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**NATIVE HEALTH NURSING
IN NEW ZEALAND 1911-1930:
'A NEW WORK AND A NEW PROFESSION
FOR WOMEN'**

THESIS PRESENTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF ARTS IN NURSING
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ABSTRACT

The focus of this thesis is the practice of the nurses employed in the Native Health Nursing Scheme in New Zealand from 1911 to 1930. These nurses were a vanguard movement for change in community nursing services as they established a new role and developed innovative ways of practising nursing while claiming greater autonomy and accountability for nurses who worked in community settings. Consequently they contributed to an increase in status for nurses in New Zealand.

The Native Health Nursing Scheme was established by the Health Department to replace the Maori Health Nursing Scheme, an initiative by Maori leaders for Maori nurses to provide nursing care for their own people. The original scheme had foundered amid under-resourcing, a lack of support from hospital boards and administrative chaos. Government policy for Maori health was openly assimilationist and the mainly non-Maori Native Health nurses carried out this policy, yet paradoxically adapting their practice in order to be culturally acceptable to Maori.

Their work with the Maori people placed the Native Health nurses in a unique position to claim professional territory in a new area of practice. As they took up the opportunities for an expanded nursing role, they practised in a manner which would develop the scope and status of nursing. The geographical isolation of their practice setting provided the nurses with the challenge of practising in an environment of minimal administrative and professional support, while also offering them the opportunity for independence and relative autonomy. Obedience, duty and virtue, qualities highly valued in women of the day, were expected especially in nurses. These expectations were in direct contrast to the qualities necessary to perform the duties of the Native Health nurse. The conditions under which these nurses worked and lived, the decisions they were required to make, and the partnerships they needed to establish to be effective in the communities in which they worked, required courage, strength, organisational ability and commitment.

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*GLOSSARY*¹

hui	a meeting of people for a particular purpose
kainga	a village inhabited by a subtribe
pa	a fortified place where Maori lived. The enemy could be seen for miles around. It was fenced with large posts as a protection from the enemy.
pakeha	white skinned people not of Maori extraction
tangi	crying at the time of death; shortened version of tangihui, a funeral
tohunga	a spiritual leader

¹ Prepared by Terahingahinga Reti to reflect the contemporary usage of 1910-1930.

ABBREVIATIONS

AJHR *Appendices to the Journals of the House of Representatives*

KT *Kai Tiaki, The New Zealand Nursing Journal*

NZG *New Zealand Gazette*

NHNS Native Health Nursing Service

NZANS New Zealand Army Nursing Service

TACSA Te Aute College Students' Association

PHOTOGRAPHS

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INTRODUCTION

This history features a group of working women, Native Health nurses, whose contribution to the development of the New Zealand health service has not yet been well explored. Early nursing histories of nursing in New Zealand have been more likely to feature exceptional nurse leaders¹ and their role in major events and developments. More recent histories have acknowledged the everyday work of the ordinary nurse as an alternative perspective to understanding nursing practice.² An analysis of the everyday practice of the Native Health nurses provides an interpretation which is the basis for the claim that nurses were able to develop agency through their work. The innovative approach they adopted contributed to other developments in nursing at this time which advanced the status of the profession. Although the Native Health Nursing Scheme (NHNS) existed over a nineteen year period from 1911 to 1930, the work of the nurses in Maori communities in nursing the sick and containing the spread of infection during the first decade of the scheme provided them with the most significant opportunities to develop their new role.

Because there are no longer any of the nurses still living who were working as part of the NHNS during the decade between 1911 and 1920, it has not been possible to glimpse their everyday practice through oral histories. However, a rich resource exists in *Kai Tiaki, The New Zealand Nursing Journal* which was published quarterly and regularly included an article on the Native Health nurses. These articles were often in the form of letters or were written by the nurses themselves so through them it has been

¹ Mary Lambie, *My Story: Memoirs of a New Zealand Nurse*, Peryer, Christchurch, 1956; Hester Maclean, *Nursing in New Zealand: History and Reminiscences*, Tolan Printing Company, Wellington, 1932; Joan Rattray, *Great Days in New Zealand Nursing*, Reed, Wellington, 1961. Celia Davies refers to this approach as the Whig interpretation of history in *Rewriting Nursing History*, London, Croom Helm, 1980.

² See for example, A. McKegg, 'Ministering Angels': The Government Backblock Nursing Service and the Maori Health Nurses, 1909-1939. MA Thesis, University of Auckland, 1991; Jan A. Rodgers, 'A Paradox of Power and Marginality': New Zealand Nurses' Professional Campaign During War, 1900-1920, PhD thesis, Massey University, 1994, p.242; K. F Wilson, *Professional Closure: The Case of the Professional Development of Nursing in Rotorua 1840-1934*, MA Thesis, Massey University, 1995.

possible to gain an insight into the nurses' view of their practice. Oral histories have been recorded of nurses who worked as district health nurses at a later time and these have been provided a useful resource.³

A suitable perspective for interpreting the complex context of the practice world of Native Health nurses involves the interconnected analytic categories of gender, race and class. The discourses of race and class are considered in this analysis particularly as they relate to the relationship between the nurses and the Maori people and between government agencies and the Maori. The prevailing ideology regarding the Maori is explored in relation to the institutional racism evident in the health care system of the time. The discourse of class contributes to the analysis by informing the power differential between those who control resources and those who do not. While the examination of various power bases provides important insights into the environment of nursing practice for the Native Health nurses, these are not based on class differences but rather on the notion of gender as a category for historical analysis as developed and explained in Chapter 1.

While the environment of their practice was constructed by social and institutional forces beyond their control, the Native Health nurses were far from passive in the development of this, 'a new work and a new profession for women'.⁴ The Nightingale reforms in nursing introduced in New Zealand in the 1880s had established a profession for women of propriety.⁵ The objective for nurse leaders over subsequent decades was to consolidate its legitimate position in any health care setting in which a nurse could be placed. Native Health nursing offered an ideal opportunity to claim new

³ Interview with Margaret MacNab by Alexandra McKegg, 23 August 1990, Wanganui. University of Auckland Library Cassettes C94-26 and C94-27; New Zealand Nursing Education and Research Foundation, Oral History Collection, Alexander Turnbull Library, Wellington, interview with Lillian Ada Hill, MSC 46, LC 38.

⁴ Florence Nightingale to Fred Verney, 1891, Reproduction of a printed report originally submitted to the Bucks County Council containing letters from Florence Nightingale on rural district health visiting, published for the National League for Physical Education and Improvement, 1911. A copy of this publication is held at the Florence Nightingale Museum, St Thomas' Hospital, London. The original letter is held at the Claydon Archive, England.

⁵ Jan A. Rodgers, *Nursing Education in New Zealand, 1883-1930: The Persistence of the Nightingale Ethos*, M.A. thesis, Massey University, 1985.

territory while developing a greater level of autonomy in practice. Although the Native Health nurses themselves may not have consciously sought this new territory and consequent status, the opportunities offered by this new work and the effectiveness by which they took on the new role earned them greater independence and an enhanced reputation.

The NHNS was initiated in 1911 by the Health Department as a replacement for the Maori Health Nursing Scheme which had foundered in an environment of official apathy resulting in a lack of support and resources. It was absorbed into the district health nursing service in 1930. From a staff of three nurses in 1911, the NHNS steadily expanded to 20 by 1920. Over this time at least 42 nurses had been at some time employed as Native Health nurses. The majority remained for around two years. The longest serving nurse over this period remained for eight years, apart from the supervisor, Amelia Bagley, who was there from the inception of the NHNS and remained in this position until her retirement in 1931. The purpose of the scheme was purported to be driven by humanitarian concern for Maori whose health status was devastated by poverty and European-introduced infectious disease following the colonisation of New Zealand. More evident motives for the scheme were the fear of spread of infection from the Maori population to the Pakeha population and the enforcement of assimilationist Government policy.

The nurses worked in remote areas with Maori communities, often without an assistant. During the period 1911-1920, their work was mainly related to nursing those with typhoid and smallpox and preventing the spread of an epidemic to other communities. The regions most affected and therefore most likely to have a nurse were those in the northern half of the North Island of New Zealand although there was also a nurse stationed in the South Island for a time. A thematic analysis of the accounts of Native Health nursing practice in *Kai Tiaki* revealed four key elements in the change in role. Firstly their work took on an element of living and working closely with Maori communities in a social role not previously considered the domain of nursing. There was also the development of relative autonomy and independence from medical domination. The third change was the adaptation of nursing practice for a remote rural setting and

fourthly the evolution of a working relationship with a different cultural group as most of the Native Health nurses were Pakeha - only five of the nurses who worked in the scheme during the period under study were Maori.

A number of valuable data sources have yielded insights into the practice world of the Native Health nurses. The reports in *Kai Tiaki, The New Zealand Nursing Journal*, have been mentioned. Health Department files in the National Archives of New Zealand in Wellington and Auckland have also been valuable particularly in communicating the contemporary official ideology. The New Zealand Nurses Association (now New Zealand Nurses Organisation) files and oral history collection at the Alexander Turnbull Library, National Library of New Zealand, have also provided valuable data for this study. Useful data were located at the New Zealand Nurses Organisation library in Wellington, the Auckland Institute and Museum, the Archives of the Catholic Church, Auckland, the Philson Library, University of Auckland Medical School, the Auckland Public Library and the Northland Room and Official Publications Room at the Whangarei Public Library.

Chapter One discusses the place of this study among existing work in related areas. Approaches to women's history are examined along with the notion of agency and its relevance to the aspirations and achievements of the Native Health nurses. Sources which contribute to an understanding of post-colonial constructs of gender, class and race are reviewed.

Chapter Two traces the development of nursing as a profession in New Zealand particularly in the community setting. The demise of the Maori Health Nursing Scheme provides the context for the emergence of its replacement, the Native Health Nursing Scheme. The contemporary environment and its influence on women is examined as a contributing factor to the calibre of those who worked as Native Health nurses. The struggle for autonomy and recognition by Maori in the patriarchal post-colonial health service is analysed as it relates to the practice context for the NHNS.

Chapter Three provides an overview of the infrastructure in which the NHNS developed during the decade 1910-1920. Key events and issues are presented which shaped the quality and rate of change in community based nursing practice over this time. The traditional nursing role of subservience and obedience is critiqued in relation to the new role of Native Health nurse as a self-sufficient, autonomous practitioner.

Chapter Four presents an analysis of the practice of the Native Health nurses. It complements and builds on Alex McKegg's⁶ history of the nurses who worked in district areas between 1909 and 1939. This chapter explores the changes in nursing practice adopted by these nurses whereby they claimed an expanded role, carved out a new approach to nursing and adapted their practice in order to be culturally acceptable to Maori. The recognition gained through this work earned status for nursing that was officially recognised when a restructuring of the Health Department into seven divisions in 1920 included a separate Division of Nursing with a nurse at its head.

Chapter Five briefly reviews the progress of the NHNS, renamed the Maori Health Nursing Service in 1923, over its second decade 1920-30. Infectious diseases were under better control and the nurses' attention was directed towards health teaching and health promotion. Health Department officials recognised the special education needs of community based nurses and a school for advanced studies was opened in conjunction with Victoria University in Wellington. With the retirement of NHNS supervisor Bagley and Chief Health Officer Valintine in 1930 the scheme was modified so that the nurse who worked in remote districts provided a service to both the Maori and European population with another change in title to District Health nurse.

Chapter Six summarises and underlines the main thesis that the Native Health nurses made good use of the opportunity for professional gains through their work in Maori communities and raised the profile of nursing generally among the profession itself, in the Health Department, and with the general public of New Zealand.

⁶ McKegg, "Ministering Angels":

**CHAPTER 1 - WOMEN AS WOMEN, WOMEN AS NURSES :
A REVIEW OF THE LITERATURE**

A commitment to history that has an interest in class, race and gender must capture an analysis of the complex context which shapes the meaning and nature of human experience.¹ The experience of women as Native Health nurses in New Zealand early this century comes to life through a study of the relevant 'social institutions, aesthetic productions, political systems and popular cultures'² and through the 'ideological belief systems and the material circumstances of [their] life'³. This study explores elements which construed the context in which the Native Health nurses defined their identity and shaped their work practices. In this endeavour, their gender and their occupation were inextricably linked.⁴ Some of the discourses which informed inter-racial relationships in post-colonial New Zealand society also contribute to an understanding of the context in which the Native Health nurses worked although it is not intended to explore Maori health issues per se.⁵ The discourse of class is also important in this analysis as it informs the relationship between those whose positions of power were maintained by the status quo and those who were less powerful.

The study of discourses is the study of how events are made sensible.⁶ Experience, therefore, is made comprehensible through discourses which work to shape cultural meanings within certain parameters. Through interaction with others, people construct their own meanings, understand themselves and define their identities always

¹ Joan Scott, Gender: a useful category of historical analysis, *American History Review*, 91(5), 1985, pp.1053-1075; Joy Parr, Gender History and Historical Practice, *The Canadian Historical Review*, 76(3), Sept., 1995, pp.354-375.

² Louise M. Newman, Critical theory and the History of Women: What's at stake in Deconstructing Woman's History, *Journal of Women's History*, 2 (3) 1991, p.62.

³ Parr, Gender History, p.365.

⁴ M. Vicinus, *Independent Women, Work and Community for Single Women, 1850-1920*, The University of Chicago Press, Chicago, 1985.

⁵ Ngahuia Te Awekotuku, *He Tikanga Whakaaro: Research Ethics in the Maori Community*, Manatu Maori: Ministry of Maori Affairs, 1991, is a discussion paper which provides valuable comments for those who are involved in researching with Maori.

⁶ Parr, Gender History, p.365.

in relation to and sometimes in struggle against the identities others might want to recognise in them.⁷ In order to develop some understanding of the experience of the Native Health nurses, it is important to gain a perspective of the meanings they may have gained through their relationships with the Maori people, government officials, other nurses, and members of the medical profession. Joan Scott, using 'gender' as a category for analysing women's history, supports this view by acknowledging the interrelationship between the individual subject and the social organisation and rejects the notion that social power is unified, coherent and centralised.⁸ Associated with this view of relationships is the:

concept of human agency as the attempt (at least partly rational) to construct an identity, a life, a set of relationships, a society with certain limits and with language...⁹

In her PhD thesis¹⁰, Caroline Daley acknowledges that gender is a social construct which is relational, historical and subject to change. Quoting Ann Game and Rosemary Pringle she states that, "Gender is fundamental to the way work is organised; and work is central in the social construction of gender."¹¹ Her case study of the Taradale area examines many dimensions of gender to explicate the complex relationships between and among men and women. She concludes that the work activities of men and women were gender specific and laden with gendered meanings. Gender as an integral element of social relationships acknowledges the multidimensional social positions women and men occupy. Gender may signify relationships of social power¹² but other forms of power and markers of difference (such as class and race) may impact on how the discourse of gender operates.¹³ The discourses of gender, class,

⁷ Charles Taylor, *The Malaise of Modernity*, Concord, House of Anansi, 1991 cited in Parr, *Gender History*, p.366.

⁸ Scott, *Gender*, pp.1053-1075.

⁹ *ibid.*, p.1067.

¹⁰ Caroline Daley, *Gender in the Community: A Study of the Women and Men of the Taradale Area, 1886-1930*, PhD Thesis, Victoria University of Wellington, 1992, p.15.

¹¹ *ibid.*, p.301.

¹² Scott, *Gender*, p.1067.

¹³ Parr, *Gender History*, p.363.

and race simultaneously reflect patriarchal power and the social hierarchies which are sustained by them. It is more useful to consider all three concurrently in order to understand the experience of the Native Health nurses.

Conventional notions of power as that which is possessed, flows from a centralized source from top to bottom and is primarily repressive in nature have been challenged. Foucault sees power as exercised rather than possessed, coming from the bottom up and productive rather than repressive, "Where there is power there is resistance...We're never trapped by power: it's always possible to modify its hold, in determined conditions and following a precise strategy".¹⁴ It is this Foucauldian notion of power and resistance which underpins an analysis of how power relations were modified to enable the Native Health nurses to develop and adapt their nursing role.

An investigation of the symbols and myths which pervaded post-colonial New Zealand early this century and the normative ways that these were expressed to shape the alternatives and possibilities for women has been informed by a number of key works. Barbara Brookes, Charlotte Macdonald and Margaret Tennant have edited two volumes of New Zealand women's history¹⁵ which although not directly about nurses or nursing provide insight into a variety of aspects affecting women's lives including attitudes to sexuality, the role of women and their occupations, women's suffrage and education. In particular, Raewyn Dalziel¹⁶ provides a clear argument for New Zealand women being rewarded with the vote for their success as preservers of the moral fibre of the nation by safeguarding the two sanctified institutions of home and family while accepting their inferior status to men. The process of women gaining status and power in return for obedience to rigid gender stereotyping is a mechanism also used by nurses who traded inferiority in relation to doctors for gains in professional status.

¹⁴ Jana Sawicki, *Disciplining Foucault Feminism, Power and the Body*, New York, Routledge, 1991, pp.20-5.

¹⁵ Barbara Brookes, Charlotte Macdonald, Margaret Tennant (Eds.), *Women in History: Essays on European Women in New Zealand*, Allen and Unwin Wellington, 1986; *Women in History 2*, Bridget Williams Books, Wellington, 1992.

¹⁶ 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*.

Charlotte Macdonald contributes further to an understanding of the social context for women with her detailed history¹⁷ of single women as immigrant settlers in nineteenth-century New Zealand, providing rich description of the working conditions and wages of those women employed mostly as domestic workers. While this covers valuable ground towards an understanding of the myths, attitudes and context of working life for New Zealand women at this time, specific references to nurses are few.

A collection of essays edited by Phillida Bunkle and Beryl Hughes¹⁸ variously informs women's history including political life, the role and status of Maori women and women's role in work and family. In particular, Hughes¹⁹ traces the development of women and the professions in New Zealand providing insight into a social movement which for nursing was a catalyst for the formalisation of nursing as a profession through the Nurses Registration Act 1901. In this same anthology, Jock Phillips contributes to an understanding of gender-based social relations through his analysis of the development of male culture, shedding light on factors which contributed to perceptions of male superiority.²⁰ Sandra Coney's history²¹ of New Zealand women since they won the vote, commemorating the centennial of women's suffrage in New Zealand, covers a comprehensive range of women's experiences. Included is a two-page section on Native Health nurses describing some of the key aspects of their work. These sources provide valuable contextual material regarding the way in which gender was constructed within social life, the economy and politics of post-colonial New Zealand. However they are not intended to specifically address the development of nursing within this context.

¹⁷ C. Macdonald, *A Woman of Good Character: Single Women as Immigrant Settlers in Nineteenth-century New Zealand*, Allen and Unwin, Wellington, 1990.

¹⁸ P. Bunkle and B. Hughes, *Women in New Zealand Society*, George Allen and Unwin, Auckland, 1980.

¹⁹ B. Hughes, Women and the Professions in New Zealand, in P. Bunkle and B. Hughes, *Women in New Zealand Society*.

²⁰ J. Phillips, Mummy's Boys: Pakeha Men and Male Culture in New Zealand, in P. Bunkle and B. Hughes, *Women in New Zealand Society*.

²¹ S. Coney, *Standing in the Sunshine: A History of New Zealand Women Since They Won the Vote*, Viking, Auckland, 1993.

Essential to an investigation of the professional development of Native Health nursing is a background to the position of Maori in New Zealand society in the period 1910 to 1920 and in particular their health status. James Belich's general history of New Zealand from Polynesian settlement to the end of the nineteenth century²² provides a valuable account of the traumatic interaction between Maori and Pakeha,²³ the neo-European people of New Zealand, during the process of colonisation and provides much useful material regarding the health effects of this interaction. Mason Durie offers his analysis of Maori health development²⁴ as a tribute to early Maori leaders and their total rejection of the concept of a dying race. His emphasis is on the central notion of Maori control of Maori health development. Durie urges that while the beneficial effects of well-intentioned health professionals and major advances in medical science could not be ignored, advances in Maori health have only been achieved through active participation by Maori in developing health policy and services in association with strong Maori leadership. The work of the Native Health nurses could not have been effective without the active participation of Maori in the reversal of a plummeting health status. The health of Maori before British settlement has been well documented by Best²⁵ and Gluckman²⁶ and provide a basis for contrasting post-settlement health status. Jocelyn Keith²⁷ further contributes with her account of Florence Nightingale's advice to Sir George Grey, Governor of New Zealand 1845-53, regarding the rapid decline in the numbers of the Maori people.

²² J. Belich, *Making Peoples: a History of the New Zealanders From Polynesian Settlement to the End of the Nineteenth Century*, Allen Lane, Auckland, 1996.

²³ Throughout this work the neo-European people of New Zealand will be referred to as Pakeha, an accepted convention. Refer J. Belich, *Making Peoples* and D. A. Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health*, Victoria University Press, Wellington, 1995.

²⁴ M. Durie, *Whaiora: Maori Health Development*, Oxford, Auckland, 1994.

²⁵ Elsdon Best, *The Maori as He Was: a Brief Account of Maori life as It Was in Pre-European Days*, Govt. Printer, Wellington, 1974.

²⁶ L. K. Gluckman, *Tangiawai: Medical History of New Zealand Prior to 1860*, Whitcoulls, Auckland, 1976.

²⁷ J. M. Keith, Florence Nightingale: Statistician and Consultant Epidemiologist, *International Nursing Review*, 1988, 35 (5), pp.147-150.

An examination of the processes which constructed and shaped the subjective identity of the Native Health nurses leads to a focus on the nurses themselves and the extent to which they exercised a degree of human agency through their work. Christopher Maggs²⁸ strongly advocates a focus on the history of power and of change as it is through such history that conventional myths can be exposed and human agency can be explored.

A number of 'broad-brush' historical overviews of nursing history are available. These wide-ranging histories²⁹ skim over periods of nursing history providing overviews of events. Bridges³⁰ synopsis of the first sixty-five years of the International Council of Nurses provides important factual data about key nurse leaders and significant events internationally particularly with regard to nursing's struggle for professional recognition and a sense of world-wide cohesion and parity. While exemplifying these nurses as exceptional leaders, however, these overviews are not intended to provide a perspective of the ordinary everyday world of practice.

Various works contribute to an analysis of the development of nursing as a profession. Chua and Clegg³¹ illuminate the issues of professional closure through an analysis of the profession which acknowledges that "words" and "deeds" are inseparable particularly where an analysis of practice is concerned. Other forces which have had a significant effect on the development of the profession of nursing are identified in this work, in particular the institution and organization of medical, male power and those of gender, subservience, vocation, discipline and morality. Maggs³² investigation of the

²⁸ C. Maggs, Reclaiming the Past to Own the Future, in S.J. Rankin Zerr, E. A. Fitzpatrick and G. Zilm (Eds), *Past is Present: The CAHN/ACHN Keynote Presentations 1988-1996*, Vancouver, 1997.

²⁹ An example of a "broad brush" approach to nursing history is L. Seymer, M.A. Nutting and L. Dock, *A History of Nursing*, 1907, Putnam, New York; Mary Lambie, *My Story: Memoirs of a New Zealand Nurse*, Peryer, Christchurch, 1956.

³⁰ D.C. Bridges, *A History of the International Council of Nurses 1899-1964: The First Sixty-five Years*, 1967, Toronto, Lippincott.

³¹ W-F Chua and S Clegg, Professional Closure, The Case of British Nursing, *Theory and Society*, 1990, 19(2), pp.136-172.

³² C. Maggs, *The Origins of General Nursing*, Croom Helm, England, 1983.

emergence of the 'reformed' nurse in Britain identifies the struggle that British nurses had in carving out their professional niche once the medical profession had become aware of the potential threat to their superior status. Kathryn Wilson³³ provides a critical analysis of the complex processes of professional closure as they related to a New Zealand setting. Her thesis explains how nursing, itself subordinated to the medical profession in an intensely patriarchal hierarchical structure, adopted the rules of closure to effectively marginalise the untrained nurse while elevating the status of the trained nurse at Rotorua. Jan Rodgers³⁴ analysis of the Nightingale influence on the earlier years of nursing education in New Zealand aligns the womanly virtues of forbearance, endurance and obedience to the ideal vision of the nurse. Rodgers provides persuasive evidence that it was this ethos that permitted nursing its place in the health structure while limiting its potential to develop. These works provide useful insights into the professional environment of the hospital based nurse of the period but do not investigate the practice world of the community environment of nursing.

Hester Maclean, the nurse leader during the establishment and development of the Native Health Nursing Scheme, adopts a chronological approach to her autobiographical work.³⁵ While recording valuable information about significant events and key players, she also provides the reader with insight into the contemporary attitudes and beliefs of health administrators. For example, she illustrates the contemporary view of the time regarding an uncertainty as to the competence of Maori nurses when they were initially appointed to districts in her statement that they were at first under the supervision of a Pakeha nurse until they "gained experience and proved themselves" to be suitable to take charge of their own districts. She also claimed that the Maori nurses "had more difficulty in establishing any influence over the natives than the Pakeha nurses, and it has not been possible to leave this work entirely to them".

³³ K. Wilson, *Professional Closure: The Case of the Professional Development of Nursing in Rotorua 1840-1934*, MA thesis (embargoed), Massey University, 1995. Permission to refer to this work has been given by the author.

³⁴ Rodgers, *Nursing*.

³⁵ Hester Maclean, *Nursing in New Zealand: History and Reminiscences*, Tolan Printing Company, Wellington, 1932, p.90.

Barbara Ancott-Johnson's autobiographical work³⁶ of her work as a nurse in the Hokianga area on the north west coast area of New Zealand is a detailed record of her work among Maori communities. She does not give the dates of her work in the Hokianga but it would seem that it was during the 1940s. This autobiography provides valuable insight into the extent to which Ancott-Johnson and her colleagues were subservient to medical staff in almost all aspects of their life and work. This is clearly indicated in the association with Dr G. M. Smith that she makes in the title of the book and continues as a major thread through the book. A collection compiled by Sister Mary Damian³⁷ of autobiographical accounts of work "out in the districts" also provides clear descriptions of some aspects nursing practice in the early part of this century. Isobel Haresnape's chapter³⁸ describes the nursing of a twelve-year old girl with typhoid and pneumonia at a remote East Coast settlement towards the end of the First World War. A graphic account is given of the transport difficulties in such remote areas as well as the lonely nature of such nursing work in isolation of other health professionals. As with Ancott-Johnson's work, an important contribution is the perspective gained of how this nurse viewed her practice and some aspects of its context. However, these contemporary works do not provide an analysis of the socio-political context as it relates to nursing at the time.

A number of New Zealand histories explore issues of power in nursing and health care. Jan Rodgers³⁹ provides a convincing argument that the New Zealand nurses who went to World War I embarked on a deliberate campaign to limit the place of untrained women in the military nursing work force thereby claiming professional ground for themselves. However, the claim for status in the military structure was limited by the conventional feminine ideal of the time. Nursing as 'women's work' was

³⁶ B. Ancott-Johnson, *Nurse in the North: With Dr G.M. Smith in the Hokianga*, Whitcombe and Tombs, Christchurch, 1973.

³⁷ Sister M. Damian, *Growl You May but Go You Must*, A.H. and A.W. Reed, Wellington, 1968.

³⁸ I. Haresnape, A Case Down the Coast in Damian, *Growl You May*.

³⁹ Jan A. Rodgers, 'A Paradox of Power and Marginality': New Zealand Nurses' Professional Campaign During War, 1900-1920, PhD thesis, Massey University, 1994, p.242.

sufficiently innocuous to allow a place for the profession in peacetime hospitals but lacked the standing required to count in the military hierarchy.

A key work which this history builds on is Alex McKegg's thesis⁴⁰ which traces the background to and the development of nursing as a service in the rural areas of New Zealand. While acknowledging that there were several agencies which administered this service, she concentrates on those nurses working for Government agencies. Her discussion provides an insightful analysis of the movement of nursing in England from the public domain, in hospitals, to the private domain, in people's homes, as an endeavour to intervene in family life. This gave nurses the opportunity to influence against not only health dangers but also against what were perceived as moral and social dangers and to correct people's behaviour. She contrasts the development of district nursing in New Zealand with other post-colonial societies, Australia and Canada noting, in particular, that the New Zealand scheme was a government supported operation and therefore not wholly reliant on donations.⁴¹ McKegg supports Rodgers'⁴² claim that the gender order of society was clearly maintained in the hospitals with women involved in occupations which mirrored the maternal/domestic role and with men pursuing the accepted masculine functions of making policy and issuing orders. She describes the difficulties encountered by nurses and doctors when these gendered relationships were transferred out of the hospital and into rural settings.⁴³ Some doctors felt that a nurse working in their area would threaten their livelihood and sphere of authority and some nurses found their work was hampered by strained relationships with medical staff.

McKegg's study investigates the two main branches of nurses who worked in government supported schemes, the district nurses and those nurses who worked with Maori. She states that because of the limitations of time and space the examination of those nurses who worked with Maori is not as extensive as it could be.⁴⁴ This study

⁴⁰ A. McKegg, "Ministering Angels": The Government Backblock Nursing Service and the Maori Health Nurses, 1901-1939, MA thesis, University of Auckland, 1991.

⁴¹ A. McKegg, "Ministering Angels", p.28,31.

⁴² Rodgers, Nursing.

⁴³ A. McKegg, "Ministering Angels", p.36-39.

