reverby, pp.233-234; Abel-Smith, pp.22-24.

5 Reverby, p.87.

6 Reverby, pp.87-90.

7 AJHR, 1884 (I), H-7A, p.20.

8 Letter to editor, *LT*, 29 March 1895, p.3c; T.E. Taylor, *ibid*, 18 September 1895, p.2e; *Daybreak*, 27 April 1895, p.4.

delay the transition to trained female nursing in New Zealand hospitals, particularly in Christchurch. In 1912, Hester Maclean noted that New Zealand nurses came from a variety of backgrounds, wealthy and less well-to-do, urban and rural, adding that "it seems the rule that the better bred and more gently nurtured women" were more prepared to make the sacrifices necessary for good nursing.⁹ More recently, both Alexandra McKegg and Deborah Dunsford have suggested in their theses that nurses here were, unlike their British counterparts, probably from middle and upper-middle class homes.¹⁰

By analysing the records of pupil nurses at Dunedin and Christchurch Hospitals in the period up to the end of the first World War, it has been possible to test these assumptions. The roll book of the nursing staff at Christchurch Hospital lists the names of all nurses who entered training there from 1892 until 1944, with brief notes on the time spent in training, dates of promotions, dates when examinations were passed and certificates granted, and sometimes notes on the reason for the nurse's leaving the hospital.¹¹ There were 206 women who entered the hospital between 1892 and 1910, and information on them has been supplemented from a variety of other sources.¹²

The personal files of the nurses who trained at Dunedin Hospital from 1910 until 1930 are held in the Hocken Library. These files are much more complete than those in Christchurch, containing each nurse's letter of application and application form, her referees' letters, ward reports written about her during training and sometimes letters to or from the matron about her later career. Nurses who did not achieve registration are not

9 *KT*, 5:4, October 1912, p.94.

10 A. McKegg, 'Ministering angels', pp.15-16; Dunsford, 'The privilege to serve others', p.27.

11 Christchurch Hospital records, CH 303/31c, NA (Christchurch).

12 These include published biographical works, newspaper and other obituaries, electoral rolls, the indexes to births, deaths and marriages at the Registrar-General's Office, the indexes to baptisms, marriages and deaths in church registers held at Canterbury Public Library, *Wise's New Zealand post office directories*, the *Cyclopaedia of New Zealand*, the registers of nurses and midwives published in the *New Zealand gazette* annually from 1903 until 1933 and the files of *Kai tiaki* first published in 1908.

included.¹³ Some 159 nurses entered training between 1910 and 1918 (including a few who began training earlier but whose files have survived) and again further information has been added from other sources.

Race

First, it is evident that nursing was almost exclusively a pakeha occupation in New Zealand in the years before World War 1. Not one of those who trained at Christchurch and Dunedin Hospitals in this period appears to have been Maori. The same was true of most of hospitals in the country. Although the government developed a Maori nursing scheme from 1899 onwards, the first Maori probationers were not accepted for full nurse training until 1905 and the first Maori nurse, Akenehi Hei, did not become registered until 1908. Miss Hei trained at Napier Hospital and Heni Whangapirita, who qualified the same year, trained at Wellington, these two hospitals being among the very few which would agree to accept Maori probationers. Christchurch declined on the grounds that there was no accommodation,¹⁴ while Wanganui, although it did train one Maori woman, "disapprove[d] of the imposition".¹⁵ Hester Maclean noted in her 1910 annual report that "the training of the Maori nurses presents much difficulty, chiefly owing to the reluctance of the hospital authorities to take these girls into their training schools".¹⁶ Maclean's attitude towards Maori nurses was typical of most nursing authorities. She regarded them as "rather inclined to shirk responsibility" and requiring "stiffening up" by pakeha colleagues. Most, she said, were not keen to take up the profession and simply relapsed into their old native ways when they returned to their homes.¹⁷ The cross-cultural difficulties which Maori nurses faced remained unacknowledged and the Maori nurse training scheme continued to stutter along with little support and consequently little success.¹⁸

13 Dunedin Hospital School of Nursing registered nurses' personal files, Arch. 37/94, DUHO.

14 CHB minutes, 20 December 1905, p.36 and 24 January 1906, p.39.

15 Wright-St Clair, *Caring for people*, pp.28-29; ODT, 30 October 1914, OHB newspaper cutting books, v.8, p.119.

16 AJHR, H-22, 1910, p.10.

17 AJHR, H-31, 1911, appendix 3, p.183; Maclean, *Nursing in New Zealand*, p.90.

18 For a full discussion of the Maori nurse training scheme, see A. McKegg, "The Maori Health Nursing Scheme: an experiment in autonomous health care", *NZJH*, 26:2, October 1992, pp.145-160; P. Sargison, "Efficient preachers of the gospel of health: Akenehi Hei", *Notable women in New Zealand health*, pp. 21-24; P. Sargison, "Hei, Akenehi, 1878/9?-

Place of origin

New Zealand's Nightingales were not only almost all of European descent but were also largely New Zealand-born. Of the Christchurch nurses known to have been born outside New Zealand, five came from England and two from Australia. Not surprisingly, a number of Dunedin nurses were Scottish-born. Nurse probationers came from both rural and urban environments, as indicated in the tables below which list the birthplaces of the nurses in each cohort.

Birthplaces of Christchurch Nurses:1892-1910			
Location	No	%	%
Christchurch (includes Lyttelton)	46	31%	
Timaru/Waimate	4	3%	
Country Districts		0%	
- Lincoln/Leeston etc	16	11%	
- North Canterbury	14	10%	
- Oxford	5	3%	
- Banks Peninsula	8	5%	
- Ashburton	5	3%	
Total Canterbury			67%
Dunedin	12	8%	
Oamaru	1	1%	
Country Districts			
- Otago	3	2%	
- South Otago	4	3%	
- Southland	5	3%	
Total Otago			17%
Westland	7	5%	5%
Nelson/Marlborough	7	5%	5%
North Island		0%	
- Auckland	3	2%	
- Wellington	3	2%	
- Other	4	3%	
total North Island			7%
total	147		100%

1910", *DNZB, volume 3, 1900-1920*, pp. 204-205; R. Lange, *May the people live: a history of Maori health development, 1900-1920*, Auckland: Auckland University Press, 1999, pp.166-176; P. Wood, "Efficient preachers of the gospel of health": the 1898 scheme for educating Maori nurses", *Nursing praxis in New Zealand*, 7:1, March 1992, pp.12-21.

Birthplaces of Dunedin Nurses, 1910-18			
Location	No	%	%
Dunedin	64	47%	
Country Districts			
- Taieri/Mosgiel	12	9%	
- Central Otago	18	13%	
- South Otago	9	7%	
- North Otago (incl Oamaru)	5	4%	
total Otago			79%
Invercargill	3	2%	
Bluff	1	1%	
Country Districts	2	1%	
total Southland			4%
Christchurch	1	1%	
Ashburton area	3	2%	
Timaru/Waimate	4	3%	
South Canterbury	2	1%	
North Canterbury	2	1%	
total Canterbury			9%
Nelson	1		1%
North Island			7%
- Wellington	2	1%	
- Auckland	1	1%	
- other	7	5%	
	137		100%

About two-thirds of Christchurch nurses came either from the city or from Canterbury rural districts, approximately one third from each area. Many West Coast women chose to train at the hospital, with the bulk of the remaining probationers coming from Dunedin and Otago rural areas. Nearly half Dunedin's nurses came from Dunedin city itself, and another third came from Otago rural districts. Although many Dunedin women travelled to Christchurch to train, fewer seem to have come the other way. From an early stage the Otago Hospital Board pursued a policy of engaging "the nurses residing in this Hospital District" as probationers,¹⁹ and although other applicants were less rigidly excluded as time went on, the general principle of preferring local women prevailed. Auckland Hospital implemented a similar selection policy.²⁰

Many factors influenced prospective probationers' choice of training hospital. Susan Reverby has suggested nursing offered rural women

19 OHB Hospital Committee minutes, 6 April 1892. In the 1890s, all applicants from outside Otago were firmly rejected. On 29 May 1901, the Committee saw "no reason to depart from usual custom".

20 Auckland's 1893 by-laws specified that preference should be given to those residing in the Auckland Hospital District, Brown, *The Auckland School of Nursing, 1883-1990*, appendix 4.

geographic mobility, an opportunity for them to participate safely in the excitement and independence of urban life.²¹ This was no doubt also true in New Zealand, although as time went on and the country gradually became more urbanised, more nurses were already living in urban areas, as is evident from the Dunedin sample. Certainly a number of rural women wanted the better training offered by a large hospital. Charlotte Macintyre and Ada Hore, who were probationers at Riverton and Naseby hospitals respectively before coming to Dunedin, both said that they preferred to train at a busy hospital with the variety of patients which offered a broader nursing education. That urban life was appealing is evident in the difficulties experienced by health authorities in getting trained nurses to return to country districts. Senior officials constantly bemoaned the selfishness of nurses who refused to accept backblocks nursing or rural midwife appointments, and cottage hospitals were chronically short of qualified staff. Sometimes, too, the training offered by one large hospital was perceived to be better than another. Ada Saunders of Pleasant Point, for example, was accepted for Christchurch "but hearing how much superior the training is in Dunedin, I would much prefer if possible to be trained there".²² At other times, family considerations prevailed. the Bretherton sisters from Waipawa in Hawke's Bay trained at Dunedin because their brother worked in the Public Trust Office there and wanted them under his eye.²³ In many cases, nurses simply went to whichever hospital accepted them first. Most of the larger hospitals had long waiting lists and many women applied to several institutions before being offered a place. In the 1890s about 60% of applicants at Dunedin Hospital became probationers after one to four months while by 1909/10, less than a third were accepted within this time. Most had to wait from six to 12 months, while three waited for 18 months and two for over two years.²⁴

Social class

The social backgrounds of 129 Christchurch nurses and 122 Dunedin nurses have been established, using the occupation of the father (or

²¹ Reverby, p.77.

²² Dunedin Hospital Nursing School records for Miss Saunders.

²³ *ibid*, file of Frances Bretherton.

²⁴ Data extracted from the minutes of the Hospital Committee, in which names are noted to have been added to waiting list and later to have been appointed as probationers.

occasionally that of a widowed mother) as a guide. Given the rural nature of colonial New Zealand, it is hardly surprising that around a third of the nurses who trained in both institutions came from farming families, 44 nurses in Christchurch and 45 in Dunedin. Of the Christchurch nurses, the families of 19 of the 44 were substantial landowners and runholders. Louisa Barrett's father ran sheep on 6000 acres at Tai Tapu, while Elizabeth Belton's father was a very prosperous Brookside farmer.²⁵ Barbara Washbourne's parents' property at Dunsandel was valued at over L25,000 in 1882²⁶ and Florence and Winifred Scott came from a well-known Southbridge runholding family.²⁷

A further 31 Christchurch nurses came from families with professional backgrounds. Their fathers were teachers, accountants, lawyers, clergymen, senior civil servants, army officers and doctors. Annie Campbell was the daughter of a Presbyterian minister, while Agnes Cruden's father was an archdeacon in the Anglican church. Alice Jacobson's and Louisa Nicholls' fathers were school teachers, while Mary Nalder's father was a lawyer who was also an extensive landowner. Isabel Martin's father was a photographer in Opawa. The fathers of Mary Beswick, Kate Bowie and Elizabeth and Gwyneth Field were listed in baptismal and marriage registers simply as "gentleman".

Businessmen's and merchants' daughters added another 23 names to Christchurch's early nursing staff. Mary Lambie's father was the manager of the Christchurch branch of the Union Steamship Company while Kassie Turner's father was also involved in shipping and other substantial business ventures.²⁸ Mary Christmas's family were flourmillers at Ohoka, Dora Bull's father a substantial fruit and seed importer in Dunedin. Muriel Hassal's father described himself as a "gentleman and merchant" at the baptisms of his children, while the fathers of five other nurses were hotel proprietors.

²⁵ *Cyclopaedia of New Zealand: volume 3, Canterbury*. Ch: Cyclopaedia Co., 1903, pp.670, 685.

²⁶ *The return of freeholders, 1882*, Wellington: Govt Printer, 1884.

²⁷ *ibid.*

²⁸ Lambie, *My story*, p.1; *Cyclopaedia*, v.3, pp. 111, 333, 375.

Ninety-eight out of 129 or approximately 76% of the first trained nurses at Christchurch Hospital therefore came from farming, business or professional families and many of them were also very well-off. Rather fewer Dunedin nurses came from such privileged backgrounds. Only 12 Dunedin nurses came from substantial farms. Most, like Mary Anderson of Poolburn, Mabel Ross of Waimakuku and Annie Haggart of Wangatua came from much smaller properties. Twenty-two were daughters of professional men, including six clergymen, two doctors and three accountants, while 14 others came from business and merchant families. As with the farming families, many of these businessmen operated in a smaller way than their Christchurch counterparts. Hadassah Davey's mother was a boardinghouse proprietor, Elinor Gabites' father a draper, Edith Hay's father a commercial traveller and Elsie Loudon's father a salesman (although her uncle was a substantial Dunedin merchant and chairman of the Otago Hospital Board in 1918).²⁹ Thus only about 66% of Dunedin nurses came from farming, professional or business families and many of these were accustomed to moderate rather than very high incomes.

More Dunedin nurses came from the working classes. Twenty-five were the daughters of skilled tradesmen (carpenters, bootmakers, strikers, platelayers, engine drivers) while 13 belonged to unskilled working families (six labourers, three miners, two gardeners, a caretaker and a seaman). Two nurses were the daughters of clerks and Jessie McRae's father was a police constable. Christchurch's nurses included only 28 working class women and the fathers of 20 of these were skilled tradesmen. Only eight Christchurch nurses came from the unskilled working classes. There were two labourers' daughters and one each of a gardener, a shepherd, a storeman, a miner, a bushman and a rabbitier. The fathers of three nurses were clerks.

It is clear that the first trained nurses at Christchurch Hospital were middle and upper-middle class white women who were also in many cases the

²⁹ Obituary, *KT*, 12:1, January 1919, p.45.

daughters of particularly well-established and well-to-do colonial families. Nursing was in the 1890s and 1900s an occupation which attracted well-educated and well-heeled young women. While the trend over the next decade does show a definite move in the direction of more lower middle-class and working class women of the type who populated American and English hospitals, many nurses at Dunedin Hospital in this period still came from Grabham's "higher order of society". This is confirmed by looking at records of their previous occupations. Christopher Maggs found that 71% of English nursing recruits had already experienced paid employment before training as nurses, most of them in domestic service or other areas of nursing.³⁰ At least half of Dunedin Hospital's 1910s trainees, on the other hand, were engaged in home duties before beginning their nursing training. Clearly, their wages were not needed to augment the family budget. Many of the women who had been in paid employment were engaged in other types of nursing, work chosen specifically to fit themselves for selection into general training schools when they became old enough. Twenty-three women worked as probationers in private hospitals, six in mental hospitals, three in children's homes and one as a maternity nurse, while two women worked as dental nurses, one as a doctor's assistant and one as an optician's assistant. Of the remainder, twelve women were engaged in office work, ten in dressmaking or millinery and seven were teachers, a very middle-class occupation. Of the 16 women who were in domestic service, eight described themselves as lady companions or companion helps, at least one was a cook and two others children's nursemaids.³¹

Age when entering nursing

New Zealand's Nightingales were not very young women.

It was generally accepted that nursing was an occupation which required a certain degree of maturity in its practitioners. When training was first

³⁰ Maggs, pp.76-85.

³¹These findings are corroborated in a study done on nine women who were educated at Nelson College for Girls before 1910 and who subsequently trained as nurses. The school catered for the socially advantaged, since it charged high fees. All nine girls attended the school for at least three years and Eva Livesey matriculated. She later trained at Christchurch Hospital, A. Kennedy, "Educating our nurses: Nelson College for Girls, 1892-1910", in *Looking back, moving forward*, pp.17-22.

introduced, probationers were seldom accepted unless they were at least 23 years old. Dr Hawkins-Ambler's *The gentle art of nursing the sick*, which was summarised in the *Lyttelton times* in 1895, declared that "twenty-three the author considers the proper age; if not 'sensible and discreet' at that age he thinks they never will be ...".³² Probationers entering training were to be aged between 21 and 30 or 35 in most hospital by-laws,³³(although some smaller hospitals accepted women aged 20),³⁴ and the Nurses' Registration Act in 1901 formalised these provisions by making it impossible for a nurse to become registered until she had completed three years' training and was at least 23 years old.³⁵ Most of the larger hospitals continued to prefer older probationers. The president of the Medical Association noted as late as 1910 that it was only recently that some boards had allowed women to begin nursing before the age of 23,³⁶ while Mary Lambie, who was 20 when she began training at Christchurch in 1911, noted in her autobiography that "Miss Turner [Kassie Turner who had trained at Christchurch Hospital from 1892 until 1895 and was then matron of the Limes Private Hospital in Christchurch] had advised me that I would be foolish to think of training before I was 23 ...".³⁷

The table below tabulates the ages of probationer nurses at Christchurch and Dunedin Hospitals in the years before the war.

32 *LT*, 8 June 1895, p.4g.

33 Auckland and Wellington Hospitals accepted women aged 21-35, Dunedin and Christchurch, 21-30, Auckland Hospital by-laws, 1893, published in Brown, appendix 4; Wellington Hospital by-laws, 1909, published in McDonald & Tulloch, p.9; *Christchurch Hospital by-laws, 1910*, p. 7; *Dunedin Hospital by-laws, 1890*, p.27.

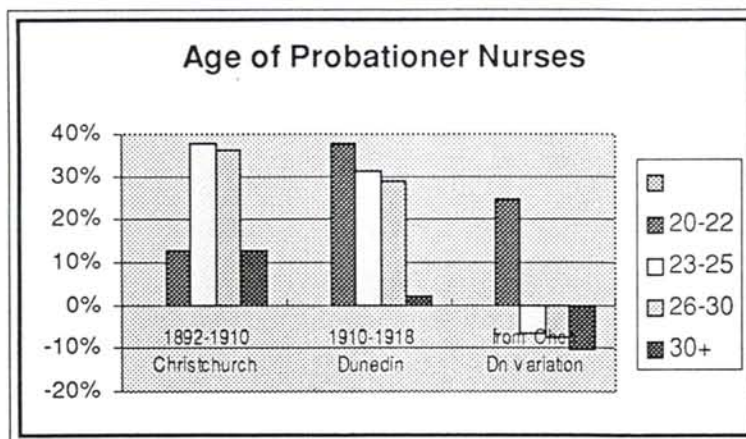
34 See for example, K.C. McDonald, *A century of service: the history of Oamaru Hospital*, Oamaru: Waitaki Hospital Board, 1972, p.21. Napier Hospital did not accept women under the age of 21, G. Conly, *A case history*, p.37.

35 Nurses' Registration Act, 1901, New Zealand statutes, 1901, no.12, para.4 (3), p.23.

36 *NZMJ*, 8:33, February 1910, pp.12-13. Dunsford notes that Auckland Hospital raised the age from 21 to 23 in 1907, 'The privilege to serve others', p.40.

37 Lambie, pp.3-4.

Age of Probationer Nurses			
Age	Christchurch 1892-1910	Dunedin 1910-1918	Dn variation from Chch
	%	%	
20-22	13%	38%	25%
23-25	38%	31%	-7%
26-30	36%	29%	-8%
30+	13%	2%	-10%
	100%	100%	



Three-quarters of the women who trained at Christchurch Hospital from 1892 until 1910 were aged between 23 and 30 years when they began nursing, while more than 10% were over 30, with at least two, Mary Beswick and Catherine Hickey, being over 40 years old. Nurses at Dunedin Hospital in the 1910s were definitely younger women. Of the 128 whose ages have been established, 48 or 38% were aged 20-22 and a further 40 (31%) were aged 23-25. Thirty-seven (29%) were aged 26-30 and only three women were over 30, one aged 31 and two aged 34.³⁸ In at least one of these cases, that of Mary Erlandson who at 34 was already a trained mental nurse, the Board resolved to suspend the by-law

³⁸ Angela Kennedy's study of Nelson College for Girls nurses found the average age of registration was 28, "Educating our nurses", *Looking back, moving forward*, p. 20.

regarding age (fixed at a maximum of 30 in Dunedin) so that she could undertake general training. Miss Erlandson's ward reports give some indication of the reasons why women over 35 were not generally favoured. She was recorded as anxious to learn, quiet and respectful but "painfully slow".³⁹ Women of this age were believed to be too fixed in their ways to learn new methods or to accept rigid discipline.

It was not only hospital policies which prevented women from becoming nurses until they were well into their twenties. Trained nursing was overwhelmingly a single woman's occupation and single women tended to have family obligations which prevented them from seeking paid employment outside the home. Maria Hodge, for example, was 29 years old when she entered Dunedin Hospital in 1918 and explained her circumstances in her letter of application.

Nearly four years ago I had a very unhappy ending to a seven year engagement. After that my brothers claimed me as a housekeeper, a place I was more than content to fill, simply because they had become all my little world & their interests mine. But one by one their country called until the third brother gave up his lease to a married brother & left with the last reinforcement. So for the first time I feel myself at a loose end & free to choose. I have seen this state of affairs approaching, & for some time past have had a great desire to take up nursing, for one reason to fit myself to be a useful member of any community ... [and] also ... [of] a profession with the highest motives.⁴⁰

Isabel Lawson, aged 26, informed the matron of Dunedin Hospital in 1916 that she had always wanted to nurse but as the eldest in a family of six brothers and three sisters, she could not previously be spared from home. Now that four of her brothers were married, she was free to choose her own career. Charlotte Bartlett was freed from home responsibilities in 1917 at the age of 28 because her younger sisters had left school and were able to take her place, while Christina Gillies, also 28, wrote wistfully in 1917 that her parents could not yet spare her, so she must remain "for a time at least ... I have not yet given up hope". She finally began training in June 1918. In many cases, only death freed a woman from family ties. At

³⁹Dunedin Hospital School of Nursing records, file for Miss Erlandson.

⁴⁰ Personal file of Maria Hodge, Dunedin Hospital Nursing School of Nursing records.

least 12 Dunedin nurses in the 1910s were the daughters of widows, another seven of widowers and four were orphans. Catherine Harrington who began training in 1912 at the age of 30 had wanted to nurse for some time but as the only daughter, could not leave her sick mother until she died. Lilian Alexander (aged 30) also had to nurse her dying mother for some years, while 26 year old Kate McIndoe's mother was a widow who needed her daughter's company. In some cases, the death of a parent merely transferred family obligations to siblings and other relatives. Like Miss Hodge, Margaret Copland (30) housekept for her farmer brother for several years, as did Grace Bretherton and Rose Dale. Margaret Gordon (25) looked after her grandmother until her death and Emily Knowles (29) nursed her brother for several years until he was sufficiently recovered to free her from his care.⁴¹ Lucy Trumble emigrated to Westport from Australia in the 1890s in order to look after her dying sister, remaining with her nieces for a further ten years before beginning her nursing training at Christchurch Hospital in 1909.⁴²

Parental opposition was undoubtedly a factor in preventing some women from training as early as they might have wished or indeed from training at all. Mary Lindsay, who began training at Dunedin Hospital in 1914 when she 26, did so against the wishes of her parents,⁴³ and Emily Hodges, who entered Christchurch Hospital in 1907 also acknowledged that her family did not approve. Her grandfather had served in the Crimean war, she said, and was not very impressed with the nursing there. He did not want his grand-daughter in a profession like that.⁴⁴ Emily was presumably able to reassure him, for her sister Mai joined her at the hospital in 1911. Jane Maria Atkinson persuaded her daughter, Alice, to leave her training at Wellington Hospital in the 1890s because she was spoiling her hands doing the work of a charwoman and learning nothing,⁴⁵ while Alice Holford's father, a man of strict principles, thought it a "terrible thing" for a daughter to leave home except for marriage. Miss Holford had to wait until

41 All the details in the above paragraph come from the personal files of the nurses concerned, Dunedin Hospital School of Nursing records, DUHO.

42 Obituary, *NZNJ*, 48:6, December 1955, p.214.

43 *South Canterbury women*, p.82.

44 Miss Hodges' reminiscences, NERF oral history project, tape 12, ATL.

45 M. Lash, *Nelson notables, 1840-1940: a dictionary of regional biography*, Nelson Historical Society, 1992, p.11.

shortly before her father's death in 1897 to begin training, by which time she was already 30 years of age.⁴⁶ Other parents were more supportive of their daughters' choice of occupation. Martha Cameron's parents probably reflected the views of many when they declared that it was a "good and educative profession for a woman", which also helped others.⁴⁷

Reasons for choosing nursing as a career

New Zealand's Nightingales were thus women who made a conscious choice to train as nurses at an age when most women were already wives and mothers. Yet nursing involved hard work, a great deal of drudgery and an awesome degree of stamina and devotion to duty. Why did New Zealand hospitals attract middle-class women who seemed to find nursing appealing when apparently those in England and the United States did not?

a) size of hospitals and numbers of nurses required

First, the small size of New Zealand hospitals was probably of some importance. New Zealand matrons were able to select middle-class applicants from waiting-lists because large numbers of nurses were not required. In 1909, for example, Wellington Hospital had 61 probationers, Auckland 60, Dunedin 52 and Christchurch only 35. The next largest hospitals, Waikato, Napier and Wanganui had only 17 probationers, while the remainder varied from one to twelve.⁴⁸ Hester Maclean noted the following year that of the four main hospitals, Auckland and Wellington produced 20-25 trained nurses a year and Dunedin 18, while Christchurch produced only ten.⁴⁹ It was far easier to find well-educated and well-brought up young women to fill these places than it was in the much larger institutions which were the norm in Britain or the United States.

46 P. Sargison, "Holford, Alice Hannah, 1867-1966", *DNZB, volume 3, 1901-1920*, pp.225-226.

47 Miss Cameron's personal file, Dunedin Hospital School of Nursing records.

48 AJHR, H-22, 1909.

49 *KT*, 3:1, January 1910, p.11.

b) ideological conviction

More important, New Zealand's Nightingales appear to have accepted the ideologies upon which trained nursing was premised and to have been happy to pattern their lives accordingly. Nursing offered a "good" woman the means of earning an independent livelihood without losing her femininity. The chairman of the Christchurch Hospital Board summarised these views in a well-received speech to mark the opening of the Nurses' Home in 1894:

the duties of the nurse, painful and disagreeable though they often are, are preeminently duties which are for women to discharge. They are duties, moreover, which, instead of unfitting her for a domestic life, are peculiarly adapted to teach her to adorn that sphere.(Applause) ... she must learn to submit herself to discipline. She must be punctual, clean, tidy and orderly ... they are the qualities upon the existence of which domestic happiness very much depends.(Hear, hear) ... the nurse's calling is in every way an eminently suitable one for young women who, for the sake of finding regular occupation for mind and body ... desire to obtain employment outside their own homes.⁵⁰

Rose Dale who trained at Dunedin Hospital declared in her application letter in 1916 that she wanted to be a nurse because "of all employment for women I consider it the most womanly & useful ... I wish to be independent".⁵¹ Rosie McLelland also wanted a useful profession and regarded nursing as the most suitable for women. For Beatrice McIntyre in 1913 it was "honourable & noble work", while Mabel Ross in 1911 called it one of "the noblest professions for women and one that should call forth only the highest and best within you, to help your suffering fellow creatures". The same year domestic servant Jessie Douglas expressed a wish to "do better work than I am doing at present & I wish to make my better best". Caring for the suffering masses, she added, was truly noble work.⁵²

⁵⁰ *Press*, 20 April 1894, p.6b.

⁵¹ Rose Dale's personal file, Dunedin Hospital School of Nursing records.

⁵² All quotations come from the personal files of the nurses named.

c) religious motivation

Prospective probationers seeking entry into nurse training schools no doubt used terminology in their letters of application which they believed matrons wanted to hear. Nevertheless many nurses were clearly motivated by deep religious and charitable concern. It is evident that many agreed with *Kai tiaki*, which in 1910 suggested that a nurse's reward was "the sweet and sacred joy which comes into the hearts of those who love and serve in Christ's name".⁵³ Christchurch nurse Sybilla Maude, who trained at Middlesex Hospital in London and was matron of Christchurch Hospital from 1893 until 1896, when she founded the district nursing service in Christchurch, was a woman of "simple Christian faith", "granite-like in its substance" who regarded nursing as her "call for life", the "trust remitted to her care for which she had to account". She stated that

When I was a young girl, I used to be very fond of visiting among the poor and in the hospital, and I conceived the idea that by being trained as a nurse, I could best serve my fellow creatures.⁵⁴

Margaret Houston, who trained at Christchurch Hospital from 1908 and was assistant matron there for 16 years, shared Nurse Maude's interests. She was remembered for her good works among the poor and needy of the city, whom she would visit on her bicycle in her off-duty hours, providing them with social services and nursing care at her own expense.⁵⁵ Alice Holford held "service to mankind" as a measure of an individual's success and was an active member of several community welfare organisations, including Plunket, the Nurses' Memorial Fund and the Otago Women's Club. Through this organisation, she instigated the opening of a women's restroom in Dunedin and founded the city's first creche.⁵⁶ Nora Fitzgibbon who entered Christchurch Hospital in 1909 and

53 *KT*, 3:4, October 1910, p.131.

54 P. Sargison, "Nurse Maude", *The book of New Zealand women*, pp.430-433. Before she trained as a nurse, Nurse Maude was a regular hospital visitor in Christchurch and was active in establishing a Destitute Patients' Fund and the Hospital Lady Visitors' Association in the city in the early 1880s, P. Sargison, "Hospital Lady Visitors' Association", A. Else (ed.), *Women together*, p.301.

55 Obituary, *KT*, 54:11, November 1961, p.18; reminiscences of Annie Busch, tape 58, NERF oral history project, ATL.

56 P. Sargison, "Holford, Alice Hannah, 1867-1966", *DNZB, volume 3, 1901-1920*, pp. 225-226.

was later director of Plunket nursing was a "woman of deep religious faith", a devout Roman Catholic who was instrumental in establishing the Catholic Nurses' Guild and was an active member of the Catholic Women's League. She believed it was important "to give the sick the best possible care inspired by principles of Christian charity".⁵⁷ At least five nurses who trained at Christchurch Hospital before 1910 were the daughters of clergymen, as were six nurses at Dunedin Hospital between 1910 and 1918. Two Dunedin nurses were brought up in Brethren evangelist households and many others at both hospitals were recorded as having been Sunday School teachers, active church workers, members of church choirs and Bible classes or simply as "thoroughly Christian" women.

A significant number of women trained as nurses specifically for the purpose of entering the mission field. Nine of the nurses who trained at Christchurch before 1910 are known to have become missionaries: Annie Campbell, Agnes Cruden and Maude Manning worked with the Maori mission, Phoebe Law, Hephizibah Kennedy, Isobel Milne and Cecelia Savage went to India and Jessie Mackay to China. Margaret Rogers planned to work in the New Hebrides but was prevented from doing so by an earthquake which destroyed the mission hospital there. Instead she became a district nurse with Nurse Maude, giving service to the sick poor in Christchurch in an organisation founded by church interests and shaped by its leader's unshakeable belief in the power of prayer and faith. At Dunedin, Lilian Alexander, who in her application wanted to help those "not too happily placed in life", was involved in the Maori mission. Mary Cameron, who declared her purpose in life was to serve others, worked in China. Gladys Peters was a missionary in India along with a Dunedin nurse who trained in the 1890s, Emma Beckingsdale.⁵⁸

Some nurses joined religious orders. Jessie Sexton and Eva Webber who trained together at Wellington Hospital from 1903 until 1907, became sisters in the Order of Our Lady of Compassion, continuing their nursing

⁵⁷ N. De Courcy, *Nora Philomena Fitzgibbon, 1889-1979: a biography of an outstanding New Zealand woman*, Dunedin, 1990.

