Public virtue, private ambition: The quiet rise of entrepreneurial women in New Zealand's private hospitals 1890-1935

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Abstract

Historians say that nursing in New Zealand became professionalised while riding the first wave of feminism in the late nineteenth century. This was supposedly achieved by preserving the doctor-nurse hierarchy, thus presenting no threat to the medical man's status or prejudices. Social norms of the time meant nurses generally worked until they were married but for those who remained single or who became single through death or divorce, it offered a career path and an opportunity for independence in a feminine and socially acceptable vocation. By the early twentieth century, New Zealand's health service had evolved into a two-tier system of Government-owned public hospitals in most of the country's major towns supported by a network of private hospitals predominantly owned by nurses and midwives. The strong legislative framework introduced between 1901 and 1906 requiring nurses, midwives and their hospitals to be registered, licensed and regularly monitored could potentially have put a straight jacket around the industry. Instead it required women to be politically, financially and vocationally savvy to meet the exacting standards of the evolving regulatory environment. This proved to be fertile ground on which many women were able to succeed. This thesis argues that the creation of this significant social and commercial space dominated by women breaks with the traditional idea of nurses as carers and handmaidens to the doctors and positions them as enterprising, independent businesswomen with authority and agency within their hospitals and a new power dynamic between themselves and the medical community.

Acknowledgements

I embarked on this research curious about the reasons behind a woman's choice to opt for a nursing career in early twentieth century New Zealand. The initial focus was on those who rose through the ranks to become a matron as matrons, anecdotally, had reputations as formidable, impressive women who were not to be trifled with. Nothing in my research has changed that opinion. What emerged early on, however, were the number of women involved in either private nursing or who worked at private hospitals. In piecing together how and where this fit within the wider health sector it became apparent that the matron of a private hospital was almost always the owner of the business. Any thoughts that these were small three or four bed maternity hospitals were quickly dispelled as the owners and operators of some of the country's largest private medical and surgical hospitals were also part of this group. It also became clear that private hospitals were critical to the provision of healthcare in New Zealand and so became enshrined in legislation that ensured they could continue to survive. And so, the focus narrowed and the adventure began in teasing out who, how many, where and why these women chose to, and were able to choose to, take the plunge into private hospital ownership.

An enormous vote of thanks goes to my supervisors Professor Michael Belgrave and Dr Carol Neill who have been constant, insightful, motivating and kind in their rigorous oversight of this process. One of the major challenges has been corralling the myriad data from diverse sources in a way that becomes both meaningful and compelling. Archives New Zealand in Auckland and Wellington were essential resources as were records sourced through local councils and libraries. The *Papers Past* database with *AJHRs*, newspapers and journals were also invaluable in building a story. Michael and Carol's guidance through this has been excellent. My thanks too to the study group whose shared frustrations, ideas and collaborations through the wonders of zoom have made this otherwise solitary process enjoyable.

On a personal note, special thanks to Ant, Seb and Georgie for your patience and support, and for sharing this dream with me. Mum, you are an inspiration and were probably a matron in a past life! Friends and family – your messages, food parcels and constant enquiries as to progress have kept me going. You know who you are. Thank you.

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Introduction

When Miss Kassie Turner of 'The Limes' Hospital in Christchurch died in 1922 her obituary in the nursing journal *Kai Tiaki* mourned the loss of 'one of its most honoured and beloved members'.[1] Her career developed alongside the changes that marked the professionalisation of nursing in New Zealand. Her story is an illustration of the opportunity for independence that private hospital ownership and management created for women in the feminine, caring and socially acceptable vocation of nursing. Miss Turner began her career in 1893 as a probationer when nurse training had just begun at Christchurch Hospital and was on an upward trajectory when she became the owner and licensee of one of the garden city's most popular private hospitals. In doing so, Miss Turner demonstrated her ability to be independent, entrepreneurial and successful in an era where both the medical landscape and nurses themselves were becoming more regulated and increasingly subordinate to medical practitioners and hospital administrations.

This thesis is about a group of women who, like Miss Turner, in early twentieth century New Zealand, stepped outside the state sector and achieved a degree of financial and professional independence for themselves and their families by carving out their own business careers. As owners and licensees of private hospitals they became integral to a healthcare sector that was changing dramatically under the Liberal government intent on using regulation to bring order and purpose to its rapid expansion. A nurse's agency as a licensee also shifted the power balance between her and the doctors she worked with to create a more mutually beneficial relationship. Miss Turner's business ambition and commitment to her profession, like many other women in this thesis, also helped her develop a business acumen that might otherwise have had few outlets and opportunities during this period. This thesis will show how the changing environment, rather than stifling opportunities for nurses in fact created gaps where those who chose to could step into their own domain with agency and self-determination.

[1] "Obituary," *Kai Tiaki: the journal of the nurses of New Zealand* XV, no. 4 (1 October 1922): 183, https://paperspast.natlib.govt.nz/periodicals/KT19221001.2.44.

As with many private hospitals of the time, Miss Turner's first venture began in her home with mainly maternity patients. By 1904 the hospital had outgrown its modest accommodation and, with her sister Alice Annie Kirk, she bought Dr Irving's premises on Victoria Square to convert into the private hospital The Limes.[2] Under her stewardship and with her sights set on what Geoffrey Rice described as 'the top end of the market', The Limes served an ever-increasing number of medical, surgical and maternity patients to become one of the city's leading private hospitals.[3] To meet demand, Miss Turner added another wing to her hospital following a six-month trip to England. Newspaper reports suggest her trip was designed to compare English hospitals with New Zealand's and identify best practice to bring to her own establishment.[4] The fact that her sojourn was regarded as newsworthy is an indication of the profile she had built within the city and the credibility she had earned.

At this time, all licensed private hospitals in New Zealand were subject to the standards set out in the Private Hospitals Act 1906. This was another step in the new regulatory environment designed to control a rapidly burgeoning industry. As the licensee, it was Miss Turner's responsibility for The Limes to meet those standards. Seeking out best practice and continuing her own professional development, along with adherence to the regulations, was part of ensuring this happened. Miss Turner died in 1922 leaving The Limes to her brother and brother-in-law on the condition that it continued to operate as a hospital.[5] Her wishes were honoured until 1937 when the site was acquired by the City Council for the construction of a new town hall and, in a nod to the history of the site and Miss Turner's legacy, one of the chambers in the building is still known as The Limes.

Miss Turner's story is not uncommon in colonial New Zealand. Hers was one of many large families from the United Kingdom that, in settling in the colony, worked in diverse ways to create essential services to both emulate and align with 'Home' while at the same time grappling with New Zealand's harsh remoteness and cohabitation with the indigenous Māori

[2] Geoffrey W. Rice, *Victoria Square: Cradle of Christchurch* (Christchurch: Canterbury University Press, 2014), 168.
[3] Rice, *Victoria Square*, 168.
[4] "London personals," *New Zealand Times* (Wellington), 30 September 1912, 8239, 7.
[5] Rice, *Victoria Square*. 214

population. Miss Turner's mother died relatively young and her father remarried, producing another four children with her after their arrival in New Zealand to carry on the family name. Charles Wesley Turner was an entrepreneur seemingly suited to the precarity of the New Zealand environment who enjoyed notable successes and spectacular failures not least the bankruptcy of the failed shipping and property company Peacock and Co in 1867.[6] Just a half a dozen years later he moved to London to open an office of the New Zealand Shipping Company, securing a fleet of ships which would revolutionise New Zealand's export and passenger trade before returning home to continue his business endeavours.[7]

One of three unmarried women in the family, she was determined to forge her own path, starting her nurse training at 29 at the newly established programme at Christchurch Hospital. She is one of the first nurses to appear on the Register of Nurses, the document of record for all New Zealand nurses who had completed a training programme in New Zealand or at a recognised institution overseas, as laid out in the terms of the Nurses Registration Act 1901. The Act marked a significant milestone in New Zealand's nursing history and, as the first of its kind in the world, set the benchmark for the professionalisation of nursing internationally. During Miss Turner's eight-year tenure at Christchurch Hospital she rose through the ranks to become Sister of the Men's Accident Ward before leaving to further her training – this time as a maternity nurse at the midwifery programme at the St Vincent's Hospital in Sydney. A year later she returned to Christchurch and opened her first private hospital.[8]

What Kassie Turner's story reveals are attitudes and achievements in her life that fly in the face of commonly held views about women in general and, as the focus of this thesis, nurses in the early twentieth century. Miss Turner was a successful, independent woman who created a well-respected business in one of New Zealand's largest cities.[9] Nursing as a profession had evolved hugely from the slovenly, domestic-servant role degradingly depicted by Charles

[6] "Turner, Charles Wesley," An Encyclopaedia of New Zealand, Te Ara - the Encyclopedia of New Zealand, 1966, 2022, https://teara.govt.nz/en/1966/turner-charles-wesley.
[7] McLintock, "Turner, Charles Wesley."
[8] "Obituary, KT ".
[9] "Obituary, KT ".; Rice, *Victoria Square*, 169.

Dickens' Sairey Gamp to the noble Florence Nightingale, heroine of the Crimean war. Nightingale's staunch but feminine depiction of nurses as caring and capable women of good character had elevated the profession into a redefined role within the healthcare framework. This use of feminine qualities as a prerequisite for nursing work has been described as a deliberate tactic to legitimise the professionalisation of nursing.[10] Whether deliberate or not, New Zealand nurses forged ahead to continue their professional development through the establishment of their own nursing organisation, they travelled outside of New Zealand to secure additional qualifications and they fought hard to ensure that their New Zealand qualifications had reciprocity that would sustain their mobility and capacity to work in other places.

Methodology

This research has been inspired by a curiosity about and fascination with a group of nurse entrepreneurs in the late nineteenth and early twentieth centuries. Their back-stories and reasons for either choosing or finding themselves as entrepreneurs and professionals in a traditionally male-dominated world were as individual as the women themselves. Examining them separately in granular detail – their family histories, life experiences, professional choices and public personas – helps to draw a series of portraits which exemplify a wider cohort of women. This thesis will show that while their public nursing personas as nurturers and carers sat comfortably alongside traditional feminine attributes expected of women at this time, the nurses who took the next step into hospital ownership and management carved out a distinct space in the public sphere of commerce and business, otherwise regarded as a male domain. Understanding this environment and their achievements reveals new insights into how women came to dominate the burgeoning private hospital industry, facilitated by an evolving public health sector and its inspectorate and bureaucrats, in spite of the traditionally male-dominated medical profession. This is, however, a story about only pakeha women. In the period of focus for this thesis 1890 to 1935, while there was a growing cadre of Māori nurses around the

[10] Eva Gamarnikow, "Nurse or woman: Gender and professionalism in reformed nursing 1860-1923," in *Anthropology and nursing* ed. Pat Holden and Jenny Littlewood (London: Routledge, Taylor & Francis Group, 2016), 110.

country, their numbers were still relatively small and no evidence was found of a Māori woman owning a private hospital.

The starting point for this research came through a search of the Register of Nurses Volume 1 for women who had risen to positions of authority and influence in the nursing sector. The Register recorded in beautifully hand-written script the names of each nurse who registered from 1902 when the Nurses Registration Act 1901 was enacted. Volume 1 contained 3419 names from 10 January 1902 through to 18 August 1922.[11] The Register states the hospital where they trained, the date of their registration and, occasionally, when they retired from nursing. A separate register for midwives was started following the Midwives Act 1904 which shows their Class A or Class B status, based on whether they were formally trained (Class A) or untrained but with at least four years practical experience (Class B). Using resources such as the nursing journal *Kai Tiaki* and local newspapers in *Papers Past* as well as genealogical websites such as Ancestry.com, Find My Past and Familysearch.org helped to build a picture while cross-referencing for accuracy some, but certainly not all, of the names on the respective registers. The initial approach was to research the backgrounds of at least 50 nurses to see what patterns or issues emerged that warranted further investigation. In recording the nurses' details and finding snippets of their life stories, personalities began to emerge. Stories of businesses, community standing, reputation and commercial success became evident. Some had experiences of war. Some immersed themselves in the city environment, others took on the challenges of small-town New Zealand. Some worked in the state system, some went private nursing into the homes of more well-to-do New Zealanders. Others, who have come to be the focus of this research, started, built or bought into private hospitals.

As the emphasis of this study shifted towards private hospitals, so too did the criteria for research. Rather than being solely driven by what information could be accessed about the nurse licensees, availability of archival material on the hospitals also became an important criteria. National Archive files for individual hospitals revealed a wealth of information,

[11] Nurses and midwives board, "Register of nurses: Nos. 1 — 3419," (Wellington: Nurses and midwives board, 1922).

although many were incomplete and provided a snapshot of information rather than the complete timeline of a particular hospital. Forty-four hospital files as well as seven additional background files included correspondence between hospital owners, nurse inspectors, community members and various government officials. Of these, 12 hospitals were licensed for medical and surgical procedures, 29 for maternity cases and three were unsuccessful applications for hospital licenses. Auckland Council archives provided rates information for some of the Auckland Hospitals and Oamaru Council archives were also able to furnish some background information about private hospitals there. Each of these hospital files was thoroughly reviewed and their stories fleshed out, where possible, with information gleaned from *Papers Past*, genealogical websites, family histories and local museums or historical groups. This created a balanced and broader picture drawn from official documentation and informal reporting. Shifting the focus this way became central to ensuring that the data and narrative compiled in this thesis was robust and illustrative while at the same time retaining the energy and authenticity of the individual women who were central to the story.

Working through these various sources, the questions that were central to guiding this research were:

- What were the circumstances and background – personal and professional – which contributed to a nurse's decision to establish or take over a private hospital?
- Were there particular challenges or issues that influenced her experiences as a private hospital licensee?
- What conclusions could be drawn about her business, her community standing and her relationships with departmental and medical contacts?
- How does this person's story contribute to the premise of this thesis that these nurses navigated a changing social and medical landscape to secure their own niche as well as independent businesswomen with agency?

By using this framework common themes began to emerge along with some interesting case studies of individual experience. This was mostly driven by availability of information which then needed to be cross-referenced with different sources in order to contextualise and gain perspective on individual findings. For example, in the case of Nurse Alice Clymo in Paeroa, the National Archives file on her Arohanui Hospital revealed the challenges presented by the depression years, the low-income community in which she worked, the financial challenges that

this created for her and the difficult relationship she experienced with one of the local doctors. On the basis of this information alone it would have been easy to conclude that she was hampered by the circumstances in which she operated and potentially suffered as a result. Instead, by searching for references to her in *Papers Past* another, more robust version of Nurse Clymo emerged who was a respected community member who served Paeroa for 16 years, hosted bridge parties and judged baby competitions while providing employment and accommodation for herself and her sister's family at the hospital.[12] In addition, genealogy sites showed she was probably born in Cornwall in 1871,[13] completed her midwifery training in England in 1908[14] and arrived in New Zealand as a single woman in her late 40s in 1919 ready to carve out a new life.[15]

The nomenclature of the nursing community formed an interesting aspect to this study in that there appeared to be no formal structure to nursing titles within the private hospital sector. This provides another small and yet significant indicator of the self-determination afforded these women as they assumed their roles as managers and licensees. For example, in correspondence between the Department of Health and Alice Clymo she is referred to as Miss Clymo but in her own advertising she refers to herself as Nurse Clymo and is also referred to this way in published newspaper birth notices.[16] Kassie Turner, on the other hand, refers to herself in her advertising as Miss K. Turner, while in newspaper articles her hospital is referred

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[12] "Social Gatherings," *Auckland Star* (Auckland), 22 August 1932, 10, https://paperspast.natlib.govt.nz/newspapers/auckland-star/1932/08/22/10.; "Successful fair and Paddy's Market at Turua last night," *Thames Star* (Thames), 4 March 1932, 2, https://paperspast.natlib.govt.nz/newspapers/thames-star/1932/03/04/2.

[13] "Births registered in January, February and March 1871: Truro, Cornwall," (England & Wales Births 1837-2006: Find My Past, 1871), 98. https://search.findmypast.com.au/record?id=BMD%2FB%2F1871%2F1%2FAZ%2F000125&parentid=BMD%2FB%2F1871%2F1%2FAZ%2F000125%2F335.

[14] Ancestry.com, "The Midwives Roll 1904-1959," in *Reference b24389596_i13779497* (London, England: Central Midwives Board, 1910), 208.

[15] "Names and descriptions of British passengers embarked at the port of London," in *Passenger lists leaving UK 1890-1960* (England: Find My Past, 1919). https://www.findmypast.com.au/transcript?id=TNA/BT27/0901000093/00038.

[16] "Wanted known," *Waihi Daily Telegraph* (Waihi), 6 February 1923, https://paperspast.natlib.govt.nz/newspapers/WHDT19230206.2.37.8?end_date=31-12-1950&items_per_page=100&phrase=2&query=Clymo&snippet=true&sort_by=byDA&start_date=01-01-1923.

to as 'Sister Turner's'.[17] For the purposes of this thesis, the way women featured will be referred to will be determined, where possible, by how they refer to themselves. This will result in a range of titles including 'Nurse', 'Sister', 'Matron', 'Miss' or 'Mrs'.

Academic literature about this small but important sector of New Zealand's healthcare history is sparse and generally presented in the wider context of the country's nursing history.[18] The same can be said for much of the international literature. Chapter One will review the literature and explore attitudes towards women in early twentieth century New Zealand alongside the historical analysis of nursing in New Zealand. It will show the blurry and often confused lines drawn between the public and private spheres in which women functioned. As a backdrop to this the literature will show the influence of the Liberal government's campaign to legislate the country into a more ordered, better Britain, the aspirational shift that occurred with access for women to education and employment, and the effects of World War One on women's roles generally all of which created opportunities for this cohort of nurses. Chapter Two shows the effect of the changing legislative environment that enabled nurses to carve out a distinct space within the medical landscape whilst retaining the soft glow of Florence Nightingale's view of nursing. Under the cover of the feminine nurturing guise of nursing, private hospital licensees were able to sidestep the traditional medical hierarchy and create their own domains with agency and autonomy. Chapter Three specifically explores the rise of the private hospital as a critical part of New Zealand's healthcare system. Although rigorous in

[17] "Situations vacant," *Press* (Christchurch), 26 January 1910, 9, https://paperspast.natlib.govt.nz/newspapers/CHP19100126.2.53.5?end_date=31-12-1950&items_per_page=100&phrase=2&query=The+Limes&snippet=true&sort_by=byDA&start_date=01-01-1910.

[18] Patricia French, "A study of the regulations of nursing in New Zealand 1901-1997" (Master of Arts Victoria University of Wellington, 1998). Patricia Ann Sargison, "Essentially a woman's work: A history of general nursing in New Zealand, 1830-1930" (Doctor of Philosophy University of Otago, 2001); Marie E. Burgess, *Nursing in New Zealand society* (Auckland, New Zealand: Longman Paul Limited, 1984). Mary I. Lambie, *Historical development of nursing in New Zealand, 1840-1950* (Wellington: Department of Health, 1950). Jan A. Rodgers, "Nursing education in New Zealand, 1883 to 1930 : the persistence of the Nightingale ethos " (Master of Arts (M. A.) Masters, Massey University, 1985). Kathryn Faye Wilson, "Professional closure : the case of the professional development of nursing in Rotorua 1840-1934" (Master of Arts Massey University, 1995); Jayne Krisjanous and Pamela Wood, ""For quiet nerves and steady poise" : A historical analysis of advertising to New Zealand nurses in the Kai Tiaki Journal 1908-1929," *Journal of Historical Research in Marketing* 12, no. 1 (11 January 2019). Philippa Mein Smith, *Maternity in dispute: New Zealand 1920-1939* (Wellington: Department of Internal Affairs, 1986). Minister of Health, A health service for New Zealand, (Wellington, New Zealand: A.R. Shearer, Government Printer, 1974). Pamela Wood, *New Zealand nurses: Caring for our people 1880 - 1950* (Dunedin: Otago University Press, 2022).

its intent, the new legislation was implemented by a hospital inspectorate that actively encouraged nurse licensees to meet departmental requirements with a degree of leniency and pragmatism that also enabled success. Chapter Four takes an even closer look at the financial aspects of running a private hospital, analysing incomes and outgoings against a backdrop of challenging social and economic times. This chapter reveals the complexities faced by the licensees and the business acumen acquired and required in order to succeed. The final chapter, Chapter Five, will show how the working relationships between the medical fraternity, departmental officials and the licensees trod a delicate line. It illustrates how relationships and reputation were required to preserve the unique space a nurse licensee had created and provides definitive examples of how the power balance between the nurse licensees and the doctors shifted in the private hospital environment.

This thesis contributes to a wider understanding of New Zealand's nursing history than has been previously explored. Catherine Bishop's *Women Mean Business* argued that 'despite the rhetoric of female domesticity, running a business was neither unusual nor unacceptable for most women' in colonial New Zealand.[19] This thesis suggests that half a century later while those opportunities had diminished, a changing regulatory and healthcare landscape created space for these nurses to succeed. It looks beyond the public hospitals and suggests that in establishing themselves as businesswomen and licensees of private hospitals a shift occurred in the power balance between the medical men and nurses as the licensee had both responsibility and authority within her domain which in turn created a more level playing field. Not all nurses and midwives assumed this mantle easily. In her annual reports to parliament, Hester Maclean repeatedly lamented the inability or unwillingness of some nurses in private hospitals to assume the responsibility that came with the recognition they so proudly earned.[20] In this cohort of nurses there were those who were more successful than others and those for whom their circumstances, environment and community relationships proved too challenging to

[19] Catherine Bishop, *Women mean business: Colonial businesswomen in New Zealand* (Dunedin: Otago University Press, 2019), 12.
[20] 1912, *Public Health and Hospitals and Charitable Aid: Report thereon by the Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer*, (Wellington: AJHR H.-31). H.-31, 19

overcome but there was a significant cadre for whom running their own business provided an independence and agency they might not otherwise have enjoyed.

There are stories of success, of failure, of resilience and of personal and community achievements. Most of all they are human stories about women who have stepped outside what was generally considered ‘normal’ at that time and yet retained their carefully nurtured veneer of feminine caring and kindness. Under the guise of the womanly attributes of Florence Nightingale, nursing was 'allowed' and supported to become a profession, complete with training, certification and registration. The reality was, however, that these women were also steely, competent and clever enough to navigate the social, academic and political landscapes that their profession required. In many cases, and perhaps not surprisingly, they also branched out to become successful entrepreneurs and community figures in their own right. This research will add to the body of knowledge of New Zealand’s nursing history by specifically focusing on the women who, for myriad reasons, took the step into business ownership and/or management of the country’s network of private hospitals. By examining their lives in detail through a variety of sources it will reveal the impact of their endeavours on their lives, their families, their communities and their contribution to the changing medical landscape.

Chapter One – Literature Review

Historians have written extensively about the conflicting messages received by New Zealand women at the end of the nineteenth century and the public persona they should present. On the one hand, with the religious connotations suggested by Laurie Guy, they were the wives and mothers of a nation protecting and moderating the unruly and bullish behaviour of men, many of whom had been single well into their adulthood and many of whom had adopted unhealthy relationships with alcohol.[21] On the other hand, married women remained within the home – away from the day-to-day activities of the men they were expected to control – as part of what Melanie Nolan described as a consensual view in New Zealand's historiography of 'the state's promotion of women's domesticity.'[22] Raewyn Dalziel's seminal 'Colonial Helpmeet' article is a touchstone for this view with women being seen as 'wives, mothers, homemakers and housekeepers' as well as guardians of moral health and welfare.[23] Dalziel described the intersection of these roles as the 'helpmeet' whereby a woman was expected to have a hands-on role within the working dynamics of a family and its business but was also responsible for its emotional stability. This almost deification of a woman's role is a central theme to this thesis as I examine how nurses were able to push the boundaries of this image and assert themselves as entrepreneurs, businesswomen and community leaders.

The focus for this research is 1890 to 1935, a period shaped by the Liberal government, changing attitudes amongst and towards women, the indelible print of the Great War and the depression. Although sparked by different aspects of New Zealand's emerging identity, these strands served to create an environment where women became more publicly involved in society and through the expanding opportunities available to them, became a significant part of the work force. Erik Olssen described it as 'the altered status of women', whereby acts of parliament such as the Married Women's Property Act 1884 and the Divorce Act 1898 as well as

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[21] Laurie Guy, *Shaping Godzone: Public issues and church voices in New Zealand 1840-2000* (Wellington: Victoria University of Wellington, 2011), 183.
[22] Melanie Nolan, "Unstitching the New Zealand state: Its role in domesticity and its decline," *International Review of Social History* 45, no. 2 (8 January 2000): 251.
[23] Raewyn Dalziel, "The Colonial Helpmeet: Women's Role and the Vote in Nineteenth-Century New Zealand," 11, no. 2 (1977): 113.

women's franchise in 1893 and improved educational opportunities all contributed to women being more present in the social fabric.[24] Having said that, the lines were blurred. Margaret Tennant noted that although legislation and funding made it possible for girls to participate in schooling alongside their brothers, parents were not necessarily convinced that a 'sound education of girls was just as important as that of boys.'[25] Girls were starting school later and finishing secondary school earlier as well, with attitudes to those who did attend not always complimentary.[26] So while their presence was becoming obvious it was within the confines of a well-constructed notion of femininity and womanhood and what Tennant described as 'a preoccupation with racial fitness and purity'.[27] It would be easy to say that this was driven by men, but women were as active in determining the boundaries of their agency and for many that remained strictly within the domain of the home as wives and mothers.

The Liberal government's commitment to nation building was a driving force during this period with an agenda of legislation focused on the wellbeing of the country. In 1958 Peter J. Coleman wrote of a country 'where men complained that they had not come halfway around the world in order to suffer the neglect of a government seemingly indifferent to their needs.'[28] He suggested that the social reform undertaken by the Liberal government which included new factory laws, votes for women, the old age pension and an industrial arbitration court for dispute resolution cemented the country's reputation as a social laboratory.[29] Four decades later Hamer described it as the 'great expansion of the apparatus of government' and 'pragmatic interventionism' aimed at stabilising New Zealand through a dominant central government.[30] Dalziel assessed it from a feminist perspective and suggested that while defining

[24] Erik Olssen, "Towards a new society," in *The Oxford History of New Zealand*, ed. Geoffrey W. Rice (Auckland: Oxford University Press, 1998), 265.
[25] Margaret Tennant, "Natural directions," in *Women in History: Essays on European women in New Zealand*, ed. Barbara Brookes, Charlotte Macdonald, and Margaret Tennant (Wellington: Allen & Unwin New Zealand Limited, 1986), 87.
[26] Tennant, "Natural directions," 88.
[27] Tennant, "Natural directions," 89.
[28] Peter J. Coleman, "The spirit of New Zealand Liberalism in the nineteenth century," *Journal of Modern History* 30, no. 3 (1958): 232.
[29] Coleman, "The spirit of New Zealand Liberalism in the nineteenth century," 227.
[30] David Hamer, "Centralization and Nationalism (1891-1912)," in *The Oxford illustrated history of New Zealand*, ed. Keith Sinclair (Auckland: Oxford University Press, 1997), 126-30.

nationhood was central to the Liberal's 'experimental state interventions in social and economic issues', women's enfranchisement afforded only a limited level of power.[31] This tension between enabling women and corralling them continued in legislation that addressed their roles as workers, for example, by regulating women's workplaces but with a protective, patriarchal application reflecting women's perceived fragility and femininity. Barbara Harrison and Melanie Nolan's view of the Liberals approach was that it created 'a raft of legislation restricting women's work: at night, on heavy tasks, dirty processes and anything which was deemed to endanger their maternal or moral health.'[32] They described the gendered approach to legislation as being a mechanism which 'served to institutionalise a sexual division of labour in certain industries and disadvantage women's participation in others.'[33] The Nurses Registration Act 1901, Midwives Act 1904 and Private Hospitals Act 1906 were all part of this pattern but this thesis will argue enabled them to secure their space within the medical landscape.

While there is an excellent body of work related to nursing history and women's experiences within the state hospital system and at war, there is a dearth of information focusing on private hospitals. The most recent was published in 2022 by Pamela Wood whose *New Zealand Nurses: Caring for our people 1880-1950* charted the history of general nursing in this country. Using solely historical primary sources Wood argued that New Zealand nurses 'defined a new female occupation within a relatively new country that needed them to help implement its emerging health system.'[34] She explored the hospital landscape through the lens of the state system with private hospitals an adjunct to public hospitals. For example, she referenced the use of private hospitals as a precursor to formal training in the state system or, once training was completed, as an option which offered more financial security.[35] Two decades earlier,

[31] Raewyn Dalziel, "An experiment in the social laboratory? Suffrage, national identity, and mythologies of race in New Zealand in the 1890s," in *Women's suffrage in the British Empire : citizenship, nation, and race*, ed. Ian Christopher Fletcher, Laura E. Nym Mayhall, and Philippa Levine (London: Routledge, 2000), 88.
[32] Barbara Harrison and Melanie Nolan, "Reflections in colonial glass? Women Factory Inspectors in Britain and New Zealand 1893-1921," *Women's History Review* 13, no. 2 (2004): 268, https://www-tandfonline-com.ezproxy.massey.ac.nz/doi/abs/10.1080/09612020400200392.
[33] Barbara Harrison and Nolan, "Reflections in colonial glass?," 269.
[34] Wood, *New Zealand nurses*, 19.
[35] Wood, *New Zealand nurses*, 69, 231.

