

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**‘AN EXCELLENT PREPARATION
FOR MARRIAGE AND
FAMILIES OF THEIR OWN’**

Karitane Nursing in New Zealand 1959-1979



A thesis presented in partial fulfilment of the requirements for the degree
of Master of Arts in History at Massey University

Lesley Courtney

2001

‘My greatest asset is my children
and who would I give my greatest asset to for care
- no one but a professional person’

Charmaine Foster
employer of Karitane nurses
1976-89

Karitane nursing has been important to me. It was my first foray into post-primary training and my first 'real' job. While I long ago left it behind, and largely forgot it, it was an important part of my growing up and no doubt says a lot about me as a New Zealand 'girl' of the sixties and seventies. I have learned a lot in writing this thesis and have been encouraged by the interest and enthusiasm that people have shown in my research. I must first thank all the people who contacted me and were willing to be interviewed or wrote me copious notes about their days involved with Karitane nursing. Without their willingness to reminisce this thesis would not be possible. Second, thank you to my supervisor, Dr Margaret Tennant, who has encouraged and inspired me not only during this thesis but throughout all my studies at Massey. Lastly, I must acknowledge all past Karitane nurses who are part of this story also.

Lesley Courtney, Dec 2001

CONTENTS

Acknowledgements
Contents

| | |
|---|-----|
| Introduction | 1 |
| Chapter 1 A School for Mothers | 18 |
| Chapter 2 1959: The Consultative Committee on Infant and Pre-School Health | 40 |
| Chapter 3 Apparently Attractive to Young Girls | 53 |
| Chapter 4 Basic Practical Training | 65 |
| Chapter 5 Cheerful Competent Girls | 97 |
| Chapter 6 No Longer a Primary Function | 127 |
| Chapter 7 A Thing of the Past? | 143 |
| Conclusion | 156 |
| Appendices | 161 |
| Bibliography | 168 |



KINDLINESS IS ESSENTIAL.

ALWAYS COMBINE WITH KNOWLEDGE,
TACT AND RESOURCEFULNESS.

REMEMBER THE TRUST PLACED IN
YOU

IS A GREAT ONE, AND YOUR FAITHFUL
DISCHARGE OF IT BRINGS HONOUR TO

THE NURSING PROFESSION OF WHICH
YOU ARE A PART.

AIM TO OBSERVE CAREFULLY THE
ESSENTIALS FOR HEALTHY LIVING—
FOR—

NURSES BY THEIR OWN EXAMPLE DO
MUCH TO ENCOURAGE OTHERS.

EVER FACE DIFFICULTIES AND CRITIC-
ISM WITH PATIENCE AND THE QUIET
DIGNITY DUE TO YOUR PROFESSION.

SERVE FAITHFULLY AND DILIGENTLY,
RESPECTING CONFIDENCES—WITH A
LOVE FOR THE BABIES IN YOUR CARE.

Introduction

The Karitane baby nurse is qualified to undertake the care of young children and babies. Before qualification she has had sixteen months of intensive instruction and practical experience in a Karitane Hospital under the eye of the visiting physicians and the matron and sisters. In addition she has had four months' practical work in private homes under the supervision of the Plunket nurse and bureau secretary. The Karitane nurse will do everything possible to ensure the highest standard of health and happiness for the child under her care.....She is not a general-trained nurse and should not be asked to carry the responsibility of a child who is not well. The aim of the Karitane nurse is to help the mother to accept full care of her child with competence and confidence....The Karitane nurse will be there to help the mother and to guide and support her with the problems of mothercraft. A close and understanding relationship between the mother and the Karitane nurse is an essential foundation for an efficient service....The Society would like mothers to understand that the Karitane nurse holds a responsible position, and that her status in the household should be that of a trained children's nurse. Karitane nursing is an arduous profession....It is in the interests of the parents to ensure that the nurse's health and strength is safeguarded and that she is not overloaded with household duties. In this way the Karitane nursing service will remain a popular one.¹

By the time these 'Rules' were issued, the training of Karitane nurses was already under threat. They illustrate, however, the key characteristics of the Karitane nurse: she was not trained to deal with sick children, and although trained in an institution, her final place of work was in family homes, but she was not to be mistaken for a domestic servant.

While other countries had their nannies and mothercraft nurses, twentieth century New Zealand had Karitane nurses, who shared some of their characteristics, but were also a distinctively local phenomenon that evolved out of the needs of the Plunket Society. This distinctiveness did not reside in the name alone, but was manifest in the actual job and status of the 'Karitane'.² Now, largely secondary to broader studies of Plunket and rarely making an appearance in studies of nursing and women's work, it demands analysis as a career for women on the margins of the

¹ The Royal New Zealand Society for the Health of Women and Children (RNZSHWC), 'Rules for Karitane Nurses, Scope and Duties', circa 1960s, DU:HO, AG-145-27

² Mary King, *Truby King the Man*, London: George Allen and Unwin Ltd, 1948. The name Karitane came from the area in Otago where Truby King first took babies with problems into his own seaside house. King notes (p.107) that Karitane is not a Maori word but a corruption of English, after the Reverend Creed who ministered on the Karitane Peninsula. Kariti (Creed) + Tane (man) = Creed the man.

professions. The period of this study begins with the 1959 Consultative Committee Report on Infant and Pre-School Health Services. It ends with the closure of the hospitals. While many of the nurses continued to work as Karitanes after this date, Karitane 'nurse' training was no longer an option for young women.

This thesis will be a study of how Karitane nursing fitted within the context of women's education, work (specifically nursing) and the history of the Plunket Society at the time.³ It seeks to clarify just who and what a Karitane nurse was, and her importance and value to the Society. The equivocal nature of Karitane nursing is a recurring theme as the training and future destinations of the certificated nurses are explored. Karitane nurses were institutionally trained and domestically bound, and even if the Karitane hospitals had not closed it is unlikely that young women would still have been lining up to train for such an ambiguously situated job in the twenty first century. This will necessarily be a gendered study as Karitane nursing never sought to attract any men. The Plunket Society itself, until fairly recently, has been a female dominated organization, with men usually only holding the important but singular job of representing the medical profession within its structure.⁴

Historiography

'There can be no quarrel about the significance of domesticity in Pakeha women's lives throughout the last hundred years', writes Melanie Nolan.⁵ Because of the domestic base of Karitane nursing and the maternal aims of the Plunket Society, baby nursing appears to have been the ideal career for young women in New Zealand during the earlier part of the twentieth century. Marriage and motherhood were the

³The society registered itself in December 1907 as 'The Society for the Promotion of the Health of Women and Children'. While being recognised officially as the Plunket Society since 1914 its formal title has varied. In 1909 it became 'The Society for the Health of Women and Children', 1917 Royal New Zealand Society for the Health of Women and Children' and finally in 1980 'Royal New Zealand Plunket Society Inc.' For the purposes of this thesis I will refer to it as the Plunket Society throughout.

⁴Dr Helen Deem was the notable exception. She was Medical Director of the Plunket Society from 1938-1957. Most of the 'visiting physicians' to the Karitane Hospitals were local obstetricians and were largely men.

⁵Melanie Nolan, *Breadwinning: New Zealand Women and the State*, Christchurch: Canterbury University Press, 2000, p.15

supposed destination and ambition of all women, who were supposed to have an equal but separate role to play in society.

With the advent of 'women's history' and the foregrounding of women's unique role in our past, historians have tended to argue until recently that New Zealand women were subsumed by their deliberate placement within the domestic arena, to their detriment and unchallenging acceptance. It was the paternalistic nature of the state and New Zealand society that actively encouraged and promoted this role. More recently there has been some acknowledgement that women in fact had more control of how they perceived and enacted their place in society. This manifested itself within women's education and work. Although the relatively low numbers of Karitane nurses trained over the years meant that historians have paid little attention to Karitane nursing as an occupational choice, it fitted domestic ideologies very well. It idealised women as mothers, was a caring and service 'profession' and required a minimum education.

Within the recent historiography of education gender has been a dominant theme, portraying the promotion in New Zealand of equal but separate education for girls and boys. The teaching of 'domestic science' to girls was both relevant and fitting for future lives which would increasingly include paid employment, but would ultimately lead to marriage, motherhood and a 'job' in the home. Much historical discourse has suggested that women were shaped by this deliberate policy into an 'unequal' domestic position in life. However, there is currently more discussion that this is only part of the picture and that women in New Zealand in the twentieth century were in the position to break out of the so called narrow mould that they were destined for, if they wished to.

Ruth Fry has emphasised a gendered education that saw young women's educational advancement limited by subject choice, with more girls having taken subjects that terminated at fifth form level. She suggests that, initially, domestically inspired education was provided to elevate the image of domestic work in the hope that it might lead to a 'better class' of girl seeking it as a job, as had happened in nursing. However, she further suggests that at least into the seventies, even though

girls were receiving more, and a wider, education, they continued to conform to traditional work opportunities. One could argue that many of those who took up Karitane nursing fitted this argument.⁶

In an essay on 'Women in Technical Education' Barbara Day also supports the view that women themselves maintained gendered job boundaries but she argues that the chance of wider employment has always existed and women have chosen to be influenced by societal expectations. While relatively few women took up domestic job opportunities that were promoted in the early part of the century they accepted their domestic destination and, until more recently, 'have disregarded the literal application of the girls-can-do-anything slogans'.⁷

Further to this argument Melanie Nolan also discusses state promotion of a gendered workforce through education in her book *Breadwinning*. She sees that while 'It is generally held that the ideology of a woman's place being in the home [was] "absolutely dominant" in the twentieth century', the state's agenda was for domestic education to act as a class leveller, and that it responded too, rather than caused, changes.⁸ Like Day she sees that women had choices and also supports the idea that if women had to be taught to be good housewives and mothers then it was not innate and changes could be effected.

The position of women in New Zealand society is a complex one and it is too simplistic to just see it as the aim of a paternalistic state with a male ethos. While women were traditionally placed within the domestic sphere, and the majority conformed to this role, it was not only patriarchy or the state but also women themselves who actively promoted and enjoyed this position. Karitane nursing was an area that was almost entirely organised, controlled, promoted and taken up by women. Well into the 'second wave of feminism' there was a maintained interest in

⁶Ruth Fry, *Its Different for Daughters*, Wellington: New Zealand Council for Educational Research, 1985

⁷Barbara Day, 'Women in Technical Education', in *Women in Education in Aotearoa*, Sue Middleton and Alison Jones (eds), Wellington: Bridget Williams Books, 1992, pp.68-82, p.82

⁸ Nolan, p.16

this career that was entirely female and domestically located, physically and ideologically.

Defining Karitane nursing is a difficult and contentious issue because of its hospital training and domestic destination. It was also practised at a time when 'well-health' was perceived to be at variance with 'nursing'. Today the term 'nanny' is often used in a bid to describe the work, if not the training. Nannying is seen as a relatively new occupation in New Zealand, as Karitane nursing never sought to promote itself along those lines, but a comparison can be made. Within New Zealand no study has been done so one must look to England for some sort of historiography. Jonathan Gathorne-Hardy has written of the traditional nanny in Britain.⁹ As an on-the-job training, it required rising through the ranks of seniority to the position of nanny in its own right. The term 'nurse' was used (from the nursery), particularly in lesser positions than nanny, and a uniform worn. Viewed as superior to servants or superior servant, the status of the nanny within the household staff was high. It also accorded the employer status. Gathorne-Hardy sees that it was career, with seniority bringing increased wages and responsibility. Although the British nanny was more likely to anticipate long-term employment within a household, definite similarities would appear to exist with the New Zealand Karitane nurse. Nicky Gregson and Michelle Lowe take the study further in discussing the re-emergence of the nanny in Britain in the late twentieth century. They see that state policy, for much of the twentieth century, made the mother central to her children's care, but since the 1980s the working mother has brought about the need for a 'new servant class', namely nannies and cleaners. Their study reveals the nanny to be almost exclusively female and one whose 'gender identities are primarily traditional and conformist'.¹⁰ It is a 'labour of love', often carried out until the nanny's foreseeable marriage. She is often attracted to 'women's work' and the non-academic nature of the job. While childcare is the prime task, frequently domestic work is carried out, often beyond the brief of the job. Most of these nannies viewed their work with children positively but some

⁹Jonathan Gathorne-Hardy, *The Rise and Fall of the British Nanny*, London: Arrow, 1974

¹⁰Nicky Gregson, Michelle Lowe, *Servicing the Middle Classes: Class, Gender and Waged Domestic Labour in Contemporary Britain*, London: Routledge, 1994, p.143

recognised it as a stopgap due to its limited career structure and challenge. Overall, these nannies make an interesting comparison to the women interviewed for this thesis.

Within New Zealand Helen May looked at early childhood in 1997. She commented that it had been a neglected area of research because 'it is mainly a history of women's activism, taking place in the experimental and voluntary/charity sectors. Early childhood services have often been small scale and out of sight in homes, houses and halls....[and] have been entwined...with changing ideas of child rearing, the roles of women, the welfare of children and families and the place of the state in supporting and fostering that welfare.'¹¹ Looking at the broader aims of pre school child care she traces the movement of children from being 'chattels' to 'social capital.'¹² By the early twentieth century the welfare of children was moving into the public domain. King and the Plunket Society's emphasis on the 'science' of mothering greatly influenced public investment in children. While initially May sees that education and the care of the child tended to be catered for separately, more recently these have merged in a more holistic approach to the welfare of the child.

Any historiography of Karitane nursing exists within writings on the Plunket Society but it should also take its place within the wider context of women's work, particularly the health professions. General nursing has most usually been studied within this context. The Karitane nurses' inclusion in the category 'nurse' has been, and is, a debatable issue. However, many of the discussions of nursing historically would appear to have implications for our understanding of Karitane nurses, and their status while in training and in practice. Nursing in general has long been an accepted respectable occupation for women of standing and some education. For the majority of the twentieth century it stood alongside teaching and secretarial work as one of the alternatives for a working girl. More recently nursing has been looked at in the struggle to attain professional status. The professional status (or otherwise) of

¹¹ Helen May, *The Discovery of Early Childhood*, Auckland: Auckland University Press/ Bridget Williams Books, 1997, p.xi

¹² *ibid*, p.xv

Karitane nursing has not been examined. From an official perspective, even Plunket nurse training was problematic, with Plunket nurses only being deemed 'nurses' because of their prior general training.

Karitane nursing was closely modelled on the nursing profession of the time. Marion Penny's 1968 thesis looked at how general nurses perceived their role then. The main characteristics nurses identified of nursing were an 'emphasis on care and concern for others in an immediate and tangible way...order and routine...[and] technical skill'.¹³ The nurses interviewed also saw a distinction between nursing contact with patients and menial tasks. Penny further discussed that the 'professionalization' of nursing was required as the skill base of the job increased.¹⁴

Kathryn Wilson, who explores the development of nursing specifically in the Rotorua area, sees that by the early twentieth century nursing had developed as a 'respectable vocation for educated young ladies...not undertaken for purely commercial motives'.¹⁵ The 'new' scientific approach to health care, and apprenticeship hospital training, 'provided a reliable source of cheap nursing labour...which in their turn, provided young women with their training, board, uniform [and] a hospital certificate'.¹⁶ While registration was regarded as giving nursing a professional status at the time, hindsight would see that it was limited, although it did lay claim to the title 'nurse'. In her 1985 thesis Jan Rodgers puts forward much the same argument: that nursing was a natural extension of the role of women. She further argues that the low status of nurses reflected the low status of women in the early part of the twentieth century. General nursing was service-based and learnt through example not knowledge, from senior student nurses. This was seen as 'the most valuable contribution made by the hospital training method'.¹⁷ She

¹³Marion Winifred Penny, 'The Student Nurse in New Zealand: An Exploration in Role Perception', MA thesis in Sociology, University of Canterbury, 1968, p.41

¹⁴Penny says 'Professionalization is the process through which an occupation gains a monopoly of specialized knowledge and a high degree of competence in its utilization'. *ibid* p.21

¹⁵Kathryn Wilson, *Angels in the Devil's Pit: Nursing in Rotorua 1840-1940*, Wellington: Karo Press, 1998, p.29

¹⁶*ibid*, p.32

¹⁷Jan A.Rodgers, 'Nursing Education in New Zealand 1883-1930: The Persistence of the Nightingale Ethos', MA Thesis in Education, Massey University, 1985, p.57

contends that while training remained in the hospitals, it perpetuated the perception that nursing was women's work. However, registration was the first step in nurses gaining 'power' over nursing. This, and the development of their own magazine, *Kai Tiaki*, united nurses and fostered growth in a nursing profession, even if it took many more years to achieve autonomy.

Another paper that offers a perspective worth looking at in a study of Karitane nurses is the 1984 Australian *Characteristics of Entrants into 5 Types of Nursing Courses: A Comparative Analysis*.¹⁸ This paper funded by the College of Nursing in Australia includes Mothercraft nursing in its comparison. The Mothercraft nursing entrant is pictured as one who: had a 'personal interest in children' and a 'love of this particular type of work', wanted to gain 'practical' experience in the field, intended working full time, preferably with direct 'patient' contact, saw the most important characteristics of nursing as responsibility, understanding, observation, dedication and co-operation, was less educated than general nurse entrants (largely to 5th form level), chose this as her first choice of occupation and identified the most important attribute of the work as 'emotional satisfaction'. This study revealed that many of these characteristics were universal to all types of nursing in Australia. This picture of the mothercraft nurse as part of the nursing profession holding universal characteristics would make an interesting comparison with the entrant into Karitane nursing in New Zealand as looked at in this thesis.

A discussion of the professionalization of particular occupations has gained some following amongst historians. It is perhaps the 'elusive nature of professionalism'¹⁹ that causes some controversy over the use of the word

¹⁸ N. Bruni, R.P. Tisher, A. Walsh, *Characteristics of Entrants into 5 Types of Nursing Courses: A Comparative Analysis*, Monash University, 1984. Australia directly based their Mothercraft Hospitals and Mothercraft Nurses on Truby King's philosophy, the Karitane hospitals and Karitane nursing training curriculum. By 1984 this training was College based and Karitane nurse training was no longer being offered. See 'Enrolment of Mothercraft Nurses: Approval of Training Institutions' which appears identical to the New Zealand Plunket Society training. It was sent to New Zealand for comments and proposals (circa 1940s?). NA H1-24627-127/4/1

¹⁹Daniel J. Walkowitz, 'The Making of a Feminine Professional Identity: Social Workers in the 1920s', *American Historical Review*, Oct 1990, Vol 95 No 4, pp.1051-1075, p.1052

'profession', and the protective response of those already in a 'professional' occupation. The professionalizing of feminine occupations has the added burden of gender to overcome when seeking professional status.

Daniel Walkowitz examined 'The Making of a Feminine Professional Identity: Social Workers in the 1920s'.²⁰ His discussion raises issues relevant to the professionalizing of all feminine occupations. Professionalism promises status and autonomy, but Walkowitz argues that there are inherent difficulties in professionalizing feminine occupations under traditional 'male' terms. The raising of a feminine occupation to a profession, when available ideologies and representations placed women in the domestic site, was difficult. At the time women were encouraged into occupations that used their supposed inherent nurturing skills, giving women's paid employment domestic overtones. This made the specialist knowledge and language that is perceived to go with a profession, difficult to define. For social workers, professionalization came from within and was seen to have been achieved by placing restrictions on the entry to training, and through the introduction of 'scientific' social work. Walkowitz suggests that to achieve professionalization, women social workers had to either take on the role of the 'Professional Woman' or 'Professional Worker'. As professional women they accepted the 'male' attributes of a professional, without competing or threatening men's positions, and their power was manifested in keeping the untrained out. Alternatively, some became 'Professional Workers', in the manner of trade unionists. Neither of these types acknowledged gender as an issue in defining a 'profession', and this created tensions for women professionals. Nursing in general would suffer from its identification with domesticity in defining its professionalism. Karitane nursing would be further disadvantaged by its association with babies. For example, in education, the status of the teacher increases with the age of the client, with the suggestion that the skills required are more valued and specialist the older the recipient.

Historians have argued that the professionalization of nursing came from the

²⁰ *ibid*

nurses themselves in a bid to raise the status of the job. Nurses increasingly perceived that their role was not one of handmaidens to doctors but was complementary to them and an occupation in its own right. Beryl Hughes, when discussing nursing as a gender issue, argues it was an occupation that had been ‘admirably suited to women, since it allows them to care for others, to work hard and to take orders’.²¹ However, in a time of growing unrest at the inequality of women’s work it was due for change. The call for a tertiary base to nurse training was a means of professionalising nursing and would raise the status of the job. After an unsuccessful attempt in the 1920s the success of a university-nursing course in 1973 ensured that nursing ‘achieved the status of an honoured profession’.²² Kim Filshie also views the changes in nurse training as a ‘sign of the time’ in the struggle to attain professional status for New Zealand nurses from 1960 to 1973.²³ She notes that the apprenticeship training of nurses made education secondary to the service needs of the hospital in which they trained, and that the hierarchical structure of nursing was geared to the training of young women. With the changing social trends of girls staying and achieving more at school, no longer seeing work as a stop gap to marriage and expecting to return to work after children, the perceived recruitment and retention problems could perhaps be remedied by radical changes in the delivery of nursing training. More than ‘gentleness and compassion’ were required with new approaches to healthcare. Nurses needed teaching, not training, and this was gradually phased in from 1973 as the technical institutes and universities took over.

One can see that many of the characteristics perceived in nursing prior to ‘professionalization’ would fit Karitane nurses. However, given the solitary employment of qualified Karitane nurses and their limited time in the job they lacked unity and an association. The changes that occurred in general nursing, from 1973 onwards, meant that even the Karitane ‘training’ no longer accorded with this new image of ‘nursing’. Karitane nurse training would have had to change drastically if it

²¹ Beryl Hughes, ‘Women and the Professions in New Zealand’, *Women in New Zealand Society*, Phillida Bunkle and Beryl Hughes (eds), Sydney: George, Allen, Unwin, 1980, pp.118-138, p121

²² *ibid*, p.123

²³ Kim Filshie, ‘Nursing Education in New Zealand 1960-1973: The Struggle to Attain Professional Status for the New Zealand Nurse’, M.A. Thesis, University of Canterbury, 1968

was to try and remain part of the 'new' nursing profession.

There were also other groups, on the periphery of the nursing profession that struggled in their bid to receive acknowledgement. Midwives, like Plunket nurses, were largely seen to have taken themselves out of the general 'nurse' sphere, and dental nurses were another peculiarly New Zealand phenomenon. Like Karitane nursing they dealt in 'well health'.

Written in 1986, some seven years after the demise of Karitane nurse training, Joan Donley's *Save the Midwife* explored the debate of midwives and general nurses.²⁴ In caring for the healthy, midwives are an entirely different type of 'nurse', and have struggled longer for recognition. Donley argues that this is because, unlike nurses, they are competing with doctors for their patients. She further argues that those who choose this profession have different needs and desires to those choosing general nursing. This also applied to those who chose Karitane nursing, as we will see in the oral interviews. It may be that the term 'nurse' medicalised the care of healthy babies and was an inappropriate term to use. A debate on whether 'well-health' is nursing could also have prevented Karitane nurses from inclusion in the nursing fraternity.

Dental nurses, like Karitane nurses, had a very ambiguous status and title, and are now called dental therapists. It was perceived in the 1920s that 'a new profession of "dental nurse" should be created, to be the same help to the public in promoting the dental health of children as the Plunket nurse was in the wider field of child health'.²⁵ It was developed as a gendered occupation, for the 'ministering' and 'maternal' instincts' young women could provide. They were deemed to enjoy 'professional standing in [their] own right'.²⁶ The 'outward and visible evidence of their status' was seen in the training, uniform, department, rank and grades, relationship with the

²⁴ Joan Donley, *Save the Midwife*, Auckland: New Women's Press Ltd, 1986

²⁵ Llewellyn Saunders, *The New Zealand School Dental Service: Its Initiation and Development 1920-60*, Wellington: Government Printer, n.d., p.3

²⁶ *ibid*, p.11

dental profession and their subsequent employment.²⁷ Dental nurses have been little examined as an occupation and one can see many of the same issues about definition and status arising as with Karitane nursing.

While general historical works have barely touched on Karitane nursing, two more specialised books have gone further than others have. Sue Kedgley's *Mum's the Word* was written for the popular market in a general discussion of motherhood in New Zealand and *Not Just Weighing Babies* was a commissioned history by historian of medicine, Linda Bryder. Sue Kedgley largely looks at Karitane nurses in their early history as part of Truby King's scientific approach to motherhood. As part of her argument that early twentieth century New Zealand turned motherhood and child rearing into a science that had to be learned, she sees that the 1907 aims of the Plunket Society were 'to educate women about motherhood and inculcate in them "a lofty view of maternity and the duty of every mother to fit herself for the perfect fulfilment of the natural calls of motherhood"'.²⁸ Karitane nurses were part of the structure that Plunket developed to spread Plunket methods and ideals. Trained in Karitane hospitals, which looked after babies that failed to thrive and taught mothercraft, these 'quiet, sensible, trained nurses' worked in the hospitals and on completion of their training could be sent into homes where their status was one of a 'trained baby nurse'.²⁹ In later years she also stresses the importance of single mothers working in the hospitals where their babies were housed, as domestic labour for low pay. She argues the advent of the Domestic Purposes Benefit dried up this source of cheap labour. This and the technology that proliferated in maternity hospitals, put the Karitane hospitals into financial strife and brought about their demise.

Linda Bryder, a specialist on the social history of medicine, has written a history of Plunket in Auckland 1908-1998.³⁰ As part of this study she discusses the

²⁷ *ibid*, p.12

²⁸ Sue Kedgley, *Mum's the Word: The Untold Story of Motherhood in New Zealand*, Auckland: Random House, 1996, p.45. King quoted by Kedgley

²⁹ *ibid*, pp.57 & 95

³⁰ Linda Bryder, *Not Just Weighing Babies: Plunket in Auckland, 1908-1998*, Auckland: Pyramid Press, 1998

contribution of Karitane nurses, particularly in the functioning of the Karitane hospitals until their demise. She notes that they did not require any previous training as nurses as they were to be trained in the Karitane hospitals, and that they would then become baby nurses in private homes. She follows the increasing trend of Karitane nurse employment in other hospitals after training and the radical change in the curriculum from 1974 to a more community based training in response to the needs of society and the new direction Plunket was moving in. She takes a more sympathetic view to single mothers being employed by the hospitals, viewing it as an alternative to adoption which allowed the trainees to see 'normal' babies as part of their training. As in Sue Kedgley's book little mention is made of the Karitane nurses' role or experiences once they left the confines of the Karitane hospital and moved largely outside the Plunket sphere.

While mention of Karitane nursing is usually made in any general Plunket writing it is rare that more than a cursory mention is given to the specifics of the work, its importance to Plunket's aims or the nurses' activities after their training..

For a voluntary organization the Plunket Society has managed to have a high profile within historical study. Historians initially focussed on Truby King, the founder, and later on his influence upon New Zealand women and the 'cult of motherhood' he bestowed upon many generations through the Plunket Society. More recently Plunket has been discussed as providing 'well health' and as a voluntary organization.

Karitane nursing has often been depicted as a means of cheap labour for the hospitals and, post training, as a service for the rich. This view is argued by Philippa Mein Smith in her 'revisionist view' of Truby King in Australia, where she supports the early historical view of Karitane nurses as King's 'keenest disciples'. She sees the Karitane hospitals as little more than 'finishing schools for the well-to-do', who had to pay fees for that training.³¹ This view seems to be substantiated by Plunket Society

³¹ Philippa Mein Smith, 'Truby King in Australia: A Revisionist View of Infant Mortality', *NZJH*, Vol.22, No. 2, 1988, pp.23-43, p.42

material, at least into the 1950s, with a booklet of the time stating, ‘many... look on it as a finishing touch to their general education...their training admirably fitting them to becoming efficient wives and mothers’, among other things.³²

Gordon Parry’s 1982 Plunket-commissioned work *A Fence at the Top* is obligatory reading for all research on the Plunket Society. Writing after the demise of Karitane nurse training he too perpetuates the idea that Karitane nurses were from ‘comfortable homes and some of them looked upon Karitane training as a sort of finishing school’.³³ He determined that they had an entirely different role to play from Plunket nurses. While acknowledging that their role was ‘educational as well as supportive’ and that they ‘made an important contribution to the New Zealand way of life’ he never negates his earlier description of their training at a ‘finishing school’ as often only being useful for their futures as mothers.³⁴ He concludes that the new training of Karitanes that took place after the hospitals closed made them ‘no longer the unpaid help in hospitals while training and nannies to the rich when qualified’.³⁵

Writing in 1975, Neil Begg, Medical Director of Plunket, saw the Karitane nurse as a key agent in Plunket’s mission. In fore fronting the work of the Karitane nurse within the Plunket structure, Begg saw that with a changing society, and new needs emerging, the Karitane nurse could play an important role in the Plunket service. This was at a time of the Social Welfare Department funding home help for families of young children in need: ‘The Karitane service is merely an extension of the district Plunket work and should not be regarded as different or separate from the mainstream mother and child work’.³⁶

The 1990s saw many theses devoted to the Plunket Society, such as Elizabeth

³²RNZSHWC, *The Origin and Development of the Work of the Society*, Dunedin: Stone, Son and Co., 1953, p.24

³³Gordon Parry, *Fence at the Top: The First 75 Years of the Plunket Society*, Dunedin: Royal New Zealand Plunket Society (RNZPS), 1982, p.88

³⁴*ibid*, p.89

³⁵*ibid*, p.166

³⁶Neil, C. Begg, *Changing Patterns of Child Care: Some thoughts as the Plunket Society enters the last quarter of the 20th century*, Dunedin: RNZPS, 1975, p.31

Cox's 'Plunket Plus Common Sense: Women and the Plunket Society 1940-60'.³⁷ However, whether the focus is the years of the Karitane hospitals or more recent times it is usually Plunket nurses that come in for attention. It is interesting to note that Cox gives as much profile to the debate of how the Plunket Society could help in the lack of domestic servants as it does to Karitane nurses. This could illustrate the equivocal status and perceived lack of importance of the Karitane nurses within the Plunket Society structure.

Outside of direct Plunket Society material Karitane nursing, as part of Plunket, has been effectively ignored. One can speculate about their lack of visibility to outsiders. Factors such as the relatively low profile of the Karitane hospitals themselves, the limited numbers of Karitane nurses trained, the nurses' loss to the Plunket Society once certificated and their invisibility in the community when working would have all played a part.

Sources

Primary material for this thesis largely came from health-related archives and interviews or correspondence with former Karitane nurses. With Karitane hospitals now closed, archival material is fragmented and dispersed around New Zealand. Material under the auspices of the Plunket Society was central to this paper but only provided part of the picture. Privacy issues also restricted some of the material available. For much of my thesis I have relied on the voices of Karitane nurses themselves. Over the years the Plunket Society trained 8,350 Karitane nurses.³⁸ In my search for the Karitane nurses' perspective I personally interviewed or corresponded with 36 women from all over New Zealand who trained during the period 1959 to 1978. As well as Karitane nurses, I have spoken to a number of people involved with them at the time: Plunket nurses who were instrumental in their training or who trained with them, mothers who availed themselves of the services of either the Karitane hospitals or nurses in their own home and a Community Karitane who

³⁷Elizabeth Cox, 'Plunket Plus Common Sense: Women and the Plunket Society 1940-60', MA Thesis in History, Victoria University, 1996

³⁸Information from the 'Karitane Nurse Register', Plunket Headquarters, Wellington, 29 Oct 2001

trained in the 1980s, for comparison purposes. This allows a more balanced view in the discussion of Karitane nurses. In listening to their stories I have seen Karitane nursing from a variety of points of view. In the use of both archives and interviews I have had to be mindful of the privacy of particularly third parties. It is not my intention to highlight individuals or individual issues in discussing Karitane nursing. My thesis does not claim to be definitive, but is merely reflective of those who, first, saw my advertisement for contact or contacted me through word of mouth, and then agreed to participate.³⁹ Direct quotes allow me to make use of their actual words in trying to capture a picture of this lost occupation. As a former Karitane nurse myself I am aware of my own perceptions but I have sought to reach outside of myself in this study and leave this story to the many women I have interviewed, and archival material, for this is a story that has not been documented in any depth.

The Karitane nurse can be seen as having three other reference groups in terms of women's occupations - nannying, early childhood teacher and nursing - but none of these provide an exact fit. This thesis will highlight the uniqueness of the Karitane nurse's position. First, she was trained in a hospital yet her destination was domestic. Second, she was called a nurse but was not accepted by the nursing profession officially. Third, she was a product of the Plunket Society but was not monitored or controlled by it after certification unless working through the Karitane Nurses' Bureau. Karitane nursing stood alone as an occupation and since its demise it has never been duplicated.

Subsequent chapters in this thesis will, first, explore the history and position of the Plunket Society and the role and place of nurses historically within New Zealand. This will help to position the Karitane nurse within both Plunket and the nursing fraternity. Chapter three will explore the 1959 Report of the Consultative Committee on Infant and Pre-School Health Services, specifically as it related to Karitane nursing. This report, while very positive about the Karitane service, also discussed its

³⁹In keeping with Massey University's ethical protocols I placed advertisements in the *New Zealand Woman's Weekly* and *Woman's Day*. A number of the respondents then passed my name to others.

viability. It raised issues that did not go away until the hospitals closed in 1978. Chapters four, five and six will be based upon the oral and written interviews in an attempt to reveal the Karitane nurses' training and their subsequent work. It explores the life of Karitane nurses as they perceived it. Chapter seven discusses the closing of the hospitals, which brought about the end of the nurse training. While financial worries were instrumental it will also explore the new direction that the Plunket Society was seen to be heading towards during the 1970s. Chapter eight, again based largely on the interviews, looks briefly at the Karitane service and nurses of today - in their current work and views of their life as Karitane nurses.

Because of the relative invisibility of Karitane nursing, it is necessary to place it historically within New Zealand. To do this we must first look at the origins and aims of the Plunket Society, and the creator of a training that prepared young girls for the 'ultimate career of all women, that of being a capable wife and mother.'⁴⁰

⁴⁰ *Wanganui Chronicle*, 13 May 1972

2.

‘A School for Mothers’⁴¹

For almost a century the Plunket Society has been an integral part of the New Zealand health service. It was founded in 1907 with the prime aim of protecting and promoting the health of infants. While this focus has remained, there have been changes in the means of delivering the service and achieving the desired ends.

Frederic Truby King was instrumental in the setting up of the organization. In seeking to explain the causes of mental illness, King determined that the physical health of the infant was vital to the total well being of the adult. After experimenting on calves at Seacliff’s farm he developed ‘scientific’ theories for raising children and believed breastfeeding would give them the best possible start in life. If breastfeeding was not possible then a special formula of ‘humanised milk’ could be used. King’s influence was, and has been, visible throughout Plunket’s existence. But, importantly, he had the support of female devotees, beginning with his wife Bella, then Lady Plunket, wife to the Governor General of New Zealand. These and nameless other women were vital in establishing King’s work. The *Otago Daily Times*, in reporting on the inception of the Society, had stated that ‘The Society’s work might now be very well left to the ladies. It [is] work for the women to attend to not the men.’⁴² Within a year a national society had been born, the first Karitane home caring for malnourished and needy babies had opened in Dunedin and training for both Plunket and Karitane nurses had begun.

Historians have made much mention of King’s belief in eugenics and his development of the ‘cult of motherhood’. King would certainly appear to have been a

⁴¹Truby F. King, *The New Zealand Scheme for the Promotion of the Health of Women and Children*, Manchester: Henry Blacelock and Co., 1913, p.8, DU:HO, AG-7-8-19-2

⁴²*Otago Daily Times*, 15 May 1907, as quoted in Cox

dynamic and forceful promoter of these beliefs.

[He] was convinced that if mothers, actual and prospective, could be roused from their enforced ignorance, and if some system of maternal and infant care and management could be established on a national basis whereby a knowledge of what we now call 'mothercraft' could be disseminated amongst all classes of the community, many infant lives could be saved and many ailments prevented.⁴³

Lynne Giddings claims that 'King's personal qualities, dramatic oratory and apparent lack of sensitivity to criticism enabled him to establish the organization and remain its public spokesman into the 1930s'.⁴⁴ While his outlook would not have been unique, it was reinforced by his medical status.

King believed that intellectual over-exertion could 'impair the potentialities of reproduction and healthy maternity' in young women, and that educating women in domesticity would benefit them personally, and the race as a whole.⁴⁵ These ideas were seemingly long held beliefs of King. According to Erik Olssen, King spoke of girls needing training for motherhood and then 'something that will enable them to learn a living, but which also directs their minds towards home life', in the 1890s.⁴⁶ King's philosophy was somewhat contradictory, however, in that while he believed motherhood and domesticity were women's natural destiny, he also believed that women needed to be trained to fulfil this role. He saw this as a failing of modern society. 'What our New Zealand women realised was that practically none of them had had adequate reliable knowledge and training in motherhood, and that this was not a class question but a universal failing of civilised communities.'⁴⁷ These views were accepted by the large numbers of women who supported the Society.

With King's tracts gaining currency, Bella's column 'Hygeia' syndicated in many newspapers, and media support, the Plunket Society became firmly established

⁴³RNZSHWC, *The Plunket Society*, Dunedin: 1961, p.3

⁴⁴Lynne Giddings, 'Royal New Zealand Plunket Society' in *Women Together: A History of Women's Organisation in New Zealand*, Anne Else (ed.), Wellington: Historical Branch, Department of Internal Affairs, Daphne Brasell Associates, 1993, pp257-260, p.257

⁴⁵Erik Olssen, 'Truby King and the Plunket Society: An Analysis of a Prescriptive Ideology', *New Zealand Journal of History*, Vol 15 No 1, April 1981, pp3-23, p.6

⁴⁶Erik Olssen, 'Women, Work and Family: 1880-1926', in *Women in New Zealand Society*, Phillida Bunkle and Beryl Hughes (eds), Sydney: George Allen Unwin, 1980, pp 159-183. p.179

⁴⁷Truby King, p.4

and its philosophy became 'parent lore'.⁴⁸ In 1921 the Government appointed King as the first Director of Child Welfare, thus cementing government commitment to and recognition of a uniform infant care system supplied by the Plunket Society.⁴⁹ King spent a great deal of time travelling and promoting the ideals of the Society and in government work. Internationally, he was seen to be the prime mover of Plunket during his life. James Russell, an American educationalist visiting New Zealand in 1928, reported that '[King's] interest in infant welfare has led to the development of the most successful organization of its kind in the world... I learn he is a man of great ability, abounding enthusiasm, devoted to one idea, intolerant of criticism or suggestion, and satisfied with his own decisions.'⁵⁰ But, while much is made of King's personal involvement and influence in the Society until his death in 1938, he was largely a figurehead by the 1930s. His ideas remained fundamental to the Society but his other activities had removed him from its day to day business. The Society ran itself smoothly as a grassroots organization and King's death did not leave a gap in its administration. But for the phenomenal success of Plunket King may have had much less influence upon New Zealand society.

The longstanding aims and objects of the society, that remained relatively unchanged until after the Karitane hospitals closed, were:

To uphold the sacredness of the body and the duty to health...To acquire accurate information and knowledge of matters affecting the health of women and children and to disseminate such knowledge...To train specially, and to employ qualified nurses, to be called Plunket nurses, whose duty it [would] be to give sound, reliable instruction, advice and assistance, gratis, to any member of the community desiring such services...To cooperate with any present or future organizations which are working for any of the foregoing or cognate objects.⁵¹

⁴⁸'History of Plunket', www.plunket.org.nz/, 23 Aug 2001

⁴⁹Plunket Society care largely catered to pakeha babies. The Health Department actively discouraged Plunket from Maori homes, which were then mainly rural and were as the preserve of the District Health Nurse.

⁵⁰James Earl Russell, 1928, WTU, MS-Papers-2102, pp12-13. Russell was commissioned by the Carnegie Corporation of New York, which made various grants to New Zealand educational institutes, to report on New Zealand educational conditions in 1928.

⁵¹RNZSHWC, *The Origin and Development of the Society*, p.6 The stated emphasis is now the child and the family (as opposed to the infant and mother) with Plunket's 'Direction: to ensure that New Zealand children are among the healthiest in the world [and] 'Purpose: Plunket believes in supporting the development of healthy families', www.plunket.org.nz/, 23 Aug 2001

The main function was intended to be, and still is, educational. It was to be carried out by the specially trained Plunket nurses and by word of mouth. 'This form of education will be free, because it is in the highest interests of the state that as far as possible every woman in the Dominion shall be induced to avail herself of the services offered by the Society with a view to the betterment of the race, the recipient herself being always regarded as a potential health-advocate and teacher.'⁵² The services were not intended as charity but were promoted as 'patriotic and educational' activities. With government support the Society aimed to reach all women.⁵³ The initial intentions were to form local branches and committees to voluntarily 'help the mothers and save the babies' through support and fundraising, and to train and employ suitably skilled women.⁵⁴ They would move into the community and spread the methods and ideals of the society by reducing to 'the simplest language the teachings of science and commonsense as to the rearing of infants'.⁵⁵

Having the ability to rally a large, influential contingent of women who specialised in working voluntarily, the Society took off rapidly. Historians have discussed why the Plunket Society became so widespread and popular within such a short length of time. Giddings sees it as two-pronged, with changing family structures and women's involvement contributing. As parents were having fewer children, 'scientific' motherhood appealed and elevated the role of the mother at home. Also, influential women's involvement lent respectability to Plunket, making the Society's work, in turn, a respectable activity.⁵⁶ This was critical in obtaining financial support from all avenues. Some also see that Plunket's advocates exploited current issues. Olssen argues that 'superb propaganda and organization' were factors.⁵⁷ King capitalised on a popular belief in science by adding a scientific element to domesticity. Likewise, the Society profited from a decline in infant mortality that saw New

⁵²Unidentified early paper of the Society for the Protection of the Health of Women and Children, p.17, DU:HO, AG-7-5-27

⁵³Department of Health (Infant Welfare Division), *The Expectant Mother and Baby's First Month*, Wellington: Government Printer, 1921

⁵⁴RNZSHWC, *The Plunket Society*, p.7

⁵⁵*The Expectant Mother and Baby's First Month*

⁵⁶Giddings, p.258

⁵⁷Olssen, 'Truby King and the Plunket Society', p.11

Zealand apparently lead the world, attributing this to its own influence of regimes.⁵⁸ Historians would now challenge claims that Plunket was the prime mover in New Zealand's declining infant mortality rate. It is generally accepted that rates had been dropping prior to the Society, and that smaller families and improving nutrition would have contributed to the fall.⁵⁹



Lady Bledisloe, wife of the governor General of New Zealand, seen here with babies, nurses and other women at a Karitane Hospital was one such notable figure to endorse the society.