⁴⁴ *ibid*, p.5.

builds on McKegg's work and is complementary to it by more closely examining the actual nursing practice of Native Health nurses during the period that their work was taken up with infectious disease nursing and identifying the elements of practice which constituted a change in role made possible by these particular circumstances. A limitation of this study is that it does not look in any depth at the development of the health teaching, disease prevention responsibilities of the district nurses role as it became evident during the 1920s and on. This is another significant development in public health nursing history which warrants investigation. McKegg provides strong evidence to support the claim that the nurses were agents of assimilation and that Maori exercised their autonomy by accepting or rejecting what the nurses were offering. There is a rich description of the work of the nurses and impressive evidence of their assimilationist approach to Maori. McKegg explains that the peculiar circumstances of district nurses forced them to take on positions requiring more independence and initiative than their contemporaries working in hospitals, often in direct competition with doctors.

Pamela Wood traces the rise and fall of the Maori Health Nursing Scheme from its inception on the proposal of young Maori leaders and its phasing out due to insufficient acceptance and support in all levels of the health system.⁴⁵ She introduces the Maori nurses as "Efficient Preachers of the Gospel of Health" and the notion that the Maori Health Nursing Scheme was grounded in a genuine concern for Maori health. Maureen Holdaway⁴⁶ offers a challenge to Wood's analysis by examining the resistance to the scheme from within nursing and the wider socio-political environment. She asserts that the abandonment of the Maori Health Nursing Scheme a little more than a decade after it commenced is an illustration that reforms are not necessarily progressive and reflect the views of the most powerful. She asks "Where are the Maori nurses who were to become the efficient preachers of the gospel of health?" and comes to the conclusion that institutional racism operated to smother and eventually extinguish the scheme.

⁴⁵ P.J. Wood, Efficient Preachers of the Gospel of Health: The 1898 scheme for educating Maori nurses, *Nursing Praxis in New Zealand*, March 1992, 7(1), pp.12-21.

⁴⁶ M. Holdaway, "Where are the Maori Nurses who were to Become those "Efficient Preachers of the Gospel of Health?", *Nursing Praxis in New Zealand*, March 1993, 8(1), pp.25-34.

The available literature has provided a solid foundation for this investigation of the work of the Native Health nurses as a new and innovative vehicle for claiming professional ground. The themes of Maori health, power issues in nursing and women's history have been represented in the literature to differing degrees. This thesis looks specifically at the social processes which constructed the complex context in which the NHNS originated. It carefully examines the actual practice of the nurses over the period of time when infectious disease nursing was the focus of their work, because it was during this time that their positive reputation was established and consolidated both with the Maori people and with the Health Department. The result of their work was that nursing successfully moved into a new sphere of professional territory and gained in status as a result.

**CHAPTER 2 - SETTING THE SCENE: THE BACKGROUND TO THE
NATIVE HEALTH NURSING SCHEME, 1900-1911**

This chapter examines the background to the Native Health Nursing Scheme including the health care context of colonial New Zealand in the period up to 1910, the early development of the nursing profession in New Zealand and a Maori health initiative, the Maori Health Nursing Scheme. During this period nursing was strongly motivated to seek professional identity and status. Maori were also active especially in seeking opportunities for self-determination with regard to health care for their people. The dominant ideology and infrastructure of the time, however, had constructed a health service which held both Maori and nurses in a disadvantaged position in terms of status and power. The discourses of class, gender and race synergistically inform an analysis of this environment. In particular, the position of the Maori was significantly at risk due to the devastating effects of infectious diseases introduced as a result of colonisation of New Zealand by the British, a rapid process effected within only a few decades, and a health system which failed to address their needs.¹ The struggle for nurses was one of professional identity and status in a health service dominated by male doctors.² Although the struggles of Maori and nurses were conducted separately in the period up to 1910, they both worked vigorously within the health service to effect changes that would gain them recognition.

The role of the colonial government in the health care system began in 1846 with the establishment of four state hospitals in Auckland, Wellington, Wanganui and New Plymouth following a plea from an Irish immigrant doctor, John Patrick Fitzgerald, in

¹ Irihapeti Ramsden, Moving to Better Health, *New Zealand Nursing Journal*, March 1990, pp.15-17; Mason Durie, *Whaiora*; L.K. Gluckman, *Tangiwai*, p.161, 168. About 1790 a severe often fatal dysenteric disorder known as tikotiko toto (bloody faeces) broke out among Maori after the arrival of an English ship in Mercury Bay. A rapidly fatal disorder not previously known by Maori but named Tingara broke out in 1795 in the Bay of Islands, a port used by Pakeha whalers and traders. Epidemics then became more frequent; influenza in 1826 and 1837, whooping cough and mumps in the 1820s, measles in 1838.

² Patricia Sargison, *Notable Women in New Zealand Health: Te Hauora ki Aotearoa: Ona Wahini Rongonui*, Longman Paul, Auckland, 1993. Emily Siedeberg McKinnon graduated in 1896, the first woman to be awarded a medical degree in New Zealand. In the early 1890s an English woman Eliza Frikart had practised medicine briefly in Wellington.

1840³ for hospital care to be available for those who could not afford private care. Originally, these hospitals were to serve both the immigrant and Maori populations. However as the management and funding of hospitals became more regionalised in later decades, health and welfare services for Maori and Pakeha became separate and unequal. The Pakeha population doubled between 1857 and 1861 and doubled again by 1866 due to the flood of immigrants during the gold rushes of the 1860s. In response to this, a proliferation of hospitals appeared especially near mining communities where severe accidents requiring surgery were common.⁴

New Zealand was swift to implement antiseptic surgical techniques in an effort to keep up with medical innovations from the Old Country. This became an impetus for the transformation of hospitals into places of cure rather than long term accommodation for chronic and incurable patients who could not afford private care.⁵ As chronic patients were increasingly discouraged from entering the hospital system, a system of "outdoor relief" in the form of financial assistance was administered regionally by charitable aid boards. The meanness of the assistance given and the searching, judgmental inquiry which preceded its delivery ensured that outdoor relief was the most controversial of all charitable aid.⁶ The financial resources which provided for relief services were funded at least partly from local rates and it was argued that because Maori did not pay rates they were not entitled to help from the charitable aid boards.⁷ The colonial government assigned responsibility for Maori welfare to the Native

³ D. A. Dow, *Springs of Charity?: The Development of the New Zealand Hospital System, 1876-1910*, in L. Bryder, *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, Bridget Williams Books, Wellington, 1991, p.46. FitzGerald, an Irishman, had undertaken medical training in Dublin, London and Glasgow before arriving in Wellington in January 1840 as surgeon superintendent on board an immigrant ship.

⁴ Dow, *Springs of Charity?* pp.44-64.

⁵ P. Sargison, *Gender, Class and Power: Ideologies and Conflict during the Transition to Trained Female Nurses at Dunedin and Christchurch Hospitals, 1889-1895*, in Bryder, L., and Dow, D., *New Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health*, Auckland, Pyramid, 1995, pp.271-278.

⁶ M. Tennant, *Paupers and Providers: Charitable Aid in New Zealand*, Wellington, Allen and Unwin, 1989, p.5.

⁷ *ibid*, p.12.

Department and some individual church missions provided voluntary assistance. Official reports of the Native Department reflect concern with the extensive loss of land by confiscation and through a series of land acts at this time but do not report on the work of the department regarding Maori health and welfare.⁸

During the nineteenth century, public health legislation in New Zealand had been initiated and amended in response largely to the threat, or actual outbreaks, of infectious disease and it was this concern that eventually fuelled any real efforts to assist the Maori with their health problems. Closely resembling the United Kingdom Public Health Act of 1848, New Zealand's Public Health Act of 1872 (following an outbreak of smallpox⁹) provided for the setting up of provincial and local boards of health. The powers of these boards were clarified particularly with regard to the notification of infectious disease, sanitary conditions, quarantine and vaccination. In 1876, the year which marked the end of the provincial period with provincial governments abolished, the Act was amended to establish a Central Board of Health reporting the general state of health of the Colony to the Governor. Each local authority was to be a local board of health for its district and could at its discretion appoint a medical officer to enforce health regulations. Local authorities did not always take their public health responsibilities seriously¹⁰ and mostly neglected to appoint a medical officer. A series of amendments to the 1876 Act in 1877, 1880, 1881, 1882, 1884, and 1893 were intended to resolve these long-standing difficulties by making locally elected boards even more responsible for public health and, in particular, infectious disease.¹¹

Meanwhile, members of the New Zealand Medical Association criticised the Act as inoperable and agitated for the establishment of a health department and a Minister of Public Health to administer an increased number of publicly funded medical officers of

⁸ Reports of the Native Department, *Appendices to the Journals of the House of Representatives* (subsequently abbreviated to *AJHR*), Vol.2, G1-3, 1899; Vol.2, G1 & 2, 1900; Vol.2, G1-8, 1904; Vol.3, G1-9, 1907.

⁹ F. S. Maclean, *Challenge for Health*, Govt. Printer, Wellington, 1964, p.224, 421.

¹⁰ *ibid.*, p.151.

¹¹ *ibid.*, pp.426-428.

health. Reconstituted as the New Zealand branch of the British Medical Association (NZBMA) in 1896, the association took every opportunity to promote the idea of a Public Health Department. Dr James Malcolm Mason¹², who had immigrated to New Zealand and established a general practice in Otaki in 1895, was appointed parliamentary secretary in 1897 to improve the lines of communication between the medical profession and the Government. According to Dr Robert Makgill, a leading figure in the health department from 1900 to his retirement in 1926, Mason had worked a 'modern miracle'¹³ by winning Prime Minister Richard Seddon's approval of the NZBMA's proposal.

As a pandemic of bubonic plague advanced through India, New Caledonia and Australia during January 1900 the increasing threat to New Zealand became the impetus which convinced the government to address the public health problems. Two health commissioners were appointed, Mason and John Gilruth (the government veterinarian) to investigate the potential of plague outbreak.¹⁴ Mason was consequently well placed as a key figure in the drafting of the Public Health Act which was passed on October 13, 1900. This act addressed the lack of power invested in either the Central Board of Health or the local boards to "carry out the functions it was intended to discharge"¹⁵. The Act provided for the establishment of the Department of Public Health under the control of a Minister of the Crown with extensive powers of enforcement. The Honourable Joseph G. Ward became the first Minister of Health in the British Empire.¹⁶ The full-time salaried position of Chief Health Officer went to Mason, and a number of district health officers and specialist positions were to be filled by qualified medical practitioners with specialised knowledge of sanitary and bacteriological science.

¹² Geoffrey Rice, The Making of New Zealand's 1920 Health Act, *New Zealand Journal of History*, 1988, 22(1), pp.3-22. Mason was an outspoken Scot qualified as a lawyer and then a doctor at Edinburgh and Glasgow. He also completed the Cambridge Diploma in Public Health with postgraduate work in Paris and Brussels.

¹³ D. Dow, Seddonic Plague: A Mythological Malady in Bryder, L., and Dow, D., *New Countries and Old Medicine*, p.41.

¹⁴ *ibid*, p.41

¹⁵ Maclean, *Challenge for Health*.

¹⁶ Rattray, *Great Days*.

Significantly Dr Maui Pomare, the first Maori doctor,¹⁷ was appointed Maori Health Officer.

Although women were not prevented from entering the medical profession, once qualified the gendered culture of the profession generally restricted them from reaching the higher income and status positions.¹⁸ Gender relations within the medical profession generally functioned to constrain the opportunities for women to advance. After gaining a Bachelor of Science in geology and biology with honours, the first Sydney University woman graduate in science, Agnes Bennett had great expectations of an exciting career in the science world. As applications were turned down and replies to advertisements were not answered, it became clear that women were being excluded from the science careers.¹⁹ Believing that Edinburgh was a more liberal environment for women, she went there to study medicine and anticipated the prospect of a rewarding career. Her hopes were buoyant as she received a recommendation from a distinguished man, Dr Cathcart, for the important and responsible post of Resident Medical Officer at Edinburgh Infirmary. However, the board of the infirmary turned her down and the only post open to her was in a mental institution which was viewed as a more lowly position. She was further rankled when she found that men graduates who had not done as well as her were finding positions with ease.²⁰ She returned to Sydney hoping for better career. It became evident when her private practice failed that it was just as difficult to become established in Australia as it had been in Britain. When she was asked to take over the medical practice of Ella Watson in Wellington, she did not hesitate to cross the Tasman to New Zealand. Primarily concerned with the health needs of mothers and children, a field of practice socially condoned for women doctors, she successfully managed her

¹⁷ Hamish Keith, *New Zealand's Yesterdays: A Look at Our Recent Past*, Sydney, Reader's Digest, 1984. Pomare was born in Taranaki in 1876 and graduated from a Seventh Day Adventist College in the USA. He was an MP from 1911 to 1928.

¹⁸ McKegg, *Ministering Angels*, p.35.

¹⁹ Cecil and Celia Manson, *Doctor Agnes Bennett*, Whitcombe and Tombs Ltd, New Zealand, 1960, p.26.

²⁰ *ibid.*, p.40.

own practice and from there developed a long and influential involvement in maternal and child health.

In 1901 New Zealand was divided into six health districts each administered by a health officer responsible for public health throughout their district. Nurse inspectors appointed under this structure reported on health matters to District Health Officers.²¹ The Act gave medical officers the power to require local bodies, doctors, chemists and members of the public to comply with health law especially as it related to sanitary conditions and the prevention of the spread of infectious disease. The Act also had significance in that it specifically addressed Maori health concerns at a legislative level. The Public Health Act of 1900 made initial steps towards acknowledging that the Government had a responsibility for Maori health concerns by providing for a health committee to be established in Maori communities elected by the people themselves or appointed by the governor with responsibility for the sanitation of that community. This provision was paradoxically to be administered by the Native Department rather than the Health Department, a key issue in the resourcing problems which were to follow.

The colonial health service had developed haphazardly up until the turn of the century. The health reforms provided for in the 1900 Health Act confirmed the status and power of the medical profession in the public health arena. To a far lesser extent the nursing profession was gaining a presence which positioned it strategically to take up the public health roles which were to emerge. Male dominance of the medical profession was in stark contrast to female dominance in the nursing profession. This gender split was a crucial element in the construction of the social and professional relations which dominated the interface of nursing and medicine at the time. The ideology of Victorian society had created rigid gender roles for men and women which were often at odds with the realities of everyday life.²² Victorian society's encouragement of both physical and social mobility, individual development and hard work were more reflective of contemporary expectations for men rather than of the ideal female behaviour which

²¹ *Public Health Nursing*, Report of the Review Committee to the Director-General of Health, 1986.

²² Vicinus, *Independent Women*, p.4.

prescribed submission of self, voluntary labour and a minimum of mobility outside the family.²³ However, as the demand increased rapidly during the nineteenth century for cheap skilled labour in the service industries, including the health care industry, middle-class, single women were quick to take advantage of the opportunities for education and meaningful employment enabling them to survive outside the family. Nursing provided just such an opportunity for women while being considered an acceptable extension of 'women's work'. In 1874, four of the 65 single women aboard the *Cathcart* were classified as nurse but a decade later 97 nurses were listed as having received assisted passage.²⁴ These women came to New Zealand as pioneers for newly developing public roles which were to have important implications for women, for nurses and more specifically for Native Health nurses.

Until the 1880s the formal nursing profession in New Zealand had been situated in hospitals which were administered by men. The role of women was more acceptably confined to the domestic functions associated with house-keeping. Community based care for the settler population was the responsibility of immigrant women who provided care for the sick at home as an extension of their role as wife, mother and neighbourly woman.²⁵ In fact most Pakeha rural women took on this role because of the isolation of many European settlements and the well-accepted belief that sickness could be better attended at home. Hospital care was avoided if possible with only the destitute, poor, or severely ill resorting to hospitalisation.²⁶ When Governor Grey, Governor of New Zealand 1845-1853 and 1861-1868 then premier 1877-1879,²⁷ proposed extending the State hospital system to include a hospital in Dunedin, there was some opposition to it on the grounds that there were "no patients and no fear of there being any" because there was an expectation that hospitals were (as was the case in Britain) a place for the

²³ *ibid*, p.5.

²⁴ J. A. Rodgers, '...A Good Nurse...A Good Woman': Duty and Obedience in Early New Zealand Nursing Education in R. Openshaw and D. McKenzie (eds.) *Reinterpreting the Educational Past*, New Zealand, NCER, p.55.

²⁵ Rodgers, *Nursing*.

²⁶ *ibid*.

²⁷ Keith, *New Zealand's Yesterdays*, p.23.

sick poor who were unable to meet the costs of their health care. In New Zealand, there was the expectation that patients should meet part if not all of the cost of care and therefore would be different to the British institutions.²⁸

Nursing as an occupation in New Zealand held such low status in 1874 that nurses were classified along with domestics in the census for that year.²⁹ The employment of female nurses in hospitals was not seriously considered until the 1880s when the employment of an all-female nursing staff was advocated along with other hospital reforms in line with those which had been introduced in Britain and Australia.³⁰ Intense immigration over the 1870s and 1880s and the advent of more complex surgical procedures under anaesthetic exerted pressure on the largely charity-funded hospital and charitable aid boards which could no longer cope with the increasing number of sick, aged, destitute and neglected.³¹ The demand for nurses who had undergone some form of training increased as hospitals became places associated with the cure of disease rather than as a form of poor-house.

Consequently, hospital and charitable aid boards began appointing British trained nurses as matrons whose influence included an emphasis on cleanliness, endurance, forbearance and obedience.³² Annie Alice Crisp was appointed matron of Auckland Hospital in 1883 at the age of 28. Her background was as a head nurse at the Royal United Hospital, Bath, after training at both Netley and Woolwich. She engaged in active service as a nursing sister with the British troops at the Zulu War in 1879 and later in the Egyptian campaign.³³ for which she had been decorated with the Royal Red Cross.³⁴ Crisp was one of a number of British trained nurses who were appointed to the

²⁸ Dow, *Springs of Charity?*

²⁹ *ibid.*

³⁰ *ibid.*

³¹ Rodgers, *Nursing*, p.20.

³² *ibid.*, p.9.

³³ Rattray, *Great Days*, p.125.

³⁴ M. B. Brown, *The Auckland School of Nursing 1883-1990: The Rise and Fall*, M.A. thesis, University of Auckland, 1991, p.38.

position of hospital matron with the expectation that they would raise the standards of care, hygiene and discipline. Following his inspection of Auckland Hospital in 1884, Dr Grabham, the Inspector of Hospitals reported that the hospital wards were clean and orderly. New bed clothing, flowers, pictures and ornaments softened the bleakness.³⁵ Presumably, Crisp had met the expectations.

The British trained matrons influenced the establishment of the first nurse training schools in New Zealand. Crisp established a one-year certificate course during her five year appointment at Auckland Hospital and 44 nurses had passed this certificate by 1891 when the training was increased to two years, then three years in 1894.³⁶ The three year programme at Auckland Hospital was strongly dominated by doctors. Nurses began their training as probationers only after being examined and approved by a physician. Of the 34 lectures in the first year, 24 were given by medical staff and 10 by the matron, the same for the second year and the 36 lectures in the third year were all by medical staff.³⁷ Even so, formal training for nurses was essential in their quest for professional identity. While there was certainly medical dominance of their formal education, this functioned to allay fears that doctors may have had about nurses posing a threat to the existing power structures in hospitals.

The transformation of nursing as a vocation for untrained women to a respectable profession for women of propriety³⁸ is attributed to the reforms engineered by Florence Nightingale. Nightingale had instituted a training programme for nurses in 1860 at St Thomas' Hospital, London, which was structured to focus on hygiene, cleanliness and nursing skills. Equally important was forbearance, endurance and obedience, attributes symbolic of the respectability of Victorian women.³⁹ This nurse

³⁵ Dr Grabham, Report of the Inspector of Hospitals, *AJHR*, H7a, 1884, p.4.

³⁶ Brown, *The Auckland School of Nursing*, p.48.

³⁷ *ibid.*, Auckland Hospital, Syllabus of Instruction to be Given to Probationer Nurses, February 1, 1901, Appendix 5.

³⁸ Rodgers, 'A Paradox of Power and Marginality', p. 25.

³⁹ *ibid.*, p. 27.

training aimed to prepare women of strong character and high moral standards as nurse leaders who would take over responsibility for supervising house-keeping, organising nursing care and training probationers.⁴⁰ The pre-reform system of nursing had the matron as the housekeeper-supervisor of woman staff and the wards were run by sisters who were to comply with the medical staff. The reforms lead by Nightingale introduced a nursing hierarchy with the matron, now a trained nurse, in charge of the organisation and supervision of nursing care and nurses training.⁴¹ Sisters ceased to be directly answerable to doctors in relation to matters of patient care and instead became subordinate to the matron.

Unfortunately there were key aspects of Nightingale's nursing curriculum which did not survive transportation to New Zealand. Omitted were course components which Nightingale considered essential for nurses to have a strong sense of their own value, and of their ability to reform and transform nursing.⁴² These key components were management, teaching and administration, all essential for the knowledge base required for the early nurse leaders to be effective. That nurses trained in New Zealand were not taught these crucial subjects probably reflects the control that hospital authorities and medical staff (all male) had over decisions which affected nursing and the perceived threat that nurses trained in management and administration might be to those in power.

The gender division of labour in hospitals closely resembled that of the domestic household with women responsible for the womanly functions of caring for the sick, supervising housekeeping and socialising those under her management into the appropriate roles within the hospital. The powerful positions of doctor, administrator and employer were reserved for men. The hierarchical structures which controlled nursing - men over women, doctors over nurses, matrons over sisters, sisters over senior nurses, senior nurses over probationers - functioned well to rapidly establish a

⁴⁰ *ibid.*, p. 25.

⁴¹ E. Gamarnikow, *Nurse or Woman: Gender and Professionalism in Reformed Nursing 1860-1923*, in *Anthropology and Nursing*, P. Holden and J. Littlewood, Routledge, London, 1991, pp.110-129.

⁴² Wilson, *Professional Closure*, p.19.

legitimate, trusted position for nurses in the hospital system which did not threaten existing power structures.⁴³

Although nursing reform was based on traditional gender roles, rather than restricting the development of the profession, it was used as a political strategy by reformers.⁴⁴ That nursing was located “unambiguously within patriarchally constructed femininity...based on an ideological equation between nursing, femininity, and women’s work to which doctors and nurses both subscribed”⁴⁵, allowed nursing to establish an identifiable professional role which did not threaten doctors. This relationship allowed nursing to effectively carve out a niche in health care which did not displace the established order. The nursing role could be seen as that of assisting the doctor to do his job better. This non-threatening, womanly, capable, trust-worthy image was a crucial foundation to the establishment of nursing in the community setting as it is unlikely that nurses would have been given the scope for such relative autonomy if there was suspicion on the part of the doctors that nurses would over-step the pre-determined boundaries of role and responsibility.

An important element in the image of the nurse constructed by the Nightingale reforms was that of the altruistic, quasi-religious, ladylike woman.⁴⁶ The reformation of nursing in Britain had occurred at a time when it had become increasingly necessary for middle-class women to be able to support themselves independently in paid employment. At the time of the nursing reforms, Britain had half a million more women than men and respectable occupations for women like nursing and teaching were essential. Nightingale reforms in nursing had created acceptable employment opportunities for women who either chose to remain unmarried or for whom there were no husbands available. The philanthropic unpaid welfare work of the British middle-class and upper-

⁴³ Rodgers, ‘A Paradox of Power and Marginality’, p. 32.

⁴⁴ Gamarnikow, *Nurse or Woman*, pp.110-129.

⁴⁵ *ibid.*

⁴⁶ Judith Godden, ‘For the Benefit of Mankind’: Nightingale’s Legacy and Hours of Work in Australian Nursing, 1868-1939, in Anne Marie Rafferty, Jane Robinson and Ruth Elkan (Eds.), *Nursing History and the Politics of Welfare*, London, Routledge, 1997, pp.177,184-5.

class lady was adapted and legitimised as paid work.⁴⁷ The situation in New Zealand, however, was demographically the reverse. In 1871, there were twice as many men as women between the ages of 21 and 65 years in this colony and only a few women joined the paid workforce.⁴⁸ Even as more balance in the population occurred during the 1880s, the incidence of marriage remained high and women were generally too busy with housework, childcare and helping on the farm to engage in voluntary welfare work.⁴⁹ There was a gap, therefore, of women available to give help to the needy especially in the rural areas and it was this gap that the Native Health nurses were to fill.

Nurse training was a key element in the nursing reforms. There were two aspects to training - theoretical instruction and nursing work on the wards. It was the former which had contradictory effects on the medical profession. On the one hand, it provided doctors with trained assistants so that they could do their work better, on the other hand it blurred the division between nursing and medicine. When nurses put this theoretical knowledge into practice in their ward work under the jurisdiction of the sister in charge, there was a consequent loss of control by doctors over nursing practice.

Her knowledge of anatomy, physiology, pathology, and the action of drugs, should be thorough, though not necessarily very minute and extensive. She should also understand the value and meaning of symptoms, the means of preventing contagion and infection. She should be able to record the variations of the pulse or thermometer, and know how to act in an emergency in the absence of a doctor.... The hospitals professing to train nurses must give a more thorough and systematic education. Not content with merely teaching them to dress a wound, put on a bandage, or to deliver a woman - acts which require but a small amount of imitative [sic] skills to attain to - they must admit them to the lectures, to teach them the reason for and the value of what they do, so that in their sphere they be no automatic servants of, but rational fellow-workers with, the physician.⁵⁰

⁴⁷ Patricia Sargison, *Gender, Class and Power: Ideologies and Conflict During the Transition to Trained Female Nursing at Two New Zealand Hospitals, 1889-95*, *Women's History Review*, 1997, 6(2), pp.184-5.

⁴⁸ Dalziel, *The Colonial Helpmeet*, p.58.

⁴⁹ M. Tennant, *Beyond Benevolence: Welfare Organisations*, in Anne Else (Ed.) *Women Together: A History of Women's Organisations in New Zealand*, Wellington, Daphne Brasell, 1993, p.110.

⁵⁰ *British Medical Journal*, 1873: 14, cited in Gamarnikow, *Nurse or Woman*, p.113.

In becoming more able to assist doctors, nurses needed to know “the reason why” and it was this knowing that strategically positioned nurses to later become agents for a more autonomous style of nursing practice.

The apprenticeship training of nurses ensured a ready supply of cheap labour in return for a qualification, board and a small wage. The entire nurse training experience was designed to maintain existing power structures in the hospital hierarchy and in particular the gender and occupational divisions were well supported. The status quo prepared nurses who would

conform to prevailing customs, traditions and practices. [They] learned to be loyal to their hospital, obedient and docile, and to accept draconian conditions and strict discipline. ... In assuming this subordinate position nurses sought to carve out and monopolise a niche for themselves in the shadow of the New Zealand medical profession.⁵¹

It was under this patriarchal shadow that nurses who moved into the community worked to carve out their unique niche in the health service.

There was one group which was displaced by the probationers undergoing formal nurse training. This was the group of nurses who made up the old order, those who had learnt on the job. Some of the old order were men who although they essentially performed nursing duties were known as attendants or wardsmen.⁵² They did not accept being squeezed out by the nurses ‘of the new order’ and in Christchurch especially remained a subversive element until an inquiry into hospital management reaffirmed the status of the “new order” nurses. Mr Richard Brown, the “chief wardman”, was described as:

unaccustomed to the scientific spirit of more modern methods...[who] may have felt honestly, though unreasonably, shocked by a system which contravened his prejudices.⁵³

⁵¹ Wilson, *Professional Closure*, p.20-21.

⁵² J. Giles, *Report of Inquiry into the Management of the Christchurch Hospital*, *AJHR*, H-18, 1895, p.1,2.

⁵³ *ibid.*, p.2.

The conflict between the old and the new order of nursing was described as inevitable. The inferiority of the old order was thought to be obvious ‘when [it was] exhibited alongside of its newer rival’.⁵⁴ This report significantly states that the nursing staff were the ‘only authority competent to pronounce upon the degree of efficiency or inefficiency displayed by this or that nurse.’⁵⁵ Acknowledgment at the level of the House of Representatives that nursing was equipped and competent to judge the performance of the members of its own profession was a step forward.⁵⁶

In Europe, pre-industrial village healing practices and post-industrial sanitary reforms had long been identified with women.⁵⁷ This claim to community health care by women was sanctioned by society generally as a ‘natural’ extension of women’s work. There were many women who rose to the challenge of meeting the health needs of their communities and being far removed from the constraints of the medical profession found themselves in circumstances which required them to fulfil the role of curer.⁵⁸ McKegg notes that these women have received little but contempt from the historical record.⁵⁹ In colonial New Zealand, there was an intense emphasis on women’s role within the home and family. Women were charged with safe-guarding the moral tone of society. Their job was “to restrain and refine the base instincts of men”.⁶⁰

In the new country woman’s function would be to create and care for house and home, thus freeing men for the work of production; it would be her duty to guard the virtue, morality and gentility of the settlers ...⁶¹

⁵⁴ *ibid.*, p.9.

⁵⁵ *ibid.*, p.9.

⁵⁶ Elizabeth Grace Neill, Assistant Inspector of Hospitals and Asylums was a member of the investigating team in her capacity as a nurse.

⁵⁷ P. Laing, *Colonial Constructions of Maori Health: First Encounters and the Resistance of a Dying Race*, in Bryder and Dow, *New Countries and Old Medicine*.

⁵⁸ McKegg, *Ministering Angels*, p.20.

⁵⁹ *ibid.*, p.20.

⁶⁰ Dalziel, *The Colonial Helpmeet*, p. 63.

⁶¹ *ibid.*, pp 55-68.

Women gained suffrage on 19 September 1893 in recognition of their role as wife, mother, homemaker and guardian of society's morals.⁶² Their very role legitimated their claim to the vote and was not in conflict with tradition. Women were to make voting an exercise of moral judgement by evaluating a candidate's moral character and voting accordingly.⁶³ In this way, it was expected by early feminists that women would cleanse the political system. The approach of women reformers to gaining political power closely mirrored the strategy of the nurse reformers who did not challenge the ideology of nursing as woman's work.