⁵⁸ *KT*, 5:1, January 1912, p.5.

work at the Home of Compassion in Wellington,⁵⁹ while Margaret Macalister joined the Sisters of Mercy in 1912 after working at the Mater Misericordiae Hospital in Auckland.⁶⁰

d) professionalism and travel

For New Zealand's Nightingales, dedicated service to others was the mark of true professionalism. As Hester Maclean declared in 1909,

Nurses are anxious to be recognised not as tradespeople, labourers or clerks, but as members of an honourable profession; sisters and co-workers with the members of the profession which, for humanitarianism and ungrudging self-sacrifice, ranks highest in the world. To attain and keep that recognition we must give up something, sacrifice some ease and comfort, and allow no bar or limit to be placed on our right to do so.⁶¹

The success of New Zealand nurses in achieving another mark of professional status, that of state registration, some twenty years before their English and American counterparts certainly helped to attract middle class women to nursing. Deborah Dunsford has suggested that middle class women were the ones who benefitted from registration, because applicants needed at least a basic primary education before they could consider nursing.⁶² Registration also ensured at least some uniformity of training in hospitals, laying down guidelines which guaranteed that the nurse's education would not be totally ignored in the rush of ward work. The State examination system meant that the registered nurse was in possession of a nationally recognised certificate which granted her the status of a professional woman and provided her with the means of earning a reasonable living, both in New Zealand and overseas. Mary Lambie noted in 1914 that "As with most girls, the thought of travel and experience out of New Zealand was in our minds".⁶³ Certainly many nurses used their qualifications to work in other countries. Well over 30 of the nurses who trained at Christchurch Hospital before 1910 are known to

59 *KT*, 4:2, April 1911, pp.58-59.

60 *KT*, 5:1, January 1912, p.47.

61 Editorial, *KT*, 2:1, January 1909, pp.1-3.

62 Dunsford, 'The privilege to serve others', p.27.

63 Lambie, pp.11-12.

have travelled (apart from those who served in the war), and a similar number of Dunedin nurses also did so. At least eight nurses from each hospital lived and worked permanently overseas, usually in England or the United States. South Africa was a popular destination in the early years, seven Christchurch nurses working there at some stage. Rose Fanning, for example, was responsible for setting up the Plunket nursing scheme in South Africa.⁶⁴ Perhaps surprisingly, only a small number of nurses seem to have gone to Australia, three from Christchurch and two from Dunedin, but two Christchurch nurses (not missionaries) worked in India and another in Egypt.

Louise Bennett's career exemplifies the interesting worklife which nursing could offer the enterprising woman. After training at Christchurch Hospital in the 1890s, followed by a period spent private nursing, Miss Bennett was successively matron of four New Zealand hospitals (Ashburton, Kumara, the Jubilee Institute for the Blind in Christchurch and Stratford). She then travelled extensively in England and America, where she worked as a private nurse. She served during the first world war, spent a period as matron of St Helena Hospital in the Atlantic, worked in South Africa and finally retired to Wellington at the end of 1926.⁶⁵

e) war service

Miss Bennett was only one of the hundreds of New Zealand nurses who saw active service during the 1914-1918 war. The Nightingales had already shown enthusiasm for war work. Nine Christchurch and seven Dunedin nurses had served in the South African war from 1899 to 1902. During World War 1, 37% of the total trained nursing workforce joined either the New Zealand Army Nursing Service, Queen Alexandra's Imperial Army Nursing Service or the Australian Army Nursing Service.⁶⁶ Jan Rodgers has commented on the intense patriotism exhibited by

64 *NZMJ*, 32:7, July 1939, p.266.

65 Obituary, *NZMJ*, 47:1, January 1954, p.22.

66 Jan Rodgers has identified nearly 600 nurses who served during the war, 549 as members of the New Zealand Army Nursing Service and at least 40 others with other nursing services, "A paradox of power and marginality", pp.1-2.

nurses, combined with a desire to gain overseas military nursing experience, to visit 'Home', and to promote nursing status and advance the profession.⁶⁷ Forty Christchurch nurses who trained before 1910 saw war service, nine being on board the *Marquette* when it was torpedoed and sunk in 1915. Margaret Rogers was among the ten nurses who lost their lives in this disaster, as were two younger Christchurch nurses, Laura Rattray and Nora Hildyard, and Catherine Fox who trained at Dunedin from 1904 until 1907. Ten Christchurch nurses were awarded the highest nursing honour, the Royal Red Cross, either first or second class.⁶⁸ All nine of the nurses in Angela Kennedy's study served overseas, and were feted in the school magazine during the war years.⁶⁹ Only 29 of the 1910-18 Dunedin nurses served (having begun training at a later date), with four receiving the Royal Red Cross, but the war inspired many women to enter nursing at this time. Harriet Kinmont noted in 1915 that her long-held desire to become a nurse was "stronger at this time of national need", while Dorothy McDonald wrote in 1918 that "The war has made me wish to be helpful in this way if possible".⁷⁰

Life-long service and post-graduate training

New Zealand's Nightingales then, were on the whole women who fulfilled the ideological model created by nursing reformers. They were pious and altruistic women of good family, who committed themselves to the "true spirit of nursing" by dedicating their lives to the self-sacrificing service of others. Nursing was a vocation and a life-long commitment. Caroline Stewart, who retired as matron of Gisborne Hospital in 1909 referred to her 20 years' service as "absolutely a labour of love".⁷¹ Margaret Myles, matron of Dunedin Hospital from 1912 until her early death from pernicious anaemia in 1922, was mourned as a great loss to the profession because "Her example in making her hospital work the chief

67 Rodgers, 'A paradox of power and marginality', pp.20, 94-95.

68 Twelve New Zealand nurses were awarded the Royal Red Cross (1st class) and 64 the RRC (2nd class), so Christchurch nurses were well represented, *KT*, 25:5, p.246.

69 A. Kennedy, "Educating our nurses", pp.20-21.

70 All details from the personal files of the nurses named, Dunedin Hospital School of Nursing records.

71 *KT*, 2:3, July 1909, pp.123-124.

interest in her life cannot fail to influence those who worked under her".⁷² Sibylla Maude and Mary Christmas were seldom seen out of uniform. Nurse Maude even wore her uniform under her royal robes when she was elected Queen of the Carnival in 1915, "a nurse at the front and a queen at the back", as she put it. After her death in 1935, she was buried in it.⁷³

This commitment is reflected in the statistics which describe the Nightingales' nursing careers, particularly those of the Christchurch nurses who trained before 1910. Of the 206 women who entered the hospital in this period, only 29 did not complete the course. Health breakdowns accounted for nine departures, although two women, Maud Martin and Constance Walker later completed their training at smaller institutions, where the work was less demanding.⁷⁴ Jessie Nisbet died of heart failure a year after beginning training in 1909.⁷⁵ Seven nurses left to marry, four for family reasons, two failed their examinations and two were dismissed as unsuitable after disciplinary proceedings. One woman did not like the work, another left to travel with her family and another resigned because she was not assigned a single room in the Nurses' Home (an incident which illuminates the middle-class expectations of some probationers). A further 28 nurses appear to have left the hospital at the end of the training period and taken no further part in nursing work. Marriage accounted for the departure of six women and health problems for three more, but no reason is given for the rest. It seems probable, given that many women returned home, that family obligations prevented them from pursuing their careers further. Thus 57 women either did not complete training or did not continue nursing; 149 or 72.4% did.

These nurses pursued their nursing careers with dedicated enthusiasm. Many sought further qualifications at the end of their three-year general

72 Obituary, *KT*, 16:1, January 1923, p.36.

73 P. Sargison, "Nurse Maude", *The book of New Zealand women*, pp.430-434; obituary for Mary Christmas, *NZMJ*, 57:6, June 1964, p.31.

74 Maud Martin began training at Dunedin in August 1905 and left in November 1907. After more than a year's break, she recovered sufficiently to complete her training at Napier Hospital, *KT*, 3:1, January 1910, p.45. Constance Walker began training at Dunedin in November 1908 and left in September 1909, later qualifying at Timaru Hospital.

75 Obituary, *KT*, 3:3, July 1910, p.107.

training. Thirty-two nurses went on to complete a midwifery course, although this was neither readily available nor cheap in New Zealand at this time. Midwifery training was first offered at the four St Helens hospitals in Wellington, Christchurch, Dunedin and Auckland in the period between 1905 and 1907. Pupil midwives were given board and lodging but were not paid a salary and had to supply their own uniforms for the six-month course. Moreover, a fee of L20 was required. As late as 1926, Mary Lambie noted that, even though the fee had been abolished, without pay and with the cost of both an indoor and an outdoor uniform and an obstetric bag, "there was considerable expense for any nurse undertaking this training".⁷⁶ Twelve Christchurch nurses actually travelled overseas to study midwifery, seven training at the Melbourne Women's Hospital and five in London. These courses required an even greater sacrifice on the part of nurses, as fees were very high. In 1902 Alice Holford paid L50 for her course at the Crown Street Hospital in Sydney, her living expenses for the period of her training amounting to a further L150. This money she borrowed from her brother.⁷⁷ Nevertheless, many nurses were prepared to make this sacrifice for the sake of their work. Midwifery experience was necessary for nurses working in the fields of public health, district and native health and infant health, and was also increasingly regarded as essential for women in senior administrative positions, both in hospitals and in the Department of Health. As these new career openings developed, many nurses showed their determination to fit themselves for the work by undertaking further training as long as 16 years after they first registered as general nurses. Louise Green, who registered in 1913, became a midwife in 1921 prior to her appointment as matron of Waimate Hospital and later Wakari Hospital in Dunedin. Alice Ingold also registered in 1913 but did not do her midwifery training until 1929, when she had become a Plunket nurse. Mary Lambie, who entered Wellington's St Helens in 1926 at the age of 37, described just how difficult it was for experienced nurses to return to student status:

In the first place I was much older than the rest of the trainees and ... I felt that I was frequently unfairly treated. I had forgotten how unkindly sisters could speak to nurses

76 Lambie, p.54.

77 "Pioneer in women's work keeps her 87th birthday", *ODT*, 16 November 1954: interview with Miss Holford. See also P. Sargison, "Holford, Alice Hannah, 1867-1966", *DNZB, volume 3, 1901-1920*, pp. 225-226.

under them or how indifferently they could speak to both patients and staff.

Two years earlier, she had found institutional life at the Karitane-Harris Hospital in Dunedin, where she did her Plunket training, "very irksome". Nevertheless, she added, "for many reasons it was necessary that I should have this experience" and the opportunity to take it could not be ignored.⁷⁸

Christchurch's Nightingales took up other training opportunities as they became available. Mary Beswick and May Chalmer were awarded sanitary certificates by the Royal Sanitary Institute in London, which were useful prerequisites in public health nursing. Several nurses acquired therapeutic massage qualifications during their war service years and at least two women, Maude Haste and Mary Gould, established private massage practices. Eleven women became Plunket nurses which necessitated a four-month training course in Dunedin, and eleven others worked as tuberculosis nurses, which again required special training. Ella Wiggins trained as an x-ray nurse, being appointed sister in Christchurch Hospital's x-ray department in 1920. Mary Lambie became the first New Zealand nurse to undertake postgraduate training in public health nursing, when she spent a year at Toronto University in 1925-1926 and Gladys Metherell trained as a child welfare officer in the Education Department.

By the 1910s, commitment to nursing as a life-long career was less common. It is not known how many Dunedin nurses failed to finish their training between 1910 and 1918 (the files available record only those nurses who registered), but a very much higher proportion of nurses left the hospital at the end of the training years and did not continue nursing. Of the 159 nurses at the hospital in this period, 62 or just under 40% apparently did not pursue nursing careers. Marriage claimed 21 women, ten left for health reasons, five for family reasons, three to travel and three for disciplinary reasons. For the remaining 20, no reason is recorded but no doubt family commitments played a part.

⁷⁸ Lambie, pp.34, 53, 56.

Nevertheless, over half the nurses who trained at Dunedin in the 1910s did continue nursing. Thirty-six nurses acquired midwifery qualifications, an even higher proportion than among the Christchurch nurses. By the 1920s, midwifery was increasingly regarded as essential for all trained nurses who desired to perform with maximum efficiency.⁷⁹ The Dunedin cohort included nine Plunket nurses and nine tuberculosis nurses including Mary Timlin who was a pioneer sister in Dunedin Hospital's tuberculosis outpatients' department. There were two x-ray specialists, Elsie Loudon and Mary Hunter, and two private masseuses, Gertrude Petre and Ruby Makeig. Janet Moore studied for the International Red Cross Postgraduate diploma at Bedford College in London in 1924-25 and, along with Mary Lambie, established New Zealand's own postgraduate nursing course in Wellington in 1928. Margaret Mackie, by then matron of Oamaru Hospital, was one of the 17 nurses who attended the first course. Dolores Macdonald was one of the first nurses to specialise in ante-natal work and Isabel Lawson was a pioneer in venereal disease clinic nursing.

Marriage

Because so many Christchurch and Dunedin nurses enjoyed long and active nursing careers, marriage tended to occur later in life or not at all. In both cohorts, only about half of those whose marital status has been established eventually married, 73 out of 148 women in Christchurch and 67 out of 132 women in Dunedin. Thirteen Christchurch nurses either did not complete their training or left at the end of their training to marry while 21 Dunedin nurses married at the end of their training. Many of the others married only after spending several years nursing and some, like Letty Croft who was matron of Napier Hospital for 20 years, and Catherine Nosworthy, assistant matron of Dunedin Hospital for 17 years, did not marry until after retirement.⁸⁰ The following tables show the ages at which

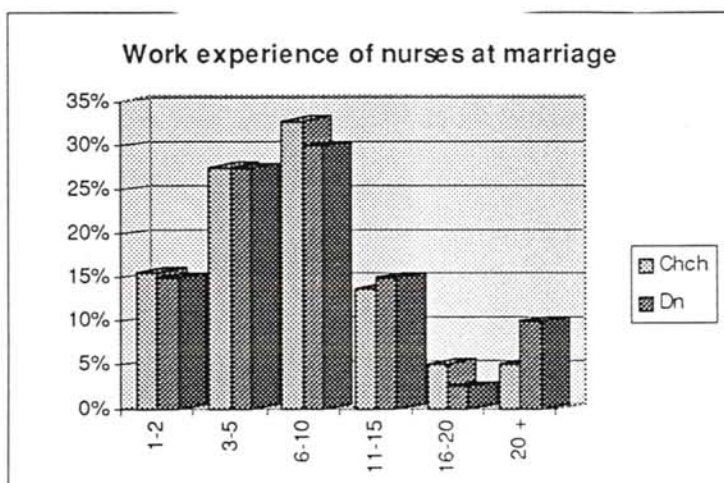
79 See for example, *KT*, 16:3, July 1923, p.114; 19:1, January 1926, p.10.

80 Miss Croft was awarded an OBE for services to nursing in June 1951 and retired from Napier Hospital early the following year. She married Mr H. Steele of Napier in June 1952, when she was 56 years old, *KT*, 44:5, 1951, p.148, 45:2, 1952, p.60 & 45:3, 1952, p.125. Miss Nosworthy retired from Dunedin Hospital in October 1932 and married Mr James Taylor in April 1934, *KT*, 25:4, 1932, p.238 & 25:6, 1932, p.313, 27:2, 1934, p.88 & 27:4, 1934, p.191.

nurses married and the number of years between their registration date and marriage date.

Marriage of Nurses, pre 1918		
Age at marriage	Christchurch	Dunedin
	%	%
under 25	1%	2%
25-27	10%	14%
28-30	18%	33%
31-35	28%	19%
36-40	24%	17%
41-50	12%	10%
over 50	6%	5%
total	100%	100%

Years of nursing before marriage	Chch	Dn
	%	%
1-2	16%	15%
3-5	28%	28%
6-10	33%	30%
11-15	14%	15%
16-20	5%	3%
20 +	5%	10%
	100%	100%



The earliest trainees from Christchurch Hospital definitely married at a later age than the Dunedin nurses of the 1910s. Only about 30% of these women married before they were 30, with some 57% marrying between the ages of 30 and 40. Nearly 50% of the Dunedin nurses were married by the time they were 30 and only about 36% married between 30 and 40. This is hardly surprising, however, as the Christchurch nurses were, as we have already noted, rather older on average than the Dunedin nurses when they began training. More revealing is that in both cases,

approximately 58% of the nurses married between 3 and 10 years after qualifying and about 25% more than ten years after qualifying. Although far more Dunedin nurses married immediately after training, in neither cohort did nurses who continued nursing readily give up their careers for marriage.

Married women were not generally accepted as probationers in nursing schools. Not one of the sample of nurses who trained at Christchurch and Dunedin Hospitals up to 1918 seems to have been either a married woman or a widow, although one widow, Mrs Wingfield, is known to have trained at Dunedin Hospital from 1895 until 1898. Later, as Mrs Henderson, she ran a private hospital in Waimate.⁸¹ Two other married women, presumably also widows, are recorded as beginning training at Dunedin in the 1890s, Mrs Luhman on 4 September 1895 and Mrs Fulton on 27 July 1898.⁸² Mrs Fulton apparently did some of her training at Timaru Hospital and took up private nursing after registering.⁸³ The 1903 application of Mrs Cook, however, was firmly declined, the Hospital Committee "seeing no reason to change the existing arrangement". Possibly this woman's husband was still living.⁸⁴

Marriage after registration usually signalled the end of a woman's hospital career although in at least one instance before the war, the difficulty of obtaining a trained nurse opened the way for a married nurse to remain at her hospital. Miss Thompson was matron of Kaitangata Cottage Hospital in 1910 when she married the town clerk and hospital secretary, Mr Clements, but the Board allowed her to retain her position.⁸⁵ During the war, quite a number of married nurses, whose husbands were at the front, continued working in hospitals, both in New Zealand and overseas. When the war ended or when husbands returned, however, these women generally resigned,⁸⁶ just as women in other occupations gave up their jobs as the men returned from overseas.

81 Register of nurses, New Zealand gazette, 1, 1914, p.454.

82 OHB House Committee minutes, 4 September 1895 and 27 July 1898.

83 Register of nurses, New Zealand gazette, 1, 1903, p.194.

84 OHB House Committee minutes, 11 February 1903.

85 *KT*, 3:2, April 1910, p.89.

86 Sister Dorothy Rose of Christchurch Hospital, for example, continued to nurse in Egypt after her marriage to Major White in 1916, *KT*, 9:2, April 1916, p.113. Mrs Fleming worked for over two years as Home Sister at Napier Hospital after her marriage, before

Marriage did not necessarily end a woman's involvement in nursing. A number of married nurses continued to work, usually as private nurses and midwives or as proprietors of private hospitals, nursing homes and rest homes. Mrs Eleanor Boyd was appointed district midwife in Lyttelton in 1920,⁸⁷ and Mrs Bartie, whose marriage was recorded in *Kai tiaki* in 1921, carried on her midwifery practice, as did Mabel Baker who married Alick Gunn the same year.⁸⁸ Mary Waters who trained at Christchurch from 1905 to 1908 seems to have worked as a Plunket nurse in Auckland both before and after her marriage to Mr Atkinson in 1915.⁸⁹ Several married Dunedin and Christchurch nurses ran private hospitals. Annie Isbister who trained at Christchurch from 1909 until 1913, was a district nurse in Kaiapoi for several years before her marriage in 1917 to local chemist Bernard Fulsdeth. Mrs Fulsdeth was then matron of a Kaiapoi nursing home for 14 years, although she was also the mother of at least one son.⁹⁰ Louisa Oakden was a district health nurse in the Waikato for 20 years before her marriage to Mr Pocock of Thames in 1939, when she took over a rest home at Puru.⁹¹ Ivy Barrett who trained at Dunedin during the war, bought the Chalet Hospital in Dunedin in 1920 and continued to run it after her marriage to Mr Hislop in November 1928.⁹² Florence Abbott (Mrs Smith) and Sophia Mandeno (Mrs Phillips) both ran private hospitals in Auckland, while Gertrude Littlecott (Mrs Loxton) ran a nursing home in Durban, South Africa with her doctor husband.⁹³

Other married nurses continued to nurse in a less formal way. Barbara Washbourne who trained at Christchurch from 1909 to 1912 and married Frank Orr in 1915, lived in the "roadless North", where doctors did not venture out, so was able to make much use of her training among her

resigning to join her husband in England, *ibid*, 9:4, October 1916, p.245.

87 NCHB minutes, 29 April 1920, p.233.

88 *KT*, 14:1, January 1921, p.49 and 14:2, April 1921, p.101.

89 Register of nurses, New Zealand gazette, 1, 1933, p.837.

90 Obituaries, *Press*, 8 April 1959, p.2; *NZNJ*, 52:3, 1959, p.106.

91 *NZNJ*, 32:1, January 1939, p.25 and 32:2, February 1939, p.72.

92 *KT*, 22:1, January 1929, p.36 and 24:3, May 1931, p.106.

93 *NZNJ*, 43:5, August 1950, p.167 and 44:1, 1951, p.18.

neighbours. She nursed a large Maori community at Kaihu during the influenza epidemic, conducted first aid and home nursing classes, and was active in both the Red Cross and the Bay of Islands branch of the New Zealand Trained Nurses' Association.⁹⁴ Doris Watson of Dunedin Hospital found her nursing training very useful in her husband's country practice when she married Dr Reid of Darfield in 1928.⁹⁵ Hester Maclean, in describing the work of two married nurses in remote areas in 1923, commented that it was good to know that the married nurse "can still exercise her professional knowledge for the benefit of those around her".⁹⁶

Many married nurses took an active role in health-related community organisations like Plunket, the Red Cross and St Johns and they were often the driving forces in local branches of the Trained Nurses' Association. Mrs Holgate was the founder of the Wellington Private Nurses' Association in 1905 and Mrs Kendall was the first president of the branch after the New Zealand association was founded.⁹⁷ Dora Peiper, matron of Auckland Hospital, 1910-1911, became a leading member of both the Auckland branch and central council of the association after her marriage to William Oliphant in 1911, her husband acting as the association's honorary solicitor.⁹⁸

Widowhood often propelled trained nurses back into paid employment, especially if they had young children to support. Louisa Nicholls who trained at Christchurch from 1894 until 1898 married Westport miner, G.A. Smith in 1898 and gave birth to four children before his death in 1910. She returned to nursing as matron of Denniston Hospital until 1917 and was then appointed to the Macarthy Children's Convalescent Home in Lower Hutt, a position she held until her retirement in 1928. According to her

94 Obituary, *NZNJ*, 56:12, 1963, p.9; historical questionnaire completed by Mrs Orr in 1936, CH 293/87b, NA (Christchurch).

95 *KT*, 22:2, April 1929, p.95.

96 *KT*, 16:4, October 1923, pp.189, 193. The two nurses were Mrs Coates (nee Illingworth) of Putorino and Ethel Pritchard (nee Taylor) of Te Hau station, Whatatutu.

97 *KT*, 2:1, January 1909, pp.21-22 (Mrs Kendall); obituary, *ibid*, 13:4, October 1920, p.193 (Mrs Holgate).

98 *KT*, 12:1, January 1919, p.2 and 12:3, July 1919, p.105.

obituary, her "mother's experience and mother's instinct" made her a "true nurse", much loved by both the children in her care and the young nurses under her rule.⁹⁹ Dora Peiper (Mrs Oliphant) was widowed when her youngest child was still only ten and became a district nurse in the Hastings area.¹⁰⁰ The missionary husband of Nellie Cushen (Mrs Suckling) died in the influenza epidemic in Fiji, leaving her with two small children so she accepted an appointment as matron of an orphanage there.¹⁰¹ Other widowed nurses did not have children but still needed to support themselves. Myra Everett of Dunedin Hospital was married in 1917 but widowed shortly afterwards and took up a sistership at Nelson Hospital. Edith Harris of Christchurch Hospital was also widowed soon after her marriage to Keith Smith in 1916, so joined her friend, Eva Livesey, in running the Vivian Street Private Hospital in New Plymouth. Mrs Smith married again in 1930, the same year as Miss Livesey, the hospital being sold at that time.¹⁰²

Family obligations

It was not so much marriage as other family obligations which tended to force women out of nursing, as nursing authorities were well aware. At both the Christchurch and Dunedin Hospitals, applicants were obliged to state that they were free from all domestic responsibilities which might interfere with their obligations to the hospital during the period of training. Christchurch Hospital's 1910 by-laws stated that "Probationers will only be received on the distinct understanding that they remain for the full time" and that they would not be released to nurse sick relatives at home.¹⁰³ Nevertheless, many nurses were obliged to interrupt their training for this purpose. Lydia Bazley, Frances Bretherton, Elizabeth Bunbury, Theresa Culling and Catherine McMillan of Dunedin Hospital all took leave for varying periods to nurse family members. Janet Cochrane and Christina Melrose were among the many who left nursing completely to return to domestic duties. Rosie McLelland, who began training in 1916, had been

99 Obituaries, *NZNJ*, 23:3, May 1930, p.134, *Press*, 26 April 1930, p.2.

100 Register of nurses, *New Zealand gazette*, 1, 1933, p.971.

101 *KT*, 12:4, October 1919, p.197.

102 *KT*, 23:4, October 1930, pp.176, 218.

103 *Christchurch Hospital by-laws, 1910*, nos.181 and 190, p.7.

poor health and took several weeks' leave from the hospital in 1919 to nurse her. For the same reason, she was unable to continue nursing after completing her training in 1920. Annie Busch, who trained at Christchurch Hospital from 1915 to 1919, demonstrated particular devotion to family demands. Miss Busch left the hospital after her training to care for her parents because her sister, the previous family caregiver, died in the 1918 influenza epidemic. Although she was able to do a little private nursing from home, Miss Busch gave up paid employment when her mother became ill, continuing to nurse her parent with financial support from the Nurses' Memorial Fund for nearly fifty years. Mrs Busch finally died just before her 104th birthday in the 1970s.¹⁰⁴

Seniority within the profession did not free women from familial obligations. Elizabeth Field, who trained at Christchurch Hospital from 1899 until 1902, resigned as matron of Nelson Hospital in 1909 for family reasons and Maude Hayward resigned from the matronship of Masterton Hospital in 1913 to care for her seriously ill mother. Nora Fitzgibbon, who trained at Christchurch from 1910 until 1913 resigned as matron of the Karitane-Harris Hospital in Dunedin in 1927 to care for her widowed mother. She remained at home until her mother's death in 1930, before returning to continue her long and distinguished career in Plunket work.¹⁰⁵ Mary Lambie left Christchurch Hospital in 1914, shortly after completing her training to nurse her dying mother and remained at home for the next four years to care for her father and younger siblings. After her father's death, she sought an appointment as a school nurse rather than another hospital position, so that she could maintain a home for her youngest sister, then still at school.¹⁰⁶ Ida Willis left Wellington Hospital at the end of her training in 1910 "with a sad heart" to go to Australia with her mother and sister after her father's death.¹⁰⁷

104 Reminiscences of Annie Busch, tape 58, NERF oral history project. ATL.

105 De Courcy, p.13.

106 Lambie, pp.12-15.

107 Willis, p.20.

Matrons and other nursing leadership positions

As we have seen, many Nightingales enjoyed a lifetime's involvement in nursing and their commitment to their careers was rewarded by positions of power and influence within the profession. No fewer than 42 women who trained at Christchurch Hospital before 1910 became hospital matrons, about 21% of the total number of trainees but 28% of those who continued nursing. Two others, Margaret Houston and Ruby Wood, held posts as assistant matrons. In 1903, the Hospital Board was able to congratulate itself on having trained the matrons of every South Island hospital, except Dunedin.¹⁰⁸ Many matrons were in charge of important training schools and thus exerted a powerful influence over the next generation of nurses. Mary Ewart was matron of Christchurch Hospital itself from 1898 until 1908, while Jessie Ewart (no relation) was matron of Southland Hospital from 1900 until 1924. Her sister, Jane was matron of Timaru Hospital from 1903 until her marriage the following year. Ada Taylor was matron of Auckland Hospital from 1918 until 1929, having previously served as matron at Waihi.¹⁰⁹ Kate Benjamin was matron of Gisborne Hospital from 1924 until her retirement in 1933, having previously served as matron of the Cashmere Sanatorium in Christchurch.¹¹⁰

Several women held successive matronships of increasingly larger hospitals as they advanced their careers. Gertrude Clapcott was matron of Naseby Hospital in 1905-1906, then of Hokitika Hospital (1906) and finally of Hawera Hospital (1907-1913). Susannah Kitto was successively matron of Wairau (1903-1904), Timaru (1904-1906), assistant matron, Christchurch (1906-1910), matron, Cashmere Sanatorium (1910-1911), and matron, Greymouth (1911-1923). She ended her career as matron of the Quamby Old People's Home in Christchurch.¹¹¹ Two women, Mary Lambie and Nora Fitzgibbon, achieved the highest positions open to nurses, Miss Lambie as Director of the Division of Nursing of the Health Department and Miss Fitzgibbon as Director of Plunket Nursing. Both

¹⁰⁸ *Press*, 29 October 1903, p.5a.

¹⁰⁹ *KT*, 11:3, July 1918, p.140.

¹¹⁰ Obituary, *Press*, 27 December 1938, p.2.

¹¹¹ Obituary, *NZNJ*, 53:3, 1960, p.18.

these women, along with Theresa Butler who had a long career in various Pacific Island hospitals, were awarded royal honours, and both were closely involved in postgraduate nursing education programmes in the 1920s and 1930s. Mary Christmas, as Christchurch Hospital's first tutor sister, was responsible for teaching all probationers there from the time of her appointment in 1923 until her retirement in 1938.

That opportunities for advancement to the top of the profession decreased as time went on is evident in the Dunedin nursing group. Only 20 (12.5%) of the 159 women who trained there in the 1910s became matrons, although six further women held posts as assistant matrons. Often these matrons presided over smaller hospitals like Stratford (Louise Bennett) and Tapanui (Agnes Denford) but Helen Brown was matron of Dunedin (1923-1924) and Letty Croft was matron at Napier (1931-1952). A further 40 women (25%) became ward sisters and Isabella Myles was New Zealand's first tutor sister, taking up her appointment at Dunedin Hospital in 1918.¹¹² Janet Moore was one of the founders of the postgraduate nursing course in 1928, having served earlier as matron of Waikato Hospital. She and Miss Croft were both awarded royal honours.

The vision which these dedicated women brought to nursing, a vision deeply embedded in the ideals propounded by the first reformers, was crucial in shaping the profession's development in New Zealand. For the Nightingales, the "true spirit of nursing" signified religious commitment, self-sacrificing service and dedicated professionalism during a life-long career. They established the New Zealand Trained Nurses' Association to further these objectives, which they rightly perceived to be those of most nurses at this time. Yet, as has been shown in the profile of the Dunedin nurses training in the 1910s, changes were being signalled even before the war broke out. Nurses were becoming younger and were more often women from lower middle-class backgrounds for whom earning a living was a necessity. They were less likely to continue in nursing after registration and were marrying sooner. After the war, the trickle of change

¹¹² ODT, 16 August 1918, published in *Journal of the Department of Public Health*, 1:15, September 1918, p.274.

rapidly became a flood, one with which the Nightingales were ill-fitted to cope. The harmony of interests which had characterised the early period of trained nursing was fractured and inevitably tensions within the profession increased, as a new generation of nurses insisted that service and humanitarianism could co-exist with requests for adequate material rewards. It was these dichotomies which occupied the minds of nursing leaders in the 1920s and beyond, as a new wave of reformers struggled to come to terms with the demands placed on a profession perceived by everyone to be first and foremost a "womanly occupation".

Chapter 7

"A readiness to endure cheerful discomfort and hardship at need": working conditions for nurses in hospitals in New Zealand

The ideologies which permitted doctors to retain control of nurse training also allowed hospital administrators to take little interest in paying adequate salaries to nurses or in giving them access to comfortable working conditions. As 'women's work', nursing was linked to both unpaid domestic labour and charitable or welfare work. Low pay, long hours and inadequate holidays, like substandard accommodation and lack of health care, were accepted as 'normal' for work which was regarded as a woman's duty, rather than as a means of earning a living.

In the years immediately before the first world war, dissatisfaction with working conditions in hospitals become a matter of public debate at a number of hospitals in New Zealand. In Dunedin, Matron Isabella Fraser resigned after she was accused of imposing an inflexible regime of great hardship on her nurses.¹ In 1909, the issue of hours of work became the subject of parliamentary debate. Most pre-war nurses, however, accepted that nursing could only become a respectable womanly occupation if it was based on ideologies of self-sacrificing service. The war added patriotism to ideas of duty and sacrifice and criticism of working conditions remained muted.