Circa 1930s WTU, 1/2-019637

Linda Bryder challenges the ideas, in particular Erik Olssen's, that Plunket and King were synonymous and that 'unwanted, unwarranted scientific ideas [were] imposed on a passively receptive female audience'.⁶⁰ She argues that women took up

⁵⁸Figures for the birth rate were based on pakeha births alone. The figures would not have been so impressive if all births in New Zealand were taken into account.

⁵⁹ Argued in Mein Smith pp.23-25, Giddings p.258, and Sandra Coney, *Standing in the Sunshine*, Auckland: Penguin Books, 1993, pp.64-67

⁶⁰Linda Bryder, 'Perceptions of Plunket: Time to Review Historians' Interpretations' in *New*

the invitation to attend Plunket on a number of fronts. The role of the Plunket nurse was paramount, as a woman giving free, practical advice in an increasingly isolated suburban existence. Bronwyn Dalley also argues that in the late 19th century developments in a 'public' health system meant the state was already playing a greater part in people's lives. Plunket work seemed an extension of this, despite its voluntary nature. As well, ideas of correct breeding and healthy environments were gaining currency in many areas of the world, including New Zealand, and combined with declining birth rates, made maternal health of great interest.⁶¹ The Plunket Society would appear to be the right organization at the right time, and was voicing widely held beliefs. Mein Smith suggests the popularity of the Society was more a consequence of an already falling rate of infant mortality and the lower birth rate. Fewer children made prescribed child rearing practices possible and desired as the status of children consequently rose. She also argues that the hegemony of Plunket Society was a peculiarly New Zealand phenomenon. New Zealand was 'smaller, with a more homogeneous Anglo-Scottish population, was more bound to the imperium and less assertive unless in the imperial interest'.⁶²

Probably no other country at the time had a greater proportion of like-minded women with the time and ethos to accept one regime so forcefully. Although King promulgated his ideas abroad, particularly to England and Australia, it was New Zealand women who were seemingly more receptive to outside experts having such a powerful say of what went on in their homes. As a society that measured success in terms of education and the male breadwinner, New Zealand women at home in the early twentieth century had the time, the will and the interest in doing their best for their children and their country. Married women were not an integral part of the work force for much of the twentieth century. While the poorer classes were more likely to

Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health, Linda Bryder and Derek A. Dow (eds), Auckland: Auckland Medical Historical Society, 1995, pp.97-103, p.100

⁶¹Bronwyn Dalley, *Family Matters: Child Welfare in Twentieth-Century New Zealand*, Auckland: Auckland University Press, 1998, p.14

⁶²Mein Smith, p.32

have married women in work of some sort, most working class women aspired to be 'housewives' and full-time mothers. Although Plunket was not the instigator of the idealisation of women as mothers, its leaders did raise this to a new level with their promise of healthier children. To New Zealand women the Society gave kudos to their role and a means of best raising their smaller number of more precious offspring. Government funds were given to support Plunket from 1908 onwards and the state distributed Plunket publications to new mothers and couples applying for marriage licenses. This 'official' sanctioning, made the Society's ideas more plausible and their distribution wide reaching.⁶³ With New Zealand maturing Plunket was also established in a time when the public health system was developing. It appeared to be a vital part of public health. With the Society's entrenchment no other organization seemed necessary in fulfilling aims of infant health. It can be seen that through the years Pakeha women overwhelmingly used Plunket, and the Society's aim that mothers would then work for was frequently realised. It was an activity that busy mothers had an interest and commitment too, and it provided them with social contact.

In the same year as the formation of the Society King had begun to take malnourished babies into his own seaside home at Karitane. Such was the success of his regime on their health that the idea of a 'hospital' for infants was developed, and realised when the first Karitane Home for Babies was opened in December 1907, at Anderson's Bay in Dunedin. The large villa with substantial grounds was initially leased and then donated by Wolff Harris. The Karitane-Harris Hospital, as it was later known, was staffed with a matron, probationers and trainee Society nurses.⁶⁴

The Dunedin Karitane Hospital provided a model for subsequent ventures. Their establishment was not a national strategy but came about by the efforts of individual committees or generous donations. Christchurch was the next to be established, due to very successful fund raising in 1917, when a house was bought,

⁶³Nolan, p.108.

⁶⁴Parry, p.46. Parry suggests that the title Plunket nurse was bestowed on the Society nurses in 1908 by King after a suggestion by Lord and Lady Plunket.

altered and adapted. In 1919 the Stewart-Karitane Hospital was opened in Wanganui.



*The house of J.T. Stewart in Wanganui in 1911. On donating his home to the Society, J.T. Stewart remarked: 'I regard the saving and well being of children in the early years...as one of the most important problems of the age, and I leave and bequeath this property for the use and advancement of such purpose.'*⁶⁵

Tesla Studios, WTU, 1/1-016889 PAColl-3046

Another large family home, donated by A.C. Caughey, became the Auckland Karitane Hospital in 1924. Invercargill had two homes donated, one of which became the Invercargill Karitane Hospital in 1926. Wellington had opened a small 'Plunket Mothercraft Home' as part of the Plunket rooms in 1923 but a need was perceived for a hospital. Although it was the last to open, Wellington Karitane Hospital was the first that was purpose built, on land donated by Truby King, in 1927. As a measure of public approbation of the Plunket service, all the hospitals had opened without

⁶⁵Extract from the will of J.T. Stewart re Stewart Home, WA MS 7/5

government funding. However, this independence was not to last, and the use of older-style family homes was to prove problematic in the long-term.



The Truby King Karitane Hospital, Melrose, Wellington, N. Z.

The Wellington Karitane Hospital was the first purpose-built Karitane Hospital in 1926. The land was donated by Truby King and was adjacent to his home which later became the nurses home.

Private Collection: Gwen Diver

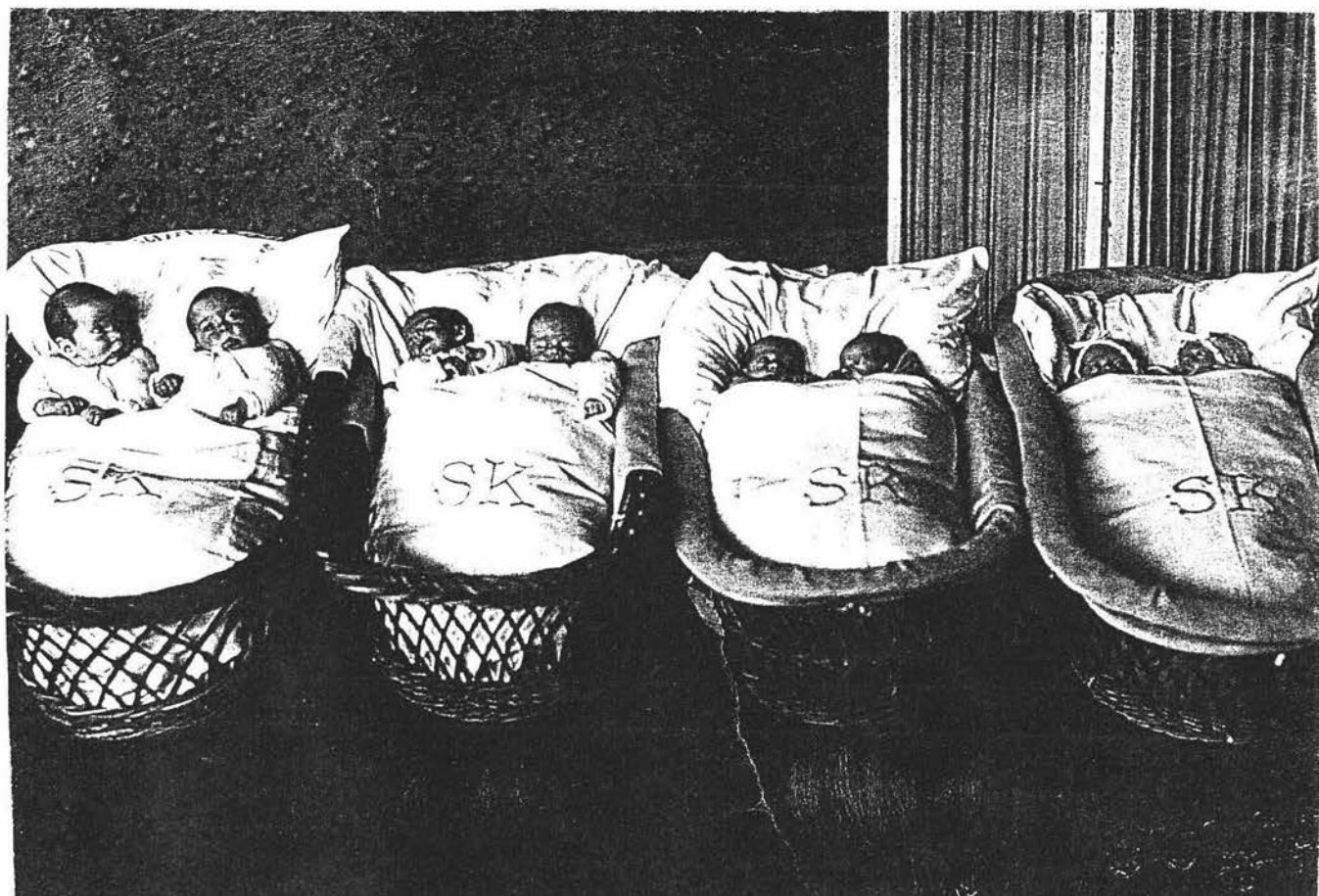
While hospitals were not an initial aim of the Society, they developed out of the perceived need to take some infants into care to bring them up to full health. Strict routines and diets were adhered to. The care of premature babies also increasingly filled a gap in hospital services, with specially heated rooms being made available for such infants in Dunedin by 1914.⁶⁶ The hospitals were also seen as another means to educate women in mothercraft, beyond the 'district' work done by Plunket nurses. The Dunedin Karitane Hospital was extended to accommodate mothers and their babies in 1910, taking four mothers in in the first year.⁶⁷ An early Plunket history uses contemporary nomenclature in describing these women as 'inmates'⁶⁸, possibly a legacy from King's time at Seacliff, and notes that instruction should be on 'broad,

⁶⁶RNZSHWC, *The Origin and Development of the Work of the Society*, p.20

⁶⁷ibid. In 1915 20 mothers were admitted and another 30 by the day. Information from 'General Conference Reports: 1914-1926', p.12

⁶⁸Babies were also referred to as inmates in early literature such as RNZSHWC, 'Karitane Hospitals: Admissible and Non-admissible Cases', circa 1930s, DU:HO, AG-7-11-47

simple, practical, scientific lines, easily comprehensible by the ordinary mother.⁶⁹ Within twenty years of the inception of the Plunket Society six Karitane hospitals were in operation, largely funded by voluntary contributions. With the co-operation of other voluntary agencies, the government and influential women, the Plunket Society was soon instrumental in all-infant health services and issues.



Small and premature babies were particularly catered for over the years. Four sets of twins were resident at the Stewart-Wanganui Karitane Hospitals in the 1920s.

WA, MS7/17, Box 2

Accord between the Health Department and the Plunket Society was always seen as desirable and necessary. The Society aimed to be complementary to and 'part' of the public health system in offering a free service to all. At the 1914 Annual Conference King stated he had offered all district nurses three months training, free of

⁶⁹RNZSHWC, *A Short Account of the Society and its Work*, Dunedin: n.d., pp5-6. DU:HO, AG-7-11-47. Quote from Mr Wolf Harris who endowed the Dunedin Karitane Hospital.

charge, in the Karitane hospital.⁷⁰ King extended this offer to maternity nurses and midwives in later years in a bid to 'establish uniformity of purpose among all nurses'. While it never became mandatory, many of the public health system nurses did take up the offer. The Director of Nursing, Annie Patrick, felt the issue should not be forced, however.⁷¹

Into this organization we must now place the Karitane nurse. The establishment of the Karitane nurse as a distinctive element is linked to Plunket's hegemonic status. She was part of the structure of Plunket from its beginning and remained so as long as the Karitane hospitals existed. The term 'Karitane' nurse developed out of the name given to the original Karitane hospital.

The training initially developed from a need to staff such hospitals as cheaply as possible. Despite the success of the Society staffing was always a major expense. While the government was generous over the years, a set sum could never be anticipated. Unpaid trainees were crucial to the hospital's survival, and would remain so until the hospitals' final closure. Plunket nurse training, for district work, was undertaken in Dunedin by fully registered nurses who received a 'bursary' during their four months training. Karitane trainees had no previous hospital experience and paid a fee for their one-year training.

Three Karitane nurses and three Plunket nurses are reported to have been 'trained' in the first year, with King lecturing in the evenings.⁷² It would appear that the training quickly became formalised and attracted a steady supply of young women who were prepared to work and learn mothercraft for a fee.⁷³ Nine trained in 1924, and by then Karitane nurses were also receiving classes in sewing, cooking and

⁷⁰RNZSHWC, *General Conference Reports: Condensed Summaries of Reports for Thirteen Years (1914-1926)*, p.6, WA, MS 7/3, Box 1

⁷¹*ibid*, pp. 49 & 81

⁷²RNZSHWC, *The Origin and Development of the Work of the Society*, p.20

⁷³A fee for training was required until 1958 when it was abolished. Board and keep were provided and trainees had to supply their own uniforms and pocket money for personal expenses through all the years.

laundry work.⁷⁴ It was necessarily a practical training, given that the care of the babies was paramount. On completion the girls could go into private homes as baby nurses for new infants. If the Plunket nurses were the elite of the Plunket service, the Karitane nurses were to be the ground-level troops, actually living in homes to help stressed mothers. Their destination could be complementary to the Plunket nurse and integral to the aims of the Society.

It is not known why a fee was initially set. As Plunket was a voluntary organization, still substantially dependent on donations, fees were no doubt a welcome source of income. King was certainly keen to maintain it in 1926 when a delegate questioned them. With the training 'undoubtedly one of the finest in the world...He did not think in the country where the Karitane nurse course had originated the fees should be reduced, rather the other way'.⁷⁵ However, there must have been a realisation that this would limit the girls who could enter. Perhaps, then, this move by the Plunket Society was deliberate, to distinguish Karitane nursing from a domestic image. It could be argued that the setting of a fee for training was the reason for its initial attraction. Mein Smith describes the early Karitane nurse as:

the English nanny and the American nursery maid metamorphosed - whose families paid a handsome fee of twenty pounds for their daughters to be taught how to care for babies in private homes [which] enhanced the status of Truby King's hospitals by converting them into finishing schools for the well-to-do. Karitane training had to be superior, because of the fees paid by trainee mothers and nurses.⁷⁶

For some time the exclusive image of this training seemed to be a successful tool for recruitment. The fee, which rose to 40 pounds by the 1930s, along with 'pocket money' for daily expenses, was not an inconsiderable amount of money to provide. Parental support for the trainees would have been necessary, both financially and morally. Thus a finishing school for a 'good-sort-of-girl' image developed. There was some recognition 'that many of the girls [did] not need to work' after certification.⁷⁷ On applying for training, candidates were asked if they intended to continue to work

⁷⁴*Report of Twenty First General Conference 1934*, p. 14, WA, MS 7/3, Box 1

⁷⁵*General Conference Reports: 1914-1926*, p.75

⁷⁶ Mein Smith, p.42

⁷⁷ Memorandum for Minister of Health from Deputy Director-General of Health, H.B. Turbott, 20 Sept 1949. NA, H1, 24627 127/4/1

afterwards, and during the first years this did not appear to worry the Society.⁷⁸ ‘Whether or not such students pursue the work as a career, the training in practical mothercraft is invaluable and takes its place in the Society’s campaign’, wrote the Director of Plunket nursing in 1928.⁷⁹ Comments by the Department of Health to the effect that the employment of Karitane nurses in public hospital nurseries was an ‘unnecessary refinement’, would suggest a perceived view of the Karitane nurse as being elitist⁸⁰

Some girls did work to save for the training, as will be discussed in later chapters, but this would have only been a dedicated few, particularly early on, and would still require some parental support.⁸¹ A mother wrote to the Minister of Health in 1949 inquiring into the possibility of pay for trainees.⁸² The Minister then requested information from the Department of Health. It replied that as the Society had always stated they had ‘sufficient trainees to fill vacancies...it was therefore unnecessary’, although a limited number of bursaries were now available. The Department also commented that if they recommended payment of all trainees to the Plunket Society, ‘it is certain that the Plunket Society would request additional finance from the Government...approximately 20,000 [pounds] per annum.’⁸³ At that time there would have been little need for the Society to change the system, or incentive for the Department of Health to request it. After the status and popularity of the course were well established, the Society could be seen to change direction somewhat with the abolition of fees in the 1950s.

There seemed to be no problem in recruiting enough trainees to service the

⁷⁸ RNZSHWC information sheet on Karitane nurse training, circa 1920s, DU:HO, AG-7-11-47

⁷⁹ Anne Patrick, Director of Plunket Nursing, ‘Infant Welfare in New Zealand, 1928: With specific reference to the Work of the RNZSHWC’, p.196, DU:HO, AG-7-8-30

⁸⁰ Department of Health correspondence about Karitane nurses in hospitals, (circa 1946) NA, H1 22893 21/23/142

⁸¹ Interviews and correspondence with Karitane nurses prior to 1959 was had and some mention was made of using personal savings to train.

⁸² This illustrates the public perception of Plunket being part of the public health system.

⁸³ Memorandum for Minister of Health, 1949. It is interesting that the Minister actually referred this letter to the Department, not the Plunket Society. It would appear that the Deputy Director-General did not speak of it to the Society but could reply from ‘the matter [having] been discussed with the Plunket Society on several occasions’.

hospitals in the early years. Karitane nursing meshed with the domestic thrust of young women's education and the highly gendered workforce then in existence. During the first half of the twentieth century the occupations that both attracted and sought female employees were those that built on and employed the 'innate' qualities and abilities of women - the maternal and domestic side. Both Karitane and general nursing, particularly, fitted with Truby King's philosophy of women's roles. King's belief that girls would best benefit from a vocational education, rather than an exam driven one, remained popular as long as it was assumed women would ultimately begin a 'career' in the home on marriage. With motherhood and child rearing considered natural outcomes for women, the 'short adventure between school and marriage' would best be one that could benefit women when they married.⁸⁴



In 1929, ten years after opening, the Stewart-Wanganui Karitane Hospital appeared to have no trouble recruiting enough young women to be trained in baby care.

Tesla Studios, WTU, 1/1-016980 PAColl-3046

⁸⁴Sue Middleton, 'Feminism and Education in Post-War New Zealand: An Oral History Perspective', in *Reinterpreting the Educational Past: Essays in the History of New Zealand Education*, Roger Openshaw and David McKenzie (eds), Wellington: New Zealand Council of Educational Research, 1987, pp132-146, p.134

If, as Olssen argues, childrearing was portrayed as a 'professional enterprise requiring managerial know-how and scientific method', then Karitane nurse training would have been an ideal choice of vocation.⁸⁵ It was popularly acclaimed for training future mothers for their 'ultimate career'. In 1940 Christina Guy highlighted the plight of mothers without domestic help or advice in a book. 'Motherhood', she wrote, 'is one of the most exacting careers a woman can chose yet, outside the small circle of the family, it receives the least recognition of all women's professions, and many who undertake it are poorly trained for such a career and so find caring for a home and family very arduous.'⁸⁶ Karitane nurses would not fall into this description when they too became mothers. They were 'one group who specialised in childcare before marriage.'⁸⁷

The role of the Karitane nurse could have fallen into one of two areas - nursing or domestic. The legacy of the nanny or nursery maid from England could have seen the job promoted in the manner of a superior servant. This was never the case despite the similarities that were apparent once the trainees left the hospitals. However, New Zealand did not have a tradition of hierarchical household staff that could put Karitane nurses in a superior position within the home.

It would appear that the unique training given to Karitane nurses, not the career that would follow, placed them more in the 'nurse' category. The Plunket Society from the start could be seen to actively align the position with nursing. In responding to a request to train orphans as nursery maids in the early years the Director of Nursing replied that it would have to be a very different course to Karitane nursing. A three month training could not 'justify the name of nurse' but could better be called a home or mother's help.⁸⁸ Although the length of the Karitane nurse training could be seen to be of advantage to the staffing of the hospitals, it was

⁸⁵Olssen, 'Truby King and the Plunket Society', pp10-11

⁸⁶Christina Guy, *Women on the Home Front: An S.O.S. from Mothers*, Wellington: Progressive Publishing Society, 1943, p.12

⁸⁷'Child Care in Ideal Surroundings', unidentified newspaper article, circa 1950s, DU:HO, AG-7-6-68

⁸⁸RNZSHWC, *General Conference Reports 1914-1926*, p.39

also necessary in order to fulfil the curriculum. The training was increased to sixteen months in the 1930s to allow for greater responsibility and instruction. While the Plunket Society never attempted to compete with the more comprehensive three year general nurse training, the length was commensurate with more specialised nursing programmes, such as maternity nursing. The Dominion Council of the NZSHWC stated in 1942 'The Karitane nurse is placed on the same professional footing as the hospital nurse, but at one time the children's nurse in the house was relegated to the servant's quarters. Now all that is changed. The children's nurse is now a professional woman'⁸⁹.

By aligning the training with nursing, the Plunket Society was riding on the coat tails of a rising profession. However, clearly the job was relying on the training element to place it within the nursing profession. There can be no doubt that once certificated the job the graduates were to do was domestically based and clearly a large component of it was domestic duties. Conditions of employment through the years continually reiterated that Karitane nurses were 'trained baby nurses' and not general domestic help, but at the same time allowed for domestic work to take place.⁹⁰

The Karitane nurse is to do everything possible, on the lines indicated in her training, to ensure the highest standard of health for the baby....care, cleanliness and neatness of the baby's room...washing, ironing and mending...make simple clothes...care of everything in connection with the baby's food....any other duties required may be undertaken by mutual arrangement'⁹¹.

While discussion surrounding Karitane nursing would place this job in a category of its own it was recognised for its domiciliary role. Over the years whenever the lack of domestic help raised its head in New Zealand Karitane nursing was cited as an example of what could be done to raise the status of a 'domestic' job. In 1942 the Dominion Executive of the Young Women's Christian Association (YWCA) stated

⁸⁹ Plunket Society contribution to the YWCA 'Domestic Service Survey' sent to the Director of Education, April, 1942, NA, E2- 32/1/60

⁹⁰ RNZSHWC, *Rules regarding the Engagement and Duties of Karitane Baby Nurses for the Guidance of Mothers and Nurses*, Dunedin: Stone Son and Co., Revised 1938, p.2, 7, DU:HO, AG-7-8-22. Likewise it was pointed out they were not general nurses, or to nurse 'definite illness'.

⁹¹ *ibid*, p.2. These rules remained the same until at least the 1951 version.

that 'practically nothing had been done to make domestic service attractive to girls and women, and practically nothing to elevate it to the dignity of a profession. With one interesting exception...the Karitane nurses who were no longer 'mere nursemaids' but had the 'dignity of a trained career'⁹². The 1946 Christchurch Plunket committee suggested that training 'mother aids' at Karitane Hospitals would automatically raise the status of their job.⁹³ A special name, uniform, training and certificate could make all the difference. Karitane nursing was seen to have successfully attracted a 'better class of girl', had a waiting list of applicants⁹⁴, was practically based but with scientific content and was one that was relevant to girls' futures, 'fitting them admirably for becoming efficient wives and mothers'.⁹⁵ It was an example of how to professionalise a domestically based job.

It would appear to be an opportune move by the Plunket Society to elevate the job of Karitane nurses to one that immediately bestowed status and professionalism upon the girls that took it up. It was done in several ways. First, the title nurse was given to the occupation and training occurred in a 'hospital'. Second, it required the wearing of a distinctive uniform and badge. Third, it resulted in certification. Last, it attracted a 'nice' sort of girl from a 'good home' by virtue of the fee charged. A publication in 1942 by the Federation and Professional Women's Clubs of the YWCA of New Zealand would suggest something of the public perception of a feminine profession and the status of Karitane nurses at that time:

The Karitane (Plunket Society) system of training which enables a Karitane Nurse to take complete charge of an infant after it leaves the maternity hospital is a remarkable example of the entire removal of the stigma of "Nurse-maid" and the elevation of the work to that of a proudly sustained profession. This is done by a recognised training (plus uniform, certificate and badge), payment of a premium, and the selection of suitable types of candidates.⁹⁶

⁹²Federation of Business and Professional Women's Clubs of the Young Christian Women's Association of New Zealand (YWCA), 'Domestic Service: Conditions of Training and Employment in New Zealand', April 1942, NA, E2-32/1/60

⁹³Cox, p.75. Training of domestic servants never occurred at any stage in the Karitane hospitals.

⁹⁴In the 1930s the Society had up to four years waiting list for places. 'Karitane Portfolio', DU:HO, AG-782-6-06

⁹⁵RNZSHWC, 'Karitane Hospitals', pamphlet, circa late 1940s, DU:HO, AG-7-1159

⁹⁶'Domestic Service: Conditions of Training and Employment in New Zealand', p.3

It could be argued that this perception remained until the 1970s, when nursing sought to align itself with professions in general by taking training into the academic arena.

At its inception Karitane nursing had all the hallmarks of nursing. Until Florence Nightingale, nursing was largely unskilled and of a domestic nature. In the early part of the twentieth century, the distinction between domestic and nursing duties was still blurred. As training schools for nurses developed, it became an occupation in its own right, with exclusive skills and techniques, but remained apprenticeship training. Education was largely secondary to the needs of the hospitals and could vary in quality and importance, and the hierarchical nature of the training and job could see a lot of domestic duties fall to the lower ranks. Marie Burgess argues that these early trainees were not students at all but were in fact employees because hospital work took priority over education.⁹⁷ The status of nursing was raised with compulsory registration in 1901 and regulations regarding training. But the legacy of untrained nurses carrying out the duties of trained doctors was hard to dismiss. Bückenham's description of the student nurse being 'subjected to a system which demands deferential and subordinate behaviour, which teaches her to consider herself subservient' could fit a domestic servant.⁹⁸ The qualities required of nursing, as the job developed, were ones you supposedly found in any women. A 1950s recruitment booklet about nursing maintained the image.

Nursing is women's work, satisfying the impulse to help others, and at the same time to give service to the nation....Nursing gives opportunities to use head, hands and heart....Others again are happier when giving full play to the maternal instinct in the actual care of sick folk, mothers and babies.⁹⁹

While there was debate throughout the twentieth century on how to improve the status and training of nurses there was always the dilemma that advancing the educational qualifications and standard of trainees could lead to a decline in the innate requirements of nurses. The qualities of caring and tenderness, and the ability to follow orders were not ones that higher education could necessarily provide. The

⁹⁷Marie, E. Burgess, *Nursing in New Zealand Society*, Auckland: Longman Paul, 1984, p.63

⁹⁸J.E. Bückenham, G. McGrath, *The Social Reality of Nursing*, Sydney: Health Science Press, 1983, p.105

⁹⁹Department of Health, 'Nursing As a Career', recruitment pamphlet, reprinted 1959, NA, H1 33295 1/8/1, p.13

image of nursing was also not largely one that would have attracted a girl set on intellectual pursuits. However, over time, as theoretical study was seen as a distinct and essential part of the training, full 'professionalisation' of the job occurred. This was seen to be achieved when nurse training was taken out of the hospitals and became a separate academic course, with a practical component.¹⁰⁰ At this juncture Karitane nursing could be seen to diverge from 'nursing'.

Until 1973 Karitane nursing, like general nursing, had been deemed a vocation and was based upon the lines of any student-nurse hospital training. Karitane nurses received on the job training in 'theoretical and practical aspects of baby care' in a hospital, under a matron and registered nursing staff, with doctor input at lectures.¹⁰¹ The system was hierarchical and authoritarian, with trainees rising through the ranks of junior, intermediate and senior. Responsibility increased with seniority and juniors were subordinate and under the discipline and instruction, at times, of the older trainees. The central role of caring that was traditional to nursing was very evident in Karitane nursing. Dedication and commitment, patient contact, and hard work were all desired and expected. While their patients were babies and toddlers, they required the care and attention that any nurse would give on duty. Hospital procedures of routines, hygiene, bed making, diets, etc, were all strictly adhered to. 'The most modern equipment and strict nursing techniques do not clash with the comfortable relaxing atmosphere' was the Plunket Society's own description.¹⁰²

As in all hospitals the girls were required to live in a protective environment with their counterparts, usually of a similar age straight from school. The hospital expected to be, and was, given parental rights. In 1956 it was stated the, 'Parents need have no worries about the welfare of their daughters while they are training, as their off duty time is personally supervised by the matron and an eye kept on their friendships.'¹⁰³ Infractions, particularly when it involved the opposite sex, could

¹⁰⁰This was begun in New Zealand in 1973 with the first nursing course run through Massey University. It was gradually achieved throughout the country during the 1970s.

¹⁰¹RNZSHWC, *The Origin and Development of the Work of the Society*, p.19

¹⁰²RNZSHWC, *The Plunket Society*, p.9

¹⁰³*Evening Star*, 24 Nov 1956

require termination of training.



The Christchurch Mothercraft section was a separate two-storied house next to the hospital. It was made as homely as possible for the mothers to live in with their babies and learn aspects of mothercraft. 1943.

John Pascoe Collection, WTU, F-449-1/4 PAColl-0783

Karitane nursing was promoted as one of a number of nurse-trainings that could be undertaken, by both the Plunket Society and the Department of Health. However, this use of the word nurse and the Karitane nurse's role in 'nursing' has been debated and disputed intermittently by, particularly, the Health Department, over the years. When I embarked on this thesis a former Nurse Advisor of the Department of Health contacted and informed me:

There is no thing as a Karitane nurse. The term nurse is protected by legislation and is restricted to those people registered on the Nurses' Register or enrolled on the Nurses' Roll.... Karitanes have never been formally recognised as nurses and are not entitled to use this term. Clearly some have done so but in the majority of cases the term was probably bestowed on them by others (and left uncorrected?).¹⁰⁴

Department of Health statements to the Consultative Committee on Infants and Pre School Health Services in 1959 back up this attitude. They also rejected involvement

¹⁰⁴Private correspondence with Lesley Courtney, 26 March 2001

in the training in any manner when financial difficulties of the Plunket Society prompted enquiries for such. However Karitane nurses were accorded the title by society in general and the Health Department at times. A 1950s nursing recruitment pamphlet listed the different categories and included Karitane nursing, stating that 'Qualifications for each of these branches of nursing vary only slightly; the same qualities of personality are required with special interest in the particular type of work which is ultimately aimed for.'¹⁰⁵ The Department also frequently fielded enquiries about the training, either giving information directly or passing them onto the Plunket Society.¹⁰⁶ A 1940s Plunket Society paper suggested 'All Karitane nurses in training should be members of the Student Nurses' Association, and when trained they should become associate members of the Registered Nurses Association.'¹⁰⁷ While there is no evidence that this ever happened it indicates their intended inclusion, at least by the Plunket Society. Clearly there was recognition of Karitane 'nursing', despite their later rejection by the nursing profession which is now moving into domains once exclusive to doctors. Under the current Nurses' Act 'nothing shall prevent a Karitane nurse...from taking or using the name or title of nurse'¹⁰⁸.

Karitane nursing fits into the general history of nursing, if only to show how some specialised branches of nursing were left behind as a professional identity developed. One can see nursing in transition over the twentieth century in a bid to gain autonomy. Specialised forms of nursing have had to struggle to maintain credibility. Maternity nursing was absorbed into the general training, dental nurses (debatably even more peripheral than Karitane nurses) have developed their own image as dental therapists and Plunket nurses have retained their status by being required to be registered nurses as well. Midwives have successfully developed their own autonomy and divorced themselves from a 'nursing' image. Their training no longer requires a nursing background and is a stand-alone qualification with its own

¹⁰⁵'Nursing As a Career'. Karitane and Plunket nurse training are included under preventative nursing. 'The nurse on qualifying may work as a Karitane nurse', p.12-13

¹⁰⁶'Karitane Trainees' file, NA, H1 24627 127/4/1

¹⁰⁷RNZSHWC, 'Guiding Lines for Matrons', circa 1940s, DU:HO, AG-7-4-68

¹⁰⁸'Nurses' Act 1977', VII/52/3a, Website: www.gplegislation.co.nz/acts.html, 27 March 2001

philosophy and College.¹⁰⁹ Karitane nurses were always going to be vulnerable to changes in 'nursing'. The lower educational requirement, the shorter training, their location outside of the public health system and their association with babies gave the work a domestic/nanny image which would contribute to its demarcation from nursing per se. However, through to the 1960s it was 'apparently attractive to young girls [and] the supply [was] never equal to the demand'.¹¹⁰

¹⁰⁹ Direct entry into Midwife training occurred in 1994 and will become the norm in the near future. It is a three-year training. Registered nurses have been able to enter at year 2 but increasingly there is no space for their inclusion in the programme.

¹¹⁰ *Report of the Consultative Committee on Infant and Pre School Health Services*, Wellington, Government Printer, 1960, p.15

3.

1959: The Consultative Committee on Infant and Pre School Health

A key government-commissioned report of 1959 provided a snapshot of the Plunket Society and its Karitane hospitals in the mid-twentieth century. Ostensibly the Consultative Committee was to look into all infant and pre-school health in New Zealand as provided by various agencies, but this really meant the Plunket Society and the Department of Health. It was a timely and challenging exercise for both organizations and its results shaped the Society for the next twenty years.

By the late 1950s the Plunket Society was increasingly managing to fulfil its role only with government support.¹¹¹ The Department of Health was now openly resentful of the amount of money being absorbed by the Society and its seemingly duplicated services. Its representatives demanded that as the financial burden of the taxpayer had increased so greatly the Department should assume the whole responsibility for the administration of the service.¹¹² A casualty of this 'take-over' would be the Karitane hospitals whose role could easily be assumed by public hospitals.¹¹³

In New Zealand the 1950s were giving way to a new era. After decades that had seen war and depression dominate since the early part of the century, the 1950s were a time of stability and rising prosperity for New Zealand. The government appointment of a Minister for the Welfare of Women and Children in 1950 indicated the importance placed upon preserving the traditional family structure. While women

¹¹¹Until 1938 government aid to the Karitane hospitals was on a flat rate basis, averaging 5,417 pounds per year through the thirties. However in the year to March 1948 the Society received 24, 816 pounds, the year to March 1958 59,237 pounds and the following year a drastic rise to 86,973 pounds for the year. On top of this was a further 117,956 pounds for Plunket services in 1959, the majority of which was for salaries. Information from the Report of the Consultative Committee, pp.21, 44

¹¹²*Report of the Consultative Committee*, p.17

¹¹³*ibid*, p.22

ministers filled this position they held the distinctly conservative view of a male breadwinner providing for the mother and children at home.¹¹⁴ Girls were continuing to be taught at school that 'joint responsibility ... must be shared by mother and father alike, but while the father as the breadwinner is obliged to provide and maintain the home, its management and the immediate care of the children falls to the lot of the mother.'¹¹⁵ Melanie Nolan views motherhood at this time as 'being generally regarded as the apotheosis of womanhood', something that had developed over the twentieth century.¹¹⁶ By the 1950s the younger age of women at marriage, the more compressed period of child-bearing and increasing home technology to help busy housewives gave women more time. Having a successful marriage and being a successful housewife were seen as 'domestic arts' that could be achieved by following certain guidelines. A good home was one in which there was a 'a capable housewife, where the facilities [were] such that good health and a reasonable standard of living [could] be maintained and above all where there [was] a serene and happy atmosphere'.¹¹⁷ Magazines for women abounded, discussing these issues and how to be the envy of other housewives.

Helen May, however, argues that quiet changes were occurring, particularly within the family home. She views the 1950s as a time of conflict between women accepting their role as housewives and mothers and the 'ideal of independence'.¹¹⁸ Greater responsibility with regard to budgeting and purchasing, and perhaps even part time work, gave women a growing independence. More time for voluntary work and membership of women's groups allowed them to communicate with like-minded women.¹¹⁹ More women were also being isolated in nuclear families in suburbs, but near others in the same circumstances. With the increasing time and prosperity available to women their expectations would rise. While these were initially focussed

¹¹⁴Nolan, pp.195-96. This position was held by Hilda Ross (National), 1950-57 and Mabel Howard (Labour), 1957-60.

¹¹⁵RNZSHWC, *The Care of Babies and Small Children: A Guide for School Girls*, revised 1956, p.5, WA, MS7/13, Box 2. A book for the instruction of girls in mothercraft at secondary school.

¹¹⁶Nolan, p.196

¹¹⁷RNZSHWC, *The Care of Babies and Small Children*, pp.5-7

¹¹⁸May, Helen, *Minding Children, Managing Men: Conflict and Compromise in the Lives of Post-war Pakeha Women*, Wellington: Bridget Williams Books, 1992, p.76

¹¹⁹*ibid*, p.176

on the family women gradually began to expect physical, emotional and material well-being, not only for their children but also themselves. However, May also contends that the 1950s were not a period of conscious change for most women. Externally the decade epitomised 'happy families' and women outwardly appeared contented with their role.¹²⁰

Girls followed the same core curriculum as boys in the first two years of secondary school. While more were choosing to stay at school longer they were still entering a gendered workforce.¹²¹ Commercial and home science options were the preserve of girls who saw work before marriage as a stopgap. In the 1950s the RNZSHWC provided a booklet for the instruction of girls in mothercraft in schools. This booklet maintained King's view that women needed training for motherhood. Knowledge used to be 'handed on from mother to daughter' but with smaller families girls were not getting training in childcare in their own homes. While it was stated that 'it is necessary for boys and girls to be educated for [parentcraft] work, and that such education should take a prominent place in the school syllabus' this course was designed only for girls. As a future mother, she would be the 'central figure in the home, and the health and happiness of the family depend[ed] to a great extent on her knowledge and efficiency'. It continued: 'Even if the privilege of motherhood does not come to the way of every woman, a knowledge of mothercraft will never go amiss, as she might have to take care of children at some time during her life; furthermore, many professions are open to women where such knowledge can be turned to good account.'¹²² Two such professions were of course nursing and teaching. Girls looking for careers, which would traditionally cease on marriage, were still opting for the familiar and acceptable. Recruitment aimed at single girls, usually straight out of school.

¹²⁰ibid, p.176

¹²¹Slightly fewer girls than boys attended secondary school, but the numbers of both increased at a similar rate. From 1950-75 secondary school roles increased almost fourfold, and the bulk of school leavers shifted from coming from the 4th-6th forms in 1965 to the 5th-6th forms in 1975.

Information from *New Zealand Official Yearbook*, 1957, 1967, 1977.

¹²²RNZSHWC, *The Care of Babies and Small Children*, pp.5-6

The Karitane nursing course remained much as it had started, and sufficient numbers meant a waiting list was in place for training. Taking domestic science at school would appear to have been an advantage educationally for the girls electing this training. A 1950s newspaper article stated that ‘those girls who have learned to sew neatly, cook simple meals, and keep a home clean and attractive have the best foundation for the [Karitane] training’. Almost as an aside they mention that having helped care for children would be useful.¹²³ There was still some ambiguity about the place of Karitane nursing. While it had settled into its own unique category of job, it still had domestic overtones. As Plunket was seeking to widen its reach into poorer communities the part Karitane nurses could play within the Society was seen to be limited because of finances. The Government would fund home aids to needy families on request but at times the Society felt a Karitane nurse was more suited. The Dominion Secretary of the Plunket Society in 1959 wrote: ‘We were advised some years ago that if a Karitane nurse would register as a home aid, she could, as a home aid, be made available to a case where financial assistance was necessary.’¹²⁴ This option was never taken up, despite the Plunket Society seeking to reach these families. Instead they built up an alternative ‘Plunket Society Home Aid Service’, run through the Karitane Nurses’ Bureau, that could be government-funded on application.¹²⁵ Plunket leaders were protective of the status they had built up for Karitane nurses.