Patricia Ann Sargison's doctoral thesis traced the history of New Zealand's nursing 'Nightingales', exploring the ideology of nursing as a womanly career. Her focus on the working relationships within the state system drew a picture of 'nurses as 'handmaidens' of doctors and 'servants' of hospital administrators.'[36] Jan A. Rodgers on other the other hand had previously suggested that while the 'Nightingale ethos' was entrenched in traditional views of nursing, 'it was incompatible with advanced training for nurses' and again her work was focused on the state system.[37] Colleen De Vore wrote an illuminating essay on midwives as businesswomen in a similar period as is explored in this thesis. She described midwifery in the early twentieth century as being 'inevitably shaped by economic, social and political pressures,' suggesting that property ownership, business acumen and access to capital were key factors to their success.[38] She highlighted the financial pressure placed on licensees as they struggled to meet the high cost of improvements and equipment required to meet regulatory standards. She also explored the importance of reputation as an essential tool to securing a midwife's livelihood.[39] Gaynor Smith, in looking at the options for women in Palmerston North giving birth in the early twentieth century, illustrated the importance of the network of private maternity hospitals as integral to the region's medical landscape.[40]

The subject of private hospitals is also scarce in international literature and generally viewed in the context of wider research about nursing and healthcare systems. Australian Noeline Kyle studied women who established private hospitals in north-eastern New South Wales between 1890 and 1950. Kyle found that their work and entrepreneurship had not been widely researched but in the predominantly small towns where they worked, the women were valued members of the community.[41] Entrepreneurial nurses have also been highlighted recently in

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[36] Sargison, "Essentially a woman's work," iv.
[37] Rodgers, "Nursing Education in New Zealand," Abstract & vii.
[38] Colleen De Vore, "Midwives as businesswomen 1900 to 1938," in *Looking back, moving forward: Essays in the history of New Zealand nursing and midwifery*, ed. Norma Chick and Jan Rodgers (Massey University, Dept. of Nursing and Midwifery, 1997), 44.
[39] Vore, "Midwives as businesswomen," 52 50.
[40] Gaynor Smith, "Essentially a woman's question: A study of maternity services in Palmerston North 1915 - 1945" (Batchelor of Arts with Honours Massey University, 1987).
[41] Alison C. Kay, *The foundations of female entrepreneurship : enterprise, home, and household in London, c. 1800-1870*, Routledge studies in business history: 17, (Routledge, 2009), 607. http://ezproxy.massey.ac.nz/login?url=https://www.taylorfrancis.com/books/9780203873793.

the context of private duty nurse registries operating in the United States in the nineteenth and early twentieth century. In a co-authored paper, D'Antonio et al described the establishment of nurse-owned and operated private duty registries as 'a critical historical illustration of the power nurses have held over their professional lives.'[42] Expanding on this notion of agency and control, Jean C. Whelan in her 2012 article suggested that this aspect of entrepreneurship has been little acknowledged but was the backbone of the early twentieth century American nursing workforce. An estimated 80 percent of nurses worked as independent contractors through these registries, responsible for their own employment.[43] Power in public hospitals lay with the doctors and hospital superintendents but in the central nursing registries, largely owned and run by nurses, that power balance shifted.[44] Meanwhile in Britain, the evolution of the hospital network which would form the basis of the National Health Service hospitals had little in common with what was happening either in the USA or New Zealand. Barry Doyle outlined the development of hospitals throughout the country prior to the NHS suggesting that provisions came from a combination of voluntary organisations and their subscribers, local authorities and the poor law guardians.[45] Private hospitals do not feature other than in the context of 'pay beds' in some voluntary hospitals, an issue Doyle said '[h]istorians have paid little attention to.'[46]

A common theme in much of the writing about women's roles in creating New Zealand's new society was, and still is, often expressed in the context of marriage. Opportunities for marriage were good and New Zealand's early achievement of securing women's suffrage suggested a freedom and independence not enjoyed in other parts of the world. Barbara Brookes described women's suffrage as appealing to women with no political aspirations because they could

[42] Patricia D'Antonio et al., "Histories of nursing: The power and the possibilities," *Nursing Outlook* 58, no. 4 (2010): 208.
[43] J. C. Whelan, "When the business of nursing was the nursing business: The private duty registry system, 1900-1940," Article, *Online Journal of Issues in Nursing* 17, no. 2 (1 January 2012): 2, https://doi.org/10.3912/OJIN.Vol17No02Man06.
[44] Whelan, "When the business of nursing was the nursing business," 4.
[45] Barry M. Doyle, *The politics of hospital provision in early twentieth-century Britain*, Studies for the Society for the Social History of Medicine: no. 19, (Pickering & Chatto, 2014), 35.
[46] Doyle, *The politics of hospital provision in early twentieth-century Britain*, 47.

assert their power but within a context of improved well-being for children and families.[47] Dalziel interpreted it as a consolidation of their mission in life as homemakers and guardians of moral health, making a career of marriage.[48] Deborah Montgomerie suggested, however, that the notion of the 'modern woman' in this period was 'the antithesis of the colonial helpmeet' and represented women who were unconvinced that domesticity and marriage would be fulfilling and bring happiness.[49] She concluded that the tension between a new-found political freedom and the prevailing ideas of domesticity, marriage and motherhood was challenging and only a very few New Zealand women 'advocated radical notions of women's absolute equality with men.'[50]

Clare Toynbee suggested legislation introduced at the end of the nineteenth century was key to breaking down the power of men and 'laid the foundations for greater freedoms for both women and children'.[51] However, even through this feminist and somewhat optimistic lens of New Zealand society, attitudes towards women were still embedded in the context of familial responsibilities and marriage, something Nolan described as 'the relationship between marriage and employment'.[52] She cited employment figures which show that in 1891 'about thirty-nine per cent of women aged between fifteen and twenty-four were in paid employment. By 1921 the proportion had grown to over one half'.[53] A tension was created because this increase occurred simultaneously with the 'more or less [sic] enforced dependency of married women', suggesting attitudes against women working once they were married remained intact while it became increasingly acceptable for single women to be out in the workforce.[54] This was never more pointed than in the experience of nurses serving their country during the Great War. Anna Rogers described marriage as 'a vexed issue for nurses'.[55] She cited the draft order

[47] Barbara Brookes, *A history of New Zealand women* (Wellington: Bridget Williams Books Ltd, 2016), 122.
[48] Dalziel, "The colonial helpmeet."113
[49] Deborah Montgomerie, "New women and not-so-new men: Discussions about marriage in New Zealand, 1890--1914," *New Zealand Journal of History* 51, no. 1 (2017): 39-41.
[50] Montgomerie, "New women and not-so-new men," 55.
[51] Clare Toynbee, *Her work and his: Family, kin and community in New Zealand 1900-1930* (Wellington: Victoria University Press, 1995), 161.
[52] Nolan, "Unstitching the New Zealand state," 252.
[53] Nolan, "Unstitching the New Zealand state," 254.
[54] Nolan, "Unstitching the New Zealand state," 255.
[55] Anna Rogers, *While you're away* (Auckland New Zealand: Auckland University Press, 2003), 185.

that New Zealand Army Nursing Service nurses would not be allowed to marry while on active service without special permission, despite Hester Maclean's acknowledgement and protest that '[w]ith over 400 young women away and engaged in Military service which may last for several years, it is asking of them a big sacrifice which is not expected from any other class of men or women'.[56]

The gap between the political ambition of the Liberal government and the on-the-ground reality is apparent when analysing the research and writing about Māori women's experience in nursing. Much that has been written in a nursing context tends to be on nursing *in* Māori communities rather than Māori being nurses themselves, despite government and Māori leaders' efforts to bring Māori women into nurse training. Ann Margaret McKillop and Raeburn T. Lange traced the dire history of Māori health and attempts to effect change through, amongst other things, the Māori Health Nursing Scheme.[57] Charlotte M. Parkes highlighted the tension between the desire for 'change from within' and the resistance by hospitals to employ Māori women in their training programmes.[58] The idea of Māori leading their own change was championed by the so-called 'Young Māori Party', which included Maui Pomare, Te Rangi Hiroa and Apiriana Ngata, as early as 1891. These issues manifested as only a small number entering nursing, generally in a supporting and sometimes even untrained role alongside the European nurses, and in many cases those who did train were required to Europeanise both their names and demeanour.[59] This may go some way to explaining McKillop's findings that between 1911 and 1920 there were just five Māori nurses who worked in the scheme.[60] That is not to say that Māori women were not interested in nursing, however. McKillop noted that Māori volunteers served in the South African war 'with a contingent of ten nurses, one doctor and seven

[56] Rogers, *While you're away*, 185.
[57] Ann Margaret McKillop, "Native health nursing in New Zealand 1911-1930 : a new work and a new profession for women " (Master of Arts (M. A.) Masters, Massey University, 1998).; Raeburn T. Lange, "The revival of a dying race: A study of Maori health reform, 1900-1918, and its nineteenth century background" (Master of Arts in History Auckland, 1972).
[58] Charlotte M. Parkes, "District nurses in Māori areas: Nursing on horseback`," in *Standing in the sunshine*, ed. Sandra Coney (Auckland, New Zealand: Penguin Books, 1993), 92.
[59] Alexandra Helen McKegg, "'Ministering angels' : the government backblock nursing service and the Maori health nurses, 1909-1939 " (Master of Arts (M.A.) University of Auckland, 1991), 78.; McKillop, "Native health nursing in New Zealand," 44.
[60] McKillop, "Native health nursing in New Zealand," 4.

orderlies' under the United Tribes of New Zealand flag while back in New Zealand.[61] Another group known as the Ngāpuhi Sisters had organised themselves as nursing sisters ready to serve their Northland community and also prepared to go to South Africa should volunteers be called into active service.[62] Despite their service, none of the Ngāpuhi Sisters appear on the nursing registers from 1902 onwards, nor have any nurses of Māori descent been found to go on to own private hospitals.

Nursing was accepted as an option for women as a career or, more commonly, as an interim between school and marriage. Sargison suggested that by linking the words 'good nurse' with 'good woman', nurses created 'a place for themselves within the public world of paid employment which was both respected and admired.'[63] Key to this was being 'subservient and unquestioningly obedient to male authority' and effectively staying under the radar of the doctors.[64] Sargison noted, however, that while matrons assumed new levels of operational authority over nursing staff in public hospitals, they were at the same time caught between this and the unquestioning obedience required in their dealings with the male superiors.[65] The increased standing of a matron reflected the gradual professionalisation of the hospital environment from 'small cottage hospitals to rambling collections of buildings, with specialised roles and increasingly professional staff'[66] but at the same time the issues of gender and what French described as the 'medical profession's control of nursing' meant a power imbalance continued with doctor's controlling both knowledge and authority.[67]

A crucial part of nursing professionalisation in New Zealand was the implementation of the Nurses Registration Act 1901 which required nurses to have undergone a three-year training programme and to have passed a state examination. Rodgers described this development as a

[61] McKillop, "Native health nursing in New Zealand," 43.
[62] Parkes, "District nurses in Māori areas: Nursing on horseback`."; "News items," *New Zealand Herald* (Auckland), 17 April 1901, Local and general news, 4.
[63] Sargison, "Essentially a woman's work," 6-7.
[64] Sargison, "Essentially a woman's work." 7.
[65] Sargison, "Essentially a woman's work," 8.
[66] Michael Belgrave, *The Mater: A history of Auckland's Mercy Hospital 1900-2000* (Palmerston North: Dunmore Press Ltd, 2000), 32.
[67] French, "A study of the regulations of nursing in New Zealand 1901-1997," 43.

culmination of the evolving medical and hospital landscape and an opportunity to develop 'the monopoly that women had achieved as nurses.'[68] She suggested this monopoly strengthened women's control over nursing through the development of training credentials and a central nursing body, and elevated their position by excluding untrained and unregistered nurses.[69] French, in contrast, reiterated that success was still dependent on cooperation with and subservience to the medical profession. Both, nevertheless, agreed that registration and the associated professionalisation of nursing was a watershed moment in New Zealand's nursing history.[70] In England, this process of national registration was a debate that raged for nearly three decades with schisms forming between the women who were theoretically striving for the same outcome. In New Zealand the process took barely two years, with a cohesive campaign run by Grace Neill as Assistant Inspector to the Department of Hospitals, Asylums and Charitable Institutions of New Zealand meeting little resistance or debate from either the medical profession or the politicians in their parliamentary debate.

Charlotte Macdonald explored New Zealand's position as part of the wider and new Britain and suggested that it 'offered a highly pliable context for democratic experiment', in this case suffrage and more particularly the professionalisation of nursing.[71] Wishing to portray itself as the leading liberal democracy, characteristic of the wider British Empire, New Zealand politicians facilitated the progression of the trappings of emancipated women by giving them the vote but curtailed their full potential by stopping short of allowing women to become decision-makers and politicians in their own right. This was generally supported by the female community itself under the guidance of organisations such as the Women's Christian Temperance Union which whole-heartedly supported women's suffrage but in their context, as a means to 'protect home and family from the predations of male drunkenness'.[72]

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[68] Rodgers, "Nursing Education in New Zealand," 21.
[69] Rodgers, "Nursing Education in New Zealand," 21.
[70] French, "A study of the regulations of nursing in New Zealand 1901-1997," 44. Rodgers, "Nursing Education in New Zealand," 21, 27.
[71] Charlotte Macdonald, "Suffrage, gender and sovereignty in New Zealand," in *Suffrage, Gender and Citizenship : International Perspectives on Parliamentary Reforms*, ed. Pirjo Markkola, Seija-Leena Nevala-Nurmi, and Irma Sulkunen (Newcastle: Cambridge Scholars Publishing, 2009), 16.
[72] Macdonald, "Suffrage, gender and sovereignty in New Zealand," 17.

Geographical isolation and the poorly developed infrastructure in New Zealand meant that women's work was vital in sustaining the economic wellbeing of the family.[73] Toynbee defined it as a 'reordering of gender relationships to create a better 'fit' with the productive base of society…' and a clear distinction between the public and private spheres.[74] Belgrave's analysis of women's participation in the medical profession dampened that view slightly by suggesting that while New Zealand women were enthusiastic and ambitious participants in studying medicine, for example, achieving a medical degree was not necessarily a passport to earning a living.[75] Professional qualifications did not equate to automatic entry into the market for private practices thereby limiting women's opportunities for entrepreneurial success.[76] Brookes was even harsher in her assessment of attitudes towards women and suggested that while an expanding state health sector did provide some stability, the pay was poor as were the prospects for advancement and while medical men could expect support from their wives and families, that choice for a woman might instead mean abandoning her hard fought career.[77] This was a vastly different experience from women who trained as nurses and went on to own and manage private hospitals throughout the country and is central to this thesis which focuses on their business and professional acumen.

Women were increasingly caught in a conflicted picture of both independence and reliance, as their expected subservient, maternal and familial roles gave way to education and personal ambition. In discussing this, Martha Vicinus spotlighted the conundrum of how a woman could be both successful and superfluous at the same time in what she describes as the symbolic triad: '…the ideal mother/wife or a celibate spinster or a promiscuous prostitute.'[78] This limited definition of womanhood meant that a single woman had '…absolute purity and goodness…' thrust upon her which was ultimately transformed into celibacy, spirituality and passionate social service, a veritable definition of the deified nurse. Nurses embodied the

[73] Toynbee, *Her work and his*. 92.
[74] Toynbee, *Her work and his*, 160.
[75] Michael Belgrave, "A subtle containment: Women in New Zealand medicine, 1893-1941," 22, no. 1 (1988): 48.
[76] Belgrave, "A subtle containment," 50.
[77] Barbara Brookes, "A corresponding community: Dr Agnes Bennett and her friends from the Edinburgh Medical College for Women of the 1890s," *Medical History* 52, no. 2 (04/01/ 2008): 251 - 54.
[78] Martha Vicinus, *Independent women* (Chicago, London: The University of Chicago Press, 1985), 5.

notion of femininity 'required' of women in New Zealand's late nineteenth century, assuming an aura with almost religious connotations.[79] This religiosity was also hallmark of women's organisations such as the Women's Christian Temperance Union and the National Council of Women, both of which were staunch advocates of equality for women, but with slightly differing agendas.

The shift in generational attitudes and aspirations for young women could be attributed to parents wanting more or different opportunities for their children, something Toynbee alluded to particularly in relation to girls' education.[80] Catherine Bishop's *Women mean business* provided an excellent overview of women who, through a variety of causes and consequences, ended up or deliberately sought to own their own businesses. She described this as a kind of freedom that many chose instead to pursue their own interests and independence through business ownership, despite the possibility of adopting or re-entering the more conventional norms of marriage.[81] Bishop's research importantly notes that for many women, owning their own business provided a new start after a dramatic change in their lives. Having been married and then losing that status through death or divorce, women found providing for themselves became more than just a pragmatic solution to a social or economic problem. Running their own business in many cases gave them the respectability and a reclaimed status, and business provided an alternative to marriage whether for avoidance or surviving a failed one.[82]

Attitudes towards marriage remained entrenched in New Zealand society, albeit with emerging aspirations of becoming more modern. Brookes described early twentieth century feminist ambitions for women's lives as being 'no longer governed by the economic necessity of forming a sexual contract with one man as a wife.'[83] She suggested that the suffrage campaign envisaged educated and independent citizens who took up new employment opportunities and did not necessarily marry. Vicinus' asserted that more commonly amongst Victorian women in

[79] Vicinus, *Independent women*, 5.
[80] Toynbee, *Her work and his*, 161.
[81] Bishop, *Women mean business*, 14.
[82] Bishop, *Women mean business*. 41
[83] Brookes, *A history of New Zealand women*, 146.

Britain there was a view that 'any marriage was better than being an old maid' and any thoughts of seeking skilled training were left too late while the wait for a husband took precedence.[84] The notion of 'working' was not clear cut either. Paid employment outside the home was one sphere of activity but providing muscle, brainpower and skill within the context of the family home was quite another which most often went unnoticed and usually unpaid.

In contrast, Beryl Hughes described the slow pace at which women assumed professional positions and suggests that New Zealand was more reluctant to shed these prejudices, despite being the first country in the world to give women the vote.[85] Written in 1980, Hughes study bemoaned the lack of female representation in New Zealand's legal, medical and political arenas at that time, a view that might be much changed today with the country having seen women in every key political leadership role and a more gender-balanced parliament. However, the central point she raised was that while women here operated in a supposedly more liberated environment, it took almost 50 years for Mabel Howard to be appointed to the Cabinet, some 20 years behind her British counterparts. British women only achieved the vote on the same terms as men in 1928, twenty-five years after New Zealand women and yet seemingly had a faster trajectory into positions of power. Similarly, New Zealand's first legal graduate appeared in 1897 but it was 1976 before the first female District Court judge was appointed and a further 17 years before a woman was appointed as a High Court judge.

Resistance to equalising women's position in society manifest itself under the guise of the preservation of women's femininity and fragility. Tennant described the view at the time of a '…growing feeling that girls in particular were not benefiting from the existing system of education, and that they might even be suffering irreparable damage…', playing into the idea of women's lack of mental robustness.[86] She cites Truby King as the troublesome voice promoting these ideas of young women weakened by education who were also becoming accustomed to

[84] Vicinus, *Independent women*, 13.
[85] Beryl Hughes, "Women and the professions in New Zealand," in *Women in New Zealand society*, ed. Beryl Hughes Phillida Bunkle (Auckland, New Zealand: George Allen & Unwin Australia Pty Ltd, 1980). 120
[86] Tennant, "Natural directions," 90.

turning their backs on their familial and domestic obligations.[87] However Erik Olssen's analysis of employment statistics between 1880 and 1926 showed that the equalising sex-ratio coupled with a developing manufacturing sector and rapidly expanding tertiary sector created more and acceptable opportunities for women.[88] The reality was that female labour was cheaper than male labour, an opportunity that many employers were happy to grab. Melanie Nolan has suggested that male unionists sought to negotiate lower rates for women in the few occupations where men and women both worked together. The effect of this 'reinforced women's segregation into a small band of female occupations and their relegation to the bottom of labour hierarchies.'[89] While this was not ideal, in a perverse kind of way the frustration of pay inequality opened doors for many women to find employment in women-only spaces, such as nursing, that were previously unobtainable.

Opportunities for married women to work outside the home were severely limited and even frowned upon by society. Brookes described this as the shame attached to women seeking financial and personal independence outside the home because '[t]he role of family breadwinner was so central to what it meant to be a man that for a wife to seek work outside the home brought shame.'[90] A woman's desire, and in many cases need, to work outside the family home was somehow a reflection on the masculinity and capability of the man of the house, instilling a sense of failure. There is also an element of control in that sentiment whereby it could be construed that the power balance within the home had shifted because of the perceived failure of the husband to keep his wife in check and at home, regardless of what was negotiated and agreed between them. Brookes added a further dimension to this notion by suggesting that the success of the independent, working 'New Woman' also relied on whether she could effectively create and manage a modern 'New Man'.[91] Toynbee suggested that the norm for married women in the early twentieth century was to remain in the home

[87] Tennant, "Natural directions," 90-91.
[88] Erik Olssen, "Women, work and family: 1880-1926," in *Women in New Zealand society*, ed. Beryl Hughes Phillida Bunkle (Auckland: George Allen & Unwin Australia Pty Ltd., 1980), 159 - 61.
[89] Nolan, "Unstitching the New Zealand state," 258.
[90] Barbara Brookes, "Shame and Its histories in the twentieth century," *Journal of New Zealand Studies*, no. 9 (2010): 44.
[91] Brookes, *A history of New Zealand women*, 145.

where their domestic skills were valued and important to the running of the household. While some married women did have jobs, this was '…usually under conditions of severe economic pressure, such the illness or disability of their husbands', a circumstance which became more prevalent in post-war New Zealand where employment became a necessity for many women who were widowed.[92] Married midwives running their own businesses were not uncommon, however, which may have been a combination that for most the business was run from their home so they weren't, in effect, working outside the home but also because the nature of their work was specialised and remained squarely within the female domain.

The tension between public perception of what was acceptable for women and their private ambition for independence and agency could be seen in the experiences of nurses who served on various battlefields. The tenacity of nurses who served during the South African War showed a determination and commitment to their careers that was largely disregarded by the those controlling the war effort. Rogers estimated that approximately 30 New Zealand nurses travelled from different parts of the globe to South Africa to serve in the war effort there, many at their own expense.[93] The fact that there are no definitive records providing exact numbers and identities speaks to the low priority attached to the role that nurses played and the haphazard manner in which New Zealand's army nursing service evolved. In 1914 similar attempts by New Zealand nurses to join the war effort were again rebuffed amidst a long-running dispute tracing back to 1908 where attempts to establish an Army Nursing Reserve and subsequently the New Zealand Army Nursing Service were repeatedly dismissed. Hannah Clark's view was that the notion of emancipated, enfranchised women did not necessarily sit comfortably with decision-makers in Britain's War Office and it was only when it became apparent that the war was going to drag on much longer than had initially been thought that they relented.[94] Clark suggested that the young New Zealand nurses had grown up in a society where they had 'greater autonomy, independence and political rights' than their sisters in Britain and were used to a hospital nursing hierarchy where Matrons and Sisters had authority

[92] Toynbee, *Her work and his*. Toynbee, 63.
[93] Rogers, *While you're away*. 16
[94] Hannah Clark, "Beyond the wards: Exploring the personal accounts of three New Zealand nurses during the Great War in Egypt" (Master of Arts Te Herenga Waka — Victoria University of Wellington, 2016), 56-57.

and respect.[95] Women and particularly nurses were supposed to be conservative and angelic but the reality of their role did not sit easily with 'many army medical officers and male orderlies who thought it was unnatural to take orders from women'.[96]

Such were the murky and confusing waters in which dedicated, entrepreneurial and professional women operated in the early twentieth century. Conflicting messages about their required femininity and genteelness were underscored by an expectation that they also had a responsibility to maintain discipline and appropriate behaviors in the spheres in which they operated. For most women, being married that meant staying within the home while for others, working outside the home meant an uneven playing field where pay rates, career opportunities and professional advancement were often hindered by their gender and attitudes and expectations of women generally. In the medical profession, women doctors felt this quite keenly. This thesis will show that nurses, on the other hand, having usurped the role of male nurses by the late nineteenth century, carved out their own space as a uniquely female sphere that would shift the traditional balance of power between themselves and medical men. It will look beyond midwives to include nurses who also ran large medical and surgical hospitals, exploring their relationships with medical men, their business acumen and the complexities of fulfilling their requirements as licensees. By using case studies of individual women and their hospitals this thesis will highlight the successes and sometimes failures of those women who stepped into the business world, ran their own private hospitals and created a unique space hitherto relatively unexplored.

[95] Clark, "Beyond the wards," 49.
[96] Clark, "Beyond the wards," 76-77.

Chapter Two – Creating space

In March 1902 Miss Jean Foote opened the doors of Rawlingstone Private Hospital, situated at the northern end of Grafton Road close to Auckland Hospital where she had trained. Her advertisement read that she was '…prepared to undertake the Nursing (sic) of all cases, except infectious fevers.'[97] Billed as 'a high class nursing hospital'[98] 'thoroughly fitted up with Up-to-Date Appliances.'[99] Rawlingstone would become one of the largest private medical and surgical hospitals in the rapidly-growing Auckland region. Miss Foote's life illustrates the extent to which the legislative framework that emerged created this space for her. Hers is a story of determination where she actively chose a nursing career relatively early in the development of the private hospital sector, with perhaps already an idea of embarking on an enterprise outside of the state system. As Rawlingstone grew under her leadership Miss Foote became an excellent example of one woman's efforts to secure a position as an independent and successful businesswoman. This chapter will analyse the shifting landscape of nursing training and legislation between 1890 and 1910. Alongside those formal developments, changing social attitudes also played a part in enabling Jean and many women like her to build a business and become part of the economic fabric of New Zealand's urban and rural communities.

Jean, who was christened Jane, was the sixth child of William Foote, an early settler who arrived in Onehunga in 1867 on board Clara, a boat he had built himself and sailed from Newfoundland. She was just seven years old when she arrived in Onehunga with her parents and eight siblings; another four children would be born after the family's arrival in New Zealand. They originally settled in the Manukau Heads before moving north of Whangarei to develop an 850-acre farm named Hope Station, while her brothers established a kauri logging and milling business just outside of Whangarei.[100] Jean lived with the family in Northland and,

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[97] "Miscellaneous," *New Zealand Herald* (Auckland), 26 March 1902, 1, https://paperspast.natlib.govt.nz/newspapers/NZH19020326.2.3.6?end_date=31-12-1917&items_per_page=100&phrase=2&query=Nurse+Foote&snippet=true&start_date=01-01-1885.
[98] "Personal items," *New Zealand Herald* (Auckland), 5 November 1901, 6, https://paperspast.natlib.govt.nz/newspapers/NZH19011105.2.51?end_date=31-12-1917&items_per_page=100&phrase=2&query=Nurse+Foote&snippet=true&start_date=01-01-1885.
[99] "Miscellaneous."
[100] "Captain William Foote," *Star* (Christchurch), 7 July 1919, 2.

according to family historical documents, the Foote women 'while they were living with their parents at Opuawhanga were not allowed to work for wages or go into business as it was considered unladylike'.[101] Jean clearly had other ideas and in 1897 when she was 37 went to Auckland for a holiday and, apparently unbeknownst to the family, began her nurse training at Auckland hospital instead of returning home. She was one of the first women to achieve registration in February 1902 and appeared on the newly created Nurses Register as nurse number 45.[102] Not satisfied with only her nursing qualification, she then went to Melbourne to do maternity training at the Royal Melbourne Hospital, returning determined to start her own hospital.

Professionalising New Zealand's nurses and midwives

Formal nurse training began in New Zealand in the 1880s as hospital boards around the country sought to improve the standard of care and treatment administered in hospitals modelled on the Florence Nightingale approach to nursing. By the time Miss Foote began as a probationer at Auckland hospital, the nurse training programme was well-established and had been running for thirteen years. Wellington and Auckland Hospitals were the first to embark on a formal training programme in 1884, followed by Christchurch Hospital in 1891 and Dunedin Hospital in 1893, with other hospitals within the network also following suit.[103] Training varied in different hospitals but essentially a probationer worked for very low wages for at least two years learning her craft and sitting exams, as determined by each hospital board, before earning her nursing certificate.[104] Prior to this, hospitals had been run by a master and matron, often a husband-and-wife team, with their 'nurses' regarded more as a domestic who cleaned and cared for patients, with minimal formal medical training and poor wages while male nurses were more common and better paid as warders.[105] As a domestic servant in the hospital environment, there was little concern for a nurse's experience or reputation other than under

[101] Finlay Foote, *Foote prints* (Finlay Foote, 1980), 29.; Bill Haigh, *Foote prints among the kauri: The lives and times of seven brothes and six sisters in the Kauri Timber Days* (Whangarei: Bill Haigh, 1991), 151.
[102] Nurses and midwives board, "Register of nurses," 5.
[103] Hester Maclean, *Nursing in New Zealand: History and reminiscences* (Wellington: Tolan Printing Company, 1932), 265.
[104] Wood, *New Zealand nurses*, 26.
[105] Burgess, *Nursing in New Zealand society*. 5

the banner of the hospital generally and how it was perceived within the community. In 1891 there were just over 1000 nurses around the country, 230 of whom were men, with varying degrees of experience and training.[106] By 1911 that number had more than tripled to 3403, about a third of whom appear on the nurses register having completed some form of training in New Zealand or at a recognised hospital in another country.[107] All were women with the exception of one Gustave Adolph Brandstater, who had trained at the Battle Creek Sanitorium in Michigan in the United States of America, and was manager of the Papanui Sanatorium in Christchurch.[108]

The shift to female nurses began in the 1890s following investigations by senior medical men into nursing practices in other countries. They began encouraging hospital trustees to make the change which culminated in a nation-wide survey being sent to medical men asking for their views on the issue.[109] The transition was passed by a unanimous vote with hospital administrators realising that not only would women bring a calm efficiency to the wards, they could get two female nurses and a probationer for the price of a single wardsman.[110] Nurse Foote began her training at Auckland Hospital in 1897, in an environment that was fiercely hierarchical and delineated on gender lines. As a probationer her earnings would have ranged between £5 and £25 per year, as her experience grew, and then once certificated, she would have received a salary of around £40.[111] A male attendant's salary, on the other hand, was £60 per year. Simple economics provided a compelling argument to make the shift to female nurses so rather than competing with men for the same positions, women moved into their own nursing space within the wider medical field, albeit with lower remuneration.

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[106] Olssen, "Women, work and family: 1880-1926," 163.; New Zealand Government, Census of New Zealand 1891, (Wellington: New Zealand Government, 1891).
[107] Nurses and midwives board, "Register of nurses."
[108] "Items from everywhere," *Waimate Daily Advertiser* (Waimate), 11 October 1911, 4, https://paperspast.natlib.govt.nz/newspapers/waimate-daily-advertiser/1911/10/11/4.
[109] Wood, *New Zealand nurses*. 24-25
[110] "Dunedin Hospital management: Meeting of the medical staff," *Otago Daily Times* (Dunedin), 7 March 1889, 3, https://paperspast.natlib.govt.nz/newspapers/otago-daily-times/1889/03/07/3.
[111] "Hospital nurses: The eight hours day question," *Auckland Star* (Auckland), 27 April 1897, 2, https://paperspast.natlib.govt.nz/newspapers/AS18970427.2.10.

The Nurses Registration Act 1901

Having reached agreement around the country to transition to female nurses, the next step was the introduction of formalised, national nurse training, culminating in one of the most significant milestones in the history of nursing in New Zealand. Grace Neill was the Assistant Inspector to the Department of Hospitals, Asylums and Charitable Institutions of New Zealand and had begun her career in New Zealand in 1894 working for the Department of Labour as New Zealand's first female inspector of factories. In 1895 she was appointed Deputy Inspector Lunatic Asylums, Hospitals, Licensed Houses and Charitable Institutions, again to address specifically women's issues in health and welfare, travelling the country to assess conditions, resolve disputes and even writing the annual report to Parliament on occasion deputising for the then Chief Inspector Duncan MacGregor.[112] She was herself a trained nurse and believed strongly in nursing reform, becoming a key figure in the drafting of the Nurses Registration Act 1901. The Act, which set the benchmark for nursing reform around the world, drew a line in the professional sand requiring that all new probationer nurses were to be trained and registered under the terms of the Act as the state system became the hub of training for nurses working in both the public and private sector. A twelve-month transition period was allowed for all currently practicing nurses to apply for their registration, acknowledging their work experience both in New Zealand and abroad.

The first name to appear on the Nurses Register in 1902 was Ellen Dougherty. Born at a whaling station at Port Underwood in the Marlborough Sounds, Nurse Dougherty completed her training a Wellington Hospital in 1887. She quickly rose to become head of the hospital's accident ward and surgery ward before accepting the post as matron of Palmerston North hospital. As a certificated nurse with 16 years of work experience, registration was in one sense a mere formality. In another it was an illuminating example of how the character and position of New Zealand's nurses would be redefined within the medical landscape. In 1902, 297 names appeared on the register comprising 261 nurses who were trained in New Zealand and 36 from

[112] "Elizabeth Grace Neill," Dictionary of New Zealand Biography, Te Ara - the Encyclopedia of New Zealand, 1993, accessed 3 March, 2023.

overseas.[113] Some were as experienced as Matron Dougherty while others had just completed their three years of training. Approximately two thirds worked in public hospitals while one third were listed as working privately, either at private hospitals or private nursing in people's homes.[114]

Under the terms of the Act, new nurses applying for positions in New Zealand hospitals had to be at least 23 years old with three years of training as a probationer. This meant young women were on average 21 when they were embarking on their career as a nurse, five or six years younger than the average age of marriage. While there was no explicit level of education required to enter nursing, in their training they completed the 'systematic instruction in theoretical and practical nursing from the medical officer and the matron' in a hospital so had to at least be competent at reading and writing.[115] A fee of one-pound was paid to complete the examination and registration process. Nurses who had trained in other countries were entitled to register as long as the hospital they had trained in was a recognised institution. It was poorly paid but provided live-in accommodation which served to keep them close at hand for the long days and nights they were required to work. It also meant they were chaperoned to satisfy the social mores of the educated middle class young women the hospitals wanted to apply.[116] Successful registration provided a certificate and a badge bearing the nurse's name and the date of registration. The Act did not make it mandatory for a hospital to employ a registered nurse, rather it recommended that state hospitals give preference to registered nurses but with no reference to private hospitals.[117] The function of the Register of Nurses was therefore informational. It was published annually and showed where each nurse had trained and the hospitals and/or private nursing in which they had been employed. The decision of who to employ – whether registered or not – remained with the boards and owners of individual hospitals.