Yet within two years of the war's ending, the Department of Health admitted "That there is a serious shortage of nurses and midwives is unquestionable ...".² The *Evening star* in Dunedin acknowledged that it was an accepted fact that "eligible young women [were] not coming forward in sufficient numbers to train as nurses", and that many of those who did apply for probationer positions were unsuitable.³ Parents, it

1 M.H. Murray, "Fraser, Isabella, 1857-1932", *DNZB, volume 2, 1870-1900*, p. 155.

2 *New Zealand journal of health and hospitals*, 3:9, September 1920, p.237.

3 *ES*, 7 January 1921, OHB newspaper cuttings, v.18, p.33.

appeared, were no longer encouraging their daughters to enter nursing, perceiving it to be "too hard a life for a girl".⁴ Even members of parliament entered the debate on nursing conditions, several speakers claiming in the House that they were "the hardest worked section of the community", who deserved better remuneration and shorter working hours.⁵ Furthermore, dissatisfaction appeared to be rife among those women who did choose to nurse. In 1919, Auckland nurses addressed a wide range of grievances in a petition to the Board. They wrote in strong disapprobation of their long hours, the lack of leave, including annual and sick leave, their poor salaries, lack of adequate accommodation and staff shortages.⁶ In Christchurch, no lesser person than Nurse Maude, in an address to the Council of Churches, advised hospital boards that "if you have a good nurse, do not kill her". Nurses got very tired, she said, and were often not looked after properly by their employers. They would last much longer, she added, if they could enjoy a day off each week, as her district nurses did.⁷ Other letters to the press supported her view. Many described the tough working conditions imposed upon nurses, concluding firmly that "nurses should have more pay, but above all, more holidays".⁸

Rumblings of trouble also began at Dunedin Hospital in 1919, with complaints about staff shortages, pay and other working conditions.⁹ Little was done to address these issues, and by early in 1924 the hospital was said to be "seething with discontent from top to bottom".¹⁰ Controversy raged in the press, as letter after letter accused the hospital board of imposing on the generosity of its staff and turning the "noblest profession in the world" into little more than drudgery. After reading the correspondence, expostulated the *Otago daily times*, many will wonder not

4 Dunsford, 'The privilege to serve others', p.72. The Minister of Health admitted in the House that "relatives are of the opinion that conditions were unduly hard", NZPD, 3 September 1920, v.187, p.616.

5 Debate on supply for public health, hospitals and charitable aid, NZPD, 3 September 1920, v.187, pp.615-626.

6 Dunsford, p.65; *KT*, 13:1, January 1920, p.26.

7 *Press*, 18 May 1920, p.2b; NCHB minutes, 23 June 1920, pp.61-63.

8 Letters to editor, *Press*, 31 May, 1 June 1920; *LT*, 27 May 1920, NCHB newspaper cuttings, book 2, pp.1-3.

9 *ODT*, *ES*, 21, 22 & 30 May 1919, OHB newspaper cutting books, v.15, pp.92-96, 125-126.

10 Letter to editor, *ODT*, 22 January 1924, *ibid*, v.23, p.119.

at the shortages of nurses, but that any women at all were willing to enter the profession.¹¹ Even Miss Bicknell, who had replaced Hester Maclean as director of the Division of Nursing at the end of 1923, acknowledged that there was a problem. "I think that there is more than a slight probability that the Dunedin nurses are overworked", she minuted judiciously on a letter from the board about the issue. Despite every care, it had to be said that the percentage of sick nurses and nurses leaving the course because of ill-health was "fairly large". The Department was therefore happy to support the matron's proposals for an increase in the staff and other reforms which might address the difficulty.¹²

Miss Bicknell's acquiescence, which came at the end of a long period of revolt at the hospital, was typical of the spasmodic response of the authorities to demands for reform in nursing both before and after the war. As Dunsford found in Auckland, hospital boards tended to tackle problems only when the situation became so desperate that it was impossible to find staff at all.¹³ Parsimonious hospital boards were always reluctant to spend money and the requirement for cheap nursing services remained strong. Many were therefore wont to say, as did the chairman of the Otago Hospital Board in 1928, that they did not believe nurses were overworked at all. They had to work hard at times, he admitted, but it was only for eight hours a day!¹⁴

This dilatory approach was made possible by the extreme reluctance of nursing authorities to push for change. Complaints of long hours and lack of time off, they said, were "hopelessly incongruous when associated with a profession. If work is to be done and the sick to be nursed, then women who call themselves nurses should willingly answer the call".¹⁵

11 OHB newspaper cutting books, v.23, pp.118-125: correspondence in both newspapers, 22-24 January 1924; editorial, *ODT*, 30 January 1924, v.23, p.135.

12 Letter from Secretary, OHB to Director-General of Health, 20 November 1923, minuted by Miss Bicknell, H1 89/3/2, NA.

13 Dunsford, p. 66.

14 *KT*, October 1928, p.173.

15 *KT*, October 1927, p.216. When Auckland nurses presented their petition in 1919, Hester Maclean expressed the hope that the board would show its disapproval of nurses who ventilated their grievances outside the proper channels, *ibid*, 13:1, January 1920, p.26.

Dr Fox, medical superintendent of Christchurch Hospital, and his loyal supporter, Rose Muir, the matron, were among the many authorities who regarded all nursing work as noble and no task as too menial. These attitudes were vital to "the true spirit of nursing, if any idealism is to be retained", said Muir.¹⁶ Dr Fox poured scorn on Nurse Maude's criticism of working conditions:

It must be remembered that the practice of nursing is a service of sacrifices ... Commercialism has taken away much of the beautiful traits of nursing character. There is a tendency to lose sight of the humanity of the job.¹⁷

As far as he was concerned, the nursing staff had already "had much favour bestowed on it" and it remained to be seen whether the ideals of the profession would survive the onslaught.¹⁸

Those who fought for better conditions for nurses were very well aware of the attitudes which engendered nursing leaders' reactions to change. The magic words, "Florence Nightingale", said one commentator, were invoked against any nurse tempted to ask for her just dues. But nurses, she added, would rather forgo canonization and be treated instead as rational human beings and worked and paid accordingly.¹⁹ Another writer asserted firmly and with some justification that it was "only the true spirit of nursing" which was keeping any nurses at all in the hospitals.²⁰ Yet nursing leaders were determined to maintain the ideals which they believed reinforced the image of nursing as a respectable occupation for women, second only to motherhood. These attitudes constantly limited the success which

16 Report from Rose Muir, NCHB Hospital Committee minutes, 8 February 1926, pp.155-156.

17 Fox's report to the board, NCHB minutes, 23 June 1920, p. 63.

18 Annual report of Dr Fox for 1920-21, NCHB minutes, 27 April 1921, p.592.

19 *New Zealand journal of health and hospitals*, 3:9, September 1920, p.238. See also a letter to the editor by "Nursing Feeling", *ODT*, 21 January 1924, OHB newspaper cuttings, v.23, p.121 which talks of the stock phrase thrown at those seeking to improve conditions: "You lack the proper nursing spirit".

20 Letter to editor by "Humanity", *ODT*, 22 January 1924, OHB newspaper cuttings, v.23, p.120.

reformers were able to achieve in the improvement of nurses' working conditions.

Length of training

That hospital authorities saw pupil nurses as a most useful source of cheap labour, essential for maintaining the hospital's services at a minimum cost, was evident in the debate over the optimum length of nurse training in hospitals. Each extra year of training recommended by nursing leaders was a bonus for hospitals, because it enabled them to retain staff at minimum wages for longer. Boards were only too pleased to agree that two and then three years' training was needed to complete a nurse's education. As early as 1888, Dunedin Hospital introduced a two-year training, following a request from the nurses themselves, which was supported by the house surgeon and the hospital secretary.²¹ Auckland Hospital followed in 1892, when Dr Knight recommended that a two-year curriculum was desirable "if not actually necessary".²² By 1894, the Otago trustees were happy to accept Matron Isabella Fraser's recommendation of a three year training course²³ and the following year Matron Sibylla Maude urged Christchurch Hospital authorities to follow suit.²⁴ The three-year training period was gradually adopted by all hospitals and was finally enshrined in law with the Nurses' Registration Act in 1901, which stipulated that no nurse might sit the state examination before completing a full three years of training in a hospital.

The introduction of a four-year training period in the years immediately before the war provides an excellent illustration of hospital authorities' attitudes to their nursing staff. By about 1905, it was clear that very few nurses were prepared to remain in hospital employment once training was completed, because private nursing offered both more freedom and a considerably higher remuneration. In September 1905, therefore, Matron

21 OHB House Committee minutes, v.1, 11 September 1888; Hospital Trustees minutes, 19 September 1888.

22 *NZMJ*, 5, 1892, pp.140 & 213.

23 OHB House Committee minutes, 25 April 1894.

24 *Press*, 22 June 1895, p.4g.

Fraser at Dunedin Hospital asked the Board if increased salaries could be offered to certain suitable certificated nurses "to induce them to stay".²⁵ Christchurch Hospital faced the same problem in 1907.²⁶ Salaries for trained staff did gradually increase to an average of £65 by 1908,²⁷ but eventually boards came up with a far cheaper solution. They simply stipulated that pupil nurses must sign on for four years rather than three at the the beginning of the training period, thus guaranteeing themselves a supply of trained nurses at salaries very little more than those paid to third year pupil nurses. The North Canterbury Hospital Board first discussed this proposal in 1907, members freely acknowledging that while it was a "moot point whether four years' training would ... be in the interests of the nurses ... it would certainly be in the interests of the hospital".²⁸ Dr Valentine, the hospital inspector, refused to allow any change to the timing of the state examination, which he said must continue to be held after three years, but was happy to agree that student nurses be received only on the condition that they sign on for four years.²⁹ The Otago Hospital Board approved the four-year term in August 1908,³⁰ Wellington in 1909,³¹ Auckland in 1911,³² New Plymouth in 1912,³³ and Napier in 1914.³⁴ Christchurch introduced the system informally from 1910 (the matron decided which nurses would be invited to remain for a fourth year),³⁵ but did not formalise it until 1915 when Matron Thurston advised that "The present arrangement is such that the staff may easily become depleted of Senior Nurses". In support of her recommendation, she cited the "very dishonourable action" of one nurse who found a more lucrative post after graduating, and slipped off during her annual holiday.³⁶ The

25 OHB House Committee minutes, 27 September 1905.

26 *Press*, 25 April 1907, p.2c.

27 AJHR, 1908, H-22, p.2.

28 *Press*, 24 October 1907, p.2c.

29 OHB minutes, 16 October 1907, p.3; *Press*, 19 December 1907, p.2c.

30 OHB minutes, 19 August 1908, p.101.

31 The hospital's rules for 1909 noted that although nurses would sit the state examination at the end of three years, they would not receive their hospital certificate (necessary when applying for most positions) until four years had been completed, McDonald & Tulloch, *Wellington Hospital*, p.9.

32 Brown, *The Auckland Hospital School of Nursing*, p.59; *KT*, 6:4, October 1913, pp.147-148.

33 *KT*, 5:3, July 1912, p.57.

34 G. Conly, *A case history*, p.71.

35 NCHB minutes, 26 May 1910, p.18; *Christchurch Hospital by-laws, 1910*, no.180, p.7 & no.193, p.8.

36 NCHB minutes, 9 September 1915, p.468 and 22 September 1915, p.361.

justification for a fourth year of training was confirmed when the Hospitals Act (1909) limited nurses' working hours, thus allowing authorities to insist that the value of the three year training period was very materially altered.³⁷

Few hospitals were prepared to offer any extra training in return for this fourth year of service. Instead, it was said that the nurse greatly benefitted from the scheme by being able to enjoy the delights of working without the fag of constant studying.³⁸ Auckland and Dunedin Hospitals were among the few which offered a definite syllabus, including massage, tuberculosis nursing, dispensing, ward management and administration, bacteriology, and maternity nursing, with an examination and higher certificate at the end.³⁹ As late as 1929, the New Zealand Trained Nurses' Association was still trying to persuade hospitals that if they demanded an extra year's service, then it should meet the needs of the student as well as the institution.⁴⁰

Hours of work

Hospitals expected their pupil nurses to work for almost every single day of the years they spent in the hospital. As Marian Thorp noted in her autobiography, she arrived at Wellington Hospital from the Wairarapa in September 1908 at midday, and was on duty in a men's medical ward by 4pm, "as green a new probationer as can be imagined".⁴¹ Ida Willis added that this plunge into immediate ward work was "a real ordeal for shy, inexperienced girls", commenting, however, that the patients sensed "the near panic and bewilderment of the young probationers" and helped them with quiet hints and advice.⁴² From that first day, neither sickness,

37 In 1917, a contributor noted that it had never been stated whether the 4th year was required so that the student nurse might obtain more practical experience than was possible in working shorter hours, or whether authorities thought she owed it to the hospital to give the extra service which had been lost, *KT*, 10:3, July 1917, p.156.

38 *ibid*, 5:4, October 1912, p.95.

39 *KT*, 6:4, October 1913, pp.147-148; *ODT*, 5 October 1911, OHB newspaper cuttings, v.4, p.74 & 22 July 1914, v.8, p.67.

40 *KT*, 22:4, November 1929, p.160.

41 M. Thorp, *The long, long trail*, p.29.

42 Willis, *A nurse remembers*, p.19.

bereavement nor study could deprive the hospital of its full three years of service. Every day away from the wards for any reason at all had to be made up,⁴³ no nurse being permitted to receive her hospital certificate until the requisite number of days had been worked. Although some hospitals, like Dunedin, conceded that nurses might sit the biannual state examinations (held in June and December each year) if they were within two months of completing their training,⁴⁴ the extra time still had to be worked afterwards. Smaller hospitals, whose pupils had to travel to a larger centre to sit the state examinations, complained bitterly about this loss of staff time and expected it to be made up as well.⁴⁵

Not only was every day of training devoted to work, but every day was also a very long day. In the first years of trained nursing, 12-hour days seven days a week were the norm. Isabel Fraser remembered her work hours at Dunedin Hospital in 1888 to be from 6am until 6pm, with a half-day off on Saturday, "but, lest they should suffer from this excess of freedom, they were required to make it up by remaining on duty from 6am till 10pm on Sunday".⁴⁶ The 1890 by-laws specified a 12-hour duty, either day or night, with one afternoon off a fortnight from 2pm until 10pm.⁴⁷ New Plymouth Hospital nurses worked a 14-hour day in 1888,⁴⁸ while those at Christchurch Hospital in 1890 worked from 6.30am until 8pm with a half-day off each week, and those in Auckland worked from 7.30am until 8pm with the hours of 1pm until 5.30pm off every second day.⁴⁹ In 1900, Louise Renouf at Napier Hospital worked for 11 hours one day and 12 the next.⁵⁰ An annual holiday of two weeks a year was first granted to Christchurch nurses in 1886,⁵¹ although when the matron, Miss Boys was given leave in 1889, she had not had a holiday for 18 months.⁵² Similar

43 Christchurch Hospital's 1910 by-laws, for example, specified that sick nurses would be cared for gratuitously but "time so lost must be made up", no.195, p.8.

44 OHB House Committee minutes, 14 May 1902.

45 Report of the Hospitals conference, AJHR, H-31, 1911, p.202.

46 "Pioneer nurses", *Dunedin Hospital diamond jubilee*, p.13.

47 *Dunedin Hospital by-laws, 1890*, p.38.

48 New Plymouth School of Nursing Old Girls' Association, *Silver jubilee, 1957-1982*.

49 *Press*, 1 July 1890, p.6c.

50 Conly, p.36.

51 NCHB House Committee minutes, 30 March 1886, pp.63-64.

52 *LT*, 3 October 1889, p.3c.

holidays were granted to Dunedin nurses in 1890, but the Board declared firmly that leave could be taken only when "most conducive to the interests of the Hospital and strictly in conformity with the bylaws".⁵³ The two-week annual holiday remained in force until about 1911, when "a cry from Bluff to Auckland of overworked nurses"⁵⁴ caused a number of boards to extend annual leave for trained staff to four weeks, with nurses in training receiving three weeks.⁵⁵ Even then, the medical superintendent of Auckland Hospital pointed out that this "privilege" would necessitate employing three extra nurses, and that while he was not opposed to the extra week, it should be remembered that nurses worked only eight hours each day, and therefore had sixteen off!⁵⁶ Smaller hospitals like New Plymouth continued to give nurses only two weeks off each year.⁵⁷

During the 1890s, both the government and the public became interested in the working hours of women, and legislation was introduced to control women's work in factories and in the clothing industry. Excessive work was regarded as detrimental to women's childbearing and mothering roles. This movement also impacted on nursing. It was suggested by various people that the eight-hour day, which prevailed in a number of other occupations, should also be applied to nursing. Wellington Hospital was probably the first to organise its nursing staff into three shifts of eight hours each (6am-2pm, 2pm-10pm and 10pm-6am), this reform being reported by MacGregor in his 1895 annual report on the hospital.⁵⁸ Several other hospitals also adopted the system, among them Waikato, Wanganui and New Plymouth. Yet many authorities, including MacGregor himself, were very wary about the costs incurred by the eight-hour system. In reporting on Wellington Hospital, MacGregor commented that the reform was "likely

53 OHB Hospital Committee minutes, v.3, 25 January 1893.

54 *ODT*, 7 December 1910, OHB newspaper cuttings, v.2, p.119.

55 The Otago Board brought in these holidays in 1911 as a result of Miss Maclean's inquiry into working conditions at the hospital, an issue which engendered a great deal of media attention and resulted in the resignation of the matron, Miss Fraser, *ES*, 5 September 1911, OHB newspaper cuttings, v.4, p.43. At Christchurch Hospital, these holidays were not introduced until 1913, NCHB Hospital Committee minutes, 13 February 1913, p.246 and NCHB minutes, 26 February 1913, p.71.

56 *ODT*, 2 September 1913, OHB newspaper cuttings, v.6, p.87.

57 New Plymouth School of Nursing Old Girls' Association, *Silver jubilee* notes that in 1917 nurses had 14 days' holiday, sisters 21 days and the matron one month.

58 *AJHR*, 1895, H-22, p.28.

to prove beneficial to the health and efficiency of the junior nurses",⁵⁹ and he continued to believe that in this busy hospital it was, "if anywhere ... justified",⁶⁰ but he added gloomily, "If the cost of providing accommodation for the nurses as at the Wellington Hospital ... be emulated elsewhere our expenditure will go up by leaps and bounds".⁶¹

MacGregor greatly deprecated the introduction of eight-hour shifts at smaller institutions like Waikato, New Plymouth, Wanganui and Gisborne, noting that in other small hospitals, like Thames, the nurses worked 12-hour days and were "content".⁶² With reference to Wanganui, he reported that the system had been introduced "without any apparent necessity".

Unless the public mind resolves that all labour whether continuous or not, shall be limited to an eight-hours day, I think the nurses in hospitals of this size should work as formerly ... the expense is too great ... I am a thorough believer in limiting the hours of heavy labour to the utmost but I fear that, to make the experiment with our hospitals of this class, will ultimately prove a hindrance to a most beneficial movement. The cost will be found too burdensome and I am apprehensive that the whole system of female nursing will collapse under its own weight.⁶³

The same year he expressed similar concerns about Auckland Hospital. The eight-hour system would necessitate increasing the nursing staff by at least a third and the benefits accruing from having trained women nurses would be lost.⁶⁴

MacGregor was correct in thinking that many hospital boards would look askance at the costs of employing extra staff. At Auckland, for example, although the system was introduced in 1890s, its application was erratic. A trial in the fever wards in 1899 was abandoned because of the extra staff

59 AJHR, 1895, H-22, p.28.

60 AJHR, 1899, H-22, p.31.

61 AJHR, H-22, 1905, p.34.

62 AJHR, H-22, 1906, p.30.

63 AJHR, H-22, 1897, p.28. See also his comments on New Plymouth, AJHR, 1898, H-22, p.24, Waikato, AJHR, 1894, H-22, p.24 & 1898, p.32 and Gisborne, AJHR, H-31, 1911, p.96.

64 AJHR, 1897, H-22, p.4 & 1898, p.9.

numbers required, and elsewhere the system was regularly suspended when the hospital was full, or when there were staff shortages. In 1902, the matron reported that nurses were working up to 12 hours a day because of staff sickness and an increased number of patients.⁶⁵ Christchurch Hospital's board discussed the eight-hour system as early as 1895, members expressing their desire to introduce it, as long as it was not too expensive,⁶⁶ but the change did not actually come until 1909.⁶⁷ Dunedin Hospital's matron first recommended the eight-hour system in 1904 and the matter was discussed in 1906 and 1907 but was not finally introduced until 1908.⁶⁸

The eight-hour day

The eight-hour day was officially introduced into hospitals in 1909 only because public concern about the exploitation of nurses had become sufficiently vociferous that the government finally felt obliged to legislate. Nursing work might be a woman's duty but as trade unionist J. Paul declared, it was still work. No matter how devoted and self-sacrificing she was or how much her heart was dedicated to service, surely no nurse wanted to work more than 56 hours a week. No woman's constitution could be improved by working 12-16 hours a day.⁶⁹ Others agreed. It was the responsibility of parliament, said members, to "look after ... women", to "protect tender womanhood from enslavement". If it was necessary to prevent strain among shopgirls and factory workers by restricting their hours to eight a day, it was even more necessary that nurses be similarly protected.⁷⁰ Accordingly, when the Hospitals and Charitable Institutions Bill was introduced into the House in 1909, it contained a clause limiting

65 Rauch, *The history of Auckland Hospital*, p.82. Dunsford, pp.30-31.

66 *Press*, 5 September 1895, p.3.

67 Lambie, p.5.

68 OHB Hospital Committee minutes, 30 March 1904; OHB minutes, 19 September 1906, v.3, p.522 and 21 December 1906, v.3, p.533; special meeting, September 1907; approved, 6 February 1908, p.25. See also OHB newspaper cuttings, v.1, p.4 for report on the introduction of the system.

69 NZPD, 148, 1 December 1909, pp.516-518 (debate in Legislative Council on Hospital and Charitable Institutions Bill).

70 Debate on the Hospitals and Charitable Institutions Bill, NZPD, 148, 1 December 1909, pp.510-512: Mr Jones and Mr Beehan, Legislative Council.

nurses' hours to a maximum of 56 per week (that is, eight hours on each of the seven days of the week).

Paul believed that nurses would welcome the restriction on their hours, and pupil nurses probably did so. But nursing leaders were outraged. As Dunsford has suggested, the question of the legal enforcement of the eight-hour day revealed more than any other issue the conflict between the goals of nursing leadership - which focused on ideals of unselfish service and dedicated professionalism - and rank-and-file nurses, who, more mundanely, sought to work in conditions which were similar to those accorded other women workers.⁷¹ The debate illustrates clearly the determination of nursing leaders to maintain the ideologies of "good womanhood" which they saw as essential for achieving respectability and acceptance for the nursing profession.

Nursing leaders were determined that nurses should not be identified with other women workers, "tradespeople, labourers or clerks", but as "members of an honourable profession; sisters and co-workers with the members of the profession which, for humanitarianism and ungrudging self-sacrifice, ranks highest in the world". This exalted state, the pinnacle of nursing and womanly respectability, could only be attained by sacrificing ease and comfort and allowing no "bar or limit to be placed on our right to do so". Reasonable rest and recreation were necessary for nurses but "must not be arrived at by the sacrifice of the higher ideals of nursing". No nurse worthy of the name would dream of abandoning a seriously ill patient who depended on her for every care and attention, just because her shift was ended.⁷² Maclean and others particularly deprecated any attempt to introduce "trade union" practices into nursing. This concept, it was said,

excite[s] indignation among those who feel that the uncalled-for pity ... is both degrading and lowering to the profession to which no one need expect to belong without some effort ... [Nursing is an occupation] which calls for more than professional skill. It demands firmness of character,

71 Dunsford, pp.47-53.

72 Editorial by Hester Maclean, *KT*, 2:1, January 1909, pp.1-3.

readiness to endure cheerfully discomfort and hardship at need; willing subordination to authority, and other qualities that are not learned at any easy school ... We are not sure that the first-class nurse can be made by 'advanced' trade union methods.⁷³

Miss Thurston, matron of Christchurch Hospital was even more blunt. "As soon as you provide trade union hours, the profession ceases to be a profession, and becomes a mere trade which can be commenced and left off at any stage", she said.⁷⁴

Nurse leaders campaigned tirelessly against the provisions of the bill through local trained nurses' associations⁷⁵ and then the New Zealand Trained Nurses' Association which came into being in 1909, largely as a result of the perceived need to prevent this "serious danger" to nursing work.⁷⁶ Several members of parliament spoke on nurses' behalf during the debate on the offending clause, including Dr Collins, who declared that

Nursing is a profession just like the doctor's profession. You cannot expect a doctor to work only eight hours in twenty four ... They want to [work] and they like to do it and would feel that it was against their human nature not to do their work.⁷⁷

The "noble instinct that is in a woman's heart in the presence of suffering", added Mr Luke, "and feeling the responsibility of the care of those that are committed to them, will no more be stifled ... by Acts of Parliament than you would be able to chain the sun ...".⁷⁸

Eventually a compromise was reached, the clause being modified so that its provisions only applied to nurses in training in hospitals with over 100

73 Editorial, *KT*, 5:4, October 1912, p.140.

74 *Press*, 2 December 1909, p.8f.

75 All four local associations sent messages to parliament objecting to the bill. See M. Murray, *Always on duty*, p. 9; Canterbury Trained Nurses' Association minute book, 26 April 1909; notes on campaigns of the four associations and the NZTNA, *KT*, 3:1, January 1910, pp.16-22.

76 *KT*, 3:4, October 1910, p.16; Maclean, p. 69.

77 NZPD, 148, 1 December 1909, p.513.

78 *ibid*, p.504.

beds.⁷⁹ As Maclean reported with satisfaction, the work of the hospitals remained largely unaffected. Nurses in training would be given more time for study, and although a valuable part of training was lost (the testing of patience and endurance over a long working period), "the profession and status of trained nurses is not in any way encroached upon".⁸⁰

Nurse leaders continued to argue strongly against the eight-hour day, suggesting that it benefitted neither hospital, patient, nor nurse. It was expensive for hospitals in that more staff were required, irritating for the patient who had to endure three changes of nurse instead of two, and detrimental to nurse training in that the nurse's sense of responsibility was diminished. She tended to come on duty already tired after having frittered away her free time in pleasure, the total hours of training were reduced, work was far more rushed during a short duty, and the opportunity to acquire mental and physical endurance, as well as to suppress self-consideration, was lost.⁸¹ When the issue was debated at the 1911 Hospitals conference, a paper was presented which advanced "a very few arguments on the side of the eight-hours system" and did not compare "in weight or importance with those advanced against this system".⁸² As far as nurses were concerned, said Dr Hardwick Smith of Wellington Hospital,

a nurse's work in training is a serious vocation, and if she wishes to do it thoroughly she cannot keep up her social duties outside her nursing hours. Her life and relaxations should be quiet and orderly.⁸³

The whole tone of the profession was lowered when nursing was regarded as a charity instead of in its proper light.⁸⁴ Nurse leaders claimed that the eight-hour day encouraged nurses into "excesses of gaiety".⁸⁵ One retired

79 *ibid*, 2 December 1909, p.546.

80 *KT*, 3:1, January 1910, p. 16.

81 *KT*, 5:1, January 1912, p.5 (discussion at Central Council of NZTNA); 5:2, April 1912, p.32 (responses to departmental circular on issue); *AJHR*, H-31, 1912, p.8.

82 Report of the conference, *AJHR*, H-31, 1911, pp.197-198.

83 Reported in *ODT*, 27 January 1912, *OHB* newspaper cuttings, v.3, p.174.

84 *KT*, 5:1, January 1912, p.31.

85 See for example, *KT*, 11:4, October 1918, pp.202-203. Maclean hoped that if nurses were given a day off each week, they would defer outings until that day, and not rush back on duty each day, already fatigued, editorial, *KT*, 14:3, July 1920, p.110.

nurse in 1930 declared that present-day nurses worked to earn a living for eight hours, slept for six and indulged in selfish pleasure for the other ten. "Why, in some schools", she exclaimed in horrified tones, "you are encouraged to go out!"⁸⁶ At Invercargill Hospital, the mother of a probationer, herself a former nurse, informed the matron that her daughter's ill-health was entirely due to too much play. Afternoon duty nurses spent their mornings shopping, socialising and even lunching out, so that they came on duty already tired and unfit for work.⁸⁷

By the 1920s, the eight-hour duty was supposedly firmly in place, even smaller hospitals like Thames having introduced it after a new nurses' home was finally built and extra staff engaged.⁸⁸ Yet, as Maclean wrote in her autobiography at the end of her life, the eight-hour system was "never ... very rigidly adhered to".⁸⁹ Barbara Washbourne, who trained at Christchurch Hospital from 1909, remembered that nurses still worked 12 or 13 hours a day at times of epidemics.⁹⁰ Even a normal eight-hour day was seldom such; "any nurse who trained during these years remembers that the duty which was supposed to commence at 6am really started at 5am and things had to go really well for them to get off at ... 3pm".⁹¹ As Ann Watt of Invercargill Hospital pointed out, "You had to finish what you were doing. You didn't just walk off".⁹² Greta Fraser remembered that extra duties were added to the eight-hour shift - 2-4pm, 4-6pm, 6-8pm or 8-10pm - which "you were expected to work ... you didn't get any extra money".⁹³ Emily Hodges who began training at Christchurch in 1907 commented on one particularly tough duty - coming off three month's night duty at 6am and going on duty again at 2pm the same day.⁹⁴ Conversely, Mary Lambie, who trained from 1910, remembered the "cherished privilege" introduced by Matron Thurston which gave the semblance of a

86 *KT*, 23:4, July 1930, p.180.

87 Lind, *Step by step*, p.33.

88 *Thames star*, 7 February 1919, published in *Journal of the Department of Public Health*, 2:3, March 1919, p.74.

89 Maclean, pp.45, 69.

90 *Reminiscences*, CH 293/87b, NA (Christchurch).

91 Murray, p. 23; Pengelly, p.13 also mentions the 5am starts.

92 Lind, p.28.

93 *ibid*, p.29.

94 *Reminiscences*, NERF oral history tapes, no.12, ATL.

"day off". A roster was begun whereby staff worked mornings one week and afternoons the next, so that a nurse might finish at 2pm on Saturday and not start duty again until 2pm on Sunday. An all-night pass could be obtained once a fortnight and any curtailment of this marvellous improvement "was the greatest punishment we could be given".⁹⁵

Weekly holidays

In the 1920s a campaign was mounted for nurses to be granted a genuine day off each week, as well as three weeks' annual leave. It was a campaign instigated by the government and it was supported by the Department of Health and by Hester Maclean, who advocated such a reform as early as 1918.⁹⁶ Accordingly, it was reasonably successful, Mary Lambie reporting in 1932 that every hospital in the country gave 21 days' annual leave to its nurses, although only ten gave a day off each week. A further 14 hospitals gave two days off each month, three gave three days a month, and five one day per month. The remaining two hospitals gave one day off each fortnight.⁹⁷ Success was thus by no means complete.

Nor was it instantly achieved. Dr Valintine informed hospital boards on 27 January 1921 that the Minister of Health wished both a weekly holiday and longer annual leave to be introduced as soon as possible.⁹⁸ Board procrastination on a variety of grounds, however, assisted by the failure of many matrons and medical superintendents to respond positively to the proposal meant that many years passed before even a majority of nurses enjoyed any break at all from their daily duty. In 1929, the Minister was again obliged to inform boards that he was "not going to be a party to working any man or woman seven days a week", and to further insist on the introduction of the weekly holiday.⁹⁹ Nevertheless, as late as 1931, one medical superintendent could still declare that "nurses do not need a

95 Lambie, pp.6-7.

96 *KT*, 11:4, October 1918, p. 202.