It was not in the interest of the nursing profession to offer a challenge to the notion of nursing as women's work because it was this very norm that legitimated their claim to control nursing. The nurse as the epitome of the "good woman" in Victorian terms had all the right qualities to bring health care from the hospitals into people's homes. Although it had been largely within the hospital setting that reformed nursing had gained its professional identity, the work of nurses in other settings contributed to this rise in status. Florence Nightingale had earned a strong reputation for nursing during war through her reorganisation and management of army field hospitals. As a result, the field of army nursing opened up for trained nurses and it became accepted practice that they would be deployed to the front during war. Another branch of nursing outside of the hospital was private nursing. Many nurses on completing their training took up positions as private nurses. Those who could afford it employed nurses in their homes to care for them through illness and convalescence.

The post-reform work of trained nurses moved out of hospitals into the community. Nightingale had developed a strong reputation in the public health arena and was a key consultant for the British Army regarding public health issues, especially in India. She had established herself as an expert in matters of sanitation and disease prevention. Her international influence extended to New Zealand when she was

⁶² *ibid.*, p. 64.

⁶³ P. Bunkle, *The Origins of the Women's Movement in New Zealand: The Women's Christian Temperance Union 1885-1895*, in P. Bunkle, and B Hughes, *Women in New Zealand Society*, Allen and Unwin, Australia, 1980, p.67.

consulted by Sir George Grey, Governor of New Zealand, as he was most concerned about the dramatic decline in the Maori population.⁶⁴ She was asked to provide an analysis of Maori health problems based on information provided by Dr A. S. Thomson who had concluded that the major health problem for Maori was scrofula.⁶⁵ Her analysis revealed that the health problems of the Maori were caused by environmental factors and she proposed solutions that had been effective in other settings. Her belief was that the environment had to be manipulated to allow nature to heal.⁶⁶ She anticipated the influence that nurses could have in putting into place her philosophy of public health practice and from her position of influence was a strong advocate of nurses being the most appropriate community health protagonists. A prolific letter writer, in 1891 she wrote to the Bucks County Council emphasising that nurses “must create a new work and a new profession for women”.⁶⁷ This statement, however, presumes that nursing had not had a place in the community previously. Maggs acknowledges that in England there had been a well established training scheme for nurses which trained them in the community (because that is where most of their patients were) as well as giving them some hospital experience. The scheme had been well regarded but had been disbanded when the Nightingale reforms appeared on the scene at nearby Birmingham Hospital.⁶⁸ Such was the extent of Nightingale’s influence, however, that the invention of a ‘new’ profession was accepted. With the dominance of reformed nursing firmly established within the hospital environment, it was time to move out into the community. In New Zealand, this was the challenge that the Native Health nurses took up.

⁶⁴ Keith, Florence Nightingale, pp.147-150.

⁶⁵ Scrofula was tuberculosis lymphatic adenitis which was thought at the time to emanate from swampy ground (miasma theory) or from some genetic taint. Robert Koch identified the tubercle bacillus in 1882.

⁶⁶ Keith, Florence Nightingale, pp.147-150.

⁶⁷ Florence Nightingale to Fred Verney, 1891, Reproduction of a printed report originally submitted to the Bucks County Council containing letters from Florence Nightingale on rural district health visiting, published for the National League for Physical Education and Improvement, 1911. A copy of this publication is held at the Florence Nightingale Museum, St Thomas’ Hospital, London. The original letter is held at the Claydon Archive.

⁶⁸ C. Maggs, Reclaiming the Past to Own the Future, in S.J. Rankin Zerr, E. A. Fitzpatrick and G. Zilm (Eds), *Past is Present: The CAHN/ACHN Keynote Presentations 1988-1996*, Vancouver, 1997, p.114.

A number of nurse leaders were influential in establishing the move of reformed nursing into the community setting in New Zealand. Suzanne Aubert de Laye (1835-1926) (Mother Mary Joseph Suzanne Aubert), a French nun of the Sisters of Compassion and trained nurse, was instrumental in establishing nursing in the community. She and the Sisters established a mission in Jerusalem near Wanganui in 1883 working with the Maori, teaching and caring for the sick.⁶⁹ Sibylla Maude initiated a district nursing scheme in Christchurch which still operates today as the Nurse Maude Association. After completing a one-year training at the Middlesex Hospital in London in 1889 as a “paying lady probationer”, she returned in 1893 to become Matron of Christchurch Hospital.⁷⁰ Her concern for the poor and elderly moved her to consider their need to be nursed at home and she initiated a district nursing service to provide this care. Maude’s motto illustrates her philosophy for district nursing: “Sometimes to relieve, sometimes to heal, always to console”.⁷¹ She was also a pioneer in the care of people with the “great white plague”, tuberculosis, which was one of the most dreaded diseases of the early twentieth century. With the support of working men’s clubs, she set up the first sanatorium for men at New Brighton near Christchurch in 1903 in the form of a field hospital.⁷² A woman’s camp followed in 1905. This community based nursing was funded through charity as there were no mechanisms in the public health system of the time to pay for nursing outside of the hospital.

A significant contribution to the development of nursing in the community was made by Elizabeth Grace Neill⁷³, a Scottish nurse who immigrated to New Zealand via Australia where she had been a Factory Inspector. Neill was tall, charming, a red-head, physically vigorous, and a smoker who having been widowed in 1888 worked as a journalist and a public servant to support herself and her son having been left penniless after being cut out of her wealthy father’s will for “sink[ing] so low as to marry a

⁶⁹ M. E. Burgess, *Nursing in New Zealand Society*, Longman Paul, Auckland, 1984.

⁷⁰ *ibid.*

⁷¹ P. Sargison, *Notable Women in New Zealand Health*, p.10.

⁷² *ibid.*

⁷³ Referred to as Grace Neill.

doctor.”⁷⁴ An active participant in the suffrage campaign, she said of herself that she could have

developed into a more or less amiable old lady with a lace cap, a taste for knitting, local gossip or bridge, with a decent cloak of religiosity. But the fates willed otherwise and made me a nondescript combatant against drink, poverty, factory owners, and the medical profession of New Zealand.⁷⁵

In a thirteen year career from 1894 with the Department of Hospitals and Charitable Institutions, she toured the country to inspect institutions as Assistant Inspector of Hospitals, an unusual responsibility for a woman at that time. This brought her into contact with hospital and asylum nurses giving her comparisons which increasingly concerned her. There was a great deal of variance in standards between various hospital nurse training schemes and she became committed to achieving uniformity for the sake of the public and also the profession.⁷⁶ Along with Dr Duncan MacGregor, Inspector-General of Hospitals and Asylums 1886-1906, she worked to improve the standards and conditions in hospitals.

Neill’s concern for regulating the standard of nursing practice in New Zealand was discussed with other nurse leaders at the International Council of Nurses in 1899. In the same year she addressed the Congress of the International Council of Women in London:

It is passing strange how some medical men say, “Oh! we don’t want an educated hospital-trained nurse, she thinks she knows too much!

To such I would say - remember, good sir, a little knowledge is a dangerous thing. If you value your patient’s lives and your professional reputation, help hospital nurses to raise their status by honest certification, together with the registration you insist upon in your own profession.

In conclusion, let me urge upon every woman having a profession, unceasingly to work for political enfranchisement. You can have no idea what a difference it will make to your interest and your status when once it is an accepted fact that women and men have equal electoral rights as citizens and subjects of the Queen.⁷⁷

⁷⁴ K. Stodart, A Pioneer for Nursing, *Nursing New Zealand*, September 1993, pp. 28-29; W. B. Sutch, *Women With a Cause*, Wellington, Price Milburn & Co., 1973, p.94.

⁷⁵ Cited in Stodart, A Pioneer for Nursing, p. 29, original source not provided.

⁷⁶ Burgess, *Nursing in New Zealand Society*.

⁷⁷ Cited in J. O. C. Neill, *Grace Neill: The Story of a Noble Woman*, Christchurch, N. M. Peryer, 1961, p.44-45, original source not provided.

On her return to New Zealand, Neill proposed in her report to the New Zealand Government that nurses should be State registered. This proposal was followed up with draft regulations for the examinations, a national curriculum and the design for a medal for New Zealand registered nurses. The Nurses' Registration Act was passed in 1901, an international first. Two years later there were 320 names on the register including her own.⁷⁸ One view is that the status and recognition of nursing as a profession was greatly enhanced by State registration and placed nurses in a better position to develop a new role in the public health arena. However, another view is that the Nurses Registration Act of 1901 placed the control of nursing training and service firmly in the hand of politicians, thereby removing nursing's chance for self-direction. Pivotal as it was in strengthening nursing as a female profession, the Act satisfied the medical profession that there was no longer a threat from nursing. With the roles, functions, rights and responsibilities of the nurse firmly enshrined in legislation, the development of nursing could occur in the shadow of the medical profession.⁷⁹

The newly formed Health Department was staffed and administered by medical men whose function was to safe-guard the population from public health hazards which at that time came mainly from infectious disease. Communities that had shortcomings in the management of sanitation and hygiene were considered to be at risk of harbouring and transmitting disease. The ideological context regarding health and the social environment had been undergoing change in Europe following the industrial and French revolutions. There was a major shift from an understanding of a social/community responsibility for health to one in which people were solely responsible for themselves.⁸⁰ This transformation required that the pursuit of health through diet, exercise, hygiene and hard work was the responsibility of each individual citizen. Individuals became the cause of disease and the political responsibility was to enforce measures that would ensure their healthy behaviour.

⁷⁸ *ibid*, p.28.

⁷⁹ Wilson, *Professional Closure*, p.21.

⁸⁰ Laing, *Colonial Constructions*, p.349.

It has been argued that in colonial societies, the conditions which allowed medical dominance also supported cultural dominance.⁸¹ On the one hand, the medical profession achieved high social and political status as a function of the opportunities provided by imperial expansion. On the other hand, colonial power relations reflected elements of medical domination. Medical and cultural dominance in the late nineteenth century are evident in two contrasting images of Maori. One view was that the Maori was dying out as an inevitable consequence of evolution. Newman, a doctor, wrote that:

taking all things into consideration, the disappearance of the race is scarcely subject for much regret. They are dying out in a quick, easy, way, and are being supplanted by a superior race.⁸²

That 'smoothing the pillow of a dying race' was 'the plain duty as good compassionate colonists' so that 'history will have nothing to reproach us with' was a commonly held belief.⁸³ A contrasting but equally dominating view was proffered by James Pope, Organising Inspector of Native Schools, who although he agreed that Maori seemed to be dying out, questioned its inevitability on the basis of their inherent nobility. In his view their salvation was assimilation. His views are explained in a manual he developed for use in Native schools:

In the first chapter we learnt that in past times the Europeans used to die off as the Maoris do now, - not quite so fast, but very nearly: if disease had done quite as bad work amongst the white people as it is doing amongst the Maoris, there would not be one left. Instead of that, they increased in number, but very, very slowly, just as the Maoris do now in places where they do not drink very much, and where they work, and live much in the same way as the white man does.⁸⁴

The remedy for the ills of the Maori was identified by Pope as a combination of pure air, clean water, a healthy site for residence, wholesome food, cleanliness, sufficient warmth, proper clothing, regular work, proper treatment of the sick, European trained Maori

⁸¹ *ibid.*, p.350.

⁸² A. K. Newman, *A Study of the Causes Leading to the Extinction of the Maori*, *Trans and Proc NZ Institute*, 14, 1881, p.477, cited in *ibid.*, p.350.

⁸³ Dr. Issac Featherston, Superintendent of Wellington Province, reflected this view in his speech to the Wellington Philosophical Society in 1856. Cited in Keith, *New Zealand Yesterdays*, p.40.

⁸⁴ J. H. Pope, *Health for the Maori: A Manual for Use in Native Schools*, Wellington, Government Printer, 1884.

doctors, proper funeral rites, better control of behaviour at hui (meetings), curbing extravagance, changing marriage customs, Europeanised education. In short, in Pope's view the Maori was to adapt all aspects of lifestyle and culture to the European way or perish. It was this assimilationist view that became prominent and provided the context for European dominated health care for Maori.

The rapid colonisation of New Zealand following the signing of the Treaty of Waitangi by some of the Maori chiefs in 1840 had brought about a reversal in power relations between Maori and Pakeha. Whereas Pakeha had previously been guests in a land dominated by Maori, the rapid rate of Pakeha immigration had brought about political, economic and cultural dominance by a self-contained and aggressively growing European society.⁸⁵ The pace at which land became available for Pakeha settlement was insufficient for the settlers. The passing of a series of Land Acts administered by the Native Land Court effectively transferred millions of acres of land from Maori ownership to Pakeha and triggered armed revolt by some Maori tribes and confiscation of more land by Pakeha. In the 1890's alone, 1.2 million hectares were prised from Maori ownership.⁸⁶ The resulting wars, the consequent poverty and the effects of infectious diseases such as typhoid, cholera, tuberculosis and influenza, for which the Maori had much less immunity than Pakeha, brought about a sharp decline in the Maori population from an estimated 200,000 in 1820⁸⁷ to an estimated 43,595 in 1878 and a further drop to 39,854 in 1896.⁸⁸ In sharp contrast the Pakeha population rose from about 25,000 in 1830 to 625,500 by 1890⁸⁹.

The period following the Land Wars in New Zealand presented a series of conflicts both between Maori and Pakeha interests and also within both societies

⁸⁵ J. A. Williams, *Politics of the New Zealand Maori :Protest and Cooperation 1890-1910*. Auckland, University of Auckland, 1969, p. 12.

⁸⁶ Keith, *New Zealand Yesterdays*, p.41.

⁸⁷ Williams, *Politics of the New Zealand Maori*, p. 12.

⁸⁸ Holdaway, *Where are the Maori Nurses?*; F.S. Maclean, *Challenge for Health*, Government Print, Wellington, 1964; AJHR 1903, H-31, p.72; AJHR, 1904, H-31, p. 65.

⁸⁹ *The New Zealand Official Yearbook*, Wellington, 1909.

themselves. The years 1870-1900 were characterized by the conflicting interests of the settlers eager to acquire more land, and the Maori effort to retain what land was left in an effort to salvage their situation. Social improvement as perceived by European society was slow as Maori had lost control over decisions which affected their welfare. Within Pakeha society was a fervent assimilationist attitude that had the Maori either adapting fully to the European way of life or perishing. Although there was a special regard for the Maori by many Pakeha, their actions and attitudes, in retrospect, have been considered paternalistic. Maori culture (although its passing was regretted by some Pakeha) was regarded by others at best a hindrance to Maori participation in the new order and at worst a depraved and obscene culture.⁹⁰

Along with a pervasive ethnocentrism there was in general a sense of humanitarianism. The romantic myth of the 'old-time Maori' and the tragic image of the dying out of the noble savage had an irresistible pull for Pakeha. It had been created to soften their guilt for the rapacious land grabbing that occurred around the imagined death-bed.⁹¹ The feeling that no injustice should be done was not sufficient to safeguard Maori interests.

Many Maori were keen to adopt those aspects of Pakeha culture that they considered to be valuable to their society while retaining their own culture.⁹² It was for this reason that the post-war period saw many tribes engage in vigorous commercial activity mainly in pastoral farming and trade. Maori leaders requested that the government send magistrates among them to teach them the law; they asked for policemen; they asked for roads and villages to expand their markets.⁹³ Meanwhile, a number of Maori parents actively sought Pakeha education for their children to ensure that they would have knowledge to operate in the new world. While Maori had come to

⁹⁰ A. Ward, *A Show of Justice: Racial 'Amalgamation' in Nineteenth Century New Zealand*. Auckland, Auckland University Press, 1995, p. 305.

⁹¹ Keith, *New Zealand Yesterdays*, p.40.

⁹² Williams, *Politics of the New Zealand Maori*.

⁹³ Ward, *A Show of Justice*.

accept the permanence of European settlement following military defeat, in general they rejected Pakeha paternalism and were confident in their ability to achieve equality given the resources. In growing numbers Maori became more articulate in the English language, more cohesive and more able to adopt European political techniques to achieve their goals.⁹⁴

It had become clear to Maori that the appalling decline in the Maori population and health status was not a high priority for the colonial government. In a bid to exercise more autonomy in governing their affairs a Maori Parliament, Paremata Maori, was established near Hastings in 1892 with the objective of self-government and jurisdiction over all Maori. This parliament was held to be constitutional under the Treaty of Waitangi 1840 and the New Zealand Constitution Act 1852.⁹⁵ In the face of this direct challenge to the State, the Maori voice articulated by tribal leaders began to have an impact. The result was a tentative but important step towards recognising Maori autonomy. In 1900 two Acts of Parliament were passed which made an initial attempt at specifically addressing the needs of Maori. The first was the Health Act of 1900 described above. The second was the Maori Councils Act 1900 which established nineteen elected Maori Councils providing a vehicle for some input by Maori into local affairs.⁹⁶

A more tangible expression of any official commitment to Maori health was the appointment of Maui Pomare as the first Maori medical officer in the Department of Public Health.⁹⁷ He saw the opportunity to closely link the work of the Maori health committees and the Maori Councils and rather than develop a separate health workforce the Maori Councils became, among their other functions, the vehicles for health promotion, disease prevention and data collection. In this way the mana of the Iwi was acknowledged and the crucial link between Iwi and the State was forged. Sanitary

⁹⁴ Williams, *Politics of the New Zealand Maori*.

⁹⁵ Durie, *Whaiora*.

⁹⁶ *ibid.*

⁹⁷ *ibid*; Dow, *Safeguarding the Public Health*.

works carried out by the Maori Councils would be subsidised pound for pound by the Government⁹⁸. At the first conference of Maori Councils in 1903, a new breed of health worker emerged - Maori health workers and officers. They were men of standing within their communities, who played an important role in improving housing, sanitation and water supplies.⁹⁹

A number of articulate, outspoken young Maori were past pupils of Te Aute College near Hastings. In 1897 the Te Aute College Students Association (TACSA) was founded by a group of prominent young university-educated Maori as a social reform movement. This group of talented men who included Maui Pomare,¹⁰⁰ Te Rangi Hiroa,¹⁰¹ Apirana Ngata¹⁰² and Tutere WiRepa were members of an influential group, the Young Maori Party. Annual TACSA conferences provided a forum for discussion about the plight of Maori regarding land issues, hygiene and health issues, employment and education.¹⁰³ At the second conference of TACSA, Hei¹⁰⁴ presented a paper, 'Maori Girls and Nursing', which proposed the training of Maori women to nurse their own people and to give health advice in order to improve the health status of Maori.

⁹⁸ Maclean, *Challenge for Health*.

⁹⁹ Durie, *Whaiora*.

¹⁰⁰ Maui Pomare, born in Taranaki in 1876, was the first Maori doctor, a graduate from a Seventh-Day Adventist college in the USA. He was the first Native Health Officer and an MP from 1911-1928. During this time he was Minister for the Cook Islands, Health and Internal Affairs (Keith, 1984).

¹⁰¹ Also known as Peter Buck, Te Rangi Hiroa graduated from Otago University in medicine in 1904. He was a Native Health Officer from 1905-1909. An active member of the Young Maori Party he became MP for Northern Maori and Minister representing the Native Race. After WW1 he was the Director for Maori Hygiene. He resigned in 1927 to work as an anthropologist at the Bishop Museum in Honolulu. He later became its director and a professor of anthropology at Yale University (Keith, 1984).

¹⁰² Apirana Ngata was law graduate. He represented Eastern Maori as MP from 1905-1943. From 1928-1934 he was Minister of Native affairs and the Cook Islands. Like the other members of the Young Maori Party, he was an early advocate for assimilation but later became an ardent preserver of the Maori culture and was devoted to Maori language, arts and traditions.

¹⁰³ Te Aute College Students' Association, *Papers and Addresses Read Before the Second Conference*, Napier, December, 1897.

¹⁰⁴ Hamiora Hei of the Te Ehutu sub-tribe of Te Whanau-a-Apanui was at this time an undergraduate student at Auckland University College.

These prominent young Maori of the time believed that assimilation of Pakeha health practices would be the answer to the many health problems of the Maori and that Maori nurses would be the ones to take the message to the people. John Thornton who was the principal of Te Aute School from 1878 to 1913 was a disciple of Pope's ideas on Maori health and was in a position to make a deep impression on many of his pupils.¹⁰⁵ The process of assimilation is not to be underestimated. Hei believed that in order for Maori girls to become 'good, useful wives and mothers, it [was] essential that a knowledge of the most simple rules of health and medicine should be imparted to them'.¹⁰⁶ He advocated for long standing customs to be broken down and for Maori women to rear their children as the Pakeha women did.

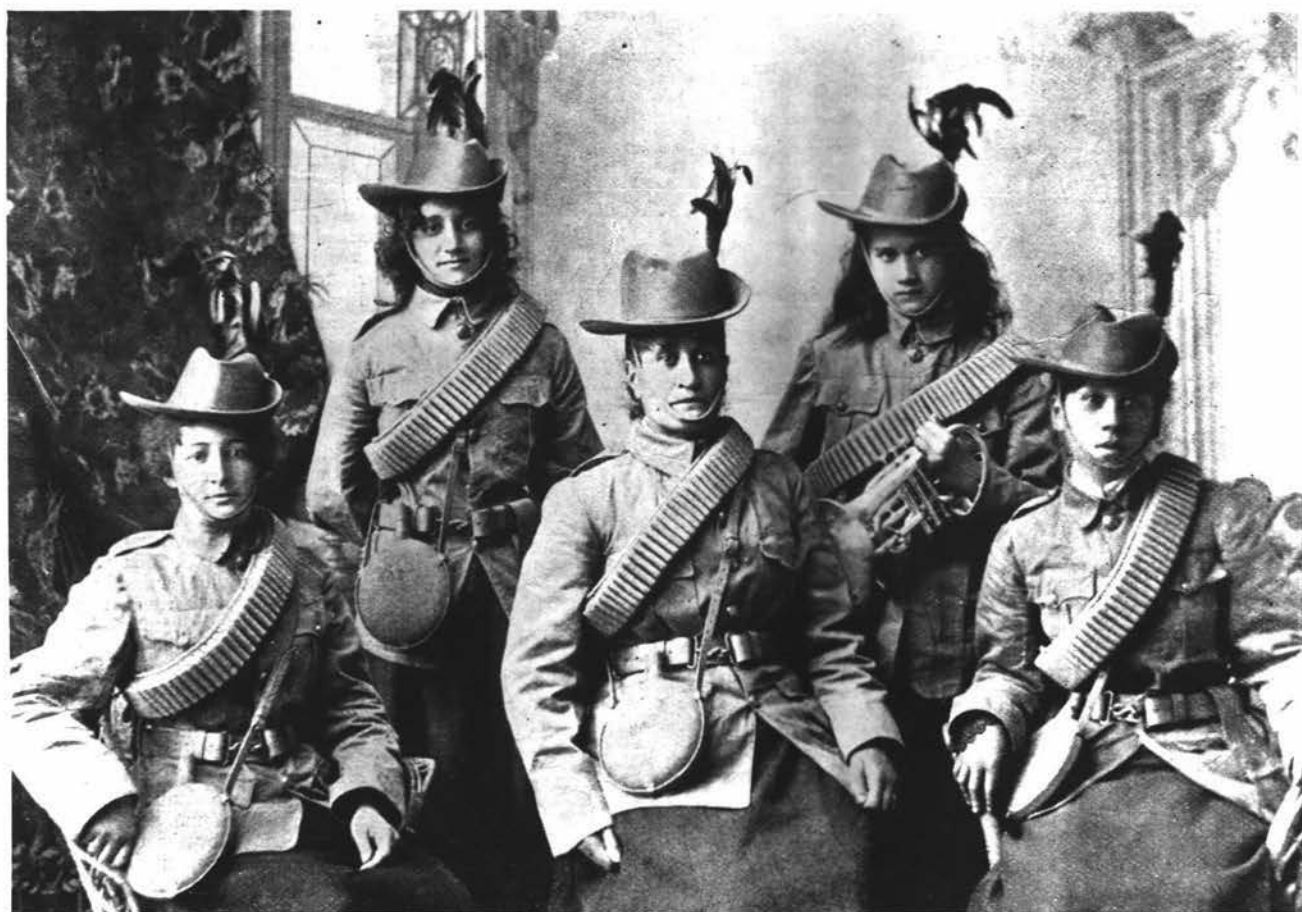
With Pope's cooperation it was agreed that the Maori Health Nursing Scheme was to be funded by the Education Department. A scholarship would be set aside (as for Maori university students) to assist Maori girls to "acquire a knowledge that is of the greatest value to our people"¹⁰⁷. Initially the scholarships were for one year as a day pupil in a hospital to gain experience which could be taken back to the community. Through their quiet influence it was believed that Maori women trained as nurses would make the most 'effective sanitary reformers' of the Maori population proving their worth by initiating change and encouraging the scheme 'to assume much larger proportions'.¹⁰⁸ Early supporters of the scheme were adamant that the nurses working with Maori communities should be Maori because their intimate knowledge of the language and customs of their people gave them the edge over the most highly trained

¹⁰⁵ Laing, *Colonial Constructions*, p.350.

¹⁰⁶ Te Aute College Students' Association, *Papers and Addresses Read Before the Second Conference*, Napier, December, 1897, p.31.

¹⁰⁷ H. Hei, *Maori Girls and Nursing*, *Papers and Addresses Read Before the Second Conference*, Napier, Te Aute College Students' Association, December, 1897, p. 30.

¹⁰⁸ *AJHR*, 1898, E-2, p.12.



Photograph 1: The Ngapuhi Sisters,
Auckland Weekly News, July 5, 1901, p.8.

Pakeha nurse.¹⁰⁹ Maori remained cautious and circumspect about foreign methods of health care and it was hoped by Pakeha health care officials that the Maori Health nurses would assume the role of 'agents of assimilation.'¹¹⁰ The Maori Health Nursing Scheme got off to a tentative start in 1899 with two hospital scholarships taken up. By 1903 the numbers had risen to only three, prompting Pomare to make a plea for more as 'the Maoris are dying by hundreds for the need of them'.¹¹¹

The idea of Maori women adopting a post-colonial style nursing role was not new and neither was their separation from their Pakeha sisters. At this time there were at least two contingents of Maori military nurses. Maori volunteers in South Africa during the Anglo-Boer war included the Maori Medical Corps under the flag of the United Tribes of New Zealand with a contingent of ten nurses, one doctor and seven orderlies. They were not allowed to go as Maori and had to change their names to European ones. The commander, Maremare Kunaiti of Ngati Kahungunu, was known as Captain Murray; the doctor, Wiremu of Ngapuhi was known as Corporal Williams and Hana Kunaiti (also called Hariata Te Puaha) of Ngati Kahungunu, known as Hannah Goodnight, was commander of the nursing corps.¹¹² At about the same time, another group of Maori women had adopted the role of military nurse. Known as the Ngapuhi Sisters, a group of Ngapuhi women descended from the chief Hongi Hika organised themselves so that they were ready to ride long distances to tend to the sick or wounded. Photograph 1 shows these nurses in their European-military style hats and jackets and equipped with water bottles and cartridge belts indicating their intention to be taken seriously as military nurses equal to their European counterparts. They were all good horsewomen and well mounted. Their reputation was as "true nursing sisters".¹¹³

¹⁰⁹ A. McKegg, The Maori Health Nursing Scheme: An Experiment in Autonomous Health Care, *The New Zealand Journal of History*, Vol.26, No.2, 145-160.

¹¹⁰ *ibid.*

¹¹¹ Report on Hospitals and Charitable Institutions of the Colony, *AJHR*, H-31, 1903, p.72.

¹¹² Auckland Institute and Museum, M1053. This information was recorded by D. R. Simmons from informant Maremare Kunaiti Whareherehere, grandson and son of Maremare Kunaiti and Hana Kunaiti.

¹¹³ Auckland Weekly News, July 5, 1901, p.8; S. Coney, *Standing in the Sunshine: A History of New Zealand Women Since They Won the Vote*, Auckland, Viking, 1993, p.92.

While the assimilative European influence is evident in these two examples of military nursing, it is noted that these Maori nurses were not considered sufficiently qualified to be eligible for entry on the first register of New Zealand nurses in 1901.

Despite assurances of support made by hospital boards, very few hospitals supported the Maori Health Nursing Scheme by accepting Maori nurse probationers, finding many objections to the scheme even in districts with a high Maori population.¹¹⁴ A further impediment to the scheme was finding Maori girls with the prerequisite academic preparation in an environment that did not encourage academic achievement among women generally and for Maori women in particular. For those who were accepted into the scheme there were difficulties with being educated in English as a second language and learning to adapt to a foreign culture amidst diffidence, isolation and the demands of family. A key requirement, likely to disadvantage them further¹¹⁵ was that successful applicants were from families with "Maori habits of life", although the qualities admired in Maoridom were seldom recognised in the European world. As well as working and studying in an environment in which their own language was not spoken, a further hurdle for the Maori probationers was that their training period was in fact one year longer than the three year programme leading to registration for their Pakeha colleagues. Each Maori probationer had to first go through a one year trial period working as an assistant in order to prove herself capable of the full training.¹¹⁶ Only then were they deemed suitable to move into the three-year programme. These problems were, to some extent, addressed by a shorter certification programme instituted in 1905 for Maori girls to enable them to work in their own communities. This however, created a second-level Maori nurse, not fully registered and without the qualification of their Pakeha colleagues.

¹¹⁴ *AJHR*, 1911, E-3, p. 11.

¹¹⁵ M. Holdaway, *Where are the Maori Nurses?*, pp. 25-34.

¹¹⁶ McKegg, *The Maori Health Nursing Scheme*.

