NURSING, NURSES AND THEIR WORK IN ROCKHAMPTON, 1930 - 1950

W. L. MADSEN
Master of Health Science

1997

NURSING, NURSES AND THEIR WORK IN ROCKHAMPTON, 1930 - 1950

Wendy Madsen

A dissertation in fulfillment
of the requirements for a
Master of Health Science

Faculty of Health Science
Central Queensland University
Rockhampton

1997

Abstract

This dissertation has used an historical approach to investigate nursing at the Rockhampton Hospital between 1930 and 1950. It has focussed on the work practices of those nurses who carried out the majority of the work, the trainee nurses. The work practices examined include those related to infection control, treatments and interventions, monitoring activities and ward management issues such as hierarchical structure and communication.

This dissertation has placed nursing history at the centrepoint of three related disciplinary fields - medical, labour and women's history. This has allowed some of the origins of the rituals, traditions and culture of nursing to be identified. In particular the image of nurses as the doctor's handmaiden has been examined. This dissertation has revealed that while a large proportion of nursing activities were regulated by doctors, nurses controlled a significant amount of their work. This dissertation has, therefore, supported and challenged the foundations of the handmaiden image.

CONTENTS

Abbreviations

ATNA	Australasian Trained Nurses' Association
PTS	Preliminary Training School
QATNA	Queensland branch of the ATNA
QNA	Queensland Nurses' Association
SNA	Student Nurses' Association
VAD	Voluntary Aid Detatchment

Conversion Tables

Currency Conversion as of the February 14, 1966.

1 penny equalled 1cent
6 pennies equalled 5 cents
1 shilling equalled 10 cents
10 shillings equalled 1 dollar
1 pound equalled 2 dollars

Temperature Conversion

36.0 Celsius equals 96.8 Fahrenheit
37.0 Celsius equals 98.6 Fahrenheit
38.0 Celsius equals 100.4 Fahrenheit
39.0 Celsius equals 102.2 Fahrenheit
40.0 Celsius equals 104.0 Fahrenheit
41.0 Celsius equals 105.8 Fahrenheit
42.0 Celsius equals 107.6 Fahrenheit

Weight Conversion

1 kilogram equals 2.2 pounds

Glossary of Terms

Acriflavin: an antiseptic solution

Albumin: a water-soluble protein.

Albuminuria: the presence of albumin in the urine, indicative of kidney disease.

Antisepsis: destruction of micro-organisms through the use of antiseptics.

Asepsis: the complete destruction and elimination of micro-organisms.

Bacteriology: the study of bacteria.

Cystitis: bladder infection.

Epigastrium: the upper-middle part of the abdomen.

Miasmic Theory: belief that disease was caused by "bad" air.

Naso-gastric feeding: the delivery of fluids via a tube that is inserted into the stomach via the nose.

Sordes: collection of matter within the mouth, usually associated with ill patients who cannot eat or drink normally, and with lack of oral hygiene.

Subcutaneous Injection: one that is given into the fatty layer under the skin.

Tulle gras: petroleum impregnated gauze dressing.

Unna's paste: a mixture of ichthyol, zinc oxide, gelatin and water[1] . Used as a topical dressing.

[1] Hainsworth, M. *Modern Professional Nursing, Vol. 4.* London; The Caxton Publishing Company, Ltd. 1949, p. 14

List of Illustrations

List of Tables

Acknowledgements

Two years ago I dived into the academic ocean again, after a significant absence, to explore the hidden reef of nursing history. That I have emerged relatively unscathed is due to the guidance and support of my two supervisors, Hon. Prof. Amy Zelmer, and Dr. Denis Cryle. I thank them both for their courage and patience for guiding me when my visibility was limited and for allowing me considerable freedom to chart my own course. I would also like to thank Mrs Yvonne Kelley for helping me navigate the uncharted waters of the Rockhampton Hospital Museum.

As with any voyage of discovery, this journey would not have been possible without a very supportive crew. In particular, I would like to thank my chief babysitters, Mum and Dad for their constant love and support; my husband, Peter, who has anchored this entire project with his encouragement and love; and my two sons, Joshua and Jack, who have helped to keep things in perspective.

DECLARATION

I declare that all material used in this thesis has not previously been submitted for any other degree and that the main text of the thesis is an original work. Also, I declare that to the best of my knowledge, all sources used have been acknowledged.

Signature Redacted

December, 1997

Introduction

In 1866, five women arrived in Sydney to take up nursing positions. They came from the St. Thomas's Hospital in London, where they had undertaken the Nightingale nurse training course. They were known as trained nurses, and had come to the New South Wales colony to impart their knowledge and skill to the would-be carers within the Sydney Hospital. This was the start of official nurse training in Australia. It was the beginning of a new era when those who undertook nursing would be given increasing levels of responsibility for patient care, when hospitals came to be utilised by the wider community, and when nurses became increasingly respected by the community. As these nurses were taken on by hospitals, patient care and survival rates improved. From that point in the nineteenth century until today, the relationship between nurses, doctors, hospitals and society has undergone considerable change, as has the work undertaken by the nurses. The early Nightingale nurses were sought after because of the type of work they undertook. That work has evolved through the interaction of nurses within the hospitals and community. It is the purpose of this thesis to investigate, from an historical perspective, the work of nurses and the effect of the various interactions on their work, in the State of Queensland, and more particularly, the Central Queensland region.

In order to focus the research, one hospital has been selected for study. This has allowed a deeper investigation to be undertaken of nursing work within the hospital. Although the majority of trained nurses worked in non-hospital settings, the training these nurses gained within the hospitals largely influenced the way they conducted their work and themselves

throughout their nursing careers. The Rockhampton Hospital was selected because it was a major regional hospital within Queensland, and the only state funded hospital within the city of Rockhampton. This hospital was also the main training centre for nurses in the central Queensland region. Due to the wide variety of nursing activities found within the hospital, it was decided to further restrict the study to that of general nursing, that is medical and surgical nursing. Speciality areas like theatre nursing and midwifery have been excluded from the study.

The decades 1930 to 1950 were selected because they spanned a period of time which saw many changes within society, medical science and therefore, in hospitals. Prior to 1930, nursing practice appears to have changed little since the arrival of the Nightingale nurses in the previous century. Significant advances in medicine and surgery were made in early decades of the twentieth century, such as surgical technique advances, the introduction of X-rays and blood transfusions. As a result, the location of health care gradually moved from the home to the hospital. The period under review is also framed by an economic depression and a world war. These two major events impacted greatly on Australian society and hence, influenced the working lives of nurses. Hospitals were forced to work within smaller budgets during the depression, while the most significant effect of the war on the lives of civilian nurses was an acute shortage of staff. These factors, therefore, make this slice of time particularly interesting.

Literature Review

The study of nursing history is beginning to be recognised by researchers and professionals alike as a legitimate avenue for exploring the nature of nursing. There have been an increasing number of "nursing history" publications throughout the 1980s and 1990s. However, as American authors Hezel and Linebach[1] have noted, the majority of these books are little more than chronological records which outline events but offer no analysis or interpretation of the events. This view has been echoed in Australia by Godden, Curry and Delacour[2] and more recently, by Cushing[3], all of whom lament the lack of contextualization and analysis in many Australian nursing history accounts.

There are two main reasons for the lack of academic analysis to be found within nursing history. Firstly, nursing is primarily a female occupation, and as with most female endeavours, has been neglected by mainstream historians. This neglect began to be addressed in the mid 1970s, when a number of publications which focussed on women working in the home as well as in paid employment were released.[4] These studies examined working conditions, wages and union involvement within a number of

---

1 Hezel, L.R. and Linebach, L.M. "The Development of a Regional Nursing History Collection: Its Relevance to Practice, Education, and Research." *Nursing Outlook* No.39, Vol.6, November-December 1991, pp. 268-272.

2 Godden, J., Curry, G., Delacour, S. "The Decline of Myths and Myopia? The Use and Abuse of Nursing History." *The Australian Journal of Advanced Nursing,* No.10, Vol.2, December 1992 - February 1993, pp. 27-34.

3 Cushing, A. "Nursing History in Australia." *International History of Nursing Journal,* No.1, Vol.1, Summer 1995, pp. 69-70.

4 Kingston, B. *My Wife, My Daughter and Poor Mary Anne. Women and Work in Australia.* Melbourne; Thomas Nelson (Australia) Ltd. ,1975; Curthoys, A., Eade, S., Spearritt, P. *Women at Work.* Canberra; Australian Society for the Study of Labour History, 1975; Ryan, E. and Conlon, A. *Gentle Invaders. Australian Women at Work.* Ringwood; Penguin Books Australia Ltd., 1975.

occupations, nursing included. Kingston[5] broadly analysed nursing in terms of social class and the effect of middle class values on the conditions endured by nurses until World War 1. However, nursing has generally not been the main focus of such studies. The second factor, which is likely to be related to the first, is that nurses who have attempted to write their own history, have not usually been skilled in historical methodology. The result has been a myriad of celebratory accounts of particular hospitals or prominent persons.[6] Australian nursing history publications therefore, may be broadly classified into two categories: those which deal with the activities of institutions such as professional nursing bodies[7], unions[8], specific hospitals[9], or a particular state[10]; and those which are more concerned with issues pertaining to the rank and file. This second category tends to originate from the works of labour or feminist historians, and therefore tends to be more sociologically focused and more analytical.[11] Only one author has attempted to outline the many facets of nursing service within Australia; this has however, been at the expense of any analysis.[12]

---

5 Kingston, op.cit. pp. 81-91.

6 For example: Brown, L.M. *History and Memories of Nursing at the Launceston General Hospital,* Launceston; The Launceston General Hospital Ex-Trainees Association, 1980; Goddard, J. "Jessie Street and the Formation of the New South Wales Nurses Association." *The Lamp,* July 1989, pp. 14-17.

7 For example: Trembath, R. and Hellier, D. *All Care and Responsibility. A History of Nursing in Victoria 1850-1934.* Victoria; The Florence Nightingale Committee Australia, Victoria Branch, 1987.

8 For example: Dickenson, M. *An Unsentimental Union. The New South Wales Nurses Association 1931-1992.* Sydney; Hale & Iremonger Pty. Ltd., 1993.

9 For example: Gregory, H. *A Tradition of Care. The History of Nursing at the Royal Brisbane Hospital.* Brisbane; Boolarong Publications, 1988.

10 For example: Birchill, E. *Australian Nurses since Nightingale 1860 - 1990.* Richmond; Spectrum Publications Pty. Ltd., 1992.

11 For example: Keneley, M. "Handmaidens of Medicine: Working Conditions for Nurses in Late Nineteenth Century Victoria." *Journal of Australian Studies,* May 22, 1988, pp. 57-68; Bessant, J. "Good Women and Good Nurses. Conflicting Identities in the Victorian Nurses Strikes 1985-86. " *Labour History,* No.63, November 1992, pp. 155-173.

12 Schultz, B. *A Tapestry of Service. The Evolution of Nursing in Australia, Vol 1, Foundation to Federation 1788-1900.* South Melbourne; Churchill Livingstone, 1991.

Due to the nature of Australian nursing history, there has been little emphasis on the actual clinical work undertaken by nurses. A number of publications have briefly outlined some of the tasks nurses carried out on the wards, but none has systematically analysed the work nor examined the external and internal influences on that work. However, there are three international publications which have been relevant to this study. Melosh's[13] work is one of the few that explores the changes within nursing from a rank and file perspective. Although it looks at nursing within the United States of America (a system that has some fundamental differences to the system within Australia), it contains pertinent references to the culture that existed within apprentice style nurse training. Maggs[14] undertook an analysis of ward nursing at the turn of the century in British hospitals. Maggs particularly outlines the work of the probationer nurse on a general ward. The final publication which has contributed significantly to this study is the work of McPherson.[15] This book has also taken a rank and file perspective, but unlike other publications, has specifically located nursing at the junction of three related bodies of scholarship - those of labour, women's and medical history.[16] From this idea, a framework was designed for the analysis of nursing work within this study.

The conditions of nursing, especially ward nursing, within Queensland have been extensively covered in Strachan's work.[17] Her book, based on

---

13 Melosh, B. *The Physician's Hand. Work, Culture and Conflict in American Nursing.* Philadelphia; Temple University Press, 1982.

14 Maggs, C.J. *The Origins of General Nursing.* London; Croom Helm Ltd., 1983.

15 McPherson, K. *Bedside Matters. The Transformation of Canadian Nursing 1900-1990.* Toronto; Oxford University Press, 1996.

16 Ibid., p. 2.

17 Strachan, G. *Labour of Love. The History of the Nurses' Association in Queensland 1860-1950.* St. Leonards; Allen and Unwin Pty. Ltd. 1996.

her doctoral research, focusses on the main professional nursing body in Queensland during the first part of this century, and provides much of the background information necessary for this study. However, Strachan's work emphasises metropolitan hospitals, mainly due to the lack of involvement of regional centres in the activities of the Australasian Trained Nurses Association (ATNA) during this time period.

Methodological Considerations

An historical approach has been used throughout this research. Sarnecky[18] suggests this approach is one whereby data is collected from the past, examined, and integrated into a coherent understanding of the past, which in turn influences one's understanding of the present and the future. Historical research should allow insight into the behaviours and identity of individuals and communities, and therefore allow one to anticipate the consequences of decisions and actions of similar individuals and communities.[19] This goes beyond simply gathering facts about events, and placing them in some sort of chronological order. As well as the context in which the events occurred, there must be consideration as to the perspective to be taken, for example an official or elitist view or a grass-roots perspective. This research has taken the bottom-up approach, that is it has focussed on issues and events that related to rank and file nurses.

Historical research contains a number of distinct stages, not dissimilar to other methodologies. These stages include asking historical questions,

---

[18] Sarnecky, M.T. "Historiography: A Legitimate Research Methodology for Nursing." *Advances in Nursing Science,* July 1990, p. 2.

[19] Gilderhus, M.T. *History and Historians. A Historiographical Introduction. 2nd Ed.* New Jersey; Prentice Hall, 1992, p. 7.

gathering relevant primary source material and analysing this material in order that conclusions may be drawn. However, within each of these methodological stages, there are a number of issues that must be addressed in order to satisfy the requirements of historical research. Issues need to be examined, such as determining the historical approach to be used and the reliability and validity of the primary source material. These factors form the basis of historical research, and therefore will be discussed in relation to this research project.

Historical Questions. There are two principles which govern the direction of original historical research. In one approach, the historian investigates sources that are related to the area of interest, and allows the content of these sources to determine the nature of the inquiry. The second approach involves the formulation of a specific historical question and exploration of the relevant sources in order to draw appropriate conclusions.[20] The approach used in this research was a combination of the two. As the subject under investigation has not been well researched in the past, and hence there are few relevant secondary sources, it was not possible to formulate specific historical questions at the commencement of the project. In addition, the local nursing museum is not currently catalogued, nor is much of the other source material used in the research. Therefore, the direction the research took initially was to ascertain what sources were available and what could be extracted from these that was relevant to the broad area of nursing work. It was only after a significant amount of information was collected that specific questions could be asked, and these

[20] Tosh, J. *The Pursuit of History. 2nd Ed.* Essex; Longman Group UK Ltd., 1991, p. 54.

tended to arise from the sources themselves. This has necessitated retracing previous paths in order to seek the specific information relevant to the questions being asked.

Under the realm of nursing work, a number of broad categories have been identified - infection control, monitoring activities, interventions and ward management. The chapters contained within this study represent the multifocus of nurses as they tended to patient needs, striving to uphold the principles of nursing as outlined by the Nightingale pledge.[21] Chapter One outlines the background of nursing in Queensland and gives an overview of the development of the Rockhampton Hospital. In Chapter Two, infection control issues, which were an integral part of day to day nursing, are explored. With the prevalence of epidemics during the first half of this century, nurses were acutely aware of the need to prevent the spread of infection from patient to patient. They, therefore, constructed a range of elaborate regimes designed to minimise contamination of themselves and hospital objects.

Chapters Three and Four explore the relationship between nurses and the various groups which influenced nursing work. The range of monitoring activities undertaken by nurses represent the extent to which their work was controlled by other groups, such as doctors and administrators. This also illustrates the important role nurses have played in the evolution of medical science. Similarly, many of the interventions and treatments undertaken by nurses were influenced by doctors. However, Chapter Three also outlines the variety of activities that nurses controlled, challenging the idea that nurses were exclusively the handmaidens of doctors. Finally, Chapter Five

[21] See Appendix A for Nightingale's Pledge.

deals with the structures within the ward environment which influenced the way nurses conducted themselves and their work. In particular, the nursing hierarchy, with its rigid system of duty allocation and communication, will be explored to ascertain the effect this structure had on the daily running of the ward. One of the aims of this study is to determine the convergence of the activities of the nurses at the Rockhampton Hospital and the procedures outlined in the available nursing literature. After all, the nursing texts and journals were likely to describe the ideal, and it was unlikely that a rural hospital in the midst of a depression or war was able to provide ideal conditions.

Within each category of work identified, there have been particular questions asked that have determined the direction of investigation. However, the fundamental structure of the research has been based on the following questions: What work was done by nurses? That is, what tasks and procedures were carried out? How were these tasks and procedures carried out? Why was the work conducted in the way it was? What influenced the carrying out of these tasks and procedures? Who benefited from the work being carried out? In particular these questions have been asked in relation to the three background areas as outlined by McPherson[22] : the medical profession, the hospital, and women's traditional constraints. Figure 1 illustrates the model utilized for this study based on these three parameters. This model has provided a framework enabling the various nursing activities and tasks identified to be more effectively analysed.

---

22 McPherson, op.cit., p. 2.

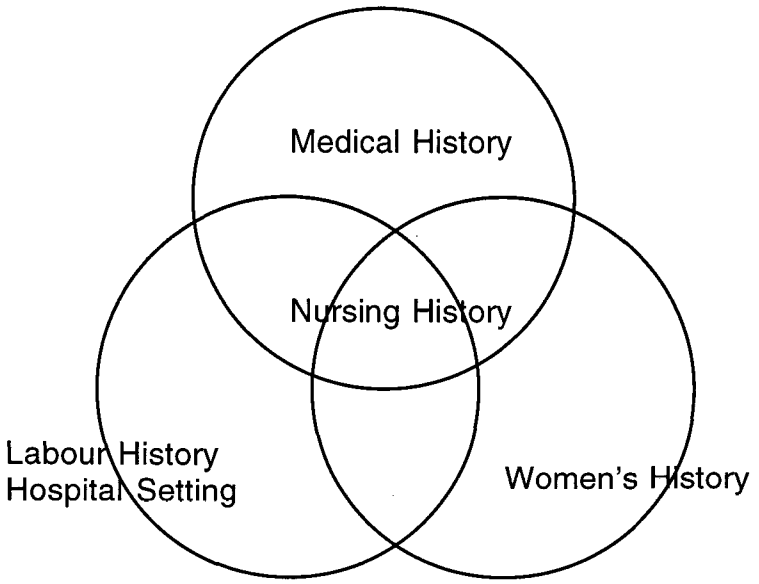

Figure 1. Tripartite Model for Nursing History Analysis

Collecting Primary Source Data

The majority of the primary source data was collected from the Rockhampton Hospital Museum, the Queensland Nurses' Union Library and the Queensland State Archives. In addition, personal items, such as lecture notes, memoirs and text books were accessed as a consequence of interviewing former nurses. Each piece of evidence was judged according to relevance, authenticity and reliability.

A wide variety of primary sources were used in this study. Text books used by the nursing students, professional nursing journal articles, newspaper articles, government letters and documents, lecture notes of students, exam questions and answers, ATNA reports, memoirs and oral testimonies. Of the published material, there is little reason to doubt the authenticity of these documents. Most contained a publishing date, were in a condition

that was consistent with that date, and used language that correlated to other pieces of a similar era. With regards to internal credibility, Maggs[23] has shown that most of the early nursing text books were either written by doctors, and therefore contained information consistent with what doctors thought nurses ought to know and do; or written by senior nurses which included the detailed nursing procedures practised by the author in a particular hospital. As many of these texts were British, one has to consider whether the information was relevant to Australian conditions, especially Central Queensland conditions. Australian nursing texts did become available during this period. However until 1935, when Gwen Burbidge[24] was the first Australian nurse to publish a nursing text, these had been written by doctors. The text written by Doherty, Sirl and Ring[25] also appears to have been popular after being published in 1944.

A significant amount has come from newspaper and journal articles; however, with these sources, one must consider author bias and prejudice, as well as any hidden agendas of the publication. The journal most often referred to in this study is the official publication of the Australasian Trained Nurses Association (ATNA). This journal contained the minutes of the state branches, articles from members, and a number of reprinted articles, usually from British professional journals. One of the main difficulties associated with this journal was establishing what nursing position the author held as this was not printed with the article, however, as it was a relatively small association, often the author's name would appear in another section, for example in a letter to the editor, and it was then

23 Maggs, op.cit., p. 115.

24 Burbidge, G.N. *Lectures for Nurses.* Glebe; Australasian Medical Publishing Co. Ltd., 1935.

25 Doherty, M.K., Sirl, M.B., Ring, O.I., *Modern Practical Nursing Procedures.* Sydney; Dymocks Book Arcade Ltd. 1944.

possible to establish the author's credentials. As the voice of a professional association which was keen to promote a professional image of nursing through education, this journal was often more concerned with promoting the ideal than the reality of nursing. Similarly, the minutes of the Queensland branch of the Australasian Trained Nurses' Association (QATNA) reflect this philosophy of professional promotion.

The governmental documents referred to were obtained from the Queensland State Archives and are assumed to be authentic. Most of the relevant documentation was in the form of letters between the Rockhampton Hospital Board and the various government departments. The newspaper cited most frequently was the *Rockhampton Evening News*, but this paper ceased operation during World War Two. This newspaper reported the minutes of the Rockhampton Hospital Board in considerable detail each month, and hence has provided information not otherwise available, as most of the hospital records were destroyed during a cyclone in 1949. This newspaper seems to have published a wide range of viewpoints, although some articles could be construed as sensationalistic. One of the difficulties associated with this paper was that occasionally the author of the reports could not be identified.

Oral histories have contributed significantly to this research, in that they have allowed the researcher to gain an understanding of the ward and working conditions of nurses during the 1930s and 1940s. Paper was in short supply, and these women worked very long hours, so very few of them kept personal diaries. Ethical clearance was obtained from the Central Queensland University prior to interviewing fifteen former nurses. Two

interviews were conducted with women who were finishing their training in 1930. A further two testimonies were obtained from other researchers which also covered this era, up to 1934. One of the interviewees started her training in 1950, and completed it in 1954. The remainder of the interviewees nursed between 1937 and 1950. Of those interviewed, one worked at the hospital as a trained nurse only, two partially trained at the Rockhampton Hospital and then transferred to complete their training at the Rockhampton Mater Hospital, one did not finish her training after completing three years, one worked as a Voluntary Aid Detachment (VAD) at the hospital during the war and then commenced her training after the war. In all, eleven of the interviewees completed their training at the Rockhampton Hospital.[26]

In order to gather the oral history testimonies, a variety of methods were used, in an effort to increase the range of interviewees, and therefore reduce data bias. Thompson[27] outlines three methodologies used to collect oral histories. "Snowballing" is the method whereby interviewees give the researcher names of potential interviewees. This method allows the researcher to build a strong picture of a particular social group, as the contacts tend to come from the same socioeconomic group. In order to gain a broader representation, interviewees are sought from all significant social layers, with the "community stratified sample" method. The "quota" sample further refines this by seeking representation from each social group that reflects the size of that group, for example, a small number of management interviews, and a large number from the rank and file. As it was not possible to select potential interviewees, it was decided to invite

[26] See Appendix B for a brief profile of the informants interviewed for this study.

[27] Thompson, P. *The Voice of the Past. Oral History.* Oxford; Oxford University Press, 1988, pp. 130-131.

women who had nursed during the time period through a variety of means. A letter was posted to the Director of Nursing of each of the nursing homes in the region, an invitation to former nurses to contact the author was also published in the Queensland Nurses' Union journal. The other informants were introduced through personal contacts. This allowed a wider base of initial contacts, from which the "snowballing" method was then implemented. Although many of the informants later worked at the hospital as trained nurses, only one worked at the hospital in this capacity during the time period under review. While it may be suggested that this may have skewed the data toward trainees, the reality was that the bulk of the work was done by the trainee nurses, who were supervised during the day by the trained nurse on the ward, and to a less extent, by the sister in charge of the hospital during the evening and night.

Interviews were generally conducted in the informant's home, at a time that was convenient for the informant. The interviews were recorded on a cassette recorder, after permission to do so was granted. Recording the interview is seen as an ideal way of gathering oral testimonies, although it is not the only method. Tape recording is a more objective process than taking notes[28] and allows the interviewer to concentrate on the informant's answers and to follow up on issues mentioned. At the conclusion of the interview, the informant was asked to sign a consent form, indicating they were satisfied with the information given and the future storage of the information. The tapes were later transcribed verbatim, a copy of the transcript was sent to each of the informants, with return envelopes, asking

[28] Seldon, A. and Pappworth, J. *By Word of Mouth, Elite Oral History.* London; Methuan and Co., 1983, p. 71.

for their confirmation of the information. This allowed informants to correct or enlarge on their recollections. The majority of informants returned the transcripts with few alterations.

The interviews were conducted throughout the data collection phase of the research. Seldon and Pappworth[29], suggest that oral histories conducted towards the conclusion of the research are useful in order to enhance the understanding of the subject. Interviews conducted at the beginning of the research are useful in giving an overview of the topic, directing other research activities. As the interviews were conducted over a time period of eight months, there was a certain amount of reciprocal influence between the more traditional historical research activities and the oral histories. In particular, it was decided to alter the interview guide being used after the first four interviews. This was a result of further reading and reflection undertaken, thereby refining the type of information sought. The interview guide structure remained the same, that is, based on open ended questions, however, some of the questions were reworded, extra ones added, and the sequence was altered. The revamped guide elicited more pertinent information in the subsequent interviews. Conversely, the information collected from the oral histories influenced the direction of data gathering in other areas.

One of the difficulties with using oral histories, is the influence the researcher may have on the interview through his or her attitude and control of the conversation, including omitting asking relevant questions.[30] The use of open ended questions countered this to a certain extent by

[29] Seldon and Pappworth, op.cit., p. 57.

[30] Cowden, V. "Historiography and Oral History: A Plea for Reconciliation." *Oral History Association of Australia Journal,* No. 5, 1982-83, p. 36.

enabling the informant to answer freely. Also the question guide was not rigidly adhered to, allowing the informant a significant amount of control over the conversation. Adequate preparation also minimised the risk of inadvertently omitting areas of importance, and allowed appropriate questions to be asked.[31] In addition, towards the end of the interview, the informant was invited to add any further information. Sufficient time was allowed for an interview to be conducted, so the informant would not feel pressured to answer questions quickly. There was also an awareness on the part of the researcher of the importance of encouraging the informant to feel relaxed and at ease with the process. Therefore, time was usually spent, prior to the interview, in becoming acquainted.

Terminology

As this study has focussed on a period in the past, many of the terms used then are not necessarily used today, nor are some aspects associated with nursing entirely clear. Therefore it is appropriate to explore and define some of the terms used within this study. Many persons of authority have attempted to define the term "nursing", including Nightingale[32], yet a comprehensive definition is still not available. However, for the purposes of this research, "nursing" will be used to distinguish the work that nurses did and will include the attitudes and values that are associated with that work by those who nurse. The "nurse" is defined as someone who was employed as such, and includes those who had completed a recognised period of training, called the "trained nurse" or "sister" , and those who were gaining their training, called "student nurses" or "trainees". There has been

31 Jamieson, R. "Rewards and Frustrations in Oral History". *Oral History Association of Australia Journal,* No. 4, 1981-82, p. 70.

32 Nightingale, F. *Notes on Nursing: What it is and What it is Not,* Glasgow; Blackie and Sons Ltd., 1974.

a conscious decision to use the terminology of the era, and therefore the terms "sister" and "matron" have been used. Generally "nurse" will refer to a trainee. The reasoning behind this decision relates to the significant contribution of oral histories as this is the terminology used by the participants. This is also the terminology used in most of the other primary sources.

With regard to gendered language, as all the nurses at the Rockhampton Hospital were all female during the 1930s and 1940s, feminine pronouns have been utilised throughout this paper. In addition, it should be noted that the terminology used in the literature and in conversation during the early part of this century suggested that all doctors were male, which did not accurately describe the demographics of the medical profession, although there was a majority of male doctors. However, it has been decided not to adjust the quotes and citations used for this study as in many instances the gendered language used is as significant as the content.

Limitations

A number of limitations have been identified within this study, some of which were voluntarily imposed. As mentioned earlier, this study was restricted to the examination of medical and surgical nursing in one hospital, the Rockhampton Hospital. In addition, there has been a conscious effort to exclude from the study, those areas of nurses' lives which were not directly related to nursing work, such as the imposition of hospital rules and regulations in off duty time. However, as it was compulsory for nurses to live on the hospital premises, it was sometimes

difficult to discern the influence this factor had on their work responsibilities. Therefore this factor has only been addressed when it was identified as an issue in regards to nursing work.

One of the major limitations identified as the study progressed related to the time constraints. Many of the activities explored could not be adequately explained without going further back in time, indicating the strong influence of nursing tradition on the procedures carried out by nurses during this era. To have traced these traditional influences would have constituted a much larger study than this current project. This factor has highlighted the limitations of using a tripartite model which is bound by a time line. While the model encouraged contextual issues to be explored from the perspectives of medical, labour and women's historical developments, it does not adequately allow for investigation into those aspects of nursing which developed over time within the nursing profession, independent of other influences.

Despite these limitations, this study has endeavoured to present a comprehensive analysis of the work of nurses in a regional part of Queensland during the 1930s and 1940s, a time of social and political turmoil. It is hoped this contribution will further the understanding of nursing practice in Australia.

CHAPTER 1

Nursing Developments in Queensland 1900 - 1950

The first fifty years of the twentieth century are historically interesting because of the many challenges faced by our society. The many industrial and professional changes that occurred within nursing in Queensland throughout the first half of this century need to be viewed within the context of wider social issues which involved women. These years contained two world wars and a major economic depression, with each accompanied by political, social and economic dislocation. In particular, the roles and expectations of women underwent considerable change during this period. As nurses at the Rockhampton Hospital were exclusively women, it is pertinent to explore some of the images and issues relating to women that were apparent prior to and during the 1930s and 1940s. It is, therefore, necessary to review the roles and expectations of women while establishing the professional nursing background against which nurses at the Rockhampton Hospital operated.

The first professional nursing organisation to be established in Queensland was the Queensland branch of the Australasian Trained Nurses Association (QATNA) in 1904.[1] The formation of this association was based on the view that trained nurses needed to improve their professional standing within society and that this could be accomplished with a representative professional body which in turn, could be instrumental in establishing standards for the profession. That these nurses chose to improve the status

---

[1] Strachan, G. "Sacred Office, Trade or Profession? The Dilemma of Nurses' Involvement in Industrial Activities in Queensland, 1900-1950," in Frances, R., Scates, B. *Women, Work and the Labour Movement in Australia and Aotearoa/New Zealand,* Sydney; Australian Society for the Study of Labour History, 1991, p. 152.

of nursing via this avenue reflects the propensity of these women towards Victorian middle class values. As Strachan[2] points out, this middle class ethos of dedication, self-sacrifice and service without material reward was very prevalent among nurses at the turn of the century. Although middle class women during this period had been agitating for greater legal and political rights[3], nurses appear to have abided by more conservative notions, although occasionally individual nurses were noted for more radical actions.[4] This is especially evident when considering the members of the fledgling nurses' association, many of whom were male medical practitioners. In particular, the senior positions within the executive were held by these doctors for many years.[5] It was not until 1943 that a nurse held the position of president within the QATNA.[6]

The QATNA was only concerned with representing the interests of trained nurses at this initial stage.[7] The interest in student nurses was confined to establishing training levels to ensure a certain standard of trained nurse would be eligible to join the association. Many of the positions within the QATNA were held by senior nursing personalities from within the major Brisbane hospitals, although a significant proportion of the trained nurses the QATNA represented were known as private nurses. However, because

---

2 Ibid., p. 148.

3 Patmore, G. *Australian Labour History,* Melbourne; Longman Cheshire Pty. Ltd. 1991, p. 168.

4 Young, P. *Proud to be a Rebel. The Life and Times of Emma Miller,* St. Lucia; University of Queensland Press, 1991, p. 85. A Clermont nurse, Clara Jones, was dismissed from the Muttaburra Hospital after hoisting a red flag over the hospital in 1892, in celebration of Queensland's first endorsed Labour candidate.

5 Strachan, G. *Labour of Love. The History of the Nurses' Association in Queensland, 1860 -1950,* St. Leonards; Allen & Unwin Pty. Ltd., 1996, p. 38.

6 Ibid., p. 40.

7 Strachan, op.cit., 1991, p. 152.

of the long and irregular hours these nurses worked, few of them were able to participate actively in the activities of their professional body.[8] Private nurses worked independently, nursing people in their own homes. Private nursing was one of the many avenues open to trained nurses until the 1930s[9] , when the depression and advances in medical science contributed to the move from the home to hospitals as the primary location of health care. This caused considerable levels of unemployment within the ranks of private nurses during the late 1930s[10], and may have contributed to the QATNA denying there was a nursing shortage problem.[11]

The QATNA, while representing the interests of trained nurses statewide, tended to cater to the needs of southeast Queensland nurses. This fact was related primarily to the problems of distance and transport so prevalent in this country's history. One of the primary principles of the QATNA was that of improving the knowledge of its members through regular lectures. However, these were inevitably held in Brisbane, as were all of the association's meetings. Therefore, due to the tyranny of distance, country and regional members were largely excluded from participating in the affairs of their representative body.

As the bulk of the nursing work force during the first part of this century was made up of students , who were not represented by the QATNA, this meant the majority of nurses had to rely on the good will of matrons and hospital administrations for their working conditions. These conditions included

---

[8] Ibid., p. 138.

[9] Dickenson, M. *An Unsentimental Union. The New South Wales Nurses' Association 1931 - 1992,* Sydney; Hale and Iremonger Pty. Ltd. 1993, p. 23.

[10] Strachan, op.cit., 1996, p. 148.

[11] Queensland branch of the Australasian Trained Nurses' Association, Minutes, May 10, 1938, Queensland Nurses' Union.

domestic duties, monotonous regulatory duties, excessively long hours with no recognised overtime, a lack of food[12] and strict off-duty regulations which included curfews and penalties. This situation lead to the formation of the Queensland Nurses' Association (QNA) in 1920, a group comprised primarily of student nurses from the Royal Brisbane Hospital.[13] The main purpose of this group was to improve the wages and conditions of nurses, culminating in the introduction of the first nurses' award in 1921.[14] This award contained a significant wage increase. In 1925, the award was amended to limit the number of hours nurses worked to 88 per fortnight, in line with other hospital workers.[15] The ideals of the QNA clashed markedly with those of the QATNA, the latter spurning the industrial activities of the former as they were not compatible with the vocational attitude of its members. Bessant[16] suggests that it was the belief in the vocational basis of nursing which provided the basis for the trained nurses' claim to professional status.

This conflict between these two nursing groups was indicative of the conflicting images of women's role in society during this era. By the late 1920s, the print media was portraying two images - one which celebrated the achievements of women[17], while the other deplored the feminist movement and called for the return of women to their rightful place, the home.[18] By 1930, women were calling to be represented within traditional

12 De Vries, S. "Nursing History: Hope for the Present," *Central Queensland Journal of Regional Development,* Vol. 3, No. 3, 1995, pp. 32 - 33.

13 Strachan, op.cit., 1991, p. 156.

14 Strachan, op.cit., 1996, p. 107.

15 Ibid., p. 117.

16 Bessant, J. "Good Women and Good Nurses. Conflicting Identities in the Victorian Nurses' Strike, 1985-1986," *Labour History,* Vol. 63, November 1992, p. 160.

17 For example, *Rockhampton Evening News,* November 30, 1929, p. 10.

18 For example, ibid., December 23, 1929, p. 3.

male bastions of control such as hospital boards.[19] In an environment where women were challenging the status quo, it was not unlikely, that a group such as the QNA should form. However, the onset of the depression meant the achievements of the QNA were quickly undone and, in 1930, a Queensland Royal Commission into hospitals ruled that nurses' hours were to officially be restored to 96 hours a fortnight.[20] In 1931, nurses received a reduction in wages and conditions, in accordance with most employees, with their wages decreased by five percent and holiday and sick leave each reduced by a week.[21]

Underpinning the argument that women remain in the home were the strong connections of women to motherhood. The image of women being natural mothers' to the exclusion of any other role, ran deeply through Australian society for many years. In 1902, a Commonwealth Public Service Act was passed which required women employed as public servants to resign from their jobs upon marriage.[22] It was assumed that married women would be adequately provided for by their husbands, whose wage was designed to support dependents. There was some speculation in the 1930s that married women who did not resign were contributing to the unemployment of unmarried women[23], although in 1933 married women made up just over five percent of the paid work force.[24] Work was therefore, seen as an interim occupation for women and to prepare them for marriage.

---

19 Ibid., July 9, 1930, p. 2.

20 Ibid., November 11, 1930, p. 1.

21 "Annual Report of the Queensland Branch of the Australasian Trained Nurses' Association," *The Australasian Nurses' Journal,* September 15, 1931, p. 176.

22 Patmore, op.cit., p. 170.

23 *Rockhampton Evening News,* May 14, 1932, p. 7.

24 Patmore., op.cit., p. 170.

Nursing was suggested by some to be ideal training for marriage and motherhood because of the qualities developed such as self-control, self-discipline, co-operation and deftness.[25] The social expectation of resignation upon marriage was particularly evident in nursing. As the age of entry into nursing at the Rockhampton Hospital was eighteen years of age[26] , trainee nurses experienced a significant drop in their numbers due to marriage. Although a number of nurses managed to marry and continue their training, their marital state had to remain a secret, for instant dismissal would have resulted had their secret been detected, despite the nursing shortages experienced in the 1930s and 1940s.

> You weren't allowed to be, if you were training and got married, that was it. There was a few girls that were secretly married but....if ever found out, you were finished. You couldn't nurse once you were married.[27]

These women, therefore, continued to live in the nurses' quarters at the hospital, only able to see their husbands on a limited basis.

Married women were, however, actively encouraged to join the work force during times of national crisis, such as the two world wars. World War II particularly mobilised many women into non-traditional areas of work, that is outside those areas which were seen as feminine domains, such as health, education, manufacturing, clerical administration and domestic service.[28] World War II was also the catalyst for change within the nursing

---

25 Cameron, N. "The Art and Profession of Nursing," *The Australasian Nurses' Journal,* March 1947, p. 56.

26 *Rockhampton Evening News,* March 20, 1931, p. 16.

27 Interview, W. Madsen with M. Baggett, June 6, 1996.

28 Patmore, op.cit., p. 169.

profession. For the first time hospitals were forced to employ married trained nurses on a part-time basis or retain married trainees in order to maintain minimal staffing levels.[29]

It was during World War II that the disparity of conditions between what was considered to be "male" and "female" work, was highlighted. Until that point it was generally accepted that wages and working conditions were lower for women than men. This was primarily related to the lack of union involvement of women.[30] In the 1930s, women employees could work up to fourteen hour days[31], not incur penalties for shift work, and be granted as little as two weeks holiday per year.[32] The conditions inherent in nursing were not dissimilar to these, although as Strachan[33] acknowledged, many women workers, especially those employed in clerical positions, had considerably better working conditions than nurses.

Women generally received a minimum wage which was fifty-four percent of the male basic wage, and which was increased to seventy-five percent in 1950.[34] The trade union support women did receive during the 1930s and 1940s was limited to requests for equal pay for work that women undertook that was traditionally "male". The rationale behind this support was that if an employer had to pay equal wages, a male would be favoured for the

---

29 Queensland Australasian Trained Nurses' Association, Minutes, September 15, 1943, Queensland Nurses' Union .

30 Wright, A. "Jessie Street, Feminist," in Curthoys, A., Eade, S., Spearritt, P. *Women at Work,* Canberra; Australian Society for the Study of Labour History, 1975, p. 61.