[113] Nurses and midwives board, "Register of nurses."
[114] Nurses and midwives board, "Register of nurses."
[115] *The Nurses Registration Act, 1901*, S4.(1) (Wellington: New Zealand Government, 1901).
[116] Toynbee, *Her work and his*, 98.
[117] *The Nurses Registration Act*, S9.

The specificity of the Act signalled the determination to attract a certain calibre of young women into a nursing career. Not only did they have to work through a strict and structured probationary period of three years, they were required to attend at least 12 lectures each year and sit a state exam on completion of their training. This level of academic application required a standard of education that had hitherto not been deemed important for nurse training. The Act did not dictate that nurses had to be single but the requirement to 'live in' at the Nurses Hostel, coupled with the social norm of married women retreating to the home served to create a workforce of predominantly single women. Responsibility for managing these hostels fell to the hospital Matron, a trained and registered nurse who had risen through the ranks. As well as managing her staff within the hospital environment the Matron had pastoral responsibility outside of it. While establishing the criteria to achieve registration, the Act also spelled out the criteria by which a nurse could be struck off the register. Firstly, any person who sought registration with 'false or fraudulent representation' was liable to a five pound fine and to be struck off the register.[118] Any registered nurse who was convicted of an indictable offence or found guilty of grave misconduct would also be struck off. All the penalties and fees received under the Act would form part of the funding model for its future management.

As the first country in the world to formalise and regulate nurse training and registration, New Zealand achieved this in just two years with relatively little fanfare. In presenting the Bill for its second reading the Hon W.C. Walker sought to assure the House of Representatives that its purpose was to elevate the status of nurses and protect their reputation and professional character.[119] He went on to state that the standard of New Zealand's hospitals was so high as to guarantee a calibre of nurse who is 'able to deal in a manner such as ought to be desired with all cases of disease and sickness.'[120] The debate generally was measured and, to some extent self-congratulatory about the state of the country's hospitals and the calibre of the nurses this new act would now attract. Its passage was smooth with an allowance made for

[118] *The Nurses Registration Act*, S8.
[119] New Zealand Parliament, *Hospital nurses registration bill*, 2, House of Representatives 179-81 (1901).
[120] *Hospital nurses registration bill*, 180.

registrations of existing nursing staff during the transitional period to be completed within a year of its enforcement date of 1 January 1902.

The Act defined a 'hospital' as any place 'instituted for the reception, relief, treatment, and cure of disease, and includes any public establishment instituted for the reception or relief of orphans, aged, infirm, incurable, or destitute persons'[121] and listed the 37 hospitals and 32 charitable institutions to which the Act applied. This kept private hospitals in a grey and unregulated area. The Hospitals and Charitable Institutions Act 1885 governed the standards required of the public institutions without direct reference to private hospitals other than the establishment of so-called 'separate institutions' which fell under state management but were funded within local communities. These were defined as 'institutions supported in whole or in part by the voluntary contributions of not less than one hundred persons, who shall have signified their intention to contribute and have contributed thereto as mentioned in section thirty-eight'.[122] This was far removed from the commercial model of private hospital owner, possibly in partnership, responsible for the fiscal and medical success of their institution and it was not until the introduction of the Private Hospitals Act 1906 that this sector became fully regulated. In the meantime, Seddon's government would implement another piece of legislation that would significantly affect the midwives working in an even more unregulated industry but wielding what was perceived as a far greater potential impact on the wellbeing and growth of the country.

The Midwives Act 1904

While the Nurses Registration Act paved the way for establishing a similar pathway for midwives, in many ways the Midwives Act 1904 would prove to be even more significant as it affected far more women working in the traditional space of midwifery. Over 730 names appeared in the 1906 register with almost 900 names in the 1907 register, a stark indication of the scope and significance of this hitherto unregulated sector which flew quietly under the radar as women's work. Unlike the nurse's register, the Register of Midwives had two classes

[121] *Hospitals and Charitable Institutions Act 1885*, S4 (Wellington: Government Printer, 1885).
[122] *Hospitals and Charitable Institutions Act*, S42.

of qualification. Class A midwives held a Certificate of Training in Midwifery approved by the Registrar, of which there were 75, while the balance were Class B midwives who had 'satisfied the Registrar' that they had at least three years in *bona fide* practice as midwives and that they were women of good character.[123]

For Mrs Starkie, midwife number 15, her initial classification as a Class B midwife on the first midwives register was quickly adjusted to a Class A registration.[124] The Central Midwives Board Certificate from the Obstetrical Society of London and her work experience at the Queen Charlotte Hospital in London were not initially deemed sufficient for her to achieve Class A status. The following year, however, her name appears on the Class A registry and remained there for the rest of her time in Wellington. This change would have been initiated by her for the following year's registry which gives an indication of the value she placed on the classification. Her midwifery career in New Zealand began in 1904 where she advertised herself as a 'certificated midwife' available to attend patients in their own homes.[125] A year later she had opened a private maternity home in Kent Terrace in Wellington promoting '[a]ccommodation for In-lying Patients and attends Out-Patients as usual…Authorised to practise in Great Britain and New Zealand.[126] The addition of the last tag line to her advertising at this point shows the significance she attached to her credentials and work experience. A prolific advertiser, she placed just under 600 advertisements in Wellington newspapers

[123] T.H.A Valintine, "Register of Midwives under "The Midwives Act, 1904"," in *New Zealand Gazette* (25 April, Wellington: Hospitals Department, 1907).
[124] Ancestry.com, "List of registered midwives," in *New Zealand, Registers of Medical Practitioners and Nurses, 1873, 1882-1933* (New Zealand Gazette: Hospitals Department, 11 April 1905).
[125] "Mrs. Starkie Certificated Midwife," *Evening Post* (Wellington), 25 October 1904, 1, https://paperspast.natlib.govt.nz/newspapers/EP19041025.2.2.1?end_date=31-12-1920&items_per_page=100&phrase=2&query=Mrs+Starkie&snippet=true&sort_by=byDA&start_date=01-01-1890.
[126] "Private maternity home," *New Zealand Times* (Wellington), 13 September 1905, 1, https://paperspast.natlib.govt.nz/newspapers/NZTIM19050913.2.2.5?end_date=31-12-1920&items_per_page=100&phrase=2&query=Mrs+Starkie&snippet=true&sort_by=byDA&start_date=01-01-1890.

between October 1904 and January 1909 when she appears to have left New Zealand and returned to England.[127]

The Midwives Act reflected the importance being directed towards building a healthy, growing nation and the fear that the dwindling birth rate would be disastrous for the country.[128] This could be seen the highly emotive rhetoric during the introduction of the Bill where Premier Richard Seddon cited the 15,767 pākehā children under one year old who had died between 1894 and 1903, declaring that 'reproduction and the preservation of life is one of the duties of mankind…essential for the continuation for the human race'.[129] The implications of women dying in childbirth were significant as he stated that mothers were responsible for 'the inward life of the family…and the loss under these conditions is disastrous in many instances to the husband, and irreparable so far as the children are concerned.'[130] Between 1894 and 1903, 732 pakeha women had died in childbirth, a number Seddon found unacceptable but hopefully fixable through his proposed programme of training and registration of midwives.[131]

The safety of women and their babies during childbirth were brought in to focus in two main strands within the Midwives Act – the instruction of midwives in their craft and the creation of a network well-managed state maternity hospitals where working class women could safely deliver their babies. It was passed on the 8th of November 1904 and brought into law on the 1st of January 1905 and included the introduction of the network of St Helen's Hospitals to be opened around the country. The first was St Helen's hospital opened in Wellington in May 1905 with hospitals in Dunedin, Auckland and Christchurch opened over the next two years followed by Gisborne in 1915, Invercargill in 1917 and finally Wanganui in 1921. The establishment of these hospitals marked a shift from birthing at home to a more medical environment and in part fuelled the growth of small private maternity hospitals, particularly in

[127] Ancestry.com, "Register of Midwives under "The Midwives Act 1904"," in *New Zealand, Registers of Medical Practitioners and Nurses, 1873, 1882-1933* (New Zealand Gazette: Ancestry.com, 4 April 1911).
[128] New Zealand Parliament, *Midwives Bill*, 2, House of Representatives 70-91, 70 (1904).
[129] *Midwives Bill*, 70.; NB data presented in the parliamentary debate related only to pākehā women and children. No data for Māori children at that time is available
[130] *Midwives Bill*, 70.
[131] *Midwives Bill*, 71.

rural areas. Demand for the St Helen's hospitals quickly exceeded supply so private hospitals became part of the mix as women were referred on to them when the St Helen's hospitals were full. [132]

A significant difference between the Nurses Registration Act and the Midwives Act was that the latter made registration compulsory in order to practice lawfully. Midwives were expected to have applied for registration by 1 January 1906. From 1 January 1907, anyone working as a midwife without registration was subject a fine of up to £20, regardless of their track record or length of service. False documentation and advertising claims could also lead to a twelve-month prison sentence.[133] The two-tiered system with Class A and Class B midwives recognised and validated previous work experience while signalling that the new standards had not been met. Training in private hospitals was initially not accepted despite provision being made in the Midwives Act for any existing public or private hospital to be able to instruct pupil nurses under certain conditions.[134] The preference was for a uniform system of training in the network of St Helen's hospitals with the goal of securing the future outcomes of maternal and infant welfare.

A perhaps unexpected consequence of the Midwives Act was the new competitive environment it created between midwives and medical men. Having established a two-tier classification system, Class B midwives tended to be older women who had practiced over a number of years and were well-schooled in the traditional medical hierarchy. While they were 'allowed' under the terms of their registration to attend births on their own, the more common practice was to call the doctor in towards the end of the first stage of labour, thereby also ensuring the doctor could claim his fee.[135] In difficult cases Mein-Smith suggests it was not uncommon for doctors to shift the blame to these lesser qualified women when things went wrong as they were less likely to speak out because of their reliance on the doctor for work.[136] Class A midwives, on the other hand, were less likely to succumb to this kind of intimidation. As the numbers of Class A

[132] 1909, *Hospitals and Charitable Aid in the Dominion: Report thereon by the Inspector-General of Hospitals and Charitable Institutions*, 11 (Wellington: AJHR H.-22).
[133] *Midwives Act 1904*, S16. (Wellington: New Zealand Government, 1904).
[134] *Midwives Act*, S21.
[135] Smith, *Maternity in dispute*, 16.
[136] Smith, *Maternity in dispute*, 17.

midwives grew, many opted to establish private hospitals working without direct input from the medical men who had hitherto dominated the private obstetric market, thereby creating fierce competition between them.[137]

Private Hospitals Act 1906

The introduction of the Private Hospitals Act 1906 was in many ways the final step in creating a space for nurses and midwives to operate independently and with authority in their own hospital environments. Its precursor was the amendment to the Public Health Act 1903 which required for the first time, private hospitals to be licensed and inspected in the same way as public hospitals. District Health Officers were instructed to 'make themselves acquainted with all such institutions' in their areas and in the first year of operation the Chief Health Officer Malcolm Mason reported that the increased power afforded these officers in their inspections had had a significant, improving effect.[138] 1905 presented a reality check, however, with an accident which occurred at a licensed private hospital involving the death of a young woman.[139] The incident threw a harsh light on the effectiveness of the regulations and shifted the discussion from being solely about licensing and inspecting premises towards ensuring that the hospital operators themselves were registered medical men or nurses and 'of the character' that would ensure a higher standard of treatment.[140]

As the role of the licensee became the focus of regulatory and professional compliance the private hospital licensees were afforded an enhanced status along with the new heightened levels of responsibility. The Private Hospitals Act meant that any private hospital, defined as a house, building or tent where medical, surgical or lying-in cases were received had to be licensed. The licensee had to be a registered nurse, midwife or doctor with each institution subject to regular checks by the hospital inspectors meaning that nurse and midwife registration became an even more significant qualification for women wishing to expand their careers. This controlled and regulated environment would become the space in which the

[137] Smith, *Maternity in dispute*, 18.
[138] 1904, *Public Health Statement by the Minister of Public Health*, xiii (Wellington: AJHR H.-31).
[139] 1905, *Public health statement by the Minister of Public Health*, xxx (Wellington AJHR H.-31).
[140] 1905, *Public health statement by the Minister of Public Health*, xxxi.

qualified women could continue their tradition of working alongside local doctors but were empowered to be the license-holder and thereby have equal agency and in most cases sole responsibility for how the hospital was run. This was particularly so in the maternity hospitals where childbirth was increasingly being managed without intervention by a doctor.

The impact of the legislation was encouraging according to Thomas Paget's annual reports to the Minister.[141] Initial inspections had revealed inconsistencies in the standards of nursing provision, adherence to the regulations and adequate fire escape provisions but by the end of 1910 almost all private hospitals were inspected and were found to be 'very much improved.'[142] The *AJHR* reports by the Inspector of Hospitals show that between 1908 and 1925 the number of private hospitals grew from 191 to 313.[143] Prior to 1908, the main source of information about private hospitals was in published medical directories. These provided a snapshot of numbers but at best were only a glimpse of what the numbers might have been given it was up to the owner to submit an entry at their own expense. The numbers show significant growth during 1907 and 1908, and while not all of the hospitals listed in the directories were owned by women, official records state that the vast majority were.[144]

As hospital numbers grew so too did a shortage of nurses to meet the increasing demand in both the public and private hospital system. To address the shortage, the department looked at a range of ways to attract women into the profession in New Zealand. In 1911, for example, 44 nurses were registered from Australia and Great Britain which alleviated some pressure on the system but many worked in different locations only for a short time.[145] The introduction of a fourth year of training at some hospitals also stemmed the movement of New Zealand-trained staff but perhaps most significantly nearly all Hospital Boards found in necessary to increase salaries.[146] The following year a debate around the introduction of a fixed payment

[141] 1911, *Public Health and Hospitals and Charitable Aid: Report thereon by the Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer*, 79 (Wellington: AJHR H.-31).
[142] 1911, *Public Health and Hospitals and Charitable Aid*, 79.
[143] 1926, *Department of Health Annual Report of Director-General of Health*, 23 (Wellington: AJHR H.-31).
[144] 1909, *Hospitals and Charitable Aid in the Dominion*, 14.
[145] 1912, *Public Health and Hospitals and Charitable Aid*, 19.
[146] 1912, *Public Health and Hospitals and Charitable Aid*, 19.

schedule for nurses in public hospitals around the country was introduced at the annual conference of hospital boards.[147] This was met with a muted reaction, not least from the nurses themselves who, via *Kai Tiaki,* urged consideration of the effects of 'throwing out inducements for nurses to remain in the service of their hospitals.' It was suggested that this might rather cause many to 'lose sight of the fact that a training school would cease to perform its function if its staff remained stationary' and that promotion of the most capable nurses was at the heart of the most successful training programmes.[148] Another approach taken by one hospital board was to provide free training for midwives as long as they agreed to practise for two years in a rural area in return.[149] This allowed the midwife to build up her practice without the debt of her training costs, particularly in more rural areas where locals were frequently unable to pay private hospital fees. Maclean noted, however, that there was 'considerable expense…incurred by the licensee, especially during the first year and this must be recovered if a living is to be made.'[150]

Despite these challenges, the number of private hospitals continued to increase as did the numbers of New Zealand-trained nurses and midwives, a fact positively reported by Hester Maclean as evidence that the new system was delivering results.[151] Formal training and registration was mandatory for women who advertised and presented themselves as midwives under the terms of the Midwives Act. For some women who were not trained and registered, there were potentially serious financial repercussions and the risk of not being able to practice at all. Mrs Emma McNichol of Wyndham was one of the first unregistered midwives to be convicted in July 1908.[152] Annie Jones of Waihi followed shortly after in September 1908, receiving a fine of just 20 shillings plus 30 shillings costs, well short of the maximum £20 fine

[147] "Payment of hospital nursing staffs," *Kai Tiaki: the journal of the nurses of New Zealand* VII, no. 1 (1 January 1914): 43, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1914/01/01/51.
[148] "Payment of hospital nursing staffs," 45.
[149] 1912, *Public Health and Hospitals and Charitable Aid*, 22.
[150] 1913, *Public Health and Hospitals and Charitable Aid: Report thereon by the Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer*, 14 (Wellington: AJHR H.-31).
[151] 1913, *Public Health and Hospitals and Charitable Aid*, 14.
[152] "Brevities," *Evening Star* (Dunedin), 15 July 1908, 8, https://paperspast.natlib.govt.nz/newspapers/evening-star/1908/07/15/8.

which she could have received. The police stated she had 'acted out of ignorance, and did not intend to practice further as a midwife'.[153] Margaret Bradley was fined 10s in June 1909 following the death of new born twins in her care but was acknowledged by both the police and the Magistrate to be 'a respectable woman', thus ensuring a lower penalty.[154] In other instances, women who had established lengthy careers did not take the next step to become registered. One such example was Sarah Foster who despite three decades of experience in Feilding opted not to register and delivered her last baby in 1906, just prior to the act being fully enforced.[155]

Nurse training

New Zealand's commitment to professionalising its nurses and midwives continued to evolve to reflect the demands of the expanding hospital network and the communities they served but did not recognise private hospitals as part of the mix. A new hub and spoke training model was introduced in 1910 whereby the main hospital of the district was deemed the base hospital with various outlying cottage and specialist hospitals such as maternity units and sanatoriums became part of its network. The nurse training school was at the base hospital but all student nurses would serve part of their training in a consumptive sanatorium or fever hospital, a chronic ward, or a cottage or emergency hospital in the region attached to the main hospital.[156] Training for midwives was channelled into the network of St Helen's hospitals which grew to seven establishments around the country.

Private hospitals remained outside this framework but continued to reap the benefits of the publicly trained nurses. Assistant Inspector of Hospitals Hester Maclean's conflicted view was that for the nurses destined for private hospital work 'a private-hospital training is of great value' but at the same time dismissed it as not rigorous enough for ward sisters or matrons of

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[153] "Waihi Police Court," *Waihi Daily Telegraph* (Waihi), 1 September 1908, 2, https://paperspast.natlib.govt.nz/newspapers/waihi-daily-telegraph/1908/09/01/2.
[154] "Magistrate's Court," *Press* (Christchurch), 9 June 1909, 3, https://paperspast.natlib.govt.nz/newspapers/press/1909/06/09/3.
[155] "Old Manchester Block Settler Passes Away," *Manawatu Times* (Palmerston North), 2 February 1929, 3, https://paperspast.natlib.govt.nz/newspapers/manawatu-times/1929/02/02/3.
[156] 1910, *Hospitals and Charitable Aid in the Dominion: Report thereon by the Inspector-General of Hospitals and Charitable Institutions*, 9 (Wellington: AJHR H.-22).

training hospitals.[157] These views were driven as much by the nurses themselves as they were by central government with Maclean citing the strong comments expressed at the nursing national conference in late 1909 as the voice of a profession which did not think good training standards could be met at private hospitals and discipline could not be enforced. Perhaps more realistically, the conference also recognised that private patients would not necessarily be happy to pay for inexperienced and unqualified nursing unlike the public hospitals where the user-pays ethos was less pronounced.[158]

Financial and business management were not core subjects in the nurse training programme. This meant that most nurse licensees had to operate on instinct or perhaps from what they had learnt working in a family or small business before embarking on their nurse training. As some of the larger hospitals extended to a four year programme, ward administration was added to the final year's curriculum, providing useful insight into the economics and financial model of managing the hospital environment.[159] It was also intended to be part of the five-year nursing diploma course at Otago University in the 1920s which failed through lack of funding and academic support without any nurses having completed the course.[160] By keeping the training within state management it could shape the knowledge and skills of the nurses moving through the system. Then, by regulating the private hospital industry there was a measure of control over the environments in which they worked and at the same time legitimised this space, allowing registered nurses and midwives to carve out a commercially viable business cloaked in the femininity of a caring profession. It was not until the successful campaign of the Sisters of Mercy to make Mercy Hospital in Auckland a training establishment in 1937 that the dominance of public hospital training began to change.

New Zealand Trained Nurses Association

As their working world became more professionalised, so too did the nurses themselves by creating nursing organisations around the country. Wellington nurses were as the first to

[157] 1910, *Hospitals and Charitable Aid in the Dominion*, 10.
[158] 1910, *Hospitals and Charitable Aid in the Dominion*, 9.
[159] "Training of nurses," *Kai Tiaki: the journal of the nurses of New Zealand* V, no. 2 (1 April 1912): 19.
[160] Beryl Hughes, "Nursing education : the collapse of the Diploma of Nursing at the University of Otago, 1925-1926," *New Zealand journal of history* 12, no. 1 (1978): 24.

formally set up an association in June 1905 for nurses working in the private rather than state sector.[161] A group of nurses, struggling with the lack of employment opportunities, pooled their resources to form the Wellington Private Nurses' Association. The pragmatic objective was to create an employment bureau but it 'also recognised a professional responsibility to guarantee a public service that would be provided by qualified and registered nurses.'[162] In other words, the registered nurses saw this as an opportunity to distinguish themselves from so-called nurses with no qualifications. In the early years of the Nurses Registration Act, while registered nurses were 'given preference' for employment, it was not a requirement. The Act merely provided a list of those who were registered and their work experience. Having some means of distinguishing themselves from untrained nurses was desirable. During the Bill's second reading The Hon. Mr. W.C. Walker, Minister in charge of Hospitals and Charitable Aid, had a more concrete ambition for the Act stating '[w]e want the public to be assured that when a hospital nurse goes out with a badge on her arm she is there as a certificated minister of health…'[163] At the grass roots level, the Wellington nurses took this to heart and galvanised themselves into a group that 'would help them to organise work on their own account, protect the public from unqualified practitioners and advance the standards of nursing practice.'[164] This was followed by Dunedin shortly afterwards then Auckland and Christchurch the following year.

The marginalisation of unregistered nurses by their registered sisters was a form of control designed to preserve and elevate the space they earned through their training.[165] This form of ring-fencing had already been seen in other medical professions such as the doctors themselves, dentists and pharmacists. By declaring the boundaries and requirements for a particular profession the desire to exclude others was at least as strong as the desire to identify those who had achieved the standards. That is not to say that at the time the Nurses

[161] Lambie, *Historical development of nursing in New Zealand, 1840-1950*, 10.
[162] Anne L. McDonald, *Things accomplished: A history of the Wellington branch of the New Zealand Nurses' Association 1905-1989* (Wellington: New Zealand Nurses' Organisation Inc., 1993), 8.
[163] Hansard, *Hospital Nurses Registration Bill*, 180 (Wellington: Hathi Trust, 1901).
[164] McDonald, *Things accomplished*, 10.
[165] Wilson, "Professional closure : the case of the professional development of nursing in Rotorua 1840-1934," 13.

Registration Act was passed that the majority of nurses were pursuing the dream of professionalisation, more that once the Act was passed it presented an opportunity to create some leverage and enhance their prospects of employment in both the public and private arena.

By 1913 the Wellington Nurses' Club was opened on the corner of Abel Smith and Kensington Streets, funded, designed and run by the Wellington Branch of the New Zealand Trained Nurses Association. It had three main functions – to provide residential accommodation, operate as an employment bureau and provide a venue for branch activities.[166] Permanent boarders and nurses who moved in and out of the club as their employment dictated made up the bulk of the residents but there was also space for out of town nurses on a casual basis as and when rooms were available.[167] The 14 bedrooms accommodated 31 nurses at the start but by April 1932, at the height of the Depression, there were between 47 and 68 nurses in residence each week.[168] The employment bureau acted as a hub where doctors could seek nursing support for their patients who were being treated or recuperating at home. Patients could also apply for nursing support directly. Nurses who worked through the bureau paid £1 annual membership fee and a percentage from each position they took. Cases were allocated on a rotating basis with nurses given only a limited opportunity to refuse a position. Any more than a week's refusal would see her board increased to the rate that visiting nurses were charged. Initially each region set its own charges for nursing fees but gradually a national fee structure was established.

What started as a grass roots effort to create better work opportunities for private nurses in one city quickly spread into a nationwide platform for advocacy for all trained and registered nurses over the following decades. Similar models to the Wellington branch were established with Otago the first branch to include nurses in public hospitals.[169] Auckland and Christchurch followed suit and all regional associations had the support of their local medical

[166] McDonald, *Things accomplished*, 16.
[167] McDonald, *Things accomplished*, 18.
[168] McDonald, *Things accomplished*, 19.
[169] Hester Maclean, "President's address," in *Central Council Meeting*, NZNA - Minutes, annual reports etc (79-032-32/1 National Library of New Zealand: New Zealand Trained Nurses' Association, 17 November 1909), 2.

communities.[170] In 1909 the New Zealand Trained Nurses Association (NZTNA) was formed with its stated objectives[171]:

1. To bring into accord the Association of Trained Nurses formed in the four centres of New Zealand, and to promote fellowship throughout the profession of nursing in the Dominion.
2. To further the interests of trained nurses and encourage a high ideal of their profession.
3. By discussion of debatable points in regard to present and future conditions of nursing to assist in maintaining a high standard of training throughout the Dominion.
4. To discuss and arrive at a mutual agreement with regard to any proposed legislation concerning nurses and submit such agreement to the Government.
5. In view of the probable recognition of nurses in Great Britain to guard against the probability of nurses trained in New Zealand not being eligible for registration on equal terms with the nurses of Great Britain.

The regional and national fora became a space where views could be aired and teased out before being presented to government on behalf of the profession. For example, the debate around moving from a twelve hour to an eight hour shift proved divisive and was a major topic of debate at the first meeting of the national body the New Zealand Trained Nurses Association (NZTNA) in 1909.[172] Similarly the decision by some of the larger hospital boards to extend nurse training to a four year programme raised the ire of some nurses who saw it as a means of retaining lower paid but better qualified nursing staff.[173] While this was cost-efficient for the hospital it reduced the number of qualified nurses required in its workforce meaning there were ultimately fewer jobs for them to go on to within the hospital. Critics also suggested that the need to extend the training programme was an unexpected consequence of moving to the eight-hour shift pattern as the same amount of training required could not be achieved within the significantly reduced hours.

[170] Maclean, "President's address," 2.
[171] New Zealand Trained Nurses' Association, "Objects," in *Central Council Meeting*, NZNA - Minutes, annual reports etc (79-032-32/1 National Library of New Zealand, 1909).
[172] "New Zealand Trained Nurses' Association: Triennial meeting of Central Council, and conference of nurses at Dunedin, November 12th, 1912," *Kai Tiaki: the journal of the nurses of New Zealand* VI, no. 1 (1 January 1913): 3.
[173] "Second day — 18th November," *Kai Tiaki: the journal of the nurses of New Zealand* III, no. 1 (1 January 1910): 10.

These kinds of issues were debated at a regional and national level creating a more cohesive voice, described by Mary Lambie in her report to parliament in 1939 as '…the moulding of nursing opinion and of developing a unity of thought and purpose.'[174] A strong theme underpinning much of the activity of the fledgling organisation was the desire for independence and professionalism for its members – independence in the where and how the organisation would function as a representative association on behalf of members and professionalism in the exacting standards of learning, nursing skills and behaviour which were expected of and applied to its members. Membership applications had to be supported by two testimonials, one of which was from the Matron at the nurse's training school, and the other as a testimonial to her good character.

As the NZTNA consolidated its position in the first decade of the twentieth century, recently appointed Assistant Inspector of Hospitals Hester Maclean, who had taken over from Grace Neill, travelled the country familiarising herself with her new role and forming relationships with the nurses organisations. It was her influence that encouraged the regional organisations to come together as a national association serving both public and private nurses. All registered nurses were trained in the same regulated system so her main focus was to ensure that the rapidly expanding service had a singular approach that 'would shape the future of nursing' while continuing to meet the changing needs of the country.[175] This included Plunket nurses, school and 'back blocks' district nursing, the Māori health nursing service and nurse training for Māori women.[176] Her influence expanded when she started the nursing journal *Kai Tiaki* in January 1908. Maclean unashamedly used it as a vehicle to steer the debate around nurse training, shift work, and developments in domestic and international nursing. News from 'Home' was frequent, particularly as New Zealand-trained nurses travelled to further their training and work experience. Analysis of New Zealand's health and nursing reforms were compared with Britain, Canada and Australia and were also featured as a means of promoting and sometimes encouraging a different perspective on issues such as nurse training in private

[174] 1939, *Annual report of the Director-General of Health*, 59 (Wellington: AJHR H.-31).
[175] "Hester Maclean," Dictionary of New Zealand biography, Te Ara - the Encyclopedia of New Zealand, 1996, accessed 4 April, 2022, https://teara.govt.nz/en/biographies/3m25/maclean-hester.
[176] Sargison, "Hester Maclean."

hospitals,[177] the terms and conditions of nursing employment[178] and private nursing fees.[179] A *Kai Tiaki* editorial in April 1910, for example, assured readers that the fee structure was 'not from a spirit of commercialism on the part of our members that this has become necessary', rather it was a means to establish an equitable fee structure throughout the country that recognised experience and longevity of service while protecting both the public and nurses from 'those who were unscrupulous'. Maclean's approach was a curious mix of strident advocacy for nurses but unquestioning subordination to authority which, in a public hospital environment, inevitably meant to the medical men. On the other hand, she is reported to have congratulated a nurse on her successful libel action against a doctor and argued for matrons to have full authority over selecting and training their staff.[180]

Maclean also used *Kai Tiaki* as a platform to engender an aspirational confidence amongst members of the NZTNA. Whilst a huge supporter and advocate of state registration and training, Maclean was also adamant that Association members were expected to be of a certain demeanour and standing. This was never more clear than in her quarterly reflection on the activities of the Central Council meeting in April, 1910 which stated that 'the Association partakes more of the nature of a private club, and the personnel and the social attributes of members can be taken into consideration.'[181] State registration had to be recognised in the work environment, of course, but 'so many registered nurses would not be desirable as members of a club, though professionally nothing can be said against them.'[182] So while the government and nurses themselves were busy creating a level playing field for their working environment and professional development, it was still tinged with the remnants of a class structure harking back to 'Home' and the vestiges of the Nightingale ethos of nursing.

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[177] Hester Maclean, "The training of nurses in private hospitals: Advantages and disadvantages," *Kai Tiaki: the journal of the nurses of New Zealand* 3, no. 3 (1910): 98.
[178] Hester Maclean, "The Hospitals and Charitable Institutions Acts, 1909 as it will affect nurses and other women," *Kai Tiaki: the journal of the nurses of New Zealand* 3, no. 4 (1910): 139.
[179] Hester Maclean, "Fees for private nurses," *Kai Tiaki: the journal of the nurses of New Zealand* 3, no. 2 (1910): 47.
[180] Sargison, "Hester Maclean."
[181] Hester Maclean, "New Zealand Trained Nurses' Association Central Council," *Kai Tiaki: the journal of the nurses of New Zealand* 3, no. 2 (1910): 49.
[182] Maclean, "New Zealand Trained Nurses' Association Central Council," 49.

Interestingly, Maclean's view was not an issue of state versus private nurses it was simply the belief that while the training, registration and payment of nurses should and would be uniform and on an equal platform, their capacity to join the 'prestigious' NZTNA was not a given, at least until they had proved themselves as appropriate future members.[183]

Conclusion

In the lead up to the first world war the levers of control in both public and private hospitals were taking hold. Nurse and midwife training was well-established with records showing that by 1914 eighty-four percent of registered nurses had trained in New Zealand with the bulk of those who trained overseas registering between 1910 and 1914 as more international recruits were brought in to address nursing shortages.[184] In 1914 there were 1632 registered nurses and 1373 registered midwives, some of whom were qualified in both areas.[185] The New Zealand Official Yearbook shows that for the year ended 31 March 1915 there were 63 public hospitals with just 301 trained nurses and 647 probationers servicing 3531 beds. What this data shows is just how many of nurses who finished their training in the public system then either chose to or were forced to find work in the private sector through lack of opportunity.[186] Although private hospitals and private nursing were still a preferred option for many who could afford it, attitudes towards public hospitals were becoming more favourable.[187] This was not universally welcomed with doctors in one hospital board threatening to withdraw their services if every patient was allowed access to public hospitals regardless of their ability to pay for services.[188] However, availability of public hospital beds for a growing population could not be met solely by the public sector. The recently regulated private hospital sector was still crucial to the medical landscape which helped fuel their continued rise over the next two decades.