At the time of the Consultative Committee, Karitane training required girls to be 17 years of age with a ‘good secondary education’. Academic qualifications were ‘a good thing’, but the matron of one hospital reported that selection was ‘judged on practical ability rather than theoretical’.¹²⁶ Fees for training were no longer required but the trainees still had to supply their own uniforms, books and pocket money. By now the Plunket Society could supply a limited number of bursaries for training purposes. The Society would canvass local Plunket committees and private businesses

¹²³*Evening Star*, 28 Aug 1954

¹²⁴Letter from Kathleen Rapps, Dominion Secretary of the Plunket Society, to Miss Bayne, Matron of Wellington Karitane Hospital, 21 April 1959, DU:HO, A-7-2-223

¹²⁵‘Home Aid Service 1959-60’ file, DU:HO, AG-7-2-223

¹²⁶*Evening Star*, 24 Nov 1956

asking them to donate a set sum for the training of a particular girl. The bursary was intended to cover the personal expenses of living away from home, and one could be applied for on application for training.¹²⁷ If the applicant was successful in obtaining a bursary she had to enter the hospital she was directed to by the Dominion Executive and was bound to case for a further twenty months through the Karitane Nurses' Bureau on certification.¹²⁸ At the time the total length of training was 20 months, with the last four months compulsory 'casing' in approved homes.¹²⁹ While no reason for the cancelling of the training fee has been discovered, the Plunket Society may have wanted to attract more recruits and a wider range of girls into training. The provision of a bursary demonstrated an awareness that some girls were missing out on training for financial reasons. From this time on bursaries were increasingly seen as a means of maintaining sufficient trainees. The Society also benefited from the increased period of casing required through the bureau. More bursaries meant more girls with valuable experience on the books. The retention of trained Karitane nurses for casing became an issue as more people began to use the service. 'The wastage because of marriage' was recognised as part of the problem, with the solution seeming to lie in attracting more girls into training.¹³⁰ Recipients of bursaries could also be directed to 'difficult-to-fill' cases.

However, while the Karitane hospitals and training had changed little, all was not well. Among the Society's worries were the rising costs of maintaining the hospital service. Despite drastic increases in government support during the 1950s, by 1958 the total hospitals' debt was 40,000 pounds.¹³¹ The Society, the Government which was financially involved, and the Health Department as an interested party,

¹²⁷ See 'Conditions Governing the Award of a Karitane Bursary' in the appendices.

¹²⁸ Money could be supplied for a one-off bursary or successive ones, or, a lesser sum could be donated to the fund. Initially the bursaries came from the J.R. McKenzie Trust Board, but later from diverse sources. For example the Karilac Company, owned by the Plunket Society, consistently supplied a number of bursaries. The trainees were informed who had supplied their bursary and were expected to acknowledge the support given to the donor by letter. In the initial period of this thesis the bursary was valued at 80 pounds and by the end was worth \$300, in total. Gradually the bonded time was reduced to six months in a bid to attract more trainees.

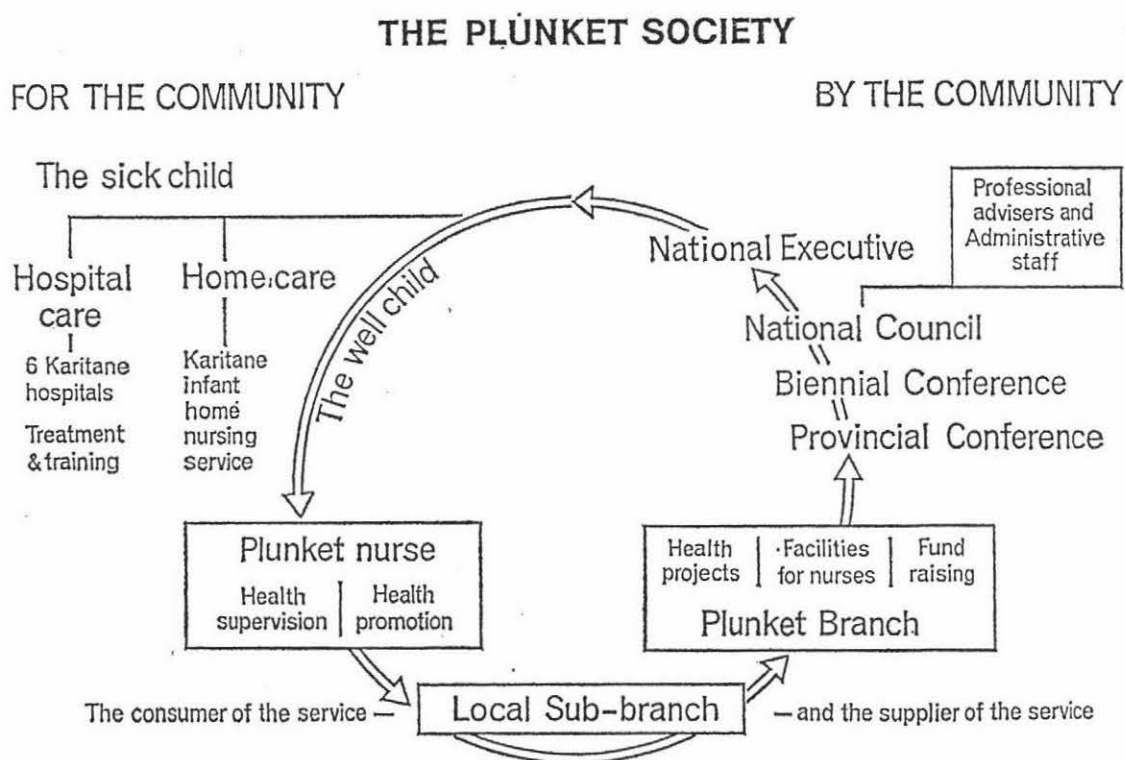
¹²⁹ RNZSHWC, 'Karitane Training Centres: Curriculum of training for Karitane nurses including information pertaining to the scheme of training', Revised 1958. DU:HO, AG-7-11-25

¹³⁰ 'Karitane Hospital at Dunedin Very Popular', unidentified newspaper article, circa 1950s, DU:HO, AG-7-8-18

¹³¹ *Report of the Consultative Committee*, p.22

were all questioning the hospitals' viability.

In 1959 a Consultative Committee, chaired by Mr Justice Finlay, was set up. It was to report to the Minister of Health on the provision of infant and pre-school health services. The primary parties involved were the Department of Health and the Plunket Society. The committee was to look at existing provisions, the function and responsibilities of Government, Plunket, the Health Boards and other agencies, the role of Karitane hospitals and the training of Plunket and Karitane nurses, the financial responsibilities of the government to voluntary services and the wider implications of Plunket and their role in the social structure of the community.¹³² They would then make proposals.



The structure of the Plunket Society during the period of this thesis.

Begg, *The New Zealand Child and His Family*, 1970

¹³²Information from 'Report of the Consultative Committee on Infant and Pre School Health' file, DU:HO, AG-7-1-8-4

The Department of Health had always had some animosity to the Plunket Society. A proportion of the funds designated for health were side-lined to Plunket from its inception and there had been some perceived overlap of services. This was particularly seen to be between Plunket nurses and district nurses, in their care of infants in the home. Accord had been reached quite early over the training of Plunket nurses, who had to be registered nurses to take up the training.¹³³ Also, there was mostly agreement over where and at whom Plunket should aim its service. Plunket nurses had been directed away from caring for the largely rural, Maori population. For the most part Plunket developed as a pakeha service.¹³⁴

The Department gave no recognition to the training of Karitane nurses per se. Flora Cameron, Director of the Division of Nursing, noted in 1958 that there had never been any 'provision made under statutory powers for Karitane nurses to register'.¹³⁵ However, indirectly their training and qualifications were acknowledged and Karitane nurses were also being increasingly employed in public maternity hospitals, children's wards and the neo natal units that were springing up.¹³⁶ General hospitals also used the Karitane hospitals widely for the care of particularly premature and weak babies after birth, prior to them going home. Relationships between individual hospitals and their staff to Karitane hospitals and nurses appeared cordial, with recognition of the strengths they could provide in the delivery of certain health services. It would seem that any suspicion came from the Department of Health administration. The Department of Health was very protective of what it considered

¹³³Parry, p.58

¹³⁴Information from *Report of the Consultative Committee*, p.6. Plunket stated it reached 88.6% of all pakeha babies in 1958 and 'Correspondence re the Report of the Consultative Committee on Infant and Pre School Health', DU:HO, AG-7-1-8-15. Plunket had never sought to ignore Maori infant health. The 1934 Annual Report recognised the higher death rate of Maori infants and the disappointing results of work undertaken. They also prepared material to be used in native schools, written in Maori. However, Maori health was seen to be the district nurse's domain. As the Maori population urbanised Plunket still lagged in providing infant care services for them. It has been an ongoing commitment by the Plunket Society over the last twenty years to increase their service to Maori babies.

¹³⁵Letter from F.J. Cameron, Director, Division of Nursing (General) in reply to an enquiry from an English trained Mothercraft nurse, 3 April 1958, NA, H1, 2646 37994 127/4/2

¹³⁶Correspondence re Karitane nurses employed in public hospitals, NA, H1 22893 21/23/142.

Karitane nurses were required to be under the direction of the Sister in charge and were not to carry out certain procedures e.g. tube feeding.

their sole rights to the training of nurses. All nurses in New Zealand, except for Karitane nurses, were trained through them. Nothing duplicated the Karitane training as such. Paediatrics made up 4-5 weeks of the general nurse training and maternity nursing mainly dealt with services to the mother. By the time of the report the Department of Health was seen to be consolidating its general nurse training with the inclusion of maternity into the three-year programme.



Trainees at Christchurch Karitane Hospital in 1943 with their seemingly healthy 'patients'. Karitane nurse training centred on making the 'sick child' healthy, and all aspects of childcare and mothercraft were covered. It was not duplicated in any manner by any Department of Health nurse training.

John Pascoe Collection, WTU, F-440-1/4 PAColl-078

Papers surrounding the Report of the Consultative Committee expose many of the prejudices the Department of Health had against the Plunket Society. There was recognised antagonism between the two organizations from outside as well. A submission by the New Zealand Federation of Housewives commented: 'Opposition to or an inability to appreciate the need for, or the value of, various forms of nursing

has been the traditional attitude of the nursing division.¹³⁷ After the findings of the committee were released an editorial in the *Auckland Star* concluded that government financial support for the Plunket Society was 'sufficient reason for some Health Department officials, headed by the Director of Nursing, to demand the liquidation of Karitane hospitals'.¹³⁸

The Committee Report saw that a major function of the Plunket Society was the Karitane hospitals, where 'Karitane trainees provide the bulk of the labour force'.¹³⁹ They recognised the necessity of Karitane nurse training to the hospitals' survival:

The Karitane trainees provide the essential nursing services for the hospitals and at the same time learn the principles of mothercraft and infant care necessary to fit them for their future work in the community. The work is apparently attractive to young girls and there are substantial numbers on the waiting lists seeking training. About 150 nurses qualify each year, but the supply is never equal to the demand.¹⁴⁰

It is significant that the Committee uses the terms 'nurses' and 'nursing duties' in reflecting contemporary popular perceptions of the Karitanes.

The Plunket Society canvassed support by asking likely people or organizations to present submissions. Medical doctors were amongst those in support of Karitane hospitals and nurses. The editor of the *Auckland Star* commented that 'The Health Department has expressed doubts about the professional standing of the Society's nurses. Yet doctors with great experience in working with those nurses have expressed their admiration...The Karitane nurse, although lacking the academic background of ordinary nurses, in their opinion is much more suited to caring for young children and teaching their mothers how to look after them'.¹⁴¹ Howard Williams of the Royal Children's Hospital in Melbourne stated that the Karitane hospitals 'provide the best type of nursing care'¹⁴² and G.H. Green, Acting Medical

¹³⁷Submission of the New Zealand Federation of Housewives (NZFH) to the Consultative Committee, DU:HO, AG-7-1-8-15

¹³⁸ *Auckland Star*, 27 July 1959

¹³⁹ *Report of the Consultative Committee*, p.17

¹⁴⁰ *ibid*, p.15

¹⁴¹ *Auckland Star*, 27 July 1959

¹⁴²Report by Howard E. Williams, Physician to patients at Royal Children's Hospital, Melbourne, to the Consultative Committee, DU:HO, AG-7-1-8-7

Director of National Women's Hospital in Auckland, wrote prior to speaking to the Committee that his institution was interested in the training of Karitane nurses because 'we, as you know, find these nurses extremely useful in the premature unit and in the nurseries of the wards where rooming in is not practised'.¹⁴³ Murray McGeorge, Senior Lecturer in Paediatrics, University of Otago Medical School, extended the argument further in suggesting a subsidy to make the service more available, regardless of income.¹⁴⁴ Other support came from such diverse sources as the director of a Plunket commissioned film and Lady Aspinall, as a user of both the Karitane hospital and nurse services.¹⁴⁵

The Health Department's submissions came from within, to support the recommendation that the state should run much of the Society's activities. Their medical staff took the line that Karitane hospitals and nursing were not recognised needs and could be abolished. Dr H.B. Turbott commented that 'The department's nursing division questioned the value of the Karitane nurse-training programme in the light of modern social conditions'. Dr G.A.Q. Lennane, Director of Child Hygiene, dismissed Karitane nurses as too expensive and claimed that 'what mothers really needed was efficient, reliable and inexperienced help in the house'. The New Zealand Federation of Housewives was quick in its support of Plunket. It singled out the 'social conditions' as 'insufficient hospital accommodation, nursing shortages, the H Bug and a lack of domestic help [making] the need for Karitane nurses...very great'.¹⁴⁶ They also refuted the claim for domestic help, seeing it as invalid and unobtainable. The cost of a government employed home aid for a 39 hour week was greater than a Karitane nurse was for an 84 hour week, and domestic help in New Zealand had always been notable for its lack.¹⁴⁷ The Parent's Centres and Play Centres' Associations also made criticism of Plunket for its rigid routines and habits.

¹⁴³Letter from G.H. Green to Neil Begg, 9 July 1959, DU:HO, AG-7-1-8-15

¹⁴⁴Submission by Murray McGeorge to the Consultative Committee, DU:HO, AG-7-1-8-15

¹⁴⁵Letters privately submitted by Frank Chiltern and Frances Aspinall, Mt Aspiring Station, Wanaka, July 1959, DU:HO, AG-7-1-8-15

¹⁴⁶Submission by the NZFH to the Consultative Committee, DU:HO, AG-7-1-8-15

¹⁴⁷ibid. Figures quoted were eight-pounds live out, for a Home Aid and six pound 3s live in, for a Karitane nurse, per week.

After hearing all the submissions the Committee presented its report. Overwhelmingly the Commission recognised the public's support for the Society and that taxpayer's money was being well spent.¹⁴⁸ Plunket was seen to be providing services for the community that would have public costs no matter who provided them.¹⁴⁹ The many proposals, about infant and pre school health, that were made by the committee included the maintenance of the Karitane hospitals and the Karitane nurse training. Both were presented in a very favourable light. Karitane nurses were seen to provide a 'useful function and...give help to the community who should not be denied to it....Skilled help is...the source of great relief'.¹⁵⁰ They also recommended that the service be extended as there was a 'widespread unsatisfied demand' for Karitane nurses, particularly among the less well to do.¹⁵¹ However, the Committee made no proposals about how to go about extending the service, recognising the probable financial implications of doing so. The Committee also discussed the shortening of the Karitane training to a year but accepted the Plunket Society's view that 'any limitation of the period of training would unduly limit the practical experience of the trainee'.¹⁵² The Society also pointed out that once Karitane nurses were out in the home they were no longer under direct supervision and, at possibly only 18 years of age, this placed a great deal of responsibility upon them. 'The lengthening of the course was undertaken in order to protect the customer as well as the nurse.'¹⁵³ Other proposals were made that could help to alleviate the Department's negativity to Karitane nurses when casing. The Committee recommended widening the nurses' responsibility to make all pre schoolers in the family the subject of their care and that they should help in the home if this accorded with their primary obligation to baby and childcare. Both recommendations were accepted by the Society, although to all intents and purposes they were already being carried out.¹⁵⁴

¹⁴⁸*New Zealand Herald*, 7 July 1960

¹⁴⁹*Report of the Consultative Committee*, p.28

¹⁵⁰*ibid*, pp.39-40

¹⁵¹*ibid*, p.42

¹⁵²*ibid*, p.43

¹⁵³Plunket Society responses to questions of the Committee, 28 Sept 1959, p.2, DU:HO, AG-7-1-8-4

¹⁵⁴*Report of the Consultative Committee*, p.44

The Committee supported the Karitane hospitals largely for their uniqueness. They recognised that much of their popular appeal was psychological because mothers saw them as their 'own institutions' and therefore their use was 'readily accepted'. 'Much of the value would, we think, be lost if popular appeal of the Plunket Society in respect of its Karitane activities and otherwise were dissipated as it would necessarily be to a not inconsiderable extent if the Karitane institutions were converted into wards of the public hospital system'. Other factors in recommending their retention was the very low cross infection rates because of the high ratio of nurses to babies and the provision of invaluable mothercraft training for mothers. They felt neither of these could be duplicated in the public hospitals. The Karitane hospitals were also seen as advantageous to the state as a 'substantial part of their cost is provided by public subscription'¹⁵⁵.

All in all, the Committee's views of the Karitane service offered by the Plunket Society were very positive. The Prime Minister, Walter Nash, stated that while the Health Department had to control the overall health of New Zealand, the 'keynote of the agreement would be complete co-operation between the Health Department and the Society'.¹⁵⁶ The Society headed into the new decade with high hopes. But, while the Report of the Consultative Committee affirmed the Plunket Society's delivery of services it did not provide a quick-fix remedy for the financial worries that were beginning to be felt - particularly in the provision of hospital care. Although the recommendation was to extend the Karitane nurse service their unique training was in turn reliant on the Karitane hospital system. Karitane hospitals and nurses, as they were known, could not exist without each other.

However, with affirmation from the Consultative Committee the Plunket Society looked forward to a new decade and rising fortunes. New Karitane hospitals were built in Auckland and Christchurch, a new nurses' home in Wellington, and hospitals elsewhere were renovated and modernised. Political support for the Karitane

¹⁵⁵ *ibid* pp.25-26

¹⁵⁶ *Christchurch Star*, 6 July 1960

hospitals was still strong with nearly half the costs coming from this source. The Society's immediate aim was to attract more interest and involvement in its hospital service. With the Karitane nurse training and the hospitals inextricably linked this could only benefit the training. However, Health Department reservations about the role of the Karitane hospitals remained an ominous sub-text.

6.

‘Apparently Attractive to Young Girls’

Throughout the 1960s and 1970s Karitane nursing was still ‘apparently attractive to young girls’, as the Consultative Committee had indicated.¹⁵⁷ This was not unexpected as female school leavers were still choosing to enter a much narrower range of occupations than boys, and tended towards those that were traditionally acceptable. Fry argues that girls prized conformity more than individualism at this time.¹⁵⁸ Certainly my informants were exploring very traditional feminine occupations. In 1969 the Labour Department commented: ‘It would appear that the traditional attitude about the role of females still prevails...Girls still see themselves predominately as housewives and mothers’.¹⁵⁹ Karitane nursing could be a good prelude to this and the Society used this image of their futures to try and attract trainees. Asking, ‘As a trained Karitane what are your prospects?’, a recruitment sheet followed with, ‘For Marriage: You will be prepared for the ultimate career for all women - by being a capable wife and mother’.¹⁶⁰

As mentioned earlier the Plunket Society trained 8,350 Karitane nurses over the years. For the purposes of this thesis I interviewed or corresponded with 36 former Karitane nurses, who trained during the period 1959-1978 across the six Karitane hospitals in New Zealand.¹⁶¹ These women’s retrospective views will form the basis of the next three chapters.

¹⁵⁷*Report of the Consultative Committee*, p.20

¹⁵⁸Fry, p.184

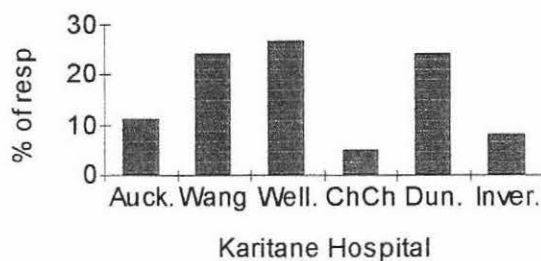
¹⁵⁹Day, p.78

¹⁶⁰Karitane nursing promotion sheet, circa 1960s, DU:HO, AG-145-27

¹⁶¹Any percentages, or figures quoted about Karitane nurses is based on this number.

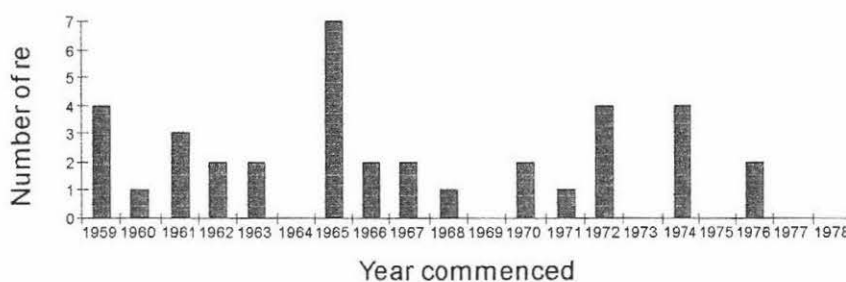
Training Hospital of Respondents

1959-78



Year Respondents Commenced Training

1959-78



This limited study, by oral interview or written questionnaire, has revealed some similarities in the prospective candidates for Karitane nurse training, despite the changes that were occurring in education and society. However, some of the traditional images of Karitane nurses were not evident here. Only 27 per cent of the women interviewed had a rural upbringing, although there was a perception, even from the trainees themselves at the time, that a lot came from the country. Almost half indicated that they had a city upbringing. The lower numbers from the country could be explained by the fact that New Zealand was becoming much more urbanised. Another anomaly was found in the status of the families these young women came from. Both Parry and Mein Smith suggested a 'finishing school' image of the Karitane training, for girls from well-to-do families. However, the fathers of the women interviewed worked in a wide range of fields. Manual workers, including farmers, made up over half the occupations and many of these were blue-collar workers. While 30 per cent of all those interviewed indicated that their father was a farmer, some of these worked smallholdings and did this only part time. This particular group of

trainees could not be categorised into any clear socio-economic group. Their parents' statuses were also reflected in their education. Most of my informants went to their local public secondary school, either co-ed or single sex. While 30 per cent of those spoken to went to a private school, and this is greater than in society at large, it refutes the reputation that Karitane hospitals were only catering for girls from a privileged background.¹⁶²

Most of the interviewees came from very 'typical' New Zealand families. They were born in the period from the early 1940s to 1960. Overwhelmingly their father was the breadwinner and their mother worked in the home. Of the few mothers who were in paid employment, none did so outside of school hours and the majority worked when their children were in their teens.¹⁶³ The interviewees all had other siblings, and most mentioned a lot of contact with the children of their extended families during their upbringing. It was often as a child that they developed the notion of work with babies and children. The word 'love' surfaced frequently at the mention of contact with infants. Julia's sister was born when she was eight or nine. 'That's when I decided what I was going to be....Just loved them, there was something there. Maternal?' She was considered responsible enough to be babysitting from the age of eight.¹⁶⁴ Others mentioned being 'baby mad' and into dolls.

Similarities surfaced in the schooling of trainees. Home Science was a popular option for these girls, with 46 per cent of my informants having elected to take it.¹⁶⁵ While 39 per cent took the 'academic' course, often this was not by choice.¹⁶⁶ Sometimes the school offered no other course, or they were 'persuaded' to take it because they performed well at primary school. Two of my respondents mentioned that it was a waste of time for what they wanted to do. On her father's insistence

¹⁶²Girls in private secondary schools: 1955:18 per cent, 1965:17 per cent, 1975:15 per cent. *New Zealand Official Yearbook*, 1957, 1967, 1977

¹⁶³One interviewee was atypical in that she was virtually raised by a 'nurse'. Her stepmother did a lot of charity work and was 'constantly out of the home'. Heather Lyons (trained 1958-59), interview with Lesley Courtney, 30 May 2001

¹⁶⁴Julia de Weck (trained 1965-67) interview with Lesley Courtney, 4 July 2001

¹⁶⁵This was considerably above the average of 29 per cent taking 'Homelife' in 1959. *AJHR*, 1960, E1, p.92

¹⁶⁶The professional or academic stream included languages as opposed to practical subjects.

Linda took languages. She felt she 'would have been far happier and achieved a lot more if I had done a practical course.'¹⁶⁷ Education was generally not a priority by the time these future trainees reached secondary school. Thirty eight per cent stated they did not like school by then and two used the word 'hate'. Frequently it was something to be endured or tolerated. Even when school was 'alright' many just wanted to leave and get on with their lives. Most of them left in or at the end of the fifth form without School Certificate.¹⁶⁸ While girls in general were electing to stay at school longer and gain more qualifications, this was not that unusual. Girls were still leaving school earlier than boys into the 1970s. Fry states that more girls were taking School Certificate subjects that ended in the fifth form, and not continuing on to the sixth form.¹⁶⁹ For my informants a contributing factor to their poor attitude to school was that the majority had already investigated Karitane nursing and planned to go. Raewyn lost interest at the end of the fourth form. 'I knew that I didn't have to have qualifications to go Karitane and that was all I wanted to do.'¹⁷⁰ This was not an uncommon reflection. Karitane nursing promotional material of the 1960s stated, 'School certificate is ideal, but girls with a special interest and aptitude may be accepted with a minimum of two years' secondary education'.¹⁷¹ These young women certainly had the 'interest and aptitude'. In this period of high employment, leaving school for a job was seen as a practical option, particularly if you were not planning on an academic career nor needed the qualification.

My informants found out about Karitane nursing in a variety of ways. The Plunket Society made sure information was in the 'Vocational Guidance Manual'¹⁷² and mention was made of a stand at a 1971 'Careers Week' in the Hutt Valley. It was reported that this mainly attracted the attention of 15-year-olds.¹⁷³ Articles in

¹⁶⁷ Linda Campbell (trained 1971-71), personal correspondence with Lesley Courtney, 11 May 2001

¹⁶⁸ This would be common for the early 1960s when only 30 per cent of females left School Certificate or higher. By 1967 this was over 50 per cent and by 1978 was 70 per cent. Information from Statistics New Zealand, *All About Women in New Zealand*, Wellington, 1993

¹⁶⁹ Fry, p. 189

¹⁷⁰ Raewyn Edwards (trained 1965-66), personal correspondence with Lesley Courtney, 9 July 2001

¹⁷¹ Karitane Nursing promotion sheet, circa 1960s, DU:HO, AG-145-27

¹⁷² Karitane Hospital Minute Book 1959-74, Plunket Society Wellington Branch, 3 May 1971, DU:HO, AG-782-2-1

¹⁷³ *ibid*, 9 Aug 1971

newspapers and magazines were not infrequent, often around Daffodil Day.¹⁷⁴ These were, to all intents and purposes, advertisements for the hospitals and training. By the 1960s there was an open recruitment plan that included advertising in the local papers, with headings such as 'For Girls Who Love Babies - A Most Satisfying Career is Karitane Nursing'.¹⁷⁵



**FOR GIRLS
WHO LOVE
BABIES ...**

THE MOST SATISFYING CAREER IS

KARITANE NURSING

After training in the care of babies and small children, nurses are qualified to care in private homes or take positions in the nurseries of maternity hospitals. Girls from 16½ years of age are accepted for training and a number of bursaries are available. Further particulars can be obtained from the . . .

KARITANE BUREAU SECRETARY,
36 Albany Street, Dunedin. Phone 88-542.

Otago Daily Times, 18 July 1970, p.7 DU:HO, AG-145-27

The majority of the women interviewed recalled they did not seek help from a careers advisor. Frequently they did not remember them being available and some felt there was 'no need to see a Careers Advisor as I knew I wanted to be a Karitane nurse.'¹⁷⁶ Of those who did most either enquired about Karitane nursing or work with children. The women who could not recall where they heard about Karitane nursing from were

¹⁷⁴Daffodil Day is now used by the Cancer Society as its 'collection day' each year but was originally used by the Plunket Society for the same purpose.

¹⁷⁵*Otago Daily Times*, 18 July 1970, p.7

¹⁷⁶Linda Campbell correspondence

frequently ones who had 'always known about them and wanted to be one'. Many had known Karitane nurses either within their family or friends, or they knew others in training. The interviewees were often told they had 'an aptitude with children' and Karitane nursing was suggested. Julie's mother's aunt and sister were Karitane nurses.

I can never remember a time I didn't want to be a Karitane nurse because I suppose I always loved children and they used to say to me, "you'd be a good Karitane nurse". I always knew that's what I wanted to do. Never even thought of anything else. It was always what I wanted to do. I just loved children.¹⁷⁷

Two visited the local Karitane hospital. Susan recalled when her mother's cousin, a Karitane nurse, took her 'over there one day...I just fell in love with it'.¹⁷⁸

For my informants it was almost unanimously their own choice to go. Sixty five per cent of the interviewees said that Karitane nursing was their first choice of occupation. At a Karitane graduation in 1973 the speaker acknowledged the commitment of the girls. "I believe that you only became a Karitane nurse because you wanted to. In our very materialistic world there are few young people who would undertake training unpaid."¹⁷⁹ For a few it was a change of direction. Four went to Karitane nursing when they did not meet the requirements needed for their first choice and some intended some other form of nursing first.¹⁸⁰ Occasionally there was opposition within the family. 'My mother tried to dissuade me but I was quite convinced I wanted to go', Gillian recalled. Her mother was also not keen on her leaving school at the end of the fifth form so this may have contributed to this attitude.¹⁸¹ On a rare occasion a girl was 'sent'. After missing University Entrance one of my informants went. 'It was not a matter of choice. I was sent....all planned for me. I think she thought, "She's going to have children one day, get out there and learn all about it because it's very important", and of course she was right in many respects.'¹⁸²

¹⁷⁷Julie Mohekey (trained 1961-62), interview with Lesley Courtney, 1 May 2001

¹⁷⁸Susan Hardy (trained 1972-74), interview with Lesley Courtney, 23 June 2001

¹⁷⁹*Plunket News*, Oct 1973, Vol.10, No.4, p.42, DU:HO, AG-7-8-16. The speaker, Mrs Babe, was the Senior Sister of Hamilton's Post-graduate School of Advanced Nursing Studies.

¹⁸⁰Two required University Entrance for their first choice and two failed to get into police because they were too short.

¹⁸¹Gillian Perkins (trained 1966-67), interview with Lesley Courtney, 5 July 2001

¹⁸²Heather Lyons interview

Another, on leaving school, was given two options by her mother - secretarial work or Karitane nursing. But these were the exception. Interestingly, Julia, who spent much of her childhood in England, was sure she would not have been allowed to do nanny training over there if they had stayed. 'Coming back to New Zealand to be a Karitane nurse was fine - a totally different social thing. An English nanny was a servant.' Her mother, who was English, had always employed Karitane nurses in England to look after the children as newborns.¹⁸³

My respondents, on the whole, loved babies and children and wanted to work with them. 'I enjoyed their company and I believe I had the romantic idea that I would change children's lives forever and that every child I looked after would be better for it', recalled Alison.¹⁸⁴ Helen decided to go after listening to Plunket nurse talks in Home Economics class. 'I had always wanted to be a 'lady with a baby'.¹⁸⁵ Some also saw attractions in moving away from home, opportunities to travel with the job, the lack of academic qualifications required or perceived Karitane training as the gateway to other nurse training. Liz chose Karitane nursing for many reasons. She had considered Kindergarten teaching but did not have the qualifications and she also looked forward to the prospect of moving to Wellington. As well as the childcare she also recognised it

being sort of home based. I knew that I had the skills to cook good meals and I didn't mind that side of life. I didn't see it as being the slushy... making meals and doing things that were nice was part of what I enjoyed doing. It was the whole spectrum of being home based. You could go and take children out for a walk. And you could go out and take children shopping. It was exciting. An adventure.¹⁸⁶

Despite the domestic and maternal overtones only two interviewees mentioned Karitane work as a qualification for marriage. They both trained at the beginning of this period. 'At this stage, in my generation, the entire focus was on marriage...you thought of a job, travel and marriage and that's exactly the way it worked, except for me that I was already organised to get married before I went on the travel.'¹⁸⁷ Others

¹⁸³Julia de Weck interview

¹⁸⁴Alison Newell (trained 1962-63), personal correspondence with Lesley Courtney, 12 June 2001

¹⁸⁵Helen Richardson (trained 1958-59), personal correspondence with Lesley Courtney, 23 May 2001

¹⁸⁶Elizabeth Gardiner (trained 1965-66), interview with Lesley Courtney, 3 May 2001

¹⁸⁷Heather Lyons interview

recognised that it was a career until marriage took over. This was certainly true of women in general over this period. While women were returning to work after their child-bearing years there was still an expectation that on pregnancy women would give up their jobs at least until the last child was at school.¹⁸⁸

When asked if they had any future goals on starting their training some recalled not thinking of the future. One saw it as the 'be all and end all'¹⁸⁹ and another as fulfilling a 'lifetime dream. To be paid for doing something I loved doing - looking after babies and small children'.¹⁹⁰ However, travel was overwhelmingly named as a future consideration. Forty per cent indicated it was an intention or priority for them. Dianne recalled, 'Travel! I wanted to travel. I wanted to travel. That was what I could see at the end of it. I couldn't think of anything worse than being stuck in an office and doing something boring and mundane. I saw it as having a bit of scope, leading to other possibilities.'¹⁹¹ This was not an unusual ambition for the youth of New Zealand. Having an 'O.E.' was almost becoming standard practice, particularly for those with some training.¹⁹² Young people headed off to Europe for a year or so and 'saw the world' before returning to settle down to married life.

As young women, most of my respondents viewed Karitane nursing as a career. 'That's how it was promoted to me, from the careers advisor who spoke to me.'¹⁹³ Some, like Liz, were emphatic it was. 'Definitely....this was my career, my path, my choice....it was up to me to make it work', although others on reflection were not so sure.¹⁹⁴ Gillian felt 'that's a hard one. I'm not sure. I suppose I did in my own limited way'.¹⁹⁵ Some recognised that it served as a career until marriage. 'Oh yes. A career up until I met the man of my dreams on the white charger and had a

¹⁸⁸Kedgley, pp.226-27

¹⁸⁹ Raewyn Edwards personal correspondence

¹⁹⁰Christine Farrelly (trained 1974), personal correspondence with Lesley Courtney, 27 May 2001

¹⁹¹Diane Ferrel (trained 1976-78), interview with Lesley Courtney, 29 May 2001

¹⁹²O.E. is the abbreviation for overseas experience and is widely used to describe a working holiday of some duration overseas.

¹⁹³Sue Clement (trained 1965-66), personal correspondence with Lesley Courtney, 3 June 2001

¹⁹⁴Elizabeth Gardiner interview

¹⁹⁵Gillian Perkins interview

baby of my own.’¹⁹⁶

Karitane nursing was portrayed as a form of nursing to the women involved. The recruitment material they read as girls fully exploited the nursing image. A uniform with veil or cap, hospital training, living in a nurses’ home and being called ‘nurse’ could not be taken any other way. The reasons most of my informants did not want to go general nursing revolved around academic qualifications, the ‘blood and guts’ aspect, and their wish to work with babies and children in a ‘well’ environment. At least five felt they were not ‘bright enough’ to cope, as nursing was seen as more academically rigorous, although School Certificate was the minimum educational standard for general nursing only from 1966. The matron of the Wellington Karitane Hospital was quoted as saying that if girls had School certificate they would be encouraged to do general nursing and then their Plunket training.¹⁹⁷ There is no indication that this happened, certainly not to any of my informants with qualifications, but it does suggest that higher education was not deemed necessary for Karitane training. This was later somewhat modified since an Annual Report of 1972-73 notes it is ‘gratifying’ that many had School Certificate and some with University Entrance were applying.¹⁹⁸ Lani’s mother felt she should do general nursing first and then Karitane after, if she wished, but she ‘dug her heels in. Looking back she must have known it wasn’t going to be much of a career. It [general nursing] never appealed to me. I was no more going to be a nurse than fly to the moon’.¹⁹⁹ While many were attracted to work in a hospital environment only a few saw Karitane nursing as a precursor to other nurse training and most of these did not realise this ambition.²⁰⁰ They were either because they were having a good time casing or the maternity-nursing programme, which was a popular subsequent choice, was being phased out. Two respondents became enrolled nurses and one did ‘paediatric’ nurse

¹⁹⁶Julia de Weck interview

¹⁹⁷‘Saturday Profile’ about Miss M.A.E. Bayne, matron of Wellington Karitane Hospital, unidentified newspaper clipping, circa 1960s, WA, MS 7/10

¹⁹⁸*Annual Report of Council 1972-73*, WA, MS 7/1/46

¹⁹⁹Lani Bull (trained 1965-66), interview with Lesley Courtney, 30 May 2001

²⁰⁰At least 16 per cent specifically mentioned they wished to work in a hospital after training, and many more did. Those who mentioned further training usually intended maternity nursing, one mentioned midwifery and two general nursing. Maternity nursing was an 18-month training and was phased out from 1958 -1970.

training in England. Only one went directly on to do her general training. Gillian recalled,

I wanted to be a nurse long before I thought about Karitane nursing. I think the reason I chose Karitane nursing over general nursing at that particular time, in the fifth form, was that I really liked working with children. I suppose people said I had a natural aptitude and I think I was buoyed on by that. I think that I had always wanted to be a nurse.²⁰¹

She was very much the exception in doing both forms of training, despite the recruitment material promoting this pathway.

And so these young women, who had often from an early age fixed on a career with babies and children, entered a Karitane hospital to commence their training.



A typical class of young school-leavers at Wellington Karitane Hospital in 1969.

Personal collection: Ivy Mary Gleeson

Only 27 per cent of my informants went in directly from school, but this was mainly because of the age requirement or a waiting list. Many, having left school at 15 or 16 years of age, were not old enough. On enquiring about the training in 1965 Gillian's mother was informed there would be about a year's wait if she went to Wellington or Christchurch. Instead she went to Dunedin six months earlier. Another delay could be

²⁰¹ Gillian Perkins interview

that classes entered intermittently through the year.²⁰² Most of my respondents left school and in a time of high employment they got a 'stop gap' job until they could enter. Some did so to earn money to help put themselves through the course. Nurse aiding, shop or farm work were the most common ways of filling in the time. Only four left school to pursue other work. Three moved into Karitane training after a year or two, including one who got ill during general nurse training, and one came to it after 11 or 12 years when she felt she needed some qualification. This was unusual as most of the trainees were single minded about a career caring for babies and were young on entering the hospital.

This training was definitely directed towards school leavers in the 1960s and early 1970s. A sheet for prospective candidates started: 'Young girls who love children. These are the girls who train as Karitane nurses at the Plunket Society's hospitals. It is the factor of their youth...that accounts for their success, for...they can so easily get down to the child's level.'²⁰³ Advertisements mentioned 'congenial companionship with girls of your own age in the pleasant surroundings of the nurses' home of the Karitane hospital'²⁰⁴. Living in would also have limited older candidates.

To gain entry the trainees applied to, and were interviewed by, the Plunket Society. A report in a *Plunket News* suggested, 'The main qualifications are that the girls be practical, kind, interested in babies and helpful'.²⁰⁵ Once *they* were accepted, a medical examination was required and a date given for commencement. The girls supplied their own uniforms and books for lectures, but they could apply for a bursary for personal expenses during training.

But, these young women were entering a training course that was already endangered. Despite waiting lists at some Karitane hospitals throughout this time, there was frequent concern about the lack of trainees. Early in the 1960s the Plunket

²⁰²ibid, personal letter

²⁰³'Love for Children Inspires Work', sheet for 'prospective candidates', circa 1960s-70s, DU:HO, AG-145-27

²⁰⁴*Otago Daily Times*, advertisement, 23 Nov 1963

²⁰⁵*Plunket News*, June 1970, Vol 7, No. 4, p.22, DU:HO, AG-7-8-15

Society attempted to attract more recruits by increasing the number of bursaries available, cutting the amount of compulsory 'casing' that followed and by allowing girls to begin training at 16. By the 1970s however, perhaps the effects of changing values and women's liberation was having an impact on this most traditional of occupations. One delegate at the Plunket Society Annual Meeting of 1972 suggested, 'Young people today need either to be earning substantial wages or qualifying themselves with higher education and Karitane nursing does not fall into either of these categories unfortunately'.²⁰⁶ Each year mention is made of 'insufficient numbers' in training. However, with a revised curriculum planned in the mid 1970s the Society moved away from younger trainees in an attempt to recruit and the Plunket Society felt that, 'Raising the entrance age to 17 years has resulted in better educated and more responsible students applying for training'.²⁰⁷ The girls who entered the Karitane hospitals to train were largely oblivious to these concerns. Most were bright eyed and excited to be entering a 'profession' that they had desired for a long time.

²⁰⁶*Wanganui Chronicle*, 5 May 1972

²⁰⁷*Annual Report of Council 1974-75*, WA, MS 7/1/49

was lucky enough to have a car.²¹⁰ Whatever the circumstances all the women interviewed recalled quickly settling into life in the nurses' home and work in the hospital.