31 *Rockhampton Evening News,* March 11, 1931, p. 9.

32 Goldsmith, B. and Sandford, B., *The Girls They Left Behind,* Ringwood; Penguin Books Australia Ltd. 1990, p. 37.

33 Strachan, op.cit., 1991, p. 158.

34 Patmore, op.cit., p. 176.

job.[35] This focus of the unions created considerable tension during the war when large numbers of women undertook "male" jobs and earned up to ninety percent of the male wage.[36] The result was a significant difference in income between those continuing in traditional "female" work, and those doing the "male" jobs. It also contributed to the labour shortages experienced in those "female" occupations. This contention regarding wages resulted in significant increases in union membership during the war, from thirty-three percent of the total female work force in 1939, to fifty-two percent in 1945.[37] However, good wages were not necessarily exclusive to the "male" occupations. With the introduction of American soldiers during the war, some of the "female" jobs became quite lucrative at times. For example, Goldsmith and Sandford[38] relate the experiences of a waitress who earned 30 pounds one morning in 1942 in tips alone, after serving fifty American soldiers. See Table 1 for a comparison of wages between various female occupations during 1943 and 1944.

During World War II, two institutions were introduced which impacted significantly on the working lives of women. One was the Women's Employment Board which was designed to regulate the conditions of employment for women undertaking "male" work. This included limiting the weight allowed to be lifted by women to 35lbs, and preventing them from

---

35 Johnson, P. "Gender, Class and Work: The Council of Action for Equal Pay and the Equal Pay Campaign in Australia during World War Two," *Labour History,* Vol. 50, May 1986, p. 136.

36 Larmour, C. "Women's Wages and The WEB," in Curthoys, A., Eade, S., Spearritt, P. (eds) *Women At Work,* Canberra; Australian Society for the Study of Labour History, 1975, p. 54.

37 Patmore, op.cit., p. 174.

38 Goldsmith and Sandford, op.cit., p. 34.

working after 9 pm.[39] However, it was the introduction of Manpower regulations that impacted on the more traditional "female" occupations. Manpower was designed to control the movement of working women, especially the exodus of women from those "female" jobs which were experiencing considerable staff shortages. Manpower, however, was unable to adequately address staff shortages in skilled "female" occupations such as nursing.

Table 1. Comparison of female wages, 1943 and 1944[40]

Occupation	Age	Wage (in pounds/shillings/pence)
Student nurse	18	2.10.0
Typist	18	1.14.3
Shop Assistant	18	1.13.6
Student nurse	20	3.0.0
Typist	20	2.11.9
Shop Assistant	20	2.4.9
Sister	23	4.12.6
Typist	adult	4.4.6
Shop Assistant	adult	3.13.0

It was the nursing shortages experienced during the World War II that resulted in a high level of unrest among nurses throughout Queensland. In 1944, the nurses at Goodna Memorial Hospital went on strike. Strike action was also taken or threatened at Willowburn Mental Hospital in Toowoomba,

---

[39] Ryan, E. and Conlon, A., *Gentle Invaders. Australian Women at Work,* Ringwood; Penguin Books Australia Ltd. 1975, p. 127.

[40] Comparison Between State Service Award and Nurses' Award, Queensland State Archives, A/31807.

Collinsville Hospital and Cairns Hospital.[41] These isolated strikes were initiated by the nurses themselves in the individual hospitals, with no apparent attempt to co-ordinate with other institutions. However, in 1944 a Student Nurses' Association (SNA) was formed and became affiliated with the QATNA, to enable students to participate in the QATNA's affairs for the first time.[42] In Rockhampton, the shortage and conditions led to the formation of the first sub-branch of the QATNA in 1944.[43] Although there was unrest among the nurses in Rockhampton, the conservative nature of this group led them to seek avenues within the established structures of the QATNA as a means of improving their working conditions, rather than to undertake industrial action. Despite the lack of enthusiasm for industrial issues, the QATNA secured considerable improvements in wages and hours for nurses from 1946. The number of hours nurses worked were reduced to 88 per fortnight in 1946, and to 80 per fortnight in 1948[44], and a significant wage rise was claimed in 1947.[45]

Although the QATNA was slowly being reconciled to an industrial role by the 1940s, the association consistently missed or ignored the underlying issues affecting nurses during this time. For example, in 1945 the SNA reported on a questionnaire which had been sent to all training school matrons to ascertain the living-in conditions of student nurses. The results revealed that few hospitals had study facilities for students, including a reference library. In addition, few hospitals had indoor or outdoor

---

41 Strachan, op.cit., 1991, p. 160.

42 Ibid., p. 170.

43 Queensland Branch of the Australasian Nurses' Association, Minutes, March 21, 1944, Queensland Nurses' Union

44 Strachan, op.cit., 1991, p. 159

45 "Annual Report Queensland Australasian Nurses' Association," *The Australasian Nurses' Journal,* December 1947, p. 295.

recreation facilities. The SNA concluded that the nursing shortage would continue, especially in country areas, until these conditions were remedied.[46] In 1946, a matron from Mount Isa insisted the nursing shortages were related to inadequate accommodation and amenities provided for nurses and poor working conditions.[47] However, the QATNA ignored this evidence, and persisted in their belief that the shortages were related to the unsuitability to nursing of first year students and hoped that the introduction of sister tutors would alleviate this situation.[48]

Rockhampton Hospital

Aside from those changes occurring within the general nursing profession, the majority of nurses working within the hospitals of Queensland were also affected by economic and political developments regarding health affairs made by governments and individual hospitals. The Rockhampton Hospital received significant financial assistance from the state government and was not isolated from the political changes that occurred in the 1930s and 1940s. The following gives a brief background of the Rockhampton Hospital's major developments from its inception to 1950. It is pertinent to review this background information in order to establish the environment within which nurses worked.

The origins of the Rockhampton Hospital can be traced to the erection of a prefabricated building on Victoria Parade in 1858. After a brief closure in

---

46 Queensland Australasian Nurses' Association, Minutes, July 18, 1945, Queensland Nurses' Union.

47 Grant, N. "Letter to the Editor," *The Australasian Nurses' Journal,* October 1945, p. 191.

48 "Annual Report Queensland Australasian Nurses' Association," *The Australasian Nurses' Journal,* December 1947, p. 296.

1859, the hospital continued operation under the control of the Port Curtis and Leichhardt District Hospital Board, reliant on public donations and small government grants.[49] The hospital relocated to its current site on Athelstane Range in 1868. Twenty-five patients were transferred to the new hospital.[50] In 1896, the hospital's name was altered to the Rockhampton Hospital. Over the ensuing thirty years it amalgamated with the Children's and Women's Hospitals[51], although it was not until 1930 that all services were located on the same premises, with the move of the Women's Hospital.[52] The hospital has had a further three name changes since the turn of the century, being known as the Rockhampton General Hospital, the Rockhampton Base Hospital, and more recently has had the name of Rockhampton Hospital restored. It is by this latter name that the hospital will be referred throughout this study.

Wards within the hospital were based on the traditional open plan, often referred to as "Nightingale" wards. These wards were rectangular in shape, with beds lined up on each length, facing each other. The main advantage of this type of layout was that it provided the best conditions for the supervision of patients and nursing staff.[53] Throughout the study period, the hospital increased in occupancy size, although no major buildings were added. Examples of monthly admissions, discharges and the all important daily averages during this period are displayed in Table 2. Daily averages were important because this figure was used to compare hospitals on a

---

49 McDonald, L. *Rockhampton. A History of City and District,* St. Lucia; University of Queensland Press, 1981, p. 357.

50 Ibid., p. 358.

51 Ibid., p. 359.

52 *Rockhampton Evening News*, February 3, 1930, p. 1.

53 Parkes, C. "The Development in Planning of a Nursing Ward Unit," *The Australasian Nurses' Journal,* April 15, 1944, p. 43.

state wide basis which, in turn, determined the length of time nurses were required to train, the higher the daily average, the fewer years required in order to have training recognised by the QATNA and the Nurses' and Masseurs' Registration Board.[54] Figure 1.1 shows the Rockhampton Hospital complex as it stood in the 1930s and 1940s.

Table 2. Examples of monthly occupancy rates, Rockhampton Hospital

	1929[55]	1944[56]	1947[57]
Admissions	122	263	297
Discharges	103	274	288
Daily Average	N/A	151.4	107.3

The hospital was able to accommodate the increase in patient numbers by enclosing the verandahs. Former nurses of the late 1920s recalled only occasionally tending to patients on the open verandahs; however, women who nursed in the 1940s recalled patients being nursed on enclosed and open verandahs as normal practice. Strachan[58] notes that one effect of the introduction of "free" treatment in Queensland hospitals during the 1940s, was a ten percent increase in the number of patients being treated, however, during the same period, there was a decrease of six percent in the number of nursing staff providing care. This trend was also evident in the Rockhampton Hospital's figures for admission and discharges for the

54 The Queensland Nurses' and Masseurs' Registration Board, although legislated for in 1912, did not have a registration act until 1929, outlining the number of training years, *Queensland Government Gazette,* Vol. 133, No. 13, July 15, 1929, pp. 123-132.

55 *Rockhampton Evening News,* November 22, 1929, p. 4.

56 *The Morning Bulletin,* September 20, 1944, p. 6.

57 Ibid., October 18, 1947, p. 5.

58 Strachan, op.cit.,1996, p. 196.

general section of the hospital. The drop in the daily average figures noted in 1947 reflects the effect of the introduction of penicillin for the treatment of infections and the subsequent decrease in the length of time each patient spent in hospital.

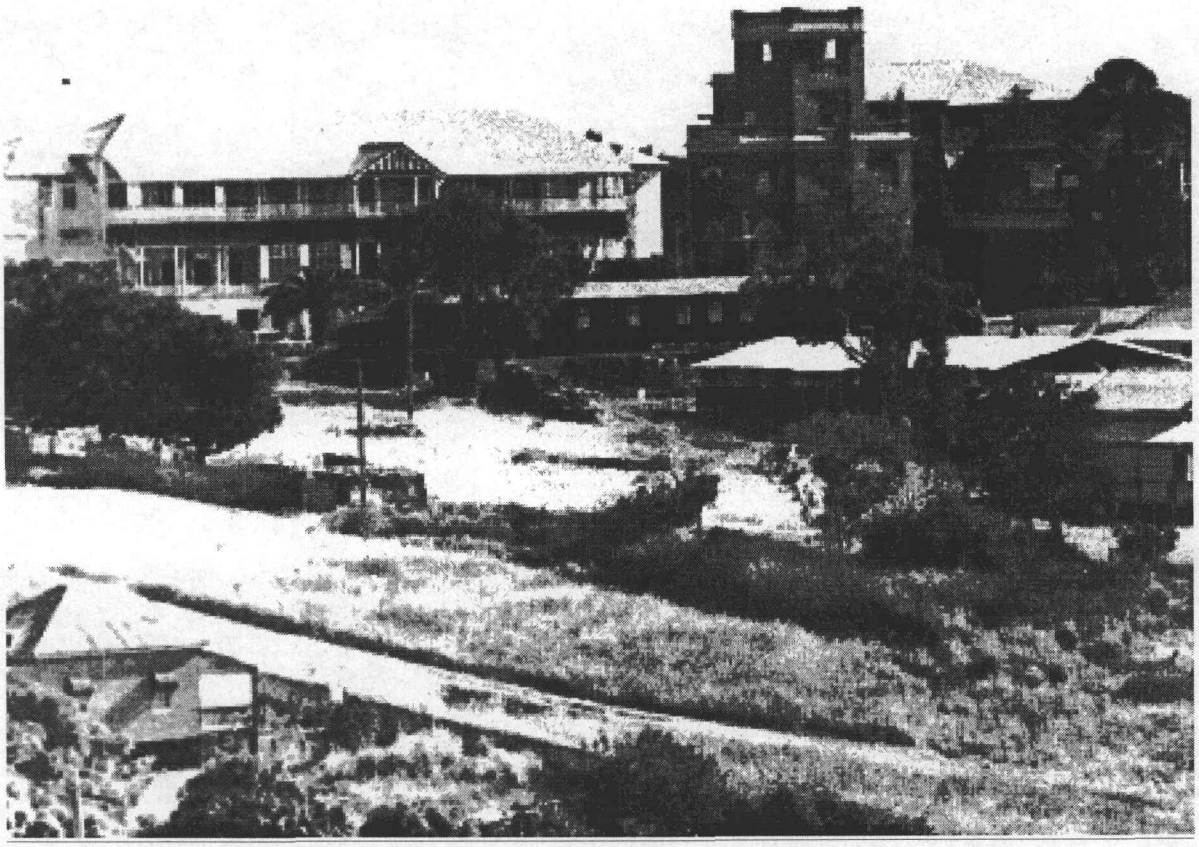

Figure 1.1 Rockhampton Hospital as it stood in the 1930s and 1940s (Courtesy of Rockhampton Hospital Museum)

In 1925, the hospital ceased to be administered by a voluntary committee and came under the jurisdiction of a board of members as outlined in the Hospital Act of 1923.[59] This Act provided hospitals with a more stable source of funding, with sixty percent of the running costs coming from the state government, and forty percent being provided by local authorities. As

[59] *Notes re Hospital Development in Rockhampton,* 1930, Queensland State Archives, Col. 363.

the Board controlled a number of institutions, including the Yeppoon Hospital and Emu Park Convalescent Home, the Livingstone, Broadsound, Duaringa and Fitzroy Shires, as well as the Rockhampton City Council contributed funds, however, the Shire of Broadsound was excluded by 1930.[60] In return, the Councils were given representation on the Board. Under the Act, the Board was to be made up of three government members, three members from the various industries contributing funds, and three local government members. However, this balance was not always maintained; for example, in 1930, the state government had five representatives, the Shires had two representatives, and the City Council provided the other two members on the Rockhampton Hospital Board.[61] Neither the Medical Superintendent, nor the Matron, were allowed to sit on the Board, although they regularly attended meetings. The boards were closely aligned with the state government and were subject to changes in membership when a new political party was elected to government. For example, this occurred in 1932 when the new Labor Government installed six of its party members on the Rockhampton Board[62]. This control of hospital boards by the government was formalised in the 1944 Hospital Act whereby local authorities were relieved of their financial responsibilities toward hospital maintenance, and were allocated only one position on the board, all other members being appointed by the government.[63]

The income for the hospital was not confined to the two governmental sources. The Hospital regularly received donations from local groups such as the Styx Coal Miners, Railway Benefit Society, Lakes Creek Benefit Fund

60 Ibid.

61 *Rockhampton Evening News*, July 23, 1930, p. 2.

62 Ibid., July 8, 1932, p. 1.

63 Patrick, op.cit., p. 77.

and The Morning Bulletin Pty. Ltd. These donations were acknowledged in the newspaper reports of the Board meetings. How these extra funds were spent is not clear, but they may have been used for extra amenities, such as the installation of a radio in 1933, reported as having been provided by public funds.[64] In addition, the Board was expected to collect fees from those patients who could afford to contribute to their hospitalisation. However, the Board was not always diligent in this respect[65], a situation that was not restricted to this Board, as many New Zealand boards were accused of similar laxity in the 1920s.[66]

Despite the steady source of income from government bodies, the Hospital Board was continuously monitoring its financial situation. Economic viability was an issue not confined to Queensland hospitals as Maggs'[67] study of British hospitals during this time indicated. In 1930 a major review of all Queensland hospitals was undertaken by the government, the Royal Commission on Public Hospitals, which aimed to increase the efficiency of hospitals' financial management.[68] The bulk of Queensland hospital funding was raised through the Golden Casket lottery, and it is perhaps not a coincidence that the Rockhampton Hospital Board meetings were extensively publicised in the local newspapers, along with accounts of finances, admissions and discharges. This may have been one way of advising the investors in hospitals - Casket ticket buyers - of the soundness of their investment, and to encourage support of this lottery. The Board was

64 *Rockhampton Evening News*, July 22, 1933, p. 2.
65 Ibid., April 22, 1933, p. 2.
66 Wright-St Clair, R.E. "Hospital Reform: Hot Topic in the 1920's," in Bryder L., Dow, D.A. *New Countries and Old Medicine. Proceedings of an International Conference of the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society, 1995, p. 238.
67 Maggs, C. *Nursing History: The State of the Art,* Kent; Croom Helm Ltd. 1987, p. 177.
68 *Rockhampton Evening News,* June 2, 1930, p. 8.

noted in the 1930s to have been efficiently run, with one of the lowest costs per patient bed, in the state.[69] The ongoing contribution of nursing staff to this economic stability will be revealed throughout this thesis.

In addition to managing the finances of the hospital, the Board was also responsible for the overall administration, including the hiring and firing of medical, nursing and domestic staff, and in the resolution of disputes. This function of the Board was particularly highlighted during an inquiry into the hospital in 1930. This inquiry concerned a number of nursing students who brought complaints against the Medical Superintendent, in front of the police magistrate. The outcome of this inquiry saw a number of criticisms levelled at the Board for not dealing adequately with the disputes.[70] Following the inquiry, the Board decided to eliminate one of the two matron's positions. Prior to this, Matron Smith was matron of the general section of the hospital, while Matron Green was in charge of the maternity section.[71] Matron Green was the successful applicant, and she continued in this position until the mid 1940s. Matron Fraser, a women who had held the deputy position for many year, acted in the position of matron until being officially appointed in 1946.[72] Matron Fraser, who suffered from ill health remained in the position until her death in 1952.[73] Matron Collins acted in the position for the last couple of years of Matron Fraser's life.[74] This

---

69 Harris, W. (Chairman) *Royal Commission on Public Hospitals Report,* Queensland Government, 1930, Appendix C. This table showed the Rockhampton Hospital to have the second lowest average cost per bed of all Queensland public hospitals.

70 *Rockhampton Evening News,* November 11, 1930, p. 1.

71 Ibid., December 6, 1930, p. 16.

72 *The Morning Bulletin,* April 24, 1952, p. 3.

73 Ibid.

74 Interview, W. Madsen with B. Cagney, June 3, 1996.

period between 1930 to 1950 represents a particularly stable time with regards to nursing leadership at the Rockhampton Hospital. In the years preceding 1930, the position of matron was frequently refilled.

This brief outline of the major developments and events which surrounded the working lives of nurses at the Rockhampton Hospital, illustrates that although nurses worked long hours, had a strong tradition of vocation and lived in a somewhat isolated environment, they were not exempt from political, economic or social influences. It was these influences which set the framework within which nurses had to work. It was also these factors which affected the number of staff available for each shift, the number of patients within the wards, the level of resources that was available and the set of social norms that were rigidly forced upon the nursing staff, both while on duty and off duty. This study into nursing work practices has, therefore, been mindful of the influences these contextual issues may have had on the hospital ward.

Chapter 2

"Keeping the Lid on Infection"

Limiting the spread of infection has been a problem for hospital staff since the inception of hospitals as a place of congregation for sick people. Nurses play a vital role in infection control practices because of the amount of time they spend at the bedside, and the intimacy with the patients that is a necessary part of some procedures. Nursing in the 1930s and 1940s was similarly credited with playing a central role in preventing the spread of infection within a hospital. In many respects the responsibility was greater for these nurses than it is now as they operated without the safety net of antibiotic therapy. For these nurses, breaches in infection control practices would lead to serious illness and often death. Therefore a variety of simple and elaborate routines were developed by nurses in an effort to minimise the spread of infection. These routines were part of almost every aspect of nursing work - from the disposal of bodily wastes to cleaning virtually every surface and item within the ward. This chapter will explore those routines and procedures which were concerned with the spread of infection, although, as will be shown, concern for microbial migration was not always the rationale for a number of these nursing tasks. Professional image and economic restraints of the times may also have been influential.

The basis of infection control practices in the 1930s and 1940s was in the use of antiseptics and aseptic techniques. Carbolic acid was the first antiseptic to be used in an operating room by Joseph Lister in Scotland during the mid-nineteenth century.[1] Much of the improved success of

[1] Parker, L. "From Pestilence to Asepsis," *Nursing Times,* Vol. 86, No.46, December 5, 1990, p. 64.

surgery in the early part of this century in Australia was brought about by the insight of Thomas Fiaschi. Fiaschi, a Sydney surgeon, had strongly advocated the use of antiseptics since 1878.[2] Antiseptics were used in the operating room and formed an important component of after-care dressings. In addition, particular attention was paid to ward cleanliness.[3] In 1896, Fiaschi introduced aseptic techniques, learnt in the United States of America, to Australia.[4] Aseptic and antiseptic techniques meant fewer people succumbed to post-operative infection. These factors, in association with the refinement of anaesthetics, allowed surgeons to further their techniques. This resulted in surgeons attempting more complex operations, necessitating more surgery to be conducted in hospitals as opposed to the private home, as had been the custom. By the 1920s, a combination of aseptic and antiseptic techniques had become the norm within hospital wards as well as operating theatres. Instruments were boiled for a certain length of time or steamed under pressure, the surgeon's rubber gloves were autoclaved, and the patient's skin and the hands of the surgeon and nurses were treated with antiseptic lotion.[5] Hand washing with soap and water, as well as antiseptics, was particularly emphasised on the wards. In addition to asepsis and antiseptics, infection control during the 1930s and 1940s utilised the principle of isolation to minimise the spread of disease.

---

[2] Murray, J.C. "Thomas Fiaschi and Listerian Antisepsis in Sydney, 1880 - 1900," In Attwood, H., Gillespie, R., Lewis, M. *New Perspectives on the History of Medicine,* Melbourne; Australian Society for the History of Medicine, University of Melbourne, 1990, p. 28.

[3] Ibid., p. 31.

[4] Ibid., p. 33.

[5] Ashdown, A.M. *A Complete System of Nursing,* London; Waverly Book Company Ltd., 1925, p. 367.

Disposal of Bodily Fluids

Cleaning Bedpans. The relationship between disease and excreta was well understood by the 1930s. Florence Nightingale was an early advocate of sanitary reform in the mid nineteenth century. Indeed, most social historians agree that the decline of mortality rates in western societies between 1880 and 1930 was mainly due to environmental reforms of improved sanitation, nutrition and housing, rather than medical intervention.[6] In this respect, nurses played a key role. It was the nurses who were generally handling the excreta of infectious patients, and who were responsible for the disposal of these bodily fluids. In the absence of sophisticated sewage treatment, the control of many diseases depended on the diligence of nurses in the performance of their duties. This need for diligence was illustrated by Petrovsky[7] who noted that those country hospitals not connected to sewage systems risked contaminating the waterways of the community through the leaching of disease-causing agents through the soil after the disposal of excreta into the ground. Even when sewage became available, it was only crudely treated before being emptied into rivers and streams. However, it was believed that sewage treatment was sufficient treatment for the control of infection, as evidenced by a general nursing exam question in 1941:

> If nursing in a country district where sewage is not available, how would you destroy infection in a) sputum, b) urine, c) faeces, d) dust, e) rags?[8]

---

6 Gillespie, J. "Medical Matters and Australian Medical Politics, 1920-1945," *Labour History,* Vol. 54, May 1988, p. 30.

7 Petrovsky, C.C. *Notes on Technical Procedures, 5th edition,* Tasmania; L.G. Shea, Government Printer, 1927, p. 43.

8 Nurses Registration Board examination question, *The Australasian Nurses' Journal,* June 16, 1941, p. 114.

The Rockhampton City Council began connecting buildings to sewage in the mid 1930s. The Rockhampton Hospital was connected to this system towards the end of the decade.[9] This practice of connecting hospital drains to the general sewage was acceptable practice in most industrialised countries.[10] It was impressed upon nurses, therefore, that appropriate treatment of excreta was a nursing responsibility. There seems to be considerable consensus within the texts that the bedpan contents of infectious patients needed to be covered with a disinfectant for one to two hours before disposal.[11] The recommended disinfectant solutions varied - carbolic acid (commonly known as Phenol) or cresol (commonly known as Lysol) appear to be the most frequently used in Australia. In addition, the bedpans were to be covered with disinfectant soaked bedpan covers throughout the disinfection process. While this was the procedure for disposing of infectious excreta as outlined in the texts of this era, how prevalent this procedure was in practice is unclear, as none of the interviewees recalled soaking excreta before disposal, either before the introduction of sewage or after. This discrepancy may be accounted for by considering the vagaries of memory. This task was mundane, unpleasant and socially unacceptable and therefore, may not have been retained in the memories of those interviewed.

While it may have been recognised that infectious excreta needed to be treated in a particular way, nurses were very aware of the need to clean bedpans after the use by those patients who had not been identified with an

---

9 Rockhampton City Council archives, Engineering Department.

10 Hainsworth, M. *Modern Professional Nursing, 2nd edition, Vol. 2.* London; The Caxton Publishing Company, Ltd. 1949, pp. 47-63.

11 Riddell, M.S. *Lectures to nurses, 5th edition,* London; The Scientific Press Faber and Faber Ltd., 1933, p. 246; Petrovsky, op.cit., p. 43; Hainsworth, op.cit., p.120.

infectious disease. In an era when patients were not encouraged to mobilise, nor were there many toilet facilities available, the provision of bedpans constituted a major nursing task. Prior to the introduction of a bedpan steriliser, the contents of the bedpans were emptied down a sluice. The bedpans were then washed thoroughly, dried and put into a rack.[12] Matron Green of the Rockhampton Hospital instructed the nursing students in 1935 that pans would need to be scalded if the patient suffered from an infectious disease when no steriliser was available, but disinfectant was only to be used for the contents of the pans of infectious patients.[13] It is unclear why Matron Green made this point regarding disinfectant as Ashdown[14] recommended in 1925 that all bedpans should be well disinfected after use with carbolic acid or some other reliable disinfectant. However, stringent economic constraints may have been responsible. A former nurse of that era recalled soaking bedpans in Lysol prior to 1930 when Matron Green took up her position at the hospital.[15] Lysol was a disinfectant noted by Hainsworth[16] to be stronger and cheaper than carbolic acid.

When the bedpan steriliser became available in the mid 1930s, bedpans continued to be cleaned manually and only placed into the steriliser to be boiled occasionally. The steriliser took the place of disinfecting bedpans. Not all wards were supplied with a bedpan steriliser which necessitated the nurses gathering up the bedpans into a sheet or a bag and taking them to a

12 Interview, W. Madsen with N. McKenzie, July 31, 1996.
13 Matron Green, General Nursing Lecture Notes, 1935.
14 Ashdown, op.cit.,1925, p. 9.
15 Interview, W. Madsen with M. Chambers, August 5, 1996.
16 Hainsworth, op.cit., Vol. 2, p. 117.

ward that had a steriliser.[17] One former nurse remembers that the male surgical ward was equipped with a bedpan steriliser while the female ward was noy.[18] The steriliser was a large chest steriliser with a foot pedal, capable of holding up to 6 bedpans[19], and as the bedpans required boiling for twenty minutes, this process would have necessitated a considerable amount of time and walking between wards for the nurse responsible. By 1945, the Matron of the hospital was recommending bedpans and urinals be boiled at least twice a week.[20] However, in practice, this appears to have been done on a daily basis by the junior nurse.[21] The practice was therefore, to rinse and scrub the bedpans using a brush after each use. The bedpans were then scrubbed daily with a powder cleanser, rinsed and boiled. Except for those bedpans which were kept separate for patients with infectious diseases, bedpans were indiscriminately distributed among the patients once they had been cleaned after each use.

This practice of manually cleaning bedpans after use and daily sterilising them is not outside acceptable practice of the time period. Doherty et al.[22] recommended bedpans and urinals be rinsed after each use and boiled for ten minutes each day. Hainsworth[23] outlined the procedure for the care of pans in 1949, involving the bedpans being flushed through a special apparatus immediately after use. They were then rinsed out on a daily basis with a strong disinfectant, followed by washing with soap and hot

---

17 Interviews, W. Madsen with B. West, June 4, 1996; V. Manly, October 1, 1996.
18 Interview, W. Madsen with B. West, June 4, 1996.
19 Interview, W. Madsen with J. Kidd, September 12, 1996.
20 Matron Fraser, General Nursing Lecture Notes, 1945.
21 Interview, W. Madsen with M. Baggett, June 6, 1996.
22 Doherty, M.K., Sirl, M.B., Ring, O.I. *Modern Practical Nursing Procedures,* Sydney; Dymocks Book Arcade Ltd. 1944, p. 41.
23 Hainsworth, op.cit., Vol. 2, p. 366.

water. The special apparatus referred to only cleaned bedpans with high pressure water[24] - it did not sterilise the bedpan. This technology was unavailable to the nurses at the Rockhampton Hospital, but the procedure of manually cleaning and daily sterilising would have come as close to ideal as circumstances allowed. Figure 2.1 shows a ceramic bedpan and enamel urinal similiar to those used at the Rockhampton Hospital.

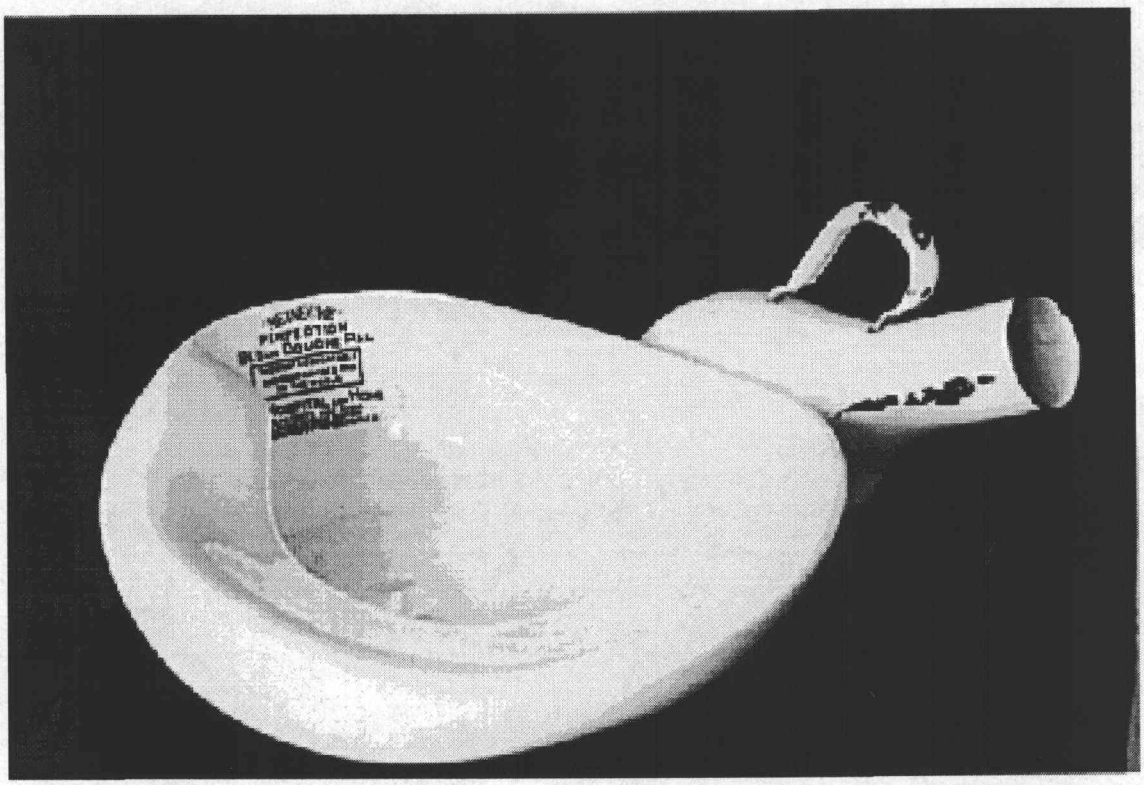

Figure 2.1 Ceramic bedpan and enamel urinal (Courtesy of Rockhampton Hospital Museum)

The other aspect of infection control regarding bedpans is the use of bedpan covers. As already noted, it was necessary to soak the cloth covers with disinfectant if the bedpan contents were to be left for any length of time. Bedpan covers were also used to cover the bedpan when taking it to and from a patient. This practice was adhered to throughout the study period,

---

[24] Ibid., p. 58.

and was recognised as an important aspect of the prevention of cross infection within a ward.[25] However, there seems to be considerable variation in what happened to the bedpan covers after each use at the hospital. A number of former nurses recalled that bedpan covers would not necessarily go to the laundry after each use unless they were soiled.[26] The reason given was to economise on laundry costs. Other former nurses suggested that the reuse of bedpan covers would have been frowned upon because infection control procedures were based on keeping things separate.[27] This discrepancy may be due to varying practices within each of the wards. However, it suggests that while there were fairly rigid procedures in place for the cleaning and care of bedpans, bedpan covers were not necessarily identified as potential sources of infection. The lack of attention paid to bedpan covers regarding infection was reflected in Doherty et al.'s[28] recommendations that bedpan covers be hung up to air on a hook unless soiled. The practice of using a bedpan cover during the transport of bedpans was however, rigidly enforced, the rationale for which may have been related to infection control as well as aesthetic reasons.

Sputum. Tuberculosis (T.B.) was a common medical condition throughout the study period. A sanatorium was available at Westwood, approximately 50 km west of Rockhampton, but the Rockhampton Hospital regularly took in T.B. inpatients, most of whom were nursed on the verandah of the men's medical ward. As T.B. was quite prevalent, the appropriate disposal of sputum would have been a significant infection control issue. During this

---

25 Holland, D.L. "Stricter Ward Ritual to Avoid Cross Infection Of Wounds," *Nursing Mirror,* Vol. 73, No. 1901, August 30, 1941, p. 240.

26 Interviews, W. Madsen with B. Cagney, June 3, 1996; I. Dennison, October 4, 1996.

27 Interview, W. Madsen with K. Austin, June 20, 1996.

28 Doherty et al., p. 41.

time, burning was recognised as the appropriate method of disposal for sputum.[29] However, this does not appear to be the method adopted by the nursing staff at the Rockhampton Hospital. Matron Fraser instructed the nursing students in 1945 to "train patients to keep the lids of their sputum mugs closed at all times", and to place disinfectant in the mugs before use[30], although she did not specify the method for content disposal. Former nurses recalled that sputum mugs were collected daily by a nurse, and boiled in a four gallon kerosene tin.[31] It was a task that was generally despised by the nurses.[32] The reason for this approach to the disposal of sputum is unclear, but economic constraints may have been a primary influencing factor. The use of cardboard cups or gauze in which to collect sputum which could be easily burnt, as recommended by Hainsworth[33], was probably not possible during an era when gauze was retrieved from dressings in order to be recycled[34] , as it was in extremely short supply. Hainsworth[35] also acknowledged the wide use of sputum mugs, especially within sanatoriums and recommended they be adequately sterilised.

Whether this practice of emptying sputum mugs adversely affected the health of the nurses is not known. While T.B. is mostly spread by airborne droplets, it may also be spread by direct contact or through the use of vectors, such as milk.[36] Therefore, this practice was potentially problematic. However, it is not possible to ascertain the extent of the risk to nurses, for

[29] Ashdown, op.cit., p. 46; Hainsworth, op.cit., Vol. 2, p. 120.
[30] Matron Fraser, op.cit.
[31] Interview, W. Madsen with R. Dalrymple, October 3, 1996.
[32] Interview, W. Madsen with N. Windsor, October 9, 1996.
[33] Hainsworth, op.cit., Vol. 2, p. 120.
[34] Interview, W. Madsen with I. Dennison, October 4, 1996.
[35] Hainsworth, op.cit., Vol. 4, p. 429.
[36] Henderson, M. "*Infection Control. The British Medical Association Guide*," London; Edward Arnold, 1989, p. 96.

although at least one former nurse is aware of a few of her colleagues who later succumbed to T.B.[37], these nurses may have contracted the disease through normal nursing of unidentified T.B. patients, and not necessarily as a result of emptying and boiling sputum mugs.

Soiled Linen. Nurses had the sole responsibility for the removal and appropriate disposal of bodily substances. In addition to their care of bedpans and sputum mugs, they were also expected to clean any soiled linen before it was sent to the laundry. This task was reserved for the more junior members of the nursing staff. It was a task that was not relished by these nurses and was often one of the last things they had to do before going off duty. One former nurse recalled that you could not leave until it was all done, and if another load came in as you were leaving, you went back and did it, "even if it was your half day off."[38] The linen had to be washed and scrubbed using a long handled brush.[39] If the linen had been used by a patient with an infectious disease, then it was to be soaked in Lysol for a period of time, rinsed out and then sent to the laundry. The laundry staff would not accept any foul linen, and had been known to send the linen back to the ward if it were not satisfactorily cleaned.[40]

This nursing procedure was internationally accepted throughout this era, with most contemporary nursing texts recommending that soiled linen be cleaned prior to going to the laundry. The rationale for this was that the immediate removal of stains would prevent permanent disfigurement of the

---

[37] Interview, W. Madsen with V. Manly, October 1, 1996.
[38] Interview, W. Madsen with K. Austin, June 20, 1996.
[39] Cagney, B. Memoirs, Rockhampton Hospital Museum.
[40] Ibid.

linen[41], rather than for any infection control reasons. This view was reinforced during the general nursing lectures given to the nurses by the various matrons. Matron Fraser emphasised the ease with which this could be done, "by washing in cold or tepid water while stains are still wet."[42] What Matron Fraser and others failed to consider was the strict hierarchy of duty delegation. This task of washing linen was definitely a junior nurses' responsibility and, as such, was not likely to be carried out until after lunch[43], or before going off night duty[44], by which time many of the stains would have infiltrated the linen. The procedure on the wards was, therefore, that any soiled linen would be taken to the pan room or designated sink or bath, and left there until tended to by the junior nurse.

The origins of this practice are unclear, but it does not appear to be related to infection control. While this procedure tended to restrict the number of hospital staff who actually came in contact with excreta and therefore may have limited the spread of potential infection, leaving the linen for considerable lengths of time exposed it to flies and other vectors of infection. The practice of junior nurses washing out linen probably was more related to economic viability than infection control measures. In Queensland in 1943, a junior nurse of eighteen years of age was paid two pounds, ten shillings a fortnight, while a laundress of a similar age was only paid one pound, fifteen shillings and nine pence. This wage rapidly rose to the adult rate of three pounds, four shillings and six pence for a twenty year laundress.[45] Therefore, provided the majority of laundry staff were eligible

41 Hainsworth, op.cit., Vol. 2, p. 285.
42 Matron Fraser, op.cit.
43 Cagney, op.cit.
44 Interview, W. Madsen with B. West, June 4, 1996.
45 "Comparison Junior Employees with Other Callings," Queensland State Archives, A/31807.

for adult wages, the hospital management was more likely to have supported the practice of junior nurses undertaking the menial task of removing stains from linen.

One of the difficulties presented by the nurse attending to duties such as bedpan cleaning and washing soiled linen was that most of these tasks were carried out without gloves.[46] Ashdown[47] noted in the 1920s that nurses' hands were prone to becoming roughened, sore and difficult to cleanse due to the constant use of antiseptics. Such hands would have posed a substantial risk of transporting micro organisms from the pan room to the patients.

Ward Cleaning

Ward cleaning constituted a major part of a nurse's time, especially for a junior nurse, for almost a century after Florence Nightingale wrote her *Notes on Nursing* .[48] Ward cleaning involved not only the removal of dirt and dust, but the general outlook of the ward.

> ...for a neat and tidy ward has a good moral effect on the patients and thus staff; the cleanliness of it reflects on the staff and well being of the patients.[49]

Bessant[50] claims that the late nineteenth and early twentieth centuries saw domestic duties professionalised, which became part of nursing hygiene

46 Interview, W. Madsen with K. Austin, June 6, 1996.
47 Ashdown, op.cit., p. 45.
48 Nightingale, F. *Notes on Nursing: What it is and What it is not,* Glasgow; Blackie and Sons Ltd., 1974.
49 Hainsworth, op.cit., Vol. 2, p. 281.
50 Bessant, J. "Good Women, Good Nurses," *Labour History.* Vol. 63, November 1992, p. 160.

training, as a result of the shortage of domestic staff and subsequent higher wage demands. Thus cleaning duties were promoted as having scientific rationales, and dust become the enemy of all nurses. Ashdown[51] noted in 1925 that air was contaminated with dust, carbon and other solid bodies which could be the source of infection. Dust could carry acute diseases which could then be inhaled by others. Hainsworth[52] reiterated similar sentiments in 1949, noting that bacteria was present in the small particles of dust which floated in the air, and without adequate cleaning, nurses were exposing their patients to cross infection. Of particular importance was the avoidance of dust collections which were believed to be reservoirs of multiplying germs.[53] If a junior nurse was not utterly convinced of the scientific need to undertake all of the necessary cleaning activities, then she may have been persuaded by the management reasons outlined by Doherty et al.[54], that a trained nurse must have knowledge of domestic affairs as she would supervise the work of maids and could not do so efficiently unless she had carried out the duties herself.

