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COLONIAL CARING

A history of colonial and post-colonial nursing

Edited by
Helen Sweet and Sue Hawkins

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Colonial caring

MANCHESTER 1824
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Manchester University Press

Published by Manchester University Press
Altrincham Street, Manchester M1 7JA
www.manchesteruniversitypress.co.uk

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data applied for

ISBN 978 0 7190 9970 0 hardback

First published 2015

Typeset by Out of House Publishing

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Liesbeth Hesselink After graduating in History, Liesbeth Hesselink worked as a teacher in secondary schools and then as a civil servant, first for the Dutch Ministry of Education and later for the municipality of Leiden. She also represented the Dutch Labour Party as a member of the board of Councillors for the municipality of Leiden for eight years. After retirement, she attained her doctorate in 2009 with her thesis entitled *Genezers op de koloniale markt, inheemse dokters en vroedvrouwen in Nederlands Oost-Indië 1850–1915* (Amsterdam: Amsterdam University Press, 2009), translated into English as *Healers on the Colonial Market: Native Doctors and Midwives in the Dutch East Indies* (Leiden: KITLV Press, 2011).

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Acknowledgements

Colonial Caring: A History of Colonial and Post-colonial Nursing emerged from a history of nursing colloquium hosted at the Modern History Faculty of the University of Oxford and co-organised by the Oxford Wellcome Unit for the History of Medicine and the UK Association for the History of Nursing conference committee. Our sincere thanks go to both organisations as well as to those who attended the colloquium, contributing ideas and enthusiasm for this book. We are especially grateful to Professor Mark Harrison, who gave this event his departmental and personal support, and to Belinda Michaelides, who oversaw so much of the administrative work.

We would also like to acknowledge a number of people without whom this book would not have been possible: first and foremost, our gratitude to the nurses about whom this is written, some of whom have contributed through memoirs, letters, oral histories or photographic records. We would also like to thank Emma Brennan and the team at Manchester University Press and our anonymous reviewers, for support, helpful advice and perceptive comments throughout the publication process.

Enormous thanks are also due to all the contributors, who have given their wholehearted backing to this project and made this book what it is – we hope they all feel the hard work was worthwhile now the book is finished.

Finally, numerous friends and relations at home and work have been extremely supportive – especially our husbands and immediate families – and we should both like to thank them for their encouragement and moral support, especially as deadlines approached!

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Introduction: contextualising colonial and post-colonial nursing

Helen Sweet and Sue Hawkins

Nursing history has until recently been an insular analysis whose central theme was most often professionalisation within national borders, and although a more international perspective has been emerging over the past five to ten years there is still a big gap in its literature when examining the role nurses and nursing played in a country's colonial and post-colonial past and the impact that experience of this particular form of nursing had on the wider development of nursing.[1] This omission has already been addressed in the closely related field of history of medicine through a number of publications over a long period of time,[2] and this book aims to help correct the balance for nursing's history.

The history of nursing presents a unique perspective from which to interrogate colonialism and post-colonialism, which includes aspects of race and cultural difference, as well as class and gender. Simultaneously, viewing nursing's development under colonial and post-colonial rule can reveal the different faces of what, on the surface, may appear to be a profession that is consistent and coherent yet in reality presents different facets and is constantly in the process of reinventing itself. Considering such areas as transnational relationships, class, gender, race and politics, this book aims to present current work in progress within this field to better understand the complex entanglements in the development of nursing as it was imagined and practised in local imperial, colonial and post-colonial contexts. In addition, taking the more global view of nursing's history not only offers new insights into what is particular and what is more universal about nursing's uptake and development in different countries, but also enables us to explore different methodological approaches

to the subject, as has already been the case with the fast-developing field of 'medical humanities' for some time. This multifaceted view of colonial and post-colonial nursing, therefore, brings together contributions from scholars working in different disciplines and from a variety of perspectives, geographical, historiographical and, to some extent, methodological, among others. Anne Marie Rafferty provides us with one example of this, noting: '[the archives of the CNA] expose the complexity of the British nurses' positions in the specific colonies, factors that motivated them to apply for overseas posts, the range of their attitudes to their colonial experiences, perceptions of their place in the imperial mission and the eventual decline in their status and the effects on the nursing profession.'[3] In the chapters that follow we hope to go a step further by looking at some of these aspects of nurses and nursing viewed in a number of colonial and post-colonial settings.

Whilst we have taken pains to select chapters that incorporate nursing provided by colonial powers across Western Europe and the USA to make this as globally representative as possible, we are well aware that in the ten chapters that follow we can only touch the surface of the story. By the end of the First World War, and despite the Western nations' 'Scramble for Africa'[4] the British Empire still covered about one quarter of the Earth's total land area and ruled a population in excess of 500 million people. The composition of this book reflects that reality.[5]

This introductory chapter provides an overview of the book's focus, structure and remit. It explains what the book sets out to accomplish and its overall structure. Here we highlight the commonalities as well as the differences between the experiences of colonial nurses as they will be presented in the coming chapters. Drawing from our own experience in researching and writing gender and racial social histories and in colonial and post-colonial nursing history respectively, our aim here is to tease out the emerging themes and place these within a clear chronological and historiographical framework. Further, we will examine how this field has developed in the history of medicine and identify questions which the current state of research still leaves unanswered, but which nursing's history is uniquely placed to answer. In particular we will be expanding upon the underlying racial and cultural tensions which existed, or perhaps did not exist, between nurses and their patients; nurses and the doctors they worked alongside; and

colonial nurses and their indigenous counterparts. This chapter asks whether the subject has not been hitherto grossly oversimplified by projecting a single image of imperial collaboration/co-operation onto all forms of colonial nursing by all countries across a long time span. In so doing, we not only hope to enhance the understanding of nursing's history over a more global scale but also to provide historical context to explain some of the problems that have faced the profession in the post-colonial era.

Structure and content

The book can be divided roughly into three sections, based on chronology: the mid-to late Victorian period, the early twentieth century and the mid-twentieth century. The first three chapters focus on the colonial experiences of British nurses between 1857 and 1902; and perhaps inevitably, as Britain becomes entangled in conflicts related to challenges to its Empire, two chapters examine the role and duties of British nurses working in conjunction with the military. They explore nursing and nurses during the Indian Mutiny of 1853 and in southern Africa during the bloody Anglo-Boer war of 1899–1902. A third chapter in this group focuses on Hong Kong and the British response to a threat of a different kind – the emergence and subsequent rampage of plague through China and beyond at the end of the century. The authors offer a number of observations, including women's reasons for volunteering to work in such challenging environments, far from home, and the personal as well as professional challenges they faced. Recruitment and the professionalisation of nursing, and of military nursing in particular, are therefore considered here, particularly focusing on themes of class and gender.

Moving into the twentieth century the next four chapters begin to examine the embedding of Western-style nursing culture into indigenous cultures. These chapters widen our scope beyond the British Empire to include not only Australia and New Zealand, but also the Dutch East Indies and the American colonies of Puerto Rico and the Philippines. Issues such as racism and clashes of culture now come to the fore. The tensions between colonial nurses and their 'Western' culture of medicine and the traditional practices of indigenous trainees

and their patients are examined, as are issues of race and ethnicity associated with segregation and 'protection'. The discussions are then taken further into the twentieth century for the final third of the book, reflecting upon Italian colonialism in Ethiopia, guerrilla nursing in China by British and American nurses and Irish Catholic missionary doctors and nurses working in colonial and post-colonial Nigeria. In these chapters, religion and humanitarianism – as well as nursing in the face of stark inhumanity – become part of the equation, whilst relationships between colonised and colonisers is explored further, delving into the immediate post-colonial phases, again bringing race, cultural differences and gender back into the discussion. These chapters also introduce pioneering methodologies relatively new to the study of nursing history, including quantitative analysis of collective biographies.

Colonialism applied to nursing's history

In *Medicine and Colonial Identity*, Mary Sutphen and Bridie Andrews described the challenge of trying to understand and study colonialism because the 'crass lumping of colonial subjects by an imperial power and the local subjectivity of individuals are two ends of the spectrum of perceived identity'.[6] They identify the problem of writing history whilst doing 'justice to more than a couple of strands of identity',[7] for example region and class, gender and religion, as categories of historical analysis. They found instead that the history of medicine allowed this juxtaposition whilst avoiding the pitfalls of grand historical narrative. This perhaps applies to an even greater extent to nursing history, where we encounter clashes of gender, class, race and culture within a variety of geographical settings and yet where the broad brush of nurses' and nursing's identities may be more easily separated from those of the individual practitioners. Yet to what extent did nurses embody and present the imperial identity, and how did this vary according to time and place, group collective and individual nurses?

We are interpreting colonialism throughout this book in its broadest sense. It is a concept that may be taken to cover the European project of political domination that began in the sixteenth

century and ran through to the twentieth century, culminating with the national liberation movements of the 1960s. As it can be construed as covering such a long period of time, colonialism has been divided into several, somewhat arbitrary phases, and *Colonial Caring* will focus on the later phase, commonly recognised as 'the modern European colonial project' or 'period of New Imperialism'. According to Margaret Kohn, this phase was born of and sustained by the developments in transport and communications in the nineteenth century, through which 'it became possible to move large numbers of people across the ocean and to maintain political sovereignty in spite of geographical dispersion'.[8] Post-colonialism will be used here to describe the period in which political and theoretical struggles of previously colonised societies broached their transition from political, military and economic dependence to independent sovereignty.[9]

Medicine's and, by association, nursing's role in this later colonial process may be seen as part of an attempt by the colonisers to justify the harsher sides of imperialism. These attempts at justification were taking place at the same time that political and religious thinkers were trying to reconcile post-Enlightenment views on the equality of man, justice and 'Natural Law', with heightened levels of imperialism throughout Europe and America which had resulted in colonisation of large parts of Africa, Asia and the Caribbean. Simultaneously, Western medicine and nursing were undergoing rapid and revolutionary developments in techniques and technology, together with a more scientific understanding of disease, hygiene and sanitation. The introduction of nursing and medical knowledge and 'improvements' in public health in the colonies might therefore be presented as part of a 'civilising mission' and therefore offer a more benevolent and positive – almost innocuous – contribution to the colonised countries. Initially the medical aspect of missions and of colonial infrastructure was aimed primarily at the white 'European' missionaries, colonial administrators, traders and military personnel rather than altruistically providing 'improved' healthcare for the indigenous population of the colonies. However, colonisation had a negative impact on indigenous populations' traditional lifestyles, forcing urbanisation and migrant working and leading to often disastrous effects on what Howard Phillips refers to as 'pathogenic innocence'.[10] The colonial

response to disease outbreaks among the indigenous population was to introduce preventive measures such as segregated housing and vaccination so that, as Phillips says, 'it would not be far off the mark to suggest that the spread of biomedicine in the 19th century was led by the tip of a vaccinating lancet'.[11] In this view, the medical colonist is a key contributor to the civilising mission and is coming to the rescue of indigenous populations, but paradoxically rescuing them from situations their colonising actions have caused.

On the other hand, medical colonialism may also be perceived from a more Foucauldian perspective,[12] with doctors and nurses representing more sinister 'agents of empire'. Such activities might be overt, for example in imposing religion, language, education and a hierarchical power structure for healthcare provision or in collecting and feeding statistical information to government; or more covert, for example in gradually imposing one set of cultural standards whilst undermining another. Foucault argued that, with urbanisation the body had become increasingly a politicised object not only for the exercise of effective military force and maintenance of civil order but for the 'disposition of society as a milieu of physical well-being, health and optimal longevity' with hospitals (and nursing by association) at the core of this.[13] In addition, it was frequently the case that colonisers inadvertently introduced diseases such as tuberculosis, measles and venereal diseases which challenged 'pathogenic innocence' and decimated the indigenous population. Sheldon Watts argues that, not only did Western medicine fail to cure the diseases that its own expansion engendered, but it effectively became an agent and tool of empire.[14] Sheryl Nestel takes this argument further, claiming that, 'The motivations for colonial nurses were many, however, and all were deeply entangled in the politics of class, race and gender.'[15] Africa and Africans were repeatedly portrayed as 'dirty', lacking in hygiene and devoid of well-ordered domesticity, all accusations, according to Anne McClintock, used to legitimise 'the imperialist violent enforcement of their [own] cultural and economic values'.[16] Such lack of concern for hygiene and undomesticated behaviour paved the way for European nurses to enter the arena in their pristine uniforms, wielding bottles of carbolic. And such imperatives are not restricted to the African continent; across the British Empire armies of nurses were proselytising the 'new' ideals of nursing and sanitary reform.[17] Who

better than they to deal with such an affront to civilised society? As Nestel continued:

> Proffering middle-class hygienics against the 'dirt' of Africa, modesty in contrast to discourses of unrestrained African female sexuality, and the beacon of a Christian medical science in the dark face of African disease and superstition, the European nurse in the first half of this century was positioned squarely at the nexus of race, class and gender politics in the arena of empire.[18]

Missionary nurses unsurprisingly occupy a considerable proportion of this book as it was often the missions that first introduced and provided Western biomedical healthcare to the indigenous populations of colonies, establishing small clinics and later hospitals and nurse-training, just as they 'insinuated new forms of individualism, new regimes of value, new kinds of wealth, new means and relations of production, new religious practices and set in train processes of class formation'.[19] Yet it should be noted that the missionaries working in many of the colonies were not necessarily from, nor answerable to the colonial country – for example, medical missions working in South Africa came not only from the UK and Holland but also from Germany, Norway, Sweden, Switzerland and the USA.

Additionally, there were clearly times, particularly but not exclusively in the case of missionary nursing, where the imperial ethos conflicted with the personal and professional nursing ethos. Winifred Connerton, in her chapter on American colonial and missionary nurses in Puerto Rico, demonstrates this well, with reference to the agenda of the Protestant missionary nurses for replacing Catholicism being one that was in conflict with the American ideological goal of secularisation.[20]

Hilary Marland argues that 'comparing the reform of midwifery in a "home" or "overseas" context, offers a means of exploring the idea that not only charity, but also missionary enterprise, begins at home'.[21] The language of reform when comparing the struggle experienced in the home country in seeking to supply basic trained midwifery to the poorer parts of the Netherlands in the mid-nineteenth century, and later to the Dutch East Indies, was found to be almost interchangeably one of 'missionary endeavour'. The Dutch missionary nursing and midwifery challenge is explored in greater depth in Chapter 7 by Liesbeth Hesselink, and reveals a perhaps less than enthusiastic

response to the call for help from the colonies. However, we find throughout this book that missionary zeal cannot be established as the rule for all colonial nurses, especially in the later colonial and immediate post-colonial periods and we also often find that nursing, alongside scientific medicine, not only helped to shape colonialism but was also shaped by it.

In their keynote lecture given at the nursing history colloquium 'Colonial and Post-Colonial Nursing' which initiated the publication of this volume, Anne Marie Rafferty and Rosemary Wall described how nurses were 'expected not only to "embody" empire insofar as they were often expected to accept responsibility for its safety but to manage their own bodies as well as those of fellow colonists, patients and the social and physical boundaries between them'.[22] They described how nurses laboured with their bodies often under extreme, tropical or semi-tropical conditions, whilst being subject to 'regimes of regulation in terms not only of deportment and comportment but through prescriptions regarding personal, mental and moral practices of hygiene'. This theme is also taken up within the chapters contributed by Charlotte Dale, writing about nurses in southern Africa during the second Boer War, and Liesbeth Hesselink's discussion of Dutch colonial nursing in the East Indies. Foucault has argued that sanitation and medicine provide the means and mechanism to control and contain the body both morally and materially, giving it multiple meanings for the doctor, nurse and patient through their interaction with each other.[23] Rafferty and Wall argue 'the management of protocols of protection and prevention' brought colonial nursing and medicine to the centre of constructive imperialism through their 'civilising mission'.[24]

Sam Goodman takes up this argument in the opening chapter when looking at the literature of diaries and memoirs by women who lived through the 'Indian Mutiny', facing the challenges of caring for their sick and wounded whilst under siege.[25] These women were not trained nurses, they were the leisured wives and daughters of colonial men, in peacetime supporting them in their colonial enterprise and in times of conflict called upon out of necessity to undertake a very different role. Yet also, following the Victorian fashion for keeping journals or diaries, they recorded their experiences in detail. Goodman argues that the Indian Mutiny diary functions as both a vital record of women's voices in the history of British colonial experience and a unique example of a

nineteenth-century practitioner narrative told from a female perspective. Angharad Fletcher and Charlotte Dale continue this examination of early nursing during situations of crisis in Chapters 2 and 3. Using the British response to a plague epidemic which originated in China and came to global attention when it hit Hong Kong in 1894, Fletcher takes a long-term view (1880–1914) and a comparative approach, arguing that although nursing practice might originate at the centre it was constituted on the peripheries of the Empire. Thus colonial nursing engendered a complex network of nursing ideas which was fuelled and expanded by the mass migration of nurses from various locations within the Empire. Fletcher argues that by using crises, such as a major disease outbreak, as a prism through which to examine historical questions, invisible or overlooked processes can be revealed. Dale also uses a crisis, in her case the Second Anglo-Boer War (1899–1902), to question the motivation, control and organisation of military nursing at the end of the nineteenth century. Her study reveals a crisis within military nursing, performed at the time by a mix of trained and lay nurses, as the army struggled to meet the demand for professional nursing in the first major conflict to involve nurses in large numbers since the Crimea. The young women it recruited came with a mix of motivations and desires, some with aspirations to improve their professional standing, some with a desire for adventure, but most reflecting the changing attitudes in English society towards women in the public sphere, which were becoming unavoidable back home.[26] This internal crisis in military nursing, highlighted by the crisis of war, resulted in the establishment of the professionalised Queen Alexandra's Imperial Military Nursing Service in 1902.[27]

Gender and class are both central to this discussion in which the behaviour, expectations and experiences of these women emerge from their diaries and letters. Professionalisation was also a factor, from the early twentieth century onwards, in providing nurses with the opportunities to practise with greater autonomy, experiencing challenges not available to them at home. Nestel quotes a British colonial nurse, Bridget Robertson as remarking: 'Doctors and nurses often … worked together on equal partnership to a very much greater degree … than they did in the United Kingdom … the sister acted as the doctor's "right hand man" frequently deputising for him when he went on safari or local leave.'[28] This was even more the case with

missionary nurses, many of whom founded and ran small rural hospitals and clinics with only occasional medical support through much of the first half of the twentieth century.[29] Echoing Fletcher's argument about the balance between the centre and the peripheries of Empire, Nestel argues that as a result of the thin-spreading of medical staff in the outposts, 'class and gender boundaries between doctor and nurse became increasingly blurred in the colonial climate'.[30]

With Chapters 4 and 5 the book's focus moves from the colonial military nursing experience to civil nursing in Australasia, considering two quite different scenarios. In the first, Linda Bryder considers the New Zealand 'Native Health Nursing Scheme', an assimilation policy by the colonial government introduced in 1911, and the experiences of the nurses who worked under it. In that the origins of the government scheme can be traced back to initiatives taken by a group of young male Māori campaigning for Māori welfare in the late nineteenth century, the discussion has resonances with Siphamandla Zondi's PhD research findings on Western medicine in South Africa.[31] In that work, Zondi demonstrated that rather than colonialists imposing biomedicine on defenceless Africans, it was more commonly the discerning African chiefs who selectively adopted it, whilst at the same time retaining traditional practitioners and thereby increasing their pluralistic medical choice. Drawing on a rich source, a local nursing journal, Bryder is able to interrogate the experiences of these nurses and gain insight into their cultural interactions with Māori communities. In contrast, Odette Best describes the Australian system which ignored British policy and chose to recruit nurses either from overseas or from its white community. It specifically excluded the native Australian population, imposing Western biomedicine on the indigenous population whilst at the same time ignoring their own medical systems and knowledge. Her comments echo in places those of Susanne Parry, who argues that the continuing differential health problems of Aboriginal people in north Australia have their roots in a colonial path.[32] Both politics and race are therefore at the forefront in these two chapters and this theme is continued and added to by Winifred Connerton in her study of American colonial policy towards missionary nurses working in Puerto Rico. She highlights a growing professional confidence amongst these nurses in their political communications with the US government and the connection between the evangelical mission goals

and the colonial goals of the US government, particularly regarding the power of nursing training to 'improve' Puerto Rican society.

In Chapter 7, Liesbeth Hesselink moves our attention back to the Far East to consider the development of nursing by the Dutch in the Dutch East Indies. Hesselink echoes the ideas of 'embodying empire' discussed earlier, describing the adaptation needed to nurse in tropical climates and cultural shifts required by Dutch nurses to reconcile their training with the realities of the tropics. These tensions are symbolised as the move away from pure white sheets and night-clothes to plaited mats and sarongs, and perhaps most strikingly, the Javanese failure to perceive nursing as a career for their women. In this chapter Hesselink introduces the concept of the male nurse training alongside female nurses and explores the reasons for greater success rates; which are built on gendered hierarchies of responsibility. In early twentieth-century Indonesia, while nursing was promoted as a suitable occupation for both indigenous men and women, it was only the male nurses who were able to progress and to take up semi-autonomous or specialist roles which resulted from the same sort of phenomenon described by Nestel in rural Africa. In the Dutch East Indies the importance of recruiting local nurses was given extra impetus by the failure of the motherland to provide required numbers of European-trained white female nurses. As one local administrator bemoaned, 'How come that our neighbours can feel a sense of vocation to go to the colonies while the Dutch deaconesses cannot?'[33]

Hesselink also takes up issues of class, already discussed in the context of British colonial nursing, but encountered again in a Dutch colonial setting. She stresses the importance of attracting women 'of good birth' from the Netherlands to nurse in the Dutch colony, as only then will the occupation be legitimated among the young women (and men) from the higher echelons of Indonesian society. Race also raises its head in this chapter, as in several others, although it is absent from the chapter on the Second Boer War. In the Dutch East Indies, white, European nurses were the prerogative of the rich white settlers, while people lower down the hierarchy, both European and indigenous, were more likely to be cared for by Eurasian or Indonesian nurses. This situation appears rather more relaxed than that described by Shula Marks in South Africa, where African doctors and nurses were trained on the assumption that they would 'provide health care

primarily, or entirely, for the Black community in the African "locations" and rural areas'.[34]

Our focus finally moves to the end of the colonial period and its overlap with post-colonial history, firstly through an ongoing prosopographical research study of Italian Fascist colonialism in Ethiopia by Anna La Torre, Celeri Bellotti and Cecilia Sironi. Their study again indicates a gendered differential within nursing, with male military nurses and 'health soldiers' being the main protagonists during periods of conflict, contrasting with the work done by women from the higher social classes: 'Lady Nurses', together with Red Cross nurses and missionary sisters. In their chapter, the authors demonstrate the use of nurses and healthcare more generally, as part of the Fascists' propaganda machine whilst the nursing provided to the Ethiopians by the International Red Cross also became drawn into the counter-propaganda as the World Health Organisation became involved. This is strongly reminiscent of the work by Wall and Rafferty on Malaysia and the 'battle for hearts and minds' in which nurses and healthcare provision were at the centre of an ideological battle between capitalism and communism in the 1950s and again reminds us of our earlier discussion about nurses as agents of the state.[35] It also finds echoes in the work of Anja Peters on midwives under the Nazi regime in Germany and of Maria Eugenia Galiana-Sanchez and colleagues on nursing and health polices in Franco's Spain.[36] In both these situations nurses became fully integrated into the politics of the state, acting as emissaries and implementers of doctrine and collectors of statistics and information on their patients.

Anne Hardy and Tilli Tansy describe the post-colonial, post-Second World War situation as one in which: 'the West's determination to establish what it perceived as a better world order was paralleled, in many post-colonial countries, by a sense that Western aid was compensation for colonial rule. … Health improvements, it was thought, would logically follow on improved economic performance and rising living standards.'[37] As the final two chapters of this book demonstrate, the NGOs were left to focus on provision of emergency aid such as civil war disasters and famine relief, whilst the World Health Organisation (established in 1948 and replacing the earlier League of Nations in this role) was left to concentrate its efforts on controlling public health problems, particularly communicable diseases.

Staying with Africa, the book's move into post-colonial nursing history is taken up by Barbra Mann Wall's chapter about the changing face of Medical Missions in Nigeria, in which she analyses the shifting dynamics of medical missionary work in Nigeria from support for French Roman Catholicism and British colonialism to humanitarianism provided under extreme hardships. She explores Irish Catholic missionaries as sister nurses, midwives and physicians from the first of their hospitals in 1937 through 1970 and the end of the Nigerian Civil War. This takes us from the more familiar picture in which Catholic nursing sisters saw Africa as a fertile ground for converts, through to a more liberalised period which Wall claims complicates Vaughan's[38] one-dimensional notion of a compliant indigenous population to one of an overbearing Western presence.

The final chapter is an account of 'guerrilla nursing' with the Friends Ambulance Unit – a precursor to other international humanitarian agencies such as Médecins sans Frontières – at the time of the Chinese Civil War between Nationalists and Communists. In this, Susan Armstrong-Reid follows the experiences of two female nurses – one British and the other American – proposing a re-evaluation of post-colonial scholarship 'that views nurses as agents of a top-down, donor-driven, Western humanitarian diplomacy'.[39] In this chapter as with many that precede it, we see nurses as individuals working through personal as well as professional experiences, difficulties and dilemmas, not necessarily following the prescribed route laid down by the government or organisation which they are seen to represent.

It is also important to consider the impact of colonial nursing on the nurses themselves: as Armstrong-Reid reflects in her own chapter's conclusion, these nurses were themselves changed by their experiences.[40] In some cases, the environment in which they worked affected their health, whilst the politics and cultures in which they were immersed changed them both on a personal and on a professional basis.[41] At an earlier Oxford conference in 2001, 'Nursing Diasporas', this concept was discussed in a keynote paper by Catherine Burns, who stated that we should bear in mind the experiences of those not only going from one country to another, taking and imparting their knowledge out to the colonies, but we should look at their impact on those returning home, changed by their experiences.

Notes

1 See for example: P. D'Antonio, J. A. Fairman, J. C. Whelan (eds), *Routledge Handbook on the Global History of Nursing* (Abingdon and New York: Routledge, 2013); E. Fleischmann, S. Grypma, M. Marten and I. M. Okkenhaug (eds), *Transnational and Historical Perspectives on Global Health, Welfare and Humanitarianism* (Kristiansand: Portal Forlag, 2013).

2 See for example: R. MacLeod and M. Lewis (eds), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (Abingdon and New York: Routledge, 1988); D. Arnold (ed.), *Warm Climates and Western Medicine* (Amsterdam and New York: Rodopi, 1996); M. P. Sutphen and B. Andrews (eds), *Medicine and Colonial Identity* (London and New York: Routledge, 2003); M. Harrison, M. Jones and H. Sweet (eds), *From Western Medicine to Global Medicine: The Hospital beyond the West* (Hyderabad: Orient Blackswan, 2009); A. Digby, W. Ernst and P. B. Muhkarji (eds), *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective* (Newcastle upon Tyne: Cambridge Scholars Publishing, 2010); P. Chakrabarti, *Medicine and Empire 1600–1960* (London: Palgrave Macmillan, 2014).

3 A. M. Rafferty, 'The seductions of history and the nursing diaspora', *Health and History*, 7:2 (2005), 2–16.

4 In particular, France, Germany, Belgium and Portugal – for more detail on this see: T. Pakenham, *The Scramble for Africa* (London: Abacus, 1992) or P. Brendon, *The Decline and Fall of the British Empire 1781–1997* (London: Vintage, 2008).

5 Nevertheless, we recommend the work of others in this field, see for example the work by S. Malchau Dietz on Danish deaconesses in the West Indies, and I. M. Okkenhaug on Norwegian nurses in the Middle East.

6 Sutphen and Andrews, *Medicine and Colonial Identity*, pp. 4–5.

7 Sutphen and Andrews, *Medicine and Colonial Identity*, pp. 4–5.

8 M. Kohn, 'Colonialism', in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (spring 2014 edition), http://plato.stanford.edu/archives/spr2014/entries/colonialism (accessed August 2014).

9 For a lengthier discussion on the theory of colonialism and post-colonialism see: M. Kohn with K. McBride *Colonial Critique and Post-colonial Foundations* (Oxford: Oxford University Press, forthcoming).

10 H. Philips, *Epidemics, the Story of South Africa's Five Most Lethal Human Diseases* (Athens, OH: Ohio University Press, 2012), p. 48.

11 Philips, *Epidemics*, p. 56. See also: M. Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859–1914* (Cambridge: Cambridge University Press, 1994).

12 M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Tavistock, 1973) stresses the significance of power relationships

expressed through language and behaviour, including institutional, racial and political categorisations and relationships.

13 Foucault, *The Birth of the Clinic*, p. 170.

14 S. Watts, *Epidemics and History: Disease, Power and Imperialism* (New Haven: Yale University Press, 1997).

15 S. Nestel, '(Ad)ministering angels: colonial nursing and the extension of Empire in Africa', *Journal of Medical Humanities*, 19:4 (1998), 262.

16 A. McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Context* (NewYork: Routledge, 1995), p. 226.

17 H. Sweet and A. Digby, 'Race, identity and the nursing profession in South Africa, *c.* 1850–1958', in B. Mortimer and S. McGann (eds), *New Directions in the History of Nursing: International Perspectives* (London: Routledge, 2005), pp. 109–24.

18 Nestel, '(Ad)ministering angels', 258.

19 J. and J. Comaroff, 'Cultivation, Christianity and colonialism', in J. de Grunchy (ed.), *The London Missionary Society in Southern Africa* (Cape Town: David Phillip, 1999), p. 81.

20 The comparative differences between nurses working for the 'colonial enterprise' such as the Colonial Nursing Association (CNA, later the Overseas Nursing Association) and those working as missionaries has been explored elsewhere, see: H. Sweet, '"Wanted: 16 nurses of the better educated type": provision of nurses to South Africa in the late nineteenth and early twentieth centuries', *Nursing Inquiry*, 11:3 (2004), 176–84. With missionary nursing it was common for nurses to stay with their mission, sometimes remaining for the rest of their lives, as with Norwegian Lutheran nurse Petrine Solveig in KwaZulu Natal, South Africa. This was not the case for nurses working for most other non-governmental agencies such as the CNA.

21 H. Marland, 'Midwives, missions and reform: colonising Dutch childbirth services at home and abroad ca. 1900', in Sutphen and Andrews, *Medicine and Colonial Identity*, p. 62.

22 A. M. Rafferty and R. Wall, '"Embodying nursing" in the British Empire, 1896–1946', presented at Colonial and Post-colonial Nursing History: History of Nursing Annual Research Colloquium, held at University of Oxford, 4 July 2013.

23 Foucault, *The Birth of the Clinic*.

24 Rafferty and Wall, '"Embodying nursing"'.

25 Christine Hallett has discussed later examples of the nurse's diary and memoir as a source – see for example: C. E. Hallett, 'Portrayals of suffering: perceptions of trauma in the writings of First World War nurses and volunteers', *Canadian Journal of Medical History*, 27:1 (2010), 65–84; C. E. Hallett, 'The personal writings of First World War nurses: a study of the interplay of authorial intention and scholarly interpretation', *Nursing Inquiry*, 14:4 (2007), 320–9.

26 For a discussion of the 'almost universal spirit of restlessness and discontent' which was pervading nursing at the end of the century (according to a writer in *Nursing Mirror*), see S. Hawkins, *Nursing and Women's Labour in the Nineteenth Century: A Quest for Independence* (Abingdon: Routledge, 2010), p. 167.

27 For more on nursing in the Anglo-Boer War see: K. Spires, 'Nurses in the Boer War' (PhD thesis, University of the South Bank, 2013); E. van Heyningen, *The Concentration Camps of the Anglo-Boer War: A Social History* (Cape Town: Jacana, 2013).

28 B. M. Robertson, *Angels in Africa: A Memoir of Nursing with the Colonial Service* (New York: The Radcliffe Press, 1993), quoted in Nestel, '(Ad)ministering angels', 263.

29 H. Sweet, 'Mission nursing in the South African context: the spread of knowledge during the colonial and apartheid periods', in Fleischmann *et al.*, *Transnational and Historical Perspectives*, pp. 137–55.

30 Nestel, '(Ad)ministering angels', 263.

31 W. S. Zondi, 'Medical missions and African demand in Kwazulu-Natal, 1836–1918' (PhD thesis, University of Cambridge, 2000).

32 S. Parry, 'Tropical medicine and colonial identity in Northern Australia', in Sutphen and Andrews, *Medicine and Colonial Identity*, pp. 109–10.

33 L. Hesselink, 'The early years of nursing in the Dutch East Indies, 1895–1920', in this volume.

34 Sweet and Digby, 'Race, identity and the nursing profession'. See also Shula Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (New York: St. Martin's Press, 1994).

35 R. Wall and A. M. Rafferty, 'Nursing and the "Hearts and Minds" campaign. The Malayan emergency, 1948–1958', in D'Antonio *et al.*, *Routledge Handbook on the Global History of Nursing*, pp. 218–36.

36 M. E. Galiana-Sanchez, J. Bernabeu-Mestre and P. García-Paramio, 'Nurses for a new fatherland: gender and ideology in the health policies of the early Franco regime in Spain (1938–1942)', *Women's History Magazine*, 68 (2012), 33–41 and A. Peters, 'Nanna Conti: the Nazis' *Reichshebammenfuehrerin* (1841–1951)', *Women's History Magazine*, 65 (2011), 33–41.

37 A. Hardy and E. M. Tansy, 'Medical enterprise and global response, 1945–2000', in W. F. Bynum, A. Hardy, S. Jacyna, C. Lawrence and E. M. Tansy, *The Western Medical Tradition 1800 to 2000* (Cambridge: Cambridge University Press, 2006), p. 519.

38 M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Oxford: Polity Press, 1991). In her discussion of Africans' encounters with Protestant missionary medicine (pp. 55–76) Megan Vaughan criticises missionaries of the early and mid-twentieth century and 'the popular representations of Africa and Africans [that] came via the accounts in missionary journals of the woes of the "sick continent", and the trials, tribulations, and triumphs of heroic medical missionaries' (p. 56).

39 S. Armstrong-Reid, 'Two China "gadabouts": guerrilla nursing with the Friends Ambulance Unit, 1946–1948', in this volume.

40 This concept has been explored elsewhere, see: H. Sweet, 'A mission to nurse: the mission hospital's role in the development of nursing in South Africa *c.* 1948–1975', in D'Antonio *et al.*, *Routledge Handbook on the Global History of Nursing*, pp. 198–217; Sweet, 'Mission nursing in the South African context'.

41 Perhaps an extreme example of this is a retired American Lutheran missionary nurse, Nurse June Kjome, who was so profoundly affected by the injustices of South African Apartheid that she says she returned home a changed person, '[under apartheid] it became intolerable not to be able to speak out for the oppressed Zulu people' – see S. T. Hessel and G. Holinagel, *Justice: Not Just Us. June Kjome and the Making of an Old Lady Activist* (Mishawaka, IN: Lessons from Life Publishing, 2008).

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Lady amateurs and gentleman professionals: emergency nursing in the Indian Mutiny

Sam Goodman

The events that took place in central India during the summer of 1857 have gone by many names over the last 150 years. Historians of colonial India have variously referred to the disorder of that year as the Sepoy Rebellion, the First War of Independence and, perhaps more familiarly, the Indian Mutiny, often reflecting the partisan positions of the original participants.[1] Despite the discrepancy over what to call it, most historians agree that the initial uprising at Meerut in May 1857 took the British civil and military administration in India almost entirely by surprise, and, as the disorder spread, scant resources left cities and garrisons not only woefully under-defended but also unprepared for the protracted nature of the violence that followed. However, against the odds, British fortunes prevailed and over the course of the following year, the East India Company army, reinforced by British troops, gradually reconsolidated their control over central India.[2] The events that transpired at Delhi, Meerut, Lucknow and most infamously at Cawnpore, would be retained in the British national consciousness for decades to follow. This remembrance, however, was not just because of shock at the violence perpetrated by both British and Indian participants, but because the dual narrative of triumph in the face of adversity and national solidarity satisfied the British disposition towards mythologising their Imperial presence in India. Like other events in Anglo-Indian history, such as Robert Clive's victory at the Battle of Plassey or the so-called 'Black Hole' of Calcutta, the Indian Mutiny became part of the central narrative of British India and remained so until the end of the Raj in 1947, and, in many cases, beyond it.[3]

Examining how and why the Indian Mutiny remained in the British consciousness in this fashion involves the consideration of a medium perennially associated with the British experience in India, as well as the wider Empire, namely that of the diary or journal. Originating in its recognisable modern form in the Enlightenment of the eighteenth century, a period contemporaneous with the consolidation of British rule in India, the colonial diary was a popular, and often lucrative, activity for those generals or notable soldiers engaged in overseas service. However, unlike accounts from other conflicts of the period, the journals generated by the Indian Mutiny were not only those of soldiers, politicians and religious figures as was the case with earlier, and arguably more destructive, wars in India such as the Anglo-Sikh War of 1845–46. Rather, the prolonged and localised nature of various sieges, in particular that of Lucknow which this chapter will focus on, meant that its chief chroniclers represented a cross-section of gender, class and professional status in colonial society, including a range of medical practitioners but also, and perhaps most significantly, women of various social ranks who by necessity and compulsion had been drawn into medical service.

This chapter examines the narrative accounts of various participants of the Indian Mutiny, as expressed in diaries and journals largely written and published during 1857–58. Given that these texts are a hybrid form of writing, comprising eyewitness accounts of battle, narratives of privation and medical testimony, this chapter subjects them to literary and historical analysis, and explores both the narrative form of the diaries as well as what they reveal about accounts of nursing and medical service that their female authors engage in over the course of their experiences. Indeed, the two are, as this analysis will demonstrate, intrinsically linked, with the diary format having direct influence on the choice of events recorded and the manner in which they are presented in these texts. This chapter is composed therefore of two sections; it begins by briefly considering the culture of textual production that surrounds both the period in question and also Anglo-Indian society of nineteenth-century Britain, outlining the significance of the diary format itself to female authors and medical practitioners in colonial India and the wider British Empire at this time.

The chapter then considers specific printed accounts of female participants from the Siege of Lucknow, particularly those of Colina

Brydon, Emily Polehampton, Georgina Harris and Lady Julia Inglis, analysing how these women were engaged in or experienced the provision of care throughout the siege, and the manner in which they chose to record their experiences. It will be shown that these accounts function as both a vital record of early colonial nursing and as examples of nineteenth-century practitioner narratives told from a female perspective. These diaries illustrate how the women present at Lucknow were able to engage in activities and actions, such as the nursing of the sick and wounded, that they typically considered beyond the remit of their usual role in colonial society. The opportunity to engage in the care of the sick and wounded, as well as the ability to then record such service in print, offered practical and ideological channels through which women were able to contribute to the project of British imperialism in India. However, rather than suggest that nursing is wholly a way in which gender and class roles were contested in the pages of the colonial medical diary, this chapter will consider how nursing and diary writing are presented as natural extensions of typical female activity, conducted through and enabled by the extraordinary circumstances of the Mutiny. Women were able to keep diaries and contribute to the garrison's defence through nursing because these acts of writing or caregiving were in keeping with prevailing Victorian ideals of womanhood. Similarly, the emphasis placed on the amateur status of these women (by the women themselves), both in their medical and literary endeavours, in comparison to their male counterparts is a significant factor, and means that these narratives become once again about triumph over the odds; women, in their actions as nurses and writers, are yet again placed back into a subservient position despite their active, and in many cases vital, participation in the defence of British interests. Whilst the activity of nursing is in most cases considered laudable by participants and chroniclers of the siege, it is nonetheless subject to a range of unspoken, seemingly understood yet entirely unsystematic, social codes of behaviour.

Writing a chapter of history

Unlike so many other conflicts in British history, the Indian Mutiny possesses a distinctly, if not uniquely, female presence at nearly all of

its major engagements. The Mutiny itself began on 10 May 1857 in Meerut, central India and, whilst beginning as a localised disturbance there, rebellion soon spread to Delhi, Agra, Cawnpore, Gwalior and, of course, Lucknow. The cause of the Mutiny has traditionally been attributed to rumours that the cartridge fired by the new Lee Enfield rifle issued to native Indian Sepoys was greased with either pork or beef tallow and thus offensive to both Muslim and Hindu alike; as the loading and firing drill necessitated biting the top off the paper cartridge before inserting it into the gun, the sepoys viewed this as a surreptitious means of either forcing them to break their caste or defile their religion.[4] However, there were a number of additional contributing factors, and the situation was more complex than traditional narratives have asserted, with the annexation of Oudh in 1856 and the general increase in Christian missionary activity in India also causing localised and more general native discontentment respectively. Jane Robinson provides evidence that at Lucknow the cause of rebellion had also been medical in origin; Robinson asserts that 'one of the European doctors had been seen sipping medicine from a bottle in the hospital stores, thereby contaminating it for all his Hindu patients' and offending their caste.[5] Lucknow was besieged between late May and November 1857, and the defence force consisted of Company troops, loyal native regiments and civilian (or Irregular) volunteers. Though the city was first 'relieved' in September by troops under the command of General Henry Havelock and Sir James Outram, Outram's force did not have enough men or supplies to break the siege and instead provided reinforcement (and exacerbated supply problems) rather than salvation. A second relief force finally lifted the siege in November, under General Colin Campbell. Elsewhere in India, it took Company and Crown troops (freshly shipped from Britain) until June 1858 to finally suppress all resistance. East India Company control and governance of India was subsequently transferred to the Crown, beginning the British Raj that would last until Indian Independence in 1947.

Very different in character to the Anglo-Sikh war of the previous decade, the nature of the Mutiny meant that rather than traditional battles between standing armies, in its initial stages the conflict took the form of civil disturbances in which a great number of British casualties were women, either unable to escape their cantonments or

garrisons in time or who were killed along with their husbands and families as rioting spread. Similarly, in those cities that were able to mobilise a defence in time and which were placed under siege conditions, women and children accounted for a considerable proportion of the European presence; the diary of Lady Julia Inglis, considered the 'burra-mem' or first lady of Lucknow as she was married to the garrison commander, records that there were 220 women present on 16 August. That figure was recorded after two long months of siege and disease, and does not take into account the large number of Eurasian women present.[6] In fact, at the beginning of the siege there were close to 3,000 non-military residents within the Lucknow perimeter (European, native Indian or Eurasian in origin) and 600 of these were women.[7] Claudia Klaver has explored the explanation for such a strong female presence in British India at this time in relation to the 'civilising mission' of British colonialism in India, and indeed the presence of British women and children in India stemmed from a shift in colonial policy in the early part of the nineteenth century that emphasised the presence of soldiers' and administrators' families for various socially performative and practical reasons. Klaver explains that the rationale behind this shift in practice was that the soldiers themselves would be comforted by the presence of their wives and children during long postings away from England, and that Anglo-Indian society would in turn provide an example of matrimonial and familial harmony for native Indians to aspire to.[8] However, the civilian presence in many of the key engagements of the Mutiny is another reason why the conflict took on such a potent afterlife in the British cultural imaginary; the symbolic signification of the vulnerable female body, along with the frailty and helplessness of their malnourished children, gave events a more lurid and shocking quality to the British public at home. Thus British actions in putting down the revolt were not merely servicing the re-imposition of control over querulous natives, but rather became a defence of British values and virtues.

Along with the high female presence at Lucknow, there was an unusual concentration of medical officers and civilian doctors present during the siege. As a consequence of various locally based units retreating to Lucknow, the medical presence there consisted of Company doctors, civilian practitioners and Army surgeons and

medical officers, as well as three loyal native Indian doctors (though their names were not recorded by the diarists).[9] These incumbent and incoming personnel would later be put to work in the garrison's two improvised medical facilities, the European hospital in the residency banquet hall and the Native hospital; both hospitals were in use throughout the siege, though they would each be subject to intense artillery fire and a number of wounded or sick men would be further injured or sometimes killed by shelling, whilst many of the doctors were themselves hurt when performing their duties.[10] N. A. Chick's *Annals of the Indian Rebellion* (1859) lists eleven medical men apparently worthy of note in Lucknow, ranging from the rank of surgeon through to apothecary.[11] Most notable among them were Surgeon William Brydon, the sole survivor of the ill-fated Afghan expedition of 1838–42, Henry Martineau Greenhow, who compiled a statistical list of those military personnel killed at Lucknow and was recommend for the Victoria Cross for actions during the siege, and Assistant Surgeon Joseph Fayrer, who would go on to be a respected authority on the transmission and treatment of cholera, as well as the venomous snakes of India. Not all the medical officers wrote up their experiences in the form of diaries, but many did; six published memoirs, written by medical practitioners, appeared in the year after the Mutiny, alongside Greenhow's more practical *Notes Medical and Surgical Taken during the Late Siege of Lucknow* (1858).[12] Along with recording key aspects of the struggle (the common events that Klaver terms the 'public narrative' of the siege) these texts provide considerable detail of individual actions both in the native and European hospitals and in the defence of the garrison.[13] From this range of sources, it is reasonable to conclude that alongside the public interest in the events that transpired at Lucknow, there was equal interest in both female and medical experiences of the siege.[14]

The number of published perspectives available on the Siege of Lucknow, as well as the Indian Mutiny itself, is both notable in its own right and indicative of the place of the diary within mid-century Victorian publishing culture.[15] With very few exceptions, and although recollections of the Mutiny would be published at various points up until the beginning of the First World War, the majority of these accounts were published within six to twelve months of

the relief in November 1857. Such expediency in terms of publication is indicative of the temporal concerns that surround these texts. Differing from memoirs or historical accounts, which are often produced long after the events they describe, diaries possess a greater sense of immediacy to the perspective they represent; diaries are a cumulative format, written daily and thus with less distance in which the elision of memory can obscure recall, suggesting a more reliable account. In the case of the Mutiny, diaries were written and published not only to satisfy a British public hungry for news of the conflict, but also as a means of piecing together an accurate timeline of events, at this point still unclear, especially when it came to what had transpired at Cawnpore.[16]

Whilst few historians would now consider the use of these diaries as unproblematic, they are nonetheless useful in reconstructing the historical conditions of mid-nineteenth-century colonial Britain and the culture of textual production that existed around colonial India at this time, as well as in understanding the diary, in Rebecca Steinitz's terms, 'as a cultural and discursive practice' appealing to a readership in Britain as well as within Anglo-Indian Society.[17] Felicity Nussbaum argues that the traditionally understood format of the private diary is a production of the late eighteenth century, a time when autobiography developed a set of practices 'distinct from other kinds of writing'.[18] However, whilst many of the Indian Mutiny diaries conform to the daily entry format that Nussbaum refers to, they are influenced by an older form of diary first published over a century earlier. George Walker's *A True Account of the Siege of Londonderry* from 1689 combined both eyewitness testimony and the personal perspective of a diary or journal, and as Steinitz argues 'signalled the diary's use-value in the service of current events'.[19] When later coupled with colonialism and the 'ever popular' travel diary, the result was a succession of peaks in diary production which corresponded with 'the course of nineteenth-century military history', from Eliza Fay's account of captivity at the hands of Hyder Ali, published 1817, through to Lady Sale's account of the retreat from Afghanistan in the 1840s, those of the Crimea in 1856 and then the diaries produced by the ladies of Lucknow in 1857–58.[20]

An explanation in part for this popularity is provided by Robert Fothergill, who argues that 'diary-writing, as a conventional habit

among persons of culture' reached its apogee in the mid-Victorian era; a time at which the values of Empire and society were repeatedly scrutinised and questioned.[21] Benedict Anderson's formulation of national identity developed in *Imagined Communities* is particularly useful in exploring Fothergill's observation further, and in framing the wider significance of the diary format that the chroniclers of the Lucknow garrison employ.[22] In an era in which Anderson argues that the bonds of horizontal comradeship are consistently being secured by the global reach of print capitalism, the colonial diary represents a way in which women were able to engage with and join the imperial endeavour in print culture. The diary becomes the textual space which reflects, reinforces and expresses anxieties over the British presence in the physical space of the Indian subcontinent. The regular cataloguing of disease, illness and medical procedures, not to mention instances of violent death that abound throughout each of these accounts from Lucknow, is a reflection of the contemporary commonly held belief in the inhospitable nature of India to the European physique, what Mark Harrison has called the 'pathogenic space' of India, and an understanding that the civilising work of British colonialism was deadly, yet necessary.[23] In the case of the Siege of Lucknow this spatial dimension is of course further compounded by the army of hostile mutineers beyond the perimeter walls of the compound, drawing a clear physical as well as moral line between Anglo-Indian society and that of the native population. Such choices of content by these authors influence their stylistic mode of expression, reflecting Nussbaum's assertion that the diary and other serial narratives 'imitate traditional and emergent generic codes' including romance, epic, drama, comedy and tragedy; indeed, in *Angels of Albion*, Jane Robinson describes the Mutiny as 'the ultimate Victorian melodrama'.[24] However, through the intimation that they are written in private, diaries 'affect to escape pre-existing categories' and suggest an ability to tell the truth of existence.[25] Consequently, the diary exists in a state of generic and narrative haze or contradiction, supposedly truthful, yet composed in the same terms and by the same means as fiction. What these diaries purport to give us is an ordinary view of extraordinary events; the truth of Lucknow, as written by an eyewitness and participant, alongside the dramatic tales of British heroism expected by their readers.