Karitane Intakes

The Plunket Society aimed to train approximately 190 Karitane nurses per year, in keeping with the number of babies they could accommodate.²¹¹ Most of the trainees were pakeha, just as most of Plunket's clients were pakeha. Only one Maori girl was recalled by my sample group and one of the women interviewed was Asian.²¹² However, during the 1960s six of the bursaries available were earmarked for Maori trainees, with the first being awarded in 1964. The Plunket Society was in correspondence with the Maori Affairs Department in a bid to encourage Maori girls to enter training. They would have increased the number of bursaries available if needed, although Maori girls could also enter by the usual channels too.²¹³ There was recognition, however, that more encouragement was needed by the 1970s and mention was made in the 1972 Annual Report that a 'special effort' should be made to award bursaries to Maori girls.²¹⁴ Further to this, the new curriculum, brought in in 1974 -75, planned to attract a wider diversity of applicants. It was envisaged that in certain circumstances some trainees would be on a six-month trial period and be paid a salary. If they were found not suitable their job could then be terminated. 'The trial period would be for those under the age of 17, and would be aimed particularly at the Maoris and Islanders who had not been able to cope with the language examinations.'²¹⁵ There is no indication whether these moves were successful. Obviously the training was still known overseas in certain circles. Young women from Australia, Canada and the United States were remembered as coming for their

²¹⁰ Vanessa Bloxham (trained 1972-74), Personal correspondence with Lesley Courtney, June 2001

²¹¹ Numbers trained varied over the years. For example: 1959:158 in training, 1966:190, 1971:179, 1976:150. These figures are for the total in training not for one year's intake. From *Annual Report of Council*: 1959-60, 1965-66, 1970-71, 1975-76. WA, MS 7/1 Box 1

²¹² Maori girls had been admitted for training in the 1940s under J.R. McKenzie Trust Board sponsorship. It was hoped these girls would work for the benefit of the Maori race to help lower the death rate. Information available would indicate it was not easy to recruit many girls and the scheme died out. Information from NA, MA W2490 36/9/2, Box 98, Pt 1

²¹³ *ibid*

²¹⁴ *Annual Report of Council 1971-72*, p.5, WA, MS 7/1/46.

²¹⁵ *Wanganui Chronicle*, 1974, WA, MS 7/10, Box 2

training. Only one of these was from a New Zealand family resident overseas.

Although there was some perception that a lot of the trainees came from farms and private schools, 'It was amazing the diverse backgrounds we all came from', remembered Glenys. This was reiterated by most of my informants.²¹⁶ Joan felt that the 'lower income ones probably made the better Karitanes - wanted to be there. For some it was like "finishing school", ready for the trip overseas, then marriage - not for a career'.²¹⁷ Despite the passage of time and a wider variety of girls entering, there was still perhaps an overrepresentation from young women of more affluent backgrounds who could afford to come. But, there were other means of support.

To attract enough recruits bursaries were made available throughout the 1960s and 1970s, and information on them was sent out to prospective candidates. No one recalled being turned down for one but they were limited in number and people were discouraged from applying for them as a matter of course. Gillian's mother was told, 'I understand that you would be able to finance Gillian's training...The bursaries are primarily intended for girls who require the finance, and we often have more applicants than bursaries available.'²¹⁸ Parents were told they could continue to receive the family benefit until their daughters were 18 and still in training. Many of the girls remembered that their parents passed it on to them.²¹⁹ For some of the girls a bursary was what allowed them to go into training. Either their parents were not in the financial position to help them, or in one case refused to do so. While the bursary amount was limited, baby sitting when in training could supplement it, and some of the girls had previously worked to save all or part of the money needed for the course. Julie, who got a job at the telephone exchange, worked out she needed two pounds a week for the 16 months and saved accordingly. Her mother bought the uniforms, which were not cheap.²²⁰ *Plunket News* reported in

²¹⁶ Glenys Nicol (trained 1966-68), personal correspondence with Lesley Courtney, 20 July 2001

²¹⁷ Joan Smith (trained 1968-70), interview with Lesley Courtney, 26 July 2001

²¹⁸ Letter from Director of Nursing Services, Plunket Society, to Gillian's mother, 6 Dec 1965, personal correspondence of Gillian Perkins

²¹⁹ Normally the family benefit, paid by the government to the mother of the family for each child, ceased on the child leaving school.

²²⁰ Julie Mohekey interview and 'Conditions for Entry to Karitane Training', personal papers of

1973: 'It is increasingly obvious that girls today are not prepared, or not able, to undertake the training without some financial help'.²²¹ The majority however were financed, at least in part, by their parents, most being given a set amount per month.

The trainees were usually admitted for training in ones and twos over a two to three month period, to make up a class. This meant that new nurses were being admitted almost continually, probably for practical purposes. They made up approximately three classes a year, and about four to five classes were in training at any one time. One class always seemed to be entering as another was leaving on completing their full sixteen months hospital training period. This system changed with the new curriculum introduced in 1974 when whole intakes were admitted together. Class sizes varied considerably, with anything from four to fifteen being quoted. This seemed to be due to the number of trainees available or the size of the hospital, and Dunedin always had fewer as the hospital catered for Plunket nurse trainees as well.²²² The aim of the hospitals was to maintain one nurse for every baby admitted, and at times the numbers of babies were restricted because of this policy.²²³

Initial reactions to entering were varied. Some instantly loved it. Despite being apprehensive Sue recalled thinking 'I was walking into heaven. I thought this was me. I just loved it, absolutely loved it.'²²⁴ Others were unsure or even terrified, and the senior trainees could be quite daunting. Alison felt, 'completely out of my depth. My senior was a bossy person. Expected more from you than you knew and put you down in a nasty way. I remember thinking I would never do that when I was a senior and I'm pleased to say I never did'.²²⁵ The 'junior' always started training with nappy duties. This was remembered vividly by all. On her first shift, Glenys remembered the pouring rain, and going out in it to the laundry to scrub nappies. 'I thought, what am I

Gillian Perkins. Seven uniforms, caps, cardigan, shoes and stockings had to be provided by the trainee.

²²¹ *Plunket News*, April 1973, Vol 10 No 2, p.19, WA, MS 7/14, Box 1

²²² This would also have been the case in Auckland and Wellington when they too admitted Plunket trainees in the later years.

²²³ *Annual Report of Council 1972-73*, p.30

²²⁴ Susan Ellis (trained 1970-71), interview with Lesley Courtney, 8 May 2001

²²⁵ Alison Newell personal correspondence

doing!'²²⁶

A Practical Training

The training was unanimously perceived as being foremost a practical one. It was on-the-job training in the care of babies and young children, and gave some experience of imparting 'mothercraft' to mothers. A tutor sister on the staff in the 1970s backed up this view of apprenticeship training. She felt the main business of the hospitals was 'caring for babies' and that the Karitane nurses were trained primarily for staffing reasons.²²⁷

The different hospitals were structured and run along very similar lines. They were divided into different wards and departments. They all had premature and 'weaking' wards, a 'General' ward for older babies, a toddlers section, 'Mothercraft' and a milk room.²²⁸ The Karitane nurses worked an eight-hour shift, six days a week. They started at either 6a.m. or 2p.m. and did night duty in a block three times during their training. They rotated around the departments at different stages of seniority, with increasing responsibility.

The babies in the hospitals were never acutely ill. They usually had a problem of some sort: they were poor feeders, malnourished, failing to thrive or premature, for example. Sometimes they had a condition such as pyloric stenosis, extreme eczema, hernias or congenital problems. Increasingly, until the hospitals closed, they were perfectly normal babies and children who were admitted for 'social' reasons, with some of these children remaining in the hospital for a considerable time.²²⁹ Working in shifts, the trainees performed the everyday care of the infants as in feeding, bathing, dressing, and the duties surrounding their care: cleaning, laundry, ironing and

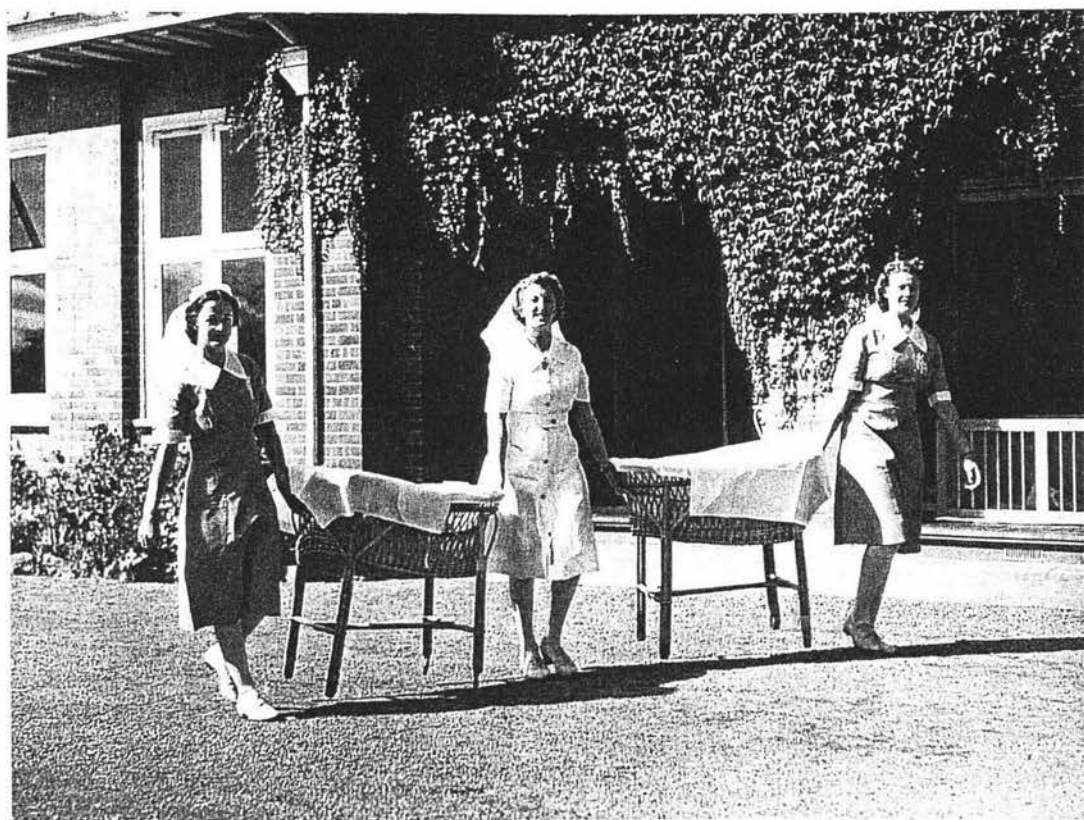
²²⁶Glenys Nicol personal correspondence

²²⁷Colleen Brown interview with Lesley Courtney, 19 June 2001

²²⁸Mothercraft was a part of the hospital devoted to the care of mother and baby. The milk room or dairy was for the making of milk mixtures. Most of the babies were necessarily bottle-fed and a nurse was rostered on each day to make up the formulas for each of the babies. This was a legacy of Truby King and the mixtures were worked out to a precise method depending on size and age. It was rare to use pre-prepared formulas.

²²⁹For example, babies for adoption, abused children and babies whose parents needed a rest. This will be discussed more fully in the chapter on the closing of the hospitals.

preparation of milk and food.



Daily fresh air, a legacy of Truby King, was given to all but the smallest babies if possible. This photo of the 1940s at Christchurch Karitane Hospital could have been during the years of this thesis.

New Zealand Free Lance Collection, WTU, C-17436-1/2

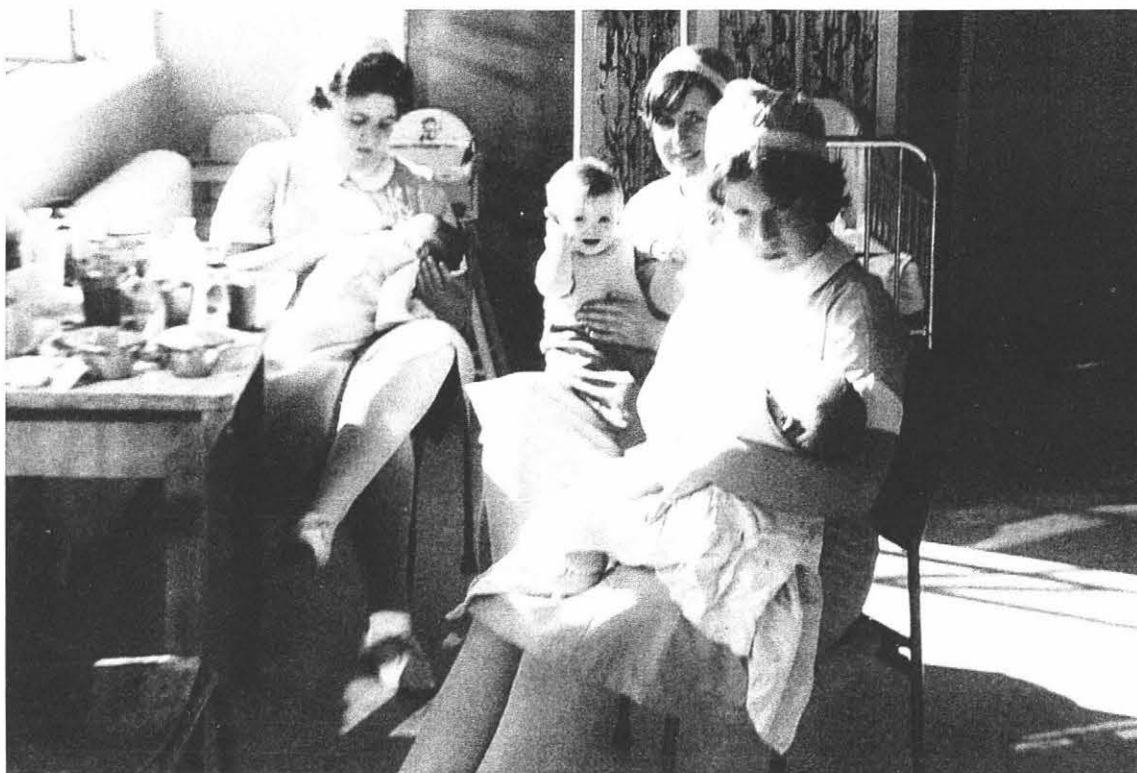
Routine was very important and ‘procedures’ had to be done in a certain way. A list of about 60 ‘procedures’ were required to be assessed throughout the training and ‘signed off’ by the staff. These ranged from washing hands, to taking a temperature and preparing and cleaning a tray for tube feeding. Most of the procedures had distinctly hospital overtones, largely of the most basic kind. They also included some preparation for casing such as ‘feeding a normal baby’ and ‘putting an older child to bed’. They even included the ‘ventilation, cleanliness, tidiness of the nurse’s bedroom, care of facecloths, towels and toothbrushes’.²³⁰ Many of the interviewees recalled procedure number 37, usually unfavourably. This required that

each Karitane nurse in training must bring to the practical examination a complete layette made by herself. These infant sets are cut under supervision from materials provided by the hospital. Advice is given on making the various garments. Although first seams may be

²³⁰NZSHWC, ‘Curriculum of Training For Karitane Nurses: Including Information Pertaining to the Scheme of Training’, Revised 1958, pp.8-10, DU:HO, AG-7-11-25

machined students must show in their “sets” hand sewn examples of hemming, running, felling, herring-bone stitching and making of button holes.²³¹

The set also included a knitted singlet. ‘I’m not quite sure what that was supposed to achieve!’ recalled Diane.²³²



The General Ward for babies up to one year, but not weaklings, was the single largest ward and had the largest number of rostered staff. All ‘Juniors’ started here.

Private Collection: Gillian Perkins

The trainees entered as ‘juniors’ and worked up to being senior nurses with greater responsibilities. This responsibility included involvement in the training of new recruits. It particularly occurred in the general ward where all the juniors started. The junior would be directly under the senior nurse on duty and would go to her rather than a sister for direction and guidance. While tutor sisters were employed specifically to be in charge of the theoretical and some practical components of the training, much of what was learnt happened on the job. Diana felt there was a lot of role modelling and the interviewees recalled that the seniors directly demonstrated many of the

²³¹ *ibid*, p.9&.5

²³² Diane Ferrel interview

procedures.²³³ It would appear that everyone involved in the running of the Karitane hospitals played a part in the training. The nurses received the bulk of their training in the care of children aged under one year, in the main part of the hospitals. However, the areas that were often of greatest importance to casing were mothercraft and, increasingly, toddlers.²³⁴

The amount and depth of training in mothercraft could depend on the mothers in residence when the girls were scheduled on in that section. Mothers were admitted with their babies to a distinct area of the hospital that was supposedly homely and comfortable. They came for a multitude of reasons, but had to be referred by a doctor, often at the Plunket nurses' or maternity hospitals' instigation. Raewyn and Janet were not atypical in that they, and their 'small' babies, entered from maternity hospitals. They both mentioned the strict routines and attitudes to the care. Janet recalled most of the help with her baby being given by Karitane nurses. At the time she was the only mother in residence and found it quite lonely although the nurses ate meals with her. Both of these mothers considered they were receiving nursing care from the girls and the staff.²³⁵ Like all the other areas of training some girls enjoyed this more than others did. On reflection three of the interviewees mentioned their inadequacies in imparting 'mothercraft'. They felt ill at ease because of their age, and Juliet remembered 'supposedly helping them to breast-feed. We didn't actually have a clue. How would a 17-year-old know?'.²³⁶

The 'Toddlers' or 'Older Children' section was usually the smallest department. The Consultative Committee had mentioned that they wished to see the training putting an equal emphasis on the older child as well as the baby but toddlers were never admitted at the same rate as infants.²³⁷ Experience with this age group

²³³Diana Bevins (trained 1967-68), interview with Lesley Courtney, 14 May 2001

²³⁴'Curriculum of Training for Karitane Nurses', p.4

²³⁵Raewyn Sutherland, personal correspondence with Lesley Courtney, 10 May 2001, Janet Bishop, personal correspondence with Lesley Courtney, 19 July 2001

²³⁶Juliet Neale (trained 1967-68), interview with Lesley Courtney, 2 July 2001

²³⁷This was in spite of the recognition of the need for pre-school involvement to the extent that the Plunket Society, in conjunction with the Free Kindergarten Association, opened a Pre-School

could depend on the numbers and children admitted. Initially during this time only two weeks experience was required in 'O.C.', compared with a minimum of 16 weeks in 'General'.²³⁸ This was in spite of the time here seeming so relevant to casing, with the trainees having to plan a routine day, cook meals and consider how to prevent accidents or plan playtimes.²³⁹ Increasingly the children of toddler-age had a disability of some sort and their period in hospital was to give parental respite. This went against the pattern in the rest of the hospital where the children were increasingly 'normal'. It also demonstrated marked changes in Plunket's delivery of service. Up until at least the 1930s 'mental defectives...were rigidly excluded from the Institution'.²⁴⁰ Experience with the everyday needs of a normal preschooler could be very minimal. Only one of my informants expressed a preference for this area of the training and remembered 'some sad cases'.²⁴¹ Gillian recalled the lack of toys and stimulation of toddlers, and even the lack of love.

It was very regimented...even then I thought that. Work with the children was quite clinical. Compared with now I'm saying that, but I had that feeling even then. That they were fed and they were put to bed and it was a bit frowned on to be playing. I felt we were limited in what we could do. You felt a bit restricted. This was not really imposed but sort of filtered down.²⁴²

However, this view may have changed if she had trained later. The 1970-71 Annual Report mentions the need of more 'mothering' by the use of slings, and that the nurses needed practice in helping the child explore and learn.²⁴³ Work in this area was supplemented by visits to kindergartens and play centres, but the amount of experience received from these visits varied. It could be very hands on or almost completely observational. Many of my informants recalled no input from these areas and yet records suggest it was a compulsory part of the training.²⁴⁴ If so, this side of the training had little impact upon my respondents, at least. However, after 1974 the

Education Centre at Dunedin Karitane Hospital in 1940. This later moved to Forbury Road as the Helen Deem Centre. All the Dunedin trainees spent time there.

²³⁸'Curriculum of Training for Karitane Nurses', p.3

²³⁹ *ibid*, p.4

²⁴⁰'Karitane Hospitals: Admissible and Non-admissible Cases'. This would have been because the Society's aim was to help 'normalise' the baby and bring it back to full health.

²⁴¹Gwen Diver (trained 1958-1960), interview with Lesley Courtney, 1 May 2001

²⁴²Gillian Perkins interview. Gillian is now supervisor of an Early Childhood Centre and has seen changes in pre school care first hand over the years.

²⁴³*Annual Report of Council 1970-71*, p.39,

²⁴⁴'Curriculum of Training for Karitane Nurses', pp.3 &5 'Special work with children over two years of age - 30 hours'.

extra-mural training received was widened considerably and provided far greater opportunities for work in this area.

Most of my informants recognised the domestic element of the training, but it was rarely an issue and was accepted as relevant. 'You can't get away from that fact when babies and children are concerned', it was felt.²⁴⁵ Much of the domestic work was related to hygiene around the babies, such as 'damp dusting' and cleaning down cots. The washing of woollens and ironing was directly related to the care of infants. However, carrying out some of the domestic work, which was not seen as being directly related to either of these fields, was viewed as questionable. There was some debate as to who should be responsible for cleaning windows inside and out, and doing general laundry duties on public holidays or when domestic staff were not available. As a tutor sister, Colleen felt 'they needed domestic training, no doubt about' but that 'sometimes the more important side of training was neglected because they spent too much time doing domestic work'.²⁴⁶ Overall, however, domestic duties were known to be necessary for casing and as Raewyn recalled, at the time general-trained nurses had an element of domestic work in their training too.²⁴⁷

Dunedin, and later Auckland and Wellington, Karitane Hospitals, were slightly different in that they trained Plunket nurses. Plunket trainees were counted on to provide the same baby care as the Karitane trainees, but had only four months in training, much of this spent out in the field and in lectures. They were considered more senior because they were registered nurses but received a considerable amount of their training with the actual babies from Karitane nurses. This did not appear to be a problem. Colleen, when in training as a Plunket nurse, felt the Karitane nurses, 'took us under their wings. I think they thought sometimes we were pretty sort-of green, and we were too really....[They were] a lot more patient and clued up on the babies than I ever was'. She also felt they 'probably enjoyed showing a bit of "I know more

²⁴⁵Lois Davies (trained 1962-63), personal correspondence with Lesley Courtney, 18 June 2001

²⁴⁶Colleen Brown interview

²⁴⁷Raewyn Edwards personal correspondence

of this than you do”, but we didn’t mind.²⁴⁸ Anne backed up this appreciation for the Karitane nurses’ skills and knowledge. She recalled the importance of the senior Karitanes to her training. She was ‘only too glad to listen to them’ otherwise she ‘would have made a hash of it’.²⁴⁹



Dunedin Karitane and Plunket trainees with staff in 1967. Dunedin was the only training school for Plunket nurses for most of the time of hospital training. They helped make up the complement of one nurse to one baby.

Private Collection: Gillian Perkins

Theoretical Training

A tutor sister was on the staff of each hospital, in charge of the theoretical side of the training. Lectures were given to each class in blocks and were at a set time, usually weekly. Attendance was mandatory whether you were on or off duty. On being asked about the theoretical content of the training the interviewees were similarly vague. Most felt it had some importance and that it complemented the practical work done, but there was little recall of the actual content. It was generally perceived to be secondary to hospital work, ‘because there were these babies who needed attending

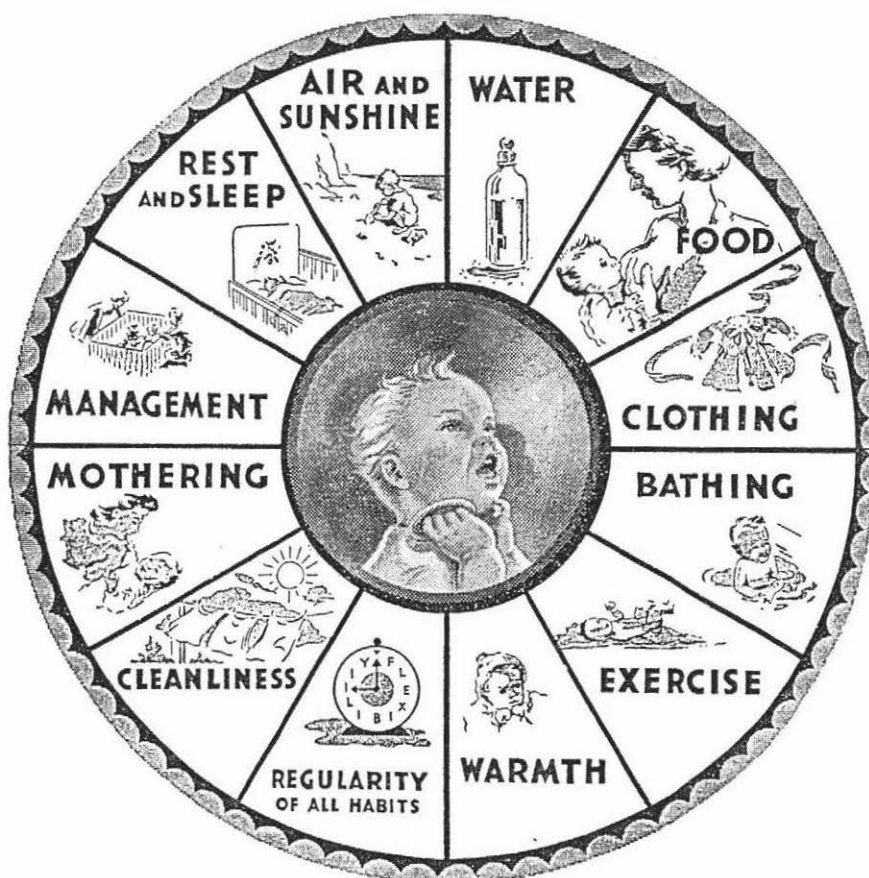
²⁴⁸ Colleen Brown interview

²⁴⁹ Anne Cressey, interview with Lesley Courtney, 16 June 2001. Anne Cressey was the former Anne Kerley who oversaw the completion of the Karitane nurse trainees who were still in training in 1978.

to, so of course...it was the nurses who did all these things. It wasn't the sisters, it wasn't the matron.²⁵⁰ Anne, who was on the staff, felt the girls 'had to have a little bit of theory but only the theory they would put into practice'.²⁵¹

THESE TWELVE ESSENTIALS

form a protective circle
safeguarding the baby



The 'Twelve Essentials' were part of Truby King's philosophy of a healthy baby. They continued to be taught as the ideal care for an infant during the period of this thesis.

RNZPS The Care of Babies and Small Children, 1956

Some found the lectures 'boring'. 'I don't think we took it seriously', Penny recalled, and it was 'not nearly as important as hospital work'.²⁵² Conversely, many of my

²⁵⁰Diane Ferrrel interview

²⁵¹Anne Cressey, interview

²⁵²Penny Ure (trained 1963-64), personal correspondence with Lesley Courtney, 17 July 2001

informants enjoyed the lectures and found them interesting, although they were considered 'not too onerous'²⁵³. Theory was based upon either the Plunket Society book *Mothercraft* or, after 1970, *The New Zealand Child and His Family*. The content of the book, case studies²⁵⁴ and a basic knowledge of anatomy, growth and development, feeding and mothercraft, made up the theoretical instruction.²⁵⁵ The history of the Plunket Society was covered along with a big emphasis on both breast feeding and bottle mixtures.²⁵⁶ Colleen, as tutor sister to both Plunket and Karitane trainees, 'sometimes thought the Karitane nurses had a poor deal' being fitted in around the Plunket nurses and having to have off-duty lectures.²⁵⁷

The trainees sat tests throughout their course and a national oral and written exam at the end of their training. The final written exam seemed to be entirely based on knowledge for casing, suggesting that the curriculum covered this aspect adequately.²⁵⁸ These tests and exams had to be passed, and along with reports on hospital work and the compulsory four months casing, made up the final mark of the trainees.²⁵⁹ The girls could obtain honours if they excelled in all areas. The progress of the trainees was monitored all the way through and in such intimate surroundings little escaped the staff.

Each nurse has a training report card on which reports are made during training. The first thing is consideration for and approach to mothers, babies and young children. Then there is skill, initiative, accuracy, reliability, patience and perseverance, tact and courtesy, conduct, progress with theoretical and practical work, tidiness on duty and care of property.²⁶⁰

The interviewees recalled girls not passing exams but they could resit them.

²⁵³Elizabeth Gardiner interview

²⁵⁴Throughout their training the nurses were assigned babies whose progress had to be followed. These 'case studies' were handed in for assessment. The nurses often became quite attached to their 'case' baby especially if it remained in the hospital for some time.

²⁵⁵'Curriculum for the Training of Karitane Nurses' and interviews. An outline of the theoretical component is included in the appendices.

²⁵⁶'Curriculum for the Training of Karitane Nurses', pp.5-8

²⁵⁷Colleen Brown interview

²⁵⁸RNZSHWC, 'Karitane Nurses Written Examination Questions: July 1967', personal papers of Gillian Perkins, included in the appendices.

²⁵⁹'Curriculum for the Training of Karitane Nurses', p.8

²⁶⁰*Otago Daily Times*, 9 May, 1969

The New Curriculum, 1974

In 1974 the new curriculum was trialled and included six months extra-mural work. There was mention that financial problems made this hard to develop but 'it is obvious that education must be developed independently of the hospital service needs, even though some aspects of the apprentice method of teaching and learning are very valuable'.²⁶¹ This effectively cut down the in-hospital training to 12 months followed by six months 'guided experience in a variety of family and child care situations in the community'.²⁶² The trainees then left fully qualified. With this change came a rise in entry age to 17 and a preference for admission with School Certificate. A study day was built into the week and the new theoretical approach was one of 'ages and stages'. 'The nurse we aim to produce could be described as a kind of "Super-Mum"', enthused *Plunket News* in 1974.²⁶³ During the last six months of the new course trainees were based at the hospitals but were sent out on placements, either daily or live-in, to gain 'theoretical and practical instruction on health, social and educational care of young children. Living out at this stage was possible with parental approval'.²⁶⁴ The Plunket Society was changing its thinking in line with changes in society, and there was recognition that the hospitals were not providing all the experiences that a Karitane nurse might require. The feeling was that 'This new type of training programme really is a big step forward....The Karitane nurses feel more like student nurses and feel that there is continuity and regularity of study which they have not had before'.²⁶⁵

Staff of Karitane Hospitals

Besides the Karitane trainees the hospitals were staffed with a matron and sisters who were all registered nurses, ideally with Plunket training. Most hospitals also employed staff nurses, who were experienced Karitane nurses. While the Karitane nurses performed the bulk of the duties a small number of domestic staff were also

²⁶¹ *Annual Report of Council 1972-73*, p.35

²⁶² 'Karitane Nurse Training Programme', circa 1975, DU:HO, AG-145-27

²⁶³ *Plunket News*, April 1974, Vol.11 No.2, p.3, WA, MS 7/14, Box 1

²⁶⁴ 'Karitane Nurses' Extra-Mural Programme', circa 1975, DU:HO, AG-509-10

²⁶⁵ 'Matron's Reports', Otago Plunket/Karitane Hospital, Jan 1975, DU:HO, AG-145-32

employed.

In the hospital a sister would oversee each ward. Karitane nurses were never left in complete charge except on night duty when the matrons were usually the ones on call. While the amount of 'hands-on' work by the senior staff varied the interviewees felt that there was help when necessary and that the sisters were available at all times. Only the registered staff could carry out certain procedures and they were always present during the doctors' visits. They also did practical demonstrations or taught the skills required of the trainees, both formally and incidentally. Mary recalled they were 'always monitoring what you were doing'.²⁶⁶ The Karitane hospitals were very small in relation to general perceptions of hospitals so the staff were always very close at hand. Jo, a Plunket trainee, remembers this difference. The hierarchy made it a hospital but the atmosphere was friendlier.²⁶⁷ However, the size of Karitane hospitals and the nature of the care did not exclude hospital etiquette. The sisters were recalled as strict, professional, knowing their job and usually approachable. Aside from personal preferences most of my respondents perceived their relationship with them as entirely formal, as was the norm in all hospitals at that time. Many of them were remembered as being single and older, and perhaps this was a factor in later years when the Society found it a problem recruiting paid staff.

Perceptions of the matrons were varied. Inevitably they were seen as the overall administrators of the hospitals and people to be slightly scared of. They were career nurses and single, living on site in their own quarters. They spent a lot of time in their offices, walked the hospital daily and were rarely seen to handle a baby. Very often these matrons had been in their jobs for a long time and they were often perceived to be elderly.²⁶⁸ Liz voiced it for many in saying "I think its fair to say she was 90 in the shade".²⁶⁹ While most of the girls respected their professionalism their views could be influenced by their contact with them. A lot of the matrons' contacts

²⁶⁶A. Mary Bingham (trained 1965-66), interview with Lesley Courtney, 3 May 2001

²⁶⁷Jo Brown, interview with Lesley Courtney, 3 July 2001

²⁶⁸This could be seen to change towards the end of the hospitals when the interviewees mentioned having more than one matron during their training. It was rare for the earlier trainees, of the period studied, to have done so.

²⁶⁹Elizabeth Gardiner interview

with the girls was over off-duty matters. They administered leave passes and dealt with any disciplinary matters. Whether they were good at it or not, part of their job was seen to be surrogate mothers. At the time this was expected of any institution that housed young women. The matrons were responsible to the parents for the girls' overall behaviour and well being, remembering that they could be as young as 16 on entering. For many of the trainees this was their first venture into the wider world and more than one mentioned 'rules were there to be broken'. On another level there was informal contact that some of the girls found slightly unnerving. The tradition of waking the matron in her darkened bedroom with morning tea, followed by an oral report by the night staff, was often met with nervous humour. Recall was also made of matrons occasionally inviting some of the nurses to afternoon tea, and, in Dunedin, dinner at the matron's table was dreaded by some. She would choose people to sit at her table and would show a 'benevolent interest'.²⁷⁰



Sister Barnett (later matron), Miss Bayne (matron) and Sister Monaghan of Wellington Karitane Hospital were typical of the career staff of Karitane hospitals and were remembered by many of my informants.

Private Collection: Gwen Diver

The matrons had to deal with a variety of problems in their role as

²⁷⁰Gillian Perkins interview

administrators - from homesickness, to accidents and ill health, to disobeying the rules. Most of my respondents recalled the matrons dealt with these situations sympathetically and fairly. While calling the doctor out seemed to have been a rare occurrence many of the girls had to go home at some stage for a medical reason or because of the illness of a parent. Leave was generally granted for recuperation or for personal reasons, although only one girl remembered not having to make up the time at the end. Occasionally the whole staff became involved, as when one of my informants attempted suicide. She felt everyone really looked after her when she was moved into the staff wing so an eye could be kept on her. While some of my respondents felt they could approach the matron with a problem others recalled dealing with situations themselves. One remembered being so shy she didn't go to the lounge for about three months and would walk home after morning duty, a distance of five miles, to avoid doing so. She didn't think anyone was aware of the extent of her shyness and it was eventually overcome as she got to know more people. Another interviewee recalled her roommate being extremely homesick and leaving training because of this.²⁷¹ In retrospect, not all situations were felt to be dealt with adequately either. Julia recalled the shortcomings of them being given tin cans with coins in as a warning system when a prowler was seen in the grounds.²⁷² However, later, when a trainee was assaulted in her bedroom at one of the hospitals, it was taken very seriously with a recognition that 'the safety of these Karitane nurse trainees is entrusted to us when they commence their training as they are required to live in, and it is therefore our responsibility to ensure that the Nurses' home is as safe as it can be, especially at night.' Many steps were then taken to improve the security around the home.²⁷³ While some recalled that the rules had to be strictly kept there appeared to be some leeway. Being gated for continually floating the curfew times was not unusual but this only tended to happen after repeated transgressions. A 'slap over the hand' was sufficient for most girls. Supervising young girls can not have been an enviable task for these single, elderly women. A matron of Wellington Karitane Hospital stated, on retiring, that she would not miss 'the worries of supervising young

²⁷¹ *ibid*

²⁷² Julia de Weck interview

²⁷³ 'Matron's Reports', 1975

Karitane nurses impatient of adult guidance'.²⁷⁴

Domestic staff were employed in the hospitals to carry out certain duties, especially cooking and laundry. The numbers were determined by financial constraints on the Plunket Society and records show that the hospitals often had difficulties recruiting and keeping domestic staff. During the 1970s the Wellington Karitane Hospital even employed Karitane nurses in their off duty time at 85 cents an hour. This was seen as preferable by the matron. 'The trainees cooking on the cook's day off was legitimate training but not domestic work in duty time'.²⁷⁵ However, later, trainees were used in the laundry on duty. 'Against my will I am having to use Karitane trainees in there', the matron reported.²⁷⁶ This may have been part of the reason that some of the hospitals used single mothers as live-in help.

Both Dunedin and Wellington were recalled as employing solo mothers. They might come while pregnant and would then stay, with their child, often for a number of years. The trainees at these hospitals remembered that the children lived in the wards. Some recalled that the mothers fed and bathed them on breaks and took them out in the weekends. Looking back they found it a 'strange situation', but perhaps advantageous for both sides. Informants from both the hospitals concerned recalled they were not encouraged to mix with 'the domestics' and that they had little idea where they slept and ate. Generally there was only limited contact but Lani once went to a party with one and remembered being told off.²⁷⁷ As Julie recollected, 'They were always "domestics" and in the chain of things we were above them'.²⁷⁸

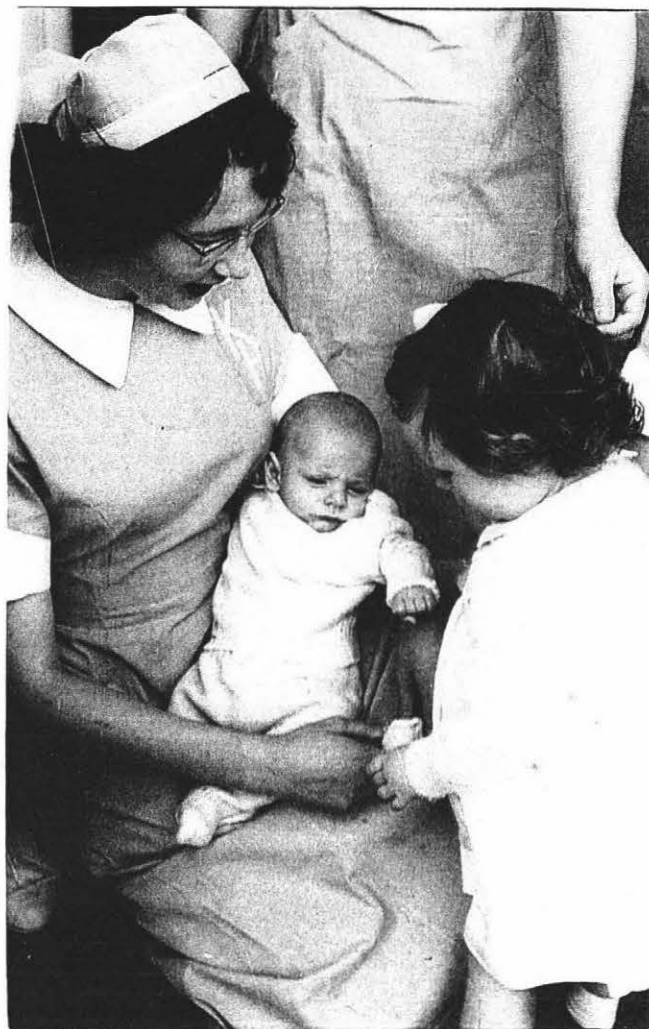
²⁷⁴ *Plunket News*, June 1970, p.11

²⁷⁵ 'Karitane Hospital Minute Book 1959-1974', 6 June 1973

²⁷⁶ 'Karitane Hospital Minute Book 1974-81', Plunket Society Wellington Branch, 19 June 1974, DU:HO, AG-782-2-2

²⁷⁷ Lani Bull interview

²⁷⁸ Julie Mohekey interview



Gwen with children at Wellington Karitane Hospital in 1960. The toddler was the daughter of one of the domestic staff and lived in the hospital. Private Collection: Gwen Diver

Living In

Living in was mandatory whether you lived near by or not.²⁷⁹ Most trainees did not question this at a time when girls who left home usually went into the care of a hostel or private board. Hospitals had long provided nurses' homes, which were very practical as being on site, particularly given shift work. Also, the unpaid training made the provision of free board and keep very necessary. There is no doubt that the nurses considered living in as part of the experience of training as Karitane nurses. Asked

²⁷⁹Unidentified newspaper article, Sept 1974, WA, MS 7/10. Box 2, indicates that the Auckland Karitane Hospital would accept girls living out, 'and for the first time, solo mothers for training'. There is no other evidence either for or against this happening.

about it my informants frequently came up with the word 'fun'. Friendships, support, companionship and growing up were all mentioned.

The nurses' homes of Karitane hospitals catered for about 30 to 50 girls depending on the hospitals' size. The hospitals provided all meals, clean sheets and towels each week and they laundered the trainees' uniforms. The accommodation varied but was fairly standard in providing a furnished bedroom, bathrooms, lounge, television for most of this period, laundry facilities, a kitchenette for the making of hot drinks and a dining room, shared with the staff, for on or off duty. While some girls shared a bedroom, most graduated to a single room or had one all along. Life around the nurses' home was fairly relaxed. The girls had a responsibility to keep their rooms clean and tidy and, as mentioned, it was one of the 'procedures' to be signed off. As Julia recalled there was no privacy. Room checks could involve inspecting cupboards and drawers, but then 'we knew no different'.²⁸⁰ During the 1960s some of my informants remembered that meals had to be attended unless you had permission, but this was later relaxed. Two sittings were provided to allow for duty staff but off duty girls were expected to go to the first sitting. The first sitting required some etiquette however and took almost the full thirty minutes allowed. The most junior nurses served the tables and no one started before the matron. At second sitting the meal took about five to ten minutes in total and was much preferred.

Living on the job with free meals and board was important for the trainees. They could exist on very minimal money. Money was not remembered to be an issue. Most were not used to more than pocket money and they were 'all in the same boat'. 'I wanted to be a Karitane nurse and work with babies and young children....I saw myself as "in training" for a qualification'²⁸¹ and 'there was never a thought that I wouldn't get a job at the end of it'.²⁸² A *Sunday Times* article in 1977 stated the girls in training 'had no complaints' about the lack of pay.²⁸³ While some of the interviewees may have found it harder than others and no one recalled any

²⁸⁰ Julia de Weck interview

²⁸¹ Sue Clement interview

²⁸² Kay Moen (trained 1963-65), interview with Lesley Courtney, 21 June 2001

²⁸³ *Sunday Times*, 17 Apr 1977

extravagant living, one acknowledged that, ‘we all smoked and we all drank!’²⁸⁴ From outside, however, it was perceived to be difficult financially for the trainees. The *Wanganui Herald* of 1971 was of the opinion that it was a sacrifice:

A group of dedicated young women...work long, gruelling hours for no wages at all. The Karitane student nurses sacrifice many of the things their peers consider absolutely essential to modern day life....although board is free, no allowance is made for incidentals²⁸⁵.