Ward cleanliness was entirely the responsibility of those nurses who worked at the Rockhampton Hospital prior to the mid 1930s. These nurses would often start sweeping verandahs between 4.30 and 5 am.[55] They would tear up wet paper and throw it onto the floor before sweeping the ward.[56] Wet tea leaves or damp saw dust were also recommended in some texts as a method to minimise dust rising into the air.[57] This method of

51 Ashdown, op.cit., p. 256.
52 Hainsworth, op.cit., Vol.2, p. 280.
53 Matron Fraser, op.cit.
54 Doherty et al., op.cit., p. 1.
55 Interview, S. DeVries with M. Jensen, date of interview unknown.
56 Interview, W. Madsen with M. Chambers, August 8, 1996.
57 Doherty et al., op.cit., p. 1.

damp sweeping was superseded by vacuum cleaners in the mid 1940s as they were believed to be the most hygienic method of removing dust.[58] When maids were employed by the hospital, nurses only needed to sweep floors on the maid's day off[59] until after World War II when sufficient domestic aid was available in order to relieve nurses of this task altogether. A former nurse recalled when domestic staff took over ward cleaning that the hospital employed extra staff, but the cleaning was never completed before 2 pm, whereas when nurses were responsible, the ward had to be swept and all patients sponged by 9 am.[60] However, the floors were more thoroughly cleaned when domestic staff took over these duties, with the floor being mopped everyday and regularly being scrubbed by the staff.[61]

Other labour intensive cleaning tasks undertaken by nurses included washing beds with Lysol, washing out the insides of patient drawers[62], cleaning the tops of lockers[63], scrubbing the kitchen cupboards[64], cleaning the bathroom sinks and baths and the pan room.[65] In addition, all the crockery and cutlery were also washed and dried by nurses after each meal. The majority of these tasks were undertaken by junior nurses and constituted a significant part of their workload. These tasks were gradually taken over by domestic staff throughout the twenty year period under review, so that by 1950, the ward cleaning activities undertaken by the junior nurse were reduced to cleaning the lockers, washing out water jugs

---

58 Matron Fraser, op.cit.
59 Interview, W. Madsen with B. West, June 4, 1996.
60 Interview, W. Madsen with D. Ross, October 17, 1996.
61 Schneider, V., Memoirs, Rockhampton Hospital Museum.
62 Interview, W. Madsen with L. Lowry, October 2, 1996.
63 Interview, W. Madsen with B. Cagney, June 3, 1996.
64 Interview, W. Madsen with B. West, June 4, 1996.
65 Interview, W. Madsen with J. Kidd, September 12, 1996.

and glasses each morning and cleaning the pan room.[66] There was an expectation that those items which nurses cleaned would shine. This included the inside of the pan steriliser[67] and the brass jardinieres.[68] The reason for this was the belief that germs were incapable of thriving on dry, shiny surfaces.[69]

A good deal of time was devoted to ward cleaning in the lectures given to nursing students. Almost the entire second lecture in general nursing given by the matron, was devoted to ward cleaning and remedies for the removal of stains from various surfaces. For example:

> To remove stains from coloured wood, the stain should be removed by tincture of champor or equal parts of oil and turpentine.[70]

Ink stains, acid stains, blood stains, coffee and fruit stains, scorch stains and iodine stains were also mentioned among others. This time devoted to cleaning constituted almost ten percent of the total general nursing lecture time.

Why was ward cleaning such an important issue for nurses pre-1950? Was it a ritual that had descended from the Nightingale era, associated with ward management, or was there a genuine desire to minimise cross infection through making the ward as hygienic as possible? Schulz[71] notes that immediately after the war in 1945, domestic staff were practically

---

66 Interview, W. Madsen with B. Cagney, June 3, 1996.
67 Interview, W. Madsen with R. Dalrymple, October 3, 1996.
68 Interview, W. Madsen with I. Dennison, October 4, 1996.
69 Hainsworth, op.cit., Vol. 2, p. 280.
70 Matron Fraser, op.cit.
71 Schulz, B. "All the Way," *Australian Nurses Journal,* Vol. 4, No. 4, October 1974, p. 17.

unprocurable and that this necessitated nurses taking on more domestic duties. This does not seem to be the case for the Rockhampton Hospital, for it was during this era that nurses were able to shed many of their cleaning tasks, indicating the issue may have been more complex than a simple labour shortage. The nursing authorities, that is nursing authors and matrons, were certainly emphasising the scientific, hygienic aspects of cleaning, yet one has to question their understanding of their own rationales. For while a great deal of energy was expended in the cleaning of furniture and items including light shades within the ward in order to control cross infection between patients, the same rationale was not applied to the care of blankets. Blankets were routinely removed from patients' beds each morning, folded in the correct manner, and then stored collectively in a "blanket" cupboard.[72] The fluff on the floor resulting from bed making was believed to harbour infection, but there appears to be considerable inconsistency when blankets were involved, where they were stored together and distributed to patients without discretion. The reason behind this "oversight" may be related to the tendency of blankets to shrink with repeated washing and were therefore only laundered occasionally.[73] This would have prolonged the life of the blanket and therefore reduced the cost to the hospital, however, this procedure was certainly not consistent with the hygienic principles of separation and dust elimination espoused at the time.

A further question emerges from this examination of cleaning. If domestic tasks were professionalised as suggested by Bessant, what prompted nurses to shed these tasks a decade prior to the introduction of infection

[72] Interview, W. Madsen with J. Kidd, September 12, 1996.
[73] Hainsworth, op.cit., Vol. 2, p. 282.

control nurses[74], and the increased understanding of ward cleaning activities in the spread of bacterial infection?[75] It may be that Strachan's[76] observation of a ten percent increase in patient numbers in Queensland, corresponding with a six percent decrease in nursing staff, may have been the most influential factor. The delegation of many ward cleaning tasks to domestic staff would have allowed nurses to take up the extra workload generated by an increased patient load. Importantly, however, would be that the matron would have remained in control of this as she was also in charge of domestic services within the hospital. In this way the hygienic principles of infection control as they were understood at the time could have been overseen and maintained, and matrons could still justify the need for junior nurses to clean in order for them to be able to effectively supervise domestic staff in later years.

Asepsis

One of the most important responsibilities undertaken by nurses throughout the first part of this century was the maintenance of asepsis. Asepsis was described to the nursing students in 1945 as literally meaning without poisoning, or a condition where there is an entire absence of germs.[77] It was stressed to the students that absolute cleanliness was required and that failure to maintain asepsis at one point meant failure in all.

---

74 Sadler, C. "Dirt in Hospitals. Soap Opera," *Nursing Times,* Vol. 86, No. 24, June 13, 1990, p. 30.

75 Cruickshank, R. "Hospital Infection: A Historical Review," *The Australasian Nurses' Journal,* February-March 1946, p. 33.

76 Strachan, G. *Labour of Love. The History of the Nurses' Association in Queensland 1860-1950,* St Leonards; Allen & Unwin Pty, Ltd. 1996, p. 196.

77 Matron Fraser, op.cit.

Sterilisation of metal instruments and ward utensils. It was recognised that all instruments and ward utensils that came into contact with patients were potential sources of infection. It was the duty of the nurse to eliminate bacterial contamination from instruments and utensils through sterilisation prior to any invasive procedures. Such procedures included dressings, injections, catheter insertions and other procedures carried out on the ward either by a doctor or a nurse. The methods to achieve instrument sterilisation appear to have altered only slightly throughout the twenty years under review.

Gas sterilisers were a feature in the day rooms, or procedure rooms, of all the wards at the Rockhampton Hospital throughout the 1930s and 1940s. Figure 2.2 illustrates a typical instrument steriliser used in the 1940s. They were powered by gas, a type of steriliser later noted to be extremely dangerous due to an increased fire risk as they were not thermostatically controlled.[78] Indeed, the nurses were aware of how easily the sterilisers could burn out.[79] Once a day the steriliser was emptied and cleaned, which included polishing the outside, and refilling with water. This daily procedure may have been carried out in order to prevent a build-up of scaling substances on the inside of the steriliser due to repeated use.[80] This appears to have been a standard procedure.[81] There were also a number of recommendations whereby an additive was mixed with the water, although it is not clear why some of these were recommended.

---

78 Nash, D.F.E. *The Principles and Practice of Surgical Nursing,* London; Edward Arnold Publishers Ltd. 1955, p. 299.

79 Interview, W. Madsen with J. Kidd, September 12, 1996.

80 Nash, op.cit., p. 328.

81 Doherty et al., op.cit., p. 4.

Figure 2.2 Chest Instrument Steriliser (Courtesy of Rockhampton Hospital Museum)

Gordon[82] noted that sodium bicarbonate was commonly added in order to stop instruments from becoming dull. Nash[83] advocated the addition of sodium carbonate (two percent) in order to render the destruction of bacterial spores as it had been discovered that boiling alone was not enough. One percent washing soda was recommended by Ashdown[84] in 1925 although no reason was given for its inclusion. However, it is unknown if any substance was routinely added to the sterilisers at the Rockhampton Hospital.

Once the steriliser was refilled, all metal instruments and utensils were scrubbed with a powder cleanser, rinsed and boiled for twenty minutes.[85]

---

82 Gordon, A.E. " Nurses Role in Penicillin Treatment. " *The Australasian Nurses' Journal,* May 1945, p. 64.

83 Nash, op.cit., p. 321.

84 Ashdown, op.cit., p. 41.

85 Cagney, op.cit.

After the required time, the articles were taken from the steriliser with special lifters which were kept soaking in antiseptic solution.[86] Figure 2.3 shows the type of lifters used for this purpose. The articles were placed on a trolley covered with a sterile cloth. A further sterile cloth was placed over the articles which were then ready for use.[87] When preparing for a procedure, the required instruments were picked up, again using the lifters, and placed on the nurse's tray. As the articles were not kept separate from each other while being stored, extreme caution would have been necessary when selecting an item from the storage tray. Interestingly, the storage of sterilised equipment did not feature in any of the nursing texts reviewed in

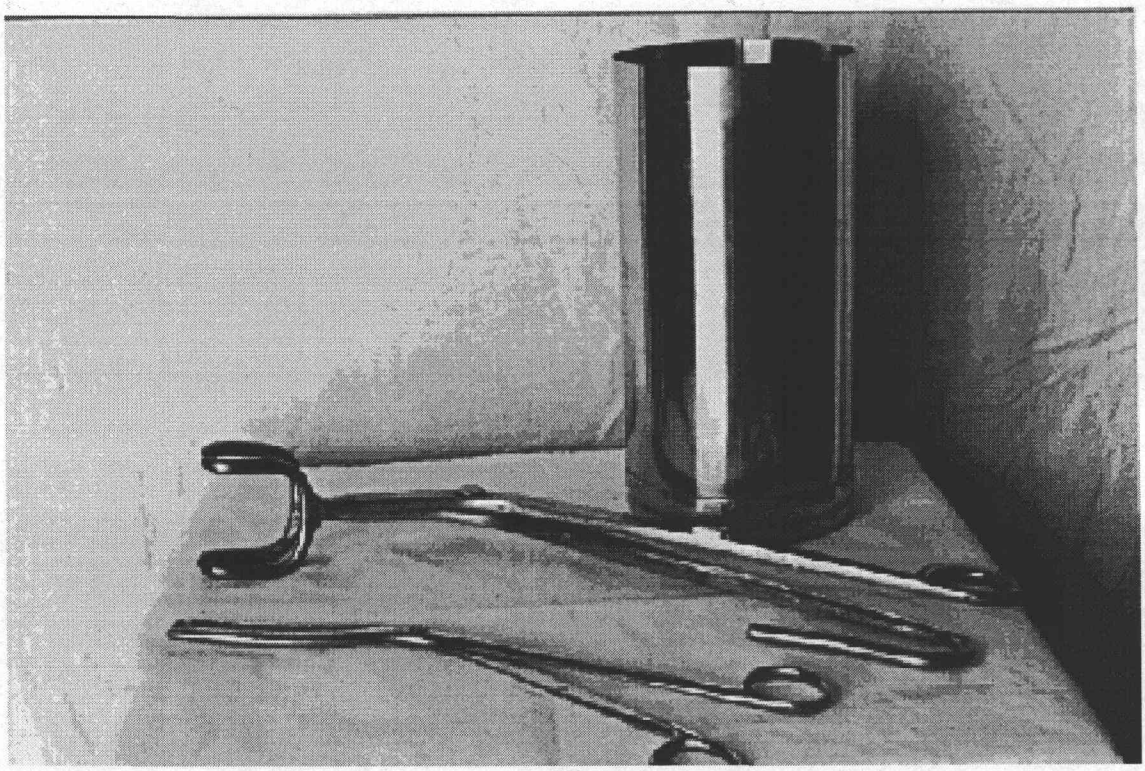

Figure 2.3 Lifters used for removing instruments from a steriliser (Courtesy of Rockhampton Hospital Museum)

86 Interview, W. Madsen with J. Kidd, September 12, 1996.

87 Interview, W. Madsen with B. Cagney, June 3, 1996.

this study. While the cleansing and boiling of instruments were well detailed, as was the aseptic procedures, the storage of instruments from the completion of sterilisation to their use, seemed to have been neglected. For example, the wet instruments were placed on a sterile cloth surface whereby the dampness would have diminished the protectiveness of the cloth. While early text books do not specifically outline the need for cloth to be dry as in later texts[88], they do describe the use of dressing drums which allowed for the drying of cloth contents. It is therefore unclear if this principle of sterile field maintenance was completely understood at the time.

This lack of understanding of the importance of storage was further highlighted in an article in 1940 which cited a number of studies whereby bacteria had been successfully grown from syringes soaked in alcohol.[89] It was common practice at the Rockhampton Hospital to store sharp instruments such as scalpels in methylated spirits. This was in accordance with recommendations from most nursing authors[90], and was a practice that appears to have continued despite the 1940 revelations. The reason for the resistance to change may have been related to the limited range of sterilisation alternatives. Boiling sharp instruments for long periods of time, that is twenty minutes, tended to quickly blunt the edges[91], therefore a reduced boiling time was recommended for these instruments, which when removed, were immersed into some type of disinfectant solution, with the assumption that this would compensate for the reduced boiling time. Needles were regularly sharpened by the hospital engineer[92], and it is

88 Nash, op.cit., p. 323.

89 Unknown author, "The Supposedly Sterile Syringe," reprinted from *British Medical Journal,* January 20,1940, *The Australasian Nurses' Journal,* April 15,1941, pp. 68-69.

90 Hainsworth, Vol. 2, op.cit., p. 382; Ashdown, op.cit., p. 42.

91 Hainsworth, op.cit., Vol. 2, p. 387.

92 Interview, W. Madsen with D. Ross, October 17, 1996.

likely other sharp edged instruments were also similarly treated, but this would have limited the life of the instrument and probably affected its functioning. During a time of economic rationing, replacement of instruments would have been discouraged. As no infection control records were kept during this era, it is impossible to ascertain if such compromises in the sterility chain had any clinical implications, although oral evidence suggests that cross infection between patients was low.[93]

Sterilisation of dressing products. Ready made dressings became available in the United States of America in the 1920s and were adopted in that country by many hospitals following studies which showed standardised dressings cost less compared with hospital made dressings.[94] Despite the availability of ready made dressings, junior nurses at the Rockhampton Hospital continued to be responsible for the preparation of dressing products, which were later sterilised. Cotton wool balls had to be made up, and gauze squares and various sizes of combine dressings were cut up.[95] These were then packed into calico bags, fastened with a safety pin and sent to the theatre to be sterilised.

Up until 1930, the sterilising of these products was carried out in a large oven in the kitchen and were tended to by the night wardsman.[96] An autoclave was available in the theatre during this time, but it was reserved for sterilising theatre linen. Baking or using dry heat to sterilise articles was one of the earliest methods of treating items, where articles were subject to

---

93 Interview, W. Madsen with K. Austin, June 20, 1996.

94 Ward, P.D. "Standard Ready-made Versus Hospital-made Dressings," *The Australasian Nurses' Journal,* May 15, 1933, p. 98.

95 Interview, W. Madsen with K. Austin, June 20, 1996.

96 Interview, W. Madsen with N. McKenzie, July 31, 1996.

heat of 302° Fahrenheit[97], but there were significant disadvantages to using this method. Firstly, this method tended to scorch[98] and even destroy the articles.[99] Secondly, there was no way of testing the effectiveness of this method. It was recognised in the 1920s that this method was at best, "makeshift."[100] It is not known when this practice ceased at Rockhampton Hospital, but the majority of former nurses interviewed recalled dressings being sent to the theatre for autoclaving. Only one who had finished nursing in 1930 remembered the oven being used. It is therefore likely that the theatre autoclave began to be used for ward sterilising around 1930.

Autoclaving was the preferred method of sterilising throughout the study period. This process subjected articles to steam of at least 248 degrees Fahrenheit, at fifteen pounds of pressure for twenty minutes.[101] Calico bags of dressing products were placed in metal steriliser drums before going into the autoclave. These drums allowed steam to penetrate their contents through holes in their sides. After the sterilisation process was completed, and the contents given time to dry, these holes were closed off by moving a sliding band which was situated around the drum, thus sealing the container. Figure 2.4 illustrates the dressing drum used at the Rockhampton Hospital for holding dressing products for autoclaving, and an example of the bulk dressings which had to be cut to size by the nurses.

---

97 Ashdown, op.cit., p. 39.
98 Matron Fraser, op.cit.
99 Ashdown, op.cit., p. 39.
100 Ibid., p. 39.
101 Ashdown, op.cit., p. 39.

Figure 2.4 Dressing drum and bulk gauze dressings (Courtesy of Rockhampton Hospital Museum)

Once back in the ward, the packets of dressings were stored in a cupboard.[102] Monometal bins with lids were kept in the day room. These were boiled or flamed[103] on a regular basis. The contents of the dressing packages were then emptied into one of these bins. As the nurse was setting up for a procedure, she was able to take the required number of articles from the bins, with the use of lifters, and then replace the lid.[104] As with the storage of sterilised instruments, diligence on behalf of all of the nursing staff was required in order to avoid contamination of these stocks of dressing products. Indeed, throughout the 1930s and 1940s, one of the qualifications considered as necessary for a nurse was that of

---

[102] Interview, W. Madsen with J. Kidd, September 12, 1996.

[103] Flaming of bins required a small amount of alcohol being wiped over the inside of the bin and set alight. Interview, W. Madsen with J. Kidd, September 12, 1996.

[104] Interview, W. Madsen with K. Austin, June 20, 1996.

conscientiousness, for a nurse "lacking in this virtue...is likely to be careless in giving treatment and the aseptic technique of her duties and so endanger peoples lives."[105]

The only dressing related articles which were not subject to this type of sterilisation were the bandages. Gauze bandages were washed and boiled up on the ward.[106] They were hung out to dry and then rolled up by the junior nurses. Most nurses soon learnt of the therapeutic advantages of bandage rolling for patients, and encouraged this activity. Figure 2.5 illustrates the bandage roller used by the nurses at the Rockhampton Hospital.

Aseptic Technique. As the previous sections have shown, great emphasis was placed on the elimination of bacteria from the instruments, products and utensils which would come into contact with patients during ward procedures. However, it was often the procedure itself that attracted the most attention with regards to infection control. It was also this aspect which held the least amount of consensus among nursing authorities. This is particularly illustrated when comparing dressing procedures, where although it may be noted that all procedures were attempting to maintain asepsis, the approaches were quite different. The two main areas of deviation involved the number of people required to do a dressing, ranging from one to three; and the setting up of the tray or trolley from which the dressing was conducted.

---

105 Matron Green, op.cit.

106 Interview, W. Madsen with J. Kidd, September 12, 1996.

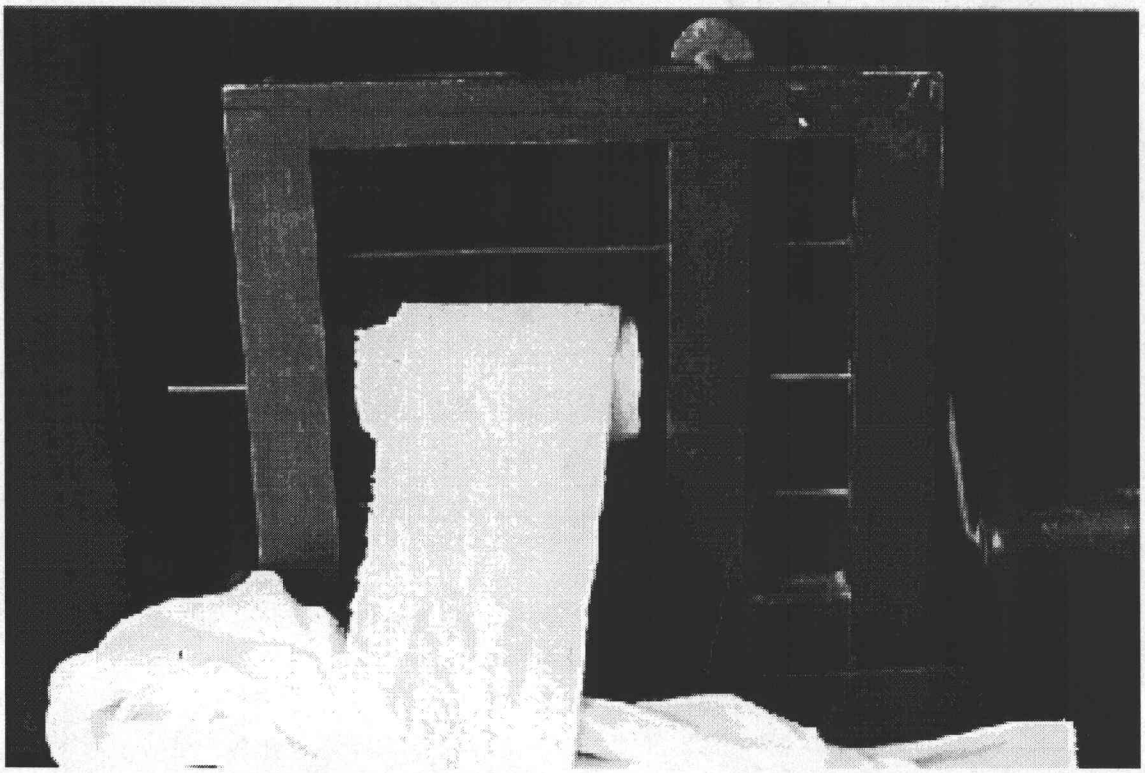

Figure 2.5 Bandage Roller (Courtesy of Rockhampton Hospital Musuem)

In 1944, Miles[107] advocated the need for three people to be involved in the dressing of wounds, in order to use a "no-touch" technique. The dresser manipulated the dressings and cleaned the wound with the use of forceps. Her hands were not required to be surgically sterile, but clean and dry. All the material required for the dressing was passed to the dresser by the second person whose sole duty was to look after the trolley which contained all clean and sterile material. A third person was required to adjust the patient clothing and do the bandaging. The dresser and third assistant were required to wash their hands in between each dressing. However, the second assistant, as she was supposedly only in contact with sterile material, would not need to wash her hands between dressings, and

107 Miles, A.A. "Observations on the Control of Hospital Infection," *The Australasian Nurses' Journal,* April-May 1946, p. 56 .

could move on to the next bed. Rutherford[108] and Petrovsky[109] suggested two nurses were required to carry out a dressing, although the duties of the assistant varied from passing the clean items to the dresser, to that of patient preparation. Both authors advocated the use of forceps rather than fingers. It also appears that both authors were describing a "dressing round", that is moving a trolley, from which the dressings were conducted, from bed to bed.

Doherty et al.[110] and Houghton[111] described two dressing procedures, each of which involved only the one nurse. The procedure used for routine ward dressings also used a dressing trolley. These trolleys were basically set up with sterile articles on the top shelf, and the bottom used for unsterile items. The top shelf contained dressing products which were contained in bulk in canisters, from which the required number were lifted out with lifters, sufficient sterile kidney dishes and bowls, necessary instruments such as forceps and scissors and sterile towels. Figure 2.6 shows the type of canisters and lifters used at the Rockhampton Hospital. The lower shelf contained lotions, strapping bandages, safety pins and receptacles for soiled instruments and dishes. The second method was suggested by Doherty et al.[112] to be used for individual or once-off dressings and involved the setting up of a sterile tray to be carried to the bedside. This tray was set up in the day room, taking required dressings from the canisters, setting out kidney dishes, bowls and sterile instruments. All the equipment was placed

---

108 Rutherford Darling, H.C. *Surgical Nursing and After Treatment. A Handbook for Nurses and Others, 3rd edition,* London; J & A Churchill, 1928, p. 128.

109 Petrovsky, op.cit., pp. 9-10.

110 Doherty et al., op.cit., pp. 192-193.

111 Houghton, M. *Aids to Tray and Trolley Setting, 5th edition,* London; Bailliere, Tindall, Cox, 1952, p. 134.

112 Doherty et al., op.cit., p. 192.

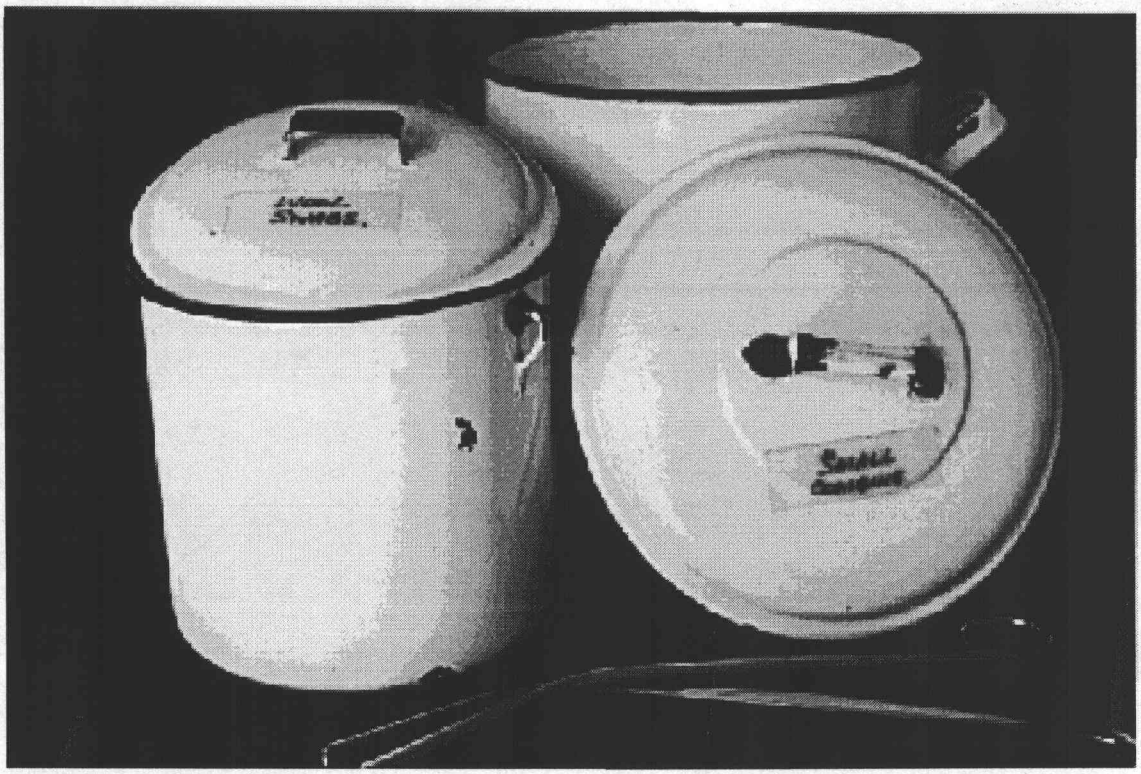

Figure 2.6 Bulk dressing canisters (Courtesy of Rockhampton Hospital Museum)

on a sterile cloth,while a second sterile cloth covered the completed tray. It was this second method that was routinely used at the Rockhampton Hospital.

There seems to be considerable consistency between the oral testimonies collected regarding the dressing procedure used at the hospital. This procedure required the nurse to wash her hands, set up her sterile tray with the instruments and items required for the dressing, go into the ward, screen the patient and uncover the area to be dressed. The nurse was required to wash her hands for three minutes at a sink in the middle of the ward which was controlled by a foot pedal. After washing her hands, she draped the wound area with sterile towels, swabbed down the wound using

forceps, applied whatever ointments and dressing had been ordered by the doctor, and bandaged the area. She was then required to clean the instruments used and to boil them.[113] Figure 2.7 shows a typical dressing tray set-up. Interestingly, this procedure was not outlined in any of the general nursing lectures given to the students. These were the only lectures given by nursing staff to the nurses, therefore, it must be assumed this procedure was taught exclusively on the ward, either by the senior nurse or the sister in charge of the ward, which would have increased the potential for variations. As there appear to have been very few variations within the procedure, one may conclude that there was either some form of directive set by the matron, or that this was the procedure that had become entrenched at this hospital over time and was reinforced by previous students gaining positions of authority. This second scenario is more likely as the procedure remained the same over the two decades reviewed, despite a change of matron.

The main question to arise from this investigation into dressings is why this method of using a tray was adopted by a small regional hospital, when the majority of nursing texts were recommending the use of trolleys and doing dressing rounds. Although there was some evidence in the early 1940s recommending that main dressing canisters not be brought to the bedside for infection control reasons[114], which suggests the use of a tray to have been a better option at the time, nurses at the Rockhampton Hospital had been utilising trays for some years prior to this revelation. This study has been unable to uncover a particular reason for why this approach to dressings was favoured, other than the influence of local tradition.

[113] Interviews, W. Madsen with L. Lowry, October 2, 1996; I. Dennison, October 4, 1996; V. Manly, October 1, 1996.

[114] Holland, op.cit., p. 240.

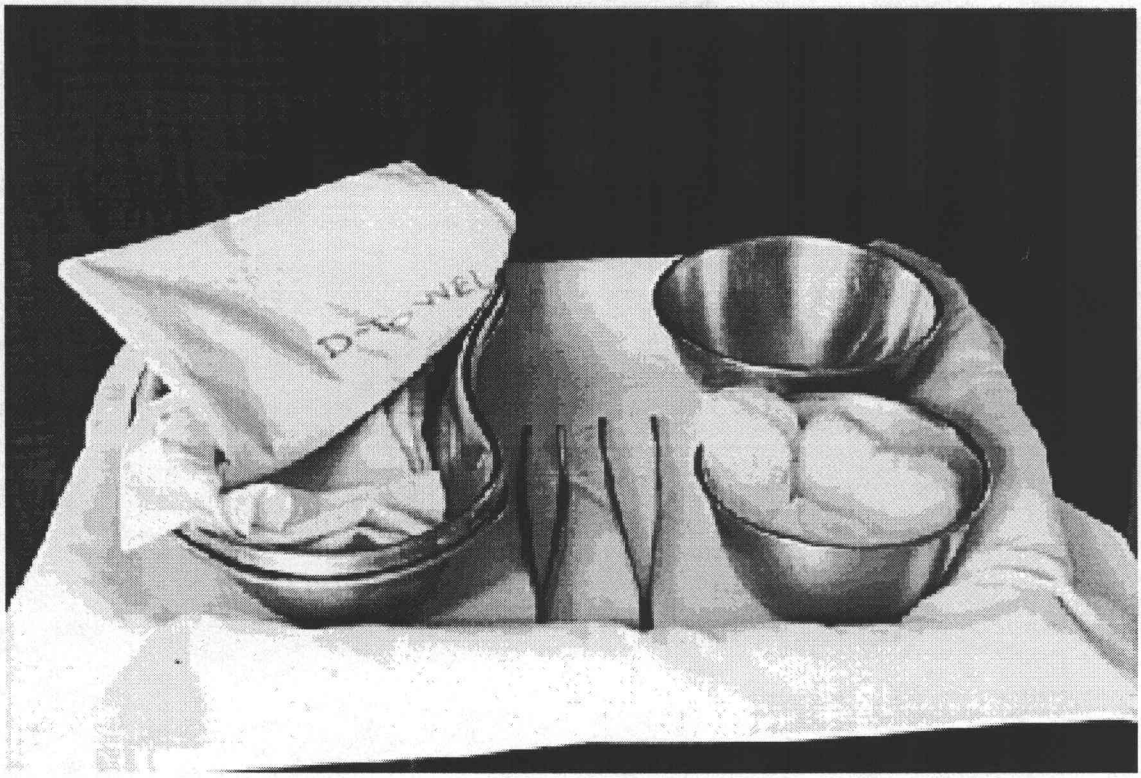

Figure 2.7 Dressing tray set-up (Courtesy of Rockhampton Hospital Museum)

Dressings, however, were not the only aseptic techniques carried out on the ward. A very common procedure was the passing of urinary catheters. Catheterisation was generally required in order to collect micro urine specimens[115], although a few were left in situ.[116] This procedure was carried out without the use of gloves. The nurses needed to rely on hand washing and the adept use of cotton wool balls[117] to minimise contamination of the catheter. One of the consequences of catheterisation was the increased risk to the patient of contracting cystitis. This was seen as a "sign of grave carelessness on the part of the nurse"[118], and was likely

115 Interview, W. Madsen with B. Cagney, June 3, 1996.
116 Interview, W. Madsen with B. West, June 4, 1996.
117 Interview, W. Madsen with B. Cagney, June 3, 1996.
118 Doherty et al., op.cit., p. 203.

to result in a reprimand from the medical superintendent.[119] Catheters had to be inspected prior to use in order to ascertain their integrity, as many were made out of rubber or glass as well as metal, and as such were subject to cracking.[120] The sterilisation of catheters, like other ward equipment, was the responsibility of the nursing staff. Ashdown[121] recommended that catheters be reboiled for twenty minutes prior to insertion and this was the procedure followed by the nurses in Rockhampton.[122] As it was not possible to insert a catheter using a "no touch" technique, the hands of the nurse were a significant potential source of contamination, although this was not the only potential source. The catheter's composition and structure could have contributed to some infections, as could the kidney trays, drapes and cotton balls which had come from questionable storage trays and containers. It does not appear that masks were routinely used by nurses during the catheterisation procedure. Although Holland[123] recommended the use of masks for dressings, other authors did not mention the use of masks except when nursing infectious patients. It is unlikely the nurse's expired air was seen as a potential source of infection, as Ashdown[124] suggested that cystitis was the direct result of lack of surgical cleanliness and inattention to procedural detail.

Catheterisation serves as an example of nurses being expected to take on the sole responsibility of infection control within the wards. This expectation

---

119 Interview, W. Madsen with B. West, June 4, 1996.

120 Registration examination questions, *The Australasian Nurses' Journal,* April 15,1932, p. 90.

121 Ashdown, op.cit., p. 46.

122 Matron Green, op.cit.

123 Holland, op.cit., p. 240.

124 Ashdown, op.cit., p. 66.

came from not only those in authority but from the nurses themselves who understood the need to be careful with aseptic techniques, because "we really had to keep the lid on cross infection ourselves."[125] The hospital administration and medical authorities do not seem to have become involved except to reprimand if an infection occurred.

Personal Cleanliness

Personal cleanliness became synonymous with nurses throughout the first part of this century. The virtues of cleanliness were extolled by all nursing authorities. Nurses were expected to be the perfect example of cleanliness and neatness as this was the result of not only good breeding and good manners, but reflected the nurses' sense of professionalism.[126] This would suggest that the notion of personal hygiene involved more than infection control measures. For although certain hygiene activities may be seen as being strictly concerned with cross infection, such as washing hands prior to carrying out a procedure, other issues, especially those relating to the nurses' uniform, do not appear to have been consistent with known infection control standards.

Washing hands with antiseptics became routine for nurses on a ward in the 1890s as part of a range of measures to decrease cross infection.[127] All the former nurses interviewed conveyed the importance of hand washing prior to attending patients. Soap and water were mainly used for this function, except if nursing an infectious case, when pink biniodide[128] or some other

[125] Interview, W. Madsen with K. Austin, June 20, 1996.
[126] Ashdown, op.cit., p. 3.
[127] Cruickshank, R. op.cit., p. 31.
[128] Interview, W. Madsen with N. McKenzie, July 31, 1996.

antiseptic solution was used to soak hands after a three to five minute wash with soap and water. Nurses were encouraged to keep nails clipped short to minimise cross infection.[129] This was especially important when one considers gloves were not used routinely for many of the ward cleaning activities which involved bodily fluids. Jewellery was actively discouraged although it is not certain if this was necessarily because of the potential for spreading infection. Ashdown included the no-jewellery rule as part of her outline of expectations regarding uniforms.

> (The nurse must be)...careful to wear her uniform with spotless cleanliness, neatness, and simplicity, with hair tidy, no jewellery, her general bearing that of military smartness...[130]

Although hand washing was known to be an important infection control measure, the placement of sinks within the ward would have made this measure difficult to adhere to at times. The sinks were located in the centre of the large wards, which would have been relatively convenient when patients were only found within this ward, as in the early 1930s. As an increasing number of patients were nursed on the enclosed verandahs, however, regular hand washing at a central sink would have constituted a considerable commitment of time and energy. One must then question how often nurses' hands were washed between patients during rounds such as pressure area care. There is some evidence to suggest that this situation of a central sink was considered to be somewhat old fashioned, and that more modern hospitals were being planned with more sinks and in more readily

---

[129] Interview, W. Madsen with K. Austin, June 20, 1996.

[130] Ashdown, op.cit., p. 1.

accessible places.[131] However, while it may have been recognised that the central sink was not ideal, this situation remained unchanged while the open wards were utilised.

Another area which was seen primarily as an infection control measure was the covering up of nurses' hair. Caps were routinely worn by student nurses and veils by the trained nurses. It was imperative for nurses to have all hair hidden under these caps as hair was considered to be a source of infection.[132] Ensuring all nurses' hair was covered was a duty some trained nurses took very seriously, some of whom were known to severely reprimand nurses for any stray locks.

> The X-ray sister came in, while I was cleaning up in X-ray one day, and she took one look at me and she flew at me with her hands open, and almost knocked me to the ground, and said, "Nurse, how many times have I told you, all your hair must be under your cap."[133]

The nurses' cap formed part of the nurses uniform. It was the attitude of many nursing authorities towards the uniform which clouded much of the rationale behind the use of uniforms. Ashdown[134] advocated that a dress worn in the sick room should not be worn out of doors as it would become contaminated with dust and mud and would no longer be suitable for the sick room. In order to minimise this contamination by dust and dirt, it was recommended that nurses' uniforms should be made of "smooth" materials

---

131 Parkes, C. "The Development in Planning of a Nursing Ward Unit, " *The Australasian Nurses' Journal,* April 15,1944, p. 45.

132 Interview, W. Madsen with L. Lowry, October 2, 1996.

133 Interview, W. Madsen with V. Manly, October 1, 1996.

134 Ashdown, op.cit., p. 3.

particularly after being starched and ironed. Therefore cotton was seen as an ideal sanitary material for nurses' indoor dresses and aprons. Although linen was seen to repel dirt more than cotton, it was significantly more expensive.[135] It is at this point that certain inconsistencies appear, for regardless of the material of the uniform, one would expect that infection control measures would dictate the uniform be changed daily. However, in the late 1920s and early 1930s at the Rockhampton Hospital student nurses only owned two uniforms, one of which was worn for a week, while the other was being washed. Admittedly, a clean apron was worn each day which covered most of the bodice and skirt front.[136]

By the mid 1940s the number of uniforms available had increased, but nurses were expected to come on shift in the morning in the previous day's uniform in order to do the patient sponges, and then change into a clean uniform at breakfast.[137] Aprons were not a part of the uniform by this stage. These accounts do not seem to fit with the notions of scientific cleanliness espoused by nursing authors of this era. Changing the uniform at breakfast does however, make more sense when viewed from the perspective of nursing image. Student nurses were informed of the dignity of the nurses' uniform during their first lecture.