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[183] Maclean, "New Zealand Trained Nurses' Association Central Council," 49.
[184] Nurses and midwives board, "Register of nurses." Data analysis
[185] Nurses and midwives board, "Register of nurses," 191.; Government Statistician, *The New Zealand Official Year-Book, 1915*, (Wellington, New Zealand 1915).
[186] Government Statistician, *The New Zealand Official Year-Book, 1915*.
[187] Minister of Health, "A health service for New Zealand: Presented to the House of Representatives by leave," (Wellington: Department of Health, 1974), 39.
[188] Minister of Health, "A health service for New Zealand," 40.

As childbirth became more medicalised in response to concerns about infant and maternal mortality, opportunities for private midwifery hospitals became more common. Women practiced in the art of delivering babies could expand into a more commercial model in the form of small maternity hospitals based in their homes or, for the more ambitious, larger hospitals serving a dozen or so women at a time. They could still operate within the accepted, womanly maternity space but own their own businesses and/or properties, set their own fees and build their own client bases, independent from but collaboratively with the medical men. The expansion of the private hospital network was not limited to maternity hospitals, however, with at least one third to a half of all businesses being dedicated to medical and surgical units and in smaller towns, so-called 'mixed hospitals' catering to medical, surgical and maternity needs.[189]

The government's somewhat conflicted view about the role of private hospitals in the mix of hospital provision may have served to promote the rise of the sector. The improved standards resulting from the private hospital legislation created better outcomes for patients and eventually led to private hospitals being used as training venues to boost nursing numbers and address shortages. That was not achieved until 1937 during which time the government's refusal to bring private hospitals into the training mix may have helped to embed them into a commercially viable niche unencumbered with the requirements of training and the external scrutiny that would have come with it. In addition the formalisation of training and registration for nurses and midwives saw the nurses galvanise into a national body that articulated a more a cohesive voice and brought both the private and public nursing sectors onto more equal footing. The next chapter will investigate the rise of the private hospital and how it continued to flourish, despite increased regulation and controls implemented by government and predominantly with women at the helm.

[189] *AJHR* and yearbook data. See Figure 1. on page 56 in next chapter.

Chapter Three – The rise of the private hospital

The government's attitude towards private hospitals and their nursing staff reflects the complex and often conflicted view it had about the provision of medical services in the early twentieth century. On the one hand it wanted to implement a robust, uniform state system throughout the country that was representative of and partially funded by the communities it served, but on the other hand it could not or did not want to fund the entire hospital system. This 'user pays' model was a sliding scale of investment that saw the deserving poor not expected to make direct contributions in public hospitals unless they could afford it and those who were able to afford medical treatment encouraged to go down the private hospital route. Private hospitals were complementary to this and, once the necessary legislation was in place, were intended to be self-funding but centrally controlled. Regulations laying out robust standards for the management, training, staffing, hygiene and record-keeping in those hospitals were put into effect but with no financial support to the licensees to achieve this. The Private Hospitals Act 1906 was superseded by the Hospitals and Charitable Institutions Act, 1909, bringing private hospitals into the same regulatory environment as public hospitals. So, while the number of public hospitals grew steadily from 43 in 1900 to 56 in 1910, the private hospital network had a slightly more confused trajectory as the implications of the newly regulated environment created volatility. This had stabilised by 1912 at 198 private hospitals and then rocketed to 327 in 1929 – almost 65 percent growth – before the inevitable slump of the depression saw 53 private hospitals close down in just two years.[190]

This chapter will explore these changes looking at the different types of private hospitals, who owned them and how they served the communities in which they operated.

The evolution of private hospitals

The path to the niche business sector traces back to the very early days of settlement in New Zealand. As early as 1860 there are references to private hospitals, sanitoriums and nursing homes throughout the country which were available for those who were 'in a position to pay

[190] 1912, *Public Health and Hospitals and Charitable Aid*; 1929, *Department of Health Annual Report of Director-General of Health*, (Wellington: AJHR.-31).

for in-door medical relief and support'.[191] Hotels were sometimes used as an alternative when private hospitals were not available as '[m]any would almost rather perish than be taken to the public hospital'. Historically, medical and surgical hospitals were owned by both medical men and nurses while maternity hospitals were predominantly a female domain. The term 'nursing home', most often associated with maternity services, only emerged in the last decade of the century and until then was more often referred to as a 'lying-in' or 'accoucheuse' hospital, the French word for midwife. While there was some formal training for general nursing in the major hospitals from 1884 onwards, midwifery was still very much an informal skill carried out by women who gained their knowledge through hands-on experience and shared learning.

In 1867 the Southland Times promoted the Invercargill Sanatorium and Private Hospital as 'an institution that promises to supply a need much felt in the Colonies'.[192] The primary reason given was the cost for people requiring medical treatment at home was prohibitive but that they 'are yet too independent to submit to the alternative of becoming the inmates of a charitable institution'.[193] Mr F.A. Monckton, who had previously been the surgeon to the Provincial Hospital of Southland, was the new Superintendent for the Clyde Street property which offered services to both men and women. The intention of providing this 'middle ground' for people not wanting to be in a public hospital also offered options to the patients – at least to men. Similarly in Christchurch the rejection of state hospitals by upper and middle class New Zealanders saw the establishment of a private hospital '… where persons may be

[191] "Private hospital at Hokitika," *Wellington Independent* (Wellington), 19 December 1865, 7, https://paperspast.natlib.govt.nz/newspapers/WI18651219.2.27.1?end_date=31-12-1890&items_per_page=100&phrase=2&query=private+hospital&snippet=true&start_date=01-01-1850.; "Private hospital," *West Coast Times* (Hokitika), 19 December 1867, 4, https://paperspast.natlib.govt.nz/newspapers/WCT18671219.2.18.3?end_date=31-12-1890&items_per_page=100&page=2&phrase=2&query=private+hospital&snippet=true&start_date=01-01-1860.; "Private hospital," *Star* (Christchurch), 2 April 1878, 4, https://paperspast.natlib.govt.nz/newspapers/TS18780402.2.21.3?end_date=31-12-1890&items_per_page=100&page=2&phrase=2&query=private+hospital&snippet=true&start_date=01-01-1860.
[192] "Inveniam viam aut Faciam," *The Otago Daily Times* (Dunedin), 2 May 1867, 4, https://paperspast.natlib.govt.nz/newspapers/ODT18670502.2.15?end_date=31-12-1890&items_per_page=100&page=23&phrase=2&query=private+hospital&snippet=true&start_date=01-01-1860.
[193] "Inveniam."

treated who have an objection to become inmates of a Government institution'.[194] In the latter half of the nineteenth century, these private hospitals were largely the domain of doctors but increasingly women and occasionally husband-and-wife names began to appear advertising their services primarily for medical and surgical hospitals.[195] As more nurses moved into this space their advertising also included their work experience and training as a means of establishing their credentials in the eyes of the public and the local medical community. This was an important aspect as they built relationships with the doctors who were integral to the success of their business but increasingly were in direct competition.[196] Interestingly, much of the advertising during this period related to medical and surgical hospitals with very few advertisements appearing for private maternity hospitals. This is not to say that there were none, simply that until the government began to take an interest in their operation in the early twentieth century, they appear to have flown under the radar and operated by word of mouth within local communities.

For those hospitals promoting their services, charges varied considerably depending on the area and the expertise that was offered. At Mr Monckton's hospital in Christchurch in 1867, for example, male and female patients would pay £5 per week for 'First Class treatment' while male patients could also opt for 'Second Class treatment' for just £3 per week.[197] Almost 30 years later Mrs Hesk's hospital in Wellington, which was owned and staffed by women, charged four guineas (£4 4 shillings) per week exclusive of surgical dressings, drugs, stimulants and personal laundry.[198] Mrs Cornish in Dunedin was also charging £4 4 shillings including medical attendance for the first week after childbirth and £2 2 shillings for the second week while

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[194] "Local and general: Private hospital," *Star* (Christchurch), 29 January 1873, 2, https://paperspast.natlib.govt.nz/newspapers/TS18730129.2.9?end_date=31-12-1890&items_per_page=100&page=23&phrase=2&query=private+hospital&snippet=true&start_date=01-01-1860.
[195] There is no central record for this information. Data is gleaned from a search of 'private hospital' and 'nursing home' between 1860 and 1900 in *Papers Past*.
[196] "Private Hospital: Grant Road, Wellington," *New Zealand Mail* (Wellington), 16 February 1894, 12, https://paperspast.natlib.govt.nz/newspapers/NZMAIL18940216.2.22.2?end_date=31-12-1894&items_per_page=100&phrase=2&query=private+hospital&snippet=true&sort_by=byDA&start_date=01-01-1894&type=ADVERTISEMENT.
[197] "Sanatarium and Private Hospital," *Southland Times* (Invercargill), 22 April 1867, 1, https://paperspast.natlib.govt.nz/newspapers/ST18670422.2.2.2?end_date=31-12-1890&items_per_page=100&page=3&phrase=2&query=private+hospital&snippet=true&start_date=01-01-1860.
[198] "Grant Road."

surgical and other cases were charged from 30 shillings per week depending on their seriousness and length of stay.[199] Around the same time in Christchurch, in 1897, the Strathmore Private Hospital, which was built for mainly surgical cases and was pioneering in aseptic surgery under the guidance of Dr Joseph Townend,[200] charged from just two guineas (£2 2 shillings) per week with patients advised they could be seen by their own medical advisor.[201] As it accommodated 40 patients it may have been a function of scale that allowed for seemingly cheaper rates.

The independence of the licensee of the hospital from the medical men who served in them is central to the premise of this thesis in that the private hospital created a more symbiotic environment where both parties had a level of reliance on the other in order to treat their patients. In the early development of private hospitals, many were owned and operated by medical men, in which case it was a given that they would provide their services to the patients of that hospital. However, as the sector expanded and became more regulated, more registered nurses and midwives stepped in to private hospital management and were working closely with the local medical men in their communities.[202] Unlike entering a public hospital where generally, but not exclusively, the patient received the treatment from the doctors and nurses attached to that particular institution, the proposition of the private hospital was that it provided the premises and nursing support for whatever surgery or treatment was required with the choice of the medical man, if there was a choice in the town, generally up to the patient. This three-way relationship, on paper anyway, put the patient's choice into the mix with a different professional power balance between the male doctors and female nurses, enabling license-holding nurses and midwives to ring-fence a small corner of the medical

[199] "Nursing Home," *Evening Star* (Dunedin) 1899, 5 August, 4, https://paperspast.natlib.govt.nz/newspapers/ESD18990805.2.34.2?end_date=31-12-1899&items_per_page=100&page=2&phrase=2&query=Nursing+home&snippet=true&sort_by=byDA&start_date=01-01-1899&type=ADVERTISEMENT.
[200] "A modern surgical hospital," *Press* (Christchurch), 29 October 1895, 3, https://paperspast.natlib.govt.nz/newspapers/CHP18951029.2.14.
[201] "Strathmore Private Hospital," *Ashubrton Guardian* (Ashburton) 1897, 1, https://paperspast.natlib.govt.nz/newspapers/AG18970917.2.6.6?end_date=31-12-1897&items_per_page=100&page=5&phrase=2&query=private+hospital&snippet=true&sort_by=byDA&start_date=01-01-1897&type=ADVERTISEMENT.
[202] 1909, *Hospitals and Charitable Aid in the Dominion*, 14.

commercial environment and stamp it clearly as their own. Of course in many small towns there was very little choice, particularly at the turn of the twentieth century which marks the beginning of this thesis research. The geographic distribution of medical men and women showed the inevitable draw away from small town rural life throughout the country between 1901 and 1931. The four major cities saw the number of doctors rising from 36 percent of the total pool to 45 percent while the so-called 'major towns' enjoyed a slight increase rising from 29 percent to 32 percent.[203] Small and rural towns felt this impact the most dropping from 34 percent of the total pool in 1901 to just 22 per cent in 1931 with the biggest hit occurring in rural Otago.[204] Nevertheless, where doctors and nurses co-existed to treat their local community, there was a mutual need and a degree of collaboration previously unseen in the state hospital environment.

Community needs and commercial opportunities

The numbers of private hospitals were not consistently reported by the government prior to the implementation of the Private Hospitals Act 1906 making it difficult to accurately assess how many there were in operation throughout the country before that time. Sporadic regional reporting such as that which appeared in the Public Health Statement 1905 by the Minister of Public Health Sir J.G. Ward, showed that in the Wellington and Nelson Districts, for example, applications for 43 private hospital licenses were submitted for approval with 34 being issued.[205] The lack of reporting is not surprising given that it was not until the amendment of the Public Health Act 1903, which incorporated public hospitals as part of the regulatory environment for the first time, that there was any reason for a national number to exist. With the implementation of the Act, central reporting became more robust with the first national number reported for 1908.[206] When the year started there were 191 private hospitals and by the end of that same year this had grown to 205. The Assistant Inspector of Hospitals Hester Maclean did not regard these numbers as showing a specific trend, however, as many hospitals

[203] Michael Peter Belgrave, ""Medical men" and "lady doctors" : the making of a New Zealand profession, 1867-1941" (Doctor of Philosophy The Victoria University of Wellington, 1985), 257.
[204] Belgrave, "“Medical men” and “lady doctors”," 257.
[205] 1905, *Public health statement by the Minister of Public Health*, 34.
[206] 1909, *Hospitals and Charitable Aid in the Dominion*, 14.

had changed hands, several were closed down and some were completely new licenses. A more significant data point showed that of the fifty eight general medical and surgical hospitals only 'two or three' were established by medical men, the rest were '…owned and conducted by well-qualified nurses.'[207] The remainder were maternity hospitals, eleven of which were operated by '…fully trained and qualified midwives…' and 136 owned by midwives who were already practicing when the Midwives Act 1904 was passed. Some of these will have been Class A midwives who had been formally trained but the majority Class B, those women whose classification was based on their work experience.

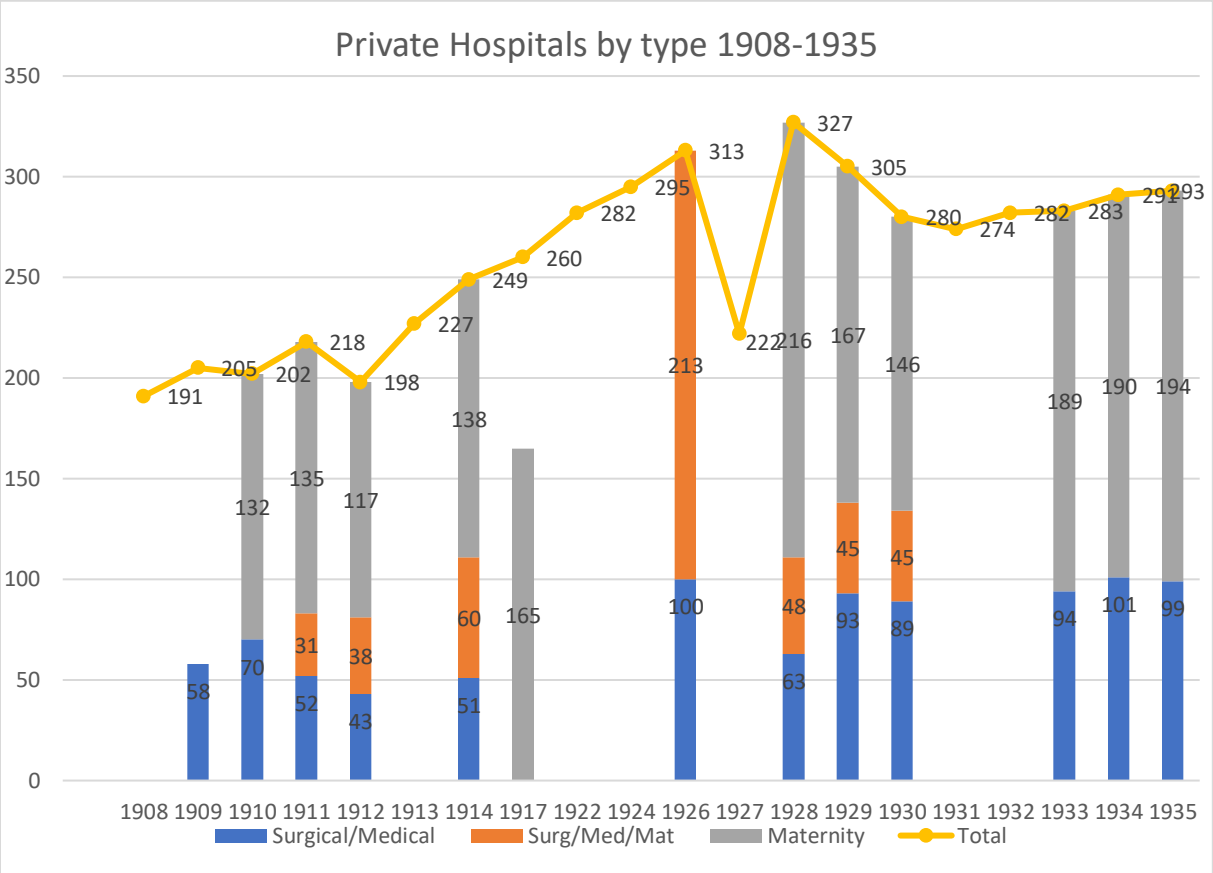

Figure 1: Private hospital numbers in New Zealand between 1908 and 1935 based on the New Zealand Official Year Book data and annual AJHR reports. Inconsistencies in the way and frequency the data was reported have created an incomplete data set.
Source: AJHR Health reports 1908 – 1935; New Zealand Official Year Book 1908 - 1937

[207] 1909, *Hospitals and Charitable Aid in the Dominion*, 14.

Maclean's observation, supported by methodical data gathering, was the first time nurse's ownership roles in the medical landscape had been so clearly articulated. Until that point, nursing was regarded, particularly in relation to midwifery, as a womanly career choice rarely considered as a commercial endeavour with some even regarding nursing as being above the grubbiness of commercial endeavour. The role of the matron and her nurses in the public sector was respected but operated in a strict hierarchical environment where they were unquestioningly subordinate to the doctor. This emerging perspective of nurses as business women, managers, entrepreneurs and independent operators was a new dimension in the nursing lexicon. During the early stages of transition, as could be seen by the number of closures and changes of management noted by Maclean, it was clear that this new standing was not suited to everyone. Equally some doctors were not willing to comply with the new regulations that required the licensees to get to sign off from the medical men on patient registers. Some doctors even went so far as keeping their records locked up away from licensees and showing them only to the government inspectors.[208]

In one case two Invercargill doctors successfully had charges dismissed for failing to provide necessary information to the matron of the Park Hospital where they were treating their patients. The Department of Health reported there had been 'considerable difficulties with Park Hospital authorities as two of the [doctors] would not comply with the regulations' which placed the matron 'in an extremely awkward position.'[209] The doctors' defence was that the hospital registers were not adequately protected and confidential patient information could be accessed by non-medical staff. They advised, however, that they had provided patient information in relation to the treatment plan which was adequate for the matron to then complete her records. The matron was charged with failing to keep her medical register up to date and on the basis of their respective testimonies, the charges against the doctors were dismissed but the matron was convicted and fined £2 with costs of £3 3 shillings.[210] The Department of Health brought the cases against all three parties but was 'very greatly surprised

[208] 1909, *Hospitals and Charitable Aid in the Dominion*, 14.
[209] "Doctors' secrets: Invercargill case. Local practitioners charged: Point of professional etiquette," *Southland Times* (Invercargill), 8 July 1926, 8, https://paperspast.natlib.govt.nz/newspapers/southland-times/1926/07/08/8.
[210] "Doctors' secrets," 8.

when in the case against the matron the doctors allowed her take all the blame on her own shoulders.'[211]

During the first full year of inspections after the implementation of the new Act it was established that well over half of the 202 licensed private hospitals in 1910 in the Dominion were small maternity homes 'owned by some of the old-time untrained midwives, who do not read or understand regulations.'[212] The inspections involved a visit from a member of the department's nurse inspectorate who checked that the hospital was being used according to its license – the number of patients, types of cases and required nursing practices. Seventy of the private hospitals were medical and surgical and owned mainly by trained and registered nurses with just a few owned by doctors who were allowed to take maternity cases as well, particularly in more rural areas.[213] They were larger and better equipped than those owned by the untrained midwives, and, according to Assistant Inspector Hester Maclean, were generally well conducted.

Under the terms of the Act, a medical, surgical or maternity hospital was defined as an institution which had two or more beds dedicated to patients and therefore had to comply with the regulations. In her report to parliament in 1910, Maclean observed that any lack of adherence to the new regulations by older, untrained midwives was ignorance rather than wilful disobedience.[214] This presented the department with an issue of how to manage discrepancies effectively while still ensuring there was an appropriate balance between compliance and availability of midwifery services, particularly in more rural areas. Sole operators taking on one maternity case at a time sat outside the Act's remit but still created safety concerns about the mother and her baby. Community education and ante natal clinics run by midwives became part of this solution but ongoing nervousness about unqualified

[211] "Doctors' secrets."
[212] 1910, *Hospitals and Charitable Aid in the Dominion*, 14.
[213] 1910, *Hospitals and Charitable Aid in the Dominion*, 14.
[214] 1910, *Hospitals and Charitable Aid in the Dominion*, 14.

women proffering their services was seen not only as dangerous to the expectant mothers but as very real competition to the qualified midwives trying to establish themselves.[215]

Doctors were usually only called for the later stages of labour but even this was not compulsory for women who could not afford or preferred not to have a doctor present. Most maternity hospitals tended to be small operations so despite their dominance in the number of institutions, they did not dominate the number of beds compared with private medical and surgical hospitals. The first year that bed numbers were reported by the department was in 1910 when the 1021 beds available around the country were divided roughly in half between the 132 maternity hospitals and 70 medical and surgical hospitals.[216] Over the next two decades this balanced shifted considerably with more women at the helm of larger medical and surgical hospitals. The next complete report of comparative data was in 1930 which showed that the 275 private hospitals provided 2291 beds, of which 884 were for maternity patients.[217] What is perhaps more significant is that private maternity beds still far outnumbered those in the public system. The 1930 *New Zealand Official Yearbook* reported that in 1928 there were just 128 beds offered at the seven St Helen's maternity hospitals around the country with a further 71 public maternity units or wards attached to state hospitals providing 479 beds.[218] This meant that the combined St Helen's hospitals and state hospital maternity units represented around 40 percent fewer beds than those in the private hospital network.[219]

Maternity hospitals – a blessing and a curse

The Department of Health inspection process also served to highlight where unregistered midwives were operating and force the owners to either become registered or close the hospital. Because demand for maternity services was high across the country, particularly in more rural areas, an enforced closure created an opportunity for another registered midwife to

[215] 1917, *Public Health and Hospitals and Charitable Aid: Report thereon by the Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer*, 8 (Wellington: AJHR H.-31).
[216] 1910, *Hospitals and Charitable Aid in the Dominion*: , 14.
[217] 1930*, Department of Health Annual Report of Director-General of Health*, 52 (Wellington: AJHR H.-31). 1930 Yearbook
[218] Government Statistician, *The New Zealand official year-book, 1931*, (Wellington, New Zealand 1932).
[219] Based on yearbook and *AJHR* statistics

take over or open a new hospital in her wake. By 1917, 35 private maternity hospitals had been established by nurses who had trained at St Helens.[220] The size and scale of the hospitals ranged from 178 deliveries in one maternity hospital over the course of a year to just three or four in the smallest maternity wing of a mixed medical, surgical and maternity hospital.[221] The average annual number was 58 confinements with a total of 1737 births in private hospitals In the year 1915 – 16.[222] While optimistic about the importance of private hospitals in the medical mix, Assistant Inspector Hester Maclean was also realistic about the obstacles facing many of the licensees. She observed that nurses were hampered by a lack of funds required to establish their business in a house suitable or at least easily adaptable for hospital purposes.[223] This, coupled with the cost of living increase raging through the country unmatched by the meagre three or four guinea fees charged '…does not give much profit for the arduous work, often without sufficient help.'[224] Such was her concern for small operators in country districts that she recommended Hospital Boards be required to give subsidies to midwives willing to start maternity homes in country districts.[225] Nothing came of her recommendation but it illustrates the department's awareness of the challenges facing licensees around the country, particularly in rural New Zealand.

The predominance of maternity and mixed maternity hospitals provided a unique opportunity for women wanting to own or run their own business and often placed them in direct competition with the doctors. A registered midwife had autonomy in her hospital as the licensee of her own premises and as the primary caregiver for the duration of what was usually a two-week confinement in hospital. The Department of Health's 'Campaign for Safe Maternity' was launched in the wake of the 1921 public inquiry into maternal and infant mortality rates. The *Maternal Mortality in New Zealand* inquiry was triggered by the Children's Bureau of the United States Department of Labour in 1921 which placed New Zealand second

[220] 1917, *Public Health and Hospitals and Charitable Aid*, 7.
[221] 1917, *Public Health and Hospitals and Charitable Aid*, 7.
[222] 1917, *Public Health and Hospitals and Charitable Aid*, 7.
[223] 1917, *Public Health and Hospitals and Charitable Aid*, 7.
[224] 1917, *Public Health and Hospitals and Charitable Aid*, 7.
[225] 1917, *Public Health and Hospitals and Charitable Aid*, 8.

highest in its list of nations in pregnancy and childbirth mortality statistics.[226] This drew attention to the country's poor maternity record and led to a special committee being established to investigate 'the question of deaths of mothers in connection with childbirth' in private and public hospitals throughout New Zealand.[227] The safe maternity campaign reflected the preventive approach to puerperal sepsis recommended in the inquiry's report and actively encouraged a more scientific and medical approach to childbirth.[228]

The unfortunate deaths of five women over the course of five months in 1923 from complications associated with their confinements at Kelvin Hospital raised concerns about the limitations of private maternity hospitals. The incidents occurred against a backdrop of continued concerns about low birth rates, the effects of the Great War and the impact of the flu pandemic in 1918, all of which had heightened awareness of the vulnerability of New Zealand's population. The Health Act 1920 was explicit about the role of the doctor in ensuring that notifiable infectious diseases such as puerperal sepsis were reported and carefully managed.[229] The 1921 *Maternal Mortality in New Zealand* report had recommended investigation by the Medical Officer of Health into each case of puerperal sepsis, quarterly reporting of morbidity and mortality rates and that 'every mother should be attended during confinement by a reliable and highly trained midwifery nurse.'[230] Suffice it to say the public shaming of New Zealand's maternal mortality statistics was enough of a spur for the findings of the committee to be followed through by the Department of Health but unfortunately failed to prevent the incidents.

Josephine Anne Gibbons was a registered nurse and midwife and with a certificate in the then described genre of 'mental hospital nursing'. She opened the Kelvin Private Maternity Hospital

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[226] D. McGavin C.J. Parr, J.S. Elliott, Maternal Mortality in New Zealand: Report of Special Committee set up by board of Health to Consider and Report on the Question of the Deaths of Mothers in Connection with Childbirth, (Wellington: AJHR, H.31B, 1921).
[227] C.J. Parr, Short Maternal Mortality in New Zealand: Report of Special Committee set up by board of Health to Consider and Report on the Question of the Deaths of Mothers in Connection with Childbirth, 1.
[228] Smith, *Maternity in dispute*, 23, 30.
[229] *Report of the Kelvin Hospital Commission*, 7 (Wellington: AJHR H.31A., 1924). https://paperspast.natlib.govt.nz/parliamentary/AJHR1924-I.2.3.5.39
[230] C.J. Parr, Short Maternal Mortality in New Zealand: Report of Special Committee set up by board of Health to Consider and Report on the Question of the Deaths of Mothers in Connection with Childbirth, 3.

in 1918 having purchased 22 Clonbern Road[231] and quickly earned a reputation as one of the most efficient private hospitals in Auckland.[232] The *Report of the Kelvin Hospital Commission* released in the wake of the deaths of the five women described the nursing at the hospital as proper and sufficient but in the same breath acknowledged '…the limitation of facilities common to practically all private maternity hospitals.'[233] The findings suggested an understanding that nurses in this hospital and around New Zealand worked as best they could in difficult and sometimes inadequate circumstances. The report ascribed this to the limited financial resources of the predominantly female licensees for whom '[i]t is, almost without exception, beyond the financial ability of these women to supply the class of building and equipment which the welfare of the patients…urgently demand…'[234]

While the findings of the report have subsequently been deconstructed and, to a certain extent challenged, [235] any shortcomings are perhaps best summarised by Mein Smith. She noted the Commission's willingness to ignore other issues such as the use of forceps during deliveries and its eagerness to blame the Department by adopting '…the unprofessional but easily understood explanation that the Kelvin cases were "connected one with the other"'.[236] The evidence showed they simply were not.[237] In parliament much of the debate focused on the notion of the inadequacy of private maternity homes with the Reform Party MP for Roskill Mr Vivian Potter describing them as '…too small to be run efficiently with safety…'[238] and acknowledging that while recommendations from the 1921 report had been made which may have averted the Kelvin Hospital tragedy, the implementation and enforcement of them had been sorely

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[231] "Kelvin Private Hospital," *New Zealand Herald* (Auckland), 6 September 1918, https://paperspast.natlib.govt.nz/newspapers/NZH19180906.2.78.4?end_date=31-12-1918&items_per_page=100&phrase=2&query=Kelvin+Private+Hospital&snippet=true&sort_by=byDA&start_date=01-01-1918&title=NZH.
[232] *Report of the Kelvin Hospital Commission*, 16.
[233] *Report of the Kelvin Hospital Commission*, 7.
[234] *Report of the Kelvin Hospital Commission*, 15.
[235] F.S. Maclean, *Challenge for health: A history of public health in New Zealand* (Wellington: Government Printer, 1964), 301.
[236] Smith, *Maternity in dispute*, 22.
[237] *Report of the Kelvin Hospital Commission*, 4-6.
[238] Hansard, Financial statement, v.203, 1077 (Wellington: Government Printer, 1924). https://babel.hathitrust.org/cgi/pt?id=uc1.32106019929220&view=1up&seq=5&skin=2021&q1=Kelvin

lacking.[239] As a result, the Kelvin Report acted as a lightning rod for legislative change that would affect the hundreds of mainly women around the country who owned and managed private hospitals. At the same time, it did not control the proliferation of private hospitals. The practical realities of life in small-town New Zealand created a need for more hospitals and a space that women like Nurse Gibbons were prepared to step into. Unfortunately for Nurse Gibbons, the tragedy led to a loss of reputation and ultimately her confidence, and she walked away from a profession in which she had been highly regarded and sought after by the women of Auckland.

The implications of the Kelvin Inquiry were not only reputational and operational for hospitals and licensees, there were also very real financial implications for hospitals where infectious outbreaks occurred. The protocols for managing puerperal sepsis were detailed and far reaching and had heavy implications for hospital operations. For example, regulations required that if a case of sepsis was found in a hospital the staff member responsible was sent home from the hospital immediately and the hospital temporarily closed. The room the patient occupied was immediately closed, a deep cleaning process implemented, and the used bed linen and clothing burned. An estimate found in relation to one such incident in Auckland suggested the cost of such a single episode could be as high as £13 13 shillings through lost fees, chemical treatments, the nurse suspension and the cost of a replacement nurse.[240] In the case of a larger hospital where more patients would have to be deferred, the costs would have been even higher. In Christchurch, Mrs Jean Stewart's private hospital came under both departmental and media scrutiny when one of her patients died from septicaemia. A public inquiry into the incident revealed that a seemingly mild fingernail infection of a nurse was the cause of the outbreak.[241] The hospital was closed, prospective patients made other arrangements, rooms were disinfected then repainted and papered all of which came at

[239] Hansard, Financial statement, 971.
[240] Mr Smith, "Note to H. Rich: Unbooked septic case," in *R23417696 - Creditors meeting minutes - Henrietta Rich* (Auckland: National Archives, 6 September 1918). IMG_5522.HEIC
[241] Inspector of Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Christchurch," in *R20963082 Private Hospitals - Mrs Jean Stewart, Christchurch* (Wellington: National Archives, 29 September 1927). 4585

considerable cost to her business.[242] The tragedy of the patient's death and the repercussions to Mrs Stewart's business were deemed sufficient so that no further punitive action was taken but, like Sister Gibbons, Mrs Stewart's reputation was immediately impacted and her business suffered.