Colleen, on the staff in the 1970s, recalled some finding it hard. She felt it was a big commitment and admired their dedication.²⁸⁶ Throughout the years the Plunket Society was of the understanding that it was a hindrance to more girls applying for training.

While the rules were many and varied, being centred around both hospital and off duty work, those remembered were about curfew times.²⁸⁷ The girls were expected to be by 10.45 p.m. each night unless a late leave had been granted. Late leaves were limited and had to be applied for to the matron, with girls having to sign in on return. Much of the returning was based on trust, although some nurses’ homes were locked at certain times and there were surprise room checks. While these curfews caused much controversy, hours to be in by would have been pretty standard for any hostel or private homes at the time. Most of the girls were school leavers who had come straight from boarding school or home and had little experience of a great deal of freedom. Of course this also meant they were testing the boundaries. One recalled, ‘The rules were for our protection and our families concerns....But, we did see rules were made to be broken’.²⁸⁸ Fire escapes and rooms with french doors were utilised for entry when girls were late. One very devious junior soon devised a plan that saw her through her time in training. On night duty the key was entrusted to the night staff to let in the nurses. New keys were cut from this and even sold to seniors! After that ‘it was never a problem to us although we had to be a bit careful’.²⁸⁹

²⁸⁴Diana Bevins interview

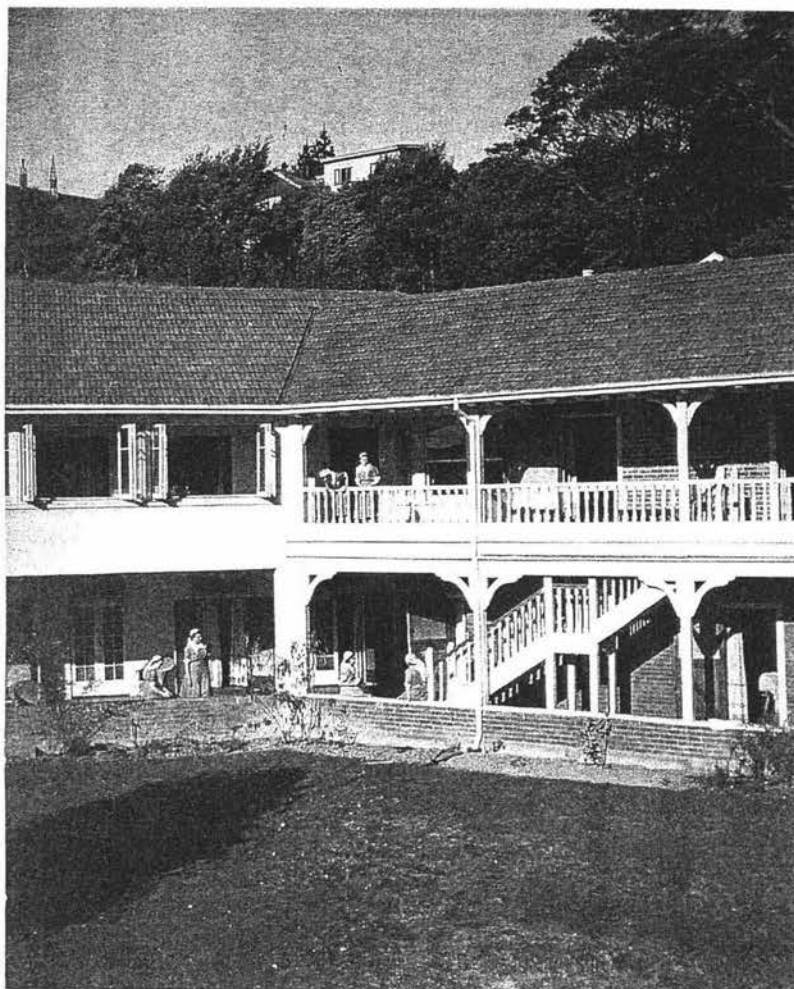
²⁸⁵*Wanganui Herald*, 16 July 1971

²⁸⁶Colleen Brown, interview

²⁸⁷ See a list of rules of the 1960s in the appendices. Personal papers of Gillian Perkins.

²⁸⁸TG (trained 1961-63), personal correspondence with Lesley Courtney, 14 July 2001

²⁸⁹Diane Ferrel interview



The Christchurch Karitane Nurses Home connected the new hospital to the Mothercraft house during this period. With the rooms all opening off the verandah, supervision would have been very difficult.

John Pascoe Collection, WTU, F-440-1/4 PAColl-0783

Many of the rules centred on consideration and respect for others. No excessive noise, no visitors after a certain time and cleaning up after oneself were all expected. It is mentioned that at one stage the home kitchen was locked 'owing to its disgraceful condition'.²⁹⁰ Many of the registered staff also lived in. While they had limited off duty contact with the girls they seemed to have been responsible for obedience to the rules. 'My feeling was it [supervision] was a little haphazard. The matron was in the hospital so I don't know how she supervised us. I think the sisters must have done it along with everything else expected of them.'²⁹¹ This may have

²⁹⁰'Karitane Hospital Minute Book 1959-1974', 5 Mar 1968

²⁹¹Gillian Perkins interview

become more an issue as time went on. Girls were testing the boundaries in more serious ways. One sister felt that the 'role of looking out for the girls was not there enough'²⁹², and in 1976 a matron reported: 'The need for a home supervisor is becoming more urgent, someone to whom the nurses can talk and who would supervise them in the evenings.'²⁹³



Christmas dinner at Wellington Karitane Hospital in 1970. They had a rule that all staff worked a duty on Christmas Day, and everyone attended dinner.

Private Collection: Ivy Mary Gleeson

Social Life

The trainees had one day off a week but got a '48er' off every now and then and sometimes more, by arrangement or good luck.²⁹⁴ There was one fortnight's break midway through the training when most of them went home. Staying away from the nurses home was relatively easy to arrange but most of the 16 months was spent on site. New recruits soon made friends, aside from the soon to be departing seniors, and

²⁹² Colleen Brown interview

²⁹³ 'Matron's Reports', 31 March 1976

²⁹⁴ A '48er' meant 2 days off together, often with a morning duty prior and an afternoon on return.

because of the size of the nurses' homes all the girls knew each other well. There was always someone else off duty to share times with, either by going out or just talking. Because of the shift work and a six-day week friends around the nurses home often took precedence over outside friends. With few recreational facilities provided for off duty hours, the girls made most of their own fun.

Because of the scarcity of money the girls' social life was necessarily limited. When no money was available they would stay around the home or walk around the city. At other times they pooled their money and made do. Coffee lounges, the pictures and sharing fish and chips were all common activities that did not change over the period of this thesis. Some girls had boyfriends, and some went to parties and dances. Generally the girls went out in a group, often with whoever was off duty at the same time. A phone was provided in the nurses' homes and Liz recalled it was not uncommon that 'guys in flats would call up the nurses' home to get girls to come to a party on Saturday night and in those days it was as safe as houses to do that.'²⁹⁵ The phone also provided the means of casual work. Parents from around the cities would ring in the hope of babysitters. The wall of the phone box at the Christchurch Karitane Hospital was remembered as being full of notes of prospective babysitting jobs. When in need the trainees would peruse the wall for the best looking job. Most of the girls who lived in town would take out-of-towners home with them on occasions. Quite a lot of the earlier trainees remembered going to church, not necessarily because they were religious but for the outing. Alison remembered they 'went to every type of church in Wanganui' and were made very welcome. 'It was a known thing that Karitane trainees did this kind of thing.'²⁹⁶

Karitane 'Nurse' Training

Throughout their time in training and, usually, off duty, the trainees were referred to as Nurse _____ by the staff. Much of what Karitane trainees experienced was common to general nurse training, although those student nurses had separate lecture days and a more rigorous academic content. For much of the period of this thesis nursing of all

²⁹⁵Elizabeth Gardiner interview

²⁹⁶Alison Newell personal correspondence

kinds was traditionally apprenticeship training and the Plunket Society in training 'nurses' was no different. Theory complemented the largely practical training. Also, as with all hospital nurse trainings, rising through the ranks was part of the process. Jill recognised that in Karitane nurse training 'the nursing hierarchy was alive and well. You certainly knew your place from prelim. to senior nurse'.²⁹⁷ Nursing in general was geared to the training of young girls who were used to obeying orders and who had few other experiences that may make them question authority.

However, while the hierarchy at the Karitane hospitals was similar it had some inherent difficulties because of the size of the institutions and the length of training. Given the circumstances, it was possible to become seniors in a relatively short period of time, and at a young age. In retrospect some questioned their ability to be in charge of someone their own age, or even older. Gillian recalled being shocked when a junior nurse told her 'you're nothing but a bitch'. Looking back she thought she was probably ill equipped to tell someone what to do.²⁹⁸ The trainees were also living in close quarters, making responsibility over others more difficult for some.

During their training most of the girls felt that they were valued, but the majority were not sure how they knew. Many took it for granted because they knew their importance to the hospitals, and others recalled it depended on the individual staff members. Praise was limited but most interviewees felt that because they knew when they did something wrong there was an assumption that no comment meant everything was all right. Reports came out periodically to tell the individual trainees how they were performing in very general terms, and if there were any worries they were made aware of them. The trainees knew that they were in training and that certain levels of competency had to be reached.

The interviewees remembered being at the bottom of the pecking order in the hospitals, but this was to be expected. Many of them referred to feeling 'part of a team' in fulfilling their duties. They knew they played a vital and important role in

²⁹⁷ Jill Pearce (trained 1972-74), personal correspondence with Lesley Courtney, June 2001

²⁹⁸ Gillian Perkins interview

carrying out the practical work that allowed the hospitals to function. 'We thought we were doing a worthwhile job', it was recalled.²⁹⁹ The smallness of the Karitane hospitals was never meant to impinge on them functioning along rigid hospital lines, but there was a friendliness and knowledge of each other that the trainees, and often the staff, brought to work with them. Juliet was not the only to recall, 'we were almost like one big happy family'.³⁰⁰ On duty the trainees referred to each other as nurses and followed hospital procedures strictly, although the atmosphere could be more relaxed, depending on the sisters, and was particularly so on nights when no paid staff were on duty. Everyone knew their responsibilities and what was expected of them, but generally they helped each other. Apart from the distinction between the very senior and junior nurses no one recalled any conflicts that could not be sorted out, rather it was the support for each other that they most remembered.

Karitane nurse training was viewed as a distinct branch of nursing, and my informants had chosen it as such. There was awareness that it was caring for 'well babies' and 'not straight nursing, not all thermometers and medicine. It wasn't clinical nursing, although once you were in your uniform with your white shoes and stockings and you had your veil on you certainly had a purpose and professional expectation that went with the uniform'.³⁰¹ All the women interviewed felt they were 'nursing' at the time, although they often qualified this as being Karitane nursing. 'We just accepted that we were then a Karitane nurse but I was well aware in no way was I a general nurse, quite different'.³⁰² As tutor sister, Colleen definitely felt she was training nurses. 'We certainly trained them to work in the hospital as nurses. I'd like to think that they were nurses...we trained them with all sorts of hygiene things and we taught them to sterilise and we taught them all sorts of things that nurses do...they were taught to be nurses'.³⁰³ Anne, on the staff and later Director of Nursing for the Plunket Society, definitely saw the trainees as nurses. '[I] would defend that all the time. Some people thought not but some of the public perceived them as higher

²⁹⁹Diana Bevins interview

³⁰⁰Juliet Neale interview

³⁰¹Elizabeth Gardiner interview

³⁰²Heather Lyons interview

³⁰³Colleen Brown interview

trained than Plunket nurses - we just weighed the baby'.³⁰⁴ Jo, in training as a Plunket nurse soon after her general training, recognised the Karitanes as nurses and acknowledged that the 'knowledge they had in their field was excellent'.³⁰⁵ Recognition of their contribution to nursing outside of the Plunket Society was also evident at the time, and Raewyn knew she was a nurse or 'I wouldn't have been able to go into a maternity ward and look after sometimes very fragile babies on my own'.³⁰⁶ However, on reflection some questioned if they had been carrying out nursing duties. Kathy, who trained in the late 1970s, felt a nurse at the time 'but having now worked in a hospital, no. We were the dogsbody',³⁰⁷ and Lani was told in no uncertain terms that she was a Karitane and not a nurse when she went to work in a neo-natal unit.³⁰⁸

Although most of my respondents were aware that their unpaid training was important to the running of the hospitals they were never made to feel that it was secondary to hospital needs. Mary probably voiced it for most when she commented that she certainly 'never felt we were there as non-paid domestic staff'.³⁰⁹ They were training as 'baby nurses' but in retrospect were not sure what that might mean. Casing in the home would often prove to be an entirely different experience than what they were trained for. There was some recognition that it was training for being a mother in the future, and to have the ability to run a home. Colleen looked back on it as a 'wonderful training for motherhood. Nobody else has that....That was a wonderful sort of beginning for them'.³¹⁰ Certainly the set books gave a very traditional view of women and motherhood. As late as 1970 Neil Begg was still expressing the equal but separate roles of women. 'The most important and rewarding tasks a woman can have...is that of wife, homemaker and mother. Any other task is of less importance.'³¹¹ Gillian had an 'ideal of being with children' but questioned the training at the time. She talked with friends already out casing and remembered the

³⁰⁴ Anne Cressey interview

³⁰⁵ Jo Brown interview

³⁰⁶ Raewyn Edwards personal correspondence

³⁰⁷ Kathleen Brereton (trained 1976-78), interview with Lesley Courtney, 1 May 2001

³⁰⁸ Lani Bull interview

³⁰⁹ A. Mary Bingham interview

³¹⁰ Colleen Brown interview

³¹¹ Begg, Neil, *The New Zealand Child and His Family*, Christchurch: RNZPS, 1970, p.21

‘glamorised ideal of the children’s nurse that wasn’t being met by what they said and that was substantiated once I got out there’.³¹² By the late 1970s when the clientele of the hospitals had changed considerably Diane felt, ‘On reflection the focus of the training was quite narrow. You didn’t look at the social issues. I guess it was looking at the babies in the context of the nuclear family’.³¹³ However, at the time, all of the women interviewed felt their training prepared them to look after a baby well, and most left the hospital feeling they ‘knew it all’.

Leaving the Hospitals



Gillian's parents travelled from Nelson to Dunedin for her graduation in 1967. There was a ceremony and then dinner out with the matron.

Private Collection: Gillian Perkins

Overall my informants enjoyed their training, with obvious ups and downs. The quality admired in the ‘best’ trainees was always a love of infants and children, followed by a ‘kind, caring and competent’³¹⁴ manner, ‘qualities that every mother

³¹²Gillian Perkins interview

³¹³Diane Ferrel interview

³¹⁴Christine Farrelley personal correspondence

needs³¹⁵. Not all were observed to have them however. 'There were a few girls that I met at Karitane who did not have that and I often wondered why they were there. Some had come because at that time it was looked on as a prestigious sort of career for a girl to have.'³¹⁶ It was not uncommon for my informants to make such comments. The two most enjoyable aspects of the experience given were the 'hands-on' work with the babies and children and the companionship of the nursing home. Friendships were made there for life. In their hospital work most of my informants felt they were doing something worthwhile, and delighted in seeing the babies grow strong and happy. It was everything Sue anticipated it would be. 'I just loved everything about it. If I had my time again I'd probably do exactly the same thing.'³¹⁷ While many felt the length of time was 'about right' at 16 months, and later 12 months, in the hospitals, others saw it as too long and becoming repetitive. Many of the girls were ready to get out into the world and on with their jobs. 'I know I felt confident looking after babies, after I'd been through it, never having handled a baby in my life,' recalled Heather.³¹⁸ If anything was disliked it mainly centred around the nurse' home. Restricted leave, noise and lack of privacy were all mentioned. However, one of the nurses felt the 'minuses became the positives i.e. learning to live on very little money; valuing others; appreciating your own family more and enjoying what others have to give ; laughing together and seeking to make our own fun and entertainment.'³¹⁹ It was time of growing up and experiencing new things and generally the girls lived life as fully as they wished.

Some of the girls had left before completing their training. The interviewees recollected that a major factor for leaving was pregnancy.³²⁰ This would not be unusual at this time with greater freedom allowing more sexual activity outside of marriage, but with a marked lack of knowledge about, or access to, contraception. Pregnancy did not necessarily mean having to leave. One of the trainees recalled the

³¹⁵Heather Lyons interview

³¹⁶Raewyn Edwards personal correspondence

³¹⁷Susan Ellis interview

³¹⁸Heather Lyons interview

³¹⁹TG personal correspondence

³²⁰This was to be expected as ex-nuptial births doubled in the 1960s and by the 1970s 1:8 babies were born out of wedlock. Information Kedgley, p.267

matron 'really encouraged' a pregnant girl to sit her final exam, but she chose to leave. Other girls were 'just not nursing material'.³²¹ There was only occasional recall of bad behaviour resulting in dismissal, but this may have been a growing problem. In 1977 one of the hospitals had four girls on trial for repeated misbehaviour and two more were asked to leave because they were considered 'unsafe with children'.³²² It was unclear whether the hospital specifically asked many girls to leave. While my respondents remembered few girls leaving it was an issue for the Plunket Society throughout the 1970s at least. The Annual Report of 1970-71 noted the 'disturbing feature' of girls discontinuing training. Forty left that year - 27 by their own choice, 8 for poor health and 5 after being advised to leave. 'Various explanations are easily seen, but it is obvious that no effort can be spared in trying to stop this drain on resources. Mental ill health was more prevalent than previously. In order to develop their sense of responsibility and self-discipline the Karitane nurses have been persuaded to form their own committee and good results are evident.'³²³

Only about a third of the girls leaving the hospital felt they were part of the Plunket Society in some way. Despite pre-entry material mentioning the role of the Plunket Society and some content in the lectures there was little memory of the connection. Many of the trainees also had some contact through participating in street collections for the Society in their uniforms and talking with Plunket nurses. One even presented Miss McKinnon, the first Plunket nurse, with a bouquet at Plunket House in Dunedin on Plunket Founder's Day.³²⁴ However it was common for the trainees to feel separate from the Society itself. Diana felt it was 'out there somewhere. It didn't affect us a lot. I knew they were around. In some ways they seemed liked two separate things'.³²⁵

³²¹ Glenys Nicol personal correspondence

³²² 'Karitane Hospital Minute Book 1974-81', April 1977

³²³ *Annual Report of Council 1970-71*, p.41

³²⁴ Gillian Perkins interview, *New Zealand Home Journal*, August 1967

³²⁵ Diana Bevins interview



A publicity photo of trainees with children for the annual Daffodil Day appeal. Dunedin, 1967.

Private Collection: Gillian Perkins

For all their positive memories and happy times at the nurse' home the girls overwhelmingly left that life behind them once and for all when their time was up. Most never returned to the hospital again. If they did it was mostly much later, for a reunion. Yuen was unusual in that she boarded at the hospital when she was day casing in the city.³²⁶ A graduate address by one of the classes summed up their training from start to finish. 'It was with a mixture of fear, excitement, ignorance and wonder that 10 nurses entered the gates of this Karitane Hospital 16 months ago....It has all been worthwhile and we can never forget or regret our Karitane training....It is something we will always remember.'³²⁷

With their hospital training completed the girls looked forward to at last

³²⁶Yuen Wong (trained 1974-75), interview with Lesley Courtney, 17 June 2001

³²⁷*Plunket News*, July 1974, Vol.11 No.3, p.38, WA, MS 7/14, Box 1

moving into paid employment. Until 1974 the girls were still ostensibly in training for a further four months, when their cases were particularly chosen and the employers had to write reports on the girls' work. But to all intents and purposes the trainees were finished and ready to move on. Many of the girls felt that growing up in a large, caring family in which they were expected to 'lend a hand' had been good preparation for their training. Now they were to put it into practice in private homes as a baby nurse to individual families. Expectations were high and this would be tested against the reality.



The author's graduation class at Christchurch Karitane Hospital in 1973.

Private Collection: Lesley Courtney

6.

'Cheerful, Competent Girls'³²⁸

After qualifying Karitane nurses 'case' in private homes, either giving help and support to the mother with her new baby, or else caring for a family when the mother is away at a maternity hospital or receiving surgical or medical treatment in a general hospital. A few are employed in maternity hospitals or in children's wards.³²⁹

This was the Plunket Society's view of the Karitane nurse's future employment in 1961. Prior to 1974 there was a compulsory four months 'casing' period at the end of the training before the girls were certificated 'Karitane Baby Nurses' and received their badges.³³⁰ This was paid employment, by the individual families concerned, arranged through Plunket's Karitane nurses' bureaux. After 1974, and the change in the curriculum, the trainees did 6 weeks casing during their hospital-based extra-mural component and graduated with certificates in the 'Management of Infants and Young Children' from the hospital. While the wording on the certificate was changed they were deemed to be able to perform much the same job.³³¹

The nurses' value to the mother was intended to be three fold: 'She inspires confidence, imparts valuable baby care knowledge and affords timely practical help'.³³² Initially the aim of this service was to help new mothers care for their babies and to impart prescriptive Plunket mothercraft. The Karitane hospitals had been set up to care for babies under one year of age so the training was good preparation for this. However, by the 1960s families were using Karitane nurses for more general child care, such as the care of all children when the mother was incapacitated or away for some reason, or when both parents went on holiday. This meant that children of all ages could be encountered in homes. The Consultative Committee of 1959 had

³²⁸Report by Neil Begg for the Maternal and Child Care Committee of the American Medical Association, 1968, p.15, DU:HO, AG-7-8-19-2

³²⁹RNZSHWC, *The Plunket Society*, p.11

³³⁰This compulsory casing period before certification began in 1959. *Dominion*, 6 Jan 1961.

³³¹The author's Karitane Nurse certificate of 1973, prior to the new curriculum is in the appendices.

³³²'Duties of Karitane Nurses', included in submission of the NZFH to the Consultative Committee, 1959, DU:HO, AG-7-8-15

proposed that the training widen the focus to include all pre-schoolers. This area was particularly expanded with the change in training in 1974-75, which saw the trainees experiencing much more hands-on care with older children in their six months extra-mural training.

Traditionally, because of its aim to aid new mothers, the service involved short-term help. The Plunket Society actively discouraged cases longer than six weeks.³³³ This was in keeping with the concept of the New Zealand mothers' primary role being at home caring for their own children, and the Consultative Committee had commented that relieving the mother of the care of her children could offend against 'The true principle, that the children...should have the mother's care.'³³⁴ The 'nanny', who lives in or out and works permanently as the primary care giver of a family's children has only become popular with full time working mothers in well-paid jobs. This was not a feature of the 1960s and was only slowly emerging in the 1970s.³³⁵ Therefore the service, as we are looking at it, was for short-term employment with individual families. The average case placement for Karitane nurses was approximately two to four weeks. Sole charge work, without the parents, could be for as little as a weekend or as long as three months for extensive travel overseas.

The average age of the interviewees on leaving hospital training was 18. It was often their first paid job. The girls began their casing period with many future intentions. Just over a half intended casing for some years or had little idea at that stage. Of the rest a half only intended to get certificated and the other half wanted to case long enough to save for travel. In reality the average time for which my informants worked in this capacity was approximately 18 months. This was slightly longer than the average of one year's casing through the bureaux by the 1970s.³³⁶ Some followed their intentions and moved overseas to work or went into public

³³³*Dominion*, 6 Jan 1961

³³⁴*Report of the Consultative Committee*, p.40

³³⁵RNZSHWC, Sub. 74, 'Submissions to Select Committee Inquiring into Discrimination Against Women in New Zealand 1974', NA AANK Acc W3285 Box 3. The Plunket Society discusses the 'changing structure of today's society' and notes the place of the Karitane nurse in providing one-to-one day care in private homes.

³³⁶*Annual Report of Council 1973-74*, p.31, WA, MS 7/1/48. Many nurses moved on to finding their own jobs as will be discussed later.

hospitals as Karitane nurses. Only one interviewee already had other plans to move on. Gillian had applied and been accepted for general training while still at her Karitane hospital.³³⁷ Some girls had intended doing maternity nursing but missed out because the training was being phased out during the 1960s.³³⁸

Linda was not unusual in wanting to enjoy life and travel, and 'saw the job as the means of do both.'³³⁹ Almost half of the girls thought about travelling with the job. It gave them the ability to travel within New Zealand and was also seen as being very marketable overseas. Karitane nurses were known to be well regarded in other countries and employment was not a problem. Vanessa turned 21 in the U.S.A., then nannied in Canada and England.³⁴⁰ The Society used this fact in promotional material.³⁴¹ Comment by the secretary of a 'Karitane Nurses' Bureau' in Australia was that 'we are really glad to have them and they are a credit to their New Zealand training'.³⁴² By 1970 it was noted there was a 'significant decline in the length of time that qualified nurses continue to work through the bureaux, [with] the first goal of many being to travel'.³⁴³ Not all made it overseas, or as far or for as long as intended, but it was an important driving secondary motive for taking the training. Annual Reports of Council and *Plunket News* frequently cite the movement of Karitane nurses overseas.

Overall, most just wanted to enjoy themselves and do a good job, and as long as they did so they would be happy. As young women, my informants ultimately saw themselves as married with children of their own. While for some it was a real desire, like Yuen who supposed, 'all I wanted to do was get married and have kids', most

³³⁷Gillian Perkins interview. She always intended to complete the Karitane training but only cased for six months

³³⁸Burgess, pp.61-62. Maternity training was for eighteen months. When obstetric training was incorporated into general nurse training in 1958 the need for it declined and it has not been offered since 1970.

³³⁹Linda Campbell personal correspondence

³⁴⁰ Vanessa Bloxham personal correspondence

³⁴¹'Karitane Nursing' promotional sheet, circa 1960s, DU:HO, AG-145-27. Many of the interviewees mentioned obtaining or being offered jobs overseas while still in New Zealand.

³⁴²Quoted in *Plunket News*, April 1973, Vol 10, No 2, p.18. New Zealand Karitane nurses were not the only girls casing with them.

³⁴³*Annual Report of Council 1970-71*, p.31

looked forward to it sometime in the future.³⁴⁴

Karitane Nurses Bureaux

Karitane nurses' bureaux were set up by the Plunket Society in Auckland, Wellington, Christchurch and Dunedin and run by 'secretaries'.³⁴⁵ The bureaux were started to obtain and place nurses in cases and were there for support when needed. Secretaries were usually experienced Karitane nurses who had familiarity with the job. They generally made contact with the graduating nurses near the end of their hospital training, often in person, although some never met their particular secretary. Families requiring nurses would contact bureaux and the secretaries would assign cases.

It was particularly the secretaries' role to keep an eye on the girls before certification and assign suitable jobs. Prior to certification the nurses were subject to reports from the parents and these early cases were to allow them to be supervised and to gain experience. The bureau secretaries collated the reports and, along with the nurses' hospital records the Society determined whether they would be certificated.³⁴⁶

Assigning cases to nurses still in training was a perennial problem for the secretaries. Families who were experienced and happy with their Karitanes would often ask the same nurses back privately and did not necessarily use the bureaux. This was substantiated by my respondents who recalled that many of their jobs were to 'first-time' parents. Therefore, there was often less 'experienced' families on the books who had few points of comparison in assessing the nurses' abilities. Bureau secretaries complained that, 'in desperation, people seek the help of the Karitane bureau when the work required, and associated responsibilities are beyond the scope,

³⁴⁴Yuen Wong interview

³⁴⁵Some of the Bureaux stayed in operation for the duration of the hospitals but there was some disarray in the latter years and newly graduating nurses could not always access a bureau for work (Diane Ferrel interview). The Auckland Bureau closed in 1975 (Bryder, *Not Just Weighing Babies*, p89). This would have been when the new curriculum came in and casing was organised within the hospital training. Given the financial problems of running the Karitane hospitals and service this may have been an expense that could be done without.

³⁴⁶While there is ample evidence that girls left training for various reasons it is unknown how many may not have been certificated at this stage.

experience and maturity of the majority of the Karitane nurses [available]'.³⁴⁷ In order to certificate girls and fill cases it did mean that it was not unusual for the nurses to be 'sole charging' prior to certification. That meant that no adult was in residence, although occasionally grandparents would stay or drop into the home to give support.

'Matching up families and nurses'³⁴⁸ was important, and most girls felt this happened. Mary recalled her secretary 'knew a lot about the families. "Yes I think you'd fit in nicely with this family"'. It was almost as if she'd sort out the nurse for the family rather than just names'.³⁴⁹ There were usually more jobs than there were nurses, and often they were given a choice.³⁵⁰ Also, preferences for country or city cases, or cases with parents or in a sole charge capacity were certainly taken into account. Once the nurses were certificated they could take a case or not and have breaks when they chose. The secretaries always tried to ensure that girls took some time off between cases if possible. The relationship was professional but could become friendly. Christine recalled 'we became very good friends and often had coffee together and enjoyed chatting and sharing good times'.³⁵¹

Those girls who had trained on a bursary were required to give more time to the bureaux, beyond the four months, or, after 1974 give three months work.³⁵² The intention was that the bureaux would benefit from their seniority in casing. When bound to the bureaux there was also the premise that Karitanes could be directed to cases that were 'hard to fill', although this was rarely seen to happen. There was no indication from my informants that bursary girls were singled out in any manner when

³⁴⁷ *Annual Report of Council 1968-69*, p.28

³⁴⁸ *Annual Report of Council 1966-67*, p.25, WA, MS 7/1/42, p.33

³⁴⁹ A. Mary Bingham interview

³⁵⁰ *Annual Report of Council 1968-69*, p.28. For example, in 1968-69 only 78% of requests for help were able to be filled.

³⁵¹ Christine Farrelly personal correspondence. Christine cased for eight years, which was unusually long.

³⁵² The Plunket Society bound them to casing for two years in 1959. This was reduced to one year, then six months by the 1970s in a bid to attract more girls. The extra compulsory time was not only 'repayment' for the money but also meant more senior girls remained casing through the Bureau who could be directed to so called 'necessitous cases'. Information on the new curriculum from 'Karitane Nurse Training Programme'

casing, and guidelines to secretaries stated: 'All girls should share this task [necessitous cases] not just a handful of bursars.'³⁵³

Casing

Casing varied for my respondents. Everyone experienced jobs with or without parents, and often preferred one to the other. The commonest first case was with a new baby, and many of my informants could recall it quite vividly. Julia remembered being with 'lovely people, just lovely people', and Sue's was sharing the bedroom with newborn triplets and getting little sleep.³⁵⁴ One mother, who had little idea what to expect, got a new nurse for her first baby. It was a complete success.

She helped me enormously in the art of looking after a baby, and when she left we had the easiest possible baby to care for. She set a high standard for others that were to follow. It was natural when our second baby was born we asked her to come back.³⁵⁵

Casing for a new baby could require the Karitane to start by caring for the siblings when the mother went into the hospital for the birth. Seven to ten days in hospital was the norm for much of this time. When they returned home with the new baby the amount and type of work the Karitane nurse did varied. Sometimes the mother required her to take full charge of the baby or to attend to other children or the house to give her bonding time. The job at hand depended very much upon what the family, usually the mother, desired and every job could be different. The job description that the bureau supplied for parents stipulated that the nurse was available to attend to all the children's needs. This meant any cleaning, cooking and laundry pertaining to the children in their charge. Julie, who loved hands-on contact, felt it was her job to stand back with a new baby.

Our role was actually to care for the baby...but I tended to think, especially if I was there with a new mother, as much as I loved to have the hands-on with the baby, I always used to try and get the mother to know the baby and would do the washing, cooking or cleaning for the family. I didn't mind, played with the other children. I always used to think there was no point in me looking after the baby....I was there to help the mother out but the main thing was to get the mother and the baby used to each other.³⁵⁶

³⁵³'Employment of Karitane Nurses', circa 1960, DU:HO, AG-7-1159

³⁵⁴Julia de Weck and Susan Ellis interviews

³⁵⁵F.A. Davis (employer), personal correspondence with Lesley Courtney, 15 July 2001

³⁵⁶Julie Mohekey interview

This was encouraged by the Plunket Society, with the Director of Nursing stating in 1958:

Karitane nurses are to teach and show the mother how her baby should be handled and let her do things for herself for the child, so that when the nurse's time is up the mother will be self reliant and at home with her new duties...[It is] no help... leaving an inexperienced, nervous mother.³⁵⁷

The other main type of case was sole charge. Being in sole charge was likened to being a surrogate mother and doing all that was entailed of her. Some preferred sole charge because of 'being in control' and the enjoyment of independently running the house. Usually all the children were left in the Karitane nurse's care when the parents were on holiday or with a working father while the mother was absent. It often required additional responsibilities such as caring for pets and farm animals and using the family car to transport the children to school or elsewhere.³⁵⁸ Diana recalled an aquarium that required special attention and Julia had memories of feeding out on a remote farm.³⁵⁹ For some, the isolation of sole charge made it unattractive, as they much preferred the company of others. Even if the job was close to home it meant a lot of time alone, in the evenings or with young children. Heather found the isolation was quite difficult and it was then she realised what women went through on their own.³⁶⁰

Whatever the reason for the case, the work was six days a week and on call 24 hours a day. Breast-feeding could make night duties unnecessary, but some required the nurse to prepare the baby and wait until it was ready to go back to bed. On the other hand Yuen remembered taking night about bottle-feeding with a mother.³⁶¹ If the mother was present the nurse was meant to receive two hours off a day. Hours of work did not surface as a problem to my respondents but it was recalled that there

³⁵⁷Janet Mackay, Director of Nursing Services to the Plunket Society, quoted in Karitane Nurses Club Yearly Report Sept 1957-58, DU:HO, AG-7-2-223

³⁵⁸'Rules for Karitane Nurses, Scope and Duties', circa 1960s, DU:HO, AG-145-27. Leaving a car for Karitane nurses was discouraged by the Bureau but was often essential and frequently done. If it was done the Bureau pointed out that the car must be insured and that the family took full responsibility if there was a problem.

³⁵⁹Diana Bevins and Julia de Weck interviews

³⁶⁰Heather Lyons interview

³⁶¹Yuen Wong interview

were inherent problems. Two hours off in the home was not always easy with young children around and a day off in the country could be impractical. When sole charging no time off could be taken, although some recalled baby sitters being available for longer cases. It was not unusual to spend the entire time of a case without a day off, remembering that the average case was probably two to four weeks. There was no pressure to be working continuously during the day but, there was an obligation to be 'on call'. Time could sometimes drag and Sue remembered the frustrations of having to watch one mother looking after the new baby and the toddler while she had nothing to do.³⁶²

All the interviewees were aware that domestic work was involved in their job and most were quite happy to do it within bounds. Some felt that if it helped the mother they would voluntarily do more than was required and others thought it was part of living as one of the family. One mother recalled,

I understood on engaging a Karitane nurse that their job was to look after the baby only. I was fortunate in that all the nurses I had were more than happy to be one of the family, pick up a tea towel, hang out the family washing, and give a hand when they saw it was needed. I was always conscious that some nurses were badly overused by some employers.³⁶³

It very much depended on the individual nurses and where they saw a need. Kathy felt it was her role to 'use my initiative to help her [the mother] and usually do housework even though I knew it was not my job'.³⁶⁴ The main criteria for deciding whether it was beyond their scope was if the girls felt it was expected rather than done voluntarily. Rose remembered she didn't mind a bit of domestic work to fill in the day.³⁶⁵ Sole charge work automatically required more cleaning than when the mother was around. Although most of the Karitanes had entered the training because of their love of babies they considered their prime role was in being of value to the mother and much domestic work was done with this in mind. The job could mean a number things depending on the best way to help. On first arriving it was usual to sort out what was required and expected. This got easier with more experience. Generally

³⁶²Susan Ellis interview. This woman was foreign and found it difficult to communicate in English.

³⁶³F.A. Davis personal correspondence

³⁶⁴Kathleen Brereton interview

³⁶⁵Rose Arlidge (trained 1970-72), interview with Lesley Courtney, 30 May 2001

the nurse did what the mother wished. As Kay felt, 'It was her home and her decisions and it was her children. I was there to abide by her rules'.³⁶⁶ Diana recalled that 'some would say, "No, you're not here to do housework, you're here solely to look after the children", and so that took the pressure off'³⁶⁷.

Most often my informants wished for cases where they were genuinely needed for their skills and support. This could be for a multitude of reasons. Ruth's 'only preference was for cases where I was needed.'³⁶⁸ This attitude was apparent throughout this whole period from certain of my respondents. There was an awareness that the relatively well to do were mainly the ones who made use of the service, particularly in the earlier part of this period, but this did not necessarily negate their need.

Enjoyment in the job was gained when the mother, if present, and Karitane nurse worked together. The Society stated: 'A close and understanding relationship between the mother and the Karitane nurse is an essential foundation for an efficient service,' and communication was recognised as an extremely important component of the work.³⁶⁹ While some nurses were asked for guidance very often there were a number of children in the family and the mother was quite competent. For some this could be frustrating and one interviewee recalled always being 'told what to do, no one ever looked for guidance or asked for a professional opinion....this was not Karitane nursing as I saw it'.³⁷⁰

My respondents largely had good relationships with the families involved. Being made part of the family and being asked back were signs of a healthy working relationship. The ideal case was mainly perceived as being one in which there was mutual respect and where the nurses were treated as professionals. This was more often than not the norm for my respondents. Generally they recollected their cases

³⁶⁶Kay Moen interview

³⁶⁷Diana Bevins interview

³⁶⁸Ruth Howe (trained 1958-60) personal correspondence with Lesley Courtney, 22 June 2001

³⁶⁹'Rules for Karitane Nurses'

³⁷⁰MR, personal correspondence with Lesley Courtney, 17 July 20 01

with affection. Fathers bringing in cups of tea in the morning, being taken on family visits and holidays, enjoying a drink and a leisurely meal in the evening when the children were in bed, were all remembered. One nurse recalled being taken away on holiday with a family and on her day off a babysitter looked after the children while she went fishing with the parents. However, it was not unknown for a nurse to be treated with less consideration. Gwen recalled having to sit in the kitchen in the evenings and Lani ate with one family but 'knew her place'. When they put on a garden party she was in the kitchen doing dishes.³⁷¹ But, these were the exceptions. 'Good' cases could be on a professional level or become very friendly. Almost all of my respondents maintained personal contact with at least one of their families for some time. Many made lifelong friends and are still in touch today. It was not uncommon to be made godmothers of subsequent babies and some have attended weddings of former charges.



The author first went to this family to look after Michael and then the baby Bridget when she returned home after her birth. Lesley returned frequently in a work capacity. A close personal relationship was maintained long after Lesley gave up Karitane nursing.

Private Collection: Lesley Courtney

³⁷¹Gwen Diver and Lani Bull interviews

Most employers went out of their way to welcome the nurses into their homes as one of the family. While some literature of earlier times would suggest that the Karitane nurse was a 'status symbol', by the 1960s the job was generally relaxed and collegial between the mother and the nurse.³⁷² The uniform was supposedly worn in the home and it was clearly spelt out that 'When on duty...a Karitane nurse must wear her uniform, including her cap'.³⁷³ However, in reality this was not always adhered to, particularly through the 1970s. More often the uniform, minus cap, was worn with new babies or on first starting casing but was frequently abandoned with the mother's blessing.



Gwen always wore her uniform when casing in the early 1960s. Her first case was for premature twins.

Private Collection: Gwen Diver

³⁷²Cox, p.89

³⁷³'Conditions of Entry for Karitane Training', personal papers of Gillian Perkins

With such long hours and being sent to cases that could be a long way away my informants recognised that they sacrificed some of their social life. Keeping up relationships with boys or friends was not easy, even if they were in the same town. But the perception was that that came with the territory. They could make up for it with breaks between cases and if they enjoyed the family it was not an issue. The bureaux would also consider preferences for staying in a certain area. Some girls recalled meeting up with other nurses and their charges during the day, and the parents happily accepted this.

There was a great deal of trust placed in these young women by virtue of their title 'Karitane nurse'. Usually when casing nurses were arriving unknown to a family and given great responsibility for children of all ages. As Rose said, they 'just assumed you were a very trustworthy person'.³⁷⁴ Sole charge work exhibited the epitome of trust. It was not uncommon for parents to leave for holidays very soon after the nurse arrived, sometimes before she had even met all the children. Cash and, often, cars were left to use with no knowledge of the girls' abilities to use them wisely. The assumption was that the Karitane nurses' bureaux would supply nurses who were capable of the responsibilities they were given. On reflection many of my informants commented that they could not do the same with their children now, although at the time they all felt confident to do the job. Likewise, the Karitanes would arrive to case at unknown homes with complete trust. Frequently these jobs could be in very isolated settings with no knowledge of the area. Sue remembered once catching the train at midnight to be picked up by the husband very early in the morning in the unknown city of Wellington.³⁷⁵ It is only from a 1990s standpoint that my respondents reflected that casing could be an unsafe practice in terms of childcare and personal safety. Society today is very aware of potential dangers to children and young women and, perhaps, better informed on the psychology of child rearing. We might doubt whether parents or young women alike would place themselves in some of these positions.

