IN SAFE HANDS:

A history of aged care in Tasmania

by

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“Our society must make it right and possible for old people not to fear the young or be deserted by them, for the test of a civilization is the way that it cares for its helpless members.”

Pearl S. Buck (1892-1973), *My Several Worlds* [1954]

For Dad

Statement of Authorship

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Abstract

Perhaps no part of the world can show relatively so many aged people.[1]

Aged care is one of the more controversial and problematic areas of healthcare in Australia in the 21st century. Whilst most people today accept that residential care is an essential service for those who can no longer cope on their own in the community, few people want to end up in a nursing home, and few nurses aspire to work there. But was this always the case?

This diachronic study integrates archival research and oral history interviews to explore the history of aged care in one state of Australia, Tasmania. Tasmania began its white history as Van Diemen's Land, a penal settlement on a remote island intended to be the 'gaol for the entire British Empire'. The high number of convicts transported to the colony and the resulting large emancipist population, many of whom were both impoverished and without family to help them as they aged, meant that the colonial administration was forced to make official arrangements for their care from almost the first days of the state's existence. These arrangements bore some similarities to those in other Australian states and in the mother country, but the peculiarities of life on the edge of civilization brought their own unique solutions in that century, and the next.

This thesis follows the development of Tasmanian aged care from the early colonial charitable institutions, to the early 20th century period of 'making do', to the ennursement of aged care in the middle of that century, and finally to developments in the 1980s that led to today's highly regulated and businesslike aged care sector. It illuminates the changes and continuities in conditions and practices within homes for the aged, and the shifting attitudes of Tasmanian society towards the elderly and those that cared for them. Official records paint an almost uniformly positive picture of aged care. In contrast, public opinion is almost equally negative. This study provides a more balanced story, in the hope that an understanding of the successes and failures of the past will provide some guidance for the future to assist our aging population in the 21st century.

[1] 'Tasmania', *Encyclopaedia Britannica,* 9th ed, (Edinburgh,1888)

List of Abbreviations and Glossary

ACAT	Aged Care Assessment Team
AOT	Archives Office of Tasmania
APHA	Aged Persons' Homes Act, 1954
DON	Director of Nursing (equivalent to 'Matron')
EN	Enrolled Nurse
GAT	Geriatric Assessment Team
LGH	Launceston General Hospital
NRB	Nurses' Registration Board
RCI	Resident Classification Instrument
RN	Registered Nurse
TLC	Tasmanian Legislative Council Papers 1858 to 1883
TPP	Tasmanian Parliamentary Papers 1884 to present

Abbreviated names of government institutions and dates in use

New Norfolk	New Norfolk Invalid Hospital, New Norfolk, 1824–1848
Impression Bay	Impression Bay Convict Station, Impression Bay, 1848–1857
Port Arthur	The Pauper House, Port Arthur, 1857–1859/1877
Brickfields	Brickfields Invalid Station, Hobart, 1859–1882
Cascades	Cascades Invalid Depot, Hobart, 1867–1879
New Town	New Town Charitable Institution, Hobart, 1874–1913
	New Town Infirmary and Consumptive Home, 1913–1934
	New Town Rest Home, 1934–1938
St John's Park	St John's Park, 1938–1994
	(in private hands from 1994 to date, as Rosary Gardens)
IDL	Invalid Depot, Launceston, 1868-1912
HFI	Home for Invalids, Launceston, 1913–1954
Cosgrove Park	Cosgrove Park Home for the Aged, Launceston, 1954–1993
	(in private hands from 1993 to 2008)

The term ‘aged care’ refers to the care provided to aged people in long-term residential accommodation, by paid employees who are not their relatives. In this thesis, the capitalized word ‘Home’ refers to any formal establishment providing aged care, ‘public’ means government-run, whilst ‘private’ denotes a Home run by an organization or person outside the government, whether philanthropic or proprietary. Trained nurses are denoted by the accepted abbreviations ‘RN’ or ‘EN’, whilst untrained or semi-trained care staff are called ‘aides’. The uncapitalized word ‘nurse’ is used when referring to all staff who provide personal care to residents, trained and untrained, both as a collective noun and also when it is not possible to differentiate between the two groups.

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First and foremost, enormous thanks go to the participants in this study. Without them, it would have been a very different story indeed, and I hope I have done their words justice.

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Chapter 1

‘In safe hands’: an introduction to the thesis

> Residents’ physical and mental health will be promoted and achieved at the optimum level… Residents [will] live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.[1]

Elaine’s story

Elaine Sturzaker preferred to work the night shift at Cosgrove Park Home for the Aged.[2] Even though she was the only registered nurse on duty, she had three nurse’s aides to help her with the one hundred and forty patients, and the two-hourly rounds were usually quiet and uneventful. She would get home in the morning in time to make sure her children were dressed, fed and off to school, and she could look after them after school as well, until her husband came home. It was that flexibility that had first attracted her to the job.

Tonight had begun as quietly as usual. Most of the patients were asleep when Elaine did her first round soon after coming on duty at 11pm. She completed the circuit of the women’s wing and began to walk around the men’s. She passed George’s* bed, and noticed he was not in it; no cause for alarm, he was ambulant and mentally competent, and had no doubt gone to the toilet. She’d check on him on the way back. Two doors further along, she stopped to see John*. She had slipped into the habit of dropping in for a chat with him when she came on duty, and he’d wait for her visit before going to sleep. She could spend a bit of time with him tonight, as no-one was ill and the other staff would let her know if there was an emergency.

She’d been with John for about fifteen minutes when she heard the sound of running feet—most unusual—and someone cried out “get Sturzaker here fast!” Something was wrong… that attendant would *never* run, not in a fit, it must be serious. She rushed out of the room and down the corridor towards the uproar, to the main bathroom, and there he was—George—on the floor. She was right, he *had* gone to the toilet … and he’d taken a

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[1] Standards 2 and 4, *Accreditation Standards*, Aged Care Standards and Accreditation Agency Ltd, 2012

[2] This narrative is based on a passage from an interview with Elaine Sturzaker, much of it using her own words. Some names have been changed, indicated with an asterisk.

gun with him. He'd put the barrel under his chin and pulled the trigger. The bullet had gone right through his head, and it was clear that there was little she could do. She left the attendant with him and ran to call the ambulance. There was no outside line in the men's wing, so she raced back to the female division and dialed 000. A second call followed, to the Administrator. "Bernard, I'm sorry to call you in the middle of the night, but do I call the police now? What do you want to do?"

It didn't matter anyway. As soon as the ambulance dispatch officer heard about a gunshot wound they'd notified the police automatically, and soon crews from both services descended on Cosgrove Park. The police were there for hours, and it crossed Elaine's mind that the staff might be under suspicion. An officer told her, "don't worry, Sister, it's just part of the job". But no, it wasn't, not HER job! Not in a nursing home! People die all the time, but quietly, in bed, not violently by their own hand. She returned to the office after the police left and the ambulance took George away for the final time. She was white as a sheet, and the attendants said, "Come on, we'll make you a cup of tea", but somehow tea wasn't the comfort it usually was. She started to shake.