In spite of increasingly desperate annual requests from Dr Maui Pomare for 'hygienic lady missionaries'¹¹⁷ in the form of Maori registered nurses, the Maori Health Nursing Scheme was deemed unsuccessful, not because of lack of will on the part of the Maori but rather the inequalities in the socio-political environment of the time.¹¹⁸ Pomare passionately denounced the Government for what he could only construe as racial prejudice, for so pathetically limiting an essential programme.¹¹⁹

Akenei Hei, the first Maori registered nurse, made a significant contribution to the Maori Health Nursing Scheme and to Maori health in general. She completed her nurse training at Napier Hospital and passed the State examination in June 1908 at the age of thirty years. She was also registered as a midwife in the same year after completing the Certificate of Midwifery at St Helens in Christchurch. It was acknowledged that although there was ample work for Maori nurses, there was no money to pay them and it was only after a recommendation to Cabinet early in 1909 that approval for payment of £60 per annum (plus boarding and equipment allowances) was made and Akenei Hei was offered a position.

Hei began nursing among the Maori under the Health Department in 1909¹²⁰ being dispatched to Te Kao where there was an outbreak of typhoid. As well as nursing the people, she courageously tackled siting and sanitation problems.¹²¹ Her progress was noted with interest by Valintine who was keen to see "how these Maori nurses act[ed] on their own responsibility".¹²² In fact her initial contact with her own people was

¹¹⁷ P. Wood, *Efficient Preachers of the Gospel of Health*, pp.12-21; R.T. Lange, *The Revival of a Dying Race: A Study of Maori Health Reform, 1900-1918, and its Nineteenth Century Background*, MA Thesis, February 1972, University of Auckland p.233.

¹¹⁸ M. Holdaway, *Where are the Maori Nurses*, pp. 25-34.

¹¹⁹ Lange, *The Revival of a Dying Race*.

¹²⁰ *New Zealand Gazette*, 1910, No.9, January 31.

¹²¹ Lange, *The Revival of a Dying Race*.

¹²² Valintine to Fowlds, 12 June 1909, MA, 1/1910, N.3921, in McKegg, *The Maori Health Nursing Scheme*, p.152.

successful due to her intimate knowledge of the language and customs. But a subsequent visit to the Far North had a less satisfactory outcome as the locals refused to cooperate with her instructions. This may be because on this occasion she decided to take a 'hard-line approach' and her threatening manner may have alienated the people there.¹²³ She was, however called back to this area by the local Maori of Parengarenga harbour to help them cope with an outbreak of influenza. There is no evidence of officials taking into account the iwi (tribal) and hapu (family) affiliations of the Maori nurses at the time of their postings.¹²⁴ Nurses placed out of their own districts may have had difficulty establishing credibility with people who were not of their own tribe. In the meantime the Maori health work had been transferred back to the Native Department and her services seemed to have been forgotten. She anxiously sought further instructions eventually from her former superiors at the Health Department.¹²⁵ In a later posting to New Plymouth, she was pleased with the good reception she received from the Taranaki Maori for her nursing and education work.¹²⁶

Over the next year, she commenced a series of postings to the Wanganui River, Waihi and then back to Taranaki. She requested special leave to go to Gisborne to nurse her brother Hamiora and his family who had contracted typhoid where she remained for three months before contracting the disease herself. She died of the disease on 28 November 1909.¹²⁷ Her death was a blow to her people, to nursing and to the Maori Health Nursing Scheme because she had proven herself to be woman of ability, charm and integrity motivated by an ideal of service to her people and that she was equal to any of the challenges of her newly defined role.

¹²³ Hei to Valintine, 7 July 1909, MA, 1/1910, N.3921, in McKegg, *The Maori Health Nursing Scheme*, p.152.

¹²⁴ *ibid.*, pp.145-160.

¹²⁵ Lange, *The Revival of a Dying Race*, p.234.

¹²⁶ Lange, *The Revival of a Dying Race*, p.235.

¹²⁷ *ibid.*

Although her brief career was cut short, her contribution to nursing was significant. As the first Maori registered nurse and midwife, she proved herself more than academically capable compared to her Pakeha nursing and midwifery colleagues. As a staff nurse at Napier Hospital she was in charge of the operating theatre, a position which Valintine claimed could "not be any higher recommendation to a nurse than for a medical man to intrust [sic] her with those duties".¹²⁸ Her performance countered the claims made by Valintine¹²⁹ that Maori nurses were unsuitable in positions of responsibility. In an article in *Kai Tiaki*,¹³⁰ she provided an explanation of the Maori view of health and illness in an attempt to assist her Pakeha colleagues to understand some of the values and beliefs of the Maori. At least one Pakeha nurse at this time considered that, although the Maori were "very intelligent", they had an entirely different view of health, were "only partially civilised" and there was the potential for much misunderstanding between them and the "highly and scientifically-trained nurse".¹³¹

Hei exhorted her colleagues to consider that traditional Maori health customs had kept her race in vigorous health for many generations. She suggested that a greater knowledge of Maori views on health and illness would assist the nurse to understand the Maori people and reduce misunderstanding between the two races. A deeper appreciation of the Maori world view by nurses would support Maori more than any Parliamentary laws and health regulations could ever do.¹³² The greatest difficulty encountered by those health professionals who worked among the Maori, according to Hei, was to ensure that the "greatest of discretion was used so as not to offend the patient's beliefs but at the same time to uphold one's own mission".¹³³ She was able to

¹²⁸ Report of the Hospital Boards Conference, *AJHR*, 1911, H-31, p.183.

¹²⁹ *ibid.*

¹³⁰ Akenei Hei, *Nursing Amongst the Maoris*, *KT*, July, 1910, p.103-104..

¹³¹ *Nurse Street*, *KT*, July, 1911, Vol.4, No. 3, p.110.

¹³² Akenei Hei, *Kai Tiaki*, July 1910, Vol.3, No.3, p.103.

¹³³ *ibid.*

be influential both within the nursing profession and among her people. The suspicion shown to Pakeha health professionals by the Maori was not shown to her and her effectiveness as a health educator among her own people was in part due to this. Her acceptance by Maori was as the instigators of the Maori Health Nursing Scheme had hoped. However, this separate pathway for Maori health was not sustainable in the socio-political climate of the time. The intentions of government agencies for Maori health were clearly assimilationist and when the nursing scheme initiated by Maori struggled to survive and was eventually disbanded in this unsympathetic environment, the replacement scheme of mainly Pakeha nurses adopted an assimilationist approach with full Government support.

The Maori Councils Act 1900 had required tribes to administer health regulations particularly in relation to infectious disease and sanitary conditions. Health inspectors were appointed to enforce the regulations and to make environmental improvements as they saw fit within a budget of a dollar-for-dollar subsidy. Six sanitary inspectors were working among the Maori by 1904 one of whom was Elsdon Best, a Pakeha who many considered to be an expert on Maori ethnology. In 1905, his report gave this picture:

In regard to latrines the matter is in a very unsatisfactory state. A strong feeling exists against the erection of these places. Some are built which are scarcely ever used. The pollution of water by excrement is of very common occurrence...As it is one notes human excrement quite close to houses, and even among them, on paths, and on the watershed of water holes from whence domestic supplies are drawn.¹³⁴

Health teaching by the sanitary inspectors and also by Drs Maui Pomare and Te Rangi Hiroa, Native Department medical officers, had limited success largely due to the severely restricted budget available for such work.¹³⁵ In his report to Mason in 1907 Pomare wrote:

This year finds me sending you the usual *compte rendu*, the use of which you and I cannot discern, for nearly all the suggestions contained in previous ones

¹³⁴ Maclean, *Challenge for Health*, p.195.

¹³⁵ *ibid*, p.197. Both of these energetic, well-respected doctors resigned from the Department just before the closure of their branch of the Native Department out of a sense of frustration borne from a lack of commitment from government to achieve health goals for Maori.

are seldom acted upon. I suppose we must keep aiming at the moon - we might hit a tree ...¹³⁶

Pomare resigned in 1909 in despair that the extent of the health problems for Maori and his recommendations for action to address the problems had all but been ignored by government. With the transfer of responsibility for Maori health from the Native Department to the Department of Public Health, the Maori sanitary inspectors were disestablished and Dr Valentine's vision was that the Native Health nurses would take up this work. In July 1911, he announced that the

...whole control of these matters [Maori health] would now be under the Public Health Department, which would enforce measures to safe-guard the health of the Natives, the same as it did amongst pakehas."¹³⁷

The annual vote of £3600 which had previously funded the work of the Maori Health Inspectors and the medical staff subsidy was transferred to cover the Native Health Nursing Scheme and this would now fund the salaries of 17 nurses.¹³⁸

During the period of Pomare's tenure, the administration of Maori health matters had become a political football. At the time of Pomare's appointment in 1901 and in spite of his suggestion otherwise, Maori health was administered by the Justice Department having been transferred from the Native Department in 1892. In 1906 Maori Health was transferred to the Health Department, back to the Native Department in 1909 returning to the Health Department in 1911.¹³⁹ With so many administrative changes it is not surprising that Pomare became frustrated and was dissatisfied with the lack of clear direction for Maori health. From 1905 Pomare was assisted by Dr Peter Buck, known from 1907 as Te Rangihiroa. Both of these doctors resigned in 1909 to begin their political careers perhaps in the hope of having more effect as Members of Parliament. Their resignations left an obvious absence of Maori in senior health

¹³⁶ *ibid.*, p.197.

¹³⁷ The Health of the Maoris: Measures being Taken, *Kai Tiaki, The New Zealand Nursing Journal*, July, 1911, p.108.

¹³⁸ *ibid.*

¹³⁹ D. Dow, *Safeguarding the Public Health*.

positions. This was a time of economic retrenchment and there was no attempt to replace them even if that had been possible.¹⁴⁰ In 1909, Mason also resigned and Valentine was selected as his replacement taking on the expanded role of Inspector General of Hospitals and also Chief Health Officer as part of a major public service cost-cutting and restructuring exercise. He introduced a complete change of policy involving a significant change in the direction and emphasis of the Health Department.¹⁴¹ The Maori health inspectors were disbanded; the responsibility for Maori health was transferred from the Native Department to the Department of Health;¹⁴² the Maori Nursing Scheme was shelved and replaced by the Native Health Nursing Scheme. This constituted a significant shift from what had been a Maori health initiative to a Pakeha dominated one.¹⁴³

It was the end of a decade of government rhetoric about acknowledging and supporting Maori in addressing health problems without the commitment and action required for results. In 1911, Dr Makgill, Medical Officer of Health for the Auckland district, revealed the patriarchal attitude of the department stating:

The efforts of the last 10 years to encourage Maoris to adopt a system of local government as regards sanitary matters has proved a dismal failure.¹⁴⁴

The perceived failure was placed squarely at the feet of the Maori rather than the Department of Health who had neglected to take into account that in spite of unequal resources there had been significant improvements in housing, sanitation and an increase in Maori population during the period 1904-1909. In comparison, the record of the Pakeha local authorities with regard to sanitary matters had in fact been a “dismal

¹⁴⁰ *ibid.*

¹⁴¹ Rice, *The Making of New Zealand's 1920 Health Act*, pp.3-22.

¹⁴² Mason notes in a letter to Dr A. J. Garland, Oamaru, that the Health Department took over the administration of the Native Medical and Health Services on November 1 1908, National Archives, Wellington, H 1 12968 160/34.

¹⁴³ Maclean, *Challenge for Health*.

¹⁴⁴ *ibid.*, p.198.

failure” during the decade 1890-1900 despite the superior financial resources, access to knowledge and experience in local government available to them.¹⁴⁵

During the period 1900 to 1910, there were significant changes in the health care system, within the nursing profession and with regard to health care for Maori. These changes constructed the environment for the emergence of the Native Nursing Scheme. Public health legislation signalled the recognition by Government that local authorities had not taken their responsibilities seriously enough and that a Health Department with its own officers was the answer to the lack of coordinated action. Maori leaders had convinced the Government of the pressing urgency of Maori health problems and the need for separate health initiatives. However, the decade had spelt disaster for Maori seeking self-determination in health care because of the lack of support and funding. With the transfer of the administration of nursing services to Maori from the Native Department to the Health Department in 1911 and the replacement of the Maori Health Nursing Scheme with the Native Nursing Scheme, an important Maori health initiative was displaced by a Pakeha dominated one. The Maori Health Nursing Scheme had been handicapped from the start by the attitudes of government and hospital officials. Nursing was claiming a rapid rise in status as a registered and respectable profession. This change in status paved the way for a move from the hospital to the community setting and strategically positioned nurses to grasp the opportunity to create an expanded role through the vehicle of the Native Health Nursing Scheme.

¹⁴⁵ *ibid.*, p.198.

CHAPTER 3 - THE NATIVE HEALTH NURSING SCHEME, 1911-20

This chapter examines the infrastructure which shaped the development of the Native Health Nursing Scheme (NHNS) over the decade 1910-1920. The scheme provided a unique opportunity for nurses to prove themselves as effective, capable practitioners who could adopt a public health role not previously seen as the domain of nursing and use this to their advantage in terms of professional status. The chance to exercise their agency through the changes brought in was perhaps more consciously appreciated by nurse leaders but it was the work of the nurses in the field that earned recognition.

In the wake of administrative bungling and an unsupportive institutional ethos, a significant Maori health initiative, the Maori Health Nursing Scheme, had lost its place in the New Zealand health system. As a replacement, the period of time from 1910 to 1920 saw the development of the NHNS, a steadily expanding service of mainly Pakeha nurses. In 1910, Amelia Bagley was the sole nurse employed in this scheme. By 1920, there were 20 Native Health nurses and there was support for further expansion. With no formal preparation for their formidable role, with minimal administrative and professional support and often located in isolated areas, these nurses provided a service to the sick, contained highly infectious epidemics, and gave health education in an period when obedience, duty and virtue were the qualities most highly valued in women. The determination and skill required for their work, in contrast to the qualities expected of women of the day, substantially advanced the profession of nursing and raised its profile. The status of nursing was sufficiently enhanced over the decade 1910-1920 that when a restructuring of the Health Department took place in 1920, there was a Division of Nursing created among the seven new divisions and Hester Maclean, previously Assistant Inspector of Hospitals, became the first Director of Nursing.

In 1911 Dr Valintine, Inspector General of Hospitals and Chief Health Officer, announced that the control of health matters relating to Maori would be transferred from the Native Department to the Public Health Department. It was believed that this move would ensure that measures which safe-guarded the health of Maori would be the same

as those for Pakeha.¹ A major incentive for some attention being given to Maori health appears to be the fear of the spread of infection from the Maori communities to Pakeha communities. In 1911, R.H. Makgill, District Officer of Health to Auckland, stated that it was “high time that a Department was organised to break them [Maori] of their uncivilized habits and teach them to be clean”.² The NHNS was established as part of the policy to improve the sanitary conditions of the Maori settlements, to prevent the spread of infectious disease and to avoid further epidemics. The nursing profession capitalised on this policy to develop a new nursing role with expanded responsibilities.

The major difference between the replacement NHNS administered by the Department of Public Health and the discontinued Maori Health Nursing Scheme was that the majority of nurses recruited into the revamped scheme were Pakeha. This may have been a more acceptable option to the policy-makers owing to the contemporary belief that Pakeha women were seen as being more authoritative, more responsible and better agents of 'scientific' health practices.³ Under the auspices of the Public Health Department, the authoritative guidance of Hester Maclean, Assistant Inspector of Hospitals, and Amelia Bagley, in charge of the NHNS, the scheme was established in accordance with Government policy and was given far more support than the Maori Health Nursing Scheme had ever had.⁴

Maclean was an Australian nurse of Scottish heritage with twelve years of experience in midwifery, mental health and community nursing when she succeeded Neill as Assistant Inspector of Hospitals in 1906.⁵ The formidable partnership of MacGregor and Neill was replaced in 1906 with the equally powerful partnership of Valintine and Maclean. As assistant to Valintine, Maclean's concern, in the Nightingale tradition, was

¹ The Health of Maoris: Measures being Taken, *KT*, July, 1911, p.108.

² *AJHR*, 1911, H-31, p.50.

³ McKegg, *The Maori Health Nursing Scheme*, pp.145-160.

⁴ *ibid.*

⁵ Rodgers, 'A Paradox of Power', p.242.

to consolidate the place of nursing rather than to challenge the established social order. She acquired a strategic position for herself throughout her seventeen-year career as the most highly ranked nurse in New Zealand. Maclean established *Kai Tiaki, The New Zealand Nursing Journal* in 1908 and was owner and editor until her retirement in 1923. This nursing journal provided a collection of professional news, articles of clinical interest and was a point of contact among nurses especially those working in remote areas. She founded the Trained Nurses' Association and was its first president from 1909 to 1912.⁶ Her impressive influence on the development of nursing as a respectable profession for women was exercised through her role in the monitoring of nursing standards as Assistant Inspector of Hospitals and through her explicit views expressed in her editorials regarding the type of woman who was likely to be a successful nurse. Maclean was of the opinion that the indicators of a successful nurse were evident in her 'bearing, manner and general address' and her belief was that a nurse was first and foremost a woman of propriety.⁷ She earned a position of respect and trust both within the nursing profession and with Health Department officials especially Valintine. With her appointment as matron-in-chief of the military nursing service in 1910 under Valintine's supervision, for which she had recommended herself, her sphere of influence expanded to encompass both civilian and military nursing. On 15 April 1915, when the first contingent of fifty nurses embarked on the *Rotorua* for England to commence their World War I overseas service as members of the New Zealand Army Nursing Service, Maclean accompanied them as their senior officer.⁸ The Health Department restructuring following the 1920 Health Act established seven departmental divisions one of which was the Division of Nursing with Maclean as its director. She retired in 1923 and was succeeded by Jessie Bicknell.

Maclean's influence over the NHNS was substantial. As Valintine's assistant, she was charged with implementing his instructions to establish the service in parallel with, but separate from, the district nursing service which was a rural service to settler

⁶ *ibid.*, p.80.

⁷ *ibid.*, p.82.

⁸ *ibid.*, p.107.

families. Nurses were appointed to the NHNS directly by the Health Department, each one personally vetted or recommended by Maclean or her assistant Amelia Bagley. Maclean's concern that the image of nursing was to be one of womanly, dedicated and morally respectable women⁹ directed her to choose the Native Health nurses with care. She considered nursing to be the highest ideal for women, next to motherhood and had a clear idea of the criteria for the 'right stamp of women' for the profession.¹⁰ 'Patience, gentleness, tact, observation, attention to detail, thoughtfulness as to the comfort of their patients, trustworthiness, sense of responsibility, &c [sic]'¹¹ were the necessary qualifications. This view was endorsed by Valintine who stated

Nurses for this work [district nursing] would need to be women of rare character, devoted to duty and undeterred by hardship.¹²

McKegg describes the process of selection of one district nurse to be employed by a hospital board illustrating the veto power of the Health Department in the selection of nurses for this work.¹³ The gendered culture of nursing was very evident in the expectations for these nurses. There were 15 applicants whose names were sent to the Health Department for information about their suitability for the position. Four were considered suitable, one more so than the rest as judged by her experience, qualifications and stability. The Health Department rejected one as too young (aged 25 years), another as too old (aged 43 years) and another because of poor health. Two were rejected because of their previous performance as district nurses and one because she was not qualified as a midwife. Of the rest two had extremely difficult temperaments; one was 'of the rather gay type'; one was unsuitable because of her off duty conduct; the last had a morphia addiction.

⁹ *ibid.*, p.82.

¹⁰ Report by H. Maclean, Nurses' Registration Act, Midwives Act, and Part III of the Hospitals and Charitable Institutions Act (Private Hospitals), *AJHR*, 1914, Vol. 3, H-31, p.6.

¹¹ Report by H. Maclean on Nurses Registration Act, Midwives, and Private Hospitals, *AJHR*, 1912, Vol. 3, H-31,p19.

¹² T. Valintine, Report of the Inspector-General of Hospitals and Charitable Institutions, *AJHR*, 1909, Vol. 4, H-22, p.6.

¹³ McKegg, *Ministering Angels*, p.30-1 citing H.16349, 23/21/53, R. A. Shore, for the Director-General of Health, to H. B. Turbott, Medical Officer of Health, Gisborne, 20 August, 1934.

The discourse of race is reflected in the way that the Health Department officials wrote about Maori nurses. Maclean was skeptical about Maori women being of the calibre she required for nursing generally and for the NHNS in particular. She was of the opinion that young Maori women were not keen to take up nursing and 'that after their general education, return to their homes and relapse into their old native ways'.¹⁴ Presumably these ways were antithetical to the qualities of the nurse. She made it clear that those Maori women who did qualify as nurses and gained positions in the NHNS were not suitable to work unless supervised stating

There is no doubt the Maori nurses had more difficulty in establishing any influence over the natives than the Pakeha nurses, and it has not been possible to leave this work entirely to them.¹⁵

There appeared to be significant economic reasons for the Public Health Department to invest in nursing services for Maori. Until this time the most expensive measure the government had employed in the area of Maori health was to subsidise 38 doctors at a rate of £25 to £100 each per annum to treat Maori in their communities.¹⁶ The total subsidy paid to medical officers in 1906 was £1915/11/4 for a total of 4,363 patients attended.¹⁷ An annual vote of £3600 was allocated for all health care for Maori which also included the cost of medicines, medical supplies to native school teachers, extra funds to control epidemics and also the salary of health inspectors.¹⁸ This budget had never been sufficient to address Maori health needs. When responsibility for Maori health was transferred to the Health Department from the Native Department in 1906, the funding went with it. Medical subsidies came under scrutiny and Valintine decided to use some of the budget to employ nurses to visit the kainga (villages), report on and attend to sanitation and sickness among the Maori and to provide health education. The

¹⁴ Maclean, *Nursing in New Zealand*, p.90.

¹⁵ *ibid.*, p.90.

¹⁶ Maclean, *Challenge for Health*, p.197.

¹⁷ Medical Attendance on Maori, *AJHR*, 1906, G-4.

¹⁸ This amount was meagre in relation to the total budget for the Health Department in 1909 was £42,000, almost half of which was spent on salaries. This was a modest sum compared with the total government spending of £5.6 million in 1908 (Dow, 1995).

medical subsidies were stopped because the results had not warranted continuing this payment as it had been found that in most cases "medical attendance on Natives [by Pakeha doctors] had been very perfunctorily performed".¹⁹ Criticism was levelled at the doctors for allegedly not giving Maori sufficient attendance, being too hurried, not giving patients enough time to give an adequate description of symptoms, and making no attempt to cross barriers of language and culture.²⁰ It was estimated that for the cost of subsidising one doctor annually for intermittent visits, a nurse could be employed full-time to live and work in a Maori community.²¹

Valentine demonstrated that his perspective on health care extended beyond the hospital walls. The 1911 Hospitals' Conference was a forum for many of the proposals he had raised previously. The agenda included the medical inspection of school-children, control of tuberculosis, Maori health services, bacteriologists in hospitals, medical services for the poor and for settler families living in remote areas.²² He considered the development of the role and influence of the nurse as one of the key strategies towards meeting his health objectives. Advised and encouraged by Maclean, he was convinced of the potential of the nurse in the community setting especially in Maori communities. He believed that sending in nurses to Maori communities was the only way that the health status of Maori could be improved.²³

The NHNS commenced in 1911 and gradually the numbers of nurses and the communities they served increased. Although paid by the Department of Public Health, the nurses were under the control of the local hospital boards to whom they reported and who directed their work.²⁴ When there was an outbreak of infectious disease,

¹⁹ Report on the Hospital Boards Conference, *AJHR*, 1911, H-31, p.183.

²⁰ McKegg, *The Maori Health Nursing Scheme*, pp.145-160.

²¹ *ibid.*, pp.145-160.

²² Dow, *Safeguarding the Public Health*.

²³ Report of Inspector-General of Hospitals and Charitable Aid Institutions, Dr T Valentine, *AJHR*, 1911, H-31.

²⁴ *KT*, October 1911.

commonly cholera and typhoid, the hospital boards reported it to the Health Department and one or more nurses were sent to the area to manage the situation. If there was a need to have a nurse permanently in that area, she would stay on there being provided with accommodation either by the local Maori community or by the hospital board. The scheme officially commenced when Amelia Bagley was sent to Ahipara in the Far North district in 1911 to nurse Maori during an outbreak of typhoid.

Nurses had already been nursing Maori during outbreaks of epidemics but there had been no systematic approach to the management of infectious disease and it was difficult to find nurses at the times they were needed.²⁵ On Mason's suggestion, the Native Department had sent a nurse to Papawai in December 1902 where there was an epidemic of dysentery. As well as nursing the sick, she was instructed to teach Maori women food preparation for the sick. Mason was impressed with how well the nurse was received and concluded that, "Much good would result from sending pakeha nurses among the Maoris..."²⁶ In 1905, Louise Barrett, a Pakeha nurse, was paid £25 as a subsidy to work amongst Maori in Tuahiwi, Canterbury. She was appointed after a long campaign by the Native School teacher but the appointment only lasted a year.²⁷ Cicely Beetham was nursing Maori at Rotorua in 1907. Pomare reported that she was the kind of worker needed because she got through to the people at their level and demonstrated a healthy lifestyle by example and through teaching.²⁸ Three nurses were nursing Maori with typhoid in 1911, although not officially under the NHNS, Eva Wi Repa²⁹ at Petane, seven miles from Napier, and Florence Gill and Nurse Herdman in the Wairoa district.³⁰ Wi Repa and Gill later joined the NHNS. Another five nurses were appointed over the following year, one in the Stratford, Hawera, and Patea districts (a Maori

²⁵ Report on Nurses' Registration Act, Midwives and Private Hospitals, Assistant Inspector of Hospitals, H. Maclean, *AJHR*, H-31, 1912, p.20.

²⁶ *AJHR*, 1903, H-31, p.40, cited in McKegg, *Ministering Angels*, p.76.

²⁷ McKegg, *Ministering Angels*, p.77.

²⁸ *ibid*, p.77.

²⁹ Eva Wi Repa registered as a nurse in June 1911 after training at Wanganui Hospital. She was a Native Health nurse from 1911 to 1914 (*NZ Gazette*, Register of Nurses, 1916, Vol. 1, p.363).

³⁰ Back-blocks District Nursing, *KT*, April, 1911, p.75.

population of 1803) and another two in North Taranaki (a Maori population of 2007). There were eight by 1912,³¹ 11 by 1913, gradually increasing to 20 by 1920.³² Over the decade at least 42 nurses were employed in the scheme but not more than 20 at any one time. The districts served by these nurses had a high proportion of Maori and were mainly in the northern half of the North Island.³³

Bagley made a significant contribution to the Native Health Nursing scheme not only as supervisor but also as a key person in the establishment, maintenance and supervision of the scheme. She was born in 1871 in Dunedin to Amelia (born Proctor) and Benjamin Bagley, a chemist.³⁴ After training at Dunedin Hospital between 1892 and 1895, she worked as a ward sister at Auckland Hospital until 1902. Her leadership qualities were recognised early in her career when she was appointed Matron at Masterton Hospital in 1903. After qualifying as a midwife at St Helens in 1905, she worked in private nursing until 1906.³⁵ At this time she was appointed Assistant Inspector of Private Hospitals and Midwives and in 1912 Superintendent of Native Health Nurses.³⁶ Bagley launched the NHNS in 1911 Ahipara in the Far North where there was an outbreak of typhoid. She set up a temporary hospital for sixteen patients, assisted and then relieved by Mary Purcell³⁷ from the Bay of Islands, and successfully contained the outbreak within three months.³⁸ Bagley travelled widely in the early years

³¹ Report of Inspector General of Hospitals and Chief Health Officer, Dr T Valentine, *AJHR*, H-31, 1912, p.4.

³² Report of Assistant Inspector of Hospitals, H. Maclean, *AJHR*, H-31, 1920, p.10.

³³ District Nurses to Natives, National Archives, Wellington, H1 15863 21/34; *KT* 1911-1920.

³⁴ C Macdonald, M. Penfold and B. Williams (eds.), *The Book of New Zealand Women: Ko Kui Te Kaupapa*, Wellington, Bridget Williams, 1991, p.33.

³⁵ *New Zealand Gazette*, 1910, Jan.31, No.9.

³⁶ Macdonald, Penfold and Williams (eds.), *The Book of New Zealand Women*, p.33.

³⁷ *The Health of the Maoris*, *KT*, July, 1911, p.108. Mary Purcell completed her training at Wellington Hospital and registered as a nurse in 1903. She received the St Helens Hospital Certificate in Midwifery in Wellington in 1905 and was private nursing 1906-1910 (*NZ Gazette*, 1910, Vol.1, Register of Nurses, p.422).

³⁸ The Nurses Registration Act, Midwives Act, and Private Hospitals, Report by Miss H. Maclean, *AJHR*, 1912, p.20.



Photograph 2: Amelia Bagley on Horseback,
H, W2615 2/1 - Mary Lambie Collection ,National Archives Head Office, Wellington.

of the Native Health Nursing Scheme responding to outbreaks of disease, providing nursing care to the ill and setting up nurse's cottage clinics often staying until a nurse new to the service was ready to take over. During 1911, she travelled hundreds of kilometers visiting pa in the Rotorua and Gisborne areas establishing the nursing service among Maori before also assessing the needs of the people in the Waiapu district and establishing a nursing centre there.³⁹ In 1913, she managed outbreaks of typhoid at Te Ahuahu and Paeroa, and helped to establish nurses at Te Araroa (where she set up a clinic and ran it herself for several months), Otaki and Thames.⁴⁰ Within three years of being established, Valentine was praising the service as "an unqualified success"⁴¹ and Maclean was claiming that the value of their work was reflected in the decrease in cases of enteric (typhoid) and better sanitary conditions in areas where there were nurses established.⁴² Maclean wrote of Bagley, "She was a most loyal officer to me, and we worked together in the greatest harmony until my retirement."⁴³

During World War I Bagley served as matron of the hospital ship *Maheno* on its third commission and later as matron on the ship *Marama*.⁴⁴ On her return from active service, she resumed her work as Deputy Inspector of Hospitals and supervisor of the NHNS. Taking advantage of a 1919 amendment to the Discharged Soldiers Settlement Act which enabled nurses to apply for land settlement following active service, Bagley took a renewable lease on 534 acres in 1921 at Retaruki, near Ratahi.⁴⁵ She retired in 1931 at the age of 62, one year after selling her land. Throughout her nursing career,

³⁹ *ibid.*, p.20.