97 Memorandum, 23 November 1932, H1 111/35, NA.

98 Circular letter, 27 January 1921, NCHB minutes, 23 February 1921, p.420.

99 *ODT*, 16 May 1929, OHB newspaper cuttings, v.38, p.193.

day off ... [They] are well looked after and are allowed to go off duty if they are even slightly unwell ... they do not work as hard as they did a few years ago.¹⁰⁰

In the months following the Minister's instruction on the weekly holiday in 1921, Valentine reported on the response of hospital boards round the country. Almost all, he said, supported the proposal in theory but raised a number of difficulties in the way of implementing it. The cost of employing additional staff was considerable, they said - Wellington suggested a figure of at least L3250 a year - and the cost of accommodating them was even more so. Almost all the boards claimed that extensions to the nurses' home would be necessary and that time would be needed to undertake this work.¹⁰¹ At the same time, a number of nursing authorities raised objections. Nora Kinsford remembered that senior nurses who had trained before the war thought weekly holidays meant nurses were "being very well looked after, pampered ...".¹⁰² Miss Stott of Wellington Hospital suggested to Hester Maclean that training time would be too much reduced and too much necessary practical experience and knowledge lost.¹⁰³ Wellington Hospital was, however, the first of the large institutions to offer any respite from the seven-days-a-week regime, 48 hours off a month being granted to staff from 3 January 1921.¹⁰⁴ After a time, Challis Hooper and her friends requested that nurses might be told in advance (rather than on the day itself) which days off they were to get so that they might plan excursions or visits home. The matron was unenthusiastic but the medical superintendent supported the move, so the nurses involved did not lose their jobs as they feared, and notices were posted each week.¹⁰⁵

100 Report of a meeting of the Wanganui Hospital Board, *Taihape times*, 19 June 1931, H1 54/11/19, NA.

101 *Journal of health and hospitals*, 4:3, March 1921, pp.70-73; 4:4, pp.98-100; 4:7, p.197; 4:8, p.227; 4:9, p.264.

102 Reminiscences, quoted in Dunsford, p.63.

103 Miss Stott to Maclean, 16 August 1919, H1 21/23/19, NA.

104 *Journal of the Department of Public Health*, 4:1, January 1921, pp. 16-17.

105 *Wellington Hospital nurses' journal, 1980: 75th jubilee*, Wellington: NZNA Wellington Branch, 1980, p.41.

Auckland Hospital announced the introduction of a weekly holiday in mid-1921 and found that its waiting list for probationer positions lengthened immediately.¹⁰⁶ Miss Campbell of New Plymouth Hospital on the other hand, while she accepted a proposal for one month's annual leave for all nurses and one day off a month for sisters, firmly declined her board's offer of a day off a fortnight for nurses in training. "It was mooted while I was away", she told Hester Maclean, "but Dr Home and I did not approve - it would have meant increasing our Staff - extra expense etc."¹⁰⁷

The case of Christchurch Hospital throws light on the debates and ideologies which shaped the introduction of the weekly holiday for nurses. The Board's immediate response to the Minister's request was to declare that at present not enough accommodation was available to house the extra staff required.¹⁰⁸ A proposal to extend annual leave instead was deferred.¹⁰⁹ It was not until March 1923 that the board resolved to give nurses one day off a fortnight (even although the new nurses' home was still unbuilt).¹¹⁰ Miss Muir, in advising nurses of the holiday, made her opinions clear. Nurses must understand, she said, that the privilege might at any time be forfeited in cases of sickness or emergency, that the welfare of the patient "must at all times be the first and chief consideration of all members of the Nursing Staff", and that no concession whatsoever would be made for lectures which must be attended on days off if necessary. Neither staff nurses nor sisters would be granted the "privilege".¹¹¹ Privately, Miss Muir complained to Hester Maclean about the amount of training time being lost.¹¹² Within a few months, the fortnightly holiday had disappeared, as an influenza epidemic and a backlog of annual leave reduced staff numbers to a minimum. Nurses petitioned the board about this in January 1924, and the matron was

106 *KT*, 14:2, April 1921, p.97.

107 Memorandum to Maclean, 9 July 1923, H21/23/12, NA. Nurses at New Plymouth Hospital were not granted a weekly holiday until December 1934, Scanlan, *Hospital on the hill*, p.80.

108 NCHB minutes, 14 February 1921, p.132.

109 NCHB Hospital Committee minutes, 18 July 1921, p.205; 15 August 1921, p.221.

110 NCHB minutes, 28 March 1923, p.845.

111 Notice, 18 March 1923, CH 426/26a, NA (Christchurch).

112 Letter from Maclean to Muir, 23 July 1923, CH 426/26a, NA (Christchurch).

informed of the board's desire to adhere strictly to the leave provisions.¹¹³ The weekly holiday was finally formally introduced on 21 March 1927, the Hospital Committee resolving to express its thanks to the matron and medical superintendent "for the expedition in which the 'weekly holiday' for Nurses has been brought about!"¹¹⁴ Sisters were granted a weekly holiday from January 1929.¹¹⁵ Even then nurses got the holiday only irregularly - "If your luck was in, you got one", recalled Margaret Petre, who trained from 1927 until 1930.¹¹⁶ Sometimes nurses went for as long as six weeks without a break. Neither Dr Fox nor Miss Muir had any problems with that. Indeed, Dr Fox still questioned the justice of nursing reforms. For him, it was

a questionable point when in trying to improve the staff's position we have not overshot the mark ... When idealism, self-sacrifice, loyalty and discipline are scoffed at and lowered and abolished the sick are bound to suffer.¹¹⁷

The nursing profession, added Miss Muir, "could not rank as an industrial concern",¹¹⁸ although she did acknowledge in 1929 to Miss Bicknell that the privilege of weekly holidays was now running continuously "with little or no upset and I think the result after all is beneficial".¹¹⁹ Her nurses would have agreed; Margaret Wootton recalled that it was "a real life-saver, and I am not the only one who thought so",¹²⁰ while Dorothy Ford declared the two full days off allowed off after a six-week stint in the Isolation Ward was "the nearest thing to heaven".¹²¹

113 NCHB minutes 17 January 1924, pp.14-16; *LT*, 17 January 1924, NCHB newspaper cuttings, p.83.

114 NCHB Hospital Committee minutes, 11 April 1927, p.94; Miss Muir's annual report, NCHB minutes, 13 April 1927, p.377.

115 Miss Muir's annual report, NCHB minutes, 24 April 1929, p.382.

116 Reminiscences, Christchurch Hospital records, 1962 nurses' reunion, historical questionnaire, CH 293/87a, NA (Christchurch). Many other nurses in this questionnaire made similar comments eg Marjorie Barnett, Letitia Heslop, Claire Mulcock, Anne Clark, Amy Kensington, Margaret Fisher, Beatrice Butcher.

117 Letter from Dr Fox to Board, NCHB minutes, 24 October 1928, p.195.

118 NCHB minutes, 22 June 1927, p.202.

119 Miss Muir to Miss Bicknell, 22 May 1929, Christchurch Hospital records, CH 426/26a, NA (Christchurch). Miss Bicknell reported in 1931 that all the matrons of hospitals which offered a weekly holiday found that nurses' health was much improved and that there was less discontent, Miss Bicknell to the Director-General of Health, 26 June 1931, H1 54/11/19, NA.

120 Reminiscences, Christchurch Hospital records, 1962 nurses' reunion, historical questionnaire, CH 293/87a, NA (Christchurch).

121 Ford, *Journey from Stranger's Rest*, p.119.

Smaller hospitals were less likely to give a weekly holiday. Mary Clark, who trained at Taumaraunui Hospital in the 1930s knew that theoretically they were supposed to work an eight-hour day with one day off each week, but added,

In practice, we were a small hospital with a small staff and sometimes we worked for two or three weeks or more, and then got our days off all together. I remember once being on night duty for eight weeks before I had any time off.¹²²

In 1929, the North Canterbury Hospital Board ordered Miss Muir and Dr Fox to investigate ways of granting its country hospital staff a weekly holiday, but agreed that it could only be done "where practicable".¹²³ Approval to build extra accommodation for Sanitorium staff was only given at the end of 1929 and holidays were introduced some time after that.¹²⁴ As Miss Muir informed one nurse, neither the eight-hour day nor the weekly holiday applied in private hospitals or nursing homes, where it was the "privilege" of trained staff to work cheerfully and well, caring for patients for as long as the matron chose, in order to add to the happiness of the community.¹²⁵

In 1929, the government was embarrassed to learn that midwives and pupil midwives working in the state-run St Helens hospitals did not work an eight-hour day, nor did they receive a weekly holiday. The Minister ordered an immediate enquiry and the implementation of both policies. By 1931, the Department of Health had to admit that only Wellington and Auckland had introduced the reforms which, matrons complained, meant patients could not be properly cared for nor satisfactory staff training carried out. Eventually, the Minister agreed to a nine-hour working day, provided the weekly holiday was permitted.¹²⁶

¹²² M Clark, "Nursing - as it was in my day", *Auckland-Waikato historical journal*, 62, April 1993, p.27.

¹²³ NCHB minutes, 25 September 1929, p.307; Hospital Committee minutes, 16 September 1929, p.280.

¹²⁴ NCHB minutes, 18 December 1929, p.60.

¹²⁵ NCHB minutes, 30 July 1928, p.65.

¹²⁶ Correspondence between the Minister, the Department of Health and St Helens hospitals, 1929-1931, H1 111/35, NA.

Salaries

Employing student nurses to provide most of the care given to patients saved hospitals a great deal of money. Unsurprisingly, hospital authorities were only too happy to take full advantage of the premise on which nursing training was based - that nurses paid for their education with the work they did for patients in the wards. Auckland Hospital's 1893 regulations spelled out the matter clearly: "Probationer Nurses will be required to give their services in return for the training received".¹²⁷ Nursing leaders agreed with this interpretation of the contract between pupil nurse and hospital. As Hester Maclean put it in 1920, when she declined to recommend a salary increase for pupil nurses, these young women were being offered, in return for nursing the sick, a comfortable home and sufficient money for dress and recreation as well as free tuition. All other professions and even some trades required fees or premiums to be paid, together with maintenance expenses while training.¹²⁸ Nevertheless, both student nurses and trained nurses did petition boards for increased salaries from time to time.¹²⁹ These requests were viewed unsympathetically by nursing leaders, for they threatened the very ideologies on which trained nursing was premised. Miss Thurston of Christchurch Hospital was extremely displeased in 1912 when her board recommended that nurses be paid for their work during the three month trial period, when previously they had worked for nothing during this time.

I cannot help feeling that the offer of salary (when they are practically useless to the Hospital) brings the profession too much to a commercial venture ... There is not the slightest doubt but that we shall turn out better women if at the beginning they sacrifice something for the sake of their work.¹³⁰

¹²⁷ Brown, appendix 4.

¹²⁸ *Journal of the Department of Public Health*, 3:1, January 1920, p.19.

¹²⁹ See for example, CHB minute book, 28 February 1906, p.43 (request from nursing staff); 28 August 1907, p.107 (request from ward sisters). OHB House Committee minute book, 28 October 1903 (request from staff nurses). Dunsford also refers to such requests at Auckland Hospital, p.37.

¹³⁰ Miss Thurston's report to the Hospital Committee on the proposed payment, NCHB Hospital Committee minutes, 26 September 1912, p.178. Pay for the probationary period was approved in October, NCHB minutes, 23 October 1912, p. 293.

These ideologies shaped the levels of wages paid to nurses in training. It was accepted that they were paid an "allowance" rather than a salary, which was in addition to their board in the nurses' home. The first probationer nurses were paid £12 a year at both Christchurch and Dunedin Hospitals.¹³¹ Sophia Mandeno, who began training at Dunedin in 1902, remembered the excitement of the monthly pay packet - "one gold sovereign from the secretary's office - 5/- weekly".¹³² In the second year, the pay increased to £15, while £25 was paid in the third year.¹³³ Many women were supported by their parents, who gave them additional money. There was no uniformity among hospitals, boards paying whatever sums they found necessary in order to recruit staff. Napier Hospital paid its probationers £18 in their first year in 1904, and £27-10/- in the second year.¹³⁴ In 1906, Dunedin Hospital paid probationers £12, £15 and £35, Wellington £18, £25 and £35, Auckland £10, £20 and £25 and Christchurch £12, £25 and £35.¹³⁵ Although some attempts were made to establish a uniform salary scale, with regular consultations taking place between hospitals,¹³⁶ boards jealously guarded their right to maintain salaries at the lowest possible rates commensurate with their own circumstances.¹³⁷ At the 1911 Hospitals conference, members agreed that "there could never be a uniform system ...". As Dr Valentine said, "At Arrowtown and other country places they had to pay higher salaries in order to get nurses at all."¹³⁸ Nevertheless, the Department of Hospitals,

131 OHB House Committee minutes, v.2, 13 April 1892; letter from Matron Fraser of Dunedin to Matron Maude of Christchurch, 1894, *Dunedin Hospitals bulletin*, 3:1, 1978, p.15.

132 S. Mandeno, "Early days in Dunedin Hospital", printed in Murray, [n.p.]. At a later period, Isabella McLean recalled the thrill of her first £5 note, her monthly pay as a staff nurse at Christchurch Hospital in 1915, *Reminiscences*, CH 293/87b, NA (Christchurch).

133 Miss Fraser to Miss Maude, *Dunedin Hospital bulletin*, 3:1, 1978, p.15.

134 Conly, p.60.

135 *Press*, 29 March 1906, p.4d.

136 See for example, Christchurch's decision to consult others before setting its salary scale, *Press*, 1 March 1906, p.3d. The Otago board recorded requests for information on salary scales from Wanganui Hospital, OHB Trustees minutes, 18 February 1903, p.331, from Invercargill, 16 September 1903, p.360 and from Christchurch, Wellington and Auckland, House Committee minutes, 29 November 1905. The Otago Hospital Board, among others, expressed an interest in uniformity in 1911, *ODT*, 20 October 1911, OHB newspaper cuttings, v.4, p.96.

137 Dunsford, pp.61-62. Auckland Hospital, for example, agreed in 1912, that a uniform scale was desirable, provided "that no reductions should be made in Auckland", *ES*, 14 June 1912, OHB newspaper cuttings, v.4, p.68.

138 *AJHR*, H-31, 1911, p.205.

in response to pressure from some boards, did draw up guidelines on what they regarded as fair recompense for nurses in 1914. They warned however, that salaries should not be too generous: "hospitals are largely charitable institutions and not in any way self-supporting or worked at a profit ...". These guidelines suggested £12-36 for pupil nurses, £50-70 for staff nurses, £75-140 for sisters and £140-300 for matrons.¹³⁹

Low levels of pay were identified by many commentators as a primary reason for staff shortages in the 1920s. One Dunedin doctor declared that nursing simply offered "inadequate reward for responsible service".¹⁴⁰ The pay was not enough to meet the needs of respectable women, said another. "Is it justice to require those self-sacrificing women to be out of pocket, in order that they might serve the community?"¹⁴¹ Experienced nurses who had served in the New Zealand Army Nursing Service had been well paid and they were not prepared to return to hospital work at the current levels.¹⁴² The new generation of pupil nurses no longer came from well-to-do families, said Dunedin's *Evening star*. "Most nurses are largely dependent on their earnings, and what before was a happy sacrifice had now become a painful duty".¹⁴³

Staff shortages forced hospital boards to make changes. It was acknowledged that the war had greatly increased the cost of living and that pay in other occupations had risen considerably. Accordingly, most hospitals raised salary levels for both trained and untrained staff to the extent that by 1920 the Wellington Hospital Board could announce that salaries had risen by 100% since 1914.¹⁴⁴ The same year, it was finally

¹³⁹ *KT*, 7:3, July 1914, pp.139-140.

¹⁴⁰ *ES*, 7 January 1921, OHB newspaper cuttings, v.18, p.33.

¹⁴¹ *ODT*, 19 May 1919, OHB newspaper cuttings, v.15, p.88.

¹⁴² Miss Myles, matron of Dunedin Hospital, *ES*, 21 May 1919, OHB newspaper cuttings, v.15, p.94. NZANS sisters were paid 10/- a day in 1918, with a travelling allowance of 12/6 a day. Matrons and charge sisters received more (*KT*, 12:1, January 1919, p.30). Jan Rodgers, 'A paradox of power and marginality', p.237 quotes salaries of £215-19-2 p.a. for sisters and £156-12-11 for staff nurses. Travelling allowances were additional to these salaries.

¹⁴³ *ES*, 14 February 1924.

¹⁴⁴ *Dominion*, 26 March 1920, *Journal of the Department of Public Health*, 3:4, April 1920, pp.141-142. Other hospital increases are reported in 3:2, February 1920, p.59 and 3:7, July 1920 (Hawera Hospital); 2:8, August 1919, p.248 (Wairau Hospital); NCHB minutes, 26 April 1918 (Christchurch Hospital); *ODT*, 19 April 1918, OHB newspaper cuttings, v.12, p.126.

agreed that uniform salaries should be offered by the four metropolitan hospitals, thereby eliminating competition for staff among them. The salaries were set at £30 for first year pupils, rising by £10 each year in the second and third years. Fourth year pupils were to be paid £75, sisters £110-£175, assistant matrons £175-£200 and matrons, £250-£350 (the precise rate depending on length of service).¹⁴⁵ A number of smaller hospitals also chose to accept these guidelines.¹⁴⁶ Although some increases occurred later in the decade, hospital salaries remained at approximately these levels until the mid-1930s.¹⁴⁷

Nursing leaders in the 1920s drew a clear distinction between pupil nurses and trained nurses in their policies on salaries. They were extremely reluctant to see pupil nurses receive anything other than basic pocket money, for fear of attracting the "wrong class of girls". The *Otago daily times* reported in 1919 that moves to increase nurses' salaries were hampered by the serious objections of the Trained Nurses' Association which felt "it is distinctly undesirable that anyone should be attracted from purely mercenary motives into such an unselfish profession as nursing".¹⁴⁸ Hester Maclean believed sympathy for the small salary received by pupil nurses was entirely misplaced. They received in return for their hospital services tuition which in other professions had to be paid for.¹⁴⁹ Pupil nurses received board and lodging, part of their uniform, and free medical and dental services, as well as money for clothes and shoes. "If a nurse is sufficiently interested in her work", said one senior nurse, "this sacrifice will not be difficult to make".¹⁵⁰ Yet as one nursing sister pointed out, although most nurses took up nursing for the love of it, for many women in the 1920s it was also their sole means of livelihood, and probationers without private means found it impossible to keep out of

145 *Journal of the Department of Public Health*, 3:7, July 1920, p.199.

146 See for example, Patea Hospital, *ibid*, 3:10, October 1920, p.264, and Timaru Hospital, 4:7, July 1921, p.197.

147 Salaries at all hospitals were cut by at least 10% during the Depression but restored to former levels about 1933. Major improvements for probationers occurred in the mid-1930s, Dunsford, p.160.

148 *ODT*, 21 May 1919, OHB newspaper cuttings, v.15, p.92; *KT*, 12:3, July 1919, p.135.

149 *KT*, 12:2, April 1919, pp.86-87; *AJHR*, 1919, H-31, p.10.

150 Miss Stott of Wellington Hospital, *Evening post*, 2 July 1927; letter to editor from M.V., *ODT*, 22 January 1924, OHB newspaper cuttings, v.23, pp.118-119.

debt.¹⁵¹ Many prospective trainees simply could not afford to enter nursing.

Superannuation

Nursing leaders believed that trained nurses deserved to be paid as professional women. They fully supported the just rewarding of qualified women for skills and experience, while still taking into account that hospitals were not money-making but charitable institutions where economy must rule the day.¹⁵² Nurses on completion of their training, said Hester Maclean, should be, like medical students, free agents to shape their own course for success. They should not have to remain in a state of servitude all their working lives.¹⁵³ If they were able to charge higher fees for specialist knowledge and skill, then so much the better.¹⁵⁴ These attitudes were reflected in the long campaign for nurses' superannuation, which finally achieved success in 1925 with the National Provident Fund Amendment Act.¹⁵⁵ As Dunsford has stated, from the time of its inception in 1909, the New Zealand Trained Nurses' Association pursued superannuation more vigorously than any other aspect of work conditions. The energy and resolve devoted to this issue was, she argues, part of the Association's campaign for professionalism. Superannuation would guarantee nurses independence in retirement and enable them to conduct their professional lives in the same way as other professionals.¹⁵⁶

For nursing leaders who trained before the war, this goal was both necessary and realistic. The majority of these women did work throughout their lives for minimal salaries and were indeed seriously disadvantaged in old age. As Hester Maclean noted

151 *ODT*, 21 May 1919, OHB newspaper cuttings, v.15, p.93.

152 Dunsford, pp.67-68; *KT*, 14:2, April 1921, p.60.

153 Editorial, *KT*, 13:1, January 1920, p.5.

154 Hester Maclean, *KT*, 11:3, July 1918, p.140. Many nurses did not agree with this policy and in fact, private nursing fees were set nationally, initially at L3-3/- a week, and after the war at L4-4/- per week. Nurses who tried to charge more than these fees were treated very severely.

155 New Zealand statutes, 1925, no.14, pp.32-36.

156 Dunsford, pp.75, 83-84.

The profession was a hard one; she wished it might be possible for all nurses to retire from it and enjoy some years of leisure and the comforts of private life before they grew too old to enjoy them.¹⁵⁷

The distressed plight of many older nurses became increasingly evident in the post war years. These women were unable to earn and their means were extremely limited. One Christchurch nurse whose "tragic end" was noted by MP Mark Cohen was driven to commit suicide when, after a lifetime of useful work, she was forced to face the "hard world, [her] material resources at an end, through being burdened with the support of an aged mother ...".¹⁵⁸

A number of steps were taken to try to alleviate the problem. As early as 1911, the Wellington Branch of the Trained Nurses' Association established a Sick Nurses' Fund to assist seriously ill nurses unable to work but, with only a few subscribers, the Fund proved unworkable.¹⁵⁹ The Canterbury Branch of the Association set up a similar scheme in 1914 for its own sick and destitute members, who were of "approved good character". This scheme was well supported by local people but in 1919 was amalgamated with the Nurses' Memorial Fund.¹⁶⁰ The Nurses' Memorial Fund was set up in 1917 by the Otago Branch of the Association, with the support of a group of doctors as a memorial to the nurses who had given their lives during the war. The interest on donations and bequests was used to pay annuities to deserving nurses and to help others in need of temporary relief.¹⁶¹ By 1923, however, the government subsidy originally paid on each annuity had been discontinued and public interest had died away. The *Otago daily times* found it "hardly creditable"

¹⁵⁷ *KT*, 16:4, October 1923, p.186.

¹⁵⁸ Letter from Cohen to the NZTNA, undated, NZNA records, box 6/1, ATL. Nursing leaders also commented on the number of older nurses still working who should retire and leave younger hands to take up the reins, but were unable to do so. This was not good either for themselves or their institutions, *KT*, 9:1, January 1917, p.26.

¹⁵⁹ *KT*, 4:1, January 1911, p.4; 4:4, October 1911, p.142.

¹⁶⁰ *KT*, 7:2, April 1914, pp.58-59; 7:3, July 1914; 7:4, October 1914, p.150; 12:2, April 1919, p.59. See also Canterbury Trained Nurses' Association minute book, 23 April and 17 September 1914, 11 February 1919.

¹⁶¹ "New Zealand Nurses' Memorial Fund", *NZMJ*, 16:71, February 1917, pp.30-32; *KT*, July 1928, pp.109-110.

that the thousands of New Zealanders who had cause to remember gratefully "the tender offices of nurses" were not more generous in supporting such a fund.¹⁶²

Senior hospital nurses and matrons who gave their boards long and faithful service were not paid well but were otherwise treated not ungenerously. Many nurses were able to undertake travel and study abroad on full pay during their service,¹⁶³ and most were given at least six months' leave on full pay at retirement. This did not, however, solve the long-term problems of those who lived for many years after retirement. The government recognised this in 1920 when it passed the Hospitals and Charitable Institutions Amendment Act (No.2). Section 11b of this act enabled hospital boards to offer a pension of up to £2 per week to nurses retiring from senior positions after at least ten years' good service.¹⁶⁴ It was only right, said Dr Valentine, that women who had given a lifetime to public service should receive appropriate recompense.¹⁶⁵ The Department of Health fought a number of battles on these women's behalf, badgering boards to provide pensions not only for recently retired nurses, but also for former employees. It was able to persuade the North Canterbury Hospital Board to provide for two former matrons, Miss Mary Ewart and Miss Mabel Thurston,¹⁶⁶ and the Wellington Board for Miss Frances Payne.¹⁶⁷ Miss Alice Rothwell of Waikato Hospital was awarded a pension of £2 per week for life in 1920,¹⁶⁸ and Miss Isabella Fraser,

162 *ODT*, 17 July 1923; editorial, 18 July 1923, *OHB newspaper cuttings*, v.22, pp. 72, 74. The fund has continued its work until the present day.

163 Miss Ewart and Miss Fraser, for example, respectively matrons of Christchurch and Dunedin Hospitals, were each granted six months' leave on half-pay to travel to and study in England, *NCHB minutes*, 22 February 1905, p.365 and *OHB Trustees minutes*, 16 March 1904, v.3, p.386. Rose Muir, a later Christchurch matron, travelled for a year to the United States and England during 1922 on full pay, and her friend, Sister Atherton Molyneaux who accompanied her, was granted leave for three months on full pay.

164 *New Zealand statutes*, 1920, no.72, section 11b, p.485.

165 Director-General of Health to Superintendent, National Provident Fund, 17 May 1920, H1 54/11/9, NA.

166 *NCHB minutes*, 24 October 1923, p.348; section 53 of the Finance Act, 1924 (*New Zealand statutes*, no.64, 1924, p.590) empowered the Board to pay Miss Ewart £1 per week for the rest of her life from January 1924. See correspondence between Board and Department on this issue and on Miss Thurston's pension, October 1923 - December 1924, H1 85/1/2, NA. Miss Thurston's pension of £50 per year was not finally agreed to until 1927, *NCHB minutes*, 28 September 1927, p.106.

167 *KT*, 16:1, January 1923, p.2.

168 *ibid*, 14:2, April 1921, p.105.

Dunedin Hospital's second trained matron, whose circumstances were so straitened that she was said to be "in actual want", was also awarded £100 a year from November 1924.¹⁶⁹ The Southland Hospital Board, however, absolutely refused to consider granting a pension to Miss Jessie Ewart, matron of Invercargill hospital for 23 years, although she was paid 18 months' salary at the time of her retirement.¹⁷⁰

While private schemes of one sort or another could help the few, the Nurses' Association really wanted a national superannuation scheme for the many. Nurses, it was said, did not want to be the recipients of "charity". Professional women deserved to be economically independent and a properly devised superannuation scheme was necessary for this purpose. For many years, the government found endless reasons for putting the question into the "too hard" basket. First, there were not enough nurses for a special fund. Then, nurses moved around too much between too many employers to make a scheme practicable. Then there were the problems engendered by private nurses, who often worked only intermittently. Then the whole scheme was simply too expensive. When the Act was finally passed in 1925, it still omitted all government-employed nurses (who were obliged to join the government superannuation scheme), Plunket nurses and privately employed midwives.¹⁷¹ Nevertheless, a superannuation scheme was in place and nurse leaders were delighted with this achievement.

Senior members of the profession were accordingly very disappointed to find that young nurses did not seem to value superannuation. Of the 668 nurses who left hospital board service in 1927-8, noted Dr Begg, 547 of them immediately withdrew from the scheme.¹⁷² The new generation of nurses who trained from the 1920s did not expect to give a lifetime of

169 Correspondence between Board and Department, July-December 1924, H1 89/3/2, NA; W. Downie Stewart to the Minister of Health, 25 July 1923, H1 21/60, NA. Finance Act 1924, New Zealand statutes, no.64, 1924, section 54, p.590.

170 Correspondence between Board and Department, February - March 1924, H1 21/60, NA; *ODT*, 9 July, 11 & 12 September 1924, *OHB newspaper cuttings*, v.24, p.160, v.25, p.73.

171 *KT*, October 1926. p.147.

172 *KT*, 22:2, April 1929, p.66.

service to nursing. Most expected to marry so they used the money for things which seemed to them to be more important - a wedding reception or a deposit on a home.¹⁷³ The superannuation issue demonstrated convincingly to nursing leaders of the post-war period that the ideals of service, sacrifice and devotion to duty, which they believed had served the profession so well, were under threat. Accordingly, they became more determined to preserve through training and discipline the "true spirit of nursing". Only by these means would nursing remain the most womanly and therefore the most respectable of occupations for women.

¹⁷³ Dunsford, p.85.

Chapter 8

"Communities of warmth, encouragement and relaxing recreation"?: life within the nursing world in New Zealand

Martha Vicinus in her book *Independent women* has described the way single middle-class women in Britain in the nineteenth and early twentieth centuries used their "passion for meaningful work" to move "out of the garden, out of idleness, out of ignorance, and into wisdom, service and adventure". They transformed ideals of purity, celibacy and self-sacrifice in caring for others into "active spirituality and passionate social service". They built separate women's communities which enabled them to move into paid work and this gave them dignity and independence. "Formal institutions were alternatives to the nuclear family. Within them we can see the development of leadership skills, friendship networks, and a power base for public work". One of the most important of these communities was that of trained female nursing.¹ Within the walls of the nurses' home, where all nurses had to live during training, a female world was created which, as Vicinus suggests, was both "powerful and peripheral".² Nurses formed bonds which gave them strength in a male world but had to yield to the power of lay administrators and others over their rights to adequate accommodation and health care.

Friends, family and fun

Vicinus argues that in Britain the "rigid ordering of women that masqueraded as a family" in English hospitals "acted to inhibit a sense of community among women nurses". Stringent regulations, rigid discipline and high drop-out rates among pupil nurses "seemed to cast a pall upon those who succeeded".³ In New Zealand, however, the nursing world was small. As late as 1926, there were still only about 7000 nurses in the country, less than 5% of the total female working population, and many of

1 M. Vicinus, *Independent women*, pp.1-9.

2 *ibid*, p. 9.

3 *ibid*, pp.111-112.

these were not in active practice.⁴ Within the closed environments of the nurses' homes, where all nurses spent at least three years during training, friendships were forged which lasted a lifetime. As Jan Rodgers has noted, shared experiences and shared suffering, together with similarities in age, race, class and common interests created a female camaraderie which endured down the years.⁵

Nursing was therefore very much a family affair, both in the real sense - most training schools numbered families of sisters among their graduates, and in later years, added the daughters and grand-daughters of previous staff - and in a more artificial sense, through the forging of relationships which provided a basis for "family" life both during and after a nurse's working career.

A tradition of families of nurses began early. Charlotte Herbert, who was one of the first nurses trained at New Plymouth Hospital (she completed her course in 1894), was followed into the profession by her daughter, five grand-daughters, one grandson and two great-grand-daughters.⁶ Louisa May Smith, who trained at Christchurch in the 1920s, was the daughter of a nurse and the mother of another.⁷ Both Dunedin and Christchurch Hospitals trained at least 11 pairs of sisters in the years before 1920. Mary Kirk, who began training at Dunedin in 1916, was followed into nursing by no fewer than five of her seven younger sisters, while Eliza Stubbs, who entered Christchurch Hospital in 1905, was the first of three sisters to train there. In the 1920s, Christchurch Hospital trained at least seven pairs of sisters (Gladys Seymour, for example, who began her training in 1922, was the youngest of three sisters to enter the hospital), although Dunedin seems to have had only three sister pairs among its graduates for the period 1919-1930. This no doubt reflected the much wider range of occupations open to women after the war. Mary Holderness who began training at Christchurch in 1916, noted that the other members of her

4 *Census of New Zealand, 1926*, 9, pp. 12, 48.

5 Jan Rodgers, 'A paradox of power and marginality', p.77.

6 New Plymouth School of Nursing Old Girls' Association, *Silver jubilee, 1957-1982*, p.19.

7 Christchurch Hospital records, 1962 nurses' reunion, historical questionnaire, CH 293/87a, NA (Christchurch).

family were teachers. Nevertheless, it is clear that for all its hardships and disadvantages, nursing was work which appealed to many women who were not deterred by the experiences of their siblings.