At last the shift ended and she went home, but despite her exhaustion sleep was impossible. Sometimes watching television helped her to wind down after a hectic shift; she curled up on the beanbag and switched on the set. But this day, every station seemed to showing movies of people shooting each other… Across Launceston, the night shift workers of Cosgrove Park were all at home, switching television channels, searching desperately for something peaceful to watch, to take their minds off the horror they had just witnessed and help them finally get to sleep.

George had suffered from COPD.[3] Despite the shelter of Cosgrove Park, regular medical attention and the care of nurses and attendants, he'd had enough of life. He had gone into town while he still could and bought a gun, wrapping it in brown paper and storing it in the back of his wardrobe. And then, when the time was right, he used it.

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[3] Chronic obstructive pulmonary disease: respiratory function is impaired and the person finds it increasingly difficult to breathe and thus to carry out the activities of daily living.

I first learned about George's tragic end when I went to work at Cosgrove Park as a newly registered nurse (RN) some twenty years later. It was not the first unpleasant story I had heard about aged care—the media occasionally report tales of bad management, ill treatment and neglect, fires, outbreaks of disease, poor facilities, and physical and sexual abuse of vulnerable old people[4]— but it was certainly the most dramatic. Not the bare fact of George's suicide, for that act is not uncommon in the community when a person is ill, in pain, or in despair, but the fact that such a violent suicide could happen in a nursing home, a place where the residents were supposed to be kept sheltered and secure, 'in safe hands'.

As the weeks wore on, I was told more and more stories about the things that 'used to happen' in Homes, usually at some unspecified time in the past. Colleagues, friends and acquaintances told tales of neglect, lack of care and downright abuse. I heard of residents being tied to chairs for hours on end, sitting in puddles of urine because the staff wouldn't take them to the toilet, of the bedridden old man who was left to lie in his own excrement until his bedsores reached the bone, of sadistic nurses who hit their frail, defensive charges and scalded them with boiling hot baths. Others spoke of less dramatic but more grinding unpleasantness: of sad and bewildered old people discarded by their families and left to sit forlornly in wheelchairs, abandoned and forgotten, in corridors that smelt of cabbage and urine; cold baths and cold food, inedible food, and insufficient food; lack of entertainment, lack of privacy and lack of care.

I wondered about these accounts. I had seen no evidence of such abuse or neglect in any of the Homes I had worked in during my practical placements as a student nurse, or at work. Indeed, we nurses seemed to spend most of our time ensuring the residents' safety, whether they wanted us to or not. We operated under a blanket of policies and procedures that were aimed at preventing risk or damage to the people we cared for: we underwent training in cardiopulmonary resuscitation, fire drills, and manual handling, we undertook medication audits, we implemented falls limitation procedures. The residents

[4] This is not a new phenomenon, nor is it exclusively Australian; Patricia Shaw noted in 1963 that 'usually incidents of a disagreeable nature seem to provide more interest to the Press than pleasant ones': Patricia Shaw, *Old People in Homes: A Handbook for Matrons*, (London, 1963), page 90. Rhonda Nay points out that newspapers rarely expose the abuse and neglect of old people that occurs in domestic settings, where they are considered private matters: 'An ageing society', Genevieve Gray and Rosalie Pratt, (eds), *Issues in Australian Nursing*, (South Melbourne, 1992)

were regularly assessed for skin integrity, mental and physical health, weight and blood pressure. We regulated the number of cigarettes a resident could smoke, the type of foods they could eat, the amount of fluids they drank, even the places they could go, both inside and outside the Home, to keep them as healthy as possible for as long as possible.

But despite these efforts, public opinion is still not in favour of the Homes. They are seen as a last resort at best, and at worst, places of misery and torment. At Cosgrove Park itself, George's story had acquired something of the nature of myth. The person who told it to me asserted that his action was the result of his desperate wish to escape the Home. The circumstances of his illness and the possibility that he may have simply wanted to end his life on his own terms were not considered; his suicide had become simply an extreme example of the despair felt by old people forced to move into aged care. Even the nurses with whom I worked did not seem to view their workplace positively. Despite the fact that most of them admitted they enjoyed their work, they all agreed that aged care was dull and unchallenging, a place to end a career, not to begin it.[5] They encouraged me to move on to work in a more 'exciting' area, to do 'real' nursing, so as not to waste my newfound skills and knowledge.

I found myself asking questions about this state of affairs. Were the negative stories real, apocryphal, or simply exaggerated? Had conditions in the Homes been far worse in the past? What social function did the Homes fulfil, and had that function changed over time? Why had they begun in the first place? Who went into them? Had there ever been a time when going into a Home was a good thing? What of the nurses—why were they so negative about their work? Had aged care nursing ever been 'real' nursing? If not, were trained nurses really necessary in the Homes? If the measure of a society really is how it treats its weakest members, what does the aged care sector reveal about the status of old people in our society? And finally, why, despite the many safeguards put in place and the efforts of the government, the industry regulators, the administrators and the staff, does aged care still engender such negativity?

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[5] Many studies have shown that aged care is consistently the bottom career choice for graduate nurses in Australia: see, for example, Barbara Happell, 'When I grow up I want to be a …? Where undergraduate student nurses want to work after graduation', in *Journal of Advanced Nursing*, 29:2(1999), 499-505; Barbara Happell and Jenny Brooker, 'Who will look after my grandmother?' in *Journal of Gerontological Nursing*, 27:12(2001), 12-17; interview with Marguerite Bramble

The literature

I turned to the literature to answer my questions, but found little to help me. There have been a great number of publications about the Australian aged care sector produced in the last few decades, but they concentrate almost exclusively on policy development and the workings of the welfare state—government Acts and policies, rules and regulations, financial arrangements and administrative details. They paint a picture of aged care as a triumph of modern welfare, with increasingly high standards of practice ensuring great care and concern for the wellbeing of Home residents, but very few include descriptions of that care, or of how things were in the past. The details of life in a Home, the day-to-day routines of resident and nurse, are all but missing from the narrative. I could find no formal history of the development of aged care as a social phenomenon in Australia at all, so I moved on to the international literature. Here, too, there were few works on the subject, although there are many social histories of old age, general histories of nursing, and histories of health care and welfare, which mention aged care in passing or as a small part of a larger text.

Old age itself has been the subject of several cultural and social histories in recent times.[6] Many of the social histories of old age mention old age institutions to some extent, but rarely in any great depth. Pat Thane's exhaustive study of *Old Age in English History*[7] traces the care of aged people in that country from ancient times to the present day. Her detailed sociological analysis of the welfare provisions made for old people briefly mentions institutional aged care, in the form of almshouses and the workhouse, throughout the work. Doreen Norton's short book, *The Age of Old Age: the story of care provision for the elderly over the centuries*[8], briefly mentions ancient cultures, but is essentially a history of English aged care only. Her work concentrates on the broad details—social, political and economic developments and changes—and although she mentions nurses and the low status of geriatric nursing (the nursing of aged people in

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[6] These include Leo Simmons' *The Role of the Aged in Primitive Society* (New Haven, 1945); Ethel Shanas et al, *Old People in three Industrial Societies* (New York, 1968); Jay Sokolovsky, (ed), *Growing Old in Different Societies* (Belmont, CA, 1983); Shulamith Shahar, *Growing Old in the Middle Ages* (New York, 2004); Pat Thane, (ed), *The Long History of Old Age* (London 2005). The 1995 edition of *Australian Cultural History* (volume 14) was devoted to 'Ageing', covering several different aspects of old age in Australia, including an exploration of the origins of Australian ageism by Graeme Davison in 'Our youth is spent and our backs are bent'. Dawn Peel analyzed the changing attitudes towards old age in one specific town in 'Towards a history of old age in Australia' in *Australian Historical Studies*, 117(2001), 257-275

[7] Pat Thane, *Old Age in English History: Past Experiences, Present Issues*, (Oxford, 2002)

[8] Doreen Norton, *The Age of Old Age*, (Harrow, 1990)

dedicated wards within hospitals), she does not examine care practices or life within Homes.