⁴⁰ The Nurses Registration Act, Midwives Act, and Part III of the Hospitals and Charitable Institutions Act (Private Hospitals), Report by Miss H. Maclean, *AJHR*, Vol.4, 1913, p.13.

⁴¹ Report of the Inspector General of Hospitals and Chief Health Officer, *AJHR*, H-31, Vol. 4, 1913, p.3.

⁴² The Nurses Registration Act, Midwives Act, and Part III of the Hospitals and Charitable Institutions Act (Private Hospitals), Report by Miss H. Maclean, *AJHR*, Vol.4, 1913, p.13.

⁴³ Maclean, *Nursing In New Zealand*, p.88.

⁴⁴ Macdonald, Penfold and Williams (eds.), *The Book of New Zealand Women*, p.34.

⁴⁵ Rodgers, 'A Paradox of Power', p.242.

Bagley had been active in the New Zealand Trained Nurses' Association, was a regular contributor to *Kai Tiaki* (later named the *New Zealand Nursing Journal*) and convened the Public Health Nursing Section of the association in 1930. After her retirement she was an active member of the New Zealand Returned Army Sisters Association. She died in Auckland on 30 January 1956 at the age of eighty-five.⁴⁶

It was intended that where there were two nurses stationed, one would be Maori. When Maori registered nurses were appointed to districts they were at first under the supervision of a Pakeha nurse until they 'gained experience and proved themselves'⁴⁷ to be suitable to take charge of their own districts as judged by Health Department officials. Because there were so few Maori registered nurses, Pakeha nurses commonly enlisted young Maori women to assist them. This practice operated as both a screening and a recruitment process by the nurses who hand-picked local women whom they thought would be suitable as nurses. It was hoped that this initiation to nursing work would encourage them to enter into a hospital training school to complete their formal nursing training.

In direct contrast to any claim by the Department that Maori were to be encouraged into nursing was a prevailing ideology that Maori nurses were inferior to Pakeha nurses. The discourse of race, at least the attitude of government officials towards Maori, is clearly evident in official reports. Valintine claimed that, "The trouble with the Maori nurse was that she was rather inclined to shirk responsibility. It was found the work was better done when they had a pakeha nurse to stiffen up the Native nurse."⁴⁸ In 1912 there were three Maori working as Native Health nurses, each as an assistant to a Pakeha nurse. Maud Mataira, trained at Wanganui Hospital, was assisting Miss Purcell in the Rotorua district; Eva Wi Repa, trained at Napier Hospital, was assisting Miss Beetham in the Hawera district; and Heni Whangaparita, trained in

⁴⁶ Macdonald, Penfold and Williams (eds.), *The Book of New Zealand Women*, p.34.

⁴⁷ Maclean, *Nursing in New Zealand*.

⁴⁸ Report on the Hospital Boards Conference, *AJHR*, 1911, H-31, p.183.



Photograph 3: Unnamed Maori and European Nurses
in Charge of a Fever Camp, East Coast, 1912,
Appendix to the Journals of the House of Representatives, 1912, E-3, p.11.

nursing at Napier Hospital⁴⁹ and in midwifery at St Helens, Wellington, was assisting Nurse McElligott even though McElligott's qualifications were recognised as insufficient for the NHNS.⁵⁰ Prior to assisting McElligott, Whangaparita had been appointed as a Maori Health nurse (the second one after Hei) in March 1909 in a sole charge position at Tokaanu treating Maori patients and supervising sanitation in cooperation with the Maori Council.⁵¹ As a qualified nurse and midwife with experience in the position already, Whangaparita may have been more qualified for the position than McElligott. Furthermore, McElligott's name does not appear on the Register of Nurses in any year 1910-1913.⁵² In 1915 a further two Maori nurses, Rena Te Au and Ngapori Naera, were appointed to the NHNS again as assistants, while Ellen Taere and Maud Mataira resigned supposedly because they were tired of the conditions of working in typhoid camps.⁵³ In spite of the inferior opportunities available to Maori nurses, it was claimed that Maori nurses were the preferred candidates for these positions and that every encouragement would be given to young Maori women to enter into the three-year training programme.

A reliable supporter of Valintine, Maclean reinforced this patronising view. Her preference for Pakeha nurses and her misgivings about the suitability of Maori women for nursing had been clearly stated. In 1914 when she reported that there were four Maori nurses completing their training that year, she was hopeful that this would stimulate others to enter nursing and "encourage teachers to persevere in their rather uphill work." Although she wondered if it was expecting too much for Maori girls to

⁴⁹ Heni Whangaparita completed her training in 1908, a short time after Akenei Hei. She worked as the only other Maori nurse along with Hei in the fated Maori Health Nursing Scheme commencing in March, 1909, at Tokaanu where she worked alone and then later with Hei at Wanganui.

⁵⁰ H. Maclean, Report on Nurses Registration Act, Midwives, and Private Hospitals, *AJHR*, H-31, 1912, p.20.

⁵¹ Lange R.T., *The Revival of a Dying Race: A Study of Maori Health Reform, 1900-1918, and its Nineteenth Century Background*, MA Thesis, University of Auckland, 1972, p.235.

⁵² *New Zealand Gazette*, Vol. 1, 1910, 1911, 1912, 1913.

⁵³ H. Maclean, Report on Nurses Registration Act, Midwives, and Part III of the Hospitals and Charitable Institutions Act 1909, *AJHR*, H-31, 1915, p.6.

pass the same exams as Pakeha, she had to admit that they had all passed and even "taken fair places among their fellow trainees." In her view the Maori nurses were not lacking in intelligence and adaptability but in application and reliability. Her report failed to provide the reasons for her view.⁵⁴

The role of the Native Health nurse developed according to the skill and experience of the individual nurses. Although guidelines and responsibilities were produced by the Health Department, the reality of every day practice was the major force in the evolution of this sphere of nursing. Officially, the duties of the Native Health nurses were concerned with two main aspects of public health work. Firstly, they were to play a major role in reporting the incidence and preventing the spread of infectious disease. Secondly, they were to instruct Maori in European health practices especially with regard to sanitation and the health of women and children.⁵⁵ It was expected that for them to be able to carry out these duties, the nurses would have to exhibit attributes of "great devotion and self-sacrifice".⁵⁶ The detail of how to put these guidelines into practice was worked out by the nurses themselves often under the guidance of their supervisor, Bagley, who was stationed at the Auckland District Health Office when not working with them in the communities.

The education and training of nurses at this time did not prepare the Native Health nurses for their new role in Maori communities. The curricula did not include health promotion, health teaching and cultural sensitivity which were essential for the position.⁵⁷ Nurses were expected to know about the symptoms and nursing management of people with various conditions including enteric fever (typhoid) and also the hygiene requirements for people with infectious disease.⁵⁸ However, there was a great deal more

⁵⁴ H. Maclean, Report on Nurses Registration Act, Midwives Act, and Part III of the Hospitals and Charitable Institutions Act (Private Hospitals), *AJHR*, H-31, 1914, p.5

⁵⁵ Nursing for Maoris, *KT*, April, 1912, p.26.

⁵⁶ Report on the Hospital Boards Conference, *AJHR*, 1911, H-31, p.183.

⁵⁷ The 1908 Syllabus of Subjects for Examination Under the Nurses' Registration Act, 1901, in Rodgers, *Nursing*, p.108.

⁵⁸ *ibid.*, p.111.

knowledge required than this to successfully establish a field hospital and enlist the help of a community to whom they were often a stranger. For example, they had to know how to transport equipment across difficult terrain, organise for tents to be erected, establish facilities for obtaining and preparing food, washing laundry and disposing of infected sewage. They also needed to know how to organise volunteer helpers who may have been unfamiliar with what was required of them and who may not have understood English. As well as the lack of the specific knowledge base, the socialisation of nurses as obedient, womanly and deferring to medical opinion was contradictory to the qualities required. In direct contrast to the contemporary qualities of the nurse, the conditions under which the nurses of the NHNS worked and lived, the decisions they made, the respect and cooperation they needed to be effective in the communities in which they lived required tremendous courage, strength, organisational ability and commitment as well as the ability to transfer knowledge and skills from their training to an entirely different setting. The extent to which the Native Health nurses capitalised on the opportunity to raise the profile of nursing through their work in the Maori communities and to establish a new field of nursing practice has been barely recognised.

The conventional womanly qualities of the time were to be embodied in the Native Health nurse. She was to display "noble and selfish devotion to her duty in the face of almost insuperable difficulty".⁵⁹ The nurse was to be tactful in all her dealings with the Maori community, the hospital board, the Health Inspectors, the medical officers, the Native schools. In her work among the Maori she was to introduce to "the girls how to live a more hygienic life, and to raise their standard of living by her example of purity, strength and courage".⁶⁰ More practically, the qualities of resourcefulness, independence, the ability to fathom the power dynamics of the community to which they were assigned and manage the work of others, and the skills of self-sufficiency were those most required in these back-blocks nurses. Nurse Whitaker writes about learning to ride horses, milk cows and put in a vegetable garden and Nurse

⁵⁹ Report on the Hospital Boards Conference, *AJHR*, 1911, H-31, p.182.

⁶⁰ Nurse Street, *Nursing Maoris*, *KT*, July 1911, p.110.

Ferguson at the Bay of Islands established herself on her own section of land and built herself a small home for herself and her assistant.⁶¹

Because the Native Health nurses worked in remote areas and were isolated from professional assistance, situations arose when, of necessity, they stepped outside the conventional limitations of the nursing role. One requirement was to decide whether or not the services of a medical practitioner were needed and if so, they were to follow out his instructions, and “do nothing that can be construed as usurping the functions of the medical practitioner”.⁶² Although it had been identified that medical staff had generally not been effective in their work among Maori, the nurse was expected to step into this breach while at no time upsetting the status quo. The medical-nursing hierarchy was firmly established on the shared understanding of responsibilities regarding diagnosis and treatment.

The nursing reforms which had underpinned the development of nursing in New Zealand as a regulated profession were based on a clear differentiation of medical and nursing roles. The gendered socialisation of nurses was a key process of their training and reinforced their subordination to doctors. Nurses were to support the position of doctors rather than challenge the power balance.⁶³ The post-reform role had been based on the nurse as an intelligent, tactful, tireless and, most importantly, subordinate assistant to the doctor.⁶⁴ The role would not have survived if there was any clouding of the master-servant relationship. Nightingale had seen this as the key to the establishment of nursing as a profession in its own right. She was adamant that nurses were to be obedient to medical orders:

⁶¹ *KT*, April, 1917, p.70.

⁶² *AJHR*, 1911, H-31, Report on the Hospital Boards Conference, p.183.

⁶³ E. Garmarnikow, *Nurse or Woman: Gender and Professionalism in Reformed Nursing 1860-1923*, in P. Holden and J. Littlewood, *Anthropology in Nursing*, London, Routledge, 1991.

⁶⁴ *Lancet*, 1879, p. 736 in Garmarnikow, *Nurse or Woman*, p. 115.

It is the duty of the Medical Officer to give what orders, in regard to the sick, he thinks fit to the Nurses. And it is unquestionably the duty of the Nurses to obey or to see his orders carried out.⁶⁵

The division of labour was clearly defined. Nurse were to observe and report; doctors were to diagnose and prescribe:

It is the nurses' business to observe and report symptoms, but never her business to give a name to the disease or any set of symptoms.⁶⁶

The nurse-doctor division of labour was, in reality, difficult because in order to appropriately observe and report patient symptoms, a nurse had to apply a medical framework to her observations in order to decide what was medically relevant.⁶⁷ In fact nurses were examined in the State Examination for registration on their knowledge regarding their assessment of patients and the inferences they would make from various symptoms.⁶⁸ With nurses as ever-present carers in the hospital and doctors as absent consultants, doctors were forced to provide nurses with medical orders to be enacted at the discretion of the nurse. This situation had the nurses standing in for doctors and legitimated the functions of diagnosis and prescription as part of nursing practice. The administration of drugs by nurses under the direction of conditional medical orders illustrates the extent of the contradictions implicit in this artificial division of labour. This position was even more so for the Native Health nurses as they were stationed in remote areas with the nearest doctor usually several hours away by horseback.

Instructions to Native health nurses in 1912 were clear with regard to the division of responsibilities between nurses and doctors:

They must not assume the functions of a medical practitioner but should do all in their power to enlist the sympathy and co-operation of the medical men in their districts in connection with the work...

⁶⁵ F. Nightingale, *Suggestions for Improving the Nursing Service of Hospitals and on the Method of Training Nurses for the Sick Poor*, 1874, in Garmarnikow, *Nurse or Woman*, 1991.

⁶⁶ *Nursing Times* 1906, p. 457, in Garmarnikow, p. 117.

⁶⁷ Garmarnikow, *Nurse or Woman*.

⁶⁸ The 1908 Syllabus of Subjects for Examination Under the Nurses' Registration Act, 1901, in Rodgers, *Nursing*, p.109.

2) To make such recommendations as she thinks fit for the improvement thereof or with a view to prevent the spread of diseases. In these matters the nurse must look for the co-operation of the medical men of the district, the medical officer appointed by the Board for this purpose, the District Health Officer, and the Sanitary Inspector...

5) In the event of sickness in a native family, she shall advise the Secretary of the Hospital Board, with the view of obtaining the services of a medical man.⁶⁹

The Rules Relating to the Appointment of District Nurses⁷⁰ were equally supportive of the division of labour between nursing and medical staff:

5. She shall work under the doctor appointed by the Board, and other doctors practising in her district.

6. She shall visit all cases of sickness in her district where her services may be required. She shall decide as soon as possible whether or not the services of a medical practitioner are needed, and shall advise the head of the household accordingly. In such cases she shall advise the head of the household to call in the services of the usual family medical attendant, and be specially careful not to exercise her influence in favour of any particular medical man or medical men.

7. She shall faithfully carry out the instructions of the medical practitioner, and shall from time to time advise him as to the condition of the patient.

Valintine was adamant that:

In no sense of the word would the district nurse be expected to prescribe, use instruments, or in any way take the place of a general practitioner.⁷¹

In spite of these carefully worded safeguards, the conditions under which the Native Health nurses worked and the situations they encountered required that their sphere of practice did encroach on the medical domain of diagnosing and prescribing.

Central to the prevailing Nightingale ethos in nursing education of the time were the ethics of obedience, unaltering moral standards, propriety and possession of nursing "instinct".⁷² The gendered culture of nursing, absorbed through discipline and detail,

⁶⁹ *KT*, April 1912, pp. 26-27.

⁷⁰ *KT*, July 1911, pp. 130-131.

⁷¹ Dr T. Valintine, Report of the Inspector-General of Hospitals and Charitable Institutions, *AJHR*, Vol.4, H-22, 1909, p.5.

⁷² Rodgers, *A Good Nurse... A Good Woman*, pp.54-63

gave emphasis to obedience. This was most obvious in the "consistent attention to the fulfilling of orders and an assumption that prescription was all that was required for implementing nursing duties".⁷³ The emphasis on prescriptive orders is evident in the "Rules Relating to the Appointment of District Nurses"⁷⁴ and "Nursing for Maoris".⁷⁵ The gap between the reality of the work and their hospital-based training was cavernous especially as they adapted existing knowledge and skills to an entirely new mode of practice in a setting that could hardly have been more removed from the environment in which they were trained.

During the period 1911-1920, the main emphasis of the nurses' work was dealing with infectious diseases. It was the outbreaks of typhoid, cholera and smallpox that kept the Native Health nurses busy during the first decade of the scheme and it was through this work that they proved themselves invaluable to both the Maori communities and the Health Department officials. A lack of immunity combined with poor sanitation and overcrowding created an increased susceptibility among Maori which led to a disproportionate level of morbidity and mortality.⁷⁶ Traditional Maori medicine, although used successfully by Maori for centuries to treat people with health problems,⁷⁷ was not effective in dealing with these introduced diseases and the success of the nurses in isolating and containing epidemics while nursing the sick had a major impact on Maori communities. The health teaching role was incorporated with providing nursing care to the sick with the nurses giving instruction to families regarding special nutritional needs, disposing of infected sewage and preventing cross-infection so that the care of the patient continued in the absence of the nurse.

⁷³ *ibid.*, pp.54-63.

⁷⁴ *KT*, July 1911, pp. 130-131.

⁷⁵ *KT*, April 1912, pp. 26-27.

⁷⁶ Dow, *Safeguarding the Public Health*, p.82.

⁷⁷ Gluckman, *Tangiwai*, p.150.c

The Health Department under Valintine considered vaccination was a key prophylactic measure against infectious disease. The Public Health Act 1876, Part IV, required parents to have new-borns vaccinated against small-pox but this requirement was made farcical by a conscience clause added to the 1900 Health Act which allowed for exemptions to be granted if parents thought vaccination would harm the child's health.⁷⁸ Consequently only 1,078 vaccinations (including adults) were carried out in 1911 although the birth rate for that year was 26,354.⁷⁹ The level of complacency about the risk of smallpox was probably because it had not been a serious threat up until that time. The smallpox epidemic of 1913-14 highlighted the threat, however. A Mormon missionary came from Vancouver, arriving in Auckland on 12 April 1913, to work among the Maori. As he travelled around the Auckland and Northland areas meeting with large numbers of Maori he had a mild case of undiagnosed smallpox which he spread widely eventually affecting 1,978 Maori. In comparison, only 116 Pakeha were affected.⁸⁰ The Health Department responded by vaccinating as many Maori as possible and by restricting travel to Maori not in possession of a vaccination certificate. The diary of the Native School teacher, John Adkins, at Orumahoe in Northland records that on Monday July 4, 1913, Dr Gordon came to vaccinate about 40 people. He returned on Tuesday July 29 and vaccinated another 111 persons. On Thursday September 4 he made another visit to vaccinate more of the community.⁸¹ The photograph on the next page was taken by Mr Adkins of a family waiting to have their vaccinations. The vaccinations were given by the medical officers and nurses of the Health Department. This may have been the first time that nurses were permitted to administer vaccinations.

Although immunisation against typhoid fever was available to physicians and nurses by 1911,⁸² it was not compulsory for Native Health nurses to be vaccinated until

⁷⁸ Maclean, *Challenge for Health*, p.244; Dow, *Safeguarding the Public Health*, p.73.

⁷⁹ Dow, *Safeguarding the Public Health*, p.73.

⁸⁰ Maclean, *Challenge for Health*, p.235-6.

⁸¹ Diaries of Emily Adkins and family, private collection held by Carol Fleet, Ngunguru, Northland.

⁸² Vaccine Therapy in Typhoid Fever, *KT*, April 1911, p.60.



Photograph 4: A Maori Family Waiting for Smallpox Vaccination, Oromahoe,
Bay of Islands, Northland, 1913.

Private Collection, Carol Fleet, Ngunguru, Northland.

1915.⁸³ McElligott had been working as a Native Health nurse for three years in the Waiapu district when she contracted typhoid fever.⁸⁴ Although the Native Health nurses were approved as public vaccinators⁸⁵ and antityphoid vaccination was recognised as an effective prophylactic measure,⁸⁶ it was not commonly available to the general public until the 1920s probably because prior to that time it was feared that typhoid inoculation activated incipient tuberculosis or weakened natural resistance to tuberculosis.⁸⁷ By 1922, Te Rangi Hiroa, Director of Maori Hygiene, was exhorting the Native Health nurses to inoculate as many people as possible and to report any opposition directly to the Department of Health.⁸⁸ Prior to this practice, however, the death rate for enteric fever dropped from 0.62 per 10,000 population in 1910⁸⁹ to 0.33 per 10,000 in 1920 and typhoid fever deaths dropped from 1.386 per 10,000 in 1896-1900 to 0.246 per 10,000 in 1921-1925.⁹⁰ The preventative and therapeutic work of the Native Health nurses may well have contributed to this improvement.

The Native Health nurses generally worked effectively in relationship with the Department of Health and the local hospital boards. They were assisted in their work in the various Maori settlements of their districts by young Maori women (usually from one of the Maori girls' colleges) who, if they showed aptitude for the work, would be offered the chance to enter into nursing training. During epidemics of infectious diseases, these nurses took care of people on the spot setting up field hospitals if

⁸³ Natives District Nursing, *KT*, October 1915, p.199.

⁸⁴ Native Health Nurses, *KT*, April 1913, p.74.

⁸⁵ District Nursing and Native Health Nursing, *KT*, January 1914, p.46.

⁸⁶ Sanitation and Typhoid Vaccination, *KT*, January 1914, p.49.

⁸⁷ *ibid.*

⁸⁸ Confidential Circular to Native Health nurses from the Director of Maori Hygiene, 5th July 1922, H1 B.86, National Archives of NZ, Wellington..

⁸⁹ The figures for 1910 do not include Maori as records were not kept at this time for the incidence of infectious disease (or for births and deaths). The Native Health nurses and the Health Inspectors began to collect mortality and morbidity statistics for Maori as part of their monthly reports to the Department of Health.

⁹⁰ Deaths from Enteric Fever, H1 B.86 131/4, National Archives of NZ, Wellington.

necessary and teaching relatives how to manage their kin suffering from these introduced diseases. This strategy avoided a common fear held by Maori of admission to a Pakeha hospital usually some distance away from their family.

As early as 1914 Valintine considered the NHNS to be an unqualified success.⁹¹ By 1920, it was considered that the protective health agencies under the Department of Health were providing an extremely effective service among Maori. Due to the "splendid" work of these agencies and the cooperation of the Maori, there was improved health status and a significant increase in population numbers for Maori.⁹² These agencies included the Maori Health Councils, the Native Health nurses, Inspectors of Health, Native-School teachers, subsidized medical officers and the Division of Maori Hygiene.⁹³ It was believed that this was almost entirely due to the effects of education of Maori to remove the "ignorance and superstition with regard to the treatment of disease and health matters".⁹⁴ The official policy of these agencies was one of assimilation of the Maori and those who worked in the Public Health Service were expected to put the policy into action.

During World War One the NHNS was greatly disrupted because a number of the nurses left to serve overseas, Bagley and Maclean among them. There was difficulty in replacing those who were away and the pressure on those left was compounded by a serious shortage of doctors also because of war service. As a result the role of the nurses was enhanced with the extra demand for their services. Maclean saw the advantages in this situation and advocated for larger salaries and better conditions in order to attract nurses to the service.⁹⁵

⁹¹ Report of the Inspector General of Hospitals, *AJHR*, 1913, Vol.4, H-31, p.3.

⁹² Public Health Work Among the Maoris, *Journal of the Department of Public Health, Hospitals and Charitable Aid*, V.4, No.12, December 1921, pp 351-3.

⁹³ *ibid.*

⁹⁴ *ibid.*

⁹⁵ McKegg, *Ministering Angels*, p.91.

The Native Health nurses collaborated with and worked alongside various others in their work, for example health inspectors, medical officers and teachers in the native schools. The nurses were the key health professionals, however, as they lived right there among the people providing continuous every day care. The Inspectors of Health mainly played a monitoring role in disease prevention and detection of unsanitary conditions and reported their findings to the Department of Health. In areas of high Maori population, the inspectors were Maori themselves and assisted the Maori Health Councils to enforce the health by-laws. The native school teachers reported the outbreak of diseases to the Health Department who sent in a nurse, medical officer or health inspector as required. On 27 April 1917 Mr Woodhead, the native school teacher at Tanoa (north of Auckland), reported an outbreak of scarlatina (scarlet fever) in the settlement in which he worked and asked for a doctor to investigate. On 28 September of the same year, one of his pupils died of infantile paralysis⁹⁶ (poliomyelitis) and he recorded that Nurse Ngapo, Native Health nurse, arrived on 11 October to visit each household in the area, examine all the children and advise the parents on the precautions to take to prevent any further cases.⁹⁷ There appears to have been effective collaboration and communication among and between the teachers, nurses and health inspectors in their community health work.

When Te Rangi Hiroa⁹⁸ returned to the Health Department as director of the Division of Maori Hygiene he had a positive view of the health work among Maori. This view was not universal, however. Other sources describe the "pahs"⁹⁹ as quite devoid of hygiene and sanitation with much prejudice among Maori¹⁰⁰ especially with

⁹⁶ There were two cases reported nationally in September 1917 and 18 reported in October. A total of 54 cases were reported in 1917 after an epidemic of 1,018 the previous year (F.S.Maclean, 1964).

⁹⁷ (Batley) Tanoa Maori School Log Book, 1914-1919, BAAA 1003, National Archives, Auckland.

⁹⁸ Te Rangihiroa had left the Health Department in 1909 to become the Northern Maori Member of Parliament, a seat which he gave up in 1914. Following his distinguished war service, he worked as a District Health Officer based at the Auckland office.

⁹⁹ Maori villages were sometimes referred to as pahs or pas rather than kainga.

¹⁰⁰ Maclean, *Nursing in New Zealand*, KT, July 1911, p.108.

regard to hospitals, resulting at times in sick people being hidden away in the bush when a Native Health nurse or a Health Inspector was expected to visit.¹⁰¹

Changes in health legislation and policy early this century reflected the development of a public health focus which enabled nurses to adopt a change in their model and context of practice. As nurses moved out of the hierarchical environment of the hospital with its emphasis on obedience to nursing superiors and medical staff and into the community, they took advantage of the opportunity to develop a new independent role which allowed for relatively autonomous practice. The Native Health nurses were better placed for this transformation than other community-based nurses as they were employed by the Public Health Department and as such were supervised by administrative staff from a provincial centre often a great distance away. The Native Health nurses were uniquely positioned to develop an autonomy in their practice that was not possible in other settings.

During the decade 1910-1920, Native Health nursing developed as a new dimension of nursing practice in close parallel with the establishment of nursing as a respectable vocation in its own right. Under the considerable guidance of Maclean, nursing was flexing its muscle in several ways at this time. As well as the role of the nurse developing her practice within the community through the NHNS, other community based roles were providing opportunities for nursing to demonstrate itself as respectable, reliable, effective and able to work collaboratively rather than subservient to the medical profession. The District Nursing Service, administered by local hospital boards, was established in 1909¹⁰² and ran parallel to the NHNS providing for settler families in remote areas. The Plunket Society, established in 1907 by Sir Truby King to educate and support mothers and babies, also had nurses working in the community specialising in mothercraft and child health.¹⁰³

¹⁰¹ *ibid.*

¹⁰² Rattray, *Great Days*, p. 39; Report of the Inspector-General of Hospitals and Charitable Institutions, T. Valantine, *AJHR*, H-22, 1909, p.6. Margaret Bilton pioneered the district nursing service in Uruti, 30 miles north of New Plymouth.

¹⁰³ Coney, *Standing in the Sunshine*, p.64. Coney notes that the purpose of the Plunket Society was 'scientific motherhood' to produce babies for the Empire meaning people of British

Those Native Health nurses who were effective demonstrated uncommon commitment, dedication and skill in their work in Maori communities. While the scheme was not staffed solely by Maori nurses as had at first been hoped, on the whole the nurses collaborated effectively with the communities in which they lived and worked. Distrust of Pakeha hospitals and Pakeha health practices was to some extent averted by the nursing of people in their own homes or in local field hospitals during epidemics of infectious disease. The nurses who were able to assist Maori communities deal with their plummeting health status in the wake of colonisation were those who developed trust by respecting the health beliefs and practices of the Maori and achieving a balance between this and their hospital-based training. It was not only the adaptability of the Native Health nurses which underscored the change in role. They were required to have personal resources which would enable them to cope with the exceptional hardships encountered in the course of their work.

The Native Health nurses were uniquely positioned to develop the role of the nurse as a independent practitioner thereby developing a new nursing role in the community. Geographical isolation, distance from traditional hierarchical supervision and the urgent health problems of the Maori created the context for these nurses to develop the skills and knowledge from their hospital based training in a new way. As agents for autonomous nursing practice, these nurses were the vanguard for professional change. The nature of their work required them to develop aspects of practice that up until then had not been viewed as conventional nursing work.

Over the period 1911-1920, the plight of Maori in relation to health matters had taken on a higher official profile. Earlier in the decade great emphasis was placed on the control of disease¹⁰⁴ and the work of the Native Health nurses in this respect was hailed as an unqualified success.¹⁰⁵ There was difficulty enlisting sufficient nurses to this

descent. The Plunket Society showed little interest in Maori babies until after the Second World War (p.65).

¹⁰⁴ *AJHR*, H-31, 1911, 1912, 1913.

¹⁰⁵ Report of Dr. T. Valintine, Inspector General of Hospitals and Chief Health Officer, *AJHR*, H-31, 1913, p.65.

scheme because of the nature of the work but in spite of this careful selection was made. By 1920, there were 20 nurses attached to the service. Sanitary conditions had significantly improved and consequently outbreaks of typhoid were more under control. The Maori were generally appreciative of the work the nurses had done and many districts were asking for their own nurse. The cost-effectiveness of the NHNS was recognised in terms of the early recognition, isolation and treatment at the outbreak of infectious disease.¹⁰⁶ The assimilative effect was a decrease in the fear of hospitals by Maori which resulted in cases of serious illness being transferred to hospital thereby freeing up the Native Health nurse for health teaching.¹⁰⁷ Te Rangi Hiroa, appointed Medical Officer of Health for Maori in 1920, considered the nursing branch of the health work among the Maori to be most effective and that it should be assisted and promoted more than any others.¹⁰⁸

¹⁰⁶ Annual Report of the Director Division of Maori Hygiene, Te Rangi Hiroa, 14 May 1926, H1-12197 172/21/52, National Archives, Wellington..