Sisters who became nurses gained support and comfort from their siblings during their careers. Sometimes they nursed together. Sophie and Nettie Mandeno who trained in Dunedin at the turn of the century, ran a private hospital together in Te Awamutu.⁸ Some sisters pursued separate careers but lived together after retirement, like Matilda and Caroline Stewart, respectively matrons of Thames and Gisborne Hospitals. Edith and Myrtle Williams who trained at Christchurch Hospital between 1919 and 1928 and retired in the 1960s, were living at the Holly Lea Home in Fendalton at the time of Myrtle's death in 1983.⁹

Unmarried sisters frequently lived together in this period but nursing offered "family" relationships in the shape of deep and long-lasting friendships for many women who might otherwise have been alone. These friendships were first formed in the crucible of shared trials during training. Dr McDowell of Auckland spoke of the "clannish feeling among nurses" in an address in 1911, of how they always liked to talk "shop" and help each other through regular association.¹⁰ These sentiments are echoed time and again by nurses themselves. Annie Busch recalled the "great fraternity among nurses" who remained friends all her life, the feelings of love, care and affection which bound them together.¹¹ Dorothy Frampton talked of the comradeship in the Home, the support given in bad times and good by friends who were still with her after 60 years.¹² Alice Holford wrote

We are but a band of sisters working for that great cause - the alleviation of suffering ... the confidence with which nurses discuss their knotting problems together, feeling so sure of being understood. That is the cord which draws us

8 *KT*, 6:2, April 1913, p.86.

9 File of Edith Williams, Christchurch Hospital nurses' personal records, 1918-1925, NA (Christchurch).

10 *KT*, 4:3, July 1911, p.97.

11 NERF oral history project, tape 58, ATL.

12 *ibid*, tape 29, ATL.

together ... we all feel we belong to one family...[bonded] ...
with these three strong links, Sympathy, Understanding and
Loyalty¹³

The pages of *Kai tiaki* offer endless testimony to these friendships and their importance in the lives of the nurses who enjoyed them. Time and again mention is made of nurses travelling together, holidaying together, undergoing postgraduate training together, running hospitals together, or living together in retirement. Among early Christchurch nurses were Constance Walker and Nurse McLellan who went to Gisborne Hospital as ward sisters, then opened a private hospital in Hastings. They travelled to Australia and England on holiday and both worked in South Africa until Miss Walker's marriage in 1926.¹⁴ Edith Harris was widowed shortly after her 1916 wedding, at which her friend, Eva Livesey, had been a bridesmaid. The two women then ran a private hospital in New Plymouth until 1930, when both married.¹⁵ Alice Bawden was nursed in her final illness by her friend, Sister Hilditch,¹⁶ Bessie Dashwood offering the same devoted service to her friend, Kassie Turner, matron of Limes Hospital.¹⁷ Jeannie Beck and Ethel Welsman undertook midwifery training together in Melbourne, ran a private hospital for 14 years and then retired together to Sumner after a long overseas holiday.¹⁸

These bonds of friendship were especially important to senior hospital nurses who lived for many years in the somewhat confining surroundings of nurses' homes. However comfortable their rooms, the small pleasures of a real home were inevitably missing. Deborah Dunsford quotes Jessie Kirkness's recollection of a conversation with the deputy lady superintendent of Auckland Hospital, Miss Cussen, in 1930. Miss Kirkness, who was living outside the hospital, made some reference to an evening spent in front of the fire, only to be told, in a tone of heart-rending

¹³ *KT*, 1:1, January 1908, p.22.

¹⁴ *KT*, 9:1, January 1916, p.61; 13:2, April 1920, p.101; 14:2, April 1921, p.103; 15:1, January 1922, p.51; 19:1, January 1926, p.20; 19:4, October 1926, p.181.

¹⁵ Marriage of Edith Harris, Canterbury Public Library church register index; *KT*, 23:4, October 1930, pp.176, 218.

¹⁶ *KT*, 15:3, July 1922, p.26.

¹⁷ *KT*, 15:4, October 1922, p.183; 23:2, April 1930, p.61.

¹⁸ *KT*, 20:1, January 1927, p.49; *NZNJ*, 46:4, p.142. Rodgers, pp.77-8 gives other examples of nurses who ran private hospitals or travelled together.

sadness, "Do you realise we never have a fire to sit beside? You're a very lucky girl".¹⁹ So friends in hospital situations liked to remain together. In one issue alone of *Kai tiaki*, there are recorded three instances of women promoted to the matronships of small hospitals, whose friends accompanied them to their new posts.²⁰ Matrons were particularly vulnerable to the loneliness of high office. They were, said Hester Maclean, "as a rule ... lonely people".²¹ After the first matrons' conference, held in Wellington in 1927, many matrons spoke of the pleasure they had had in holding discussions with colleagues of their own "class". Jean Williams who trained at Christchurch Hospital in the late 1930s recalls her amazement when her matron, Grace Widdowson, was greeted like a long lost friend by the Auckland nurses to whom she had been tutor sister before her appointment in Christchurch. "When she was elevated to the more senior position", Williams noted, "she had adopted a reserve, or an aloofness, so that discipline would be easier for her". Not until her retirement was her natural warmth again allowed to emerge.²² So a close friendship, like that enjoyed by Miss Widdowson's predecessor, Rose Muir, was very important. Miss Muir's friend was Sister Atherton Molineaux, with whom she spent most of her annual holidays and who took leave without pay to accompany her to the United States for a period of study leave in 1922. Misses Muir and Molineaux lived together in Sydney for nearly thirty years after their retirement from active nursing in the mid-1930s.²³

Senior nurses in hospitals fulfilled other "family" functions. Sister James, long-serving night superintendent at Dunedin Hospital regarded the night nurses as her personal "family" and would take them to tea in town as a treat.²⁴ Many nurses were married from their hospital, and sometimes the

19 Dunsford, p.97.

20 *KT*, 9:2, April 1916, pp.115, 117: Charlotte Bird of Riverton appointed matron of Taumaranui, Nurse Henry of Riverton also going to Taumaranui; Miss Robinson of Auckland appointed matron, Wairoa, with Nurse Scott going as sister; Sister Pelling of Wanganui, appointed matron, Taihape, Sister Williams going with her.

21 *KT*, 20:3, July 1927, p.107.

22 J.C. Williams, *Slate pencil to word-processor*, Christchurch: Waverley Press, 1995, p.72.

23 P. Sargison, "Muir, Rose Caroline, 1884-1970", *DNZB, volume 4, 1921-1940*, pp.361-362.

24 *KT*, 11:4, October 1918, p.209.

matron would give away the bride, as Mabel Thurston did for Jessie Beer at Queen Mary Hospital in Hanmer in 1923. After the ceremony, Miss Thurston and the ward sisters acted as hostesses for the wedding breakfast.²⁵ Assistant matron Catherine Nosworthy, who married in 1934 after a long career at Dunedin Hospital, was given away by the medical superintendent, Dr Falconer. Falconer also hosted the wedding breakfast.²⁶

This close-knit "family" life did much to ameliorate the less pleasant aspects of nursing. As Jessie Kirkness said, the strict discipline rarely annoyed because of the strong companionship which bound nurses together.²⁷ Nurses enjoyed a great deal of merriment and laughter during their training days. Irene Booth, who trained at Waipukurau Hospital asked, "Do you remember the friendships made - singing around the piano, the fun and the love of nursing?"²⁸ Nurse Fraser, one of the first five nurses to train at Dunedin Hospital, recalled that in spite of the long workdays (12 hours at that time), she and her fellow nurses often used to walk to Port Chalmers in the evening, have supper, and take the train back to town.²⁹ Most hospitals provided well-used tennis courts and some institutions made use of other local facilities. Mary Lambie remembered picnic teas on boats on the Avon as well as hard-fought tennis matches.³⁰ Nurses from the Pleasant Valley Sanitorium in Palmerston were taken to a local beach in 1911 by the doctor-in-charge to enjoy the "newly popularised sport of surf-bathing", an outing thoroughly enjoyed by the women, although the doctor broke his collar-bone after being knocked over by a wave!³¹ Swimming became almost as popular as tennis as the years passed. Ivy Pratt loved swimming and digging for toheroas on the

25 *KT*, 17:1, January 1924, p.49.

26 *KT*, 28:6, January 1935, p.253. This was common during the war, when weddings often took place at short notice. Gertrude Taylor was given away by her matron at her marriage to Mr Melville in 1917, and the same year, Miss Orr of Auckland Hospital gave away Sister Alice Minall at her marriage to Mr Hart, *KT*, 10:3, July 1917, p.181; 10:4, October 1917, p.233.

27 Dunsford, p.96.

28 *Waipukurau Hospital souvenir centennial souvenir booklet, 1897-1979*, Waipawa Hospital Board, 1979, p.29.

29 *Dunedin Hospital diamond jubilee*, pp.13-14.

30 Lambie, p. 9.

31 *ODT*, 26 January 1911, OHB newspaper cuttings, v.2, p.152.

beaches near Te Kopuru Hospital,³² and beach swimming was also popular with nurses at Napier Hospital, where the medical superintendent in the 1920s organised transport so that everyone could participate.³³ At Wairoa Hospital, Dorothy Ford could remember riding down to the beach for picnics.³⁴ In 1924, Auckland Hospital became the first institution in the country to provide its nurses with a swimming pool at the nurses' home,³⁵ a facility much envied by other nurses. Christchurch nurses frequently requested a pool throughout the 1920s but were not able to persuade the Board of its desirability.³⁶ At Te Waikato Sanitorium, "many irksome duties and daily routines" were forgotten on the golf-links next door, which offered magnificent panoramic views over the plains below.³⁷ Theatre and movie outings were expensive and difficult to arrange because of the early hours enforced at nurses' homes, but most hospitals organised dances and balls. Jean Erwin, who trained at Christchurch from 1911 till 1914, recalled that the dances were mostly fancy-dress and "there was much ingenuity displayed in the get-ups - much caricaturing of staff - both Honorary, Resident & Senior Nursing".³⁸ Frances Hayman remembered a dance in the 1920s where everyone dressed as an historical character and in the evening of "hilarious laughter" which followed, "the sordid side of life at St Helens", its regulations and, at times, rigid discipline, were completely forgotten.³⁹ Garden parties were also common and many nurses remembered with great pleasure special occasions such as the visits of the Prince of Wales in 1920 and the Duke and Duchess of York in 1927.

Hospital authorities tended to be wary of mixed-sex activities, since it was essential that nursing maintain its respectability by depressing sexuality and ensuring moral probity within its ranks. The matron of Dunedin

32 I. Pratt, *The history of Te Kopuru Hospital, 1903-1971*, Whangarei, 1992, p.61.

33 *ODT*, 17 November 1928, OHB newspaper cutting books, v.37, p. 121.

34 Ford, *Journey from Stranger's Rest*, pp.125-126.

35 *ODT*, 3 March 1924, OHB newspaper cuttings, v.23, p.193.

36 See, for example, NCHB Hospital Committee minutes, 18 November 1929, p.301.

37 *KT*, 12:4, October 1919, p.172.

38 Christchurch Hospital records, 1936 nurses' reunion, historical questionnaire, CH 293/87a, NA (Christchurch). Marion Shepherd remembered a dance where one of the house surgeons came dressed as Miss Muir, and "baffled us all" until the matron herself walked in.

39 F. Hayman, *Suzie in transit: an autobiography*, Birkenhead, 1990, p.71-72.

Hospital was warned that the constant presence of medical students in the wards required the "greatest vigilance and energy ... to prevent the possibility of any irregularities arising".⁴⁰ At least one beach-bathing outing in Christchurch was cancelled because some nurses objected to the idea of mixed bathing.⁴¹ Nor would the Otago Hospital Board countenance a suggestion that house surgeons and nurses might play croquet together within the hospital grounds.⁴²

Nevertheless, male friends were welcomed to dances, albeit under the watchful eye of the matron, and as more than one nurse noted, young men in districts where hospitals were located were keen to be invited.⁴³ In the 1920s, several large hospitals provided holiday cottages for staff, where they might spend off-duty time relaxing with their friends away from the hospital. The Hospital Lady Visitors' Association in Christchurch opened the Adeline Turner Rest Cottage in Sumner in 1920 and Wellington followed in 1924, when a grateful patient bequeathed a cottage at Opuia Bay, complete with boat shed and boat.⁴⁴

Nurses were far from conservative in their choice of recreational activities. Many nurses experienced outings together which would have been beyond the reach of young women living at home at this period. In 1910 Edna Pengelly was one of a party of about 30 nurses who camped in tents up the Wanganui River at Christmas and had "a delightful time", bathing, cooking and playing cards despite the "fiendish" mosquitoes.⁴⁵ In 1912, three nurses travelled from Christchurch to the West Coast through the Otira Gorge, hired a trap and in "nailed boots and short skirts" became the first nurses to climb and explore Franz Josef Glacier.⁴⁶ Other nurses enjoyed rock climbing, rambling and bird watching in the Catlins Forest,⁴⁷

40 AJHR, 1895, H-22, p. 9.

41 Canterbury Trained Nurses' Association minute book, 5 and 19 February 1914.

42 OHB Trustees minutes, 21 October 1908, pp.118-119.

43 Ford, p.126; New Plymouth School of Nursing Old Girls' Association, p.46.

44 P. Sargison, "Hospital Lady Visitors' Association", A. Else (ed.): *Women together*, p.302; *Wellington nurses' journal*, 1980, p.15.

45 E. Pengelly, *Nursing in peace and war*, p. 16.

46 *KT*, 5:3, July 1912, pp.77-78.

47 *ibid*, 10:3, July 1917, p.157.

and mountain climbing near Palmerston.⁴⁸ Jeannie Cran remembered the thrill enjoyed by her 1921 graduation class of 22 nurses, when Miss Muir gave permission for them to have the "wonderful treat" of a flight over the city in planes owned by Captain Dickson - and Miss Muir's enormous relief when they all returned safely to the ground!⁴⁹ Frances Hayman and a friend paid for a 10-minute flight in a Gypsy Moth in 1927, somewhat regretting their spirit of daring when they flew out over the sea and then did a complete somersault,⁵⁰ while in 1930, Nurse Higgins became the first nurse in New Zealand to take a working trip by plane, when she was called to attend a patient living on a remote station at Otaha, near Kawakawa.⁵¹

Nurses' homes

The provision of nurses' homes was central to the development of trained female nursing. Deborah Dunsford has enumerated the ideologies which underpinned their management. She notes the closed worlds which echoed earlier religious nursing orders, the need for matrons to be able to assure middle class parents that their daughters were safe and protected, the long hours which made it sensible and cost-effective to maintain staff on site and to limit their outside activities, and the low pay, which was justified by the provision of living expenses and isolation from social distractions.⁵² Most important of all was the need to preserve the moral standing of the newly respectable profession, its freedom from the sexual licence which had characterised untrained nursing and its representation of women who worked to serve mankind, not for personal enjoyment or advancement.

Nevertheless, hospital boards were not always prepared to spend money on providing adequate accommodation. Christchurch Hospital's nurses'

48 *ES*, 3 April 1913, OHB newspaper cuttings, v.5, p.114.

49 Christchurch Hospital records, 1936 nurses' reunion, historical questionnaire, CH 293/87a, NA (Christchurch).

50 Hayman, pp. 69-70.

51 *ODT*, 6 January 1930, OHB newspaper cuttings, v.40, p.135.

52 Dunsford, pp.31-32.

quarters were in 1892 declared to be "little better than dog kennels". They were situated in an old, foul-smelling and dilapidated building, had no private bathrooms or sitting rooms, and caused nurses to be constantly sick.⁵³ Nurses at Timaru Hospital were "tucked away in odd corners, even sometimes sleeping in the wards", while in other institutions, they were accommodated in rooms attached to the wards or located over the kitchens.⁵⁴ Dunsford found in Auckland that nurses' homes of a suitable standard of comfort often had to take second place to more "pressing" needs in a climate of major hospital expansion.⁵⁵ Premier Richard Seddon, in answer to a request from the Canterbury Hospital Board for additional funds for building purposes in 1894, told members that providing accommodation for patients was more important than for nurses,⁵⁶ while in Wanganui in 1903, the "burning question" was whether a new building should be erected or whether the nurses could be accommodated in one of the wards divided into cubicles.⁵⁷ Only a public outcry, led by the mayor, who declared that "noble" women who cared for the suffering deserved anything which would make them bright, cheerful and contented, persuaded the board to set aside money for a separate home. This was opened in 1904, having been furnished with money raised by public subscription.⁵⁸

Although the larger hospitals all had separate nurses' homes by the end of the century, the rapid expansion of nursing in the new decade meant that overcrowding was a constant problem. In many cases, nurses slept two or three to a small room,⁵⁹ while some homes, like the Christchurch one, used dormitories for six or eight students. As numbers grew, living quarters spread out into nearby disused buildings. Houses and cottages in the hospital grounds were utilised, even the medical superintendent's house when it fell empty. At times, nurses found themselves sleeping in tents erected on the lawns as available space overflowed. Such was the

53 Editorial, *Press*, 2 August 1892, p.4.

54 McKenzie, *A history of Timaru Hospital*, p.97.

55 Dunsford, p.32.

56 *Press*, 20 July 1894, p.3e.

57 AJHR, H-22, 1903, p.30.

58 R. Wright-St Clair, *Caring for the people*, p.28; AJHR, H-22, 1904, p.31.

59 See for example, Dunedin Hospital, AJHR, H-31, 1911, p.90.

case for Oamaru nurses in 1901, Timaru nurses in 1902, Christchurch nurses in 1909 and Auckland nurses in 1910. The use of tents was considered preferable to the alternative, which would have necessitated nurses living outside the hospital environs and away from the supervision of the matron.⁶⁰ The needs of the nurses remained at all times secondary to those of the patients. New Plymouth Hospital's nurses, some of whom slept in a nearby cottage because of space shortages, came home one evening to find all their belongings on the front lawn. The cottage had been commandeered for diphtheria patients.⁶¹

Inadequate kitchens which produced poor quality food were another ongoing problem. As early as 1899, the cooking at Christchurch's nurses' home was said to be "abominable", very monotonous, the puddings "hard-stuff" and the meat served in a very disagreeable way.⁶² A decade later, poor food, indigestion caused by the short time allowed for meals and health breakdowns were the trigger for a media campaign against nurses' working conditions at Dunedin Hospital. When the chairman of the Otago Hospital Board made an unscheduled visit to the nurses' dining room, he found a cockroach in his soup, although he was assured that "this is not an ordinary occurrence".⁶³ Hester Maclean was called to investigate and found "a legitimate ground for complaint"; food was not well cooked, more variety was needed and presentation was unappetising.⁶⁴ At this point, a new dietary scale was finally approved, the head cook was fired (a female cook had been appointed as an economy measure but proved inadequate for the task), and separate cooking facilities for the nurses' home were provided (the nurses' meals had previously been prepared in the hospital kitchens and transported to the home where they usually arrived cold).⁶⁵ In 1911, a Home Sister was appointed to supervise the housekeeping and other arrangements.⁶⁶ Other hospitals were less fortunate. Timaru nurses

60 Oamaru Hospital, McDonald, *A century of service*, p. 21; Timaru Hospital, *Press*, 20 August 1902, p.7a; Christchurch Hospital, 23 September 1909, p.8c and 2 December 1909, p.6c (editorial); Auckland Hospital, Dunford, p.33.

61 Scanlan, *Hospital on the hill*, p.55.

62 *Press*, 27 July 1899, p.3d.

63 *ODT*, 2 November 1910, OHB newspaper cuttings, v.2, p.47.

64 Maclean's report, *ODT*, 2 December 1910, OHB newspaper cuttings, v.1, pp.83-84.

65 *ODT*, 17 November 1910, OHB newspaper cuttings, v.2, p.52; 2 December 1910, p.87; 7 December 1910, p.119; *ES*, 24 January 1911, p.152.

66 *ES*, 8 August 1911, OHB newspaper cuttings, v.4, p.6.

at this time were apparently often hungry and enjoyed being sent for duty at the fever hospital, where they could raid the vegetable gardens and hen houses. Other staff were said to cultivate boyfriends who might take them home to Mother or bring them a meal.⁶⁷

Nursing leaders were anxious to avoid any suggestion of indulgence in nurses' accommodation. Their quarters, said Hester Maclean, "should be on the scale of an ordinary middle class home. There should be comfort, but not luxury". Such comfort should include single rooms, sitting rooms, study and lecture rooms and dining rooms with small tables and a variety of good food.⁶⁸ In 1918, she deplored the decision of one hospital board to provide heating in the bedrooms of its nurses' home. During a war, it was quite inappropriate for those far from strife to receive such undue indulgence. Nurses, she added, would rather learn to live "simply and hardily and so ... be prepared to serve without complaint even when lacking almost necessary comforts".⁶⁹

Nevertheless, in response to the surge of discontent which swept through many institutions in the years immediately before the war, several of the larger hospitals began to provide better accommodation during the 1910s. The new Auckland Hospital nurses' home opened in 1912, Hester Maclean hoping that "the privilege of working in such beautiful surroundings and living in such comfortable conditions" would make the nurses "a contented and happy body".⁷⁰ Dunedin Hospital, having lost its matron in 1911 as a result of the seething dissatisfaction displayed by nurses and the public, began planning a new home in 1913, although medical staff would only approve the proposal if it would not delay the erection of a new ward for consumptives. A "fine and imposing building" was finally opened in 1916.⁷¹ Christchurch Hospital added a new three-story wing to its home in 1911, which included separate suites for the

67 McKenzie, p.114.

68 *KT*, 5:3, July 1912, p.67.

69 "The comfort of our nurses", *KT*, 11:4, October 1918.

70 Dunsford, p.34.

71 *ES*, 12 December 1913, OHB newspaper cuttings, v.6, p.199; *KT*, 9:4, October 1916, pp.212-213.

matron and the submatron.⁷² Smaller hospitals also began to erect separate homes, Invercargill and Waikato in 1908, Napier in 1909 and Gisborne in 1915. Wairau Hospital in Blenheim, where nurses previously had slept two or three to a room, with little or no privacy, opened a new home in 1926 with single rooms for everyone, comfortably furnished sitting rooms and study rooms, its pleasant surroundings giving the "greatest joy" to staff.⁷³ New Plymouth's nurses' home, described by one nurse as "the black hole of Calcutta", was replaced in 1921 by "a delightful place", thoroughly equipped and with plenty of space.⁷⁴ Increasing staff numbers in the 1920s brought further developments. Extensive additions were made at Auckland Hospital between 1922 and 1927, the result being, according to one disgruntled taxpayer, "sufficiently luxurious for a bishop",⁷⁵ while Christchurch Hospital's new home finally opened in 1931 after endless debates on its location and design.⁷⁶

The debates over the new Christchurch nurses' home during the 1920s throw some light on ideologies which continued to shape nursing at this time. It was proposed initially that the new home should be built on land at some distance from the hospital. Both the matron and the medical superintendent considered this to be "quite impossible". Discipline could not be maintained nor nurses' welfare supervised adequately if they lived away from the hospital's environs.⁷⁷ The Department of Health agreed. Nurses in training, it was asserted, "must for their own protection be under supervision and guidance until they have attained a measure of self-reliance and stability".⁷⁸ Accordingly, nurses' homes maintained a rigid formality in all matters of precedence and authority. Separate sitting rooms were provided for students, staff nurses and sisters, in order to "preserve

72 Bennett, *Hospital on the Avon*, p.105.

73 Lewis, *Joy in the caring*, pp.98-99.

74 Cath James, NERF oral history tape no. 61, ATL; Jessie Lovell, NERF oral history tape, no.189, ATL; *KT*, 11:3, July 1918; *Journal of the Department of Public Health*, 1:14, August 1918, pp.237-239.

75 M. Brown, D. Masters, B. Smith, *Nurses of Auckland*, Auckland: The Authors, 1994, p.45.

76 Bennett, pp. 241-244.

77 *Press*, 23 June 1927.

78 *AJHR*, H-31, 1931, p. 28. See also Dr Valentine's comments on the Christchurch Hospital proposal, NCHB Hospital Committee minutes, 17 October 1927, p. 272.

a proper discipline".⁷⁹ Dining was particularly formal; the dining room was furnished with linen and silverware, everyone sat in strict order of seniority, with the seniors "so dignified and professional that they had an awe about them". The matron presided, she and her assistants entering and leaving the room in procession.⁸⁰

Nevertheless, Christchurch Hospital also established a cafeteria in 1930, where nurses could buy light lunches or morning teas and entertain their friends. This innovation heartily welcomed by staff and was heavily patronised.⁸¹ The enormous cost of maintaining large nurses' homes also led to discussions about the possibility of the trained staff at least living out.⁸² Mary Lambie, who replaced Jessie Bicknell as director of the Division of Nursing in 1931, supported the notion of senior staff enjoying more independence. If modifications were not made, she said, the right type of woman would not be attracted to nursing. By the mid-1930s, many sisters did live away from the hospitals, although some at least were initially reluctant to make the break.⁸³

Financial pressures, the power of the medical fraternity and the willingness of nurses to sacrifice their interests to duty enabled hospital boards to take a minimalist approach to nursing accommodation, just as they did to all aspects of nurses' working conditions. Nevertheless, boards could not afford to appear too miserly. Neither the public nor the government would tolerate the sight of respectable women who devoted their lives to caring for the suffering living in cramped and sordid conditions. Furthermore, boards (and nursing leaders) justified the low salaries paid to nurses on

79 AJHR, 1909, H-22, p.27.

80 Jean Bell's reminiscences of life at Christchurch Hospital in the 1930s, Williams, p. 61.

81 NCHB Hospital Committee minutes, 4 November 1929, p.298, 23 April 1930, p.320.

Several nurses mention how "wonderful" this informal cafeteria was in their reminiscences. See for example, Margaret McNab, Beatrice De Lautour, Edith Worn, Christchurch Hospital records, 1936 nurses' reunion, historical questionnaire, CH 293/87a, NA (Christchurch).

82 *KT*, October 1928: chairman of NCHB. Dr Shore of Auckland Hospital first proposed that senior nurses live away from the hospital in 1931, Dunsford, p.93.

83 Dunsford, pp.94-97. Kathleen Falls Tutill remembered being "quite narked" when asked to leave the home, because the sisters' accommodation was so pleasant, with lovely harbour views. However, in the end she very much enjoyed living out, Dunsford, p.90.

the grounds that their board and lodging were provided. It was therefore necessary that such board and lodging be on a reasonable scale. Nursing homes by 1930 were certainly not palaces, but they did in most cases offer a degree of homeliness and comfort that was probably at least equal to that found in most middle-class New Zealand homes.

Health care for nursing staff

Poor accommodation was one of several factors which contributed to health breakdowns among nurses in hospitals, along with long hours, the absence of a weekly holiday and the heavy domestic work undertaken by student nurses. Poor health was sufficiently prevalent among nurses to cause concern to both parents and the public. The mother of one Christchurch nurse declared in 1928 that "if our hospital nurses felt absolutely free to unburden their souls as to their experiences the general public would be astounded". The level of overwork and understaffing in the wards, she said, was such that even the strongest nurses eventually became prostrate.⁸⁴ The mother of Kathleen Miller who trained at Dunedin Hospital from 1926 wrote worriedly to the matron in 1929, requesting extended leave for her daughter after a long tour of night duty. "When I think of the big strong girl that she was when she started her training", she wrote, " & now she is just a wreck".⁸⁵

Not all nurses suffered ill-health. In 1926, Mrs Fraser, one of the first five women to train at Dunedin Hospital, stated

Strange to say ... all those first nurses are still living, so it did not kill us ... We five have far above average health and are able to enjoy ourselves and do a great deal of hard work ... hard work never kills - only discontent and unhappiness.⁸⁶

Louise Renouf who became Napier Hospital's first registered nurse in 1903, echoed these sentiments when she celebrated her 86th birthday in

⁸⁴ *Christchurch star*, 18 August 1928, NCHB newspaper cuttings, 1920-1930, p.258.

⁸⁵ Letter to matron, August 1929, personal file, Dunedin Hospital School of Nursing records, DUHO.

⁸⁶ *Dunedin Hospital diamond jubilee*, pp.13, 15.

1960. Hard work seldom kills, she said, and "we worked hard, studied hard and lived hard".⁸⁷ Christchurch Hospital's first trained nurses certainly seem to have been a relatively hardy lot. Of the nurses who trained there before the war, at least four women lived until they were over 90, while 14 more lived till over 80. Only 21 died before the age of 60, including one during the war (when the *Marquette* was torpedoed) and three during the influenza epidemic in 1918. All but eight had left nursing before death.

Nevertheless, ill health was a common cause of nurses failing to complete their training. Six of the 27 women who left training at Christchurch Hospital before 1910 did so for health reasons. Student nurse Jessie Nisbet died in 1910 during a diphtheria and typhoid epidemic, which also resulted in several fatal cases among the patients.⁸⁸ Around a quarter of those who failed to complete training at Christchurch Hospital in the period 1919-1924 were ill (10 out of 44), and several more left after sitting the final examination, too unwell to continue. Amy Risdon died in 1927 and Helen Jones in 1928, both women having contracted tuberculosis during their training.⁸⁹ Figures are available for those who entered training at Dunedin Hospital between 1918 and 1927, including those who did not survive the probation period of three months. Seventy women left training in these ten years for health reasons, the largest number of twelve becoming ill in each of the years 1921 and 1924. A further 16 nurses left after their training was complete.⁹⁰ At least three nurses died at Dunedin in the 1920s, Ivy Stock of tuberculosis in 1923, and Freda Saxon and Sybil Kensington in 1928 of scarlet fever and pneumonia. Agnes Orr remembered how traumatic these deaths were for the other nurses. "It took us a long time to recover," she said. "I don't think anything upset us more in all of our training".⁹¹ Even the matron, Miss Edith Tennant,

87 Conly, *A case history*, p.37.

88 NCHB minutes, 15 June 1910, p.27.

89 Death certificate 3722/1927, index to the records of the Registrar of Births, Deaths and Marriages. These figures relate only to the nurses whose files have been retained. They include all those who continued training after the probationary period but not those who left during or just after this three months.

90 One was later found to have been pregnant. See P. Sargison. "The wages of sin: aspects of nurse training at Dunedin Hospital in the 1920s and 1930s", *Women's studies journal*, 11:1/2, August 1995, pp.165-178 for an account of her experiences.

91 Reminiscences, NERF oral history tape, no.154, ATL.

usually both cool and phlegmatic, wrote in some distress to Miss Bicknell of "the terrible shock" which the two deaths, within six weeks of each other, caused her and the medical superintendent.⁹²

Nurses were particularly susceptible to infectious diseases and dozens of instances of scarlet fever, diphtheria, pneumonia, measles and typhoid are reported in the pages of *Kai tiaki*. Marie Farquhar recorded that in one eight-month period during her training at Wellington Hospital, seven nurses caught scarlet fever, two each were ill with measles, mumps, chickenpox, mastoid infections, diphtheria and abscesses, and 22 others were generally unwell.⁹³ Sometimes these illnesses were, like those mentioned above, fatal.⁹⁴

Typhoid was particularly rife among backblocks district nurses and Maori health nurses. Akenehei Hei, the first registered Maori nurse, died of the disease in 1910,⁹⁵ as did Nurse C. A. Parker, district nurse in the Waipiro area in 1912.⁹⁶ Many others, like Nurses Herdman, Gill and Moore, were severely ill.⁹⁷ In 1916, *Kai tiaki* suggested that so many nurses contracted typhoid, it seemed evident that training schools were not sufficiently emphasising the necessary precautions.⁹⁸ Even experienced nurses were not immune from infection. Inez Powell, matron of the Rotorua sanatorium, died of typhoid in 1914,⁹⁹ and Miss Shillington, matron of Waiapu Hospital also caught the disease.¹⁰⁰

92 Miss Tennant to Miss Bicknell, 30 July 1928, H1 89/3/2, NA.

93 Cleland, *It just goes to show*, p.3, covering the period 12 April-4 December 1926.

94 Other deaths included Helen Robertson of Dunedin Hospital who died in 1909 of scarlet fever, *KT*, 2:2, April 1909, p. 67 and Agnes Redwood of Blenheim who died of the same disease, *KT*, 1:2, April 1908, p. 52. Nurse Keyworth of Auckland Hospital died of septicaemia in 1913, *ibid*, 7:1, January 1914, p.45, as did Janet Aitken, *ibid*, 1:1, January 1908, p. 28.

95 P. Sargison, "Akenehi Hei, 1877/78?-1910", *DNZB, volume three, 1910-1920*, p.205.

96 *KT*, 5:4, October 1912, p.131.