> The dignity of the nurses' uniform is most important for if it is neat and clean it always enhances a nurses' appearance.[138]

---

135 Hainsworth, op.cit., Vol. 2, p. 101.
136 Interview, W. Madsen with N. McKenzie, July 31, 1996.
137 Interview, W. Madsen with I. Dennison, October 4, 1996.
138 Matron Green, op.cit.

A clean uniform after all the heavy morning work was done would have been more in keeping with the appropriate image. As noted earlier, jewellery was not allowed to be worn by nurses, not because of infection concerns, but because it was "not in keeping with the impressions the uniform is intended to create".[139] Clearly the rationales behind the strict uniform policy were not entirely concerned with infection control. Adherence to a professional image was important to the nursing authorities which may have had its roots in feminine sanitary reformist notions of the mid nineteenth century as outlined by Bashford[140], whereby nurses were expected to mirror purity and chastity.

Isolation

One of the main strategies adopted by hospitals to control infection was that of isolation. This strategy had been used in Australia since the 1880s when Fiaschi recommended the use of separate buildings in which to house infectious patients.[141] The 1900 Health Act in Queensland demanded local authorities provide accommodation for persons with infectious diseases[142] and indeed, evidence given to the Hospitals Commission by the Rockhampton Hospital Board in 1930 indicated that the local authority was bearing the whole cost of treatment for and detection of infectious diseases.[143] It is therefore conceivable the Board would have taken a particular interest in minimising the spread of certain diseases.

139 Ibid.

140 Bashford, A. "Female Bodies at Work: Gender and the Re-forming of Colonial Hospitals," in Walker, D., Garton, S., Horne, J. (eds) "Bodies," *Australian Cultural History,* Vol. 13, 1994, p. 74.

141 Murray, op.cit., p. 31.

142 Patrick, R. *A History of Health and Medicine in Queensland 1824-1960,* St Lucia; University of Queensland Press, 1987, p. 212.

143 *Rockhampton Evening News,* June 18, 1930, p. 9.

Until 1930, those patients classified as infectious, that is those with diseases such as scarlet fever, measles, diphtheria, smallpox, and typhus were nursed in an area at one end of the hospital which contained two or three beds, known as the "hut".[144] These patients were "specialled", that is, one nurse provided all the care and remained in this ward.[145] By the early 1930s, a special building, set apart from the main building, was utilised for the housing of infectious patients.[146] When nurses were assigned to work in this isolation ward they were expected to remain completely separated from the rest of the hospital, having to move quarters down to the building, where there was provision for three people.[147] Most of the nurses interviewed had very vivid memories of their time spent in isolation ward, especially if they had been there on night duty. This was related to the inability to secure the building adequately and the lack of supervision by trained staff, who may not have visited the ward at all overnight.[148] In particular, nurses were often left to care for seriously ill diphtheria patients who were in danger of suffering from respiratory obstruction.[149] This anxiety significantly affected the nurses.

The principles of isolation nursing were based on separateness and disinfection. Within the isolation building, specific disease cases were nursed in separate rooms.[150] When it was not possible to maintain separation, disinfection was employed. For example, there was only one bath in the building which was used for washing out dirty linen, scrubbing

144 Interview, W. Madsen with M. Chambers, August 5, 1996.
145 Ibid.
146 Interview, S. DeVries with M. Jensen, date of interview unknown.
147 Interview, W. Madsen with J. Kidd, September 12, 1996.
148 West, B. Memoirs, Rockhampton Hospital Museum.
149 Interview, W. Madsen with D. Ross, October 17, 1996.
150 West, op.cit.

down patients with scabies, and bathing patients who were able to go to the bath. The nurse, therefore, had to disinfect the bath prior to bathing someone.[151] In order to minimise contact with these patients, visitors were not allowed, and nurses were expected to wear gowns and gloves at all times while working in this ward.[152]

When a patient was discharged, all items in the room were required to be disinfected, including the mattress. Furniture was washed down with diluted carbolic acid, and small items such as bowls were scrubbed and sterilised.[153] Linen was soaked in carbolic acid prior to being sent to the laundry.[154] Mattresses, which were made of fibre and were very heavy, were taken to a room where the windows and doors were sealed. Formaldehyde was placed in a dish on the floor and then the door was locked for 24 hours. This room was also used for fumigating mattresses and other items from the main hospital[155], where many patients were nursed who had infectious diseases such as tuberculosis.

By the early 1950s the isolation ward had closed and patients with these diseases were barrier-nursed on the verandah, off the medical ward.[156] Barrier nursing on the wards involved the same principles of separation and disinfection as had occurred in the isolation ward. Hand washing facilities were limited to two enamel bowls, one of which contained an antiseptic. Ward staff were required to don a gown and mask up prior to attending

---

151 Ibid.
152 Interview, W. Madsen with K. Austin, June 20, 1996.
153 Ibid.
154 Interview, W. Madsen with B. Cagney, June 3, 1996.
155 West, op.cit.
156 Interview, W. Madsen with B. Cagney, June 3, 1996.

these patients, although gloves were not routinely used on the ward.[157] The gown was left hanging outside the area, and while masks were often kept separate, by each nurse carrying her own inside her pocket, gowns were shared.[158] All equipment and utensils used by the patients were boiled in the pan room, including eating utensils.[159] The main difference between barrier-nursing in the ward and nursing in the isolation ward, was the number of nurses who came in contact with the patients. While in the isolation ward, patients were attended by only one to two nurses who were responsible for all their care. On the medical ward, whichever nurse was responsible for a particular task would have carried out that for all patients including those being barrier nursed. Therefore the number of nurses coming in contact with infectious cases was increased.

All these aspects of barrier-nursing at the Rockhampton Hospital appear to be in accordance with recommendations made within the nursing literature of the time. Doherty et al.[160] suggested infectious cases should be nursed in small rooms or on the balcony. Open ventilation was also recommended by Petrovsky.[161] All equipment was to be kept separate for each patient and treated after being used[162], and nurses were expected to gown and mask prior to entering the room, and wash hands with disinfectant after attending the patient.[163]

---

157 Interview, W. Madsen with J. Kidd, September 12, 1996.
158 Ibid.
159 Interview, W. Madsen with K. Austin, June 20, 1996.
160 Doherty et al., op.cit., p. 253.
161 Petrovsky, op.cit., p. 42.
162 Ibid; Doherty et al., op.cit., p. 254.
163 Petrovsky, op.cit., p. 42; Doherty et al., op.cit., p. 256.

Conclusion

Prior to the introduction of antibiotics, infections posed a serious threat to patient and hospital staff. Therefore, infection control was a major concern for the nurses of the 1930s and 1940s. The routines that were practised during this era were based on the principles of cleanliness and asepsis, the use of antiseptics and isolation or separation. Many of these practices had become ritualised and the nurses who carried out these tasks, as well as their supervising trained nurses, may not have completely comprehended the significance of many of these routines. In addition, it has been shown that concern for limiting the spread of infection was not the only influencing rationale behind some of these practices. Economic constraints and professional image may also be identified as contributing factors.

Chapter 3

Treatments, Cares and Cures

Nursing procedures in the 1930s and 1940s were very labour intensive, and nurses spent a large proportion of their time carrying out treatments on patients. These treatments, most of which were ordered by doctors, were seen as an integral part of the "curing" role of nurses. In addition, nurses spent a significant amount of time undertaking tasks which may be seen as "caring" interventions. These two aspects of nursing, "curing" and "caring", and their associated controlling mechanisms, form the focus of this chapter. Nursing interventions, that is those nursing actions which directly involved the patient, may be broadly categorised into two groups based upon these aspects. Treatments which were ordered and controlled by the doctor, and which may be seen to be focussed on curing the patient, formed one category. The image of nurses as doctor's handmaidens stems from this nursing function.[1] The other category involves those activities which were controlled by the nurse, and which may be viewed as the "caring" functions of nursing. Generally this division of control of nursing tasks appears to have caused little conflict or tension among the nurses at the Rockhampton Hospital in the 1930s and 1940s. These nurses had a clear understanding of when a doctor's order was required prior to undertaking an intervention, although in emergency situations and over a period of time, some of these parameters of control changed.

---

[1] Bridges, J.M. "Literature review on the images of the nurse and nursing in the media," *Journal of Advanced Nursing,* 15, 1990, p. 852.

The complex relationship between doctors and nurses has intrigued a number of nurse historians. Oakley[2] suggests that nursing emerged under Nightingale's influence to become concerned with caring for patients in a moral as well as a sanitary sense. This caring role was to complement the curing aspects of medicine, derived from medicine's control of drugs, operations and complex technologies. Oakley[3] suggests this situation remained until the 1930s and 1940s when nursing became clearly subordinate to medicine, based on a new hierarchy of technical division of labour. Maggs'[4] review of the literature relating to nursing practice, suggests that nursing has been created from conflicting power and professional relationships between doctors and nurses, whereby doctors have delegated those tasks which were seen as less worthy to nurses. Maggs[5] also suggests that the ideological views of womanhood and motherhood have been influential in this process.

This study has been able to clearly identify duties which were undertaken by nurses and that were absolutely controlled by doctors. The majority of these tasks were associated with the curing aspects of medicine. However, a considerable amount of nursing time was spent undertaking tasks over which doctors had no input. These tasks were often related to providing the optimal environment for patients and could be categorised as "caring" tasks. It should be noted that while these activities have been referred as "caring"

---

2 Oakley, A. *Essays on Women, Medicine and Health,* Edinburgh; Edinburgh University Press, 1993, pp. 41-42.

3 Ibid., p. 43.

4 Maggs, C. "A History of Nursing: A History of Caring?" *Journal of Advanced Nursing,* 23, 1996, p. 633.

5 Ibid.

tasks, Olsen[6] suggests that the concept of caring, as is now understood, was not one that was prevalent on the wards in the early part of this century. Terms such as "handling", "managing" and "controlling" were more likely to be used by the rank and file nurses, to describe the work they undertook. The results of this study would support Oakley's proposal that the 1930s and 1940s were a transitional period whereby nursing's environmental model was evident while at the same time nurses were undertaking duties previously done by doctors. In addition, that this process was influenced by the issue of nurses being women would also be supported by this study through its investigation into the division of tasks. However, while all these factors may have been evident, this study would suggest that the relationship between doctors, nurses and nursing practice was more complex as these factors do not adequately deal with the role nurses played in taking on medical tasks.

Doctor-controlled Interventions

Many of the doctor-controlled procedures conducted by nurses originated when doctors' training moved from an apprenticeship system to a more formal educational system in the late nineteenth century. The result of this move was that many of the monitoring tasks and bedside procedures previously carried out by trainee doctors were to then be performed by nurses.[7] This was a gradual transition over many years. For example, after World War I, dressings became increasingly the domain of the nurse, so

---

6 Olsen, T. C. "Laying Claim to Caring: Nursing and the Language of Training, 1915 - 1937," *Nursing Outlook,* Vol. 41, No.2, pp. 68-72.

7 Hawker, R. "For the Good of the Patient," in Maggs, C. *Nursing History: A State of the Art,* Kent; Croom Helm Ltd. 1987, p. 148.

that by the 1930s all ward dressings were done by the nurse.[8] Similarly in the 1950s, nurses routinely began to undertake blood pressure measurements, a task that was definitely seen as a doctor's responsibility in the 1940s.[9] This transition of tasks has not been reviewed in any depth in Australia. While it is beyond the realm of this study to investigate this in any detail, it is pertinent to consider a number of points regarding this transitional trend.

Firstly, there is the issue of decision-making in regard to these tasks. Control was definitely retained by the medical profession who dictated the parameters of tasks to the nurses. Although there are exceptions to this where over time a number of the doctor-controlled tasks became so routine to nurses that it is sometimes difficult to identify the extent of decision-making the doctor maintained. A prime example of this is tepid sponging, a task that was ordered by the doctor in the 1920s[10]; however, by the 1940s few nurses would have consulted a doctor prior to tepid sponging a feverish patient.[11] This transition of tasks may also have influenced the amount of interest the medical profession took in the training of nurses. Doctors were intimately involved in delivering lectures on medical and surgical nursing to students. Doctors also held positions of authority in professional organisations, such as the Australasian Trained Nurses' Association

---

[8] Maxwell, A.C. and Pope, A.E. *Practical Nursing: A Textbook for Nurses,* New York; G. P. Putnam's Sons. 1914, p. 548. This edition notes nurse's role in dressings was to prepare the patients and to assist the doctor. In the fourth edition, published in 1923, the author outlined important points for nurses undertaking dressings.

[9] Interview, W. Madsen with K. Austin, June 20, 1996.

[10] Ashdown, A. M. *A Complete System of Nursing, 6th Edition,* London; The Waverly Book Company Ltd. 1925, p. 95.

[11] Hainsworth, M. *Modern Professional Nursing, 2nd Edition, Vol. 3*, London; The Caxton Publishing Co. Ltd. 1949, p. 62.

(ATNA).[12] Such interest ensured that doctors maintained control of various tasks as the nurses followed their directions precisely and without question. In short, doctors needed to have tasks performed to their satisfaction without their direct supervision; hence the creation of the handmaiden. In order for this to take place, nurses had to be prepared to submit to the notion of intelligent obedience. Intelligent obedience was a notion that was raised repeatedly in nursing text books well into the 1940s. Stewart and Cuff outlined the qualifications of a nurse in 1919. These qualifications were regularly cited at nursing lectures in Queensland.

> Obedience is the first duty of a nurse and the best test of her training. It must not be the dull mechanical obedience of the ignorant or uninterested. To be effective, it must be whole-minded, intelligent and loyal.[13]

Such obedience also involved completely refraining from criticism of a doctor's treatment or suggestions as to the forms of treatment. Oakley[14] suggests the notion of obedience originated from Nightingale. However, it is unclear when such obedience became linked with the concept of intelligence.

Bessant[15] has noted that during the early part of this century, nursing was portrayed by emphasising "feminine" traits such as loyalty, subordination, service and cheerfulness rather than skill acquisition and training based on scientific or theoretical education. Nurses believed these latter aspects

---

12 Strachan, G. *Labour of Love. The History of the Nurses' Association in Queensland 1860 - 1950.,* St. Leonards; Allen & Unwin Pty. Ltd. 1996, p. 38.

13 Stewart, I. and Cuff, H.E. *Practical Nursing, 5th Edition,* London; William Blackwood & Sons. 1919, p. 4.

14 Oakley, op.cit., p. 44.

15 Bessant, J. "Good Women and Good Nurses. Conflicting Identities in the Victorian Nurses' Strike 1985 - 1986," *Labour History,* Vol. 63, November, 1992, p. 162.

detracted from the professional organisations claims of professional status. This research would only partially support this claim in that the ATNA, which was largely influenced by doctors, did allow nurses to acquire skills, but did not accompany such acquisition with adequate knowledge. Therefore, the medical profession maintained control of those skills. Interestingly, a number of doctors publicly called for nurses to move beyond passive obedience and to increase their knowledge. In 1917, Howard[16] believed this was necessary in order for nurses to render more efficient help to doctors, although he did not specify what type of knowledge was necessary in order for the nurse to be able to obey orders intelligently. It was perhaps thought that a nurse possessing intelligent obedience would no longer require a doctor to spell everything out, but could be given a general command and be assured his wishes would be followed. By 1944, there was even a suggestion that nurses should be seen as part of the medical team and not as the servitor.[17] However, this view does not appear to have been widespread within Queensland hospitals. In addition, this latter view does not openly advocate doctors relinquishing control.

Medications. One of the most obvious tasks nurses carried out which was strictly controlled by doctors was the administration of medications. Most medications during the 1930s and 1940s were given orally, either as pills or liquid medicine, often called mixtures. Intramuscular and subcutaneous injections were also commonly given by the nurse. The intravenous route was mainly used for the replacement of fluids only, and medications were not routinely given via this route during this era. Medication dose and

---

16 Howard, R. *Surgical Nursing,* London; Edward Arnold and Co. 1917, preface vii.

17 Doherty, M.K., Sirl, M.B., Ring, O.I. *Modern Practical Nursing Procedures,* Sydney; Dymocks Book Arcade Ltd. 1944, preface written by Dr. B.T. Mayes.

frequency were ordered by the doctor, usually during daily rounds, and it was expected that the nurse would deliver that medication to the right person on time.[18] The procedure that was involved from the original order to the eventual arrival of the medication was quite involved and ritualistic.

Medications were written in the patient's chart when ordered by the doctor. However, it would have been cumbersome to refer to these charts every time a medication was due. Therefore, the nurse wrote the medication orders in their own notes, which they carried around with them.[19] In addition, a "mixture list" was also written out, which was kept in the day room. This mixture list was rewritten and updated by the senior nurse on almost every shift.[20] This practice of using a mixture list was considered to be quite normal, as outlined in a 1940 article in *Nursing Illustrated* , which noted that the medicine list was usually attached to the inside of the medicine cupboard.[21] The main difficulty with this practice was the high risk of transcription errors. It is unknown if the senior nurse copied each new list from the previous one, or if she rewrote it from the patients' charts; either way, there was considerable potential for mistakes to occur, although such errors would obviously have been compounded should the new list be copied from the old. In addition, one has to wonder why nurses felt it was necessary to also carry a copy of the patient's medication orders in their own notes. This may have been a safety mechanism that may have enabled mixture list errors to be detected; however, it may have also been related to the expectation that nurses were to be seen "doing" as opposed to reading

---

[18] E.G.R. "Administration of Medicine By Mouth." *Nursing Illustrated,* Vol. 3, No.22, January 2, 1940, p. 613.

[19] Interview, W. Madsen with D. Ross, October 17, 1996.

[20] Interviews, W. Madsen with D. Ross, October 17, 1996; B. Cagney, June 3, 1996.

[21] E.G.R., op.cit., p. 613.

patients' charts. Another factor which may have aided in reducing possible errors was that patients tended to be long staying and generally only the more senior nurses would have administered the medication, so they would have become quite familiar with each patient's medication regime. There was certainly little concern expressed by nurses of this era regarding this practice of copying the medication list.

The ritual of administering medications in the 1930s and 1940s was very similar to the procedure today in that the "five rights of medication" were strictly adhered to: the right time, the right drug, the right dose, the right route and the right patient, although it was not expressed in this way during this era. In addition, there was particular concern regarding the mechanics of pouring mixtures, as outlined by the following extract:

> When pouring out liquid medicines, the medicine glass or measure should be held in the left hand, with the tip of the thumb at the mark required. The measure is held at eye level. The bottle containing the medicine is lifted in the right hand with the label facing the palm of the hand, so that when it is tilted the label on it remains uppermost and is kept clean.[22]

This elaborate description of the method for pouring out medications was also reflected in the recollections of former nurses.[23]

The next step in administering the medication was taking it to the patient. Although one former nurse recalled using a medication trolley, the majority remembered using a tray. This tray would contain a small bowl of water or

---

[22] Ibid.

[23] Interview, W. Madsen with K. Austin, June 20, 1996.

a hand towel to wash out the glasses.[24] The nurse would prepare the medications for a particular time by pouring out the required mixtures and placing pills on teaspoons on the tray with the patient's names written underneath the corresponding medication. This tray was then taken to be checked by the sister of the ward.[25] The medications could then be administered to the patients. Again the potential for errors to occur would have been fairly high by adopting this routine; however, the nurse's familiarity with the patients and their medication regimes may have reduced this potential. The use of a tray necessitated that medications be measured out in the day room taking only what medications were required at that time out of the storage cupboards as opposed to using a trolley with a wide range of medications. While both transport systems were mentioned in the literature, the use of a trolley was the preferred method, with a tray being advocated when only a few medications were to be administered.[26]

A number of medications were also administered via an injection, either subcutaneously or less commonly, intramuscularly.[27] Herrmann[28] has suggested that doctors encouraged nurses to undertake the administration of injections because of difficulties they had in maintaining the syringes and needles and because of the tendency syringes had for breaking if poorly maintained. Also there was a belief that a feminine touch would cause less patient discomfort. The maintenance of syringes was seen as a nursing responsibility throughout the 1930s and 1940s and was one which was

---

24 Interview, W. Madsen with J. Kidd, September 12, 1996.

25 Interviews, W. Madsen with M. Baggett, June 6, 1996; B. Cagney, June 3, 1996; N. Windsor, October 9, 1996.

26 E.G.R., op.cit., p. 613.

27 Doherty et al., op.cit., p. 138.

28 Herrmann, E. K. "Turn of the Century Hypodermic Therapy," *Western Journal of Nursing Research,* Vol. 16, No. 3, June, 1994, pp. 333-334.

fraught with difficulties as the metal barrels commonly jammed in the glass syringes.[29] Figure 3.1 shows the range of needles and syringes used at the Rockhampton Hospital. Injections were also time-consuming to prepare as the medication tended to come in tablet form and had to be dissolved before being drawn up from a spoon.[30] The medications which were injected may have been perceived by the patients as being particularly powerful or dangerous, as Doherty et al. recommended the nurses not take a hypodermic tray containing drugs to the bedside, "for one never knows when a patient may attempt suicide."[31] This illustrates the mystery that surrounded medications for patients which was perpetuated by nurses who believed that a patient should not know what drug was being administered.[32]

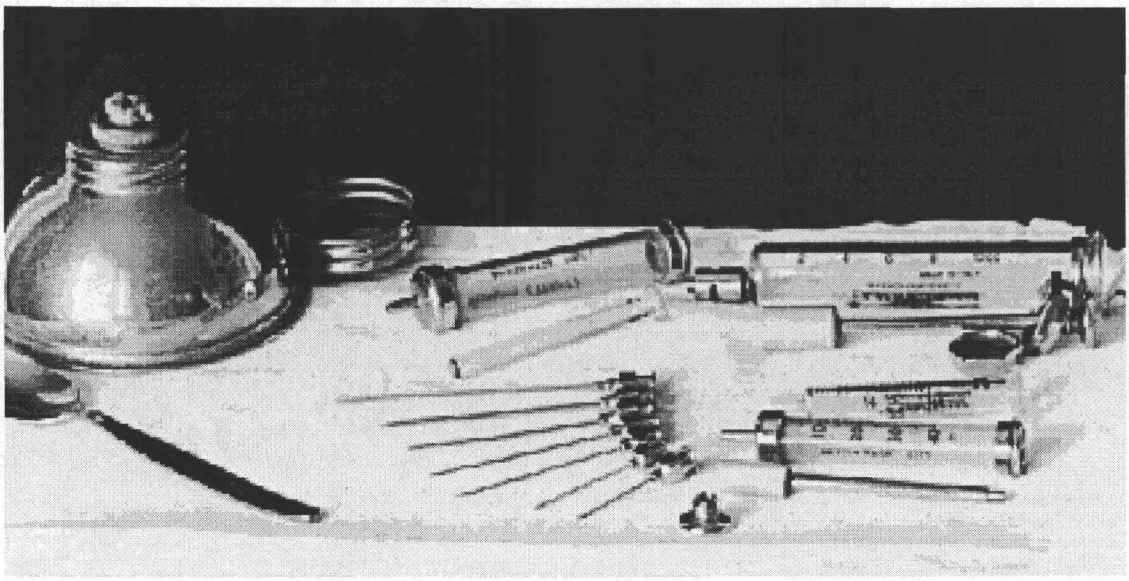

Figure 3.1 Needles and Syringes used in the 1930s and 1940s for giving intramuscular and subcutaneous injections (Courtesy of Rockhampton Hospital Museum)

---

[29] Hatcher, W. J. *Nursing Illustrated,* Vol. 3, No. 19, January 12, 1940, p. 519.

[30] Doherty et al., op.cit., p. 135.

[31] Ibid., p. 137.

[32] Ibid., p. 115.

Applications. Nurses spent a considerable amount of time applying various treatments to the surface of patient's bodies. Many of these treatments were carried out in association with heat or cold applications, although many also contained some type of medication. Applications of heat were applied to patients for warmth, to relax muscular spasms, to relieve pain, to check inflammation, to stimulate organ activity and to arrest haemorrhage. Cold was applied to reduce temperatures and to also reduce inflammation, swelling and haemorrhage, and to act as a sedative.[33] Applications could be made directly onto the skin or be used as part of a wound dressing. As noted earlier, dressings were routinely carried out by the nursing staff by the 1930s, although it was the presiding doctor who determined what products were to be applied. It is not the intention of this chapter to outline what products were applied, although tulle gras, unnas paste, and acriflavin were commonly mentioned by nurses of that era.[34] The aim of this section is to outline two commonly used applications, fomentations and poultices, and to explore some of the implications for the nurses who carried out these treatments.

Fomentations were applications of moist heat applied to the body or wound.[35] Surgical fomentations were a form of surgical dressing used for infected wounds.[36] This type of dressing was not only time consuming for the nurses, but it also required considerable skill and experience in order to carry it out effectively. The procedure for preparing a surgical fomentation

---

[33] Matron Fraser, General Nursing Lecture Notes, 1945.

[34] Interviews, W. Madsen with K. Austin, June 20, 1996; N. Windsor, October 9, 1996; D. Ross, October 17, 1996.

[35] Pearce, E. *Medical and Nursing Dictionary and Encyclopaedia, 9th Edition,* London; Faber and Faber Ltd. 1949, p. 244.

[36] Ashdown, A.M. "Fomentations, Medical and Surgical," *Nursing Illustrated,* January 19, 1940, p. 558.

required the nurse to take a piece of lint, double the required size, and wrap it up in a "wringer" of strong towelling. This material was placed into a bowl and then covered with boiling water[37]; or alternatively, placed into a saucepan and boiled for five minutes. The ends of the towelling overhung the sides of the bowl or saucepan to enable the wringer to be removed. Once the apparatus was removed, it was wrung out by twisting the ends of the towelling. This was then unfolded and the lint removed with forceps by the nurse attending the dressing. The lint was shaken, allowing steam to escape and then applied to the wound. This was covered with protective material such as jaconet, batiste or oiled silk; cotton wool and then bandaged.[38] Considerable skill and experience was required in order to wring out the water from the lint, otherwise the surrounding skin would have been scalded. In addition, if the lint was applied with too much moisture, it became cold and clammy rapidly, whereas a properly applied fomentation would remain dry and comfortable as it dried.[39] Fomentations needed to be changed every two to four hours.

Medical fomentations were also applied. These were applied to intact skin and may have contained a medication. Fomentations containing medications were known as "stupes". The procedure for preparing a medical fomentation was the same as for surgical fomentations. The medications were applied in a variety of ways, according to the medication: for example, turpentine was added to the boiling water, opium to the wrung-out lint, and soda to the lint prior to boiling.[40] The rationales for applying fomentations were not given in early nursing texts such as Ashdown's *A*

[37] Hainsworth, op.cit., Vol. 2, p. 363.
[38] E.G.R. *Nursing Illustrated,* May 26, 1939, p. 381.
[39] Ashdown, op.cit., 1940, p. 558.
[40] Ashdown, op.cit., 1925, pp. 80-81.

Complete System of Nursing[41] ; however, later texts noted that the external application of heat was believed to relieve pain by encouraging blood to reach the surface of the skin and relieve the pressure in the underlying tissues, thus reducing the stimulation on the nerve endings.[42] Medical fomentations were classified as rubefacients, a class of counter-irritants which caused redness. Counter-irritants relied on violent skin reactions as a method of treatment, and were used regularly prior to the introduction of more advanced pharmaceutical treatments. They ranged from treatments which caused a mild reddening of the skin to more severe treatments which caused an injury to the skin. By the 1940s, the majority of counter-irritant techniques had been discarded although the milder forms such as turpentine stupes continued.[43] The main implication for nurses with any of these moist heat applications was the risk of burning the skin of the patient and hence creating further injury.

Poultices or plasters were noted by Hainsworth[44] in 1949 to have been dramatically reduced in their use throughout the first half of the century, so that linseed poultices were only occasionally used by that date. However, the regular use of poultices appears to have continued at Rockhampton Hospital well into the 1940s with most of the nurses interviewed for this study recalling making them. In addition, a number of poultice preparations were noted in the 1945 general nursing lecture notes.[45] This would

---

41 Ibid.

42 Hainsworth, op.cit., Vol. 2, p. 353.

43 Shiel, D.W. *Medical Nursing Lectures for Pupil Nurses,* Brisbane; Waverly Press, 1941, p. 13.

44 Hainsworth, op.cit., Vol. 3, p. 42.

45 Matron Fraser, op.cit.

suggest that the practice of poultice application remained prevalent throughout this time, although it is not possible to determine if the practice was in decline by 1950.

Poultices were made up of a substance which when boiled retained heat and moisture.[46] As such, the base of many poultices was linseed because it contained an oil and therefore did not cool as quickly as other substances, such as bread. The procedure for making up a poultice involved mixing boiling water and linseed meal in a bowl until a thick paste was formed. This was spread onto flannel or linen.[47] The nursing staff at the Rockhampton Hospital tore up old bed linen for poultices.[48] Gauze was laid on top of the poultice mixture and the edges of the cloth were folded inwards. This was further warmed on top of the steriliser before being applied to the patient, with the gauze surface being next to the skin and held in place with a binder.[49] The poultice could be reheated when necessary by placing it on the steriliser. Mustard plasters were also commonly used by the nurses of this era. These poultices were similarly prepared to a linseed poultice, with a little mustard paste being added to the linseed prior to spreading the mixture onto the linen.[50]

As with fomentations, the main risk associated with applying poultices was that of burning the patient. This was not just related to the heat of the application, but also to the use of any additives. For example, a mustard poultice was applied for its mild counter-irritant properties and it was found

---

[46] Ibid.

[47] Hainsworth, op.cit., Vol. 3, p. 43.

[48] Interview, W. Madsen with L. Lowry, October 2, 1996.

[49] Interview, W. Madsen with M. Chambers, August 5, 1996.

[50] Matron Fraser, op.cit.

that leaving it in place for longer than necessary could seriously irritate the patient's skin.[51] Therefore nurses had to be careful with regards to the temperature of the application when applying it, and about the length of time the application was left in place. This was necessary not only because of the risk of irritation with the medicated applications, but to avoid leaving a cold application in place longer than the recommended time.

Enemas. Enemas were a common nursing procedure during the first part of this century. A variety of enemas were given for purposes other than cleaning out the bowel. These included astringent enemas which were used to contract the tissues and superficial capillaries of the bowel in order to control haemorrhage and diarrhoea; carmative enemas, used to relieve flatulence; stimulating and sedating enemas; and nutritive enemas which were used to provide a patient with nutrients when oral feeding was not possible.[52] How effective or widespread these enemas were is unknown for although these enemas were mentioned in nursing texts throughout the 1930s and 1940s[53], most of the former nurses who were interviewed recalled only giving soap and water enemas, used to relieve constipation or for a bowel washout prior to surgery. As many of these enemas contained medications, such as turpentine, magnesium sulphate or opium, it is assumed these enemas would have needed to be ordered by a doctor. Whether a doctor's order was necessary for a soap and water enema for relief of constipation is not clear. The method of giving enemas was not dissimilar to the procedure today, with the patient lying on the left side, and the enema being delivered via a reservoir attached to tubing which was

---

[51] Ibid.

[52] Pope, A.E. and Pope, T.A. *A Quiz Book for Nurses, 2nd Edition,* New York; G.P. Putnam's Sons, 1915, pp. 41-42.

[53] For example, Hainsworth, op.cit., Vol. 2, pp. 356-361.

inserted into the rectum. However, there were alternative devices used, such as the Higginson's Syringe, which included a pump action mechanism situated along the tubing.[54]

Peri-operative Nursing. One area of nursing that was significantly influenced by doctors, and in particularly individual surgeons, was that of surgical nursing. This involved the care of the patient prior to and after an operation. The preparation of a patient for theatre remained virtually unchanged throughout the twenty years under review, except in relation to the giving of enemas. Although nurses followed a number of basic principles, individual surgeons often had particular requirements which needed to be observed, especially in relation to skin preparation.[55] Former nurses recalled referring to a book while nursing in the private ward of the Rockhampton Hospital, which contained the preferences of the honorary surgeons.[56] Preoperative care was seen by nurses as a preventative measure, which if effectively carried out, minimised the risk of complications for the patient whilst under anaesthetic and incisional infections after the operation. Hence it was in the surgeon's interest, as well as that of the patient, that the nurses diligently carried out preoperative procedures. This was acknowledged by some surgeons who were usually quick to point out the therapeutic aspects of good preparation by nurses, and the implications of "slipshod" nursing.[57]

---

[54] Ibid., p. 356.

[55] Exam question and answer, *The Australasian Nurses' Journal,* October 15, 1932, p. 217.

[56] Interview, W. Madsen with D.Ross, October 17, 1996.

[57] Nash, E.F.E. *The Principles and Practice of Surgical Nursing,* London; Edward Arnold Publishers Ltd. 1955, p. 348.

On the day prior to an operation, the nurse would ensure the patient would be bathed and weighed. Temperature, pulse and respirations would be recorded, as were the results of a ward urinalysis. The patient would then be seen by an anaesthetist.[58] Although until the 1920s, an enema was routinely given the night before or the morning of the operation[59], this practice seems to have become less common by the early 1930s, with the recommendation being to give an enema only if the patient was constipated.[60] The diet the night before would consist of a light, high carbohydrate diet. The morning of the operation, the patient would be permitted to have tea and toast if the operation was not until the afternoon.[61] This practice of eating until four hours prior to an operation is noted in a number of texts available through the study period[62], although Boyd[63] noted in 1939 that the rule of fluids up to midnight and then nil by mouth was best because this was associated with a reduction in post anaesthetic nausea and vomiting. The routine at the Rockhampton Hospital was to allow patients to have breakfast if they were towards the end of the theatre list. One of the former nurses recalled an incident relating to withholding breakfast from a patient prior to an operation, which indicated that the only method of ensuring such patients were not given breakfast was via verbal communication between the nursing staff, that is, there was no sign on or near the patient's bed to remind staff of their nil by mouth status.[64]

---

58 Boyd, R.N. "Surgical Cases: Preoperative and Immediate After Care," *Nursing Illustrated,* February 24, 1939, p. 17.

59 Ashdown, op.cit., 1925, p. 374.

60 Exam question and answer, *The Australasian Nurses' Journal,* October 15, 1932, p. 217.

61 Ashdown, op.cit., 1925, p. 374.

62 For example, Hainsworth, op.cit., Vol. 3, p. 72.

63 Boyd, op.cit., p. 17.

64 Interview, W. Madsen with D. Ross, October 17, 1996.

Patients who were to have an incision made to the external part of the body were usually required to be shaved. The area to be shaved was quite extensive and was followed by skin preparation which consisted of scrubbing the skin for five minutes with a soap solution, washing with 70 percent alcohol and then painting with an antiseptic solution.[65] Common solutions used at the Rockhampton Hospital were tincture of iodine and one percent picric acid, which was cheaper than iodine. Less commonly used was perchloride of biniodide of mercury. Bonney's Paint was also available and was apparently very effective although very expensive.[66] It was the surgeon's prerogative as to which antiseptic was used. Once the skin was painted with antiseptic, the area was then covered with sterile towels which were held in place with a bandage.[67] Prior to leaving the ward to go to theatre, the nurse had to ensure the patient's bladder was empty and that all jewellery and artificial teeth and other prostheses were removed.

As far as can be ascertained, patients were brought directly to the ward from theatre, and the period of time now known as recovery, immediately after surgery, was managed in the ward. Patients were placed in a recumbent position in a previously warmed bed, with the head turned to one side. This position was preferred because it was believed it caused wakefulness.[68] As the patient was still under the effects of the anaesthetic, a nurse was required to remain at the bedside until the patient was more alert.[69] During this time the nurse needed to closely monitor the patient's pulse, colour and

---

65 Boyd, op.cit., p. 17.

66 Author unknown, *Surgical Nursing Lectures, Rockhampton Hospital,* Rockhampton; Rockhampton City Printing, date unknown, probably mid 1940s, p. 3.

67 Boyd, op.cit., p. 17.

68 *Surgical Nursing Lectures, Rockhampton Hospital,* op.cit., p. 16.

69 Ibid.

breathing.[70] Post-operative management, therefore would have meant one nurse "specialling" the patient until consciousness was regained. Given the patient workloads of the time, this need for "specialling" must have meant the rest of the staff had increased workloads. This management of post-operative cases also meant a considerable amount of responsibility was placed on the nurse who, although supervised by a sister within the ward, was still a trainee and therefore of limited experience. In addition, should a doctor be required due to complications during recovery, there may have been considerable time delays before a doctor could have attended, although the surgical ward was positioned as close as possible to the theatre.

Nurse-controlled Interventions

The procedures mentioned above were not the only nursing tasks which were controlled by doctors, but they cover the main categories, and illustrate the basis of nurses' "handmaiden" image which existed during this pre 1950 era. The following section will address those areas of nursing practice in which nurses exercised considerably more control. Issues relating to nutrition and fluid balance continued to be influenced by medical staff, although nurses had an increased role in this decision-making process. In addition, there were a number of nursing tasks over which nurses had complete control. These involved pressure area care, hygiene needs, comfort, rest and environmental factors. Most of these areas were identified by Florence Nightingale as being fundamental to nursing. In her *Notes on Nursing* she identified that nursing was not just the administration of medications, but that it...

[70] Hainsworth, op.cit., Vol. 3, p. 73.

> ...ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet - all at the least expense of vital power to the patient.[71]

It is therefore, these autonomous areas of nursing and associated transitions that will be focused on for the remainder of the chapter.

Diet. Nash[72] identified that the nurse controlled the balance between the principle of rest and the principle of nutritional intake, thereby aiding the patient's recovery. He noted that diet, in quality, quantity and presentation was one of the greatest principles of treatment and that it was the nurse who coordinated this, with very broad guidance from the medical staff. This would suggest that the doctor decided on the type of diet - for example, full diet or diabetic diet - and the nurse would then decide what foods were given, and how much. The aim of the nurse was to ensure that patients received adequate nutrition, so there was emphasis on the serving of meals and special diets, as well as assisting debilitated patients to eat. As nutritionists were generally not available in hospitals, invalid cookery was an integral part of the nursing curriculum throughout the 1930s and 1940s. This subject not only taught nurses how to cook appropriate meals for persons who were ill, but also taught the rudiments of nutritional food values.[73]

---

[71] Nightingale, F. *Notes on Nursing: What it is and what it is not,* Glasgow; Blackie & Son Ltd. 1974, p. 6.

[72] Nash, op.cit., pp. 31-32.

[73] For example, questions contained in a 1943 Department of Public Instruction, Queensland, Invalid Cookery Exam, asked the students to identify the food values of three vegetables, eggs and cereals.

The bulk of the cooking was done in the kitchen by cooks. Large containers of food were brought up to the ward by the nurses who would dish out the meals and serve them to the patients.[74] It was generally the senior nurse or sister of the ward who would serve out the meals, ensuring the appropriate content and amount for each patient. This meal would then be taken to the patient by a more junior nurse. Ashdown[75] noted that serving meals was an important component in encouraging patients to eat. She expected nurses to understand the importance of presenting a meal as a means of enticing patients to eat as well as knowing the patient's likes and dislikes. Any special diets were cooked by the junior nurse on the ward[76] as were any eggs the patients may have brought with them into hospital.[77] Special diets included diabetic diets, diets for gout, fat reducing or Salisbury diet[78], and ulcer diets.[79] Patients with infections were given cream[80], and those with tuberculosis were given milk every two hours.[81] In addition, those patients unable to eat needed to be fed a fluid diet. Although nasogastric feeding was a recognised method of feeding unconscious patients or those who could not be fed normally[82], none of the former nurses interviewed recalled carrying out this procedure, nor did they recall feeding patients rectally, that is by giving nutrient enemas, another recognised method of providing nutrition during this era.[83]

---

74 Interview, W. Madsen with I. Dennison, October 4, 1996.
75 Ashdown, op.cit., 1932, p. 654.
76 Interview, W. Madsen with M. Baggett, June 6, 1996.
77 Interview, W. Madsen with J. Kidd, September 12, 1996.
78 Ashdown, op.cit., 1925, pp. 675-676.
79 Interview, W. Madsen with D. Ross, October 17, 1996.
80 Interview, W. Madsen with K. Austin, June 20, 1996.
81 Interview, W. Madsen with I. Dennison, October 4, 1996.
82 Ashdown, op.cit., 1925, p. 53.
83 Ibid., p. 58.