Several authors have looked at the development of the aged care sector in the United States of America (USA) from its colonial beginnings. David Rothman examines the common roots of the poorhouse, the insane asylum and the prison in *The Discovery of the Asylum*[9], in which he states that the provisions made to care for the inmates of these institutions were as much to control them as to help them. Michael Katz's *In the Shadow of the Poorhouse* is a social history of welfare which mentions old people peripherally[10], and Carole Haber includes a chapter on 'Institutionalizing the elderly' in *Beyond Sixty-Five*, in which she traces the development of American Homes through the 19th century and links this to the prevailing attitudes towards old age and appropriate care arrangements.[11] Her discussion on the philosophy of care and the conditions within these Homes is interesting in both the similarities and differences displayed to contemporaneous Tasmanian conditions. Other writers have published articles concentrating on changing government policy and financial arrangements, or on specific sections of the American sector, such as Homes for specific ethnic, occupational and socio-economic groups.[12] The focus of these articles is on the social history of the time rather than an exploration of the care given, although this is sometimes mentioned in passing.

The Canadian situation is described in Megan Davies' *Into the House of Old*, an in-depth history of residential aged care in British Columbia.[13] It covers policy changes, the development of the Homes and conditions within, and gives a vivid picture of the

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[9] David J Rothman, *The Discovery of the Asylum: Social order and Disorder in the New Republic*, (Boston, 1971)
[10] Michael Katz, *In the Shadow of the Poorhouse*, (New York 1986)
[11] Carole Haber, *Beyond Sixty-Five*, (Cambridge, 1983)
[12] Robert Morris, 'The evolution of the nursing home as an intermediary institution' in *Generations*, 19:4(1995), 57-61; Kevin Fleming, Jonathan Evans and Darryl Chutka, 'A cultural and economic history of old age in America' in *Mayo Clinic Proceedings*, 78:7(2003), 914-921. Sue Weiler, 'Religion, ethnicity and the development of private homes for the aged' in *Journal of American Ethnic History*, 12:1(1992), 64-90; Seamus Metress, 'The history of Irish-American care of the aged' in *The Social Service Review*, 59:1(1985), 18-31; Susan Reed and Nancy Davis, 'The Jane Dent Home: the rise and fall of homes for the aged in low-income communities' in *Journal of Health Care for the Poor and Underserved*, 15(2004), 547-561; Janna L Dieckmann, 'From almshouse to city nursing home: Philadelphia's Riverview Home for the Aged' in *Nursing History Review*, 1(1993), 217-228
[13] Megan Davies, *Into the House of Old: A History of Residential Aged Care in British Columbia*, (Montreal, 2003). The book is based on her PhD thesis.

changing social and cultural climate and their effect on aged care. It does not look at nursing particularly but it is the only book identified that concentrates on the formal aged care sector in a particular politico-geographical region rather than the broader social phenomenon of old age. It is also a balanced portrayal, unlike the almost universally negative publications mentioned in the next few paragraphs, most of which were written with overtly political motivations, as advocates for change.

Although I could find no historiographical study of American aged care, a number of studies of nursing homes were published over the decades which include descriptions of nursing staff (trained and untrained, but mostly untrained) and their duties and routines at that time, which provide a useful insight into past practices in that country. Some were carried out by anthropologists and social researchers working within particular facilities[14], others were written about the experience of working as an aide in a Home by the protagonists themselves.[15] I was unable to find any book written by a RN about working in aged care, although several wrote articles describing conditions and practices in particular Homes for the *American Journal of Nursing* in the 1940s and 1950s, when aged care was still a relatively new phenomenon.[16] Several books have been written by residents: Joyce Horner's *That Time of Year,* and Carobeth Laird's *Limbo,* which were both written in the 1970s[17], and Clifford Bennett's *Nursing Home Life.*[18] Bennett was a nursing home administrator of many years' standing who took on a false persona and had himself admitted briefly to a distant facility as a resident, where he discovered the full effect that the Home environment and routine has on a person who cannot escape the often well-meaning ministrations. His book gives particularly valuable insights, combining as it does the cerebral knowledge of the administrator and the visceral reactions of the resident into a single narrative.

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[14] Jules Henry, *Culture Against Man*, (London, 1966); Jaber Gubrium, *Living and Dying in Murray Manor*, (Springfield, Ill, 1973); Sally Tisdale, *Harvest Moon: Portrait of a Nursing Home* (New York, 1988); Renee Rose Shield, *Uneasy Endings: Daily Life in an American Nursing Home*, (New York, 1988); Joel Savishinsky, *The Ends of Time: Life and Work in a Nursing Home* (New York, 1991); Mary O'Brien, *Anatomy of a Nursing Home*, (Maryland, 1989); Nancy Foner, *The Caregiving Dilemma*, (Berkeley, 1995)
[15] Timothy Diamond, *Making Grey Gold* (Chicago, 1992); Maria Vesperi, 'The reluctant consumer: nursing home residents in the post-Bergman era' in Jay Sokolovsky, (ed), *Growing Old in Different Societies* (Belmont, 1983); Thomas Gass, *Nobody's Home* (Ithaca, 2004)
[16] For example, Edith Marsh, 'The care of the chronically ill: at the Cuyahoga County Nursing Home', 41:2(1941), 161-166; Elizabeth Black, 'Nursing home care', 50:5(1950), 289-291; Delia Ingles-Smith, 'A home with a heart', 53:9(1953), 1098-1099
[17] Carobeth Laird, *Limbo: A Memoir About Life in a Nursing Home by a Survivor*, (Novato, Cal, 1979); Joyce Horner, *That Time of Year: A Chronicle of Life in a Nursing Home* (Massachusetts, 1982)
[18] Clifford Bennett, *Nursing Home Life: What It Is and What it Could Be* (New York, 1980)

There are also a number of books which were published in the 1970s onwards which exposed the dreadful conditions in many American nursing homes and which have probably influenced public perceptions of the sector even outside that country. An early example was *Old Age: The Last Segregation* revealed the results of the Nader Report on nursing home conditions, which found

> shocking callousness among nursing home employees, terrible understaffing, nursing home administrators with no medical experience whatsoever, and almost total failure by local, state, and federal authorities to remedy the situation.[19]

Robert Butler's germinal work on old age, *Why Survive? Being Old in America,* included a chapter on nursing homes called 'Houses of death are a lively business', in which he stated that 'a nursing home is a facility that has few or no nurses and can hardly qualify as a home'.[20] This comment was echoed by Frank Moss and Val Halamandaris in their 1977 book *Too Old, Too Sick, Too Bad*, a culmination of fourteen years of hearings, legislation and research into the American aged care sector.[21] Mary Mendelson also wrote about the "scandal of the American nursing home industry" in *Tender Loving Greed*[22] which, as its title suggests, exposed the sector as one more concerned with money-making than providing good care for residents. Nearly ten years after the Nader Report, Bruce Vladeck uncovered the continuing poor conditions for staff and residents and looked at what had gone wrong with the aged care sector in his 1980 book, *Unloving Care: The Nursing Home Tragedy.*[23] Despite these publications and the outrage they provoked, a 1996 study on nursing staff levels in the USA[24] found that staffing was still inadequate and standards of care suffered in consequence, but stated that changes were unlikely without more financing being made available. The theme of financial hardship and expediency echoes throughout the literature, and its relevancy to the Australian (and particularly the Tasmanian) situation will be demonstrated in the later chapters of this thesis.