Administering angels

The chief female chroniclers of Lucknow are drawn from a fairly broad middle- to upper-class spectrum, as might be expected, given the period. The class ranking of these diarists corresponds entirely to their husbands' military rank, and can broadly be seen as beginning with Julia Inglis, wife of Brigadier Inglis. She is one of the few diarists who did not compose her account until much later, finally publishing it in 1894. Adelaide Case, wife of Colonel Case, is just below her in the Lucknow hierarchy; Maria Germon, wife of Lieutenant Charles Germon, is next, roughly equivalent to Emily Polehampton, wife of the Reverend Henry Polehampton, and Georgina Harris, wife of the Chaplain, James Harris. Finally on the lowest rung of this particular ladder comes Colina Brydon, married to surgeon William Brydon, and Katherine Bartrum, whose husband, though a captain, was a medical officer with a native regiment, and thus considered less prestigious than a regular corps officer.[26] It is unlikely that these were the only women to record their experiences, and these diarists represent a particular class perspective; there are no diaries from Lucknow written by lower-class or native eyewitnesses, even though history records that these figures were present.[27] There are instances of private soldiers compiling memoirs, such as Joseph Lee's *The Indian Mutiny & in Particular a Narrative of Events at Cawnpore, June and July 1857* (1890), but these are written much later, and when their writers had gained a modicum of respectability.[28]

Despite their positions within Lucknow society, none of these diarists claims to be endowed with any literary skill. In the paratextual material that precedes each of their diaries or journals, the women all emphasise their amateur status as historians and writers, mirroring that of their tentative endeavours in matters medical and domestic that comprise the contents of their diaries. Kathryn Carter argues that 'during a period when writing was becoming an increasingly commodified activity' it became important to 'maintain the idea of the diary as a literary product exempt from the marketplace'.[29] Carter's analysis suggests that the admission by each of these authors that their recollections are not those of professional writers was intended to lend a degree of authenticity to their respective accounts. The claims imply that the text has not been subject to any literary or editorial

manipulation, or aesthetic adornment, although passing through an established publishing house as most of these texts did, the reverse is almost certainly the case.[30] The declarations thus become again illustrative of the tension between the form of these texts and their supposedly 'truthful' content. It is important to note, too, that such declarations of amateurship are entirely absent from their male equivalents, suggesting a particularly gendered divide in the way in which the siege is represented in print. Whereas for the ladies of Lucknow a declaration of inexperience gives their recollections a ring of further truth, for soldiers or medical men the admission of such amateur status would undermine the authority of their position and by extension their account of events.

The majority of these texts largely corroborate their authors' assertions, and many of these accounts are written in a simple, informative style. However, there are exceptions, and indeed notable tonal shifts within individual accounts. For instance, Adelaide Case published her siege diary *Day by Day at Lucknow* in 1858. Her diary opens with a preface in which she states that her work is merely a stopgap measure until some 'more practised person' writes a complete and detailed history, immediately identifying herself and her writerly identity with the amateur. However, Case's denial of literary intention is somewhat disingenuous. The main body of her diary is tellingly entitled 'Narrative' and begins with a striking vignette from her pre-siege life, where she describes the view over Lucknow in notably descriptive terms: 'when the sun begins to shine on the gilded mosques and minarets, and towers, it is like a fairy scene'.[31] Case's 'Narrative' bears many hallmarks of a literary composition; indeed, as well as in her emphasis on the markers of exotic otherness such as the mosques and minarets, Case reflects a long tradition of British writing on India in her focus on light and the sun, a well-established trope of Anglo-Indian fiction at her time of writing and for many decades afterwards.[32] Her account connects the diary with the travelogues of empire, as well as in its artifice creating a dramatic contrast in terms of the state of Lucknow under British rule and how it would later appear after the destructive actions of the mutineers.

Similarly, though much less marked by the literary artifice of Case's writing, the accounts of Germon and Inglis both demonstrate over the course of their own narratives the way in which the authors began

to warm to their theme as well as develop their literary voices and authorial personae; the tension in Inglis's writing increased in parallel with the duration of the siege, with a gradual yet noticeable increase in emotive language as her account progresses. For example, the initial stages of Inglis's diary are composed largely of short and mostly informative statements. However, late in the siege she is given to far more emotional reflections on their situation, either using more evocative imagery, or increased use of exclamation marks. In one representative example, she writes: '[O]ne of our saddest thoughts during the siege was the reflection of how those we loved must be suffering. How one used to long to hear something of them!'[33] Inglis, in particular, is returning to these events after considerable time has passed, and her stylistic decisions may thus be read as another example of how these texts imitate other narratives, here building to an emotional climax at the same time that the siege reached its most desperate stages.

The manner in which these accounts are composed influences their content and intended message. Claudia Klaver's work on diaries from the Siege of Lucknow suggests that women's service throughout the Mutiny is defined in terms of its domesticity, and that its concomitant relationship to Victorian social codes is not only how the diaries should be understood, but also how the diarists will have understood and chosen to represent their own roles: as wives and mothers of Empire.[34] Indeed, given the anomalous situation of the rebellion in that so many women were present on what was the front line, denying the army, it was alleged, full freedom to fight the enemy in an open theatre of war, women would have to be seen to be useful in other ways, often far outside of their usual positions. These diaries suggest a range of ways in which they were able to do so; these women cook, perform childcare or act as store-mistresses of their own supplies; all roles that they were entirely unused to in their pre-siege lives, and would not ordinarily be performing were it not for the fact that their servants had either fled or were charging greatly inflated prices for their services. Such duties were met initially with amusement at the novelty of the work, and a sense of pride found in a sudden usefulness, rather than the reluctance that might be expected from women unused to activities of this kind. Georgina Harris remarks on the camaraderie and cohesion of the garrison, attributes that would become synonymous with British representation of the Mutiny in subsequent fictional and

historical portrayals: 'we are all obliged to put our shoulders to the wheel and divide the work between us'.[35] Maria Germon, too, remarks on how having to perform menial labour is 'perhaps … a good thing', as it kept their minds from more troubling thoughts, such as the risks experienced by their husbands or the threat of being overrun.[36]

Klaver's focus in her article, however, is largely limited to those instances in the diaries that included domestic service, or those aspects of the diary that were related to domestic environs; she does not examine cases where the women undertook tasks which exceeded the demands of their own survival or their children's. Whilst the Lucknow diaries do not, like those of Edith Sharpley at Agra, record women loading or handling weapons, itself a celebrated myth of the Mutiny in later years, many of these women volunteered for a range of duties and not just those confined to the home.[37] For instance, Colina Brydon's diary repeatedly mentions her work 'at the bastion', presumably Grant's Bastion, a strongpoint in the residency defences, and how she took her turn on watch between midnight and 3 a.m.[38] Though her account provides little further information on what she does at the bastion, the fact that she was employed there and not at the hospital with her husband suggests that the women of Lucknow possessed a degree of agency in terms of how they volunteered their services. It is noteworthy that there was seemingly no effort on the part of the military to form any organised means of enabling women to work or contribute to the garrison's defence, though. Those women who did engage in activities beyond their domestic labours chose to do so seemingly as a result of their own initiative and on an *ad hoc* basis, especially in relation to the nursing of the sick and wounded.

'Nursing', as it appears in these texts, straddles the boundary of the domestic and the professional sphere. In many of these accounts the term is used to refer interchangeably to the care of children, an activity that the majority of these authors were obliged to perform in the absence of an *ayah* or native wet nurse after many of the servants deserted the garrison in July, as well as the tending of the sick or injured. This slippage is indicative of how nursing can be viewed as an extension of the role of women as caregivers, and as such can be seen as an extension of the values Klaver identifies into the male, and professional, environment outside the home.[39] Nursing likewise involves many of the same qualities of idealised Victorian womanhood as are

evident in the domestic milieu, including compassion, tenderness, empathy and selflessness; however, when applied in a hospital setting they are not merely implicit in the defence of English society in India but appear to become an active part of that defence. Women are no longer the inert signifiers of Britishness designed to spur on the fighting men, but rather shape and support that fight in various ways. Such an analysis affirms how colonial nursing was always implicated in the preservation of colonialism, albeit initially in emergency situations such as the Mutiny but also in the later nineteenth century and beyond once the presence of the colonial nurse had been formalised and established professionally.

Of the female diarists of Lucknow, Emily Polehampton and Georgina Harris are those who engage most readily in medical service. In the same fashion that none of the Lucknow diarists lay claim to any literary talent, none of the women who volunteered for service in the hospitals were trained nurses, and Harris's engagement as both nurse and maid is seemingly entirely new to her. In a conflation of her domestic and official duties, Harris writes that 'my share is to act as housemaid and keep the rooms we inhabit tidy and clean: I am also to nurse Mr Lawrence [George Lawrence, who was shot through the shoulder on 4 July] and any sick or wounded brought to this house'. Harris's account indicates that those women who did engage in nursing were under the supervision and direction of medical officers; her statement that she is to nurse any wounded brought to her house indicates that they will first have been seen by the doctors or trained medical personnel at the makeshift hospital before being transferred to her residence. There are various instances throughout these texts where women change dressings or administer medication to those already treated by the surgeons, or where they seek advice from one of the medical staff. Later in Harris's account she writes that when one of the children, Herbert Dashwood (who had been ill for some time), began once more to decline she 'called up Dr Partridge, who ordered a warm bath', indicating how these volunteer nurses would defer to their professional counterparts for guidance and remain under their direction.[40]

The texts also provide insight into the medical methods of the garrison's many doctors, which produce varying degrees of success. Harris's diary provides an account of her care for Sir Henry Lawrence,

the garrison's original commander until grievously wounded by cannon-fire, in his dying hours: 'Once we thought he was going, but he rallied, and has taken an immense quantity of arrowroot and champagne during the day. Once when I was feeding him he looked at me so hard, as he was trying to remember who I was.'[41]

There is every chance that Lawrence was struggling with the delirium of his evident agony. But it is well documented that British physicians actively prescribed champagne in particular as a measure against the Indian climate and there is just as much chance, having suffered blood loss through traumatic injury, an immediate amputation in unsanitary conditions and chronic dehydration as a result of the heat and lack of clean water, that he was also insensibly and dangerously drunk.[42] As much as Harris's efforts indicate her contribution to easing Lawrence's last hours, the tone in which they are conveyed casts doubt on her abilities and instead plays up her naivety, affirming her amateur position and unworldly nature, and the divide between trained personnel and volunteers. It is further well documented that the doctors at Lucknow made extensive use of alcohol as part of their treatment of cholera, and in place of pain relief for amputations; Robinson states that the usual dose for the amputation of a limb was 'a single bottle, taken at one draught immediately before the operation began'.[43] In the context of Harris's diary, whilst her efforts are applauded, they also rearticulate her secondary status.

In contrast, Emily Polehampton's reputation as a medical nurse differs greatly from Harris's, influenced predominantly by the fact that she left the confines of her home in order to devote herself more readily to nursing the sick and wounded, and because she apparently treated a greater number and much more varied selection of patients. Polehampton's role as nurse begins early on in the siege, after she and her husband move into a small room at the back of the hospital in order to offer assistance to the wounded and the medical personnel there. She continued in this role throughout the siege, and after her husband died of cholera in late July 1857, roomed with two other widows, Mrs Gall and Mrs Barbor. For much of the siege, Polehampton is too busy at the hospital to keep a diary, and her own testimony is recorded after the second relief of Lucknow in November, when she returns to England. It was published as part of a compendium of her husband's sermons and own short diary. However, we know

from the diaries of other women, including Colina Brydon, Katherine Bartrum and Georgina Harris, that Gall, Barbor and Polehampton were working every day in the hospital by 3 July 1857, and from these accounts we are able to reconstruct the duties the women performed.[44] Polehampton herself remarks in a letter that her daily routine involved attending the hospital after breakfast and 'spend[ing] as many hours there as I saw necessary', leaving for dinner, before then attending for a further hour in the evening.[45]

In the later stages of the siege, after the garrison's commanders decided that the hospital was too dangerous for her to reside in because of increasing attacks, Polehampton appears to have expanded her efforts beyond the hospital and performed nursing duties where needed throughout the garrison. On 1 August, Katherine Bartrum records that Dr Wells had informed her that her child was dying of cholera, and that Polehampton came to assist Bartrum in nursing him through his final hours: 'she was ever ready in the midst of her own sorrow to comfort those who were in trouble. We administered the strongest remedies which could be given to a child.'[46] It is evident that Polehampton was afforded a good deal of responsibility in terms of her ministrations, and was not continually overseen by Wells or other medical personnel. This lack of observation may have been the result of competing demands on the trained doctors to tend to more severe wounds, however, it may also be seen as indicative of the trust placed in Polehampton's abilities; as a result of her efforts on 1 August, and unlike a great number of the Lucknow garrison, Bartrum's child made a full recovery.

Despite the evident talents of women such as Barbor, Gall and Polehampton, there appears to have been no systematic process for mobilising the female members of the garrison, nor even any direct pressure from those in command of the garrison's defence for women to contribute. However, those diarists who engaged in medical service all shared certain characteristics, which provide insight into why they volunteered and others did not. Differing from the diarists (who were typically married), those female members of the garrison who engaged in nursing the sick and wounded in the hospitals were unmarried or widowed in the case of Polehampton, Barbor and Gall, and none had children or other dependants. Those with children, such as Kate Bartrum, did not volunteer and received

no censure for doing so, despite the possibility that as a medical officer's wife she may have possessed knowledge, however rudimentary, of the treatment of wounds. Further, medical volunteers were all drawn from the middle classes present at Lucknow as opposed to the upper-middle class. As head of the class hierarchy, Julia Inglis's role appears to exceed little beyond the care of her own son and efforts to raise morale, though she writes on 8 July that she 'quite envied' Gall, Barbor and Polehampton 'for being able to do some good'.[47] It is perhaps easy to be cynical at this juncture, and it is likewise tempting to criticise Inglis's desire to help, professed long after the events of Lucknow and once the position of the formidable memsahib had been secured in the popular imagination. However, Inglis may have been motivated by a genuine desire to help others but was prevented from doing so by Anglo-Indian society's rigid class hierarchy, which would not condone the garrison commander's wife coming into close proximity with the battered bodies of wounded ordinary soldiers. This apparent exemption from service was not reserved, however, only for those at the top of the social ladder, as Kate Bartrum's similar lack of engagement proves. Instead, these women were able to contribute by tending to their own families, an action that though exceptional, given that it would typically be performed by a lower class of society, did not deviate from class-based Victorian understandings of gendered identity.

Alongside class as a determinant of involvement, of equal note is the observation that the most prominent of those women who volunteered for medical service, Polehampton and Harris, were connected to the Church. The alacrity with which both women engaged in medical work may well have been a reflection of traditional religious nursing, and the perception of such ministrations as an extension of Christian charity.[48] Unsurprisingly, as the wife of a minister, Polehampton's account refers regularly to her religious beliefs. For example, with apparently characteristic modesty she remarks that, 'It has certainly been through the most wonderful interposition of providence that the remnant of our garrison has been brought out safely, and more marvellous still that we were enabled to hold out as we did with our limited supply of provisions and medicines.'[49] For Polehampton and Harris, medical service appears to have been a Christian duty, as well as a social one. The diary of Henry S. Polehampton adds further insight

into his wife's role in medical care during the siege. In it he reveals that he (and presumably his wife) had cared for cholera patients during the outbreak at Shrewsbury in 1849, and Emily may have acquired her medical knowledge and experience at this time.[50] However, despite the historical and Church-related nature of the Polehamptons' experience of nursing, there is no suggestion that Barbor or Gall were anything other than soldiers' wives and not involved in any charitable or missionary work of any kind. The involvement of Barbor and Gall therefore conforms to the emergent myth of the Mutiny, namely that women with no prior experience of caregiving were able to pitch in alongside more knowledgeable and capable women of their own class, and contribute to the preservation of colonial rule.

Another explanation of why these women volunteered so readily may be provided by the historical context of the late 1850s. The Indian Rebellion came not long after the war in the Crimea and a period of intense public interest in nursing as a result of Florence Nightingale's efforts in Scutari, as reported by William Russell in *The Times*.[51] That the Crimea and Nightingale's work had traction in the contemporary imaginary is evident from these texts. For example, in a letter to her father, Katherine Bartrum referred to Polehampton as 'the "Florence Nightingale of Lucknow" '.[52] Similarly, in Brigadier Inglis's after-action report on the siege, included as part of Chick's *Annals of the Indian Mutiny*, he wrote 'I cannot refrain from bringing to the prominent notice of his Lordship … the patient endurance and Christian resignation which have been evinced by the women of this garrison … many, among whom may be mentioned the honoured names of Birch, of Polehampton, of Barbor and of Gall, have, after the example of Miss Nightingale, constituted themselves the tender and solicitous nurses of the wounded and dying soldiers in the hospital.'[53] Brigadier Inglis may be guilty of hindsight here. Earlier attitudes of the garrison's doctors were not so effusive, as revealed in Polehampton's diary. In a letter she writes that 'A day or two after General Havelock relieved us … I went to the hospital and asked the doctors to let me return there to help to nurse. They at once gave me leave to do so.'[54] Though she was welcomed back, she does not record whether any effort was made to compel her to stay in the first instance or why she left, and Polehampton's continued service at the hospital is done of her own volition.

Inglis's report was written long after the relief of Lucknow, by which time the character of the siege and the Mutiny had taken root via the press and the commercial publication of many diaries. As control over India was gradually reasserted by British troops, the prevailing mood became one of celebration. Elsewhere throughout India, spontaneous contributions to nursing were noted; at Agra, volunteer nurses were honoured with both a 'grand fete' in their honour and also with red and white satin rosettes in recognition of their service.[55] The doctors' seeming indifference to Polehampton's help during the siege itself might simply be an indication of the more pressing matters to which they no doubt had to attend, or that once the extreme danger of the summer months had passed, the existing medical provision at Lucknow was once again able to cope. Again, some further insight is suggested by Henry Polehampton's diary, in which he records an unnamed doctor's anger at him for preaching in the hospital and doing 'harm', despite having acted with the best intentions.[56] It is possible that the doctors felt similarly about Mrs Polehampton's presence, and once the siege had concluded were able to discreetly reduce her involvement in medical care, avoiding public airing of their views, given the prevailing feeling towards female volunteers.

On a national and international level, in a similar way to the rewriting of the Crimea, the embarrassment over the origins of the Mutiny was rewritten as a testament to the fortitude of the British character in times of adversity. Moreover, though women had been seen to capably exceed their typical social roles, the praise heaped on them by Inglis and others largely returned them to the prevailing definitions of Victorian womanhood, as maternal, patient and enduring. It seems, too, that not everyone held nursing in such high regard once the immediate danger of the Indian Mutiny had passed; in November 1857 Florence Nightingale herself wrote to Charlotte Canning, the then-Viceroy's wife, to offer any assistance necessary; she was rebuffed immediately, Canning replying that there was nothing for her to do 'in her line of business'.[57] With the relief of the sieges and the arrival of reinforcements in the form of Regular Army troops from England, it appears that Anglo-Indian society was determined to return to some semblance of normality, one in which women's roles would once again be of the sedentary, domestic kind whilst their husbands went about their business of pacifying India.

Conclusion

This chapter has sought to illustrate how the Indian Mutiny diary represents a unique genre of women's writing on colonialism, and a valuable addition to the history of colonial nursing. The diaries from the Siege of Lucknow illustrate the ways in which female participants were able to assume vital roles as caregivers and medical assistants in a time of localised emergency and how their efforts were later recognised, propagated and, ultimately, mythologised. The chapter has also sought to highlight the contradictory and sometimes paradoxical status of these diaries as texts, especially the manner in which notions of truth and representation, public and private, objective and subjective are continually confused by the medium of the diary itself, and its ability to hybridise genres and forms of writing. Despite their assertions to the contrary, these texts are stylised literary productions, telling individual narratives against those larger background narratives of the British presence in India and British colonialism in general. Whilst it is apparent that their authors believed they were presenting objective record of events as they saw them, these diaries must be treated with appreciation for their artifice and composition, and approached from a critical position.

In terms of the accounts of nursing that they provide, the diaries are evidently responsive to their context; they are reflective of the post-Crimea perception and popularity of nursing, as a result of Nightingale's role in the Crimea, but also suggest again that the British provision of medical care in either battle or civil emergency was still sorely lacking. They illustrate that although women were encouraged to effectively 'pull their weight' throughout the siege as a result of the supposed burden they placed on the army, there was no systematic means to enable them to do so. The lack of central organisation of the medical service during the Siege of Lucknow meant that whilst the talents of women such as Emily Polehampton and Georgina Harris were put to effective use, others present, such as Adelaide Case, did comparatively little beyond protecting their own interests or taking on those roles that threatened far more the rigid colonial boundaries of class than those of gender. In this sense, as much as these diaries indicate that female eyewitnesses in the Indian Mutiny can be read as participants in the maintenance of Empire in both action and voice,

they may also continue to be read as maternal, domestic and restricted in their roles. The nurses of the Mutiny are placed into a contradictory position where they are celebrated as vital to the defence of the garrison and eventual British triumph, yet retain a subaltern status as subordinate, temporary and accepted out of necessity. The memsahibs of India thus become an inert embodiment of what the Army and East India Company were fighting for throughout the remainder of the rebellion: the idealised mothers, dutiful wives and ladies of colonial India, and of the wider Empire. As much as these diaries are a testament to the efforts of lady amateurs, they remain also a consolidation of the position of the gentleman professional.

Notes

1 Throughout the chapter, the events of 1857 are largely referred to as the Indian Mutiny, not for any political or ideological reason, but rather as a reflection of the language and terms used in the source material.
2 Indian affairs would be transferred from the East India Company to the crown once the rebellion had been suppressed in 1858, beginning the Raj period of Anglo-Indian colonialism.
3 In addition to British fears of another potential 'mutiny' during the First and Second World Wars, Lawrence James records how 'Remember Cawnpore' was still a popular tattoo among British servicemen in India during the early 1940s. See L. James, *Raj: The Making and Unmaking of British India* (London: Abacus, 1997), p. 253. Further, a range of novelists, from John Masters through to J. G. Farrell and G. M. Fraser, would return to the events of the Mutiny either for the purposes of parody or earnest remembrance.
4 See Lawrence James's *Raj* for a comprehensive account of the beginnings of the Indian Rebellion.
5 J. Robinson, *Angels of Albion: The Women of the Indian Mutiny* (London: Penguin, 1997), p. 156.
6 J. Inglis, *The Siege of Lucknow, a Diary* (London: James R. Osgood, McIlvaine & Co., 1892), p. 120.
7 C. Klaver, 'Domesticity under siege: British women and Imperial Crisis at the Siege of Lucknow, 1857', *Women's Writing*, 8:1 (2001), 26.
8 Klaver, 'Domesticity under siege', 24–5.
9 J. C. Cunningham, *The Last Man: The Life and Times of Surgeon Major William Brydon CB* (Oxford: New Cherwell Press, 2003), p. 213.
10 Cunningham notes that 'hardly a doctor went through the siege without being confined to bed', either through wounds sustained in the course of their duties in the case of Surgeon William Brydon, or cholera in the case of Surgeon

John MacDonald, who later died of the disease. Cunningham, *The Last Man*, p. 212.

11 N. A. Chick. *Annals of the Indian Rebellion* (Calcutta: Sanders Cones & Co., 1859), p. 872.

12 See H. M. Greenhow, *Notes Medical and Surgical Taken during the Late Siege of Lucknow* (Alum Bagh: Military Orphan Press, 1858) and R. Wilberforce Bird, *The Indian Mutiny. Two Lectures Delivered at the Southampton Athenæum, Feb. 16, and March 30 1858* (London: Bosworth & Harrison, 1858) as representative examples of these publications. Joseph Fayrer's Mutiny experiences were recounted in *Recollections of My Life* (London: William Blackwood & Sons, 1900).

13 Klaver, 'Domesticity under siege', 24.

14 In the course of my research to date, I have examined six memoirs of the Siege of Lucknow written by medical officers, from a total of seventeen published works (excluding manuscript diaries), including the six written by women.

15 For an overview of the extent to which the diary had consolidated its place within Victorian letters see Cynthia Huff's *British Women's Diaries: A Descriptive Bibliography of Selected Nineteenth Century Women's Manuscript Diaries* (New York: AMS, 1985).

16 It is unclear to what extent the diarists of Lucknow considered publication when they commenced writing their accounts of the siege. Some, such as Georgina Harris, explicitly mention their intended audience, in this case subtitling her work 'for the perusal of friends at home'. However, stylistic decisions such as these may be criticised as part of a desire to further add to the air of authenticity these works trade on; as Jane Robinson points out, the long voyage back to Britain would have provided ample time for the writing and editing of their experiences, and at least one diarist, Kate Bartrum, stated that her status as a widow compelled her to publish. See Robinson, *Angels of Albion*, pp. 249–51.

17 R. Steinitz, *Time, Space, and Gender in the Nineteenth-Century British Diary* (Basingstoke: Palgrave Macmillan, 2011), p. 4.

18 F. Nussbaum, *The Autobiographical Subject: Gender and Ideology in Eighteenth-Century England* (London: Johns Hopkins University Press, 1995), p. xi.

19 Steinitz, *Time, Space and Gender*, p. 110.

20 Steinitz, *Time, Space and Gender*, p. 111.

21 R. Fothergill, *Private Chronicles: A Study of English Diaries* (Oxford: Oxford University Press, 1974), p. xx.

22 B. Anderson, *Imagined Communities: Reflections on the Origins and Spread of Nationalism* (London: Verso, 2006), p. 5.

23 M. Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India 1600–1850* (Oxford: Oxford University Press, 2002), p. 19.

24 Robinson, *Angels of Albion*, p. 252.
25 Nussbaum, *The Autobiographical Subject*, p. 28.
26 Klaver, 'Domesticity under siege', 27. As well as delineating their standing in the social hierarchy, Klaver also notes that the diarists were nearly all married, or were widowed in the course of the siege.
27 Emily Polehampton mentions the presence of another woman, Mrs MacDonough, who volunteered at the hospital after her child died. Spelling of names varies between diarists, and MacDonough may be a corruption of MacDonald; it is possible that this woman is Surgeon John MacDonald's widow. See H. S. Polehampton, *A Memoir, Letters and Diary of the Rev. Henry S. Polehampton, M. A.* (London: Richard Bentley, 1858), p. 347.
28 In later life Joseph Lee became a hotelier, and whilst perhaps not quite a member of high society, had increased his social standing to the point where his recollections were considered valid, or he could afford to publish them himself.
29 K. Carter, 'The cultural work of diaries in mid-century Victorian Britain', *Victorian Review*, 23.2 (1997), 81–2.
30 It is interesting to note the frequency with which the same publishing houses print accounts of the Mutiny, with Richard Bentley and John Murray publishing the majority of the testimonies from Lucknow.
31 A. Case, *Day by Day at Lucknow* (London: Richard Bentley, 1858), p. 20.
32 Fascination with the elements of India can be found earlier in the letters of Eliza Fay, and much later in E. M. Forster's *A Passage to India* (1924) or Salman Rushdie's *Shame* (1983).
33 Inglis, *The Siege of Lucknow*, p. 182.
34 Klaver, 'Domesticity under siege', 28.
35 G. Harris, *A Lady's Diary of the Siege of Lucknow (Written for the Perusal of Friends at Home)* (London: John Murray, 1858), p. 80.
36 M. Germon, *Journal of the Siege of Lucknow* (London: Constable and Co., 1958), pp. 58–9.
37 Robinson, *Angels of Albion*, pp. 74–5. Instances of women using or servicing weapons at Lucknow appear in sources as diverse as J. G. Farrell's *The Siege of Krishnapur* (1973), which drew on the diaries produced at Lucknow in its creation of the fictional cantonment of Krishnapur, and episode 1 of series 2 of *Downton Abbey*, in which the Dowager Countess of Grantham, played by Dame Maggie Smith, mentions a relative who 'loaded the guns at Lucknow'.
38 G. Moore (ed.), *Diary of the Doctor's Lady* (Bedford: Jaycopy Ltd, 1979), p. 20.
39 Much has been written about the development of nursing as an extension of the idealised role of women in Victorian society; see for instance, A. Bashford, *Purity and Pollution: Gender, Embodiment and Victorian Medicine* (Basingstoke: Macmillan Press, 1998), esp. chs 2 and 3; or M. Vicinus, *Independent Women: Work and Community for Single Women, 1850–1920* (London: Virago, 1985).

40 Harris, *A Lady's Diary*, p. 101. Despite their efforts, Herbert Dashwood died that evening.
41 Harris, *A Lady's Diary*, pp. 78–9.
42 An overview of the changing role of alcohol in contemporary Indian medicine can be found in Ethel Landon's *Alcohol: A Menace to India* (Madras: Christian Literature Society for India, 1918). Though there are religious links evident in this publication as well as connotations of the temperance movement, the debate over alcohol and medicine in India was largely secular in nature. For a wider discussion of the use of alcohol in medicine in nineteenth-century Europe see H. Paul, *Bacchic Medicine: Wine and Alcohol Therapies from Napoleon to the French Paradox* (Amsterdam: Rodopi, 2001).
43 Robinson, *Angels of Albion*, p. 171.
44 Moore, *Diary of the Doctor's Lady*, p. 20.
45 Polehampton, *A Memoir*, p. 347.
46 K. M. Bartrum, *A Widow's Reminiscences of the Siege of Lucknow* (London: James Nisbet & Co., 1858), part 6.
47 Inglis, *The Siege of Lucknow*, p. 73.
48 For a discussion of the links between religion and nursing see A. Summers, 'The costs and benefits of caring: nursing charities *c.* 1830–1860', in J. Barry and C. Jones (eds), *Medicine and Charity before the Welfare State* (London: Routledge, 1991), pp. 133–48.
49 Polehampton, *A Memoir*, p. 345.
50 Polehampton, *A Memoir*, p. 107.
51 See W. Russell, *The Crimea: As Seen by Those who Reported It* (Baton Rouge: Louisiana State University Press, 2009, first published 1856).
52 Bartrum, *A Widow's Reminiscences*, chs 4 and 6.
53 Chick, *Annals of the Indian Mutiny*, p. 870.
54 Polehampton, *A Memoir*, p. 345.
55 Robinson, *Angels of Albion*, pp. 224–5.
56 Polehampton, *A Memoir*, p. 291.
57 Robinson, *Angels of Albion*, p. 236.

2

Imperial sisters in Hong Kong: disease, conflict and nursing in the British Empire, 1880–1914

Angharad Fletcher

British nurses, much like those enlisted in the colonial or military services, frequently circulated within the Empire as a professional necessity, often in response to the development of perceived crisis in the form of conflicts or disease outbreaks, prompting reciprocally shaping encounters between individuals within the various colonial outposts. More traditional approaches to the history of nursing are enclavist in the sense that they have argued that nursing practice, education and policy were established and consolidated in the metropole before being exported to the colonies by British nurses, and as a consequence, professional nursing developed independently in each of the colonial outposts. However, cases like that of 'Nellie' Gould illustrate that nursing practice was equally constituted on the peripheries, and that a complex network of nursing ideas existed within the British Empire, fuelled and enhanced by the mass migration of nurses between various colonial locations.

Ellen Julia Gould (known as Nellie) was a well-travelled woman. Born in the Monmouthshire town of Aberystwyth in 1860, she spent ten years of her youth studying languages in Portugal before returning to London and later working as a governess in Hamburg. After a family visit to New South Wales she began a two-year nurse training course in January 1885 at Sydney's Royal Prince Albert Hospital, a shift in vocation resulting in the almost continual accumulation of professional accolades over the coming four decades. In February 1899, while she was matron of the Hospital for the Insane at Rydalmere, Colonel (Sir) William Williams sought her advice on the formation of an Army Nursing Service Reserve (ANSR) that was to be attached

to the New South Wales Army Medical Corps (NSWAMC). Three months later, Gould had amassed twenty-six nurses and assumed the post of lady superintendent. On 17 January 1900 she, along with thirteen nursing sisters, left Australia to participate in the Second Boer War (1899–1902), serving at hospitals in Sterkstroom, Kroonstad, Johannesburg and Ermelo, often beside Buller, the Rhodesian ridgeback that had become the adoptive mascot of the ANSR team. Upon returning to Australia, Gould, alongside fellow veteran Julia Bligh Johnston, founded the Ermelo Private Hospital in Sydney, and continued to work tirelessly towards the professionalisation and amelioration of both general and military nursing in Australia, the latter in her role as principal matron of the 2nd Military District. As part of this process she helped create the Australasian Trained Nurses Association (ATNA) in 1899, serving as a council member until her retirement in 1921 and instigating the publication of the association's journal in 1903. On 27 September 1914, shortly after the outbreak of the First World War, Gould joined the Australian Imperial force (AIF) as matron of the No. 2 Australian General Hospital (AGH). She and six other nurses arrived in Alexandria on 4 December, remaining there long enough to nurse casualties from the Battle of Gallipoli (from April 1915 to January 1916). She finally returned to Australia in 1919, after a stint on the Western Front and the award of a Royal Red Cross (1st Class) and was discharged from the AIF at the age of fifty-seven, at which point she retired from professional nursing.[1]

Nellie Gould is remembered as a visionary and pioneer, prompting the often rather triumphalist and sanitised recording of her biographical details. She has frequently appeared in military and medical histories of both the Second Boer War and the First World War, and has been central to many commemorative endeavours, for example the Australian War Memorial's 2011 exhibition *Nurses: From Zululand to Afghanistan* and, most recently, ABC's celebratory TV miniseries *Anzac Girls* (2014). Like her colleagues in South Africa, Gould was unmarried (as were all nurses of her time) and dedicated to her profession, and early photographs are constructed depictions delineating her embodiment of idealised nursing qualities, including bravery, selfless commitment and education, qualities that were subsequently among those of the quintessential Australian combatant immortalised in the Hall of Memory at the Australian War Memorial. Her

perpetual association with the development of Antipodean nursing is understandable. She was trained in Australia, dedicated her professional life to the instigation and expansion of nursing infrastructures in New South Wales and her 'frontier experiences', her links to the 'old country' and her military experiences (particularly at Gallipoli), allow her to be easily assimilated within the early formation of notions surrounding Australian nationalism. More specifically, her encounters have rendered her an integral part of the feminised reshaping of the Anzac Legend, the controversial and evolving cultural concept founded partially upon the apparent personal qualities of the romanticised Antipodean soldier.[2] Consequently, it might be argued that her professional sense of self-identity was decidedly local.

However, despite being claimed as Australian as part of a process of patriotic redefinition and the resultant need for domestic cultural icons, a process that was largely posthumous in her case, Nellie Gould was a true product of empire. Her origins were British, her training Australian, and much of her experience gathered in the European metropoles and their colonial outposts. The knowledge she gained as a result was utilised to help expand and reshape professional infrastructures in her adoptive homeland. To remember her predominantly in an Australian setting, or within the confines of histories exploring the Second Boer War or the First World War, disregards the formative impact of Gould's colonial experiences and is indicative of the enclavist, overly descriptive and somewhat atheoretical tendencies that have predominated a great deal of nursing history in preceding decades.[3] Her encounters, and their professional and personal resonances, transcend national borders and the chronological boundaries of the conflicts she is most frequently associated with. These experiences and their influences were transnational, and they should be considered, like those of many of her fellow sisters, particularly those in colonial or military service, within the context of what Tony Ballantyne has labelled 'webs of empire'; cultural and economic networks which connected colonial outposts to other locations, thus creating mutually influential relationships aided by technological developments, for example the expansion of print culture.[4] The recognition of such networks allows the internationalisation of colonial history and challenges previous suppositions regarding the interaction between metropole and colonies.

This approach is not designed to perpetuate assumptions surrounding the 'global' as an analytical and descriptive category, nor yield to what Warwick Anderson has labelled 'the hydraulic turn'.[5] It does not assert that a universal, identically replicable 'placelessness' existed in nursing education and practice. Instead, the intention is to look precisely at the individuals, institutions, ideas and events that connect these places, while at the same time recognising the impact inherent differences between locations had on the development of the nursing profession. The examination of specific sites is productive as it allows the influence of their interconnected nature to be recognised, as well as facilitating the equally revealing exploration and comparison of their differences, comparisons which often prompt interesting further questions surrounding race, gender and professional relationships within medical infrastructures and among the wider populace.[6]

While distinguished, Gould's experiences as a nurse are indicative of broader trends rather than mere idiosyncrasies. Sister Brenda Marie Hoare, born of Irish aristocracy in Ceylon, trained at St Thomas' Hospital in London before working at Bloemfontein during the Second Boer War and later returning to the Indian subcontinent in 1903 as Lady Superintendent of the Afzalgunj Hospital at Hyderabad. Marianne Rawson, one of only three Australian women to be awarded a Royal Red Cross (1st Class) during the Second Boer War, received her education in the UK and Ireland, experiences that would, collectively, lead the Governor-General's wife to seek her advice on the establishment of the organisation that would later become the Australian Red Cross. Some, like Miss Eastmond, the first matron of the Government Civil Hospital in Hong Kong, would return repeatedly to the same location to complete numerous tours of service.[7] Others utilised their overseas experiences to help leverage promotions at home and in different outposts. Sister Helen Batchelor, for example, used her training from The London Hospital to gain a post at the Government Civil Hospital in Hong Kong in 1898, and five years later she appears as the newly appointed matron of the Government Civil Hospital in Mauritius.[8]

The pages of professional journals from the age, including the *Nursing Record/British Journal of Nursing*, are replete with similar overseas opportunities and appointments from all areas of the British Empire, allowing nurses at various stages of their careers to exploit

the professional networks contained within. The use of biographical fragments, like those of Nellie Gould and her colleagues that appear within these journals, as well as other contemporary textual sources, enrich evidence offered by more conventional representations of nursing. This allows, as Clare Anderson, Alan Lester and David Lambert have demonstrated, a fresh interpretation of the character and significance of 'networked empire' and supports a restatement of the importance of individual agency to the development of the type of administrative systems and reformative undertakings that often arose in response to societally disruptive events like disease outbreaks or wars.[9] The evident movement of nurses within the Empire was not characterised by seamless 'flows' of capital, trends or ideas. The implementation of British nursing practice and education varied between outposts, was facilitated by the conscious, strategic choices made by career-minded individuals, and was often a point of contestation for colonial authorities that only the bigger danger of a perceived crisis could help assuage.

Crisis as a lens

The prevalence of existing medical histories exploring the development of nursing during the Second Boer War or the First World War means that the decades between 1880 and 1914 remain largely neglected despite being crucial to the institutional expansion of nursing in the British Empire. The period witnessed many of the numerous expected markers of professional standardisation and stratification on an international level. These included the formation of the first nursing schools in dozens of colonial outposts, the first registration and national regulation of nurses in the Cape Colony and New Zealand respectively, the foundation of the International Council of Nurses and the Colonial Nursing Service, the addition of a nursing corps to the military medical services of numerous countries and the growth of the International Committee of the Red Cross.[10] Such developments were the result of years of collective effort and again indicate that the expansion of nursing practice transcends the selective geographical and chronological focus of many existing histories.

The period was also characterised by instances of global crisis, which provide an important context for reappraising the history of nursing at a local, national and transcontinental level, as well as acting, at least in part, as a catalyst for many of the operational changes listed above. Perceived crisis, as exemplified by the Second Boer War and outbreak of what was later referred to as the third plague pandemic, exist as disruptive events and reveal underlying and often invisible social, economic and political processes. The period between 1880 and 1914 encompassed various other examples of perceived crisis in which nurses played a vital role. Aya Takahashi, for example, has written eloquently about the transformative function of Japanese nurses during the Russo-Japanese war (1904/5), particularly their encounters with enemy wounded and their part in the adoption of innovative triage procedures. Such events, while able to command the attention of the international medical community, were not necessarily recognised as 'global' in their outcomes or impact.[11]

As Charles Rosenberg demonstrated in his work on cholera in America, crisis functions as a sampling technique as well as a subject, creating a stimulus and contrast, and thus allowing an assessment of the reactions and social changes prompted by the event.[12] However, despite describing a compelling paradigm Rosenberg ignores the fact that wars are equally revealing as opportunities to examine societal change. In the late nineteenth and early twentieth century warfare was often prompted or prolonged by similar developments in disease outbreaks, including expanding transport networks, economic competition between nations and technological advancements. Reactions to such events were often shaped by numerous influences. The individual character of different locations of crisis, its racial and socio-economic composition, administrative structure and geography all played their part; and comparisons between such sites expose municipal deficiencies, assigned culpability and administrative solutions that were often strikingly similar.

Case study: plague in Hong Kong

Carol Benedict argues that the outbreak later referred to globally as the third plague pandemic probably originated in the Chinese

province of Yunnan in the 1850s. Intermittent rebellions against the Qing court, and a lucrative trade in opium and tin, provided corridors for inland disease reservoirs to costal ports such as Guangdong, Guangxi and Guangzhou. This process is likely to have been further aided by the growing opium trade between Yunnan and coastal cities such as Beihai, a focal point on both the Red River and You Jiang trade routes. Plague probably first entered Hong Kong via Beihai, where it had been present since 1867, although it was only when the junk boats travelling between the two ports were replaced by steamships in the 1880s, making travel faster and more convenient, that the likelihood of transmission was greatly increased. From its arrival in Hong Kong in 1894, the disease spread internationally, as well as to other ports along the Chinese coast, including Xiamen, Shantou and Fuzhou. While precise figures remain contested, Myron Echenberg estimates that the third plague pandemic claimed 15 million lives globally between 1894 and 1950.[13]

While the financial and demographic impact of the plague across the Empire remains questionable, a general consensus has emerged among many scholars that plague was an idiosyncratic threat within the realm of colonial medicine. Mark Harrison has claimed that most people perceived plague as 'yesterday's disease' before 1894, a reminder of the unenlightened and insanitary conditions of the past, while Dorothy Crawford argues that it was only when this outbreak actually hit Hong Kong and threatened global trade interests that any serious preventive measures were taken or systematic research attempted.[14] Despite the fact that later changes to the colony's medical infrastructures, though extensive, were more evolutionary than revolutionary, the economic implications of the epidemic certainly meant that a local sanitary issue drew global attention. As Robert Peckham states, 'The plague, with its epicentre in China, confirmed a perceived shift of global orientation eastwards from Europe to Asia and, in particular, to China.'[15] While the economic importance of the colony is rarely debated, some scholars question Hong Kong's strategic significance as a vital link in Britain's imperial defences.[16] But in the context of the plague pandemic, the actual economic and strategic significance of the enclave is of less importance than its professed prominence, just as the actual threat posed by disease outbreaks is of less interest than the *perception* of danger. As plague spread, municipal leaders in Hong

Kong fell increasingly under pressure to act decisively. Global scrutiny and the potential introduction of international quarantine rules threatened the colony's economy, which depended on trade. This and the danger of mass emigration by the colony's transient labour pool were enough to prompt extensive alterations to municipal systems.

Cities like Hong Kong are of significance because, as imperial hubs of trade and transportation networks, they were amongst the first places to be affected by epidemic outbreaks of disease. As a result, they became cornerstones for imperial prevention measures against the spread of disease, and arguably developed to some extent with this purpose in mind. By the time plague arrived in the colony, Hong Kong was an intrinsic part of an imperial web spanning the globe and bound by new developments in transportation, technology and telecommunications. It was one of the busiest ports in the world, handling half of all Chinese imports and a third of exports, comprising 22 million tons of goods, 2 million more than London. Trade was facilitated by approximately 4,000 European residents working alongside 200,000 Chinese labourers, most of whom were Cantonese immigrants from the mainland.[17] Although it was an overwhelmingly Chinese city, John Carroll has argued that Hong Kong was, to some extent, a multi-ethnic society comprising Chinese, Europeans, Americans, Armenians, Indians, Portuguese from Macau, Jews from Bombay and Eurasians, who gravitated towards segregated communities yet maintained extensive daily contact.[18] Successive Governors noted that Hong Kong was a 'peculiar colony, unlike any other', founded not as a settlement but as a mercantile station and although a small overseas community slowly took up residence, it was not meant as a place for permanent British inhabitation but, rather, an important part of 'a commercial and not territorial empire'.[19] Nevertheless, the city remained a gateway between East and West, a point at which the transference of people and ideas helped foster a space characterised by cultural tensions and interchanges.[20] However, the disassociated and transient nature of community, and the policies of retrenchment and *laissez-faire* governance adopted by both Britain and the various governorships, meant spending on societal infrastructures was limited and sanitary problems persisted for decades until expansive change was both catalysed and financially justified by instances of perceived socioeconomic crisis, for example the arrival of disease outbreaks.

The fragmented nature of the community was reflected in the medical services available, with hospital care often left to various charitable organisations. By 1894, the colony was equipped with around half a dozen hospitals including the Government Civil Hospital, which catered predominantly to the small European community and those of different ethnicities with governmental connections, and the Tung Wah Hospital, which embraced the principles of traditional Chinese medicine. However, the scale of the plague outbreak, when it hit the colony, warranted the rapid establishment of several supporting institutions, including the redeployment of the hospital ship *Hygeia* (1891), the Kennedy Town Infectious Diseases Hospital and the Glassworks Hospital.[21] As might be expected, the quality of care varied between institutions, with the Tung Wah Hospital frequently criticised as an institution which 'at present hardly deserves the name of Hospital'.[22] The newly arrived European nurses were based predominantly at the Government Civil Hospital, although they did visit, sanitise and occasionally work shifts at other hospitals. Their indispensability was quickly established and firmly asserted by Dr James Lowson, then Acting Superintendent of the Government Civil Hospital, who felt the institution would cease functioning if they were moved, even on a temporary basis.[23]

As the point of international origin, Hong Kong's size, status and geographical location meant that plague, and any solutions developed to prevent future outbreaks, including the attempted implementation of a stratified and professional nursing system, would draw international interest. From the first days of the infection, the professed fiscal significance and insanitary conditions of Hong Kong's Chinese districts internationalised the issue; the latter further strengthened by proximity to the apparent sanitary threat posed by mainland China and the Chinese workers who frequently migrated across the border. The established trope of the inherently unhygienic indigenous populace, and the danger their numbers and immediacy posed to European settlers, permeates governmental correspondence of the age as this example from the annual report of Dr Philip Bernard Chenery Ayres, appointed as the last Colonial Surgeon of Hong Kong in 1873, illustrates:

> The habits of the Chinese do not assist in the sanitation of the house. In each of the partitions referred to is a bed on which the family sleep, under the bed is a poo poo tub, which is of glazed earthenware with a cover to it,

> this is used for the night soil for the women and children, and is emptied according to the class inhabiting the house from once every two days to once a week. The bedding used by the Chinese is never washed, and among the lower classes they seldom wash themselves …. As for the roads and streets, Chinamen are to be seen pursuing their avocations on the paths and even in the roadway, throwing slops, animal and vegetable refuse out of their houses into the road at all hours …. The drain traps are openly used by coolies as urinals, and the stench so caused in some places is abominable … the road always in a state of wet and filth from the refuse, offal and slops thrown out of the houses. If this is so in the principle thoroughfare of Hongkong [*sic*], what it must be in Tai-ping-shan, where few Europeans go, it is not difficult to imagine.[24]

As plague cases began to appear in other treaty ports around the world, equally pathologised phobias surrounding local populations were again evoked. In this instance perceived crisis was so traumatic because it revealed not only the inherent weaknesses in the fractured and disparate medical systems that rapidly became overwhelmed as the number of cases rose, but also wider civic tensions surrounding such issues as the deplorable sanitary condition of several areas of the city, or the arguments presented by many foreigners that the indigenous population were intrinsically insanitary. As Mark Harrison has shown of the 'plague-like' disease that struck India in the 1830s, the illness, 'and what it is framing tells us about the imperial ideologies and the economic and political priorities of the colonial government'.[25] In Hong Kong, as in other locations, the outbreak consequently expedited the fulfilment of a longstanding political agenda of the colonial government that advocated, among other measures, the demolition and rebuilding of the "native Chinese" neighbourhood of Taipingshan, as well as providing an opportunity for the administrative justification of the substantial governmental expenditure required to implement such changes.

Crisis and policy

Among the governmental expenses that could now be justified, in the face of threat to the colony's economic future posed by the appearance of plague in their midst, was the recruitment of qualified British nurses. In Hong Kong, as in other treaty ports, the need for professional European nurses to replace the *ad hoc* system of indigenous

workers of both genders, and members of religious orders, predated their arrival by decades. Such shortfalls in the provision of care are likely to have arisen at least partly as a result of the colonial government's desire to keep administrative costs to a minimum and a bipartisan attitude of retrenchment towards the colonies in Britain, at least before the outbreak of the Second Boer War.[26]

The same was not true of 'settler societies' like Melbourne or Sydney, cities that developed with the aid of the transplantation of entire administrative systems from Britain, including those related to the education of nurses.[27] In other colonial locations it required the presence of a medical crisis for local authorities to recognise the importance of good nursing, exemplified by the new approach to nursing and nursing infrastructures which had been developing in Europe and the USA since the mid nineteenth century. A mere twelve years before the third plague pandemic struck, Dr John Ivor Murray, Surgeon-Major and then Acting Superintendent of the Government Civil Hospital in Hong Kong, stated this need in his annual report:

> As in former years, much of the credit of the good results attained in this institution is due to the care and assiduity of Dr. Cochran, the Resident Surgeon Superintendent; but the one great difficulty he has to contend with, and which apart from the mere defects of the building, he will continue to find the most embarrassing, is that of obtaining good nursing. The Chinese coolies are altogether unsuited to this employment and are utterly untrustworthy – and the few Europeans who are willing to serve in the capacity of wardmasters, are generally men who can obtain nothing better, and are only a degree superior, in many respects, to the Chinese. If it were possible to induce the Sisters of Charity to undertake this duty, the benefit would be incalculable.[28]

In Hong Kong, as in other locations, the demand for trained European nurses must be viewed within the context of more general sanitary reforms designed to address the immediate threat of plague and at the same time, demonstrate that the colony was doing all it could to improve standards of cleanliness, in accordance with new understandings of hygiene science. The period between 1880 and 1914 saw significant shifts in the understanding of disease and the provision of healthcare, underpinned by transnational developments in biomedicine, economic priorities and broader social changes. The plague bacillus, for example, was first isolated in 1894 in Hong

Kong after an intercontinental race between Kitasato Shibasaburo, a Japanese bacteriologist and protégé of Robert Koch, and Franco-Swiss alumnus of the Pasteur Institute Alexandre Yersin.[29]

Technology presented a double-edged sword: not only did it reshape disease prevention and healthcare policy, it also facilitated the mass migration of people, creating new pathways for the spread of disease. At the same time, new conduits for the exchange of knowledge on combating the spread of disease were being formed, not least by the movement of nurses from colony to colony. In Hong Kong, changes in sanitary practices (and the associated costs) were justified not only by new understandings of disease causation and the economic dangers posed by outbreaks in a city dependent on transnational commerce, but also, after the 1830s, as a result of changing scientific theories surrounding 'acclimatisation'. According to contemporary arguments, the various 'racial types' struggled to adapt to new climates; and new ideas surrounding ethnic constitutions and regional climates began to gradually affect administrative policy and were increasingly utilised to justify the disparity in death rates between European and indigenous populations. As a result, it was now the task of the colonial authorities to remake spaces in order to bolster health and meet their requirements.[30]

By the time plague appeared in Hong Kong, medical and administrative authorities of most other colonial outposts were advocating the reshaping of the existing environment to improve the health of all concerned. In Hong Kong, however, foreigners continued to be advised to either adapt to their new environment or remain isolated from volatile indigenous elements. The arrival of British nurses was part of an ongoing wider redefinition and reformation of both medical and civic roles and spaces designed to improve the entire sanitary condition of the colony. These included the rebuilding of the native district of Taipingshan, the completion of the Tai Tam reservoir, the construction of the first designated mortuaries and the restructured role of hospitals throughout the city. Thus nurses were finally recognised as a fundamental part of the public health provision that Hong Kong had long required and now apparently could not function without. They would be a crucial part of the expansive hygienic reforms initiated by the third plague pandemic, many of which resulted in the increased demarcation and stratification of

Hong Kong's medical spaces and personnel. As nurses were increasingly viewed as an essential part of the clinic or hospital, as a locus of emerging biomedicine, they also became an advertisement for the provision of Western medicine within what Mary Louise Pratt has termed a colonial 'contact zone'.[31]

Such changes are discernible in etymological shifts visible in administrative correspondence from the colony; before the 1894 plague pandemic, the term 'nurse' was indiscriminately applied and could denote a private or missionary nurse of unspecified training and nationality, or any of the local men and women, referred to on other occasions as 'coolies', performing a range of custodial or nurturing functions inside the city's hospitals. After 1894 and the arrival of certified European nurses, the distinction between 'nurses' and 'sisters' became gradually more concrete, and many of those previously deemed 'nurses' became 'amahs' or merely 'prohibitioners', as restrictions determined by education, experience and ethnicity were implemented. The term 'Sister' now applied only to trained European practitioners or to the members of the French and Italian convents required to intermittently perform nursing functions during preceding decades.