Business Models

For women like Sister Gibbons and Mrs Stewart, service was clearly at the heart of their nursing and midwifery vocations but a desire to succeed in business must also have been a driving force and a necessity. Whether that motivation was rooted in financial independence, professional agency or social standing cannot be determined from this distance but the ownership and/or management of a private hospital certainly provided the opportunity to develop all three. To achieve this, licensees had to embrace an even broader business skill set which included balancing staff numbers with patients, recruiting, housing and retaining staff, keeping the premises and nursing practices up to departmental standards, building a reputation to secure relationships with medical men and attract patients, and ultimately take the financial risk required for this finely balanced equation to succeed.

Searching for patterns and common themes of why licensees chose that path revealed only that the stories and reasons were as individual as the women themselves. An analysis of the 1923 Register of Nurses who had served in World War One, for example, did not show any significant evidence of greater or fewer numbers embarking on ownership or management of a private hospital.[243] However, in her report to government in 1921, Hester Maclean suggested that the war years were transitional for the profession stating '[n]urses who felt obliged to carry on during the war years have [now] retired, and their places have been taken by returned sisters.'[244] There were of course women who did go into private hospitals, women who appeared to have connected while serving together, women who married and gave up their careers and women who returned and continued their service. In relation to private hospital

[242] Medical Officer of Health T. Fletcher Telford, "Memorandum for: The Diretor-General of Health, Wellington," in *R20963082 Private Hospitals - Mrs Jean Stewart, Christchurch* (Wellington: National Archives, 21 September 1927).
[243] 1923 Nurses Register used as the basis for this analysis as it would have included nurses up to and including 1922, allowing time for their return home and to have re-established themselves.
[244] 1921, *Department of Health Annual Report of Director-General of Health*, 24 (Wellington: AJHR H.31).

ownership and/or management, this manifested itself in a variety of different business models from families to friendships, sole operators and occasionally partnerships with medical men, each with different backgrounds and, presumably, each with different reasons for entering into such a venture.

Faith-based hospitals

Perhaps the most unexpected cadre of women to carve out a space in the private hospital sector did so under the guise of religion. Mater Misericordiae Hospital in Auckland was the first significant faith-based hospital in the country and opened in 1900 after a determined campaign by the Catholic order of Mercy nuns. The political pragmatism which had facilitated the opening of the Mater hospital in Auckland was almost immediately followed by a push to allow nurse-training to also come under the auspices of the faith-based private hospital. At that time, nurse nuns from the Mater Hospital trained at St Vincent's Catholic Hospital in Sydney as it was deemed inappropriate for them to attend the state nurse training schools in New Zealand but a concerted campaign with a network of supporters from within and outside the church yielded results.[245] The Mercy Sisters' ability to navigate the political system through third party endorsement and deft management of resistance to sectarian interests has been well-documented in Belgrave's *The Mater* but even then, it took until 1937 for the hospital to be officially designated as a training hospital.[246] Collaboration between the three Catholic hospitals, the Mater in Auckland and Our Lady's Home of Compassion and Calvary Hospital which were both in Wellington, along with the St George's Anglican Hospital in Christchurch would build momentum to overcome the issue. St Georges was established in 1928 and served by the Order of St. Elizabeth nursing nuns founded 'for the purpose of exercising a cheerful religious influence in hospitals.'[247]

While collaboration between the faiths helped diminish the obvious sectarian argument, resistance to the move was not solely about religion. Having made the high standards and

[245] Belgrave, *The Mater*, 59.
[246] Belgrave, *The Mater*, 60.
[247] "Order of St. Elizabeth: Rev. Mother in New Zealand," *Evening Star* (Dunedin), 4 February 1927, 10, https://paperspast.natlib.govt.nz/newspapers/evening-star/1927/02/04/10.

uniformity of New Zealand's nurse training programme one of the cornerstones to the regulation of nurses and midwives, to then move that control into the hands of faith-based institutions was a giant leap that tested the notion of reciprocity agreements with other countries. The New Zealand Trained Nurses Association was particularly nervous that by shifting training into the larger faith-based hospitals, there was a danger that the British Medical Association's support for New Zealand nurses might be lost. Ultimately, approval was granted with strong endorsement from the Department of Health.[248]

The Salvation Army Bethany Homes were also part of this faith-based grouping but on a slightly different footing. In collaboration with the St Helen's hospitals, the Army's nurses would attend lectures on midwifery at St Helen's hospitals while gaining practical experience within the Army's own network of maternity hospitals.[249] The Salvation Army Bethany Homes were primarily for single mothers giving birth but also catered to the wider maternity needs of the seven communities they served. In contrast to the other faith-based hospitals which were owned and run by female orders of nuns, the Bethany Homes were part of the male-dominated Salvation Army, albeit supported by predominantly female officers around the country.[250]

Mt Pleasant Private Hospital, Auckland – a case study

The Mount Pleasant Private Hospital in Auckland city is a case study in the many and varied partnerships and backgrounds of its nurse owners. Spanning from 1906 until 1958 at two different locations, the hospital had six different licensees, four in partnerships and four as individuals. The hospital's path over that time illustrates the diversity of the women who were the licensees and the opportunities and challenges, both personal and professional, that they faced during their respective tenures. All of the nurse licensees had trained at Auckland Hospital. Two had served in the New Zealand Army Nursing Service at different times during

[248] Belgrave, *The Mater*, 60.
[249] "State examinations," *Kai Tiaki: the journal of the nurses of New Zealand* II, no. 1 (1 January 1909): 27, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1909/01/01/27. "State midwifery examination," *Kai Tiaki: the journal of the nurses of New Zealand* VII, no. 1 (1 January 1914): 29, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1914/01/01/37.
[250] Raewyn Hendy, ""Lasses, live up to your privileges, and stand up for your rights!" : gender equality in the Salvation Army in New Zealand, 1883-1960" (A thesis submitted in fulfilment of the requirements for the degree of Master of Arts in History Massey University, 2017), 53-54.

World War One. One partnership dissolved when one party died suddenly. Most licensees rented the premises continuing to make improvements and expand. The final partnership purchased a building outright and had the longest tenure of 25 years. Mount Pleasant was licensed for surgical and medical patients and grew to be one of the largest in the city, employing at least 26 staff with a license for 34 patients.[251] No direct relationships between the various licensees and any of the medical men of the city have been sighted for this thesis but the 1901 census states that there were 58 medical practitioners in the urban centre of Auckland and by the 1941 census that number had quadrupled to 258.[252]

Established in 1906, Mount Pleasant Hospital's nurse founder Annie E. Green had already two decades of experience including the management of two other private surgical and medical hospitals. Over the course of her career Miss Green trained at Auckland Hospital from 1887 to 1890 before moving in to private nursing and then, according to the Register of Nurses, at private hospitals from 1897 until her retirement in 1912.[253] During her early years of private nursing she was based at nursing homes at 12 Karangahape Road and 1 Carlton Gore Road where she appears to have had some managerial responsibility.[254] In 1900 she established Woodside Private Hospital in partnership with Miss Ada Morrison who had trained at Auckland Hospital, before heading to the Royal Prince Alfred Hospital in Sydney and then Edinburgh to further her studies.[255] The partnership dissolved at the end of its two year agreement in 1902 when Miss Green opened Lynnholme Private Hospital in Ponsonby and Nurse Morrison continued to operate Woodside until her retirement in 1914.[256]

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[251] "Disposal of "Wickford."," *New Zealand Herald* (Auckland), 6 June 1932 1932, https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1932/06/06/8.
[252] Belgrave, ""Medical men" and "lady doctors"." 257
[253] 1915, Register of Nurses, 417 (Wellington: New Zealand Gazette). http://www.nzlii.org/nz/other/nz_gazette/1915/12.pdf
[254] "Nurses' Home: Notice of removal," *New Zealand Herald* (Auckland), 12 December 1896, https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1896/12/12/8.
[255] 1915, Register of Nurses, 431.
[256] "Woodside Private Hospital Auckland," *Taranaki Herald* (New Plymouth), 29 May 1914, 7, https://paperspast.natlib.govt.nz/newspapers/taranaki-herald/1914/05/29/7.; "Notice," Advertisement, *Taranaki Herald* (New Plymouth), 19 April 1902, 3, https://paperspast.natlib.govt.nz/newspapers/taranaki-herald/1902/04/19/3.

Miss Green's Lynnholme Private Hospital was a 16-room, two-storey wooden building on Ponsonby Road in Auckland licensed for medical and surgical patients and enjoyed the benefits of her excellent reputation.[257] In an horrific accident in November 1905 Lynnholme burnt to the ground with the loss of the life of Mrs Margaret Amelia Higgins.[258] The inquest blamed the Grey Lynn Borough for its lax regulations, given it had not required mandatory fire escapes nor adequate fire hydrants and water pressure to douse the fire.[259] It recommended that all private nursing homes should be licensed by the government and that all private hospitals should be brick rather than wooden. The tragic incident caused the loss of Miss Green's business and served to fuel growing public calls for the regulation of private hospitals. Miss Green's loss of business must have been a significant blow but by August the following year she had salvaged and auctioned what little she could from Lynnholme and opened Mount Pleasant Hospital, beginning a new chapter.[260]

Miss Green's successful six-year tenure of Mount Pleasant Hospital was beneficial to her both professionally and financially. Located at 84 Wakefield Street on the corner Mount and Wakefield Streets in Auckland, it offered both medical and surgical services. The building was owned by the Auckland City Council and leased to Miss Green.[261] Miss Green's stature grew as a key figure in the nursing sector in Auckland such that in 1912 she was the nursing representative for the oral and practical examinations for nurses seeking state registration.[262]

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[257] "Miss Green: Late Morrison and Green," *New Zealand Herald* (Auckland), 7 April 1902, 1, https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1902/04/07/1.
"Plague precautions," *New Zealand Herald* (Auckland), 30 April 1902, 4, https://paperspast.natlib.govt.nz/newspapers/auckland-star/1902/04/30/4.
[258] "Fire in private hospital: One patient burned to death," *Auckland Star* (Auckland), 27 November 1905, 5, https://paperspast.natlib.govt.nz/newspapers/AS19051127.2.46?end_date=31-12-1910&items_per_page=100&phrase=2&query=Lynnholme&snippet=true&start_date=01-01-1890.
[259] "Auckland: From our own correspondent," *Otago Daily Times* (Dunedin), 22 December 1905, 4, https://paperspast.natlib.govt.nz/newspapers/ODT19051222.2.98?end_date=31-12-1910&items_per_page=100&phrase=2&query=Lynnholme&snippet=true&start_date=01-01-1890.
[260] "Salvage," *Auckland Star* (Auckland), 12 December 1905, https://paperspast.natlib.govt.nz/newspapers/AS19051212.2.66.4?end_date=31-12-1910&items_per_page=100&phrase=2&query=Lynnholme&snippet=true&start_date=01-01-1890.
[261] "Wakefield Street 1912 - 1961," in *32619 ACC 213 Valuation Field Sheets 1912-1913*, Box 194 (Auckland: Auckland Council). 5326
[262] "State examinations," *Kai Tiaki: the journal of the nurses of New Zealand* V, no. 1 (1 January 1912): 12, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1912/01/01/19.

There are no archival records of Mount Pleasant but its successful continuation suggests that Miss Green successfully navigated her period as the hospital's owner. One of the few direct references to her success was on her decision to retire from nursing, the hospital was described in the *Kai Tiaki* nursing journal as 'the private hospital so successfully run for many years by Nurse Green.'[263] She was also financially secure, leaving over £1000 in her estate to her friend Mabel Fisher when she died.[264] Despite this auspicious and successful career, after retiring in 1912 Nurse Green disappeared from any kind of public profile and upon her death on 9 September, 1934, a single death notice appeared in the New Zealand Herald announcing her passing.[265]

The partnership of Marion Buchanan Bell and Marie Williams as the next licensees of Mount Pleasant Hospital ended abruptly with the sudden death of Nurse Williams. Nurse Bell had trained and worked at Auckland Hospital from 1897 until 1910, rising to become Assistant Matron in 1909.[266] Nurse Williams joined Auckland Hospital as a probationer in 1898 and, apart from a brief stint as a private nurse in 1904 and 1905, worked with Nurse Bell until the pair departed on a European excursion in 1911. The young women travelled to Europe together and while the trip appears to have been partly for pleasure, Nurse Bell also took the opportunity to secure her midwife certification at the Rotunda Hospital in Dublin. This kind of professional development was not uncommon amongst the nursing profession.[267] Prior to the Midwives Registration Act, nurses and midwives had been forced to go offshore to secure midwifery qualifications. The Rotunda was recognised as one of the world's leading teaching hospitals having been established in Dublin in 1745 and even after New Zealand's own training

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[263] "Notes from the hospitals and personal items," *Kai Tiaki: the journal of the nurses of New Zealand* V, no. 3 (1 July 1912): 91, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1912/07/01/52.

[264] "The Will of Annie Elizabeth Green," in *R9386822* (Auckland: Archives New Zealand, 31 October 1931), Lodged 28 September 1934. https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE48925507.

[265] "Deaths," *New Zealand Herald* (Auckland), 11 September 1934, https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1934/09/11/1.

[266] Register of Nurses, 407 (Wellington: New Zealand Gazette, 1913). http://www.nzlii.org/nz/other/nz_gazette/1913/7.pdf

[267] Register of Nurses, (Wellington: New Zealand Gazette, 1917). See Nurses Bell 640, Brewer 643, Damett 650, Holford 663, Lukin 670, Sanderson 685, Thomson 691, Wyatt 698 http://www.nzlii.org/nz/other/nz_gazette/1917/31.pdf

system was established, there was a certain kudos attached to having trained there. Returning to Auckland, the pair took over the lease on Mount Pleasant Private Hospital and expanded to include maternity services at the hospital.[268] There is little additional information about the hospital or indeed their partnership until the tragic demise of Nurse Williams in 1914 when she died of appendicitis while holidaying on Waiheke Island.[269] Rather than close the hospital, Nurse Bell continued to operate as the sole licensee until 1919 when another Auckland Hospital graduate, Adeline Gilmore, took over.

Each time a private hospital changed hands an application had to be lodged by the new licensee. When Adeline Gilmore applied for her licence, it was for 20 patients in 17 rooms for medical and surgical procedures. Adeline Gilmore had become a registered nurse in January of 1911 after finishing in the middle of her cohort of 75 young women from around the country.[270] She worked at Auckland Hospital for more than eight years before taking the leap into the private sector in 1919. Her records show she did not go beyond the rank of nurse or leave the public system so it is hard to imagine that the transition to running a private hospital of this size, responsible for staffing, budgeting, departmental inspections and general maintenance of the facility would have been an easy step. Her stint at Mount Pleasant was a short one and in July of 1921 Nurse Bertha Taylor became the new licensee.

At 38 Bertha Taylor was significantly older than most of her fellow students when she entered Auckland Hospital as a probationer in 1906. Her father had opposed her nursing ambitions so it was not until he died that she felt able to begin her training.[271] In 1916 she joined the New Zealand Army Nursing Service and was assigned to the hospital ship the Marama on its second charter to the Somme where it transported wounded soldiers to England for further treatment. Taylor then sailed back to New Zealand with convalescent soldiers on board before returning to

[268] "Notes from the hospitals and personal items," 88.
[269] "Obituary," *Kai Tiaki: the journal of the nurses of New Zealand* VII, no. 2 (1 April 1914): 92, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1914/04/01/46.
[270] G.W.A. Lester, "State examination of nurses," *Kai Tiaki: the journal of the nurses of New Zealand* IV, no. 1 (1 January 1911): 11, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1911/01/01/16.
[271] Rogers, *While you're away*, 90.

England where she was assigned to work at Codford Hospital in Wiltshire, England.[272] Having led a somewhat sheltered life in New Zealand looking after both her parents, the makeshift and often haphazard nature of nursing on board ship and in the field must have seemed a world away from her former life. Her enthusiasm for this new life can be seen in her joy at the simplest things while attached to the New Zealand Stationary Hospital in Wisques, northern France, where she would 'take a rug sometimes and sit in a patch of bluebells and do my mending, and the air is so fresh and crisp and everything is so beautiful.'[273]

Once back in New Zealand, Nurse Taylor was finally discharged from the NZANS in August 1919. It is not clear where, or indeed if she worked over the next two years, but in July 1921 the licence for the Mount Pleasant Private Hospital was transferred to into her name. In 1924, Nurse Taylor began a series of improvements which would see the hospital temporarily closed for 12 months, patients relocated to their homes and served by private nurses or sent to other hospitals. It reopened in 1925 and was run for the next four years by Nurse Taylor before a new partnership of Nurses Mander and Keyes secured their licence in 1929.

Annie Gertrude Mander and Isabel Cauldery Keyes were the first licensees to purchase a building for the hospital rather than renting. They had both trained at Auckland Hospital with Nurse Keyes achieving registration in December 1914 and Nurse Mander twelve months later. By 1919, Nurse Mander had been appointed as Sister at Auckland Hospital and continued working there until her departure in 1929. Nurse Keyes, however, joined the NZANS early in 1918 and sailed on board the *Corinthic* to England in one of the last convoys to assist the war effort.[274] She returned to Auckland Hospital in December 1919 and remained there with her colleague until they jointly took over the lease of Mount Pleasant Hospital in 1929. At this

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[272] Bertha Emily Taylor, "1878 - 1962: Letters and journal," (Wellington: Alexander Turnbull Library, 1917), MS-Papers-1291_006. https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE39925554&dps_custom_att_1=emu.p. https://www.nzans.org/NZANS%20History/NZANSHistory-1915-1922.html#HS

[273] Taylor, "1878 - 1962: Letters and journal," MS-Papers-1291_024. https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE39925554&dps_custom_att_1=emu

[274] "Nurses and masseuses proceeding to England on "Corinthic"," *Kai Tiaki: the journal of the nurses of New Zealand* XI, no. 2 (1 April 1918): 62, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1918/04/01/13.

stage, the hospital was still located at 84 Wakefield Street, however, just two years later, Mander and Keyes purchased a new building at 24 Princes Street. Originally known as 'Wickford', it was designed by well-known Auckland architect John Currie and home to Auckland businessman Nathan Alfred Nathan. Nurses Keyes and Mander bought the property for an estimated £8000 in mid-1932 however, in an agreement with the vendor's trustees did not take possession for another 12 months as their lease at Wakefield Street had another 17 months to run.[275] 'Wickford' had been built in 1906 as a private residence so required significant alterations. This included the rearrangements of the sink rooms and water closets, reconfiguring access to accommodation service areas and creating the operating theatre. The Wakefield Street property had expanded and was licenced to treat 24 patients with a staff of six registered and seven unregistered nurses, and a cook and a laundress, both of whom lived away from the hospital. The Princes Street property had an even more ambitious plan with the licence eventually increasing to 34 patients under the care of eight registered and 11 unregistered nurses as well as seven domestic staff.[276] Twenty of the twenty-six staff lived at the hospital, including Nurses Mander and Keyes, with the other six living in their own accommodation. The move to Princes Street took place in December 1933 and Mount Pleasant Private Hospital continued under the steady hands of Nurses Mander and Keyes for another 25 years until 1958 when it was bought by the University of Auckland. It has since been restored to its original glory and is now the University's registry office.

[275] "Disposal of "Wickford."."
[276] Inspector of Hospitals T.L. Paget, "Memorandum for: The Medical Officer of Health, Auckland," in *R6901597 Hospitals and institutions - private hospitals - Kenmare* (Auckland: National Archives, 7 July 1936). Photo #1794

Figure 2: Mt Pleasant Hospital, Princes Street, 1958. Nurses Mander and Keyes purchased, renovated and moved into these premises in 1933. The hospital continued to operate until 1958.

Source: Auckland War Memorial Museum Tāmaki Paenga Hira PH-NEG-H291

Nursing partnerships

As was seen at the Mt Pleasant Private Hospital, nursing friendships could be a starting point to shared ownership of a private hospital. In Wanganui, Eliza Livingstone and Annie Chambers took over the Braemar Private Hospital from Sister Alice Gordon who was in failing health. The 10-bed medical and surgical hospital opened in 1925 and just 18 months later, Sisters Livingstone and Chambers became the licensees. Sister Gordon had also owned a private hospital in Wanganui prior to 1914 when she moved into her purpose-built premises in Plymouth Street known as Braemar.[277] By 1930 Sisters Livingstone and Chambers had extended

[277] "Local and general," *Wanganui Chronicle* (Wanganui), 6 January 1914, 4, https://paperspast.natlib.govt.nz/newspapers/WC19140106.2.22?end_date=31-12-1930&items_per_page=100&phrase=2&query=Nurse+Gordon&snippet=true&sort_by=byDA&start_date=01-01-1910&title=WC%2cWH.

the license to 20 beds employing seven additional staff. Inspection reports were fulsome in their praise describing the hospital as being '…in splendid order.'[278] What is interesting about their partnership was that Sister Chambers moved away from Wanganui having married but retained her financial interest and position as joint licensee. Just two years later, Sister Livingstone also married but stayed working until a manager was appointed in 1941. Both women remained as licensees, and presumably beneficiaries of the hospital until Sister Livingstone's death in 1958.[279]

Families

While most hospitals had a single licensee responsible for its operational compliance, many relied on the support of family members to secure the success of their business. In Oamaru, the Symington sisters took over Glen Mavis in November 1934 having trained and worked separately in different parts of the country. With a population of 7680 at that time and at least five other private hospitals in the area, there was competition, so reputation was all-important.[280] Robina was the licensee for Glen Mavis and the eldest of the family of nine, having trained at the Batchelor Maternity Hospital in Dunedin and registered in 1917. Younger sister Elizabeth trained at St Helen's in Christchurch in 1922. Another sister Jessie also worked there as a domestic in an arrangement not unfamiliar to the family who had previously established a dressmaking business which sustained them when their father John died suddenly in 1909. The beautiful two-storey hospital was the third manse to the local Presbyterian church property and licensed for seven patients in four rooms with three additional rooms for the sisters and other staff members to stay.[281] Over the course of the next decade, the three

[278] L.M. Lea Nurse Inspector, "Inspection of private hospitals: Medical and surgical hospitals," in *R20963067 Private Hospitals – Regulations* (Wellington: National Archives, Department of Health, 30 August 1932); L.M. Lea Nurse Inspector, "Inspection of private hospitals: Medical and surgical hospitals."Photo number 3508
[279] J.P. Kennedy for Director Division of Hospitals, "The Medical Officer of Health, Wanganui: Braemar Private Hospital," in *R20963067 Private Hospitals – Regulations* (Wellington: National Archives 11 June 1964). Photo 3539
[280] Government Statistician, *The New Zealand official year-book, 1934*, (Wellington, New Zealand 1935). https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1935/NZOYB_1935.html#idsect2_1_17817
[281] "St Paul's Manse (Former)," Heritage New Zealand Pouhere Taonga, 2015, accessed 21 November, 2021, https://www.heritage.org.nz/list-details/3221/St-Paul%E2%80%99s-Manse-Forme#details.

sisters worked and lived there before Jessie as the last surviving sister finally closed the business and sold the property in 1944.

Lasswade private hospital, opened in in Palmerston North 1908, was also run by sisters Muriel and Evelyn Linton. They were two of six children brought to New Zealand in the 1880s by their parents John and Jemima. They started their New Zealand lives in Picton but in 1891 John died aged 63. At around the same time, Jemima established a private boarding school in Picton before moving the family to Masterton where she opened a boarding and day school.[282] Her determination and work ethic appears to have influenced her children with Muriel and Evelyn running Lasswade for 25 years with siblings Maude and Jessie living and working with them. All four sisters remained unmarried, were active church members and stalwarts of the local community, retiring together in 1933 and moving to Plimmerton, just north of Wellington to begin their retirement.[283]

Mother-daughter pairings were also common. In Thames, Janet Brown Waddell and her daughter Isabella Smith ran the Sperry Maternity Hospital, the largest in the town. When the Midwives Registration Act came in, both were designated Class B midwives in recognition of their respective years of experience but no formal training. The official departmental file for the hospital starts in 1916 with Mrs Smith as the licensee with just one patient in the hospital at the time of inspection. By 1920 and Mrs Smith had her mother, Janet, and two daughters assisting her and were much in demand as there was no other licensed hospital in the town.[284] The six-roomed house was licensed for four patients and although generally reported as being a well-run establishment, the stricter reporting requirements articulated in the Health Act 1920 coupled with ongoing nervousness in the wake of the *Report of the Kelvin Hospital Commission*

[282] "Mrs Linton (of Picton, Marlborough)," *Wairarapa Daily Times* (Masterton), 30 November 1897, 1, https://paperspast.natlib.govt.nz/newspapers/WDT18971130.2.4.7.
[283] "Valedictory function St Peter's Church: Misses Linton honoured," *Manawatu Standard* (Palmerston North), 24 February 1933, 11, https://paperspast.natlib.govt.nz/newspapers/MS19330224.2.120?end_date=31-12-1940&items_per_page=100&page=5&phrase=2&query=Misses+Linton&snippet=true&sort_by=byDA&start_date=01-01-1890; "Valedictory function St Peter's Church: Misses Linton honoured."
[284] Assistant Inspector, "Memorandum for the District Health Officer, Auckland: Mrs. Smith, Karaka Creek, Thames," in *R20963172 Private Hospitals — Smith, Mrs. Isobel, Karaka Creek, Thames. MATERNITY* (Wellington: National Archives, 12 July 1920). Photo 140436

in 1924 was driving more rigid adherence to private hospital standards. Concerns started to creep into the inspection reports suggesting that her age and experience did not necessarily equate to grasping modern medical standards.[285]

Figure 3: Janet Waddell and daughter Isabella Smith. (Date unknown.)
Barbara Faithfull Collection, The Treasury Research Centre and Archive, Ref: 2017.074.123

What redeemed Nurse Smith's position was that the medical men of the district were supportive of her, showing the importance of good relationships with the local doctors.[286] The

[285] Nurse Inspector Amelia Bagley, "Inspection of private hospitals: Maternity hospitals," in *R20963172* (Wellington: National Archives, 31 July 1924). Photo 140304
[286] Inspector of Private Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Auckland: Mrs. Smith's Hospital, Thames," in *R20963172 Privaate Hospitals — Smith, Mirs. Isobel, Karaka Creek, Thames.* (Wellington: National Archives, 20 August 1931). Photo 135619

medical profession, particularly outside the larger towns, needed the private hospitals in which to conduct their business just as the licensees needed the support of the doctors to provide a steady stream of work. Had they not been supportive of her experience and community standing, Mrs Smith may not have survived the ongoing departmental scrutiny and the doctors' place of business would have been compromised. The department's acknowledgement of Sperry Maternity Hospital as the main provider of maternal deliveries appears to have engendered a more pragmatic response from the Department of Health, an approach not always enjoyed in areas where there was more competition.

An example of a hospital that did not receive the same level of support was Kenmare Private Hospital in Otahuhu. Daisy Pee worked alongside her mother and sister at the Church Street premises. Both Cora and her daughter Violet were class B midwives appearing consecutively on the Register of Midwives but Daisy was not.[287] When Cora died in 1920, Daisy applied to take over the license but was declined because she was unregistered.[288] With two other maternity hospitals operating in Otahuhu offering nine beds the Department saw no need to make any concession, despite Daisy's years of experience.[289] She was advised she could only offer her midwifery services to one patient at a time in her home; any more would constitute a breach of the act and she would be liable to prosecution.[290] Her sister Violet took over the premises, licensed for two patients while Daisy opted to end her midwifery career and moved to New Plymouth.[291]

Non-registered owners

All private hospital licensees had to be a licensed nurse or doctor to run a medical and/or surgical hospital or a registered nurse, midwife or doctor to run a maternity hospital. There were, however, those who opted to invest in the business opportunity of a private hospital

[287] Register of midwives under the Midwives Act, 1908, 1982 (Wellington: New Zealand Gazette, 1914).
[288] C.J. Parr Minister of Health, "Letter to Miss Daisy Pee, Church Street, Otahuhu," in *R6901597 Hospitals and institutions – private hospitals – Kenmare* (Auckland: National Archives, 3 December 1921). 1637
[289] C.J. Parr Minister of Health, "Letter to Daisy Pee." IMG_1637.HEIC
[290] Assistant Inspector, "Letter to Miss D. Pee, Otahuhu," in *R6901597 Hospitals and institutions – private hospitals – Kenmare* (Auckland: National Archives, 19 May 1923). IMG_1643.HEIC
[291] Assistant Inspector, "Letter to Miss V. Pee," in *R6901597 Hospitals and institutions – private hospitals – Kenmare* (Auckland: National Archives, 10 October 1923). 1646

despite a lack of qualifications. In doing so the business owner was required to appoint a registered nurse, midwife or doctor to assume the mantel of licensee. Prospect House in Dunedin was a well-recognised medical and surgical hospital that had served the city since 1900. Miss Annie Tombe, a certificated nurse who trained at Dunedin Hospital, opened Prospect House in April 1900 to much fanfare and celebration.[292] The 14-room hospital had six wards, an operating theatre, accommodation for staff and the all-essential smoking room.

The building was owned by a Mrs James and leased by Miss Tombe who steered Prospect House through the legislative changes of 1903 and then 1906 to become a fully-licensed private hospital. In 1913 she sold her business to Nurse Helen Hay, a Class A midwife who had served in the South African War.[293] Under the terms of the Private Hospitals Act, while Nurse Hay was eligible to be a licensee of a maternity hospital, she was required to have a registered nurse as a co-licensee in order to operate a medical and surgical hospital. Sister Anne Spilman fulfilled that role and, when the hospital was sold to Miss Margaret Scott, Sister Spilman became the official licensee. Miss Scott was not a trained nurse but when her fiancé died during the early stages of World War One, she purchased the hospital, dedicating her life to the business until her retirement in 1943. The pairing of Miss Scott and Sister Spilman saw Miss Scott running the business for almost 30 years with Sister Spilman as the licensee between 1915 and 1940.[294] Despite not having nursing qualifications, Miss Scott was the public face of the hospital and was commonly referred to as Matron or Nurse Scott.

[292] "Miss Tombe's private hospital," *Otago Daily Times* (Dunedin), 14 April 1900, 4, https://paperspast.natlib.govt.nz/newspapers/otago-daily-times/1900/04/14/4.
[293] "Otago branch," *Kai Tiaki: the journal of the nurses of New Zealand* VI, no. 3 (1 July 1913): 92, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1913/07/01/9.
[294] "Notable personality of nursing profession — Sister Margaret Scott," *Evening Star* (Dunedin), 23 August 1947, 11, https://paperspast.natlib.govt.nz/newspapers/evening-star/1947/08/23/11; Medical Officer of Health, "Memorandum for the Director-General of Health, Wellington: "Prospect House" Private Hospital, Dunedin. Miss A. Spilman, Licensee.," in *R22503064 Private hospital - "Prospect House", St. David Street, Dunedin* (Wellington: National Arcives, 19 February 1940).