Pressure Area Care. One of the earliest tasks learnt by a junior nurse was how to "do backs". This term referred to the regular rounds of washing patient's backs, and other preventative measures to minimise the development of pressure sores. Pressure sore development was a complication of long stays on hospital mattresses which were made out of fibre or some other unyielding material.[84] Most of the causes of pressure sores were well documented in the nursing texts available in the 1930s and 1940s. They included chafing, pressure or injury[85], friction, diseases of the spinal cord[86], lowered vitality, impaired circulation, general oedema and extreme obesity.[87] However, despite the knowledge that was available which suggested intrinsic factors contributed to the development of pressure sores, such as lowered vitality, there was a strong belief that pressure sore development was "due to the want of care on the part of the nurse."[88] Such a belief was related to the view that nurses were representatives of their training hospitals and that they were not to bring discredit to that institution by allowing anything to happen to their patients. This notion was clearly illustrated by Ashdown:

> Nurses should recognise that it is a characteristic of nursing work either to bring out all that is great, noble and self-sacrificing, or to tend to deterioration by affording opportunities for selfishness, liberty of action and thought, and frivolous amusement; thereby bringing either credit or discredit upon the

84 Interviews, W. Madsen with B. West, June 4, 1996; M. Chambers, August 5, 1996.
85 Ashdown, op.cit., 1925, p. 16.
86 Riddell, M.S. *Lectures to Nurses, 5th Edition,* London; The Scientific Press, Faber and Faber Ltd. 1933, p. 26.
87 Doherty et al., op.cit., p. 37.
88 Riddell, op.cit., p. 26.

> school which has trained them, the influence of which they will carry with them so long as they do nursing work within or without its walls.[89]

There is no middle ground in this viewpoint - one was either a "good" nurse or not, and the development of a pressure sore in one of the patients one was nursing was certainly a sign of "deterioration", and therefore indicative of "bad" nursing. Not surprisingly, former nurses recalled very clearly the measures they undertook to prevent the formation of pressure sores. "You had to do their backs whether they were ambulatory or not."[90] This activity was carried out every two to fours, depending on the frailty of the patient[91], and was an issue which was taken very seriously by nurses.

The procedure involved in "doing backs" did not change throughout the twenty years under review at the Rockhampton Hospital. Patients had their backs washed with warm water and soap, dried, then firmly rubbed over with methylated spirits. This was followed by a dusting of talcum powder.[92] In addition, the nurse made sure there were no crumbs or wrinkles in the bed before settling the patient and moving on to the next.[93] Wet beds were changed immediately.[94] This procedure exactly followed the recommendations outlined in the available literature.[95] The reasoning given by the nursing texts behind the procedures was similar to those expressed by the former nurses. Soap and water were used "to replace the

---

89 Ashdown, op.cit., 1925, p. 2.

90 Interview, W. Madsen with K. Austin, June 20, 1996

91 Interviews, W. Madsen with L. Lowrey, October 2, 1996; B. Cagney, June 3, 1996; D. Ross, October 17, 1996.

92 Interview, W. Madsen with D. Ross, October 17, 1996.

93 Interview, W. Madsen with K. Austin, June 20, 1996.

94 Interview, W. Madsen with N. McKenzie, July 31, 1996.

95 Riddell, op.cit., p. 27; Doherty, et al., op.cit., p. 37; Ashdown, op.cit., 1932, p. 16.

natural oils of the skin lost by repeated washing"(sic).[96] Methylated spirits was used to promote circulation and to harden the skin.[97] The promotion of circulation was also the reason for vigorously rubbing the patient's skin.[98] However, how these rationales were formulated is not clear, nor was this study able to uncover the origins of this practice. Other actions undertaken by the nurses to prevent bedsores was regular repositioning of the patient every two to four hours, and strategically using water and air cushions and rings to dissipate the pressure.[99]

Patient Hygiene. The first duty carried out at the commencement of a day shift was the sponging of patients. Very few patients, if any, were permitted to use the bathroom for their ablutions[100], although a bath was available in the ward. Normally, each patient was given a basin of water to wash in at their bedside. Those who were able, sponged themselves, with the nurse only helping out with their backs. Those who were more debilitated were completely washed by the nurses.[101] In addition, the patient's hair was brushed and their teeth cleaned.[102] The rationale for bathing patients centred on the belief that bathing helped to rectify the sluggish circulation of blood to the skin glands as a result of illness. Hence bathing helped to keep the skin in good order, prevented pressure sores, and promoted a feeling of comfort for the patient.[103] However, this does not explain why it was felt necessary for patients to remain in bed for their baths. This may

---

96 Bishop, H.A. 'The Treatment of Bedsores," *Nursing Illustrated,* April 26, 1940, p. 250.
97 Riddell, op.cit., p. 27.
98 Ashdown, op.cit., 1932, p. 17.
99 Ashdown, op.cit., 1925, p. 17.
100 Interview, W. Madsen with V. Manly, October 1, 1996.
101 Interview, W. Madsen with K. Austin, June 20, 1996.
102 Ibid.
103 Matron Green, General Nursing Lecture Notes, 1935.

have been related to a traditional notion espoused by Florence Nightingale[104] that the role of the nurse was to assist the reparative process. This was done by conserving the "vital powers" of the patient, that is through promoting absolute rest. Bathing was seen as a taxing activity for the patient. Even when the nurse was carrying out the sponge, she was advised to be quick and as efficient as possible to avoid tiring the patient.[105] As a result of this belief, or perhaps compounding it, the wards were equipped with very few bathroom facilities. There is some evidence that the principle of rest was being reviewed by 1950, with some surgeons suggesting too much inactivity could be harmful.[106] However, most of the nursing literature during this era supported the principles of complete rest.

In addition to daily sponging patients, nurses were also responsible for oral hygiene. As mentioned earlier, the teeth of patients were cleaned each morning, but if the patient was debilitated or feverish, the nurse was expected to clean the mouth out with cotton wool soaked in mouth wash, for example borax and glycerine.[107] It was believed cleaning the mouth before and after meals would prevent the formation of sordes. Sordes, like bed sores, were taken to be a sign of carelessness on behalf of the nurse.[108]

Patient Comfort. One of the main underlying principles of nursing during the 1930s and 1940s was the promotion of patient comfort. When one considers the array of nursing activities that nurses controlled, patient comfort was a common denominator. This research supports that of

---

[104] Nightingale, op.cit., p. 6.
[105] Ashdown, op.cit., 1925, p. 11.
[106] Nash, op.cit., p. 19.
[107] Matron Fraser, op.cit.
[108] Matron Green, op.cit.

McIlveen and Morse[109] in that during the period under review, the comfort of patients was not only a primary goal of nursing but was concurrent with other nursing goals. Meals were served to satisfy patient nutritional needs as well as comfort needs. Pressure area care was carried out to maintain skin integrity and for patient comfort. Sponging and oral hygiene measures were performed for cleanliness and comfort. It was expected that the nurse would make the patient comfortable after completing any procedure.

The following aspects of nursing may be loosely dealt with under the heading of patient comfort as all of them related specifically to making the patient as comfortable as possible, although some of the actions also had other rationales. This grouping became evident after reviewing the nursing management for a variety of medical conditions as outlined in the nursing texts and journal articles. The same words and phrases were repeated - well ventilated room, no draughts, warm, light. When this was considered with other nursing actions which emerged from the oral testimonies, such as warming bedpans, screening off the patients, relieving loneliness and warming beds with hot water bottles, it appeared that the nurse of this era was concerned with providing physical, psychological and emotional comfort to patients who had restricted access to family and friends and who were in hospital for extended periods of time.

The Rockhampton Hospital, like many other hospitals in the area during this era, was an old wooden building with no floor coverings.[110] It was therefore a difficult building in which to regulate temperatures. Nurses of this time

[109] McIlveen, K.H. and Morse, J.M. "The Role of Comfort in Nursing Care: 1900 - 1980," *Clinical Nursing Research,* Vol. 4, No. 2, May 1995, pp. 127-148.

[110] McDonald, L. *A Ministry of Caring. A History of St. Andrew's Presbyterian Welfare Administrative Board 1952 - 1992,* Rockhampton; St. Andrew's Presbyterian Welfare Administrative Board, 1992, pp. 7-11.

remember the wards as being hot in summer, and bitterly cold in winter.[111] While there was not much that could be done about the heat in summer, hot water bottles were regularly used to warm up the beds during winter.[112] Due to the risk of burning patients with the hot water bottles, it was recommended that one to two thicknesses of blanket be used between the patient and the bottle.[113] This was accomplished at the Rockhampton Hospital by making up covers for the hot water bottles out of old blankets.[114] Another example of ensuring the patient's physical comfort was the warming of bedpans prior to taking them to the patient.[115]

Light was another environmental factor that needed to be controlled by nurses for patients with certain medical conditions. For example, patients with tetanus were nursed in a darkened room.[116] For those patients accommodated on verandahs in the 1940s, the sun created problems for the patients as the main building faced the east. Canvas blinds were used in the isolation ward, to provide relief from the sun.[117] The main building had been enclosed with louvres around its verandahs, which provided some control of the light and breezes.[118]

Psychological comfort was provided by the nurses, but it was not usually labelled as such by them. McIlveen and Morse[119] note that non-physical

---

111 Interview, W. Madsen with M. Baggett, June 6, 1996.
112 Interview, W. Madsen with N. Windsor, October 9, 1996.
113 Doherty et al., op.cit., p. 26.
114 Rockhampton Hospital Museum artifact.
115 Interviews, W. Madsen with B. West, June 4, 1996; B. Cagney, June 3, 1996.
116 Interview, W. Madsen with L. Lowry, October 2, 1996.
117 West, B., Memoirs, Rockhampton Hospital Museum.
118 Interview, W. Madsen with B. West, June 4, 1996.
119 McIlveen and Morse, op.cit., p. 140.

interventions such as listening, empathy, sympathy and diversion were often labelled as comfort measures that could be undertaken by nurses. One of the former nurses of the Rockhampton Hospital recalled that nurses spent a considerable amount of time talking to and playing games with a patient who had leprosy and was isolated from the rest of the ward.

> We had an old German man who was brought down from Palm Island, no, Peel Island, and he'd been a leper for years and years. He'd worked up on the island and he'd caught it. It's a slow thing and it was moving really slowly in his system, and his problem was loneliness because he was kept inside a big room, near the T.B. verandah, so he didn't have the T.B. chaps to talk to....We used to go in on our time off and play cards with him, or dominoes or anything he wanted to play, and write letters for him.[120]

Patient privacy was also an important issue for these nurses. Before sponging, giving a bedpan, or undertaking a procedure, nurses had to ensure screens surrounded the patient's bed. These screens were heavy and not easily manoeuvred, and only a limited number were provided for each ward, which necessitated frequently moving them.[121]

---

120 Interview, W. Madsen with K. Austin, June 20, 1996.
121 Ibid.

Nurses tended to patients twenty-four hours a day. Therefore a significant amount of time was spent nursing patients who were asleep. Ashdown[122] noted that an important duty of the nurse was to observe the quantity and quality of sleep their patients experienced. Nurses were expected to note various sleeping activities such as talking, moaning or twitching and to determine how rested and refreshed the patient was upon awaking. Ensuring patients got a good night's sleep was often not an easy task. As there was usually only one nurse on each ward for the night shift, and specific duties needed to be performed, this sometimes meant awakening patients to begin procedures, such as urine testing, at very early hours of the morning.[123] In addition, the activities of some the the nursing staff was not conducive to sleeping. One former nurse recalled a particular sister, who when on night shift, would noisily "trump up the back stairs and through the ward, and shine the light on every patient"[124], rousing everyone in her wake. This nurse found that keeping a saucepan of simmering milk on the stove, to be given immediately after the sister's round, enabled the patients to settle quickly back to sleep. However, insomnia was an issue nurses had to address. Although medications were available to assist patients to sleep, these appear to have only been ordered by the doctor in acute cases.[125] Nurses were advised that there were a number of actions which could be carried out in order to induce sleep. These included raising the head, applying heat to the extremities, applying a mustard leaf or hot water bottle to the epigastrium, a hot drink, massage or sponging the hands and face with warm water.[126] It is interesting to note that during the early part of this

---

122 Ashdown, op.cit., 1925, p. 171.

123 Interview, W. Madsen with R. Dalrymple, October 3, 1996.

124 Interview, W. Madsen with D. Ross, October 17, 1996.

125 Ashdown, op.cit., 1925, p. 298.

126 Ibid.

century, narcotics, especially morphine, were also used to induce sleep.[127] Narcotics were defined during this era as medications which relieved pain and had an intensified hypnotic or sedative action.[128]

Emergencies. The staffing of the wards during the 1930s and 1940s was such that for extended periods of time relatively inexperienced nurses were in the immediate charge of the patient's care. After 9pm the hospital was only staffed by one trained nurse to supervise nurses who were two or three years into their training.[129] In emergency cases, it was expected that the nurse on the ward would inform the sister in charge of the hospital, who would ring the doctor on call. Given that during after hours the switchboard was frequently operated by junior nurses who had no telephone exchange training[130], time delays could have been considerable before a doctor arrived. While these aspects of management will be discussed in Chapter Five, it is necessary to note this time delay here, as it meant the nurses would have had to have made decisions that would normally not have been expected of them. This aspect of nursing responsibility was not generally explored in the literature, however, nurses commencing treatments prior to the arrival of the doctor was mentioned in a couple of oral testimonies, in at least one nursing text, and in exam questions of the time. This is an area that requires further research, research that is beyond the scope of this study. The following examples have been included in this chapter to illustrate that while the differentiation between tasks that required doctors'

---

127 Maxwell and Pope, op.cit., p. 869.

128 Ashdown, op.cit., 1925, p. 660.

129 Interview, W. Madsen with I. Dennison, October 4, 1996.

130 Interview, W. Madsen with K. Austin, June 20, 1996.

orders and those which were controlled by nurses, was generally quite clear cut, situations did occur in which the nurse acted independently until a doctor became available.

Ashdown[131] noted in 1932 that no drug should be given by a nurse unless ordered by a doctor, except in the case of syncope, which referred to fainting in connection to the "sudden suspension of the heart's action"[132]. It should be noted that by the late 1940s, syncope referred to fainting as a result of haemorrhage[133], indicating that cardiovascular conditions were not well understood during the 1930s and 1940s. In a situation where the nurse was to deal with syncope, Ashdown[134] suggested an oral stimulant could be given in order to keep the patient alive until the doctor arrived, if the patient was able to swallow. Oral stimulants available at the time included alcohol, ether, ammonia, caffeine, tea and others. Rectal stimulants included saline solution, brandy and black coffee. Stimulants could also have been given intravenously and subcutaneously, one of which was adrenaline[135], although Ashdown[136] recommended a hypodermic injection of strychnine if oral stimulants were not possible. However, it would have been unlikely these latter routes would have been chosen initially by the nurse at this time as they were relatively uncommon means of administration, and intravenous access was not readily available. An exam question published in *The Australasian Nurses' Journal*[137] further

131 Ashdown, op.cit., 1932, p. 170.
132 Ashdown, op.cit., 1925, p. 752.
133 Hainsworth, op.cit., Vol. 4, p. 6.
134 Ashdown, op.cit., 1932, p. 170.
135 Ashdown, op.cit., 1925, p. 661.
136 Ibid., p. 238.
137 Exam questions and answers, *The Australasian Nurses' Journal,* January 15, 1931, p. 20.

illustrates another example of nurses being expected to commence treatment. This question asked the nurse to describe her actions in the case of infantile convulsions prior to the arrival of a doctor. The actions outlined included placing the child in a mustard bath. Mustard was considered to be a stimulant[138] and therefore would normally have required a medical prescription.

A more extraordinary example occurred at the Rockhampton Hospital as recalled by one of the former nurses. In this situation, a known diabetic patient was found to be unconscious one night by the nurse, who informed the supervising sister. This sister rang the doctor who suggested insulin be given. However, the sister was able to assess that the patient in fact required glucose and gave this instead of the insulin, as ordered by the doctor. When the doctor arrived the patient had regained consciousness.[139] These actions do not appear to support the notions of strict obedience that were espoused by the authors of nursing texts of the time. While this latter example may have been particularly exceptional, it does raise an issue that has not been addressed in the literature, that is, the expectation that nurses were to initiate appropriate treatment in emergencies. However, nurse training during this era does not seem to have formally taken this aspect into account. Formal nursing education was minimal during this era, with much of the learning taking place on the ward. Given the level of training, nurses were expected to initiate treatment in the absence of a doctor, or at least make appropriate preparations, while at the same time unquestioningly following doctors' orders.

---

138 Ashdown, op.cit., 1925, p. 98.

139 Interview, W. Madsen with N. McKenzie, July 31, 1996.

Nurses in the 1930s and 1940s had very few means of artificially supporting life. Although the Iron Lung became available at the Rockhampton Hospital in 1938[140] providing a means of mechanical ventilation, no effective method of artificial respiration had been devised during this period. A number of artificial methods were recommended prior to 1950, such as Schafer's method and Sylvester's method, but it is likely these methods were quite ineffectual, although Shiel assured nurses in 1941 that:

> (life) has often been saved after more than two hours continuous performance of artificial respiration when no signs of vitality have been present.[141]

Both of these methods aimed to expand the chest via external means - for example, by raising the arms of the patient above the head, as in Sylvester's method (see Figure 3.2); or by releasing pressure placed on the chest as in Schafer's method[142] (see Figure 3.3).

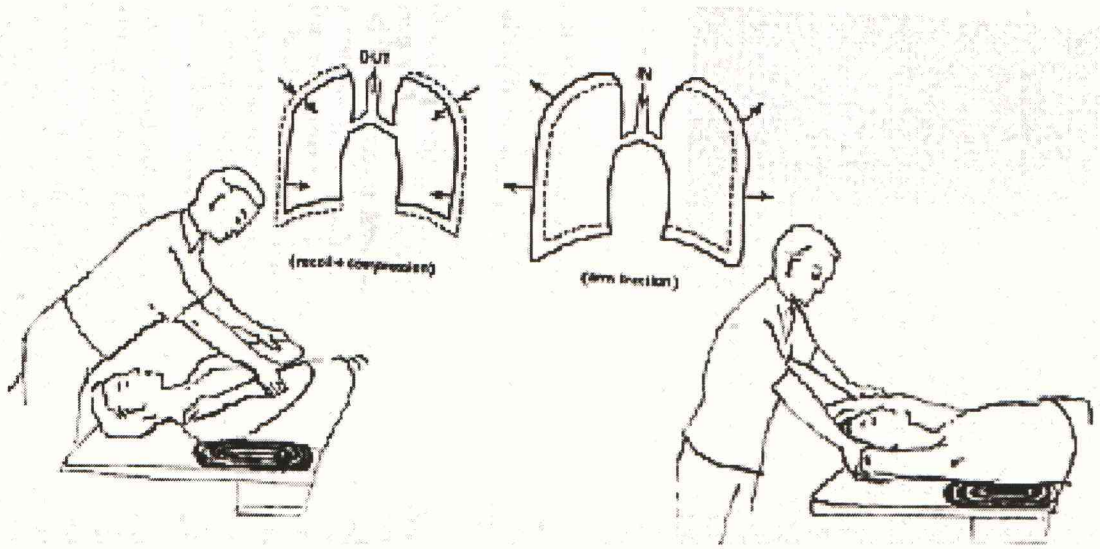

Figure 3.2 Sylvester's method of artificial respiration[143]

140 *The Morning Bulletin,* December 17, 1938, p. 10.

141 Shiel, op.cit., p. 98.

142 Slater, C. B. "Injuries to the Thorax. Principles and Practice of First Aid - 9," *Nursing Illustrated,* August 30, 1941, pp. 238-239.

143 Nash, op.cit., p. 182.

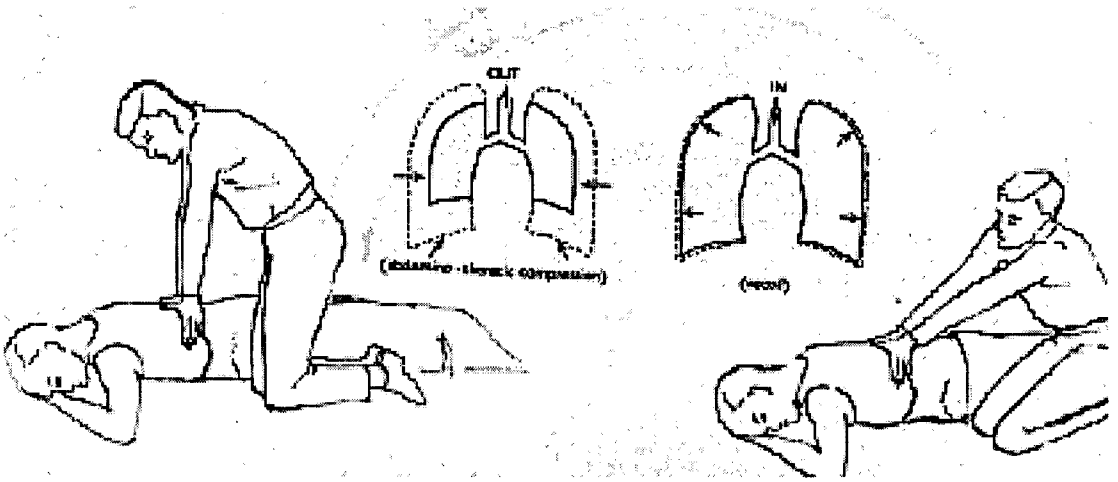

Figure 3.3 Schafer's method of artificial respiration[144]

Conclusion

The tasks outlined above, while by no means all inclusive, have illustrated the fundamentals of much of the nursing work carried out in the 1930s and 1940s. Analysing these tasks in association with McPherson's model is helpful in exploring the influences upon that work. Those tasks which were controlled by doctors may be located in the medical science realm. These activities involved monitoring patients to aid the diagnostic process or to observe the effectiveness of a medical treatment. This aspect will be further explored in Chapter Four. There were also activities that could be considered the end products or the practicalities of medical science, such as administering medications, or carrying out dressings. The rationales behind all these activities were related to physiological or pharmaceutical principles or theories. McPherson's model, however, does not aid in addressing the criteria used by the medical profession to determine which tasks became transitional, that is, carried out by nurses. Was the criteria

144 Ibid., p.178.

based on technical difficulty or invasiveness? Invasive procedures such as injections and catheterisation were readily seen as nursing responsibilities throughout the 1930s and 1940s. These activities also required a reasonable level of technical skill, yet, blood pressure measurement remained a doctor responsibility until the 1950s. This was an activity that was not invasive, although it required some technical skill.

Lawlor's[145] research may offer some insight into this issue. Lawler has outlined some of the criteria associated with "dirty" work, particularly in relation to bodily care and nursing work. She has illustrated that dealing with bodily fluids was, and still is, considered to be dirty work. It is perhaps in this context that the transitional or doctor-controlled tasks should be considered. For example, even though catheterisation was a highly technical and invasive procedure, that had serious infection implications if not carried out correctly, this activity dealt directly with urine, a body product that was not considered to be socially acceptable. Whereas, taking blood pressure did not deal with any bodily fluids directly. The invasive procedures that were carried out by doctors, such as surgery, were conducted behind the barriers of gowns, gloves and masks. During this era, none of these protective mechanisms were used by nurses on the ward, except in highly infectious situations.

The nursing-controlled activities fit best into the women's history realm of McPherson's model. These activities, concerned with nutrition, comfort and environmental factors may be seen as reflective of women's traditional role in the household. Oakley[146] described Florence Nightingale's influence as

[145] Lawlor, J. *Behind the Screen. Nursing, Somology and the Problem of the Body,* Melbourne; Churchill Livingstone, 1991, pp. 41-49.
[146] Oakley, op.cit., p. 41.

being one which weaned nursing from the cruder aspects of domestic work and attempted to develop nursing based on the need to supervise the environment and hygiene of a patient in order to allow healing to occur. Nightingale wished to develop a profession that would complement the medical model which was based on curing patients through the use of drugs, operations and alienating technologies.[147] Although Nightingale's theories were based on the miasmic theory of disease[148], which later lost favour with scientists, nursing continued to develop within these domestic constraints.

This domestic development is significant, as Melosh[149] and others in the United States of America have outlined, those nurses who were involved in bedside nursing defined their role in terms consistent with the ideology of domesticity.[150] This research would support this assertion. The former nurses who were interviewed saw nursing in terms of "cleanliness, compassion and common sense"[151], of looking after the patient first and foremost[152], of having a good bedside manner[153], and being dedicated[154]. Only one of these nurses mentioned theory and that was in association with

---

147 Ibid.

148 Cordery, C. "Another Victorian Legacy: Florence Nightingale, Miasmic Theory and Nursing Practice," in Bryder, L. and Dow, D.A. *Proceedings of an International Conference on the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society, 1995, pp. 298-304.

149 Melosh, B. *The Physician's Hand. Work Culture and Conflict in American Nursing,* Philadelphia; Temple University Press, 1982, p. 6.

150 Hughes, L. "Professionalising Domesticity: A Synthesis of Selected Nursing Historiography," *Advances in Nursing Science,* Vol. 12, no. 4, July 1990, pp. 25-31.

151 Interview, W. Madsen with L. Lowry, October 2, 1996.

152 Interview, W. Madsen with M. Baggett, June 6, 1996.

153 Interview, W. Madsen with I. Dennison, October 4, 1996.

154 Interview, W. Madsen with G. Elliott, June 4, 1996.

combining it with practice.[155] This would support Melosh's[156] argument that nurses' work culture was rooted in the apprenticeship system which valued careful craft methods, practical experience and self control, all of which were contained in the ideology of domesticity.

This chapter has explored some of the curing aspects of nursing, usually associated with the handmaiden image, and the caring aspects of nursing thought to have their origins in domesticity. It has been shown that although there was the perception that nursing provided the hands of medicine, nurses did in fact conduct a significant number of activities in their own right, and had to make decisions and judgments within the clinical setting that would normally have been outside their jurisdiction. The socialisation during this era was so complete that nurses themselves did not necessarily recognise the extent of their understanding or decision-making, advocating that nurses would never do anything without a doctor's order. Without this self-recognition, nurses were destined to remain in the position of servitude that had been carved out for them by their medical counterparts.

---

155 Interview, W. Madsen with B. Cagney, June 3, 1996.

156 Melosh, op.cit., p. 6.

Chapter 4

Nursing, Monitoring and Medicine

During the time of nursing reforms being advocated by Nightingale in the 1860s, the medical profession was also undergoing considerable change and reform. Scientific developments were beginning to make an impact on the world of medicine, and health reformists were campaigning for public health initiatives. As part of this health reformation, nurses took on the tasks of observation and monitoring of patients (formally delegated to trainee doctors) within the wards of the general hospitals. This was a significant alteration in responsibility for nurses, when compared with the almost exclusive domestic duties they were responsible for prior to these reforms. However, this monitoring role did not remain solely at the bedside, and over time nurses became engaged in a number of ward monitoring activities as well, such as counting cutlery and crockery. This chapter will explore this monitoring role of nurses and how it related to the activities of doctors. It is, therefore, necessary to briefly review the evolution of the medical profession and the significant medical and scientific developments that occurred in the latter part of the nineteenth century and earlier decades of the twentieth century.

Durdin[1] notes that the need for nurses to become involved in taking patient observations evolved as part of the eighteenth and nineteenth centuries' medical reforms and technological advances, whereby diagnosis was based on repeated measurement and recording of certain bodily functions.

---

1 Durdin, J. "Doctors and the Training of Nurses in South Australia 1880-1920," in Attwood, H. and Kenny, G. (eds.) *Reflections on Medical History and Health in Australia. Third National Conference on Medical History and Health in Australia, 1986,* Parkville; Medical History Unit, University of Melbourne, 1987, p. 94.

It was also realised that the taking and interpretation of such measurements could be separated provided a trustworthy accomplice could be taught the skill accurately and record the readings diligently. This time frame outlined by Durdin would be disputed by medical historians such as Youngson[2] and Waddington[3] who noted that the medical profession lagged behind scientific developments well into the latter part of the nineteenth century. As a consequence of this, certain technological and scientific advancements were not taken advantage of by doctors and hence the treatments prescribed were not as up to date as they might have been. This may be illustrated by considering the time lag between when nitrous oxide and ether were noted for their analgesic and anaesthetic effects in the late 1790s, and when surgeons actually began using such technology, some fifty years later.[4] Similarly with antisepsis, Lister first published his paper on the advantages of antiseptic surgery in 1867[5], yet it was another 23 years before antisepsis was the rule rather than the exception in Australian hospitals.[6] Youngson[7] suggests part of the reason why medical practice trailed scientific innovations was because of the system of education prevalent during the mid nineteenth century which taught students to memorise the accepted answers to accepted questions and to gain experience through observing others within the hospital. This did not allow

---

2 Youngson, A. J. *The Scientific Revolution in Victorian Medicine,* London; Croom Helm Ltd. 1979.

3 Waddington, I. " General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict," in Woodward, J. and Richards, D. (eds) *Health Care and Popular Medicine in Nineteenth Century England. Essays in the Social History of Medicine,* London; Croom Helm Ltd. pp. 164-188.

4 Youngson, op.cit., pp. 42-52.

5 Ibid., p. 144.

6 Murray, J. C., "Thomas Fiaschi and Listerian Antisepsis in Sydney, 1880-1900," in Attwood, H., Gillepsie, R., Lewis, M. (eds) *New Perspectives on the History of Medicine,* Melbourne; Australian Society for the History of Medicine, University of Melbourne, 1990, p. 28.

7 Youngson, op.cit., pp. 226-227.

doctors to be able to evaluate new science or technology critically, and to be able to adapt such advances to the practice of medicine. As such, medical knowledge was gained primarily through experience and observation.

While surgery made significant advances after the introduction of anaesthetics, antiseptics and asepsis during the latter part of the nineteenth century, advances in medicine were not as dramatic until the first half of the twentieth century. Although the germ theory was well established by the turn of the century, the concept of viruses was in its infancy. Hyslop[8] noted in her research into the 1919 influenza epidemic, that the term virus was used to indicate a poison or source of illness. Bacteriology was also beginning to become established during this era, as evident by the founding of the Australian Institute of Tropical Medicine in 1910.[9] However, the approach to medical science was often by trial and error as opposed to controlled experimentation.[10] Despite this, significant advances were made with regards to understanding disease processes and means of combating diseases, for example, the advent of the diphtheria antitoxin. This vaccine became widely available in the mid 1920's in Queensland, but was suspended for three years after twelve people died in Bundaberg in 1928 due to a contaminated vial.[11] Insulin was isolated in 1921 and became available in Australia in 1923.[12]

[8] Hyslop, A. "Old Ways, New Means: Fighting Spanish Influenza in Australia, 1918 - 1919," in Bryder, L. and Dow, D.A. (eds) *New Countries and Old Medicine. Proceedings of an International Conference on the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society,1995, p. 56.

[9] Doherty, R. L. "Dr E.H. Derrick and the Queensland Fevers," in Thearle, J.M. (ed) *People, Places and Pestilence. Vignettes of Queensland Medical Past,* Brisbane; Department of Child Health, University of Queensland, 1986, p. 103.

[10] Hyslop, op.cit., p. 60.

[11] Patrick, op.cit., p. 233.

[12] Ibid., p. 372.

Patrick[13] suggests the reason medicine lagged behind its surgical counterpart - the College of Physicians was not formed until 1938 - may be partly related to the lack of pathology facilities. These were not widely available in Queensland until the mid 1920s.[14] However, many pathology tests were still quite crude, as evidenced by the Weil's disease epidemics in the early 1930s.[15]

The early 1930s saw another cyclical epidemic of polio myelitis in Queensland[16]; however, this was the last time that sufferers of this disease would have to rely on manual methods of artificial respiration. The "new" artificial respirator, commonly known as the "Iron Lung" was introduced to Australia in 1933.[17] The Rockhampton Hospital had one installed by 1938, the result of a donation from Lord Nuffield.[18] Some progress was being made with the understanding of other communicable diseases, especially typhoid and malaria.[19] In 1946 a research centre, the Queensland Institute of Medical Research, was established in the north of the state. This institute undertook a great deal of research into diseases such as Q fever.[20] However, one the main technological achievements of this period related to pharmaceutical advances. Up until World War II, few pharmaceuticals underwent rigorous, scientific testing, and were likely to only relieve the

13 Ibid., p. 373.

14 Ibid., p. 383.

15 Gillespie, R. "Epidemics and Power: Weil's Disease in North Queensland, 1929 - 39," in Attwood, H, Gillepsie, R., Lewis, M. (eds) *New Perspectives on the History of Medicine,* Melbourne; Australian Society of the History of Medicine, University of Melbourne, 1990, pp. 59-60.

16 Paterson, R.A. "Some Aspects of Polio myelitis in Queensland," in Thearle, J.M. (ed) *People, Places and Pestilence. Vignettes of Queensland Medical Past,* Brisbane; Department of Child Health, University of Queensland, 1986, p. 92.

17 *Rockhampton Evening News*, November 20, 1933, p. 7.

18 *The Morning Bulletin*, December 17 , 1938, p. 10.

19 Doherty op.cit., p. 103.

20 Ibid., p. 103.

symptoms of a medical condition.[21] The introduction of the sulphonamide drugs into Queensland in 1937 heralded the first wave of "wonder drugs" available to physicians in the fight against infection.[22] Penicillin soon followed, although this was not available to civilians until after the war.

In addition to the many fever-related diseases, venereal disease was also an issue for physicians during this time. By 1927, the Queensland government had set up fourteen centres outside Brisbane where prostitutes were required to report on a regular basis for examination.[23] These centres eventually housed the prostitutes for the duration of their treatment. The centre in Rockhampton held twelve beds by 1943 and was known as the "crystal palace". The 1930s also saw the advancement of medical education in Queensland with the establishment of a Faculty of Medicine at the University of Queensland [24] and the eventual opening of a medical school in 1939.[25] This was associated with an eventual increase in the number of doctors within Queensland hospitals, although the increase was not evident at the Rockhampton Hospital until after 1950, as most nurses interviewed who worked at this hospital recalled only one or two doctors aside from the medical superintendent, being in attendance.[26]

---

21 Patrick, op.cit., p. 371.

22 Ibid., p. 373.

23 Ibid., p. 263.

24 Ibid., p. 370.

25 Biggs, J.S.C. "A Medical School for Queensland," in Thearle, J.M. (ed) *People, Places and Pestilence. Vignettes of Queensland Medical Past,* Brisbane; Department of Child Health, University of Queensland, 1986, p. 73.

26 Interview, W. Madsen with J. Kidd, September 12, 1996.

This brief outline of medical developments in Queensland illustrates four factors which may have been influential in the importance nurses placed on the association between observing signs and symptoms and medical conditions. First, pharmaceuticals were relatively primitive until the World War II. Second, although some vaccines had been developed, epidemics were still prevalent. Third, as a result of the former two factors, nurses tended to large numbers of patients with the same medical condition throughout the entire disease process. Monitoring techniques were dependent on hands-on skills such as pulse, respirations, temperature and observable features. Therefore, nurses gained immense experience in what to expect from certain disease states. Finally, there were not many doctors on the hospital premises, which meant nurses had to take on a considerable amount of responsibility in regards to determining when and if a doctor would be called in to review a patient, and managing the patient in the interim. These factors need to be viewed along with the fact that nursing education in the 1930s and 1940s consisted of very little formal training in the way of lectures. The Nurses and Masseurs Registration Regulations of 1929 remained unchanged with regards to syllabus throughout this time period.[27] The main avenue of learning took place on the wards in a more informal way, in association with the experiences being gained while nursing the patients.[28] This method of training was not dissimilar to that of doctors, less than a century beforehand.

---

[27] *Queensland Government Gazette* July 15, 1929, pp. 123-125; February 23, 1935, p. 895; July 27, 1935, p. 259; September 7, 1935, p. 697; June 5, 1937, p. 1968; December 18, 1937, p. 2108; February 15, 1941, p. 402; October 18, 1941, p. 1317; December 12, 1942, p. 1828; February 17, 1943, p. 577; July 17, 1943, p. 99; December 22, 1945, p. 1557.

[28] Interview, W. Madsen with L. Lowry, October 2, 1996.

Nightingale[29], who was advocating nursing reforms during the same time period as the early medical reforms, believed that the most important practical lesson that could be taught to nurses was the ability to observe. Observation of the sick included what symptoms to observe and how to observe, which included what types of questions to ask. Nightingale[30] stressed the need for nurses to gather accurate and objective data regarding the patient status. Cordery[31] suggests that the importance Nightingale placed on the observation of patients and their environment was based on her conception of the environment as the cause of disease. This concept was fundamental to the miasmic theory which was quite prevalent during the middle of the nineteenth century, and of which Nightingale was a firm supporter. As a result of this support and the need for doctors to have a capable, reliable and diligent assistant to enhance diagnosis, the monitoring of patients became a major part of the nurse's duty. Nurses monitored a patient's progress throughout the disease process and before and after any intervention, including medications and surgery, such that doctors could ascertain the effectiveness of the treatment or intervention.

Observation and monitoring of symptoms remained an important part of nursing work in the twentieth century. In 1915, Pope & Pope noted that:

---

29 Nightingale, F. *Notes on Nursing: What it is, and what it is not,* Glasgow; Blackie & Son Ltd. 1974, p. 59.

30 Ibid., pp. 59-64.

31 Cordery, C. "Another Victorian Legacy: Florence Nightingale, Miasmic Theory and Nursing Practice," in Bryder, L. & Dow, D.A. (eds) *New Countries and Old Medicine. Proceedings of an International Conference on the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society. 1995, p. 303.

> ...by observing and reporting intelligently symptoms occurring in the course of the disease and those following the use of drugs, nurses can often assist the doctor in forming a diagnosis... [32]

This early text is mentioned because it formed the basis of the lecture notes given to the nurses in the 1930s at the Rockhampton Hospital. Similar sentiments regarding the importance of observation were echoed by Ashdown[33] in 1932 and Hainsworth[34] in 1949. Riddle[35] suggested that the skill of observation was one of four qualities necessary to be a nurse, the other three being trustworthiness, obedience and tact. All these texts stressed the importance of monitoring patients in order to aid the doctor's diagnosis and treatment orders.

Symptoms were divided into two categories - subjective and objective.[36] The subjective symptoms were those complained of by the patient, including pain, discomfort, nausea, bad dreams, defects in any of the sensory systems and loss or changes in muscular power.[37] These symptoms were not usually dealt with in any depth in the nursing texts or lectures. The main symptoms outlined were the objective ones, that is those that could be seen and described by the nurse. Nurses were frequently reminded to develop their observational ability in order to

---

[32] Pope, A.E.A. and Pope, T.A. *A Quiz Book of Nursing,* New York; G.P. Putnam's Sons. 1915, p. 15.

[33] Ashdown, A.M. *A Complete System of Nursing, 13th Edition,* London; The Waverely Book Co. Ltd. 1932, p. 141.

[34] Hainsworth, M. *Modern Professional Nursing. Vol. 2,* London; The Caxton Publishing Co. Ltd. 1949, p. 317.

[35] Riddle, M.S. *Lectures to Nurses, 5th Edition,* London; The Scientific Press Faber and Faber Ltd. 1933, p. 3.

[36] Matron Green, General Nursing Lecture Notes, 1935.