Despite now being viewed as an essential part of healthcare provision, the employment of nurses, and the implementation of wider sanitary reforms, still required fiscal justification. The decades between 1880 and 1914 were a time of retrenchment for the British Empire, as the Gladstonian Liberal Party adopted, partially in response to the Second Boer War, the motto of 'Peace, Retrenchment and Reform', calling for reduced public spending and the removal of monopolies, arguing that they were undemocratic and that the Empire itself was a financial burden that impeded the development of Britain. Such policies had an effect on the changing provision of healthcare and the development of the nursing profession in the various colonial outposts of the British Empire. These changes were manifested in Hong Kong as concerns in response to demands for any increase in funding required to combat the arrival of plague. By the spring of 1895, Dr John Mitford Atkinson was not the only member of the colonial medical establishment to recognise the inherent value of the nine British sisters who had arrived to help combat the outbreak of plague, and his comments were echoed by other affiliates from the special

sanitary committee assembled to deconstruct and assess precisely how the infection had been managed within the colony. According to Dr Philip Bernard Chenery Ayres, encouraging more European nurses to come to Hong Kong 'would be very much for the benefit of the Colony'.[32] His report continued that despite the acknowledged expense incurred by the colonial and home governments in this course of action, identifying and training local European or Eurasian replacements would be impossible, thanks to the unwillingness of resident women to undertake such rigorous instruction and the inability of the medical authorities to provide a nursing education equal to that available elsewhere.[33] The possibility of training Chinese nurses in the same capacity was tentatively raised but then rapidly dismissed. Miss Eastmond, now matron of the Government Civil Hospital and leader of the newly arrived sisters, was equally condemnatory when questioned about the professional potential of both European and Chinese residents of Hong Kong. Instead, after being encouraged to speak in terms of medical benefits rather than economic costs, she chose to advocate the recruitment of additional colleagues from the London hospitals if required, as it was the only way to ensure quality.[34]

Dr Lowson agreed with Ayres in part. However, although when he considered the cost of bringing more professional nurses to the colony, and the need to provide those already there with sufficient leave to meet contractual stipulations and preserve their health, he balked at the prospect. He proposed instead a scheme for instructing Eurasian locals, who could then be utilised in the hospitals of Hong Kong before finding useful employment as private nurses throughout the treaty ports of China. Nevertheless, he was careful to state that these women would only ever be 'nurses', always subordinate to the invaluable European 'sisters'.[35] His plans were shelved as concerns regarding the maintenance of quality medical care, particularly that available to Europeans, and the questionable ability of local women to assume a vocation as personally and professionally challenging as nursing, superseded fiscal worries. Dr Atkinson was careful to note that:

> His (Dr. James Lowson's) idea was that Eurasian girls should be trained at the Hospital. I do not think we could make any reduction in the staff of Sisters. I do not think it would be advisable to put these Eurasian girls on the same footing as the trained European nurses. They are not only trained European nurses but ladies, and these Eurasians would lower the status

> of the nursing staff. They would require to be simply prohibitions, under European trained nurses; I would never appoint them on a level with the European nurses.[36]

It is worth noting that such racially influenced views were not so prevalent in greater China, where the dominance of missionary hospitals meant that the frequently reiterated goal had always been to teach the Chinese to care for their own people. However, in locations administered to a greater or lesser extent by European powers, concerns surrounding the preservation of professional standards and racial boundaries, alongside an apparent commitment to improving local sanitary conditions, often took precedence over cost. Crisis provided an opportunity to ignore financial restrictions and justify longstanding objectives. It was perhaps internalised concerns surrounding cost, as well as a desire to capitalise on the associated professional kudos of introducing professional nurses to the colony, that caused Dr Lowson to identify nursing reforms as one of the triumphs of the plague:

> If ever this Colony has had reason to congratulate itself it was when we were able to procure well-trained British nurses. I think the greatest compliment that I can pay these ladies is to say that had it not been for their presence there could have been no well-run epidemic hospital during last summer. Amateur nurses at the beginning of an epidemic, or indeed at any stage where there is a rush, are worse than useless, and multiply the worries of a medical officer *ad infinitum*; not only this but all outsiders took care to give our hospitals a wide berth. When the hospitals were crowded it was often a matter of difficulty for the Medical Officers employed to keep their meals in their stomachs. It would have been much harder if they had had to remain in constant attendance all the time as our Sisters had to.[37]

Conclusion

While this chapter examines Hong Kong as a neglected case study in the history of nursing it also argues that the expansion of the city's medical infrastructures, like those of any colonial outpost, should be viewed in relation to developments in the metropole, as well as other locations throughout the Empire and beyond. This is not to argue that there was uniformity in nursing practice and education, or that it was universally replicable. Instead, the aim is to acknowledge the influence of other locations, while at the same

time to explore the factors that made nursing practice in Hong Kong inherently different, for example the ways in which British nurses were employed in the city, as well as the reluctance to use European or Eurasian women in similar roles. To adopt such a methodology allows us to challenge previously held misconceptions regarding the metropole–periphery binary, for example the argument that nursing education and practice was formulated and consolidated in the capital before being exported, inviolate and uncontested, to the colonies. When not bound by the limitations enforced by discussing nurses exclusively within the confines of chronological and geographical enclaves, we can at the same time acknowledge the fact that they, like other forms of colonial labour, were part of complex and nuanced circulatory network.

While the need for nurses, or the reform of existing nursing practice, may be longstanding in different locations, pragmatic and expansive change was often prompted by instances of perceived crisis in the form of wars and disease outbreaks. These events helped shape nursing infrastructures by creating unprecedented professional opportunities and mutually influential encounters, while at the same time acting as a sampling technique that highlights instances of institutional continuity and change. In the case of Hong Kong, the arrival of plague in 1894 exposed existing shortfalls in the fragmented medical institutions, an *ad hoc* approach to nurses that had previously served the colony. The incident was also used to financially justify the recruitment of the professional British nurses the local medical authorities had long felt the city required. In this case, crisis and the movement of medical personnel it prompted indicate that the arrival of British nurses was part of both local and international sanitary reforms, as Hong Kong dealt with the plague as part of an attempt to bring domestic healthcare standards up to those available elsewhere in the empire.

Notes

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3 Notable exceptions to this trend include A. Digby and H. Sweet, 'Nurses as culture brokers in 20th century South Africa', in E. Waltraud (ed.), *Plural Medicine: Tradition and Modernity, 1800–2000* (London: Routledge, 2001), pp. 113–29; J. Howell, A. M. Rafferty, R. Wall and A. Snaith, 'Nursing in the tropics: nurses as agents of imperial hygiene', *Journal of Public Health*, 35 (2013), 338–41; M. Jones, 'Heroines of lonely outposts or tools of empire? British nurses in Britain's model colony, Ceylon 1878–1948', *Nursing Inquiry*, 11:3 (2004), 148–60; D. Solano and A. M. Rafferty, 'The rise and demise of the Colonial Nursing Service: British nurses in the colonies, 1896–1966', *Nursing History Review*, 15 (2007), 147–54.

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10 See B. Abel-Smith, *A History of the Nursing Profession* (London: Heinemann Educational Books, 1960); R. Dingwall, A. M. Marie Rafferty and C. Webster, *An Introduction to the Social History of Nursing* (London: Routledge, 1988); A. M. Rafferty, J. Robinson and R. Elkan, *Nursing History and the Politics of Welfare* (London: Routledge, 1997).

11 A. Takahashi, *The Development of the Japanese Nursing Profession: Adopting and Adapting Western Influences* (London: Routledge Curzon, 2004).

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13 Literature on the spread and impact of the third plague pandemic is extensive and varied. Excellent summaries of the illness in a global or local context include

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14 M. Harrison, *Contagion: How Commerce Has Spread Disease* (New Haven: Yale University Press, 2012), p. 174; D. H. Crawford, *Deadly Companions: How Microbes Shaped Our History* (Oxford: Oxford University Press, 2007), p. 90.

15 R. Peckham, 'Infective economies: empire, panic and the business of disease', *Journal of Imperial and Commonwealth History*, 41:2 (2013), 211.

16 F. Welsh, *A History of Hong Kong* (London: HarperCollins, 1993), p. 285.

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34 'Medical Committee Report on the Plague', 3 April 1895, pp. 11–14.
35 'Medical Committee Report on the Plague', 3 April 1895, pp. 39–41.
36 'Medical Committee Report on the Plague', 3 April 1895, p. 70.
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3

The social exploits and behaviour of nurses during the Anglo-Boer War, 1899–1902[1]

Charlotte Dale

During the Second Anglo-Boer War, two key watchwords associated with serving nurses were 'duty' and 'respectability'.[2] At the commencement of war, women from across the Empire, including trained nurses, saw the opportunity to travel to South Africa to experience war and work alongside men as their equals, caught up in a patriotic fervour to defend and expand the Queen's lands. The war, which resulted from years of ambitious encounters over gold deposits, Afrikaner expansionism and continued conflict between long-term settlers in South Africa and newly arrived British subjects, had an inevitability about it.[3] Conflict had followed conflict in the previous two decades as Britain attempted to expand its Empire and take control of the rich mineral fields of southern Africa, fighting first the Zulus (in the first Anglo-Zulu War of 1879) and then the Boers, in the first Anglo-Boer War of 1880–81. A series of smaller skirmishes followed, culminating in the Second Anglo-Boer War (1899–1902) at the end of the century.[4]

This chapter will reveal the weaknesses in the organisation of military nursing at this time and the disciplinary problems resulting from the presence of large numbers of young women, detached from social bonds which maintained their behaviour within acceptable limits. It provides an insight into the social exploits and experiences of nurses during the Second Anglo-Boer War and illustrates societal expectations of moral conduct and the impact accusations of 'frivolous' behaviour had on the views of both the medical authorities and nurses themselves. In this specific colonial context, also referred to by Angharad Fletcher in Chapter 2, nursing was being provided across

(what was to become) 'South Africa' by a number of different agencies which have been described as 'reflecting the disjointed course of colonial development [in South Africa]'.[5] This 'nursing' included care by family members and traditional healers for much of the indigenous population, the basic nursing and medical knowledge of European missionaries, the presence of trained European nurses, as well as the Afrikaners' and their servants' own home remedies and nursing methods. Furthermore, Indian immigrants, 'brought with them their own systems of medicine and associated beliefs and practices, including Ayurvedic medicine, Siddha, massage, a vast range of herbs, oils and spices and even a variant of Acupuncture'.[6] Rather than viewing military and military-associated nursing in isolation it should be appreciated therefore that nursing in the Boer War needed to navigate this gamut of systems.

Furthermore, the nurses who came to support the military at the outbreak of the Second Anglo-Boer War were at the forefront of a vocation that had a particular need to assert itself as a 'profession', reflected in the fact that South Africa was the first country to introduce state registration.[7] Keiron Spires has shown that these same women were mostly 'ordinary nurses who wanted the experience and challenge of working in South Africa, or who were caught up in the conflict and continued to nurse the sick and wounded under new circumstances'.[8] His research demonstrated their 'relative youth and inexperience and the lack of a nursing structure within which to practice'. And yet, as Anne Marie Rafferty has pointed out, these relatively inexperienced and naive 'new nurses' who were 'charged with a civilising mission at home' were sent to the colonies where they became 'bearers of that same mission across a great expanse of empire'.[9] Such nurses were to play a crucial role in winning the confidence of indigenous communities, and the decorum and demeanor of the nurse was her most powerful tool in asserting her authority over the 'native personnel'.[10] This chapter will examine how this expectation of nurses to be couriers of the colonial project was challenged by the poor organisational structures in place at the beginning of the Boer War and how the Boer War experience led to a complete overhaul of the structure and management of military nursing and nurses in wars to come.

The importance of good military nursing first emerged following the medical atrocities of the Crimean War and the widespread

acknowledgement of Florence Nightingale's nursing endeavours. In 1857, in the wake of that war, the Army Sanitary Commission proposed that trained female nurses should be introduced into Army hospitals. These nurses would take charge of and be responsible for patients' cleanliness and nourishment, attend to minor dressings and administer medications, all under the orders of the Medical Officer.[11] Anticipating the problems which might arise if young men and women were to join together in the armed services, Nightingale recommended that only women deemed to be of appropriate character and with previous experience as head nurses should be proposed as candidates; only such women could be trusted to behave respectably, as, she claimed, 'misconduct in women is more pernicious in a military hospital than any other'.[12] After persuasive lobbying from Nightingale and her supporters, and despite strong opposition from the military, a small Army Nursing Service (ANS) was established in 1861. But it failed to thrive, and the Army reverted, for the most part, to its old system of male orderlies.[13]

In the following decade, as need dictated, small numbers of female nurses were recruited into the service of the Army, and accompanied them on the various African campaigns, including those in Egypt and Sudan in the 1870s and early 1880s. Fourteen nurses served during the Anglo-Zulu War of 1879, but it was not until 1881 that the call for a more formal Army nursing service was revived. It was proposed that the National Society for Aid of the Sick and Wounded in War (also known as the National Aid Society and the forerunner of the British Red Cross) would provide training for nurses destined to support the Army during times of conflict.[14] This initiative marked the rebirth of the Army nursing service, with a code of regulations for a 'Female Nursing Service' published in 1884. However, the full implementation of the National Aid Society's original plans, which included the creation of a reserve of nurses trained in military nursing, did not take place, hampered by a lack of space in military hospitals in which to accommodate such nurses in times of peace.[15] By 1897, though, it was accepted that the existing ANS, which consisted of one Lady Superintendent, nine Superintendents and sixty Nursing Sisters, was totally inadequate to serve the needs of the armed forces in the event of large-scale war.[16] This led to the establishment of the Army Nursing Service Reserve, with Princess Christian, Queen Victoria's daughter,

as its president (henceforth PCANSR).[17] Its aim was to guarantee sufficient numbers of trained nursing staff in the event of war, while preventing an influx of unqualified volunteers, such as the 'lady war tourists' who had meddled in the nursing management during the Crimean War.[18]

The establishment of the PCANSR was not universally welcomed: at least one national newspaper charged that wartime service held a 'rather romantic glamour' whereby an 'average nurse' could experience the realities of war, from the comparative safety of the base camp.[19] Nevertheless, whether nurses felt it their duty to serve as patriotic members of the wider Empire, or desired to participate in the 'romantic glamour' of wartime service, hundreds of female nurses were enlisted into the Reserve during the three-year period of the Second Anglo-Boer War. Against a background of growing patriotic jingoism and a sense of duty to Queen and Empire, it is perhaps unsurprising that so many British nurses, and women in general, wished to 'do their bit'.[20] A further motivation for some nurses may have been the lure of public recognition: the Royal Red Cross (RRC), inaugurated in 1883, was a prestigious award that provided nurses with tangible evidence of their service. It allowed recipients to place themselves alongside Florence Nightingale and other 'heroic' recipients such as Nurse Catherine Grace Loch, of the Indian Army, and Sister Janet King, who had served during the Anglo-Zulu War.[21] Historically, female nurses have been motivated for a variety of reasons to engage in military campaigns: as historian Jane Schultz illustrates in the case of the American Civil War, women were 'moved variously by patriotism, self-sacrifice' and of course in a search for adventure.[22] At the commencement of the Second Anglo-Boer War in 1899, female nurses were also attracted to wartime service by the increased opportunities it offered to travel unchaperoned and to experience the theatre of war, with less censure than that received by their predecessors.[23]

Nevertheless, those women enlisting for wartime service who were tempted by the prospect of opportunities for travel and social exploits alone were condemned by many of their peers and by the general public as 'frivolous'.[24] In this period, an era heavily steeped in social ideals concerning the respectability and suitable role of women in society, a woman who behaved in such a manner risked her own reputation (and respectability) and also that of her family and her institution.[25]

According to contemporary rhetoric, there were only two types of nurse: the 'good nurse', presented as a self-sacrificing angel, a woman ready to deny all in her dedication to those within her care; or her polar opposite, the 'bad nurse'. This was a woman willing to abuse her position of 'power and authority' for her own means. This depiction of nurses as either 'good' or 'bad' reflects the Victorian rhetorical device of dichotomies, where, as Juliet Hallam points out, nurses are situated within the 'virgin/whore dichotomy'.[26] So influential was this discourse that it continued through the First and Second World Wars, when nurses were often depicted as 'sexless white angels' or as 'predatory' and 'highly sexualised' women who preyed on officers or doctors in search of an advantageous marriage.[27]

It should be recalled, that back in England at the end of the nineteenth century, the battle for state recognition and control of nursing was being waged with government, the medical profession and within the body of nursing itself. It was imperative for nursing leaders to ensure that the 'good nurse' image was not only protected, but that it dominated public discourse. While there was no central control over the practice of nursing (no national standardised training or systems of examination were in place) and in theory anyone could call themselves a 'nurse', in practice all large hospitals (and most small ones by the end of the century) provided some level of training and certification for their probationary nurses.[28] Nevertheless, this essentially unregulated environment created an ambiguity regarding the position of nurses and news of 'frivolling women' acting as nurses from southern Africa would do nothing to promote the cause.[29] Furthermore, the nurses who served in southern Africa came from across the British Empire, and British nurses, both military and civilian, found themselves working alongside nurses from the colonies, some of whom had already attained registration. The British nurses would have been acutely aware that the heritage of nursing within the colonies was instigated by their predecessors, who went out to support and establish the first schools of nursing. The fact that many of these nurses from outposts of the Empire, such as New Zealand and South Africa, had achieved through registration what the British nurses had so far failed to do must have rankled.[30] Minnie Goodnow has argued that although England was in a class of its own as a 'great leader' in nursing practice and innovation, and that 'the world … followed her move',

yet in respect of registration Britain was not at the forefront, other British Dominions were winning the battle for professional recognition ahead of the mother country.[31] Anne Marie Rafferty observes that leaders such as Ethel Fenwick, who spearheaded the registration movement in Britain, used the achievement of registration in British dominions as further support for her arguments for nurse registration in Britain.[32] Paradoxically, the Cape Colony in southern Africa was the first part of the British Empire to introduce a form of nurse registration, in the late nineteenth century.[33] It was therefore feared that detrimental allegations of bad behaviour by nurses in South Africa might have a negative impact on the drive for registration at home.

The behaviour and respectability of British nurses, therefore, came under close scrutiny during the Second Anglo-Boer War, starting as soon as they boarded their ships. Princess Christian entreated the senior nurses who were travelling out to South Africa with the nursing corps to act as moral supervisors over their junior nurses and to provide reports on those who did not behave appropriately, to both the head of the Red Cross and to Princess Christian herself.[34] While ensconced in the relative safety of the ship, it was possible to exert strict control over the nurses, but this was no longer possible on landing in South Africa, where numerous opportunities for the nurses to 'frivol' opened up.[35] Later, during the Royal Commission of 1901 into the reorganisation of the Army nursing service, part of the blame for this lack of control was put on weaknesses in its organisation, and particularly a lack of leadership of the nurses in South Africa. The problem lay in the structure of this nascent Army nursing service. Its Lady Superintendent was based at Netley in the UK, thousands of miles from the nurses over whom she wielded authority; and that authority was further diminished by her position in the Army hierarchy relative to her male counterparts.[36] As a consequence lines of command were weak and unclear.

On arrival in South Africa, the majority of British and colonial nurses from Australia, New Zealand and Canada were based in military camps or garrisons caring for wounded or sick soldiers of the Empire. Increasingly, however, some found themselves assigned to the concentration camps established by the British, initially for Boer refugees fleeing from the fighting. As the camps grew in size and number, as a result of the British 'scorched-earth' policy adopted in 1901 which saw Boer

families burned out of their homes and their farms destroyed to cut the supply lines to the Boer fighters, demand for nurses in these desperate places became more and more pressing.[37] Africans attempting to escape the fighting were also caught up in the 'scorched-earth' policy and were interred, in separate camps. Disease was rife within the camps, with high numbers succumbing to measles, typhoid and pneumonia.[38] Concerns were raised in Britain by social reformers such as the radical liberal Emily Hobhouse over living standards in the camps and the lack of medical care.[39] There were insufficient doctors and nurses to properly staff the camps, and priority was given to the care of British and Empire soldiers.[40] Following outcry in the press and in response to reports raised by Hobhouse and others over standards of care in the camps, a large-scale recruitment campaign commenced, with approximately a hundred nurses joining up, many from Scotland.[41] As Elizabeth van Heyningen has explained, they came for a variety of reasons, including 'a sense of adventure', but also (and perhaps more importantly) for financial reward, as the pay was superior to that in Britain.[42] However, while van Heyningen has revealed new evidence in her most recent book on the experiences of life in the camps, she has found little relating to the doctors and nurses who worked in them, making a discussion of the social life of nurses who worked in the camps, in comparison to the military hospitals, beyond the scope of this chapter.[43]

The main medical challenge facing newly arrived nurses and doctors was not, as might be expected, the care of the seriously wounded but, rather, the challenges created by conditions in the military camps of poor sanitation and overcrowding. Morbidity studies of serving soldiers reveal that typhoid fever was the most prominent of all diseases and featured regularly in nurses' personal testimonies and in the wider nursing press.[44] Although typhoid was not the only disease affecting the troops, their living conditions and general poor health left them particularly vulnerable to outbreaks of this disease.[45] In the absence of any pharmaceutical tools with which to tackle typhoid, careful nursing was the key to successful treatment, a fact well known and recorded by doctors. For example, Dr A. Knyvett Gordon, writing in the *Nursing Record* in 1901, acknowledged that 'the recovery of the [typhoid] patient depends not so much on the prescribing of any particular drug, or line of treatment as on the way in which the treatment is carried out – that is to say, the efficiency of the nursing'.[46]

It is clear that alongside their clinical duties, nurses also had the opportunity to participate in a varied and active social life despite the high demands of caring for the Army's sick and wounded. In Bloemfontein, where an epidemic of typhoid fever was raging through the ranks, Nurse Dora Harris chronicled in her diary the many social events she had attended, despite the overwhelming numbers of typhoid cases to be nursed. Although exhausted after a demanding shift nursing typhoid patients, she recalled one night staying up until midnight making a fancy-dress outfit for a 'Variety Race' she had been invited to the next day:

> In the afternoon Sister's Friend, Ross, Smyth and I went to Bloemfontein to buy material for fancy dresses for the Variety Race, and we sat up till 12 making them. The most absurd is the ballet girl's – pink tarlatan and roses. Mine is a Japanese Kimono, and the other two a clown and [a] baby.[47]

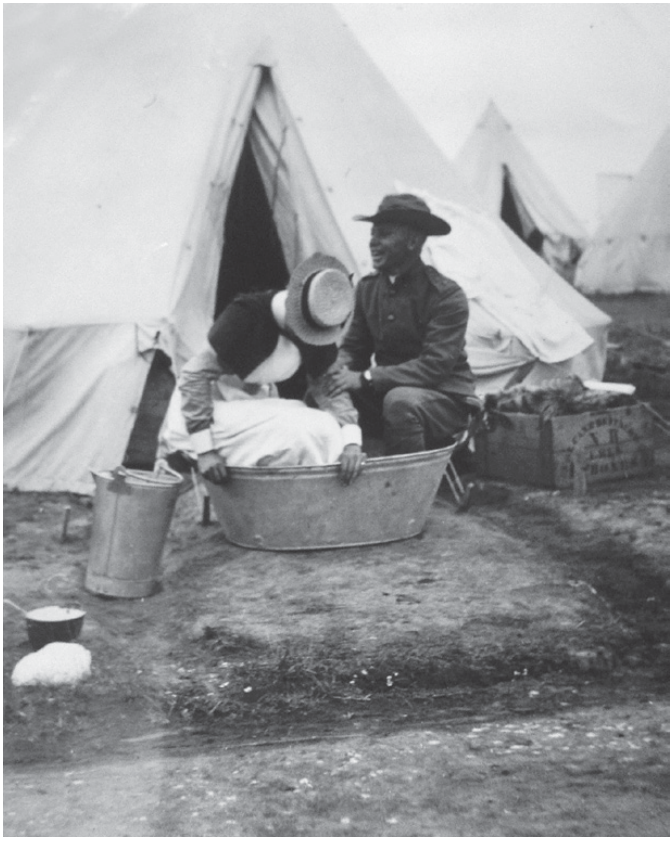
After the success of the fancy dress 'Variety Race' and during a period of night duty, Harris persuaded another nurse to cover her duties until 3 a.m. so that she could attend a local English colonists' dance, leaving at 2 a.m. to complete her duty. It seems she did not even stop to change into civilian clothes, claiming to have proudly worn her nurse's uniform while indulging in 'plenty of dancing' and enjoying herself 'immensely' as it 'was very jolly'.[48] During their service in South Africa, nurses recorded their many varied excursions in their personal correspondence. They recorded their daily opportunities for riding or how they spent their off-duty hours in learning to ride. They attended regular musical concerts within camps or in local towns, croquet and polo parties and went on numerous picnics across the veldt, in addition to afternoons spent rowing with medical officers, before participating in games of cricket and hockey.[49] Emily Wood, a Scottish Reserve nurse based at the Royal Red Cross Hospital in Kroonstad, proudly wrote to her family that she had formed part of the nurses' team pitted against the hospital's male cricket team, before going on an outing to the zoo to see the springboks.[50] On another occasion she was invited to attend a 'Cinderella Dance'. In preparation for the dance, she wrote in her journal:

> On Monday I had to buy a pair of white silk gloves 3/-, plus a pair of fancy slippers 8/6 plus some lace for fancy capes, the Colonel having given his

> sanction to our going to the Cinderella Dance at the Kroonstad Hotel. [However] we were not allowed to wear our scarlet capes.[51]

Although the nurses discussed in this chapter regularly described their social exploits in their diaries, they also commented on their working lives and the hardships of working life in South Africa. It is clear many nurses worked long and arduous hours, but there were disparities owing to a lack of overall authority over the various groups of nurses. PCANSR nurse Edith Hancock recorded that following a long and tiresome journey to her nursing assignment she was required to reside in less than salubrious surroundings. Hancock wrote on arrival at Green Point that the work 'was killing', owing to a lack of equipment and suitable accommodation as there were 'no extras, barely necessities, which made it much harder – we had to pig it no end in our own quarters too – we were so cramped and the only place to cook, a small open fireplace'.[52] Opportunities to participate in social encounters may well have offered light relief from the everyday trials of camp life. Like the women who followed the Army in campaigns such as the Crimean War, the women and nurses of the Anglo-Boer War were required to endure and adapt to insalubrious and often insanitary conditions with few complaints.[53] The social events described with such relish by nurses may have helped them to 'escape' their daily hard work, while continued praise and public acknowledgement of their uncomplaining acceptance of arduous conditions encountered in the course of providing a humanitarian service to the sick and wounded would have raised their professional confidence, and challenged the perception that women were physically inferior.[54]

Nevertheless, not all nurses were seeking opportunities for social exploits during their wartime service. Ethel Becher, who by the First World War had been promoted to Matron-in-Chief of the Queen Alexandra's Imperial Military Nursing Service, had left her position at The London Hospital in December 1899 to enlist as a Reserve nurse.[55] Eager to distance herself from accusations of 'frivolling', Becher wrote to Sydney Holland, chairman of The London Hospital House Committee, to assure him that his nurses were maintaining the respectable image of his hospital, demonstrating impeccable behaviour while in South Africa. She wrote, 'of course we have in many circumstances refused to go to picnics, riding and driving parties in company with many khaki clad young men'.[56] She makes clear in the



3.1 'Two in a tub', Estcourt 1900

same letter her disillusionment at the behaviour of some of her nursing colleagues and the potential damage they did to the reputation of nurses generally:

> We are associated in every way with a body of women so many of whom one feels ashamed to think were ever nurses, in fact I have been tempted to wish I had never come out to be mixed up in the mind of the public with such a collection.[57]

Fellow Reserve nurse Eleanor Laurence also recorded her distaste at the behaviour of some her nursing colleagues, recounting in a letter

written at the General Hospital, Natal in 1901 that twelve of her fellow nurses had attended a 'big dance', and on another night had gone to 'some theatricals' which in Laurence's opinion seemed to be 'festivities' that were

> a little out of place while the war is going on. Some of the sisters appear to think that they have come out here to have as much fun as they can get, and talk about very little except the men they have been dancing with, and so on.[58]

Laurence remarked how, at first, the nurses had been allowed to attend dances and riding picnics with soldiers, until their conduct began to be talked of in an unfavourable manner.[59] As a result of the disquiet surrounding such behaviour, the nurses had been provided with 'rules to conduct', rules that Laurence felt it should not have been necessary to issue to a lady. But unladylike behaviour did occur and Laurence was aware of a colleague who had been seen at a local station hotel 'smoking a cigarette with a most undesirable companion!'.[60] The issue bothered her, and she returned to it again, stating that though there are plenty of sisters out here who are working hard and well, they will probably all get classed together in the public estimation with those who are simply "frivolling" and getting themselves talked about'.[61] With respectability identified as a 'Victorian watchword', and despite the fact that by the end of the century more women were moving into the public sphere to take up employment, the close proximity of unchaperoned women to a large body of men challenged ideals of Victorian respectability.[62] There was an expectation that women would not be 'open' with men or allude to heterosexual feeling, nor were they expected to consort unchaperoned without risk to their 'good name'.[63] Prevalent views of the period held that young women should be 'both sexually unawakened and inviolable', and were at risk of corruption by close contact with men.[64] These views account for the censuring of female nurses who appeared to revel in this inappropriate proximity.[65] Rafferty has observed such censure in her study of the Colonial Nursing Association, where 'The highly regulated and scrutinised order of [nurses' lives] as representatives of the empire meant any breach of the codes of conduct were met with stern criticism at best, and at worst the termination of their position as a CNA nurse.'[66]

The position of women in British society at the end of the nineteenth century was on the cusp of significant change: access to the workplace was increasing, more women were going out into the world and working alongside men (although often in gender-segregated spaces) and access to higher education was improving. Politically, the emergence of the 'new woman', promoted by the growing feminist/suffrage movement, was making significant challenges to the assumptions and mores of the earlier Victorian period. In this environment it seems only natural that some women would view an opportunity to travel to places like South Africa as a way of speeding up this process.[67] The idealised 'new woman' may have expected to go 'wherever she pleased without a chaperone', yet it is apparent that some nurses, such as Ethel Becher and Eleanor Laurence, found close social contact with male colleagues a source of discomfort for them and raised fears over personal respectability.

The preservation of respectability was also a consideration for Katharine Nisbet, matron of the voluntary Imperial Yeomanry Hospital in Pretoria, when rumours began to circulate that she had become engaged to a man, whom she claimed never to have actually met.[68] Eager to quash the rumours and preserve her reputation, Nisbet wrote to her fiancé, who was on a posting to Egypt, that she had heard that the man in question was already engaged to another nursing sister, who in turn had boasted to Nisbet that this was her '5th since coming out' and had declared that she was anyway already 'engaged to someone at home'.[69] Nisbet was anxious to ascertain what her fiancé's family thought of nurses, as she claimed, 'If I heard the mere fact with no particulars that a brother of mine was engaged to a nurse, call her a Sister or a Matron or anything you like, I should be dreadfully worried till I knew what she was like.'[70] Nisbet was worried that some nurses were 'improved so immensely by uniform … [and] by the regular rules of hospital life', but if just 'one in 100 is socially or any other "ally" [not] quite all right' then the reputation of all nurses was tarnished: just because a woman held the title of nurse and wore a uniform did not mean they were respectable.[71] The worrisome behaviour of some nurses in South Africa was further pondered by Nisbet in another letter sent some months later, reporting that her brother had

> told us terrible tales of the hospitals at Bloemfontein. He says he has been ashamed to own to having a sister nursing out here. Round where he is they

> have a horror of the whole thing, hospitals [and] all connected with them [and] to be a nursing sister is tantamount to being no longer a respectable member of society. Isn't it terrible to think such things can be …. They say it is the scandal of South Africa.[72]

Nisbet was fully aware of the ramifications for all nurses' perceived sense of propriety, with respectability contemporaneously understood as a style of living that demonstrated 'a proper respect for morals and morality'.[73] She appeared eager to reassure her new fiancé of her personal distaste for such behaviour; as a future wife she would have been expected to serve as her husband's 'helpmeet' and, as Patricia Branca states, to 'provide the proper environment of respectability'.[74] In this letter, Nisbet is merely reflecting the fears of nursing leaders and educators of the period, that such behaviour would encourage society to view nurses as anything but 'self-sacrificing angel[s]'.[75] Eva Luckes, matron of The London Hospital and author of training texts for nurses, echoed these fears:

> Think of the harm that is done if a nurse gives one man cause to think and speak worse of women than before he entered the hospital! Every nurse should remember that it depends upon herself, rather than upon the men with whom she comes in contact, whether they will ultimately leave the hospital declaring that they would not have their sisters enter upon such a life for all the world.[76]

It is apparent that men were not generally held accountable for a woman's fall from grace; rather, the responsibility lay with the woman to protect her own reputation. For nurses, it could be argued, the need was even greater as not only her own reputation was at stake but also the high 'measure of public distinction', in which nursing as a whole was held.[77] If nurses were discovered to have enlisted for wartime service with the sole aim of excitement and social pleasures, there would be an increased risk of 'nursing scandals' reaching the public back home and further challenges to the desire to shape nursing as a respectable and professional occupation for young women.[78]

Such concerns, over the appropriate behaviour and the perceived respectability of nurses, were central to discussions in the War Office Committee, which had been given the task in 1901 of reorganising the Army nursing services. The thrust of their recommendations was to

adopt the organisational structure found in the best civilian hospitals, to strengthen the authority of the Matron-in-Chief, putting the management of Army nursing under a newly constituted Nursing Board, and more in the control of senior nurses. Some members of the military found these ideas abhorrent and campaigned against them. Lieutenant-Colonel Alfred Keogh cautioned the Committee that in his opinion he did not believe a group of women could be trusted with the power they were going to be afforded under the new organisational structure. Women, he contended, were too likely to indulge in 'petty spites' and 'give it hot' to any nurse who usurped their position when going out into society, for example within garrisons to enjoy 'tea, dances and dinner parties'. They could not be trusted to behave rationally in the face of social pleasures and required guidance and support. Keogh concluded, 'Women have not the same feeling about these things. Theoretically it may be all right, but practically, in a garrison town, where these nurses are very much in society, going out to dinner parties, and all the rest of it, if the Matron-in-Chief is not the head in the society they are in, and goes amongst them and takes the lead', then he assumed that she could not be trusted to distance herself from perceived social slights and would behave in a 'spiteful' manner towards her fellow nurses.[79]

This was not a new complaint against women, but reflected prevalent views that women were incapable of organising themselves. They were held to be physically and intellectually inferior and therefore unable to deal with the realities of the male-dominated public sphere where all major decisions were made.[80] Hence the issue for the 'new woman' was not simply how to gain equal rights with men, but how to obtain recognition for their achievements in a man's world in their own right, this being problematic when faced with the opposition of powerful men such as Alfred Keogh.[81] For Keogh and his ilk, this 'power grab' on the part of nurses was part and parcel of the 'new woman' movement, another example of women overstepping the mark and setting themselves up against accepted behavioural norms. Keogh was ultimately unsuccessful, and in 1902, as the Second Anglo-Boer War was ending, a new Army nursing service was born under the presidency of Queen Alexandra, and named in her honour: the Queen Alexandra's Imperial Military Nursing Service (QAIMNS), which delivered most of the objectives the nurses had been fighting for.

Once female nurses were given a permanent place in the sphere of war it was necessary to ensure that there would be no future scandals at 'the front' regarding nurses' behaviour, and that they would not behave in any way which might serve as a distraction to the medical men and officers.[82] The nurses who had travelled to southern Africa with a combined sense of patriotic duty and a desire for new experiences had found themselves with no head of nursing and a lack of defined control.[83] Following accusations of 'frivolity', there was a need not only for reform, but also for consideration of the future social exploits of nurses during periods of war and peace. An article entitled 'Nurses, you must not dance!', written by John Strange Winter in the early years of the new service's creation, relayed recent discussions in Parliament regarding the testing question of whether Army nurses should be permitted to dance in their off-duty hours.[84] The question was raised in the House, and Mr Haldane, Secretary of State for War, replied that he had consulted the Nursing Board on the matter and had been advised that:

> The Nursing Board requires for His Majesty's nursing service gentlewomen who are devoted first and foremost to their work for its own sake and for the sake of their patients, and who will, therefore, desire to live quietly and unostentatiously without looking for much gaiety.[85]

It would appear that henceforth nurses would be required to behave respectably and that those social exploits enjoyed by nurses such as Dora Harris, who danced till 2 a.m. during a night shift, or Emily Wood, buying lace for new capes to attend a ball, would no longer be tolerated.

Yet, despite this penchant to 'go out into society' during their wartime service, army medical officials still acknowledged the vital importance of good nursing and nurses.[86] Wartime service offered women the prospect of travelling abroad to experience 'every exotic detail' of war, which for many was viewed as 'a once-in-a-lifetime' opportunity which had previously been the exclusive domain of men.[87] The behaviour which prompted accusations of 'frivolling' was the result perhaps of the combination of a relaxation of the social constraints at home and the unimaginable pressures during their shifts: 'frivolling' was a letting-off of steam during their off-duty time. This war has been described as the last of the gentlemen's wars, embodying Victorian

ideals of chivalry and a country-club atmosphere of polo parties and balls, which provided ample opportunity for nurses to escape the horrors of the wards.[88]

The accusations of frivolity, so pointedly made against nurses in the early phase of the Second Anglo-Boer War, served to support the arguments for enhanced authority over nurses serving in the sphere of war. The formation of QAIMNS in 1902 provided the organisational structure through which authority and discipline could be implemented. The permanent presence of nurses in war necessitated a new hierarchy of authority and the internal control of nurses by nurses. Although this new hierarchy remained ultimately subordinate to male authority, the 'problem' of nurses during the Second Anglo-Boer War appears to have been an important facilitator in the reform of military nursing.

Conclusion

On their arrival in South Africa, nurses appeared to exploit new-found freedoms to enjoy their off-duty hours alongside male colleagues, while still demonstrating their worth as expert practitioners. However, the social exploits of nurses in South Africa prompted anxieties surrounding the respectability and general behaviour of female nurses; it became obvious that if the 'good nurse' image was to be upheld, it was imperative that scandals which could damage the 'self-sacrificing angels' imagery should be avoided.[89] Summers has claimed that no other group of women 'received anything like the measure of public distinction and exposure accorded to nurses', and the body of nurses was determined to protect their hard-won and newly elevated position in society.[90] It is also apparent that such concerns guided reform of the regulations which would control the lifestyles of future Army nurses, with strict guidance on social intercourse in place by the First World War.[91]

The Second Anglo-Boer War provided an opportunity for British nurses to contribute to the maintenance of Empire and publicly demonstrate their worth as professionals, as women and arguably as citizens eligible for the vote.[92] Those nurses who demonstrated the superiority of their knowledge and skills provided further evidence for the need for State registration, to ensure that those with acknowledged training could be distinguished from 'amateurs'. And despite

concerns over nurses' social exploits and behaviour, historian Laura Nym Mayhall has argued that campaigners for women's suffrage, such as Millicent Garrett Fawcett (president of the National Union of Women's Suffrage Societies), believed the Second Anglo-Boer War provided British women with the ideal opportunity 'to demonstrate their fitness for citizenship by their willingness to perform services for the nation and empire in its hour of need'.[93] In addition it may be argued that the desire by nursing's leaders to curb nurses' 'frivolities', also (probably inadvertently) made them instrumental proponents of imperialism. Arguments surrounding women's contribution to this war and thus their rights to citizenship continued into the First World War, with claims that 'citizenship was itself validated by participation in the war effort, which in turn gave women confidence to make claims for greater equality'.[94]

It could be argued that while the project to professionalise nursing was buoyed by the work of nurses during the Second Anglo-Boer War, paradoxically, concerns over their behaviour and their social exploits were also key to the establishment of a more professional Army nursing service, and made a significant contribution to the drive for nurse registration at home. The establishment of the QAIMNS resulted in clear definition and demarcation of the work of the matron and sisters and their nurses, which became enshrined in the *Regulations for Admission to the Queen Alexandra's Imperial Military Nursing Service*. The regulations included specific guidance on the nurses' clinical role and duties and, as in civilian hospitals, extended into control of their personal lives, for instance dictating the time that nurses were to retire to bed and indeed to turn out their lights.[95] It also provided further evidence that one of the main aims on the establishment of the QAIMNS was to bring female nurses under the control of one single hierarchy, subject to a clear set of rules.

It is apparent that by the beginning of the First World War, only twelve years later, control over nurses' social exploits was firmly in place, with one nurse noting that, 'The rules regulating the social life of the Sisters are very severe and social intercourse with the Medical Officers is prohibited.'[96] The experiences of the Second Anglo-Boer War had produced a complete overhaul of Army nursing services with ramifications for all British nurses who ventured into the theatre of war in the future.

Notes

1 I would like to offer my sincere thanks and gratitude to Dr Sue Hawkins and Dr Helen Sweet for their excellent editorial input and additions. An earlier, shortened version of this chapter was published in the *Bulletin of the UK Association for the History of Nursing*, Issue 2, November 2013. Published here by kind permission of the Editor of the *Bulletin*.

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4

‘They do what you wish; they like you; you the good nurse!’:[1] colonialism and Native Health nursing in New Zealand, 1900–40

Linda Bryder

Introduction

In 1911 New Zealand’s Department of Public Health launched its Native Health nursing scheme, to serve the health needs of the local indigenous population, the Māori.[2] At that time the Māori population numbered about 52,000; most lived in extremely isolated small communities and had much poorer health standards than non-Māori. The circular announcing the scheme explained that the appointees would be trained nurses and midwives (nursing and midwifery registration had been introduced to New Zealand in 1902 and 1904 respectively). Their job was to ‘advise expecting native mothers, and … where possible, attend them in their confinements’ and to give instructions in ‘hygiene, the management of sick children, and the preparation of suitable food’. Appointments were open to Māori and European (Pakeha) nurses, although the announcement stated that ‘first preference … will be given to Maori nurses’. The nurses were also directed to encourage and assist young Māori girls who showed aptitude for nursing. The circular ended with a quotation from the English social reformer, John Ruskin, ‘In every moment of our lives we should be trying to find out not in what we differ from other people, but in what we agree with them.’[3]

This chapter focuses on these nurses, and how they were received by their Māori clients. It is not intended to be a celebratory account of

nurses educating and rescuing 'natives', fighting ignorance and superstition. But nor does it advance the argument that these nurses were simply agents of Western medicine and the State, as suggested by some commentators informed by social control and victimisation models of history writing.[4] Rather, I will show how Native Health nurses were often thrown into emergency situations during outbreaks of infectious disease, totally reliant on the help and co-operation of the local people who far outnumbered them, and how they were required to negotiate and be flexible in their nursing practices. Past historians have addressed the origins of the scheme and some of the obstacles faced, but have not examined in depth the nurses' experiences.[5] The following account utilises the rich source of the local nursing journal, *Kai Tiaki* (translated as 'Guardian' or 'Watcher'), launched in 1908. The journal's editor from 1908 to 1932 was Hester Maclean, who encouraged nurses to send accounts of their experiences, which she published in the journal. They provide a rare glimpse of the everyday lives of nurses at that time. Native Health nurses reflected on their experiences and offered plentiful advice to other intending nurses, providing insights into their cultural interactions with Māori communities.

The scale of the problem

Māori health was indisputably poor around the turn of the twentieth century relative to the local Pakeha (non-Māori) population. New Zealand became a British colony in 1840 and this was followed by an exponential increase in the European population, as well as a fall in the Māori population. Census data show that Māori population had declined from approximately 56,000 in 1857 to 42,000 in 1896.[6] There were no accurate data on births and deaths, since Māori were not required by law to register births and deaths until the 1912 Births and Deaths Registration Act.[7] Yet many estimates were made, including one in 1903 which showed that fewer than half of all Māori infants made it to their fourth birthday, at a time when New Zealand in general boasted the lowest infant mortality rate in the world.[8] Tuberculosis was recognised as a major disease for Māori (the first accurate estimates, produced in the 1930s, found it to be at least ten times higher than for non-Māori).[9] Both infant mortality and tuberculosis death

rates are indicative of the relative poverty of the Māori population at that time. In 1913 a smallpox epidemic claimed fifty-five Māori but no Pakeha lives.[10] The death rate from influenza in 1918 was ten times higher amongst Māori than non-Māori.[11] But the most immediate challenges in the early twentieth century were repeated outbreaks of typhoid in Māori *kainga* (villages). Public health historian F. S. Maclean estimated that in one small Māori community there were 258 known cases of typhoid in 1916 alone.[12] Typhoid was reflective of the poor sanitary conditions of Māori settlements in that era.

Origins of the Native Nursing scheme

The concept of a nursing scheme for Māori was first mooted in the 1890s by a group of young Māori men who had attended a private Māori school – Te Aute College – and who had formed an organisation to address Māori welfare.[13] The Te Aute Students' Association supported the suggestion in 1897 by one of its members, Hamiora Hei, to set up a system of nursing scholarships for Māori girls. They lobbied James Pope, Inspector of Native Schools, who in turn persuaded the Education Department to provide scholarships for Māori girls to spend one year training in a hospital, after which they would return to work in their communities. This new generation of Māori saw value in Western medicine.

The scheme was trialled in 1898 at Napier Hospital in the Hawke's Bay, a predominantly Māori area, and later at Auckland Hospital. The scholarships were extended in 1902 to three years, and in 1905 to include a full nursing training. By the following year, nine Māori women had completed their training. Hamiora Hei's sister, Akenehi Hei, was one of those early Māori nurses, entering Napier Hospital in 1901.[14] In 1909 the Department of Public Health employed her in Te Kao, Northland, during a typhoid epidemic, and she was subsequently stationed in other Māori areas, in Taranaki and Gisborne.