Partnerships with medical men

Business partnerships with medical men do not appear to have been the norm in private hospital ownership and in general, doctors stayed outside this commercial world. This may in part have been due to the way the Hospitals and Charitable Institutions Act 1909 was constructed whereby every licensed hospital was required to have a resident manager on the premises.[295] A medical man would be unlikely to be solely resident in a hospital as the success of his practice was defined by the portfolio of public hospital and/or university appointments he also secured.[296] Private hospital ownership would dictate that he employ a manager who was a registered nurse or midwife which would incur an additional cost. There are examples, such as Matron Ellen Gosling who went into partnership in 1913 with four Nelson doctors at Te Rangi private hospital. It is understood she bought a share in the hospital and became the resident manager of the 12-bed establishment which offered both surgical and maternity care.[297] Ironically, it was not uncommon during her eight-year tenure as Matron for the hospital to be referred to as Nurse Gosling's nursing home or hospital such was her reputation and standing in the town.[298] It's not clear how long Nurse Gosling retained her investment in the hospital or whether subsequent nurses had the same opportunity to invest but her lengthy tenure suggested she was at the very least a reliable business partner by her business colleagues and forged an unusual path for that time.

Owning a private hospital was another potential income stream for doctors who chose to invest in them but without the responsibility of being a licensee. Sister Beatrice Brooks was sponsored by four local medical men when she opened Belverdale Private Hospital in

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[295] *Hospitals and Charitable Institutions Act*, S118 (1) (Wellington: New Zealand Government, 1909).
[296] Belgrave, "“Medical men” and “lady doctors”," 5.
[297] "Maternity care in Nelson - Te Rangi," The Prow, 2014, 2022, https://www.theprow.org.nz/society/maternity-care-in-nelson/#.Y22r4exBxkpb.
[298] "Lost," *Nelson Evening Mail* (Nelson), 15 February 1917, 1, https://paperspast.natlib.govt.nz/newspapers/NEM19170215.2.7.6?end_date=31-12-1940&items_per_page=100&phrase=2&query=Nurse+Gosling&snippet=true&sort_by=byDA&start_date=01-01-1890; "Personal," *Colonist* (Nelson), 7 April 1917, https://paperspast.natlib.govt.nz/newspapers/TC19170407.2.27?end_date=31-12-1940&items_per_page=100&phrase=2&query=Nurse+Gosling&snippet=true&sort_by=byDA&start_date=01-01-1890. 4

Wanganui.[299] The purpose-built 12-bed medical and surgical hospital was originally in Bell Street but just three years later moved to another purpose-built establishment in Campbell Street accommodating 18 patients.[300] The accepted tender for the construction of the new hospital was £2340 in December 1912, a substantial investment that required considerable additional spending on specialist equipment in addition to the construction costs.[301] Although Sister Brooks retired to get married in 1918, having served on the hospital ship Maheno in 1916-17, the hospital has continued to serve the community at the same site as a private surgical hospital. Meanwhile, in Taranaki, Dr Doris Gordon and her husband Dr Bill Gordon pursued a different business model again, this time through the acquisition of a medical practice and an accompanying small private hospital. They bought Marire Private Hospital in 1919 from Dr Tom Paget, who went on to become the Chief Inspector of Hospitals. Dr Doris carved out a unique and iconic role as a robust and pragmatic health advocate, particularly for women, in rural New Zealand. [302]

Two sisters in Oamaru started their private hospital in February 1925, on quite a different kind of footing with local medical men who invested in the hospital but only with a minority share. Oamaru Private Hospital (Ltd.,) was formally registered as a private company with capital of £7000 with 7000 shares valued at £1 each.[303] 5000 of those shares were preference shares and 2000 ordinary shares and were split between the two major shareholders Gertrude Hall, a registered nurse and midwife and hospital licensee, and her sister, Mrs Lydia Tweed. By December 1925 the shareholding had expanded to 8250 shares with three Oamaru medical men – Doctors Douglas Alexander, Ronald Graeme Scott Orbell and John McGregor Scott – joining the company. Each took out a shareholding of 800 ordinary shares while local

[299] "History: Then," Belverdale Hospital Ltd, 2023, https://www.belverdale.co.nz/page/history/3/5/.
[300] ""Belverdale.": New private hospital," *Wanganui Chronicle* (Wanganui), 5 October 1909, 5, https://paperspast.natlib.govt.nz/newspapers/wanganui-chronicle/1909/10/05/5.
[301] "Local and general.," *Wanganui Chronicle* (Wanganui), 26 December 1912, 4, https://paperspast.natlib.govt.nz/newspapers/WC19121226.2.14?end_date=31-12-1940&items_per_page=100&phrase=2&query=Sister+Brooks&snippet=true&sort_by=byDA&start_date=01-01-1910.
[302] "Gordon, Doris Clifton," Dictionary of New Zealand Biography, Te Ara - the Encyclopedia of New Zealand, 1998, accessed 19 March 2023, https://teara.govt.nz/en/biographies/4g14/gordon-doris-clifton.
[303] "Companies registered," *Evening Star* (Dunedin), 28 February 1925, 6, https://paperspast.natlib.govt.nz/newspapers/evening-star/1925/02/28/6.

accountant Rhoderic Finch invested in 100 ordinary shares. Miss Hall held 3000 preference and 500 ordinary shares while her sister Mrs Tweed, a silent partner and presumably start-up investor, subscribed to 2000 preference shares and 1500 ordinary shares. Shortly after establishing the medical and surgical hospital, Miss Hall married and by 1930 no longer appeared on the register of nurses however all the respective investments in the business remained intact, at least until 1935.[304]

Wives and widows

While most women in the public system were single women who never married, this was not necessarily the case in the private hospital sector. It was not uncommon for private hospitals to provide a business opportunity for a woman who had been widowed or abandoned by her husband. Equally, there were married woman who took the opportunity to run their business from within the home, complete with husband, children and often other family members. This appears to be more common within small maternity homes but there are also examples where larger surgical and medical hospitals were run by a married woman.

Northcote Hospital in Palmerston North was a medical and surgical hospital started by Mrs Emma Freeman in a property she purchased in 1884. A former staff member of Northcote Hospital records that a transfer of land from the Congregational Church to Mrs Freeman 'to the values of £70 and £60' would become the hospital but it is not clear exactly when the transition from home to hospital occurred.[305] Mrs Freeman had trained as a nurse in England and appears on the New Zealand Nurse's Register in April 1902. According to a written history of the hospital, she had been widowed with three young children before opening her first hospital in Duke Street. The business grew rapidly so she commissioned the building of new premises, having bought more land adjacent to the original site. The new medical and surgical hospital on

[304] Public Accountant Oamaru D.V.G. Smith, "Copy annual list and summary: Oamaru Private Hospital Limited, Nen Street," in *R2503693* (Dunedin: National Archives, 1935). https://research.archivesnz.info/44pjUO5pzDbh/iwAQkEk6mYUe/FUXCB5jSI0SFWERVjDeGVA/R2503693%201935%20Copy%20Annual%20list%20and%20summary.pdf.

[305] Elva Wright: Staff Member, A history of Northcote Hospital, 1985, Palmerston North Public Library, Palmerston North.

the corner of Duke (later renamed Princess Street) and Grey Street was valued at £800.[306] Subsequent owners included Miss Anne Louisa Roby who added another building valued at £2300 in 1914 as well as completing numerous upgrades in the following years.[307] Nurse Roby retired in 1920 due to ill health and was farewelled with a high-profile public event hosted by the mayor, Mr J.A. Nash, illustrating the esteem in which she was held within the community.[308] Her successor was Mrs Annie Margareta Essex. Harry Essex bought the property for his wife Annie, who became the licensee and Matron. She ran the hospital for nine years before ill health forced her to appoint a new matron to take over. Under the consecutive watch of these three women, the Northcote Private Hospital grew from a 12 bed establishment to a 24 bed medical and surgical hospital employing at least six nursing sisters and five probationers, as well as the usual array of domestic and kitchen staff.[309] Fees were relatively high at seven guineas per week during Mrs Essex's tenure, with an additional two guineas required for surgical patients.[310] Standard fees for most private hospitals at the time were generally between four and six pounds at this time. The hospital continued as part of the fabric of Palmerston North's medical landscape until the 1980s when it was taken over by Southern Cross Hospital Trust.[311]

[306] Elva Wright: Staff Member, A history of Northcote Hospital, 2.
[307] Elva Wright: Staff Member, A history of Northcote Hospital, 3.
[308] "Empire Hall Monday June 28 at 8 p.m.," *Manawatu Standard* (Palmerston North), 26 June 1920, 1, https://paperspast.natlib.govt.nz/newspapers/MS19200626.2.5.3?end_date=01-01-1950&items_per_page=100&page=3&phrase=2&query=Roby&snippet=true&sort_by=byDA&start_date=02-01-1900&title=MH%2cMS%2cMT.
[309] "Resignations, appointments, etc.," *Kai Tiaki: the journal of the nurses of New Zealand* XIV, no. 1 (1 January 1921): 53, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1921/01/01/62.
[310] Elva Wright: Staff Member, A history of Northcote Hospital, 4.
[311] Elva Wright: Staff Member, A history of Northcote Hospital, 6.

Figure 4: Northcote private hospital, Grey Street – *Unknown* 1944
The building was constructed around 1904 for Mrs Freeman and then modified in 1944 by Miss Flower.
Manawatu Heritage Collection, Palmerston North City Library Digitisation ID 2011N_H57_004761
https://manawatuheritage.pncc.govt.nz/item/d5e886d1-af2c-4660-b5bb-8ab4368d2a87

Conclusion

Between 1910 and the advent of the Social Security Act 1938 women dominated the private hospital sector as licensees, property owners, employers and colleagues of licensed men and women doctors around New Zealand. The nurse licensees provided the premises, fielded the rigorous inspection processes, invested in all medical, sanitary and building requirements, took the financial risk and, to a greater and lesser extent, reaped the financial rewards of their endeavours. In doing so they created a unique space that was almost entirely their own. For both the Linton sisters and the Symington sisters in Oamaru, for example, the deaths of their fathers triggered the need to find another source of income. Nursing fit that bill and by bringing the family back together into one establishment they created an economic model that, if well run, would secure their financial future. In both these cases, the women trained and

worked for several years in the public and private system before taking the step and financial risk to own their own establishment.

The licensees' preparedness to take the financial risks to build their businesses also worked well for doctors wishing to focus their energies on building their own practices with honoraria and academic appointments and without the day-to-day grind of running a business. Women could call on their family members to be part of their work force and scale a business up or down to meet the needs of their local communities balanced with their own family commitments. Private hospitals were the very fabric of every community, large or small, around New Zealand and provided a platform where relationships between the licensees and the doctors they worked with operated on a more level playing field requiring mutual respect and trust. New Zealand's rapidly changing environment in the early twentieth century was affected by war and a global epidemic. This created challenges that led to successes and failures for some women and exposed how their ambition in this new business space as entrepreneurs also came with inherent risks. In this context the next chapter will explore the day-to-day running and costs of a private hospital as well as some of the factors that influenced their successes and failures.

Chapter Four – The business of running a business

The commercial aspects of running a business did not necessarily sit easily with the Florence Nightingale hallowed view of nursing as vocational and service driven. Nightingale expected nurses to be women of good character who had the 'highest ideals of service and sacrifice rather than a career that might provide the means…to become independent.'[312] There was therefore a tension between Nightingale's deification of nursing as one of the 'greatest vocations' and the practicality of attracting capable, intelligent young women who needed and wanted to make a living from their profession. Dunsford cited Grace Neill as being more pragmatic, however, 'recognising that adequate material rewards were vital if enough of the "right kind" of young women could be attracted to the profession.'[313] The private hospital sector created an opportunity for women to exhibit all the right qualities and at the same time earn themselves a living. As many nurses around the country would find to their personal cost, running a business and balancing the books was not always easy or successful, particularly when already in the stressful business of managing people's health.

The purpose of this chapter is to review the scope of the key areas of cost and expenditure to illustrate the scale and extent of the professional, financial and management skills required by licensees, some of whom were overwhelmed by the challenge while others managed to thrive. While nurse licensees were presumably committed to their vocation as a nurse, many had limited or no experience in the practical, day-to-day management decisions required in the commercial world that was her hospital. The physical environment of the hospital had to meet specific standards set by the Department of Health. These related to room size and height, the amount of light and air through the building, the access and availability of separate ablutions for patients and staff, accommodations for staff, the standard of operating theatres and so the list goes on. Staff lived-in at most hospitals so they also had to be fed and have access to ablutions, as did patients, and work as a cohesive unit. Staff-to-patient ratios had to be maintained along with the rigorous standards of hygiene required to minimise infection and

[312] Deborah Ann Dunsford, "The privilege to serve others: The working conditions of general nurses in Auckland's public hospitals, 1908-1950" (Master of Arts in History The University of Auckland, 1994), 36.
[313] Dunsford, "The privilege to serve others," 26.

cross-contamination. The skills and knowledge required to do this successfully had elements of Dalziel's 'helpmeet', steeped in pragmatism and a hands-on approach. It required rigour from both a medical and commercial perspective in order to keep the wheels of the hospital machine turning – regardless of its size and scale – and with the nurse licensee at the helm and taking the commercial risk.

The role of the private hospital in the medical mix was essential to and supported by both the Department of Health and the medical men and women who relied on these hospitals to treat their patients and perform surgeries. This mutually beneficial scenario, while subtly different from the state hospital environment, did not appear to undermine the medical community who were reliant on having access to private hospitals in order to treat and perform operations on their patients. Nurse licensees built their own reputations based on their nursing practice and consolidated their position by forging relationships with the medical community. It was not without challenges, however. For some women hospital ownership was a leap of faith made in a time of crisis to secure their own futures with little or no financial expertise or experience. That risk-taking was seemingly supported and as we will see in the coming chapters sometimes wilfully encouraged by doctors happy themselves to remain outside of the rigour of running a business but sometimes at the licensee's expense.

A regulated industry

The business framework for private hospitals was dictated by the legislation and regulations which governed them. Every aspect of the business had to be kept to the exacting standards of the department and were subject to at least annual and usually twice-yearly inspections. The private hospital licensee was, therefore, expected to be an excellent nurse and/or midwife with the added skills of running a financially robust business while successfully navigating the complexities of departmental requirements. Her relationship with the District Health Officer was key as was her relationship with the Assistant Inspector of Hospitals, or a delegate, who would do the regular inspections and report on the licensee's competence and compliance to the department. Figure 1 below outlines the process for licensing a new private hospital. The country was divided into eight health districts with each District Officer of Health managing the

licensing issues in their area. The application form supplied by the Department required a scaled floor plan of the hospital with each room being numbered and its purpose identified along with dimensions, window size and proposed number of patients.[314] This included private rooms where the family lived and the ablutions they used. Once a license had been approved, any changes to a room whether structural or in its use had to be pre-approved by the hospital inspectorate. The Assistant Inspector of Hospitals was responsible for the inspectorate that undertook the hospital inspections.

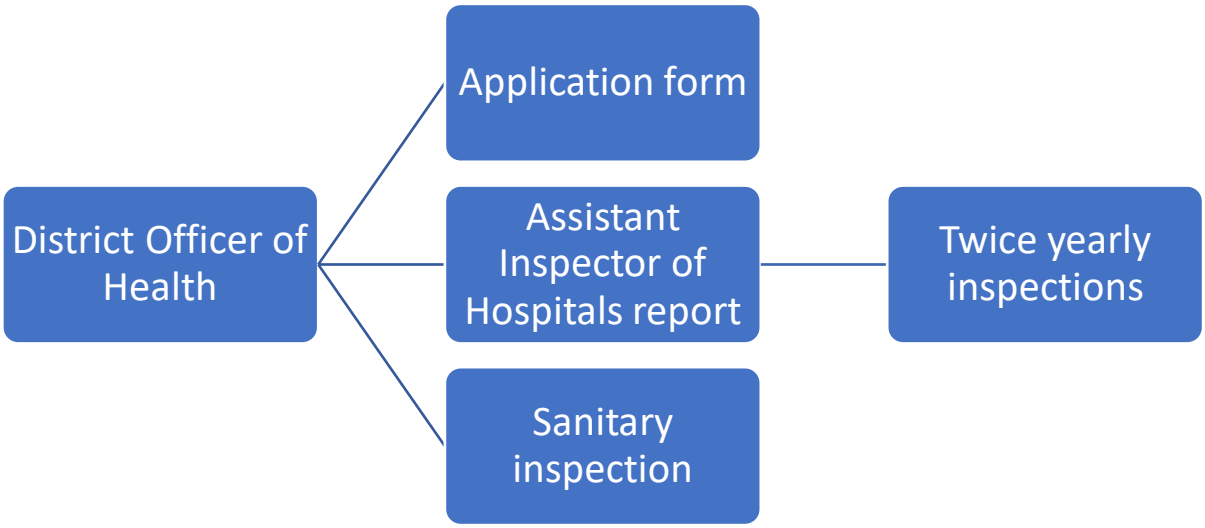

Figure 5: Process for licensing a new private hospital managed by the District Officer of Health. Prospective licensees were assessed on their good character and registration. The building was also had to meet sanitation standards and was assessed for size, scale and layout.

To open a new hospital the licensing process dictated that the Sanitary Inspector assess the condition of the proposed hospital and its surroundings while the Assistant Inspector of Hospitals reviewed all other aspects of the application including, and perhaps most importantly in the context of this research, the fitness of the applicant. This aspect was specifically written into the Hospitals and Charitable Institutions Act 1909 s109(2) which stated that '[n]o license shall be granted unless the Minister is satisfied as to the character and fitness of the

[314] "Private Hospitals: Information for the guidance of persons conducting or contemplating the establishment of a private hospital, with extracts from the Hospitals and Charitable Institutions Act, 1909," in *R20963067 Private Hospitals - Regulations* (Wellington: Archives New Zealand, 1916).

applicant.'[315] Their respective findings were submitted to the District Health Officer who was responsible for coordinating this process and liaising with the applicant as well as the other branches of the department. Once the hospital was licensed, the actual business of nursing and patient management was, of course, a top priority while on the business side, records, referrals and doctor interactions also had to be meticulously recorded and kept.

As medical knowledge grew, increasingly sophisticated equipment was sought by the doctors and in some cases was required by the Department of Health. This in turn put pressure on the private hospital licensees, a lot of whom in the first few years of the enforcement of the Act, were old-school, trained and untrained nurses and midwives. In the case of midwives, for example, Assistant Inspector of Hospitals Miss Bagley observed that what had in many cases been a community service and an adjunct to their daily lives as wives, mothers, farmers and workers, increasingly became a full-time job, not least in order to recoup some of the investment costs for their training and equipment.[316] Put bluntly in her report to Miss Maclean, Miss Bagley noted that the shift to a paid profession was not always a comfortable one with the financial aspect of the business '… frequently a difficulty to both patients and nurses and is apt to increase as the trained nurse is generally dependent entirely upon her work.' This meant that those nurses prepared to take the plunge into hospital ownership, even in a small three or four bed unit, were committing to a full-time business requiring a reasonably high level of business acumen, professional skill and financial stability to make it a success, not to mention good communication and relationships with their communities, medical men and the Department of Health.

[315] *Hospitals and Charitable Institutions Act*, S109 (2.).
[316] 1909, *Hospitals and Charitable Aid in the Dominion*, 10.

Promoting the business

While forging and sustaining relationships with the medical community remained at the heart of a successful private hospital, promoting her business to the wider community was also key to a nurse building her profile. In a somewhat chicken-and-egg situation, the independence of a nurse owning her own business was hedged by her reliance on the referrals and ongoing goodwill with the local medical men. But as an independent businesswoman she also had her own standing within the community as can be seen by the number references throughout historic newspaper records to Nurse ---'s hospital or Matron ---'s hospital. As noted earlier this also occurred even if the establishment was owned by another investor or doctor. As the public face of the hospital the licensee was afforded ownership and status even if it was not in the true financial sense of the word. The interconnectedness of community life meant that as a vital part of her community, a hospital licensee might also be involved in events such as judging baby competitions, hosting bridge evenings, and becoming a community leader in times of crisis.[317] It is difficult to assess whether these activities were a deliberate strategy to boost her business or simply the actions of a woman invested in her local community but either way, based on the reporting of these many and varied events, they served to elevate her standing.

For more explicit promotion, there is clear evidence that newspaper advertising in newspapers was a major avenue for some nurses. *Papers Past* reveals a treasure trove of advertisements promoting the experience of the owner, the standard of care and, in some cases, their length of service within a community. One such example was Nurse Emily Stratford who, in a search of *Papers Past* for advertisements for her Wainui Private maternity Hospital appeared 1,384 times. These included advertising vacancies, changes of address and promoting her expertise.[318] Mrs

[317] "Woman's world and its ways: Social gatherings," *Auckland Star* (Auckland), 6 June 1931 1931, 14, https://paperspast.natlib.govt.nz/newspapers/auckland-star/1931/06/06/14. "Successful fair and Paddy's Market at Turua last night," 2. "A unique wedding on hospital balcony," *Evening Star* (Dunedin), 24 December 1926, 10, https://paperspast.natlib.govt.nz/newspapers/evening-star/1926/12/24/10. "The epidemic: Feilding organises, sets up health bureau, gets to work at once.," *Feilding Star* (Feilding), 18 November 1918, 3, https://paperspast.natlib.govt.nz/newspapers/feilding-star/1918/11/18/3. "Farewelling a clever nurse," *Manawatu Times* (Palmerston North), 1 August 1908, https://paperspast.natlib.govt.nz/newspapers/manawatu-times/1908/08/01/7; "Farewelling a clever nurse."

[318] "Nurse Stratford," in *Papers Past Newspapers* (1908 - 1915). https://paperspast.natlib.govt.nz/newspapers?phrase=2&sort_by=byDA.rev&items_per_page=100&snippet=true&query=Nurse+Stratford&start_date=01-01-1890&end_date=31-12-1915&type=ADVERTISEMENT.

Stratford (neé Rawle) was registered as a Class B Midwife earned through her 21 years of experience in midwifery prior to the introduction of the Midwives Act 1904.[319] She was born in Birmingham in the north of England in 1852 and came to New Zealand as a single woman, marrying her husband Richard Edmund Stratford in 1870.[320] Richard was born in Petone in 1847 before moving to the West Coast where he became an experienced sawmiller.[321] The couple had at least five children, born in different parts of the South Island. The first record of Nurse Stratford's private maternity hospital appears in Wellington's *Evening Post* newspaper in April 1908.[322] Listed as the Wainui Private Maternity Hospital in Pirie Street 'a few doors from Kent-terrace tram station', Nurse Stratford also took the opportunity to promote her expertise, proudly citing her twenty-five years of experience. Between 1908 and 1915 when she retired, Nurse Stratford occupied five premises at 28 Pirie Street, 24 Cambridge Terrace, 26 Seatoun Road, 31 Kent Terrace and York Street Miramar, some for as short a period as twelve months.[323]

Nurse Nairn in Hastings also used advertising strategically when she expanded her already successful private hospital into a nursing bureau providing medical, surgical and maternity nurses to the wider community. Opened in 1909, her 12-bed hospital was 'looked upon as one

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[319] "Nurse Stratford," *Evening Post* (Wellington), 6 April 1908, 1, https://paperspast.natlib.govt.nz/newspapers/EP19080406.2.2.3?end_date=31-12-1930&items_per_page=100&phrase=2&query=Wainui+Private+Maternity+Hospital&snippet=true&sort_by=byDA&start_date=01-01-1890.

[320] "1870 Richard Stratford," in *New Zealand, marriage Index, 1840-1937* (Original data: New Zealand Marriage Index, 1840-1940: Ancestry.com). https://www.ancestry.com.au/discoveryui-content/view/120915:8950?tid=&pid=&queryId=fac158b922099396702920ebca58c4ab&_phsrc=Xtb2138&_phstart=successSource.

[321] "Richard Edmund Stratford," in *Family tree* (Online: Ancestry.com, 1847-1929), Genealogy. https://www.ancestry.com.au/family-tree/person/tree/174449933/person/232269866118/facts.

[322] "Wainui Private Maternity Hospital," *Evening Post* (Wellington), 1 April 1908, 1, https://paperspast.natlib.govt.nz/newspapers/EP19080401.2.2.3?end_date=31-12-1929&items_per_page=100&phrase=2&query=Nurse+Stratford&snippet=true&sort_by=byDA&start_date=01-01-1901&type=ADVERTISEMENT.

[323] "Public notices: Removal," *New Zealand Times* (Wellington), 22 November` 1913, https://paperspast.natlib.govt.nz/newspapers/NZTIM19131122.2.2.6?end_date=31-12-1940&items_per_page=100&phrase=2&query=Nurse+Stratford&snippet=true&sort_by=byDA.rev&start_date=01-01-1890. ; "Births," *Evening Post* (Wellington), 29 December 1914 1914, 1, https://paperspast.natlib.govt.nz/newspapers/EP19141229.2.2?end_date=31-12-1940&items_per_page=100&phrase=2&query=Nurse+Stratford&snippet=true&sort_by=byDA.rev&start_date=01-01-1890.

of the most commodious and best quipped institutions of its kind in the district'.[324] In 1910 an operating theatre was added and a further four bedrooms for staff, along with a bathroom, lavatory and an improved hot and cold-water supply. Despite the availability of both private and state hospitals in the Hawkes Bay Nurse Nairn sought to consolidate her position in both sectors and embarked on an intense advertising campaign promoting her newly established nurse's bureau which offered nursing services to the wider, largely rural community in their homes.[325] Viewing these two options as complementary rather than in competition with each other, her advertising campaign between 1910 and 1913 included over 320 advertisements in the Hawkes Bay newspapers promoting both the hospital and the bureau.[326] However, in 1913 she quit her business to get married. The hospital was sold early in 1913 and in December of that year her daughter Flora was born.[327] Nurse Nairn remained on the Nurses Register as Mrs Flora E. Kent at least until 1932 but did not appear to be actively working.

One of the most prolific but understated advertisers in the Hawkes' Bay region was Nurse Bamforth, a registered Class B Midwife who ran her premises in King Street, Hastings. Between March 1915 and September 1920 Nurse Bamforth placed over 1000 advertisements promoting her business.[328] The modest advertisement simply stated her address and registration with no other fanfare. This may in part have been to do with the cost of advertising. Although I was

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[324] "Local and General," *Hastings Standard* (Hastings), 17 April 1910, 4, https://paperspast.natlib.govt.nz/newspapers/HAST19100427.2.11?end_date=31-12-1930&items_per_page=100&phrase=2&query=Nurse+Nairn&snippet=true&sort_by=byDA&start_date=01-01-1905&title=LT%2cCHP%2cTS%2cBA%2cDTN%2cHAST%2cHBH%2cHBT%2cHBTRIB%2cHBWT%2cWAIPM.

[325] Napier Hospital with 78 beds, Waipawa Hospital with 43 beds and Wairoa Hospital with 12 beds were operating at this time; 1909, *Hospitals and Charitable Aid in the Dominion*, 24 29 43.

[326] "Nurse Nairn," in *Papers Past Newspapers* (1909 - 1913). https://paperspast.natlib.govt.nz/newspapers?phrase=2&sort_by=byDA&items_per_page=100&snippet=true&title=LT%2CCHP%2CTS%2CBA%2CDTN%2CHAST%2CHBH%2CHBT%2CHBTRIB%2CHBWT%2CWAIPM&query=Nurse+Nairn&start_date=01-01-1900&end_date=31-12-1930&type=ADVERTISEMENT.

[327] "An ideal opportunity for an up-to-date nursing home or boarding house," *Hawke's Bay Tribune* (Hastings), 11 January 1913, 8, https://paperspast.natlib.govt.nz/newspapers/HBTRIB19130111.2.85.5?end_date=31-12-1940&items_per_page=100&page=3&phrase=2&query=private+hospital&snippet=true&sort_by=byDA&start_date=01-01-1910&title=BA%2cDTN%2cHAST%2cHBH%2cHBT%2cHBTRIB%2cHBWT%2cWAIPM&type=ADVERTISEMENT.

[328] "Nurse Bamforth," in *Papers Past Newspapers* (1916 - 1919). https://paperspast.natlib.govt.nz/newspapers?end_date=31-12-1940&items_per_page=100&phrase=2&query=Registered+Maternity+Home&snippet=true&sort_by=byDA.rev&start_date=01-01-1910&title=BA%2cDTN%2cHAST%2cHBH%2cHBT%2cHBTRIB%2cHBWT%2cWAIPM&type=ADVERTISEMENT.

unable to source rates for Hawkes Bay newspapers in 1920, as an indicator as to what charges might have been the Wanganui Herald charged five shillings per column inch for 'Public Notices, Meetings, Theatrical, and Concert Advertisements.'[329] The Horowhenua Chronicle charged four shillings per column inch or five shillings for a whole week's advertising of 'Wanted, For Sale, To Let, Lost and Found'[330] while the New Zealand Herald charged per word and for the number of insertions.[331] In a region that had at least 17 private hospitals operating between 1910 and 1940, with almost all commencing operation prior to 1920, the environment was competitive. Most were maternity hospitals with five offering medical and surgical services. This was in addition to the public hospitals in Napier, Waipawa and Wairoa.[332]

Premises

The nurses central to this research established their businesses in every sector of the property market by leasing or renting, purchasing and in some cases, commissioning purpose-built premises. Often, in the initial stages, these were established in women's private homes. Others, such as Jean Foote's Rawlingstone Private Hospital in Auckland, were purpose built. Family archives suggested that Miss Foote commissioned Rawlingstone having purchased some land.[333] It is not clear how it was funded – whether her father's success extended to helping his daughter start her own business or whether she was able to secure a loan through her own devices. However she achieved it, Rawlingstone's success saw her outgrow the first premises within three years and move to a two-storey wooden house at 125 Grafton Road with sweeping views down Grafton Gully to Auckland's busy harbour.

[329] "Note to advertisers: Advertising rates," *Wanganui Herald* (Wanganui), 20 January 1920, 9, https://paperspast.natlib.govt.nz/newspapers/wanganui-herald/1920/01/20/9.
[330] "Advertising rates," *Horowhenua Chronicle* (Levin), 29 April 1925, 1, https://paperspast.natlib.govt.nz/newspapers/horowhenua-chronicle/1925/04/29/1.
[331] "Advertising rates," *New Zealand Herald* (Auckland), 15 January 1920, 12, https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1920/01/15/12.
[332] N.B. for clarification, Waipawa was considered to be part of the Wellington Health District but geographically speaking it is in central Hawkes Bay. Similarly, Cook Hospital was considered to be part of the Hawkes Bay district but is located in Gisborne. To this end I have used geographic locations to indicate proximity and practical use.
[333] Haigh, *Foote prints among the kauri*, 151.

The use of private homes as hospital premises was common and this was reflected in the specifications that had to be met to secure a private hospital license. The private home requirements sought to ensure boundaries between family space and the formal hospital areas were strictly observed. The department had a series of templates of ideal hospital designs for new licensees on the understanding that they could be modified to suit the site and local conditions.[334] Private Hospital Regulations specified that a description of the site, premises and a detailed floor plan had to be submitted to the Department of Health as part of the license application.[335] Each room was numbered with a description of its use, size and number of people housed in each room. This included family, staff and patient rooms, how they were accessed and whether any potential cross-over might occur that might heighten the risk of contamination. In particular, a separate bathroom/toilet for family members and staff was required, meaning that in most instances an additional lavatory had to be built to specific requirements at the cost of the licensee. In addition, the height and dimensions of rooms were closely monitored to minimise overcrowding and ensure proper ventilation and light in each ward.

[334] 1925, Department of Health: Annual report of Director-General of Health, 37 (Wellington: AJHR H-.31).
[335] C.A. Jeffery, "Private Hospitals Regulations (H. 122)," in *The New Zealand Gazette* (13 May, Wellington: New Zealand Government, 1924), 1274. http://www8.austlii.edu.au/nz/other/nz_gazette/1924/35.pdf.