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[19] From the cover description on Claire Townsend, *Old Age: The Last Segregation,* (New York, 1971). , cover description.
[20] Robert Butler, *Why Survive? Being Old in America,* (Baltimore, 1975), p 263
[21] Frank Moss & Val Halamandaris, *Too Old, Too Sick, Too Bad: Nursing Homes in America,* (Germantown, 1977). Other chapter titles include 'Nursing homes: the greatest fear of the elderly', 'Nursing home abuses', 'Nursing home drugs: pharmaceutical Russian roulette', 'Nursing home fires', 'Profiteering', and 'The physician's abdication of responsibility'.
[22] Mary Mendelson, *Tender Loving Greed* (New York, 1975)
[23] Bruce Vladeck, *Unloving Care: The Nursing Home Tragedy*, (New York,1980)
[24] Report by the Committee, Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?,* (Washington 1996)

Looking more widely at the place of the elderly in American society, Curtin's *Nobody Ever Died of Old Age* is a fascinating study of the various roles which old people could fill in the 1970s: from bag ladies living in rooming houses to wealthy retirement villagers; carer spouses struggling at home with help from community nurses; the demented living in geriatric wards in mental hospitals, and, of course, the nursing home.[25] Curtin was a nurse herself, and her book gives great insight into the difficulties and ethical problems of caring for aged people and helping aged people care for themselves.

Within the Australian literature, the aged care sector has mainly been seen as a subsidiary of the welfare system. Several books have examined the development of social welfare in Australia and, in passing, the provision of services to aged people. Cyril Cummins's history of the Benevolent (Sydney) Asylum[26] looks at the earliest charitable care institution in the colony, established in 1821. Although it was not built expressly for aged people but for the destitute (as were the poorhouses and almshouses of England and the United States of America), the average age of the inmates was sixty-five and it was for all intents and purposes a *de facto* aged care Home. Cummins looks at demographics, financial arrangements and administration within the asylum. There is some mention of patient care—discipline, crowded conditions and the occasional treat—but nurses were not part of the staff, although some inmates received 'gratuities' to provide nursing care.

Robert Cage examined conditions for the inmates as part of his study of the various charitable institutions in Victoria in *Poverty Abounding, Charity Aplenty*, covering the Benevolent Asylums of Melbourne and Ballarat in particular.[27] Anne O'Brien's *Poverty's Prison* examines the development of welfare in New South Wales, and includes a chapter on the provisions made for old people in particular.[28] Brian Dickey takes a broader view in *No Charity There*, covering welfare arrangements for the whole of Australia, and the section on provisions for old people is of necessity only a brief section of the book.[29] Several publications on the history of social welfare have also included

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[25] Sharon Curtin, *Nobody Ever Died of Old Age*, (Boston, 1972)
[26] Cyril J Cummins, *The Development of the Benevolent (Sydney) Asylum*, (Sydney, 1971)
[27] Robert A Cage, *Poverty Abounding, Charity Aplenty: The Charity Network in Colonial Victoria*, (Sydney, 1992)
[28] Anne O'Brien, 'In the shadow of the asylum', *Poverty's Prison: The Poor in New South Wales 1880-1918*, (Carlton, Vic, 1988)
[29] Brian Dickey, *No Charity There: A Short History of Social Welfare in Australia*, (Sydney, 1987); the Tasmanian situation is described on pages 35-36

broad information on arrangements for the aged poor.[30] In 2001 the Commonwealth Department of Health and Aged Care published a celebration of its part in the provision of health care to Australians since Federation.[31] Despite the fact that aged care legislation and funding has been a federal rather than a state responsibility since that time, it includes only basic chronological information on the various Acts and policies that have affected the sector. There is a paragraph on the growing aged population (accompanied by a photograph of the then Minister for Aging clasping the hand of a resident in a Home in Victoria), and a mention of the now notorious 'kerosene bath' incident[32] (a good example of negative media attention) to illustrate the need for the accreditation standards now in place and largely adhered to throughout the industry.

Other studies have looked at old age in Australia, and covered the subject of aged care as an aspect of aging. Most of these concentrate on policy, demographics and economic considerations[33] although Bertram Hutchinson's 1954 *Old People in a Modern Australian Community* included a chapter on 'Homes and Institutions for the aged'.[34] Hutchinson inspected several institutions in the state of Victoria and interviewed elderly members of the public about their attitudes towards entering a Home. He found that many viewed this eventuality with dread, and his description of the Homes he visited made this attitude understandable. His is the only book identified which paints a clear picture of day-to-day activity and physical conditions within Australian Homes in the middle of the 20th century.

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[30] For example, Richard Kennedy, 'Charity and ideology in Colonial Victoria' in Richard Kennedy, (ed), *Australian Welfare History,* (South Melbourne, 1982)
[31] Francesca Beddie, *Putting Life Into Years: The Commonwealth Government's Role in Australia's Health since 1901,* (Canberra, 2001)
[32] This occurred at the Riverview Nursing Home in Victoria in January 2000, which was experiencing an outbreak of scabies. All fifty-seven residents were bathed in water containing kerosene; thirteen experienced severe skin blistering and one (who was in palliative care at the time) died two days later. It was alleged the kerosene was used to save money on skin ointments, but it should be kept in mind that it was commonly used in the past as a folk remedy for the problem, which might have also been a factor.
[33] See, for example, RA Parker, *The Elderly and Residential Care: Australian Lessons for Britain,* (Aldershot, 1987); Hal Kendig and John McCallum, (eds), *Grey Policy: Australian policies for an Ageing Society* (Sydney, 1990); Anna Howe, (ed), *Towards an Older Australia*, (St Lucia, 1994); Diane Gibson, 'Reforming aged care in Australia: change and consequence' in *Journal of Social Policy*, 25:2(1996), 157-179, and *Aged Care: Old Policies, New Problems*, (Cambridge, 1998); and Michael Fine and John Stevens, 'Innovation on the margins: aged care policies since white settlement' in Celia Bevan and Basseer Jeeawody, (eds), *Successful Ageing*, (Artarmon, 1998)
[34] Bertram Hutchinson, *Old People in A Modern Australian Community,* (Melbourne, 1954)

In the next decade, John Stubbs' *The Hidden People* revealed that old age was a major risk factor for poverty. His descriptions of the desperate lives of many old people in the community made it clear why Homes were becoming an essential part of society by the 1960s.[35] In 1970, Dr Alan Foster[36] lobbied passionately for increased assistance from state governments for aged care services, and also advocated for community care rather than institutional. Five years later the Social Welfare Commission published its report on *Care of the Aged*[37], which examined policy and provision of care and made recommendations to the federal government regarding improvements to the system. Mention is also made of the lack of geriatricians and a consequent deficiency in geriatric training for nurses at that time. Bruce Ford's 1984 book *The Elderly Australian*[38] briefly traces the development of aged care from its roots in the English monasteries and the passing of the Elizabethan Poor Law of 1601, and also draws attention to the health professionals who provide that care, including nurses and untrained nurses' aides. He points out that geriatric nursing received scant recognition—of the more than 700 training programmes in Australia at the time, only four were in geriatrics—and mentions the shortage of nurses in this area.