The Department of Public Health, which had been set up in 1901, began employing Māori nurses for Māori areas in 1907. Historians have assessed the scheme to train Māori nurses and employ them within their own communities as a failure, owing in part to the reluctance of some matrons to train Māori women and because there were simply not enough to meet the demand.[15] Yet this conclusion is probably

overstated; taking a longer view over subsequent decades indicates that many more Māori nurses were trained than had been assumed. In 1923 *Kai Tiaki* reported, 'Quite a number of Maori girls have gone through the Auckland Hospital, the Napier Hospital, and the Waikato Hospital, and have qualified as nurses and done valuable service afterwards for their own people.'[16] In 1929, the Superintendent of Native Nurses, Amelia Bagley, maintained, 'Applications from Maori girls for nurse training are always sympathetically considered, and there are always a number of Maori nurses in training, and we always have a certain number acting as Maori Health Nurses.'[17] A 1954 article suggested there were 'many highly qualified Maori nurses', although it is difficult to quantify them; while their names can be used as a partial indicator of ethnicity, this is not necessarily a reliable index.[18]

The first European woman employed by the Health Department to nurse amongst Māori seems to have been a Miss McElligot, who nursed in an isolation camp during a typhoid epidemic in the Waiapu District in 1910.[19] Following the official launch of the Native Health nursing scheme in 1911, Amelia Bagley, a qualified nurse and midwife who had been an assistant inspector in the Department of Hospitals and Charitable Aid since 1908, was appointed to Ahipara in Northland, again during a typhoid epidemic. Bagley described her experience at Ahipara as 'quite out of the usual run of nursing'.[20] She set up a temporary hospital at the local *marae* (meeting place) during the epidemic. By the end of 1912 Bagley had established five nursing stations around the country under the Health Department scheme, leading to her appointment as Superintendent of Native Health Nurses in 1913. She soon had twelve nurses working for her, and in 1915 the District Health Officer paid tribute to her efforts: 'the establishment of eight or nine hospital camps during the year at short notice, and in more or less inaccessible places, is no small work'.[21] By 1920 there were twenty stations, and by 1940 there were fifty, each serving communities of about 1,750 people.[22]

Whether the nurses were Māori or Pakeha, to a large extent their experiences were similar. In particular, their accounts show that the first challenge was the physical one of survival in remote areas with few resources, making them totally reliant on the local population. Mostly they were coping with typhoid epidemics under the guidance of Bagley; *Kai Tiaki* pronounced: 'the necessity for the district nurses

to concentrate on this strenuous nursing … does not permit of our nurses doing so much in other directions, where they could teach that prevention is better than cure'.[23]

A position of responsibility

In setting out the requirements for nurses to take up Native Health nursing Amelia Bagley made it clear she wanted the best: with the 'very best qualifications, both general and midwifery'.[24] When she advertised a position in the Māori district of Te Araroa in 1912 she explained that the posting was 'a most responsible one, the nearest doctor being fifty miles away, at Waipiro. When he is connected by telephone, it will be a great relief to the nurse. Even then, she must act on her own initiative a great deal.'[25]

Nurses in post underscored that sense of responsibility. Akeheni Hei sent letters to *Kai Tiaki* describing her experiences, starting in 1909 when she was stationed in Te Kao. Patients in Hei's area included 'two rheumatic fever, two tubercular children, eight with symptoms of typhoid', and the nearest doctor was located some twenty-five miles away.[26] Qualifying as a nurse and midwife in 1916, Ngapori Naera was 'appointed district nurse to Te Kaha [in the Bay of Plenty], perhaps the most cut off district in the country'.[27] *Kai Taiki* described this as a huge responsibility since the nearest doctor was at Opotiki, some sixty miles away.[28] In 1923, a tribute to Nurse Blair, who had worked as Native District nurse for two years at Kahakara, gives an impression of the work involved. The district was cut off by a flooded river and bad roads from any medical aid, except by telephone, making the nurse 'entirely responsible' for all cases of accident, illness and maternity in her area.[29] Nurse Tait, who had taken up the position at Te Araroa advertised by Bagley in 1912, reflected on this responsibility: 'the position the nurse is placed in, to act as doctor, to diagnose, treat, prescribe and dispense, makes one sharpen every faculty to do the very best possible. … I like the work and read more medical books now than ever before, in my nursing career.'[30]

There was little mention in their accounts of interactions with local doctors. Historian Derek Dow has documented some opposition to the presence of Native Health nurses from doctors, who had been

subsidised by the government to work in Māori areas since the 1840s.[31] Nurses were not deterred, however; as one 'old district nurse' declared in 1917: 'There is no doubt a good nurse is better than the average medical practitioner in the back-blocks.'[32] The number of subsidised doctors fluctuated between thirty and fifty in the first two decades of the twentieth century; with almost half stationed in the South Island or near Wellington, i.e. not in the most populous Māori areas, this meant that the nurses had little recourse to them in any case.[33]

Jane Minnie Jarrett, who had been a Native Health nurse since arriving in New Zealand from Newcastle upon Tyne in England in 1913, spoke at a refresher course on Native Health nursing in 1928. She too mentioned the 'anxiety of relying solely on oneself', which she said was a great responsibility and required nurses to 'keep up with the times'.[34] However, keeping up with the latest medical developments was not the only, or even the most important, requirement for a Native Health nurse.

A hostile environment

Among the prerequisites which Amelia Bagley listed for a Native Health nurse was 'good health'.[35] From their accounts it is clear that the position required considerable physical stamina and the ability to withstand disease. In the course of her duties Akeheni Hei was thrown from her horse and drenched with rain so that she was laid up for six weeks in 1910.[36] *Kai Tiaki*, which followed Hei's career with great interest, regretted in October 1910 that the next instalment of her interesting account was not yet to hand, and in the following issue announced the sad news of her death on 28 November 1910. Still in her early thirties, she had succumbed to typhoid whilst nursing members of her family. Nurse Tira Parone, who was in her second year of training at Gisborne Hospital, and described as 'a very promising Maori probationer, and a great favourite with her teachers and fellow nurses', also died of typhoid in 1913.[37] Another Māori nurse, Maud Mataira, who had trained at Wanganui Hospital in 1911, died in the 1918 influenza epidemic.[38]

It was not only Māori women who were susceptible, and nor was it necessarily peculiar to New Zealand; anyone working in such epidemics is subject to risk. Florence Gill, nursing typhoid cases in 1911,

contracted the disease, along with her colleague, Nurse Herdman.[39] In 1914 Nurse Grigor at Waikato contracted measles, then 'shortly after closing her camp hospital, nurse had the misfortune to develop typhoid herself, and is now being nursed in Hamilton Hospital'.[40] In 1916 *Kai Tiaki* referred to Nurse Blackie at Tauranga as 'not having recovered sufficiently from her very severe attack of enteric [typhoid] last year'.[41] Gladys Johnson, who qualified at Wanganui Hospital in 1922, contracted typhoid fever and diphtheria in the course of her duties.[42]

Even when they did not contract an infectious disease, the work was physically demanding. When trying to attract a nurse to the Māori district of Te Araroa in 1912, Bagley put a positive spin on the physical environment, explaining the necessity of riding: 'You reach them by tracks or beaches, and a good canter over a hard wet beach is truly exhilarating, and helps through the worry usually found at the other end.'[43] In 1914 *Kai Tiaki* reported on Nurse Dawson's work in Thames, commenting, 'The journeys to many of her kaingas have been most trying during the winters particularly those on the Hauraki swamp after leaving the launches.' Dawson herself explained, 'The swamp is simply appalling in the way of bad roads and mud, and Waitakaruru is the worst. In one place it took me an hour and three-quarters to do less than two miles, and I got bogged at the end of it. My horse simply could not get out. Just had to sit still and possess my soul in patience till two Maoris [*sic*] came to my assistance.'[44]

Nurse Fergusson was stationed in Northland from 1919. *Kai Tiaki* commented on her building and carpentry skills as 'an unequalled example of what a woman can accomplish if she so desires, and the need presents itself, in work that she is supposed to be incapable of doing'.[45] She even made most of the furniture herself, admittedly with some assistance from the local teacher, Mr Vine, and local Māori who raised money to provide materials for her house.

Local assistance

Teachers in the Native Schools had acted as informal health workers since the advent of the Native school system in 1867, including dispensing medicine and health advice.[46] Teachers were well established in the communities and far more numerous than nurses. When she

was stationed in Te Kao, Akeheni Hei was accommodated and assisted by the local schoolteacher.[47] Nurse Dawson referred to a schoolmaster who went to Mokamoke with her because he thought the road was not safe for any stranger to go alone – much less a woman: 'He is a very nice man, and so interested in the Māori children. I found him very helpful indeed.'[48]

Most of the support, however, came from Māori residents. Bagley warned nurses that they could not expect to function under the 'approved hospital style', but must work with the assistance of the people concerned.[49] After setting up a temporary hospital at a Māori meeting house in 1911, she explained, 'I am making them all bring their own things … and for help I am engaging a Maori woman at 15s. a week, whose child is just recovering, and who, with the child, is sleeping with me in the house to-night …. Then I am getting a girl (Maori) of 16 to do the rough work, and stay in the house for messages etc.' For Bagley 'rough work' simply meant unskilled household work. Parents of sick children often helped out, and Bagley commented that 'These Maoris [*sic*] are not bad nurses – especially the men.'[50]

Nurse Street reported in 1911, 'I cannot speak highly enough of the kindness and consideration shown by the Maoris [*sic*] to their nurse.' She pinpointed language as a problem, but added, 'usually there is a Maori on hand who can speak English well, and interpret for the nurse; also nearly every Maori can speak a good deal of English, and unless one was a very good Maori scholar, there would be a great risk of misunderstanding'.[51] Other nurses did learn to speak Māori. Nurse Cormack wrote in 1913 that 'I think I like this work more every day, especially now the Maoris [*sic*] know me, and I can speak Maori a little now.'[52]

Local stories abounded. One nurse described 'Three weeks in a Pah [a fortified village, now spelt *pa*]' in 1913, concluding, 'My best friend was the most untidy woman in the pah. Half-a dozen times a day she would come over to see if she could do anything for me. Every morning she brought a beautiful bunch of flowers and generally a rock melon, or fruit of some kind.' After this nurse left the *pa* she wrote that it was 'quite a treat to go back to the pah to see all the Maoris [*sic*]. They seem to regard me as quite an old friend.'[53] A 'Camp in the North' was described in 1913, where eleven patients were being nursed and where there had been one death. The nurse explained that

she had received help from a Māori man called Sam who 'attended to the firewood, carried all the water … went the messages etc. He had enough to do and was invaluable. He always left us a boiler full of hot water for our own baths before he finished for the night.'[54]

While there are a multitude of narratives illustrating successful interaction between the nurses and local communities, not all women managed to integrate so well. In 1914 *Kai Tiaki* told of a Native district nurse in Opunake, Taranaki, who resigned after nine months, 'failing to receive help and support in her work … finding that she could make no satisfactory headway with it'.[55] The editor hastened to add that this was 'the only retrograde step that has been experienced since the inauguration of the Native District Nursing Scheme'. The common impression was that the nurse had become 'quite a necessary institution in her district'.[56] Nurse Beetham at Okaiawa in 1912 was one such nurse; nursing in a large district kept her busy, with *Kai Tiaki* reporting, 'the natives are now becoming acquainted with her and where at first they looked upon the pakeha nurse with suspicion, they now send for her and consult her freely'.[57] One of the reasons for her success was probably that she was assisted by a Māori nurse, Eva Wi Repa.[58] Rapidly becoming an 'institution' in Māori areas, they could not do so without considerable Māori support.

Empathy and humility

Qualities other than good nursing qualifications and good health were also required. Nurses were well aware that they had to earn co-operation. Setting out the necessary requirements in 1912 Amelia Bagley stressed tact, patience, common sense and a sense of humour 'and above all things a great love of humanity and a deep insight into human nature, both its light and its dark side'.[59] The nurses were to be 'possessed with the happy spirit which can see the funny side of things and the faculty of making friends'.[60] These were not qualities which could be taught in a nursing school, as Nurse Anderson of Rotorua pointed out in 1914: 'They are so quick to realise one's attitude towards them, and a slight fancied or real will drive them away, while a little sympathy works wonders which proves again that a nurse's personality counts for as much as her training.'[61] These comments by Bagley

and Anderson suggest that initially at least Māori were quite wary of these newcomers.

Māori women had the advantage of knowledge of the language and customs but some historians have suggested that unless they returned to their own *iwi* (tribe) they were not given much respect, and that European nurses commanded more respect.[62] This was not the case with Akenehi Hei, who appeared to be well received wherever she went, as she herself wrote, 'They seem pleased to see me among them.'[63] Māori in fact took advantage of her knowledge of European society; in Taranaki they asked her to attend a native land meeting and to represent to the Minister of Native Affairs the need for a small local Māori hospital.[64]

Yet in bringing her European training into the local community, Hei faced similar challenges to those experienced by her Pakeha colleagues. She reported in 1909 that the death of a Māori girl in her temporary hospital had turned the locals against her for a time.[65] She was aware of the need not to ride roughshod over local customs and culture; this comprised an understanding of health and wellbeing which included not only physical and mental health but also spiritual health.[66] She recounted how Māori were widely debating the 'effects of European civilisation', noting that 'Even in the most Europeanised families there lurks a secret attachment for those dear old customs, which are the result of so many centuries of experience, and [significantly] *no doubt contain many things worth keeping*' [my emphasis]. She advised, 'Such customs (ancestral), having kept the Maori race in vigorous health for many generations, deserve consideration …. A greater knowledge of the native mind will inspire a greater and thereby a deeper sympathy for the Maori people.' Above all she concluded, 'Great discretion must be used not to offend the patient's beliefs, and at the same time uphold one's own mission.'[67]

Hei's message was not lost on Bagley. She advised nurses: 'By working with them and getting them to work with her on right lines the nurse is enabled to realise more the Maoris' point of view, which is not without reason, and also to understand the difficulties which come in the way of their doing things "pakeha fashion", as we would like.'[68]

It was not just the patients they had to deal with, Bagley warned, but the wider community. She told the nurses, 'It is seldom the patient, but always the friends who make difficulties, but to totally exclude the

friends would, in most cases, unduly depress, or cause injurious fretting on the patient's part, and arouse strong suspicions of the nurse's intentions towards the patient on the part of the friend.'[69] Her strategy was to engage a selected relative or friend to help nurse the patient. Again, she was cognisant of the need for tact.

In her 1928 lecture Nurse Jarrett stressed the importance of respecting cultural differences, informing her listeners of the tact and patience required, pointing out how months of good work could be lost if, for instance, a patient admitted to hospital for a simple abdominal operation died of anaesthetic pneumonia. She spoke of the need to respect the *tapu* (sacred things) of all sects, explaining that was where newly appointed nurses sometimes failed. She said, 'One must respect their religion, and be able and sincere when asked by the head of the household to hold a karakia (say a prayer) for their sick.' She also thought it important to 'be able to see the other chap's point of view, and gently insinuate one's own'. She believed it important to be honest, while 'Above all, one must have a keen sense of humour that is the saving grace.'[70]

Challenges confronting the nurses

With the best intentions in the world, affection for Māori, an open mind and a sense of humour, nurses still faced major challenges. Imbued with modern (Western) ideas about disease causation and prevention, they did attempt to confront what they regarded as hindrances to effective nursing and impose their will on the locals, even to the extent of admitting they could be 'quite bossy' with patients.[71] Challenges included isolation when dealing with infectious diseases, *tangi* (burial practices), maternity practices and the nurses' relationships with *tohunga* (traditional healers). At every step of the way they were required – or chose – to compromise.

The first issue many nurses had to deal with, as noted earlier, was typhoid. Bagley regretted that nurses were not trained adequately to deal with this condition outside a hospital setting. She believed the teaching did not prepare them for temporary camp hospitals which had poor or no drainage systems.[72] Nurses were instructed that 'early diagnosis and isolation' were essential, and that lack of sanitation was

a major factor.[73] Through *Kai Tiaki* they were instructed how to deal with typhoid. One nurse recounted how she dealt with 'excreta and sputum'; the latter she explained was very copious owing to chest complications. She explained her scrupulous cleaning methods and how she kept separate kerosene tins for excreta and for bath water. All utensils were brought to the boil for an hour or so.[74]

Maintaining such a strict hygienic environment was not always possible, however. In 1916 a nurse gave an account of extremely ill children, suffering from typhoid, ranging from five to nineteen years of age, whom she discovered 'in the most wretched surrounds on this Māori farm'. The old *whare* (house) was overcrowded and very exposed, 'Gales from various directions raged, and nursing could not be done under worse conditions than our nurses encountered there, I think, even in the trenches.' This nurse commented, 'To see what Māori typhoids live through, and the conditions they are frequently found in, makes one utterly disbelieve the hackneyed saying that "The Māori has no stamina, and, like other dark races, cannot fight out an illness etc.".'[75]

Understanding the need for isolation created a constant dilemma for the nurses. An account of typhoid nursing in 1920 advised, 'In nursing a case you must stay with them all the time. As soon as your back is turned all the family are in to rub noses, sit upon the bed, shake hands, have a talk and, if patient is hungry, give him something to eat.'[76] This closeness did not end when the patient died. The nurse who gave the account of typhoid nursing in 1916 explained how a nine-year-old child, who had been ill with typhoid for about eight weeks, was lying in state when the nurse arrived, awaiting the arrival of her coffin. The nurse reported, 'An extraordinary proceeding on the part of the Maoris … was that they were sleeping in this place, beside the dead body. They usually remain with an unburied body all night.'[77] Writing about tuberculosis in Kawhia in the 1930s, missionary nurse Frances Hayman opined, 'Obviously the worst source of infection was the *tangi*, when all present were allowed to sleep in a room where a dead body lay for some days in an open coffin.' She spoke to the Minister of Health about it, who told her 'when it came to passing any law forbidding *tangis*, he shook his head. This was a religious rite of the Maori race and we must not interfere in any way.'[78] While government policy was broadly assimilationist, this comment presaged

the post-Second World War approach of 'integration', which aimed to form one nation but keep Māori culture distinct, and suggests perhaps more flexibility in official approaches in the earlier period than normally assumed.[79]

Despite the fact that *tohunga* had been outlawed under the 1907 Tohunga Suppression Act it is apparent from the nurses' accounts that *tohunga* still flourished in many Māori communities.[80] Native Health nurses in general learned to work with *tohunga*. Francis Hayman was well aware that she was only consulted after the treatment by the local *tohunga*, whose name was Mahara, had proved ineffectual.[81] Nurse Myra McCormick stated that she always let Māori use their own treatments. She believed that it was this willingness to compromise and the fact that she learnt to speak Māori which endeared her to Māori.[82]

When the scheme was set up in 1911 the nurses, who were also required to be registered midwives, were instructed that 'where possible' they were to attend Māori women in childbirth.[83] In 1912 Nurse Anderson at Rotorua proudly reported that 'three women had engaged her to attend them in confinement'.[84] This was not a common experience; others commented that the nurses were only summoned in emergencies. Bagley explained that Māori 'are at a loss with abnormalities' but qualified this by adding that they 'know how to knead the uterus for haemorrhage'.[85] Similarly, in 1917 Nurse Whitaker told *Kai Tiaki* readers, 'The Maori confinements are very funny, but there is a wonderful lot of common sense about them. Our doctor thinks the native women are better unattended.'[86] Leaving Māori to birth in their own ways continued into the following decades. In the 1930s Hayman reported that it was very hard to get an expectant mother to enter a maternity hospital, which was becoming increasingly popular for non-Māori women.[87] She wrote that 'Maori women preferred their husbands or their male relatives to midwives.'[88] Kathleen Shepherd, who worked as a district health nurse in the late 1930s, also explained that they were 'not supposed to go to maternity cases – mostly Maori looked after their own folk'.[89]

Nurses in isolated districts did come across obstetric emergencies. In 1928 one nurse described a 'Case of Complete Inversion of the Uterus' which she had to deal with in a Māori home with very poor lighting, as the doctor was fifty miles away. She administered chloroform to render the woman unconscious and 'hastened to re-pose the

inverted uterus before the patient had come round', and then injected pituitrin. She proudly reported that the woman recovered and had another baby two years later.[90]

Nurse Whitaker's 1917 description of Māori births as 'very funny' provoked an indignant reply from 'H. M. La F.', saying confinement was 'anything but funny', adding that it showed Whitaker had had very little experience amongst the Māori: 'It will be the greatest factor in preserving the Maori race, when their women seek efficient medical assistance, with hygienic and humane treatment.'[91] This commentator had a point, in that the Māori maternal death rate was much higher than the non-Māori. In 1920 Māori maternal mortality was estimated to be 22.86 per 1,000 live births, compared to 6.48 for European births.[92] A 1938 report of a government inquiry into maternity services dismissed 'any preconceived idea that childbirth is easy and safe and that the Natives can well be left to themselves [as] not supported by the facts', pointing out that the Māori maternity death rate was twice as high as the non-Māori.[93] It noted that a large number were still 'confined in the Native fashion with the assistance of their own folk', and that district nurses only assisted 'where some difficulty has arisen'. The committee added that the limited number of nurses, their large districts and their manifold duties made it impossible to adopt any other course of action, in any case. The main problem it found with the 'Native methods' of childbirth was the 'very unhygienic environment in which it was now so frequently practised'.[94] Environmental factors were also recognised as responsible for the persistent high rates of infant deaths; Dr Helen Deem, Chief Medical Adviser to the infant welfare organisation, the Plunket Society, commented that little would change until the major issues of housing and poverty were addressed.[95]

From the accounts in *Kai Tiaki* in the early twentieth century it is clear that nurses had to devote much of their time to emergency epidemic nursing with few resources in impoverished communities. These nurses improvised and were totally dependent on local help. By the 1930s typhoid epidemics had subsided, at least partly related to the nurses' success with typhoid inoculation in Māori schools from the 1920s. This allowed nurses to devote more attention to health education, and in particular infant care, which had been among the original aims of the scheme. Another issue which concerned nurses in the

1930s was the decline of breastfeeding among Māori mothers.[96] They continued to be cognisant of the importance of working through local structures and networks And nowhere was this better illustrated than the *Te Ropu o te Ora* (Women's Health League), founded in Rotorua in 1937 by District Nurse Ruby Cameron. Cameron had been a Native Health nurse in Opotiki from 1919 and a district nurse in Rotorua from 1931. She founded the League with the support of Te Arawa elders. Its focus was the health of Māori women and children, and it worked through *marae*-based women's committees. Cameron was well known amongst the Māori for her 'knack of getting her message across' and her 'gift of inspiring confidence and co-operation'.[97] These were attributes which many of the early Native Health nurses had shared.

Conclusion

A letter from a Māori *kaumatua*, Houtai Hohepa, from Waima, Hokianga, in 1913, to the Chief Health Officer in Wellington enclosed some cash, 'by way of a present to the Nurses who have been attending to us Maoris [*sic*] hereabout [during the smallpox epidemic]. Although our monetary gift is a small one, we ask you to be assured that our love and gratitude towards them is boundless and we trust that this will specially be remembered in the days to come.'[98]

Official government policy in the first half of the twentieth century was one of assimilation of the Māori; as medical officer Dr Harold Turbott declared in 1938, the goal was to turn Māori into 'hardy, healthy, self-supporting, brown-skinned New Zealanders'.[99] Adopting Western health practices was the goal of the young Māori men who formed the Te Aute Students' Association and they advocated a nursing scheme as part of that model. The reality was that nurses on the ground were thrust into emergency nursing situations with few resources and in impoverished communities, which accentuated the health problems they had to deal with. Despite the best efforts of those who initiated the Native Nursing scheme and the nurses who serviced it, the roots of Māori ill health lay in structural economic circumstances, including poor housing. Nevertheless, this does not diminish the endeavours of the nurses themselves, and nor should they be seen

as simply agents of the State imposing Western values on colonial subjects. These nurses soon learned that healthcare was not a matter of foisting their own culture on others. Māori historian Aroha Harris has similarly argued in her analysis of the relationships between officers of the Department of Māori Affairs and Māori in the post-Second World War period that interpretations which depict the former as dominant and controlling, imposing themselves on an unsuspecting population from above, are 'too rigid, implying flat statistic relationships; the reality was much more complex and multifaceted'.[100] Providing healthcare and other forms of social assistance was always a two-way process. While it is difficult to elicit the responses of Māori to the activities of the Native Health nurses, and recognising the pitfalls of relying on accounts written by nurses themselves with their potential biases, there is nonetheless enough evidence in these narratives to gain an indication of the interaction that occurred. It is clear that Amelia Bagley was not alone in eliciting this response from the Māori *kaumatua* when he told her, 'They do what you wish; they like you; you the good nurse!'[101]

Notes

1 A Māori *kaumatua* (elder) to Amelia Bagley, cited in *Kai Tiaki* (henceforth *KT*), 4:3 (1911), 110.
2 Originally called Native Health Nurses, by the 1930s they combined with other Health Department nurses to be renamed District Nurses.
3 *KT*, 5:2 (1912), 26.
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5 D. A. Dow, *Māori Health and Government Policy 1840–1940* (Wellington: Victoria University Press, 1999), pp. 130–6; R. Lange, *May the People Live: A History of Maōri Health Development 1900–1920* (Auckland: Auckland University Press, 1999), pp. 166–76; P. J. Wood, 'Efficient Preachers of the Gospel of Health: the 1898 scheme for educating Maori nurses', *Nursing Praxis in New Zealand*, 7:1 (1992), 12–20; A. H. McKegg, 'The Maori health nursing scheme: an experiment in autonomous health care', *New Zealand Journal of History*, 26:2 (1992), 145–60; A. H. McMegg, '"Ministering angels": the government backblock nursing service and the Maori health nurses, 1909–1939' (MA thesis, University of Auckland, 1991); A. M. McKillop, 'Native Health Nursing in New Zealand 1911–1930: a new work and a new profession for women' (MA thesis, Massey University, 1998).

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12 Maclean, *Challenge for Health*, p. 202.
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14 See P. A. Sargison, 'Hei, Akenehi, 1877/78?–1910', in *The Dictionary of New Zealand Biography*, vol. 3, *1900–1920* (Auckland: Auckland University Press with Bridget Williams Books, 1996), pp. 309–11.
15 P. Sargison, *Notable Women in New Zealand/Te Hauora ki Aotearoa: Ona Wahine Rongonui* (Wellington: Longman Paul, 1993), p. 24: see also McKegg, 'The Maori health nursing scheme', 153, Dow, *Māori Health*, p. 135, Lange, *May the People Live*, p. 167.
16 *KT*, 16:1 (1923), 37.
17 *KT*, 22:4 (1929), 200.
18 *KT*, 47:2 (1954), 63–4.
19 M. E. Burgess, 'The history of community health nursing in New Zealand', in M. Pyrus (ed.), *The Nurse in the Community: Community Nursing in New Zealand* (Auckland: McGraw-Hill Book Co. NZ, 1983), p. 217.
20 *KT*, 4:3 (1911), 109.
21 L. Bryder, 'Bagley, Amelia 1870–1956', in *Dictionary of New Zealand Biography*, vol. 3, *1901–1920*, pp. 26–7.
22 Lange, *May the People Live*, p. 173.
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24 *KT*, 5:1 (1912), 24.
25 *KT*, 5:3 (1912), 75.
26 *KT*, 2:3 (1909), 104.
27 *KT*, 9:4 (1916), 220.
28 *KT*, 7:4 (1914), 159.
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32 Dow, *Māori Health*, pp. 132–3; For similar debates about infant nurses in the early twentieth century, see L. Bryder, *A Voice for Mothers: Infant Welfare and the Plunket Society, 1907–2000* (Auckland: Auckland University Press, 2003).
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35 *KT*, 5:1 (1912), 24.
36 *KT*, 3:2 (1910), 92.
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39 *KT*, 4:2 (1911), 74, 88.
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44 *KT*, 7:1 (1914), 47.
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57 *KT*, 5:2 (1912), 25.
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72 *KT*, 9:3 (1916), 161.
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5

Training the 'natives' as nurses in Australia: so what went wrong?

Odette Best

Introduction

The story of the Aboriginal women who participated in Australia's nursing history remains largely untold. In the first six decades of the twentieth century, Aboriginal people were confronted with harsh exclusionary practices that forced them to live in settlements, reserves and missions.[1] While many Aboriginal women worked in domestic roles (in white people's homes and on rural properties), small numbers were trained at public hospitals and some Aboriginal women received training to be 'native nurses' who worked in hospitals on settlements

In this chapter, an indigenous historical lens is applied to the status of Indigenous nurses and midwives in Australia. I explore the establishment of Australia's nursing profession, and compare training of white nurses with training received by 'native nurses'. I suggest that Australia failed to respond to the British Colonial Nursing Service's agenda and argue that this failure, in part, contributed to the poor health status experienced by Indigenous Australians. I propose that four issues underpin the history of Indigenous nursing in Australia: the rise of social Darwinism, Australia's Dominionship status, Acts of Parliament in Australia relevant to the lives of Indigenous people, and a lack of critical mass of Indigenous people. I provide three case studies from Queensland (Woorabinda, Cherbourg and Palm Island) of the early history of training Indigenous nurses in Australia.

Aboriginal and Torres Strait Islander people face the poorest health outcomes of any population group in Australia. At birth, the current life expectancy for Indigenous Australian men is 67.2 years, 11.5 years

less than the life expectancy of non-Indigenous men (78.7 years). For Indigenous women, the life expectancy at birth is 72.9 years, 9.7 years less than that of non-Indigenous women (82.6 years).[2] Many complex factors underpin this life-expectancy gap. One important but commonly overlooked factor is the number of Indigenous Australians working within the health system. Evidence suggests that improvements in Indigenous health are strongly linked to increased numbers of Indigenous people working in health service delivery.[3]

Throughout Australia's history, there have been ongoing calls for increased numbers of Indigenous nurses and midwives.[4] For example, as early as 1934 a Queensland parliamentarian, Mr Kenny, 'criticised certain aspects of the aboriginal administration, and … advocated the training of aboriginal nurses for aboriginal races'.[5] Kenny was one of a small number of voices in Parliament who advocated for better Aboriginal health outcomes. Interestingly, he supported a protectionist agenda by promoting 'aboriginal nurses for aboriginal people'. In 1979, the Australian Aboriginal Health Report noted that:

> There are no Aboriginal doctors, few nurses and nurse trainees, and a limited number of nurse aides. One important way of improving Aboriginal health is to have Aboriginals themselves filling these positions. It is therefore necessary that as many Aboriginals as possible be trained in these professions in the shortest time possible.[6]

In 2011, Indigenous staff made up just 0.8 per cent of the nursing and midwifery workforce, even though Indigenous people accounted for 2.5 per cent of the total population. The 2011 Nursing and Midwifery Labour Force Survey identified that 2,212 of Australia's nurses and midwives identified as Aboriginal and/or Torres Strait Islander, with 1,414 working as registered nurses and 798 working as enrolled nurses. New South Wales had the highest number of Indigenous nurses, and less than one quarter (24.6 per cent) were employed in Queensland.[7]

Establishing nursing as a profession in Australia

This history of nursing in Australia was influenced by changes in nurse education in Britain, largely led by Florence Nightingale. Strachan suggests that, prior to the 1860s, nursing in Australia was regarded as a lowly occupation and was mostly undertaken by untrained men and

women who worked in institutions. Between 1860 and 1890, training emerged as a necessary prerequisite for the role, and nursing became almost exclusively an occupation for women of education.[8]

In 1863, the widow of the New South Wales Chief Justice wrote to Nightingale, asking her to send trained nurses to Australia. The plea initially fell on deaf ears but, in 1864, doctors in Sydney requested that the Board of the Sydney Infirmary employ a small number of trained sisters from the Council of the Nightingale Fund. They argued that the 'doctors at the Sydney Infirmary were sure that nurses were the key to any effective cure'.[9] In 1868, six nurses who had been trained and appointed by Florence Nightingale arrived in Sydney to 'take charge of nursing' in the colony. They worked under the leadership of Lucy Osburn. In 1871, one of the original six nurses, Sister Annie Miller, was appointed as matron of Brisbane Hospital. By 1886, the Brisbane Children's Hospital was awarding certificates to white nurses of European extraction who had completed formal training there and achieved a standard of competency.[10]

In the late 1890s, nursing was increasingly professionalised in Australia. Hospitals became training centres for nurses. In 1899, the Australasian Trained Nurses Association (ATNA) was formed. It committed to four main aims:

1. promoting the interests of trained nurses in all matters affecting their work as a class;
2. establishing a system of registration for trained nurses;
3. affording opportunities for discussing subjects bearing on the work of nurses;
4. initiating and controlling schemes that would afford nurses a means of providing an allowance during incapacity for work caused by sickness, accident, age or other necessitous circumstances.[11]

ATNA was a voluntary association that was founded in Sydney by concerned nurses and medical practitioners. As a voluntary body, it had no legal powers to enforce the standards it promoted. During the first half of the twentieth century, ATNA worked to professionalise nursing and delineate the standards relevant for a trained nurse.[12] The early history of nursing in Australia shows little acknowledgement that Indigenous Australians might be involved in the delivery of healthcare and be trained as health workers. Indigenous nurses and midwives are notable only by their absence. Prior to invasion, Aboriginal and Torres

Strait Islander people practised their own approach to medicine and healthcare. Health knowledge was passed down from generation to generation through a strong and successful oral tradition. Medicines and health resources were based on what was locally available. For Aboriginal people, hospitals with a professional staff of nurses and doctors made no sense. In addition, the Western approach of treating illness did not fit with the understanding of holistic healthcare.

Before her nurses were sent to Australia, Florence Nightingale conducted research about the health of Aboriginal Australians. Her interest in Indigenous health was established during a meeting with Sir George Grey, 'who had discussed with her the apparent deterioration and gradual disappearance of native races after contact with white civilisation'.[13] Nightingale applied to the Colonial Office for funds to carry out research 'to ascertain, if possible the precise influence which school training exercised on the health of native children'.[14] She was successful in receiving funding, and devised a 'simple school form' to send to the native schools of the colonies. She received responses from Western Australia and South Australia, and presented her research in York (UK) in 1864.[15]

The responses that Nightingale received from Australia were highly racist and showed gross ignorance. Aboriginal people were described as 'savages', 'uncivilised' and in urgent need of being brought into civilisation. In the mid-1800s, when Nightingale conducted her research, 'civilising' Aboriginal people involved conversion to Christian beliefs. Aboriginal spirituality was not acknowledged, and people's spiritual beliefs were not regarded as an essential part of their health and identity.

Within Nightingale's writings, there is no acknowledgement of the efficacy of Aboriginal traditional medicines. Only one person who responded to Nightingale hinted at the value of traditional medicines: Bishop Salvadore noted:

> A native belonging to the institution became ill with spitting of blood; a sure mark of fatal disease, if the patient is treated in the usual way. The patient begged to be allowed to go into the bush; and after days hunting of horses, he returned sufficiently recovered to resume his occupations.[16]

This is obviously a direct quotation from Bishop Salavadore: 'hunting horses' in colonial periods was largely undertaken by indigenous

men. The meat and the leather of horses was heavily utilised and also provided some sort of income for Indigenous men, as horses could be sold for both their meat and hides (for leather). It also meant for the men that they could continue traditional hunting activities to hone the skills required to hunt. It also meant accessing traditional food sources and not the introduced food sources which were prevalent on the reserves and missions and had little nutritional value in comparison with traditional diets – it is possible that the combination of traditional medicine, exercise and diet was responsible for his recovery.

During the period of early nurse education and the establishment of hospitals as training sites, the wives of white settlers wrote about the value of Aboriginal birthing practices. For example, an elderly 'Dame Mary Gilmore in the 1930's recollected that Aboriginal women were preferred to European Doctors or nurses in isolated areas [throughout Queensland] in the days before cleanliness was considered a virtue in medicine'.[17] Historian Helen Gregory recognises the value of Indigenous understandings of healthcare when she notes:

> Professional nursing and midwifery in Queensland is just over 120 years old. However the application of particular skill and learning to care for the sick, women in childbirth, the injured, the frail aged and the very young in Queensland is far older than that. Nursing history in Queensland encompasses traditional Aboriginal practices, as well as the gradual evolution of nursing education and practice on a western model.[18]

Historical factors influencing the health of Indigenous Australians

The poor health status faced by Indigenous Australians can be understood through an historical lens. Since the invasion and colonisation of Australia, Indigenous Australians have experienced many Acts of Administration that have defined their lives, limited their movements and controlled their occupations. The different approaches to Indigenous administration fall into four broad groups: the period of British invasion and settlement (from 1770 to around 1824), the period of occupation and extermination of Indigenous people (from 1824 to around 1908), the period of protection and segregation (which

started around 1873 in Queensland before spreading throughout the rest of Australia and continuing until around 1957) and the period of assimilation (which extended from around 1957 until 1980).[19]

Wearne describes the first phase of Australia's history thus:

> The history of early contact between the invaders and Aboriginal peoples across Australia was one of violence and unofficial war which lasted well over 70 years. During these early days of invasion the English government involvement was minimal and sporadic with loose administrative structure and oversight of Aboriginal peoples.[20]

While the popular narrative defines the early history of Australia as frontier years, the reality for Aboriginal Australians was very different. Massacres were rife throughout the country with little, if any, retribution against the offenders. Warne estimates that, at a conservative estimate, 10,000 Aboriginal people died violently in Queensland during this time.[21] Land owners who were expanding the British Empire through agriculture and cattle development believed that the land was theirs for the taking. They paid little or no regard to Aboriginal clans and nations who had lived on the land for more than 40,000 years.[22] There are many documented accounts of settlers who poisoned water holes and offered infected blankets to Aboriginal people. At the same time, introduced diseases such as smallpox and sexually transmitted infections had a devastating impact on Aboriginal populations.[23]

During the era of occupation and extermination, Aboriginal people were seen as vermin to be removed. In 1859, Queensland separated from New South Wales. Soon after separation, the administration of Aborigines was transferred to the Colonial Secretary of Queensland.[24] In 1880, *The Queenslander* newspaper published the following: 'I trust that you will succeed in bringing about the much-to-be desired reform you advocate, and ameliorate both white and black, the former into unquestioned possession of the vast area of the colony, the latter off the face of the earth which they do not even serve to ornament.'[25]

The era of protection and segregation emerged when Australia's governments realised that Aboriginal people were not dying out as expected. Legislation to control Aboriginal people was first enacted in Queensland, with the Aboriginal Protection and Restriction of the Sale of Opium Act 1897 (61 Vic, no 17). Frankland described the Act thus: '[It] was the first comprehensive Aboriginal protection act in

Queensland and, indeed, Australia: it ushered in the long era of protection and segregation during which Aborigines and Torres Strait Islanders lost their legal status as British citizens and became, in effect, wards of the State.'[26]

The Act authorised mass removal of Aboriginal peoples from their traditional homes to settlements managed by either Church or government. A Chief Protector was nominated for Queensland, because Aboriginal people were seen as wards of the state. This ensured that mass relocations occurred without retribution. Throughout Queensland, non-Aboriginal people were appointed as district protectors or mission superintendents, and were given powers under the Act to decide: where and how Aboriginal people were to live and work; when or if they could practise cultural ceremonies or could marry; whether and when they could move on and off the settlements; whether wages should be removed and whether Aboriginal people should be imprisoned without offence.[27] Only minimal education was offered to their children and Aboriginal girls who reached around twelve years of age were sent across Queensland to work as domestic servants on white-owned cattle stations. They had no choice about this work, and often were not paid. By 1914, there was an emerging awareness of the value of Aboriginal workers and concern about decreasing numbers of Aboriginal children. The Governor of Queensland, McGregor, reported that: 'The most remarkable fact in connection with all the camps I have seen is the paucity of children. … This is very regrettable for several reasons, but more especially because it will become more difficult to work the north-west stations when there are no more natives to assist.'[28] McGregor's comments here clearly shows that 'natives' were heavily utilised to undertake the hard physical work on cattle stations. Indigenous men were mostly used as they were much cheaper for the pastoralists and cattle station owners to employ. In many instance not having to pay Indigenous men equal wages as non-indigenous men doing this type of work was crucial for the successes of this industry. If there was a paucity of children there was then a paucity of young Indigenous men to be able to undertake this role.

This was therefore a period of extreme segregation throughout Australia. Very few Aboriginal women succeeded in entering hospitals to pursue careers in nursing. Applying for exemption to leave

a reserve and begin nursing training was an arduous task. In some cases, Aboriginal women were able to enter nursing or midwifery by denying their Aboriginality. These women, who had one white parent (usually a father), had to apply for exemption from the Act. They signed paperwork confirming that they would cease identifying as Aboriginal and would not socialise with Aboriginal people. The era of protection and segregation saw a devastating decline in the health of Aboriginal people.

Blood quantum[29] was frequently used within the settlements as a strategy for segregating people and controlling their access to both education and healthcare. Many people believed that Aboriginality could be 'bred out'. To reflect this, settlements were often set up with segregated groups including the Superintendent's house, a house for the white staff (usually a teacher, matron and nurses), the half-caste dormitory for children who had one white parent and the full-bloods' camp. Differences between the living conditions and health status of these groups became increasingly obvious. By the 1940s, some government officials were beginning to record the disparities evident on settlements and questioning the ways they were administered.

In 1943, Dr Johnson, a visiting medical officer to Woorabinda Settlement in Queensland, was damning in his report to the Department of Home Affairs. He argued that the health of Aboriginal people was being devastated by exposure to new infections (such as gastro-enteritis), a change of diet causing impaired nutrition (with Aboriginal people shifting from a nutritious diet to a poor diet of damper, bully beef, tobacco and tea), contamination of the milk supply (the contamination came from a dried mix that was not being boiled before consumption), contamination of the water supply (the creek water was probably liable to bacterial infection, caused by new settlers and grazing cattle) and sexually transmitted infections (which were introduced into Australia by the settler population).[30] Johnson's report also stated:

> The housing was inadequate, and the buildings cold and draughty. Many Aboriginals slept on the ground in winter, and the blanket issue was insufficient. In January alone there were 31 deaths the majority of which were due to gastro-enteritis and pneumonia, both of which are preventable by adequate diet and living conditions.[31]

5.1 Half-caste dormitory

In reporting on the staff at Woorabinda, he further noted that the appalling conditions and high death rates of Woorabinda were in part due to the staff, who were 'made up of three officers of the Department who are too fond of drinking, a mentally unstable Matron and a professionally negligent Medical Officer'.[32] Johnson's report was part of the regular monthly reports sent to Brisbane from each settlement in Queensland. The superintendent, visiting medical officer and matron provided monthly reports which were compiled in Brisbane into one report for the Chief Protector. Little attention was paid to Johnson's comments at the time, and life on the settlements continued unchanged.

The Colonial Nursing Association: training nurses for the colonies

The Colonial Nursing Association operated in Britain for seventy years (1896–1966), recruiting British nurses for work in the colonies (it was renamed the Overseas Nursing Association in 1919). It recruited more than 8,000 nurses for overseas placement.[33] Rafferty

5.2 Full-bloods' camp

and Solano suggest that British nursing in the colonies reached its 'zenith' at the height of colonial rule, and subsequently declined as the colonies achieved independence and trained nurses locally. They describe three interlocking strands of the Colonial Nursing Service's work: 'expanding the colonial service through the work of nurses in government hospitals, providing nursing services for private institutions, and contributing to the development of the so called "native" nursing services'.[34]

In Australia during the first half of the twentieth century, little attention was given to the possibility (or value) of training Indigenous nurses and midwives. In Britain, however, a committee was established in 1943 'to examine the question of the training of nurses for the Colonies'.[35] The committee worked under the chairmanship of Lord Rushcliffe, and was established by the Colonial Secretary. After a preliminary survey of the position of nursing services in colonial territories, two sub-committees were formed to consider retrospectively both the training of nurses in the United Kingdom and the Dominions for services in the colonial territories and the training given in the colonies to Indigenous nurses.

In August 1945, the Colonial Office presented to Parliament its *Report of the Committee on the Training of Nurses for the Colonies* (the

Rushcliffe Report). The report identified that training of nurses in the United Kingdom and the Dominions for services in colonial territories was comprehensive. It gave a thorough overview of training needs and requirements of nurses, midwives and mental health nurses. While it recommended training of Indigenous nurses, it paid little attention to local complexities that might influence the likelihood of training, noting:

> At first the only trained nurses were those who were recruited in the United Kingdom and the Dominions or from nursing sisterhoods in Europe, but it was speedily recognised that no great extension of medical services could take place unless the greater part of the nursing staff was drawn from the local populations.[36]

In Australia, the recommendation to train Indigenous nurses fell on deaf ears. As a Dominion, Australia was not required to adopt recommendations from 'the mother country'. In addition, Australian policies such as the Acts of Administration, which made training Indigenous nurses difficult, were not considered within the context of the Rushcliffe Report.

Aboriginal people working as 'native nurses'

Throughout much of the twentieth century, government policies in Australia largely excluded Indigenous people from careers such as nursing. On the settlements, however, Aboriginal people worked in many different healthcare roles, often with little formal recognition, pay or training. In an era of rapidly declining Aboriginal health, Aboriginal women worked in the health system to 'combat' devastating illnesses facing their peoples.

Many government-run settlements faced acute staffing problems. White nurses were difficult to recruit, and staff turnover was rapid. The matron's notes at Woorabinda Settlement, for example, repeatedly report that the white nursing staff had been reduced to the matron only. Aboriginal women from the full-bloods' camp and traditional medicine men were frequently called on to treat community members and administer medicines. Their knowledge of Aboriginal languages and cultures made them indispensable to the white nursing staff.

By 1942, the monthly reports sent to the Deputy Director in Brisbane outlined the difficulties in attracting and retaining white nursing staff on the missions of Woorabinda, Palm Island and Cherbourg in Queensland. However, the report stated that: 'Hospital efficiency was maintained despite the difficulties experienced in keeping the nursing staffs up to the required strength. In all cases coloured nurses are used to the fullest and the services rendered by them is commendable and invaluable.'[37] Basic training programmes for 'native nurses' had begun to emerge in Queensland's settlements during the 1940s. Records about 'native nurse' training schemes exist for Woorabinda, Cherbourg and Palm Island, which were gazetted as Aboriginal Settlements between 1901 and 1927 and operated as such until the 1970s.

Matron Joan Olive Colledge began working at Woorabinda Settlement Hospital in 1942. She was the daughter of Woorabinda's first superintendent, H. C. Colledge. In his 1943 report, Johnson described H. C. Colledge as an 'uncouth individual, fond of complaining and rather addicted to alcohol'.[38] His daughter, Matron Colledge, was educated at Woorabinda in the white children's school. She received her General Nurse Certificate in December 1940 and her Midwifery Certificate in 1943. Soon after taking her position at Woorabinda Mission, Matron Colledge began a formal correspondence with the Director of Native Affairs, Mr O'Leary. In her letters, Matron Colledge outlined her plans for a formalised training scheme, designed to train the 'native' girls as nurses. She suggested that the scheme would replace the current *ad hoc* training received by the Aboriginal women who were crucial to the running of the hospital.

Matron Colledge's scheme was designed for Aboriginal girls who showed an interest in nursing. She planned to recruit them for an initial three-month probation period and, if probation was successfully completed, sign them on for two years of training. She suggested that:

> During training the native nurses would receive lectures by the Medical Officer and Matron on all nursing subjects, including general nursing, obstetrics, child welfare, nutrition, hygiene, anatomy etc. The native nurses would … be required to undertake periodical written and practical examinations and … at the termination of two years of training and provided they could successfully pass the set examination, the trainee would be issued with a certificate or badge of efficiency. …They will be trained to take care of

> the sick, sponging helpless cases, making beds, sweeping wards, taking temperatures in the earlier months of training and later to do dressings, bandaging, urine testing and other necessary treatments. They will be lectured in Hospital Etiquette etc …. After two years of Hospital work, lectures etc, these girls will be a great asset to the Hospital staff and could be transferred to other Settlements if necessary. They will be given the usual Nursing duty hours and with their day off weekly and should be at the end of 2 years be classed as an experienced nurse.[39]

While Matron Colledge stated that trainees would, after two years, be classed as 'experienced nurses', it is important to note that they were not expected to be nurses for the broader Australian community. Her plan was to train 'native nurses', who could work under the supervision of white nurses and could provide healthcare for Indigenous patients. The nurses who were trained under Matron Colledge's programme would be able to work at Woorabinda or on other settlements, not in other hospitals, and in August 1945, she received approval for her plans, agreeing that, 'such trainees are to be paid the wage of 12/6 per week. The Matron is to furnish monthly reports on their progress to the Office.'[40] She initially employed two young Aboriginal women. On 12 September 1945, she wrote to the Director of Native Affairs: 'I wish to advise that Doreen Bosun and Gwen Doyle the chosen assistants are at present doing well and are a great asset to the hospital. They are at present doing alternative shifts in the Wards and out patients Department.'[41] Matron Colledge appears to have been an advocate for improvements in Aboriginal health. There is scant evidence of her approach to social justice issues. However, we can assume she operated from a protectionist stance in view of her decisions about native nurses only providing care to Aboriginal patients and her agreement that the 'native nurses' only work on other missions. The 'native nurses' received a badge of efficiency and not a qualification.

Perhaps inspired by Matron Colledge's plans at Woorabinda, the Under-Secretary to the Director of Native Affairs in Queensland wrote to Matron Rynne at Cherbourg Settlement Hospital, suggesting that a similar programme should be developed at Cherbourg.[42] In a letter from August 1945, from the Department of Native Affairs to the Cherbourg Superintendent, the Under-Secretary asked: 'What steps, if any, are being taken to train native girls as nurses to assist in staffing native hospitals?'[43] Cherbourg's Matron Rynne advised

the Superintendent 'that there was no prescribed Training Course in operation at the Cherbourg Hospital'.[44] However, she noted that: '12 native girls are employed as assistants in nursing and no difficulty has been experienced in maintaining this number. The question of training Native Nurses is a particularly difficult one and many problems must be solved before a satisfactory scheme is evolved.'[45]

There is no detailed account of 'native nurse' training in Cherbourg. Matron Rynne's reply suggests her lack of interest in starting a 'native nurses' training scheme and clearly shows how each matron's opinion was critical in the schemes' establishment. International calls for training Aboriginal women not as 'native nurses' but as qualified nurses (as in the Rushcliffe Report) were meaningless without the support of the local matron.

The matron of Palm Island also received a letter from the Director of Native Affairs asking about her plans to train Indigenous nurses. Matron Thompson wrote back supporting the plan, with the assistance of Palm Island's Medical Officer, Dr Short. Her letter supported the 'training of half-caste and aboriginal girls as native nurses in the Palm Island Hospital'.[46] Matron Thompson had spent twelve years working in the Solomon Islands before moving to Palm Island. In her letter, she stated: 'I was Matron of Hospitals for 12 years, I trained Island girls to a standard of efficiency, enabling them to perform all nursing work under white qualified supervision. The girls on Palm Island have qualifications and adaptability equal to the island girls.'[47]

She then developed a training programme that differed from the one being used by Matron Colledge at Woorabinda, no doubt as a result of her experience of training in the Solomon Islands. She developed a three-year training programme, following an initial three-month probation period. This was the first proposal to provide Aboriginal nurses with the same period of training as white nurses in the public hospitals.

In a May 1947 submission outlining the programme, Matron Thompson proposed that trainee nurses would receive regular lectures from both nursing and medical staff. She outlined her desire for 'Palm Island Hospital to be officially recognised as a Training Hospital for native nurses, the intention being that the Scheme can apply to other than Palm Island natives'. She proposed that 'at the end of termination of three years' training and provided she can successfully

pass the set examinations, the trainee be issued with a Certificate or Badge of Efficiency'. The Palm Island Medical Officer, Dr Short, added to this in his statement of support: 'I believe that if education facilities here were more advanced it would be possible to train girls here to a standard required by the Queensland Nursing Services (i.e., become registered nurses).'[48] This appears to be the first suggestion in Queensland that Aboriginal women could potentially become fully qualified nurses.