Figure 6: Sperry Home, Thames 1973. Many of the private maternity hospitals operated from the midwife's home so as well as accommodating patients, families and staff also lived in at these establishments.
Barbara Faithfull Collection, The Treasury Research Centre and Archive, Ref: 2017.074.124

The establishment of the State Advances Corporation as a lending institution was a significant legislative development for women seeking independence and creating business opportunities. Finance to complete modifications or to purchase a property outright could be secured with women eligible to apply for a loan in their own right. As many nurses started their businesses working from their homes, the loan structure allowed for a timeframe that was substantial enough to buy a big enough property and, with a repayment schedule over a thirty-six-and-a-half-year period, manageable for the scale of a small business.[336] For every £100 borrowed, a £3 repayment was required over the period of the loan. To put that into context, an 11 roomed

[336] *Government Advances to Settlers Act 1894*, 197 (Wellington: New Zealand Government, 1894).

house in Auckland on three quarters of an acre advertised as 'suitable for a private hospital or convalescent home' in 1913 had an asking price of £1900, including a £100 deposit.[337] Repayments for the £1800 balance would be £54 every six months, or £9 per month, over the 36.5 year term.[338] The balance was payable at any stage during the loan period with interest calculated to the date of settlement. By owning her own premises, the licensee was afforded another level of independence and agency as she could make necessary improvements without reference to another party and ensure modifications and new designs met both departmental standards and personal needs.

Renting or leasing their properties gave women less independence and agency than ownerships. For those women renting or leasing their properties, it was not always possible to get the owner to agree to the necessary improvements to bring the building up to hospital standards. Sister Edith Hayward's story is an example. She leased her premises in Te Awamutu for a medical and surgical hospital from Miss Annette Mandeno, who had shifted to Auckland and was running a convalescent hospital. Sister Hayward took over the hospital in 1929 but by October 1931 the hospital inspectorate had decided that the staff rooms were deficient and the bathroom '…exceedingly undesirable.'[339] While the Auckland Medical Officer of Health advocated strongly for the improvements, he acknowledged that the responsibility rested with the building owner rather than Sister Hayward. He stipulated that for the license to be renewed, the alterations and additions to the staff accommodation and water closet should be completed and paid for by Miss Mandeno. However, Miss Mandeno refused, citing the £200 she had spent just four years earlier on alterations and improvements that had been approved by the department.[340] To press her point, Miss Mandeno interviewed Sister Hayward and informed the department that Te Awamutu did not warrant a larger hospital, the hospital

[337] "Remuera," *New Zealand Herald* (Auckland), 23 October 1913, 2, https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1913/10/23/2.
[338] *Government Advances to Settlers Act 1894*, 197.
[339] Inspector of Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Auckland: Miss Hayward's Hospital, Te Awamutu," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: National Archives, 15 October 1931).
[340] Miss Annette Mandeno, "District Health Officer," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: National Archives, 6 November 1931).

averaged only four patients and the accommodation was sufficient for Sister Hayward and her two probationers.[341]

Because of Miss Mandeno's resistance, Sister Hayward faced a financial dilemma that put the hospital in limbo over the course of several years. A solution was sought by the Inspector of Hospitals Dr Tom Paget who advised the Auckland Medical Officer of Health that 'the best hope of getting this hospital into good order is to attempt to get medical men practising in Te Awamutu to co-operate with Sister Hayward or Miss Mandeno to help her (sic) to improve the hospital', advice that was also sent to the Minister of Health.[342] However, none of the three doctors in the town were prepared to take that step and in fact matters escalated into a personal stoush between Sister Hayward and one of the doctors which will be discussed in the next chapter of this thesis. The financial pressure of the depression served only to harden Nurse Mandeno's resolve not to make the improvements and the department, while empathising with the economic situation, became increasingly anxious that if the license lapsed there would be no other hospital in the town for the three medical men and the community they treated. Serious cases could go to Hamilton but the day-to-day needs of a busy dairy town were very real and the department was reluctant to let the license lapse. Ultimately pragmatism won – the department conceded and extended the license twice for an additional year but with no agreement having been reached on changes or who was responsible for making.[343]

Rental properties

Renting a property may have been the preferred or only option for licensees such as Sister Hayward but it was fraught with potential difficulties, not least of which was the cost of renting itself.[344] Wellington was generally the most expensive of the four major cities in the country

[341] Miss Annette Mandeno, "District Health Officer."
[342] Inspector of Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Auckland," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, 9 March 1933).
[343] Inspector of Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Auckland: Private Hospital - Miss Hayward, Te Awamutu," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, 16 December 1932).
[344] Government Statistician, *The New Zealand Official Year-Book 1921-22*, (Wellington, New Zealand 1922).

while Hamilton, between 1922 and 1926 had the highest rental costs in the country. Prior to this through most of the war and early post-war years, Wellington wore this mantle.[345] As with the cost of living generally, supply was outstripped by demand forcing prices up and in Wellington's case, significantly ahead of the three other main centres.

Index numbers for house rent for four main centres and Dominion weighted average 1915 – 1935[346]						
Year	Auckland	Wellington	Christchurch	Dunedin	Average of four centres	Dominion weighted average
1915	1005	1191	965	965	1056	994
1920	1175	1311	1113	1012	1153	1124
1925	1720	1904	1727	1389	1685	1664
1930	953	1326	973	958	1053	1007
1935	719	964	755	802	801	774

Figure 7: Index of house rental prices for the four main centres showing Wellington as consistently the highest in the country.

The 1937 government yearbook also suggests, however, that from 1926 – 1935 the house rental index showed that the general level of rent increases was comparatively slow, in part affected by the depression but also by 'infrequent changes of residence and the difficulty of departing from customary rents'[347] This indicated that while finding appropriate premises might have been challenging in the initial instance, once they were found consistent rent prices without major increases could be expected, resulting in stable tenancies. As Sister Hayward found to her cost, renting created vulnerability for a hospital licensee so where possible, ownership of the property minimised this risk.

[345] Government Statistician, *The New Zealand Official Year-Book 1927*, (Wellington, New Zealand 1927). https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1927/NZOYB_1927.html#idsect1_1_318539
[346] Government Statistician, *The New Zealand Official Year-Book 1927*.; Government Statistician, *The New Zealand Official Year-Book 1937*, (Wellington, New Zealand 1937). https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1937/NZOYB_1937.html#idsect1_1_272745
[347] Government Statistician, *The New Zealand Official Year-Book 1937*.

The cost of doing business

As a means of assessing, at least in general terms, the cost of running a private hospital, the records of 15 private hospitals In Auckland were assessed. Of these 15 accessed from Auckland Council Archives, it was revealed that six licensees rented their premises with the remaining nine owning their own properties.[348] All six of these licensees were single women, one as a result of her husband's desertion. Five of the six licensees in this sample group rented the same establishment as the Mount Pleasant Private Hospital as discussed in the previous chapter. Situated in Wakefield Street between 1906 and 1932, the building was owned by the Auckland City Council and, after being renovated to meet hospital standards, was leased by its first licensee Miss Annie Green. It became a large and successful hospital for around 20 patients until Nurses Mander and Keyes purchased 24 Princes Street and transferred the license for Mount Pleasant Private Hospital to its new premises. The sixth Auckland licensee, Mrs Henrietta Rich, had quite a different experience with her rental property in Mount Eden. As a deserted wife and mother of two boys she struggled to meet the complexities that a world war and influenza epidemic threw into her business world and was left homeless and without an income as a result.

In 1913 Mrs Henrietta Rich, who was neither a registered nurse nor midwife, took over the lease on the 15-bed 'Erinholme' medical and surgical hospital in Mount Eden. Acknowledging that Mrs Rich was not a nurse owner, her experience and the documentation of her demise does provide an important insight into the challenges and costs associated with running a private hospital. Mrs Rich had been deserted by her husband and was supporting her 13- and 15-year-old sons by working as a Second Cook at another private hospital in Auckland, her only apparent experience in this sector.[349] The prospect of owning a business which also provided accommodation must have been attractive, but the initial outlay was beyond her limited means. With financial backing from two businessmen who, according to Mrs Rich, advised her 'it was a good proposition', she was able to go ahead with a level of debt that appeared to be

[348] "Wakefield Street 1912 - 1961."
[349] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue," in *R12169972 Rich, Henrietta* (Auckland: Archives New Zealand, 19 February 1919).

manageable and the expectation that she would be able to repay this without default.[350] The cost of acquiring the business was a weekly rent on the property of £2 10 shillings, plus £275 for goodwill and the furniture.[351] The terms of the purchase allowed Mrs Rich to pay a £100 deposit and the remaining balance over a period of time. Her investors loaned her the deposit plus a £50 investment for working capital that allowed her to upgrade some of the furniture and decor and employ the required registered nurse at £3 3 shillings per week to manage hospital. In total her initial costs escalated to £150 but, according to her report at her bankruptcy hearing, business was steady until the start of World War One.[352]

The war changed things dramatically. At that point, several doctors left the country having signed up for the war effort which reduced the number of medical and surgical cases coming to the hospital – so much so that she decided to apply for a maternity license to tap into a different source of patients. Work picked up again until the influenza epidemic in 1918 when she and several of her staff fell ill causing her to 'refuse between £300 and £400 worth of epidemic work.'[353] The result was that in February 1919 Mrs Rich's debts had spiralled to £537 12 shillings 5 pence to unsecured creditors with an outstanding balance of £292 11 shillings 4 pence to be paid. She too had debtors of her own who owed her over £50 at the time she went into receivership. Her determination to try work her way out of her downward spiral saw her pivot into the more steady maternity model. But again, her lack of experience and the emerging social and post-war issues in New Zealand coupled with the flu epidemic ultimately overwhelmed her.

There are no records of the actual staffing of Erinholme but a similar 15-bed private medical surgical establishment in Auckland in 1919 employed four nurses including the licensee, three probationers, three domestic staff including a cook and a gardener who tended the grounds.[354]

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[350] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue."
[351] "Hospital failure. Attributed to epidemic. Furniture doubly mortgaged.," *New Zealand Herald* (Auckland), 22 February 1919, 7, https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1919/02/22/7.
[352] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue."
[353] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue."
[354] A. Bagley, "Inspection of Private Hospitals: Medical and Surgical Hospitals," in *R20963093 Private Hospitals - Misses McKenzie* (Wellington: Archives New Zealand, 1925). This document relates to Rawhiti Private Hospital in Auckland which was of a similar size to Erinholme and operating at a similar period.

All staff, apart from the gardener, would generally have lived at the hospital with meals and their laundry part of their employment package. Because Mrs Rich was not a registered nurse she would most likely have assisted with domestic duties – possibly as a cook given her previous experience and because it was potentially the highest wage bill – or as a nurse aide/probationer to minimise those costs. A comparison of annual costs for three slightly larger state hospitals in 1915 reveals lower staffing levels but also hugely varied surgery and dispensary costs as well as capital expenditure. Bearing in mind that smaller hospitals of this size were in rural towns which, in pre-war New Zealand would have had a lower cost of living, the model still provides an indication of the running costs and of patient to staff ratios

1915 Public Health and Hospitals and Charitable Aid Report thereon by the Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer[355]			
Town	Otaki	Wairoa	Mangonui
Beds	17	17	17
Staff	4 registered nurses 8 domestic staff 1 honorary doctor 1 non-resident doctor	2 registered nurses 3 probationers 4 domestic staff 1 non-resident doctor	1 registered nurse 2 probationers 3 domestic staff 1 non-resident doctor
Provisions	£330	£310	£145
Surgery/dispensary costs	£47	£310	£39
Domestic/ establishment costs	£461	£355	£155
Salaries	£697	£858	£544
Administration	£139	£105	£41
Capital expenditure	£1155	£538	£155
TOTAL	**£2871**	**£2463**	**£1039**

Figure 8: Comparison of costs between three state hospitals of similar size to each other and to Erinholme Private Hospital. This provides a guide to the annual running costs and indication of staffing and expenditure categories.

[355] 1915, *Public Health and Hospitals and Charitable Aid: Report thereon by the Inspector-General of Hospitals and Charitable institutions and Chief Health Officer*, 58 (Wellington: AJHR H.-31).

An analysis of Mrs Rich's creditors provides a more granular insight into the costs of running her business. She clearly attempted to pay as much as she could as costs were incurred but was seemingly unable to consistently build up an adequate cash flow. As was common at this time, she was allowed to build a level of debt and adopt a pattern of repayment that today might be regarded as generous. As her financial position weakened, she borrowed £50 from a money lender and despite having paid him £20 in three instalments, reportedly still owed him £65,[356] indicating he had charged a 'very heavy interest…[and] he must have realized (sic) that the security was a doubtful one.'[357] This, coupled with her own lack of experience and qualifications, as well as the effects of the war and the influenza epidemic, created pressure from her creditors which left her with no option: 'as I could not pay them I considered that the best and fairest thing I could do was to file.'[358] The sale of the contents of the hospital realised £213 10 shillings 3 pence once commission, advertising and labour costs had been met and ultimately the estate paid a dividend of 3 shillings 3 pence in the pound to the creditors.[359]

Secured Creditors	Amount	Description
Mrs Cecilia Morris Nurse and previous owner	£122/18/7d	Balance of debt on a Bill of Sale issued 28 June 1915
Bank of New Zealand	£148/0/4d	Joint and several guarantee by Charles Rhodes and William Beamish Austin Morrison for the sum of £150 in favour of Henrietta Rich
Total	**£270/18/11d**	

Figure 9: Secured creditors for Mrs Henrietta Rich. Source: Archives New Zealand[360]

[356] "Hospital failure."
[357] W. Fisher, "Minutes of the first meeting of creditors in the estate of Henrieta Rich," in *R23417696 - Creditors meeting minutes - Henrietta Rich* (Auckland Archives New Zealand, 21 February 1919).
[358] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue."
[359] Official Assignee, "The Bankruptcy Act, 1908: Report of the Assignee, filed in pursuance of section 126, subsection 4 of the said act," in *R24382519 Henrietta Rich - Hospital Proprietress, Auckland* (Auckland: Archives New Zealand, 1919).
[360] ""C." List of secured creditors," in *R24382519 Henrietta Rich - Hospital Proprietress, Auckland* (Auckland: Archives New Zealand, 1919).

Unsecured Creditors	Amount owed	Description
Margaret Mary Lonie Nurse	£30	30 weeks wages from 15 July 1918 to 10 February 1919
Frances Ethel Wilks Nurse	£12	Outstanding wages owed from 20 May to 30 September 1918 @£2 per week
Sister MacPherson Nurse	£16/16/0d	Professional services from October 1917 and February – March 1918
The Surgical Supply Company	£2/9/9d	2 x hot water bag 1 x pair scissor 5 yds of sheeting
William Henry Haslett Chemist and Druggist	£16/2/7d	Medicine and remedies
Auckland Steam Laundry Co., Ltd	£14/13/10d	Laundry work
W Exell Coal Vendor	£3/5/10	Coal
Mt Eden Borough Council	£9/15/0d	Water rates from 1 January 1918 to 10 March 1919
Walter Samuel Fisher Plumber	£4/16/5d	Plumbing work in September and October 1917
Charles William Kayes Painter	£2/2/6d	Painting and repairing work at Erinholme Hospital in June 1918
The Auckland Meat Company	£53/10/d	Outstanding balance for meats supplied between 19 July 1915 to 5 June 1918 Total cost over this period was £251/0/2½d
Amburys Ltd Butter Manufacturers and Dairymen	£43/2/5d	Outstanding balance for butter and milk supplied between February 1916 and January 1919 Total cost over this period was £173/11/2½d
Mettam and York Bakery	£18/6/3½d	Goods supplied and delivered
S.W. Smeeton Family Grocer & Provision Dealer	£10/7/6½d	Goods supplied September 1918 to January 1919

Brett Printing and Publishing Co., Ltd	£2/15/0d	Outstanding amount owing for advertising in May 1918. £4 already paid by cash
Kings College	£46/17/11d	School fees for her two sons from February 1915
James Adams Shoe Dealer Auckland	£3/6/3d	Outstanding balance for shoes for her and her sons Total cost in 1916 and 1917 £4/14/0d
Nurse S.A. Thompson (deceased)	£182/5/1d	Outstanding balance for rent from 1 May 1917 to 1 March 1919 @£10/6/8d per month Total amount of rent for this period was £281/11/9
Lazarus Wolfe Balkind Moneylender	£65/0/0d	Bill of Sale £85 on account of which £19/10/0d was paid in March and April of 1918
Total	**£537/12/5d**	

Figure 10: Unsecured creditors for Mrs Henrietta Rich. Source: Archives New Zealand[361]

	Wages		Provisions
	Medical supplies		Miscellaneous
	Running costs		Loans
	Building expenses	Key to unsecured creditors	

Cost of living

As a backdrop to Mrs Rich's problems, the cost of living between 1914 and 1924 rose dramatically under the economic shift caused by World War One. Mrs Rich declared in her statement to the bankruptcy court that the impact of the war severely affected her business as both doctors and nurses left the country to support the war effort.[362] Staffing became a major issue and for those who remained at home, the cost of living rose steadily over the course of the war years, peaking in 1921 before gradually declining and stabilising. Those cost of living challenges were being felt throughout the country. The New Zealand Official Yearbook 1925

[361] ""B." List of unsecured creditors.," in *R24382519 Henrietta Rich - Hospital Proprietress, Auckland* (Auckland: Archives New Zealand, 1919).
[362] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue."

shows how average food prices in 1923 across the country were 42.99 per cent higher across the three food groups combined (groceries, dairy and meat) compared to prices in 1914.[363] Rents rose on a steadier trajectory, increasing by 47 per cent, with fuel and light costs rocketing by just over 72 per cent.[364] The 'All Groups' in the chart below includes fuel, light, clothing, drapery, footwear and miscellaneous items as well as food and rent.

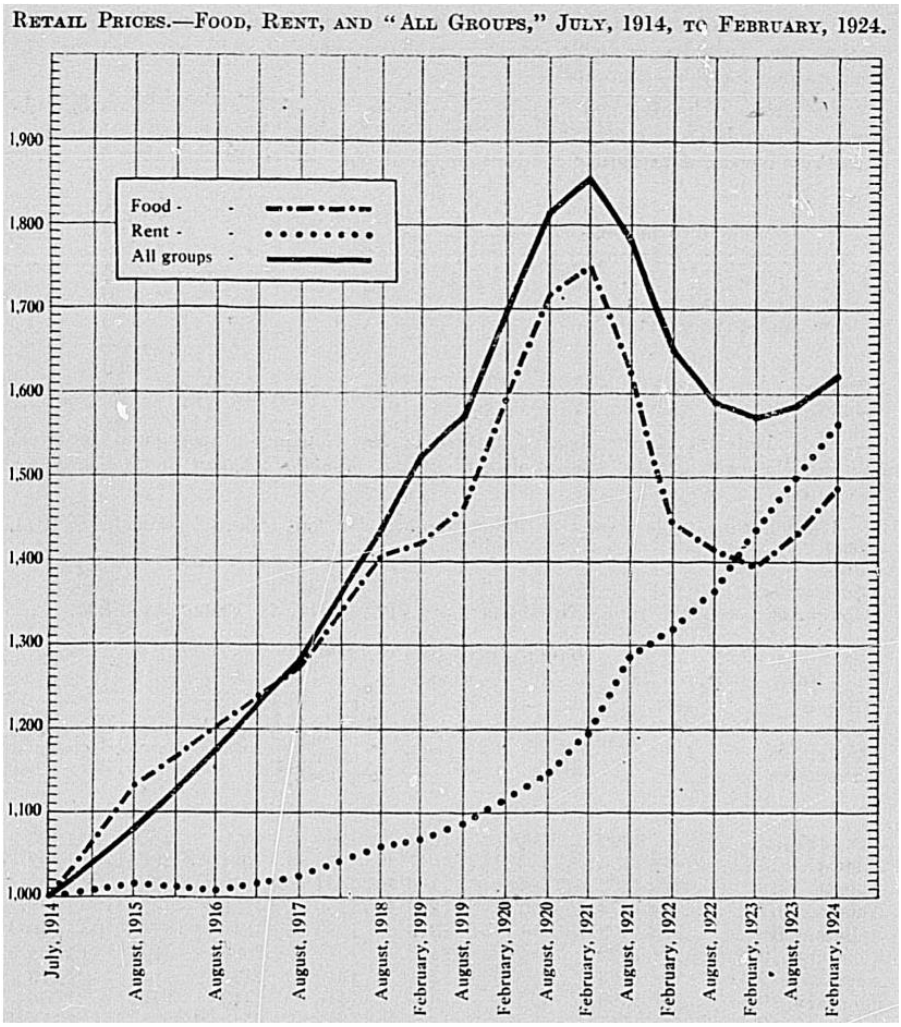

Figure 11: Inflation rose dramatically around the country between 1914 to 1921 fuelled by food, fuel and lighting costs. Rent, however, remained relatively stable until 1920 when prices rose dramatically. Much of this fluctuation was driven by the effects of World War One. Source: New Zealand Official Yearbook 1925, Chapter 33 *Prices*

[363] Government Statistician, *The New Zealand Official Year-Book, 1925*, (Wellington, New Zealand 1925). https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1925/NZOYB_1925.html#idsect1_1_273522
[364] Government Statistician, The New Zealand Official Year-Book, 1925. https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1925/NZOYB_1925.html#idsect1_1_273522

Analysis of the purchasing power in 21 towns as well as the four main centres in 1923 revealed that this was not just a city issue. Small town New Zealand was also greatly affected both in the loss of population and the spending power of the people who remained. A 20-shilling baseline created by averaging purchasing power for 1909 - 1913 was compared to purchasing power in 1923 and showed 30s/7¼d was required to purchase the same basket of goods.[365] Where rural citizens did benefit was in the housing market which was described as 'considerably cheaper in the country towns than in the more closely populated cities.'[366]

To counter the effects of inflation and the staffing issues she faced during the war years, Mrs Rich was forced to adapt her business where she had less reliance on the medical men in her community. In May 1918 she closed the hospital down as a medical surgical establishment and reapplied to the Department of Health for a maternity hospital license. The premises had already been brought up to departmental standards, but the sophistication of theatres and medical equipment required to compete with the public hospital and other medical and surgical private hospitals that were opening around Auckland was just too great. A good class of maternity hospital was, however, another proposition and had the backing of Assistant Nurse Inspector Jessie Bicknell.[367] By the end of the year though, New Zealand was in the grip of the 1918 influenza epidemic which knocked out several of her staff members, including herself, meaning she was unable to take on any work and was ultimately forced to close her doors as her creditors piled on the pressure.[368]

Conclusion

Henrietta Rich's unfortunate demise and Sister Hayward's renting struggles illustrate a number of themes that show the inherent risk-taking and aloneness, that many licensees experienced in their efforts to establish their businesses. While they enjoyed a new-found independence, they also had to navigate difficult situations, often on their own and without support. They had to

[365] Government Statistician, *The New Zealand Official Year-Book, 1925*. https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1925/NZOYB_1925.html#idsect2_1_277272
[366] Government Statistician, *The New Zealand Official Year-Book, 1925*. https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1925/NZOYB_1925.html#idsect2_1_277272
[367] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue."
[368] Henrietta Rich, "Statement of Henrietta Rich, 32 Brentwood Avenue."

become familiar with skills as diverse as bookkeeping and plumbing, from human resources to building consents as well as staying up to date with their nursing practice. For some women the decision to own or manage a private hospital was a life-saving opportunity at a crisis point in their lives that could provide an income, accommodation and a position that was respected and admired within the community. For others it allowed them to quietly continue their careers as nurses in an environment where they had authority and control. But unless they were able to own their own premises and navigate the complexities of creating an appropriate hospital space, there were still challenges that potentially left them isolated, without agency and vulnerable. So where did the balance of power lie and, given its difference from the public hospital system, how did both the nurses and medical men navigate those differences? The next chapter will examine the working relationships of these two very important figures in New Zealand's medical landscape. Both parties were inextricably linked to the Department of Health which worked hard to ensure the survival of private hospitals, particularly in smaller towns. As in any arena, there were winners and losers, good sports and cheaters and a collaboration that produced some unexpected outcomes and shifted perceptions on all sides.

Chapter Five - Working with the system and its medical men

Having taken the definitive step into private hospital management, nurse licensees needed to ensure they a steady stream of paying patients to secure their financial position. This meant attracting business from both the doctors and patients in their communities, as well as keeping their house in order to minimise the interventions of the Department of Health and its band of hospital inspectors. Although public relations was not necessarily recognised as a practice at this time, its unconscious presence in terms of managing relationships and building business profiles can be seen in the multiple ways the nurses functioned within their communities. Some were active in groups such as the bridge club or Red Cross Society while others took active leadership roles in major events such as the influenza epidemic.[369] There are reports of private hospitals being used as wedding venues, farewell parties or as a community meeting point, all of which served to cement the nurses' standing.[370] This practice of securing their operational space as a community amenity also helped navigate the delicate balance of power in their relationships with medical men by exhibiting the practical feminine and pastoral care traits expected of their nursing profession.

As with any professional relationship, the personalities of the parties involved were at the heart of how well or otherwise they functioned. Nurse licensees, having been trained for the most part in the public hospital environment, were schooled in a particular kind of doctor/nurse relationship that for the most part saw the nurse unquestioningly doing the bidding of the medical man.[371] Indeed some of the key early figures in New Zealand's nursing history were explicit in their views that that was how the nurse/doctor relationship should work.[372] That is not to say that all relationships were dominated by medical men though. Through this research it has become clear that the independence enjoyed by the nurse licensees created a different kind of hierarchy and power balance that tipped in different directions at different stages of a

[369] "The epidemic: Town improves, but country shows increase," *Manawatu Times* (Palmerston North) 1918, 5, https://paperspast.natlib.govt.nz/newspapers/manawatu-times/1918/11/21/5.
[370] "A unique wedding on hospital balcony," *Evening Star* (Dunedin), 24 December 1926, 10, https://paperspast.natlib.govt.nz/newspapers/evening-star/1926/12/24/10
[371] Sargison, "Essentially a woman's work," 17.
[372] Sargison, "Hester Maclean."

nurse licensee's career. Examples of collegiality, advice, and professional collaboration can all be found alongside arrogance, ineptitude and human weakness. Treading this delicate balance is a central theme of this chapter by looking at several case studies that explore relationships between the key figures – the Department of Health, the medical men and the nurse licensees – and illustrate how this could influence the success or failure a licensee's enterprise.

The delicate balance of reputation

In Te Awamutu Sister Edith Hayward, also discussed in the previous chapter, had established a strong reputation within the community as the licensee of the Te Whare Ora Private Hospital. She had taken over from Sister Alizon White in 1929 who had opened the medical and surgical hospital in 1926. Sister Hayward, despite working well with the local medical men, had faced challenges with the Department of Health as she struggled to get her landlady to agree to necessary modifications on the property she was renting. Significantly, the main concerns expressed by the department related to the staff accommodation rather than nursing practice, although some seemingly minor modifications such as a call bell for patients had failed to materialise, despite frequent requests.[373] Regardless of these mutual frustrations, Sister Hayward appeared to work well alongside the medical men in the community and, helped by some leniency from the department due to the lack of an alternative in Te Awamutu, established a good business over the course of three years.

Sister Hayward's position and reputation came under close and uncomfortable scrutiny with the arrival of a new doctor to the area. A series of incidents occurred which quickly escalated to a public stoush and departmental inquiry that illustrates the delicate and different kind of power balance that existed within the private hospital environment. Dr Lindsay S Rogers took over a practice in Te Awamutu in 1932 having graduated from the Otago Medical School in 1927. He had won medals in surgery, medicine, gynaecology and obstetrics as well was being resident surgical officer at the Cancer and Royal Northern Hospitals in the United Kingdom.[374]

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[373] M.H. Watt, "Letter to Dr. Clough Blundell," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, 8 March 1933).
[374] Royal College of Surgeons of England, "Rogers, Lindsay Sangster," in *Plarr's Lives of the Fellows* (London: livesonline.rcseng.ac.uk, 2014).

He followed this with a Fellowship of the Royal College of Surgeons of Edinburgh in 1929 and the Fellowship of the Royal College of Surgeons of England in 1931. Arriving in Te Awamutu in 1932 his credentials were impeccable and must have been a source of interest and perhaps even excitement for his colleagues in the district. The first indications that relations were strained between Dr Rogers and Sister Hayward appeared in a letter to the Auckland Medical Officer of Health where Dr Rogers advised that the hospital was 'closed' to him and he was forced to perform operations on his patients twenty miles away in Hamilton.[375] It was reported that neither Dr Rogers nor his predecessor Dr Hiskens could work with Sister Hayward and, perhaps most damagingly, that her work was unsatisfactory. Having looked at purchasing the hospital, Dr Rogers decided too great an investment was required to bring it up to departmental standards leaving him no option but to continue travelling to Hamilton or doing minor surgeries at patients' homes, neither of which were desirable nor particularly practical.[376]

The dispute between Dr Rogers and Sister Hayward revealed a new power dynamic between doctor and nurse not traditionally seen in the public hospital environment. While public hospital matrons certainly held a great deal of authority and were reputationally a formidable presence, the common view was that medical men had unquestioned power and influence that should not be and generally was not challenged.[377] An incident occurred in Te Whare Ora private hospital over Sister Hayward's alleged refusal to pass Dr Rogers a gown or gloves.[378] This seemingly minor spat resulted in Sister Hayward banishing him from her hospital with the instruction 'that unless he was polite to me in my theatre and hospital he could not bring his

https://livesonline.rcseng.ac.uk/client/en_GB/lives/search/detailnonmodal/ent:$002f$002fSD_ASSET$002f0$002fSD_ASSET:378274/one.

[375] Lindsay S. Rogers, "The Medical Officer of Health, Auckland," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, 19 January 1933).

[376] Rogers, "Rogers to Medical Officer of Health."

[377] Sargison, "Essentially a woman's work," 17.

[378] L.S. Rogers, "The Inspector General of Hospital. (sic)," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, 28 February 1933).; This statement was subsequently found to be untrue in the investigation and that Sister Hayward had in fact supplied him with the sterile gown and gloves as demanded. Inspector of Private Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Auckland," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, 29 March 1933).

patients to me.'[379] The disclosure of her refusal to work with him, found in the archival files, showed her authority over her domain and, perhaps even more interestingly, that she was prepared to use it. Frustrated but undeterred, Dr Rogers wrote to the Inspector of Private Hospitals, Dr Tom Paget, accusing Sister Hayward of 'acting in a most unprofessional manner towards my patients and towards Dr Hiskens' patients…, advising them in all cases to change their medical adviser and grossly overcharging my patients.'[380] The result of his allegations was a full departmental enquiry that would see the Dr Paget interviewing patients, nursing staff and doctors to assess the veracity of the claims as well as attempting to mediate between all the parties involved.

Sister Hayward's position as the sole operator in Te Awamutu meant the only other option available to doctors and patients was travelling to Hamilton for treatment at either the public hospital or one of the many private hospitals. Te Awamutu did not enjoy the benefit of a state-run cottage hospital linked to the main hospital in Hamilton as was common in many other rural towns or have another private hospital.[381] Dr Clough Blundell was Sister Hayward's main source of patients, averaging approximately three per week in the five bed hospital.[382] According to him, Dr Rogers predecessor Dr Hiskens averaged only one patient per week with the third, Dr Roberton, only requiring a hospital bed occasionally, suggesting that they either did most of their work in people's homes or drove to Hamilton.[383] Dr Blundell stepped into the fray writing to the department offering his support for Sister Hayward as 'a thoroughly conscientious and a very capable nurse' who was efficient and kind to her patients.[384] He also suggested that Dr Rogers had 'a rather inflammable temperament' and that the criticisms of Sister Hayward were unwarranted.[385] As a regular user of Sister Hayward's hospital, Dr Blundell had more at stake should the hospital close but the department also shared his concerns about

[379] Edith Hayward, "Statements," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, Date unspecified 1933), 3.
[380] Rogers, "The Inspector General of Hospital. (sic)."
[381] Dr. Clough Blundell, "Letter to Dr Watt," in *R20963123 Private Hospitals - Miss E.M. Hayward - Te Awamutu* (Wellington: Archives New Zealand, 20 February 1933), 1.
[382] Dr. Clough Blundell, "Letter to Dr Watt," 2.
[383] Dr. Clough Blundell, "Letter to Dr Watt," 2.
[384] Dr. Clough Blundell, "Letter to Dr Watt," 3.
[385] Dr. Clough Blundell, "Letter to Dr Watt," 2.