Tasmanian historical scholarship has tended to focus on the colonial period, particularly on the lives and experiences of convicts and emancipists. Many of these briefly mention institutions for the old and infirm but few give any detail.[39] A number of books have been written about particular institutions which housed destitute old people at various times, but devote little space to them in the narrative. This is probably because these places were only used for this purpose once their original and renowned function was over, and so the aged care aspect of their history is seen as incidental, irrelevant or

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[35] John Stubbs, *The Hidden People: Poverty in Australia* (Melbourne, 1966)
[36] Dr Alan Foster, 'Housing and welfare of the aged', in Sydney Sax, (ed), *The Aged in Australian Society* (Sydney, 1970). Dr Foster was Minister for Health in Tasmania at the time.
[37] Social Welfare Commission, *Care of the Aged*, (Canberra, 1975)
[38] Bruce Ford, *The Elderly Australian*, (Ringwood, Vic, 1984)
[39] For example: Joan Brown, *Poverty Is Not A Crime: The Development of Social Services in Tasmania 1803-1900* (Hobart, 1972); Peter Bolger, *Hobart Town* (Canberra, 1973); Lloyd Robson's *A History of Tasmania: Colony and State from 1856 to the 1980s* (Melbourne, 1990); Shayne Breen, *Contested Places: Tasmania's Northern Districts from Ancient Times to 1900* (Hobart, 2001); Alison Alexander, (ed), *The Companion to Tasmanian History* (Hobart, 2005); Babette Smith, *Australia's Birthstain* (Crows Nest, 2008); Alison Alexander, *Tasmania's Convicts: How Felons Built a Free Society* (Crows Next, 2010)

unimportant to their historians.[40] An exception is the work of Andrew Piper, whose PhD thesis is a detailed and fascinating history of the government and charitable institutions in Tasmania in the 19th century, and who has also published several articles on the same subject.[41] Although Piper looks at the nursing care (or lack of it) in these institutions, his main focus is on social control and the way in which this is achieved through rules, routines, and the fabric of the institutions.

A recently published history of various health care professions in Launceston, *Effecting a Cure*, does not address care of the elderly, although Andrea Vreugdenhil's chapter on 19th century attitudes to dementia shows how little provision was made in general for old people in the colony in colonial times.[42] She mentions that 'senile dementia' was used as a diagnosis from the 1860s, and those so diagnosed were sent to the Insane Asylum at New Norfolk. Several books have been written about the New Norfolk asylum, the first invalid depot in the colony and therefore the first institution to provide care for old people, but they mention this only in passing. Caitlin Bowden's Honours thesis, *The Blind, the Paralytic, the Aged and the Destitute* compares the care at the New Norfolk Colonial Hospital with comparable British institutions of the time, and shows that aged people made up a sizeable minority of the inmates. Dr Garvin Crabbe, a doctor at the New Norfolk hospital before and after World War II during its period as 'Lachlan Park', wrote a history of the institution in which he briefly mentions that an earlier incarnation of the establishment had three sections: a lunatic asylum, a hospital and an invalid depot. He states there are no records from the latter section extant, and his concern is mainly with the development of the psychiatric services.[43] Ralph Gowlland's later history, *Troubled Asylum*[44], covers the institution's entire history up to the date of publication

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[40] Examples include Maggie Weidenhofer, *Port Arthur: A Place of Misery*, (Port Arthur, 1990); Kim Pearce, *Historical Study: North Hobart*, (Hobart, 1992); Lucy Frost, *Footsteps and Voices: A Historical look into the Cascades Female Factory*, (Hobart, 2004)

[41] Andrew Piper, *Beyond the Convict System: The Aged Poor and Institutionalization in Colonial Tasmania*, PhD Thesis, University of Tasmania (2003); 'Admission to charitable institutions in colonial Tasmania: from individual failing to social problem' in *Tasmanian Historical Studies*, 9(2004), 43-62; '"Mind-Forg'd manacles": the mechanics of control inside late-nineteenth century Tasmanian charitable institutions' in *Journal of Social History*, 43:4(2010), 1045-1063

[42] Paul A Richards, (ed), *Effecting A Cure: Aspects of Health and Medicine in Launceston*, (South Launceston, 2006); Vreugdenil's chapter is entitled 'Out of sight, out of mind: senile dementia in nineteenth century Launceston'.

[43] Dr Garvin Crabbe, *History of Lachlan Park Hospital*, (Hobart, 1966)

[44] Caitlin Bowden, *The Blind, The Paralytic, The Aged and The Destitute: the New Norfolk Colonial Hospital in Van Diemen's Land*, unpublished Honours thesis, University of Tasmania, (Hobart 2007); Ralph Gowlland, *Troubled Asylum: The History of the Royal Derwent Hospital*¸ (New Norfolk, 1981)

(1981) and looks at the changing focus of the institution and the various stages of its building. Gowlland points out that although it was a dedicated psychiatric facility for most of its history, it harboured many aged people throughout the decades, not all of whom were demented. The book throws some light on the changing attitudes towards the mentally ill and the conditions in which they are kept.

There is far less literature on 20th century developments. A history of the Launceston General Hospital produced for its 100th anniversary in 1963 includes a short chapter on 'The Care of the Aged' which outlines the development of government aged care provisions for Northern Tasmanians.[45] A similar history of the Royal Hobart Hospital[46] mentions 'areas of Vaucluse hospital [that] have for many years been used for geriatric patients and … geriatric rehabilitation', but no further details are given. Beatrix Kelly alludes to a history of St John's Park, the state's long-time old age Home and official geriatric hospital, written by a previous superintendent of the institution, but no copy of this can be located in state or national libraries.[47] Some private Homes have published institutional histories, often as celebratory tomes for auspicious anniversaries, and always emphasising the care and social responsibility of their founders and management committees in promoting the health and happiness of their residents. Although these give brief attention to social and political factors that shaped development of the Homes and some mention standards of care and touch briefly on nursing staff, they are essentially congratulatory stories with positives stressed and negatives often entirely absent.[48] One of the few books to include the work and experiences of the nurses is historian Alison Alexander's in-depth history of the Mary Ogilvy Home.[49] Although she examines the usual administrative, financial and physical arrangements of the Home, she also includes details of the nurses' work routines and even mentions some of them by name, using oral history interviews with several nurses who had worked there in the 1970s. A common