Matron Thompson's correspondence shows her requests for resources to support her training programme. She requested equipment such as notebooks, nursing texts, a blackboard and a physiology chart before the programme could begin. In early 1948, Palm Island's Superintendent Sturgess wrote to the Director of Native Affairs noting that the programme was now in operation, with four 'native' girls having commenced and further nursing assistants also attending the lectures.[49]

The nursing care provided by the trainee nurses of Palm Island was well regarded. The Medical Officer, Dr Smith, wrote:

> In April to June of 1947 upon my arrival to take up duties four months ago, an epidemic of measles was in full swing. Of the 169 cases dealt with, we had no complications during or following the outbreak. This can be attributed to the nursing staff at the hospital. We were then as we are now, under staffed with white nurses and the brunt of the work fell upon native nurses. I cannot speak too highly of them and the services that they rendered. They are worthy of special mention in this respect. Their devotion to the duty at this period certainly justified the introduction of the Native Nurses Training School which was recently inaugurated.[50]

Records of the 'native nurses' training scheme

From 1947 until well into the 1950s, the 'native nurses' training schemes were consistently mentioned in the Reports of the Director of Native Affairs. The settlements of Woorabinda, Cherbourg and Palm Island recorded various levels of success. The 1948 Report of the Director of Native Affairs stated: 'Another strong thing is the high results obtained in the examination papers set out periodically to test their knowledge of nursing subjects. The teaching follows closely the curriculum of the great teaching hospitals.'[51]

However, one of the key problems faced by the training programmes, perhaps not surprisingly, was a lack of white staff to provide ongoing training lectures. The 1950 Report of the Director of Native Affairs stated that 'the difficulties being experienced in respect of tuition of the trainees will be noted from the medical officers' report. However, the training already received by the trainee nurses has in no small measure assisted in maintaining very efficient hospital services.'[52]

The training and employment of native nurses continued on government settlements well into the 1950s. In the late 1950s, regular reporting about these training schemes ceased, primarily because the structure of settlements began to change. In the late 1950s, hospitals on settlements began to be transferred across to become the responsibility of the nearest or largest public hospital. Local 'native nurse' training schemes ended.

As Australia entered the 1960s, the period of protection and segregation came to an end, and Australia entered an era of assimilation. Popular policy deemed that segregation of Aboriginal Australians was no longer appropriate, and that Aboriginal people should be assimilated into white Australia. In theory, this meant that Aboriginal people could apply to train as nurses or midwives in any public hospital in the country. Of course, entry into training was at the discretion of the hospital matron. Aboriginal women experienced difficulties in applying for and being accepted into nursing training.[53]

The 'native nursing' training programmes offered on settlements such as Woorabinda, Cherbourg and Palm Island offered an opportunity for Aboriginal women to be trained as nurses. But their training was different from the training available to white Australian women, and their employment options were markedly different. Native nurses worked under the direction of white nurses, and they worked predominantly with Aboriginal people and within Aboriginal communities.

The story of 'native nurses' is in stark contrast to the story of white Australian nurses. During the period of protection and segregation, the Australasian Trained Nurses Association and the Australian Nursing Federation worked hard to nourish collegiate bonds among nurses. Ongoing training was available; for example, the Queensland Branch of the Australian Nurses Federation began postgraduate

lecturers on a range of topics such as industrial nursing, municipal nursing (including immunisation), school nursing and bush nursing.[54] At this time, Aboriginal health was not thought of as a specialised area of nursing that required any particular knowledge or training.

Australia is different from many other British colonies in its approach to the training of Indigenous women as nurses and midwives. Other colonies, such as India and South Africa, actively drew local Indigenous women into nursing and midwifery throughout the colonial era. In Australia, there was an overwhelming assumption that Indigenous women were not recruitable or trainable as nurses and midwives. Overarching racist beliefs were reflected in the government policies of forced relocation, protection and segregation.

It seems likely that Australia's failure to respond to the Colonial Nursing Service's agenda (1896–1966) and the Rushcliffe Report (1945) was based in four broad issues: social Darwinism, and the enthusiasm with which it was adopted in Australia; Australia's Dominionship status, which gave it independence from British legislation; Acts of Parliament in Australia, which allowed for forced relocation of Aboriginal people; and the lack of a critical mass of Aboriginal people, who were quickly outnumbered by the white settlers.

Social Darwinism was wholeheartedly embraced in Australia during the era of protection and segregation. This racial theory applied Darwin's biological theory of evolution to the evolution of societies. It provided support for the notion that some races and cultures were superior, while others were inferior (almost non-people). The prevailing belief in racial 'survival of the fittest' was widespread, and many people believed that Aboriginal people were 'the missing link' and would soon die out. As Andrew Markus noted, 'one doesn't have to read extensively to discern that a central concern of anatomists was to establish whether Aboriginals were closer to the animal than human'.[55] Between the 1920s and 1940s, Aboriginal people living on the settlements were a treasure trove for the curiosity of scientists and academics who sought to advance the cause of social Darwinism.[56] As a result, thousands of Aboriginal Australians were subjected to the study of the scientific and anthropological communities. Of course, forced relocation of Aboriginal people on settlements and giving them no rights to prevent the experiments made the process easier.

The Dominionship status gained by Australia led to a lack of accountability for the government's treatment of Aboriginal people. Australia's fully autonomous status was confirmed in 1926 at the Imperial Conference in London. While autonomous, Australia retained its allegiance to the Crown. Dominionship 'removed any remaining restrictions on legislative autonomy in those realms, except regarding legislation about succession to the throne'.[57]

With autonomy, Australia was not answerable to the British government for its treatment of Indigenous Australians. Australia implemented its agenda of protection and segregation – in a way not dissimilar to more recent attempts at apartheid. Australia's Dominionship status led to the Acts of Parliament that established settlements as the places where Indigenous Australians would be forcibly relocated. These Acts had direct and devastating impacts on Aboriginal health which continue to be seen today. In addition, by forcing Aboriginal people to live together as groups segregated from the broader society, frequently with many different nations and clan groups living together in ways that had never happened before, Aboriginal people experienced highly restricted education and employment options. Living on settlements made it largely impossible for Aboriginal women to train as nurses in public hospitals.

In Australia, Aboriginal people are a small proportion of the overall population. This lack of a critical mass of Indigenous peoples, combined with the fact that Australia's Indigenous peoples consist of multiple separate nation groups, was unique to Australia. Most of the other Dominions had large, stable Indigenous populations. The number of Aboriginal Australians living in Australia at the time of invasion will always remain unknown. However, it quickly became apparent that Aboriginal Australians were relatively small in number. With the rapid increase in colonial migrants, the concerted efforts of genocide through massacre and warfare and the impact of introduced diseases, the numbers of Aboriginal peoples living in Australia declined dramatically.

Conclusion

Examining the early history of nursing in Australia provides important insights into the health crisis currently facing Australia's Indigenous

people. Australia largely ignored the Colonial Nursing Service's agenda, with its call to train Indigenous people as nurses. Instead, Australia's developing nursing profession relied on overseas-trained nurses and locally trained nurses from the settler population. Aboriginal people were excluded from the nursing profession.

During the era of segregation and protection, Indigenous Australians were forced to live on settlements run by either the state or the Church. Healthcare services were limited, and the health of Indigenous Australians rapidly declined under the poor living conditions. Staffing difficulties in the settlement hospitals led to training programmes for 'native nurses'. In the Queensland settlements of Woorabinda, Cherbourg and Palm Island, for example, there is good evidence that 'native nurses' were trained to support white nursing staff. However, these 'native nurses' were permitted to work in settlement hospitals only, not in the broader community.

The 'native nurse' training programmes came to an end in the late 1950s, when Australia entered an era of assimilation and, in theory, Indigenous women could then train as nurses. Since the 1960s, there has been a gradual increase in numbers of Indigenous women being trained as nurses and midwives. However, the legacy of their exclusion from health work remains evident, with proportionally few Indigenous people working as nurses and midwives and with ongoing health challenges confronting Australia's Indigenous population.

Notes

1 Settlements, missions and reserves were established throughout Australia, starting in Queensland with the 1897 Aboriginal Protection and Restriction of the Sale of Opium Act. They were run either by the state or by churches. Throughout this chapter, I use the term 'settlement' to refer to the various settlements, missions and reserves.

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6

Working towards health, Christianity and democracy: American colonial and missionary nurses in Puerto Rico, 1900–30[1]

Winifred C. Connerton

At the turn of the twentieth century American nurses went to Puerto Rico as members of the Army Nurse Corps, as colonial service workers and as Protestant missionaries. Though the nurses went as members of very different organisations they all espoused similar messages about America, Christianity and trained nursing. This chapter explores the overlapping messages of Protestant missionaries and of the United States (US) colonial administration in Puerto Rico from 1900 to 1930, and highlights the ways US nurses embodied those messages and participated in the Americanisation campaign.

In 1898, after the Spanish–American War, the US took possession of former Spanish colony, Puerto Rico. The transfer of colonial administration of Puerto Rico from the Spanish to the US took place on social, religious and governmental levels. The colonial and missionary administrators needed trained nurses to effectively run their public health and hospital facilities. These same administrators also wanted to reform the nation of Puerto Rico itself, and trained nursing was one way they sought to enact those reforms. Lest the nurses seem like unwitting tools, I argue that these nurses agreed that Puerto Rico needed their help and they were complicit in the colonial agenda.

The Puerto Rico colonial government's annual reports to the Department of War and mission reports reveal a strong connection between the missionary evangelical aims and the US government colonial goals for Puerto Rico. Both groups believed in the power of nursing training to 'improve' Puerto Rican society. The US colonial government promoted trained nursing as part of its Americanisation

campaign to prepare Puerto Rico for eventual statehood or self-governance. Colonial administrators believed that nursing was essential to this goal because trained nurses would minister to their countrymen and demonstrate proper sanitation and health practices. Similarly Protestant missionary nurses expected that their Puerto Rican nursing students would bring both American-style healthcare and the Gospel to their patients, families and local communities.

American nurses who worked in Puerto Rico were full participants in the colonial agenda. These nurses not only understood the expectation that they would support the colonial mission, but they agreed with that mission and worked hard to introduce American-style nursing into the Puerto Rican culture. Trained nurses believed theirs was a profession that could transform a culture through women's education, scientific medicine and proper hygiene. Nurses in public and mission hospitals all preached the same gospel of professionalism and of 'America' in their colonial work in Puerto Rico.

US Colonial administration: remaking Puerto Rico

The Spanish American War broke out in April, 1898 after the sinking of the USS *Maine* in Havana harbour.[2] The US justification for the war was to support the Cuban freedom fighters in their resistance to Spanish colonial rule. Altruism towards Cuba may not have been the only motive for the war, but any aspirations of absorbing Cuba as a US territory were hampered by the Teller Amendment to the Declaration of War. This amendment stipulated that the US would not establish a colonial presence in Cuba.[3] Although the war was focused on Cuba, the rest of Spain's colonies, including Puerto Rico, became military targets to prevent them from sending reinforcements. Active fighting was over by August, with a peace treaty signed in December, and ratified by Congress in February, 1899. With the Treaty of Paris, the US acquired Guam, Puerto Rico and Cuba, and paid Spain 20 million dollars for the Philippines. Previously the US absorbed new territory with the intention of settling it and eventually incorporating it as a state. This was the first time the US deliberately acquired territory to maintain exclusively as a colony.

Puerto Rico was administered by a military governor until 1900, when it transitioned to a civil governorship that lasted until 1949,

when the Commonwealth of Puerto Rico was established. Strikingly, the US had no formal plan for the management of the new territories. The Teller Amendment was explicit that Cuba was not to become a territory of the US after the war, but it did not place any such restrictions on any of the other Spanish territories (Guam, Puerto Rico or the Philippines).[4] There was much public debate over the legality and wisdom of taking on colonies.[5] Eventually the government decided to take an educative role in the territories, preparing them for self-rule at some unspecified date. The actual qualities that each territory needed for self-rule were left undefined.

In each of the territories the preparation for self-rule involved an Americanisation campaign designed to prepare the populace for a participatory democracy like that of the US. Julian Go has described the 'tutelary' approach that characterised the US occupation of Puerto Rico, and argues that the colonial state was created as an 'instrument of instruction' with the aim to reinvent the colony in a new American model using cultural reform as an instrument of change.[6] Americanisation of Puerto Rico took many forms: English became the official language for public education as part of an unsuccessful effort to convert the common language to English from Spanish; Military Governor George W. Davis wrote that establishing 'American customs and policy' would 'accustom the people to act for themselves and not look to the Government for everything, as has been the case until now'.[7] One of the government's largest efforts was to remove governmental associations with the Roman Catholic Church, and established secular rules for civil life, including civil marriage, divorce and burial. Although nominally secular, the colonial government maintained a close association with Protestant missionaries, and the missions were aligned with the government.

Protestant missionaries and the colonial mission

From the beginning the American presence in the islands was not limited to representatives of the US government. Protestant missionaries had their own unique rationale for participating in the American occupation of Puerto Rico. Under Spain, Roman Catholicism was the state religion, and all other forms of religion, including Protestant Christianity, were outlawed. With the transfer of control to the US,

Puerto Rico became a new Protestant mission field. Protestant missionaries promoted civil reforms because they believed that the ideals and skills of democracy would also help the population turn to Protestant Christianity. Although the missionaries had different end goals from the colonial government, they worked within the stated tutelary structure to educate Puerto Ricans in the workings of modern governance.

Samuel Silva Gotay argues that essential features of Protestantism, such as reading the Bible and worshipping without the hierarchy of ordained clergy, were explicitly political concepts when introduced into a strictly Roman Catholic society. The missionaries themselves, he points out, understood their work in political terms. Literacy would help their congregants' souls because they could then read the Bible, but it would also allow them to participate in the democratic process. Similarly freedom from the Church hierarchy would free Puerto Ricans from 'corrupt' worship, whilst at the same time ensuring the free development of fair and just government.[8] Historian Ann Wills, in her study of US Presbyterian missions, argues that the missionaries did not separate their religious plans from the country's political agenda, because they could not conceive of them being separate ideals. Rather, Wills suggests, missionaries understood their religion and politics as adding to and improving each other.[9]

H. K. Carrol detailed the interplay between religion and colonial occupiers in Puerto Rico at a 1901 meeting of the American Board of Commissioners for Foreign Missions. Regarding Puerto Rico, he said that 'the best way to Americanize it is to evangelize it. They understand that there is a difference between the civilization of Spain and that of the United States, and that the type of religion to which they have been accustomed is a bar to intellectual and moral progress.' Carroll went on to explain that evangelising Puerto Rico would not be overly difficult because it was 'now a part of the United States, and will henceforth be ruled by American ideas, embodied in American institutions and laws, and be molded by the influence of our civilization'.[10] Trained nursing became one of several avenues to introducing US culture and ideas in the newly acquired territory.

The colonial government also freely connected the colonial mission with the Christian mission promoted by the Protestants. In 1901 the first civil governor of Puerto Rico, Charles Allen, praised

the Protestant influence in the territory when enumerating the 3,715 Puerto Rican congregants and the 400 students in Protestant-run schools, 'Where the public schools are so inadequate, certainly the teaching of even 300 or 400 pupils is valuable assistance to the cause of education.'[11] Two years after taking control of the island, the colonial government considered the missionary education projects as essential to the work of transforming Puerto Rico into a culture with more distinctly American qualities.

Nursing context

By 1898 trained nursing had become a standard fixture in the landscape of American healthcare.[12] Just as Protestant Christianity introduced large social changes into a Roman Catholic society, nursing education in Puerto Rico disturbed the existing social order. Under Spain, women in Puerto Rico were sheltered from public view, and women above the lower classes did not engage in work outside their homes and did not seek higher education. Prior to the American occupation, nursing care in Puerto Rican hospitals was performed by untrained men or Roman Catholic nursing sisters. The very notion of the nursing of strangers, in hospitals and in homes, by women specially educated for the work challenged fundamental aspects of Puerto Rican social and class structure. The nature of the nursing work, the professional standards for education and behaviour and the instruction in English, all coalesced for these nursing students as they became model Americanised citizens of the new, modern Puerto Rico. Indeed, in a history of nursing in Puerto Rico the introduction of American culture that came with the US occupation is credited with completely changing the role of women, and beginning 'a new style of life … [where] [women?] began to occupy a position at the vanguard of society'.[13] Catherine Choy, historian of the American colonial nursing presence in the Philippines, has described the effect of the introduction of nursing as both 'liberating and exploitative.'[14] Filipinos were offered educational opportunities, and they benefited from health programmes, but those programmes and opportunities came with a system that promoted US ideals of gender, class and race. Nursing education had a similar social impact in Puerto Rico, and the

introduction of trained nursing into the colony was as much a part of the Americanisation colonial plan as political reforms and attempts at introducing the English language.

I have argued elsewhere that to ignore the complex relationship between nursing and imperialism is to deny the power of nurses in colonial settings.[15] The American presence in Puerto Rico was steeped in the language of benevolent duty, progress and reform. Nursing fits perfectly within that ethos. Nurses engendered the Americanisation campaign to a large degree because of the close relationship between nursing and the national mission. Indeed, one of the early colonial projects was the organisation of nursing training schools for Puerto Rican women.

Health, nursing and the colonial agenda

Upon the American takeover in 1898 there were eight municipal hospitals in Puerto Rico, but they were all relatively small and without trained nursing services. In the 1900 Superior Board of Health survey of the hospitals under the item 'qualifications of nurses' the hospital administrator for Arecibo noted that there were 'none required'.[16] Nursing care at that hospital was given by six nursing attendants: four men and two women. The Superior Board of Health believed that nurses did indeed require some qualifications. In fact, the question of nursing qualifications on the survey of hospitals indicated that the Board considered the presence of nurses to be one of the indicators of a hospital's quality. In the 1901 annual report from the government-run Boys' Orphanage, the author notes that 'the Sisters of Charity, though excellent nurses, have neither the sufficient knowledge to work up the prescriptions nor can they assist the doctor in his operations'.[17] The 1899 census counted 127 nurses working in Puerto Rico, sixty-three men and sixty-four women, ranging in age from under fifteen to over sixty-five. Of these, at least fifty nurses couldn't read or write, and only twenty-nine indicated they had any advanced schooling at all.[18] The Board of Health determined that a supply of trained nurses would be vital for the government to adequately care for vulnerable members of the community in asylums, municipal hospitals and orphanages.

In 1901 the legislature met and elected to establish a nursing training school in the three largest cities on the island: San Juan, Ponce and Mayagüez. The governor reported that the need for trained nursing was obvious 'for it has been found well-nigh impossible to have proper nursing for the sick, except such as an untrained woman may instinctively be able to give.'[19] The cities were each given $1,000 to establish the nursing schools. In San Juan the first of the Insular Training Schools was affiliated with the maternity hospital, and had twelve students. It was run by 'a graduate of one of the best schools in Boston' along with physicians from the local hospitals, and training consisted of three hours of lessons per day, with practical teaching and observation in the afternoon. The other two cities were to establish training schools as soon as they found trained nurses to be superintendents.[20]

The primary goal of the training school programme was to create an improved supply of health workers, but a secondary goal for the insular nursing school was to give the young women of Puerto Rico another opportunity for respectable employment. In promoting the insular training schools, Governor Hunt wrote, 'We shall then have in three of the largest cities opportunities for Porto Rican young women of sound physical health and earnestness of purpose and ambition to fit themselves for a career of honorable and much-needed public service.'[21] The initial nurse training programme was limited, only $3,000 was initially appropriated and there was no ongoing funding stream. Despite the limited funding, the nurse training programme continued, and in 1907 the legislature appropriated funds for an ongoing government training school for nurses under the Department of Education.[22] Nursing was a service that was important to the government's ability to provide public health services, but nursing was also part of the transformative purpose of colonial occupation. The insular nursing training school was for special young women who wanted to serve their country, not simply students who wanted a reliable job or who felt inclined towards healthcare. Thus, the work of nursing became one of the ways that the colonial administrators sought to reshape Puerto Rican society. The American Protestant missionaries saw nursing training in Puerto Rico in a similar light.

Protestant mission hospitals and training schools

The Presbyterian medical mission in Puerto Rico began in 1901 with Dr Grace Atkins, who set up a dispensary in San Juan sponsored by the Presbyterian Woman's Mission Board. Almost immediately after her arrival in San Juan, Atkins began advocating for a Presbyterian hospital for San Juan. She described the city's existing four hospitals in a letter to the Woman's Mission Board: a city hospital, 'this is a group of shacks' with Sisters of Charity as nurses; a military hospital; a private hospital for wealthy Spaniards also run by the Sisters of Charity and a small Catholic hospital of only sixteen beds. Atkins wrote of her discontent with sending her patients there:

> One patient of mine was sent there in February for an abscess in her middle ear and adjoining bone. They still have her there, and it looks as if they were going to keep her until she dies of old age …. I felt that the Catholicism had a good deal to do with her stay, and Dr. Green and I decided that she would be our only patient in the Hospital of the Immaculate Conception.[23]

Atkins did not like the connection between medical care and the Roman Catholic Church that the hospitals under the Sisters of Charity offered. She wanted to provide care to her patients and to evangelise them herself. For that she needed a Protestant hospital. Atkins was successful in her appeal for a hospital, and the Presbyterian Hospital in San Juan opened in 1904 with a nurse training school under the supervision of two American-trained nurse missionaries: Sarah Burns and Emma Bogart.[24]

The nurse training school was part of the Presbyterian Hospital plan from the beginning. Atkins wrote of her intention for the school in an early letter seeking support for the project from the Woman's Mission Board:

> We would expect to have a training school for nurses, where these Porto Rican girls could be taught to earn a good living …. The training of nurses and maids would in itself be a big power of good on the Island, as one of our greatest needs here is skilled labor of all sorts.[25]

Atkins tied the work of the training school to the wider cultural reform of the island. Nursing, in particular, represented that 'big power of good' for Puerto Rican women. A 1919 story of the first nursing graduate of the hospital focused on the benefits of nursing education for

the individual Puerto Rican woman, and through her, the benefit to her family and community:

> Had the hospital rendered Porto Rico no other service than just this one to the native girl, its contribution to the island would still have been incalculable: through it there have come to her a new independence of spirit created by a knowledge of her task and her own ability to perform it, a new view of life, and her part in it, and a vision of true service that alone could give her heart for the long years of training and send her out as a district nurse into homes of filth and disease to lighten the burden of her people.[26]

Nurse training was essential to the functioning of the hospital in order to give adequate care to the patients, but the moral uplift of the entire population was another expected benefit of the training. For the missionaries the story of the first graduate of the hospital school was an example of how ministry at the hands of trained nurses would 'lighten the burdens' of ignorance and disease among the Puerto Ricans.

In Ponce, on the other side of the island, Episcopal Bishop James A. Van Buren began a mission aimed at converting Puerto Rican Roman Catholics to Protestant Christianity. St Luke's Hospital opened in Ponce in 1906, and was expanded in 1907. Van Buren explained the purpose of the medical mission in the 1909 annual report:

> People may not listen to the preacher; but here is a message they will gladly heed. Language may be unfamiliar; but the ministrations of the physician and the nurse need no interpreter. Arguments may fail to convince; but the benefits of a Christian Hospital are expressed in terms of action, 'which speaks louder than words,' and admits of no controversy. 'I was sick, and ye ministered unto me.' To him who can say this, there can be [no] higher evidence of the quality of the service he has received.[27]

This explanation of the ministry/hospital connection was typical of medical missions in this period. Similar to the Presbyterians, the Episcopalians saw their medical work as part of a larger mission to the community, and found nursing to be a fundamental part of that outreach.

The nursing training school at St Luke's opened shortly after the hospital. In a history of the hospital training school the training programme was described in glowing terms:

> There, in their own building, are housed some twenty-five pupil nurses, daughters of Puerto Rico, who are being prepared for their noble

> profession …. One can hardly imagine the transformation which takes place in the lives and appearance of these girls during the three years of their training.[28]

These so called 'daughters of Puerto Rico' were elevated members of their communities, and according to this author, 'in most cases, they are members of our Church'.[29] Thus the nursing programme was a success both in educating nurses and in converting students to Protestant Christianity. The Episcopal training school was similar to the Presbyterian school – they were happy with their success at influencing the young women of Puerto Rico – not only by providing the skills for professional work, but also the skills for life and to improve their communities. This education was completely transformative, so much so, that the author suggests that it would be hard to imagine such a change apart from the nursing training itself. For the Episcopalians, much like the Presbyterians, nursing training represented a deeper change for the Puerto Ricans as a whole rather than simply a personal change for their students.

Nursing the new colony

In the insular training schools and the mission school it was American nurses who were the superintendents and heads of nursing. Even after they had Puerto Rican graduates capable of taking the leadership roles, the senior positions went to US citizens. The US nurses who filled these positions were strong advocates of the transformative power of trained nursing. Many had served in the Army or were graduates of elite schools of nursing in the continental US. Although there was a need for trained nurses in public health service, most American nurses worked in hospital training schools. Administrators identified that American nurses' potential influence on nursing trainees was more important to the colonial goals than their direct patient-care abilities. The American nurses also believed their brand of caregiving was superior to a system that relied on untrained attendants and religious workers because trained nursing was based on scientific principles. These nurses had an understanding of an ideal for nursing practice and education that prominently featured three years of post-high school education, in hospitals that were large enough to

offer a wide variety of clinical experiences. Among trained nurses from the mainland US, these were among the elite – trained in the most selective of nursing schools, and expected to uphold a particular standard of practice. Nursing, among this tier of nurses, represented modernity and progress, concepts which were being promoted by the government for the improvement of the island and its people in many avenues, including education, public health and law.[30]

The early years of the Presbyterian training school presented many challenges. The pupils were not well prepared for the nurse training itself. A hospital history details the specific hurdles in beginning a nursing education programme in Puerto Rico: 'Porto Rican girls were not accustomed to menial tasks. If a girl had sufficient education to be a nurse she would not do the servile work necessary, or if she were willing to do the work she was not able to learn the lesson.'[31] Edith Whitely, the Superintendent of Nurses from 1906 to 1910, wrote to the *American Journal of Nursing* (*AJN*) about her experience with nursing training in Puerto Rico. 'It is difficult to get many desirable applicants for the school. Some are unable to take any sort of a course, for they lack even ordinary intelligence, others have proved morally unfit.'[32] Whitely did not believe that the Puerto Ricans had innate qualities that would mesh with the American-style training – qualities that ranged from intelligence and moral fitness to a willingness to work and an understanding of the servile components of duty, although she thought her students were capable of learning. These qualities Whitely believed had to be inculcated in her students, just as the government tried to introduce similar ideals to the colony as a whole.

The primary education system in Puerto Rico was very limited, and many of the training-school students had little formal education prior to beginning their nursing training. Whitely documented her success two years later in a letter to *AJN* with an update on her work: 'I was quite delighted to hear a patient, a trained nurse [herself] … say she would not have believed that she was not being cared for by an American, had it not been for the language.'[33] Whitely's nursing students had changed so much they could now be mistaken for American nurses. Whitely succeeded in training her students to the US standard while outside the mainland, but as a US native in Puerto Rico she also succeeded in passing along her very 'American-ness' to her students so completely that one of Whitely's peers commented

on her success. It was not only the nursing training, or the 'American' qualities, it was both in combination that helped change the students. Changing the students was the first step: the US nursing presence in Puerto Rico was part of a colonial effort to change the country as a whole.

Ellen Hicks, an Episcopal missionary nurse from Pennsylvania, worked at St Luke's in Ponce. Like Whitely she was invested in her students' education and worked hard to promote a professional stature among her students. Hicks was a career missionary. Previous to her time in Puerto Rico she had spent fifteen years in the Philippines at St Luke's Hospital in Manila. There Hicks encouraged her Filipino students to meet high standards of practice, and to pursue graduate training in the US when possible. She continued in this manner in Puerto Rico. Arriving in 1917 she encouraged the nursing students to establish an Alumnae Association and newsletter as an opportunity for professional exchange and support. The newsletter became the first Puerto Rican nursing publication.[34] Hicks encouraged the nurses to continue advancing, and it was while she was at St Luke's that Presbyterian Hospital graduate Rosa Gonzalez wrote her first book, *Diccionario médico para enfermeras*.[35] As a missionary Hicks was, of course, concerned about the spiritual life of her students, and in that context she helped establish a Guild of St Barnabas chapter. The Guild of St Barnabas was a social and religious organisation for Christian nurses which had branches throughout the US and the *AJN* regularly published Guild reports.[36] The Guild sought to gather nurses together as a community united by their profession, because 'the community in general does not appreciate the anxieties, responsibilities, and trials of the nurse's life, and … [the Guild] aims to supply some of the comfort and power obtained by association, and thus to be helpful to the nurse, whether on duty or not'.[37] In this way Hicks mentored her students' entry into the nursing profession and promoted their growth and activism in a distinctly American approach. Hicks spent the rest of her career working at St Luke's in Ponce, finally retiring in 1938. Neither Hicks nor Whitely declared the primacy of nursing or nationalism – they went together in all settings of their work. Success was measured in student achievement and the establishment of the profession on a firm footing in the new territory.

Nursing and conflicting perspectives on race

Americanisation of Puerto Rico also included social reorganisation to align the colony with American ideas about racial and social hierarchies, and this was particularly true with the introduction of nursing into the colony. In the early twentieth century there was no racial identification of Latino ethnicity; rather, racial divisions were based solely on skin colour. This was significant in Puerto Rico, where a significant portion of the population was light-skinned and claimed a European ancestry. A military government annual report included details of the racial makeup of the island inhabitants. The report traced the origins among the Carib Indians called the *Boriqueños*, the early settlement by first Spanish traders and later plantation owners who brought African slaves to the island. The author notes that the races intermingled but that there were some people of pure Spanish ancestry.[38] The existing racial hierarchy depended much more on legitimising claims to Spain than solely on skin colour. Nursing in the US at this time was segregated by race, and nursing superintendents made an effort to select students from outside the 'domestic' classes by requiring that applicants had at least a high-school diploma.[39] This was an effort to disassociate trained nursing from housekeeping or untrained nursing, and to elevate the work to the status of a profession. In Puerto Rico both the mission hospitals tried to recruit the 'right sort' of nursing students from among the upper classes. For the mission administrators, race was a deciding factor in the effort to introduce trained nursing as a profession.

The Presbyterian training school was segregated by race from its inception. Though not stated as a formal policy in the early years, segregation in the training school remained in place until at least the 1930s. In 1920 the Presbyterian Board of Home Missions and the Woman's Board of Missions received an official petition from Puerto Rican Presbyterians requesting an end to segregation of the nursing students.[40] Jenny Ordway, hospital superintendent, wrote a reply to the Board: 'I have talked the question of coloured nurses over with all the members of the staff and they are all agreed that this change is absolutely impossible to the best interests of the hospital.'[41] Ordway explained that admitting students of all races would damage the school's reputation; that the school would lose status and

eventually they would be unable to get the 'right' quality of applicants for the training programme. Ordway justified the segregation policy as a recognition of the fact that 'coloured' nursing students would be treated differently by the other students, and that they would have very limited career opportunities after graduation because they could not work with the visiting nurses or public health departments.[42] The matter was dropped without any change in the admission policy.[43]

Like the Presbyterian Hospital, St Luke's Hospital in Ponce struggled over race relations. In 1921 Gwendoline Pocock wrote to the Episcopal Foreign Mission Board from the South Porto Rico Sugar Company in Ensenada, Puerto Rico. Pocock had been a mission nurse in Ponce, but left the hospital over her dissatisfaction with her place within the hierarchy of graduate nurses at the hospital. Pocock detailed her list of complaints: first, she had to share a residence and dining-room with the Puerto Rican nurses; second, she was bothered by the political leanings of the Puerto Rican staff towards independence; and finally, 'the American nurses received less than these Porto Rican Graduate nurses, do you realize this? We get $40.00 per month and they $50.00 to $60.00 so a white woman working for less than a colored one?' The hospital and training school at Ponce were not segregated, but US nurse missionaries did not necessarily abandon their understanding of racial hierarchies when they became missionaries. Pocock ended her letter by asking, 'Please do not send anymore unfortunate Americans to St Luke's until other arrangements have been made, it is a waste of money and energy. No sound minded girl will ever stay.'[44] There is no response to Pocock's letter in the archival record. St Luke's was not segregated, and other missionary nurses worked within the system without complaint on this issue.

Race was a point of conflict for missionaries who were struggling to inculcate 'American' values among their nursing students. At the Presbyterian Hospital the solution was segregation along some undefined colour line. At St Luke's race was one of the factors that influenced missionaries to stay or leave the hospital. Segregation in Puerto Rico under the US was a common experience, as the Presbyterian Hospital experience details; non-white trained nurses were not hired at the 'best' institutions around the island, nor were they part of the government-backed public health nursing programmes. The missions' support of racist policies was another way they supported the

Americanisation campaign on the island. This is not to suggest that a racial hierarchy did not exist in Puerto Rico prior to the arrival of the Americans, but rather that the American racial hierarchy was different from the one that existed previously in the territory, and its introduction caused ripples throughout the social structure of the colony.

Conclusion

Rosa Gonzalez was a graduate of the Presbyterian training school who went on to become a national leader for public health and nursing in Puerto Rico. Gonzalez was a graduate of the Presbyterian Hospital, where she worked from 1910 to 1916. She did postgraduate work at Presbyterian Hospital in New York City, and was in charge of relief work in western Puerto Rico following a devastating earthquake in Mayagüez. Later she became the head of the nursing department at the Episcopal Hospital in Ponce. In 1919 she went to work for the Department of Health in San Juan, where she helped reform the public health system, and eventually she returned to the Presbyterian Hospital to become superintendent.[45] Gonzalez established the Association of Registered Nurses of Puerto Rico, and extended the Presbyterian Hospital's connections with the Board of Public Health and the Red Cross visiting nurse services in San Juan.[46] Gonzalez encouraged Puerto Rican students to enrol in postgraduate study in the continental US, and to sit for the licensing boards in mainland states.[47] Gonzalez was an example of how the mission nurse training dovetailed with the government's plans for the colony. She dedicated her professional life to improving public health on the island, advancing it through the introduction of American-style trained nursing into hospitals, health departments and homes.

US nurses were intimately involved in the US colonial mission in Puerto Rico. The colonial government and missionaries preached a gospel of public health, and each instituted nursing training programmes as a vital part of that message. The Superior Board of Health and the Protestant missions' goals were similar: the education of communities in an American way of health. Nurses served as models for Puerto Rican nursing students in both government and mission schools, and they modelled more than just nursing care. American

nurses, their work and their symbolism were essential for the colonial plan for Puerto Rico because they represented America in so many different ways.

US international expansion was not limited to the Caribbean and Pacific territories obtained in the Spanish–American War. In fact, the US population was ambivalent over the benefit of colonial occupation, as was the government, and most territories were released to their own management shortly after the conclusion of the Second World War.[48] Despite the decline in US colonial presence, the US influence continued to spread through charitable aid and benevolence organisations. Ian Tyrrell suggests this was a distinctly American style of imperialism – one of ideology rather than physical territory and occupation.[49] Often it was missionaries or social aid groups that engaged in this cultural transfer, and that includes the American medical missions in India, China, Turkey and Syria. Barbara Reeves-Ellington, Kathryn Kish Sklar and Connie A. Shemo argue that American women missionaries 'reinvented the meanings of American nationalism and imperialism as they negotiated competing nationalism and imperialisms in varying colonial settings'.[50] American nurses also upheld the national mission while they offered lessons in nursing and scientifically based healthcare and cared for their students and patients. Nursing was wrapped up in the colonial message in ways too intimate for anyone to untangle, not the colonial administration, mission directors or even the nurses themselves.

Notes

1 The research for this chapter was supported through funding from Sigma Theta Tau, Xi Chapter, and the American Association of the History of Nursing. Content from this chapter was previously presented at the Association of Caribbean Historians conference in San Juan, Puerto Rico in 2011.

2 Following a season of unrest by Cuban revolutionaries and harsh reprisals from the Spanish government, President William McKinley sent the USS *Maine* to protect US interests in Cuba. On 15 February 1898, the *Maine* was destroyed by an explosion, killing 266 men. The subsequent investigation attributed the explosion to an underwater mine planted by Spain to prevent the United States from entering into the conflict in Cuba. D. Traxel, *1898: The Birth of the American Century* (New York: Alfred A. Knopf, 1998).

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14 C. C. Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham, NC: Duke University Press, 2003), p. 19.

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16 J. Van R. Hoff, *Military Government of Porto Rico from October 18, 1898, to April 30, 1900. Appendices to the Report of the Military Governor. Epitome*

of Reports of: I. The Superior Board of Health. II. The Board of Charities (Washington, DC: Government Printing Office, 1901), p. 645 (LexisNexis US Serial Set Digital Collection).

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The early years of nursing in the Dutch East Indies, 1895–1920

Liesbeth Hesselink

Before 1900 there were almost no trained nurses to be found in the Dutch East Indies. Medical progress called for qualified nurses. Initially, the solution seemed to lie in importing nurses from the Netherlands, but as they proved reluctant to travel to the colony, it was decided to attempt to train local people instead: (Indo-) European and Indonesian,[1] male and female. Remarkably, while nursing was, typically, considered a woman's occupation in the mother country, the training as offered in the colony was open to either gender. Male nurses graduating from training soon outnumbered their female colleagues. The history of this attempt to introduce 'professional' nursing into the Dutch East Indies has largely been neglected by historians.[2]

The Dutch East Indies

The Dutch East Indies – nowadays called Indonesia – have been a Dutch colony since around 1600. It is a huge archipelago with more than 17,000 islands; the most important then and now is the island of Java. Around 1900, 60 million people lived in the archipelago, roughly half of them on Java. The population consisted of Indonesians, Foreign Orientals (mainly Chinese) and a handful of Europeans. In 1900 almost 65,000 Europeans lived on Java, together with almost 30 million Indonesians. On Java alone there was a wide diversity of population groups: Javanese, Sundanese, Madurese, Chinese, Arabs, Malay, Indo-Europeans and Europeans. Officially, Indo-Europeans did not exist: children born of a European father and a native mother were counted among the group of Europeans if the father acknowledged them as his; if not, they belonged to the group of Natives.[3]

Two services provided healthcare in the archipelago, the Military Health Service and the Civil Health Service, but were in actual fact one organisation. Throughout the nineteenth century, Western medicine in the Dutch Indies was virtually synonymous with military medicine.[4] Civilians were also treated in the military hospitals. The hospitals were classified into large hospitals, garrison hospitals and infirmaries. Nursing was carried out by untrained orderlies. In addition, there were municipal clinics in the three large towns on Java (Jakarta, Semarang, Surabaya), where convicts and poor natives were treated and nursed free of charge. Here the nursing was done by untrained, often illiterate native male and female lay persons.[5] Hospitals were not popular with the population in the Dutch colony, neither with the Indonesians nor with the Europeans, understandably so given the circumstances of the hospitals around 1900: 'Gloomy walls of tarred bamboo, here and there mouldy in parts, ravaged by insects, without light, with hard wooden beds, on which lay grimy yellowish brown mats, hard leather rolls for pillows, dirt floors, with red marks, here and there, from spitting *sirih* [betel].'[6] Bad hygiene combined with unreliable and incompetent staff damaged the reputation of the hospitals. People of social standing – Indonesian and European – preferred to be treated at home by their relatives. Moreover, the native population laboured under the misconception that all the doctors did in the hospital was *potong*, literally 'cut', in this context, operate.[7] As operations and other surgical techniques were considered forbidden on religious grounds and on account of *adat* (indigenous customs and law), not surprisingly, the hospitals were viewed with a certain amount of suspicion.[8] If they were ill, Indonesians very rarely turned to Western medicine and its practitioners: simple diseases could mostly be treated by the individual himself and his or her family. For serious diseases a native healer (*dukun*) was called in.

However, with developments in the medical sciences hospitals evolved into institutions of scientifically based medical treatment, which, in turn, would ultimately lead to a demand for a more professional way of nursing. Many European physicians voiced their complaints at standards of nursing available; thus, the head of the Health Service, J. Haga, wrote: 'With coolies picked up from the street [to work in hospitals] and *babus* [female servants] stealing from the

Government and merely staying in their job until they can get a better position, it is impossible to look after sick and injured patients properly.'[9] Their nickname 'hospital hyenas' does not leave much doubt as to staff attitudes and practices.[10] At the 1898 exhibition on Women's Work in The Hague, H. F. P. Maasland – who had worked as a health officer in the Indies for some years – spoke up for enhancing the quality of nursing in the Dutch Indies. Only the employment of nurses who had taken exams, he declared, could bring about an improvement in 'the dismal situation …. While civilised countries have now universally come to recognize that nursing is a proper profession and that well-trained staff is a prerequisite, our colony assists its sick by means of folk who often, intellectually and morally, belong to the mire of Indies society.'[11] The need for professional nurses was only heightened by changes in the colonial policy.

Colonial policy

Although the Dutch had been present in the Indonesian archipelago since the early seventeenth century, fully fledged colonialism only developed in the nineteenth and early twentieth centuries. Technical and economic changes as well as a new psychological mix of both Western superiority and social concerns resulted in a renewed sense of a 'civilising mission' and a more active colonial policy. Termed the Ethical Policy, it was the Dutch version of the British 'white man's burden' or the French *mission civilisatrice*.[12] The new Ethical Policy was officially announced by Queen Wilhelmina in the annual Royal Oration of 1901. She argued that as the Netherlands prided itself on being a Christian power, this placed its government under an obligation to imbue its policies with a moral mission towards the population of its territories.[13] Rather than viewing their colony as mere patrimony and a profitable cash cow, the Ethical Policy implied a novel dedication on the part of the Dutch colonial administration to development of schools and medical services, transportation and other infrastructural improvements for the benefit of the native population. The Ethical Policy attracted more and more Europeans to the colony as engineers, educators, lawyers and doctors. In the Netherlands they had experienced good hospitals with trained

nurses and they wanted the same quality of healthcare in the colony. The Ethical Policy increased the need for medical facilities and practitioners, as did the growth in the numbers of private companies seeking medical care for their personnel, both European and non-European. So more hospitals, more outpatient clinics, more doctors, more and better-qualified nurses were required. Now that the government took responsibility for the health of all civilians – European and Indonesians alike – an independent Civil Medical Service (CMS) was founded in 1911.

Private enterprise

The government in the Dutch East Indies had so far adopted a somewhat guarded position on mission and missionary work, particularly in Islamic areas. At the time of the Ethical Policy this position changed. Missionary work and missions had been found to be beneficial in promoting healthcare and education. In the beginning the missionaries were generalists: preachers-cum-teachers-cum-doctors. Around 1900 the first fully fledged missionary physicians came to Java; they were placed in long-term missions in one location, devoting themselves entirely to treating the native population. The mission erected hospitals where they started to train native nurses: Mojowarno (East Java) and Yogyakarta (Petronella hospital) were two showpieces of the medical missions.[14] At Mojowarno, pupils at the missionary school were used as male and female probationers;[15] the training was given by L. L. Bervoets-van Ewijk – wife of the missionary-physician – who had been a nurse before her marriage. At Yogyakarta, where no such pupils were available, domestic servants, gardeners and other unskilled workers were trained as hospital attendants.[16] In Yogyakarta training was given by Jacqueline Rutgers and Johanna Kuyper, two European nurses who had come to the colony for the purpose. The Roman Catholic mission was not widely active in the archipelago until after 1925.[17]

Around 1900 Europeans formed societies in the cities concentrating on sick-nursing and on founding hospitals. Some were exclusively intended for Europeans; others welcomed all ethnic groups. Of a slightly different nature was the Semarang-based Society for the Promotion of Native Nursing Practices, whose aim was to promote

7.1 Mrs Bervoets and her husband with student nurses and student midwives in Mojowarno around 1910

the interests of native nursing – just as the mission intended to do.[18] Business interest occasioned a need for medical care among companies to serve their employees, sometimes utilising existing care provisions, sometimes founding their own hospitals.

At first, qualified nurses were brought over from the Netherlands. Thus, the Jakarta-based Society for Sick-Nursing had deaconesses brought to the Dutch East Indies for its hospital – the so-called Cikini hospital – seconded by one of the deaconesses' hospitals in the Netherlands for a five-year period.[19] In Jakarta they worked in the hospital or in patients' homes.[20] The Society for Sick-Nursing on the East Coast of Sumatra asked the medical superintendent of a hospital in Amsterdam (Wilhelmina Gasthuis) to mediate in the posting of nurses to their hospital in Medan (Sumatra).[21] Where Britain had just one Colonial Nursing Association, which provided nurses for the colonies,[22] in the Netherlands there were a number of institutions through which nurses could be recruited for the Dutch East Indies.

The pioneers' experiences

The working conditions in the colony were obviously very different from those in the motherland, except for the long working days, although the extent of the differences depended on where the nurses were posted. They could be seconded to a hospital in a city like Jakarta with a great many European patients, or at the other extreme, to a mission hospital in the bush in North Sulawesi that had native patients only; or they spent their time nursing European patients in their homes. Those working in the bush had to work much more independently than they would in the Netherlands: owing to the poor infrastructure a doctor was often hours away. Moreover, there were fewer doctors, anyway.

The nurses also had the climate to contend with. By no means everybody could cope with the heat and some were so ill that they had to return to the Netherlands. Before they left for the Indies, they had to pass a medical examination; apparently, the importance of a strong constitution was recognised.

There was no preparation whatsoever for the work in the tropics. The first impressions of Barbara Lind, a nurse who of her own accord resigned from the Amsterdam Wilhelmina Gasthuis to be posted to Aceh by the Dutch Red Cross, raises questions about how she – and other nurses as well – might have pictured her place of work prior to her arrival. She thought the military hospital in the capital of Aceh awfully cheerless: 'How I missed the pleasant wards of the W.G. [the Wilhelmina Gasthuis] in the beginning, the tables and the smaller ones with their beautiful plants, the night lamp with its beautiful lampshade, the bedspreads, the little bedside tables, yes, even the chairs!'[23] Apparently, she did not – or could not – form a mental picture of what awaited her, least of all the situation in a military hospital in Aceh, where, after all, a war was still being waged.[24] A similar kind of surprise emerges from a letter by Miss C. M. E. Kuyper. She described her first impressions of the Petronella hospital in Yogyakarta, where her sister worked as a missionary nurse and where she stayed for a few days in May 1911:

> At first sight, the wards created a strange impression. To the Dutch eye, something bare and gloomy would seem to hover over the whole place, the beds want sheets, and only have a blanket, which during the day lies folded

> up at the foot of the bed, on the beds there is no mattress, just a plaited mat … The pillows have white pillow-cases but the patients themselves wear mostly dark *sarongs*, preferably with a dark *kebaya* [the traditional blouse–dress combination]. Here, a Dutch woman misses all the pure white sheets, the white nightclothes and the cheerful sunlight pouring in.[25]

Nurses were advised to at least learn Malay before travelling out to the colony in order to be able to communicate with native patients and with the native (student) nurses. The indigenous patients were mostly poor or impecunious Indonesians, who seldom spoke Dutch and often did not speak Malay either.[26] It was therefore desirable for nurses to be able to speak a local language, such as Javanese, as well. Often, upon their arrival in the archipelago, nurses were put to work straightaway, so there was very little time, if any, in which to acquire a fair grasp of Malay or Javanese. Obviously, this created enormous barriers in their contacts with students and patients.

Nurses freshly arrived from Europe had to become accustomed to the habits of the patients and their families. More well-to-do patients often took along their own *babus*, who did the washing and mopped the room. One missionary nurse remarked: 'I have meanwhile become used to the fact that when I do my last rounds in the hospital for the evening, many patients do not lie in their beds but under them. We have to give up quite a lot of our Western ideas.'[27] Another nurse wrote: 'The visitors would either sit on the patient's bed or lie in it while the patient was walking outside for a while; others sat on the ground; well, they have to since there are no chairs.'[28]

Training young Indonesian men and women

However, the number of nurses from the Netherlands was wholly insufficient to meet the colony's increased demand for competent nursing staff.[29] As a result, around 1900, private initiatives began to emerge, designed to train (Indo-)European young women in the Indies.[30] The Society for Sick-Nursing in the Dutch East Indies had opened a training course in Jakarta in 1897, but lack of applicants meant that the first course did not begin until 1900.[31] Then six students started on the three-year course: five resident students with one student living out. Primary school education was a prerequisite for entry into the training, along with a certificate of good moral conduct

issued by a religious instructor.[32] The European physicians on the spot offered their services as teachers on the course, free of charge. The theoretical element of the training course generally proceeded well enough, but the practical part caused problems. Of the six students, three dropped out prematurely. A call in the local newspapers to fill the places that had fallen vacant did not have the intended effect.[33] The board could not but conclude that it was very hard to train young Indies women to be nurses. They explained the matter thus: '[T]he position of nurse holds but little attraction for the girls and women in the beauteous Insulindia, as a duty, it is too little valued, the work is still considered as insignificant, ignorance of its character and nature form the cause hereof.'[34]

When the plan to train (Indo-)European women in the archipelago failed to alleviate the nursing shortages, the focus shifted to training young Indonesian men and women. European physicians took their training in hand on their own initiative. Doctors in the city of Semarang proved most successful in this endeavour, and provided the model for training courses elsewhere in the archipelago. Some students came from far afield, even from other islands, to train in Semarang.[35] N. F. Lim, second municipal physician in Semarang, began to train native boys,[36] while his fellow townswoman, private physician Nel Stokvis-Cohen Stuart, trained the girls.[37] Her initial efforts to teach native girls to be nurses were disappointing and difficult. After many failures, she abandoned her plan, but not for long. After she saved the life of a seriously sick Javanese baby by taking him into her house, she acquired a certain fame among the native population. Thus encouraged, the head of a village near Semarang contacted Stokvis introducing his fourteen-year-old daughter, Soetarmijah (known as Mien); the girl very much wished to train as a nurse. Mindful of the fiascos of the past three years, Stokvis was reluctant to embark on the exercise, but the father managed to persuade her that his daughter was in no hurry to get married but was anxious to continue her studies. At first Mien was given theory lessons by Stokvis at her home. Hands-on experience and practical training would be in the clinic. Lim, by now the director of the hospital, did not object to Mien working on the women's ward but initially did not want to admit her to the lessons for his male students as he did not have enough confidence in

the ability of young Javanese women to study. Eventually, he capitulated and allowed her to participate in the male students' lessons.[38] In the end, Mien passed her exam and went on to work as a nurse.