97 *KT*, 4:2, April 1911, p.91; 6:3, April 1913. Nurse Elizabeth Ensor "[gave] her life for her profession" in 1919 when she died of typhoid after nursing her Maori patients through an epidemic, *KT*, 12:4, October, 1919, p.198. Five nurses at Whangarei Hospital were ill from typhoid in 1927, and 21 year old Nurse Potter died, *ODT*, 9 July 1927, *OHB newspaper cuttings*, v.34, p.43.

98 *KT*, 9:3, July 1916, p.161.

99 *ibid*, 7:4, October 1914, p.190.

100 *AJHR*, 1909, H-22, p.43. Matron L. E. Smith of Denniston Hospital was also a typhoid patient, *AJHR*, H-31, 1913, p.100.

Acute rheumatism was another common ailment, the result of hours spent handling cold and wet laundry, scrubbing floors and washing walls. Bleak and draughty living quarters, with only minimal heating contributed.¹⁰¹ Septic fingers required some nurses to have amputations, leaving them permanently disabled.¹⁰²

Tuberculosis became increasingly rife during the 1920s and was a common cause of death among nurses.¹⁰³ At least 11 nurses who trained at Christchurch Hospital from 1919 to 1925 suffered from the disease, as did ten nurses who trained at Dunedin Hospital in the 1920s. A nurse who was admitted to the Otaki Sanatorium in the early 1930s recalled that 19 other nurses were patients there at the same time as herself.¹⁰⁴

Jean Marie O'Donnell suggests in her study of women's health in Dunedin at the turn of the century that opinions on the relationship between work and health in women were shaped by considerations of what was appropriate women's work. While factory and shop work were considered harmful because they threatened women's domestic and childbearing abilities, domestic service was regarded as healthier and more natural, because it trained women to be good wives and mothers.¹⁰⁵ Because nursing was regarded as 'natural' part of a woman's 'duty', it was assumed that it must also be a healthy occupation. Accordingly, investigations like

101 Letter to editor by "A locally trained Nurse", *Press*, 29 April 1907, p.8d.

102 In 1914, Nurse Gunn of Christchurch Hospital had her right hand index finger amputated, and in 1919, Nurse Walker lost the top joint of her thumb through septic poisoning, NCHB minutes, 22 April 1914, p.215, 8 October & 28 October 1914, Hospital Committee minutes, 22 April 1919, p.427. In both cases, the nurses were paid compensation by the board. Louise Corkill of Wairoa Hospital wrote of the experiences of her matron, Edith Melville, who had 45 incisions in her left arm and hand after contracting septicaemia, and was left with ulnar paralysis, *Conly*, pp.168-169.

103 Nurse Annie Watt, for example, died at the Waipiata Sanatorium in 1917, *ES*, 4 August 1917, OHB newspaper cuttings, v.11, p.194; Sister Hepple-Thompson of Dunedin died in 1921, *KT*, 14:2, April 1921, p.94; and Sister Alexander of Waihi died in 1923, *KT*, 17:1, January 1924, p.42.

104 N. Allen & E. Brister, "Nurses with tuberculosis: a preliminary study", *Women's studies journal*, 5:2, December 1989, p.43.

105 J.M. O'Donnell, 'Female complaints': women's health in Dunedin, 1885-1910, MA thesis, University of Otago, 1991, pp.49-52.

the 1889-1890 Sweating Commission into the harmful effects of women's and children's employment did not cover nursing work. A letter to the editor of the *Press* in 1890 asked why nurses, who often worked 13 hour days "under trying circumstances in a polluted atmosphere" were not to be considered by the Commission. The chairman replied that nurses were not overworked and did not break down in health. The only nurse who had left the hospital on the grounds of ill health was "constitutionally weak and was not fit for nursing work".¹⁰⁶ Neither the Employment of Females Acts nor the later Factory Acts, which regulated the hours and conditions of women's work, applied to nursing. Until public pressure forced the introduction of the eight-hour day in 1909, the State was simply not interested in monitoring the conditions under which women carried out work which was the embodiment of female duty.

Nursing leaders were likewise extremely reluctant to accept any link between work conditions and ill health. In 1907, Dr Falconer, medical superintendent of Dunedin Hospital, stated firmly that overwork was not the cause of illness among nurses. Those who fell ill, he said, were women who were never strong. Nurse Torrance, for example, should never have been accepted for nursing, because she was constitutionally weak (Nurse Torrance went on to have a long and demanding career as a district nurse and social worker for Knox Church). Dunsford found in Auckland that prior to 1933, neither hospital nor nursing authorities took much interest in sickness among their nurses unless it was on such a grand scale that the running of the institution was impaired or public comment was being made.¹⁰⁷ It was, said one nursing journal, the duty of every nurse to keep herself in perfect health, in order to serve both her hospital and her patient fully. While on duty, she must keep herself scrupulously clean and practise flawless aseptic technique. Off duty hours must include rest, fresh air, exercise and sunshine.¹⁰⁸ It was implied that it was a nurse's own fault if she became ill. "My nurses do not get sick, Nurse", one matron told an errant pupil who had had the temerity to contract mumps.¹⁰⁹ Rose Macdonald, matron of Napier Hospital,

106 Letters to editor, *Press*, 1 July 1890, p.6c, 8 July, p.3c & 6c, 10 July, p.3g.

107 Dunsford, p.106.

108 *Wellington Hospital nurses' journal*, 1:2, 1933, p.17.

109 Allen & Brister, pp.43-44.

asserted that "I have found that very few girls of eighteen suffer physically or otherwise from the strain of hospital work. The majority benefit greatly from the institutional discipline".¹¹⁰

Dr Fox of Christchurch was prepared to admit that overcrowding in the wards was a problem for hard-working nurses,¹¹¹ but neither he nor Miss Muir would admit for a minute that overwork caused sickness. A hospital committee investigation into the matter in 1926, prompted by public pressure and the agitation of certain hospital board members, led by Elizabeth McCombs, reported firmly that the duties of the nurses did not affect their health.¹¹² Miss Tennant of Dunedin Hospital agreed. Heavy wards and sickness among staff inevitably led to holidays being reduced and days off being cancelled, she said in 1928. Nevertheless, staff realised they had to rise to the occasion in these circumstances. In undertaking extra duties, "they are acting loyally to the traditions of the profession by carrying on without any signs of resentment, knowing that those in authority are showing all the consideration they can."¹¹³

Authorities were particularly reluctant to acknowledge that tubercular infections were picked up within the hospital environs. Dr Fox admitted that far too many tuberculosis patients were admitted to general wards, endangering staff and other patients alike,¹¹⁴ but nevertheless, he and other authorities considered nurses need only take care to avoid infection. Dr Blackmore, the superintendent of the Cashmere Sanatorium in Christchurch, who examined all nurses suspected of having the disease in

110 Letter to Miss Bicknell, 22 April 1926, H1 21/23/86, NA.

111 *Press*, 27 October 1927, NCHB newspaper cuttings, pp.211-212. Dr Valintine, in reporting on the disgraceful state of Invercargill Hospital in 1917 also stated that overcrowding was a principal cause of the level of sickness among nurses. The hospital contained 122 beds in a building designed for 69, he said. The kitchen was horrible and food storage areas disgusting. Infective and septic cases were nursed alongside others, with the result that, although the Nurses' Home was a good one, 15 nurses had diphtheria and eight more had scarlet fever, *ODT*, 12 November 1917, OHB newspaper cuttings, v.12, p.26.

112 NCHB minutes, 17 February 1926; NCHB Hospital Committee minutes, 14 December 1925, p.121, 8 February 1926, p.171, 9 June 1926; *Sun*, 23 June 1926, NCHB newspaper cuttings, p.169.

113 *ES*, 24 July 1928, OHB newspaper cuttings, v.36, p.136.

114 NCHB minutes, 27 April 1921, p.591.

the 1920s, stated flatly that "most of these infections were due to the lighting up of invasions of early childhood".¹¹⁵ Lily Carter's infection, he said, dated back many years and her breakdown during training was "merely a recrudescence". Similarly Amy Risdon's illness, which killed her in 1927, was "merely a fresh lighting up of an old infection, which she had probably several years ago". Iris Hales was "a delicate, fragile girl" who could not stand the strain of heavy nursing.¹¹⁶

Illnesses were looked upon as "unfortunate happenings" which occurred despite every reasonable precaution being taken.¹¹⁷ Nurses were not encouraged to take sick leave. It was a "crime to get ill, report ill", remembered one nurse, adding that you were "frightened [you] wouldn't be considered fit to be a nurse if you did report sick".¹¹⁸ Furthermore, as most nurses knew only too well, if they did leave their duties, there was no one else to replace them, and those who remained simply had to take on the extra workload and/or miss out on days off.¹¹⁹ One was "not ill unless one had a definitely raised temperature", said Athole Smith. As long as you could stand, you went on duty, added Anne Cunningham.¹²⁰ At New Plymouth Hospital, according to Cath James, you didn't report ill unless "you were absolutely collapsed on duty, and then you would get a blast".¹²¹

During the war, similar attitudes to illness were evident. Personal illness, according to Jan Rodgers, was very much resented and there "appeared to be a general feeling that illness was a sign of weakness". Nurses prided

115 Medical report on Elizabeth Petre, Christchurch School of Nursing records, NA (Christchurch).

116 All comments from personal files, Christchurch Hospital School of Nursing, NA (Christchurch).

117 *ODT*, 15 January 1914, OHB newspaper cuttings, v.7, p.16 on diphtheria epidemic which killed one nurse and invalidated two others.

118 Allen & Brister, p.43.

119 *Christchurch star*, 18 August 1928, NCHB newspaper cuttings, p.258.

120 Christchurch Hospital records, 1936 nurses' reunion, historical questionnaire, CH 293/87a, NA (Christchurch). Many other nurses made similar comments. See for example, questionnaires completed by Joan Carter, Cushla Ryan, Gladys Roberts, Margaret Wootton, Charlotte Jefferies, Josephine Grant, Margaret Fisher.

121 NERF oral history tape, no.61, ATL.

themselves on remaining at the helm when doctors, orderlies and others succumbed, and continued to work through severe sea-sickness and other ailments. Nurses who suffered from neurosis were regarded, like soldiers, as cowardly.¹²²

Ill health was a part of the self-sacrifice expected of every nurse in the course of her work. Just as mothers continued to care for their children, no matter how unwell they were feeling themselves, so would nurses continue their caring work, however adverse the circumstances. Should it be necessary, the true nurse would give her life in order to save the patient's life.¹²³ Nurses in Auckland who did not hesitate to volunteer during the pneumonic plague outbreak in 1912 and "bravely remained at their posts" even when two cases proved fatal were held in high esteem.¹²⁴ A fear of contracting tuberculosis, which caused some nurses to refuse to work at Dunedin's Fever Hospital in 1910, was, said Hester Maclean, "unworthy of a woman taking up the calling of a nurse".¹²⁵ In 1917, she noted regretfully that "In days of old [infectious] cases came to the general hospital, and nurses thought no more of danger with them than with other diseases. They entered hospital prepared to face any danger of infection as a matter of course, and did not expect to be carefully watched and guarded for risk of contagion". This new approach, she concluded, was "not altogether to the best interests of nursing".¹²⁶ Those who did make the ultimate sacrifice did so with "courage and devotion" in the service of others.¹²⁷ The life of Mary Webb who died in 1909 after a three-year illness, was said to have been "really sacrificed to duty".¹²⁸

122 Rodgers, 'A paradox of power and marginality', pp.120-122.

123 This belief persisted well into the 1930s. Sue Barton, heroine of the most famous and widely read girls' nursing novels published in this period, "proves" to herself and her supervisors that she is a model nurse when she is prepared to sacrifice her life to prevent a patient from harming herself. Although her strict and formidable tutor admits to being proud of her pupil's deed, she adds that Nurse Barton was only doing her duty, and that she would expect all her nurses to do the same, H. Boylston. *Sue Barton, student nurse*, London: Bodley Head, 1939, pp.205-206.

124 AJHR, H-31, 1912, pp.4, 67-70.

125 Report on Dunedin Hospital staff, ODT, 2 December 1910, OHB newspaper cuttings, v.2, p.85.

126 Editorial, *KT*, 10:3, July 1917, pp. 127-128.

127 These words were used in reporting the death of Nurse Nisbet at Christchurch Hospital in 1910, NCHB minutes, 15 June 1910, p.27.

128 *KT*, 2:3, July 1909, p.117.

Like their leaders, nurses did not see ill health as something which might deter them from nursing. Illness, as the *Lyttelton times* noted in an editorial, seemed to be accepted as a more or less natural result of the conditions of nursing work.¹²⁹ Nurses often adopted a casual approach to the risk of disease. "I think we tried to be as careful as we could", recalled Cicely Cole, who trained in Auckland in the 1930s. "... I suppose it [tuberculosis] was one of the hazards that we knew could happen ... If you got it that was your bad luck".¹³⁰ Many sick staff were determined to continue with the work they loved. Ellen Bishop who trained at Dunedin Hospital became greatly debilitated by diphtheria and influenza in 1919 and was forced to take 10 months off. She continued to suffer from ill health after registering in 1920, and wrote to the matron, saying that she often wondered if she should have completed her training. But, she added, "hospital life & work has a great fascination & I was so happy in my training and ever so pleased I trained in Dunedin instead of a smaller hospital". Grace McMillan caught influenza, diphtheria and scarlet fever in quick succession, but did not enjoy her long sick leave at all. "I have grudged every moment I have lost", she wrote to the matron, adding that her mother would only allow her one more try. If she was forced to leave, she said, it would be "a great disappointment to me".¹³¹

Nursing acceptance of the vicissitudes associated with their work allowed hospital boards to do little to protect their staff from infection. Vaccinations were provided in some instances when nurses were working with infectious patients.¹³² In 1918, Dunedin Hospital drew up a set of guidelines for staff working with such patients. These provided for medical

129 *LT*, 23 August 1928, NCHB newspaper cuttings, p.269.

130 Quoted in D. Dunsford, "Tuberculosis and the Auckland Hospital nurse, 1938-1948", L. Bryder & D. Dow (eds.), *New countries and old medicine: proceedings of an international conference on the history of medicine and health, 1994*, Auckland: Auckland Medical History Society, 1995, p.290.

131 Personal files, Dunedin Hospital School of Nursing records, DUHO.

132 Nurses at Christchurch who were expected to nurse smallpox patients were vaccinated in 1913, *Press*, 24 July 1913, p.2c. Auckland nurses in the infectious ward were inoculated against typhoid in 1911, *AJHR*, H-31, 1911, p.85 but Christchurch Hospital staff were not advised to accept inoculation against typhoid until 1928, NCHB minutes, 26 September 1928, p.128.

examinations at the beginning and end of tours of duty in infectious disease wards and a limit of three months nursing in these wards and at the sanatorium. Pupil nurses were not to be asked to work in these wards until at least their second year of training.¹³³ Nevertheless, almost without exception, Christchurch Hospital nurses of the 1920s remembered supervision of their health as "sketchy", "erratic", "haphazard" or "none" until 1928, when the public furore caused by the death of Nurse Helen Jones from military tuberculosis in 1928¹³⁴ resulted in biannual medical examinations for every nurse, including chest x-rays. By 1930, when the furore had died away, examinations had become annual rather than biannual and were done in the late afternoon or evening "so as not to disturb the ordinary work of the Hospital".¹³⁵ Napier Hospital was apparently the only other institution to hold similar examinations, although Janet Moore proposed at the 1929 conference of the Trained Nurses' Association that periodic personal health examinations should be used throughout training, utilising the nurses themselves as lessons in preventive medicine.¹³⁶

Most hospitals provided free medical care for their own nurses, although not for nurses outside their employ,¹³⁷ and nurses were generally well looked after when they did become sick. Dunedin Hospital set aside small rooms in new wards opened in the 1910s specifically for the care of sick nurses.¹³⁸ Paid sick leave, however, was very limited in the early years.

133 OHB recommendations, 20 June 1918, H1 21/23/47, NA; *ODT*, May 1918, OHB newspaper cuttings, v.12, p.167.

134 A public inquiry was held during which the matron, Rose Muir, was accused of neglect, lack of sympathy and unkindness because she refused to give Nurse Jones time off when she first became ill. See NCHB minutes, 25 July 1928, p.1, 30 July 1928, pp.50-67 (this report includes newspaper cuttings about the inquiry); Rose Muir to Miss Bicknell, 31 July 1928, CH 426/26a, NA (Christchurch); newspaper reports on the inquiry, H1 85/54, NA.

135 NCHB minutes, 25 June 1930, p.507.

136 *KT*, 22:4, November 1929, p.165.

137 The Wellington Hospital Board, for example, refused to offer concessions to private nurses being treated in the hospital in 1911, Canterbury Trained Nurses Association minutebook, 5 April 1911. At the Hospitals Conference held in 1911, no agreement could be reached on a proposal that all nurses should be treated by boards free of charge when sick, but most boards were said to care for their own nurses gratuitously, *AJHR*, H-31, 1911, p.204.

138 *KT*, 8:1, January 1915, p.37; *ES*, 17 December 1917, OHB newspaper cutting books, v.8, p.148.

Wellington Hospital's by-laws provided for two weeks' sick leave in 1909, although if the disease was contracted through nursing duty, the board might continue pay for a longer period.¹³⁹ In 1910, Christchurch Hospital allowed one month's leave on full pay, adding however, that "the time so lost must be made up."¹⁴⁰ This policy did not change until 1918 when the Dunedin and Waikato Hospitals introduced a month's sick leave on full pay which could be taken without affecting the nurse's status.¹⁴¹

The same year the Department of Health stated that sick leave was a question for individual boards to decide, but recommended a similar policy to that used within the public service.¹⁴² This formula, which allowed for sick leave of one week on full pay for those who had served for three months, two weeks on full pay for those who had served for six months and a month on full pay for those who had served a year, rising to as much as six months on full pay and 12 months on half pay for those who had served for over 30 years, was adopted by the North Canterbury Hospital Board in 1927.¹⁴³ Most nurses in training became eligible for a month's paid leave, as well as a month on half-pay. When matrons discussed sick leave at their conference in 1929, they agreed that most boards were reasonably generous at least with their own nurses, and no further action needed to be taken.¹⁴⁴

Martha Vicinus described life within the communities of single women she investigated as a "paradox of power and marginality, of enormous strength within narrow limits, of unity and support linked with division and doubt".¹⁴⁵ New Zealand nurses were able to create a powerful world of

139 McDonald & Tulloch, p. 9.

140 *Christchurch Hospital by-laws, 1910*, p.8.

141 *ODT*, 16 May 1919, OHB newspaper cuttings, v.15, p.81; *Waikato times*, 12 July 1918, *Journal of the Department of Public Health*, 1:4, August 1918, p.251.

142 *Journal of the Department of Public Health*, 1:17, November-December 1918, pp.321-322.

143 NCHB minutes, 28 September 1927, p.106.

144 *KT*, 22:2, April 1929, p.55.

145 Vicinus, p. 9. Jan Rodgers used the phrase as the title of her PhD thesis on the community of New Zealand nurses who served during World War 1, 'A paradox of power and marginality': New Zealand nurses' professional campaign during war, 1900-1920', 1994.

friendship and encouragement which enabled many of them to survive the hardships of training and secure a professional qualification. But this achievement came at a cost. The nurse's world within hospital and nurses' home was a fragile one which required her to sacrifice her interests to the needs of others. The ideologies of self-sacrifice, obedience and submissiveness which nurses believed essential to winning acceptance for nursing as a respectable womanly occupation allowed male superiors to ignore their claims to a safe and comfortable working environment. Senior nurses, determined to maintain the "true spirit" of nursing as one of service before self, saw no need to intervene on behalf of their subordinates. The nursing 'family' could offer women a lot of fun and friendship but it could also be dangerous, sometimes fatally so.

Chapter 9

Preserving "the true spirit of nursing": the challenges for nursing created by a new generation of nurses in the 1920s

During the first world war, over 500 New Zealand nurses (nearly a quarter of the total nursing workforce) served with distinction in the New Zealand Army Nursing Service. Their work among the troops won for them a high degree of public admiration and respect.¹ The notable reputation of New Zealand nursing generally was confirmed in 1921 when New Zealand was granted full reciprocity by the newly established General Nursing Council of England. Hester Maclean, assistant inspector of hospitals within the Department of Health and matron-in-chief of the New Zealand Army Nursing Service, described this recognition as "very gratifying and ... a testimony ... to the efficiency shown by our nurses who ... were sent to serve during the war".²

Nevertheless, the war also brought in its wake enormous problems. War-time medical advances placed increasing emphasis on surgical techniques and specialist treatments, which required nurses to be better educated and to have higher levels of scientific knowledge and technical skill. A dearth of applicants for probationer positions meant that matrons could not easily select well qualified students. Hospitals were forced to accept much younger trainees in order to obtain staff. There was also an acute lack of experienced ward sisters, the most senior women having left to join the army nursing service.³ Those who remained, often new graduates themselves, had neither the time nor the skills to pay much attention to their teaching responsibilities with regard to nurses in training.⁴

1 Dr Valentine, the Director-General of Health, for example, noted in his annual report that the name of the New Zealand nursing service stood particularly high after its war efforts, *AJHR*, 1920, H-31, p.9. Mr Allen, the Minister of Defence, in welcoming nurses returning from overseas service in 1919, spoke of the high esteem in which the ladies were held and noted that the excellent reputation gained by New Zealand's soldiers was matched, if not exceeded, by the army nurses, *KT*, 12:2, April 1919, pp.83-84.

2 Maclean, *Nursing in New Zealand*, p.27.

3 For example, Rose Muir, matron of Christchurch Hospital, noted in her 1923-4 annual report, that it was the first time since the war that the hospital had had a full staff of sisters, NCHB minutes, 25 June 1924, p.18.

4 Jessie Bicknell wrote to the Director-General of Health in 1926, saying "Sisters have apparently failed of late years to recognise their responsibilities with regard to the pupils

Of even more concern to nursing leaders was the apparently changing character of the nursing workforce in the 1920s. The profession, they believed, was becoming overrun with women who became nurses for the purpose of "making a living rather than for love of the work". A "grasping spirit" of commercialism was replacing the "true spirit of nursing", which was devotion to service.⁵ A contributor to *Kai tiaki* in 1925 declared that the new generation of nurses in training were inevitably touched by the wave of "gaiety and extravagance" which broke out after the war, encouraging them to seek the pleasures of life rather than its duties. Training schools were now very different places, she said, where younger and better educated pupil nurses wore more attractive uniforms, received more pay and worked shorter hours under more relaxed disciplinary regimes. Nursing had become disassociated from its religious basis and girls were encouraged to take up the work as a means of livelihood rather than from motives of serving the poor and sick. Theoretical knowledge and the ability to pass examinations had replaced moral character and practical skills in measuring a nurse's worth.⁶ Accordingly, nursing leaders in the 1920s were determined to pursue policies on training, discipline and other nursing issues which preserved the "true spirit of nursing" which they believed had won respect and approbation for a womanly occupation.

Was the character of the nursing workforce changing in the 1920s? The analysis of New Zealand's Nightingales in Chapter 6 found that nurses who trained in Dunedin from 1910 to 1918 were younger, less middle-class and less likely to make a life-long commitment to nursing than the women who trained before 1910, although not markedly so. In order to test whether further changes occurred after the war, an analysis has been made of two cohorts of nurses who trained at Christchurch and Dunedin Hospitals in the years up to 1930. In the years between 1919 and 1925, records are available for 215 women who entered Christchurch Hospital's School of Nursing. Of these probationers, 171 became registered nurses

in training", memorandum, 24 March 1926, H1 21/9, NA.

5 Letter to editor, *KT*, 16:1, January 1923, p.25.

6 *KT*, 18:4, October 1925, pp.176-177.

after passing the state examinations.⁷ There are also records for 161 nurses who completed training at Dunedin Hospital between 1919 and 1930, although none for those who failed to complete training.⁸

Further information is available about Auckland and Wellington nurses in the 1920s. Deborah Dunsford has analysed information from the nurses' registers at Auckland Hospital between 1913 and 1947,⁹ while Margaret McDougall has examined the records of 375 women who trained at Wellington Hospital from 1916 to 1925.¹⁰

Age of student nurses

The most obvious change among nursing personnel in the 1920s was their comparative youth. Whereas in the earliest years of trained nursing, most pupil nurses had been aged between 23 and 30, by 1930 the trend towards younger women, already evident immediately before the war, had become firmly established. Over half the nurses who trained at Christchurch Hospital were aged 22 or less, while nearly 72% of those who trained at Dunedin were among this age group. For the first time, women under 20 are recorded as entering training. Christchurch Hospital engaged at least twenty-five 19-year olds, while Dunedin employed thirty-six 19-year olds and six 18-year olds. The table below gives details of the ages of pupil nurses at both hospitals at the point when they commenced training.

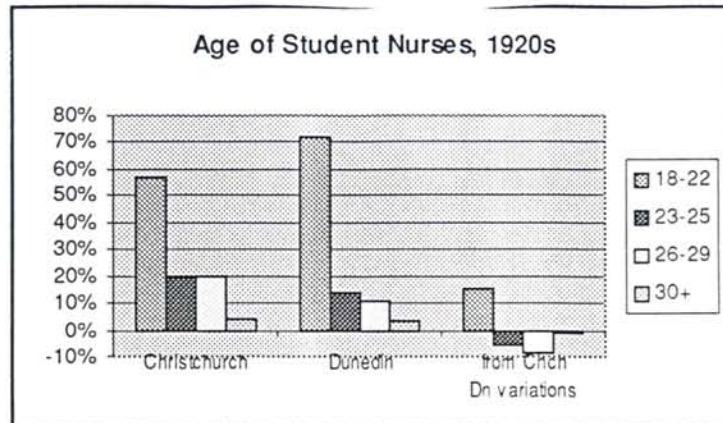
7 The personal files of these nurses are held in the Christchurch Hospital records at National Archives, Christchurch, CH 293, Box 86. They form the basis for the following analysis.

8 Personal files for these nurses are held at Hocken Library in the Dunedin Hospital Nursing School records, AG 37/94. The records for those whose surnames began with U-Z are missing.

9 Dunsford, 'The privilege to serve others', pp.134-141.

10 M. McDougall, "Discovering our past through exploring a register from Wellington Hospital, 1916-1925", *Looking back, moving forward*, pp.23-32.

Age of Student Nurses during 1920s			
Age	Christchurch	Dunedin	Dn variations from Chch
18-22	57%	72%	15%
23-25	19%	14%	-6%
26-29	19%	11%	-8%
30+	4%	3%	-1%
	100%	100%	



Dunsford found that between 1921 and 1940, the ratio of probationer nurses aged 20 or less remained at about 60-70% of total applications, with 24-40% being aged 21-25.¹¹

Nurses were increasingly younger because it was evident that not enough suitable older women could be attracted to the profession. The Nurses' Registration Act (1901) had fixed the age of registration at 23, which meant women could not enter training until they were at least 20. As early as 1912, Alice Holford, matron of St Helens Hospital in Dunedin, had noted the problems inherent in this policy:

Girls may marry and become mothers at 18 years ... and yet debar them from entering at that age upon a profession which next to motherhood, is recognised as the highest ideal for women ... A girl may enter for a medical course ... and be a fully qualified medical practitioner at the age of 21 years ...

¹¹ Dunsford, op. cit, p. 135 and appendix 1.1, p.184.

but she is debarred by an unwritten law from learning to nurse ... until she is 21 years old.¹²

With the outbreak of war and as other employment opportunities opened up, the long gap between the end of schooling and the beginning of nursing training inevitably resulted in potential nursing applicants being lost to other occupations. In August 1919, Dunedin Hospital, desperately short of staff, dropped the starting age to 19,¹³ and in 1921, dropped it again to 18.¹⁴ This was made possible by an amendment to the Nurses' Registration Act in 1920 which permitted nurses to register at 21, instead of 23.¹⁵

Although they acknowledged that recruitment demands made the lowering of the registration age unavoidable, nursing authorities were not happy about it. As one matron explained, "A nurse's life is a life of sacrifice and I consider that it is impossible to expect ... a girl of 18 to 21 to give that sacrifice".¹⁶ Young women, it was generally agreed, were both physically and emotionally too immature and unreliable to make good nurses. So, as recruitment problems eased in the early 1920s, pressure was exerted on the Health Department to restore the registration age to 23. This was done in the Nurses and Midwives Act (1925).¹⁷ Within a year, the Department advised that again there was a "difficulty in securing a sufficient number of pupil nurses".¹⁸ After exhaustive inquiries among authorities at all hospitals, it was accepted that, while nurse pupils of more mature years were certainly desirable, the higher age limit simply did not give matrons sufficient choice of probationers. Accordingly, regulations in 1927 allowed nurses to sit the state examination at the age of 21, although they could not become registered until they turned 22.¹⁹

12 *KT*, 6:1, January 1913, p. 12.

13 H1 21/23/47, 2 September 1919.

14 *ES*, 12 February 1921, OHB newspaper cuttings, v.18, p.44.

15 New Zealand statutes, 1920, no.55, p.413; *KT*, 13:3, July 1920, p.106.

16 Responses to Department of Health circular no.7/Hosp.6/1926, H1 21/23/86, NA.

17 New Zealand statutes, no.10, 1925, s.19, p.22.

18 Department of Health circular letter, 13 March 1926, H 426/26a, NA.

19 New Zealand gazette, no.16, 17 March 1927, p.644.

Older women still became nurses in the 1920s but they tended to be the exception rather than the rule. Most delayed their training for very specific reasons, usually relating to family responsibilities. Sarah Elliott, who was 30 when she entered Dunedin Hospital in May 1921, wrote that she had longed to nurse for many years "but my duty at home came first; and I have never been free before ...".²⁰ Margaret Macpherson (30) had joined her brothers in New Zealand from Scotland only weeks before she began training in February 1920, while Mary Minogue (31) and Alexandrina Gregory (34) were registered midwives who wanted to train as general nurses. Mrs Eleanor Knight, who entered Christchurch Hospital in 1920 at the grand old age of 41 had for many years been matron of the Tuarangi Old Men's Home in Ashburton. Her desire for formal nursing training was an acknowledgement of the professional qualifications now demanded of nurses in even the humblest branches of the profession.

Educational standards

The gap between schooling and nursing was closed not only by accepting younger nurses, but also by seeking applicants with higher educational attainments in the 1920s. Although there was no national regulation governing the standard of education required to enter nursing, it had long been accepted that Proficiency (Std 6) was a minimum requirement. In an era of increasing medical specialisation and technological advance, however, many doctors urged that nurses needed a good secondary education in order to cope with demands for skilled assistance which were being asked of them. As one medical examiner stated, the "ill-educated nurse", no matter how willing and kind, "can never be a first-class nurse".²¹ Nursing authorities were not entirely convinced but, as the matron of New Plymouth Hospital informed Miss Bicknell in 1924, it really was not worth accepting uneducated girls, as they caused far too much trouble at the time of the state examination.²² "Education combined with refinement is what we want", she wrote, although she agreed that it was

20 Application letter, 8 July 1920, personal file, Dunedin Hospital School of Nursing records.

21 *KT*, 21:4, October 1928, p.190.

22 Letter, 1 October 1924, H1 21/23/12, NA.

"rather difficult to get at times".²³ By 1929, a matrons' conference unanimously resolved that preference should be given to applicants with at least two years of secondary education, where possible.²⁴

The standard of education among the nurses who trained in Dunedin and Christchurch in the 1920s reflect these changes. One hundred and eight Christchurch nurses or 58.3% had attended a secondary school and three had even attended Canterbury College. Fifty-one (27.5%) had left school after passing Standard 6 (Proficiency).²⁵ A similar proportion of Dunedin nurses (31%) had only a primary school education, while 97 (60%) had attended secondary school.²⁶ Of these, eight nurses (8.2%) had attended for one year, twenty-five (25.7%) for two years, twenty (20.6%) for three years, and 32 or nearly a third (32.9%) for four years or more.²⁷

Young women of limited schooling but otherwise possessed of a refined and worthy character were by no means rejected as candidates for nursing. Jessie Bickerstaff, for example who trained at Christchurch, found study very difficult and failed several examinations on her way to achieving registration in December 1926 but was praised by authorities as a "good, solid, well-balanced type ... with excellent ideals of service", "a very excellent young woman" who was a good influence on others and should be a credit to the profession. Similarly, Edna England's "sound practical work" was perceived to "more than compensate for her lack of theory".²⁸ Nevertheless, no school of nursing could sacrifice its reputation by employing large numbers of pupil nurses who regularly failed examinations. It is clear that, as nursing became more specialised during

23 Letters to Miss Bicknell, 7 October 1924 and 30 January 1925, H1 21/23/12, NA.

24 *KT*, 20:3, July 1927, p.143: matrons at the first matrons' conference resolved to seek approval from hospital boards to select girls with secondary education; *KT*, 22:2, April 1929, p.55: resolution regarding two years' secondary education.