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[45] Clifford Craig, *Launceston General Hospital: The First Hundred Years 1863-1963*, (Hobart, 1963); chapter by BW Griffiths, page 92

[46] WG Rimmer, *Portrait of a Hospital: The Royal Hobart*, (Hobart, 1981), page 303

[47] Beatrix Kelly, *Background to the History of Nursing in Tasmania*, (Hobart, 1977), page 71

[48] There are at least two dozen such histories available, many published to celebrate the fiftieth anniversary of homes across Australia. Tasmanian examples include Bell Thompson, *The Key of the Door: The Story of the Lillian Martin Presbyterian Home*, (Hobart, 1977). Bruce Griffiths, *The Story of Ainslie* 1962-1991, (Launceston, 1992); Victoria Rigney, *Many Doorways, One Journey*, (Hobart, 2005); Douglas M Wyatt, *Caring Across Tasmania – 1969-2006*, (Hobart, 2006)

[49] Alison Alexander, *Mary Ogilvy: The Evolution of a Grand Lady: The Mary Ogilvy Homes Society, 1946-2006* (New Town, 2006). Alexander also briefly mentions other Hobart Homes in *The Eastern Shore: A History of Clarence*, (Rosny Park, 2003)

theme in all these books is the constant struggle for funding, to cover increased wage costs as more skilled workers were employed, to employ sufficient workers and to give the residents a suitable level of care and quality of life.

The residents' side of the story is seen in Ellen Newton's *This Bed My Centre*[50], based on a diary she kept of her experiences in private Homes in the late 1970s in Melbourne, and which provides a first person account the nursing care and routines in such Homes at the time. Two Tasmanian books also give a glimpse into the lives of the residents themselves. Upon its sale to private ownership in 1993, oral histories from some residents of St John's Park were collected in *No More Bread and Milk.*[51] Unlike many institutions, St John's Park housed both young and old in the same wards through much of its history, and several of the interviewees had entered the institution as young people in the 1950s or even earlier. Their descriptions of the conditions they and their fellow 'inmates' had endured in the early days, and the comparisons they drew to the contemporary Home in which they lived at the time gives an insight that is usually lost, as most residents die without leaving records. In Northern Tasmania, residents in several Homes took part in a writing group and produced a book of poetry about their lives, past and present. [52] Several poems were about their experiences coming to and living in the Homes, and these poignant pieces show a positive side to aged care not often found elsewhere in the literature.

Turning to the nursing literature, I found that aged care nurses (that is, nurses who work in long-stay wards and residential Homes for the aged as opposed to short-stay geriatric wards in acute hospitals) have very little presence in nursing histories. Until relatively recently, most histories of nursing have concentrated on the high profile and high status aspects of the profession. Mostly written by nurses rather than historians, these have tended to be eulogistic, extolling the heroines of the movement, the reforms made and triumphs won. Written to aid the acceptance of nursing as a profession, they tell of a sustained linear progress from lowly beginnings to present accomplishments, in an effort

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[50] Ellen Newton, *This Bed My Centre*, (Melbourne, 1979)
[51] Elizabeth Dean & Annie Reynolds, *No More Bread and Milk: Stories From St John's Park*, (New Town, 1993)
[52] Robyn Friend, (ed), *Fancy Seeing You Here: A Collection of Writing by Residents of Nursing Homes in Launceston and the Tamar Region*, (Launceston, 1989)

to separate the modern, trained nurse from her supposedly less learned and respectable predecessors.[53]

The majority of historical studies have focused on the growth of the hospital nurse[54], reflecting the high status of medicine within the professional hierarchy. Few histories even mention caring for aged people, apart from a passing note on 19th century provisions for paupers—the poorhouse and the workhouse—and on religious orders that cared for aged people.[55] An example of this is a chapter on 'Special Modern Nursing Problems' in John Walsh's 1929 *History of Nursing*, in which the entire coverage of aged care nursing is a single paragraph on the Little Sisters of the Poor,

> who had been in this country for many years, enlarged their work for that incurable disease, old age, which all of us who live long enough have to face, and which will inevitably get us, if some disease or accident does not anticipate its advance.[56]

Later histories have been little more informative, relegating aged care nursing to mere paragraphs in often lengthy tomes; for example, Philip and Beatrice Kalisch's 850-page history *The Advance of American Nursing* contains just four pages on 'Nurses and Nursing Homes'.[57]

More recently, revisionist historians have started to question the triumphalist approach, suggesting that the story of nursing has not been a straightforward march 'from the dark and chaotic past to the glorious present'.[58] Celia Davies' edited collection, *Rewriting Nursing History*, and the sequel by Christopher Maggs, *Nursing History: the State of the Art*, contain essays on various aspects of nursing from a political viewpoint of class and

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[53] For example, see: Adelaide Nutting and Lavinia Dock, *A History of Nursing¸ Vols 1 and 2* (New York, 1907); Lavinia Dock, *A History of Nursing*, Vols 3 and 4, (New York, 1912); Lavinia Dock and Isabella Stewart, *A Short History of Nursing*, (New York 1932); Lucy Seymer, *A General History of Nursing*, (London, 1932); Deborah Jensen, *A History of Nursing*, (St Louis, 1943); Agnes Pavey, *The Story of the Growth of Nursing as an Art, a Vocation, and a Profession*, (London, 1944)

[54] Examples include Brian Abel-Smith, *A History of the Nursing Profession*, (London, 1960); Christopher Maggs, *The Origins of General Nursing*, (London, 1983); Josephine Castle, 'The development of professional nursing in New South Wales, Australia' in Christopher Maggs, (ed), *Nursing History: The State of the Art* (London, 1987); Susan Reverby, *Ordered to Care: The Dilemma of American Nursing*, 1850-1945, (Cambridge, NY, 1987)

[55] Monica Baly, *Nursing and Social Change*, (London, 1980); Michael Katz, 'Poorhouses and the origins of the public old age home' in *The Milbank Quarterly*, 62:1(1984), 110-140; John J Walsh, *The History of Nursing*, (New York, 1929)

[56] Walsh, *The History of Nursing*, page 257

[57] Philip and Beatrice Kalisch, *The Advance of American Nursing* (Boston, 1986)

[58] Sioban Nelson, 'The fork in the road: nursing history versus the history of nursing' in *Nursing History Review*, 10(2002), 175-188, page 176

gender, re-assessing the contribution of ordinary nurses in the past.[59] But although these alternative histories examined some of the less prestigious 'Cinderella' areas of nursing, such as mental health, midwifery, and community nursing, aged care is still omitted.[60] *Oral History, Health and Welfare*, a collection of studies into the experiences of the 'ordinary' practitioner in some of the less 'glamorous' health fields, does include aged care, but it is through the memories of geriatric specialists and workhouse administrators—the men in charge— not nurses.[61]

Several articles on the history of geriatric medicine include a mention of nurses but little more, although Alan Barton and Graham Mulley do acknowledge that '[t]he contributions made by nurses … have been immense' and explain that lack of space prevents inclusion in their article.[62] The few studies of geriatric nursing history that have been produced concentrate on geriatrics within the hospital setting rather than in aged care, again illustrating the primacy of hospital nursing.[63]