The problems encountered by Stokvis were closely connected with the position young women occupied in Indonesian society. Before they could train as nurses, girls were required to have finished primary school. In principle, girls from poor families did not attend school. Girls from the middle and upper classes often did but it was considered culturally improper for upper-class girls – the ones among the population who could afford to study – to live outside their parents' home when they were of marriageable age (fourteen to sixteen). The poor reputation of the hospitals made them appropriate workplaces only for lower-class women and for women whose reputations were already dubious.[39]

Government regulations

It was not only in the mission and Semarang hospitals that physicians began to train medical personnel of their own accord. Elsewhere in the archipelago, doctors undertook similar initiatives. J. H. F. Kohlbrugge, for instance, awarded the young men he had trained the made-up title of *hulpgeneesheeren* (ancillary doctors).[40] In order to call a halt to this uncontrolled practice, the government decided to regulate matters in 1911.[41] Students received an allowance for housing, clothing and food; a maximum of 100 students across the entire archipelago were eligible for this allowance. To be admitted to the training the following requirements had to be met: the students should be at least sixteen years of age, in good health and have a primary school education. The number of students subsidised by the government grew exponentially; in 1917 the maximum for Java was set at 200. Despite this increase, the demand remained higher.[42] A year on, the maximum was again raised, this time to 500.[43] In Semarang – and maybe elsewhere, too – students were trained without being subsidised by the government but at the Society's expense.[44]

Once the students were admitted, the three-year training course started with a combination of theory and practical lessons. Their education in nursing practice was provided by a European female nurse,

who covered sick-nursing, infant care and such practical matters as handling and bathing seriously ill patients. All the training was conducted in Malay,[45] which sometimes gave rise to problems when, for instance, girls were tackled about their conduct towards patients. As Stokvis recalled: '[I]t is difficult to discuss such sensitive matters with the students since Malay is neither for them nor for us our mother tongue.'[46] What greatly contributed to the eventual success was the fact that during their training, the girls – just like the boys – were housed in a kind of boarding school, albeit a rather grand term for the housing in question.

In 1915 the colonial government imposed an exam in sick-nursing.[47] To be awarded a diploma, the candidate had to be at least twenty years of age and able to produce a certificate of good moral conduct.[48] Once graduated they became *mantri* nurses, an official function in the CMS.[49] *Mantri* refers to a lower civil servant, a foreman, a supervisor; the word is used to form all manner of compound nouns. Here, *mantri* nurse is used to indicate the difference from those who carried out unqualified nursing work.

Having acquired the diploma of *mantri* nurse, the graduates could – if found suitable – undertake a follow-up course to obtain the so-called *mantri* nurse diploma first class. After practising for two years, during which time they were also taught to do laboratory and pharmacy work, they could take the exam. Then, they were authorised to practise more or less independently, treating the most common diseases, to administer first aid in cases of disease or accident and to be in charge of a ward or an outpatient clinic.[50] This latter function was exclusively performed by male nurses. In the outpatient clinic they could recognise the more common diseases and treat them, while the more complicated cases had to be passed on to the nearest hospital. These nurses' task, then, was a curative one.

After they had obtained their nursing diploma, young women could also choose to do a follow-up course for midwives. Stokvis had noticed that most parents found a midwifery training to be a more attractive proposition for their daughters than the nursing course, the profession of nursing being unknown to native society.[51] On the other hand, the function of a midwife was well known among the native population; it constituted one of the specialisms of the *dukun*, who in that capacity would be called *dukun bayi*. The

midwifery training constituted of a two-year scheme in which the student midwives took turns working in one of the hospitals and did shifts as district nurses as well. The graduates worked for the government. They were generally allotted a post close to their family; if they were not, this often constituted a reason for them to leave.[52] These newly trained midwives experienced a great deal of competition from the *dukun bayi*, the traditional birth attendant, as they carried out their work in practice, in the village. With their youth they were no match for the trusted figure of the much older and more experienced *dukun bayi*.

The image of nursing

In the Netherlands, nursing summoned up images of a typically female occupation where qualities such as charity and self-sacrifice were central; and, in actual practice, it was primarily women who entered into the profession.[53] These women preferably came from the cultured classes, since only such women were able to exert a civilising influence on the other staff members and on the patients.[54] This image also prevailed among the Europeans in the colony, including the founders of the Cikini hospital in Jakarta, who saw nurses as women 'who with a trained and soft hand know how to ease the distress of the sick person in so many ways, support him with delicate tact, at difficult moments with a calming or uplifting word and take care that the doctor's orders are followed strictly'.[55] Their role as carers for the native population was further accentuated in their annual report, which stated:

> We emphasise the noble mainsprings that guide our deaconesses in their work, since it is our well-established conviction that sick nursing in the Indies takes to heart the fate of all classes of society and that it can only serve humankind, without regard to rank or class, if the practice of Christian virtues is its principal driving force.[56]

Apparently, these noble mainsprings were reserved for women: 'Indeed, there is well-nigh no finer vocation imaginable for woman, our superior in love and devotion, than to devote her strengths to subservient love, which expresses itself in nursing the sick.'[57] The later governor-general A. W. F. Idenburg exulted in a

report of his visit to the Petronella missionary hospital, where he had made the acquaintance of the two European nurses: 'What wonderful gifts woman has received with which to nurse the sick.'[58] Others, like a certain De H., expressed a similar ideal image of a nurse:

> Woman is a born sick nurse …. A nurse or female attendant who performs her tasks in accordance with the principles that nowadays apply to the profession, and possesses both heart and mind with it, must, in our estimation, be placed very highly. She deserves to be honoured as a priestess of mercy.[59]

The image of the profession fitted in very well with the civilising mission that the Dutch and other colonisers had set themselves around 1900. In a letter to the editor of a journal in the Netherlands, a woman who herself had been a long-term patient in the Cikini hospital wondered why so few nurses felt a calling to come to the Indies: 'How come that our neighbours can feel a sense of vocation to go to the colonies while the Dutch deaconesses cannot? Or do they indeed sense such a vocation but suppress it and if so, for reasons that incline to selfishness.'[60] Stokvis was of the opinion that one should not so much go to the Indies because of the personal advantages as

> *for the work itself* …. Because in the Indies we are strapped for staff; I mean staff who are engaged in social work, and who are not solely, nor mainly, after finding a means to support themselves, but who realise in how many respects the country and its population are still behind and how much they still lack, and who consider it a duty and a privilege to help them catch up.[61]

All in all, these views exuded a high moral tone.

Image-building during the training

The main task of most European nurses was to train Indonesian nurses. While, obviously, nurses in the Netherlands were used to training students, Dutch students were not to be compared with those in the colonies, where elementary school education was wholly or partially lacking and where the trainers differed widely from their students as to cultural background. The sources also make clear that providing training in the Indies was not exactly a sinecure. Complaints about the students' poor sense of responsibility, their different standards and values are legion:

> That a made-up list of temperatures is not the same as one based on careful observation is not immediately obvious to him. Being hard on a patient, if need be, is something he finds difficult, cleaning a wound thoroughly when this is painful, when the patient puts up a resistance, may at times be an exercise in patience that weighs too heavily on him.[62]

L. L. Bervoets-van Ewijk, the wife of the missionary-physician in Mojowarno mentioned earlier, met with similar experiences when training young native women to become nurses:

> What is lacking, however, is a serving out of love; they help the sick out of obedience born out of a love for us; but comforting and cheering up the sick of their own accord, that is something we have not seen yet …. [T]he true interest in her patients is usually still missing.[63]

Physician Miss W. Valk, who was in charge of the Budi Kemuliaän maternity clinic in Jakarta around 1920, recounted how the student nurses loved the lessons, the theory, but did not relish the work. She related 'stories of lovelessness, cruelty even, towards sick children, of duty being shirked and of a lack of responsibility, of such magnitude, that one cannot but conclude that the idea of a general charity is not part of her mentality'.[64] This quotation comes from the book that in later years formed part of the required reading for nurses as they prepared for their work in the tropics and that thus immediately conveyed to them a certain image of the natives.

These supposed characteristics of Indonesian students sat uncomfortably with the image that the Europeans had of the profession. It was therefore essential that the course taught standards and values that were in line with the Western image. The European nurses held the key to this. Not only did they have to teach the various practicalities of nursing but they also had to live up to the image of the profession. A minister wrote to a European missionary nurse: 'The duty of a nurse in the Indies is especially an educational one. She has to mould young ladies into nurses who can work among their own people. The idea is not so much for them to become sisters but rather the educator.'[65] It was not just the mission that imposed heavy demands on European nurses. Much the same happened in the Semarang hospital, where Stokvis saw the European nurses especially as role models: 'In all this, European female nurses are necessary, the best, but it is not easy to get good European nurses in the Indies.'[66]

Fortunately, there were also qualities that made young native women perfectly suited for nursing. A Dutch woman visiting the Petronella hospital remarked on how the Javanese nurses went

> round the wards on their bare little feet without a sound …. The Javanese are exquisite in their movements, very composed, they are fine and slender in shape, they always walk upright; their tone of voice is softly muffled, they are usually deft, and of a practical bent. All qualities that make the young Javanese girl so eminently suited for nursing.[67]

It was important that the training led to a profession with status. Graduates had to earn a certain standing within the native community, if only to introduce the new profession to Indonesian society and to reduce resistance to Western medicine. Stokvis thus expressly wanted to train students from among the higher classes of society. Thanks to her good relations with the native elite, she succeeded in training young women from the nobility to become nurses. And indeed, the Semarang training course swarmed with titled students, both male and female.[68] Especially among the young women, their background could pose practical problems. Stokvis sighed: 'It is quite a job to drum into the students that they have to follow the instructions from the *doctors*, even when the person concerned is a *Raden Ayu* [title of a married lady of noble birth] or someone else from the aristocracy.'[69] Similarly, descent played a role in the students' relations with the patients:

> A 'higher-class' patient will be given more attention, more delicacy is brought to the care given. And where appropriate, a wish or a refusal from such a 'higher' patient weighs decidedly more heavily than the doctor's instruction …. Conversely, the students' conduct towards the ordinary patients frequently leaves much to be desired.[70]

At the mission, it was sometimes ordinary young women who received training, sometimes young ladies from the upper classes. In a mission hospital in the Minahassa, which was run by two qualified Dutch nurses, some young ladies from the upper classes, former students of the Boarding School for the Daughters of the Heads and Notables in Tomohon, trained to become nurses.[71] One of the young ladies, the daughter of a district head, was taunted frequently by her girl friend to the effect that the work was far beneath her. ' "Oh," she said, "if Miss De Ruyter and Miss Schoch

do not deem it beneath them, then I do not need to be ashamed of it, either, I should think" ';[72] a clear demonstration that in practice Dutch nurses really did serve as role models for their native students. But it also illustrates the negative image that the nursing profession had among the native elite. We encounter something similar in Semarang, where 'a small school fight between our young ladies and the female students of a Semarang Native school [broke out], where one of our young ladies was told with a sneer: "oh yes, in the street you look very nice, but in the hospital you have to empty buckets and pots!" '.[73] Bervoets also concluded that the profession had no standing within Indonesian society, neither with Muslims nor with Christians.[74]

Because these Dutch nurses served as role models, it was important that the nurses came from good backgrounds themselves. The Indies newspapers thus stressed the descent of the first two European missionary nurses, Jacqueline Rutgers and Johanna Kuyper: 'It cannot but inspire respect, that ladies of good birth come to the Indies to undertake such a labour of love and charity.' And elsewhere: 'These most talented … distinguished ladies nurse the most hideous cases as if it were nothing. One is not only full of admiration for these sacrificial acts of love, but also full of wonder that highly civilised ladies undertake such labour.'[75] They were the daughter of an Amsterdam professor, and of the then prime minister, respectively.

In Europe descent also played a role in the evolution of the nursing profession. In the Netherlands, Lady Jeltje de Bosch Kemper (1836–1916) devoted herself to turning sick-nursing into a profession of civilised women. Just like Florence Nightingale (1820–1910), the icon of British nursing, she came from a distinguished family.

Gender, race and class

With a topic like training native men and women in a colonial context, it is useful, lastly, to devote some attention to such aspects as gender, race and class. Gender, race and class were factors in classifying the sick in the hospitals. There were wards for several classes, with men and women also being segregated. In addition, there were often different wards for each race. Class and race did not coincide,

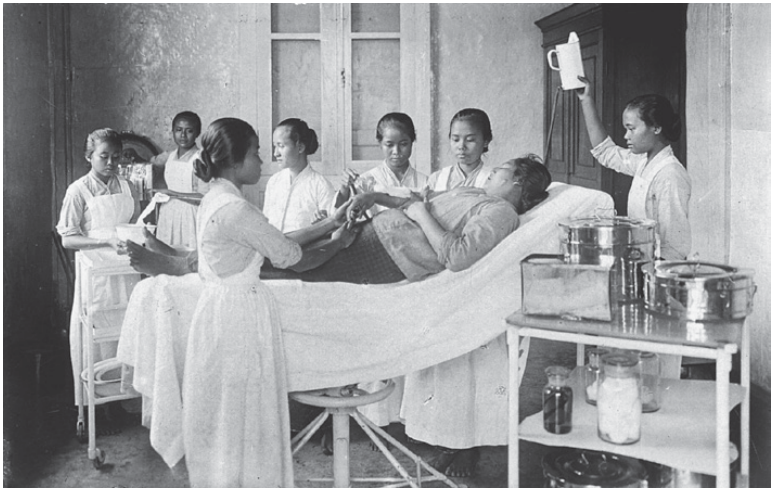
though: both Indonesians and Europeans could be classed as indigent or impecunious. Gender, class and race also played a role in the nursing itself. If possible, the richer Europeans would be taken care of by European nurses, necessarily all females, as there were no male European nurses or midwives in the colony. The board of directors of the Cikini hospital reasoned that it would harm their competitive position among other similar institutions if they no longer worked with European nursing staff.[76] A European female nurse was thus the sole prerogative of the rich and distinguished. However, given the small number of European nurses, most Europeans and Indonesians were nursed in hospitals by Indonesian nurses, with male patients cared for by a male nurse and female patients by a female nurse.

Class consciousness was also evident among the native population. The missionary hospital in Mojowarno, for example, had a separate ward for *prijaji*, the native elite – as did most other hospitals.[77] Missionary nurse Jacqueline Rutgers spotted a strategic advantage to the presence of *prijaji* as patients: 'We are getting more and more *prijaji* (Jav. nobility) in the hospital; this causes more nursing work; they always need to have a separate room. But it is so good for the influence of Christianity.'[78]

Given the image of the nursing profession outlined above, it is striking that in the Indies not just native women but native men as well were trained from the very start to become nurses. Looking at the numbers, it would seem that very soon there were more male than female native nurses; in 1921, 171 male nurses were employed by the CMS, compared with 45 female nurses.[79] Training men to become nurses raises questions both about the government and about the native men themselves. There were several reasons why nursing attracted Indonesian men. There were few possibilities for vocational training in the Indies, and in colonial times the title *mantri* had a certain status as it was the title of foremen or supervisors. Moreover, there were many possibilities to continue one's education after graduating from the nursing course, for instance, to do laboratory work, assist in an operating theatre, become a hygiene and public health promoter or become the head of a permanent outpatient clinic. In the outpatient clinic they treated patients rather as a doctor than as a nurse. In practice, they were also called *dokter desa* (village doctor).

In other words, nursing opened the way to many jobs with status, especially for men. The greater mobility of males in the local cultural context, necessary for some of these jobs, could have been a reason for the government to favour men in these positions. The government may have thought that Indonesian men would fit the female image of nursing because native men, especially the Javanese, were seen as submissive and servile.[80] Being subservient to the physician would pose no cultural problem for them. Some Europeans even openly doubted whether Indonesians were at all capable of working independently without being supervised by a European.[81] However, Javanese social structure was characterised by fluid gender systems and subtle gender boundaries;[82] in their eyes, then, there may not even have been typically male or female professions.

Two types of nursing could be said to have come into being in the Indies: on the one hand, there was the female model of nursing (care-giving in the hospitals). This was carried out by both male and female nurses, each nursing patients of their own sex. They were closely supervised and had to carry out the doctor's instructions. On the other, a male model existed which focused on technical skills such as laboratory and operating-theatre work, independent roles like that



7.2 Midwife and student midwives at Semarang around 1910

of health-promotion officers or heads of outpatient clinics. The latter had a curative task and acted as substitute for the physician. Many European physicians considered it risky for a curative task to be carried out by someone with insufficient training,[83] and formally, the medically qualified doctor from the nearest hospital was supposed to visit the outpatient clinic weekly but in practice this did not happen very often.

The proportionately smaller number of female native nurses was the result of the position of Indonesian women in society, as described earlier. The number of native girls who attended school, a prerequisite for admission to the nursing course, may have risen over the years but nevertheless remained small.[84] In Semarang the influx of young women was large (eighty-six in 1915) but the majority (sixty-one) dropped out as they did not meet the admission requirements.[85] Upon graduation most young women would have married, as was the custom in indigenous society. In the Netherlands, marriage was (until well into the twentieth century) a reason for dismissal and it is likely that much the same applied in the Indies. In any case, native nurses from the Petronella hospital and the Semarang hospital stopped working after they got married.[86] By contrast, the profession of *mantri* midwife was open to married women. This might explain the specialism's popularity, besides the natives' familiarity with the occupation of midwife. Married male nurses were allowed to continue in their roles.[87]

Conclusion

By 1920 professional nursing had obtained a firm footing in the Dutch East Indies since the arrival, in 1895, of the first qualified nurses from the Netherlands. The government had laid down clear admission and examination requirements. The training courses had become the responsibility of the heads of the large hospitals, with the hospital in Semarang having the most students. The young native men and women had quickly found their way to nurse training, one of the few training opportunities funded by the government in the archipelago. The government set a maximum number of students that could be funded to follow the course, thus restricting their influx. In 1921, over 100 young men were rejected in Semarang

alone, indicating its growing popularity as an occupation.[88] Those who had been trained with government funding subsequently joined the civil service.

The situation in the hospitals had clearly improved when compared to their condition at the turn of the century: new hospitals had been built and the quality of the nursing staff had improved enormously. Thus, the number of native patients in hospitals increased tremendously in an absolute sense, although remained a relatively small percentage of the indigenous population as a whole. However, the native population and especially women continued to have an aversion to Western medicine. This was not so much due to the costs, since nursing care in government hospitals and government-funded hospitals was free for the indigent or impecunious. Travelling expenses fell to the patient, though, and this may have had a restricting influence on the use of hospitals. Resistance to Western medicine, however, was the greatest obstacle; but with time, this dwindled as more Indonesians received a Western education.

Notes

1 The term Indonesia did not come into use until the 1920s, but it has been used here for the sake of clarity as have current names of cities (thus, Jakarta rather than Batavia) and modern spelling (thus, *babu* rather than *baboe*).
2 Only the anthropologist Rosalia Sciortino has addressed the topic. See her thesis: 'Care-takers of cure: a study of health centre nurses in rural Central Java' (Vrije Universiteit Amsterdam, 1992), pp. 48–80.
3 L. Hesselink, *Healers on the Colonial Market: Native Doctors and Midwives in the Dutch East Indies* (Leiden: KITLV Press, 2011), p. 9.
4 A. H. M. Kerkhoff, 'The organization of the Military and Civil Medical Service in the nineteenth century', in A. M. Luyendijk-Elshout *et al.* (eds), *Dutch Medicine in the Malay Archipelago 1816–1942* (Amsterdam and Atlanta, GA: Rodopi, 1989), p. 12.
5 Hesselink, *Healers on the Colonial Market*, pp. 36–7.
6 O. Degeller, 'Inlandsche ziekenverpleging', part 1, *Bulletin van den Bond van geneesheeren in Ned.-Indië*, 19 (1910), p. 1.
7 N. Stokvis-Cohen Stuart, 'Plan tot instelling eener wijkverpleging', *Bulletin van den Bond van Geneesheeren in Ned.-Indië*, 151 (1916), p. 8.
8 L. Th. Mayer, *De Javaan als doekoen, een ethnografische bijdrage* (Weltevreden: Kolff, 1918), p. 5.

9 J. Bijker *et al.*, *Rapport der Commissie tot Voorbereiding eener Reorganisatie van den Burgerlijken Geneeskundigen Dienst* (Batavia: Landsdrukkerij, 1908), p. 96.
10 Kerkhoff, 'The organization of the Military and Civil Medical Service', p. 17.
11 H. F. P. Maasland, 'Ziekenverpleging door vrouwen', paper presented at the 'Conference to discuss the work done by women in various societal areas of our Indies possessions', 1898, pp. 1, 5.
12 E. Locher-Scholten, *Women and the Colonial State: Essays on Gender and Modernity in the Netherlands Indies 1900–1942* (Amsterdam: Amsterdam University Press, 2000), p. 16.
13 H.W. van den Doel, *Het Rijk van Insulinde: opkomst en ondergang van een Nederlandse kolonie* (Amsterdam: Prometheus, 1996), p. 157.
14 Now known as Bethesda Hospital.
15 Sciortino, 'Care-takers of cure', p. 53.
16 Sciortino, 'Care-takers of cure', p. 53.
17 José Eijt has written on Catholic nurses who came to the colony after 1925, *We waren er altijd: zusters in zorg en verpleging, Franciscanessen van de H. Elisabeth 1880–2008* (Breda: Van Ierland, 2009). J. Eijt and S. Hautvast, *Een missie in de marge: Dochters van Onze Lieve Vrouwe van het Heilig Hart in Nederland en Indonesië 1911–2000* (Hilversum: Verloren, 2002).
18 The Vereeniging tot bevordering van de Inlandsche Ziekenverpleging was approved by order of the colonial government (Gouvernementsbesluit no. 42, 21 January 1915). However, the society was already in existence, as the statutes had been submitted to the Governor-General for approval in August 1914, *Tweede jaarverslag van de Vereeniging tot Bevordering van de Inlandsche Ziekenverpleging* (Semarang: H. A. Benjamins, 1916), p. 18 (hereafter *Jaarverslag Semarang*).
19 Deaconesses are Protestant nurses carrying out nursing activities out of charity; 'Sixth Annual Report Vereeniging voor Ziekenverpleging in Nederlandsch-Indië', in *Het Nieuws van den dag voor Nederlandsch Indië* (29 July 1902).
20 'Fourth Annual Report', in *Bataviaasch Nieuwsblad* (21 August 1900).
21 'Second Annual Report Vereeniging voor Ziekenverpleging ter Oostkust van Sumatra', in *De Sumatra Post* (4 September 1901).
22 In 1918 the name was changed to Overseas Nursing Association.
23 B. Lind, 'In het militair hospitaal te Kotta Radja', *Maandblad voor Ziekenverpleging*, 12 (1901–02), 81–2.
24 From 1873 until 1914 the Dutch fought a long and bloody war against the Achenes. The population remained rebellious until well after the war had ended.
25 *16th jaarverslag der Vereeniging 'Dr. Scheurer's Hospitaal' (Petronella Hospitaal)* (1912), 13–18 (hereafter *Jaarverslag Petronella*).

26 E. Siebenga, 'Het werk van de Hollandsche verpleegster bij den dienst der volksgezondheid in Indië', *Maandblad voor Ziekenverpleging*, 41 (1931), pp. 114–16.
27 Memorandum '*Het ziekenhuis te Tobelo*', n.d. [probably the annual report by Sister Jansje Lambregtse, from the missionary hospital in Tobelo; written towards the end of May 1923], Utrechts archief, Raad voor de Zending (toegangsnr 1102-1), inventory no. 2331.
28 Lind, 'In het militair hospitaal', 81–2.
29 In 1913, thirty-eight qualified nurses were employed in institutions in the Dutch Indies; in addition, an unknown number were employed by the mission and/or worked as private nurses in domiciliary care, C. E. Benjamins, *Het Juliana-ziekenhuis te Semarang* (Amsterdam: Van Rossen, 1913), p. 24.
30 The target group was made up of young women born in the colony, either to European parents or of mixed descent.
31 *Vierde jaarverslag van de Vereeniging voor Ziekenverpleging in Nederlandsch-Indië* (Batavia: Albrecht, 1900), p. 10 (hereafter *Jaarverslag Batavia*).
32 *Het Nieuws van den dag voor Nederlandsch Indië* (18 January 1901).
33 *Het Nieuws voor den dag voor Nederlandsch Indië* (29 July 1902).
34 J. A. J. Meijer, *Gedenkboek 40 jaar ziekenverpleging Koningin Emma ziekenhuis ('Tjikini') Vereeniging voor Ziekenverpleging in Ned.-Indië 1895–1935* (Batavia: Kolff, 1935), p. 10.
35 The young women came from Ambon, the young men from Sumatra, *Jaarverslag Semarang*, 5 (1919), 4, 6 and (1920), 4.
36 N. Stokvis-Cohen Stuart, 'Over Inlandsche ziekenverpleging in Nederlandsch-Indië', *De Indische Gids*, 37:1 (1915), 795 (paper presented at a meeting at the Red Cross, The Hague, 14 April 1915).
37 For more information, see L. Hesselink, 'Nel Stokvis-Cohen Stuart (1881–1964), her role in educating female nurses and midwives in the Dutch East Indies', in Hans Pols, John Harley Warner and C. Michele Thompson (eds), *Translating the Body: Medical Education in Southeast Asia* (Singapore: Singapore University Press, forthcoming).
38 Stokvis-Cohen Stuart, 'Over Inlandsche ziekenverpleging', 797–800.
39 N. Stokvis-Cohen Stuart, 'De huidige koers ten aanzien van de gezondheidszorg in Indië', *Indisch Genootschap, Verslagen der vergaderingen over de jaren 1926–1930* (1930), pp. 19–22.
40 J. H. F. Kohlbrugge, 'Geneeskundige hulp voor Javanen', *Vragen des tijds* (1904), 15 [offprint].
41 Gouvernementsbesluit 6 August 1911 no. 31 (including the alterations by Gouvernementsbesluit 9 August 1914 no. 33 and 29 May 1915 no. 42) included as Appendix 1 in *Jaarverslag Semarang*, 2 (1916), pp. 15–18.
42 *Jaarverslag Semarang*, 4 (1918), p. 5.
43 Gouvernementsbesluit 27 July 1918 no. 43, *Jaarverslag Semarang*, 5 (1919), p. 3.

44 Eighteen out of a total of fifty-five students, *Jaarverslag Semarang*, 2 (1916), pp. 11–12.
45 *Jaarverslag Semarang*, 2 (1916), pp. 7–9.
46 N. Stokvis-Cohen Stuart, *De inlandsche ziekenverpleging te Semarang* (Semarang: H. A. Benjamins, 1916), pp. 12–14.
47 *Staatsblad van Nederlandsch-Indië* 1915 no. 514. Earlier – Gouvernementsbesluit 6 August 1909 no. 31 – an exam had been mentioned as well; for this, see *Staatsblad van Nederlandsch-Indië*, 87 (1909).
48 *Bijblad op het Staatsblad van Nederlandsch-Indië*, no. 8378.
49 *Staatsblad van Nederlandsch-Indië* 1912 no. 87.
50 *Staatsblad van Nederlandsch-Indië* 1919 no. 438.
51 Stokvis-Cohen Stuart, 'Over Inlandsche ziekenverpleging', 801.
52 *Jaarverslag Semarang*, 9 (1923), p. 8.
53 In 1900, the Netherlands had 865 qualified female nurses, with a mere 48 qualified male nurses. The number of male nurses who were members of the Dutch Union of Sick-Nurses (de Nederlandsche Bond voor Ziekenverplegers) in the period 1901–21was at most 50 against a maximum of well over 4,000 female nurses. C. Bakker-van der Kooij, 'Mara. Pleegzuster zijn. Ontwikkelingen in de ziekenverpleging en de organisatiepogingen van verpleegsters in Nederland, 1870–1920', in Josine Bok *et al.* (eds), *Tweede jaarboek voor Vrouwengeschiedenis* (Nijmegen: SUN, 1981), pp. 193–222, esp. 193, 203.
54 Bakker-van der Kooij, 'Mara. Pleegzuster zijn', p. 211.
55 *Jaarverslag Batavia*, 1 (1897), p. 3.
56 *Jaarverslag Batavia*, 1 (1897), p. 4.
57 *Jaarverslag Batavia*, 2 (1898), p. 10.
58 *Jaarverslag Petronella*, 5 (1901), p. 52.
59 De H., 'Ziekenverpleging', *Sumatra Courant* (6 January 1897).
60 Frédérique Adler, 'Kreet uit het verre Oosten!', *Maandblad voor Ziekenverpleging*, 9 (1898–99), 149–50.
61 N. Stokvis-Cohen Stuart, 'De Hollandsche verpleegster in Indië', *Maandblad voor Ziekenverpleging*, 40 (1930), 412–5. Italics in the original.
62 J. W. Gunning, *De medische zending* (Baarn: Hollandia drukkerij, 1911), p. 40.
63 Mrs [L. L.] Bervoets-van Ewijck, 'De opleiding en vorming van inlandsche ziekenverpleegsters', *Maandberichten van het Nederlandsche Zendelinggenootschap*, 99 (1897), 169–82, esp. 171–2, 174.
64 Th. J. A. Hilgers and C. Lekkerkerker, *Populaire schetsen over land en volk van Indië* (Amsterdam: Tijdschrift voor ziekenverpleging, 1920), p. 51.
65 Reply from Minister Rauws to Sister G. Haandrikman dated 20 September 1924, Utrechts archief, Raad voor de Zending (toegangsnr 1102-1), inventory no. 2322.
66 Stokvis-Cohen Stuart, *Inlandsche Ziekenverpleging Semarang*, p. 2.
67 C. M. E. Kuyper, *Jaarverslag Petronella*, 16 (1912), 13–18.

68 In 1917 all nine student midwives were titled, as were eighteen out of forty-one female student nurses, while four out of six male nurses were titled, and twelve out of twenty-eight male student nurses, *Jaarverslag Semarang*, 4 (1918), 29–31.
69 Stokvis-Cohen Stuart, *Inlandsche Ziekenverpleging Semarang*, pp. 12–14. Italics in the original.
70 Stokvis-Cohen Stuart, 'Plan wijkverpleging', 5–6.
71 Gunning, *Medische Zending*, p. 18.
72 J. H. Abendanon, *De opvoeding van inlandsche meisjes in Ned.-Indië* ('s-Gravenhage: n.p., 1909), p. 6; offprint from the report of the exhibition 'Opvoeding van het kind'.
73 *Jaarverslag Semarang*, 6 (1920), 11.
74 Bervoets-van Ewijck, 'De opleiding en vorming', 170, 176.
75 Quotations from, respectively, the *Bataviaasch Nieuwsblad* (22 November 1900) and a local Yogyakarta newspaper, both included in *Jaarverslag Petronella*, 5 (1901), pp. 47–8.
76 Meijer, *Gedenkboek*, p. 34.
77 A. J. Duymaer van Twist and A. Pijsel, 'Verslag van het ziekenhuis te Madja-warna over het jaar 1905', *Mededeelingen van Wege het Nederlandsche Zendelingengenootschap*, 50 (1906), 137–41, esp. 138.
78 In a letter dated 10 June 1902, *Jaarverslag Petronella*, 7 (1903), p. 9.
79 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië over 1921', in *Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië* (Batavia: Kolff, 1923), pp. 327–461, esp. 328.
80 F. Gouda, *Dutch Culture Overseas: Colonial Practice in the Netherlands Indies 1900–1942* (Amsterdam: Amsterdam University Press, 1995), pp. 118–57, devotes a whole chapter to the matter: the native 'other' as the medieval, child-like and animal 'self'. Something similar can be witnessed in British India: M. Sinha, *Colonial Masculinity: The 'Manly Englishman' and the 'Effeminate Bengali' in the Late Nineteenth Century* (Manchester: Manchester University Press, 1995).
81 Many European physicians doubted whether the *dokter djawa* – after no less than ten years of medical training – were actually capable of working independently. Hesselink, *Healers on the Colonial Market*, p. 194.
82 Locher-Scholten, *Women and the Colonial State*, p. 92.
83 Sciortino, 'Care-takers of cure', pp. 61–2.
84 Some 14,000 girls attended school on Java and Madura in 1912; 8,081 at governmental schools, 5,745 at private schools. In addition, about 6,000 attended a *desa* (village) school, but this did not grant admission to nursing training. On the other islands, some 32,000 girls received education, but there was hardly any nursing training there. Numbers from J. H. Abendanon, *Het onderwijs in Ned.-Indië, meer in het bijzonder dat bestemd voor de meisjes*,

n.p.: n.d. [signed Amsterdam, June 1913]; lecture at the exhibition 'De vrouw [The Woman] 1813–1913', p. 10.

85 *Jaarverslag Semarang*, 2 (1916), 7.

86 From a letter by Dr Pruys dated 31 January 1908, *Jaarverslag Petronella*, 12 (1908), p. 7 and *Jaarverslag Semarang*, 4 (1918), 13, respectively.

87 *Jaarverslag Petronella*, 8 (1904), 18, mentions married and unmarried native male nurses.

88 *Jaarverslag Semarang*, 8 (1922), 11.

8

A sample of Italian Fascist colonialism: nursing and medical records in the Imperial War in Ethiopia (1935–36)[1]

Anna La Torre, Giancarlo Celeri Bellotti and Cecilia Sironi

Introduction: historical background

The Italo-Ethiopian War (also known as the Abyssinian War or the Second Italo-Ethiopian War) refers to an armed conflict waged by Italy during Mussolini's regime against the Empire of Ethiopia in 1935, which led to the proclamation of Africa Orientale Italiana (Italian East Africa) in 1936.[2] The history of Italian colonialism started approximately fifty years earlier, in 1882, with the conquest of Assad and Massaua in Eritrea, by Crispi's government and can be divided into two periods.[3] The first, called 'Liberal colonialism', includes the First Italo-Ethiopian War (1894–96) and the acquisition of Libya and Somalia, which took place in 1922.[4] It can be described as a 'soft colonialism', in which the foreign policy of Minister Giolitti promoted a mild approach to local authorities.[5] The second period is the so-called period of 'Fascist colonialism', which lasted from 1922 to 1943, when racial policy became more explicit and extreme; the main characteristics of this period being its limited geographical extent, the lack of economic productivity and the chronological short term.[6]

During the Fascist dictatorship there was a strong nationalistic component as Italian foreign policy began to take on a highly ideological resonance. Mussolini's purpose in the conquest of Ethiopia incorporated both an economic and propaganda nature.[7] On one hand, he wanted to find an outlet for a growing Italian population, forcing the

migration of the most poor families to other countries, whilst on the other he was looking forward to 'training' the Italians for a great war in which he would establish the supremacy of the Roman people.[8]

In 1934, a political border incident in Wal-Wal between Somalia and Ethiopia pushed Mussolini to invade Ethiopia, backed by a strong propaganda campaign from the regime and, on 3 October 1935, the Italian Army invaded Ethiopia. The League of Nations immediately reacted: it accused the Fascist government of aggression against a neutral country and adopted a series of economic sanctions against Italy. While these measures had no serious effect on the economy of the country, they served to fuel Italian people's resentment, which was further stoked by Mussolini's propaganda. One of the most poignant examples of the effectiveness of the propaganda against the League of Nations' economic sanctions was the success of the 'Day of the Wedding Ring', on 18 December 1935, when married Italian women offered up their wedding rings to support the economy of the colonial war in Africa.[9]

The Ethiopians fought valiantly for more than seven months, but their army, poorly organised and even worse equipped, could do nothing against an expeditionary force that came to commit around 400,000 men and made extensive use of armoured vehicles, air force and poison gas.[10] On 31 March 1936, the Ethiopian Army was defeated and on 5 May Italian troops occupied the capital, Addis Ababa. In 1936, fascism reached its peak in terms of support from the Italian people and, at the same time, fostered intolerance against anything that dared to challenge the regime. During his proclamation of the empire speech in Rome on 9 May, Mussolini's rhetoric inflamed the crowds: 'The Italian people have created the Empire with their blood', he professed; and 'That commits you in front of God and in front of men for life and death.'[11] Such speeches have been considered by historians as a prelude to the Second World War.

The organisation of Army healthcare during the campaign, 1935–36

The main official documents relating to health in the Italian Empire are *L'importanza dell'organizzazione sanitaria nella Guerra d'Etiopia* (The

importance of health organisation during the Ethiopian Campaign), published by the Institute of Military Public Health, on 30 August 1936;[12] and *L'organizzazione sanitaria e la salute delle truppe durante la Guerra d'Etiopia* (The health organisation and the health of the Army during the Ethiopian Campaign) by Professor Aldo Castellani, General-Lieutenant Inspector of the military and civil health services, published in May 1936.[13] In Castellani's introductory paragraph the spirit of the Fascist regime can immediately be recognised: 'The war began on 3 October 1935 and ended on 9 May 1936, with the proclamation of the Empire. During this period, the national troops of the north front and the south rose to approximately 500,000 men and more than 100,000 "white" workers were added.'[14] The numbers involved were certainly huge, but Castellani's claim that this was 'the first time in the history of the world that such an important mass of "white" troops was brought to, and fought in, the tropical zone'[15] can surely be disputed, and is yet another example of the Fascist regime's propaganda.

These documents provide details about the organisation of the extensive healthcare facilities imported to Ethiopia by the invading Italian forces. The Army alone was in possession of 135 hospitals and field hospitals (each with their own bacteriological and radiological laboratories), fifty-five portable field hospitals and thirteen portable surgical hospitals. It also possessed eleven ambulances for dentistry, fifteen for radiology, four central laboratories, twelve disinfection stations, 139 water purification units and four depots. The Italian Royal Navy had twenty hospitals and field hospitals on the coast at its disposal, and six hospital ships, while their Royal Air Force had twenty-two field hospitals. In addition, the Colonial Service ran thirty hospitals, each with a bacteriological laboratory and a radiology department.

All health services in Ethiopia were coordinated by a General Health Directorate directed by the Colonial Ministry created by the Fascist government; and services were provided by a range of health specialists including, surgeons, physicians, veterinarians, pharmacists and nursing staff. Among the causes of death during the military campaign, only 64 per cent were due to the consequences of war wounds; the remaining 36 per cent were due to diseases including malaria, dysentery, typhoid fever and scurvy and the effects of the climate such as heatstroke and physical exhaustion.

Through the study of these documents, it is possible to evaluate the main prophylactic measures implemented during those years, including the use of mosquito nets and quinine to protect against malaria, 'From the beginning, doctors insisted on quinine prophylaxis: every soldier received three tablets per day [provided] by the State, and took them before every meal.'[16] Dysentery was also often quoted as 'one of the worst scourges of armies at war',[17] in fact dysentery, both amoebic and bacillary, was considered endemic and almost impossible to contain.

Typhoid was included within the vaccination requirement for 'vaccines mixed very well, prepared in the laboratories of the Institute of Public Health, and in some private establishments'.[18] Other diseases they had to contend with included typical tropical diseases such as beriberi, dengue fever, skin-penetrating fleas and tropical lichen, while injuries by wild animals were reported as special cases. There were also cases of heatstroke, which turned deadly, as a result of the extreme weather conditions and exhausting marches.

Some of the precautions soldiers were instructed to take against the harshness of the climate included, 'The use of helmets by every soldier, no alcoholic drinks, not even a glass of wine, except after sunset, and whenever possible troops should move in motorised columns and avoid marches.'[19] The medical inspector concluded his observations in the typical fascist style by comparing the marvels of Italian medical science to the inferiority of healthcare of the Ethiopians: 'It also might be observed that medical science made possible whatever could be done for people to thrive in unhealthful climates under adverse conditions, and to remain in better health than the natives acclimatised by hundreds of years of continuous abode.'[20] In other words, Italian knowledge and Italian character were considered to be superior and made it possible to quickly overcome adverse conditions which indigenous peoples had struggled with and failed to overcome for centuries.

Protagonists of nursing during the war

Fascist ideology and social policy radically changed the historical path of the Italian nursing profession when compared with the previous

courses of nursing studies established in 1906 together with the first training course for nurses of the Red Cross in Milan, and in 1908 with the first psychiatric nurses' school. In 1925 only women were allowed to attend nursing schools and it was compulsory for students to live together in a boarding-school system for the entire duration of their training. The approach Fascism took towards women in nursing was characterised by its ambiguity: on the one hand, the regime continued to relegate them to a secondary role in relation to men, whilst on the other it 'enlisted' them into their organisations, increasing their involvement in a whole range of activities. Like German Nazis and Spanish Francoists, Italian Fascists used nurses to apparently place women within the system, although in reality this was a facade since it didn't effectively alter the social balance, which was based on the predominance of male authority.[21]

From 1925, the Fascist regime also changed the educational path of Italian Red Cross nurses by inserting the typical elements of fascist propaganda into their training courses. By 1927, the Corps had three different nursing roles: Family Fascist Nurses, Fascist Hospital Nurses and Public Health Nurses. The Family Fascist Nurse was responsible for educating women in the culture of hygiene and preparing them for their high mission in the family. The Fascist Hospital Nurses meanwhile were to co-operate with the government for the enhancement of hospital services and the Public Health Nurses were to be devoted to monitoring the sanitary condition of the neighbourhood, which to some extent might be compared to the work of health visitors these days. The training course duration was two years and included both theory and practice and there was an optional third year of specialisation. Subjects of the basic course of study were: hygiene, basic human physiology and anatomy, general medical and surgical knowledge, emergency procedures, basic knowledge of paediatrics, nursing techniques and the 'inevitable' fascist culture, for a total of fifty lectures and 100 days of practice in hospital. After attending the course, students had to pass a final examination to receive a certificate.

In 1929, with Fascist self-sufficiency laws, all foreign directors of nursing schools, for example Grace Baxter, were dismissed and the autonomy of all nursing schools was drastically limited.[22] In addition to being the only teachers, doctors became directors and were the

only ones who could decide on the programmes, while the matrons had to supervise the moral education of students and the observance of discipline, to monitor order, cleanliness and hygiene in schools and in the boarding schools.

During the colonial war, the Italian Red Cross sent 384 volunteer nurses to support the Army and to work in hospitals and in the 'white' ships, far away from the firing lines.[23] The nurses were lay women from Italian nobility or the upper class, and were officially called 'volunteer nurses', although the definition had nothing to do with being volunteers who worked without a salary: it was the name that identified Italian trained nurses coming from the Red Cross, who from time to time were also called 'lady nurses' or 'sisters'. In addition to the main training course, all volunteer nurses who were to be sent to East Africa attended a course on tropical diseases.[24] Female participation in the colonial war was an important element of Fascist policy, it fuelled propaganda for Italian Fascist regime that celebrated its own vision of woman in service of the war, of the regime and of men. The fact that Princess Maria Jose of Savoy, the last Italian Queen, was an Italian Red Cross nurse turned out to be very useful to Fascist propaganda.[25] She was the wife of Umberto II, the Prince of Italy who became King, but only ruled for a month (from the end of May to the end of June 1946).[26] In 1936, on 26 March, she boarded a hospital ship in Oriental Italian Africa, and from the same year until 1941 she was President of the Italian Red Cross.

Participation in the war gave these women an opportunity for female involvement in a male affair, even if Fascism did not allow the nurses to be real fighters. As one wrote, 'I feel moved by the vision of a world of soldiers on the move, ready to face, almost suddenly, a colonial war, and to find out I am an active part of it.'[27] The volunteer nurses often worked far away from battlefields and in addition to caring for wounded soldiers also assisted the settlers. 'To the bed of a worker suffering from heat exhaustion, attacked by fever or exhausted, I approach humbly', wrote another nurse, 'yes, humbly, because I recognise the superiority of the brave fighters. They give their lives for the Empire: by their sacrifice and from their pain has risen the power of Rome.'[28]

On the other hand, in apparently less fascistic writings, the services of nurses are represented as humanitarian gestures and a service to

8.1 Princess Maria Jose of Italy on a 'white boat', 1935

the nation. From a quick glance at surviving memoirs by lady nurses, we learn that their main concern was not necessarily the medical care of the sick, but to ensure the environment they were in was contributing to their recovery, undertaking tasks typical of a woman in a family: 'I have forty sick persons that I would like to see at least washed and cleaned up in their beds. I would also pick up their clothes scattered in disorder everywhere. Moreover, I would like to give to the floor a little of its original colour. An undefined smell circulates in the environment.'[29]

Most of the nurses' diaries are filled with openly nationalistic feelings, as one records:

> A deep emotion comes over me, a desire to cry, to shout, to sing. Victory is great …. The glorious breasts of our soldiers, the strong spirit of all Italians have become the great shield to adversities. Today, glory is magnified by *il*

> *Duce* and his and his people's constancy, strong arm and iron will. God has protected justice and civilisation …. I'm happy I've never lost the faith of a true Italian. Now even the lazy and the indolent will understand what we have earned, thanks to the indomitable will of *il Duce*.[30]

In the diaries of the lady nurses we also find clear examples of racism: 'I have never seen coloured people and this is interesting and eerie. All the doctors keep advising me to be very careful, to put on my usual uniform of the guards, a shirt well tightened at the wrists and neck.'[31] Another nurse comments on one of the ward maids, 'The maid Zaitù is fun in her manners and in her curious clothes: she is cute, but she is very slow. These people are idle. Even the cook boasts about everything and you have to reprimand him badly.'[32]

Nurses were provided with a guide book, 'What to do if you meet a black', which they were expected to read and learn before they set out for Ethiopia. The following abstract clearly demonstrates the extreme degree of racism:

> The natives are like children: they must be treated gently, but firmly corrected. It is appropriate whenever entering into a conversation with them to always keep calm, it's something they really appreciate and, in truth, always apply in all circumstances. They are much more impressed by those that never raise their voice and keep a serious demeanour, rather than by those who are carried away by their indignation. Anyone who deals with them must always keep in mind that prestige is the strongest and most effective defence, and it implies less effort both for the external and internal security of the occupied territories. … It is necessary to take into consideration their religious beliefs and never hinder their religious worship, indeed you should facilitate them and foster all external manifestations of respect to what is above, to which they are accustomed. You must always respect women. You should not get too familiar with the natives, but always treat them with the same character, severely punishing any attempt, however slight, to teach them European respect.[33]

The 384 volunteer nurses, despite being part of the Italian Red Cross, were providing help and assistance to the Italian Army, as if they were part of the Army.[34] Military reports show charts of personnel involved in the field, mentioning the presence of 15,500 military male nurses, but there is no evidence of their preparation and their tasks are never mentioned.

The male nurses were classified as 'nurses' and 'health soldiers', but it is not clear if they had different duties and care responsibilities,

or if they occupied different positions of rank within the military hierarchy. The available literature suggests the male nurses were trained within the Army, because after 1929 there was no male nursing school. Little is known about the 'soldiers of health', the reports do not mention whether they had been educated in nursing or not. They were described as: 'good and talented, always ready not only to care for the sick but also to fulfil their duty as soldiers. They often volunteered to build roads, forts and trenches.'[35] This leads us to suppose that they joined the Army as soldiers and that they were primarily involved in other military activities, and only from time to time were they employed as health assistants. Some reports support this, for example stating they 'were inexperienced [and] we have experienced a crisis due to lack of nurses and this happens very often'.[36]

When the Italo-Ethiopian War was about to break out, Italian Catholic missionary fathers and nuns of the *Consolata* missions of Turin were based in Ethiopia. Thanks to the good relationship established with Empress Zauditù and Ras Tafari (the future Emperor Haile Selassie), they were supported by the National Association for the Assistance of Italian Catholic Missionaries and the Anti-Slavery Society in Italy, and managed to establish ten mission stations, thirty-six schools, ten orphanages, a professional school, four 'Villages of Freedom' (places where slaves who had been freed by religious groups lived), three hospitals, three homes for the elderly and, from 1922, a seminary for the education of the local clergy.[37] On the eve of the war, the local health organisation was managed by thirty-three medical doctor priests and fifty-three nurse nuns. Although local missionaries and local clergy were opposing Fascist occupation, in May 1935 the Ethiopian government banned all Catholics from the country. The decision proved to be disastrous, since it hit local public health institutions for the indigenous population hard, because all nun nurses working in local mission hospitals and in ambulances were forced to leave the country, all the missionaries were removed also from local Catholic hospitals or clinics. Their political position embarrassed the imperial Fascist policy. Only a few remained in Ethiopia as chaplains and as spiritual support for Italian soldiers or as nurse nuns in Italian hospitals, staying even after the war was over.[38]

During the war, the International Red Cross sent foreign operators from several countries in defence of Ethiopia against the Italian occupation. About a hundred actively contributed as doctors and nurses. Among them, the Swedish Count Carl Gustav von Rosen should be mentioned.[39] He left Stockholm with an air ambulance, landing in Addis Ababa, and took part in several missions (up to fifty-five flights and eighty-one serious injuries transported), 'evacuating the wounded and transporting drugs on both sides, until an Italian aircraft destroyed the device in the field of Quoram, although it clearly displayed the insignia of the Red Cross'.[40]

Immediately after the outbreak of the war in October 1935, the ICRC offered its services to the two conflicting parties, in line with the Statutes of the International Red Cross. Italy, as the aggressor condemned by the League of Nations, rejected any assistance outright, while Ethiopia, poorly prepared as it was, accepted the offer of help without hesitation. For the first time ever, an international medical relief operation, supported by twenty-eight National Red Cross Societies, got under way.[41] At the beginning of the conflict, the International Red Cross from the United States of America, Greece and from Poland[42] equipped five ambulances helping the local population.