[37] Ashdown, A.M. *A Complete System of Nursing, 6th Edtion,* London; The Waverely Book Co. Ltd. 1925, p. 145.

become aware of these objective symptoms. Dr Ross, a medical superintendent of the Rockhampton Hospital in the 1940s, was remembered by one of the former nurses as regularly saying, "Nurse, use your powers of observation."[38] Colour, odour, viscosity, quantity and contents of the various bodily fluids could all be measured and described. Sputum, vomit, faeces, urine, menstruation, sweat, discharges from eyes and ears, breath, flatulence and coughing were all subject to scrutiny.[39] Nurses used common and medical terms to describe these substances. For example, purulent was used to describe any substance containing pus, prune-juice sputum described the amount of blood contained within the sputum, coffee-ground vomitus also described the content of blood.[40] Each type of symptom was representative of a particular condition. For example, clear fluid vomitus "occurs when the stomach is empty. It is commonly met with in hysterical patients and in pregnancy."[41] Children's cries were similarly described and analysed:

> The cry of hunger is usually fretful and the child sucks its finger while crying....the cry of temper is loud and violent,....the cry of colic is usually long and continuous, ...a feeble, whining cry is indicative of weakness and marasmus...[42]

Aside from measurable factors such as temperature, pulse, respirations and urinalysis, which will be explored later in the chapter, facial expression and colour were seen as key signs in the detection of patient abnormalities. It

---

38 Interview, W. Madsen with L. Lowry, October 2, 1996.
39 Ashdown, op.cit., 1925, p. 145.
40 Ibid., pp. 145-149.
41 Ibid., p. 146.
42 Pope and Pope, op.cit., p. 18.

was expected that nurses would be able to deduce pain, sickness, depression, exaltation, weakness and distress from facial features.[43] Texts of this era would stereotypically describe the facial expression and colour associated with various conditions. For example:

> The wide-eyed, highly flushed and restless head of acute lung trouble can be distinguished from the narrow-eyed, pale faced and stiffly held head and the pursed lips usually indicative of abdominal inflammation.[44]

Upon reading these early nursing texts and lecture notes, one must question why there was such an emphasis placed on the association between observable signs and symptoms and the particular disease processes. It is conceivable that such knowledge may have been a result of medical and surgical lectures and texts being written by doctors; however, the emphasis was also evident within general nursing lecture notes which were given by the matron or sisters. It would obviously have been an advantage to be able to develop such skills of observation as the sister in charge of a ward, who was involved in little hands-on monitoring of patients, but who was ultimately responsible for the wellbeing of those being nursed in the ward. The style of the ward was also conducive to being able to survey the patients within the ward and to note the condition of all the patients. Therefore, the hierarchical structure that was evident within nursing, may have been a factor in the development of this association between observation and disease states. In addition, many of the nurses who graduated from training hospitals, such as Rockhampton Hospital, would have found employment opportunities in one of the many of the small

---

[43] Hainsworth, op.cit., Vol. 2, p. 318.
[44] Ibid.

rural hospitals in Queensland where medical support was limited. Being able to link observable signs and symptoms to disease states would have been advantageous for those nurses working in relative isolation, allowing them to commence appropriate treatments prior to the arrival of a doctor.

The reason given to nurses by Matron Green of the Rockhampton Hospital as to why nurses had to associate their observations with the underlying causes, was to enable them to anticipate the doctors orders and to be prepared to instigate the appropriate treatment.[45] This would appear to be going further than merely taking and recording observations in order to aid the diagnostic process, although there are two possible process explanations regarding Matron Green's reasoning. The first relates to a stimulus-response type mechanism, similar to that of Pavlov's classical conditioning.[46] That is, the nurse, through experience, recognised a particular set of observations and knew that Doctor X would require certain actions/preparations to be made. The other explanation involves some sort of cognitive evaluation on the part of the nurse, that is, that she was able to go through the steps of diagnosis. This second explanation would seem to be the more likely and is supported by Hainsworth's assessment of the importance of the nurse's observational skills.

> For instance a patient may complain of pains shooting down from the small of the back to the bladder; this may be a symptom of many ailments, but when the nurse notes that in addition there is frequency of urine, coupled with a smoky or reddish appearance of the urine, she is

[45] Matron Green, op.cit.

[46] Rosenzweig, M.R., Leimen, A.L. *Physiological Psychology,* Lexington; D.C. Heath & Co. 1982, pp. 557-558.

> bringing the diagnosis to a much more accurate basis which will probably become definitely one of small stone in the kidney.[47]

This idea of nurses negotiating the process of diagnosis is not one that was recognised by the nurses themselves, who advocated that they would never have done anything without a doctor's order.[48] This is not surprising, given the importance placed on obedience as discussed in the previous chapter. However, it is difficult to ignore that nurses were the ones closely involved with patients and were taught to observe for signs of the disease process. They were not given much education in regards to pathology, but they were taught what symptoms were expected in various medical conditions. They nursed large numbers of patients with the same disease for extended periods of time, and nursed them throughout the disease process. In addition, they were left for significant periods of time alone in the wards and did not always have access to a doctor within a couple of minutes,but were expected to have made adequate preparations for the arrival of the doctor. Nurses may not have recognised these elements of diagnoses, but it is possible that some doctors were aware that these factors could lead to nurses making diagnoses and ultimately undermine doctors' realm.

In 1938 the British Medical Association submitted a report to the Interdepartmental Committee on Nursing Services in the United Kingdom. This report contained a number of points relating to the recruitment and training of nurses. Of particular interest are the objections this group raised

---

47 Hainsworth, op.cit., Vol. 2, p. 318.

48 Interview, W. Madsen with J. Kidd, September 12, 1996.

regarding the examination of nurses and the tendency for questions to relate "more to the diagnosis and treatment of disease than to the principle and practices of nursing."[49] This practice of asking diagnostic type questions in nursing exams was also evident in Australia[50], and reflected the type of information given to the students during their formal lectures. Such objections raise a number of questions. Was there a suspicion on the part of some doctors that nurses were a potential threat? Was there a recognition of the similarities between the current training and expectations of nurses and the training of doctors some fifty to eighty years beforehand? This research project has been unable to answer these questions, and has only uncovered aspects that may have been influential.

In addition to those factors outlined above, a more social contextual factor may have been the resurgence of feminism in the 1930s. Within newspapers there was a great deal of debate regarding the role of women within society, with some speculation that women could evolve to become the dominant sex within the next few years.[51] In 1931 there were calls for the abolishment of sexual discrimination within the British Civil Service.[52] This era also saw the first female minister of the British Parliament.[53] These aspects may well have challenged many males in positions of authority to contemplate, if not question, the gender basis for their positions. Doctors would have fallen into such a group and there may have been doubts

---

49 Unknown author, "Nursing Problems," extract from *British Medical Journal,* 14 May, 1938; *The Australasian Nurses 'Journal,* November 15, 1938, p. 229.

50 Exam questions reprinted in *The Australasian Nurses 'Journal,* April 15, 1932, p. 91; March 16, 1931, p. 64; October 15 1932, p. 217.

51 Ferguson, W.J. "Will Women be Dominant Sex in Future," *Rockhampton Evening News,* March 27,1933, p. 9.

52 Unknown author, "All Positions Should be Open to Women," *Rockhampton Evening News,* July 28,1931, p.7.

53 Ibid.

regarding the continuation of nurses' unquestioning obedience, the crux upon which many doctors believed medical practice and treatment depended.

Any concern regarding nurses undermining medical practice, either through obtaining too much medical knowledge and/or questioning the truism of obedience, was to remain untested, as the circumstances upon which such knowledge was being obtained, were being altered in the 1940s. The introduction of sulphonamide drugs and penicillin significantly affected the progress of diseases. Vaccination programs became more widespread and subsequently epidemics of various diseases dwindled. More doctors became available within the hospital system, thereby relieving nurses of some emergency and critical care responsibility. The effect of these alterations upon nursing knowledge is however, beyond the realm of this study, as they would not have become evident until after 1950.

The "Obs"

Although nurses were expected to exercise their "powers of observation", and describe a patient's status qualitatively throughout their shift as outlined above, they were also required to make certain quantitative observations. Commonly know as "obs", temperature, pulse and respirations were measured on each patient two to three times a day[54] or fourth-hourly for those patients whose temperature was elevated.[55] This practice at the Rockhampton Hospital was in accordance with the texts available at the

[54] Interviews, W. Madsen with N. McKenzie, July 31, 1996; N. Windsor, October 9, .1996.
[55] Interviews, W. Madsen with M. Chambers, August 5, 1996; N. Windsor, October 9, 1996.

time.[56] It was a practice that did not seem to alter throughout the study period. This duty of taking "obs" was assigned to a second year or more senior nurse[57], although a junior nurse occasionally undertook this duty if she was deemed competent by the sister.[58]

Temperature. A patient's temperature was considered to be an important diagnostic measurement. Nurses were informed of the usual difference in temperature between morning and evening, but they were also informed of characteristic patterns of temperature recordings associated with various medical conditions.[59] For example, typhoid fever was associated with a continuous fever, malaria with an intermittent fever, and pulmonary tuberculosis with remittent fever. These various types of fever patterns are illustrated in Figures 4.1 to 4.3, all of which are shown on "morning and afternoon" temperature charts. This type of charting will be discussed in more detail later in the chapter.

Other terms associated with temperature were onset or invasion period, that is the commencement of a fever; fastigium or stadium, the height of a fever; defervescence of decline, that is the termination of a fever.[60] Crisis and lysis were also common terms used in association with fevers to indicate, respectively, a rapid fall in temperature to normal, or a gradual fall taking a number of days.[61] Temperatures greater than 106^{o} F were called

---

56 Ashdown, 1932, op.cit., p. 169.
57 Interview, W. Madsen with I. Dennison, October 4, 1996.
58 Interview, W. Madsen with D. Ross, October 17, 1996.
59 Matron Green, op.cit.
60 Matron Fraser, General Nursing Lecture Notes, 1945.
61 Ibid.

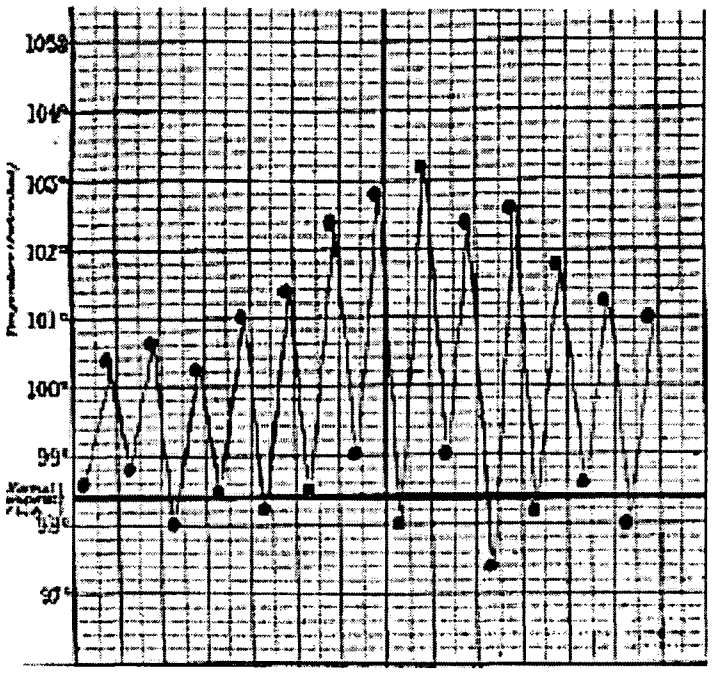

Figure 4.1 Example of intermittent fever[62]

hyperpyrexia; temperatures between 103° - 106° F were termed high fever; a moderate fever was between 101° - 103° F; normal temperature was 98° - 99° F; subnormal was 97° - 96° F; and collapse was the term used to designate a temperature less than 96° F.[63] This array of terminology assisted nurses to communicate the patterns and descriptions of temperature recordings over a period of time. This also suggests a great deal of emphasis was placed on the observation of fever. This is perhaps not surprising given the high number of fever-related diseases prevalent during this era, especially prior to the general introduction of penicillin.

62 Ashdown, op.cit., 1925, p. 158.

63 Matron Fraser, op.cit.

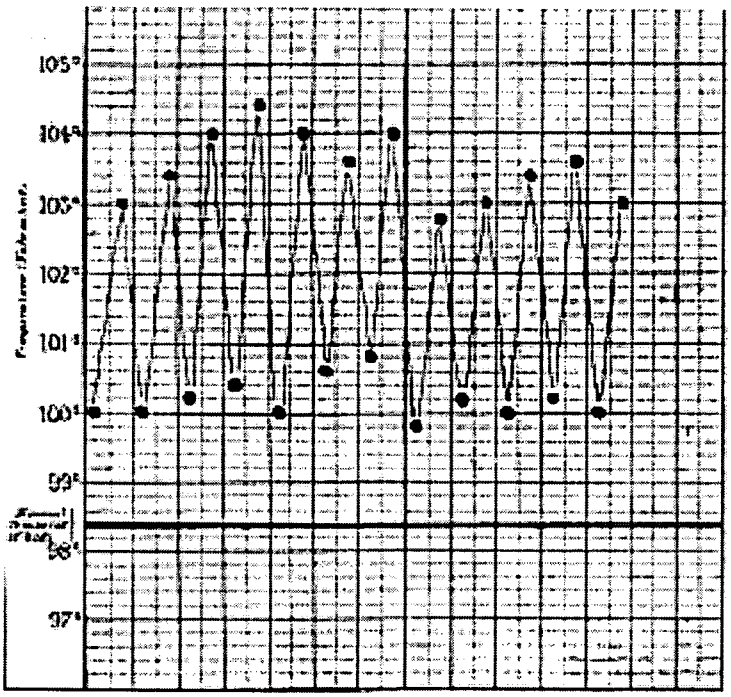

Figure 4.2 Example of remittent fever[64]

The procedure for taking a patient's temperature involved the use of a clinical thermometer, which was similar to the mercury based thermometers available today, although marked in Fahrenheit instead of Celsius.[65] Temperatures could be taken via the mouth, axilla, groin or rectum in the same fashion such thermometers are currently used. Nurses were advised to never leave a patient with a thermometer, not to allow the patient to know their temperature reading.[66] Figure 4.4 illustrates the temperature tray used by nurses at Rockhampton Hospital during the 1930s and 1940s. Thermometers had to be rinsed twice after each use, and wiped with a cotton ball before being used by the next patient. Ashdown[67] suggested

64 Ashdown, op.cit., 1925, p. 159.
65 Hainsworth, op.cit ., Vol. 2, p. 322.
66 Matron Fraser, op.cit.
67 Ashdown, op.cit., 1925, p. 155.

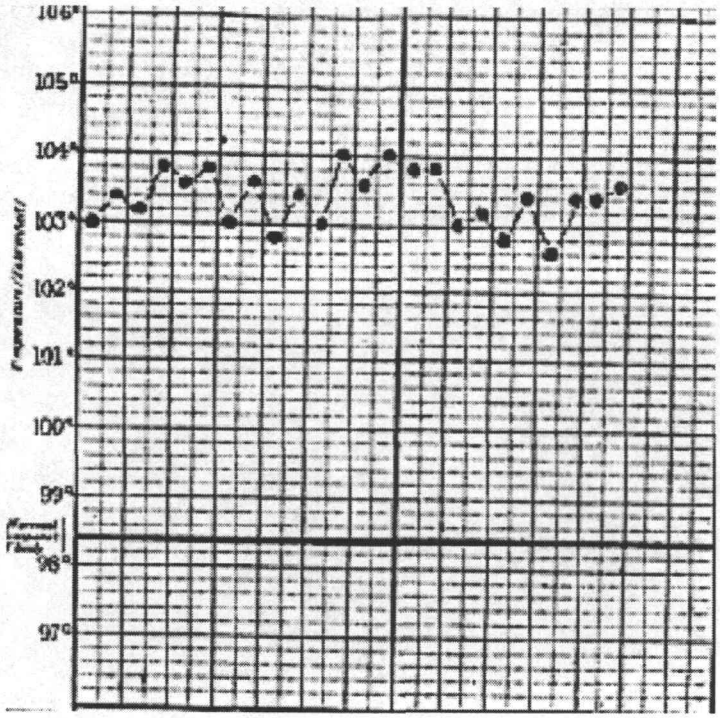

Figure 4.3 Example of continuous fever[68]

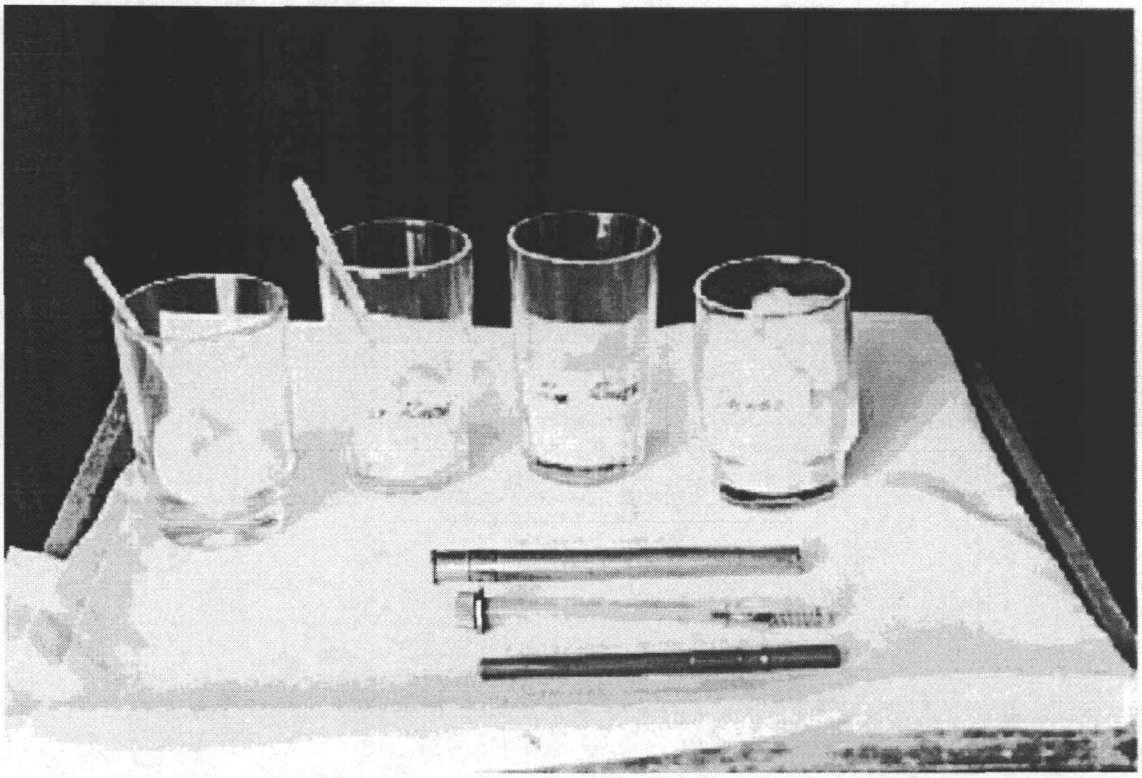

Figure 4.4 Temperature tray (Courtesy of Rockhampton Hospital Museum)

68 Ashdown, op.cit., 1925, p. 160.

thermometers be firstly rinsed in an antiseptic solution such as carbolic acid (1 - 20) and then rinsed in water. It is not clear which solutions were used by the nurses at the Rockhampton Hospital.

Pulse. Matron Fraser's lecture notes reflect a commonly held belief among nursing authorities regarding pulse. " Pulse is probably the most important indication of a patient's physical condition."[69] This was echoed by Hainsworth[70] who believed that an experienced nurse was able to sum up the general condition of the patient by the palpation of the radial artery at the wrist. From this touch, the nurse was expected to be able to assess the frequency of the pulse, the regularity of force and rhythm, the quality of volume and tension, and the condition of the artery.[71] Such qualities of the pulse were assessed through the various pressures felt at the tips of her first three fingers as they rested at the patient's wrist.[72] As with temperatures, an elaborate vocabulary was utilised to describe the various aspects of the pulse. These are outlined in Table 3. Many of these terms were used to describe the features of blood pressure and were consequently replaced by a single reading once nurses began to routinely take blood pressure readings. Just how much of this terminology was used on a daily basis is unclear. Former nurses recalled having to assess the various characteristics of the pulse - strong, weak, regular, thready, fast or slow[73],

---

69 Ibid.

70 Hainsworth, op.cit., Vol. 2, p. 330.

71 Ashdown, op.cit.,1925, p. 162.

72 Ashdown, op.cit.,1932, p. 159.

73 Interview, W. Madsen with L. Lowry, October 2, 1996.

however, only the rate was recorded by the nurses in the temperature book.[74] Any alterations in rhythm or regularity were reported to the sister who would write it in the patient's chart.[75]

Table 3. Common terms used to describe pulse[76]

Bradycardia	Less than 60 beats per minute
Normal	72 beats per minute
Frequent	80 - 100 beats per minute
Rapid	120 - 160 beats per minute
Running	Greater than 180 beats per minute
Volume	Amount of blood in artery with each beat, may be "bounding and full", to "thready" or minimal volume.
Tension	Condition of artery wall, may be hard as in arteriosclerosis. Also refers to blood pressure
Dicrotic	Two pulse beats felt for every heart beat
Colligan or water-Hammer	Characterised by rapid fall in volume and force after each beat

Respirations. As with temperature and pulse, a variety of terms were used to describe the respirations of a patient - shallow/deep, quiet/noisy, slow/quick, regular/irregular. In addition a number of specific terms were also used that were generally associated with a medical condition as outlined in Table 4. Nurses were advised to count respirations without the knowledge of the patient as breathing could be controlled by the patient.[77]

---

[74]Interview, W. Madsen with D. Ross, October 17, 1996.

[75] Interviews, W. Madsen with M. Chambers, July 5, 1996; D. Ross, October 17, 1996.

[76] Hainsworth, op.cit.,Vol. 2, pp. 331-334; Ashdown, op.cit.,1925, p. 163.

[77] Matron Fraser, op.cit.

Table 4. Common terms used to describe respirations[78]

Crowing	Associated with croup
Stridulous	Harsh breathing of diphtheria
Wheezing	Associated with bronchial afflictions
Grunting	Associated with pneumonia
Stertorous	continued loud snoring associated with cerebral haemorrhage
Cheyne-Stokes	Cycle of increasingly noisy breathing followed by a period of apnea

Many of the terms used in the 1930s and 1940s to describe symptoms and signs described above are used in current clinical practice. However, a number of these terms are rarely, if ever, used as they have been superseded by advances in technology, and the information that was yielded from these observations is now obtained by other means.

Obtaining patient information by using the nurse's senses of touch, sight and hearing elicited quantitative as well as qualitative data. The rate of the pulse was noted along with the condition of the blood vessels, breathing and temperature patterns were noted to be significant for various disease states. Given the recent interest in the literature regarding the development of the expert nurse, examination of how patient information was gathered prior to the prevalence of technology on the wards, is pertinent. Benner[79] outlines a number of aspects of intuition that resemble the elements emphasised in the 1930s and 1940s regarding observations. These aspects include pattern recognition, similarity recognition, common

---

[78] Ashdown, op.cit., 1925, pp. 166-167.

[79] Benner, P. "How Expert Nurses Use Intuition" *American Journal of Nursing,* January 1987, pp. 23-31. Benner's concept of nursing intuition was first published in 1982 as part of out outline of the five levels of nursing proficiency. In this article, Benner advocated the more proficient or expert a nurse becomes, the more reliant he or she becomes on intuitive forms of decision making. (Benner, P. "From Novice to Expert," *American Journal of Nursing,* March 1982, pp. 402-407).

sense understanding, skilled know-how, sense of salience, and deliberative rationality. All of these aspects may be found in the practice of nurses during the era under investigation, however, they were recognised elements of nursing, and taught as such, unlike the concept of intuition as outlined by Benner. This research would suggest that nursing practice was learnt primarily through experience in the 1930s and 1940s, and that the experiences of the nurses were influenced by the informal and formal association of what the nurse was hearing, seeing, feeling and smelling on the wards, with the disease process. This type of learning is more in accordance with cognitive evaluation as outlined by English[80], whereby abnormal events are recognised by the nurse because they don't match with what is normally expected:

> Accurate diagnosis comes from repeated exposure to similar incidents which were successfully resolved, and sound clinical knowledge.[81]

Such sentiments were expressed in 1949 by Hainsworth:

> Aware of the normal from her knowledge of anatomy, physiology and hygiene, the nurse must therefore be ready to discover any deviations from it, however small they may be; this is the whole art of diagnosis.[82]

Integral to this discovery of deviations was the development of observational skills as outlined above. These skills were passed on to each generation of nurses, albeit in a primarily informal fashion.

---

[80] English, I. "Intuition as a function of the expert nurse: a critique of Benner's novice to expert model." *Journal of Advanced Nursing.* 18, 1993, pp. 387-393.

[81] Ibid., p. 392.

[82] Hainsworth, op.cit.,Vol. 2, p. 318.

Urinalysis

Every patient admitted to the Rockhampton Hospital during the 1930s and 1940s would be required to go through a lengthy admission procedure, part of which included having the temperature, pulse and respirations taken by the nurse. They were also required to provide a sample of urine which would be tested for a range of substances. Each substance had to be tested separately, and as shall be seen, some of these tests required a significant amount of time. Should a particular substance be detected in a patient's urine, then regular tests would then be required throughout their hospital stay. As this urine test, known as a urinalysis, was a routine task undertaken by the nurses, former nurses who were interviewed for this research recalled in remarkable detail the specifics of urine testing, which closely correlated to the procedure outline contained in the text books of this era.

> Benedict's we used for sugar. Remember, you'd them up, if they don't change that blue colour they were negative, and if they had a little bit of cream about them, it was a one plus, and a little bit darker, it was a two plus, a bit red, well a tanny colour, it was three plus.[83]

This compares very well with the procedure for Benedict's test as outlined in the guide for urine testing, compiled by the Brisbane and South Coast Hospitals Board.

> Take eight drops of the suspected urine in a clean test-tube, add 5 c.cs of Benedict's solution and boil

---

[83] Interview, W. Madsen with J. Kidd, September 12, 1996.

> vigorously for two minutes, and then allow to cool. If glucose is present, the reagent will change colour from clear blue to opalescent green, or if a large quantity of sugar be present in the urine, the final colour will be an opaque red.[84]

The only difference detected between the testimonies related to which nursing level actually carried out this procedure. Some recalled this duty as a junior nurse task[85], others as a senior nurse duty.[86] All agreed however, that the majority of urine tests were carried out by the night staff and that patients had to be awoken quite early, often as early as 2am, to give a urine specimen in order to be able to complete the required tests by the end of the shift at 6am. Figure 4.5 illustrates the equipment used for urinalysis and the procedure sheet outlining how to do the various tests.

The main tests carried out were for albumin, sugar and blood[87], although pus and acetone tests were also commonly conducted.[88] These were in addition to noting the urine's pH, odour, specific gravity and quantity.[89] Sugar was normally tested in those patients with diabetes, and was one of the few urine tests that were not done at night, but rather prior to meals.[90]

---

84 Pye, A.D.D. *Urine Testing Notes for the Pupil Nurse.* Brisbane; Brisbane and South Coast Hospitals Board, 1910, p. 6.

85 Interviews, W. Madsen with K. Austin, June 20, 1996; M. Baggett, June 6, 1996; J. Kidd, September 12, 1996.

86 Interview, W. Madsen with B. Cagney, June 3, 1996.

87 Interviews, W. Madsen with J. Kidd, September 12, 1996; R. Dalrymple, October 3, 1996.

88 Interview, W. Madsen with D. Ross, October 17, 1996.

89 Hainsworth, op.cit.,Vol. 2, pp. 370-371.

90 Interview, W. Madsen with J. Kidd, September 12, 1996.

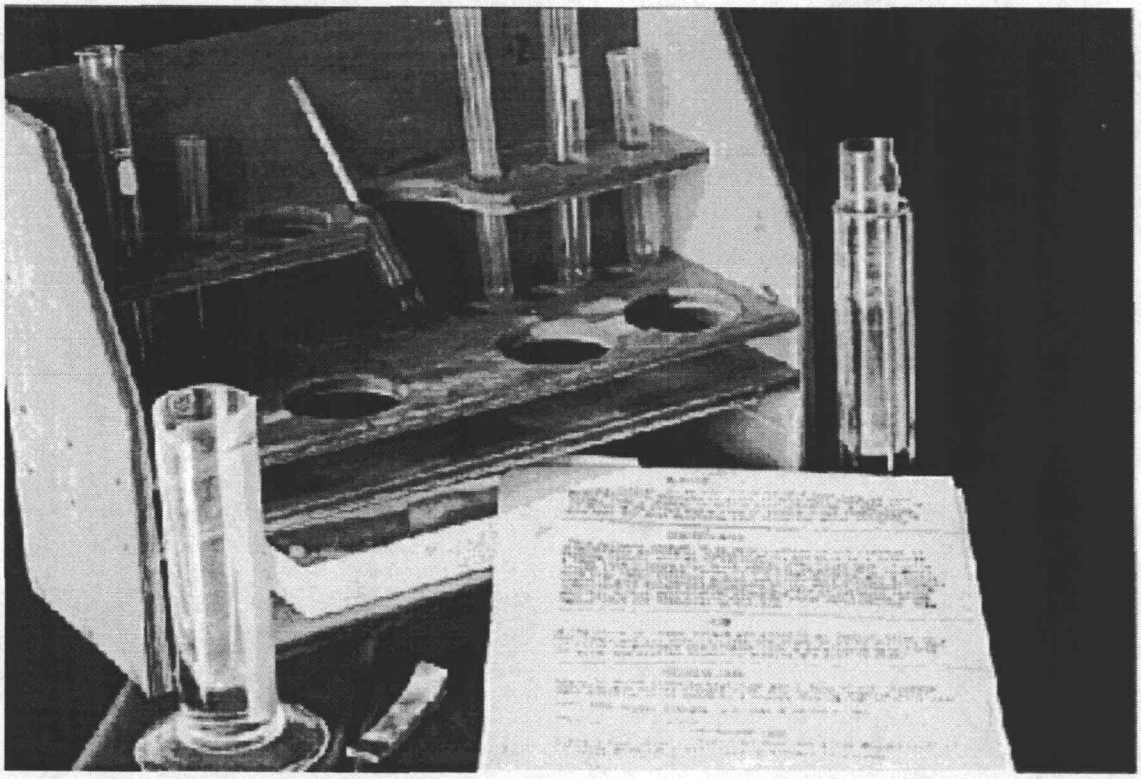

Figure 4.5 Equipment used for urinalysis (Courtesy of Rockhampton Hospital Museum)

The detection of albumin in urine was associated with diseases of the kidney, although Ashdown[91] noted albuminuria could also be associated with fever, epileptic fits, cold bathing, muscular effort, some diets and some postures. However, nephritis was a prevalent disease during the 1930s and 1940s[92], and was associated with lead paint, hence many painters suffered with nephritis in this era.[93] Albumin was tested for in the urine by boiling up the upper portion of four inches of urine in a test tube. If the urine became cloudy, a few drops of acetic acid was added. A positive test for albumin was indicated if the urine remained cloudy.[94] One of the former nurses recalled that positive albumin tests were reboiled and left to see how

91 Ashdown, op.cit.,1925, p. 201.
92 Interview, W. Madsen with B. Cagney, June 3, 1996.
93 Interview, W. Madsen with L. Lowry, October 2, 1996.
94 Hainsworth, op.cit.,Vol. 2, p. 372.

much deposit became visible, which was then recorded as a fraction of the total, for example, one quarter or one third deposit.[95] An undated sheet held at the Rockhampton Museum, outlining the various urine testing procedures also describes this procedure of ascertaining the deposit. However, Hainsworth[96] noted that nurses were rarely expected to estimate the quantity of the substances present, nor is this method mentioned in a number of texts, including the booklet on urine testing published for south east Queensland pupil nurses[97], indicating that perhaps this practice was not widespread.

The test for blood involved the addition of a few drops of tincture of guaiacum to about half an inch of urine in a test tube. This tube was shaken vigorously, with the thumb placed over the end of the tube. A little of this solution was then added to another test tube containing an inch of ozonic acid. If blood was present a blue ring would develop at the junction of the two solutions.[98] As these examples of urine testing have illustrated, urinalysis was a time consuming task. However, it was also a very necessary task in order to closely monitor a patient's progress. This is clearly demonstrated when considering the need to monitor the sugar level of the urine of a patient who had diabetes. Urinalysis was a convenient method available to the nurses which allowed them to estimate the extent of sugar contained in the blood and hence determine the diet and insulin the patient was to receive.[99]

---

95 Interview, W. Madsen with J. Kidd, September 12, 1996.
96 Hainsworth, op.cit.,Vol. 2, p. 373.
97 Pye, A.D.D. *Urine-testing Notes for the Pupil Nurse,* Unknown publisher, 1933, p. 3.
98 Hainsworth, op.cit., Vol. 2, p. 372.
99 Ashdown, op.cit.,1925, p. 197.

Recording Observations

As discussed earlier, the main reason nurses were engaged in monitoring patients was to enable the doctor to accurately diagnose and prescribe appropriate treatments. These observations, therefore, needed to be recorded in a way that would aid the doctor. Charting these observations over a period of days allowed the doctor to recognise trends that were associated with particular diseases.[100] Two common varieties of charts were used during the 1930s and 1940s. One was the "morning and evening" chart, that is, it provided for the observations to be recorded twice a day. The other was used for four-hourly observations, which allowed for more frequent recordings. Only the temperature was actually graphed. Whether this was just the way the charts were organised, or whether there was more importance placed on the temperature patterns formed over a period of time, as opposed to the other recordings, is unclear. However, as noted earlier, a great deal of emphasis was placed on these temperature patterns. These charts were attended to by the sister of the ward or the senior nurse.[101] Information required to complete the charts was obtained from a temperature book. The nurses who actually took the readings of pulse, temperature and respirations, recorded the measurements in this book.[102] This temperature book served two purposes - first was to enable the sister to transcribe measurements into the patients' respective charts, and second, it ensured patients did not have ready access to their observations. As with medications, the nurses were not to inform patients of their own condition.[103] The limitation associated with these charts was that

[100] Hainsworth, op.cit., Vol. 2, p. 322.

[101] Interview, W. Madsen with N. McKenzie, July 31,1996.

[102] Interview, W. Madsen with D. Ross, October 17, 1996.

[103] Interview, W. Madsen with R. Dalrymple, October 3, 1996.

they recorded figures only and did not allow for the more qualitative data that had been observed by nurses such as skin colour and breath sounds. This data was jotted down in the nurses' note books which they carried around during the shift and made into a type of booklet at the end of the day, from which the sister compiled her report.[104] It is unclear if the sister recorded any of this qualitative data in the patient's chart, although it appears that the sister did actually write in the progress notes at the Rockhampton Hospital.[105] Hainsworth[106] suggested that entering details on the temperature chart was the nurse's province, whereas writing in progress notes was attended to by the doctor. It is likely that the sister was able to complete other information on the temperature charts, such as bowel motions and urine quantity, from the nurse's notes. Urinalysis data was similarly treated as other observations. The nurses who did the urine testing would write the result in their nurse's notes and then later in a specially designated urine testing book.[107] These results were later transcribed into the patient's chart by the sister of the ward.[108]

As mentioned in the discussion with medications in the previous chapter, there was a significant risk of transcription errors occurring with this system of copying results in up to three different places, although none of the former nurses interviewed related any incidents with regards to transcription errors. It is assumed the doctor would primarily refer to the temperature chart to ascertain the patient's observations, however, these recordings had the potential to be misrepresented on a number of occasions prior to being

104 Interview, W. Madsen with K. Austin, June 20, 1996.
105 Interview, W. Madsen with B. Cagney, June 3, 1996.
106 Hainsworth, op.cit., Vol. 2, p. 321.
107 Interview, W. Madsen with K. Austin, June 20, 1996.
108 Interview, W. Madsen with B. Cagney, June 3, 1996.

penned onto this chart. These occasions being the time of the observations being taken and the nurse writing them against the wrong patient name in her notes, similarly when she was copying her measurements into the central books, and again when the chart was being completed by the sister. As a result, the accuracy of these charts must be questioned.

Ward Monitoring Activities

Nurses were involved in a number of ward monitoring activities, aside from those described above which related to patients. These activities appear to have been related to ensuring hospital costs were contained rather than benefiting the patients. For example, one of the former nurses recalled it was difficult for the ward sister to get new hypodermic needles from the hospital stores.[109] This meant nurses had little choice but to use those needles which had been in use for some time and which had been sharpened on numerous occasions. One of the problems associated with this use of recycled needles was the tendency for hooks to form on the end of the needle, making it more difficult for the nurse to administer an injection, and more painful for the patient receiving the infection.[110] Another difficulty associated with reusing needles was a weakening of the needle leading to possible breakages.

> I lost a needle in a fellow's arm once...I was in outpatients, and I pulled his arm up to sort of put the needle in, and it broke off at the shank.[111]

---

109 Interview, W. Madsen with K. Austin, June 20, 1996.
110 Ibid.
111 Interview, W. Madsen with M. Baggett, June 6, 1996.

Another example of this thrifty monitoring relates to the collection of broken thermometers from the ward. One of the former nurses recalled the sister of the ward needing to refer to a box of broken thermometers such that she could order the exact number of replacements from the hospital stores.

> (The sister) had the responsibility of making out the store list every week... but you'd have to take her this box, every thermometer that was broken would be placed in this box, every syringe, which were all glass at the time, that was dropped, would have to be put in this box, and she'd reorder them.[112]

This activity may have influenced the nursing staff to take greater care of the thermometers for two reasons. Firstly, it was likely that nurses would have wished to avoid placing a broken thermometer in the sister's box and risk being reprimanded. Secondly, it would have taken a certain period of time before the missing thermometer was replaced, which may have impacted directly on the nurse's ability to take a number of patients' temperatures at the same time. Therefore, she would have not been able to complete this task as efficiently as having a full quota of thermometers. Syringes were also monitored and any nurse who broke a syringe may have found herself having to report the fact to the medical superintendent.[113]

One of the main ward monitoring activities was counting the cutlery and crockery. These items were checked every morning.[114] The junior nurse was responsible for laying out the crockery and cutlery and to count it. This was checked by the sister each day and the junior nurse could not go off

---

[112] Interview, W. Madsen with B. Cagney, June 3, 1996.
[113] Interview, W. Madsen with L. Lowry, October, 2, 1996.
[114] Interviews, W. Madsen with B. West, June 4, 1996; B. Cagney, June 3, 1996.

duty until the inventory was correct and every item accounted. As all meals were served out in the ward and the washing up done in the ward, there was an assumption that crockery and cutlery numbers would not change. However, items did go missing. Nurses soon learnt to borrow the missing items from another ward and hope the sister would not check for ward markings.[115]

> All the cutlery and crockery had to be checked every morning, if anything was missing, too bad, but as you got used to it, you'd borrow something from another ward.[116]

These nursing duties reflect the emphasis placed on thrift during this era. The need for economy was stressed within the lectures given to the nurses, who were informed that: "The destruction of furniture and utensils through carelessness (was) appalling"[117], and that nurses were largely responsible for such waste. Given the economic conditions of the 1930s and the rationing of the 1940s, this practice of monitoring utensils was probably not extraordinary, it certainly was not unique to the Rockhampton Hospital[118], and is another example of the influence hospital administrations could have on nursing practice.

Conclusion

The monitoring duties that nurses undertook during the 1930s and 1940s may be traced to the evolution of medicine and the involvement of hospital

---

115 Interview, S. DeVries with M. Jensen, unknown date.

116 Interview, W. Madsen with B. West, June 4, 1996.

117 Matron Green, op.cit.; Matron Fraser, op.cit.

118 Gregory, H. *A Tradition of Care. A History of Nursing at the Royal Brisbane Hospital,* Brisbane; Boolarong Publications, 1988, p. 120.

administrations. Obtaining and charting patient observations, yet being denied the official right to understand or interpret those observations, consolidated the image of the nurse as the doctor's handmaiden. However, as this chapter has argued, nurses appeared to have inadvertently gained some understanding of patient observations and the underlying pathophysiology. This understanding was obtained through nursing large numbers of similar cases in the absence of effective pharmaceuticals and large numbers of on-site doctors. Nurses during this era also used a large vocabulary to describe the variations within a patient's observations, which suggests nurses were able to elicit considerable amounts of qualitative data as well as the quantitative data that was recorded in the patient's chart. This study has suggested that nurses during this era recognised the importance of gathering qualitative data, and that it was this ability to collect large amounts of pertinent information over an extended period of time that contributed to nurses being able to make appropriate clinical judgments.