³⁷⁴Rose Arlidge interview

³⁷⁵Susan Ellis interview

After casing for some time the main qualities perceived to be of use to the Karitane nurse besides childcare, revolved around living in a family. People skills, diplomacy, commonsense, tolerance, sensitivity, adaptability and being good communicators were all mentioned as essential attributes. Alongside this stood practicality. One mother and some of the girls felt that a sense of humour was also important in helping to fit into the family. Many of these qualities would appear to have been inherent in the girls who took this course. There was no specific teaching of them. Most girls recollected they learnt as they went along and each case was different. There is no doubt that casing did become easier as the girls progressed. Just as they had learnt on the job in their hospital training, so too did they in the casing situation.

The pay was never regarded as a lot, however, being out in the world training unpaid for 16-18 months meant that some recalled they felt quite rich.³⁷⁶ As Juliet remembered they were 'not paid and then suddenly paid...we were filthy rich'.³⁷⁷ About half recalled feeling it was low, particularly given the hours worked because 'like a mother you were never off duty'.³⁷⁸ But, others felt it was adequate as food and board made expenses minimal. Raewyn was realistic. 'No it was not adequate, but childcare of any sort is still notoriously badly paid'.³⁷⁹ It was not uncommon for the parents to give a bonus, however, if they were pleased and appreciative. Alison remembered once being told:

to "look after my most precious and treasured possessions", but on being presented with the account on their return a huge moan was given about how expensive us girls were. My reply was, "I'm sure you're paying your secretary four times this amount to keep your office running and I who was looking after your most treasured possessions feel you're being let off rather lightly". He just looked at me for what seemed like ages, then apologised, agreed with me and gave me a hundred dollars bonus, and I was asked back again.³⁸⁰

The Plunket Society set the rates, being mindful that 'a balance must be struck

³⁷⁶In this time period the pay started at seven pounds per week in 1959, \$14 a week in 1966, \$24 a week in 1974 and \$29 a week in 1975. This was for a six-day week with more for each additional child and sole charge. It was divided down to the half day if necessary.

³⁷⁷Juliet Neale interview

³⁷⁸Jill Pearce personal correspondence

³⁷⁹Raewyn Edwards personal correspondence

³⁸⁰Alison Newell interview

between ensuring the nurse receives fair regard for work - without at the same time pricing her off the market'.³⁸¹ They also commented: 'In spite of some criticism of wages paid...we note that a great many are able to travel overseas less than a year after qualifying'.³⁸² Overall, Karitane nurse wages, given that they received free board and food, were comparable to other young women in 'service' industries and those working on their 'own account'. Women at this time were still largely employed in gendered occupations and were over-represented in the caring and service industries. As such, women were traditionally lower paid than men were.³⁸³ It may be that in today's light the women are more aware of the anomaly.

Overall, my respondents derived a great deal of personal satisfaction from doing the job. It could be challenging, and provide new and interesting experiences to be faced. Smiles, recommendations, being asked back, bonuses and presents were tangible expressions that reinforced satisfaction in a job well done. However, while they felt there was importance in the job, on reflection, many questioned it in reality. Neil Begg, seemingly a champion of Karitane nurses on more than one occasion commented, 'I wonder if we realise in New Zealand what a task of national importance is done by the Karitane nurse - both in the hospital and the home'.³⁸⁴ But, for many of the nurses there was a feeling that it could be an undervalued service and that the knowledge they had gained in their hospital training was not always put to good use. Some felt that 'child minding wasn't challenging in the home environment' and could just become babysitting or 'glorified housekeeping'.³⁸⁵ Its importance to the nurses hinged around the perceived neediness of the parents and if they could 'support, reassure and advise' parents.³⁸⁶ The hospital training, which had been centred on a 'nursing' concept, was not evident in the casing

³⁸¹ *Annual Report of Council 1972-73*, p.30

³⁸² *Annual Report of Council 1970-71*, p.31

³⁸³ The census for the years of this thesis repeatedly comment that women's incomes were lower in all occupation groups than men. Karitane nurse pay would fit with the lower-average rate of the most common bracket being \$1,000-\$1,399 (1966) and \$3,000-3,999 (1976). For example in 1974 a Karitane nurse beginning casing could earn a minimum \$1,200 per year (4 weeks unpaid holiday) with free board and food. At this time 68% of females under 20 were earning less than \$3,000.

Information from *Census*, Vol.5 1966, 1976

³⁸⁴ Quoted in *Otago Daily Times*, 16 May 1963

³⁸⁵ Penny Ure personal correspondence

³⁸⁶ NB, personal correspondence with Lesley Courtney, 1 July 2001

situation. Overwhelmingly my informants felt they were no longer ‘nurses’ in the homes. There was a perception that nursing revolved around sickness and institutions and a recognition that this was rare in the work the trained Karitane nurses did. One mother ‘felt that the English word “nanny” was more appropriate as it had warmer connotations than the more clinical word “nurse”’.³⁸⁷ In retrospect, the most common word used by my respondents to describe the work was nanny, although some mentioned the domestic element gave the job housekeeping connotations. Liz summed it up as a ‘total care package for the children and the whole family...if the mother wasn’t there you were providing the total care’, and Diane thought ‘we were mothers really’.³⁸⁸ ‘I don’t know think that there’s a word that could simplify it,’ Julie recalled.³⁸⁹ Another mother felt that the ‘role went far beyond the general nursing and domestic help’.³⁹⁰ Despite this there was no thought that their title should change while they cased. They had trained as nurses even if they were not using all those skills in the home.

The girls generally felt adequately trained for the child care aspect of casing. It was living in someone else’s home and the domestic side that many felt unprepared for. Ruth recalled that ‘more interpersonal relationship skills’³⁹¹ were needed but, there was also some thought that perhaps it was ‘not something you could train for’.³⁹² Alison, who trained early in the 1960s, recalled ‘We never even had a Karitane nurse come and talk to us during our training. I felt this would have been good. It would have given the new graduates an idea of what they were getting into’.³⁹³ This was not true of the whole period. In the 1970s the bureau secretary’s job included ‘giving a lecture on the duties of a Karitane nurse to each class in training’.³⁹⁴ Some girls felt they lacked skills in the general running of a home and in preparing family meals, both of which were undertaken as part of the job on occasions. ‘You learnt as

³⁸⁷F.A. Davis personal correspondence

³⁸⁸Elizabeth Gardiner and Diane Ferrel interviews

³⁸⁹Julie Mohekey interview

³⁹⁰Charmaine Foster (employer 1976-1986), personal correspondence with Lesley Courtney, 29 May 2001

³⁹¹Ruth Howe personal correspondence

³⁹²Rose Arlidge interview

³⁹³Alison Newell interview

³⁹⁴‘Karitane Nursing 1963-77’, DU:HO AG-145-27

you went. Commonsense to a large degree,' it was felt.³⁹⁵ There was definite recognition that it was a great training for hospital work but that casing was different and not fully explored in the training. 'I was not trained at all for this. I was trained as a nurse for a Karitane hospital', it was recalled³⁹⁶. Diane, under the new curriculum, felt prepared but only because of her extra-mural training. 'It would have been a shock for my system to go from a hospital environment to a home environment'. Even then she didn't think she was prepared for living in, although it would seem that the Plunket Society was moving in the right direction.³⁹⁷ Even though the 'personal dynamics' of living in someone else's home were not specifically studied under the new curriculum they were experienced within a much more controlled working environment - one in which the girls still came together to study, question and learn after experiencing different elements of the work outside of the hospital.

Problems Faced in Casing

Working individually in a relatively uncontrolled environment meant problems could arise. Some of the nurses felt pressure, prior to certification, to conform to the families' expectations beyond the scope of the job. This may have been more self-motivated than actual but it did mean that girls put up with some misuse of their skills at this stage more readily than they did with more experience. Only limited supervision and guidance could be given in the individual homes and this was acknowledged by the Society. A Plunket letter to the Consultative Committee confirms that 'During her hospital life the Karitane's work is under strict and constant supervision. This is not possible when she is doing her domiciliary work'.³⁹⁸ While most families were thoughtful and welcoming the bureau secretaries were on call to the Karitanes and families if a problem arose. However, on first starting casing the Karitane nurses were young and sometimes lacked the confidence to complain except for the most serious reasons. They were very aware that in their trial period they could get a bad report. Heather recalled when she cased in the early 1960s she did

³⁹⁵Lois Davies personal correspondence

³⁹⁶MR personal correspondence

³⁹⁷Diane Ferrel interview

³⁹⁸Letter to the Consultative Committee from the Plunket Society re request for information on Karitane training, 28 Sept 1959, p.1, DU:HO, AG-7-1-8-15

everything to 'get a good name as a Karitane nurse'. She felt part of this was because of the 'then concept of women being there to please and make people happy'.³⁹⁹ For some girls their early experiences of casing meant that they left the job altogether. Joan had some 'lovely cases' during her four months but also two where she felt used. Both involved money. When there was insufficient food in the house she was not reimbursed for spending her own money and another time her whole cheque was cancelled for burning a bench. She never complained to her bureau.⁴⁰⁰ Likewise, Lani came to an early realisation that 'this is a mug's game'. She thought she might get a bad report and not get her badge if she refused to clean the swimming pool. The bureau was supportive when she finally rang. She was told she could leave but she stuck it out, aware that being in the country meant she would require some transport to get to a bus.⁴⁰¹ The bureaux possibly had more insight into the families than the girls imagined at the time. It was noted that the bureau secretaries 'have the difficult task of keeping before employers the needs of the nurse as a person - in times of crisis it can be overlooked'.⁴⁰² Raewyn had a bad situation and a 'nasty report' written about her but the bureau was very understanding and it was never put on her record. On reflection she wondered if the secretary had had dealings with the family before.⁴⁰³ For new nurses, being used to perform duties that were seemingly unrelated to their skills could go unchallenged but this is not to say they went unnoticed.

The biggest perceived or actual problem area in casing revolved around relationships with the parents. The girls felt confident in their ability in childcare but living in meant the job hinged very much upon personal dynamics. Isolation in the home could lead to exploitation. Thirteen per cent of my informants personally experienced sexual harassment and many others knew of friends who did. In two of the cases husbands actually got into bed with the girls. While all the men could be repelled, some of the Karitanes put up with prolonged unwanted advances, often to protect the mother. The bureaux were very supportive but could only be informed

³⁹⁹Heather Lyons interview

⁴⁰⁰Joan Smith interview

⁴⁰¹Lani Bull interview

⁴⁰²*Annual Report of Council 1972-73*, p.30

⁴⁰³Raewyn Edwards personal correspondence

after the fact, if this was done at all. This issue was never discussed prior to the nurses going out casing. In the 1960s, particularly, this would not have been unusual, when sexual education of any sort was very limited and rarely discussed. Juliet recalled telling her future husband at the time and him saying, ‘ “Don’t be so silly, you’re making it up.” People didn’t really know about those things in those days and I thought perhaps it was all up here [indicated her head]. Think I just wanted to leave. Didn’t say anything. You didn’t, just didn’t. It’s horrible now when I think about it.’⁴⁰⁴ While the girls felt uncomfortable there was an acceptance that this could happen and action was never taken against the men. In one situation the bureau blacklisted a family but informed the nurse the family would just be told no one was available. This may be because the service’s priority was the family. While always sympathetic in these cases if told, Plunket was not about endangering the family unit.

The other area of difficulty revolved around not getting on with the mother for some reason. This could lead to very uncomfortable working conditions. It could be because of personality clashes or differences in expectations of the job. Miss Fannin, secretary of the Auckland Bureau was quoted as saying: ‘Probably any Karitane’s greatest cause of unhappiness springs from the rather selfish attitude of some parents, who expect her to act as chief cook and bottle-washer for the entire family while she’s with them’.⁴⁰⁵ Dissatisfaction was felt when the Karitane nurses thought that childcare was not the primary motive for them being there. Gillian felt ‘some really only wanted you there for the children and others had deeper plans about housework and such.’⁴⁰⁶ Two of my informants described independently going to the same home and they both complained about the expectation of cleaning duties. One was told this was the third complaint and that this family would be taken off the books.⁴⁰⁷ Susan remembered that when a mother presented her with a basket of ironing, largely men’s shirts, ‘that’s the day I grew up. I said “No. I’ll do the children’s first and if I’ve got time I’ll do his.” I remember it as clear as anything. I was scared stiff she’d kick me out’. They

⁴⁰⁴ Juliet Neale interview

⁴⁰⁵ Bryder, *Not Just Weighing Babies*, p.86. Miss Fannin was an ex-Karitane and Bureau Secretary from 1946-62.

⁴⁰⁶ Gillian Perkins interview

⁴⁰⁷ Julia de Weck and Gillian Perkins interviews

actually went on to become life long friends.⁴⁰⁸ Problems of this nature could surface when sole charging too. Alison recalled that 'it was not unknown for the cleaner to be told not to come when you were there. One presumes it was thought you were going to take the place of the cleaner and they would also save a bit of money as well'.⁴⁰⁹

Largely there was disdain if the nurse felt she was employed purely for social reasons, as a built-in babysitter. One mother appeared to have a continuous supply of Karitane nurses and would be out socially all day and well into the evening with no contact available. Here Elaine felt a 'general skivvy' and left.⁴¹⁰ The Plunket Society was aware of other cases like this and looked into the situation.

It is sometimes alleged that Karitane nurses are employed mainly to enable mothers to fulfil unimportant social engagements A survey of the positions arranged through Christchurch and Dunedin Bureaux in three months...showed that 16% and 10% respectively might be classed as "unimportant entertainment".⁴¹¹

This amount was significant enough that most of the nurses would have probably experienced a case of this sort. These would be the types of cases that fuelled submissions to the Consultative Committee suggesting Karitane nurse training should be disbanded, arguing that a home aid could do the same job.

The mother was usually the only one who prevented the girls either doing the job they thought they should or the way they felt they should do it. There was general agreement that Karitanes would do what the mother wanted if at all possible. Most just weathered any difficulties and waited for the job to end. One graduation address talked of the matter, saying:

It might well be that they would feel unfairly exploited. If this was so they owed it to future Karitane nurses going into that home to make a proper protest....[But] a nice balance must be maintained with goodwill....Was a nurse to do the baby's woollie wash and leave out dad's socks, make a pudding for the children and not the adults? A nurse could not put home work into watertight compartments⁴¹².

⁴⁰⁸ Susan Hardy interview

⁴⁰⁹ Alison Newell personal correspondence

⁴¹⁰ Elaine Harvey (trained 1965-66), interview with Lesley Courtney, 8 May 2001

⁴¹¹ *Annual Report of Council 1968-69*, p.28

⁴¹² *Dominion* 24 March 1962. Graduation address by Mrs Riddiford.

Alison recalled that

often the parent had definite ideas and as they were your employer at the time you did what they wanted unless it didn't sit well with you. [Then] you had two options. You either say you disagreed and say why, which rarely worked, so usually you left the job. Most times you knew that any advice you gave would be ignored anyway so you were better out of there.⁴¹³

Perhaps information could be ambiguous to the parents though. While not all employers would have read it, *The New Zealand Child and his Family* states: 'These nurses...are usually cheerful and competent girls pleased to help you with your baby and all the things which have to be done in the home.'⁴¹⁴ Likewise, a Mother's Club was told, 'The aim is the nurse should look after the baby while the mother is getting stronger, but by the time the nurse is due to leave, she may take over the household chores'.⁴¹⁵ These statements are open to interpretation and the potential was there for misunderstandings.

The Society was mindful of the potential problems.

[Bureau secretaries] do try to vet the houses into which the girls are going. The girls may appeal to the bureau secretary if conditions are not all as they should be. The Council has tried in general to see that the younger and less experienced nurses do not have sole charge positions....that there should be a chaperon in the house and that the Council was very concerned over this matter. She also felt that sometimes too much was expected of a Karitane nurse.⁴¹⁶

However, the very nature of casing meant that situations could arise, even if the nurses were aware. There was no system in place to discuss or to seek changes, with no union or association for Karitane nurses. This was traditionally characteristic of jobs involving private homes as work places, such as domestic service. It is to be supposed that the Plunket Society could have been approached directly if the Karitanes had banded together but, when casing, the nurses were largely young, inexperienced and often isolated from each other. Recall is made of a Karitane Club in Auckland which aimed 'to keep up with "modern trends", providing nurses with a

⁴¹³ Alison Newell personal correspondence

⁴¹⁴ Begg, *The NZ Child and His Family*, p.39. This was the official Plunket Society book on child rearing as from 1970

⁴¹⁵ *Plunket News* Aug 1966, Vol.5 No.4, p.7, DU:HO, AG-7-8-13

⁴¹⁶ *ibid*, p.30

common meeting ground and a chance to keep in touch with one another'.⁴¹⁷ This could have been exploited for more political or pressure group activities if necessary, but it would appear that many of the members were not practising Karitane nurses and the group was largely social. The transitory and isolated nature of the job, combined with the short time the girls remained in casing, meant there was probably limited interest in seeking change. Most problems stemmed because of varying perceptions of the service. The Plunket Society acknowledged that 'They [Karitane nurses] are anxious to help the families who most need it. All that is required is some way in which the government can assist the families to receive the assistance we proffer.'⁴¹⁸

Government Support

In the mid 1970s the face of casing changed somewhat with a recognition of society's transition. Having the Karitane nurse service reach necessitous families had been desired by some of the girls and the Plunket Society, but the difficulty was that each family had to pay for the service. With the best of intentions the Plunket Society was limited in being able to help individual families in this way, although in 1974 they had set up a pilot scheme in the community. Two Karitane nurses worked under Plunket nurses in an area of Auckland. This provided 'practical assistance and instruction' on a daily basis where a need was apparent.⁴¹⁹ One Plunket nurse, who recalled this service in its early days, felt 'who better to do that than a Karitane nurse....Plunket was the front room nurse and the Karitane nurse knew everything that went on in every other room'. She saw that this job played a much more educational role.⁴²⁰ The new curriculum was seen as more appropriate training to meet these needs, with the Society stating that the training 'better prepared [Karitanes] to accept a more responsible community role in the family health care plan'.⁴²¹

However, the real breakthrough came in 1975 when the Social Welfare

⁴¹⁷*Plunket News*, July 1974, Vol.11 No.3, p.38

⁴¹⁸Unidentified newspaper article, circa 1975, WA, MS 7/10, Box 2

⁴¹⁹*Annual Report of Council 1973-74*, p.33

⁴²⁰Colleen Brown interview

⁴²¹*Annual Report of Council 1974-75*, p.30, WA MS 7/1/50

Department recognised a need and the skills of Karitane nurses in reaching their clients. They decided to fund necessitous families, particularly those who experienced multiple births and had other pre schoolers.⁴²² Respite care for parents of disabled children also became a right and the Accident Compensation Corporation would fund Karitane nurses if a need arose. The Consultative Committee had proposed an extension of the service to give free care to necessitous cases and at last it had happened. Between them, Social Welfare and ACC provided a lot of work from the mid 1970s on and the bureaux dealt increasingly with these cases. In 1977 the *Otago Daily Times* noted the difference:

Labelled as “nannies to the rich” by critics, Karitane nurses have obviously been used in times past as superior baby sitters. But, the Karitane’s role has also changed. Perhaps the most significant change is government recognition of the benefit of Karitane help to see families through a crisis. Karitane wages are now paid, in certain cases by Social Welfare or the ACC to help keep a family together and cope with special strains.⁴²³

The public perception of the job was in need of an update. In 1978 the Dunedin Bureau secretary stated:

I’m sure that most of the public do not understand or actually know what sort of work these nurses do in the under privileged and social welfare cases and would be surprised to learn of it. The understanding and knowledge that these girls have for their work is tremendous and I feel they are doing a great service for the community.

This type of casing was also likened to ‘more of a social worker’s role’.⁴²⁴ On further commenting about private cases, the secretary said, ‘It is welcoming to the nurses to have... nice relaxing case[s] like these.’⁴²⁵ Diane, who trained under the new curriculum, spent a very fulfilling first case with twins funded by Social Welfare and then lived in for working parents for a year. While she very much enjoyed this family

⁴²²*Annual Report of Council 1975-76*, p.6, WA MS 7/1/50. There were occasions prior to this that Karitane nurses were funded in very needy situations. The Plunket Society approached the Secretary of Labour to help a family in 1964, aware that ‘we have in the past engaged a Karitane as a home aid at Karitane wages’. The reply stated that the ‘nurse’s wages will be met by the Department as if she were a Home Aid’. Letter from Plunket to Secretary of Labour 10 Sept 1964, Letter from Secretary of Labour to Plunket Society 21 Sept 1964, ‘Home Aid Service Training’, NA, L1 32/1/10 . In 1970 the Social Security Department paid a Karitane for six months to help with new triplets when there were 2 other pre-schoolers. *Plunket News*, Aug 1970, Vol.7 No.4, DU:HO, AG-7-8-15

⁴²³*Otago Daily Times* 13 Oct 1977, p.14

⁴²⁴‘Karitane Nurses’ Bureau Monthly Reports for Branch Meetings 1975-79, Oct 1978, DU:HO, AG-509-10,

⁴²⁵*ibid*, April 1978,

and the life style they provided she realised that she 'much preferred going into the homes where the people were struggling....My training didn't prepare me for this wealthy type work....I guess I didn't want to partake in that.'⁴²⁶ Day casing also became more popular with increasing wages and lack of space in, particularly, the funded homes.⁴²⁷

For my informants casing could be exactly what they desired or better than expected, or it could be disillusioning. It was obviously not unusual to talk to friends already out in the field when they were still hospital training and have some preconceptions. Gillian was one who had initially thought casing would not be for her. She was pleasantly surprised, 'but not enough to convince me I'd stay'.⁴²⁸ Another recalled that 'unfortunately it was all I thought it would be', and only cased the required time for certification.⁴²⁹

Beyond the Bureaux

To all intents and purposes the girls were self-employed. They were always paid directly by the families and paid their own tax monthly. While casing through the bureaux was compulsory to the training, after certification other opportunities did exist and the nurses did not have to use the bureau service. In fact if they continued casing for any length of time it was rare for them to do so and it was recognised that nurses found 'free-lancing' desirable.⁴³⁰ It is noticeable in the Plunket annual reports that the new nurses out of training were only just replacing the ones leaving, if that.⁴³¹ Many Karitanes built up their own clientele and would make their own bookings. Frequently they returned to the same families, and certainly to relations and friends. It is very obvious, for the nurses and families alike, that personal recommendation meant a lot. It was also a lot easier for both sides when the nurse returned to a family. It was taken as a sign that they had enjoyed each other and the job, and certainly required no

⁴²⁶Diane Ferrel interview

⁴²⁷*Annual Report of Council 1974-75*, p.23

⁴²⁸Gillian Perkins interview

⁴²⁹MR personal correspondence

⁴³⁰'Employment of Karitane Nurses'

⁴³¹*Annual Report of Council 1970-71*, p.30. For example, in 1970 131 girls joined the bureau during the year from training, but they only had 104 nurses on the books in total.

‘settling-in’ time. One mother re-employed the same nurses twice, ‘because we had absolute confidence in them, they fitted into our way of life and we and the children grew very fond of them’.⁴³² Both times she had to change nurses because they went overseas.

There were other opportunities outside of casing too. There were some openings in hospitals, and a recognition that Karitane nurses could play a part in the public health system. Karitane hospitals usually employed at least one ‘staff nurse’, some private maternity hospitals almost entirely staffed their nurseries with Karitane nurses, and there were openings in children’s wards, maternity wards and neo-natal units of public hospitals. In the early 1970s it was noted: ‘Some nurses describe their casing as “marvellous”[while] others find it difficult to adapt to the idiosyncrasies of a variety of homes in rapid succession, and turn for employment to hospitals.’⁴³³ By then the bureau secretaries noted a ‘general preference for institutional positions’.⁴³⁴ Many girls had loved the hospital training and aspired to get a job in one and it was also seen as another avenue to explore as a Karitane nurse. Many preferred it. As one recalled, ‘I felt more satisfied and content in a hospital environment’.⁴³⁵ In all, 54% of those interviewed worked in a hospital of some sort as a Karitane nurse. Of those, 60% worked in maternity wards.

For much of the 1960s and 1970s women stayed in hospital for up to ten days after the birth of a child, and many did not room in. This meant that the nursery was full of babies to be cared for, often only being taken to mothers for feeding. Kedgley cites a trial, in 1963, of encouraging women to leave hospital at four to five days after giving birth. She notes that most women were reluctant to do so.⁴³⁶ Calvary Hospital in Christchurch was one hospital whose maternity ward was entirely staffed by Karitane nurses. The Karitane badge and uniform were worn to distinguish them and they also played a role in imparting mothercraft. Any general nurses employed were

⁴³²F. A. Davis personal correspondence

⁴³³*Annual Report of Council 1970-71*, p.31

⁴³⁴*Annual Report of Council 1971-72*, p.33

⁴³⁵SL (trained 1960s), personal correspondence with Lesley Courtney, 6 June 2001

⁴³⁶Kedgley, p.195

used for medical purposes and birthing. Karitane nurses were not as noticeable in public hospital nurseries. Some smaller centres employed them but generally they encouraged rooming in much earlier than the private hospitals and so the nurseries were not as dependent on baby care. In public hospitals the Karitane nurses were most likely to be seen in the neo-natal units which had sprung up from the 1950s onwards. Here premature and ill new-borns were given full time nursing care. Karitane nurses, who had spend much of their training with premature babies, especially in the 1960s, were ideally placed to administer this type of basic baby care. They were also employed in public children's wards. They would be in charge of the under twos who had been medically admitted for some reason. While the registered staff were deemed to have superior skills, Susan felt 'we were all one', each having a defined role to play.⁴³⁷



Ivy Mary returned to Wellington Karitane Hospital as a Staff Nurse. She worked in every area of the hospital.

Private Collection: Ivy Mary Gleeson

⁴³⁷Susan Hardy interview

Some of the women returned as staff nurses to the Karitane hospitals. They held a position somewhere between the trainees and the other registered staff. Sue felt quite happy that the 'general trained, having had extra training in Plunket, were better able to make final decisions and hold overall responsibility'.⁴³⁸ While having some responsibility, their job was much more hands-on than the other staff, and this would appear to have been expected of the job. The desire for hospital work also led to further training, one of my informants becoming general trained, one an enrolled nurse and another completing a paediatric course overseas.

For Karitane nurses, hospital work presented many advantages and challenges. Particularly it was permanent employment in one place. After living out of a suitcase in other people's homes settling down was preferable. Living in the nurses' home brought back a lot of good memories, and flatting was becoming common practice and at last a place of one's own. While the work was still the care of infants and support of the mother, it was perceived to be nursing once more. Diana, who always wanted to be a nurse, felt it was 'really nursing. I loved it. It was not just feeding and changing nappies but dealing with everything and helping in all procedures....[I was] more a nurse there than anywhere. Just picked it up as we went...all under supervision'.⁴³⁹ Some, like Rose, liked the routine and structure and enjoyed knowing exactly what was expected of the job.⁴⁴⁰ Penny recalled it as being 'more worthwhile and stimulating', and many talked of further learning.⁴⁴¹ While registered staff always supervised the work and certain duties were restricted it was not unusual to do more than had been allowed in training. Tube feeding and giving injections were relatively common practice. As one recalled 'interesting opportunities were arising all the time'.⁴⁴² For Gwen, as the only Karitane nurse in a small maternity hospital nursery, it was 'my domain'. She had nurse aids under her whom she trained.⁴⁴³

In hospitals there was a perception that the Karitane nurses were part of the

⁴³⁸SL personal correspondence

⁴³⁹Diana Bevins interview

⁴⁴⁰Rose Arlidge interview

⁴⁴¹Penny Ure personal correspondence

⁴⁴²WC (trained 1961-62), personal correspondence with Lesley Courtney 16 June 2001

⁴⁴³Gwen Diver interview

health system and were respected and valued for their skills. A sister from a Dunedin hospital spoke at a graduation of Karitane nurses in 1974:

By far the most valuable member of our ward team of nurses at present is a Karitane nurse....I have learnt...so much from her skills, her enjoyment of her work, her knowledge of varying home conditions and mothers.....I regard her as my "secret weapon".⁴⁴⁴

Allowing for some rhetoric given the circumstances, the clear message was that the Karitane nurse was a valued team member. For some, hospital work was perceived as giving more status. Whether called a staff nurse or not, once more they deservedly called themselves nurses. Heather felt there was 'a flavour of inferiority about being a Karitane nurse. I don't know how I gleaned it but I did'. But, she 'sensed more appreciation from people outside, working in a hospital'.⁴⁴⁵ Work in the home has always been notoriously undervalued in both pay and status. In taking hospital work many of my informants were silently acknowledging the lack of recognition and importance of domiciliary work, to which casing obviously belonged. It was the domestic nature of the intended destination of Karitane nurses that perhaps influenced outside opinion, more than any training qualification.

With the Karitane hospitals closing in 1978, so too did much of the other hospital work that had previously been available. Often those in a position were retained but gradually new staff were not taken on. In maternity wards a different culture had developed. Women were questioning hospital interventions at birth. This resulted in less time in hospitals and 'rooming in', making baby care by staff much less necessary. Also, perhaps, the end of training made other hospitals look at alternative options for staffing, with the idea that the supply of Karitane nurses would dry up.

Meanwhile, of those who did not seek out hospital work, most continued either live-in or day casing until marriage. Two girls only cased for the minimum. One got ill and the other felt 'the casing scenario was not for me. I did not enjoy being the paid household help'.⁴⁴⁶ Both left the job completely. The longest any of the

⁴⁴⁴*Plunket News*, Feb 1974, Vol.11, No.1,p.31, WA, MS 7/14, Box 1

⁴⁴⁵Heather Lyon interview

⁴⁴⁶MR personal correspondence

interviewees cased for was eight years.⁴⁴⁷ This was unusual at twice the length of the next longest. While most of the women had enjoyed and gained satisfaction from casing, living in was a lifestyle as well as a job and generally not suited to long term commitment. The bureau secretaries recognised that the job of live-in casing could only be of limited duration. 'Because of the onerous duties of Karitane nurses working in many homes, and the frustrations associated with living out of suitcases and adapting to so many homes, we find few Karitane nurses work for longer than one year through the Bureau'.⁴⁴⁸ Comment was made by the secretaries that, 'largely on account of marriage, there are not many Karitane nurses of what might be termed mature age'.⁴⁴⁹ Most of the women who married became full time mothers especially in the early years of their children's lives. This would not have been unusual as until the 1980s this was common practice until the children were, at least, in school.

In retrospect it was difficult for most of my respondents to see that there had been a career path for them to follow. As Gwen voiced, 'a Karitane was a Karitane'.⁴⁵⁰ While many have made a life long career out of their training as a Karitane nurse it has never been one in which they could advance to a higher level. This was clearly at odds with nursing, which had a distinct career structure once the training was completed.⁴⁵¹ Both experience and higher nursing education is rewarded with more senior positions and responsibility. Some of the interviewees perceived hospital work to be an advance on casing but this was mainly based upon it being a more structured job or reaching 'staff nurse' level. Once in this position there was nowhere else to go except sideways. Mary recognised hospital work only as a preference to casing. 'I'm not sure I'd have found the same satisfaction. I got mine from being the "surrogate mum" and that I could do it all.'⁴⁵² Further training in another field was deemed necessary to 'move up the ladder'. While their Karitane nursing skills may have played a large part in the job they then did, the position was

⁴⁴⁷ This does not count 'nanny' work overseas.

⁴⁴⁸ *Annual Report of Council 1973-74*, p.31

⁴⁴⁹ *Annual Report of Council 1968-69*, p.28

⁴⁵⁰ Gwen Diver interview

⁴⁵¹ New Zealand Nurses' Association, 'Policy Statement on Nursing in New Zealand: New Directions in Post-Basic Education', Wellington: The Association, 1976, p.17-19. This paper clearly sets out a career path for general nurses at the same time as Karitane nurses were still being trained.

⁴⁵² A. Mary Bingham interview

no longer Karitane nursing as such. Those who are still employed by the Plunket Society as mobile Karitanes or in the Family units, of which there are surprising many, cannot advance past their current position. For Diane, who trained at the end, there appeared even fewer possibilities.

What could you do besides casing? I'd have loved to have been a staff nurse [in a Karitane Hospital]...but the hospitals closed. It was wonderful training but it was quite limiting as far as the jobs you could get. A nanny? But New Zealand was not really geared for that, not a lot of security. I believed the idea was to go overseas. The bureaus had closed....It all fell down....Later, after being an at home mum, I realised I had to retrain because Karitane nursing no longer had a function to perform in society anymore.⁴⁵³

Meanwhile trained Karitane nurses were in an ambiguous situation in relation to the Plunket Society. While there had been a limited relationship when they were in training in the Karitane hospitals there would appear to be even less when the girls were out casing. Of those interviewed 56% felt they had no relationship with the Plunket Society at this stage. There was an understanding that the bureau was provided by Plunket but this seemed a very tenuous link with the Society itself. Any contact with the Society was usually perceived as meeting up with Plunket nurses when caring for a new baby. This contact was generally seen to be pleasant and even collegial at times, but was not significant in any manner. A magazine article of 1967 stated: 'The two nursing services, Plunket and Karitane, are separate but complementary. The position frequently arises where the senior, experienced Plunket nurse advises and helps the Karitane nurse on the care of the infants in her charge'.⁴⁵⁴ In reality the interviewees found the contact to be incidental and were not specifically aware that the Plunket nurse had any jurisdiction over them. Some Plunket nurses felt it their right to make comment however. Alison recalled:

Some of them felt it was their duty to lecture you on your duties and your dress code. I recall one job...bitterly cold. we were meant to wear our uniform, made of cotton, short sleeved and absolutely useless at keeping you warm, so with the mother's permission I was in trousers and a warm jersey. A very old Plunket nurse arrived to do her first check on the baby. I can still see her looking down her nose at me saying very sternly, "Since when do Karitanes wear pants"....I was completely ignored for the rest of the visit and she never appeared again until after I'd left. The mother and I had a great laugh about it after.⁴⁵⁵

⁴⁵³Diane Ferrel interview

⁴⁵⁴*New Zealand Home Journal*, Aug 1967

⁴⁵⁵Alison Newell personal correspondence

Two of the women expressed the feeling of a division between the Plunket and Karitane services, and Heather did not think it was just her that felt it.⁴⁵⁶ There was a perception, perhaps only by the Karitanes themselves, that the Plunket nurses were superior rather than complementary to the Karitane service.

Many never encountered the Society face to face again once leaving the hospital, with some only ever communicating with secretaries by phone. Certainly as soon as the nurses stopped casing or started to develop their own clientele all links were effectively broken and they on their own. While still using the title Karitane nurse, perhaps wearing the badge and uniform that identified them, and getting work on the strength of their qualification, there was no control or system in place that monitored the practice if the girls did not use the bureaux. There was a register of Karitane nurses' numbered badges held at Plunket Headquarters, but no jurisdiction over them. Despite this the nurses were well trained in Plunket methods and some still felt they were actually representing the Society in some manner in their work. Amongst my informants old habits die hard and most can still fold a nappy, tuck down a baby and hold the bottle 'the correct way'. In this manner they have, sometimes unconsciously, represented the Society for many years to come. For employers who used the service, either through the bureau or privately, there was an awareness of the training and a respect for the title Karitane nurse. This had grown out of a traditional respect for the Plunket Society itself. However, while the Karitane nurses may have felt little part of Plunket, some within the organization believed they could or should be an integral part of the Society's aims. 'The Karitane service is merely an extension of district Plunket work, and should not be regarded as different or separate from the mainstream mother and child work', stated Neil Begg in 1975.⁴⁵⁷ On reflection this was an indication of the changes to come.

⁴⁵⁶Heather Lyons interview

⁴⁵⁷Begg, *Changing Patterns of Child Care*, p.31

7.

No Longer a Primary Function ⁴⁵⁸

When the Karitane hospitals closed in 1978, their particular form of Karitane nurse training also ceased. In hindsight the writing had been on the wall for some time, although the Society was still hoping to retain the hospitals well into the 1970s. The closures were announced suddenly but they could not have been unexpected. Because the Karitane 'nurse' training was reliant on the hospitals operating the Society could not duplicate it elsewhere, even if they wished too. The hospitals' closures resulted from financial pressures and the Society's wish to move in new directions. Their eventual demise had been clearly signalled earlier.

Dr Begg explained that with a new emphasis on domiciliary nursing and with rumours of early discharge from maternity homes Karitane nurses would have an even more important part to play in the future. They were riding the crest of the wave.⁴⁵⁹

Far from Begg's optimistic assertion in 1963, the hospitals had all closed within 15 years. Their training was replaced by a new, extra-mural course aimed at producing 'Community Karitanes'. By 1981 Plunket had so distanced itself from its hospital era that Anne Kerley, deputy director of nursing services for the Plunket Society, was quoted as saying: 'We're into preventative health. We're there to support families, not to provide home help for the upper classes.'⁴⁶⁰

Finances played a very large part in the decision to close the Karitane hospitals. They were one of the biggest drains on the Society's finances throughout and by 1977 were absorbing 37 per cent of the Plunket's money while seeing only four per cent of their total clients.⁴⁶¹ While not initially an objective, they had evolved almost accidentally from King's Karitane cottage. With the donation of properties for

⁴⁵⁸Minutes of the Special Hospitals Representatives and NZ Executive Meeting, 8 March 1978 in Karitane Hospital Minute Book 1974-81, DU:HO, AG-782-2-2

⁴⁵⁹*Otago Daily Times*, 16 May 1963

⁴⁶⁰*New Zealand Women's Weekly*, 30 Nov 1981

⁴⁶¹Parry, p.159. Numbers of baby admissions 1959-78 remained similar at over 2,000 per year, but the overall client base was increasing.

hospitals by well-meaning benefactors, their development had taken on a trajectory of its own in the early years of the Society, to become, by 1959, the second major function of Plunket. However, eventually they became a millstone around the neck of the organisation. The training of Karitane nurses, likewise, was not planned but grew out of the necessity to staff the hospitals. Strangely, the training and use of Karitane nurses did become an object when the 'Rules of the RNZPS' were amended to January 1981. While this may have been an error of title, referring to the proposed new community-based training, this set of rules also included the hospitals and their functions, even though no hospitals remained.⁴⁶²



WILL HIS NEXT BOTTLE BE FULL?

Fears for the future of the Karitane hospitals were felt as far back as the 1950s.

Auckland Star, 5 Nov 1958

⁴⁶²The objects of the Plunket Society were still unchanged from the originals until this time. The 1981 rules incorporated a lot of the original objects but were considerably expanded, including the provision of the Family Day Units. 'Rules of the RNZHWC', pp. 1-2, contained in 'Wellington Plunket-Karitane Incorporation 1976-78' papers, DU:HO, AG-782-5-4. 'Rules of the RNZPS (Inc): The New Zealand Society Branches, Sub-branches, Mother's Clubs, Hospital Branches' amended to Jan 1981, DU:HO, AG-7-8-22

The donation of the properties and the success of the Plunket Society all contributed to initially making the hospitals relatively viable, with government assistance. But they were already mentioned as a burden by the 1950s. After the Consultative Committee's support and endorsement of the Society's work in 1959 a large rebuilding and remodelling programme began. This affirmed the hospitals' standing in the eyes of the Plunket and society in general. But, by the end of the 1960s the same concerns about viability were being expressed again.

The hospitals were 'registered Class "B" private hospitals...eligible to receive Social Security Benefit for patients'.⁴⁶³ There was some contention about this classification by Plunket because there was never a consideration that patients would pay. The Society firmly upheld the original aim to make the service free for all. They received only about half the amount per patient that public hospitals did, approximately five dollars a day. This was noted by the Consultative Committee and seen as a plus: 'The Karitane Hospitals are of advantage to the State in that at least a substantial part of their cost is provided by public subscription.'⁴⁶⁴ Plunket also received government subsidies of a pound for pound on all hospital building programmes and a pound for one pound ten on all voluntary contributions, towards the hospitals' upkeep.⁴⁶⁵ While this was very generous to a voluntary organization it was a fluctuating amount, depending on how much money Plunket raised each year and how many patients it admitted to its hospitals.⁴⁶⁶ The majority of the hospitals' expenses were fixed and, while the salaries of district Plunket nurses were heavily subsidised, this was not true of hospital staff. They were the biggest expenditure in the hospitals' budgets.

In 1972 a Plunket-commissioned accountants' report claimed, like the Consultative Commission, that the government was advantaged by the Karitane

⁴⁶³Letter from New Zealand secretary of the NZSHWC to businesses seeking assistance, late 1970s, DU:HO, AG-145-27

⁴⁶⁴*Report of the Consultative Committee*, p.26

⁴⁶⁵Parry, pp.126-127

⁴⁶⁶The number of nurses in training also affected the number of patients admitted as Plunket appeared to strictly adhere to its policy of one trainee per baby.

hospitals.⁴⁶⁷ They felt that the Society had a good case for asking for higher government bed subsidies but also recognised the desirability of keeping the paid staff to a minimum. Finally the report pointed out that Plunket's most valuable assets were voluntary time and the fact that trainees were not paid. The report was certainly food for thought but nothing came out of it directly and its significance lies more in the financial concerns which supposedly generated its commissioning.

In 1973 the government made an interim grant of \$181,000 to meet the Karitane hospitals' deficit. Robert Tizard, Minister of Health, was quoted as saying that the 'viability of the Karitane hospitals had deteriorated to an alarming degree, due mainly to an increase of salaries'.⁴⁶⁸ Each year the financial straits of the hospitals were discussed and the annual meeting of 1975 reported the Society had applied to government for permanent financial support for the hospitals. They had no reply.⁴⁶⁹ In 1977 the new Minister of Health, Frank Gill, was arranging another interim grant when Auckland Karitane Hospital was believed to have only enough funds for nine more days running.⁴⁷⁰ In the same year the Society decided to do an internal assessment of the hospitals' viability, which effectively spelt their end.⁴⁷¹ While financial reasons alone could justify closures their viability could also be questioned on other fronts.