Approximately twelve European doctors and nurses[43] worked in the hospitals of Harar Dessie and Addis Ababa. Many of them already lived in Ethiopia before the war, and by deciding to remain in service they openly demonstrated the extent of their attachment to that country. Ethiopian women, like their predecessors, provided support to the men in battles by cleaning rifles and shields and sharpening their swords. They packed provisions and supplies on an individual basis as was the custom. Indeed the bulk of the Ethiopian Army was still traditional despite the government's attempts to modernise it and therefore it was in need of the service of women camp-followers.[44] As an extension of this role, therefore, they also assisted members of the International Red Cross, involved in helping the local population, in carrying the wounded as well as giving first aid or a full nursing service using native traditional medicines which they prepared from roots, barks, fruits and leaves of various trees. A British transport officer, Captain Brophil, wrote of their service, 'They are fairly good at nursing and are often very

successful with their native herbs. After the doctors have dressed the injured the women will take them away to relatives.'[45] Yet a very small number of women were reported to have rendered services in modern nursing. The most popular was Woizero Senedu Gebru, who was educated in Switzerland and was married to H. E. Lorenzo Teezaz, Ethiopian Minister of Foreign Affairs.[46]

A special mention should be given to a military corps, the Askaris. Askaris, from the Arabic word 'askar' meaning soldiers, were indigenous soldiers, classified as regular members of the Italian Royal Colonial Corps Troops. The name 'Askari' was extended not only to the Army, but also to the Italian Royal Navy, the Royal Indigenous Police, the Italian Royal Air Force and the Militia of Forestry. Most of the Askaris were from Eritrea. Fascist racial laws did not allow Askari and Italian soldiers to fight together, even though Askaris were sub-components of the same army. The Askaris served in the Ethiopian War, with some being employed in health units devoted to treating 'coloured people' until the Second World War, and also in National divisions operating in the colonies. They wore the International Health bracelet and had a Medical Corps frieze consisting of a star crowned with the red cross in the centre. The distinctive band and bow were white. Healthcare in the Fascist army operated a system of apartheid. Therefore the Askari cared for themselves. Their own soldiers were assigned to a nursing service and to field hospitals, separated from white troops. While colonial physicians served in the departments of Askari companies, it was absolutely forbidden for Red Cross volunteer nurses to approach them.[47]

Healthcare during the Empire, 1936–41

Italian East Africa was divided into five regions and each region had its own governor. The regions were what we now know as Eritrea and Somalia, and three which together make up modern Ethiopia, Harar, Galla and Sidamo and Amhara. Shoa, the region with Addis Ababa as capital, was under the direct control of a viceroy, who was also General Governor of the Empire.[48] In the six years of Italian domination, the Empire was governed by the Ministry of Italian Africa who reported to the Ministry of the Interior.

The Inspectorate of African Health was part of the Ministry of Italian Africa. Its duties were to promote hygiene and public health in the colonies, to propose measures and to set rules. Italo-Ethiopian territories were divided into health districts, each headed by a competent doctor called *Medico di Circoscrizione* (colonial district surgeon).[49] The district surgeon assisted the chief of the political-administrative district in business relating to public health, reporting on the progress of all medical services and nursing in the district. It was his responsibility to propose urgent measures in order to protect public health in the case of emergencies such as a cholera epidemic and he was required to submit an annual report on the health of his district.[50] He was also responsible, through his network of local doctors, for the containment and monitoring of infectious diseases: each local doctor was required to report an outbreak of infectious disease immediately to the district surgeon and the district chief. The only compulsory vaccine was that against smallpox for children, within the first months of life and then again after six years, and typhoid inoculation for the Army.[51] Many mobile clinics were sent into the interior to provide general medical and surgical services. There were also mobile clinics which specialised in venereal diseases.

As far as their 'civilising mission', or the duty of bringing what was perceived as the great culture of ancient Rome to the African people, was concerned their only legacy was an apartheid system. The propaganda strongly emphasised the construction of roads, schools and hospitals, but even then the practice belied the propaganda. There was a strict regime of separation between the black population and white people. Local population could not attend schools and hospitals for white Italians. All the major cities, from the capital to Asmara, Massawa and Agordat had both civilian and military hospitals, where respectively colonial and military doctors worked. In smaller towns there were infirmaries, which worked also as pharmacy dispensaries and points for obtaining medication. Segregation between whites and blacks was rigorous and the division in nursing also respected these rules. Nursing care at military hospitals was guaranteed by military male nurses, while Askari assistants and Ethiopian indigenous nurses took care of African soldiers. Civilian hospitals had the same divisions: volunteer Italian Red Cross nurses and nuns who had been reintegrated after the war attended Italian

residents, while Ethiopian women servants performed auxiliary work such as cleaning of the premises; Italian doctors attended locals and, according to Italian Fascist literature, were assisted by Ethiopian male nurses.

There was also a form of district nursing, with doctors visiting patients at home, and although there is no clear evidence, we may suppose they were assisted by Ethiopian nurses when visiting natives, and by white nurses when visiting Italians. The texts of the time do not mention the training, roles or the work skills of Ethiopian nurses, while, on the other hand, they give prominence to those of female colonial Fascist nurses.

As during the colonial war, all nurses assigned to service in Africa compulsorily attended a course on colonial diseases held in Rome by the Ministry of East Africa. The texts we have examined do not mention if they were trained in specific subjects other than those that were part of the regular course. They do, however, focus on the nurses' strong character and moral decency:

> The nurse who left had to possess courage, perseverance and selflessness, requirements to which each woman should aspire. A doctor's duty is to decide what the right drug is, prescribe injections, cataplasms, massages and any other kind of treatment. A nurse's duty is to assist the patient, to clean him, air his bedroom, provide moral comfort, administer medicines, apply the treatments and take care of the diet. A nurse must be clean, honest and simple.[52]

As with other totalitarian regimes of the time, Fascism implemented a policy relating to reproduction, which is undoubtedly key to the construction of the new vision Fascism had towards women: they were particularly aware of being mothers to the generation of future Italians. Even in Italian Oriental Africa, a number of initiatives were created ranging between reform and repression, such as: economic incentives for large families, the persecution of abortion as a crime against the state, censorship of sex education and a tax on bachelors. As in Nazi Germany, the Fascist Party had a strong belief in improving birth rates and raising the standard of national health in general.[53] There were clinics for motherhood and childhood and specialised clinics for pregnant women and weaned infants, as well as family counselling, where nurses were integrated with midwives and social workers.

One of the fundamental tasks of nurses within these specialised structures was to promote children's and women's health, first of all as mothers. There were dedicated nurses with a particular professional duty, who took care of mothers, instructed them on how to raise their children, and when the mothers were breast feeding their babies, measured their milk output, since it was considered the duty of every good mother to provide enough food to bring up a good, strong Italian.[54] Fascism took the Ancient Roman motto *Mens sana in corpore sano* (A sound mind in a sound body) and made it its own – and in order to spread and reinforce this belief several activities were added to nurses' regular tasks, such as: organising courses in schools with exercise classes designed to fortify the constitution of future Italians, providing family counselling on personal hygiene and women's work, with hints on house cleaning and cooking. However, these services were supplied only in white Italian neighbourhoods and were free of charge for poor Italian mothers.[55]

Never before had women been called on to participate *en masse* to such an extent in the name of the Italian race, particularly in the sanitary and educational fields. The colonial postcards, comics, novels and pamphlets that were created concerning health and hygiene promotion did nothing but increase the sad stereotypical image of the 'black' African who appeared dirty and unfit to work. In the Royal Decree of 1935[56] 'Italy abrogates slavery' but 'the Ethiopian savages could be convicted and sentenced to hard labour'. In 1937 the new word *razza* (race) was introduced, together with the new racial laws that aimed at avoiding contact in neighbourhoods, public services, buses, etc. between 'blacks' and 'whites'.[57] The colonial race laws hit those classed as 'half-caste' and (a detail that is not often noted) local women hard. Children of 'mixed blood' could not be legally recognised by their Italian fathers. A later provision penalised Italian citizens who lived in the colonies and maintained relations 'of a conjugal character' – that is, stable relations of an intimate nature – with native women (in fact, the decree referred generically to 'subjects').[58] Therefore according to this new racist vision, African women could, at best, be considered as providing a sexual outlet for Italian men.[59] Furthermore we should note here that in Italy in 1938 the Fascist government issued the *leggi per la difesa della razza* (Laws to defend the

race), a set of legislative and administrative measures (laws, orders, circulars, etc.) against Jews.[60]

Conclusion

The Italian Fascist war and the few years of colonialism in Ethiopia proved to be a terrible waste of human lives without any real benefit to any of the participating nations. Approximately 275,000 soldiers and civilians were killed. Many towns were destroyed. The conventional war which ended in May 1936 was followed by guerrilla operations, carried out by a few remnants of Selassie's army. The resistance was sporadic, unorganised and resulted in the slaughter of 300,000–400,000 more Ethiopians for little gain and was soon eliminated. Even though the occupation of Ethiopia continued to require a large commitment of Italian resources, only the beginning of the Second World War and the intervention of British forces would allow Haile Selassie to return to his throne.

At the end of 1941, during the Second World War, the British Army freed Ethiopia. At the beginning of the conflict, the Italian resident forces were of about 90,000 Army and about 200,000 colonial soldiers. It was definitely a remarkable force, but Italian troops were spread out in different fields and this caused great difficulties because of poor logistics in the country. Despite the research of historians in recent decades, there are still several gaps that remain in the reconstruction of what really happened during these years; the few survivors are reluctant to provide testimony, because their words might lead to a reappraisal of the positive image of Italian colonisation, and because they might be less proud of their acts of repression. Access to ministerial and military archives is seldom granted and many documents and reports are still off-limits. Nowadays it is still not easy to talk about those years in Italy. For example, the Italian government officially only recently acknowledged the use of gas by the Fascist Army during the war (2 February 1996), when General Corcione,[61] Minister of Defence during Dini's government,[62] made a speech in Parliament and admitted Fascist Army guilt.[63] We also have encountered similar obstacles in examining the documents that remain in confidential dossiers, even after eighty years, and in trying to talk to

veterans, taking into consideration that only a few are still alive. With reference to the data examined, the outcomes show that, in spite of what official chronicles report, the real protagonists of nursing were male nurses. This is an interesting subject that we are sure requires further investigation. Nevertheless, we have been able to detect the presence and distribution of nurses (volunteer sisters of the Italian Red Cross, religious missionary nuns and male nurses), and the main health problems they encountered.

The documents analysed remain a fundamental witness of Fascist colonialism. The study of nursing protagonists through the regime booklets, the direct evidence, the propaganda of the Italian Red Cross volunteer nurses, with the participation of members of the Italian royal family, taken together show how Italian nursing history is directly related to the history of social policy. The ongoing research seeks to further clarify the evolution of Italian nursing through the period of Italian fascist colonialism and the continuing impact of these historical and political influences, which can still be perceived in problems faced by nursing in Italy today.

Notes

1 With special thanks to Maria Cristina Bertoni and Sue Hawkins.
2 Benito Amilcare Andrea Mussolini (1883–1945), Italian politician, journalist and dictator. He was called *Duce* from the Latin *dux* as 'leader' of the people.
3 Francesco Crispi (1818–1901) was an Italian patriot and politician.
4 G. Ottolenghi, *Gli italiani e il colonialismo* (Milan: Sugarco Edizioni, 1997), pp. 24–5.
5 Giovanni Giolitti (1842–1928) was an Italian politician, who held the post of Prime Minister in several governments.
6 F. Medard, 'The Second Ethiopian War, 1935–36', *Historiens et Géographes*, 98:396 (2006), 181–90.
7 Medard, 'The Second Ethiopian War, 1935–36', 184.
8 G. Sabbatucci and V. Vidotto, *Il mondo contemporaneo dal 1848 a oggi* (Milan: Editori Laterza, 2004), pp. 68–69.
9 In Italian *Giornata della fede*. The word *fede* means wedding ring and faith, so it could be translate as 'Day of the wedding ring' or 'Day of faith'.
10 A. Molinari, *La conquista dell'impero: 1935–1941. La guerra in Africa orientale* (Bresso: Hobby and Work Publishing, 2007), pp. 78–82.
11 Archivio storico Istituto Luce, Rome.

12 Ispettorato Superiore Generale Servizi Militari, Navali, Civili dell'Africa Orientale, *L'organizzazione sanitaria e la salute delle truppe durante la Guerra d'Etiopia* (Rome: Archivio Storico Policlinico Sezione Pratica, 1936), Fasciculus X–XI.
13 A. Castellani, *L'importanza dell'organizzazione sanitaria nella Guerra d'Etiopia, 3 ottobre 1935-XIII–10 maggio 1936-XIV* (Rome: Archivio Storico Istituto della Sanità Pubblica, 1936), Fasciculus XIV.
14 Castellani, *L'importanza dell'organizzazione sanitaria.*
15 Castellani, *L'importanza dell'organizzazione sanitaria*.
16 Ispettorato Superiore Generale Servizi Militari, *L'organizzazione sanitaria e la salute delle truppe*.
17 Ispettorato Superiore Generale Servizi Militari, *L'organizzazione sanitaria e la salute delle truppe*.
18 Ispettorato Superiore Generale Servizi Militari, *L'organizzazione sanitaria e la salute delle truppe*, X.
19 Ispettorato Superiore Generale Servizi Militari, *L'organizzazione sanitaria e la salute delle truppe*, XI.
20 Ispettorato Superiore Generale Servizi Militari, *L'organizzazione sanitaria e la salute delle truppe*, XI.
21 M. E. Galiana-Sanchez, J. Bernabeu-Mestre and P. García-Paramio, 'Nurses for a new fatherland: gender and ideology in the health policies of the early Franco regime in Spain (1938–1942)', *Women's History Magazine*, 68 (2012), 33–41.
22 Grace Baxter was an English/American nurse who had been invited to Italy to help establish a nursing school following the English model in the early twentieth century. D. Tombaccini, D. Lippi, F. Lelli and C. Rossi (eds), *Florence and its Hospitals: A History of Healthcare and Assistance in the Florentine Area* (Florence: Florence University Press, 2008).
23 S. Bartolini, *Per le strade del mondo: laiche e religiose fra otto e novecento* (Turin: Il Mulino, 2007), p. 164.
24 G. Rochat, *Le guerre italiane: 1935–1943* (Turin: Einaudi Editore, 2005), pp. 102–3.
25 Marie Jose Carlotta Sofia Amelia Enrichetta Gabriella di Sassonia Coburo-Gotha (1906–2001), Princess of Belgium, the last Italian Queen by marriage.
26 Umberto Nicola Tommaso Giovanni Maria di Savoia (1904–83), Lieutenant-General of the Kingdom of Italy and last King of Italy, before the proclamation of the Republic in 1946.
27 A. Setti Carraro, *Sorella, storia di una crocerossina* (Milan: Longanesi, 1974), p. 67.
28 Setti Carraro, *Sorella, storia di una crocerossina*, pp. 70.
29 N. Labanca, *Una guerra per l'impero: memorie della campagna d'Etiopia 1935–36* (Turin: Il Mulino, 2001), p. 132.
30 Labanca, *Una guerra per l'impero*, p. 134.
31 Labanca, *Una guerra per l'impero*, p. 154.

32 Labanca, *Una guerra per l'impero*, p. 203.
33 Labanca, *Una guerra per l'impero*, p. 206.
34 Women were not admitted into the Italian Army until 1999.
35 Ispettorato Superiore Generale Servizi Militari, *L'organizzazione sanitaria e la salute delle truppe.*
36 Rochat, *Le guerre italiane*, pp. 102–3.
37 G. Calci Novati, *Il corno d'Africa nella storia e nella politica: Etiopia, Somalia e Eritrea fra nazionalismi, sottosviluppo e guerra* (Turin: SEI Editore, 1994), pp. 257–60.
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39 Carl Gustaf von Rosen (1909–1977), Swedish pioneer, aviator and humanitarian.
40 N. Rankin, *Telegram from Guernica: The Extraordinary Life of George Steer, War Correspondent* (London: Faber & Faber, 2003), pp. 174–7.
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47 A. Randazzo, *Il colonialismo italiano in Africa, 1870–1943* (Turin: Kaos Edizioni, 2006), p. 177.
48 Condizioni Sanitarie Italia (Direzione centrale affari coloniali), *Note di patologia etiopica, 0.44767* (Rome: Archivio Nazionale Ministero delle Colonie, presso archivio storico Guardia di Finanza, 1940), pp. 4–8.
49 Condizioni Sanitarie Italia, *Note di patologia etiopica*, p. 9.
50 Condizioni Sanitarie Italia, *Note di patologia etiopica*, p. 10.
51 Condizioni Sanitarie Italia, *Note di patologia etiopica*, pp. 4–8.
52 A. Peters, 'Nanna Conti: the Nazis' *Reichshebammenfuehrerin* (1841–1951)', *Women's History Magazine*, 65 (2011), 33–41.
53 E. Dixon Whitaker, *Measuring Mamma's Milk: Fascism and the Medicalization of Maternity in Italy* (Ann Arbor: University of Michigan, 2000), pp. 93–4.
54 Whitaker, *Measuring Mamma's Milk*, pp. 93–4.
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56 Royal Decree Law no. 917, 27 April 1935.
57 Royal Legislative Decree no. 620208, 12 June 1937.
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62 Lamberto Dini (1931–), Italian politician, economist and entrepreneur.
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9

Changes in nursing and mission in post-colonial Nigeria

Barbra Mann Wall

Introduction

In 1914, Britain created the country of Nigeria by joining northern and southern protectorates together. In a colonisation process that lasted more than forty years, the British employed treaties, battles, threats of deportation and collaboration with compliant local rulers as they established a policy of 'indirect rule'. Yet racial discrimination and other forms of alienation led to anti-colonial protests and nationalist resistance movements. After the Second World War, constitutional changes increased Nigerian self-governance, and in 1960 the country obtained independence, albeit an unstable one.[1]

Political tensions and ethnic and religious differences led to the civil war that began in 1967 when the southeastern area attempted to secede to form the Republic of Biafra. During the Nigerian civil war, Catholic mission hospitals became sites for a shift in the understanding of nursing and medical practices as missionaries worked to care for survivors of violence. After the war, a dominant role for Nigerians began in Catholic healthcare missions. They provided care, sustenance, help for orphans and protection of those suffering from the violence. Several authors have described the politics and humanitarianism of organisations that flew nightly shipments of food and medicines to a starving population in the southeast region during the war.[2] As these accounts are told, the relief work was essentially a European and American enterprise. Yet examination of healthcare activities at the local level reveals both Irish Catholic missionaries and Nigerians themselves working collaboratively to care for the ill and injured.

The purpose of this chapter is to examine the changes in nursing practice and personnel in Catholic mission hospitals that resulted from the Nigerian civil war from 1967 to 1970. Until then, Catholic sisters, or nuns, who served as mission nurses, physicians and midwives had been overwhelmingly white. When expatriates were expelled during the war, however, Nigerian sisters took over the leadership of Catholic healthcare institutions.[3] This chapter focuses on the Medical Missionaries of Mary (MMM), the Missionary Sisters of Our Lady of the Holy Rosary (Holy Rosary Sisters) and the Immaculate Heart of Mary (IHM), Mother of Christ Sisters. The first two began as Irish congregations, or orders, whereas the latter is a religious congregation of Nigerian women. The focus on missionaries' viewpoints provides insight into a neglected aspect of the post-colonial era in sub-Saharan Africa, the decolonisation and independence periods and what happened to healthcare during violence and massive displacement of people.

Through their religious congregations, Catholic sisters worked with many groups of women and men as they established hospitals and schools of nursing in Nigeria. Sisters combined religious commitment and medical science to relieve physical and spiritual suffering; indeed, they were bound by strong ties of gender, professionalism and religion. Nuns were strongly affected by the Catholic Church's emphasis on women's authority in the home and family; and when sisters ran hospitals and clinics, many focused on maternal care and children. They also recruited women for their religious congregations and engaged women as students in schools of nursing.[4] Yet they also challenged gendered conventions by working as physicians and surgeons and educating some African women in these roles, and establishing large general hospitals with specialties in medicine, surgery, obstetrics, gynaecology and paediatrics.[5]

Background of medical mission work in Nigeria

Protestant missions dominated in Nigeria until 1886, when the French Spiritans, or Holy Ghost Fathers, established a stronghold in the country. However, as the British expanded their colonial management they wanted English-speakers because business associates spoke English.[6] Thus in 1905 Irish mission work in Nigeria grew

when Irish-born Bishop Joseph Shanahan took over leadership of the Holy Ghost mission in Calabar (the eastern region).[7] Soon, Irish missionaries dominated in the area. Because colonial powers' religion was Christianity, this granted the Irish missions a distinct advantage, and they benefited from British colonialism.[8] Catholic mission personnel co-operated with colonial leaders who wanted the Catholics to run hospitals and schools, while Catholic missionaries wanted access to Nigerians for conversion purposes. In many areas, this continued after independence.

Yet as Thomas Csordas argues, in the post-colonial world, the Catholic Church was operating under new conditions, which included a 'rejection of the missionary work associated with colonialism'.[9] While changes in sub-Saharan Africa after independence bore a distinct colonial legacy of education and Western medical facilities, there is a broader narrative to consider that includes how critical moments in specific times and places produced specific practices.[10]

Diana Solano and Anne Marie Rafferty detail the establishment of the Colonial Nursing Association that began in 1896 to recruit British nurses for work across the British Empire.[11] Both colonial nurses and missionaries established nursing education projects in Nigeria, each based on the European model that centred on hospital training. Nigerian students worked under the guidance of white European nurses. The British erected the first government hospital in Calabar in the southeast, and by 1914, twenty-six medical facilities and one leprosy asylum were in existence.[12] It must be noted here that throughout the colonial era and for some time during decolonisation and independence, agents of biomedicine, including missionaries, marginalised indigenous medical practitioners.

The 1930s were a key time for nursing and medical expansion in Nigeria. Andrew G. Onokerhoraye notes that the inter-war years witnessed an expansion of hospitals such that by 1930, seventy-one were in existence and twenty-three were mission-owned, the latter reflecting both Protestant and Catholic expansion. At this time, the British colonial government supported missions that could develop rural programmes at Church expense while the government concentrated in urban areas. And as Protestant services grew, Catholic Church leaders were deeply concerned to continue their own influence.[13] A registration system began with the Ordinance of 1930 that

established the Nursing and Midwives Board of Nigeria, with midwives taking an examination set by that organisation in line with the contemporary British system of nurse training and regulation.

The 1930s were significant for another reason. Compared to Protestants, Catholic sisters came late to Africa because Catholic canon law forbade them from working in operating or delivery rooms. Thus, although they could become nurses and physicians, they could not be surgeons, midwives or obstetricians. This was probably related to a modesty requirement from the nuns' vow of chastity. Yet many of the needs of Africans concerned women, and much lobbying by lay women physicians, religious sisters and Irish, American and Australian bishops occurred. They not only saw the need for women surgeons and midwives to meet the needs of other women, but sisters also were needed to teach birth control and counter the work of Protestants in this arena. Anna Dengel, a sister physician who had worked in India and who actively petitioned the Vatican, was especially concerned about caring for Muslim women who lived in seclusion through the practice of purdah. Thus, the Church finally lifted the ban in 1936.[14] The edict made it possible for Marie Martin, an Irish nurse and midwife, to establish the MMM in Nigeria in 1937, with the motherhouse in Drogheda, Ireland. Bishop Charles Heerey, vicar-apostolate in Onitsha and Owerri, Nigeria, established the IHMs in 1937, as well, to be trained as teachers, nurses and midwives.[15] Although Bishop Shanahan founded the Holy Rosary Sisters in 1924 to be teachers in Nigeria, after 1936 they expanded their work into healthcare. Both the MMM and Holy Rosary Sisters were physicians, midwives and nurses who had benefited from opportunities to get medical degrees and nursing education in Ireland.[16]

In Catholic healthcare institutions, it was sisters, or nuns, who established and administered the hospitals, clinics and schools of nursing for Nigerians. Indeed, sisters went to the mission field with the expectation that they would work themselves out of a job by eventually replacing themselves with African nurses and midwives. After the MMM established Our Lady of Lourdes Hospital in Drogheda in 1940, which became a training school for nurses and physicians, the MMM sent some Nigerian women to study with the sisters there. These Nigerians then returned to their own country to practise in the MMM hospitals.

By 1945, there were 116 hospitals in all of Nigeria, of which 46 were mission-based.[17] A report by Sir Sydney Phillipson, the British Commissioner for Regional Administration in the Gold Coast, in 1949 called for increased grants-in-aid to mission hospitals. Catholic missions welcomed this aid because they needed the money.[18] That year, the Holy Rosary Sisters had general hospitals, clinic, and maternity homes in Emekuku, Ihiala, Nsukka and Onitsha, among other places.[19] The MMM had several hospitals in the southeastern part of the country, including facilities in Ogoja, Afikpo, Arua Akpan, and the largest of all in Anua, the 300-bed St Luke's Hospital. Of the indigenous women's religious congregations, the IHMs had the largest numbers of facilities in the 1960s: they ran fifteen schools, two teachers' training colleges and several maternity homes, clinics and dispensaries.[20] By 1964, twenty maternity and general hospitals were in Catholic mission hands in southeastern Nigeria, and five were jointly run by the missions and government.[21]

The years after the Second World War also were expansion years for nursing in Nigeria. As European influence waned in the post-war years, the Registration of Nurses Ordinance was established in 1947 that set standards for all schools, and it established the Nursing Council of Nigeria as the regulating body. The Council determined specific age and minimum educational standards for entry, length of training and a syllabus; and a missionary served on the Council. The Nursing Council was part of the Ministry of Health, and it had to approve all hospitals for training purposes. Registered nurses were qualified as Nigerian Registered Nurses, or NRNs. Teaching was in English, as were the examinations. A school of nursing at University College Hospital, Ibadan, was formed in 1952, and in 1954, a Nigerian Midwifery Board was established.[22]

In this context, Catholic sisters sensed a serious situation for the future of their hospitals. In 1954 the MMM learned that each region in Nigeria, including the East, where Catholics predominated, was to have only two 'first-class' nurse training schools, one Protestant and one Catholic. The MMM were especially concerned because some medical officers in the Ministry of Health considered the Holy Rosary Sisters to have a better hospital, and the Holy Rosary Sisters also had a trained sister tutor ready to go to work. As an MMM noted, 'the whole nursing status of the Congregation depends on the next few months'.

This hastened the MMM decision to get sister tutors trained.[23] By 1958 St Luke's could boast that the school had fifty-eight Nigerian student nurses in their four-year programme. Most were women, but of the total, fourteen were men. The MMM did, indeed, obtain sister tutors and eventually met the Nursing Council of Nigeria's requirements.[24] By 1962 government and mission hospitals had well-established nursing and midwifery schools for Nigerian students. Significantly, both the Holy Rosary Sisters' hospital at Emekuku and St Luke's at Anua were some of the earliest schools of nursing to be recognised by both the Nursing Council of Nigeria and the British General Nursing Council.[25] Trained nurses and the fact that Catholic sisters could offer impressive procedures of modern medicine such as safer surgery and Caesarean sections were significant to the growth of the nursing and medical professions in Nigeria and especially after the civil war broke out.

Medical and nursing humanitarian relief during the Nigerian civil war

When the civil war broke out in 1967, sister physicians, surgeons, nurses and midwives were ready to respond, as were many students and graduates of their nursing schools. Although sources differ on the numbers of deaths during the war, it is estimated that from 1 to 3 million people, mostly unarmed civilians including women and children, lost their lives.[26] Both white missionaries and Nigerian nurses and civilians worked together in healthcare and relief centres. To illustrate these points, I have relied on archival documents that have not been examined before, including letters, a diary and film. While these mainly emphasise the sisters' work, they also hint at alliances with local people who fought for the survival of their communities during the crisis. For example, a 1969 online archive holds hundreds of thousands of hours of moving-image and sound recordings, photographs and documents, and it has been helpful in examining African sisters' work during the Nigerian civil war.[27] Without these sources, we would get an incomplete picture of relief work during the crisis.

Doing research on humanitarian relief work is problematic in many ways. Colonial leaders wrote many of the documents of African

history and they are full of cultural biases.[28] Mission documents are also plentiful, although much of the discourse was directed at an audience back home either to obtain donations or to report to the sisters' motherhouses. A major problem is the absence of voices of those excluded from power. Even though Nigerians were in the majority in their country, many lacked the means to document their personal experiences, and some archivists and librarians may not have been interested in collecting their stories. Thus, I have had to search for many different kinds of sources to get at the myriad people involved in the relief effort.

When sisters initially came to Nigeria, their purpose was to convert and establish churches where Catholicism had not yet developed. Yet even before the Nigerian civil war, missionary discourse had begun to change. Sisters wrote about treating the sick and injured even if conversions did not result. In 1962, Sister Dr Margaret Mary Nolan, a Medical Missionary of Mary in charge of St Luke's Hospital in Anua, described their work: 'Medical Mission work presupposes doing physical good to all who ask us – as Our Blessed Lord did. The question of conversion or change of life may come later.'[29] Many interpretations of change in Catholic nursing and medical practices assume that they began with the Second Vatican Council, or Vatican II (1962 to 1965), which brought about global institutional transformations. These included using English during Mass, engaging with other religions and appreciating other cultures. Yet other factors on the ground, such as violence and upheaval, significantly shaped sisters' ideas and practices.

Like other disasters, the Nigerian civil war generated large-scale displacements of people and resources.[30] The civil war was between the eastern region of Nigeria (renamed Biafra) and the rest of the country. Although the Catholic Church had made little impact in the northern part of Nigeria, which had a Muslim majority, Catholic missionaries were more successful in the southeastern region, particularly among the Ibo (Igbo). Significantly, the Ibos were the largest ethnic group to be displaced by the civil war, although many others were also affected.[31] The Biafrans declared themselves independent from Nigeria, which the Nigerian Federal Military Government ('Federals') regarded as an act of illegal secession. The Federals fought the war to reunite the country. One million people fled to the East,

and by April 1968, Biafrans had flooded into a landlocked enclave entirely surrounded by federal forces, who blockaded all the roads. Western nations were unwilling to breach Nigeria's national sovereignty and provide assistance across the border. The war lasted thirty months and Biafra collapsed in 1970.[32] Hospitals and clinics run by the MMM and Holy Rosary Sisters were in the middle of the fray.

One important written document is a diary by Sister Pauline Dean, a paediatrician and MMM who worked at St Mary's Hospital in Urua Akpan. Sister Pauline joined the MMM and went to Nigeria in 1961. As with any written document, it is important to determine who the intended audience was. In this case, Sister Pauline wrote it for private rather than public consumption, likely for her sisters back in Ireland. Perhaps it was an aid to help her recall her own experiences, or it may have served as a means of catharsis to expunge the horrors of the day from her mind so she could sleep at night. She did not say. What is known is that she did not intend to publish at the time of writing it, yet when she found it in an old suitcase forty years later, she decided to make it public. As she stated, 'I had forgotten how much the people suffered and secondly how many kind people helped us in caring for the sick and wounded.'[33] She wanted their stories told as much as hers. In writing the diary, her style is practical in form as she jotted down her own daily activities and those of the people she worked with. She squeezed in time to write after a long day of working in the hospital or in the refugee camps.

Sister Pauline recorded events from January to September 1968. The sisters at St Mary's included two nurse midwives, Sisters Eugene McCullagh and Elizabeth Dooley; two physicians, Sisters Pauline Dean and Leonie McSweeney; and administrator Sister Brigidine Murphy. The MMM established St Mary's in 1952; and at the time of the civil war it boasted 150 beds, a large surgical clinic and a training school for midwifery.[34] During the war, the hospital also was staffed by student nurses, nurses whom the sisters had trained and local volunteers. Biafran nurses and midwives, social workers, caretakers of children and distributors of relief also formed part of the hospital personnel. Men did so as well. Most Protestant organisations had already 'Africanised', so few white Protestant missionaries were left in Nigeria at the time. The MMM, Holy Rosary Sisters and many Irish priests made the crucial decision to stay in Biafra.

As the war escalated, nursing and medical care expanded to include relief work. In her diary, Sister Pauline provided an eyewitness account of bombardments and descriptions of the severe malnutrition that especially affected children in the form of kwashiorkor, caused by a severe protein deficiency that resulted in anaemia, swelling of hands and feet and large protruding abdomens.[35] Her first entry on 23 January was an acknowledgement of the food problem and how nurses and physicians dealt with it: 'Food was scarce so we started to farm. Planted pumpkin, melon and okra.' On 28 January, she noted the growing havoc of the region: 'Plane and two thuds in OPD [outpatient department]. I did not hear because of screaming children.' Food issues continued to be a problem and on 14 February, she went to Use Abat to get yams.[36] On 3 March the hospital was bombed, and on 6 March, she 'went to Ikot Ekpene to get some splints. Then back – hastily because of air raid on Ikot Ekpene.'[37] Throughout the month, in addition to caring for patients, the nuns tended to their garden, helped at St Vincent de Paul's bazaar to get clothes for refugees and found families for orphaned children. On 25 March, Sister Pauline and her colleagues treated forty-five outpatients as planes flew over them, and then she and Sister Leonie worked in the operating room all afternoon.[38]

Sister Pauline described the many types of injuries they treated. On 27 March, she mentioned several wounded soldiers who arrived at the hospital, five 'mostly "shell shocked" ', and nine who were deaf from explosions. On 28 March, Sister Pauline described a full-term pregnant woman who had walked a long distance to the hospital. That same afternoon several soldiers came with conditions that ranged from 'shell shock', beatings and all 'fatigued'.[39] Other soldiers arrived on 29 March, with 'pains all over – deaf, etc.'. One man with a shoulder injury began haemorrhaging, and the sisters had to take him back to the operating room to staunch the bleeding.

The sisters placed orphaned children in the paediatric ward to care for them there. While this offered needed sustenance, sometimes the local children protected priests and sisters. When one of the priests took an orphan, 'Justina', to Aba to look for her father, 'She made friends with everyone on the way. At one point a soldier put his gun through the window – she shook hands with it and he withdrew it.'[40]

Eventually many of the secular nurses left the hospital to be with their families, and local men and women, priests and even soldiers volunteered their time to assist the sisters with feedings and care of babies. For example, 'There were two men with severe leg wounds and they were delighted to help to feed the babies.' In the midst of the chaos, Sister Pauline could relieve some stress through humour, especially when she described her own failings. As she was working with the two men patients, she wrote that when she went to retrieve the babies after they finished feeding them, she said something in the Efik language. She intended to say, 'Did the baby feed well?' Apparently, however, she said, 'Did the baby suck the breast well?' This brought great laughter from the men, who replied, 'Yes', they did.[41]

The diary mentions other examples of Nigerian participation in caretaking and relief work. On one occasion, a woman was shot close to the hospital, and a 'laundry man' helped Sister Pauline put her on a mattress and 'tidy her up'.[42] As the war continued, famine resulted because farming could not take place amid the battles. Yet the sisters had a key resource on their side: Nigerian sisters who were part of their local communities. Sister Agnes Maria Essien, an MMM, was the biological sister of a local chief, and she and her family were instrumental in sharing produce from their farm to feed refugees.[43] Sister Veronica Akpan, the first Nigerian sister in the MMM congregation, was active as a nurse. She and three other sisters had to flee Akpa Utong, an area in the southeastern region, at half an hour's notice.[44]

Although not a religious sister, Mrs Hogan was a Nigerian nurse-midwife who had trained in the United Kingdom, and she also assisted the sisters. She often accompanied them to refugee camps,[45] but we know of her activities only because Sister Pauline mentioned them in her diary. On 30 March, without operating-theatre staff, Mrs Hogan and Sister Eugene helped Sister Pauline to care for a man named Joseph who had machete wounds on the leg, chest and arms. His hand had been cut off at the wrist. In a six-hour surgical procedure, they repaired the wounds, and in their haste, the blood transfusion crashed to the floor. It was their last one. After the procedure, even though exhausted, they made rounds in the ward, fed the patients, and the men 'were delighted and fed the babies again!'.[46]

Sister Pauline was a paediatrician, but during the civil war she had to perform many surgical procedures on adults. When she faced an

unfamiliar surgical procedure, she sometimes had to read instructions from a surgical textbook as she operated. On 4 April, she and Sister Elizabeth attended to Joseph, once again, in order to amputate the lower part of his forearm so that a good supply of blood could get to the remaining extremity. As they were setting up for the procedure, a child dying from dehydration arrived, and they had to stop to set up an intraperitoneal drip for him. Then a critically ill woman with a pelvic infection came and they had to examine and treat her. Finally they were able to get started on the surgical procedure, but with few aides available they taught one of their laboratory assistants to don sterile gloves. He held the arm as Sister Pauline read from her textbook and operated.[47] Sisters and their co-workers also treated patients with appendicitis and strangulated hernias. Significantly, the hierarchical boundaries changed in the space of the hospital as sister-doctors also taught priests how to scrub and assist them in the operating room.[48]

During the month of May, 1968, the sisters and their co-workers held many outpatient clinics where they often tended to more than a hundred people a day. Local volunteers helped with translation, and members of the local military also assisted when no staff was available. In late May, Biafran authorities informed the sisters that they would have to evacuate, although they did not know when. With a sense of urgency, Sister Pauline wrote on 31 May: 'Usual OPD [outpatient department] in ward then out to Ikot Ebak camp. There are now 1,736 people in it and the crowd waiting around the building acting as dispensary was mighty ….Very hard to keep order. The militia are there to help. We work at a very fast rate to try and see as many as possible.'[49] Cultural and racial differences between the Irish sisters, who ran the hospitals and clinics, and the Nigerians who worked in them did exist, with lingering unresolved contradictions between the Catholic Church and its monopoly of power by whites. Yet in the context of violence and displacement, some of these boundaries blurred as workers from many groups sought to resolve the demands placed on their community in times of disaster.

One other diary entry, 11 June 1968, reveals the industriousness of local Biafrans in caring for themselves. After getting lost when travelling to a refugee camp:

> Found the compound a hive of industry – garri making ….They buy a plot of land with cassava on it ready to be harvested. One group picks it and

> another peels it, then it is cut up smaller and put in a sieve. The sieve is home made – a piece of iron with a nail driven through it many many times, then heated and oil added – and finally put out on a mat for 24 hours to dry. Some is eaten and some is sold to buy another cassava patch.[50]

Indeed, these were busy days for people all around the enclosed enclave. In the diary, rhetoric relating to religious conversion was notably absent.

Eventually the government forced the sisters to evacuate, and they left in September 1968. By then, an international ecumenical airlift had begun an operation to provide food, medicine and other relief supplies. American Protestants, Catholics and the Jewish community formed the Joint Church Aid organisation. Transnational alliances developed when the Americans were joined by Protestant Church agencies in Denmark, Norway, Sweden and Finland in forming an international Joint Church Aid group. Much of the relief materials raised internationally came through these agencies, along with a Canadian group, the World Council of Churches, Africa Concern and Oxfam.[51] Male missionaries who ran the airlift and other relief operations were major sources of news to the outside world, and they were able to generate great publicity. Photos of starving Biafran children flooded publications and the airwaves, especially in the United States, generating great public support.[52]

Yet other documents provide a different record of activities during the civil war. Films, for example, can allow us to glimpse images of people not otherwise known to historians. First-person accounts of the impressions of sister-nurses and physicians, their activities, the work of Biafrans and the people they tended can be found in a film located at Raidió Teilifís Éireann Archives (RTE), Ireland's National Public Service Broadcaster. This online archive holds hundreds of thousands of hours of moving-image and sound recordings, photographs and documents. Indeed, the Internet has significantly revolutionised historians' collection of this as well as other forms of archival material. One particular video, entitled *Night Flight to Uli*, was filmed by an Irish Radharc Television team in 1968 and sponsored by Caritas, the international Catholic relief agency. Its purpose was to highlight Caritas's work as one of the many aid agencies that used a widened stretch of blacktop road at Uli airport to land their planes

and supplies. Used as propaganda for the Irish Catholic view, some of the subjects in the film were staged, but others were not. The film is useful because it shows attitudes and interactions among aid workers and the Biafrans, taken at the time the events occurred. Indeed, film archives can be very helpful for historians to see actions and gestures and rhythmic movements as they took place at the time.[53] For example, the film features interviews with Irish Holy Ghost Fathers and the Irish Holy Rosary Sisters; yet it is important for another reason. Although not specifically discussed by the narrator, it shows the work of a Biafran Holy Rosary sister at a refugee camp as she provided relief services and instructed mothers how to care for their infants. She stated, 'For Biafrans, this is a war for independence. We are fighting for our rights …. If they leave us alone, that is all we want.'[54] In addition to meeting immediate needs for survival, this Biafran nun was working for her nation.

The film also shows a white Irish nun embodying the idea of cultural change. Rather than criticising African dances, as missionaries did in the past, this nun joined in an African dance performed with Biafran women. She was Sister M. Conrad Clifford, a Holy Rosary Sister who worked closely with the Biafrans to feed refugees. The Holy Rosary Sisters' hospitals and schools of nursing in southeastern Nigeria continued to be active during the civil war. While this film highlights the work of white missionaries and Caritas, it also illustrates Biafran doctors working at the Holy Rosary hospital in Ihiala as they cared for sick and injured people.[55] Indeed, the evidence shows the local response of Biafrans caring for themselves.

While mission archives feature only missionaries, other sources provide a broader image of relief work. Nigerian writer Chinua Achebe's memoir of the war provides his reckoning of the events as he tried to come to terms with the Biafra story. Born in the southeastern region, Achebe provided a moving account of the atrocities, as he viewed them, and the role that writers and other intellectuals played. Dr Aaron Ifekwunigwe directed the Biafran health services and cared for many children. His clinical research on the impact of starvation on children was particularly noteworthy. Achebe describes refugee camps not only developed by missions but also local villagers. He found 'a new spirit among the people', one of determination, 'of a people ready to put in their best and fight for their freedom'.[56]

Achebe also mentions his sister-in-law, Elizabeth Okoli, a nurse who worked at the Umuahia hospitals during the war. This nurse was highly respected for her intelligence and clinical prowess. After the war, she became chief nursing officer of the Anambra State in south-eastern Nigeria.[57]

Evidence of international efforts can be found in Swarthmore College's Peace Collection of photographs. Indeed, historical photographs can be useful documentary evidence. Although they may appear to provide pictures of real people and real places, caution is needed with their use. Photographs are artefacts that reflect the ideological assumptions and cultural practices of their time. While they are important primary sources, they have the same biases as written historical records.[58] One photo from the Peace Collection shows UNICEF and Joint Church Aid workers posing alongside Nigerians who all rendered service at Uli airport. Without this photograph, one would have an impression that only white aid workers assisted. One hundred and twenty-two Biafrans and thirty-five North American and European Joint Church Aid workers died in the airlift relief work.[59]

After the civil war

The Catholic Church's role in the conflict caused considerable political controversy. The Nigerian government was hostile to the priests, sisters and other relief agencies, arguing that they prolonged the war by feeding the enemy.[60] To the federal government, this work was illegal, and it became the main reason for its decision to expel 300 priests and 200 sisters from the country. Only a few were invited back later in the 1970s.[61] It was Nigerian sisters who maintained the hospitals after the expatriates left.[62] As a result, the Irish MMM no longer administer any of the hospitals they had established before the civil war, although they remain active in primary healthcare projects, such as programmes for disabled teens and persons with HIV/AIDS.

The shift from Irish to Nigerian leadership in mission healthcare was significant. Indeed, what was lost for the Irish sisters became an opportunity for Nigerians. In the 1950s and early 1960s the Catholic Church in Nigeria was at its most numerous in terms of black and white members, but it was still overwhelmingly led by whites.[63] This changed after the Nigerian civil war. With fewer white expatriates in

the Church, more Nigerians were ordained as priests; and Nigerian sister-nurses, -physicians and -midwives took over leadership in nursing and medicine. Africanisation of Church institutions did, in fact, increase after the civil war.[64] The government officially took over the MMM's St Luke's Hospital in Anua.[65] High on the Minister of Health's priority list was that qualified Nigerians should take control of the Nigerian hospitals. The Ministry of Health chose two MMM to promote to key positions: Sister Agnes Marie Essien became head of the school of midwifery at St Luke's; and Sister Veronica Akpan became deputy matron and eventually matron.[66] After the wartime destruction of Holy Rosary Hospital at Emekuku, Sister M. Therese Njoku, an IHM sister, helped reconstruct the damaged hospital and nursing school in 1970. The IHM sisters also re-established and upgraded other Catholic hospitals to high standards.[67] For these nurses and for the Nigerian government, the nation's right to care for its own was reasserted.

Conclusion

Mission documents, photographic evidence, films and memoirs provide evidence of a multi-national response to the Nigerian civil war, with Nigerians themselves working alongside missionaries and international relief organisations. It is tempting to credit changes in mission medicine and nursing in the 1960s to Vatican II and efforts of the global Catholic Church to become more open to other cultures. In Nigeria, however, political events prevented that from happening. Catholic medical and nursing sisters in the 1960s and 1970s in collaboration with local Nigerians dealt with desperate conditions. While sisters had long been heavily involved in health services and nursing education, increasingly they took on relief operations. They formed alliances with members from local Nigerian communities to work towards a humanitarian commitment for those affected by war and violence.[68] Indigenous women and men also provided needed care as nurses, midwives, physicians and assistants. After the war, Nigerian sisters helped rebuild the Catholic mission infrastructure.[69] Thus, mission activities expanded to include greater roles for Nigerians who provided needed physical, psychological and spiritual support, which was a significant change in Catholic mission.

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10

Two China 'gadabouts': guerrilla nursing with the Friends Ambulance Unit, 1946–48

Susan Armstrong-Reid

> The Friends Ambulance Unit is an agency through which members of the Society of Friends and like-minded persons carry into action their deepest religious convictions and insights …. Through relief service we are able to express our sense of responsibility for and unity with our fellow human beings. We feel we need to bring food, clothing, and shelter to those in distress but far more important than even such vital material assistance, is the opportunity to share the burden of suffering of another, to help restore his sense of self-respect and integrity and to restore his faith in love and good-will through a practical demonstration of human sympathy and brotherhood. Convinced of the error of the way of violence, Friends seek to make love the basis of their relationships with others.[1]
>
> Statement of the Peace Testimony in the Service Contract for the Society of Friends Ambulance Unit (FAU)

Introduction

In 1946 British surgical nurse Elizabeth Hughes and American public-health nurse Margaret Stanley eagerly anticipated their upcoming two years with the China section of the Friends Ambulance Unit, formed in 1941, commonly known as the China Convoy. Both idealistically embraced this Quaker-sponsored organisation's Peace Testimony embodied in its GADA principle ('Go anywhere and do anything') to share the burden of suffering – hence its members' nickname 'the Gadabouts'. Believing that there were alternatives to war, Quakers sought to provide a practical demonstration of human sympathy and global fraternity through relief services. In 1939, British

10.1 Elizabeth and Margaret

Quakers assisted by the American Society of Friends reactivated the FAU to provide conscientious objectors of all faiths with an alternative to military service, as it had done in 1914. By 1945 the Convoy carved a unique humanitarian space as the first Western aid group to work 'under' the Chinese military and civil authorities in Free China (parts of west and south China not occupied by the Japanese). The unexpected end of the Sino-Japanese war marked a watershed for both China and the Convoy. Its ambitious post-war developmental plans, centred in Honan, were increasingly held hostage by events beyond its control that made foreigners unwelcome and funding impossible. On 1 October 1949, Mao Zedong declared the creation of the People's Republic of China. The dictums of the Cold War shifted Western aid priorities to contain Communism. The Convoy reluctantly closed its doors in 1951.

Recasting the stories of the China Convoy's nurses

Apt foils, Hughes and Stanley underline the entanglements of nursing as it was imagined and practised in war-torn China through this

period. Recovering their stories provides a different perspective, allowing us to focus on the 'lives of unknown or lesser known figures so as to explore what their experiences can offer to our understanding of an era, a movement or a culture'.[2] Their experiences illuminate the intersections of power with the matrix of faith, gender, class, race and place that shaped FAU nurses' work as civil war spread like wildfire. Forced to renegotiate the fragile frontiers of its pacifist humanitarianism to maintain its organisational integrity, the Convoy became the only Western aid agency to gain access into Communist-held territory. Hughes and Stanley witnessed the birth of modern China from both sides of the conflict. Both worked in three of the Western-style mission hospitals being rehabilitated as part of the Honan project, then under Nationalist control, before joining Medical Team 19 (MT19) deep in Communist-held territory 'during the intensity of battles and bombing'.[3]

Their experiences illuminate the difficulties of grounding humanitarian action in a few basic principles: independence, neutrality and impartiality. Equally important, as their personal and professional identities were tested, they developed different methods to reconcile their identities as Western nurses and soldiers of peace with prevailing views on how respectable Christian women should behave. Their humanitarian endeavours, therefore, offer timely perspectives on global nursing's engagement in the increasingly controversial 'humanitarian international'[4] – the complex of international, governmental and non-governmental agencies and organisations engaged in humanitarian or development work that arose from the ashes of the Second World War and decolonisation. This case study challenges post-colonial scholars' hegemonic views of nurses' agency within Western humanitarian diplomacy.[5] Western nurses did not always act as agents of their governments' interests abroad. It was a far more complex and fascinating story than previously realised.

Joining the Convoy

The decision to volunteer offered exotic travel, adventure, new professional horizons and an opportunity for service, but the roads that led Stanley and Hughes to China differed in significant ways.

Although raised in a middle-class family, nominally Congregationalist, Elizabeth Webb Hughes absorbed her early Christian pacifist views from an uncle, who had been imprisoned as a conscientious objector in the First World War: 'His principles sort of unnoticeably filtered through to me. And I really sort of accepted them as the norm.' Only later did she realise 'that Christians were not necessarily pacifists because to me the Christian message is so utterly pacifist …. It's love thy neighbour and do good to those who spitefully use you.'[6] As war approached, she remembered wrestling with her pacifist beliefs: 'Really only by going and living on a desert island and being utterly self-sufficient could you separate yourself from the war.' Never a strong academic, Hughes intended to be a fashion buyer but decided that being a 'properly trained nurse' was a more 'practical' alternative in wartime. In 1944, she completed a four-year nursing programme at Queen Elizabeth Hospital in Birmingham, a 'very peculiar hospital' where the clinical training was highly specialised, focusing on surgery. Viewing overseas relief work as more adventurous than hospital nursing, she immediately volunteered with the FAU. Citing her desire to atone for the damages of war, Hughes 'just got on with it because it obviously needed doing'.[7] The 'small bright woman' was initially turned down for China, the result of 'an impression she gave of emotional instability'.[8] Instead, she was assigned to FAU teams working in the Eastern Mediterranean. Her experience there reinforced her common-sense approach to nurses' work in conflict-ridden China.