Chapter 5

"Keeping Rank": The Ward Environment

All the activities referred to in the previous three chapters took place within the confines of a hospital ward. The staff who worked in the wards each had a specific duty to perform. The division of labour was based on a system of rank that was apparent in hospitals throughout the western world in the first part of this century. This hierarchical system however, went beyond the allocation of tasks for each shift. It permeated the entire culture of the hospital, especially the nursing staff. Communication channels, staff interactions and behaviour as well as the division of responsibilities and duties, were all fashioned by the hierarchy, and instrumental in maintaining these structures. This chapter aims to explore the ward environment of the 1930s and 1940s - the conditions and traditions of the ward within which nurses were expected to operate and gain nursing knowledge. The areas of ward management to be examined include the hierarchical structure of nursing within the ward and hospital, the channels of communication which developed and reinforced this structure, and the everyday working conditions which also tended to reinforce the hierarchical nature of nursing.

The wards of the Rockhampton Hospital were based on an open plan, commonly referred to as "Nightingale" wards. The wards could contain up to forty patients[1], usually lined up along the lengths of the room or located on the enclosed verandahs. Figure 5.1 illustrates a typical ward at the Rockhampton Hospital during the 1930s and 1940s. The beds were approximately three feet apart with a locker between each bed.[2] The toilets,

[1] Interviews, W. Madsen with L. Lowry, October 2, 1996; K. Austin, June 20, 1996.
[2] Interview, W. Madsen with J. Kidd, September 12, 1996.

bathroom, pan room and day room were located adjacent to the main ward. The hand-washing sinks, which were also used for cleaning dentures, were located in the middle of the ward.[3] The nurses' station was a centrally placed desk from which everyone in the main room could be seen.[4] As mentioned in the previous chapter, this layout enabled the sister to readily monitor the patients. It also allowed her to closely supervise the actions and behaviour of the nursing staff. Therefore, the physical layout of the ward also facilitated the hierarchical mechanisms.

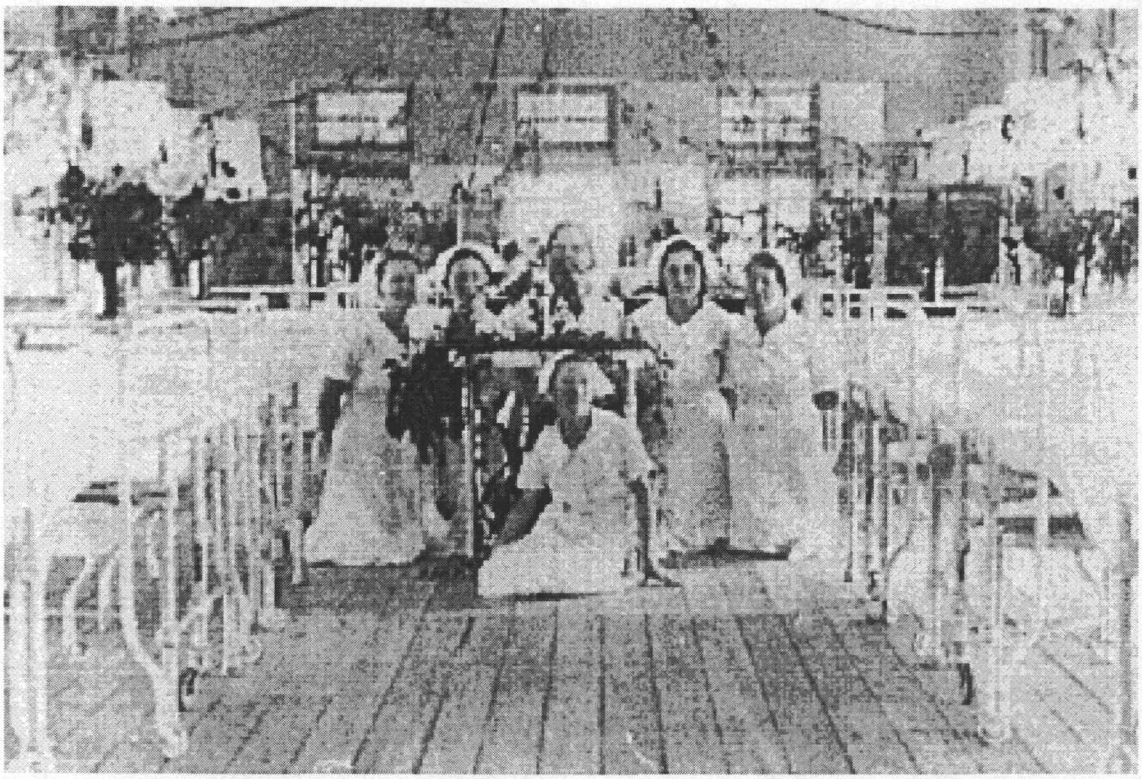

Figure 5.1 Typical ward layout at Rockhampton Hospital during the 1930s (Courtesy of Rockhampton Hospital Museum)

[3] Interview, W. Madsen with K. Austin, June 20, 1996.

[4] Interview, W. Madsen with M. Baggett, June 6, 1996.

Melosh[5] identified the importance of work culture within nursing in her analysis of American apprenticeship training during the 1930 - 1960 era. She suggests this culture was generated partly in response to specific working conditions, including the adaptions and resistance to the constraints made by those in authority. Barber[6] has also noted that nurses were informed early in their training of the totality of lifestyle that was involved in nursing. This was related to the extraordinary hospital conditions and the important role nurses played within hospitals. This type of culture could nurture an intense commitment to the profession, and this was especially evident in that many former nurses continued to identify themselves as nurses even though they had not worked as such for many years.[7] This research supports this notion of work culture. Many of the former nurses interviewed had not worked as nurses for up to 65 years, yet still strongly identified themselves as nurses. Although the ideology of caring for people was a strong feature of this identity, it is evident that the nature of the work as well as the structures in which the work was performed contributed to the generation of a work culture. One cannot underestimate the esteem the nurses had for sisters and matrons. One former nurse related that the sister was almost revered by the training nurses. "Yes, well the sister was on a high pedestal."[8] The pedestal was constructed not only on the basis of experience and knowledge, but also on a tradition of hierarchical customs and rituals. This was an era when nursing training was arduous, with many trainees never completing their training. To join the ranks of the trained nurse was

---

5 Melosh, B. *The Physician's Hand. Work Culture and Conflict in American Nursing,* Philadelphia; Temple University Press. 1982, p. 5.

6 Barber, J.A. "A Gentle Hand on the Tiller? Nurses' Lives of the 1930s," *Second National Nursing History Conference, Beyond the Black Stump,* 1995, p. 1.

7 Melosh, op.cit., p. 66.

8 Interview, W. Madsen with R. Dalrymple, October 3, 1996.

therefore seen as a major achievement in these young women's lives. This factor may also have contributed to the strong identity with nursing which these women were able to maintain over many years.

The Nursing Hierarchy

The new trainee nurse, often referred to as a probationer, began her training confronted with an entirely new world. This world consisted of patients with exotic sounding diseases and a complex system of seniority. The probationer was expected to learn the rules of this complex hospital system as best she could, picking up what she could from her colleagues.[9] Compulsory living-in aided this process of learning the rules and expectations. Fletcher[10] noted that living-in reinforced the secondary socialisation of nurses, whereby institutional norms were internalised. Within the hospital ward, nurses were accorded status which was dependent on how long they had been employed at the hospital. This system was exact to the day, in that if nurse A began her training on Thursday, and nurse B commenced on Friday, nurse A would continue to be senior to nurse B throughout their training. Seniority was viewed with a great deal of importance as certain privileges were inextricably linked to this system. The system could also be used for disciplinary purposes, such that misdemeanours were often rewarded with demotions for extended periods of time.[11]

---

9 Nurse McDonald, giving evidence at the Rockhampton Hospital Inquiry, *Rockhampton Evening News* , September 2, 1930, p. 2.

10 Fletcher, L. "We Were Proud to be Nurses: The Socialisation of Women as Student Nurses 1946 - 1961," *International History of Nursing Journal,* Vol. 2, No. 3, Spring, 1997, p. 42.

11 For example, Nurse Sinclair gave evidence at the Rockhampton Hospital Inquiry that as a third year nurse she had been assigned to locker duty, a task normally undertaken by junior nurses, *Rockhampton Evening News,* September 26, 1930, p. 16.

On the whole, there were three broad strata of nursing students at the Rockhampton Hospital - the senior nurse, the middle and the junior nurse. There was also a hierarchy among the trained staff. Each ward was assigned a sister, who was responsible for the running of a particular ward. The sisters also had to take turns to supervise the hospital after hours. The deputy matron was usually a ward sister who supported and acted in the position of matron as required. The matron was responsible for the behaviour of the nursing staff, and the overall running of nursing and domestic services within the hospital. The allocation of duties among the nursing students on the ward was in accordance with seniority. The senior nurse had either completed her final exams, or was about to sit for them, her task was to run the ward under the supervision of the sister[12], although the sister was not always in attendance. This included training more junior staff[13], learning administrative tasks[14], ensuring all nursing work was completed for the shift[15], writing out reports[16] as well as more "hands-on" duties such as giving injections[17] and the more complex dressings.[18] The junior nurse was primarily directed by the more senior staff.[19] Her duties usually incorporated the more menial ward tasks such as cleaning, monitoring equipment and utensils, and carrying out basic patient nursing such as back care. The middle nurse attended those duties which remained, that is dressings, oral medications, patient hygiene and observations among others. As each shift did not necessarily have distinct

---

12 Interview, W. Madsen with L. Lowry, October 2, 1996.
13 Interview, W. Madsen with B. West, June 4, 1996.
14 Interview, W. Madsen with L. Lowry, October 2, 1996.
15 Interview, W. Madsen with I. Dennison, October 4, 1996.
16 Interview, W. Madsen with N. Windsor, October 9, 1996.
17 Interview, W. Madsen with K. Austin, June 20, 1996.
18 Interview, W. Madsen with N. Windsor, October 9, 1996.
19 Interview, W. Madsen with M. Baggett, June 6, 1996.

senior, middle and junior nurses, the system of seniority came into play, such that should the above mentioned nurses A and B be on duty with a senior nurse, nurse A would be allocated the middle nurse status, while nurse B would be given the more labour intensive junior duties.

The tasks that were assigned to each nurse were carried out according to an established regime within the hospital. These procedures were usually standard within the hospital, although not necessarily within the state or nation, as revealed by the request for national standardisation of procedures in 1948 by an outspoken Queensland Matron.[20] This call to standardise procedures was part of the scientific management scheme that had captured the imagination of nurses and administrators throughout the world during the early part of this century. McPherson[21] explains scientific management as the process whereby particular tasks were broken down to their component parts and each stage was examined in order to become more efficient. The scientific management concept was initially involved in improving factory production efficiency, and although the measures were not easily translated into nursing, McPherson[22] suggests that the concept of standardised procedures allowed nurses to be drilled in techniques, thereby allowing a small staff of trained nurses to supervise a large number of trainees and maintain a certain standard of nursing. Just what effect the ideals of scientific management had on ward nursing is unclear at present and requires further investigation; however, it is likely that these concepts worked to further legitimise the hierarchical system that was already in

---

20 Grant, C.E.N. "The Re-Organization of Nurses' Training," *The Australasian Nurses' Journal,* August 1948, p. 166.

21 McPherson, K. *Bedside Matters. The Transformation of Canadian Nursing, 1900-1990,* Toronto; Oxford University Press, 1996, p. 88.

22 Ibid., pp. 88-92.

place. This research would support McPherson's view that procedures were broken down and "scientised" by 1930, for example bed making, pressure area care and tepid sponging. These procedures were taught as precise steps.[23] In addition, patient care was carried out to suit the management of the ward, for example, sponges attended to by a certain time, and penicillin given at times so as not to interfere with other ward activities[24].

The system of seniority extended beyond the allocation of tasks. One of the first aspects of nursing to be taught to probationers was the concept of professional etiquette. The lecture notes of this era outline professional etiquette as signifying the conventional rules, acquired through good breeding, that were observed when relating to particular persons in special places.[25] However, in practice, these conventions became a means of yielding power which sometimes became so severe as to obstruct the efficient running of a ward. The conventions included, among others, standing upon entry into the dining room of the matron, sister or midwifery students[26], placing one's hands behind the back when addressing anyone more senior[27] and never sitting in the presence of a standing senior member.[28]

---

23 Matron Fraser, General Nursing Lecture Notes, 1945.

24 Gordon, A.E. "Nurses' Role in Penicillin Treatment," *The Australasian Nurses' Journal,* May 1945, p. 64.

25 Matron Green, General Nursing Lecture Notes, 1935; Matron Fraser, op.cit.

26 Interview, W. Madsen with K. Austin, June 20, 1996.

27 Interview, W. Madsen with B. West, June 4, 1996.

28 Interview, W. Madsen with B. Cagney, June 3, 1996.

> You never, ever used Christian names, you never, ever walked in front of a senior nurse, even if she was only a couple of months your senior. A few nurses got pulled back by their belts when they did it.[29]

The rationale given for professional etiquette was that standing at attention when receiving orders heightened the recipient's understanding of the order and therefore preventing mistakes and facilitating prompt, unquestioning obedience.[30] Such rationale is strongly based on that of military training, which is not surprising given Florence Nightingale's affiliation with the army. However, this explanation fails to explain the other enforced courtesies prevalent during this era, especially the need to carry many of these rules over to off-duty time.

The hierarchical structure was integral to the Nightingale method of nurse training. Abbott[31] outlined the essential elements of this style of training, in which Matron's authority was supreme, although she had to report to a hospital administration board. Students lived-in under the supervision of a Home Sister, that is a trained nurse who supervised the nurses' quarters. Theory and practice were an integral part of training and the ward sister occupied a place of great dignity and importance. This system relied on the strict disciplining of students while on and off duty. Foucault's[32] analysis of discipline illustrates the factors necessary to maintain this type of institutional discipline. He suggests discipline requires enclosure, partition, and rank. These factors were certainly evident in the nursing hierarchy pre

29 Interview, W. Madsen with B. Cagney, June 3, 1996.

30 Matron Green, op.cit.

31 Abbott, J. "A Review of the Nursing Profession," *The Australasian Nurses' Journal,* August 1946, p. 135.

32 Foucault, M. *Discipline and Punish. The Birth of the Prison,* London; Penguin Books, 1977, pp. 141-145.

1950. Nurses had to be inside the nurses quarters by a certain time each night and could only stay out later if granted permission by the matron.[33] The matron and sisters, who ate at separate tables in the dining room, had white damask tablecloths, denoting their status. The uniform worn by the nurses also designated their particular level via the number of stripes shown or by the type of veil worn. The senior nursing and medical staff are illustrated in Figure 5.2.

Figure 5.2 Senior staff of Rockhampton Hospital, 1930 (Courtesy of Rockhampton Hospital Museum)

Such a system however, would not have succeeded without the acquiescence of the nursing students. One former nurse related that the young women entering nursing had been raised in sheltered societies,

33 Interview, W. Madsen with B. Cagney, June 3, 1996.

never questioning the position of superiors and were therefore quite ripe for this type of training.

> We would never have given cheek to any of our superiors, not only because they had to (sic) so much power over us, but we were raised in a very sheltered kind of society...We were quite ripe for that kind of training, I think.[34]

However, there was a significant level of discontent regarding these restrictions, as the Wood's[35] Report revealed in 1947. One of the main reasons nursing trainees failed to finish their training - the report found a thirty-eight percent wastage rate - was due to dissatisfaction with many of the conditions inherent in nursing. One of the recommendations of this report was that nurses in training be no longer "regarded as junior employees subject to an outworn system of discipline".[36] This would suggest that the hierarchical structure of nursing as advocated by Nightingale was beginning to fray, especially in regards to off-duty time. Dissatisfaction was evident among the nursing students at the Rockhampton Hospital during the 1930s and 1940s. In 1930 a number of nurses brought complaints against the medical superintendent and the matron before a Rockhampton police magistrate. The complaints generally related to disciplinary measures and the mannerisms of the medical

---

[34] Interview, W. Madsen with K. Austin, June 20, 1996.

[35] Wood, Sir Robert (Chairman) *The Report of the Working Party on the Recruitment and Training of Nurses,* London; His Majesty's Stationary Office, 1947. This report was conducted for the Ministry of Health of England and Scotland and the Ministry of National Service. It was commissioned in response to the nursing shortage in Britain and the high level of wastage from training. As similar conditions were being experienced in Queensland at the time, there appears to have been at least some interest in the findings by the Queensland government.

[36] Ibid., p. 42.

superintendent.[37] Discontent with nursing shortages and other conditions lead to the formation of the first sub-branch on the Queensland Branch of the Australasian Trained Nurses Association (QATNA) being formed in Rockhampton in 1944.[38] In 1947, a large group of student nurses presented a petition to the Hospital Board complaining primarily about the "iron hand" control of nurses while off-duty, rather than the disciplinary measures contained while on the wards.[39] It is likely such dissatisfaction originated from a broader societal desire by women to loosen some traditional patriarchal ties.

It should be noted that while medical staff were not a direct part of the nursing hierarchy, their status was quite elevated within the hospital and were hence accorded the courtesies of other senior staff, which included not speaking directly to them as junior nurses.[40] Although Nightingale advocated that the position of matron be separate from medical control, the medical superintendent was often seen as the superior of the matron. This was illustrated at the 1930 Nurses' Inquiry held in Rockhampton when the chairman of the Internal Management Committee of the Rockhampton Hospital was asked who disciplined the nurses. His reply indicated the matron disciplined the nurses under the supervision of the medical superintendent, who subsequently made recommendations to the Internal

---

37 De Vries, S. Bold Nurses. A Study of the Public Inquiry held at the Rockhampton Hospital, 1930, Honours Thesis, Central Queensland University, 1989.

38 "Australian Nursing Federation (Queensland Branch) Annual Report of Council 1943-44," *The Australasian Nurses' Journal,* October, 1944, p. 125.

39 *Nurses Charter.* Presented to the Rockhampton Hospital Board on October 1, 1947 including 57 signatories, outlining demands for entertainment areas and more freedom during off duty time, Rockhampton Hospital Museum.

40 Interview, W. Madsen with M. Baggett, June 6, 1996.

Management Committee which was ultimately responsible for carrying out major disciplinary measures.[41]

Trainee nurses had very few forms of redress to pursue during this era. The accepted channels were initially to Matron and then to the Hospital Board. One avenue attempted by a number of nurses was through the professional body, the QATNA, however, this usually elicited a "cannot do anything under the circumstances" type response.[42] In addition, those nurses who did attempt to question the system were likely to find resistance from a number of sources. It is interesting to note that part of Matron Green's lecture regarding professional etiquette in 1935 contained the following paragraph:

> Restraint: From grumbling and adverse criticisms of those in authority, one discontented grumbler can spoil the morals of an entire class and create a spirit of discontent and unhappiness throughout the school, therefore if there is no just cause for grumbling the pupils themselves should take a step to put a stop to it, and if there is no just cause and it is not remedied, there are other hospitals and those who find conditions too intolerable in one, they are at liberty to try another.[43]

---

41 *Rockhampton Evening News,* October 11, 1930, p. 2.

42 For example, Queensland Branch of Australasian Trained Nurses' Association, Minutes, April 4, 1933, noted reply to Miss I. McCraig of Rockhampton refusing to offer assistance. This type of reply was regularly noted throughout the minutes during this era. Queensland Nurses' Union.

43 Matron Green, op.cit.

This warning is likely to have been a direct consequence of the 1930 Nurses' Inquiry. Within a month following the Magistrate's findings, a number of changes occurred at the Rockhampton Hospital, including the termination of services of the Matrons - Matron Green from the maternity section of the hospital, and Matron Smith from the general section.[44] Calls were then made for the position of Matron of the Rockhampton Hospital, which Matron Green secured.[45] The reduction in the number of matrons associated with the hospital may have occurred at this time anyway given the economic conditions of 1930; however, the timing of this move suggests the inquiry was at least a partial factor.

As mentioned in Chapter Two, domestic staff were introduced and increased in number throughout the 1930s and 1940s. This resulted in an additional level to the ward hierarchy. Nurses were actively discouraged from associating with the domestic staff[46], however a number of nurses soon learnt the value of amicable relations with a domestic, especially as junior nurses, as the domestics would often assist with the junior's workload.[47]

Communication Channels

One of the features identified by Melosh[48] as part of the nursing work culture was the method nurses adopted to address each other. Surnames or nicknames were used exclusively, a feature that is normally associated

44 *Rockhampton Evening News,* December 12, 1930, p. 16.
45 Ibid., September 16, 1931, p. 1.
46 Interview, W. Madsen with J. Kidd, September 12, 1996.
47 Interview, W. Madsen with B. Cagney, June 3, 1996.
48 Melosh, op.cit., p. 63.

with male arenas. The nurses of the Rockhampton Hospital also addressed each other by nicknames usually associated with their surname.[49] Melosh[50] suggests this practice developed as a consequence of the strict hospital etiquette which required nurses to be addressed by a formal title, for example, "Nurse Smith", while on the ward. This habit extended to off-duty time and even many years after they had finished their training and had married, many of the former nurses interviewed continued to refer to their colleagues by their nicknames.

The communication channels that were used during this era had many consequences which went beyond nicknames. In many ways the communication channels reinforced the hierarchical structures through the control of information. One of the most obvious methods employed regarding this control of information was the specification that nurses were not to provide any information to the patient about his or her condition. This could only be done by a sister or doctor.[51] This may have been a very practical requirement, in that although the nurses were attending to the patient, they were task orientated and therefore may not have been aware of all the contributing factors. This was further confounded in that although the patients' charts were available on the ward, nurses did not often get the chance to read them[52], and gain a more comprehensive understanding of the patient and his or her condition. Therefore, there may have been a risk of nurses giving the wrong information to patients. However, by not encouraging nurses to seek a broader understanding of a patient's

---

[49] Interview, W. Madsen with I. Dennison, October 4, 1996.

[50] Melosh, op.cit., p. 63.

[51] Matron Green, op.cit.; Matron Fraser, op.cit.

[52] Interview, W. Madsen with J. Kidd, September 12, 1996.

condition nor by allowing the nurses to convey any information to the patient, the nurse's status was not only maintained, but reinforced. The use of technical language further reinforced the hierarchical structure as it took some time and experience before trainee nurses became familiar with the meanings associated with this "new" language.[53]

In many ways the nurses, especially the more junior nurses, were completely bypassed with regards to information. Data gathered by the nurses was channelled up via senior nurses to the sister who would distribute as necessary, either to the doctor or the matron. How effective this method was for channelling information back to the nurses is not clear. A number of comments made by former nurses would suggest that information often did not reach the more junior staff. For example, after a doctor's round, the sister would write up the orders in a day book which the nurses were supposed to check, although "...only the senior nurse and the next nurse (did), the junior one only did what she was told, and looked after the pan room".[54] Another former nurse recalled that nurses were expected to read the day book when coming on duty in the afternoon, and that if something had been overlooked, this was highlighted in large red writing by the sister[55]. It would seem then that the day book became a significant source of information for the nurses, and the only other source aside from word of mouth instructions, most of which was done "on the run".[56]

---

53 Fletcher, op.cit., p. 48.

54 Interview, W. Madsen with M. Baggett, June 6, 1996.

55 Interview, W. Madsen with I. Dennison, October 4, 1996.

56 Interview, W. Madsen with K. Austin, June 20, 1996.

One of the difficulties associated with this channelling of information via the hierarchical tree was inefficiency which in some cases was life threatening. If a nurse answered a phone which required a message to be relayed to a doctor on the ward, she would have to tell her senior nurse, who would tell the sister, who would tell the doctor.[57] This was regardless of how urgent the message may have been. Those who broke rank and spoke directly to a doctor had to be reprimanded, again regardless of the urgency of the situation.

> It was very stratified, you didn't speak to, if you could help it, for instructions or anything, you could speak to the sister, but you rarely did. You spoke to the next person up, who relayed your message, and it was probably a mortal sin to speak to a doctor. In kids ward once, there was a tonsillectomy kid I looked over and saw he was bleeding like a fountain, and the surgeon was still in the ward talking to the sister, and I went up and acquainted him of the fact...but I had to report to sister and then I had to report to Matron, and I also had to report to ...the medical superintendent because I'd broken rank, and of course, they knew I had done the right thing,..... but it had to be documented that I had been reprimanded and that I was truly sorry.[58]

This extract clearly illustrates the rigidity that was associated with this hierarchical pattern of communication.

---

57 Interview, W. Madsen with I. Dennison, October 4, 1996.

58 Interview, W. Madsen with K. Austin, June 20, 1996.

Aside from the written charts described in the previous chapter, one of the more formal methods of conveying patient information was through handover. Each morning the night report, written by the senior nurse would be given to Matron to read.[59] This report was then read out to the oncoming morning staff.[60] There were three handovers during a twenty-four hour period.[61] Staff coming on at times other than handover times were expected to read the day book.[62] After report, duties would be allocated according to seniority, for example mixtures or diets.[63] The ward routines for each duty were printed up on a wall.[64] This method of providing information was commonly used during this era, as no procedure manuals were available. Handwritten sheets giving specific procedural instructions were also on the ward[65]; for example the procedures used for urinalysis were on the wall in the pan room.[66]

Education. A significant feature of the Nightingale system of nursing was locating the education of nurses on the ward. Although nurses were expected to attend formal lectures, usually in their own time[67], it was expected that every nurse would take on a teaching role and train the more junior nurses[68], although the senior nurse took on the bulk of this responsibility. The senior nurse would demonstrate a procedure, then

59 Interview, W. Madsen with N. McKenzie, July 31, 1996.
60 Interview, W. Madsen with V. Manly, October 1, 1996.
61 Interview, W. Madsen with M. Baggett, June 6, 1996.
62 Interview, W. Madsen with D. Ross, October 17, 1996.
63 Ibid.
64 Interview, W. Madsen with K. Austin, June 20,1996.
65 Interview, W. Madsen with J. Kidd, September 12, 1996.
66 Interview, W. Madsen with I. Dennison, October, 4, 1996.
67 Interview, W. Madsen with K. Austin, June 20, 1996.
68 Interview, W. Madsen with L. Lowry, October 2, 1996.

oversee the junior nurse until they were considered to be proficient.[69] The senior nurse therefore came to be seen by the junior nurses as a vital link in their education. A common view expressed by the former nurses was that the senior nurse could "make or break a nurse".[70] This was especially felt by the nurses who trained during World War II, when the training time was reduced from four to three years in 1942.[71] A number of these nurses felt that they did not get a very good grounding in nursing because all the fourth year nurses graduated, leaving as the most senior those who were quite a way from sitting for their final exams.[72] A fourth year of training was recommenced in 1946.[73] This reduction in training time will be more fully discussed later in the chapter in association with other periods of staff shortages.

The structure of the nurse education system during the period under review did not alter very much except for the introduction of a Preliminary Training School (PTS) of six weeks and a sister tutor during the latter part of the 1940s. This structure included going on to the wards with no preparation. Even after the introduction of PTS, new nurses could often spend some time working on a ward before the next PTS commenced.[74] Formal lectures and demonstrations only took up approximately seventy-two hours throughout the three years - twelve general nursing lectures, twelve elementary anatomy and physiology lectures, twelve medical nursing lectures, twelve

---

69 Interviews, W. Madsen with G. Elliott, June 4, 1996; D. Ross, October 17, 1996.

70 Interview, W. Madsen with B. West, June 4, 1996.

71 Queensland Branch of Australasian Trained Nurses' Association minutes, December 12, 1942, Queensland Nurses' Union.

72 Interview, W. Madsen with N. Windsor, October 9, 1996.

73 Gregory, H. and Brazil, C. *Bearers of the Tradition. Nurses of the Royal Brisbane Hospital 1888-1993,* Brisbane; Boolarong Publications, 1993, p. 135.

74 Interview, W. Madsen with B. Cagney, June 3, 1996.

surgical nursing lectures, six hygiene lectures, six sessions of invalid cookery, six practical demonstrations, and one urinalysis demonstration.[75] No lectures were given during fourth year. Therefore, a great deal of education had to be undertaken on the wards. The move to increase the theoretical component of nurse education with the introduction of the nurses regulations in 1929, was not always welcome. In 1933, the *Australasian Nurses' Journal* published an extract questioning whether this extra theory was not placing too much stress on the nurse, noting that in 1912 the nurse's education was clearly founded on practical work.[76]

One of the consequences of locating the bulk of education within the ward was a strengthening of the socialisation of new nurses into the work culture. Bessant[77] claims that the professional socialisation of nurses pre 1980 was powerfully interwoven with the general socialisation which enforced certain values, aspirations and subordinate behaviour. It is not difficult to imagine senior nurses schooling junior staff on how to do a dressing while at the same time reinforcing the values of the hierarchy or how to best appease the ward sister.

Debriefing. Along with much of the informal education of nurses that was occurring on the wards, was the gradual "toughening" of the nurses towards the tragedies that confronted them. It is in this area of socialisation that the rigid communication channels played a significant role. Most of the former

---

75 "The Nurses and Masseurs Registration Regulation," *Government Gazette,* Vol. 8642, February 1929, pp. 3-5.

76 "The Education of the Nurse as a Problem of the Future," extract from, *The League News, St. Bartholomew's Hospital Journal; The Australasian Nurses' Journal,* April 15, 1933, p. 80.

77 Bessant, J. "Good Women and Good Nurses. Conflicting Identities in the Victorian Nurses Strikes 1985-86," *Labour History.* Vol. 63, November 1992, p. 156.

nurses interviewed were able to relate a personal episode where they had to deal with a difficult situation, usually involving death, whilst training. The situations ranged from discovering a dead child[78] to consoling relatives after a death while being short staffed.[79] In all of these situations there was no discussion after the episode with the sister of the ward, unless she thought the nurse had acted inappropriately.[80] No opportunities were given to the nurses to talk about their feelings, nor any words of encouragement or advice given by the most senior and experienced person on the ward. In the absence of assistance from the sister, most of these former nurses suggested that their youth at this time enabled them to cope; however, they also related the importance of being able to go to the nurses' home in order to talk things over with their colleagues.[81] This method of informally debriefing over difficult situations may also have strengthened the work culture and contributed to the longevity of friendships between the nurses.

An important issue that was raised by Melosh[82] in regard to dealing with these human tragedies was the expectation that nurses learn to become impersonal with patients and their relatives and that they were seen to be in control of their emotions. Lawlor[83] also noted this emotional control was seen to depict a professional approach and was traditionally associated with ideals of "good nursing". Hainsworth[84] was adamant that in no

78 Interview, W. Madsen with R. Dalrymple, October 3, 1996.
79 Interview, W. Madsen with N. McKenzie, July 31, 1996.
80 Interview, W. Madsen with N. Windsor, October 9, 1996.
81 Interviews, W. Madsen with V. Manly, October 1,1996; N. Windsor, October 9, 1996.
82 Melosh, op.cit., p. 63.
83 Lawler, J. *Behind the Screens. Nursing, Somology, and the Problem of the Body,* Melbourne; Churchill Livingstone, 1991, p. 126.
84 Hainsworth, M. *Modern Professional Nursing, Vol. 2,* London; The Caxton Publishing Co. Pty. 1949, p. 275.

circumstance should a nurse display her emotions to a patient, advocating that the cheerful presence of the nurse being essential for a patient's recovery. This control of emotions was also taught informally. One former nurse who was interviewed related her first encounter with a dead body. A senior nurse told her to touch it and then later told her to go back alone and strip the room and collect the personal items in order to allow his wife to sign for them before she left.[85] In this way the nurse was shown that death was not mysterious, that is was quite natural and that there were a number of practical considerations that needed to be attended. This was a "get used to it and get on with it" attitude which assisted nurses to develop an austere protection against everyday death and dying. However this attitude may also have limited the nurses' willingness to discuss those difficult situations with others especially once she had finished her training.

It is unclear why the lack of communication existed between nurses and the sister, although it may have been related to the view that nurses needed to learn to control their emotions as well as the rigidity of the hierarchy and the rules of not associating with nurses outside one's immediate level. There may have also been some misgivings on the part of the sister, in that if she discussed tragic situations with the nurses, she may have been perceived as acknowledging her own and the nurse's feelings, which ran counter to the ideal of impersonality. She needed to be a role model to the nurses. In addition, it appears that the channels of communication were not to be interfered with regardless of the situation. As the hierarchy was well established by the 1930s this research was not able to expand on the rationales for the rigidity. This is yet another area where nursing tradition

85 Interview, W. Madsen with J. Kidd, September 12, 1996.

was well entrenched and the behaviour cannot be adequately explained in terms of medical, industrial or women's historical parameters.

Ward Management

In addition to the constraints of a rigid hierarchical system and communication channels, the nurses on the ward had to work within the constraints imposed on them by industrial conditions, shifts, staffing, matrons rounds and discipline. These factors will be explored in the final part of this chapter. They are linked together because they were aspects of ward management that influenced the day to day running of a ward and therefore impacted on the work of nurses.

Matron's Rounds. One of the most illuminating examples of patient care being manipulated to suit the needs of the ward concerned the ritual of Matron conducting a daily tour of the hospital wards. Prior to this visitation, everything within the ward had to be in perfect order. This included all patients being washed and sitting up in their beds, beds made perfectly, wheels pointing the same way, flowers arranged and everything cleaned.[86] These rounds occurred at least once a day, sometimes twice, depending on the matron of the time and were usually around mid-morning, after breakfast. Due to the timing of this round, nurses were expected to have sponged and fed the patients, and attended to all the ward cleaning by this time, as well as going to breakfast themselves, in the space of three hours. It is little wonder many felt they had to come on duty early. In addition, the concept of a tidy ward extended well beyond the lack of litter. For example,

86 Interviews, W. Madsen with N. McKenzie, July 31,1996; B. Cagney, June 3, 1996; N. Windsor, October 9, 1996; M. Chalmers, August 5, 1996.

a tidy bed consisted of a ceaseless quilt[87], despite the presence of a patient. To achieve this, the bottom end of the sheet was pulled very tight such that the patient's feet were held in a planter flexion position (toes pointing down). Most of the former nurses immediately loosened these covers as soon as the inspection was over.[88] The mosquito nets had to be evenly pleated, although there does not appear to have been a set number of pleats that were required throughout the hospital. Many of the former nurses interviewed remembered having to fold these nets with a specific number of pleats; however the number ranged from twenty-two to fifty-two[89], suggesting that perhaps this was a requirement of certain wards only. All the wheels of the beds had to be pointing in the same direction.[90] It was also expected that pillow case openings faced away from the door. One of the ward sisters was known to sit at one end of the ward to ensure everything was in line and uniform.[91]

This type of tidiness is reminiscent of the military and was certainly not conducive to tending to the needs of the patients.[92] However, it persisted throughout the 1930s and 1940s. The rationale for this need for military tidiness was probably related to the importance placed on discipline and obedience during nurse training. Ashdown[93] noted that these two factors were the keynote to satisfactory and efficient work, and that in order to rule,

87 Interview, W. Madsen with I. Dennison, October 4, 1996.

88 Interviews, W. Madsen with L. Lowry, October 2, 1996; K. Austin, June 20, 1996.

89 Interviews, W. Madsen with K. Austin, June 20, 1996; L. Lowry, October 2, 1996; B. Cagney, June 3, 1996; J. Kidd, September 12, 1996.

90 Interview, W. Madsen with M. Chambers, August 5, 1996.

91 Interview, W. Madsen with I. Dennison, October 4, 1996.

92 Interview, W. Madsen with V. Manly, October 1, 1996.

93 Ashdown, A.M. *A Complete System of Nursing,* London; Waverley Book Company Ltd., 1925, p. 2.

one must first learn to obey. Both discipline and obedience could be measured by the tidiness of a ward. Adherence to the strict protocols was an indication that nurses were working hard, in accordance with the wishes and standards of the ward sister.

Workplace Conditions. Nursing in the 1930s and 1940s was not any easy occupation for young women to undertake. It had a reputation which consisted of "long hours, poor pay, and....very exacting work and rigid discipline".[94] Such conditions were accepted as a normal part of nursing by those in positions of authority and which were inextricably tied in with the concept of nursing as a self-sacrificing vocation.[95] Strachan[96] suggests that nurses were unable to modify any these conditions because of their obligation to self sacrifice, isolation from other workers and the divisions within the nursing hierarchy leading to the inability to form a cohesive group whereby action may have been taken. While Strachan has been able to identify pockets of industrial unrest among nurses in the 1930s and 1940s[97], nurses were unable to unite on a statewide basis in order to address the issues. The issues which concerned nurses the most were related to food and the hours worked according to a 1942-3 New South Wales report.[98] Although these were not the only concerns, as noted earlier regarding disciplinary and out-of-hours restraints, they were main issues and will be discussed separately.

---

94 Grant, C.E.N. "Letter to Editor," *The Australasian Nurses' Journal,* October 1946, p. 192.

95 Bessant, op.cit., pp. 159-160.

96 Strachan, G. "Sacred Office, Trade or Profession? The Dilemma of Nurses Involvement in Industrial Activities in Queensland 1900 - 1950," in Frances, R., States, B. (eds) *Women, Work and the Labour Movement in Australia and Aotearoa/NZ,* Sydney; Australian Society for the Study of Labour History, 1991, p. 151.

97 Ibid., p. 159-160.

98 Dickenson, M. *An Unsentimental Union. The New South Wales Nurses Association 1931 - 1992,* Sydney; Hale & Iremanger Ptd. Ltd., 1993, p. 69.

Hours. Although the first nurses' award was gained in 1921[99], it was not until 1925 that a reduction in hours occurred in Queensland from more than 140 hours per fortnight to an official 88 hours.[100] However, not all Queensland hospitals heeded this ruling, with some opting to pay the nurses overtime.[101] It is likely that the actual hours worked was in excess of the official level as most former nurses interviewed remembered working considerable amounts of overtime, although none of them recalled being paid for overtime. Most of them recalled that there was an expectation that nurses would not go off duty until all their work had been completed.[102] In 1930, the number of hours was increased to 96 hours per fortnight, and annual leave was reduced to three weeks.[103] This move was related to the economic situation of this time[104] and was not isolated to nurses. It was not until 1947 that nurses were officially granted a forty-four hour week.[105] Throughout the period under review nurses only had one and a half days off. One former nurse who commenced her training in 1950 recalled being granted two full days off after being at the hospital for six months[106], which suggests that either the Rockhampton Hospital lagged somewhat in bringing in the shorter hours, or that the nurses' time off was divided such

---

99 Strachan, G. *Labour of Love. The History of the Nurses' Association in Queensland 1860 - 1950,* St. Leonards; Allen & Unwin Pty. Ltd., 1996, p. 107.

100 Ibid., p. 120.

101 Gregory, H. *A Tradition of Care. The History of Nursing at the Royal Brisbane Hospital,* Brisbane; Boolarong Publications, 1988, p. 74.

102 Interviews, W. Madsen with B. West, June 4, 1996; M. Baggett, June 6, 1996.

103 "Queensland Nurses Award." *The Australasian Nurses' Journal,* December 15, 1930, p. 318.

104 "Queensland Annual Report." *The Australasian Nurses' Journal,* September 15, 1931, p. 176.

105 "Extracts from the Annual Report of Australasian Trained Nurses' Association (Queensland)," *The Australasian Nurses' Journal,* December 1947, p. 295.

106 Interview, W. Madsen with B. Cagney, June 3, 1996.

that they had longer periods between their split shifts, rather than have consecutive time off.

The shifts worked by the nurses, as recalled by the former nurses who were interviewed, varied considerably, especially the finishing times. This is probably related to the prevalence of overtime, leading to a blurring of finishing times. Generally the starting time for all shifts, except night duty, in the late 1920s and early 1930s was 6.30am. This had changed to 6.00am by the late 1930s although exactly when it changed or why is not evident. Except for night duty and a through day shift, all other shifts worked were broken, with everyone starting at the same time in the morning such that all the morning work could be completed, and then staggered finishing times and come back times. Table 5 illustrates the main features of the shifts worked during the 1940s, as recalled by those interviewed.