25 The remaining nurses had either been educated at home by a governess (seven women) or had been educated abroad (four each in England and Australia, three in Scotland, two in Ireland and one in South Africa).

26 Two girls had had governesses, two were educated in Scotland, and one each in England, Ireland and Australia.

27 Details on the number of years they spent at secondary school for the remaining 12 women are not given on their application forms.

28 Dunsford, pp.136-137 discusses similar trends at Auckland Hospital in this period.

the 1920s, women with little general education struggled with the theoretical aspects of the course. Inability to pass examinations was a major reason for failure to complete nursing. Ten of the 44 Christchurch nurses and at least nine of the Wellington nurses who left without finishing the training course did so for this reason.²⁹ Many other nurses, like Miss Bickerstaff, failed one or more examinations along the way to registration, at least 12 nurses at Christchurch Hospital and four at Dunedin. One Dunedin nurse failed her examinations so many times and showed so little aptitude for her work that Hester Maclean advised the board to pass a by-law prohibiting continuation of the course after two examination failures. This nurse was given a final chance (she was "quiet and respectful" and keen to qualify) and did eventually register, but the "two failures" limit was largely set in place by the end of the decade.³⁰

Race

In at least one respect, the new generation of nurses in the 1920s had changed hardly at all. Nurses remained overwhelmingly pakeha. Dunsford found in Auckland that it was difficult to establish the number of Maori applicants there, although those interviewed remembered perhaps one or two Maori pupils during their training days. Metropolitan hospitals, she suggests, probably had little appeal for potential Maori nurses, who preferred smaller and less rigidly structured training schools nearer their homes.³¹ The pool of possible Maori applicants for Christchurch and Dunedin places was even smaller, distant as they were from the main centres of Maori population. Only two of those who trained at the two hospitals in the 1920s can definitely be said to have had Maori backgrounds. Their experiences illustrate clearly why few Maori women took up nursing in this period. Hina Mahara Booth, who entered Christchurch Hospital in February 1924 resigned at the end of June, although she passed the first state final in anatomy and physiology in first place in the class. It seems likely that she found the overwhelmingly alien

29 McDougall notes that a further 24 nurses did not register after working at the hospital for 3-5 years, presumably also because they failed examinations. However, this information is not specified in the records, McDougall, pp. 27, 31.

30 Correspondence between Hester Maclean, Miss Myles (matron) and the secretary of the Otago Hospital Board, 7 November-7 December 1921, H1 21/23/47, NA.

31 Dunsford, p.140.

culture of the hospital too difficult to cope with. The experiences of Nurse M. at Dunedin Hospital (1927-1930) illustrate the kind of prejudices Maori nurses faced in pakeha training schools.³² Nurse M. was suspected of dishonesty. After she admitted borrowing some clothing from another nurse, the loss of money and other items in the Nurses' Home was immediately laid at her door. Although nothing was proved, the matron refused to give her a testimonial when she completed her training, despite police assurance that in "the borrowing of clothing among such people it is difficult to distinguish between borrowing and thieving". Nurse M.'s troubles did not end with her departure from Dunedin. When she began midwifery training at St Helens in Christchurch the following year, former colleagues from Dunedin Hospital immediately spread rumours about her thieving, and as the matron wrote to Miss Tennant of Dunedin, the "unfortunate girl" found herself ostracised. Nurse M. must have shown considerable strength of character, because she completed both courses before returning to her home town to nurse privately, but in the light of her experiences, it is hardly surprising that other Maori women found the whole idea of nurse training too daunting to contemplate.

Prejudice against Maori probationers was certainly not confined to Dunedin Hospital. Health Department officers often had considerable difficulty in finding places in training schools for Maori women desirous of becoming nurses. Matron Keddie of Waikato Hospital told Miss Bicknell in 1928, in response to a request for places for two Maori pupils, that

As we have had a good deal of trouble one way and another with the Maori nurses and still have Staff/N R. and Nurse H ... [the medical superintendent] thinks that we ought to have a rest for a time and give one of the other Hospitals the privilege of training a few.³³

³² The following details are discussed in a series of letters on Nurse M's personal file.

³³ Miss Keddie to Miss Bicknell, 5 February 1928, H1 21/15, NA. Other doctors also proved to be obstacles to Maori nurse training. The matron of Whangarei Hospital told Miss Lambie in 1933 that, although she would like to accept a Maori probationer, the medical superintendent, Dr Hall, was "rigid" in his opposition. Having been let down once by a Maori nurse, he much preferred nurses "of our own type". Regrettably, she suggested the applicant be trained elsewhere because "it would be very unpleasant for her if she came here and was not happy" (Matron to Miss Lambie, 2 August 1933, H1 21/15, NA).

Miss Bicknell accepted this dictum, agreeing that as Dr Gower was so "helpful" with Maori nurses, "we must not overtax his good nature". She then tried Napier, Gisborne and Thames Hospitals, but Thames declared it had no vacancies, while Gisborne did not want to take another Maori girl until the one they had already had finished her training. She was, said the matron "a very nice girl ... but has been a trial to train". Eventually, Miss Macdonald of Napier Hospital, consistently the institution most willing to accept Maori pupils, reluctantly agreed to take the two students, "but not more. Personally, I prefer not to have them at all", she said, "but of course we have to help train these girls to help their own people".³⁴ Pakeha nursing authorities had little understanding of either the cultural or language difficulties faced by Maori probationers in the hospital environment. Miss Bicknell, writing to the matron of Hawera Hospital about a Maori nurse's failure to pass her examinations, informed her that "We have frequently found that even the better educated Maori girl fails to express herself clearly in writing", while the examining doctor declared her papers to contain "impossible types of statement", "doubtless attributable to the Maori cerebration".³⁵ Allowances might be made to some degree, Miss Bicknell, conceded, but only if the candidate showed practical skill and an enthusiasm for working among her own people.³⁶

"Working among her own people" was the only work considered suitable for the qualified Maori nurse. It was acknowledged that Maori nurses generally did well in Maori public health positions, although only as assistants to pakeha nurses. Pakehas were perceived to have more authority among Maori patients.³⁷ Positions in the Maori health service were not always readily available however, and as Hester Maclean noted in her 1923 annual report, this created problems. Few Maori nurses were offered hospital positions. The medical superintendent of Palmerston

34 Letters between Miss Bicknell and the matrons of the three hospitals, 9 March, 12 March, 14 March, 15 March 1928, H1 21/15, NA.

35 Matron to Miss Bicknell, 30 December 1929, Miss Bicknell's reply 6 January 1930, H1 21/15, NA.

36 *ibid.*

37 Minister of Health to Bishop of Thursday Island, Queensland, 25 February 1928, H1 21/15, NA.

North Hospital wrote to Dr Valintine of a recent Maori graduate, who had passed her examinations with credit, saying that she could not very well be put in charge of a ward.³⁸ Nor could a Maori woman expect to find private work among pakeha patients. Maori nurses would simply have to hope that "the well-to-do Maoris will give them employment", concluded Maclean, adding that several nurses were carrying out private midwifery work quite successfully.³⁹

The obstacles facing Maori nurses were thus almost insurmountable and it hardly surprising that few Maori women trained and even fewer qualified. By the end of the decade, Miss Bagley had to admit that although applications from Maori girls were always considered sympathetically, over the last year or two, fewer and fewer had been received.⁴⁰

Marital status

Like their predecessors, nurses in the 1920s were overwhelmingly single women. Two married women were among Christchurch Hospital's 1920s probationers but Mrs Rita Viscon left after failing her anatomy and physiology examination while Mrs Eleanor Knight was, as has already been noted, already matron of the Turangi Home and wished to qualify in order to keep that position. There do not appear to have been any married trainees at Dunedin Hospital in this period. Dunsford cites the requirement to live in the nurses' home and the dedication to service and duty which might be hindered by a marital relationship as reasons for insistence on single women,⁴¹ but nursing authorities also shared the general public view of the time that married women should not work outside the home. Women teachers, for example, were dismissed immediately upon marriage. The Wellington Branch of the Trained Nurses' Association in 1929 questioned whether married nurses with "husbands to support them" should be entitled to work for the Nurses' Bureau (as private nurses) on

38 Dr Wilson to Dr Valintine, 23 April 1923, H1 21/15, NA.

39 AJHR, H-31, 1923, p.31.

40 *KT*, 22:4, November 1929, p.200.

41 Dunsford, pp.149-150.

the same terms as single women,⁴² while the Waikato Hospital Board stated firmly in 1934 that no married couples were to be employed by the Board.⁴³ Accordingly, as Dunedin nurse Marion Martin recalled, "If we got married, well, we were out. That was it. And they took no married staff on".⁴⁴ This policy remained unchanged until the the desperate shortages occasioned by the second world war forced authorities to encourage married women whose husbands were overseas to enter or return to training.⁴⁵ Even so, prejudice remained strong, and these nurses were accepted only "under duress and with terrible comments".⁴⁶ Furthermore, the policy was, as the Department made clear "to be regarded purely as an emergency measure for the period of the war".⁴⁷

There were some nursing positions which were perceived to be suitable for married women. Midwifery in particular, which had traditionally been the preserve of married women, continued to attract them, at least four being listed among the successful candidates at the state midwifery examination in June 1921.⁴⁸ In 1929, a Mrs Dick (formerly Sister Mary Hobbs) was appointed under the Mental Defectives Amendment Act to carry out follow-up work on the care of retarded and defective children, her experiences as a nurse and a mother believed to fit her well for the position.⁴⁹ Perhaps most significantly, gender ideologies deemed it "improper" for single women or indeed any woman to nurse venereal patients. Many hospitals retained one or two male warders for this type of nursing for many years after trained female nurses supplanted them elsewhere in the hospital⁵⁰, and as late as 1925, the *Otago daily times* asked whether "girls of the best type" could be expected to carry out duties "that are revolting to every woman of delicacy and refinement?" The

42 NZTNA Wellington Branch minutes, 8 May 1929.

43 R. Wright-St Clair, *The early history of Waikato Hospital*, p.28.

44 NERF oral history tapes, Marion Sainsbury, tape 65.

45 Department of Health circular to hospital boards, 3 January 1940, H1 54/11/19, NA.

46 Dunsford, p.157; Marion Sainsbury reminiscences, NERF oral history tape 65.

47 Department of Health circular to boards, 3 January 1940, H1 54/11/19, NA.

48 *KT*, 14:3, July 1921, p.113: Mrs Ellen Crossan and Mrs Hilda Coyle of St Helens, Auckland; Mrs Ada Jeffreys, St Helens, Gisborne; Mrs Mary Walker, St Helens, Wellington.

49 *KT*, 22:3, July 1929, p.134.

50 In 1925, Wellington Hospital stated that venereal patients were never handled by nurses, *ES*, 16 June 1925, OHB newspaper cuttings, v.27, p.111.

New Zealand herald suggested that male nurses should be reappointed for these tasks, which one English-trained matron declared no nurse should be asked to perform.⁵¹ *Kai tiaki* then took up the issue, several doctors agreeing that nurses should be exempt from rendering to male patients services which might cause them to lose their "sense of modesty". Rose Muir, matron of Christchurch Hospital, argued forcibly that the nurse's role as "social mother" overcame these objections; nursing was a service to all humanity, she said, and all nursing work was dignified by its aura of public service. "Every patient ... however disgusting or repulsive ... has once been loved and cared for by someone", and it was a nurse's place and duty to continue that care.⁵² Nevertheless, Christchurch Hospital remained the only hospital to employ a nurse at its venereal disease clinic, and even Miss Muir, all too aware of the "prejudice amongst nurses against nursing venereal disease",⁵³ selected a married woman for this role. In 1926, she allowed an English nurse, Mrs Voller to attend lectures and work in the wards at the hospital to prepare herself for the state examination, because she was "one of the most excellent people I have seen in dealing with the social question in the ... venereal disease clinic". Later Mrs Voller was replaced by another married woman, Mrs Farmer.⁵⁴

Social class

Nurses in the 1920s remained almost all white and almost all single women. Nursing authorities, however, were concerned that "commercialisation" had overtaken women in the profession. "Grasping" and "mercenary" attitudes, they believed, "overshadowed the true nursing spirit" which had been so evident among the women who trained before the war. Women now chose to nurse for the purpose of "making a living rather than for love of the work".⁵⁵ The implication was that a quite

51 *ODT*, 16 June 1925, *OHB* newspaper cuttings, v.27, p.82.

52 *KT*, 13:3, July 1925, pp.133-134.

53 *KT*, 22:4, November 1929, p.166.

54 Letters between the Department of Health and Miss Muir, 1 October 1926 and 11 April 1927, CH 426/26a, NA (Christchurch); NCHB minutes, 24 April 1929, p.249: Mrs Farmer appointed.

55 *KT*, 15:5, November 1922, p.205; 20:4, October 1927, p.216; 16:1, January 1923, p.25.

different type of young woman was now choosing to nurse, and for quite different reasons than those which had motivated the pre-war "Nightingales".

Nurse students continued to come from a variety of urban and rural backgrounds.

Birthplaces of student nurses, 1920s			
Location	Chch Nurses	Dn Nurses	Dn variation from Chch
Chch or Dn city	34%	28%	-6%
Other Sth Island cities	4%	6%	2%
Sth Island towns	25%	24%	-1%
Sth Island rural	19%	36%	17%
Nth Island cities	12%	2%	-10%
Nth Island towns	6%	2%	-3%
Nth Island rural	1%	2%	1%
	100%	100%	

Nevertheless, the proportion of nurses who came straight from farms had certainly declined, particularly in the case of Christchurch Hospital. The higher level of education demanded by matrons offers some explanation for this. However, many student nurses had already experienced paid employment so it seems as if women who chose nursing in this period either wanted or needed to earn a living, something which was much easier to accomplish in an urban environment.

More than a third of the applicants at both hospitals had not entered paid employment after leaving school. Sixty-eight Christchurch nurses (37.9%) and sixty-two Dunedin nurses (40.2%) cited home duties on their application forms, although at least four of the latter also mentioned undertaking farm work at home. However, the majority of applicants had been in paid work. Forty-five Christchurch nurses (25%) had worked in another nursing capacity, including 15 Karitane nurses (which involved a year's training) and 20 nurse aids in private hospitals (traditionally

accepted as useful way of filling the gap between school and a formal training programme).⁵⁶ The Dunedin cohort included 36 women who had worked in other nursing fields (23.3%). Several women from both groups were already professionally qualified, including eleven teachers, two maternity nurses, two journalists and two masseuses among Christchurch nurses (9.4%), and five midwives, two masseuses, two dental nurses and four teachers in Dunedin (8.4%). A further 29 from Christchurch (16.2%) and 22 from Dunedin (14.2%) had occupied clerical posts, a major change from the pre-war period when very few such positions were available to women. A number of other women were engaged in more lowly work. In Christchurch, seven women had been shop assistants, three children's nurses, four "companion helps" and two domestic servants (8.9%) while in Dunedin, there were five shop assistants, nine domestic servants, three "lady companions" and one children's nurse (11.6%). Only one Christchurch nurse worked in a skilled trade (as a dressmaker), but eight Dunedin nurses did so (two dressmakers, three milliners, two machinists and a weaver).

It might be supposed that if the women who became nurses in the 1920s needed to earn a living, then they probably came from less middle class and affluent backgrounds than their predecessors. In fact, at least at Christchurch Hospital, this does not seem to have been the case.⁵⁷ As in the earlier period, about a third (56) of Christchurch's nurses were from farming families (32.7%), at least ten women being from substantial runs or stations. The fathers of three nurses were orchardists, one a woolclasser and three others stock agents. A further 55 Christchurch nurses (32%) came from professional and business backgrounds. Among their fathers were eight clergymen, six accountants, five lawyers, four teachers, seven managers and 14 merchants. Nineteen women were the daughters of skilled tradesmen (11%) and only 14 came from the working

⁵⁶ Dunsford, pp. 139-140 notes that as more girls stayed longer at school, while at the same time the age of acceptance for nurse training dropped to 18 in the 1930s, fewer and fewer applicants had worked in private hospitals before beginning formal nursing. By the 1940s, this element had almost disappeared from Auckland Hospital's applications.

⁵⁷ Christchurch applications for nursing positions included details of father's occupation, so an analysis of most of the nurses at the hospital has been possible. The Dunedin applications did not include this information, which had to be gleaned from elsewhere. A much smaller sample - 92 nurses - has been therefore been used in this case.

classes (8%), with the remaining 20 coming from white-collar occupations, including 10 clerks (11.6%). Over a quarter of the nurses (50 women or 27%) had attended a private girls' schools,⁵⁸ with a further seven (3.7%) being taught at home by governesses.

Dunedin Hospital's nurses came from less exalted families. About a third (32 or 34.7%) came from farming families, with at least six being large farms, but the professional and business group was far smaller. Only 14 women came from this class (15.2%). The Dunedin cohort included 18 daughters of skilled tradesman (19.5%), 11 working class women (11.9%) and 11 daughters of white-collar workers, such as clerks, shopkeepers, hotelkeepers and salesmen. Only 18 women (11%) had attended a private girls' school and only two had been taught by a governess.

Reasons for choice of nursing

a) economic necessity

What is perhaps more germane, however, is that for the first time, many women said that they entered nursing because they needed to earn a living, rather than for ideological reasons of service. A large number of those training at both Christchurch and Dunedin Hospitals came from families where the father was either dead, ill, retired or otherwise unable to provide for them. At Christchurch Hospital, over a quarter (25.5%) of the applications which include details of father's occupation stated that the father was dead (seven of these women being completely orphaned), while in Dunedin an extraordinary 38% recorded either that the father was dead, ill or retired (22 dead, four ill, six retired and three orphans). In earlier years, these circumstances often obliged daughters to remain at home to care for either widowed mothers or younger siblings, but in the 1920s the money earned in paid employment seems to have been more important than unpaid familial service.

⁵⁸ For example, Rangi Ruru Girls' School, St Margaret's College, Columba College, St Hilda's College, Woodford House, Craighead, St Cuthbert's.

Many applicants wrote in their letters of application that their circumstances necessitated paid employment. Eva Sutherland and Joan Mackay stated clearly that they had to earn their own livings, Joan Mackay adding that she wanted a profession she could follow in later life if necessary. Daisy Sangster, the daughter of a Presbyterian minister, declared she had to make her own way in the world and liked nursing more than any other occupation.⁵⁹ Miss Muir of Christchurch Hospital noted in a letter to Jessie Bicknell that one of her nurses, also the daughter of a clergyman, could not afford to give up her training, even though her mother was very ill.⁶⁰ Other nurses indicated that it was their wish to be independent, whether from economic necessity or not. To get on in the world, wrote Kathleen Hardie, a girl needed to be qualified for a position, not just meander from one occupation to another.

b) traditional ideals

Nevertheless, women still chose nursing as a career for its traditional ideals of service and sacrifice. Dozens of applicants stated that they had always wanted to nurse and had waited anxiously to be old enough to begin training. Edith Lynn's referee wrote that she had "set her heart & soul on becoming a nurse". Other applicants talked of nursing as the "noblest, most unselfish profession", which, as Irene Ferguson (the daughter of a substantial runholder) put it, moulded one's character while at the same time broadened one's ideas by offering an independent livelihood. Annie Houston and Margaret Macpherson wanted to be independent but also to help the sick and needy, to be of use to others.⁶¹

⁵⁹ Personal files, Dunedin Hospital School of Nursing.

⁶⁰ Miss Muir to Miss Bicknell, 16 November 1928 about Nurse E. Cocks, CH 426/26a, NA (Christchurch).

⁶¹ Wellington pupil nurses in the early 1930s reiterated these sentiments in answering examination questions on the qualities required of a nurse: nurses must be mentally, morally and spiritually fitted for the work, one wrote, while another declared that "nursing means the giving of oneself in the service of weak and suffering humanity". It is "the practical touch of religion", added another; we must forget ourselves entirely and become a constant inspiration to the patient. Such answers, needless to say, reflected very much what pupils knew their examiners wanted to hear, but nevertheless the desire to serve others undoubtedly remained strong, *Wellington Hospital nurses' journal*, 1:1, 1932, p.7; 1:2, 1933, pp.4-5, 18; 1:3, 1934, p.8.

c) religious motivation

A number of women continued to train as nurses with the intention of becoming missionaries, although rather fewer than in earlier days. Only two women from each of the Dunedin and Christchurch cohorts in the 1920s appear to have taken up mission work (Dorothy Robertson and Winifred Thompson in Dunedin, Rhoda Heather and Agnes Jamieson in Christchurch), but others had this purpose in mind, even if it was never fulfilled. Jean Bell, for example, a teacher with a degree in home science, switched to a nursing career with a view to becoming a missionary, although in the end she married a Presbyterian minister instead.⁶² The Nurses' Christian Union was active in supporting missionary nurses, and in 1926 recorded 15 nurses who worked in China, India and Melanesia.⁶³ The successful establishment of the Union in 1924, under the patronage of Misses Maclean and Bicknell, demonstrates the importance many nurses placed on their spiritual and religious life. By 1926, the organisation included about 240 members in 19 branches.⁶⁴ Nevertheless, religious motivation was certainly perceived by outsiders to be less than in previous times. Dr Sandston, one of the supporters of the erection of a Church of England hospital in Christchurch, suggested that nursing was now more of a profession than a vocation, and that personal interest in patients and self-denial no longer existed. Nurses worked "to a time-table", he added, and "nothing spiritual at all was suggested to the patients".⁶⁵

d) life-long commitment

Some of the women who entered nursing in the 1920s intended to make the life-long commitment to service which had been so characteristic of their predecessors. Marion Shepherd, who began training at Christchurch Hospital in 1924 rejected any idea of marrying after discovering that her soldier fiance drank. The daughter of an alcoholic father, she could not

62 Williams, *Slate pencil to word-processor*, p.59.

63 *KT*, 19:4, October, 1926, p.175.

64 *KT*, 17:1, January 1924, p.26; 17:4, October 1924, pp.167-168 (constitution); 19:3, July 1926, p.13.

65 *ODT*, 22 November 1922, OHB newspaper cuttings, v.21, p.63.

face a repetition of her parents' marriage. "Firmly I shut the door on ideas of marriage", she said, "and never considered them again".⁶⁶ Miss Shepherd worked as a Plunket nurse throughout her long life. Frances Hayman, who began training as a midwife at St Helens in Christchurch in 1927 also resolutely set aside the possibility of marriage. When she received a proposal just after finishing her training, she faced " a painful tug-of-war" between the prospect of a home and family and "the fulfilment of a life's dream in which I felt I had only reached the brim". She believed she could not marry "when my profession was so paramount in my life", and accordingly chose to "find the joy and satisfaction I sought in rewarding work among mothers and their babies ...".⁶⁷

Nevertheless, nursing also began to attract women for whom the work was simply a stop-gap between school and marriage. One such woman was Gladys McLennan who trained at Invercargill Hospital in the late 1920s. The daughter of a tinsmith/gardener, Gladys left school early but through a family friendship, began nurse training at the age of 18. Having begun dating (and smoking) at the age of 15, Gladys "always thought [she] would eventually get married", and this she did at 21, after a six-week courtship and before sitting her final examinations. Leaving nursing, she added "was the happiest thing I ever did in my life".⁶⁸ In both the Christchurch and Dunedin cohorts of 1920s nurses, about 65% of those for whom information is available are known to have married, while only 25% in Christchurch and 18.6% in Dunedin are known not to have married.⁶⁹ Thus marriage was certainly more common among nurses than in the pre-war period, although still by no means universal. Only nine Christchurch nurses and ten Dunedin nurses left to marry before finishing training but 23 Wellington nurses left for this reason. A further 25 nurses in Christchurch and 16 in Dunedin left at the end of training to marry. The largest group of the rest, however, as the table below demonstrates, waited, like earlier nurses, from three to five years to marry.

66 M. Shepherd, *Some of my yesterdays: the autobiography of Marion Shepherd*. Invercargill: Craig Printing, 1989, p.75.

67 Hayman, *Suzie in transit*, pp.76-79.

68 K. Duder, *Hegemony or resistance?: the women of the skilled working class and the ideologies of domesticity and respectability*, MA thesis, University of Otago, 1992, pp.53, 57, 64, 67, 82, 84, 181.

69 A further 16% in Christchurch and 10% in Dunedin were still working as nurses ten years after registering and were unmarried at that time.

Marriage of nurses in 1920s			
Stage	Christchurch	Dunedin	Dn variations from Chch
Before exams	9 nurses	n/a	
End of training	29%	19%	-10%
1-2 years later	9%	15%	6%
3-5 years later	26%	36%	9%
6-8 years later	16%	8%	-8%
9-10 years later	5%	11%	6%
11 years +	5%	11%	6%
	100%	100%	

Certainly the younger age at which women were taking up nursing made it more likely that they would eventually marry, but the greatly increased rate of marriage, at a time when war losses meant fewer women overall were marrying, suggests a change in attitude to nursing as a lifelong career. In fact large numbers of women seem to have left nursing after completing training, whether for marriage or some other reason.⁷⁰ Forty Christchurch nurses (22.9% of those who registered) and a phenomenal 69 in Dunedin (43.9%) do not appear to have worked as nurses again.

The increasing dropout rate of nurse probationers during training also suggests a changing attitude to the profession. Of the Christchurch nurses who began training at the hospital between 1919 and 1925 and who continued after the probationary period of three months, 44 (20.1%) failed to finish the course. Nine left to marry, ten failed examinations, ten left for health reasons (Amy Risdon dying of tuberculosis), and four for disciplinary reasons. In Wellington, the drop-out rate was even higher, with 120 out of 375 trainees (32%) failing to register. Of the 102 students who lasted more than a few months, 23 left to marry, 24 for health reasons (two

⁷⁰ McDougall notes that 83% of Wellington Hospital's registered nurses left the hospital within four years of entering it. She has not, however, recorded which nurses left nursing altogether and which left to pursue other nursing careers so this figure is not definitive, McDougall, pp.27, 30-31.

died), six for family reasons, nine failed examinations and four left for disciplinary reasons.⁷¹

The careers of those who did continue to nurse reflect changing patterns in the 1920s. Far fewer nurses, for example, eventually became matrons, although many served as ward sisters.⁷² This decline is not entirely unexpected, given the expansion of the total nursing population but it does indicate that fewer women were pursuing life-long careers which might end at the most senior level. Plunket nursing was an increasingly popular choice for many nurses, who were attracted by its shorter hours and the option of independent living. By the mid-1920s, over 120 Plunket nurses were working round the country.⁷³ Private nursing also remained popular, although the rapid growth of hospitals in the period caused considerable hardship among those competing for the limited numbers of patients still requiring a nurse at home. Many private nurses in the 1920s worked largely for private hospitals. Twelve Christchurch nurses and 18 Dunedin nurses were employed full-time by such hospitals. Backblocks district nursing, regarded by authorities like Hester Maclean as demanding the highest levels of "true nursing spirit" and missionary-like devotion to duty because of its hardships suffered from a continual shortage of staff. Only three Christchurch nurses worked in this field and no Dunedin nurses took it up. Alexandra McKegg in her study of these nurses found there was a high turnover, the self-sacrifices required being tolerable apparently only for a year or so.⁷⁴ Many nurses still travelled (at least 25 Christchurch nurses and 21 Dunedin nurses spent time abroad, particularly in England and Australia) but only a very small number of those who trained in the 1920s seem to have served in the second world war (five Christchurch

71 McDougall, pp.25-27.

72 Christchurch Hospital produced three matrons of large hospitals, one assistant matron, two night superintendents, one Home Sister and ten matrons of small hospitals. Two women became matrons of St Helens hospitals, one of a Karitane hospital, two of private hospitals and two of old people's homes. Twenty five nurses worked as ward sisters in large hospitals and seven in small hospitals. Dunedin Hospital produced two matrons of large hospitals, three sub-matrons and one night superintendent. Two women became matrons of small hospitals and two of private hospitals. Seventeen nurses were ward sisters in large hospitals and 14 in smaller hospitals.

73 AJHR, H-31, 1925, p.25; Maclean, p.93.

74 A. McKegg, 'Ministering angels', pp.122-3, 127, 133-5; *KT*, 6:4, October 1913, p.153. Nevertheless, some nurses loved the work, regarding it as the best way of putting into practice the "first great principle of nursing - 'Service before self'", *KT*, July 1928, p.136.

nurses and four Dunedin nurses). This again perhaps illustrates how few women were still nursing by 1940.

The women who nursed in the 1920s shared with their predecessors some common characteristics. They were white, single and in many cases middle class women, many of whom chose to nurse for idealistic reasons of service and duty. They were, however, much younger than their predecessors and therefore much more likely to marry. Far fewer women pursued life-long careers and many worked because they needed or wanted to earn an independent living. These women had different expectations of nursing and a wider choice of careers than had their predecessors. It was these factors which influenced the development of the profession during the decade. Hospital authorities, faced with considerable staff shortages and strong public pressure, were coerced into improving working conditions, however minimally, while nursing authorities, convinced that the profession was in danger of losing everything which had made it the most respectable and acceptable of occupations for women, sought to maintain the standards of discipline and training which they believed were essential to retain "the true spirit of nursing" for the future.

Nurse training in the 1920s

Nursing leaders recognised that some changes would be required within nursing if it was to attract the right type of woman into the profession. Nurses who visited Europe and the United States found that many British and American hospitals no longer expected pupil nurses to devote most of their time to routine domestic work in the wards. Student nurses studied at preliminary training schools with specially-trained tutor sisters before entering the wards, were able to undertake postgraduate training courses and could even study nursing at university.

Serious consideration was given to these changes during the 1920s and by the end of the decade, certain modifications to training had been introduced. Some amendments were made to the theoretical curriculum,

which was considerably expanded. A degree of uniformity in training standards was achieved when small hospitals were prevented from registering as full training schools, and private hospitals were virtually prohibited from becoming training schools. The four metropolitan hospitals in Auckland, Wellington, Christchurch and Dunedin offered short preliminary training courses, run by tutor sisters, and tutor sisters were appointed at several smaller institutions. A successful postgraduate course for these tutors and for other registered nurses began in 1928.

Nevertheless, the 1920s brought no real metamorphosis to nurse training in New Zealand. The apprenticeship system remained firmly in place, with the educational requirements of the course secondary to the practical caring and domestic services given by nurses in the wards. An attempt to establish a university diploma in nursing at the University of Otago failed. Most significantly, moral character, rather than academic distinction, remained the touchstone which defined the true nurse. In the words of Millicent Ashdown, whose textbook *The complete system of nursing* was the "nursing Bible" in New Zealand nursing schools in the 1920s,⁷⁵ the ideal nurse remained

... punctual, good tempered, obedient, and loyal to all the rules as the foundation of her work. She must also be active, yet quiet and deft; methodical, reliable, careful, clean and neat; observant, intelligent, and economical; possessed of self-control, persevering gentleness, tact and sympathy, and common sense; careful to respect professional etiquette, remembering what is due to those in authority ... Nurses should always remember the sacredness of their profession, and hold it in such respect that they will never bring discredit on their uniform ... They must ever remember that discipline and obedience are the keynote to satisfactory and efficient work⁷⁶

The "true spirit of nursing" prescribed by Florence Nightingale in a letter to probationers at St Thomas's Hospital in 1881 and reprinted as a reminder in *Kai tiaki* in 1924 shaped the training programme and remained the standard against which the worth of pupil nurses was measured at all stages of their training.⁷⁷

75 Dorothy Compton, NERF oral history project, tape 29, ATL.

76 M. Ashdown, *The complete system of nursing*, 3rd ed., London: Dent, 1922, pp.1-2.

77 Nightingale's letter to the probationers of St Thomas's, 6 May 1881, *KT*, 17:3, July 1924, pp.123-124.

Nursing training was not transformed into professional education in the 1920s for a number of reasons. Like nurses everywhere, New Zealanders were constrained by the ambiguous attitudes of the medical profession towards higher status for nurses. Perhaps more important was the reluctance of hospital authorities to spend money on the educational needs of their student nurses or to recognise that these should take priority over the practical requirements of the institution for cheap nursing services. Nevertheless, while doctors and hospital administrators clearly retained a significant degree of influence over the shape of nursing education in the 1920s, by 1930 neither group had quite the same vice-like grip on its development as they had earlier enjoyed. In 1925, a new Nurses and Midwives Registration Act created a Nurses and Midwives Registration Board with five (later seven) members. Two members were doctors, one a representative of the Hospital Boards Association and the other four, including the registrar, were nurses.⁷⁸ Nurses themselves were thus in the driving seat of the organisation which determined all courses of training, approved hospitals as training schools, conducted examinations and approved all applications for registration. They were able to use this power to gain a measure of control over medical and hospital board domination in nursing education.