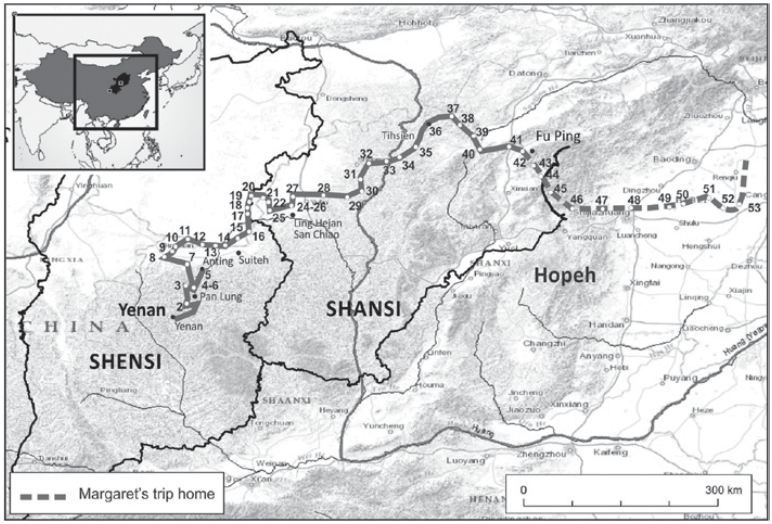
Elizabeth Hughes joined the China Convoy via a marriage certificate. While working with the FAU, she met her future husband, Eric, who wanted to serve in China. In general, the battle to admit women there had been hard fought, with the convergence of need and opportunity eventually leading to the recruitment of 'girl nurses'.[9] Despite nurses' proven toughness and skill on the front lines, many Convoy men regarded them as 'a good improvement, provided that they are not too attractive and relatively unemotional'.[10] With the prospect of longer post-war service terms, questions of couples, especially interracial marriages, and women's safety and health during pregnancies rekindled the debate. The Convoy decided it was time to try a ' "couple of couples" … who were capable, mature, hardy, well-adjusted competent human beings'.[11] In particular, doubts still lingered about

Hughes's suitability for China.[12] FAU's London headquarters carefully verified her service record and personal character to ensure she would 'fit into community life' before approving her application.[13] London, however, made it clear that Elizabeth was joining the Convoy as a fully qualified nurse in her own right and should not expect to be at Eric's side.[14] Thinking that China 'sounded tremendously romantic', and unaware that China was embroiled in a bitter civil war,[15] she quickly agreed.

Margaret Stanley's background was quite different. Raised in a devout Midwestern American Quaker family, she had graduated from Friends University in Wichita, Kansas, in 1942 with a pre-medical major. She then worked as a secretary to finance her lifelong ambition to study nursing. After earning a master's degree at Western Reserve University in 1945, she briefly worked in Cleveland's Visiting Nursing Association before volunteering. The outbreak of war forced Stanley to confront the strength of her pacifist convictions. Erroneously believing the wartime grant for nurse cadets obligated her to military service after graduation, Stanley had refused the financial aid while at Western Reserve. Increasingly identifying with close Quaker friends who had chosen jail over service, she too 'wanted to try to relieve some suffering' and to live 'in such a way as to do away with the cause of war'. Like Hughes, Stanley 'did not picture it realistically … [but I] had no question in my mind at all about [my] assignment'.[16] Few China gadabouts accurately envisioned the stark realities of convoy life.

The Honan interlude

Chinese society was a rude shock to both nurses' Western notions of civility and hygiene. Recalling her initial bewilderment, Hughes 'thought how terribly, terribly dirty and dusty everything was and how I would never be clean again'.[17] En route to Honan, Stanley, too, was taken aback by '[s]ounds, sights, and smells I had never come across before'.[18] Working in the mission hospitals was a period of transition, 'of being betwixt and between cultures'.[19] Defining asymmetrical power relationships within the intimate space of patient care challenged Stanley's perception of herself as a Western nurse. For Hughes, the Honan interlude appears to have been less transformative, either professionally or culturally.



10.2 Map of MT19 trek

On 26 March 1946 Elizabeth and Eric Hughes arrived at the Hwa Mei Hospital in Chengchow, the focal point of the Convoy's work and its new headquarters in Honan in North Central China. Margaret Stanley followed within weeks. Rehabilitating the mission hospital buildings whose Western personnel had been forced to withdraw during the Japanese occupation meant negotiating their handover from the Japanese and securing funding and supplies abroad and from the warring Chinese Nationalist and Communist relief agencies operating within the fledgling United Nations Relief and Rehabilitation Administration (UNRRA). It required recruiting and reorganising staff, and rebuilding nursing programmes from the ground up – all complicated by runaway inflation, civil war and the thousands of returning destitute refugees.

By March, the hospital was in full swing, with a heavy patient load. Instead of practising public health, Stanley found that her days 'were busy and long' as she coped with new and unexpected duties.[20] In addition to office work, she learned to administer spinal anaesthesia, so that along with Hughes, she could be part of the surgical team on call day or night. Expected to supervise and teach the more experienced

returning Chinese staff, she instead learned 'a great deal from her students', including how to diagnose cholera by smell.[21] Spending any leisure time eagerly exchanging language lessons while riding bikes or hiking with Chinese colleagues through the nearby sugar-cane fields, Stanley became increasingly enchanted by China and her people.

In contrast, on her transfer in May to the United Church of Canada's Kwang Sheng Hospital at Changte, 2,000 miles north of Chengchow and close to Communist-held territory, Stanley encountered a demoralised staff and a 'picture of filth and desolation difficult to describe'.[22] Responsible for the care of the battle casualties in the region and major non-trauma surgeries, the inexperienced staff was frustrated when normal hospital routines 'were set aside as the patients' relatives would come in and sleep under the bed … and they all have something to say'.[23] Navigating an unfamiliar professional and personal terrain in which interracial relationships were cautiously accepted at best and frowned upon at worst proved equally challenging. Quietly nurturing friendships with the Chinese nurses, Stanley proudly bore the reputation of 'being the most uncooperative [FAU] member',[24] because she fought for better living and working conditions for the Chinese staff. Margaret's diary, however, recorded her struggle to reconcile her Quaker values with her colleagues' criticism that 'she is not strict enough with them and doesn't give them a lacing when they need it'.[25] In response, Stanley 'crack[ed] down' on the nurses: 'I am working everybody at top speed. If anyone gets a bedsore or maggots – NO DAYS OFF!'[26] Equally important, she became increasingly fond of a young Chinese physician, James Chai – or Jay, as she called him: 'Although I told myself that I could not let personal feelings get in the way of work I was there to do, [we] were drawn together more and more.'[27] Despite their impending separation, Stanley welcomed the transfer to Weihwei in September, rather than remain where the goal was 'to make an efficient medical machine [without] attending to the thing for which we came – friendship with the Chinese'.[28]

Ironically, Hui Min Hospital in Weihwei proved rife with professional and racial tension. The FAU experience here speaks to the quandary its staff faced in reasserting the authority of the United Church of Canada's Mission Board.[29] Mission officials had locked heads with Dr Twan,[30] who had kept the hospital running but allowed it to fall into disrepair during the Japanese occupation. He was regarded as a

'trouble-maker', and mediation failed because of his outrageous salary demands and lack of deference to mission authority.[31] The FAU 'invited' Dr Twan, the business manager and two nurses to resign. The FAU business manager contended that his wife, a Toronto-trained nurse, had to take control because the head nurses were 'not capable of carrying on their jobs' and Miss Li [Shuying] could not be trusted to direct the nursing school:[32] it 'would be a waste of time and the lives of the students'.[33] Others, with a more positive view of the Chinese head nurses' wartime role and questioning the hospital's future sustainability once the FAU team withdrew,[34] warned that Stanley should expect a cool reception.

In June 1946, Stanley received a letter explaining why a new head nurse, 'whose compatibility with the native nurses is a strong point', was required at Weihwei.[35] While Stanley's value as a peacemaker was recognised, scepticism remained about her administrative abilities:

> With the relations between the Chinese and the foreigners what it is there, Margaret will do a lot to improve things. She is still spoken of in Chengchow as the best nurse these girls have over them. She does lack administration and routine knowledge and for that reason I suggest that Liz be responsible for the whole kit and kiboodle.[36]

The die had been cast. Margaret Stanley would be the conciliator and Elizabeth Hughes the taskmaster.[37]

Stanley arrived in September, followed shortly by Hughes. Although forewarned, she initially appeared complacent, perhaps underestimating just how 'tough' it would be 'firing people and rebuilding it all'.[38] By early October, however, she was 'beginning to feel a bit of friendliness' towards her from the Chinese hospital staff 'who are reputedly "agin" us'.[39] But she could not say the same about her FAU colleagues. Objecting to Hughes's rigid administrative approach, which pre-empted collaborative information-sharing and problem-solving, Stanley complained, 'Elizabeth takes over the Nursing Situation en force – this and that are now thus and so and everybody is expected to believe it. I think our presumptuousness is a bit much.'[40] It was with relief that she transferred back to Changte the following September: 'Old Friends there. It is the life I love.' Significantly, she decided 'to stay even if Elizabeth Hughes comes [to Changte]'.[41]

Stanley's diary noted the increasing workload in Changte Hospital as the fighting moved closer: 'Operations all day. Finished the day schedule … – Midnight.'[42] As staff juggled the delivery of babies amidst gunshot surgeries, Stanley's respect for the Chinese nurses grew: 'O.R. [operating room] people, Miss O. R. Yang, Lui Sung May and Su Chou Fu all tired but they keep at it automatically. Miss O. R. Yang is the best nurse I know.'[43] Although she recorded that she, too, 'worked up so much momentum I can't slow down; don't feel tired am energetic always', tempers did fray, including hers, under the stress.[44]

Balancing professional responsibilities with personal happiness remained a challenge for both nurses. Differences in character, training, previous experience, faith and gender expectations shaped each woman's distinctive personal and professional coping strategies. Working mainly in operating theatres, already familiar professional terrain, Hughes perceived her role as that of a vital 'bridge', interpreting the wishes of the English-speaking doctors more efficiently than the Chinese-speaking nurses could.[45] As a married woman, often separated from her husband for long periods, Hughes gave priority to her new marriage, and her professional and social contacts remained circumscribed. 'A bit saturated' by the futile language training on her previous FAU assignments, she did not have 'the incentive to persevere with [another] difficult language'.[46]

In contrast, Stanley, a public-health nurse, expected to be a nurse educator, anaesthetist and administrator, freely admitted her limitations and observed that her 'respect increased daily for our medical staff as I watched them make do with what they had while administering medical care of high standards'.[47] Her 'faith that we could find ways to help people had been sustained during my [time] in Honan, where I was one of many taking on more responsibility … and doing things we had never expected to do. We learned every day from each other, from our Chinese colleagues, from our interpreters and from our patients. We would continue learning in [Yenan].'[48] She immersed herself in Chinese language and culture and carefully cultivated close personal and professional ties with her Chinese colleagues. Her diaries reveal that she willingly faced ostracism from 'our good FAU family' to accept Miss Ma's, O. R Yang's and Miss Chang's invitation to have supper on a festival day instead of attending an FAU function with 'the Col. and Capt. coming … My My!'[49] Occasionally there was

a respite; the OR tables were covered, and Margaret joined the men for a game of poker. More frequently, she found quiet refuge from her gruelling workdays in the FAU's daily worship, or reading the Bengali poet Rabindranath Tagore in the sunshine.[50] Jay's return to work by her side and his approval – 'that things in the hospital seem to be better co-ordinated' – made 'living worth while in all respects'.[51]

Racial boundaries remained intact within the mission walls, however. Both Hughes and Stanley disapproved of the Honan missionaries' lavish lifestyles and housing and discriminatory treatment that considered it quite 'normal' that the Chinese nurses 'live in these huts with dirt floors'. Since 'many [of them] were very well qualified people', Hughes considered it 'ridiculous. Not a Christian attitude at all.'[52] Stanley distanced the Quakers from Honan missionaries' behaviour, saying, 'I was not a missionary.' The Friends were known to live 'a much different kind of life; their 'very purpose was to fit in' and try 'out ways of living in peace together'.[53] Nonetheless both resided within the Western-styled housing in Honan. Stanley, however, was prepared to breach traditional professional boundaries and/or societal expectations that contravened her Quaker beliefs – a pattern that would precipitate tensions when, in March 1947, she joined MT19, at the International Peace Hospital (IPH) in Yenan, deep within Communist territory. Elizabeth Hughes, already assigned there in late November, welcomed the opportunity to work and live with her husband more permanently. As for Stanley, it meant severing the important female and romantic relationships that had mitigated her loneliness and professional adjustment since arriving in China. Despite colleagues' (including Chinese members') stern warning to proceed with caution in her relationship, she had formed a deep attachment with James Chai.[54]

Guerrilla warfare nursing

Neither nurse knew the details of the protracted negotiations with the Communist, American and British governments, or FAU's clandestine trips to Yenan, that preceded arrival of MT19 there in November 1946. The personal intervention of General George C. Marshall had ensured their safe passage and transport of tons of UNRRA medical

supplies. Ironically, Marshall's peace teams in the area would be withdrawn in January 1947, signalling the final breakdown of negotiations for a political settlement to the civil war. Nor would MT19 function in its expected advisory capacity to improve the IPH's medical programmes along Western lines.[55] As full-scale guerrilla war eroded traditional military objectives, Mao's forces abandoned Yenan, their wartime capital, the following March.[56] As one of four mobile hospitals retreating with and completely dependent upon Mao's Eighth Route Army, MT19 moved over twenty times, treating the sick and wounded en route.[57] 'Halfway around the world from home', Stanley unexpectedly found herself 'in an isolated group of foreigners I scarcely knew, thrust together by circumstances to work in a hospital that was packing up to remove itself from the scene of potential battles and without a clue as to where we would go'.[58] Margaret described this time as 'the most memorable year of my life'.[59] Elizabeth and Eric Hughes would have heartily agreed, although they did not at first reveal their secret to the others: Elizabeth gave birth to a son, David, in November 1947. Guerrilla warfare nursing would test both women's personal and professional resilience, reshaping their self-images and world views, but their individual acculturation again differed.

Both expressed frustration at their inability to provide rudimentary nursing care. Shocked to find that the IPH cave hospital 'was far more primitive than any hospital [she] had previously seen, including the … dreadful [Chinese] cholera hospital' in Honan,'[60] Hughes recalled, 'We were often extremely short of drugs.' Water had to be carried several miles, and dressings 'had to be reused in a way entirely un-hygienic. So really it was a question of adapting, going back to first principles, and deciding what was essential and what could go by the board.'[61] However, she always believed that her Western training allowed her to determine those priorities better than those without an equivalent level of nursing education.[62] The kind of healthcare Stanley practised 'was quite different from anything I had read in textbooks or heard from teachers of public-health back home'.[63]

The team's first annual report recorded its struggle to carve out a professional niche in unfamiliar terrain. Not fully understanding that talented Chinese nurses began medical training after three years, and 'not knowing exactly what position or authority [she] was to have in the hospital', Elizabeth 'did not have an easy time settling

down'. The language barrier, unpredictable hospital schedules and lack of teaching materials compounded Elizabeth's difficulties in educating new recruits 'more interested in political activity than in medical work' and who 'had never seen a clock or running water'. She found them 'singularly disinterested in subjects which a foreign nurse is taught to consider important'. The senior nurses 'did not like receiving lectures from a nurse but wanted them given by a doctor, as they were soon to be made into doctor'. She found herself an unwanted Western interloper in the operating theatre. Applying Western surgical standards, Hughes criticised the staff as 'too large for effective work' and 'very slow and unmethodical'. Her views clashed directly with the IPH officials' desire to maximise the number of health workers trained. And the Chinese nurses 'did not take any of the hints that I threw out about being ready for emergencies or ways of improving techniques'. Shocked that patients, unable to provide a change of bedding, were left by seemingly uncaring nurses to lie in their own filth, it took time for Elizabeth to realise 'how poor the district is and how expensive soap, cloth and everyday things are'.[64] Similarly the realities of battlefront nursing as the casualties arrived in overwhelming numbers eroded Stanley's expectation that each patient would be bathed on admission: 'We found ourselves too busy dressing wounds after the doctors examined them to worry long about … patients' [comfort].'[65]

As conditions became more primitive after evacuating the IPH, Hughes's respect grew for her Chinese counterparts' adeptness 'at overcoming the difficulties associated with the lack of proper buildings, equipment, facilities that would have stumped us foreigners'. 'Learning each other's reasons for our methods', she introduced the Chinese nurses to intravenous therapy techniques, and she was shown how to sterilise dressings in a bread steamer. Hughes still fretted over her inability to persuade the nurses 'to make changes or improvements in the things that I have criticized'.[66] She sensed that the Yenan area had a 'spirit about it – getting ahead, forward looking'[67] that set it apart from Nationalist China but failed to realise that this same 'spirit' made her directive leadership style unattractive. It was not attuned to how the Communist Chinese nurses worked together, desperately seeking mutual protection and collective strategies to preserve their ideals for 'equality' and 'a fair and good life for everyone'.[68]

In contrast, Stanley relied on team meetings to improve patient care and solve bottlenecks in the supply line; Chinese nurses then passed new practices along to other units. Her 1948 article in the *American Journal of Nursing* captured the 'Yenan spirit' – the innovation and camaraderie experienced while setting up makeshift cave hospitals on their nomadic journey, making bandages from local cotton, using pork fat in making sulphur and sulphanilamide or '[trying] in vain to catch up with an epidemic of relapsing fever' when their small supply of DDT ran out.[69] But acculturation comes slowly and some irritants remained. When a new student nurse contracted typhus, Stanley implemented a strict delousing protocol, but it never became an accepted nursing routine. Despite repeated efforts, she failed to convince her Chinese colleagues that many illnesses were 'the result of carelessness in personal hygiene'. For Stanley, it was not a case of viewing her Chinese colleagues through Western eyes that equated cleanliness with cultural superiority. Rather her fixation on personal hygiene spoke to the limited weapons in her arsenal to prevent diseases, such as typhus. She would continue to struggle with her own professional limitations on MT19. She found it difficult 'to sympathize with their seeming lassitude' whereby 'illness was taken as a matter of course and accepted by the staff'.[70] But eventually she came to accept how repeated bouts of illness, long hours and poor food undermined everyone's performance.[71]

Nursing with Team 19 challenged their Western understanding of safe, competent and ethical nursing practice. It meant accepting that 'we could do nothing to help', either because medical supplies were unavailable or because they were reserved for patients who had a good chance of surviving.[72] In a 1950 article for the *American Journal of Nursing*, Stanley poignantly recounted her efforts to provide compassionate care, stripped of the luxuries of Western nursing, and how it was received. While she conceded the difficulties of squatting on a *kang* (a stone or mud waist-high bed) to tend to a patient with only a tattered comforter for warmth, she claimed, 'He was happy; this was his bed, a place to sleep and rest – he asked for nothing more.' She found 'satisfaction' in knowing that even though 'his bed was a kang in a dirty, draughty, vermin ridden cave, [she] could still help him recover from his illness or injury'.[73] Under such circumstances, Stanley looked to her Chinese counterparts to

learn 'how to make the best of the situation in which we found ourselves'.[74]

Differences in their personality, pacifist perspectives, faith, personal circumstances, language skills and nursing education shaped their individual coping strategies. Hughes sought emotional refuge within her marriage and first pregnancy and remained within her professional comfort zone. Thinking she had 'some kind of magic protection against any danger',[75] she later admitted, 'I feel the psychological effect of pregnancy made me unaware of difficulties and I really lived in a dream world.'[76] Knowing Chinese nurse-soldiers forced to endure repeated abortions, Hughes felt particularly guilty about her special treatment during her pregnancy. She elected to assist the FAU surgeons: 'I knew their likes and dislikes and their methods – many of which were revolutionary to the Chinese nurses.'[77] At the end of March 1948, she left the team regretting that she had not made a significant difference, as Margaret Stanley had.[78] It was Margaret, Elizabeth said, who developed the closest connections with their Chinese colleagues at the IPH. Years later, Hughes continued to believe that Stanley's greater acceptance by her Chinese counterparts made her a more effective teacher.[79]

By August 1947, Stanley's diary entries indicate her growing acceptance of MT19's nomadic existence: 'There is a Powerful Magnetism here attuned to myself in something that makes for Peace in my Soul in spite of the things that would be irritations if one let them. [But] I find happiness here in China which I have had no other place.'[80] Her diary attests how Quaker beliefs restored and centred her daily efforts. 'This is life that should be intensely satisfying.' But in 'human fashion', she added, 'if only Jay were here it would be. Now is my duty to make myself contented. I know that Life is never complete and my emptiness for Jay compares to the disappointments and discouragements in [the] lives of other people and I am beholden to God for his great generosity in general …. [I]f I spent the rest of my life doing for others, I would never make up for what they have done for me.'[81]

As a single woman, who sometimes felt she 'had found a place among the Chinese but not among my own kind',[82] Stanley relied on female companionship, especially her tender friendship with Nurse Wu Ming Jin, for crucial personal and professional support: 'Wu's generous, tireless nursing, her lovely voice and her

sweet temperament sustained patients and co-workers. The closer I worked with her, the more I grew to depend on her.'[83] Sharing her cave dormitory-style with the Chinese nurses, Stanley believed, made 'it easier for us to work together in the hospital'.[84] She recorded feeling 'ever more comfortable and at home' with her Chinese colleagues, who called her 'comrade' in the spirit of its literal meaning, 'one with the same goal'.[85] She depicted her relationship with her Chinese colleagues as one of friendship forged during a shared learning journey: 'Our common goal was better health. I discerned ever more clearly, that the apprentice system of learning-on-the-job in our hospital met the desperate needs for health workers and included strong concerns and feelings for health in general.'[86] Initially, she was daunted by the prospect of teaching 'little [nursing] students, who didn't know why we boiled our forceps, and couldn't understand why we asked them not to blow their noses onto the ward floors'. Eventually, she realised, 'If it hadn't been for those devoted teenagers doing the work of nurses in war-torn China, many patients would have gone unattended.'[87] She left MT19 convinced that American nurses 'should go into the situation to teach practically, thereby omitting the confusion of American contraptions and customs irrelevant to the home needs'.[88] She likewise determined to impress upon the Chinese Nurses' Association that Chinese nurses should not be sent to the United States to study.

Both nurses initially perceived nursing with the China Convoy as an opportunity for adventure in an exotic location and humanitarian service that incorporated scientific standards of nursing. In responding to human suffering, they found themselves altered. Western nursing, based upon hygiene and notions of efficiency, strict hospital routines and careful patient observation and recording, collided with the realities of mobile warfare cut off from supplies. Gradually their Chinese colleagues taught them the art of making do and helped them accept the limits of their personal humanitarian diplomacy.[89] Key to Margaret and Elizabeth's acculturation were the Chinese nurses, who were vocal in their opposition and selectively adopted and adapted structures and traditions of modern Western nursing. One striking differences was the Chinese Communists' use of the nursing profession as a stepping-stone in the education of physicians. Although neither nurse realised it at the time, they were witnessing

the birth of the 'barefoot doctor movement' that would revolutionise Chinese rural healthcare. In turn, by moving beyond the cloistered communities associated with missionary nursing to work and live with Communist troops engaged in highly mobile warfare, Hughes and Stanley were early forerunners of humanitarian nurses without borders. Agency and accommodation coloured the acculturation of the Western nurses to China and China to the Convoy nurses.

Stanley decided to leave Yenan in February 1948, having completed more than the two years of service stipulated in her contract.[90] Elizabeth followed in the spring, when the hospital permanently relocated. As the battlefront shifted south, the hospital's patient-load decreased and her nursing staff assumed more control, Margaret no longer felt as 'essential'.[91] Unable 'to shake off the mood of sadness' after witnessing a Chinese mother needlessly die after days of prolonged labour, she resolved 'to learn more about maternal and child health in order to do something about it, wherever I might be'. But she remained conflicted 'whether to pursue more education or get a job at home to help support my parents. And if I should decide on either possibility, what would become of my unrealized dream of having a family and home of my own?'[92]

During her cultural adaptation in Yenan, a new identity had emerged that was intersecting with and antagonistic to the Western culture into which Stanley had been born and socialised.[93] An unexpected and, in some respects, unwelcomed meeting with her father in Shanghai epitomised her cultural no man's land. Worried about his daughter's safety, he had travelled to China to bring her home; it was 'time to settle down', but she felt isolated and adrift. She 'did not have a job to go to. [She] did not have plans.' More important, though they spoke of Jay only 'indirectly', her father made it clear that both parents believed it 'was a mistake to marry into a different culture because of the resulting problems, especially for the children'. After a brief reunion with Jay in Shanghai, they parted company for the last time on 15 June 1948. She 'went with him in a sense, yearning, feeling that a part of me was gone. Leaving him and leaving China were somehow required of me though I didn't know why.' With his ring hidden in her pocket from colleagues' disapproving eyes, she did not want 'to say anything, wanting only to wrap myself in some kind of insulating cocoon to keep away the reality' of their final goodbye.

Stanley remembered little of the voyage home. She had changed, but remained uncertain how she would reconnect to the outside world: 'I had been in places no American had seen before. I had learned a new language and had become steeped in a different culture. I had learned that pain and suffering are the same in any language …. Having required a different way of looking at life, I could not return to my former way of thinking.' She 'floated timeless and effortless between two worlds' as her ship slipped past the International Date Line on 23 June. 'How could it be', she wondered, 'that both tides and events were carrying me back home, yet they were taking me away from what had become home to me?' Stanley experienced a greater degree of what is now recognised as 'reverse cultural shock', the difficulty in adjusting back to one's original culture: 'Conversations with friends drifted to niceties and to generalities. My feet hurt in leather shoes walking on concrete …. With no one to talk to about China, I felt isolated and very much alone.'[94] For the rest of her, life she remained a sojourner between two worlds.

The cross-cultural experiences of Margaret Stanley and Elizabeth Hughes illuminate the difficulties of viewing FAU nurses' humanitarianism as a monolithic portrait. Acculturation occurs differently for everyone. Moreover, feminist international relations scholars have recently cautioned against the assumption that 'those from outside a particular state or region are "inauthentic knowers" and actors who cannot understand or share in struggles outside of locales from which they come'.[95] Both nurses admired the Chinese people's resilience and courage and in different ways viewed MT19 as 'home'. But why did Margaret Stanley become a more effective cultural diplomat?

Skilled cross-cultural brokers must balance 'bridging social capital' that is outward-looking with 'bonding social capital' that fosters a 'shared organizational and professional identity'.[96] Both women exhibited significant 'bonding capital' that created a shared identity as pacifist humanitarians. Both viewed health as a tool of reconciliation. Both accepted the paramount importance of the humanitarian imperative to alleviate the devastating effects of war. But this weighed more heavily on Stanley's mind than on Hughes's. For Stanley, to 'realize that the few precious supplies that we had were going to mending and healing wounds that had been made from military supplies from my own country, too, was perhaps the hardest thing for me to bear'.[97]

Stanley was more keenly aware of her tenuous position as a cultural outsider. 'I could never learn enough because the culture was really obscure to me … you need to be part of it and grow up in it so that, I as foreigner, could only see it as a foreigner.' Yet she was 'accepted as a person … in spite of the fact that I was an American person and American government policy was looked upon as the enemy'.[98]

A number of factors enhanced Stanley's 'bridging capital', key to becoming an effective cultural diplomat. Hughes's broadly British Christian pacifism was more political, predisposing her towards a pragmatic, inward-looking approach that emphasised the medical relief or 'work' side of the Convoy's activities. Stanley's more intellectual turn of mind and strong Quaker beliefs emphasised the 'faith' or individual witnessing side of humanitarian aid.[99] She regarded the Convoy not as a Quaker relief organisation but as an outgrowth of individual Quakers' concern to provide a practical expression of the Peace Testimony, yet she warned that it could never 'be totally divorced from political attitudes, social concerns and religious movements'.[100] Margaret had a deeper intellectual thirst to understand China's language and culture that fostered stronger cross-cultural ties and a more compelling desire to accompany her Chinese colleagues on their own terms, 'to live my ideal of people-to-people friendship'.[101] Moreover, Stanley maintained that as a public-health nurse her 'interest was in the whole person and not just in their physical problems' and she wanted 'some kind of work that followed that philosophy'. She believed 'Friends have to try, not only to take care of people who suffer in some physical way but also try to cope with social problems, war-related problems.'[102] Here, her community-focused public-health training reinforced her Quaker views forged within the broader American social gospel tradition of progressive reform.

Conclusion

This case study of Elizabeth Hughes and Margaret Stanley invites a re-examination of post-colonial frames to interrogate humanitarian nursing in war-torn China from 1941 to 1951. Post-colonial scholars have perceptively challenged the 'binary othering' that Eurocentric discourse invoked to perpetuate imperialism and racism in nursing

work and have cogently critiqued the use of Western humanitarian medical aid to serve the self-interest of foreign powers. However, FAU nurses' humanitarian exchanges cannot be easily accommodated within this framework. FAU nurses did not perceive their role as evangelistic or themselves as agents of Western modernity that served their country's foreign interests. The majority believed that their work honoured the Quakers' long-standing Peace Testimony, albeit with significant variations in practice. Their experiences suggest that studies of global nursing should consider the concepts of hybridity (the mutuality of relationships within the intimate contact zone of patient care)[103] and extend the concept of place to include its organisational and liminal dimensions.[104] This frame, admitting the possibility of multidirectional learning and personal transformation when nurses confront unremitting human suffering, better explains why some nurses become effective cultural diplomats or 'authentic knowers'. Framing the larger study in this manner also avoids marginalising Chinese nurses' agency in the Convoy's humanitarian work and in the development of China's unique national health system. As important, it avoids a monolithic portrait of nursing in humanitarian international health and aid work, both by governmental and non-governmental organisations and agencies. Instead, it allows for a more nuanced understanding of the interplay of global nursing with gender, race, culture, as new nations emerged from the ashes of global war and colonialism during the Cold War era. In so doing, it refocuses scholarly inquiry in new and important directions.

Reframing transnational studies of global nursing – to foreground the complexities of moving ideas, resources and personnel across borders as part of a multidirectional process in which neutrality, impartiality and autonomy had to be continuously negotiated – better contextualises FAU nurses' humanitarian endeavours, and offers timely and important perspectives for contemporary humanitarian nursing. The ability of China Convoy nurses, such as Hughes and Stanley, to meet the Chinese population's humanitarian needs was mediated by the deepening civil war nested in the onset of the Cold War. Even as the Chinese civil war intensified, the contested state authority and power over humanitarian aid began to be relocated upwards to new liberal Western international organisations and transnational actors, and sideways to social movements

and subgroups. Making humanitarian negotiations central to global nursing-history inquiry illuminates the current challenges of humanitarian nurses working in high-risk conditions and daily making life-and-death choices. As in today's intra-state conflicts, humanitarian actors such as the FAU must support the national government in meeting its responsibilities to its own people and yet maintain some independence from those same authorities. At the same time, as Hughes's and Stanley's experiences demonstrate, those same principles must be applied to the non-state armed group in order for humanitarian workers to operate safely and to gain access to those most in need of care. Choosing access over speaking out against human rights violations and balancing cultural sensitivity, effectiveness and personal survival remain fundamental challenges of humanitarian nursing today. The voices of the China Convoy nurses still resonate.

Notes

1 National Quaker History Archive (hereafter NQHA), Friends House, London (hereafter FHL), FAU (1939–46), China Convoy Records Temp MSS 876, box 10, Personnel files: Joan Kennedy Woodrow.
2 K. Cruikshank, 'Education, history and the art of biography', *American Journal of Education*, 107:3 (1999), 231–9.
3 Margaret Stanley's private papers (hereafter MS), Margaret Stanley, 'A year in Yenan', unpublished manuscript, p. vi.
4 The term is from Alex de Waal, *Famine Crimes: Politics and the Disaster Relief Industry in Africa* (London: African Rights and the International African Institute, 1997).
5 See de Waal, *Famine Crimes*.
6 Imperial War Museum, London (hereafter IWM), Sound Archives (hereafter SA), Lyn Smith, catalogue 9437, 11 November 1986, interview with Edith [Elizabeth] Hughes, reel 1.
7 Smith, interview with Hughes. Ironically this is now the hospital that treats all injured military personnel returning from combat.
8 American Friends Service Committee Archives (henceforth AFSCA), American Friends Service Committee (henceforth AFSC), Philadelphia, PA, box: Foreign Service 1945, Country – China to Country – Dominican Republic, file: Country – China, Letters to London, 1945, Colin Bell to Kenneth A. Bennett, 24 September 1945.
9 See AFSCA, AFSC, box: General Files, 1942, Foreign Service Country – China, FAU Report to Doukhobors; file: AFSC – Foreign Service China-Friends

Ambulance Unit numbered reports, report no. 10, 19 June 1942. Peter Tennant, Friends Ambulance report no. 14.

10 AFSCA, AFSC, box: Foreign Service, 1944, Country – China (FAU Transport Report to Country – England (FAU Newsletters); file: FAU Un No. letters from; Unit Newsletter 134, 25 November 1944. See also NQHA, FHL, FAUCC, box: 5; file: Medical Reports, Michael Harris, Medical Report through July 1944 (Military Teams Only) 1, September 1944.

11 AFSCA, AFSC, box: Foreign Service, 1945, China Letters, John Perry to FAU Newsletters, 1945; file: Country – China, letters from KA 100 to 154, Colin Bell to Eric Johnson, 16 November 1945.

12 AFSCA, AFSC, box: Foreign Service, 1945, Country – China (FAU – Reports, Medical) to (Numbered KAB Letters from & to); file: Country – China, letters from China to London, 1945, Colin Bell to Kenneth Bennett, 24 September 1945.

13 AFSCA, AFSC, box: Foreign Service, 1945, Country – China to Country – Dominican Republic; file: Country – China, letters to China, Ken Bennett to Colin Bell, 11 October 1945.

14 AFSCA, AFSC, box: Foreign Service, 1945, Country – China (FAU – Reports, Medical) to (Numbered KAB Letters from & to); file: Country – China, Letters from London to China, 1945, Eric Johnson to Colin Bell, 6 September 1945.

15 Smith, interview with Hughes, reel 1.

16 Midwest China Oral History and Archives (hereafter MCOHA), Midwest China Oral History and Archives Project (hereafter MCOHAP), St. Paul, MN, Koons, interview with Margaret Stanley, pp. 2, 7.

17 MCOHA, MCOHAP, Margaret Stanley, interview with Elizabeth Hughes, 31 May 1977, Burlington, Ontario, p. 5.

18 Koons, interview with Margaret Stanley, p. 13.

19 Compare with V. W. Turner, '"Betwixt and between": the liminal period in the rites of passage', *Proceedings of the American Ethnological Society* (1964), symposium on *New Approaches to the Study of Religion*, 4–20.

20 MS, Diary, p. 53.

21 Koons, interview with Margaret Stanley, p. 25.

22 'Report for FSU', Bernice and Heath Thompson personal papers. Quoted in C. Cameron, *Go Anywhere Do Anything: New Zealanders in the Friends Ambulances Unit, 1945–1951* (Wellington: Beechtree, 1996), p. 28.

23 Quoted in Cameron, *Go Anywhere Do Anything*, p. 130.

24 MS, Diary, p. 53.

25 NHQA, FHL, FAUCC, box 19, file: Chengchow HQ to Weimin, 1946–47, two files, file: memo to Jack Norton, 4 September 1946.

26 MS, Diary, p. 73.

27 MS, 'Year in Yenan', p. 24.

28 MS, Diary, p. 58.

29 NQHA, FHL, FAUCC, box 19, file: Weihwei: Chengchow HQ to Hwei Min Hospital, Weihwei, 1946–47, Walter Alexander to Kathleen (Bimbo) Stokes, 15, July 1946.
30 China scholar Sonya Joy Grypma refers to Dr Twan as Dr Duan Mei-Qing. I have used the spelling found in FAU documents. See S. J. Grypma, *Healing Henan: Canadian Nurses in the North China Mission, 1888–1947* (Vancouver: UBC Press, 2008).
31 NQHA, FHL, FAUCC, box 19, file: Chengchow HQ to Weimin, 1946–47, two files, George M. King [chairman of the Hospital Board of Directors] to Dr Robert McClure, 16 May 1946; NQHA, FHL, FAUCC, box 19, file: Weihwei: Chengchow HQ to Weimin, 20 November 1946, George K. King to Dr Kenneth Cross, 7 May 1946.
32 See Grypma's *Healing Henan*, pp. 149–51.
33 NQHA, FHL, FAUCC, box 19, Weihwei: Chengchow to Weimin Hospitals, 1946–47, two files, 26/5/6, Walter Alexander to Bimbo (Stokes), 16 August 1946.
34 NQHA, FHL, FAUCC, box 12, file: Changte Hospital, 1946, November, Henry Stokes to Margaret Stanley, 5 September 1946. See also Henry Stokes to Lewis Hoskins and Walter Alexander, 22 June 1946.
35 MS, Diary, p. 63.
36 NQHA, FHL, FAUCC, box 19, file: Weihwei: Chengchow HQ to Hwei Min Hospital, 1946–47, Mark (Shaw) to Henry (Stokes), 30 June 1946. See also Al to Henry Stokes, 30 June 1946; NQHA, FHL, FAUCC, box 19, file: Chengchow HQ to Weimin 1946–47, two files, file: memo to Jack Norton, 4 September 1946.
37 MS, Diary, p. 63; NQHA, FHL, FAUCC, box 12, subject files continued, file: Changte Hospital, 19 November 1946, Henry Stokes to Margaret Stanley, 5 September 1946.
38 MS, Diary, p. 81.
39 MS, Diary, pp. 83–4.
40 MS, Diary, p. 81.
41 MS, Diary, p. 94.
42 MS, Diary, p. 95.
43 MS, Diary, p. 98.
44 MS, Diary.
45 Stanley, interview with Hughes, p. 14.
46 Stanley, interview with Hughes, p. 4.
47 MS, 'Year in Yenan', p. 20.
48 MS, 'Year in Yenan', p. 28.
49 MS, Diary, p. 106.
50 Tagore's main principles – that the universe is a manifestation of God, that there is no unbridgeable gulf between our world and God's, and that God is

the one who can provide the greatest love and joy – resonated with Quakers' own belief system.
51 MS, Diary, p. 103.
52 Stanley, interview with Hughes, p. 18.
53 MS, 'Year in Yenan', p. 30.
54 Compare with MS, 'Year in Yenan', p. 88.
55 Smith, interview with Hughes, reel 5.
56 MS, 'Year in Yenan', p. 15.
57 Margaret Stanley, 'Working west and east of the Yellow River', *Eastern Horizon*, 17:5 (1977), 40.
58 MS, 'Year in Yenan', p. 15.
59 MS, 'Year in Yenan', p. vii.
60 AFSCA, AFSC, box: Foreign Service, 1948 (Country – China, Letters to England to publicity), MT19; file: Country – China, Report on Projects, MT19, *First Annual Report*, 16 January 1948.
61 Stanley, interview with Hughes, p. 37.
62 Smith, interview with Hughes reel 11.
63 Margaret Stanley, Letters: pro and con, 'Mobile hospital unit in China', *American Journal of Nursing,* 48:8 (1948), 6.
64 MT19, *First Annual Report*.
65 MT19, *First Annual Report*.
66 MT19, *First Annual Report*.
67 Stanley, interview with Hughes, p. 24.
68 Stanley, interview with Hughes, p. 24.
69 Stanley, 'Letters: pro and con', 6.
70 AFSCA, AFSC, MT19, *First Annual Report*, 16 January 1948.
71 Koons, interview with Stanley, p. 46.
72 Koons, interview with Stanley, p. 46.
73 M. S. Tesdell, 'Hospital beds – North China style', *American Journal of Nursing*, 50:2 (1950), 113.
74 Tesdell, 'Hospital beds', 112.
75 Smith, interview with Hughes, reel 9.
76 Stanley, interview with Hughes, p. 32.
77 Smith, interview with Hughes, reel 9.
78 Smith, interview with Hughes, reel 9.
79 Smith, interview with Hughes, reel 8.
80 MS, Diary, p. 155.
81 MS, Diary, p. 138.
82 MS, Diary, p. 147.
83 MS, 'Year in Yenan', p. 57.
84 MT19, *First Annual Report*.
85 Stanley, 'Working west and east', p. 43.
86 MS, Diary, p. 167.

87 MS, Diary, p. 93; Margaret Stanley, 'Barefoot doctors and Los Angeles nursery', *Eastern Horizon*, 16:6 (1977), 39.
88 MS, Diary, p. 167.
89 Smith, interview with Hughes, reel 9.
90 MS, Diary, p. 162.
91 Koons, interview with Stanley, p. 70.
92 MS, 'Year in Honan', p. 201.
93 S. Ting-Toomey, *Communicating across Cultures* (New York: Guilford, 1999), p. 36.
94 MS, 'Year in Yenan', pp. 228–38.
95 C. Eschle, *Global Democracy, Social Movements and Feminism* (New York: Basic Books, 2000), quoted in A. S. Runyan and V. Spike Peterson, *Global Gender Issues in the New Millennium* (Boulder, CO: Westview, 2009), p. 236.
96 Compare with S. Chan, 'Cross-cultural civility in global civil society: transnational cooperation in Chinese NGOs', *Global Networks*, 8:2 (2008), 232–52.
97 Koons, interview with Stanley, p. 43.
98 MS, 'Year in Yenan', p. 68.
99 Compare with T. P. Socknat, 'The Canadian contribution to the China Convoy', *Quaker History*, 69:2 (1980), 85.
100 Koons, interview with Margaret Stanley, p. 79.
101 Stanley, 'Barefoot doctors', 39.
102 Koons, interview with Stanley, pp. 79, 3.
103 See M. L. Pratt's discussion of the contact zone in *Imperial Eyes: Travel Writing and Transculturation* (New York: Routledge, 1992); and H. Bhabha's of hybridity in *The Location of Culture* (London: Routledge, 1994).
104 Compare with P. D'Antonio, 'Thinking about place: researching and reading the global history of nursing', *Texto and Contexto Enfermagem*, 18:4 (2009), 766–72.

Afterword

Rima D. Apple

Nursing has been and is shaped by factors internal to the profession as well as external influences such as governmental concerns; cultural sensibilities; racism, sexism and classism; physical and geographical conditions; and economics. Viewed from the vantage point of imperialism, nurses can be seen as straddling the metropole and the periphery, or bridging the gap between Western and indigenous medicine. Nurses were both icons and actors in this world. They provided nursing care and health instruction, and in that sense their work reflected that of nursing around the globe throughout the twentieth century. However, their often iconic status and position made them critical components of the imperial project. The authors in this volume have located and mined crucial source material, including diaries, letters, professional journals, government reports, interviews and photographs and films, to present nuanced histories that disclose the complexities and uncertainties of colonial and post-colonial nursing and, at the same time, illuminate the imperial project and its aftermath.

Some of the nurses who worked in colonial and post-colonial settings did so in a search for adventure; some for humanitarian reasons; some were thrust into nursing out of necessity. Most struggled under adverse physical conditions, often with limited resources. Though some were closely supervised, others found themselves willing or unwilling independent healthcare providers with a limited or non-existent support network. All were sent as ambassadors of Western medicine and their presence was vital in maintaining the strength of empire. During war, they cared for the sick and wounded and therefore were indispensable to the strength of the military. At

other times, their essential role involved maintaining the health of the general population, both European and indigenous.

By investigating the 'on-the-ground' aspects of nursing, the chapters in this volume reveal intended and unintended consequences of the tensions, clashes and compromises between converging cultures, as well as the critical role of gender politics in the development of healthcare systems. With such case studies, we can avoid unwarranted generalisations. Yet there are evident similarities that underlie the histories related here. Whether the nurses came from a European culture or were recruited from the indigenous population; whether their initial impulses were adventure or patriotism or altruism; whether they saw their work as 'civilising' or as 'health'; whether they worked within or outside of imperial institutions; whether they were afforded autonomy in their work or were closely supervised, they all played vital roles in the delivery of healthcare and the shaping of colonial and post-colonial relations.

The authors in this volume have identified new and tantalising sources that disclose previously unheard stories of colonial and post-colonial nursing. Undeniably, sources shape the narratives they relate. Government pronouncements often must be read carefully, between the lines, if you will. Diaries and letters must be viewed in light of their production. Were they written as personal pieces intended for limited circulation or were they prepared for publication, often after the events with the benefit of hindsight and the objective to mythologise nursing care? For the more recent past, the interviews with participants and the discovery of photographic and film records provides opportunities for research that go well beyond the written record. Using sources such as these, the authors' careful and insightful analyses have found details about practices and policies that open up original interpretations of the topic.

There is no simple definition or description of colonial and post-colonial nursing. Nurses, both trained and untrained, were found in the midst of war conditions. In discussing the relationship between nurses and empire, the military aspects are unavoidable, though especially in the nineteenth century, military physicians were loath to accept women as nurses. Still, the image of the nurse during warfare served as an important reflection of national identity and citizenship. The nurses' position in defending the Empire was idealised

and their presence had significant rhetorical power, especially in the 'home country'. At the same time, these women were providing vital medical aid, often under dire circumstances. With the chapters in this book, we see a much more complex picture than that of the commonly told story of Florence Nightingale in the Crimea.

But imperial work was not limited to military campaigns. These chapters reveal the many other facets and versions of nurses' work within the imperial project: crisis intervention, public health, hospital building, health education for the subaltern, and the like. The conditions nurses faced were highly varied. Western nurses often found themselves in strange and difficult physical surroundings and living conditions, such as the heat and humidity of the Dutch West Indies, the cave hospitals of China, the poverty of Māori in New Zealand and the isolation of Aboriginal settlements in Queensland. These situations were distinctly and often uncomfortably different from those in which the European nurses had trained and previously practised. Many faced unfamiliar languages. Some of the nurses learned the languages of their clients and their students; others struggled with and even without translators. Many faced unfamiliar local customs. Some were so convinced of the superiority of Western medicine and the imperial culture that they dismissed practices that were inconsistent with their own. Others learned from local practices or at least accommodated them. Nurses with the Society of Friends Ambulance Unit learned from the Chinese healthcare workers how to make do in the harsh environments of caves. Nurses of the New Zealand Native Health nursing scheme sometimes acted as go-betweens when their Māori clients were negotiating with New Zealand officials. The racial, gendered and classist hierarchies of the Empire were often imposed on the raced, gendered and classed hierarchies of the local population. The apartheid imposed by Fascists in Ethiopia constrained the work of the Italian Red Cross. With nursing in low esteem in the Dutch West Indies, it was difficult to recruit local women, especially upper-class, educated women (the preferred group) to the profession. But it did attract men who saw nursing as a step up the ladder to better occupations. Another significant aspect of colonial and post-colonial nursing that drew women out of the home country was the possibility of greater autonomy. The lay women who attended the sick and wounded at Lucknow were thrust into the situation simply because

they were there, and they did not remain in the profession after the end of military actions. But the nurses in New Zealand's Native Health nursing scheme often worked without direct supervision and revelled in their independence. And British nurses during the Anglo-Boer War, freed from the constraints of respectable behaviour in the home country, enjoyed a spirited social life in South Africa.

Underlying these stark differences among colonial and post-colonial nurses, one commonality emerges. From the perspective of the Empire, the nurse was the paragon of Western medicine and Western life and as such she was expected to play a significant role in bringing these virtues to those less fortunate. In some circumstances, the nurses attempted to blend with local norms and practices, but in others, they simply ignored and trampled them. When Puerto Rico became a United States colony, the US overtly aimed to radically alter local society by Americanising the government, education and healthcare on the island. Nurses came to Puerto Rico with the goal of rewriting the role of women in civic and professional society. They trained nurses who wanted not only to work in healthcare but also to serve their country. Protestant missionaries set up hospitals and training schools on the island in part to undermine the position of the Catholic Church. Thus in this case, for better or for worse, nurses served to transform healthcare and society. In Australia, the goal was to 'civilise' the Aboriginals, who were described as 'savages'. Aboriginal healthcare and midwifery practices were discounted. With the presence of plague in Hong Kong, British doctors and nurses insisted that only European nurses could provide the necessary care, though local nurses could be utilised in closely supervised positions. But bringing Western ideas and medicine to colonial and post-colonial locales did not always mean a conscious or inadvertent erasure of the indigenous perspective. The Catholic sisters in Nigeria were missionaries; but within Biafra, conversions were less important than preparing the native population to take over healthcare and healthcare institutions. As a result, though eventually the sisters were forced to leave the country, the structures they had organised remained vital elements of the community.

The conjunction of colonial and post-colonial history and the history of nursing enables us to better appreciate the multiplicities of colonialism and post-colonialism and the diversity within

the nursing profession. By bringing together studies from around the world from the mid-nineteenth to the mid-twentieth century, *Colonial Caring: A History of Colonial and Post-colonial Nursing* allows us to untangle the complications inherent in any historical study of nursing. The overlapping foci of these chapters enrich our understanding of the role of healthcare provision in the social and cultural developments in the Empire and its aftermath. The nurses in these chapters represent a new image of woman. Whether nursing is considered an extension of woman's domestic role or as entrée into new arenas, both of which are depicted in this volume, nursing enabled women to act differently from their predecessors as they engaged in a realm beyond the generally accepted sphere for their gender and class. The essays in this volume comprise a complicated and cogent picture of the reality of nursing in colonial and post-colonial settings. They are an important opening for the study of nursing and the study of healthcare provision in imperial projects. Most significantly, they stimulate under-researched issues and broaden our perspective on these vital components of global history.

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