¹⁰⁷ The Work of Nurses in a Government Department and Under Local Authorities, 79-032-12/2, Alexander Turnbull Library.

¹⁰⁸ Dr Te Rangi Hiroa, Report on the Health of Maoris, *AJHR*, 1920, H-31.

CHAPTER 4 - THE WORK OF THE NATIVE HEALTH NURSES, 1911-1920

This chapter explores four key areas which cumulatively contributed to the change in role accomplished by the Native Health nurses. This analysis is complementary to and develops McKegg's work by focussing specifically on the nursing practice of the Native Health nurses during the first decade of the scheme and identifying the change in the role of the nurse. Firstly, their work took on an element of living and working closely with Maori communities in a social role not previously considered the domain of nursing. Secondly, in order to be effective, they were required to adapt their practice so that they were culturally acceptable to Maori communities. The third element to contribute to a change in role was the remote nature of their work which extended their scope of practice to include responsibilities not previously expected of the nurse. Because of geographical isolation, it was necessary for them, at times, to make diagnoses and decisions about medical care which were previously strictly the domain of doctors. The fourth development of the role was that health promotion and disease prevention became a major focus for the Native Health nurses in contrast to the illness care which had been central to their hospital training. These changes created the impetus for a major change in the scope and approach to practice which in turn earned for these nurses a new-found respect and eventually contributed to an increase in status and power for the profession as a whole.

The instructions to Native Health nurses in 1912 were based on those for District nurses and were equally clear with regard to the division of responsibilities between nurses and doctors. They were warned against assuming the functions of a medical practitioner and were to do all in their power to enlist the sympathy and co-operation of doctors in their districts. The appointment of a Native Health nurse in a district resulted in the medical subsidy being stopped as an annual payment and being replaced with a fee-for-service basis, a situation which may have worked against the nurse-doctor relationship in some cases. The Native Health nurses were required to make recommendations for any improvements required which would prevent the spread

of diseases working cooperatively with the doctors of the district, the medical officer appointed by the Board for this purpose, the District Health Officer, and the Sanitary Inspector. When visiting any Maori family who was ill the nurse was instructed to advise the secretary of the hospital board in order to obtain medical assistance.¹ In all aspects of the work, disease prevention or illness care, the nurse was to work closely with and remain subordinate to doctors. In spite of these carefully worded safeguards of medical supervision, the conditions under which the Native Health nurses worked and the situations they encountered required that their sphere of practice did encroach on the medical domain. The remote localities of their work and the lack of access they had to doctors, either through the reluctance of medical staff to visit Maori patients or through transport and communication difficulties, resulted in situations occurring when it was not feasible to strictly obey the instructions.

The Native Health Nursing Service was officially launched when Bagley was sent to Ahipara, south west of Kaitaia, after a serious epidemic there was reported to the Auckland District Health Office in April 1910. A registered nurse, Alice Manning² from the Anglican Mission House at Pukepoto, and her assistant, Marara Ngapo, had been nursing as many of these patients as they could manage until Manning herself became ill.³ One of the first medical priorities for Dr Monk, the Assistant Medical Officer of Health, and Health Inspector Skyner with Bagley assisting, was to obtain blood specimens to be sent to Auckland for Vidal testing.⁴ Most of the tests were positive, indicating infection with typhoid. Bagley wrote⁵ that the work was going to be most difficult and that before making any headway, the nurse had first to gain the confidence of the Maori people. She explained that there were old prejudices and superstitions "to

¹ *KT*, April 1912, pp. 26-27.

² Alice M. Manning registered as a nurse in March 1902 after training at Wellington Hospital 1897-1900 (*NZ Gazette*, 1910, Vol 1, Register of Nurses, p.418).

³ Amelia Bagley, *History of Early Native District Nursing*, 79-032-12/2, Alexander Turnbull Library.

⁴ The Vidal test is performed on a blood sample to detect the presence of typhoid infection.

⁵ Amelia Bagley, *KT*, July 1911.

get over".⁶ She described an incident of disposing of some soiled mouthswabs onto a cooking fire which caused dismay among the Maori present. She asserted that the upset was because of their fastidious cleanliness with food preparation although she did not indicate a personal understanding of the cultural significance of such an act. Her respectful approach to her work with Maori was, however, an important factor in her success as a Native Health nurse. She advised other nurses

By working with them and getting them to work with her on right lines the nurse is enabled to realise more the Maori's point of view, which is not without reason - and also to understand the difficulties which come in the way of their doing things 'Pakeha fashion', as we would like.⁷

Her lack of knowledge and preparation for her work with Maori was evident in her surprise that a funeral (tangi) for one of those who died during the epidemic went on for days and that the people, including children, slept with the corpse. She used this as an example of how she was going to have to work with Maori in a very different way than she would with Pakeha.

Bagley's first task at Ahipara was to set up a field hospital in a large meeting-house as a base for providing nursing care for the more than 25 cases (mainly children) spread among four settlements more than a mile from each other with roads knee-deep in mud.⁸ The Maori people had been told that with the Government supplying a nurse and the Hospital Board supplying a doctor, they were to set up a hospital as best they could. Bagley bought very basic supplies of sheeting and towels with two donations each of £2.10s. The families of the sick brought wash bowls, bedding and food and in the case of children the mothers stayed to help nurse them. Two young Maori women were enlisted to help with messages, laundry and cooking. The very severe cases were sometimes too sick to move to the meeting-house and Bagley would visit them on horse-back. At this time she was obviously not a proficient horse-woman claiming, "I have had to ride to see them all, and will be a horsewoman soon"⁹. She went about

⁶ *ibid.*

⁷ *KT*, October 1914, p.159.

⁸ The Health of the Maoris, Measures being Taken, *KT*, July 1911.

⁹ *ibid.*

teaching family members how to nurse the sick children finding that the men especially were faithfully obedient in following instructions.¹⁰

The control of the incidence and spread of infectious disease in the Maori population provided opportunities for the nurses to prove themselves in an unprecedented arena. Dr Lunn saw patients if he was passing by and if requested. However, medical treatment did not greatly affect the course of the disease and nursing care was of much greater significance. The context for providing care, however, was very different to a hospital. Bagley reported that, "The whole thing is quite out of the usual run of nursing."¹¹ To some extent the knowledge and skills gained through the hospital-based nurse training programme and through subsequent experience equipped the nurses for Native Health nursing but there was a great deal required of them that was beyond the scope of conventional nursing practice and through the development of practice appropriate to meet the requirements of these new positions the Native Health nurses claimed professional territory for nursing.

Bagley's genuine concern for the people is evident in the sleepless nights of worry¹², her resourcefulness in making do with very little and her endeavour to be acceptable and trusted by the people. With pride she related that, after being asked by a member of the Maori Council if there was any adjustments she required to be made at the hospital, that she had found the local men very helpful. She had them digging trenches, carrying water and lighting fires and that she was told, "They do what you wish; they like you; you the good nurse"¹³ From Ahipara she travelled extensively in the upper part of the North Island, established new Native Health nursing centres at Rotorua, Gisborne, Waiapu¹⁴ and remained there until a replacement could be found.

¹⁰ *ibid.*

¹¹ *ibid.*, p.109.

¹² The Health of the Maoris, Measures being Taken, *K7*, July 1911, p.109.

¹³ *ibid.*, p.110.

¹⁴ Hester Maclean, Report on Nurses Registration Act, Midwives and Private Hospitals, *AJHR*, H-31, 1912.

She gave inexhaustible service during epidemics of infectious disease including the many outbreaks of typhoid and the small-pox epidemic in 1914.¹⁵

Difficulties were encountered by those nurses who lacked understanding of Maori custom and appeared unwilling to appreciate different points of view and ways of dealing with illness and childbirth. The nurse at Te Teko was to relate that:

so many of the natives there being addicted to very dirty living, as well as to a good deal of tohungaism. [They are] more difficult to teach better ways on account of their many stupid superstitions.¹⁶

Maud Street¹⁷ found the difficulties were many but “not great”.¹⁸ Language was a problem easily overcome as there was usually someone there who could interpret. She found this to be preferable as unless the nurse was very fluent in Maori, there was a great risk of misunderstanding. From her perspective:

the greatest difficulty was the entirely different view taken by a very intelligent people, only partly civilised, and the highly and scientifically-trained nurse.¹⁹

Those nurses who strived to be flexible and to appreciate the point of view and customs of the Maori community were able to build confidence and rapport. Cicely Beetham²⁰, posted to the Hawera district in 1911, promoted the importance of a proper introduction to the community from a person of mana. She stated:

¹⁵ *AJHR*, H-31, 1911, 1914,

¹⁶ *KT*, January 1915, p.87.

¹⁷ Maud M. Street registered as a nurse in February 1902 after training at Auckland Hospital 1896-1902. She was Matron at Coromandel Hospital 1903-7, Matron at Alexander Convalescent Home 1907-10 and worked for the Maori Mission at Paeroa 1910-1911 (*NewZealand Gazette*, 1916, Vol. 1, Register of Nurses, p.376).

¹⁸ Nurse Street, *Nursing Maoris*, *KT*, July, 1911, p.110.

¹⁹ *Ibid.*, p.110.

²⁰ Cicely Beetham registered as a nurse in February 1902 after training at Auckland Hospital where she worked from 1898 to 1903, gained a Certificate in Midwifery at the Woman's Hospital, Melbourne; she was Matron at Mangonui Hospital 1909; was private nursing 1909-10 and joined the NHNS in 1911 (*NZ Gazette*, 1916, Vol. 1, Register of Nurses, p.332).

It proves the greatest help in working amongst the Maoris [sic], and is always necessary as regards success; otherwise they will not receive me nor willingly accept nursing assistance.²¹

Early in her posting she took the opportunity to meet with a large number of people at a tangi (funeral) where she was warmly welcomed and where people showed a great deal of interest in the NHNS. She had found that those Maori who had been formerly opposed to Pakeha nurses working among them had come to realise that the nurses were genuine in their concern for the welfare of Maori through the nurses living in the villages (kainga) and nursing the sick.²² By 1914, the nurses were on the whole accepted and supported in their districts. At this time, only one nurse had resigned because she had failed to establish rapport with her Taranaki community finding that she could make no headway with her work and this was after nine months.²³ Other nurses had found progress in their work was slow through lack of local support but in each case had managed to overcome those difficulties.

Critical to the change in role constructed by the Native Health nurses was the development of the relationship between Maori and nurse. Gaining the confidence of the Maori was acknowledged by Bagley as the key to “making any real headway”²⁴ in health teaching during her first Native Health nursing assignment at Ahipara in 1910. In 1909, Hei, the first Maori registered nurse, had provided key insights for her Pakeha colleagues regarding health customs which had kept the Maori race in vigorous health for many generations prior to colonisation by the English.²⁵ She exhorted nurses to seek an understanding of the “native mind” which would inspire a deeper sympathy for the Maori people, do more to “abate racial feeling” and for the “uplifting of the Maori” than laws and health regulations.²⁶ By working with families to nurse those with

²¹ Report on Nurses’ Registration Act, Midwives and Private Hospitals, H. Maclean, Assistant Inspector of Hospitals, *AJHR*, H-31, 1912, p.20.

²² *ibid.*, p.20.

²³ *Natives District Nursing, KT*, October 1914, p.159.

²⁴ *KT*, October 1912, p.99.

²⁵ A. Hei, *Nursing Among the Maoris, KT*, July, 1910, p. 103.

²⁶ *ibid.*

infectious diseases the nurses felt they could teach health practices by example. During the first posting of a Native health nurse at Ahipara in 1911, Amelia Bagley “let” some of the mothers remain to care for their children.

I thought they could learn something by watching me in the day-time, and they could never be persuaded to leave the children without them, and they themselves would die of fright with only the “pakeha nurse”, who cannot speak Maori.²⁷

She announced that the “natives here are a lot that need teaching and caring for” and that if a nurse could live near the school, she could “watch over the school children, and it is there that her work will tell”.²⁸ Street agreed with this approach to health teaching in Maori communities and also believed that the womanly qualities expected of the nurses could be transmitted to the girls who worked as assistants. She wrote:

The nurse in her work amongst them can assist that education by showing the girls how to live a more hygienic life, and to raise their standard of living by her example of purity, strength, and courage.²⁹

One aspect of the Native Health nurse's work was to be midwifery and therefore in the early years of the scheme they were expected to be qualified as nurses and also as midwives. In fact Bagley found she had little to offer in this respect, writing in 1912:

For confinements, although most Maori methods are different from ours, they generally manage pretty well ... and it is as well not to interfere with them too much.³⁰

The nurses were agents of assimilation through role-modelling as well as direct health teaching. Hei described her work while employed by the Native Department in the New Plymouth area in 1909 as nursing the sick in the villages and teaching European ways of dealing with sanitation. Writing from Te Araroa in 1912, Bagley advised that although she could accommodate patients at her cottage, this was never done if it was possible to nurse them at home. The advantage of this was that by gaining access to homes she could

²⁷ The Health of the Maoris: Measures being Taken, *KT*, July 1911, p.108.

²⁸ *ibid.*, p.110.

²⁹ *ibid.*, p.110.

³⁰ *KT*, July 1912, p.76.

stir up and teach your Maori women to do something useful and helpful to themselves, and it is surprising how apt some of them are.³¹

It is evident that the nurses saw home visiting as their best chance to spread the health gospel. By working alongside the people and closely supervising them in their villages, the nurses were able to demonstrate their methods of care of the sick and the prevention of the spread of infectious disease. When patients were too ill to move and lived at some distance for the nurse's cottage, the nurse would take her tent and her own bedding and set up camp 'on the spot', as spare living accommodation was a rare commodity.³²

By 1912 the nurses of the NHNS were reporting that they were generally made to feel welcome and were assisted by the Maori people in their districts. Maud Mataira³³ was a Native Health nurse in the Kaipara district near Auckland nursing those with post-measles pneumonia. She found all her Maori patients were willing helpers particularly one girl who helped her during the night and then later went on to Ohinemutu to help with an outbreak of typhoid there.³⁴ Another Maori nurse, Eva Wi Repa, had also registered in 1909 after training at Napier Hospital and joined the NHNS in 1912 as an assistant to Beetham in the Hawera-Stratford area. By April, Beetham reported that where the Maori had at first been suspicious of the Pakeha nurse, now that she had a Maori nurse assisting her, the Maori sent for her and freely consulted her. The impact of the Maori nurses in the scheme was perhaps not fully appreciated. Jean Cormack³⁵ at Te Karaka found the people there to be very friendly and hospitable, lending her horses when she visited pa in the district. Bagley found that she was very

³¹ *KT*, July 1912, p.76.

³² *KT*, October 1914, p.159.

³³ Maud Mataira gained the Wanganui Hospital Certificate and passed the state examination in June 1911. She was a Native Health nurse 1911-1914. (*NZ Gazette*, Vol. 1, 1916, Register of Nurses, p.363.)

³⁴ *KT*, January 1912, p.25.

³⁵ Jean Cormack trained at Dunedin Hospital, registered in January 1909 and gained the Medical School Maternity Certificate in Midwifery. She worked in private hospitals and as a private nurse until 1911 when she was appointed to the NHNS until 1915. She joined the NZANS and served in WW1 (*NZ Gazette*, Vol. 1, 1916, Register of Nurses, p.339).

much appreciated and that the Maori were especially kind to her while she was at Te Araroa near East Cape establishing a clinic there in 1912. Another nurse, not identified, who contracted typhoid fever after nursing Maori during an epidemic, was well cared for by local woodmen and Maori and fully recovered. She wrote that:

The Maoris are, as far as I can judge, a very affectionate race, and I should think a nurse, if working amongst them for any length of time and understood their ways, would become very fond of them. Once they gain confidence in you it seems very deeply rooted, and remains so for all time.³⁶

It is clear that through the development of close and positive relationships, the nurses created an environment in which they could bring about the changes that they had been employed for and thereby claim the health care of the Maori as a legitimate domain of nursing care.

A number of the nurses had difficulty accepting the health beliefs and practices of Maori which created problems in the development of a working relationship between them. According to one nurse, it was only those engaged in the work who could really appreciate the opposition caused by what she called "Maori superstition".³⁷ Marky Tait³⁸ wrote from Te Araroa that after working very hard to nurse a man with pneumonia through the worst, she found him to be dying one evening after having been improved the night before. She later heard that he had been dipped in the creek by the tohunga (traditional healer) which was an accepted practice.³⁹ Beetham found the custom of children being promised to relatives for adoption objectionable, unhealthy and one cause of mortality due to babies not being breast fed.⁴⁰ Cora Anderson,⁴¹ who left

³⁶ Notes from District Nurses in the Back Blocks, *KT*, January 1918, p.31.

³⁷ *KT*, October 1914, p.158.

³⁸ Marky Minto Tait completed her nurse training at the Western Infirmary, Glasgow, in 1909. She was a Native Health nurse 1912-1913. (*NZ Gazette*, 1916, Vol.1, Register of Nurses, p.377.

³⁹ *KT*, April 1913, p.73.

⁴⁰ *Ibid.*, p.74.

⁴¹ Cora Anderson trained at Thames Hospital and registered in January 1909. She gained her Certificate in Midwifery at St Helens, Auckland, in 1909; was Matron at Townley Maternity home 1910-11; was appointed to the NHNS 1911-14; joined the NZANS 1914 serving in WW1 (*New Zealand Gazette*, 1916, Vol.1, Register of Nurses, p.341).

the NHNS at Rotorua in 1914, stated that it was the personality of the nurse that was the most important factor in her success. She had found the people were very quick to gauge the nurses' attitude towards them and would be driven away if they felt any slight against them.⁴²

In particular, the nurses who were aware of and sensitive to Maori custom around the time of death were able to avoid conflict and fearful situations. When it appeared that a patient was going to die inside the clinic or field hospital, the nurse would move them out into a tent or at least onto the verandah before death occurred so that subsequent patients would not be afraid to come to the clinic for nursing care. At a large meeting-house hospital at Poroporo in the Bay of Plenty, a patient had died rather suddenly in the hospital before there was a chance to move him out.⁴³ It was no longer culturally acceptable for the rest of the patients to stay there and consequently, a tohunga (traditional healer) had ordered all the patients to be moved out. Unfortunately, a number of them had died as a result. A Native Health nurse writing in 1914,⁴⁴ related that she had been nursing five people with typhoid at a Maori meeting house when Turi, a Maori man, with severe leg and internal injuries had been brought to her almost pulseless and very cold. The man's main fear was that he would be sent to hospital. She called for the doctor, gave strychnine and tried to warm his body temperature. The doctor came but could do no more for the patient. Half an hour after the doctor had left, the nurse noticed a change in the patient's condition. Understanding the fear that Maori had about a place where someone has died, she got help to carry him out to the verandah where he died a few minutes later. Many people asked her whether Turi had actually died in the meeting house and she had a heated exchange with a tohunga about this exact point of fact. When the nurses could work in with the tohunga and the community they had more of a chance of anticipating difficulties ahead of time, and became well respected by the people. Also, by working with the people they had a

⁴² *KT*, January 1914, p.48.

⁴³ *KT*, October 1914, p.159.

⁴⁴ Some Notes from a Native Health Nurse, *KT*, July 1914, p.120.

much better opportunity to appreciate the Maori point of view and thereby to understand the reasons that Maori may have against doing things the Pakeha way.

(For the development of an effective relationship with Maori, it was important for the Native Health nurse to work in with the friends and family of the patient whenever providing care. This was a new way of working for the nurses who were used to being in charge of the patient, not having to deal with family members and expecting obedience and compliance. It was considered by the nurse to be their best opportunity to teach anything connected with sanitation and care of the sick. To exclude friends and family would arouse strong suspicion about the nurse's intentions towards the patient. It was considered advisable to have at least one selected family member to help with nursing care and to instruct this one person carefully so that they would be "honour bound" to ensure that instructions were followed.⁴⁵ By working in this way, the nurse became accepted by the community and could use opportunities as they arose to spread their health gospel.

Within two years of the NHNS being launched, the nurses were being acknowledged by Maori, by local Health Boards and by Health Department officials. In a letter to Chief Health Officer Valintine on October 9 1913, the people of Waima in the Hokianga district of Northland acknowledged the assistance the nurses had given them during a recent epidemic of chicken pox⁴⁶ with a gift of money. They expressed their boundless love and gratitude and stated that their only remedy in times of such danger was through the work of the Native Health nurses. Valintine's reply affirmed the work of the nurses and explained that both the letter from Waima and his reply would be published in *Kai Tiaki*⁴⁷ so that other nurses may hear of the generosity and appreciation shown thereby indicating the readiness of Maori to help themselves and to recognise the work of those who are helping them. Mr Jones, a Native Court judge at Gisborne was also full of praise for nurses at a fever camp on the East Coast:

⁴⁵ *KT*, October 1914, p.159.

⁴⁶ This may have in fact been small-pox. The 1913-14 small-pox epidemic started with a mild form which was initially thought to be chicken pox.

⁴⁷ Letter Translated from the Maori, *KT*, October 1915, p.151.

I would like...to say a word of commendation of those brave and noble women sent out by the Department to assist in nursing...Apart from the ordinary risks of their profession, they take their lives in their hands, and put up with hardships and discomforts which only one who travels the same roads and crosses the same rivers can realize.⁴⁸

It was clear that even early on in the scheme there were communities who valued the work of the nurses especially during epidemics of infectious disease. These were key opportunities to prove their worth and establish credibility.

[The remote nature of the Native Health nurses' districts and the fact the nurses lived among the people they nursed, meant they were in closer contact with their patients than doctors had ever been.] Medical back-up was at best many miles distant over rough roads. That medical assistance to the Native Health nurses was in real terms to be in the form of the absent consultant was evident because of the isolated nature of their work. It was an essential aspect of their work that they could manage serious illness and accidents until medical back-up became available, sometimes days later. The cottage at Te Araroa was in a remote situation requiring the nurse to

...act on her own initiative a great deal. The only doctor is fifty miles away [at Waipiro] and at times cannot possibly cross the rivers. A telephone will probably be provided in the cottage as the Post Office is some distance away.⁴⁹

At Te Kaha in the Bay of Plenty, a cottage was provided for nurses by local Maori. Mataira was appointed to the position of Native Health nurse towards the end of 1914, the nearest doctor being sixty miles away at Opotiki.⁵⁰ E. Hamblyn, a nurse who worked in this remote district ten years later, found the level responsibility

...has nearly driven me to distraction, as usually, when I have had desparately-ill [sic] patients it has been impossible to remove them by either sea or land.⁵¹

Hamblyn cites a number of situations which required her to treat patients with serious problems including a bushman in particularly inaccessible terrain with both bones of the

⁴⁸ *AJHR*, 1912, H-31, p.4, cited in McKegg, *Ministering Angels*, p.87

⁴⁹ *KT*, April 1912, p.26.

⁵⁰ *KT*, Oct. 1914, p.159.

⁵¹ *KT*, Jan. 1924, p.19.

lower leg broken who had to be carried for six hours to a hut where the nurse set the leg in splints and made him comfortable⁵². It was several days before the river could be crossed to transfer him to a homestead and another week before he arrived in Opotiki for medical treatment. She was relieved to get a satisfactory report from the doctor at Opotiki of the patient's condition. This level of responsibility for prescribing and treating patients was expected of the Native Health nurses in contrast to nurses working in other settings.

Even in those districts not so remote, the virulence of the epidemics was such that the Native Health nurses were required to manage large numbers of people suffering from serious illness in field hospitals. In the winter of 1914, a severe form of typhoid infected many people in the Auckland district. The already heavy workload of the nurses grew as Maori sought and were offered help where previously they had been "left to much their own resources with their sicknesses and deaths".⁵³ In other areas - Rotorua, Bay of Plenty, and the King Country - the numbers of typhoid sufferers were too great to be accommodated in camp hospitals. Many patients were nursed by their families in the kainga (villages) with help and supervision from the nurses.⁵⁴ No mention is made of the role of the doctor in the care and treatment of these seriously ill people but it is likely that they attended when requested or when passing rather than providing the 24 hour, every day attendance given by the nurses. One nurse wrote that it was the dedication required when there was an epidemic that contributed to her sense of job satisfaction. She was nursing five people with typhoid and two became delirious. She was the only nurse there so she had to keep going night and day. She enjoyed this aspect of the work calling it 'real nursing' and commenting that she had no complaints about the work being monotonous.⁵⁵

Inevitably, a number of nurses contracted typhoid themselves. Their close contact while nursing during epidemics placed them at extreme risk. Sadly, Hei died

⁵² This may well have involved the administration of drugs for pain relief.

⁵³ *KT*, October 1914, p.158.

⁵⁴ *ibid.*

⁵⁵ Some Notes from a Native Health Nurse, *KT*, July, 1914, p.120.

from typhoid contracted while nursing family members. Several other nurses were infected with the disease through the course of their work. Nurses Gill and Herdman became ill after nursing Maori children with typhoid at Petane, seven miles from Napier.⁵⁶ Although nurses at Auckland Hospital were being advised to have typhoid vaccination because there were frequently a large number of cases there,⁵⁷ this protection was not customary for the Native Health nurses until later in 1915.⁵⁸

The nurses were careful to officially maintain the status quo regarding the division of labour between nursing and the work of the doctors. While Street, one of the earliest Native Health nurses, acknowledged⁵⁹ that

[It was necessary to develop] a good working plan to enable the nurse to get medical attendance for her patients when needed...[It was also necessary to have a] good stock of drugs available...in tabloid form [to administer according to “standing”⁶⁰ medical orders].

She reports that there was a ⁶¹great objection [of the Maori] generally to consulting a doctor, and on the other hand the difficulty of getting a medical man to come several miles into the country when the patient and his friends are willing to have one”⁶¹ Another Native Health nurse posted to Te Araroa, in the East Cape region, described the work in the dispensary as “sometimes considerable” there being “stock mixtures *prescribed by the doctor*”⁶² to be made up. While not directly referring to the medical functions of diagnosing and prescribing, it is apparent that responsibility was given to these nurses in terms of drug administration. This was not the case for nurses working

⁵⁶ *KT*, April 1911, p.75.

⁵⁷ *KT*, April 1911, p.60.

⁵⁸ *KT*, October 1915, p.199.

⁵⁹ *KT*, July 1911, p.110.

⁶⁰ “Standing orders” is a term for medical prescriptions to be administered by a nurse according to pre-determined medical criteria.

⁶¹ *KT*, July 1911, p.110.

⁶² Emphasis in the original, *KT*, July 1912, pp. 74-76. This report, “Maori Nursing-Te Araroa”, is probably written by Amelia Bagley as the article includes a photo of her on horseback. This photo is in the National Archives, Wellington, H,W2615 2/1 - Mary Lambie Collection..

in hospitals who were to give medication on direct medical prescription and criticised if they stepped beyond this clear boundary.⁶³

The medical-nursing division of labour with the doctor diagnosing and the nurse observing and reporting was not always feasible for the Native Health nurses because the immediacy of situations required action as well as observation. The reporting often came later. Writing from Te Araroa, Tait explained that:

... the position the nurse is placed in, to act as doctor, to diagnose, treat, prescribe, and dispense, makes one sharpen every faculty to do the very best possible. Here is a life as it were, dependent to a great extent, upon you, to do all that is within your medical knowledge and power, to give relief. I like the work and read more medical books now than ever before, in my nursing career. It makes one grasp the use of drugs, and to learn which drugs (though many are advocated by the pharmacopoeia) are best.⁶⁴

J. M. Jarrett⁶⁵ expressed the anxiety and difficulty she experienced when making a diagnosis “relying solely on oneself”.⁶⁶ From her perspective:

...the question of the backblock nurse is eternally this: Am I able and justified to treat this patient? Am I absolutely sure of my diagnosis, or must the case be taken to hospital - often a great expense and danger to life - a very great responsibility.⁶⁷

The complex balancing act of playing the “nurse-doctor game” could not be expressed more completely than in the paradoxical statements of the Waikato delegate at the Hospital Boards Conference 1911, Mr Young, who on the one hand acknowledged that:

⁶³ British Medical Journal, 1912, p.644 cited by Eva Garmarnikow, *Nurse or Woman: Gender and Professionalism in Reformed Nursing 1860-1923*, p.122, in P. Holden and J Littlewood, *Anthropology and Nursing*, London, Routledge, 1991.

⁶⁴ *KT*, April 1913, p.73. The author of this article is careful to point out that this extension of nursing practice is acceptable because of the remote location of the work.

⁶⁵ J. M. Jarrett completed her three years' training at Newcastle-on-Tyne Infirmary in 1899. She was a Native Health nurse from 1916 at Te Karaka (*NZ Gazette*, Vol.1, 1916, Register of Nurses, p.377).

⁶⁶ *KT*, July 1928, p.139.