As can be seen by the number and variety of split shifts the nurses worked during this era, living on the hospital premises would have been advantageous for the hospital. This situation allowed the hospital to roster the nurses on at the busiest times - in the morning and for each meal. It also allowed the nurses to attend their lectures during their off duty time. Having the nurses living at the hospital also provided a means whereby work and off-duty time boundaries could become easily blurred. It was not unusual for a nurse to be called back on duty, in full uniform, if it was discovered she had left something on the ward unattended, regardless of the importance of the oversight.[107]

---

107 Interview, W. Madsen with M. Baggett, June 6, 1996.

Table 5. Day Shifts worked during the 1940s at Rockhampton Hospital

TIME	Shift	Shift	Shift	Shift
6AM	X	X	X	X
6.30	X	X	X	X
7.00	X	X	X	X
7.30	X	X	X	X
8.00	X	X	XX	X
8.30	X	X	XX	X
9.00	X			X
9.30	X			X
10.00	X			X
10.30	X			X
11.00	X		X	X
11.30	X		X	X
12.00	X		X	X
12.30	X		X	XX
1PM	X		X	XX
1.30	X		X	
2.00	X		X	
2.30	X		X	
3.00	XX	XX	X	
3.30	XX	XX	X	
4.00	XX	XX	X	XX
4.30		X	X	XX
5.00		X	X	XX
5.30		X	X	X
6.00		X	XX	X
6.30		X	XX	X
7.00		X	XX	X
7.30		X	XX	
8.00		X	XX	
8.30		X		
9.00		X		
9.30		X		

"X" Denotes time on duty

"XX" Denotes conflicting information

Food. Keneley[108] noted that nineteenth century accommodation in Victoria for nurses consisted of small overcrowded rooms, limited facilities and minimal amounts of poor quality food. This research would suggest this situation did not change much into the mid twentieth century. The 1930 nurses inquiry held in Rockhampton revealed nurses at the Rockhampton Hospital often suffered shortages of food, especially sugar, butter and tea[109], and that if a nurse should be late for a meal, she was likely to miss eating altogether.[110] This situation continued during the World War II.[111] However, during the few years when normal economic and political circumstances did prevailed between 1930 and 1950, the nurses were provided with adequate, if uninspiring meals.[112] Even in times of plenty, fruit and fresh vegetables were in short supply.[113] Although it is beyond the scope of this study to investigate the effects this nutritional intake may have had on the working capacity of the nurses, it is mentioned here to further illustrate the relationship between off-duty conditions and working circumstances, and that hunger and malnutrition may well have impacted on the nurses' ability to carry out their duties.

Staff Shortages. Although there was considerable concern in the early 1930s regarding the lack of work available for trained nurses[114], most of the time period under review was characterised by staff shortages at the

---

108 Keneley, M. "Handmaidens of Medicine: Working conditions for nurses in late Nineteenth Century Victoria," *Journal of Australian Studies,* Vol. 22, May 1988, p. 66.
109 *Rockhampton Evening News,* August 29, 1930, p. 9.
110 Ibid., September 2, 1930, p. 2.
111 Interview, W. Madsen with B. West, June 4, 1996.
112 Interview, W. Madsen with I. Dennison, October 4, 1996.
113 Interview, W. Madsen with V. Manly, October 1, 1996.
114 Queensland Branch of the Australasian Trained Nurses' Association, Minutes, June 9, 1931, Queensland Nurses' Union.

Rockhampton Hospital. Former nurses who worked during the late 1920s and early 1930s noted that under staffing was quite prevalent.[115]

> I remember one girl telling me Matron came up to her at 12 o'clock and said you can have your day off now.[116]

However, staff shortages reached critical levels during and after World War II. Strachan[117] suggests this was due to the demand for nurses for military service coupled with an inability to recruit new trainees due to low pay and poor working conditions. In addition to the inability to attract trainees to nursing, the rate of trainees leaving before completion, known as wastage, was also of concern, although the introduction of Manpower regulations in 1944 made it more difficult for nurses to leave.[118] Shortages were compounded by the reduction of training time to three years during the war, which saw all fourth year nurses leave at the same time. Gregory[119] noted that the wastage rate of trainees in the late 1930s from the Royal Brisbane Hospital was approximately fifty percent. Interestingly, while other states within Australia were concerned with the shortage of trainees[120] during the late 1930s, the QATNA believed there to be no scarcity of would-be trainees.[121] However within a couple of years, this branch of the ATNA also had to contend with severe nursing shortages.[122] By 1944 there were suggestions from nurses in Rockhampton that the recommended ratio of

---

115 Interviews, W. Madsen with N. McKenzie, July 31, 1996; M. Chambers, August 5, 1996.

116 Interview, W. Madsen with M. Chambers, August 5, 1996.

117 Strachan, 1996, op.cit., p. 151.

118 "Australian Nursing federation (Queensland Branch) Annual Report of Council, 1943-44," *The Australasian Nurses' Journal,* October 1944, p. 124.

119 Gregory, op.cit., p. 81.

120 Dickenson, op.cit., p. 71.

121 Queensland Branch of the Australasian Trained Nurses' Association, Minutes, May 10, 1938, Queensland Nurses' Union.

122 Ibid., October 10, 1939; October 14, 1941, Queensland Nurses' Union.

eight trainees to one sister was being greatly exceeded.[123] At this time Rockhampton Hospital was eight trainees short of its full staff.[124]

The effect of these staff shortages was an increase in the demand made upon those nurses left on the wards. One former nurse worked as a Voluntary Aid Detachment (VAD) during the war, prior to commencing her training. She recalled how grateful the nurses were regarding the VAD's presence because without them, nurses would not get days off.[125] Another former nurse who trained during the war recalled she did not get any holidays during her training due to staffing shortages.[126] Sick leave was also taken sparingly.[127] The responsibilities placed on nurses were in excess of those normally given for certain levels of training. For example one former nurse recalled having to go on night duty by herself in one of the biggest wards of the hospital, three months into her training, when her knowledge and experience would have been minimal.[128] Others recalled feeling consistently tired, with aching feet and backs.[129] Most remembered having to work back, never leaving the ward until the work was finished. In addition, during the war, the hospital not only catered for the normal civilian staff, it also admitted Australian soldiers who were returning from New Guinea.[130]

---

123 E.H. Hill, "Letter to Editor," *The Morning Bulletin,* March 23, 1944, p. 2.
124 "Particulars Concerning Shortages of Trainees in General Nursing. Report to Department of Health and Home Affairs," 1944, Queensland State Archives, A/31806.
125 Interview, W. Madsen with D. Ross, October 17, 1996.
126 Interview, W. Madsen with I. Dennison, October 4, 1996.
127 Interviews, W. Madsen with I. Dennison, October 4, 1996; V. Manly, October 1, 1996.
128 Interview, W. Madsen with N. Windsor, October 9, 1996.
129 Interview, W. Madsen with, K. Austin, June 20, 1996.
130 Interview, W. Madsen with V. Manly, October 1, 1996.

Conclusion

Although there was some discontent in Rockhampton during the 1930s and 1940s, nurse training laid the basis for self sacrifice. Matron Green extolled this virtue in her lectures, noting that unselfishness was characteristic of a good nurse, and that because of the unpredictability of emergencies, nurses could not be dictated by the clock.[131] By exploiting the noble notions of self sacrifice and the vocational aspects of nursing, administrators and nursing authorities were able to ignore the effects of shortages on the trainee nurses. In fact, the Rockhampton Hospital Board informed the undersecretary of the Department of Health and Home Affairs in 1944 that the nurses at the Rockhampton Hospital could only have complaints in relation to the state of the nurses' quarters.[132] For many nurses, this statement was not that far from the truth. Although the majority of former nurses acknowledged staff shortages, rigid hierarchical system and the accompanying hardships, they all accepted this as part of nursing; and although they recalled grumbling to each other about the conditions on and off the ward, they did not wish to be anywhere else. Whether this was due to an extremely effective socialisation process or whether natural selection processes meant only those women for whom nursing was a major component of their lives and identity were involved in this research, is unknown. What this chapter has revealed was the range of consequences which affected nurses working within the nursing hierarchical system that was in place within hospitals during the 1930s and 1940s.

---

131 Matron Green, op.cit.

132 C. Prichard, Manager of Rockhampton Hospital Board, to Undersecretary of Department of Health and Home Affairs, June 20, 1944, Queensland State Archives, A/31806.

Conclusion

"Modern" nursing, with its origins in late nineteenth century Victorian philanthropy, had a significant impact on the treatment of ill people because of the type of work that nursing involved. This study has investigated the work of nurses during the 1930s and 1940s, a time when social, economic and political upheavals were evident. It was also a transitional time when nursing began to shed some of its traditional methods and treatments. The impact of medical science on nursing was particularly evident during this era. Effective pharmaceuticals and vaccines significantly altered the demographics of patients being admitted to hospitals and the length of time they stayed, although the full impact of these advances was often not evident until after 1950. Locating nursing at the junction of medical, women's and labour historical parameters, has allowed this study to consider the extrinsic factors which have influenced the development of nursing work. Focussing on general nursing at the Rockhampton Hospital has permitted the nursing tasks and procedures to be more fully analysed and has also allowed a number of regional issues to be explored.

This study has outlined a number of issues and concerns pertinent to nursing practice in the 1930s and 1940s. These include infection control issues, treatments and interventions, the monitoring aspects of nursing, and the hierarchical constraints of hospital nursing. For the nurses of this era, each of these aspects were viewed as important parts of nursing practice. In an era when infectious diseases were prevalent and for which there were no ready cures, infection control became a priority for nurses. A number of practices, based on the principles of asepsis, antisepsis and isolation, were

developed. However, it was noted that some of the practices which were formulated seemed to have been influenced more by economic constraints than by the prevailing understanding of infection control. It has been suggested that hospital administrations were partly responsible for these nursing routines.

The relationship between doctors and nurses, and the significant role the medical profession played in nursing practice was explored in relation to the treatments carried out on the patients and the monitoring role that nurses undertook. Many of the nursing activities in the 1930s and 1940s were directly and indirectly influenced by doctors. Some of these activities were so tightly controlled by doctors that nurses were often viewed as merely the hands of medicine. However, this study has shown that while a large proportion of the nurses' time was spent undertaking these doctor-controlled activities, a significant part of nursing work involved practices and routines over which nurses had complete control. It has been argued that many of these formed the foundation of nursing practice as envisaged by Florence Nightingale, as they were primarily concerned with environmental comfort and providing for the patient the circumstances whereby healing could take place.

Finally, this study examined the ward environment within which nurses operated. Trainee nurses were expected to learn the "tools of the trade" while working on a hospital ward. It has been suggested these nurses learnt much more than nursing procedures and skills. They also internalised the culture that existed in the wards and hospitals. This culture consisted of a rigid hierarchy that dictated how nurses behaved and

communicated while on and off duty. In addition, the industrial conditions that impacted directly on nursing practice were also explored. These included staff and food shortages.

This study has begun to fill the void relating to historical analysis of nursing practice in Australia, identified in the literature review. In order to accomplish this, a large selection of primary sources were consulted, including published and unpublished documents, and a number of oral testimonies were collected from nurses who had worked at the hospital during the time period under review. The documentary and oral evidence converged at many points, with the oral evidence filling in gaps and allowing a more regional perspective to be explored. This study has outlined the arduous and ritualistic nature of nursing in the 1930s and 1940s. It has attempted to examine nursing practice in the context of medical, women's and labour historical parameters to illustrate the complex nature of nursing and the many factors which have influenced nursing practice in the past, and therefore, been instrumental in forging the practice of today.

BIBLIOGRAPHY

PRIMARY SOURCES

Queensland State Archives

"Comparison Between State Service Award and Nurses' Award." QSA. A/31807

"Comparison Junior Employees with Other Callings." QSA. A/31807

"Particulars Concerning Shortages of Trainees in General Nursing. Report to Department of Health and Home Affairs." 1944, QSA. A/31806

Correspondence between Rockhampton Hospital Board and Undersecretary of Department of Health and Home Affairs, 1944, QSA. A/31806

"Notes re Hospital Development in Rockhampton." 1930, QSA. Col. 363

Queensland State Library

Queensland Government Gazette 1929 - 1946

Queensland Nurses' Union

Queensland Branch of the Australasian Trained Nurses' Association, Minutes of Meetings: 1930 - 1950

The Australasian Trained Nurses 'Journal	Monthly reports and annual reports from the Queensland Branch of the Australasian Trained Nurses' Association 1930 - 1950
	Exam questions and answers, taken from State examinations although which State was not necessarily dentified. Answers were not always provided. 1930 - 1940
Wood, Sir R.	*The Report of the Working Party on the Recruitment and Training of Nurses,* London; His Majesty's Stationary Office, 1947

Rockhampton Hospital Museum

Exam Questions	The Nurses and Masseurs Registration Board, Queensland General Examination Questions, 1943 - 1950
Cagney, B	Memoirs of General Nursing training at Rockhampton Hospital, 1950 - 1954
West, B.	Memoirs of General Nursing training at Rockhampton Hospital, 1944 - 1951
Schneider, V.	Memoirs of domestic work in 1949

Unknown Author — *Surgical Nursing Lectures, Rockhampton Hospital,* Rockhampton, Rockhampton City Printing, no publishing date, probably mid 1940s

Nurses' Charter — Document presented to the Rockhampton Hospital Board by the trainee nurses, 1947

Centre for Remote Area Nursing, Central Queensland University

Lecture notes, Matron Green — General Nursing Lecture Notes, 1935

Personal Memorabilia

Lecture notes, Matron Fraser — General Nursing Lecture Notes, 1945, courtesy of Ms J. Kidd

Rockhampton City Council

Engineering Department — Map of Rockhampton City, showing plans of sewage connection

Correspondence with State Government regarding sewage connection

Books

Ashdown, A.M. — *A Complete System of Nursing,* London; Waverly Book Company Ltd., 1925 and 1932 editions

Burbidge, G.N. — *Lectures for Nurses,* Glebe; Australasian Medical Publishing Co. Ltd., 1935

Doherty, M.K., Sirl, M.B., Ring, O.I. — *Modern Practical Nursing Procedures,* Sydney; Dymocks Book Arcade Ltd., 1944

Hainsworth, M. — *Modern Professional Nursing, 2nd Edition,* London; The Caxton Publishing Company, Ltd., 1949

Howard, R. — *Surgical Nursing,* London; Edward Arnold and Co., 1917

Maxwell, A.C. and Pope, A.E. — *Practical Nursing: A Textbook for Nurses,* New York; G.P. Putnam's Sons, 1914; and 4th Edition, 1923

Nash, D.F.E. — *The Principles and Practices of Surgical Nursing,* London; Edward Arnold Publishers Ltd., 1955

Nightingale, F. — *Notes on Nursing: What it is and what it is not,* Glasgow; Blackie and Sons Ltd., 1974

Pearce, E. — *Medical and Nursing Dictionary and Encyclopaedia, 9th Edition,* London; Faber and Faber Ltd., 1949

Petrovsky, C.C. — *Notes on Technical Procedures, 5th Edition,* Tasmania; L.G. Shea, Government Printer, 1927

Pope, A.E. and Pope, T.A. — *A Quiz Book for Nurses, 2nd Edition,* New York; G.P. Putnam's Sons, 1915

Pye, A.D.D. — *Urine-testing Notes for the Pupil Nurse,* Brisbane; Brisbane and South Coast Hospitals Board, 1910

Riddell, M.S. — *Lectures to Nurses, 5th Edition,* London; The Scientific Press Faber and Faber Ltd., 1933

Rutherford Darling, H.C. — *Surgical Nursing and After Treatment. A Handbook for Nurses and Others, 3rd Edition,* London; J and A Churchill, 1928

Shiel, D.W. — *Medical Nursing Lectures for Pupil Nurses,* Brisbane; Waverly Press, 1941

Stewart, I. and Cuff, H.E. — *Practical Nursing, 5th Edition,* London; William Blackwood and Sons, 1919

Newspapers

Rockhampton Evening News — 1929 - 1935

The Morning Bulletin — 1938 - 1952

Ferguson, W.J. — "Will Women be Dominant Sex in Future," *Rockhampton Evening News,* March 27, 1933, p. 9

Unknown Author — "All Positions Should be Open to Women," *Rockhampton Evening News,* July 28, 1931, p.7

Journals

Abbott, J. — "A Review of the Nursing Profession," *The Australasian Nurses' Journal,* May, 1945, pp. 135-137

Ashdown, A.M. — "Fomentations, Medical and Surgical," *Nursing Illustrated,* Vol. 3, No. 20, January 19, 1940, pp. 558-559

Bishop, H.A. — "The Treatment of Bedsores," *Nursing Illustrated,* April 26, 1940, pp. 249-250

Boyd, R.N. — "Surgical Cases: Preoperative and Immediate After Care," *Nursing Illustrated,* Vol.1, No. 25, February 24, 1939, pp. 17-19

Cameron, N. — "The Art and Profession of Nursing," *The Australasian Nurses' Journal,* March, 1947, pp. 55-57

Cruickshank, R. — "Hospital Infection: A Historical Review," *The Australasian Nurses' Journal,* February-March, 1946, pp. 30-33; April-May, 1946, pp. 53-57

E.G.R. "Administration of Medicine by Mouth," *Nursing Illustrated,* Vol. 3, No. 22, January 2, 1940, pp. 613-614

"Surgical Dressings," *Nursing Illustrated,* Vol. 2, No. 12, May 26, 1939, pp. 379-381

Gordon, A.E. "Nurses Role in Penicillin Treatment," *The Australasian Nurses' Journal,* May, 1945, pp. 63-65

Grant, N. "Letter to the Editor," *The Australasian Nurses' Journal,* October, 1945, p. 191

"The Re-Organization of Nurses' Training," *The Australasian Nurses' Journal,* August, 1948, pp. 166-167

Holland, D.L. "Stricter Ward Ritual to Avoid Cross Infection of Wards," *Nursing Mirror,* Vol. 73, No. 1901, August 30, 1941, p. 240

Miles, A.A. "Observations on the Control of Hospital Infection," *The Australasian Nurses' Journal,* April-May, 1946, p. 56

Parkes, C. "The Development in Planning of a Nursing Ward Unit," *The Australasian Nurses' Journal,* April 15, 1944, pp. 43-46

Slater, C.B. "Injuries to the Thorax. Principles and Practice of First Aid-9, *Nursing Illustrated,* August 30, 1941, pp. 238-239

Unknown author "The Supposedly Sterile Syringe," Reprinted from *British Medical Journal,* January 20, 1940, in *The Australasian Nurses' Journal,* April 15, 1941, pp. 68-69

"Nursing Problems," extract from *British Medical Journal,* May 14, 1938, printed in *The Australasian Nurses' Journal,* November 15, 1938, pp. 205-208; November 15, 1938, pp. 227-233

"The Education of the Nurse as a Problem of the Future," extract from *The League News, St. Bartholomew's Hospital Journal,* printed in *The Australasian Nurses' Journal,* April 15, 1933, pp. 79-81

Ward, P.D. "Standard Ready-made Versus Hospital-made Dressings." *The Australasian Nurses' Journal,* May 15, 1933, pp. 98-99

SECONDARY SOURCES

Books and Chapters

Biggs, J.S.C. "A Medical School for Queensland," in Thearle, J.M. (ed) *People, Places and Pestilence. Vignettes of Queensland Medical Past,* Brisbane; Department of Child Health, University of Queensland, 1986, pp. 63-76

Birchill, E. *Australian Nurses since Nightingale 1860 - 1990,* Richmond; Spectrum Publications Pty. Ltd., 1992

Brown, L.M. *History and Memories of Nursing at the Launceston General Hospital,* Launceston; The Launceston General Hospital Ex-Trainees Association, 1980

Cordery, C. "Another Victorian Legacy: Florence Nightingale, Miasmic Theory and Nursing Practice,' in Bryder, L. and Dow, D.A. (eds) *Proceedings of an International Conference on the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society, 1995

Curthoys, A., Eade, S., Spearritt, P. *Women at Work,* Canberra; Australian Society for the Study of Labour History, 1975

Dickenson, M. *An Unsentimental Union. The New South Wales Nurses' Association 1931-1992,* Sydney; Hale and Iremonger Pty. Ltd., 1993

Doherty, R.L. "Dr E.H. Derrick and the Queensland Fevers," in Theale, J.M. (ed) *People, Places and Pestilence. Vignettes of Queensland Medical Past,* Brisbane; Department of Child Health, University of Queensland, 1986, pp. 7-12

Durdin, J. *They Became Nurses: A History of Nursing in South Australia,* North Sydney; Allen and Unwin, 1991

"Doctors and the Training of Nurses in South Australia 1880 - 1920," in Attwood, H. and Kenny, G. (eds) *Reflections on Medical History and Health in Australia. Third National Conference on Medical History and Health in Australia,* Parkville; Medical History Unit, University of Melbourne, 1987

Foucault, M. *Discipline and Punish. The Birth of the Prison,* London; Penguin Books, 1977

Gilderhus, M.T. *History and Historians. A Historiographical Introduction, 2nd Edition,* New Jersey; Prentice Hall, 1992

Gillespie, R. "Epidemics and Power: Weil's Disease in North Queensland, 1929 - 39," in Attwood, H, Gillepsie, R., Lewis, M. (eds) *New Perspectives on the History of Medicine,* Melbourne; Australian Society of the History of Medicine, University of Melbourne, 1990, pp. 59-65

Goldsmith, B. and Sandford, B. *The Girls They Left Behind,* Ringwood; Penguin Books Australia Ltd., 1990

Gregory, H. *A Tradition of Care. The History of Nursing at the Royal Brisbane Hospital,* Brisbane; Boolarong Publication, 1988

Gregory, H. and Brazil, C. *Bearers of the Tradition. Nurses of the Royal Brisbane Hospital 1888 - 1993,* Brisbane; Boolarong Publications, 1993

Hawker, R. "For the Good of the Patient," in Maggs, C. *Nursing History: A State of the Art,* Kent; Croom Helm Ltd., 1987, pp. 143-152

Henderson, M. *Infection Control. The British Medical Association Guide,* London; Edward Arnold, 1989

Hyslop, A. "Old Ways, New Means: Fighting Spanish Influenza in Australia, 1918 - 1919," in Bryder, L. and Dow, D.A. *New Countries and Old Medicine. Proceedings of an International Conference on the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society, 1995, pp. 54-60

Kingston, B. *My Wife, My Daughter and Poor Mary Anne. Women and Work in Australia,* Melbourne; Thomas Nelson (Australia) Ltd, 1975

Lamour, C. "Women's Wages and the WEB," in Curthoys, A., Eade, S., Spearritt, P. *Women at Work,* Canberra; Australian Society for the Study of Labour History, 1975, pp. 47-58

Lawlor, J. *Nursing, Somology and the Problem of the Body,* Melbourne; Churchill Livingstone, 1991

Maggs, C.J. *The Origins of General Nursing,* London; Croom Helm Ltd., 1983

Nursing History: The State of the Art, Kent; Croom Helm Ltd., 1987

McDonald, L. *A History of City and District,* St Lucia; University of Queensland Press, 1981

A Ministry of Caring. A History of St. Andrew's Presbyterian Welfare Administrative Board 1952 - 1992, Rockhampton; St. Andrew's Presbyterian Welfare Administrative Board, 1992

McDougall, M. and Stevenson, A. "The Interdependence of Nurse Training and Nursing Service," in Bryder, L. and Dow, D.A. (eds) *New Countries and Old Medicine. Proceedings of an International Conference on the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society, 1995, pp. 285-290

McPherson, K *Bedside Matters. The Transformation of Canadian Nursing 1900 - 1990,* Toronto; Oxford University Press, 1996

Melosh, B. — *The Physician's Hand. Work, Culture and Conflict in American Nursing,* Philadelphia; Temple University Press, 1982

Murray, J.C. — "Thomas Fiaschi and Listerian Antisepsis in Sydney, 1880 - 1900," in Attwood, H., Gillespie, R., Lewis, M. *New Perspectives on the History of Medicine,* Melbourne; Australian Society for the History of Medicine, University of Melbourne, 1990, pp. 27-34

Oakley, A. — *Essays on Women, Medicine and Health,* Edinburgh; Edinburgh University Press, 1983

Paterson, R.A. — "Some Aspects of Polio myelitis in Queensland," in Thearle, J.M. (ed) *People, Places and Pestilence. Vignettes of Queensland Medical Past,* Brisbane; Department of Child Health, University of Queensland, 1986, pp. 91-99

Patmore, G. — *Australian Labour History,* Melbourne; Longman Cheshire Pty. Ltd., 1991

Patrick, R. — *A History of Health and Medicine in Queensland 1824 - 1960,* St. Lucia; University of Queensland Press, 1987

Rosenzweig, M.R. — *Physiological Psychology,* Lexington; D.C. Health and Co., 1982

Russell, L. — *From Nightingale to Now. Nurse Education in Australia,* Sydney; W.B. Saunders/Bailliere Tindall, 1990

Ryan, E. and Conlon, A — *Gentle Invaders. Australian Women at Work,* Ringwood; Penguin Books Australia Ltd., 1975

Schultz, B. — *A Tapestry of Service. The Evolution of Nursing in Australia Vol. 1, Foundation to Federation 1788 - 1900,* South Melbourne; Churchill Livingstone, 1991

Seldon, A. and Pappworth, J. — *By Word of Mouth, Elite Oral History,* London; Methuan and Co., 1983

Smith, L. — "The Influence of Tradition in Nursing," *Nursing Times,* April 28, 1982, pp. 45-48

Strachan, G. — *Labour of Love. The History of the Nurses' Association in Queensland 1860 - 1950,* St. Leonards; Allen and Unwin Pty. Ltd., 1996

"Sacred Office, Trade or profession? The Dilemma of Nurses' Involvement in Industrial Activities in Queensland, 1900 - 1950," in Frances, R., Scates, B. *Women, Work and the Labour Movement in Australia and Aotearoa/New Zealand,* Sydney; Australian Society for the Study of Labour History, 1991, pp. 147-171

Thompson, P. — *The Voice of the Past. Oral History,* Oxford; Oxford University Press, 1988

Tosh, J. — *The Pursuit of History, 2nd Edition,* Essex; Longman Group UK Ltd., 1991

Trembath, R. and Hellier, D. — *All Care and Responsibility. A History of Nursing in Victoria 1850 - 1934,* Victoria; The Florence Nightingale Committee Australia, Victoria Branch, 1987

Waddington, I. — "General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict," in Woodward, J. and Richards, D. (eds) *Health Care and Popular Medicine in Nineteenth Century England. Essays in the Social History of Medicine,* London; Croom Helm Ltd., 1977

Weir, R.I. — "The Lecture Notes of Two Pupil Nurses of the Preliminary Training School at Glasgow Royal Infirmary," *International History of Nursing Journal,* Vol. 1, No. 4, Summer 1996, pp. 49-60

Wright, A. — "Jessie Street, Feminist," in Curthoys, A., Eade, S., Spearritt, P. *Women at Work,* Canberra; Australian Society for the Study of Labour History, 1975, pp. 59-68

Wright-St.Clair, R.E. — "Hospital Reform: Hot Topic in the 1920s," in Bryder, L. and Dow, D.A. *New Countries and Old Medicine. Proceedings of an International Conference of the History of Medicine and Health,* Auckland; The Auckland Medical Historical Society, 1995, pp. 236-241

Youngson, A.J. — *The Scientific Revolution in Victorian Medicine,* London; Croom Helm Ltd., 1979

Journals

Barber, J.A. — "A Gentle Hand on the Tiller? Nurses' Lives of the 1930s, *Second National Nursing History Conference, Beyond the Black Stump,* 1995, pp. 1-9

Bashford, A. — "Female Bodies at Work: Gender and the Re-forming of Colonial Hospitals," in Walker, D., Garton, S., Horne, J. (eds) "Bodies," *Australian Cultural History,* Vol. 13, 1994, pp. 65-81

Benner, P. — "How Expert Nurses Use Intuition," *American Journal of Nursing,* January, 1987, pp. 23-31

"From Novice to Expert," *American Journal of Nursing,* March, 1982, pp. 402-407

Bessant, J. — "Good Women and Good Nurses. Conflicting Identities in the Victorian Nurses' Strikes 1985 - 86," *Labour History,* Vol. 63, November, 1992, pp. 155-173

Bridges, J.M. "Literature Review on the Images of the Nurse and Nursing in the Media," *Journal of Advanced Nursing,* Vol. 15, 1990, pp. 850-854

Cowden, V. "Historiography and Oral History: A Plea for Reconciliation," *Oral History Association of Australia Journal,* Vol. 5, 1982-83, pp.35-40

Cushing, A. "Nursing History in Australia," *International History of Nursing Journal,* Vol. 1, No. 1, Summer, 1995. pp. 69-70

DeVries, S. "Nursing History: Hope for the Present," *Central Queensland Journal of Regional Development,* Vol. 3, No. 3, 1995, pp. 31-34

English, I. "Intuition as a Function of the Expert Nurse: a Critique of Benner's Novice to Expert Model, *Journal of Advanced Nursing,* Vol. 18, 1993, pp. 387-393

Fletcher, L. "We Were Proud to be Nurses: The Socialisation of Women as Student Nurses 1946 - 1961," *International History of Nursing Journal,* Vol. 2, No. 3, Spring, 1997, pp. 40-53

Geary, M.C. and Geary, P.J. "Nursing and Hospitals: Sacred Pasture or Corral?" *Holistic Nursing Practice,* Vol. 1, No. 1, November, 1986, pp. 73-80

Gillespie, J. "Medical Matters and Australian Medical Politics, 1920 - 1945," *Labour History,* 54, May, 1988, pp. 30-46

Goddard, J. "Jessie Street and the Formation of the New South Wales Nurses' Association," *The Lamp,* July 1989, pp. 14-17

Godden, J., Curry, G., Delacour, S. "The Decline of Myths and Myopia? The Use and Abuse of Nursing History," *The Australian Journal of Advanced Nursing,* Vol. 10, No. 2, December 1992 - February 1993, pp. 27-34

Johnson, P. "Gender, Class and Work: The Council of Action for Equal Pay and the Equal Pay Campaign in Australia during World War Two," *Labour History,* Vol. 50, May 1986, pp.132-146

Herrmann, E.K. "Turn of the Century Hypodermic Therapy," *Western Journal of Nursing Research,* Vol. 16, No. 3, June, 1994, pp. 333-334

Hezel, L. R. and Linebach, L. M. "The Development of a Regional Nursing Collection: Its Relevance to Practice, Education, and Research," *Nursing Outlook,* Vol. 39, No. 6, November-December, 1991, pp. 268-272

Hughes, L. "Professionalising Domesticity: A Synthesis of Selected Nursing Historiography, *Advances in Nursing Science,* Vol. 12, No. 4, July 1990, pp. 25-31

Jamieson, R. "Rewards and Frustrations in Oral History," *Oral History Association of Australia Journal,* Vol. 4, 1981-82, pp. 69-73

Keneley, M "Handmaidens of Medicine: Working Conditions for Nurses in Late Nineteenth Century Victoria," *Journal of Australian Studies,* May 22, 1988, pp. 57-68

Maggs, C. "A History of Nursing: A History of Caring?" *Journal of Advanced Nursing,* 23, 1996, pp. 630-635

McIllveen, K.H. and Morse, J.M. "The Role of Comfort in Nursing Care: 1900 - 1980," *Clinical Nursing Research,* Vol. 4, No. 2, May 1995, pp. 127-148

Nicks, R. "Revolution in Australian Surgery, 1914 - 1994," *The Medical Journal of Australia,* Vol. 161, July 4, 1994, pp. 8-15

Olson, T.C. "Laying Claim to Caring: Nursing and the Language of Training, 1915 - 1937," *Nursing Outlook,* Vol. 41, No. 2, pp. 68-72

"Recreating Past Separations and the Employment Pattern of Nurses, 1900 - 1940," *Nursing Outlook,* Vol. 43, No. 5, pp. 210-214

Parker, L "From Pestilence to Asepsis," *Nursing Times,* Vol. 86, No. 46, December 5, 1990, pp. 63-67

Reverby, S. "A Caring Dilemma: Womanhood and Nursing in Historical Perspective," *Nursing Research,* Vol. 36, No. 1, January-February, 1987, pp. 5-11

Sadler, C. "Dirt in Hospitals. Soap Opera," *Nursing Times,* Vol. 86, No. 24, June 13, 1990, pp. 29-31

Sarnechy, M.T. "Historiography: A Legitimate Research Methodology for Nursing," *Advances in Nursing Science,* July 1990, pp. 1-10

Schulz, B. "All the Way," *Australian Nurses' Journal,* Vol. 4, No.4, October, 1974, pp. 10-35

Theses

DeVries, S. Bold Nurses. A Study of the Public Inquiry held at the Rockhampton Hospital, 1930, Honours Thesis, Central Queensland University, 1989

Harper, H. These Nightingales use Hurricane Lamps: Discourses of Nursing During World War II in Australia. Honours Thesis, University of Queensland, 1994

Appendix A

The Nightingale Pledge[1]

I solemnly pledge myself before God and this assembly to pass my life in Purity and to Practice my Profession faithfully.

I will abstain from whatever is deleterious or mischevious or will not take or knowingly administer any harmful drug.

I will do all in my power to elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling.

With Loyalty will I endeavour to aid the Physician in his work and devote myself to the welfare of those committed to my care.

[1] Matron Green, General Nursing Lecture Notes, 1935.

Appendix B

Profiles of the Former Nurses Interviewed for this Project

The following information provides a brief profile of the women who were kind enough to be interviewed for this research.

K. Austin: Began training at the Rockhampton Hospital in 1948, and completed her training at the Mater Hospital in 1952. After completing her midwifery certificate, Ms Austin married and had eight children.

M. Baggett: Began training at the Rockhampton Hospital in 1944, completing her training in 1948. After completing her midwifery certificate, Ms Baggett married and had two children. She worked as a Registered Nurse for many years before retiring.

B. Cagney: Began training at the Rockhampton Hospital in 1950, completing her training in 1954. After completing her midwifery, Ms Cagney worked consistently as a Registered Nurse until she retired.

M. Chambers: Began training at the Rockhampton Hospital in 1926, completing her training in 1930. After completing her midwifery certificate, Ms Chambers worked consistently as a Registered Nurse until she retired.

R. Dalrymple: Began training at the Rockhampton Hospital in 1941, completing her training in 1944. Ms Dalrymple completed certificates in midwifery, child welfare and a course in midwifery tutored planning from the College of Nursing, She worked consistently as a Registered Nurse until she retired.

I. Dennison: Began training at the Rockhampton Hospital in 1940, completing her training in 1943. After completing her certificate in midwifery, Ms Dennison worked consistently as a Registered Nurse until she retired.

G. Elliott: Began training at Blackhall Hospital in 1931, completing her training in 1936. After completing her midwifery certificate, Ms Elliott worked in a number of institutions, including a short period of time as a staff nurse at the Rockhampton Hospital before taking a permanent position at the Lady Goodwin. Ms Elliott undertook the position of acting Matron from 1947.

J. Kidd: Began training at the Rockhampton Hospital in 1944, completing her training in 1947. After completing her midwifery and child welfare certificates, Ms Kidd married and had two children. Ms Kidd worked consistently as a Registered Nurse until she retired.

L. Lowry: Began training at the Rockhampton Hospital in 1948, completing her training at the Mater Hospital in 1952. After gaining her midwifery certificate, Ms Lowry married and had three children. After a break, Ms Lowry returned to work as a Registered Nurse until she retired.

V. Manly: Began training at the Rockhampton Hospital in 1943. Ms Manly completed three years of her training before marrying and having two children.

N. McKenzie: Began training at the Rockhampton Hospital in 1926, completing her training in 1930. Ms McKenzie worked briefly as a Registered Nurse before marrying and having four children.

D. Ross: Ms Ross worked as a VAD during the war. She commenced her nursing training at the Rockhampton Hospital in 1947, completing her training in 1951. After gaining her midwifery and child welfare certificates, Ms Ross worked consistently as a Registered Nurse until she retired.

A. Smith: Began training at the Rockhampton Hospital in 1937, completing her training in

1944. After gaining her midwifery certificate, Ms Smith worked consistently as a Registered Nurse until she retired.

B. West: Began training in 1944, but had to interrupt training after nine months. Recommenced in 1947 at the Rockhampton Hospital, completing her training in 1951. Ms West married and had three children. After a break away from nursing, Ms West returned and worked as a Registered Nurse until she retired.

N. Windsor: Began training at the Rockhampton Hospital in 1941, completing her training in 1944. After gaining her midwifery and child welfare certificates, Ms Windsor married and had three children. After a

break from nursing, Ms Windsor worked as a Registered Nurse until she retired.

Appendix C

ROCKHAMPTON BASE HOSPITAL NURSING

ORAL HISTORY RELEASE FORM

I, ...,grant permission to .....

working on behalf of the Central Queensland University, to tape record an interview with myself and agree subject, to my ongoing involvement, that:

1. I will have the opportunity to comment on and edit the transcript, on request.
2. The tape and transcript of the interview can be placed in the Capricornia Collection of the Central Queensland University. A copy of the tape and transcript can be placed in the Nursing Museum at the Rockhampton Base Hospital.
3. Copyright in the recording, transcript and any other material in connection with the interview is assigned to the Capricornia Collection.
4. The tape and transcript can be copied and edited by staff of the Central Queensland University.
5. The Capricornia Collection can allow bona fide researchers access to material in a responsible manner.
6. On this basis, material from the interview can be published in a book, article or other format, with acknowledgement of the source.
7. I agree the transcript may be used as part of a research thesis subject to the following conditions:
    1. no conditions.
    2. confidentiality be preserved. I wish to remain anonymous and will be for the purposes of this and any subsequent research, referred to under an agreed pseudonym only in the text and in the accompanying footnotes and references.
    3. other conditions.

.....

.....

Release date.....

Signed.....

Date.....

Central Queensland
UNIVERSITY

LIBRARY DECLARATION

(This declaration shall be appended to the first of the requisite copies of the thesis submitted for examination to the Research Services Office, Central Queensland University, Rockhampton, Queensland, 4702).

Author: Wendy Madsen *Degree:* Master of Health Science

Title of Thesis: Nursing, Nurses and Their work in Rockhampton, 1930-1950.

I acknowledge that, following successful examination, the first copy of the thesis described above, shall be deposited in the University Library and made available in accordance with the University's regulations governing the submission and examination of research higher degree theses.

☑ *I agree that the thesis shall be made freely available for the purpose of research or private study.

OR

☐ *I request that access to the thesis, or parts thereof, be restricted for a specified period, and that release of the thesis during that period for the purpose of research or private study be contingent upon the approval of the Director of the Division of Library, Information and Media Services (or nominee). I understand, in those cases where I am not reasonably available, such approval may be granted without my having been consulted.
(An author electing this option must complete the reverse side of this declaration).

* Tick the elected option.

Signature Redacted

SIGNATURE (AUTHOR)

23.12.97
DATE

REQUEST TO RESTRICT ACCESS TO HIGHER DEGREE THESIS

(I) INDICATE THE REASON(S) FOR SEEKING TO RESTRICT ACCESS TO THE THESIS OR PARTS THEREOF.
(Sufficient details should be provided in order that a decision may be made in the author's absence).

(II) IS IT INTENDED TO RESTRICT ACCESS TO THE WHOLE THESIS? YES/NO
Where the restriction is intended to apply to parts of the thesis, please nominate the relevant section. (If practicable, such sections should form a separate confidential appendix).

(III) NOMINATE THE DESIRED PERIOD OF RESTRICTED ACCESS
(Restricted access shall normally be granted for a period of twelve months. Any extension beyond that period shall be at the discretion of the Research Higher Degrees Committee).

SIGNATURE (AUTHOR) DATE

(IV) APPROVAL TO RESTRICT ACCESS TO HIGHER DEGREE THESIS
Permission is hereby granted to restrict access to the thesis or parts thereof, as detailed above, for a period of .....

SIGNATURE (CHAIR, RHD COMMITTEE) DATE

RHDFORMS2/RHD44