The Plunket service was at a crossroads by the 1970s. While it still reached the majority of parents in some form, parents had more options to choose from and were not necessarily turning to Plunket. The Plunket Society was now experiencing competition for advice about infant and pre-school health. Overseas child rearing books and practices, such as the La Leche League, were offering a more 'relaxed'

⁴⁶⁷'Report on Karitane Hospitals 1972', by Barr, Burgess and Stewart (Chartered Accountants, New Zealand), DU:HO, AG-145-29. They suggested one paid staff per five trainees, down from the 1: 2-3 it was then, pp.3-4. They further suggested the course should be either a complete one or two years and that all girls start once a year, p.4

⁴⁶⁸Unidentified newspaper article, circa early 1970s, WA, MS 7/10. Between 1970-72 salaries increased by over 55%. They represented 39% of the expenses of the hospitals in 1972 and were estimated to increase to 45% of expenses in 1974.

⁴⁶⁹*Annual Report of Council 1974-75*, p.22

⁴⁷⁰*Dominion*, 12 Aug 1977

⁴⁷¹Parry, pp.159-60

alternative to the rigidity of some Plunket methods. There was also some criticism of the Society's ethnocentric bias. Maori were urbanised and a part of mainstream New Zealand but their needs were not being met, and other cultures, particularly from the Pacific Islands, were creating a more diverse population. The monocultural basis upon which Plunket operated needed to change and Plunket had, in part, accepted the need for a new direction.

'Great social changes' had been recognised by the Plunket Society, particularly in social attitudes and environmental factors as they impacted upon children:

There has been a decline in the mortality and morbidity rates for children resulting from advances in our knowledge....But we have higher rates of accident and injury and higher incidences of social and psychological disorders. Poverty, as a potent cause of disease, has been largely eliminated but we are beginning to see the diseases of affluence.⁴⁷²

To meet these challenges Begg saw the Plunket Society's role was to take on the 'intellectual and emotional' development of the child as well as the physical care. Plunket was now openly referring to their service as 'preventative health', and as such was allied to health, social welfare and education.⁴⁷³ Increasingly the hospitals were taking on a social welfare role. The admissions, particularly in the 1970s, were more and more for children who required removal or respite from their homes. These children could be exhibiting the physical or emotional problems that the Karitane hospitals had traditionally catered for but these were linked to social concerns. In 1975 one matron commented that social welfare admissions 'have generally been taken into custody ...and have become "state wards"'. After the Court Case, rather than rush them out into unsatisfactory foster-homes, Social Welfare leave the children with us and try to be more selective with their placement.'⁴⁷⁴ Many of these children would stay in the hospitals long term.

⁴⁷²Begg, *Changing Patterns of Child Care*, p.1

⁴⁷³ibid

⁴⁷⁴Matron's Reports 1974-81, 30 Nov 1975



More aggressive advertising for funds took place in the 1970s, and postal appeals became the norm. This photo was taken for one such national campaign. The Maori toddler also reflects the changing times, although Plunket was still largely a pakeha service.

DU:HO, AG-7-8-19-1

Initially this change was seen as fitting the aims of the Society. 'I think we are able to help solve a lot of social problems in the community these days by taking the baby of the harassed mother into the hospital for a time while she gets herself organised'.⁴⁷⁵ In 1975 Alison Hunter, a medical officer of the Plunket Society, pointed out that 'Karitane was providing a community service which was not being catered for by any other source'.⁴⁷⁶

Neil Begg was personally very supportive of making 'social and preventative medicine [the hospitals] primary concern'.⁴⁷⁷ While the hospitals aimed to cater for all children, they primarily sought to aid the family unit and help the mother cope with a problem, not be the ambulance at the bottom. With concern at 'so much emphasis these days on separating mothers and babies' the hospital felt the need to encourage more mothers in to learn mothercraft.⁴⁷⁸ However, some were reluctant.⁴⁷⁹ Mothers were changing, along with society. One hospital was experiencing thefts from their Mothercraft section and matrons disparagingly reported that mothers would go out to hotels in the evenings.⁴⁸⁰ Anne Kerley, retrospectively felt in 1981, that mothers did not want to be hospitalised with their babies when problems arose and the Plunket Society had to change to keep in touch.⁴⁸¹

As well as a less malleable clientele for the hospitals it was also noticeable that there were fewer users of the service overall. The decline in the number of premature babies admitted had been apparent through the 1960s. In the past such babies had been plentiful and seen as 'perhaps the most thrilling and appealing section of the hospital',⁴⁸² but they were just about non-existent by the late 1970s.⁴⁸³ High technology neo-natal units in public hospitals had increasingly retained the babies, and

⁴⁷⁵ *Plunket News*, Aug 1970, Vol.7 No.4, DU:HO, AG-7-8-15

⁴⁷⁶ Bryder, *Not Just Weighing Babies*, p.84

⁴⁷⁷ Begg, *Changing Patterns of Child Care*, p.38

⁴⁷⁸ Matron's Reports 1968-1973, DU:HO, AG-145-31

⁴⁷⁹ Yearly figures for mother admissions only show a slight decline over the period 1959-78. There is no breakdown on the circumstances of the admissions, however.

⁴⁸⁰ Matron's Reports 1974-81, 31 March 1976, 31 Aug 1976,

⁴⁸¹ *New Zealand Women's Weekly*, 30 Nov 1981

⁴⁸² 'Karitane Hospitals' promotion pamphlet, circa late 1940s, DU:HO, AG-7-1159

⁴⁸³ Parry quotes figures of premature babies making up 17% of the admissions in 1961, down to 2.6% in 1976, p.160

with smaller babies being kept alive it was obvious that Karitane hospitals no longer had the facilities to cope with some of the more critical cases. These babies had been a guaranteed and 'lucrative' supply of numbers for the hospitals and they were missed.⁴⁸⁴

Another problem facing the hospitals was attracting and retaining staff at every level - matrons, sisters, trainees and domestics. Domestic staff were always an issue at some of the hospitals, to the stage that the trainees were used to do irrelevant domestic work.⁴⁸⁵ The pay was clearly not enough to attract long term employment. Kedgley argues that the introduction of the Domestic Purposes Benefit in 1973 directly contributed to the fall of the hospitals.⁴⁸⁶ While this source of labour did dry up during this period it is hard to see that this had much of a bearing on the closures. Some of the hospitals had never used single mothers in this way and they were never the only domestic help employed.

Trainees were also becoming increasingly hard to attract. Only 87 had applied for training for 1978.⁴⁸⁷ There were clearly some girls willing to train for no pay and 'the love of children' but, they were getting fewer. The Society was sure non-payment detracted from recruitment. It had been hoped that the bursary scheme could be extended to all trainees, but finding enough benefactors to date had been hard enough and Plunket themselves would have found the cost prohibitive.⁴⁸⁸ Another factor behind the fall in recruits could have been the increasing groundswell for feminine equality. Girls were staying at school longer, and wider opportunities were becoming much more acceptable. The 1970s were a time of women questioning and breaking out of their role within the home. There was a much greater expectation that a career would be resumed once the children were at school. With an emphasis on women's wider opportunities of workforce involvement domestic life took on a second class

⁴⁸⁴From particularly the 1970s there is a noticeable decline in premature baby admissions. 1965-66: 450, 1970-71: 369, 1975-76: 247. Figures from *Report of Annual Council*, 1965-66, 1970-71, 1975-76

⁴⁸⁵Karitane Hospital Minute Book 1959-74

⁴⁸⁶Kedgley, p.274

⁴⁸⁷*Dominion*, 20 July 1978. This was prior to an announcement about closing.

⁴⁸⁸From 1972 the Society could offer 70 bursaries per year, *Plunket News*, April 1973.

image. Nolan comments that 'some argued that domesticity was not a worthy occupation for anyone'.⁴⁸⁹ Karitane nursing appeared to be centred on babies and the home in a time when girls were looking to spread their wings. It was also a very restricted lifestyle, whether casing in the home or doing shiftwork in hospitals. This was when young women were being given much more freedom and independence at an early age. The hospitals also had trouble retaining those in training. Matrons' reports frequently commented on girls leaving during training, often because they were unsuitable or 'not sufficiently interested in the work'.⁴⁹⁰

The Society found registered staff difficult to recruit also. Plunket nurses in general earned less than their public sector counterparts.⁴⁹¹ Salaries were part-funded by the government but had to be kept as low as possible. It is noted that by the late 1970s only one in three sisters on the staff of Karitane hospitals were actually Plunket trained.⁴⁹² This would only be because other Plunket trained staff were not available, as it was an expectation that the sisters were presenting a Plunket viewpoint to trainees and mothers. Likewise, while matrons had previously stayed in their positions into old age, it was increasingly hard to obtain a permanent matron, let alone one that intended to make it her life. The matron was expected to live on site and supervise both hospital and nurses' home, making it a fully committed job. This would not be what married or younger women would want to do for 24 hours a day. Also, on reflection, it could have been a lonely and perhaps unstimulating job after Plunket 'district' work. Colleen, who was an acting-matron during the last years, felt it was 'time to get back to where the real work was' when she returned to Plunket nursing⁴⁹³, and another found field work 'preferable'.⁴⁹⁴

In hindsight, there was movement towards the inevitable during the 1970s,

⁴⁸⁹Nolan, p.273

⁴⁹⁰Matron's Reports 1968-73. For example in Auckland 1974-75 42 girls commenced training and of these 8 left without completing. Auckland Plunket-Karitane Hospital Annual Report 1974-75, WA, MS 7, Box 1

⁴⁹¹Favell, Margaret E., 'Plunket Nursing in a Social, Political and Historical Context: Clients' Perspective of Mothering and Nursing', MA thesis in Health Science, University of Otago, 1997, p.31

⁴⁹²Parry, p.160

⁴⁹³Colleen Brown interview

⁴⁹⁴*Dominion*, 20 July 1978

even if it was not always the intention. The changing direction Plunket was taking, in order to encompass a much wider spectrum of society, was evident in the new curriculum introduced in 1974, although the Karitane nurses' importance to the hospitals was such that the training could not markedly change while the hospitals ran. Also, in recognition of the growing day care industry the Society was of the mind that there should be one recognised qualification in the care of the young child. While Plunket might be involved it would require changes. The 1973 annual report had stated that

For the Society it is obvious that education must be developed independently of the hospital service needs, even though some aspects of the apprentice method of teaching and learning are very valuable.⁴⁹⁵

Under the revised curriculum the Society necessarily retained 12 months hospital training, however a full six months was then spent in diverse community practice. This demonstrated that the Society was willing to change, and it was perhaps long overdue. The extra-mural work they encountered in training gave them much better experience in the type of work that Plunket saw was most needed.

Not long after the introduction of the revised curriculum, a new scheme was piloted in Auckland. This used Karitane nurses, who were employed by the Society, in the community working under Plunket nurses. In a 40-hour week the Karitane nurses would go to homes by the hour, day or repeatedly, to help.⁴⁹⁶ This scheme was extended to Dunedin in 1976.⁴⁹⁷ In 1978, before the hospitals' demise was announced, a 'Mothercraft Unit' was opened in Porirua staffed by extra-mural students. Here the trainees spent time with mothers who could call in during day. They taught home care, cooking and mothercraft. These were very obviously the prototypes of the mobile Karitanes and Family Units that developed after closure. Rather than being separated from Plunket on certification the Karitanes were being trialled to work directly for the Plunket Society. The new curriculum and pilot

⁴⁹⁵ *Annual Report of Council 1972-73*, p.35

⁴⁹⁶ It is interesting to note that this scheme was first tried during World War One when there was shortage of nurses. The Karitane nurse was the assistant but was often recorded to have carried out the Plunket nurse's job. Information from Robert Morse Woodbury, 'Infant Mortality and Preventative Work in New Zealand', Govt Printing Office, 1922, DU:HO, AG-7-8-18

⁴⁹⁷ 'Dunedin District Field Nurse Scheme (1976)', DU:HO, AG-145-27.

programmes for Karitanes were clearly evidence that the Society could see the nurses playing a wider community role.

With the writing very firmly on the wall by 1977 Plunket became an incorporated society. This was to allow the Karitane Hospital Boards to become separate legal entities, and hospital branches were then set up with their own rules. This would also have made for smoother closures.⁴⁹⁸

By this stage there seemed little that the government would do. Throughout the 1970s the annual reports stated the Society was frequently asking for financial assistance but by the late 1970s the government was reluctant to invest further money into propping up a voluntary agency in this way. The Department of Health was certainly not going to support any such ideas. The Karitane hospitals had already drained health funds sufficiently as far as it was concerned. The Department of Health had long been antagonistic to Plunket and had voiced its opposition towards Karitane Hospitals in submissions to the Consultative Committee. This view impacted on Karitane training, which the Department had never recognised officially. In 1975 Dr Begg commented on the uneasiness between the Health Department and the Society, feeling it was probably because of competition for resources. The Consultative Committee had doubted 'the public hospitals could easily or economically afford to give this [Karitane nurse] training'⁴⁹⁹ and Begg confirmed the Department's lack of support.

Whatever the reason, the fact is that the Health Department has decided not to support either the training or the work of the Karitane nurse and it is the Department of Social Welfare which has supported the Karitane's casing to disadvantaged families and helped with her training.⁵⁰⁰

Parry suggests there was behind-the-scene movements to have the hospitals reclassified as social institutions so that funding could be transferred to the Social Welfare vote.⁵⁰¹ Begg was not unsupportive of changing 'umbrellas', as he could only

⁴⁹⁸ 'Wellington Plunket-Karitane Hospital Incorporation', Nov 1977

⁴⁹⁹ *Report of the Consultative Committee*, p.26

⁵⁰⁰ Begg, *Changing Patterns of Child Care*, p.28. In this 1975 book Begg still saw the hospitals as being very much part of Plunket thinking.

⁵⁰¹ Parry, p.160

see conflict in coming under the Department of Health, but being classified as a social welfare concern would go against the principles of the Society.⁵⁰² Ideally he saw Plunket under a Ministry of Family Affairs.

In 1976 the New Zealand Executive of the Plunket Society had a meeting with the then Minister of Health. This aimed in part to preserve the training of Karitane nurses, which indicates awareness that the hospitals were fast approaching closure. While the Minister (Frank Gill) confirmed 'that Karitane nurses would be regarded by the government as an important support service for mothers and families', he suggested moving in the direction of registration to ensure their continuation.⁵⁰³ The Society then 'put submissions on full professional status for Karitane nurses to a parliamentary select committee....to be registered with the Nursing Council of New Zealand....we'd then think it quite reasonable to seek pay for our trainees equal to the standard tertiary bursary.' They further commented that if it were not successful they would have to look at other options, perhaps polytechnic training.⁵⁰⁴ This statement hints at the demise of hospital-based Karitane training. Karitane nurses did not receive registration, but earned the right to be called nurses in the 1977 Amendment to the Nurses Act.

The hospitals themselves struggled to continue as normal under very trying circumstances. Some attempts were made to accommodate changes in society. The hospitals introduced courses in 'daily instruction' and reported good attendances. This was 'ideal for mothers who find it impossible to leave the other members of the family to live-in at the hospitals with their babies'. These mothers often brought other pre-schoolers in with them.⁵⁰⁵ Wellington Karitane Hospital developed a 'whole family unit' where the entire family could be accommodated. However, with the uncertainty, staff, trainees and clients were in short supply. When Wellington closed it had 14 Karitane nurses training, an acting-matron who had come out of retirement, no

⁵⁰²Begg, *Changing Patterns of Child Care*, pp.29-30

⁵⁰³Meeting of the Minister of Health and the NZ Executive in the minutes of the Hospital District Meeting, April 1976, Minute Book 1974-81

⁵⁰⁴Unidentified newspaper clipping, circa 1976, WA, MS 7/10, Box 2

⁵⁰⁵Unidentified newspaper clipping, circa late 1970s, private papers of Lesley Courtney

cook and 'a handful of children'.⁵⁰⁶



By 1977 Plunket was openly campaigning for funds to specifically help the Karitane hospitals.

WTU, F-28283-1/4 PAColl-0614

While perhaps closure of the hospitals was inevitable there were some significant events in the late 1970s that would have been instrumental in sealing their fate at that particular time. First, in October, 1977, the Plunket executive became representative of the whole country. Previously it had been composed of just Dunedin members. Secondly, there was a complete change in leadership at the top, because of retirement. Dr. David Geddis took over from Begg, and a new secretary, Director of Nursing Services and Assistant to the Medical Director were all in place by the beginning of 1978. Geddis' appointment would have been particularly noticed. He was a different generation to Begg and, as an Irishman, had no preconceived ideas of the Plunket Society as an institution of New Zealand. All these changes must have had a huge impact on the hospital closures given that by March a decision was made to close them. One can see the more pro-active marketing image of Plunket, particularly in advertising, that must have been representative of new thinking at the top.

⁵⁰⁶*Dominion*, 20 July 1978

In March 1978 the Plunket Society called a 'Special Hospital Representatives and New Zealand Executive Meeting' which came to the decision to phase out all the Karitane hospitals. After discussion of the reasons for admission to the hospitals it was felt that 'neighbourhood mothercraft units' could carry out the same function. The Wellington Hospital Branch sent a memo to its contributing branches stating they had come to a 'unanimous decision that the Wellington Karitane Hospital will be phased out and that the Karitane Support Units carry on the caring and supportive work of the Society'. The reasons they gave were that they were not admitting enough patients, had too few Plunket trained staff or permanent matrons, they were running at a loss, had outstanding debts and had already cut back as far as possible.

This decision immediately impacted upon Karitane nurse training. It meant it could no longer continue in the same manner, if at all. The meeting made a commitment to finish the training of all the girls in the hospitals at the time but would cancel all future intakes. By the end of 1978 all the Karitane hospitals had closed. One of my interviewees, Diane, was in the last class to finish their year's training at her hospital. For completion the trainees worked out in the community under supervision. They worked in homes and pre-school centres and met for a study day once a week. A tutor and trained Karitane nurse assisted in tuition and supervision. The Karitane trainees were put up in suitable accommodation at the Society's expense. The advantages were that the girls could complete their training in preferred locations and it was felt to be more appropriate to the duties undertaken on graduation. It was thought it might also set a pattern for the future training of Karitanes.⁵⁰⁷ Diane's class was allowed to go back to their Karitane hospital to graduate after their extra-mural work although the building was already sold.⁵⁰⁸

While times were changing within the Society to reflect changes in the community, it would appear that it was finances that really sealed the fate of the

⁵⁰⁷Information from Karitane Hospital Minute Book 1974-81: Minutes of the Special Hospitals Representatives and NZ Executive Meeting 8 March 1978, Memo to All South Island Branches in Wellington Hospital District 20 April 1978, Hospital District Minutes 21 June 1978, DU:HO, AG-782-2-2

⁵⁰⁸Diane Ferrel interview

hospitals. 'We have developed almost into a babysitting service. It's nice to be able to do this sort of thing, but it doesn't justify the expense of a hospital.'⁵⁰⁹ This is reiterated in Plunket's current website.⁵¹⁰ By 1978 there was no financial alternative, although it is doubtful the hospitals would have remained unchanged for long in any circumstances.

The notice of closures was abrupt and keenly felt. 'Obviously we felt very passionate about that,'⁵¹¹ Diane remembered. There was talk of secrecy at the top, and that it was pushed through from above. Plunket had always prided itself on being a grassroots organization that ran from the bottom up and local branches felt very left out of the decision making. There were protests at most local and hospital levels with the media supportively running articles. Wanganui was very vocal in its protests. The whole city seemed to be behind retention, and representatives of various town sectors went to Wellington to meet with Gill. It was hoped that the local hospital board might take over the Karitane hospital and run a 'new service' along identical lines.⁵¹² Southland branch took out an injunction to prevent closure, citing 'alleged irregularities at the special conference on May 2'.⁵¹³ Wanganui eagerly awaited the outcome of this. In the end the voting rights of these two smaller centres were no match against the four main centres and it was announced that all Karitane hospitals would close between July 31 and September 30. Mrs L. Stewart, former President of Wanganui Plunket Branch, who spearheaded their campaign, was finally convinced, on new information, of the inevitability of closure. Some of the hospitals were more pragmatic about the demise. The matron in Wellington had questioned keeping that hospital open as early as 1975 due to the low numbers of admissions.⁵¹⁴ Commenting on closure Wellington hospital spokespeople stated: 'The Karitane hospital has suffered for being so well established. People have been taking it for granted for years....When the Society ran galas and garden parties...to raise funds for the hospital,

⁵⁰⁹Dr Ian Hassall, Assistant Director of Medical Services. Quoted in Bryder, *Not Just Weighing Babies*, p.89.

⁵¹⁰RNZPS website, 14 May 2001

⁵¹¹Diane Ferrel interview

⁵¹²Unidentified newspaper article, circa 1978, WA, MS 7/10. Plunket, Wanganui Hospital Board, Wanganui City Council and the local medical profession were all represented.

⁵¹³*ibid*

⁵¹⁴Matron's Reports, April 1975, DU:HO, AG-145-32. Matron P.R. Babe.

folks didn't want to know. But as soon as its closure was announced...there was all sorts of hue and cry.⁵¹⁵

While for some it was a very reluctant move, in many ways the Society had already set up some systems to cushion the blow. For Head Office the transition to an organization without hospitals was relatively smooth and must have been a relief for many. Anne Cressey, who helped organise the completion of Karitane training, recalled:

I could see that it had to happen. There wasn't the need that there had been in the past. There were prem units, mothers were able to stay in the hospitals with their babies and they were becoming a financial burden to the Society. I guess it was an all round thing that it had to happen. Though it was a very sad thing. Having been in Plunket for so many years you just couldn't perceive that they would close, that it was the end of the line.⁵¹⁶

⁵¹⁵*Dominion*, 20 July 1978

⁵¹⁶Anne Cressey interview

8.

A Thing of the Past?⁵¹⁷

When the hospitals closed Karitane nursing training went into abeyance, and the service was reviewed. The hospitals were not critical to Plunket nurse training as it was largely theoretical and out in the field, so non-residential training centres were opened to cater for that aspect of the Society.⁵¹⁸ However, it was by no means definite that the Plunket Society would maintain any sort of training at Karitane level. The 1974 curriculum changes, and the ensuing years, had indicated where Plunket would like to see the training lead - into the community directly on behalf of the Society and with services accessible to all Plunket clients regardless of income. Prior to the closures, the Society could already see that Karitane nurses, in training and when casing, were filling a 'social' role. The hospitals were full of children referred for care, rather than infants who had a problem. When Karitanes were casing it was the Department of Social Welfare that enabled them to reach needy families, and which set the criteria for help. But the Plunket Society had always aligned itself with the health area and it aimed to preserve the family unit. While Plunket's leaders never denied the need for social supports, when considering the retention of a Karitane nurse training they were of two minds as to who should supply this help. Karitane nurses were ideally trained to help with the care of children and pass on mothercraft skills if possible but was it Plunket's duty to train them for a role outside the aims of the Society?

The trainees who were still in the hospital component of the course were guaranteed the chance to complete after the hospitals closed. Working on behalf of the Plunket Society, Anne Kerley travelled to the different hospitals and organised the process. She had been involved with Plunket since the 1950s, but accepted the need

⁵¹⁷Yuen Wong interview

⁵¹⁸By 1982 there were training centres for Plunket nurses in Auckland, Palmerston North, Wellington and Christchurch, *Report of Annual Council 1981-82*, p.18, WA, MS7/1/51

for change.⁵¹⁹ Completion largely involved augmenting the community-training component. The remaining trainees went into the community under supervision and met weekly for study days. The last Karitane nurses that had Karitane hospital input into their training graduated in 1979.

A New Training for 'Community Karitanes'

No Karitane-level training was given for almost two years, but in September 1981 a one-year pilot training scheme began. One of the Consultative Committee's earlier considerations was the hospitals' distance from many potential clients. In closing the hospitals the Plunket Society acknowledged the need to supply help, other than Plunket nurses, close at hand. To enable this, Family Support Units were gradually opened throughout New Zealand to 'provide a friendly non-threatening environment for the parents', who could visit during the day.⁵²⁰ The units were directly based on the centres opened in Porirua and Auckland in the late 1970s. In some areas, where a unit was not warranted, mobile Karitanes were employed to work with, and complement, the Plunket nurse service, along lines already trialled in some areas. Eighty-nine Karitanes were employed in fixed and mobile units by 1982.⁵²¹ There was an obvious need to maintain the supply of employees for these roles, so a new form of training was devised.

This was a 12-month course of 'correspondence theory with practical application in the local Family Unit and with the Plunket nurse'.⁵²² From the beginning the training was envisaged to benefit the Society directly and to supply the numbers needed.

If we are going to train a girl to carry out our aims and objects - to help families- then we can't be thinking about training them to provide nannies for the well off families and overseas work, which was an offshoot of the previous service We're into preventative health. We're there to help support families, not to provide home help for the upper classes.⁵²³

Donna, who trained as a Community Karitane in 1984-85, reiterated this. She had

⁵¹⁹ Anne Cressey interview

⁵²⁰ *Annual Report of Council 1981-82*, p.19

⁵²¹ *ibid*, p.18

⁵²² *ibid*

⁵²³ Anne Kerley quoted in *New Zealand Woman's Weekly*, 30 Nov 1981.

hoped the training might lead her into hospital work, where she saw a need. Later she attempted to find work in this field but had no luck.⁵²⁴

The criteria for acceptance were markedly different from those of the earlier Karitane nurses. They included maturity, drivers' licences, first aid and home nursing certificates and School Certificate English. Donna was 25 and married.⁵²⁵ The training, based at a unit, was, initially, unpaid. It required a 40-hour week to be worked, one day of which was for study. The theoretical module work, which Donna recalled as mainly observations made in the field, had to be completed outside of this time. She felt that most of the learning was done on the job, primarily from the two other Karitane nurses employed at her unit, whom she described as 'very experienced'. It would have been 'impossible with just the modules', she thought. Other trainees that she met on study days were all at different stages. On certification she was able to work unsupervised where needed, at the unit and sometimes in homes. Her one dislike was that she was sometimes expected to be the cleaner. 'I think Karitanes were perceived to be a little bit like that at the time. That they would breeze in and do anything and everything.' However, sometimes, in order to help the mother, she did work of a domestic nature which she felt was fully warranted. Lani also remembers her early years in a unit as the 'slushy' and babysitter.⁵²⁶ Julia, who has worked as a mobile Karitane since 1982, agreed. In the beginning she felt the Plunket nurses did not quite know how to use the Karitane nurses and it took some time to establish their positions. 'Maybe I would [do domestic chores] but [it was]not my job as such. I had skills.' She now feels she is an integral part of her team and 'I really do believe they value my skills'.⁵²⁷ The primary job was still to help the mothers but today there is no dogmatic teaching of skills, rather a collaborative approach to helping. Counselling is very much a part of the job and is commonly called for.

While there were some similarities to the Karitane nurse training and outcome,

⁵²⁴ Donna Sellars (trained 1984-85, Community Karitane), interview with Lesley Courtney, 4 July 2001

⁵²⁵ *ibid*

⁵²⁶ Lani Bull interview

⁵²⁷ Julia de Weck interview

this development was a major step away from the hospital-based situation. Particularly, the Karitanes were now very much a part of the Plunket Society, working with colleagues in a team. There was also a change in title. 'Whereas the old Karitane training was hospital based, the new scheme does not contain a nursing component, so the new recruits will be called community Karitanes, not Karitane nurses as in the past.'⁵²⁸ This training was in no way intended to duplicate the Karitane nurse training. It was an on-the-job individual training programme. Once fully trained the Karitane would be employed by the Plunket Society to supply help, during the day, to families in need.⁵²⁹ As Anne Cressey recalled, 'Suddenly the Karitane nurse became a more integral part of the whole situation'.⁵³⁰ The Society hoped that its recruits would bring life skills with them into the training, preferring not to mould school leavers as in the previous era. Kathy, who worked in a unit in the early 1980s, saw this change to taking 'adult women with experience [as being] for the better, absolutely'.⁵³¹ The Karitane 'nurse' was now confirmed to be a 'thing of the past'.

Beyond Karitane 'Nursing'

Of the Karitane nurses trained through the years some made careers in childcare, starting with this training, while others left almost immediately on certification. A surprising number of my respondents are still using their qualification, either directly or indirectly, in their work with children. Of my informants 47 per cent are still working in a childcare field: nannying, early childhood, Plunket Society employment, social work and nursing. Much of this work now focuses on education, as opposed to nursing, in the delivery of their job.

⁵²⁸ Anne Kerley quoted in *New Zealand Woman's Weekly*, 30 November 1981. This is reiterated in information on the career of Community Karitane today. 'Because Community karitane are not qualified nurses, current legislation prevents them from calling themselves Karitane nurses'. From 'Kiwicareers' website, www.careers.co.nz/jobs/3a_nur/j80248h.htm

⁵²⁹ Community Karitane are still being trained in 2001. Their training has not markedly changed except that they are now employed for training only when a vacancy exists, meaning Plunket only trains as many as are required. It is now accredited at Level 4 (NZQA). Community Karitane are targeted to work with the 'non-Maori population', although Maori health is a priority in their training. Plunket Kaiawhina are trained to assist Maori parents with their children's well being. Information from www.plunket.org.nz, 19 Oct 2001, and Plunket Headquarters nursing division.

⁵³⁰ Anne Cressey interview.

⁵³¹ Kathleen Breton interview

The majority of the women interviewed are proud to have been part of this unique training and occupation, but also have mixed feelings. No one regretted the time they spent in this area, however some of the women noted that it is largely an invisible qualification now, often having to be explained to subsequent generations and justified in today's job market. As Liz expressed, 'I'm something of a dying breed'.⁵³² Most felt being a Karitane nurse was part of their formative years and impacted on their futures as mothers and workers. 'What I feel is quite proud that Karitane nursing was the start of what I've done with my life...that from 17 until today I've done on-going training. I still work primarily with people and mostly with children and I feel quite proud that that's where I started,' remarked Gillian.⁵³³ For those still in childcare in some manner there is clear recognition that although the two jobs are 'worlds apart', their Karitane nurse training is still of use.⁵³⁴ Many of the same practical skills are used and the women are often asked their advice in baby care, in recognition of their Karitane nurse training. This applies to the women in work and out in the community. Lani, as a tutor in the 'Parents As First Teachers' programme, feels she is at last reaching the people she trained to help. With further training, experience, and particularly her own motherhood, she now feels she is coming from an educational perspective.⁵³⁵

Training as Karitane nurses impacted on these women in other ways beyond the work force. The content of the course was aimed to be of use for the trainees' own motherhood. Of my respondents 92 per cent of them married, and the majority of these had children. Overall these women believed that they were fairly traditional in the early years of their marriages. They all believed in the two parent family unit and having children within marriage. Many of their values and child rearing practices, particularly in the areas of routines and the practical care of their own children, were described as conventional. However, this was frequently qualified with the remark

⁵³²Elizabeth Gardiner interview

⁵³³Gillian Perkins interview

⁵³⁴*ibid*

⁵³⁵Lani Bull interview

that they were open to change and had certainly done so, especially as their own children moved into adulthood. The majority of my informants who were mothers stayed at home to look after their children (64 per cent), particularly prior to them going to school. This was not always viewed as an active choice. Many of the women just had not considered that they would work, believing that a mother stayed home with her children. However, most believed they would have made the choice to do so anyway. But by 1972 Elaine remembered that mothers working was 'the then thing to do' and she made the choice not to. She felt the first five years were so important and she did not want to miss them.⁵³⁶

It was common practice by the 1970s for women to at least be working during school hours and many of these women took up that opportunity, with most being in the work force by the time their children were in their teens. Generally, mothers in New Zealand were completing their families within a limited number of years. As relatively young women they were seeking to re-enter the workforce. Of the interviewees who worked when their children were pre-schoolers, most did so by having their children with them, or alternatively, having family care for them. Some worked at home, on farms or caring for other people's children. When my respondents' children were young, day care was a relatively limited option in New Zealand and does not feature as a choice for most. However, these women frequently commented that they only worked because their children could be with them or because they had family carers. Some of the so-called 'at-home' mothers were heavily involved in voluntary work of some nature or 'often looked after friend's children much more often than they looked after mine'⁵³⁷, but again this involved their children being with them.

Overwhelmingly, motherhood was no surprise for the interviewees. Karitane nursing had given them a realistic view of being a mother, and confidence was the word most often expressed. 'My training made motherhood very easy for me - I have only realised this in recent years when talking to friends who remember with horror

⁵³⁶Elaine Harvey interview

⁵³⁷Penelope Ure personal correspondence

bringing home their first babe. [I] suppose I just took it for granted the knowledge I had. It was a good basic training that was of good value and the medical content proved most useful, even now', recalled one.⁵³⁸ All were prepared for the physical care of the children and their Karitane training was the basis of the practical aspects of childcare and developmental expectations. However, there was mention by some that they were in no way prepared for the emotional attachment to their own children, and Diana recalled that the 'Karitane' label could be difficult at times as others expected you to be able to cope.⁵³⁹ There can be no doubt that my informants viewed their Karitane nursing positively in light of their own motherhood. The Plunket Society's belief that the training 'is a useful preparation for marriage' was lived out in reality.⁵⁴⁰ Sue's reflection that 'without it I can't even imagine what I would have been like as a new mum', said it for many.⁵⁴¹

Reflections About the Training and Job

In hindsight, my informants debated the 'nurse' title. For some it is not an issue, 'I will always regard myself as a registered Karitane nurse as I have a medal and certificate to prove it'.⁵⁴² But for others calling themselves nurses has become an issue. For those in Plunket Society employment today the word 'nurse' has been removed from their current title. Karitane nurses I spoke to have not taken this move lightly as they distinguish between their training and that of the Community Karitane. The majority my informants perceived their training as a branch of nursing. While they would not call themselves nurses they were 'Karitane nurses'. 'I believe that at the time I trained we were specialist baby nurses', remarked Raewyn.⁵⁴³ On reflection, they felt that they were nursing when in a hospital setting, in training and in further hospital work, but casing was different. In comparing her two trainings Gillian felt, '[Karitane nursing was] a branch of nursing because what is a nurse? A nurse is someone who cares for others. In the hospital setting we were certainly nursing.... We

⁵³⁸MR personal correspondence

⁵³⁹Diana Bevins interview.

⁵⁴⁰RNZSHWC, *The Plunket Schoolbook of Childcraft*, Christchurch: Whitcomb and Tombs, 1973, p.26

⁵⁴¹Sue Clement personal correspondence

⁵⁴²Helen Richardson personal correspondence. Helen means this in a certificated sense, Karitane nurses were never 'registered' on a special roll.

⁵⁴³Raewyn Edwards personal correspondence

were playing a nurturing role and therefore we were nurses....In the casing situation I think that's debatable.⁵⁴⁴ Alison, who currently works as a 'nanny' is unsure of what she is now. 'I certainly feel I'm well above the 'nannies' of today both in my quality of training and in my attitude to work and work ethics', but the title Karitane nurse is now obsolete when seeking employment.⁵⁴⁵ Mary calls herself a nanny but tells her employers she did her Karitane nurse training. 'I don't know about the nurse bit. It was probably a bit grandiose stuck on the end of Karitane', she feels.⁵⁴⁶ The term 'Karitane nursing' is not a current qualification for employment, except perhaps for Plunket Society work. Most of the interviewees considered that they had moved on. 'I really left that behind me when I left the Karitane hospital [although] people refer to the career as Karitane nursing', Sue commented.⁵⁴⁷

Karitane nursing certainly had an impact on the futures of most of my respondents, but there was a general awareness that it was now a 'thing of the past'.⁵⁴⁸ It was 'part of the scene of the Karitane hospitals and the whole structure that they presented', Liz remarked.⁵⁴⁹ On being asked if Karitane nursing has been replaced by another training it was commonly compared to nannying. Few acknowledged the Community Karitane training for comparison. This would suggest that most of the interviewees saw that the qualification was one that led to casing, not for community social support work. Nanny training is seen as filling the gap that developed although it is not viewed as a direct replacement. The nanny trainings offered today are viewed as lacking hands-on application and experience with childhood 'problems', and the broad 'child-centred' approach means it is perceived to lack depth in baby care.⁵⁵⁰ Liz expressed concerns in her role as an employer of child carers:

⁵⁴⁴Gillian Perkins interview

⁵⁴⁵Alison Newell personal correspondence

⁵⁴⁶A. Mary Bingham interview

⁵⁴⁷Sue Clement personal correspondence

⁵⁴⁸Yuen Wong interview

⁵⁴⁹Elizabeth Gardiner interview

⁵⁵⁰Nannying as a job in 2001 lists skills that are very similar to those perceived by my informants as important for casing. However, material would suggest that training for the job is only 'preferred', and that skills can be learned on the job. There is no monitoring body that regulates the use of the name 'nanny'. Information from website 'Kiwicareers'.

It actually bothers me, as an Early Childhood professional, that there is no such training around that provides the same level of knowledge, expertise for working with infants and toddlers particularly, that the Karitane training offered.⁵⁵¹

Community Karitane training was not recognised as a replacement training, even by those in current employment with the Plunket Society.

Karitane nurse training was mainly training in and with babies, despite the inclusion of 'older children'. No training today specialises to this degree. Babies are not a separate category for training purposes but are one of the pre-school groups studied in any early childcare training. Today's study is largely theoretical, and then applied to children. This reflects the current emphasis away from apprenticeship courses of any sort, and their transfer to educational institutions. Baby care is no longer seen as nursing but is an educational study of development. In early childhood centres the employees are classed as teachers and educators, and goals for each child to attain are set and assessed. However, young children still require a lot of practical hands-on care, so, much of what was learned by my respondents is still of benefit. Sue, who works in childcare today, has 'found that the basic needs of children haven't changed, it's more that the delivery of it has altered with the change in society and people's lifestyles'.⁵⁵²

There was a feeling by some that the Karitane nurse training could still be of value today in fulfilling the old Plunket motto "Help the Mothers and Save the Babies". Mothercraft skills, and motherhood itself, are now seen to be undervalued. Diane, in her role as a social worker, feels that some children are missing out on

good basic care....Almost no value is placed on the importance of child rearing and I think that's an incredibly important job....Sometimes "Good enough under the circumstances" is not good enough.⁵⁵³

With mothers leaving maternity hospitals early, often within 24 hours, and visits by Lead Maternity Carers and Plunket nurses limited, there is a perception that mothers are missing out. Vanessa, nursing in a maternity ward, was not the only one to feel

⁵⁵¹Elizabeth Gardiner interview

⁵⁵²Sue Clement personal correspondence

⁵⁵³Diane Ferrel interview

that Karitane nursing, in its former incarnation, could play a part in short term, private, live-in care and in an expanded social-educational role.⁵⁵⁴ However there is also an acknowledgement that no such training is likely to surface again. Institutional, apprenticeship training, which was so intrinsic to the Karitane nurse preparation, is unlikely to be 're-invented'.

Reflecting on the hospitals from today's perspective, the women felt they were mainly important for their mothercraft teaching role. They were a free, safe service for '24 hour care by dedicated staff with love and passion'.⁵⁵⁵ There was general agreement that an institution for the residential care of children without parents was not an alternative in light of current thinking, although this was certainly a large part of the Karitane hospitals' work. But, most of the women felt there was a need for somewhere that provided residential care for mothers and babies in certain circumstances. Colleen Brown, who was a Plunket nurse, backs up this view.⁵⁵⁶ Of the Karitanes currently employed by the Plunket Society, many stated that at some stage they had taken a baby home with them for the night with the parents' permission. This was seen as necessary for either the mother or the baby. Today no such official option is available as a means to help mothers. While the extended family has become so important in the support of young parents, it is usually limited in light of society today.

The hospitals were also seen in light of their role in training nurses. My informants acknowledged that Karitane nurses were not only important but were vital to the running of the Karitane hospital service. However, most perceived that Karitane nurses were only of limited importance to Plunket beyond that because, as Gillian asked, 'where did she go. She disappeared didn't she? Did the Plunket Society only value her in the hospitals?'.⁵⁵⁷ Kay felt their downfall was that they graduated into being 'something for the wealthy'.⁵⁵⁸ The Plunket Society could never afford to

⁵⁵⁴ Vanessa Bloxham personal correspondence

⁵⁵⁵ Helen Richards personal correspondence

⁵⁵⁶ Colleen Brown interview

⁵⁵⁷ Gillian Perkins interview

⁵⁵⁸ Kay Moen interview

employ all the certificated girls themselves. While the initial intention of the Society was to have trained girls preaching Plunket gospel and benefiting the masses this was never achievable while the girls had to be employed privately by each family. By the period of this thesis casing had long been the normal employment pathway for Karitane nurses. This was of no great advantage to the Society's aims, and nor was the employment of Karitanes in general. It was only when the home service became free for those in need that the nurses were helping to achieve Plunket Society aims. Unfortunately by this stage the hospitals were endangered. If the nurses were only of importance in the running of the Karitane hospitals then the Society, as a voluntary organization, could not justify training large numbers of Karitane nurses that they could not use. The Community Karitane programme that followed allowed for on-the-job-training of as many women who could directly benefit the Society.