⁶⁷ *ibid.*

Being cut off from medical assistance, they [the Native Health nurses] have not only professional anxieties to contend with, but also the dangers of flood and field.⁶⁸

While on the other hand he stated:

Her duty is to say whether or not the services of a medical practitioner are needed, and if needed she must faithfully follow out his instructions, and do nothing that can be construed as usurping the functions of the medical practitioner.⁶⁹

This seemingly impossible contradiction was dealt with by the nurses in a pragmatic manner. Mr Armstrong from Wairau speaking at the conference a short time later was enthusiastic about the contribution of the nurse in his district citing an example of life-saving work, "In the case of a woman who was burned quite recently the doctor said if the nurse had not been there to inject morphia the patient would have died from shock."⁷⁰

As the work of the nurses became established, the scope of practice developed to accommodate health teaching and disease prevention. This facet of practice had not conventionally been considered the responsibility of nurses. Vaccination was a new development in the disease prevention work of the Native Health nurse. An outbreak of smallpox towards the end of 1913 was partially contained by vaccinations carried out by Native Health and other District Nurses. Valintine recommended to the Minister for Public Health that nurses should be appointed Public Vaccinators. Once approved by the Health Department the names of the nurses were gazetted (published in the New Zealand Gazette)⁷¹ and vaccinating became one of their usual duties. A report in April 1915 confirms that Nurse Wright in the Rotorua district was very busy with typhoid inoculations and that the kainga (villages) in the district had been "much more free from enteric since Christmas."⁷²

⁶⁸ Report of the Hospital Boards Conference, *AJHR*, H-31, 1911, p. 218.

⁶⁹ *ibid.*, p.218.

⁷⁰ *ibid.*, p.219.

⁷¹ *KT*, Jan 1914, p.46.

⁷² *KT*, April 1915, p.87.

The nurses were adamant that nursing work in the community should be undertaken or at least directly supervised by registered nurses. They carefully claimed the professional territory that was being gained in this area and were disparaging about any untrained health workers unless they were assistants to the Native health nurses. The district nurse at Pongaroa when writing about the need for qualified maternity nurses for settlers in that district explained that:

Expecting mothers have to take the rough jolty drive of 40 miles to the nearest nursing homes, necessitating three or four weeks wait in town beforehand, and at least three weeks afterwards or else be nursed (?) by obliging neighbours or one of the remaining "Gamps".⁷³

As a vanguard movement for a new approach to nursing practice in the community, the Native Health nurses were key innovators in the area of health teaching and the prevention of disease. Their training had prepared them to care for sick patients in hospital, to assist doctors in their medical work and to be compliant with the existing social and political structures of the hospital. The new role of Native Health nurse required of them not only the flexibility to transfer their skill and knowledge to nursing Maori in their own villages but also a mind shift towards health promotion and disease prevention rather than the illness care they had been trained for.

The content of [nursing] syllabuses came directly from contemporary medical knowledge and practice...The practical aspects of nursing were an amalgamation of domestic service, medical practice and specific nursing skills.⁷⁴

The rationale for the establishment of the Native Health nursing service by the Public Health Department was principally to prevent the spread of infectious disease from the Maori population to the rapidly increasing European population and to a lesser degree to address the low standard of health and living conditions among Maori. Hester Maclean reported that:

The insanitary conditions under which the natives live in close proximity, and their frequent epidemics, are likely to be a serious menace to the growing

⁷³ *KT*, April 1913, p.65, question mark in the original.

⁷⁴ Rodgers, *Nursing*, p.44.

European population, unless something really practical is done to remedy the state of affairs.⁷⁵

As the most influential nurse in New Zealand at the time, Maclean may have used this argument to place nurses in community based positions so that they were poised to stake their professional claim.

Although the instructions to the Native Health nurses required them to inculcate Maori with European ways of living, there was no preparation for this role. Valentine had acknowledged that they would be women of rare character, devoted to duty and undaunted by hardship⁷⁶ but no record can be found of how they were to go about this work. The best advice Dr Barnett could offer nurses at their conference in 1912 in his address on 'The Nurse as a Health Educator'⁷⁷ was that although doctors were proud of their public health work, in spite of the financial loss they suffered by it, that it was women who could teach better. He announced that men originate ideas but that women 'hold on' to ideas and for this reason it was important that nurses took on the responsibility for teaching hygienic living. The expanded role of the nurse as health educator seemed to be readily and (with some relief) sanctioned by the medical profession. He then went on to promote fresh air as the most important weapon in the battle against disease. In fact the major health issues for Maori were in dealing with poverty and the devastating effect of European-introduced infectious disease for which they had reduced resistance and their traditional medicines were not effective.

Official concern was directed towards the lack of power to compel Maori to comply with the health regulations which governed non-Maori. Native Health nurses were seen as the part of the answer to this problem by acting as agents of protection against the spread of diseases initially introduced by the European and as teachers and models of behaviour for hygienic living according to European standards. That the

⁷⁵ The Nurses Registration Act, Midwives Act, and Part III of the Hospitals and Charitable Institutions Act (Private Hospitals), Report by Miss H. Maclean, *AJHR*, Vol. 4, 1913, p. 13.

⁷⁶ Report of Inspector of Hospitals and Chief Health Officer, T. Valentine, *AJHR*, H-22, 1904, p.6.

⁷⁷ *KT*, January 1913, p.22.

nurses enthusiastically took on this work stood them in good stead with health officials while providing them with unprecedented opportunities for development of the role and function of the nurse. Mr Powell, the conference delegate from Waiapu

... was confident that if the Government and the Board were genuine in their desire to improve the health of natives, and prevent the spread of infectious diseases, they would gladly accept the services of nurses who would not only treat cases of sickness, but would also instruct Natives as to a healthy means of living generally; and, by instructing mothers in the feeding of their children, thus lessen a large infant mortality. They would also report on the sanitation of the settlements, and bring offenders to book, and generally, as regards the prevention of disease, adopt such precautions as were adopted by the Europeans.⁷⁸

The most urgent work required by the Department of Public Health of the Native Health nurses, in the first five to six years following the establishment of the service in 1910, was to develop effective means of preventing the spread of infectious disease among Maori and to report the incidence of disease as the notification of disease to the Department had been incomplete.⁷⁹ It was through this work that they gained approval and status with the Health Department.

Initially, the approach to containing epidemics was to establish camp hospitals. In fact, the official statistics for the death rate for typhoid did not include Maori until 1920 when the Maori rate of 1.28 per 10,000 population compared dismally with the European rate of 0.01 per 10,000.⁸⁰ It would seem that the Maori death rate from typhoid preceding 1920 must have been considerably worse. Effectively the work of the nurses saved lives, relieved suffering and limited the spread of epidemics. However, it did nothing to prevent the number of outbreaks of typhoid. In 1916, the small district of the Bay of Islands had 258 recorded cases of typhoid among Maori.⁸¹ The real impact of the nurses on the incidence of infectious disease was not felt until vaccination became

⁷⁸ Report of the Hospital Boards Conference, *AJHR*, H-31, p.182.

⁷⁹ Dr Valintine reported that the nurses were responsible for discovering many cases of typhoid which would have been otherwise unnotified, Report of the Inspector General of Hospitals and Chief Health Officer, *AJHR*, H-31, 1912, p. 4.

⁸⁰ Maclean, *Challenge for Health*, p. 205.

⁸¹ Maclean, *Challenge for Health*, p. 202.

available for smallpox in 1914 and for the districts most affected by typhoid after 1920.⁸² Where the nurses did make an impact was in their presence among the people during times of illness and their attempts to relieve symptoms, reduce suffering, promote recovery and prevent further spread of the infection to nearby communities.

During the smallpox epidemic of 1913, travel restrictions were placed on Maori in an attempt to contain the spread of the disease. As Health Department officials, the nurses were able to issue travel passes. The enforcement of travel restrictions caused Lily Dawson difficulties with the Maori people in the Thames area. They were angry at being unable to travel and she felt very sad about the situation. She felt it caused a serious set-back in her work.⁸³

Conditions experienced in the camp hospitals stretched the nurses' resources to the limit. One nurse travelled from Wellington to Wairoa, Hawkes Bay, by boat to nurse three Maori patients under canvas. She writes of being plagued by heat, flies and mosquitos and then forced to shift camp after a terrible storm ripped the tents and soaked the patients with rain.⁸⁴ One of the people offered her the use of a house and several others arrived to help her move her patients and equipment. Boxes and kerosene tins did duty for almost everything. She was amazed at how she could do without other equipment considered essential under normal circumstances. Each night one of the men took over as night nurse and before going home in the morning he carried in water, emptied buckets and performed other tasks which she would have found difficult on her own.

The austere facilities in the camp hospitals tested the nurses' tenacity in maintaining the standards of practice required to isolate infectious disease. Photograph 5⁸⁵ shows Sister Annie Henry, who was not a registered nurse but a Presbyterian deaconess, at a typhoid camp at Maungapohatu. The lack of facilities are evident

⁸² *ibid.*

⁸³ McKegg, *Ministering Angels*, p.88.

⁸⁴ *Active Service in the Back Blacks, KT*, January, 1916, p.38.

⁸⁵ See p.90.



Photograph 5: Typhoid Camp at Maugapohatu, 1924.

Sister Annie Henry Collection, F-30884-1/2,
Alexander Turnbull Library, National Library of New Zealand,
Te Puna Matauranga o Aotearoa, Wellington.

although the cottage on the right may have had a stove for cooking and boiling water. It is likely that the field hospitals established by the Native Health nurses would resemble this camp. All equipment that had been in contact with patients and all body fluids and wastes had to be disinfected. Sputum, excreta, dressings, mouth swabs and bath water were boiled in kerosene tins over a fire which was a great deal more difficult in high wind or rain.⁸⁶ The heavy and dangerous work of carrying these tins both to the fire and then, boiling hot, to a waste pit was carried out by the men of the community who were generous in their help and support. Bed linen, towels, clothing and utensils were also usually boiled in the same way although soaking in disinfectant, such as IZAL, was also effective. Mattresses, pillows, furniture, walls and floors were all disinfected by wiping over with formalin. Writing in 1920, the nurse at Te Araroa, in the East Coast region, said that the measures described above were her standard practice and that she would have considered herself guilty of neglect if she fell short of this.⁸⁷ In addition, there was food to be brought in and prepared and the need for clean drinking water, usually boiled. All this domestic activity would have been impossible without the nurse first gaining the cooperation, practical commitment and respect of the local people.

The conditions were made even more difficult when patients were too ill to move from their homes to a field hospital. When patients were spread around the district, the nurse spent valuable time travelling on horseback which kept her away from the bedside. It was also stressful for her to have to leave very ill patients to go to visit others who were equally in need of her help. When possible a nurse would be sent in to help in these situations. One nurse returned home to her district from leave at the outbreak of a typhoid epidemic. After two to three days of answering calls in several directions, she had identified thirteen cases (one of whom died of haemorrhage) who were spread out in three settlements.⁸⁸ At one of the settlements at some distance from the nurse's quarters, there was a very ill woman and her five month old baby who the

⁸⁶ Prevention is Better Than Cure, *KT*, April, 1920, p.70.

⁸⁷ *ibid.*, p.71.

⁸⁸ Notes From District Nurses in the Back Blocks, *KT*, January, 1918, p.31.

nurse thought to be dying from enteric. When the doctor arrived the following day, he and the nurse spent some hours fomenting abdominally and feeding the mother. The nurse instructed the family how to look after the mother and baby and then reluctantly had to leave them to return to another patient whom she felt it was impossible to leave any longer. Eventually, another nurse was sent to help out with the mother and baby and three more cases. She had to ride in from a distance and it was only the second time she had been on a horse. She was stiff and tired on arrival but reported to be full of determination and pluck which was just as well as the accommodation was not very comfortable.⁸⁹ It took four weeks before the patients were well enough for the original nurse to return to her usual headquarters. However, when she returned home she found two babies very sick with pneumonia. She treated one with poultices and bowel infusions⁹⁰ but the other baby died before she could treat it. The first baby improved but was very emaciated and needed more care than the nurse felt the mother was able to give. It was in situations like these that the nurse had to make difficult decisions knowing that whichever course of action they took, the risk was increased for some of their patients.

That nursing was forging a new role for itself through the Native Health Nursing Scheme could not be denied but the continuation of the scheme rested firmly on the ability of the nurses to achieve the outcomes expected by the Department. In the absence of protocols or manuals except the guidelines drafted by Dr Valintine, their success or failure was dependent on the extent to which the nurses could adopt the health promotion focus of their role and put into place measures that would achieve the outcomes expected. A regular feature of *Kai Tiaki, the New Zealand Nursing Journal*, was an article promoting the work of the NHNS. The January 1914 issue admonished nurses to demonstrate the possibilities of community based nursing and for the very best nurses to put themselves forward for this work. It was not to be left to the “second bests”⁹¹ or to those whose best days for strenuous work were nearly over. Maclean was

⁸⁹ *ibid.*

⁹⁰ Extra fluid was given rectally to dehydrated patients, being absorbed into the blood stream through the intestinal mucosa.

⁹¹ *KT*, January, 1914, p.49.

owner of this journal and it appears that Bagley was the main contributor to the articles featuring the NHNS. The view of these two influential nurses must have been that the NHNS was well placed to earn prestige for the nursing profession and the regular features highlighting this work in the professional nursing journal for registered nurses functioned as regular reminders to all nurses of the importance they placed on Native Health nursing.

Nurses to whom this lifestyle and type of work would appeal, would need to have been independent women willing to tolerate the difficult living conditions of the fever camps, live in a remote areas often with few other Pakeha residents and self-reliant in a professional and personal sense. There is also an element of pride evident in the nurses' accounts, in *Kai Tiaki*, of being able to cope with out-of-the-ordinary situations, manage long periods without food and/or sleep and make do with minimal equipment and support. For these nurses, the long hours may have been a reflection of their dedication over and above the usual nurse. At this time, nurses' hours of work and working conditions were being reviewed and reformed and hospital nurses were working an eight-hour day. A number of nurses considered that providing human service should be the first concern of nursing and considerations of pay and working conditions downgraded nursing to the level of a means of livelihood rather than as a profession.⁹²

The Native Health nurses may have welcomed the opportunity that their particular circumstances offered to prove their 'purest motives of benevolence'.⁹³ Nurse Jarratt warned nurses at a refresher course in Auckland in 1928 that the work was hard, with meals taken at any time and sometimes not at all.⁹⁴ McKegg interviewed Margaret McNab, nurse at Te Kaha in 1933, who said that she preferred to give the type of individual care that the hospital system did not allow for. She also had a keen sense of adventure and a desire to try new experiences. When offered two jobs on the same day,

⁹² Nurses of a Period - The Traditions of Florence Nightingale, *KT*, October, 1925, p.176.

⁹³ Godden, *Nightingale's Legacy*, p.185.

⁹⁴ McKegg, *Ministering Angels*, p.175.

one as a Plunket nurse in Timaru and the other as a Public Health nurse at Te Kaha, she had no difficulty choosing. Not knowing where Te Kaha was, she asked a Maori man at the post office. His reply was that TeKaha was a terrible place and that the Maori were all cannibals there. That settled it for McNab. She chose Te Kaha as it sounded much more exciting than Timaru.⁹⁵ A similar attraction to the NHNS as to nursing in war time may well have been there amongst these women as at least nine of those employed as Native Health nurses had also served in the NZANS.⁹⁶ A taste of adventure, of making do in difficult circumstances and of nursing in an alternative environment to a hospital may well have been significant motivating factors for these nurses.

The Native Health nurses would not have been easily identified as such in their riding costumes in the early years. Photograph 2⁹⁷ shows Bagley mounted on a horse visiting the nurse at Te Araroa dressed in a riding skirt, jacket and large-brimmed hat with no symbols of her work evident. A later photo of 13 Native Health nurses at a gathering at Rotorua in 1924⁹⁸ shows them in a variety of jackets and skirts but evident is their identification on their hat bands of the letters 'NHN'. Photograph 3⁹⁹ shows two nurses in the type of uniform the nurses would have worn when working in a field hospital situation. This clearly identifies them as nurses, not distinctively Native Health nurses, but it is difficult to imagine how they maintained the appearance of the starched white aprons and caps in such spartan surroundings. In contrast to nurses in hospital employment, it is likely that the Native Health nurses wore street clothing suitable for travelling for a great deal of their work and were therefore not so different in their appearance from other Pakeha women in the area.

Having won the confidence of Department officials by their effective management of the typhoid epidemics of 1911-1913 and smallpox epidemic of 1914,

⁹⁵ *ibid.*, p.150.

⁹⁶ See Rodgers, *A Paradox of Power*, Appendix C, p.268, for a table of the names of NZANS members.

⁹⁷ See p.55.

⁹⁸ *KT*, July 1920, p.109.

⁹⁹ See p.58.

the focus of the Native Health nurses intensified on the living conditions in the (kainga) villages. That the Maori Councils were no longer provided with funding to pay their own officers, usually chiefs or other highly respected men of the tribe, to administer health regulations and that this responsibility was passed on to Pakeha women required a leap of faith from Maori people that would appear extremely difficult if not impossible. Many of the nurses, however, earned a great deal of trust through the sheer hard work, kindness and respect they displayed while nursing the sick during epidemics. Although they spent so much time nursing people with typhoid and other infectious illnesses and had little time for the infant welfare and public health aspects of their role, by living among and caring for the people they earned the trust prerequisite to the health teaching aspect of their role.

Following a 1910 amendment to the Public Health Act of 1908, hospital boards were required to take responsibility for the whole population in their districts, for the prevention and control of infectious disease and the promotion of sanitation not merely to maintain institutions for the cure of disease. The Native Health nurses although paid by the Health Department were sponsored by hospital boards in terms of accommodation and equipment. In return, the nurse provided preventative care and health teaching, collected health statistics and nursed those with infectious disease among Maori communities which were previously seen as outside the responsibility of hospital boards. In this way, the Native Health nurses were valuable agents of the Boards in meeting the requirements of the health legislation and thereby established their worth.

The hospital boards were not always keen and generous in their support of their local Native Health nurse. While the Health Department paid the nurse's salary, the local hospital board was expected to provide a cottage and transport. Fergusson¹⁰⁰ planned her own headquarters at Kaitaia and even partly built it herself with the help of

¹⁰⁰ E. L. R. Fergusson trained at the Royal Bristol Infirmary 1894-97 and gained the London Obstetric Society Diploma in 1897. She was private nursing 1897-1900, in the Army Nursing Reserve South Africa 1900-02, private nursing at Wanganui 1902-7, Ruanui Maternity hospital 1907-12, then Matron at Kawakawa Hospital before joining the NHNS in 1916 (*NZ Gazette*, 1916, Vol 1, Register of Nurses, p.345, *KT*, October, 1915, p.199).

locals. She had a love of tools and there was a scarcity of carpenters at that time.¹⁰¹ She repeated this approach to obtaining accommodation later when she found a way to gain a Government subsidy for a second nurse's cottage in her large, remote district of the Far North. Her Kaitaia base was too distant from the many people she needed to visit further north and she required a second base at Te Hapua. By raising money through social gatherings and jumble sales of warm clothing donated by friends at prices which could be afforded by the community, she was able to raise enough money to qualify for a subsidy to build the second cottage. She also received a donation of £6 and parcels of clothing from the Catholic Church for the Te Hapua children.¹⁰² Her innovative approach to her work was further demonstrated with her active involvement in the building of the cottage with the help of her assistant, Miss Kidner, the local school teacher Mr Vine and the local people.¹⁰³

One prominent aspect of the health teaching role concerned the health of mothers and young children. This emphasis had been directed by the Department of Hospitals and Charitable Aid¹⁰⁴. Special attention was to be paid to the feeding of children, the management of sick children and the health of school children. Advice and teaching was to be given to mothers regarding children's health and during pregnancy, attending childbirth "where possible". The Native Health nurse at Te Araroa in July 1912 reported that there was a "great deal of explanation and teaching regarding young babies and children" while births were managed well "and it was as well not to interfere with them too much",¹⁰⁵ Lily Dawson¹⁰⁶ described her difficulty in reflecting

¹⁰¹ The Work of Nurses in a Government Department and Under Local Authorities, Alexander Turnbull Library, 79-032-12/2.

¹⁰² Letter from Amelia Bagley to Bishop Cleary July 18, 1919, CLE 96-4, Catholic Archives, Auckland.

¹⁰³ A Visit to the Far North, A. Bagley, *KT*, April 1920, p.88.

¹⁰⁴ Circular No. 102, Department of Hospitals and Charitable Aid, Wellington, 31 January 1912 cited in *KT*, April 1912, p.26.

¹⁰⁵ *K T*, July 1912, p.76.

¹⁰⁶ Lily Dawson gained the Launceston General Hospital Certificate in 1897; the London Obstetric Society Certificate from Fulham Midwifery Training School; was a sister at the Pretoria Hospital; the Woman's Hospital, Melbourne; Austin Hospital; Sister-in-Charge, Heatherfield

exactly what she did in the course of her work in her regular reports to the department.¹⁰⁷ Taking informal opportunities for talking with the women about “feeding the babies and numerous other necessary things” was never reported as giving a lecture. That it took an entire day by train and many miles on foot every eight to nine days to visit a “very ill-nourished baby that [she] was trying to get them to feed properly” was not easily communicated in the reports. Anderson’s lectures to mothers and addresses to school children were considered to be proving a great help to her Rotorua community in 1914.¹⁰⁸ Ethel Lewis¹⁰⁹ found time to give lectures twice a week at the Maori school at Otaki and was pleased when one of the boys gained 98 per cent in an examination on first aid.¹¹⁰ This teaching role in the community setting would convince Health Department superiors that the nurses were well positioned to preach the health gospel of the Western world.

The nurses took their health promotion role seriously and endeavoured to find innovative ways to deliver their health message. Ruby Cameron,¹¹¹ was reported in the *Opotiki Herald*, December 2 1921, as taking on a crusade of sanitation on the Maori pa of the Opotiki district. She organised a competition for the cleanest and best kept pa providing the prize of a lamp at her own expense. Apparently the enthusiasm and keen rivalry resulted in a marked improvement in the dwelling houses and grounds of a number of pa. The article reporting this competition reveals the pervading attitude of the time with this statement:

Private Hospital, Sydney; Sister-in-Charge, Talbot Hospital, Timaru 1912-13; Native Health nurse from 1913 (*NZ Gazette*, 1916, Vol 1, Register of nurses, p.341).

¹⁰⁷ *KT*, January 1914, p.48.

¹⁰⁸ *ibid.*, p.48.

¹⁰⁹ Ethel M. Lewis gained the Bristol General Hospital Certificate in 1905 and was private nursing before joining the NHNS 1912-14. She was engaged in nursing service in WW1 in Serbia and received a decoration from King Peter. She returned to the NHNS at Otaki in 1917 and then left again for active service. (*NZ Gazette*, 1916, Vol 1, Register of Nurses, p.330; *KT*, October, 1917, p. 189).

¹¹⁰ *KT*, October 1912, p.99.

¹¹¹ Ruby I. Cameron registered in January 1915 after finishing her training at Gisborne Hospital. She joined the NZANS serving in WW1 and joined the NHNS after her return from war (*NZ Gazette*, 1916, Vol 1, Register of Nurses, p.357).

It is just about as difficult to make the native understand that cleanliness is next to godliness as it is to compel a horse to drink if he does not feel that way inclined.¹¹²

Cameron is described in glowing terms for presumably succeeding where others had not. Particularly in the period following the November 1918 Influenza Pandemic, there was a great deal of concern expressed in strong terms like “hot-beds of disease” and “menace to public health” throughout the country about the perceived risk of spreading infection from the pa to the nearby country towns. The Tauranga Hospital and Charitable Aid Board initiated a flurry of correspondence through its request to all other hospital and charitable aid boards, county councils, borough councils and town boards to petition the Government’s support in reducing the menace to country towns.¹¹³ Not only was Cameron’s approach innovative it would have struck a chord with health officials and further enhanced the growing reputation of the Native Health nurses.

Valentine himself was especially pleased with the scheme that he had put in place out of the ashes of the Maori Health Nursing Scheme making regular positive comments regarding the nurses in his annual reports to Government. His 1920 report provides a most explicit endorsement both of the scheme and of the nurses having achieved the objectives set for them by him. He recorded that the continued policy of supplying nurses to Maori had resulted in considerable improvement in sanitary conditions and that within a few years he expected that the standards of hygiene for Maori would have approached that of Europeans.¹¹⁴ The report from the Auckland District Health Officer noted that the noticeable improvements were undoubtedly due to the increased number of nurses working among the Maori and from Napier that the Maori “had become so very much Pakeha in his habits of life...as to hardly warrant a separate report on his

¹¹² A clipping from the *Opotiki Herald*, December 2 1921, National Archives, H 1 13303 36, National Archives, Wellington.

¹¹³ Circular letter to all Hospital and Charitable Aid Boards, County Councils, Borough Councils and Town Boards from Tauranga Hospital and Charitable Aid Board, H 1 13303 36, National Archives, Wellington.

¹¹⁴ Dr T. Valentine, Report by Chief Health Officer and Inspector General of Hospitals and Charitable Institutions, AJHR, H-31, 1920, p.7.

sanitary condition".¹¹⁵ The first decade of the NHNS had achieved the goal of assimilation. The nurses had enthusiastically taken up the Maori health crusade and had found endless opportunities to prove their worth.

Through the vehicle of their work with Maori, the Native Health nurses expanded the conventional boundaries of nursing practice and created a more complex and responsible role than could have been anticipated by Valintine and Maclean when they planned the development of the scheme. The Pakeha community was convinced that the nurses saved them from the ravages of infectious epidemics; the Maori themselves were generally willing to accept the help of the nurses especially during such epidemics as they had few strategies for dealing with introduced infections; and Health Department officials were singing the praises of the nurses as those who had successfully converted Maori to Pakeha ways.

¹¹⁵ Dr T. Valintine, Report by Chief Health Officer and Inspector General of Hospitals and Charitable Institutions, *AJHR*, H-31, 1920, p.8.

CHAPTER 5 - A CHANGE OF NAME AND A CHANGE IN FOCUS 1920-1930

This chapter briefly overviews administrative aspects of the decade 1920-30 in order to give a perspective of the direction the NHNS took during this time. The second decade of the NHNS was a time of consolidation and of loss. There was consolidation of the gains made in the previous ten years and then paradoxically, at the end of the decade, a loss of the whole scheme. Nursing continued to develop its role in the community through its branches in Native Health nursing, district nursing, school nursing and Plunket nursing. There was however, for the NHNS, a move in focus from the control of spread of infectious disease to health promotion and disease prevention particularly for women and children. There was also a change in name from Native Health nurse to Maori Health nurse. By 1930, the scheme in which nurses would provide nursing care specifically for Maori was superseded by a structure which had nurses providing public health nursing within a designated geographical area for all residents both Maori and Pakeha. They were now known as District health nurses and the role of the special nurse to Maori ceased to exist.

The events which most significantly influenced the NHNS between 1920 and 1930 were changes in the health service which had their roots in the 1918 influenza epidemic. A new Health Act was drafted in 1920 because of serious inadequacies in the previous legislation, the 1900 Health Act, which became evident during the influenza epidemic. There had been a serious depletion of Health Department staff during the war, which greatly increased the burden of work for those who were left to carry on. This burden reached a crisis point when the influenza epidemic broke out in November 1918. Controversy as well as tragedy surrounded the spread of infection from the ship 'Niagara' returning from the Pacific with the Prime Minister and the Minister of Finance on board when it was suspected that protocol was waived to avoid quarantine.¹ The

¹ Rice, *The Making of New Zealand's 1920 Health Act*, p. 10; Rice, G., *Black November: The 1918 Influenza Epidemic in New Zealand*, Wellington, Allen and Unwin, 1988.

epidemic revealed obvious legislative defects in the 1900 Health Act which were remedied by the rushing through of the Public Health Amendment Act in December 1918 and a more considered piece of legislation two years later. A major shortcoming was a lack of administrative structure and process to respond quickly to a devastating public health emergency. Other serious flaws were related to the inspection and demolition of insanitary buildings, overcrowding, closure of hotels and theatres, appointment of doctors to areas of special need and the establishment of regional health committees.² The aftermath of the epidemic brought strong criticism of the Minister of Health and his department for failure to quarantine the “Niagara”, failure to take adequate precautions against the epidemic and failure to prevent mortality.³

Between mid-October and mid-December 1918 at least 49% of the New Zealand population was suffering from influenza and in some areas over 80% of households were affected.⁴ Places where people usually congregated were off limits. Theatres, pubs and schools were all closed as public life ceased. Anybody with any medical or nursing background worked to exhaustion in the worst recorded natural disaster in New Zealand’s history. The overall death rate of the population of 1.15 million was 7.45 per thousand. Maori were the hardest hit with a death rate seven times higher than Pakeha.⁵ The Native Health nurses were stretched to the limit as they struggled to cope with such devastating mortality and morbidity. Ivy Driffill was undergoing nurse training at Rawene Hospital in Northland between 1916 and 1919. She contracted influenza herself, recovered from it and was therefore seen as an ideal person to help other sufferers. She spent two to three months riding into outlying Maori settlements on horseback with a bottle of whiskey and some tablets which she considered was about all she could do for the people.⁶ She was an able rider and covered about 80 kilometres per

² *ibid.*, p. 12.

³ *ibid.*, p. 11.

⁴ *ibid.*, p. 11.

⁵ *ibid.*

⁶ *Northern Advocate*, 12 June 1980.

day with the aid of a Maori escort. She became fond of the Maori people and was saddened to see so many die.

Just as Mason had been the instigator and architect of the 1900 Act, Robert Makgill⁷ seized the opportunity to put in place a legislative landmark which, it has been claimed, kept New Zealand's health system among the best in the world for the next 30 years.⁸ He had been recalled from the Defence Department to take over from Michael Herbert Watt⁹ as district health officer in Wellington for a short time and then on to Auckland to relieve Joseph P. Frengley. On his return to Wellington, Makgill called for new legislation to remove the uncertainties and loopholes which had contributed to the mismanagement of the epidemic. The Minister of Health, George Warren Russell,¹⁰ declared that "ill-advised retrenchment had been followed by neglect and indifference and for many years the Health Department had been starved and cramped."¹¹

Makgill's proposals for a new health act addressed the issues so sharply spotlighted by the influenza epidemic. The direct executive functions of the Health Department were identified and clarified as supervision of public health work by both the department and local bodies. It was also proposed that it be given mandatory powers

⁷ Robert Makgill was the first District Health Officer for Auckland. He had frequently offended the citizens of Auckland with his comments about the dirtiness of the city. Makgill had warned Valentine in 1910 of impending scandal if there was not more done for the health of Maori. An outspoken man, he had criticised Health Minister Russell's management of the Influenza Epidemic (Dow 1995).