The most important victory achieved by nurses over parsimonious hospital administrators was their success in restricting the types of hospitals permitted to train nurses. Because there were only a few large hospitals in New Zealand, small town and rural institutions had always been able to offer nurse training programmes. In 1928, twenty-two of the 36 institutions with nurse training schools had fewer than 80 beds and 13 of those fewer than 50.⁷⁹ Improved transport meant these small hospitals no longer dealt with the serious cases which had once provided suitable training material for nurses. Accordingly, the Division of Nursing within the Department of Health urged affiliation schemes, whereby students from small hospitals

⁷⁸ NZ statutes, 1925, no.10, pp.16-24 and 1930, no.21, pp.77-79.

⁷⁹ Matron E. Tennant, *KT*, 21:4, October 1928, pp.182-184.

spent at least six months of their training at a larger hospital.⁸⁰ In 1930, despite vigorous complaints from cost-conscious provincial boards, this system was formalised, hospitals being designated as either A-grade or B-grade training schools. Small B-grade schools were permitted to offer only partial training.⁸¹

The same year, nurses were also moderately successful in fighting off the demands of private hospitals to train nurses. When a bill to this effect was introduced into parliament in 1929, the Trained Nurses' Association mounted a spirited campaign against its provisions. With the full support of the Medical Association, they argued that private hospitals, because they were mainly surgical, could not conform to the nursing syllabus and that reciprocity with Great Britain would be seriously affected. Such a measure would "lower the standard of nursing in the Dominion and affect our status throughout the world", they said.⁸² Accordingly, a modified version of the bill was passed, allowing nurse training only in the public wards of private hospitals. As Hester Maclean said, only a very small number of religious hospitals qualified, and thus the Act did not provide the easy economic solution that its promoters had hoped for.⁸³

Doctors of course remained a powerful influence within nursing. During the 1920s, they sought to reinforce their superiority within the health sector by refusing to allow nurses to train as anaesthetists,⁸⁴ and by fighting against the independence of nurse-midwives. It was in this period that both the medicalisation and hospitalisation of childbirth was secured.⁸⁵ Doctors continued to regard nurses as "handmaidens" whose duties were confined

80 Balclutha Hospital, for example, sent its students to Dunedin Hospital for six months during the third year of training, letter from the matron to Jessie Bicknell, 11 October 1929, H1 21/23/26, NA.

81 Regulations, New Zealand gazette, 10 July 1930, pp.2141-2162; AJHR, 1930, H-31, p.36 and 1931, p.27.

82 *KT*, editorial, 23:3, May 1930, pp.115-116.

83 Maclean, pp.28-29.

84 See above, pp.104-107.

85 See P. Mein Smith, *Maternity in dispute*, Wellington: Historical Branch, 1986; P. Sargison, "Meddlesome midwifery: Doris Gordon (1890-1956) and the medicalisation of childbirth", *Notable women in New Zealand health*, pp.45-48.

to assisting their medical superiors.⁸⁶ Nevertheless, some doctors wanted to increase the theoretical content of the nursing syllabus so that nurses could support them in the many highly technical and complex procedures developed at this time.⁸⁷ Jessie Bicknell, who succeeded Hester Maclean as director of the Division of Nursing in the Department of Health in 1923, viewed such proposals with disquiet. It was very important, she said, that training did not become too theoretical.

After all, the care of the patient was the real purpose of all nursing, and no amount of theoretical teaching could take the place of a sound knowledge of the practical side.⁸⁸

It seems clear that New Zealand's senior nurses actually resisted any encouragement, medical or otherwise, to develop either a more education-based or scientifically-oriented training programme in the 1920s. They believed that nursing's stature as an honourable occupation for respectable women would be damaged by any break away from Nightingale's prescription of nursing as a pragmatic training based on devoted service and moral worth. Hester Maclean said in 1919 that training methods needed to be improved but in order to revive the ideals of the past.⁸⁹ Scientific teaching and monetary rewards had "overshadowed the true nursing spirit".⁹⁰ If nursing was to move forward, it must restore that "spirit of true sacrifice"⁹¹ which had achieved for nurses respect and acclaim in the past.

Nursing leaders remained committed to the apprenticeship system of training, which enabled them to control the selection process and to maintain the regime of strict moral discipline regarded as essential in shaping the worthy nurse. A divorce between hospital and training school,

86 Dr P.C. Fenwick and Dr W. Fox of Christchurch Hospital both spoke of the nurse as "truly the handmaiden of the doctor", Fenwick, *The Christchurch Hospital*, p.45; Fox's annual report, 1925-6, NCHB minutes, 16 June 1926, p.637. A state examiner in 1925 commented on a major weakness in nurses' papers being the failure to differentiate between nursing and medical duties, *KT*, 18:2, April 1925, p.87.

87 See for example, Fenwick, p.45; the surgical state examiner, *KT*, 18:4, October 1925, p.185.

88 Address to the first matrons' conference, *KT*, 20:3, July 1927, p.137.

89 *KT*, 12:2, April 1919, p.58.

90 *ibid*, 20:4, October 1927, p.216.

91 President of the Trained Nurses' Association, *KT*, 18:4, October 1925, p.170.

said Hester Maclean, would be "just as deplorable as divorces usually are".⁹² The selection process was the matron's first tool in weeding out the unfit. Dunsford found that at Auckland Hospital from 1913 until 1947 between 22% and 40% of candidates were rejected at the application stage.⁹³ Matrons chose girls with "quiet, ladylike appearance and manners ... [and] moral character ... beyond reproach", who were "deferential to authority" and "tactful, careful and obedient".⁹⁴ At the end of the three months' probation period, a further weeding took place. At Dunedin Hospital in the period 1921-1926, approximately one third of pupils left at this point in the years 1921, 1925 and 1926, one sixth in the years 1923 and 1924 and an astonishing two-thirds in the year 1922.⁹⁵ Some left of their own accord, for health reasons or because they found they disliked the work, but most were found unsuitable by the matron. Probationers said to be "unsatisfactory", "untruthful", "not of a good enough type" or "simply totally unsuitable for training" were not asked to join the permanent staff. One girl in Dunedin was rejected because the "tone of [her] conversation [was] very undesirable".⁹⁶

Discipline within the nurses' home remained strict, as matrons sought to prevent their charges from bringing nursing into disrepute. Matrons could not afford to have moral lapses made public, thus causing nursing to lose its respectability. Matron Helen Brown of Dunedin Hospital made this clear in 1923 when she dismissed a nurse for staying out all night in the company of a medical student. "The poor mother ... told me that she was not anxious about her daughter because she thought she was so well supervised", she wrote to Hester Maclean." ... I felt as if I had failed her". Brown dreaded the thought of a public inquiry because other nurses would have to give evidence and she was sure "their mothers will take them home if they are dragged into it".⁹⁷

92 *KT*, 15:5, April 1912, pp.1-2; 12:2, April 1919, pp.86-87.

93 Dunsford, p. 146.

94 Referees' reports in the files of applicants to the Dunedin Hospital School of Nursing, DUHO.

95 Dunedin Hospital School of Nursing pupil registers, 1921-1926, Arch 37/94, Box 6a, DUHO.

96 Personal files of Dunedin nurses, Dunedin Hospital School of Nursing records.

97 Brown to Maclean, 4 October 1923, H1 21/23/47, NA.

As far as matrons were concerned, sexual misconduct meant instant dismissal from nursing. Within a few months of her appointment as matron in February 1925, Edith Tennant, who succeeded Helen Brown at Dunedin Hospital, had dismissed four nurses for such offences. A woman of forceful personality whose "high ideals ... strongly influenced her life's work",⁹⁸ Miss Tennant was uncompromising in her determination to preserve the high moral tone of the nursing profession.

Nevertheless, matrons sometimes found that hospital boards would agree to dismissals only in "cases of flagrant misconduct".⁹⁹ One Dunedin nurse found sitting in a side ward with a medical student while on night duty was found guilty of "gross dereliction of duty" but permitted to sit the state examination before being discharged.¹⁰⁰ Boards were reluctant to lose their investment in the training of a nurse without extracting a full measure of work service in return. Matrons therefore developed systems to prevent "unsuitable" women from continuing in nursing, even though they might have been permitted to register. All nurses required testimonials from the matrons of their training schools in order to obtain posts in any field of nursing¹⁰¹ and as Miss Tennant said, it was her "unfailing rule ... to give recommendations only to those whose work and conduct" was entirely satisfactory during training.¹⁰² In 1925, at Miss Tennant's suggestion, a "black list" of unsuitable trainees was issued to all matrons.¹⁰³ The same year Jessie Bicknell requested a short report on every candidate for the state examination, describing her work skills, professional attitude and conduct. These reports were used when making appointments and aimed to preserve the integrity of a womanly occupation.¹⁰⁴

98 Speech by Dr Thomson at the laying of a memorial plaque to Miss Tennant, *NZNJ*, 24:4, 15 June 1949, p. 115.

99 Matron Stott of Wellington Hospital to Miss Maclean, 29 August 1918, H1 21/23/19, NA.

100 Personal files of nurses, Dunedin Hospital School of Nursing.

101 *KT*, July 1927, pp.142-143 and October 1927, pp.203-204. The first matrons' conference in 1927 passed resolutions, stating that no nurse who left training for any other reason than health should be accepted by another training school, while no nurse should be appointed to any position without a testimonial from her training school matron.

102 Letter to a nurse who was refused a recommendation, 20 March 1931, Dunedin Hospital School of Nursing records.

103 Tennant to Miss Bicknell, 16 November 1925, H1 21/23/47, NA.

104 Circular letter from the Division of Nursing, 22 October 1925, Christchurch Hospital records, CH 426/26a, NA (Christchurch).

Because they were intent on preserving the respectability of a womanly occupation, nurse leaders were also wary of suggestions that the number of menial domestic chores carried out by pupil nurses might be reduced. Domestic service was an essential characteristic of the ideal woman and women would become better nurses if they "realised that the cleanliness of [a] lampshade was as important as the correct aseptic treatment of a wound".¹⁰⁵ Neither Bicknell nor the Education Committee of the Trained Nurses' Association advocated "for one moment" that the overseas trend of employing wardmaids or nurse aids be followed in New Zealand. Too much stress on academic training, said Bicknell, meant that ordinary, everyday attention to the patient was ignored and the true nurse feeling of doing everything possible to restore her patient to health was lost.¹⁰⁶ The Committee did recommend to the Hospital Boards' Association that less time be spent on unskilled work in the last two years of training,¹⁰⁷ but their equivocal attitude on the issue allowed hospital administrators to ignore it for at least another decade. Commercial cleaning of New Zealand hospitals was not introduced until the 1940s.¹⁰⁸

Nursing leaders did accept that some nurses, particularly in smaller hospitals, were being "considerably exploited" by boards which offered little training in return for the faithful services they received.¹⁰⁹ In 1929, the Trained Nurses' Association passed a resolution asking that hospital boards recognise schools of nursing as educational as well as working institutions.¹¹⁰ "True spirit of nursing" ideologies however, enabled boards largely to ignore the request. The syllabus was expanded from 54 lectures over three years to 84 in 1930,¹¹¹ but pupil nurses still had to attend them and to study in their own time, including on their days off, and on mornings following night duty. As one nurse said in 1929, you still "had

105 *KT*, 22:4, 2 November 1929, p. 184.

106 Editorial, *KT*, 23:2, March 1930, pp.51-52; *AJHR*, 1930, H-31, p.37.

107 *AJHR*, 1930, H-31, p.37.

108 Dunsford, p. 165.

109 *KT*, 22:4, November 1929, p.165; Janet Moore, *ibid*, 22:1, January 1929, pp.9-10.

110 *KT*, 22:4, November 1929, p.164.

111 Regulations on the Nurses and Midwives Act, 7 July 1930, *New Zealand gazette*, 10 July 1930, pp.2141-2162.

that awful feeling of tearing off to lectures ... and knowing your work was piling up for you when you got back".¹¹² Even examinations were sat after a full day's duty.¹¹³ Dr Fox of Christchurch Hospital declared that the Nursing School must always be subservient to the hospital's principal objective which was "the interests of the sick".¹¹⁴ Patient care, not nurse training invariably came first in the allocation of limited funds.

One innovation which many hospital boards did accept was the appointment of tutor sisters to superintend training, demonstrate correct procedures, assist with lectures and make sure all pupil nurses received their fair share of experience.¹¹⁵ This step was actively promoted by nursing leaders who were able to convince boards of its wisdom. Jessie Bicknell made it clear that nurse tutors were essential if the "true spirit of nursing" was to be maintained. The emphasis placed by doctors on surgery, rather than medical work since the end of the war, she wrote in 1925, had been "disastrous to the nursing profession". It was medical nursing which was "the true test of a nurse's worth" and which called "forth all her best qualities". Teachers from the medical profession should be replaced by women who showed "thoughtfulness and the true nursing spirit".¹¹⁶ They would provide a thorough and practical training of "nurses to be nurses"¹¹⁷ in preliminary training schools which would emphasise the practical skills which were nurses' most valuable assets.¹¹⁸ In this way, they would restore "the true spirit of personal service which must form the basis of all true nursing".¹¹⁹

The appointment of tutor sisters and the opening of preliminary training schools where pupils learned practical nursing skills before they began to work with patients on the wards began immediately after the war. Dunedin

112 Miss Hilditch, *KT*, 22:4, November 1929, p.182.

113 Marion Sainsbury, NERF oral history project, tape 65, ATL.

114 Annual report, 1928-9, NCHB minutes, 24 April 1929, pp.374-376.

115 Editorial, *KT*, 13:4, October 1920, pp.161-162.

116 Editorial, *KT*, 20:1, January 1927, p.3.

117 *AJHR*, 1925, H-31, p.38.

118 Sister A.B. Smith, Dunedin Hospital's tutor sister, *KT*, 21:4, October 1928, pp.180-181.

119 Bicknell to the Director-General of Health, 24 March 1926, H1 21/9, NA.

Hospital appointed a part-time surgical tutor sister in 1918, the appointment becoming full-time in 1920,¹²⁰ and Christchurch Hospital followed in 1923.¹²¹ By the end of the decade all the metropolitan hospitals employed two tutor sisters, and some of the provincial hospitals also had one. New Zealand hospital boards were not prepared to pay for the three months' preliminary training common in Britain and America (extra staff had to be employed because probationers no longer worked on the wards), but Christchurch Hospital began a three-week preliminary course in February 1923. Dunedin followed a year later,¹²² and in 1926, Wellington Hospital brought in a six-week course. Hopes of establishing two independent training schools, one in the North Island and one in the South, to which small hospitals could send probationers, proved illusionary. In discussing the matter in 1929, the Trained Nurses' Association decided that the time was not right to urge hospitals boards into extra expenditure, and resolved to aim for the establishment of preliminary training schools in each hospital.¹²³

The campaign for tutor sisters was greatly hampered by the lack of suitably qualified senior nurses to take up tutorial positions. Both Auckland and Wellington Hospitals selected their first tutor sisters from England.¹²⁴ This lack was potentially dangerous, said Hester Maclean, because the wrong tutor could result in turning out a nurse who was a "letter-perfect, scientific, machine-like person who sees patients as cases bringing her a livelihood".¹²⁵ The training of tutor sisters, ward sisters and matrons, the women responsible for maintaining the moral tone and idealistic foundations of the profession, was thus at the forefront of nursing concerns in the 1920s.

120 *KT*, 11:4, October 1918, p.215; Dr Falconer to Hester Maclean, 3 March 1920, H1 21/23/47, NA.

121 NCHB minutes, 19 February 1923, p.460.

122 NCHB minutes, 28 February 1923; *ES*, 20 February 1924, OHB newspaper cutting books, v.23, p.178.

123 *KT*, 22:2, April 1929, pp.52-53.

124 *Evening post*, 11 July 1926 (held in H1 21/9, NA) reports the appointment of Miss Comerford from England as tutor sister at Auckland Hospital, despite criticism from board members about the "plums of the nursing profession going out of New Zealand."

125 Editorial, *KT*, 17:3, July 1924, pp.93-94.

Initially, it was proposed that suitable training might be obtained through the establishment of a university nursing course. Jessie Bicknell believed such a course might improve nurses' professional status in New Zealand,¹²⁶ and accordingly, at the Trained Nurses' Association conference in Dunedin in 1922, she recommended consideration be given to the idea. The scheme was taken up with some enthusiasm.¹²⁷ After discussion, the University of Otago agreed to offer a diploma course, beginning in 1925, based on programmes already run by its School of Home Science. Only the final year of the course, which was to give nurses specialist training in teaching, administration and public health, required the employment of additional staff. The Department of Health agreed to send two nurses overseas for training so that they might be appointed to these teaching posts. Janet Moore went to England to study teaching and administration at Bedford College and Mary Lambie gained a diploma in public health nursing at the University of Toronto. Misunderstandings arose, however, about the salaries of the two nurse lecturers once they were established at the university. Both the university and the Department of Health assumed that the other body would pay for them. Ultimately neither was prepared to do so and the course lapsed after only two years. Only one woman, Winifred Fraser, graduated. In 1927, however, Moore and Lambie were able to negotiate a successful deal with Victoria University of Wellington for a six-month postgraduate nursing course, focusing on those special subjects which would have formed the final year of the diploma course. The first course got underway in February 1928 with 17 nurses attending. Moore and Lambie were paid by the Department of Health, which also provided facilities jointly with Victoria University and Wellington Hospital. By 1935, 80 women had trained, 57 of whom were known to hold important nursing posts.¹²⁸

The debate over university nursing education in New Zealand in the 1920s highlights the limitations imposed on change by nurses' ideological commitment to the "true spirit of nursing". It has been suggested by one historian that lack of medical support was a major factor in bringing about the failure of the course. The Otago Medical School, which was part of the

126 AJHR, 1922, H-31, p.30.

127 B. Hughes, "Bicknell, Jessie, 1871-1956", *DNZB, volume 3, 1901-1920*, p.53.

128 Memorandum, April 1935, H1 21/9/99, NA.

University of Otago, was particularly determined to see that money which might otherwise be allocated to their work did not go elsewhere.¹²⁹ Certainly, none of the doctors who attended the original conference on the subject was enthusiastic.¹³⁰ More significant, however, were the attitudes of nurse leaders themselves. It is clear that many agreed with Hester Maclean who, in 1912 had asked who would do the work of nursing if nurses went to university.¹³¹ University education would lessen nurse control over the training process and weaken the moral discipline and ideological basis of apprenticeship training. The proposed diploma course was to have included the full practical training period in the hospital. Matron Rose Muir of Christchurch wrote to Miss Bicknell, declaring

I would not uphold the Diploma if it interfered with the 3 years' Hospital training. Every moment of Ward work is necessary in the training of a Nurse ... I cannot be too emphatic on this point. Three years practical ward work and not a day less. Otherwise the Diploma will be of no value as an educational asset.¹³²

From the first, nurse leaders focused not on the course as a whole but on its fifth year which offered teaching and administration programmes.¹³³ As Bicknell herself declared in 1924, "its greatest value ... appears to be the facilities it offers to already trained nurses to qualify themselves for positions of more responsibility".¹³⁴

Unlike university training, which would be open to any woman who could afford it, a postgraduate course meant that nurse leaders could control the selection process. They could ensure that only women who had already proved themselves in the hospital environment would be given the opportunity of qualifying for positions of influence among younger nurses. Furthermore, all the teachers in the postgraduate course were nurses, so

129 B. Hughes, "Nursing education: the collapse of the Diploma of Nursing at the University of Otago, 1925-1926", *NZJH*, 12:1, April 1978, pp.17-33.

130 All stated that it was unnecessary, *KT*, 15:5, November 1922, pp.208-209.

131 Editorial, *KT*, 5:2, April 1912, pp.1-2.

132 Muir to Bicknell, 23 February 1926, p.2, Christchurch Hospital Lady Superintendent's Office records, CH 426/26a, NA (Christchurch).

133 *KT*, 16:4, October 1923, p.153: the course would raise the standard of nurse teachers and give them academic recognition.

134 *KT*, 17:4, October 1924, pp.156-158.

there was no need to worry that nurses were being taught by persons not thoroughly imbued with the "true spirit of nursing".

Nursing in New Zealand in the 1920s was led by a director of the Division of Nursing described by her successor as "essentially a 'Victorian gentlewoman'. She was a dignified woman with a keen sense of right and wrong".¹³⁵ She was supported by a group of matrons who were also "Victorians", born in the previous century and trained in the first years after registration. These women believed that nursing interests would best be served if the "true spirit of nursing", prescribed by Florence Nightingale continued to guide the profession's development. The construction of the good nurse as first and foremost a good woman had achieved a great deal for the profession in New Zealand: a long-established professional status which was engendered by a single portal of entry permitted under state registration, the exclusion of both men and untrained women, a monopoly in many specialist health and welfare areas, like district, Maori health, infant, school, public health and maternity nursing, preferential entry into fields like physiotherapy, dietetics and child welfare work, and above all, public approbation as "angels on earth". Nurses were highly regarded in New Zealand. "There is ... no doubt", wrote one nurse after the war", that the position of the nurse ... is not in the Home Country by any means equal to that she holds in the Colonies".¹³⁶ In the 1920s, when the ideology of domesticity for women was actively encouraged and constantly reinforced by both the state and the wider population, nursing leaders fought to retain the ideals which had legitimized nursing the most womanly and therefore the most respectable of occupations.

135B. Hughes, "Bicknell, Jessie, 1871-1956", *DNZB, volume 3, 1901-1920*, p.53.

136 *KT*, 12:1, January 1919, p.24.

Conclusion

In the century which followed the first European settlement of New Zealand, nursing was transformed from an amorphous collection of domestic duties undertaken by women in the private world of the home into a clearly defined occupation in which were employed over five thousand women in the public world of paid work. This transition coincided with a period of rapid change in New Zealand society, which, according to Erik Olssen, probably affected women more than any other group. Olssen notes that

The fertility rate fell dramatically, wider occupational opportunities emerged, and the rates of maternal and infant mortality declined. Women began to enter new occupations and to assert their right to new freedoms and opportunities.¹

Among these new opportunities was access to better education. Girls' schools began to proliferate and women were also able to enter the new universities, making up an important fraction of early New Zealand university graduates.² In 1877 Kate Edger was the first woman in the British Empire to gain a Bachelor of Arts degree and four years later, Helen Connon became the Empire's first woman honours graduate. Married women achieved property rights, women became eligible to sit on school and hospital boards and in 1893 New Zealanders were the first women in the world to gain the vote.

Increasing numbers of women started to enter the world of paid employment. Demographic change meant that by 1900, early settlement patterns had completely reversed and there were more women than men in the cities. By the 1920s, as the death toll from the war took effect, this change had spread to the provinces. Thousands of women who, in earlier times, had married at a young age and started families, now needed to

1 E. Olssen. "Women, work and family", p.159.

2 B. Hughes, "Women and the professions", P. Bunkle & B. Hughes, *Women in New Zealand society*, p. 133.

earn a living. Accordingly, by 1921, the percentage of women in the paid workforce had risen to over 20%, nearly double that of 1874.³

Raewyn Dalziel⁴ has argued persuasively that the suffrage campaign of the 1880s and 1890s was successful in New Zealand because it did not seek to remove women from their "natural" vocation within marriage, home and family. Rather it aimed to reinforce women's vital mission in life as homemakers and guardians of moral health and welfare. Olssen has used similar arguments to explain women's employment patterns in the first two decades of the twentieth century. He suggests that "the dramatic expansion of female employment in the non-agricultural work-force coincided with a tendency to define motherhood and wifery as specialised vocational roles".⁵ There was a general consensus that the enlargement of women's sphere into the wider world of education and paid employment was justified only on the grounds that it would train women better for their most important tasks of motherhood and home management. This philosophy was articulated by the founder of the Plunket Society, Dr Frederic Truby King, who declared that girls ought to be trained "for something that will enable them to earn a living, but which also directs their minds towards home life ...".⁶ Nursing was one of the occupations he listed as a suitable source of such training.

It was within these ideological constraints that trained female nursing was shaped. It was consciously developed by reformers as "essentially a woman's work", the "good nurse" being first and foremost defined as a "good woman". Women's "natural" capacities for social feeling and service, already demonstrated in the domestic sphere, would be enlarged to embrace "social motherliness" in the wider spheres of charity, philanthropy and welfare. The trained nurse would, however, retain all the attributes of the ideal woman. She would be obedient, sober, honest, truthful, punctual, quiet, clean, patient, cheerful and kind. Her moral character would be unimpeachable and in no circumstances would she

3 Olssen, p. 161-162.

4 R. Dalziel, "The colonial helpmeet", in *Women in history*, pp. 55-68.

5 Olssen, p. 180.

6 Quoted in Olssen, p. 179.

attempt to compete with men or encroach upon male responsibilities. Training would give the nurse knowledge but she would have "no call to infringe upon the work of the patient's physician. Instead she [would be] enabled to carry out more intelligently his prescribed course of treatment".⁷

The transition to a trained female nursing workforce staffed by respectable, middle-class, single women, which occurred at exactly the same time as the successful suffrage campaign, did not always proceed smoothly. The ideological foundation on which the new calling of "nurse" was premised took time to become clearly established, while the roles and relationships of the several groups now employed within the rapidly growing hospitals were also confusing in the early years. Power struggles developed as doctors, matrons and male administrators fought to find their places in the new environment. Once it became obvious that nurses offered no threat to the superiority and authority of doctors, however, rapid progress was made. In 1901, New Zealand nurses became the first in the world to achieve state registration and by 1914, their credentials as the only persons qualified to nurse servicemen were sufficiently well established to ward off competition from both male orderlies and untrained women volunteers. By the end of the war, Hester Maclean was able to declare that New Zealand nurses "had gained ... a name which it must be the aim of all succeeding them to maintain".⁸ As workers in the most "womanly" of all occupations, nurses were said to be "as fine a body of noble-hearted splendid women as it is possible to find anywhere".⁹

Nevertheless, there were negative aspects to the shaping of trained nursing as "essentially a woman's work". Nurses were not independent professional women. They remained to a large extent the "handmaidens" of doctors who, until at least the 1920s, controlled training programmes, decided what kinds of work nurses might do and ran nurses'

7 Article from the English *Nursing times*, reprinted in *KT*, 2:1, January 1909, p. 20.

8 Editorial, *KT*, January 1918, quoted in M.J. Kelly (comp.), *New Zealand servicewomen, World War 1*, Auckland: The Author, 1992, v. 2, p. 91.

9 Letter to the editor from "Ex-Houghtonite", *ODT*, 14 June 1915, OHB newspaper cuttings, v. 9, p. 103. Two years earlier the Minister of Hospitals, R. H. Rhodes, referred to nurses as "the finest members of the sex", *KT*, 6:3, July 1913, pp. 91-92.

organisations. Male hospital administrators were able to impose on nurses because "women's work" was also duty, performed out of love, a sense of service, and self-sacrifice. Accordingly, nurses received minimal pay, worked long hours, had few holidays and carried out domestic as well as nursing tasks, often suffering poor health as a result.

These disadvantages did not, however, dissuade women from becoming nurses in the years before the first world war. From the time of state registration in 1901 until the outbreak of war, the numbers of trained nurses in the workforce more than quadrupled, rising from 748 in 1901 to 3,403 in 1911.¹⁰ A large proportion of these women were well-educated, well-off members of middle-class families for whom nursing was a life-long vocation. It was noble work which offered women the opportunity to give dedicated service to mankind without losing their "womanliness" or "femininity".

The 1920s brought a new generation of nurses, who were younger, more concerned to earn a reasonable living and had different long-term aspirations than their pre-war predecessors. Women began to take up clerical, factory and shop assistant work in greater numbers but "womanly" occupations remained the most admired. A Dunedin newspaper, commenting on the success of women candidates in local hospital board elections in 1915, made this very clear. The newspaper noted that the three women who topped the poll

were asking for public positions and work with which women are eminently and naturally qualified to deal. The care of the sick, the poor, the afflicted, the unhappy have throughout the ages been regarded and accepted as specially and peculiarly women's work ... [the candidates] were not, by even a hair's breadth, stepping out of the sphere of life and labour which is theirs, in order to enter into unseemly competition with men in those which the great mass of both sexes are agreed it is not desirable they should enter.¹¹

¹⁰ Figures recorded by Olssen, p. 163.

¹¹ Editorial, ES, 29 April 1915, OHB newspaper cutting books, v. 9, p. 55.

Ideologies of domesticity as the prime function of women also remained strong in the aftermath of war. The loss of so many young men on the battlefields made it seem even more important for women to focus on rebuilding the nation by marrying and breeding "babies for Empire". In 1917, the Department of Education had introduced compulsory domestic training for girls into the school curriculum and a policy of sexual differentiation in education had been adopted. New organisations like the League of Mothers, the Country Women's Institute and the Mothers' Union flourished and the work of the Plunket Society in training mothers for their most important task in life expanded rapidly.¹²

Nursing leaders were very mindful that traditional ideologies had not changed greatly and they were accordingly determined to preserve what they saw as "the true spirit of nursing". The woman who entered nursing for the purpose of making money rather than for love of the work could never be a true nurse, they said. "Nursing means the giving of oneself in the service of weak and suffering humanity [with] ... kindness, gentleness, patience and placidity ...".¹³ Thus, while some reforms occurred within nursing education and hospital practice, these had little impact overall. A short preliminary training period for student nurses under a tutor sister was introduced and postgraduate training courses for a few senior nurses established, but an attempt to offer university nurse education failed and practical nursing work in caring for patients still took up almost all the student nurse's time. Nurses achieved a superannuation scheme and most were granted more holidays but pay levels for student nurses and newly registered nurses remained low. Hours of work were long and still included many domestic tasks. A nurse's "worthiness" continued to depend more on her character than on her skill.

At the end of the 1920s, nursing was not by any means the most popular paid occupation for women. In 1926, nurses comprised only 4.57% of the working female population. There were more women teachers (5.77%), shop assistants (6.94%), clerks (6.86%) and typists (5.76%) than there

¹² See P. Sargison, "Babies for Empire", *Notable women in New Zealand health*, pp.41-44.

¹³ *Wellington Hospital nurses' journal*, 1:2, 1933, p. 4.

were nurses, and over four times as many domestic servants, still by far the largest female occupational group (20.79%).¹⁴ It was not an occupation which attracted everyone. It involved long hours of heavy, physical work for low pay and many believed it was "too hard a life for a girl".¹⁵ But more important, nursing was not an occupation which sought to welcome any woman into its fold. Nursing was consciously shaped by reformers as "essentially a woman's work". "Good nurses" were first and foremost "good women", those deemed "fit, morally, mentally and physically" for the work before them.¹⁶ As models of ideal womanhood, nurses achieved a great deal. They were women of considerable status and were universally admired. But womanly ideologies also imposed many constraints on the development of nursing as an independent profession and these constraints continue to cause problems for nurses to this day.

14 All figures come from the *Census of New Zealand, 1926: volume 9, Industrial and occupational distribution*, pp. 12, 48.

15 Dunsford, 'The privilege to serve others', p. 72.

16 *KT*, 18:2, April 1925, p. 54.

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