Australian nursing history is still a small *oeuvre* and aged care nursing as a stand-alone speciality is almost entirely overlooked, although there are a few studies of areas that encompass care of aged people as part of their work, such as district nursing and bush nursing.[64] Madsen's *Nursing History: Foundations of a Profession* has a strong focus on

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[59] Celia Davies, (ed), *Rewriting Nursing History*, (Surry Hills, 1980); Christopher Maggs, *Nursing History: The State of the Art*, (North Ryde, 1987)

[60] Robert Dingwall, Anne Marie Rafferty and Charles Webster do briefly mention nursing in workhouses in *An Introduction to the Social History of Nursing*, (London, 1991)

[61] Margot Jeffreys, 'Recollections of the pioneers of the geriatric medicine speciality', and John Adams, 'The last years of the workhouse, 1930-1965', in Joanna Bornat et al, (eds), *Oral History, Health and Welfare*, (London, 2000)

[62] John Grimley Evans, 'Geriatric medicine: a brief history' in *British Medical Journal*, 315(1997), 1075-1077; John Morley, 'A brief history of geriatrics' in *The Journals of Gerontology*, 59A:11(2004), 1132-1152; Moira Martin, 'Medical knowledge and medical practice: geriatric medicine in the 1950s' in *Social History of Medicine*, 7:3(1995), 443-461; Paul Bridgen, 'Hospitals, geriatric medicine, and the long-term care of elderly people 1946-1976' in *Social History of Medicine*, 14:3(2001), 507-523; Cecily Hunter, *Doctoring Old Age: A social history of geriatric medicine in Victoria*, PhD thesis, University of Melbourne (2003). Alan Barton and Graham Mulley, 'History of the development of geriatric medicine in the UK' in *Postgraduate Medical Journal*, 79(2003), 229-234

[63] Priscilla Ebersole & Theris Tuohy, *Geriatric Nursing: Growth of a Speciality*, (New York, 2006), covers American geriatric nursing; Jane Brooks, '"The geriatric hospital felt like a backwater": aspects of older people's nursing in Britain, 1955-1980' in *Journal of Clinical Nursing*, 18(2009), 2764-2772 uses oral histories from nurses who worked on geriatric wards in British hospitals in the 1950s to 1980s; Cecily Hunter, 'Nursing and care for the aged in Victoria: 1950s to 1970s' in *Nursing Inquiry*, 12:4(2005), 278-286 examines geriatric and rehabilitation nursing in hospitals in Victoria, Australia.

[64] Diane Snowden, *Caring for the Community: One Hundred Years of the Hobart District Nursing Service Inc 1896-1996*, (Hobart, 1996); Wendy Madsen, 'Plugging the gaps: a history of domiciliary nursing' in *Praxis*, 11:1(2006), 13-16; John Wilson, 'Bush Nightingales: a view of the nurse's role in the Australian

hospital training and nursing, and although she mentions that in the 1950s '[n]ursing homes were not always readily available, nor were they necessarily desired by the elderly', she passes on to district and community nursing and no more mention is made of aged care.[65]

John Stevens has examined the historical context of aged care in Australia in several publications, and points out that not only have nurses been associated with the care of old people since colonial times, but that trained nurses were in fact 'officially engaged and recognised in the care of older people and the infirm' a full seven years before these regulations were applied to the general hospital system. Stevens calls this relationship the 'ennursement' of aged care, a term that will be adopted in this thesis as it more accurately describes the association between healthcare professionals and nursing homes than the more familiar and physician-oriented 'medicalization'. He also collaborated on a Discussion Paper for the Royal College of Nursing Australia which explored ageism and the stigma this has cast over the development of nursing in aged care in this country.[66]

Both Joan Durdin and Victoria Hobbs allude to Homes and aged care nurses in their histories of nursing in South Australia and Western Australia respectively[67], and Durdin briefly examines conditions in the small private Homes run by trained nurses and the policy changes that affected their financial viability in the 1960s. Bartz Schultz's chronological history of nursing in Australia up to Federation[68] deals with care of aged people as a specific area. She outlines the arrangements made by various State governments to care for paupers in the 19th century, and her Tasmanian coverage mentions the establishment of the two government-run institutions, giving dates and statistics, but no description or details. Beatrix Kelly devotes just over one page of her *History of Nursing in Tasmania* to geriatric nursing, in what is essentially a listing of the

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cottage hospital industry' in *Health, History & Horizons*, (Brisbane, 1992); Marita Bardenhagen, *Professional isolation and independence of bush nurses in Tasmania 1910-1957: "We were very much individuals on our own"*, PhD thesis, University of Tasmania, (2004)

[65] Wendy Madsen, *Nursing History: Foundations of A Profession*, (Frenchs Forest, 2007)

[66] John Stevens, 'The ennursement of old age in NSW: A history of nursing and the care of old people between white settlement and Federation', in *The Collegian*, 10:2(2003), 19-24; John Stevens and Jan Herbert, *Ageism and nursing practice in Australia,* Discussion Paper No. 3, Royal College of Nursing, (Deakin, ACT, 1997)

[67] Joan Durdin, *They Became Nurses: A History of Nursing in South Australia 1836-1980*, (North Sydney, 1991); Victoria Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979*, (Nedlands, 1980)

[68] Bartz Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia, Vol 1: Foundation to Federation 1788-1900*, (South Melbourne, 1991). Unfortunately, no volume 2 was produced.

names of the superintendents and matrons of St John's Park, the state's official geriatric hospital at the time.[69] Linda M Brown's history of nursing at the Launceston General Hospital[70] mentions that geriatric patients often filled the medical wards until the opening of Cosgrove Park, but there are no further details about this hospital-run institution.[71]

A single memoir by an RN has been identified that mentions working in aged care in Australia, although the author was not actually a trained nurse at the time. Fleur Finnie's *Don't Stand On the Grass*[72] describes her work at the Melbourne Benevolent Asylum and Hospital for the Aged and Infirm in 1940, where she helped to care for 200 male patients. She writes vividly about the conditions in which the elderly patients lived, her colleagues (the Matron was the only trained nurse on staff), and the duties she carried out on a daily basis, before leaving to train as a 'real' nurse (her words) at The Royal Melbourne Hospital.

This review reveals a distinct gap in the body of nursing knowledge into which the aged care nurse falls. Although much has been written about nursing homes and aged care as a service sector, the place of the nurse within this field is often undefined, their role unclear and their influence and impact unanalysed. Yet nurses are the most numerous representatives of any profession within the sector; their influence is far-reaching and their knowledge of great benefit to society. This study will help to define that place, highlight that role, reveal that knowledge and examine the impact that nurses have made in the development of aged care.