Te Awamutu being left without any hospital facilities. Patient statements solicited by Drs Rogers and Hiskens presented a variety of complaints about their experiences under Sister Hayward's care, including overcharging and that Sister Hayward encouraged patients to go to a different doctor. Each allegation was discussed separately with each of the parties and a report with recommendations compiled by Dr Paget.

Ultimately, Sister Hayward was exonerated with Dr Paget stating that 'there was a want of frankness amounting to suppression of essential facts in favour of Sister Hayward by Dr Rogers' and that none of his findings into Dr Hiskens' and Dr Rogers' complaints 'would in any way justify me in recommending the Hon. The Minister to revoke the license.'[386] His view that the doctors' statements were 'lacking in correctness …[and] are to be deplored as being largely unjustifiable attacks upon a nurse with whom they have had a personal quarrel' put an end to the matter.[387] Sister Hayward, Dr Rogers and Dr Hiskens all resumed their respective duties in Te Awamutu and life simply went on without any apparent repercussions, personal or professional, for any of the parties involved.

What potentially could have been disastrous for Sister Hayward appeared to do little to curb her enthusiasm. By December 1934, less than two years after the issue first emerged, Sister Hayward called for tenders to construct a purpose-built hospital in the town, taking control of her earlier issues of rented premises and stamping her intention of staying in the small rural town. In August the following year the 14-room hospital, built at a cost of £2230, was officially opened by the local M.P. Mr W.J. Broadfoot, commending Sister Hayward 'for her enterprise in providing a distinct service for Te Awamutu…and trusted that she would meet with a maximum of success and a minimum of worry'[388] Dr Rogers left the district in 1940 to join the war effort becoming a surgeon specialist at York Hospital, England and ultimately serving with the Yugoslavian resistance under Marshal Tito and earning the Order of Honour from Marshal Tito

[386] T.L. Paget, "Memorandum for the Medical Officer of Health 29 March, Hayward."
[387] T.L. Paget, "Memorandum for the Medical Officer of Health 29 March, Hayward."
[388] "Local and general," *Waipa Post* (Te Awamutu), 9 August 1935, 6, https://paperspast.natlib.govt.nz/newspapers/waipa-post/1935/08/09/6.

himself.[389] He subsequently became a Professor Surgery at the University of Bagdad before returning to Te Awamutu and his practice, and was at one time Deputy Mayor.

Winning did not always mean success

In Rotorua two decades earlier, Nurse Elinor Maude Pascoe's well-documented and successful libel suit had alleged that Dr Herbert Bertram had made derogatory statements about her professional ability and the way she ran her medical, surgical and maternity hospital in 1914.[390] Nurse Pascoe described a similar scenario to Sister Hayward's with Dr Bertram's 'overbearing manner and … openly … derogatory remarks about her and her establishment' becoming increasingly frustrating.[391] The situation came to a tragic head with the death of a patient who Dr Bertram had insisted on moving to another hospital against the advice of licensee Nurse Pascoe.[392] After a week of testimonies from 60 witnesses, a settlement was suddenly reached with Dr Bertram issuing a written statement effectively clearing Nurse Pascoe. It stated that although he believed the comments he made at the time, after hearing Nurse Pascoe's evidence in the witness box in reply to those statements 'he is now prepared to admit, and does admit, that her evidence has been given in perfect and good faith' and 'that Nurse Pascoe's skill and capacity as a surgical, medical and midwifery nurse is unquestioned.'[393]

[389] "Guerilla doctor well known in Te Awamutu: Work of Dr L.S. Rogers," *Te Awamutu Courier* (Te Awamutu), 18 October 1944, 4, https://paperspast.natlib.govt.nz/newspapers/te-awamutu-courier/1944/10/18/4.
[390] Anne Smillie, "The end of tranquillity? An exploration of some organisational and societal factors that generated discord upon the introduction of trained nurses into New Zealand hospitals, 1885 - 1914" (Master of Arts (Applied) Victoria University of Wellington, 2003).; Kathryn Wilson, *Angels in the devil's pit: Nursing in Rotorua 1840 - 1940* (Wellington: Karo Press, 1998).
[391] Wilson, *Angels in the devil's pit*, 154.
[392] Wilson, *Angels in the devil's pit*, 154.
[393] "Supreme Court. Hamilton: Before Mr Justice Cooper and a jury.," *Waikato Argus* (Hamilton) 1914, 2, https://paperspast.natlib.govt.nz/newspapers/waikato-argus/1914/04/01/2.

The decision was a victory for Nurse Pascoe in that her professional reputation was restored. Both Nurse Pascoe and Dr Bertram paid their own expenses and no award was given to Nurse Pascoe other than the reinstatement of her good character. Her success in court was lauded by Hester Maclean in *Kai Tiaki*. The article wrote:

> We are glad to publish the result of an action for libel brought by a nurse against a medical man. Nurses often shrink from publicity and allow many unjust actions and mis-statements to pass rather than undergo the ordeal of bringing a case to court. Therefore, in this instance, we must congratulate Nurse Pascoe on her courage[394]

But some damage had already been done. Later that year, Nurse Pascoe closed her hospital and moved to Wellington where she attempted to work privately and pay off the debts incurred by her loss of business and the trial. However, by 1915 she was declared bankrupt with newspaper reports suggesting that the lawsuit 'ran her heavily into debt'.[395]

Nurse Pascoe and Sister Hayward both enjoyed success in tackling their grievances with their medical colleagues head on. Sister Hayward emerged from the departmental enquiry relatively unscathed and continued to grow her business. Nurse Pascoe, however, subsequently succumbed to financial pressures and lost her business. Two decades had passed between Nurse Pascoe's case and Sister Hayward's with different attitudes and a more modern outlook prevalent by the 1930s. Until Nurse Pascoe challenged Dr Bertram in 1914, she had enjoyed an excellent professional reputation in the town. Her private life, however, reportedly did not necessarily match the 'prevailing perception of what constituted a good nurse.'[396] Nurse Pascoe not only had a difficult professional relationship with Dr Bertram, she was also accused of having had a brief affair with a prominent Rotorua public servant, simply unacceptable behaviour for a nurse who was expected to be obedient and with high moral standards.[397] For both women, the situations illustrate the important role that reputation

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[394] "No title," *Kai Tiaki: the journal of the nurses of New Zealand* VII, no. 2 (1 April 1914): 91, https://paperspast.natlib.govt.nz/periodicals/kai-tiaki-the-journal-of-the-nurses-of-new-zealand/1914/04/01/45.
[395] "A nurse's affairs," *Dominion* (Wellington), 5 August 1915, 9, https://paperspast.natlib.govt.nz/newspapers/dominion/1915/08/05/9.
[396] "Supreme Court Today — Before Mr Justice Cooper and a jury.," *Waikato Argus* (Hamilton), 23 March 1914, 2, https://paperspast.natlib.govt.nz/newspapers/waikato-argus/1914/03/23/2.; Wilson, *Angels in the devil's pit*. 153
[397] Wilson, *Angels in the devil's pit*, 153.

played in sustaining both the financial and professional creditability of the business owners and how finely balanced it was.

A medical man's influence

As much as these women first and foremost sought to make a career from their nursing and midwifery, for some the struggle in a commercial world was far from an easy ride. Deciding which aspects of a hospital and how much to invest in their often modest commercial operations could be fraught with uncertainty, requiring advice from other quarters, such as the medical men in their communities. While Sister Hayward in Te Awamutu appeared to have both professional and financial confidence in her own abilities and decision-making, the story of Alice Maria Clymo and her private hospital in Paeroa revealed quite a different situation. Her reliance on the advice of a local medical man proved to be anything but helpful and it was only through the assistance of the Department of Health and its determination for the hospital to stay open that she was able to survive the ups and downs of New Zealand's economy in the inter-war years.

The depression years were hard for most New Zealanders and in the small town of Paeroa, things were particularly bad. This was felt by both Miss Clymo and local medical man Dr W.W. Little as their patients struggled to find extra money required for medical assistance. The Nurse Inspector reports repeatedly referred to the hospital's drab appearance, less-than-inviting décor and grey sheets that needed a spruce up.[398] Between 1927 and 1933, Arohanui Private Hospital was averaging fewer than four patients per month, rendering any upgrades or improvements financially unviable. Despite these reservations, the hospital operated steadily with Miss Clymo working mainly with Dr Little. In 1933, still feeling the effects of the depression, he wrote to the department asking if one of the rooms at the hospital could be converted into an operating theatre which would enable him to keep patients and their fees within reach in Paeroa rather than sending them away to larger hospitals.[399] This was approved on the condition that Miss Clymo employ a registered nurse to assist with any surgical

[398] Nurse Inspector R.J. Mirams, "Inspection of maternity hospitals: Miss Clymo," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 1929).
[399] Dr W.W. Little, "Letter to Dr Boyd Medical Officer of Health," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 23 January 1933).2873 Letter to Dr Boyd from Little

procedures and that modifications were made to the proposed operating theatre to ensure it could remain sterile. Miss Clymo had new linoleum laid on the floor but neither the proposed sterilising room nor the required equipment promised by Dr Little were installed to make the room usable.[400]

With her limited resources, Miss Clymo attempted to add improvements to her hospital as and when she had sufficient funding.[401] The unfortunate situation for Miss Clymo was that the improvements suggested by Dr Little appeared to have quite the opposite effect so that in addition to the cost of laying the new linoleum, there was no income from the room for almost nine months, leaving her out of pocket and anxious about the future of her hospital.[402] Nurse Inspector R.J. Mirams observed that this was the latest in a series of financial missteps taken by Miss Clymo but in this particular case, Dr Little had encouraged her to set up the operating theatre and subsequently refused to complete it or discuss the matter with her.[403] A letter from Dr Paget, Inspector of Private Hospitals, to Auckland's Medical Officer of Health was sympathetic to her plight and went so far as to describe Dr Little as 'quite unscrupulous in exploiting Miss Clymo where he thinks it is to his advantage.'[404] As many of her patients were the wives of relief workers and others in poor circumstances who struggled to save the £6 6 shillings required for their two-week stay at Arohanui, some patients failed to pay the full amount or not at all, creating a challenging cash flow. Despite this, Miss Mirams noted on the file that all patients were treated kindly and well looked after, regardless of their ability to pay.[405]

The commercial hardships were not solely driven solely by business costs, ill-conceived plans or even the seemingly rigid regulatory environment. Unlicensed midwives working from home

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[400] Nurse Inspector R.J. Mirams, "Special report re Miss Clymo," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 17 August 1922).
[401] Alice M. Clymo, "Letter to Dr Chesson, The Medical Officer of Health, Auckland," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 4 December 1927).
[402] R.J. Mirams, "Special report re Miss Clymo."
[403] R.J. Mirams, "Special report re Miss Clymo."
[404] Inspector of Private Hospitals T.L. Paget, "Letter to Dr. T Hughes Medical Officer of Health, Auckland," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 14 May 1937).
[405] Medical Officer of Health, "Memorandum for the Director-General of Health, Wellington: Miss Clymo's Private Hospital, Paeroa," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 6 August 1934).

were 'allowed' to operate as long as they did not treat any more than one patient at a time. In poorer areas like Paeroa, this provided an affordable alternative to private hospital treatment. While Miss Clymo struggled to keep her business afloat, there were as many as seven 'unqualified' women working in direct competition to her and while officially sanctioned, it was an issue that caused nervousness amongst officials.[406] The department's response to this was to ensure there was at least one regulated hospital in the town, in this case Arohanui, and were actively supportive of Miss Clymo in her endeavours. The Medical Officer of Health Dr Boyd observed that the better-off maternity patients in Paeroa were sent by Dr. Little to the Paeroa [Public] Hospital, which, 'I understand, is spoken of as "Dr Little's Hospital"…The poorer maternity cases are sent to Miss Clymo by Dr. Little.'[407] This was also acknowledged by another local practitioner Dr Davis who was satisfied both with her work and the standard of the hospital. Indeed, Inspector Mirams said 'Doctor Davis considered that for the poorer people Miss Clymo's private hospital is very necessary in Paeroa' and at one point he even described it as a palace for many of its patients.[408]

It would be easy to imagine from the drab descriptions and financial challenges faced by MIss Clymo and her hospital that her reputation and standing in the community might too be somehow diminished. Instead, she was an active member of Paeroa society, participating in and hosting regular bridge club meetings that occurred in the town and playing hostess to farewell and celebratory events. There are reports that Miss Clymo was responsible for the safe delivery of as many as eight to ten children in separate families, indicating a degree of trust between her and the local community that might otherwise be missed. Such was her standing that she was even a judge at a local baby show in 1932, during which she stated with pride 'that it was a difficult proposition to judge, as every one of the babies present was a credit to … the district.'[409] Arohanui Private Hospital was run by Miss Clymo between 1923 and 1938 by which

[406] Alice M. Clymo, "Letter to the Medical Officer of Health, Auckland," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 22 November 1927).2806 Letter from Sister Clymo to Medical Officer of Health

[407] Medical Officer of Health, "Memorandum for the Director-General of Health: Miss Clymo's Private Hospital, Paeroa," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 15 September 1933).

[408] Medical Officer of Health, "Memorandum for the Director-General of Health: Miss Clymo's Private Hospital, Paeroa," in *R6901579 Arohanui Private Hospital 1922-1928* (Auckland: Archives New Zealand, 6 August 1934).

[409] "Successful fair and Paddy's Market at Turua last night," 2.

time the then 67 year old was ready to retire. Her success in maintaining a business for 15 years in a poorer community and during a depression indicates that she was a trusted and able nurse woman who ran a moderately successful establishment that, despite its struggles and occasional missteps, more than met a community need.

Pragmatism for the people

The Department of Health recognised that private hospitals were integral to the healthcare landscape and that it was essential for the communities in which they operated that they continued to survive. In Otorohanga in 1920, however, the department was caught in a difficult position with unregistered midwife Mrs Severine Funnell and her unlicensed private hospital. Mrs Funnell's private hospital was the only maternity hospital available in Otorohanga. She appeared to have been practising for some years before she came to the attention of the Department of Health. While there was no suggestion that Mrs Funnell was anything other than a 'clean decent woman' who provided a valuable service to the small Waikato farming community, her lack of training and knowledge of nursing was the major concern for the department.[410] As was the case with Miss Clymo in Paeroa and Sister Hayward in Te Kuiti, the small farming community of Otorohanga did not have the luxury of a state hospital or another private maternity hospital to serve the local community leaving the department in a difficult situation. When it was suggested that legal action might be taken against her, Hester Maclean expressed doubt that 'under all the circumstances…it would have been possible to prevent Mrs Funnell from taking cases while there is no [other] provision' and the department appeared to have little option other than to find a compromise.[411] Significantly for Mrs Funnell, she had the backing of local medical man Dr C.B. Gilberd as well as the Town Board who pledged to raise £1500 to build a new hospital for the town. In the interim the board requested that the department overlook Mrs Funnell's lack of qualifications and allow her to continue to provide the very necessary service to the town.

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[410] Nurse Inspector A Bagley, "Memo for Miss Bicknall: medical and nursing facilities at Otorohanga," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 19 October 1920).

[411] Director of Nursing H. Maclean, "Handwritten note to the Director General on a letter to Mrs. Funnell, Otorohanga, from A. Bagley, Assistant Inspector," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 22 December 1920).

This type of request for dispensation from regulations was not uncommon throughout the country. Outside of the main centres and some of the larger towns, infrastructure was not keeping up with growth and officialdom was forced to find pragmatic ways to meet demand. It is perhaps not surprising that the sort of person who had the wherewithal to step into private hospital ownership was also of a mind to take matters into their own hands. Mrs Funnell appears to have been one such woman. Despite the initial fracas, she and her husband went ahead and built a new hospital without departmental approval, bringing her once again under its scrutiny. She had secured the financial backing of 'a private gentleman of the township' and had the backing of a local medical man but by the time the hospital inspector viewed the premises, the nurse inspector found, much to her irritation, that the new hospital failed to meet specifications in terms of room size, ventilation and staff accommodation.[412] However, Mrs Funnell received less blame than local doctor Dr Rylands Nicholson who was criticised for not advising the department of 'what was afoot'.[413] A report to the department made it clear that neither Mrs Funnell nor her husband and builder Mr Funnell appeared to 'properly understand the necessity of these [sanitation] requirements and pleaded the lack of finance to complete the building [to government specifications].'[414] It went on to state, however, that as Dr Nicholson had no financial interest in the hospital, it made it virtually impossible for him to influence the couple's actions. This illustrated both the autonomy that the licensees had and the desperation in many communities that led to people like the Funnells taking whatever steps were necessary to meet local needs.

With her community's support Mrs Funnell continued to work but in 1925 a change in the legislation created an even bigger obstacle for her. The Nurses and Midwives Registration Act 1925 strengthened regulations surrounding midwives and introduced the new classification of maternity nurse to its schedule. Gaining registration as a maternity nurse required less training

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[412] Dr R. Nicholson, "Letter to Dr Valentine, Wellington," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 19 October 1921).
[413] Assistant Inspector A. Bagley, "Memo to Miss Bicknell," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 3 November 1921).
[414] Technical Inspector H.W. Johnson, "Memorandum for the Director-General of Health, Wellington: Private Maternity Hospital, Otorohanga," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 11 November 1921).

than a midwife and offered recognition of experience as an alternative to undergoing formal training. Applicants for this category only had to have twelve months experience as a maternity nurse, a qualification Mrs Funnell more than met, but with the proviso that they did not practice without the supervision of a registered midwife or doctor.[415] In November 1926, just a few weeks before the twelve-month transition period to the new legislation expired, Mrs Funnell registered as a maternity nurse. She was still not, however, eligible to be a licensee.

This put the department in a difficult position. Otorohanga had no other private hospital options. Mrs Funnell had an excellent reputation, she had the support of the local doctor and was well respected within the community. However, because she was not eligible to be a licensee her hospital did not meet departmental requirements. After some encouragement from the department, Mrs Funnell employed a registered midwife to address the first issue but this solution was short-lived with Mrs Funnell declaring she would not recruit another.[416] Ultimately, the hospital's license was revoked and Mrs Funnell converted her property into a boarding house. Mrs Funnell was advised by the department that she was allowed to take in one case at a time as long as she had a doctor in attendance with her.[417] However, by 1930 she had come to the attention of the department of once again for taking on more patients than she should and the Crown Solicitor was instructed to initiate proceedings against her. She was fined and ordered to pay court costs and solicitors fees totalling £8 13 shillings.[418] The magistrate was scathing of her hospital, describing the premises as 'not in a fit and proper condition' but the community did not agree.[419] Within three weeks of the verdict a petition from 250 married women from the Otorohanga district was sent to the Minister of Health

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[415] Nurses and Midwives Registration Act 1925 (16 Geo V 1925 No 10), 16 (Wellington: New Zealand Government, 1925).

[416] Assistant Medical Officer of Health John Boyd, "Memorandum for the Director-General of Health, Wellington: Private hospital license - Mrs. Funnell, Otorohanga," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 11 August 1922).

[417] Chief Health Officer T.H.A Valintine, "Letter to the Chairman, Otorohanga Town Board: Mrs. Funnell's House," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 24 December 1920).

[418] Medical Officer of Health John Boyd, "Memorandum for the Director-General of Health, Wellington," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 29 July 1930).

[419] "Not a nice case - house used as hospital: Magistrate's caustic comment. Nurse fined £5," *Waikato Times* (Hamilton), 25 July 1930, https://paperspast.natlib.govt.nz/newspapers/waikato-times/1930/07/25/6.

asking him to reconsider the position of the department and issue Mrs Funnell with a license, despite her being unregistered.[420] She galvanised support from local community stalwarts including registered nurse Edna Fry and local medical man Doctor Gilberd, who wrote letters of recommendation, as well as employing the local law firm Corbett & Mossman to continue her campaign for a license.[421] As far as the district was concerned, her links to the community, her standard of treatment and her affordable charges of £4/4 per week were more than enough for them to continue to show their support.

Another private hospital, the Braemar, had opened in the district, theoretically improving options for the local community. But Otorohanga was not a well-off area so the weekly charges of £5 5 shillings per week were regarded by many as beyond their means.[422] Despite this, Mrs Funnell's monopoly had gone, and her bargaining position was weakened despite offering a cheaper service than her competitor. In addition, the department was cautious about showing preferential treatment to an unregistered midwife when a fully qualified and certified midwife and hospital was available in the town. What the Braemar did not offer, as was common at the time, were beds to local Māori women.[423] In a bid to bridge this gap, the department proposed to licence Mrs Funnell for four patients, providing beds for three Māori and one pakeha woman on the condition that she also made certain structural changes to the building to meet the required departmental specifications.[424] Mrs Funnell refused to budge. Her response to this proposal was unequivocal:

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[420] Corbett & Mossman, "Letter to the Minister of Health, Wellington: Mrs S.C. Funnell of Otorohanga. License for private hospital," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 17 November 1930).
[421] Edna Fry N.Z.R.N., "Letter to Mr Broadfoot M.P.," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 3 August 1930).; Dr G.B. Gilberd, "Letter to whom this may concern," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 17 November 1920).
[422] Dr C.B. Gilberd, "Letter to Dr. John Boyd Medical Officer of Health, Auckland," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 29 October 1930).
[423] Dr C.B. Gilberd, "Letter to Dr. John Boyd Medical Officer of Health, Auckland."
[424] Inspector of Private Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Auckland: Mrs. Funnell's Proposed Hospital, Otorohanga," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 10 December 1930).

> 'No. I am not prepared to carry on under your conditions. One European and three Natives (sic) would mean I could only book one European a month or they would be liable to clash and on an average I would get about two Natives (sic) a month. Therefore it would not pay me to make the necessary alterations unless I could take four Europeans or Natives just as they happen to come along.'[425]

In other words, for her business to succeed she needed to be able to take paying customers as and when they required a bed and regardless of their race. She was seemingly unprepared to negotiate on this point. Mrs Funnell's departmental file ends abruptly without resolution or clarification on whether the license was issued, or if the hospital was formally closed. What can be gleaned through *Papers Past* is that she continued to offer occasional maternity services to her community with at least one baby being born under her care in May 1934.[426]

It is extraordinary to reflect on the lengths the department was prepared to go to in its negotiations with Mrs Funnell over a ten-year period, particularly given its image of strict regulatory management. What is striking in this research is that this very willingness and recognition of necessary compromise in order to meet community needs was an acknowledgement of the unique space these women had carved out and helped to create an environment where they could survive and thrive. This could be seen with the assistance given to Miss Clymo in Paeroa and her financial struggles, to Sister Hayward in Te Awamutu as she stood her ground against an attack on her reputation and to Mrs Funnell whose departure from Otorohanga would have left the community bereft of maternity services. The skills these women offered were essential to and supported by the communities they served and, if they were lucky, by the medical men working alongside them.

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[425] Medical Officer of Health T.J. Hughes, "Memorandum for the Director-General of Health, Wellington: Mrs. Funnell's Proposed Hospital, Otorohanga," in *R20963132 Private Hospitals - Unlicensed - F.C. Funnell - Otorohanga* (Wellington: Archives New Zealand, 18 December 1930).

[426] "Births," *Evening Post* (Wellington) 1934, 1, https://paperspast.natlib.govt.nz/newspapers/EP19340508.2.2?end_date=01-01-1940&items_per_page=10&phrase=2&query=Nurse+Funnell&snippet=true&sort_by=byDA&start_date=01-01-1920.

Conclusion

This research adds to the nursing story. By understanding the actions of private hospital-owning nurses it reframes our understanding of the professionalisation of nursing and the women who were driving it. Stepping into the spaces created by legislative frameworks, these women were able to establish businesses that shifted the unequal power relationships between nurses and doctors. They found and exercised agency and independence within their own establishments and through this within their communities. They became familiar with a raft of previously unfamiliar issues such as sanitary requirements, plumbing, bookkeeping, advertising, staff management and budgeting. They provided essential services recognised both by government and the general public, and rather than simply evolving the Nightingale established ethos of vocational service these modern women effected change on New Zealand's medical landscape as a whole.

The burden of risk that the private hospital licensees shouldered and the challenges and opportunities it created for their professional and financial independence is central to this research. Nurses and midwives in New Zealand had responded to the changing legislative context created through the Nursing Registration Act 1901, the Midwives Act 1904 and the Private Hospitals Act 1906 by taking on hospital ownership. The legislation created opportunities that allowed them to establish themselves as businesswomen and entrepreneurs. In the first instance, regulation of their profession afforded nurses a new status grounded in a formal training structure and examination, an internationally recognised registration and entry into the New Zealand Trained Nurses Association which created a voice on professional development and shaped policy. As their roles as nurses and midwives expanded into private hospital ownership, they developed additional skills more commonly associated with the independence of women in early colonial New Zealand as described by Catherine Bishop in her *Women Mean Business.*[427] Business ownership at that time provided a freedom for many women who were seeking to make a new start or change their sometimes difficult

[427] Bishop, *Women mean business*.

circumstances. So too for many of the nurses in early twentieth century New Zealand where hospital ownership was an opportunity to secure their own professional space.

Private hospitals became an important part of the medical landscape in New Zealand, at the same time as strict controls implemented through the Private Hospitals Act were enforced. The act enforced more robust hygiene and infection control standards and insisted that all hospitals were managed by registered nurse and midwife licensees. It was the licensees' professional and personal reputations which were under constant scrutiny as they built their business and relationships with the department, local doctors and the community. The nurse training process, however, remained firmly within public hospitals, despite heavy lobbying by some sectors of the profession. The belief was that this created consistency across all the large training hospitals and remained in place until the large Auckland faith-based Mercy Hospital succeeded in altering government policy on the issue. The effect was, however, to free up private hospitals to focus on compliance and nursing standards as their sector continued its rapid growth and expansion. Nurse inspectors were regular visitors to every private hospital at least once if not twice a year. This research shows the high level of collaboration between the department's inspectors and the licensees. It was in both parties' interests for the hospitals to succeed and in some cases this required a higher level of coaching and advice. Owning a business meant developing new skills and dealing with multiple challenges but at the same time afforded the women owners a career with responsibility, an income and a roof over their heads.

While the balance of power shifted between licensees and doctors as the legislation took hold, nurses' new-found agency did not always attract the support of their medical colleagues. Nurses relied to some extent on doctors' recommendations for patient referrals, while at the same time advertising directly for their services in ways unavailable to doctors who were prohibited by professional rules from advertising. In return, doctors needed access to reliable hospitals with appropriate levels of nursing care and patient management, something that wasn't necessarily guaranteed. In public hospitals, they were unable to charge fees so access to high-quality private hospitals was fundamental to their incomes. However, conflict did occur.

As has been shown in the case of Sister Edith Hayward in Te Awamutu for example, her fraught relationship with two doctors in her community was triggered by the authority she exercised as licensee for her private hospital to withdraw that access. She made Te Whare Ora, the only private hospital in Te Awamutu at the time, unavailable to Dr Rogers forcing him into a difficult position that was only resolved when the Department of Health stepped in to mediate. With the support of another doctor in the town and rigorous investigation by the hospital inspectorate, Sister Hayward was exonerated and Dr Rogers' accusations found to have been wanting.[428] Additional information found through other sources including *Papers Past* created a more balanced perspective on both parties. Dr Rogers' stellar career after his early days in Te Awamutu and his return to the small rural town showed a man with a sense of adventure, commitment and drive to serve his community, wherever that happened to be. He was attached to Te Awamutu and chose to return there despite what must have been an awkward situation that did not resolve itself in his favour. So too Sister Hayward stayed and expanded her successful business until her retirement almost a decade later. Finding a story which so perfectly illustrated the shift in the power balance traditionally exercised between medical men and nurses was completed by the discovery also of their continued successes.

The day-to-day management of the business presented challenges outside the normal scope of a nursing career. Being responsible for cash flow, recruiting and paying employees and suppliers added another level of complexity to the working lives of women who were already dealing with their patients' health and wellbeing. In addition, public issues such as the *Maternal Mortality in New Zealand 1921* report, the *Kelvin Commission of Inquiry 1924* and the revision of healthcare implemented through the Health Act 1920 attracted political scrutiny onto the nursing environment that created additional pressures. The licensees were responsible for ensuring cross contaminations and sepsis did not occur and were subject to the full financial and reputational damage to their businesses if they failed to do so. Nurse Josephine Gibbons, Matron of Kelvin Hospital, chose to walk away from her hitherto impressive nursing career and successful business. Despite her nursing practice being exonerated in the

[428] T.L. Paget, "Memorandum for the Medical Officer of Health 29 March, Hayward."

Kelvin report, she found the weight of public scrutiny and the tragic loss of five lives more than she was prepared to shoulder. In other hospitals, less dramatic outcomes could still have a damaging effect with forced temporary closures and the subsequent loss of income creating financial pressure. While this served to promote vigilance under the diligent supervision of the nursing inspectorate, it created another pressure which some hospitals did not rise to. In the wake of the *Kelvin Commission*, new regulations were introduced and four private maternity hospitals representing 20 beds were closed in the Auckland Hospital district alone.[429]

The number of private hospitals continued to rise through the 1920s peaking at 327 in 1928.[430] The impact of the depression was soon felt and by 1932 just over 50 hospitals had closed before numbers stabilised again. When the Social Security Act 1938 was enacted the medical landscape in New Zealand made another dramatic shift. The new state health service provided access to free state hospital care for medical, surgical and maternity patients and subsidised 'very much cheaper attendance in even the more luxurious private hospitals.'[431] Doctors could, for the first time, be paid for working in public hospitals, making private hospitals less necessary. Nonetheless, for the nurses who owned private hospitals this new funding model 'provided a degree of economic security…that they…never enjoyed before.'[432] This led to the reportedly sustained growth of private maternity hospitals with numbers rising from 189 in 1938 to 196 in 1939.[433] Over the same period the number of beds in private medical and surgical hospitals increased from 379 to 395 but the actual number of hospitals decreased with the closure of eight of the smaller medical and surgical hospitals.[434] The sector which most benefited from the Social Security Act was the medical and convalescent hospitals which saw an increase from just 18 to 34.[435] Ultimately, however, the model of ownership began to change

[429] "Women's Corner," *Press* (Christchurch), 14 November 1924, 2, https://paperspast.natlib.govt.nz/newspapers/CHP19241114.2.8?end_date=01-01-1926&items_per_page=100&phrase=2&query=Kelvin&snippet=true&sort_by=byDA&start_date=01-01-1924&title=CHP.
[430] 1927, *Department of Health: Annual report of Director-General of Health*, 43 (Wellington: AJHR H.-31).
[431] 1940, *Department of Health: Annual report of the Director-General of Health*, (Wellington: AJHR H.-31).
[432] 1940, *Department of Health: Annual report of the Director-General of Health*, 33.
[433] 1940, *Department of Health: Annual report of the Director-General of Health*, 33.
[434] 1940, *Department of Health: Annual report of the Director-General of Health*, 43.
[435] 1940, *Department of Health: Annual report of the Director-General of Health*, 43.

as improved technology required more capital and incurred higher running costs while many smaller hospitals run from private houses and owned by individual nurses in the long term were not sustainable.

The strong legislative framework introduced between 1901 and 1906 requiring nurses, midwives and their hospitals to be registered, licensed and regularly monitored could be seen as having put a straight-jacket around the industry. Instead, it proved fertile ground for many women prepared to take on the responsibility of running their own business. They were assisted by the Department of Health which adopted a practical and collaborative approach that enabled licensees to not only survive but thrive. It is also significant is that the responsibility and authority they exercised in their premises shifted the power balance between nurse licensees and doctors in a way that with occasional exception did not threaten their working relationships. Private hospital ownership created a unique niche for New Zealand's nurses and midwives whether by providing employment, an income and accommodation for themselves and extended family, or creating a business and a long-term future that was their own.

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