⁸ Rice, *The Making of New Zealand's 1920 Health Act*, p. 21.

⁹ Michael Herbert Watt was recruited to the Health Department's Dunedin office from private practice in Ngaruawahia, north of Hamilton in 1913 and on to the Wellington office in 1917. He was a strong supporter of the benefits of vaccination at a time when there was not universal support even among medical circles. He was made Director of Public Hygiene in 1920 and was Director-General of Health 1930-47 (Dow 1995).

¹⁰ Russell, a former Wesleyan Church probationer, journalist and newspaper owner, took on the portfolio of Minister of Public Health, Hospitals, and Charitable Aid for a four month period in 1911. A volatile and sometimes intemperate man, his second term as Minister for Public Health began in August 1915. (See D. Dow 1995, p.86).

¹¹ New Zealand National Archives, H.3/1, p.634, cited in G. W. Rice, *The Making of New Zealand's 1920 Health Act*, p. 15.

to assume the duties of those bodies unable or unwilling to carry out their public health responsibilities. The role and function of the Board of Health was clearly proposed as having executive power in all health matters and that the Minister of Health should be excluded. This exclusion did not eventuate in the final version of the act.

A striking aspect of the reorganisation of the Department of Health under the 1920 Act was that among the proposed seven divisions there was to be a Division of Nursing with Maclean in the position of director.¹² Nursing had finally come of age. It had earned its place in the New Zealand health service with its own division. The Division of Public Hygiene was led by Dr Michael Watt, formerly district health officer in Wellington. A significant change in policy acknowledged that a stronger emphasis on Maori health needs was indicated and accordingly a division of Maori Welfare was established with Te Rangi Hiroa moving to the post of director from his position as District Health Officer, Auckland. Edgar Wilkins became director of School Hygiene. Thomas Hunter had been wartime Director of the New Zealand Dental Corps and was put in charge of Dental Hygiene. Davis Wylie was director of Hospitals having previously been in charge of the Dominion's military orthopaedic hospitals. Child Welfare came under the directorship of Truby King, Medical Superintendent of Seacliff Asylum but better known as the instigator of the Royal New Zealand Plunket Society which was established in 1908 with its goal to improve the health and save the lives of babies. In effect, the Plunket Society concentrated its efforts on the Pakeha population in urban centres where the Maori population was low, rebuffing Valentine's suggestion to combine with the Health Department's nursing services¹³ out in the districts where the Maori population was high. King claimed that the Plunket nurses aimed at the receptive, self-reliant classes and stated that the district nursing scheme (and presumably also the NHNS) were for "needy people seeking philanthropic aid or charitable doles".¹⁴

¹² It has been claimed that this was a change in title rather than function (Dow 1995).

¹³ Dow, *Safeguarding the Public Health*, p.81.

¹⁴ Cited in McKegg, *Ministering Angels*, p.32.

The 1920s signalled an international trend for a change in focus from a curative approach in health care delivery to a public health ideology. The previous decade in New Zealand had seen most effort going into containing infectious disease with a seriously understaffed department and legislation which failed to give any real power to health officers. The disaster of the 1918 influenza epidemic coupled with the rejection of thirty four per cent of men graded as unfit for service at the beginning of WW1¹⁵ effectively shook the country out of its complacency about the health care structure and delivery. Valentine's annual report in 1926 clearly articulated the Health Department's policy stating, "It is better policy to teach people to live healthily and to prevent disease than it is to treat them as irresponsible units for whom care has to be provided."¹⁶

For Maori health this change in ideology meant more effort was spent in educational and financial support for improved sanitation and living conditions. The Maori health nurses were looked to as being in a position to help with the implementation of this new public health philosophy in Maori communities. Under the leadership of Te Rangi Hiroa as Director of Maori Hygiene, there was a revival of the alliance between the Maori Councils and the Department of Health contained within the Native Land Amendment Act of 1919¹⁷ and a great deal of effective work was also carried out by the councils. Health education was the password of the day¹⁸ and wide dissemination of education about sanitation and hygiene was considered the most important activity in any public health programme. All nurses were encouraged to adopt a public health approach to their work whether or not they were working in the community as the principles were to be applied equally to patients in hospital as well as

¹⁵ Members of the National Public Health Committee of the New Zealand Registered Nurses' Association (Inc.), *The Story of Public Health Nursing in New Zealand*, *The New Zealand Nursing Journal*, June, 1956, p.119.

¹⁶ Dow, *Safeguarding the Public Health*, p.112.

¹⁷ *ibid.*, p.115.

¹⁸ Extract from the American Journal of Nursing, *What the Public Health Movement Expects of Nurses*, *Kai Tiaki*, July 1924, p.96.

in their own homes. Nurses were told that they should feel proud that their work in health promotion and disease prevention was recognised as being so important.¹⁹

Although outbreaks of typhoid were still occurring during the 1920s, the control of its spread was much more effective because T.A.B. inoculation became more widely available and was given to large numbers to prevent them contracting the disease.²⁰ Inoculation was not legally compulsory and there was certainly a level of coercion involved in getting people to agree to being inoculated. Some Maori particularly those who followed a spiritual and political leader, Ratana, objected to inoculation. Native Health nurses were urged by Te Rangi Hiroa, Director of Maori Hygiene, to persuade people to agree to inoculation by using the argument that if there was a high proportion of inoculated people in a settlement, they would be more likely to be free of restrictions, for example travel from one area to another, in the event of an outbreak. Furthermore, that should there be an outbreak of typhoid in a community that had refused inoculation, travel restrictions, the removal of all patients to hospital without the option of home nursing, and that the cancellation of hui, dances and tangi would automatically apply. With school children, it was advised that the nurses took it for granted that parents had consented unless they heard otherwise.²¹ Because transport was so difficult, hospital beds too few and some reluctance to go to hospital remained, patients were, in fact, often nursed in their homes as they had been in the previous decade.²²

A number of other factors contributed to a reduction in the numbers of typhoid cases during the 1920s. The Health Department recognised the cost effectiveness of providing affordable privies as a practical means of improving sanitation. For a sum of 15/-, a privy was delivered on site and as there became wider acceptance of this mode

¹⁹ Public Health Nurses, *Kai Tiaki*, April 1927, p.83.

²⁰ The Story of Public Health Nursing in New Zealand, *The New Zealand Nursing Journal*, June 1956, p.120.

²¹ Confidential circular to nurses from the Director of Maori Hygiene, July 5, 1922, H1 B.86, National Archives of NZ, Wellington.

²² The Story of Public Health Nursing in New Zealand, *The New Zealand Nursing Journal*, June 1956, p.120.

of sewage disposal the level of sanitation was said to have improved. Dr H. B. Turbott was satisfied with the changed living conditions for Maori in 1929:

The tendency is to get away from the pas. Better houses are being built, tanks are coming into favour for water supplies, the adoption of privies, general in some areas, is extending rapidly in the remainder. Huis and tangis are conducted in a satisfactory manner, suggestions for the betterment of sanitary arrangements being always attended to promptly.²³

It was claimed that the most convincing evidence of the effects of improved health status for Maori during the 1920s was a reversal in the downward population trend of the 1890s with a rise to 50,309 in 1906 and a further rise to 63,670 in 1926.²⁴ Mortality and morbidity statistics remained disproportionate, however, with the general death rate for Maori at 16.4 per 1,000 population compared with 8.5 for Pakeha. The infant mortality rate was considerably worse at 93.59 for 1,000 live births for Maori and 32.11 for Pakeha. The typhoid death rate reflected the same disproportionate trend with 1.28 per 10,000 population for Maori compared with 0.01 for Pakeha.²⁵

During 1922 Maclean signalled her intention to retire the following year. Jessie Bicknell was groomed to take over as Director of Nursing and in preparation for the role she was sent overseas to study modern trends in nursing and hospital administration. Bicknell was New Zealand-born, registered as a nurse in May 1903 after training at Nelson Hospital. She trained as a midwife in the first class of midwives, with Bagley, at the first St Helens Hospital which opened in 1904 in Wellington. She was appointed, again along with Bagley, as Assistant Inspector of Private Hospitals and Midwives and served with the New Zealand Army Nursing Service during the First World War, for which she was awarded the Associate of the Royal Red Cross.²⁶

²³ Maclean, *Challenge for Health*, p.204.

²⁴ Maclean, *Challenge for Health*, p.204.

²⁵ *ibid.*, p.205.

²⁶ Rodgers, 'A Paradox of Power and Marginality', p.285.

Shortly after her appointment as Director of Nursing in October 1923, Bicknell spoke at the New Zealand Trained Nurses Association Conference and made known her strong views about nursing education.²⁷ Maclean had previously opposed the suggestion of the need for a further qualification for nurses working in community settings stating that she did not believe any education over and above the usual three-year hospital-based training was called for apart from a course of lectures on special health questions and social problems.²⁸ Bicknell took an entirely different view. She proposed the establishment of a post-basic university based school of nursing.²⁹ The conference recommended that a five-year Diploma in Nursing be established at Otago University with a one year post-basic component also open to already registered nurses to provide them with specialist preparation for roles in public health, administration and teaching. There were two nurse lecturers required for this component of the Diploma. Janet Moore was sent to London to study nursing administration and teaching at Bedford College, University of London and Mary Lambie was sent to Toronto University to study Public Health.³⁰ The five-year diploma commenced in 1925 with three students but the postgraduate fifth year was held up waiting firstly for Moore and Lambie to return and then by an ongoing dispute between the university and the Health Department as to who was going to pay the salaries of the lecturers.³¹ The matter was never resolved and consequently it failed to get off the ground and was finally ditched after a recommendation from the Medical Committee to the Otago University Council to delete the entire five year programme.³²

²⁷ Rodgers, Nursing, p.70.

²⁸ Side note on document about the Health Visitor programme offered for nurses in England, H1 22926 21/33, NZ National Archives, Wellington.

²⁹ N. J. Kinross, Nursing Education in New Zealand: a developmental perspective, *International Journal of Nursing Studies*, 1984, 21(3), pp.193-199.

³⁰ Rodgers, Nursing, p.73.

³¹ B. Hughes, The Development of Nursing as a Profession in New Zealand, *The New Zealand Nursing Journal*, March 1978, p.19.

³² Rodgers, Nursing, p.77.

In order for nurses to put into practice the new paradigm of public health, there was a recognised need by some that, political wrangles aside, nurses needed more education than that which was currently delivered in their apprentice-style and hospital-based training. There was enduring support for university post basic nursing education, notably from Valintine, Watt,³³ Bicknell, the Minister of Health, James Alexander Young, and the hospital matrons at their inaugural conference in 1927.³⁴ Requests were made to the University of Auckland, University of Otago and also Victoria College (later to become University) to provide the programme. Meanwhile, the Department of Health was making an effort to meet the educational needs of nurses by organising for Moore and Lambie to deliver Refresher Courses in Auckland and Wellington on a range of topics from tuberculosis to child behaviour.³⁵ Eventually, an agreement was reached among Victoria College, the Department of Health and the Wellington Hospital Board to provide a six month course, which commenced on 26 February 1928,³⁶ for registered nurses preparing them for work as administrators, teachers and public health nurses.

Lambie had a significant impact on the Native Health nurses, who were renamed Maori health nurses in 1922.³⁷ After her return from studying at Toronto University she discovered with disappointment that the nursing education position promised to her at Otago University was not going to materialise. She took a further ten months unpaid leave to qualify as a midwife and returned to Health Department Head Office on April 1 1927 after a period of two and a half years' study and preparation for a position which had still not been finalised.³⁸ In the meantime, she was employed as a supervising public health nurse and it was in this position that she had a great deal of influence over the Maori Health nurses. Her teaching role, once it was established, was for six months of

³³ Memo from Dr M. Watt, Director, Division of Public Hygiene, to the Deputy Director-General of Health, Wellington, March 7, 1921, H1 22926, NZ National Archives, Wellington.

³⁴ Rodgers, *Nursing*, p.82.

³⁵ *ibid.*, p.125.

³⁶ Lambie, *My Story*, p.64.

³⁷ Dow, *Safeguarding the Public Health*, p.83.

³⁸ Lambie, *My Story*, p.57.

each year and she continued with public health nursing supervision for the remaining six months. The community based nursing staff of the Health Department at that time consisted of 50 school nurses and 20 Maori Health nurses, of whom there had been no increase in number since 1920. These nurses worked independently of each other and were attached to one of four District Health Offices. The Auckland district covered from North Cape to south of Taumaranui. The Wellington district extended from East Cape across to the Awakino River on the west and went south as far as Nelson and Marlborough in the South Island. The Canterbury district included the area down to the Waitaki River and the Dunedin district covered the remainder of the south.³⁹ The district nurses working out in communities were employed by hospital boards.

From 1927 on, Watt and Lambie formed a medical-nursing partnership to equal the MacGregor/Neill and the Valintine/Maclean partnerships that preceded it. Watt became Director General of Health in 1930 on Valintine's retirement and Lambie became Director of Nursing in April 1931 when Bicknell retired and on Watt's recommendation to the Public Service Commissioner.⁴⁰ The public health backgrounds of both these influential leaders caused them to concentrate their attention initially in this field. Watt had travelled to Canada and the United States in 1925 to observe country health units and returned convinced that the size of New Zealand's health districts made them unmanageable because of the distance from administrative support of those working in the field. He was also convinced that the Division of Maori Hygiene was a wasteful duplication of resources.⁴¹ He gained Ministerial support and Lambie's help to make a survey of three smaller districts in Taranaki, North Auckland and the East Coast in order to establish the exact number of nurses working in these districts in various roles, whether there could be a better distribution of nurses, whether there were sufficient numbers and what would be required to develop a general public health nursing service.⁴²

³⁹ Lambie, *My Story*, p.58.

⁴⁰ *ibid.*, p.72.

⁴¹ Dow, *Safeguarding the Public Health*, p.117.

⁴² Lambie, *My Story*, p.58.

Lambie saw public health nursing in an entirely new light. Her previous work had been in the South Island where the Maori population was much less than the North and she had no experience in considering the special health needs of the Maori. Her hands-on approach to the survey took her out to spend two or three days with each of the nurses working in this district and she experienced conditions that were totally new to her. She was critical of Bagley who was still supervising the Maori Health nurses from the Auckland District Health Office:

She knew the nurses and corresponded with them, and would see them in her office, but she had never worked with them.⁴³

Lambie obviously had no appreciation of Bagley's work in the NHNS and that she had in fact personally initiated many of the nurse clinics in Lambie's surveyed areas and had nursed in the area often for many months until a nurse could be recruited to the position. On the contrary, it was Lambie who was only just coming to appreciate the difficult conditions under which the nurses lived and worked. She commented on the spartan nature of their living quarters and the lack of financial support for their travel needs:

One nurse had even used an insurance policy to buy her car. The majority had to manage as best they could with public transport and a bicycle or horse, and where there was no public transport they had to borrow rides in butchers' carts or any other conveyance that might be available in the district.⁴⁴

She found that there was little health promotion and disease prevention going on and that the nurses' time was being taken up, much as it had been in the previous decade, with teaching people to look after sick family members in their homes. She commented that the nurse were very ignorant of the principles of social work, citing the example that groceries and supplies would be given to poor families with no thought to their future development.⁴⁵ She also found that some areas were far too extensive for one nurse while in others there was an overlap of Maori Health nurses and District nurses.

⁴³ *ibid.*, p.58.

⁴⁴ *ibid.*, p.59.

⁴⁵ *ibid.*, p.59.

Once her position as post-basic nurse educator commenced, Lambie continued to make supervision visits to the Maori Health nurses in the six months of each year that she was not teaching. Her reports of these visits were submitted to the respective Medical Officers of Health and to Bicknell as Director of the Division of Nursing. It is unclear how her work interfaced with Bagley's. In 1930, she made an extensive visit to the North Auckland, Auckland and South Auckland districts and in her report⁴⁶ made a number of observations and recommendations that had far reaching consequences for Maori Health nursing. She found that, if a second nurse could be stationed in the northern part of the very large district of the Bay of Islands using the subsidy currently paid to medical staff, Nurse Hall would be relieved of a great deal of her area and could be more effective. In a similar vein, she recommended that if the district nurse in the northern part of Nurse Jewiss' large Mangonui area could take over the health care of Maori also, that Jewiss could more efficiently cover the areas closer to her station including Whangaroa, which had been inefficiently covered by another nurse from a distance. There were further recommendations along the same lines so that there was a general restructuring of the nurses' geographical areas of responsibility. The distribution of the nurses workload on the basis of geographical area was of more significance than the ethnicity of the population. As each nurse took on a smaller district she was expected to provide public health nursing to all residents regardless of whether they were Maori or not. As the economic depression of the late 1920s took hold, these recommendations to use existing resources with greater cost-effectiveness would have held substantial appeal to the policy makers. The entire notion of special nurse to the Maori was phased out.

The economic climate undoubtedly had a significant influence on the decisions made in all areas of health spending at the time. The great depression was a catalyst for retrenchment in all Government Departments and the Maori Hygiene Division was a one of the casualties. Te Rangi Hiroa had resigned 1927 for a position as ethnographer at the

⁴⁶ Memo re Visit of Inspection to district Nurses in the Auckland Area from M. I. Lambie to the Director, Division of Nursing, H1 23600 23/612, NZ National Archives, Wellington.

Bishop Museum in Hawaii. His replacement was Dr Edward Pohau Ellison.⁴⁷ He was not as able or as respected as Te Rangi Hiroa and after his resignation in 1930, the Division of Maori Hygiene was conveniently wound down. Watt had just taken over from Valintine as Director-General of Health and integration of Maori health with the general work of the health districts had been his goal for some time. Valintine and Makgill both resigned in 1930 and were awarded the CBE for their services - the former to public health, the latter to hospital services.⁴⁸ Bagley resigned on October 31 1930 after thirty four years of nursing service.⁴⁹ With Bagley and Valintine gone, there were no others with influence who believed that the health problems of Maori warranted special attention over those of the general population.

During the 1920s the Native Health Nursing Scheme had undergone a number of changes. The title of the nurses had changed, they were expected to have post basic education and to work in health promotion and disease prevention and then the special nature of their work with Maori slipped away. Their client base changed to include all residents in a smaller district. It is clear that they would have had to spend less time and money travelling and therefore would have had more time for nursing. It is, however, beyond the scope of this study to examine the health effects for Maori of these changes in health policy.

⁴⁷ Edward Ellison was the third Maori medical graduate from Otago University in 1919 and was the Medical Officer to the Cook Islands prior to his appointment in the division of Maori Hygiene.

⁴⁸ Rice, *The Making of New Zealand's 1920 Health Act*, pp.3-22.

⁴⁹ Kai Tiaki, *The New Zealand Nursing Journal*, January 15, 1931, p.24.

CHAPTER 6 - CONCLUSION

The nurses who worked in Maori communities in New Zealand during the second decade of this century developed an identity and a role which enabled them to make unparalleled gains in reputation and standing within and for the profession as a whole. It was through this exercising of their agency that they constructed:

... an identity, a life, a set of relationships, a society with certain limits...¹

The building of the role with its unique function and responsibilities was, however, at the discretion of the Maori people who were in a position to either accept or reject the nurses' claim to this new professional territory. While there was mutual need between the nurses and Maori there was also mutual benefit. The reduced health status of Maori particularly in the face of infectious disease introduced at the time of colonisation created a need for health care which the nurses enthusiastically provided and in so doing took up a unique opportunity to develop the scope of nursing influence and territory.

Several concurrent and interconnected undercurrents, laden with the discourses of gender, class and race, provided the arena for the development of the NHNS as the vanguard movement for far greater autonomy and independence for nursing than had been customary in the hospital setting. Nurses were actively seeking professional identity and status within the health care context of colonial New Zealand in the period 1911-1920. The dominant ideology and infrastructure of the time, however, had constructed a health service that constrained the practice of nurses to a position of limited status and power. The struggle for nurses was one of professional identity and status in a health service dominated by men both as doctors and as bureaucrats. The focus of the NHNS was the serious health problems of Maori because of the devastating effects of infectious diseases introduced following colonisation. This practice context provided the Native Health nurses with unprecedented opportunities to prove themselves in a new role.

¹ J. Scott, Gender: a useful category of historical analysis, *American History Review*, 91(5) p.1067.

During the period 1900 to 1910, there were significant changes in the health care system, within the nursing profession and with regard to health care for Maori, which constructed an environment for the emergence of the Native Nursing Scheme. Public health legislation signalled recognition by Government that local authorities had not taken their responsibilities seriously enough and that a Health Department with its own officers was the answer to the lack of coordinated action. It was during this time that there was a rapid rise in status of nursing as a registered profession that personified all that was worthy and respectable in the Victorian woman. As such, nurses were seen to be worthy of a position of trust in the hospital as well as in society generally. It was this change in status that paved the way for the move from the hospital setting to the community and strategically positioned the Native Health nurses to make the most of this opportunity to develop an expanded role. The decade had, however, spelt disaster for Maori seeking self-determination in health care. The Maori Health Nursing Scheme provided nursing services to Maori as a Maori initiative, and was administered by the Native Department. In 1911 the Health Department abolished the scheme and replaced it with the Native Health Nursing Scheme, displacing an important Maori health initiative with a Pakeha dominated one. The social and political context in which the NHNS was launched can be viewed through discourses of gender, class and race which informed relationships between men and women, between Maori and Pakeha, between those with political power and those with limited power.

The NHNS steadily developed over the period 1911-1920 providing a unique opportunity for nurses to prove themselves as effective, capable practitioners who could take on a public health role not previously seen as the domain of nursing and this consequently raised their professional status. In 1910, Amelia Bagley was the sole nurse employed in this scheme. By 1920, there were 20 Native Health nurses and there was support for further expansion. With no formal preparation for their new role, with minimal administrative and professional support, and often located in isolated areas these nurses provided a service to the sick, contained infectious epidemics, and gave health education by adapting not only the technical aspects of their work to suit the conditions but also the way in which they developed relationships in rural communities

with a high Maori population. The success of the Native Health nurses in limiting the spread of infectious disease was a key indicator of their success.

Those Native Health nurses who were effective demonstrated uncommon commitment, dedication and skill in their work in Maori communities. While the scheme was not staffed solely by Maori nurses as was the vision for the original Maori Health Nursing scheme, the nurses adapted their practice so that, in general, they collaborated effectively with the communities in which they lived and worked. Distrust of Pakeha hospitals and Pakeha health practices was to some extent averted when the nurses provided care in their community-based clinics or in local field hospitals during epidemics of infectious disease. The nurses who were able to assist Maori communities deal with their plummeting health status in the wake of colonisation were those who developed trust by respecting the health beliefs and practices of Maori. It was not only the adaptability of the Native Health nurses which underscored the change in role. They were required to have personal resources which would enable them to cope with the exceptional hardships encountered in the course of their work.

The Native Health nurses were uniquely positioned to exercise agency by developing the role of the nurse as an independent practitioner in the community. Geographical isolation, distance from traditional hierarchical supervision and the urgent health problems of Maori created the context for these nurses to develop the skills and knowledge from their hospital based training in a new way. As agents for autonomous nursing practice, these nurses were the vanguard for professional change. The nature of their work required them to develop aspects of practice that up until then had not been viewed as conventional nursing work.

Four key areas cumulatively contributed to the change in role accomplished by the Native Health nurses. Their work took on an element of living and working closely with Maori communities in a social role not previously considered the domain of nursing. In order to be effective, they were required to adapt their practice so that they were culturally acceptable to Maori communities. Health promotion and disease prevention became a major focus for the Native Health nurses in contrast to the illness

care which had been central to their hospital training. The remote nature of their work extended their scope of practice to include responsibilities not previously expected of the nurse. At times, it was necessary for them to make diagnoses and decisions about medical care which were previously strictly the domain of doctors. These changes created the impetus for a major change in the scope and approach to practice which in turn earned for these nurses a new-found respect and eventually contributed to an increase in status and power for the profession as a whole.

As the nurses established a sound reputation as being crucial to the Health Department's answer to dealing with the health problems of Maori, there was in turn a higher official profile given to Maori health needs. Earlier in the decade great emphasis was placed on the control of disease² and the work of the Native Health nurses in this respect was hailed as an unqualified success.³ Even though there was difficulty enlisting sufficient nurses to this scheme because of the nature of the work, Maclean and Bagley carefully selected the nurses to ensure that they were of suitable moral and professional calibre. By 1920, there were 20 nurses attached to the service. Sanitary conditions had significantly improved and consequently outbreaks of typhoid were more under control. Generally, there was praise by Maori for the nurses' work and many districts were asking for their own nurse. The cost-effectiveness of the NHNS was recognised in terms of the early recognition, isolation and treatment at the outbreak of infectious disease⁴ and a decrease in the fear of hospitals by Maori which resulted in cases of serious illness being transferred to hospital thereby freeing up the Native Health nurse for health teaching.⁵ Te Rangi Hiroa, appointed Medical Officer of Health for Maori in 1920,

² *AJHR*, H-31, 1911, 1912, 1913.

³ Report of Dr. T. Valintine, Inspector General of Hospitals and Chief Health Officer, *AJHR*, H-31, 1913, p.65.

⁴ Annual Report of the Director Division of Maori Hygiene, Te Rangi Hiroa, 14 May 1926, H1-12197, National Archives, Wellington..

⁵ The Work of Nurses in a Government Department and Under Local Authorities, 79-032-12/2, Alexander Turnbull Library.

considered that the nursing branch of the health work among the Maori to be the most effective and that it should be assisted and pushed on more than any others.⁶

Valentine himself was especially pleased with the scheme that he had put in place out of the ashes of the Maori Health Nursing Scheme and made regular positive comments regarding the nurses in his annual reports to Government. His 1920 report provides a most explicit endorsement both of the scheme and of the nurses by recognising that objectives set for them by him had been achieved. He recorded that, in his opinion, the continued policy of supplying nurses to Maori had resulted in considerable improvement in sanitary conditions and that within a few years he expected that the standards of hygiene for Maori would have approached that of Europeans.⁷ The first decade of the NHNS had concentrated on the goal of assimilation. The nurses had enthusiastically taken up the Maori health crusade and had found endless opportunities to prove their worth.

Through the vehicle of their work with Maori, the Native Health nurses expanded the conventional boundaries of nursing practice and created a more complex and responsible role. Along with district nurses they developed a degree of independence and autonomy beyond that of nurses working in hospitals. A key difference between the District nurses and the Native Health nurses, however, was that, in order to be accepted into Maori communities, the Native Health nurses had to take into account cultural differences in health care, beliefs and practices. This relational aspect of their work was the key to gaining the respect of the community which was a prerequisite for having any influence either in sickness care or in health promotion. Through the work of the Native Health nurses the Pakeha community was convinced that it had been kept safe from the ravages of infectious epidemics and Health Department officials were singing the praises of the nurses as those who had successfully converted Maori to Pakeha ways. The social and political environment of

⁶ Dr Te Rangi Hiroa, Report on the Health of Maoris, *AJHR*, 1920, H-31.

⁷ Dr T. Valentine, Report by Chief Health Officer and Inspector General of Hospitals and Charitable Institutions, *AJHR*, H-31, 1920, p.7.

the time created hierarchies which limited the power of women and of Maori. Yet the watershed of Maori health needs and the desire to take up professional challenges by nurses came together to raise the profile of both these groups.

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15511 23/21/29	Nurses to Maori at Pipiriki
B125 194/1/5	Native Health Whangarei
13303 36	

New Zealand National Archives, Auckland

BAAA 1003	(Batley) Tanoa Maori School Log Book
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Auckland Catholic Diocese Archives

Cleary 96-2 29	Cleary to Miss Bagley (Health Dept)
Cleary 96-2 30	Minister of Health to Cleary 11.2.1925
Cleary 96-2 38	Maui Pomare to Cleary 27.8.1925
Cleary 96-4	Correspondence re Influenza Epidemic, 1918
Cleary 106-3	Bay of Islands
Cleary 110-3	Panguru
Cleary 110-4	Pawarenga
Cleary 110-5	Rawene
Cleary 110-6	Purahau
Cleary 110-7	Totara Point

Cleary 111-3	Kaitaia
Cleary 114-3	Northern Wairoa
Cleary 124-4,5	Whangarei
Cleary 124-6	Whangarei
Cleary 127-1	Marist Sisters
Cleary 127-4	Sisters of St Joseph
Cleary 97-5	Child Welfare
Cleary 102A-1	Needy Missions
Cleary 89-1,2 90-1,2 86-2,3 87-1,2	Letter Files
Cleary 77-15a	Motoring in the North

Auckland Institute and Museum

Nursing 452	Clipping NZ Herald 13.3.1964, Miss Alice Hall
Nursing D246	Clipping Northern Advocate 12.6.1980 Miss Ivy Driffill
MS 1684	G. Way Papers
M1053	Maori Medical Corps in South Africa During the Boer War
MS 1708 88/117	Nesta Kinder
MS 897	Miscellaneous items collected by Joan Rattray

Alexander Turnbull Library, National Library of New Zealand, Te Puna Mātauranga o Aotearoa, Wellington

NZNA Files

79-032-12/2 Government Regulation of Nursing

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MSC/46 LC 38 Lillian Hill

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H-7a 1884

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H-3 1889

H-11 1890

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