Karitane Nursing as a Profession

Was it a profession? The Society initially promoted it as such and it was perceived to be one within the times. A 1942 report by the Federation and Professional Women's Clubs of the YWCA of New Zealand stated:

The Karitane (Plunket Society) system of training which enables a Karitane nurse to take complete charge of an infant after it leaves the maternity hospitals is a remarkable example of the entire removal of the stigma of "Nurse-maid" and the elevation of the work to that of a proudly sustained profession.⁵⁵⁹

It was also viewed as such by my informants about the 1960s and 1970s, although by some only in retrospect. Working for a 'professional Society', a uniform and the 'professionalism expected of you' all contributed.⁵⁶⁰ Many, like Mary, felt that the nursing title and aspect of the training made it a profession. 'I guess I think of nursing as a profession and I guess I think of Karitane nursing as an offshoot of that.'⁵⁶¹ The Society had always encouraged the view of their Karitane nurses being part of the nursing fraternity. At a 1970 graduation the matron of Auckland Karitane Hospital, 'urged them to wear their uniforms with pride, and to encourage people to call them

⁵⁵⁹Federation and Professional Women's Clubs of the YWCA of NZ, 'Domestic Service: Conditions of Training and Employment in New Zealand', April 1942, p.3, NA, E2, 32/1/60

⁵⁶⁰Diana Bevins interview

⁵⁶¹A. Mary Bingham interview

'Nurse'. They were members of a profession they could well be proud of'.⁵⁶² Sue recalled telling a doctor what she did at the time, with him replying, "Oh, one of the professions." From then on I thought, "Well, yes it is"'.⁵⁶³ But there was also mention that not everyone else thought of the training as such. One commented that she felt it was 'not a respected training by other professions. I was always disappointed that it was not seen as such for further employment'.⁵⁶⁴

The *Concise English Dictionary* of 1964 defines a profession as a 'vocation, calling, especially one that involves some branch of learning or science'.⁵⁶⁵ Under this definition Karitane nursing could call itself such. Heather felt it was probably more of a vocation but she also saw as it as a profession as well. One might question Karitane nursing being included in the professions in light of the debate as to whether 'nursing' was a profession prior to 1972 and the direction general nursing took after that time. Penny discussed a 1962 definition in her thesis.

Professionalization is the process through which an occupation gains a monopoly of specialized knowledge and a high degree of competence in its utilization. In nursing it requires that the attention of the nurse be directed more and more towards the maintenance of educational and professional standards through increased reading of professional literature, committee work and participation in national and local professional associations....Professionalization suggests autonomy from the employer and loyalty to the nursing profession's authority and principles.⁵⁶⁶

Within this more detailed description one cannot see Karitane nursing claiming professional status at all. After training, Karitane nurses were effectively on their own, usually self employed if they stayed casing. There were no set standards, no authority over them, any register or body to oversee the maintenance of standards after certification and certainly no on-going education in the field. While popular discourse may have accorded Karitane nursing the status of a profession, probably because of the 'nurse' aspect, they cannot be viewed as such, even in light of that time.

Because neither the Department of Health nor the nursing profession officially

⁵⁶²*Plunket News*, Oct 1970, p.13, DU:HO AG-7-8-15. Miss Buerke was the matron

⁵⁶³Susan Ellis interview

⁵⁶⁴MR personal correspondence

⁵⁶⁵H.W. Fowler, F.G. Fowler, (eds), *The Concise English Dictionary of Current English*, Oxford: Clarendon Press, 1964, 5th edition, p.975

⁵⁶⁶Penny, p.21. Quote from 'Some Concomitants of Bureaucratic and Professional Conceptions of the Nursing Role', Ronald Corwin and Marvin Taves, in *Nursing Research*, Vol.11, 1962, pp. 223-27

accepted Karitane nurses they could not be protected under the nursing umbrella. In 1976 when the Minister of Health met the Society to discuss concerns about the future of the Karitane hospitals, he advised that registration of the Karitane nurses might help the retention of the training. The Society did pursue this avenue. 'We asked for our nurses to be registered with the Nursing Council of New Zealand to give them the same professional status as other nurses. We hoped there'd be a slot left for Karitane nurses in the Nurses' Amendment Act and our submissions were to this effect.'⁵⁶⁷ This was not accepted.

Perhaps the term profession is a matter of perception. Even now there is some acceptance of the 'professionalism' displayed by current Karitane 'nurses'. Jo, a recent Plunket nurse, commented:

Probably the most recent Karitane I've worked with has made a lifetime out of her profession. [It's] how you see yourself. I think those that trained back then think of themselves as nurses [and are part] of that professionalism.⁵⁶⁸

With the passage of time the name Karitane nurse will be less and less recalled. Its training style no longer accords with current thinking, and despite my informants' nostalgia, no one envisages its return. It is now just a small part of New Zealand's history.

⁵⁶⁷Unidentified newspaper article, circa 1977, WA, MS 7/10, Box 2

⁵⁶⁸Jo Brown interview

Conclusion

Within this thesis I have first charted the demise of Karitane nurse training in New Zealand and, second, supplemented the broad picture with a more personal look at the experiences of women who trained and worked as Karitane nurses from 1959-1979. While older New Zealanders are acquainted with the term 'Karitane' few have a clear idea of these women's work and later activities. Only a limited number of women ever either accessed the Karitane hospitals personally or for their infants, or employed them within their own homes. Karitane nursing is an example of a 'semi-profession' on the periphery of general nursing, which was itself struggling to establish an independent professional identity. It was destined to be marginalised because of its concern for babies, and as early childhood workers in the educational sphere show even today, work with young children is usually seen as less skilled than work with older children. Also, the skills involved with Karitane nursing could be seen as a form of domesticity, involving tasks which many saw as innate in women and coming naturally to them. Finally those certificated then mostly became self-employed and dispersed into private homes. The lack of on-going association similarly bedevilled domestic servants in terms of work place activism and promotion of a group identity.

Up until, particularly, the 1960s, society aimed to equip women for their domestic role, through socialization and education. The Plunket Society offered a training that prepared young women to be not only workers in the short term, but, in the long term, mothers. Influenced by the early twentieth century views of Truby King, who saw the need to train women for motherhood and to give it a scientific component, the training largely remained unchanged until the 1970s. The Society promoted it as of value to the trainees' own lives, as well as having a nursing and educational role.

While the 1960s saw a more equal expectation educationally of both sexes, there was still an acceptance, by girls themselves, of a gendered work force. The young women who took up Karitane nursing saw it as a branch of nursing which

specialised in the care and health of well babies, and an occupation well suited to their sex for then and the future. But the Plunket Society's worries about the decline in numbers of those taking up Karitane training over the 1960s and 1970s, indicate that there was a shift towards a broader range of jobs for female school leavers.

My sample group suggests that those who did enter training in the 1960s and 1970s were largely school leavers who 'loved' babies and children. The training was mainly their first choice of occupation, and some even went against family advice to attend. They came from a wide variety of backgrounds, most with the similarity of a happy family upbringing. The unpaid training did not mean only the wealthy attended. The Plunket Society's contribution of free board and food meant only personal spending was needed. Plunket bursaries were limited but seemed sufficient for the number who applied, some girls worked to save for the training and the family benefit could be collected up to the age of 18. Whatever the circumstances of financial assistance, all my respondents recalled that money was generally scarce, with some means of supplementing it by babysitting. Everyone was perceived to be 'in the same boat'.

While my informants may have viewed themselves in fairly traditional terms, they were not totally conventional. They all left home to train, many from a considerable distance. They also overwhelmingly wished to travel after training, if not overseas at least within New Zealand. This they did, at a time when girls were still often working close to home.

Overall, hands-on work was the highlight of the training. The domestic element was generally accepted as relevant to nursing, and part of the job to come. The theory was seen as important, but the actual classes were only vaguely recalled. Its value and recollection came from its practical application. While some of the rigidity of the routines have since been dismissed, all my respondents recognise the value of the skills and some of the theory taught. They are still of use to them today.

My respondents largely recall the social aspect and their movement into adulthood as a big part of their training. Living-in 'on the job' brought the girls

together in a way that is now gone. The close personal friendships and the process of growing up and testing boundaries, within a supervised environment were perceived as important. Raewyn commented, 'I made good friends while there and when we got together last year for a reunion it was as if we were able to start where we left off, even though it has been 35 years since some of us had seen each other.'⁵⁶⁹ Overall the training period was seen in a very positive light.

It was the work after training that prompted the greatest debate. While all knew that casing was the outcome after certification, in reality it was full of inherent difficulties. Living in undermined their long-term commitment to the work and also left the Karitane nurses very much at the mercy of the individual families. While most employers were very amenable and the bureau would help in difficulties, the interviewees recalled being very much on their own and felt quite divorced from the Plunket Society. There was often a perception that the training in the hospitals had ill prepared them for one-on-one work with individual families. At the time, work in Karitane or in other kinds of hospitals was the only alternative. This was preferred by many and they often enjoyed the set hours, routine and hospital atmosphere, for which they felt well trained.

While most of my informants had entered the training in the hopes of a career, even if only until marriage, they recognised that once they were certificated, there was no obvious career path. Travel, hospitals and, later, day casing brought variety but not advancement. Initially, in this period, the Plunket Society had no means to employ experienced Karitane nurses except in their hospitals. They employed Karitanes only in a very limited and experimental way outside of hospitals in the late 1970s. The changes that came after the demise of the Karitane hospitals led to more responsibility, opportunities for continuing education and an affinity with the Plunket Society for those employed there. However, apart from length of service giving slightly more pay and perhaps more standing and respect within their own team and community there is still no opportunity for advancement.

⁵⁶⁹Raewyn Edwards personal correspondence

Of significant importance is the lack of recognition and acceptance of the training by the Department of Health. One can see, in hindsight, that the casing outcome of the training was to the detriment of its retention. It served no direct benefit to the Society by the period of this thesis, and contributed to the Department of Health's dismissive attitude. In looking at wider issues the Consultative Committee Report of 1959, had raised the Department of Health's attitude towards the training of Karitane nurses and the standing of both the nurses and Karitane hospitals. The Department dismissed the value of trained Karitane nurses in the homes, with the view that domestic help would be of more value. Despite Karitane nurses also being widely employed in public hospitals the Department was not interested in taking over the training itself when the hospitals became endangered. Not only were Health Department personnel unconvinced of the Karitanes' value, they had already dropped their own maternity nurse course in favour of an all encompassing general training

The Karitane training, such as it was, relied on the hospital atmosphere. While the Plunket Society recognised that Karitane nurses could play a much more integral role in delivering their aims by the 1970s, the death of the hospitals had to spell the end of Karitane 'nurse' training. Casing did not directly contribute to the objects of the Society. Karitane nurses were trained in hospitals because they were needed to staff them. Without the hospitals, Plunket could no longer offer 'nurse' training along the old lines. Any second-tier training deemed necessary by the Society would in future be along educational, not nursing, lines, and it would be directly of value to the Society on completion.

The title 'Karitane nurse' was probably always a dubious description of the work, especially when the nurse was certificated. They were so designated because their training was located in a hospital, and initially because the title added status to the occupation. This meant that the prospect of Karitane nursing attracted girls of good homes to train in a largely domestic job. The early status gained by this 'profession' remained with it, despite some challenges and the clear rejection by the general nursing hierarchy. For my informants the job was regarded as both nursing and a profession, as it probably was by the Plunket Society itself.

Hindsight suggests that if the Karitane hospitals had not closed continued changes to the training of Karitane nurses would have forced their demise. If the 'nursing' element were maintained the training would probably have left the hospitals, in line with other nursing qualifications. But with no effective use of Karitanes' skills by the Plunket Society, other than for staffing the hospitals, the training and the hospitals were destined to fall together. Either way, Karitane nursing had outlived its usefulness to the Plunket Society, and training for casing activities in the home could be achieved in other ways.

Karitane nursing is a historical phenomenon. It was associated with a voluntary health organization that is still an integral part of New Zealand's health services. The history of Karitane nurse training is enmeshed with that of Karitane hospitals, but there was also an aspect of the Karitane story beyond the Plunket Society. This has been largely hidden from New Zealand's history, because of its unorganised and solitary nature. The history of Karitane nursing lies not only in 'nursing' but in domesticity. Twentieth century New Zealand women's history has strong domestic overtones and Karitane nursing is part of that history. It is linked to motherhood, mothercraft and the domestic arena. Karitane was promoted as training for the future mothers of New Zealand and for some it served this purpose after marriage. Sue remarked, 'I still do feel part of the Plunket system even today because my philosophy is based on what I learned during my Karitane training and my experience and now having brought up my own family based on that training.'⁵⁷⁰ Karitane nursing exemplifies the gendered workforce promoted within New Zealand over much of the twentieth century and the aspirations of certain school leavers to fulfil the ideal of helping and being, educated mothers. It would appear to be 'an excellent preparation for marriage and families of their own'⁵⁷¹.

⁵⁷⁰Sue Clement personal correspondence

⁵⁷¹*Evening Star*, 28 Aug 1954

THE ROYAL NEW ZEALAND SOCIETY FOR THE HEALTH OF WOMEN AND CHILDREN (INC.)
(PLUNKET SOCIETY)

The Conditions governing the award of a Karitane Bursary are as follows:-

1. The value of the bursary will be £150.
2. The bursary will be paid in four equal instalments of £37.10. 0 each at four-monthly intervals, the first instalment being payable on commencement of training.
3. The bursar must agree to train at the Karitane Hospital selected by the Plunket Society, and may be transferred from one hospital to another during training.
4. Each bursar must undertake to work, if required, for one year on completion of her twenty months training, as a Karitane nurse in any part of New Zealand selected by the Plunket Society, and to take her cases through one of the Karitane Nurses' Bureaux.
5. Sick Leave during Service - A medical certificate must be forwarded to the Secretary of the Karitane Bureau if the nurse is off duty for more than one week.
6. Holidays during service are arranged with the Bureau Secretary, and may not exceed six weeks annually.



THE ROYAL NEW ZEALAND SOCIETY FOR
THE HEALTH OF WOMEN AND CHILDREN

(INCORPORATED)
(PLUNKET SOCIETY)

FOUNDERS — SIR TRUBY KING AND LADY KING

This is to Certify that

Lesley Ann Courtenay

*has completed the Plunket Society's course of twenty months
in the management of infants and young children, and having
passed the prescribed examination is entitled to call herself a*

Karitane Baby Nurse

E. E. Gault President

N. C. Deegan

J. Blunson } Examiners

Date *1973*

A. J. Arnold Matron

No. *3746*

THEORETICAL INSTRUCTION

Throughout the training the nurses shall be required to read and study the Society's text-book "Modern Mothercraft" and "The Origin and Development of the Work of the Society". Teaching in class or wards shall be correlated to the simple principles.

WEEKLY NUTRITIONAL CLASS

The Matron conducts an evening class once weekly which must be attended by all Karitane students. A summary of the progress and behaviour of a number of infants is made by the nurses to whom the babies were allotted on admission, and all factors relating to the individual cases are discussed fully with the Matron or her deputy.

LECTURES by Tutor Sister or Matron shall cover the text books "Modern Mothercraft", and in addition the following subjects:-

1. Nursing Ethios
2. History and Development of the Plunket Society: Aims and Objects
Reference reading:- "The Origin and Development of the Work of the Society".
3. Elementary Anatomy and Physiology of the human body, especially of the digestive system. Text book "The Human Body" by Cyril Bibby, and Ian T. Morrison.
4. The Cause and Prevention of Infection (cyclostyled notes supplied). What infections means; the methods by which it is conveyed from one person to another; the special susceptibilities of young children to infections. The importance of personal and general hygiene in the prevention of infection.
5. Breast Feeding (cyclostyled notes supplied).
Reasons for advocating breast feeding. Incidence in New Zealand. The mechanism of suckling. Essentials for successful lactation. The mind of the nursing mother.
(a) Antenatal preparation for breast feeding:- Treatment of nipples.
(b) Management during first fortnight:- Establishment of lactation; manual expression; efficient emptying of breasts; difficulties associated with breast feeding in this period.
(c) Management after returning home:- Early visit of Plunket nurse to instil confidence and reassure the new mothers. Feeding times; planning the day to the advantage of all concerned. The nursing mother's dietary. Supplementary vitamins for breast-fed infants. Difficulties associated with breast-fed infants. Uses and abuses of test-weighing. Complementing and weaning. Demonstration of the nursing mother's dietary in terms of breakfast, dinner and tea.
6. Caloric Estimation (cyclostyled notes supplied, "Notes on Infant Feeding" Pages 1-2)
Each nurse receives individual tuition on this subject at the commencement of her training. The theory of caloric estimation shall be applied to both breast and artificial feeding.
7. Artificial feeding (cyclostyled notes supplied).
Principles of artificial feeding:- the infant's caloric and fluid requirement; the use of cow's milk as a basis for the formulae; the addition of sugar (karilac) to the milk mixture; daily requirements of vitamins A, D and C. Construction of a simple basic formula for normal infants. The uses of dried and evaporated milks, grading from these to fresh milk. Correct feeding techniques; feeding times; flexible regularity; teats good and bad.
8. Educational Diet (Lecture - Demonstration)
Reasons for introducing solids into the young infant's dietary. Preparation and presentation of vegetable and fruit purees, cereals, liver and meat juices, grated liver, egg yolk and crusts. Methods of introducing new foods to infants. The solid foods given to babies between 5 - 9 months of age are exhibited.
9. The Normal Baby, his growth and development (cyclostyled notes supplied)
The twelve essentials, the importance of a full understanding of the normal signs, etc., at various ages. General development and growth. The importance of "milestones". The management of the normal baby is the Karitane nurse's chief concern.
10. The Normal Pre-School Child. Revision in senior term of section in "Modern Mothercraft".

His general health, diet and feeding habits, rest and sleep, urinary and bowel functions; general behaviour. His place in the family unit.

11. The Premature Baby. Revision in senior term of section in "Modern Mothercraft".
- Definition, the characteristics of the premature infant; principles underlying premature care; care given during first 24 hours and subsequent feeding and management; protection from infection. Feeding, mother's milk; best substitute when mother's milk not available. Feeding techniques. Reasons for all routine nursing care. The weakling baby and its special needs.
12. Elementary Dietetics (cyclostyled notes supplied)
"Food and its Uses" and "Vitamins".
13. Constipation (cyclostyled notes supplied)
14. Minor Ailments, Simple Emergency Treatments and Signs of Illness
(cyclostyled notes supplied)
Notes on cuts, scratches and bruises, gravel rash, falls, burns and scalds, smothering, choking, foreign body in eye, bites and stings, poisons etc.
The importance of early recognition of illness. How to report clearly and concisely to the Doctor, etc. The various possible causes of feverishness in a baby. The needs of the feverish baby. Signs and symptoms and average incubation periods of common infection. Diseases of children etc.
15. The Duties and Responsibilities of the Karitane Nurse in a Private Home after leaving her Training Centre.
Throughout training endeavour shall be made to correlate all hospital theory and practice to work of the nurse in a home. The nurse's responsibility to the medical profession, the Plunket Society and her employer. Throughout training the nurse should be instructed in the importance of the mother-child relationship. The encouragement of the mother in performing the daily routine of baby care is of primary importance. The mother, working under the skilled supervision of the Karitane nurse, gradually assumes complete control of her baby. The steadily increasing knowledge and skill in handling her baby under competent guidance gives confidence as the mother gains in efficiency. This training phase leads on to complete and effective mothercraft when the support of the Karitane nurse is no longer needed.
16. Rules regarding the Engagement and Duties of Karitane nurses.
(leaflet supplied).
Instructions re the necessity for keeping in touch with the Training Centre, Secretary of the Karitane Nurses' Bureau or with a Plunket nurse when doing private work. The Karitane Nurses' Register. Importance of wearing uniform. Relationship of Karitane nurse to the medical profession. The Karitane nurse as associate member of Registered Nurses' Association.

KARITANE TRAINING CENTRES

COURSE OF LECTURES TO BE GIVEN BY THE MEDICAL STAFF TWICE YEARLY

- Lecture 1 Anatomy of the Digestive System - The Digestion of Foods with particular reference to the digestion of Milk - Vomiting (including a reference to pyloric Stenosis) - Constipation - Colic.
- Lecture 2 Infection - What it means and how it can be prevented. Necessity for extreme care in regard to the washing of hands prior to handling the baby, its food and feeding utensils - Summer Diarrhoea - its prevention and treatment.
- Lecture 3 Rickets, Scurvy and Anaemia. Brief general description of the deficiency diseases and their prevention. The importance of including the accessory food factors and minerals in the diet of the infant and the nursing mothers.
- Lecture 4 Simple Anatomy and Physiology of the Respiratory and Circulatory Systems - The Importance of Ventilation.
The Common Cold - Its Prevention, Treatment and possible sequelae, Bronchitis and Broncho Pneumonia - Brief reference to the signs of pneumonia, but omit treatment - Croup - its recognition and first aid treatment.

Lecture 5 The common rashes of infancy including napkin rash - their prevention and nursing treatment - Boils - Papular Urticaria - Pustular eruptions - Mosquito bites.

Lecture 6 The ethics of Karitane Nursing in relationship to the Medical Profession.
The signs of illness in the infant - when to call a Doctor - Convulsions - Choking - The management of a baby or small child following a severe fall.
Signs and symptoms of common infectious diseases.

Lecture 7 Anatomy and Physiology of the female reproductive organs - The mechanism of Child Birth. (Some Centres may arrange that this lecture is given by the Matron or the Sister-in-Charge of Group Mothercraft teaching).

The course of lectures is intended to be extremely elementary and where possible the lecturer should adhere to broad outline rather than to detail.

THE ROYAL NEW ZEALAND SOCIETY FOR THE HEALTH OF WOMEN AND CHILDREN (INC)
(PLUNKET SOCIETY)

KARITANE NURSES' WRITTEN EXAMINATION QUESTIONS:

JULY 1967

1. While the mother is in the Maternity Hospital you are left in sole charge of a family comprising 3 children aged 5 years, 3 years and 18 months.
 - ✓ Knowing that accidents to pre-school children happen all too frequently, list the special precautions you should take to protect these children in the following places:-
Kitchen, bathroom, laundry, living-room, bedroom and garden.

2.
 - (a) ✓ The 18 month old child is not attempting to feed himself. How would you encourage him to do so?
 - (b) ✓ The mother is concerned at the 3 year old girl's slowness with toilet training and asks if you can help her. How would you advise the Mother and how could you help the child?

3. When the mother returns from the Maternity Hospital with her 10 day old baby you will be with her for a further 2 weeks. The baby is breast fed and the mother is anxious to continue breast feeding.
 - (a) ✓ Tell how you can assist her to have adequate rest and sleep while you are with her.
 - (b) ✓ How to plan her day when she is alone.
 - (c) ✓ List what you consider to be 3 essential points for successful breast feeding.

4. Write briefly what you know about the following:-
 - (a) ✓ How and why egg yolk is given to young babies? What other foods are given for the same purpose?
 - (b) When is mixed feeding usually commenced and what would make you feel a baby in your care was ready for solid food?
 - (c) Why are baked crusts and raw apple given to older babies and what safety precautions should you take?

TIME ALLOWED - 3 HOURS

All questions carry equal marks.

THE ROYAL NEW ZEALAND SOCIETY FOR THE HEALTH OF WOMEN AND CHILDREN (INC.)
(PLUNKET SOCIETY).

KARITANE HOSPITAL RULES.

All students are expected to promote as far as possible the interests and objects of the Hospital. The building is maintained by the voluntary effort of the Plunket Society. Money spent in unnecessary repairs deprives the Society of the funds for necessary work for mothers and babies. Please treat all the Society's property with care.

Every student on admission promises to obey all orders and abide by all rules and regulations in force within the said Institution.

1. She shall avoid talking about its inmates and affairs outside the hospital, and endeavour generally by her own conduct and demeanour to sustain the reputation of the said hospital.
 2. She shall report to the Matron any neglect or wrong involving the babies, occurring, in her presence, or to her knowledge.
 3. She shall report at once any feeling of illness, especially a cold, vomiting, or diarrhoea. This is most important, as, if this rule is disobeyed serious consequences may result amongst the babies and other nurses.
 4. She shall be held responsible for keeping her room clean and tidy. Rooms must be ready for inspection by 10 a.m.
 5. She shall not use the telephone while on duty except in matters of urgency.
 6. She shall report all breakages immediately.
 7. She shall be punctual on duty, at classes, and at meals.
 8. She shall not wear uniform outside the grounds, unless on authorised hospital duty.
 9. She must obtain permission to take visitors over the hospital. Male callers may be invited to the sitting room while waiting, but permission to entertain visitors must be obtained from the Matron.
 10. She is forbidden to admit unauthorised persons to the hospital, or to be absent from the wards during either day or night duty without permission from the Matron or Sister in Charge.
 11. Rules governing leave:
 - (a) All students must be in by 10.45 p.m.
 - (b) Lights must be out by 11 p.m. - quietness is expected from that hour until 7 a.m.
 - (c) A day off weekly is arranged unless in an emergency or when on night duty.
 - (d) One other pass for leave until 11.30 p.m. may be requested weekly.
 - (e) Permission must be obtained for all late leave, or sleeping out leave, even on days off.
 - (f) Special dance leave is considered on request.
- These regulations are laid down in the interests of health. It is considered that students require eight hours in bed and that constant late nights render girls susceptible to infection.
12. Alcoholic liquor is strictly forbidden.
 13. Fire Precautions:
 - (a) Smoking is strictly forbidden in the bedrooms.
 - (b) All students must make themselves conversant with fire drill procedures and must know the location and use of fire extinguishers.
 - (c) Electric irons must be disconnected after use.

Bibliography

PRIMARY

A. Unpublished

1. National Archives

Health Department

- H1 20414 127/1/2 'Plunket Society - Consolidated Statements' 1929
 H1 2646 37994 127/4/2 'Karitane Hospital Trainees' 1958
 H1 24627 127/4/1 'Karitane Trainees' 1944-49
 H1 22893 21/23/142 'Karitane Trainees Experiences in Maternity Hospitals 1946-47'
 H1 3254 1/8/4 'Nursing Recruitment, National Advertising Committee' 1960-64
 H1 33295 1/8/1 'Nursing Recruitment Booklets' circa 1950s-60s
 H1 15732 21/104/1 'Maori Nurses - Karitane Training 1940-44'

Labour Department

- L1 32/1/16 'Home Aid Service, National Council of Women' 1946-51
 L1 32/1/10 'Home Aid Service Training' 1946-64

Education Department

- E2 32/1/60 'Technical-General: Training of Domestic Assistants and Workers. Domestic Science Apprenticeship Scheme' 1934-38

Maori Affairs Department

- MA W2490 36/9/2 Box 98 Pt 1, 1966

NASH 413 folio 0013 Health 1959-60

AANK Acc. W3285 Box 3 'Submissions to the Select Committee Inquiring into Discrimination Against Women in New Zealand 1974'

2. Hocken Library

Plunket Society

- AG-7-1-8-4 'Report of the Consultative Committee on Infant and Pre School Health' 1960
 AG-7-1-8-7 'Miscellaneous Correspondence on Consultative Committee' 1959
 AG-7-1-8-14 'Correspondence re Consultative Committee' 1959
 AG-7-1-8-15 'Correspondence re Consultative Committee' 1959
 AG-7-2-223 'Home Aid Service' 1959-60
 AG-7-2-444 'Karitane Nurses' Bureau 1958-60'
 AG-7-3-90 'Newsletter of the Director of Nursing' 1951-70
 AG-7-4-44 'Karitane Nurses Training in Pre-School Work' 1955
 AG-7-4-68 'Dr Deem - Karitane Hospitals' Rules and Guiding Lines' 1938-41
 AG-7-4--216 'Karitane Nurses (2)'
 AG-7-5-27 'Early Plunket Teachings 1904-12'
 AG-7-6-68 'Newspaper Clippings - Infant Welfare' 1954-61
 AG-7-8-18 'Collection of Plunket Society Publications 1907-37'
 AG-7-8-19-1 'Publications -Histories and Publicity' 1924-70s
 AG-7-8-19-2 'Plunket Society Publications - Histories and Publicity Material' 1913-68
 AG-7-8-22 'Publications -Plunket Society Rules' 1950s-80s
 AG-7-8-30 'Publications - Reports, Events and Social Issues' 1920s

- AG-7-11-25 'Plunket and Karitane Curriculum' 1955, 1958, 1959
 AG-7-11-33 'General Rules of the Karitane Hospitals including Daily Routines' circa 1930s
 AG-7-11-47 'Literature - Early Forms and Pamphlets' 1920s-30s
 AG-7-11-57 'Notes by Mrs King 1907'
 AG-7-1159 'Plunket Nurses and Karitane Nurses' 1940s-60s
 AG-145-27 'Karitane Nursing 1963-77'
 AG-145-29 'Report on Karitane Hospitals 1972 by Barr, Burgess and Stewart (Chartered Accountants, New Zealand)'
 AG-145-31 'Matron's Reports 1968-73'
 AG-145-32 'Matron's Reports 1974-81'
 AG-509-5 'Karitane Nurses' Bureau Reports for Branch Meeting' 1975-79
 AG-509-10 'Karitane Nurses Extra-Mural Programme' 1976-78
 AG-782-2-1 'Karitane Hospital Minute Book, 1959-74 Plunket Society, Wellington Branch'
 AG-782-2-2 'Karitane Hospital Minute Book, 1974-81 Plunket Society, Wellington Branch'
 AG-782-5-4 'Wellington Plunket-Karitane Hospital Incorporation 1976-78'
 AG-782-6-06 'Karitane Portfolio', 1930s
 AG-782-6-2 'Newspaper Clippings' 1960s
 AG-782-6-3 'Newspaper Clippings' 1970s

3. Wanganui Archives

Plunket Society Papers MS 7, 1915-1982

Box 2 Miscellaneous Reports, Papers and Pamphlets 1950s-80

Box 2 Newspaper Clippings 1960-78

Box 2 Photographs 1919-63

4. Alexander Turnbull Library

Russell, James, Earl, WTU, MS-Papers-2102, 1928

Photographic Collection - 'Child Care' 1930s-70s

'Nurses and Nursing' 1974

5. Plunket Society

'Karitane Nurse Register', Plunket Society Headquarters, Wellington, 29 Oct 2001

6. Private Papers and Photographs

Gillian Perkins

Lesley Courtney

Jill Pearce

Gwen Diver

Ivy Mary Gleeson

7. Oral Interviews/Personal Correspondence

Arlidge, Rose, interview with Lesley Courtney, 30 May 2001

Bevins, Diana, interview with Lesley Courtney, 14 May 2001

Bingham, A. Mary, interview with Lesley Courtney, 3 May 2001

Bishop, Janet, personal correspondence with Lesley Courtney, 19 July 2001

Bloxham, Vanessa, personal correspondence with Lesley Courtney, June 2001

Brereton, Kathleen, interview with Lesley Courtney, 1 May 2001

Brown, Colleen, interview with Lesley Courtney, 19 June 2001

Brown, Jo, interview with Lesley Courtney, 3 July 2001
 Bull, Lani, interview with Lesley Courtney, 30 May 2001
 Campbell, Linda, personal correspondence with Lesley Courtney, 11 May 2001
 Clement, Sue, personal correspondence with Lesley Courtney, 3 June 2001
 Cressey, Anne, interview with Lesley Courtney, 16 June 2001
 Davies, Lois, personal correspondence with Lesley Courtney, 18 June 2001
 Davis, F.A. personal correspondence with Lesley Courtney, 15 July 2001
 de Weck, Julia, interview with Lesley Courtney, 4 July 2001
 Diver, Gwen, interview with Lesley Courtney, 1 May 2001
 Edwards, Raewyn, personal correspondence with Lesley Courtney, 9 July 2001
 Ellis, Susan, interview with Lesley Courtney, 8 May 2001
 Farrelly, Christine, personal correspondence with Lesley Courtney, 27 May 2001
 Ferrel, Diane, interview with Lesley Courtney, 29 May 2001
 Foster, Charmaine, personal correspondence with Lesley Courtney, 29 May 2001
 Gardiner, Elizabeth, interview with Lesley Courtney, 3 May 2001
 Hardy, Susan, interview with Lesley Courtney, 23 June 2001
 Harvey, Elaine, interview with Lesley Courtney, 8 May 2001
 Howe, Ruth, personal correspondence with Lesley Courtney, 22 June 2001
 Lyons, Heather, interview with Lesley Courtney, 30 May 2001
 Moen, Kay, interview with Lesley Courtney, 21 June 2001
 Mohekey, Julie, interview with Lesley Courtney, 1 May 2001
 Neale, Juliet, interview with Lesley Courtney, 2 July 2001
 Newell, Alison, personal correspondence with Lesley Courtney, 12 June 2001
 Nicol, Glenys, personal correspondence with Lesley Courtney, 20 July 2001
 Pearce, Jill, personal correspondence with Lesley Courtney, June 2001
 Perkins, Gillian, interview with Lesley Courtney, 5 July 2001
 Richardson, Helen, personal correspondence with Lesley Courtney, 23 May 2001
 Sellars, Donna, interview with Lesley Courtney, 4 July 2001
 Smith, Joan, interview with Lesley Courtney, 26 July 2001
 Sutherland, Raewyn, personal correspondence with Lesley Courtney, 10 May 2001
 Ure, Penelope, personal correspondence with Lesley Courtney, 17 July 2001
 Wong Yuen, interview with Lesley Courtney, 17 June 2001
 MR, personal correspondence with Lesley Courtney, 17 July 2001
 NB, personal correspondence with Lesley Courtney, 1 July 2001
 SL, personal correspondence with Lesley Courtney, 6 June 2001
 TG, personal correspondence with Lesley Courtney, 14 July 2001
 WC, personal correspondence with Lesley Courtney 16 June 2001

B. Published

1. RNZSHWC

Begg, Neil, C., *Changing Patterns of Child Care: Some thoughts as the Plunket Society enters the last quarter of the 20th century*, Dunedin: RNZPS, 1975

Begg, Neil, *The New Zealand Child and His Family*, Christchurch: RNZPS, 1970

King, F. Truby, *The New Zealand Scheme for the Promotion of the Health of Women and Children*, Manchester: Henry Blacelock and Co., 1913 (DU:HO, AG7-8-19-2)

Annual Reports of Council 1959-81

Auckland Plunket-Karitane Hospital Annual Report 1974-75, (WA, MS 7 Box 1)

The Care of Babies and Small Children: A Guide for School Girls, 1956, (WA, MS7/13 Box 2)

General Conference Reports: Condensed summaries of reports for 13 years (1914-1926),
(WA, MS7/3, Box 1)

Plunket News, 1959-81

The Plunket Schoolbook of Childcraft, Christchurch: Whitcomb and Tombs, 1973 (WA MS7/8 Box 2)

The Plunket Society, Dunedin: 1961

The Origin and Development of the Work of the Society, Dunedin: Stone, Son and Co., 1953
(DU:HO AG-7-8-19-2)

Report of Twenty First General Conference 1934, (WA, MS 7/3, Box 1)

Rules regarding the Engagement and Duties of Karitane Baby Nurses for the Guidance of Mothers and Nurses, Dunedin: Stone Son & Co., Revised 1938, (DU:HO, AG7-8-22)

A Short Account of the Society and its Work, Dunedin: n.d., (DU:HO, AG7-11-47)

2. Official

Appendix to the Journals of the House of Representatives 1960

Department of Health (Infant Welfare Division), *The Expectant Mother and Baby's First Month*, Wellington: Government Printer, 1921

New Zealand Census 1966, 1976

'Nurses' Act' 1977, VII/52/3a, Website: www.gplegislation.co.nz/acts.html, 27 March 2001

Official New Zealand Yearbook, 1880, 1895, 1905, 1915, 1925, 1935, 1937, 1945, 1946, 1955, 1957, 1965, 1967, 1975, 1977

Report of the Consultative Committee on Infant and Pre School Health Services, Wellington: Government Printer, 1960

3. Nurses' Association

New Zealand Nurses' Association, 'Policy Statement on Nursing in New Zealand: New Directions in Post-Basic Education', Wellington: The Association, 1976

4. Newspapers

Auckland Star 1959

Christchurch Star 1960

Dominion 1961-62, 1977-78

Evening Star 1954, 1956

New Zealand Herald 1960, 1973

Otago Daily Times 1907, 1963, 1969, 1970, 1977

Sunday Times 1977

Wanganui Chronicle 1972, 1974

Wanganui Herald 1971

5. Magazines

New Zealand Home Journal 1967
New Zealand Woman's Weekly 1981

SECONDARY

A. Books

- Bruni, N., Tisher, R.P., Walsh, A., *Characteristics of Entrants into 5 Types of Nursing Courses: A Comparative Analysis*, Monash University, 1984.
- Bryder, Linda, *Not Just Weighing Babies: Plunket in Auckland, 1908-1998*, Auckland: Pyramid Press, 1998
- Buckenham, J.E., McGrath, G., *The Social Reality of Nursing*, Sydney: Health Science Press, 1983
- Burgess, Marie, E., *Nursing in New Zealand Society*, Auckland: Longman Paul, 1984
- Coney, Sandra, *Standing in the Sunshine*, Auckland: Penguin Books, 1993
- Dalley, Bronwyn, *Family Matters: Child Welfare in Twentieth-Century New Zealand*, Auckland: Auckland University Press, 1998
- Donley, Joan, *Save the Midwife*, Auckland: New Women's Press Ltd, 1986
- Fowler, H.W., Fowler, F.G.(eds), *The Concise English Dictionary of Current English*, Oxford: Clarendon Press, 1964, 5th edition
- Fry, Ruth, *Its Different for Daughters*, Wellington: New Zealand Council for Educational Research, 1985
- Gathorne-Hardy, Jonathan, *The Rise and Fall of the British Nanny*, London: Arrow, 1974
- Gregson, Nicky, Lowe, Michelle, *Servicing the Middle Classes: Class, Gender and Waged Domestic Labour in Contemporary Britain*, London: Routledge, 1994
- Guy, Christina, *Women on the Home Front: An S.O.S. from Mothers*, Wellington: Progressive Publishing Society, 1943
- Kedgley, Sue, *Mum's the Word: The Untold Story of Motherhood in New Zealand*, Auckland: Random House, 1996
- King, Mary, *Truby King the Man*, London: George Allen and Unwin Ltd, 1948
- May, Helen, *The Discovery of Early Childhood*, Auckland: Auckland University Press/ Bridget Williams Books, 1997
- May, Helen, *Minding Children, Managing Men: Conflict and Compromise in the Lives of Post-war Pakeha Women*, Wellington: Bridget Williams Books, 1992
- Nolan, Melanie, *Breadwinning: New Zealand Women and the State*, Christchurch: Canterbury University Press, 2000

- Gathorne-Hardy, Jonathan, *The Rise and Fall of the British Nanny*, London: Arrow, 1974
- Gregson, Nicky, Lowe, Michelle, *Servicing the Middle Classes: Class, Gender and Waged Domestic Labour in Contemporary Britain*, London: Routledge, 1994
- Guy, Christina, *Women on the Home Front: An S.O.S. from Mothers*, Wellington: Progressive Publishing Society, 1943
- Kedgley, Sue, *Mum's the Word: The Untold Story of Motherhood in New Zealand*, Auckland: Random House, 1996
- King, Mary, *Truby King the Man*, London: George Allen and Unwin Ltd, 1948
- May, Helen, *The Discovery of Early Childhood*, Auckland: Auckland University Press/ Bridget Williams Books, 1997
- May, Helen, *Minding Children, Managing Men: Conflict and Compromise in the Lives of Post-war Pakeha Women*, Wellington: Bridget Williams Books, 1992
- Nolan, Melanie, *Breadwinning: New Zealand Women and the State*, Christchurch: Canterbury University Press, 2000
- Parry, Gordon, *Fence at the Top: The First 75 Years of the Plunket Society*, Dunedin: Royal New Zealand Plunket Society, 1982
- Saunders, Llewellyn, *The New Zealand School Dental Service: Its Initiation and Development 1920-60*, Wellington: Government Printer, circa 1960
- Statistics New Zealand, *All About Women in New Zealand*, Wellington, 1993
- Wilson, Kathryn, *Angels in the Devil's Pit: Nursing in Rotorua 1840-1940*, Wellington: Karo Press, 1998

B. Articles

- Bryder, Linda, 'Perceptions of Plunket: Time to Review Historians' Interpretations' in *New Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health*, Linda Bryder and Derek A. Dow (eds), Auckland: Auckland Medical Historical Society, 1995
- Day, Barbara, 'Women in Technical Education', in *Women in Education in Aotearoa*, Sue Middleton and Alison Jones (eds), Wellington: Bridget Williams Books, 1992
- Giddings, Lynne, 'Royal New Zealand Plunket Society' in *Women Together: A History of Women's Organisation in New Zealand*, (ed) Anne Else, Wellington: Historical Branch, Department of Internal Affairs, Daphne Brasell Associates, 1993, pp.257-260
- Hughes, Beryl, 'Women and the Professions in New Zealand' in *Women in New Zealand Society*, Phillida Bunkle and Beryl Hughes (eds), Sydney: George, Allen, Unwin, 1980, pp.118-138
- Mein Smith, Philippa 'Truby King in Australia: A Revisionist View of Infant Mortality' in *NZJH*, Vol.22, No. 2, 1988, pp.23-43
- Middleton, Sue, 'Feminism and Education in Post-War New Zealand: An Oral History Perspective', in Roger Openshaw and David McKenzie (eds) *Reinterpreting the*

- Rodgers, Jan, A, 'Nursing Education in New Zealand 1883-1930: The Persistence of the Nightingale Ethos', MA Thesis in Education, Massey University, 1985
- Penny, Marion, Winifred, 'The Student Nurse in New Zealand: An Exploration in Role Perception', MA thesis in Sociology, University of Canterbury, 1968
- Favell, Margaret, E., 'Plunket Nursing in a Social, Political and Historical Context: Clients' Perspective of Mothering and Nursing', MA thesis in Health Science, University of Otago, 1997

D. Websites

www.plunket.org.nz/
www.careers.co.nz/jobs/3a_nur/j80248h.htm
www.gplegislation.co.nz/acts.html