My original intention was to explore the history of the last fifty years of aged care in Australia, in order to uncover the origins of the image of the sector.[73] I quickly realized

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[69] Kelly, *History of Nursing in Tasmania*, pages 71-2. Contrast the twenty-one pages devoted to another 'Cinderella' speciality, psychiatric services, at the Lachlan Park Hospital.
[70] Linda M Brown, *History and Memories of Nursing at the Launceston General Hospital*, (Launceston, 1980)
[71] The geriatric wards are spoken about in many of the oral histories in this thesis but are almost entirely absent from the official records. For example, Anne Green's exhaustive listing of the many medical and health care facilities in Launceston during its two hundred year existence, *A Model Municipality: Places of Management, Mentoring and Medicine in Launceston*, (Launceston, 2007), mentions many long-gone establishments, but the psycho-geriatric ward at the Queen Victoria Hospital in the 1980s and a special dementia unit at Allambi in the 1990s is completely absent from her reports on those respective facilities.
[72] Fleur Finnie, *Don't Stand on the Grass*, (Melbourne, 1996)
[73] By 'aged care', I mean the formal provision of care to old people within a house that is not their own, by people who are not their relatives but who are paid to look after them. Aged care also encompasses care

that I needed to extend the chronological frame, because although modern aged care can be almost precisely dated to federal policies and welfare changes in the early 1950s[74], the sector was heavily influenced by preceding conditions which needed to be explained. I also discovered that to look at Australia as a whole was well beyond the scope of a PhD thesis. Each state had its own trajectory and these were quite different to each other, so I decided to concentrate on Tasmania. Tasmanian aged care has had a particularly interesting evolution. Although it has been regulated by the same Acts and standards as the other Australian states since federation, the island's physical isolation and its unique colonial history as the penal settlement *nonpareil* have posed different problems for care and offered different solutions which have influenced public attitudes even up to the present day.

Tasmania's relatively large number of old people, particularly old men, coupled with its small population, made it necessary for the colonial administration to provide formal aged care almost from inception of the colony, unlike the mainland colonies where the old, poor and destitute were cared for by public organizations such as benevolent societies and religious bodies.[75] But whilst the political arrangements and particular details of the state institutions and private Homes examined here might be specific to Tasmania, the minutiae of daily care routines and the administrative demands of bureaucratic requirements will be similar in other states of the country, and probably recognizable in other industrialized countries with a similar philosophy of social welfare and medical knowledge and a shared background of Nightingale nursing.[76] For this reason, I believe it is possible to draw some general conclusions about the origins of the nursing home image that extend beyond the shores of Tasmania itself.

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and support given to people in their own homes, and can cover both health and welfare aspects; this area will be touched on briefly in chapter 7, but it is not the focus of this study.

[74] The majority of today's aged care homes had their origins in or after this decade, due to the passing of the *Aged Persons Home Act, 1954* and associated policies and funding arrangements, as will be shown later in this thesis.

[75] The governments of the other colonies provided financial assistance to these bodies, but did not offer direct support. In Tasmania, the colonial government did both; a Royal Commission into charitable institutions in Tasmania in 1871 noted that for every pound paid by the state governments towards welfare, voluntary contributions in NSW were 4s 7½d, Victorians donated 5s 9¼d, whilst the Tasmanian public donated just 6 ¾ pence. TLC, 17, 1871, Paper 47, page xxxvii

[76] Florence Nightingale is seen as the originator of the modern nursing profession, instigating a system of nursing that has dominated Western medical establishments and spread to almost every country in the world. See Monica Baly, *Florence Nightingale and the Nursing Legacy*, (Philadelphia, 1998)

My intention with this thesis is to examine the origins of the Tasmanian nursing home sector, to explore the social institutions and attitudes that have influenced modern aged care. I am particularly interested in the role of the nurse within the Homes, as it is in their hands that the residents' safety has often rested. Whilst there has been a great deal of research on aged care practices and the attitudes of aged care nurses in recent decades, there has been little inquiry into the role that these nurses have played in the past and their influence on the development of the sector, and that is the contribution that this work will bring to nursing and history scholarship in Australia. This thesis is therefore intended as both a social history and a nursing history, to uncover both the story of Tasmanian aged care and to shed light on the working lives of the nurses themselves.

Methodology and methods

> To know about the past is to know that things have not always been as they are now and by implication that they need not always be as they are now.[77]

Social and cultural histories have been written on all aspects of everyday life, and health and welfare has provided a rich field of study, but as seen in the preceding literature review, nursing has not often been given a prominent role in these accounts.[78] As I began to do the research for this study, I realized why: there is very little documentary evidence about nurses or nursing practice in the official records, and very little detail on day-to-day practices or routines. What has been preserved is what has been seen as important: financial records, organizational details, letters to and from important people, and official documentation. It was the story from above, but what was the story from below?

The concept of 'history from below' allows groups who are unaware that they have a history to discover it. This has revitalized historiography in the past few decades, as histories of the great and powerful have been augmented by stories about ordinary people and everyday lives. We now recognise that the rank-and-file are as involved as the generals in shaping the world, and understanding their part in it allows us to gain a more

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[77] Trudy Yuginovich, 'More than time and place: using historical comparative research as a tool for nursing' in *International Journal of Nursing Practice*, 6(2000), 70-75. 2000

[78] In *Caring in Crisis: An Oral History of Critical Care Nursing*, (Philadelphia, 1995), Jacqueline Zalumas mentions her 'gradual realization of the invisibility of nurses and nursing practice in the history of health care'.

detailed and richer understanding of historical events.[79] In order to achieve this understanding, I have utilized two separate methods to explore both the 'authorized' and 'unauthorized' versions of the story: analysis of primary and secondary documentary sources, both published and unpublished, and the collection of oral history interviews with people who have worked in the aged care industry over the last sixty years in various settings throughout Tasmania.

Documentary sources

The majority of primary written sources were derived from the Tasmanian Government archives, from records of the various departments dealing with health services. These included extensive files on the two main public institutions in their various incarnations, but despite their number these files were fragmentary. There were very few records prior to the 1930s, nothing at all after the mid-1970s and a large gap for the duration of World War Two. Other records included general correspondence files, minutes of departmental and public meetings, policy and procedural documents, and official inspection reports of private and public Homes. I also explored the Tasmanian Parliamentary Papers, annual reports of the public institutions, and publicity material for several philanthropic and proprietary Homes. Unfortunately, it appears that very little documentation has survived from the private sector, if it ever existed at all; the participants interviewed for this study included several nurses in supervisory and ownership roles, and all agreed that paperwork was minimalist at best, at least until the 1980s. Most of the smaller proprietary Homes have long since disappeared, bought by larger corporations which did not inherit such records as did exist. Disappointingly but not surprisingly, no nursing notes were found at all for any Home, public or private. Not only are they often considered too unimportant to keep, containing as they do the minutiae of day-to-day care, but they are often destroyed for privacy reasons.[80]

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[79] Jim Sharpe, 'History from below' in Peter Burke, (ed), *New Perspectives on Historical Writing*, (Cambridge, 1991). Edward Thompson originally coined the phrase in an article titled 'History from below' in the Times Literary Supplement of 7th April 1966.

[80] Even those written records that do exist are not always reliable; they sometimes record what should have been done rather than what was done, especially in aged care where funding relies on reported behaviours. It is also in the nature of nursing documentation to only write 'objective' rather than 'subjective' details; only facts that can be observed or measured are usually considered worthy of preserving, and this tends to obscure much of the role of the nurse along with the personality of the patient; see Marie Heartfield, 'Nursing documentation and nursing practice: a discourse analysis' in *Journal of Advanced Nursing*, 24(1996), 98-103

Secondary sources used include Tasmanian newspaper articles, published histories of public and private institutions, and unpublished academic theses. I have also made use of articles from both Australian and international nursing publications contemporaneous to the chronological narrative, to provide additional insight into practices of the times. Where possible, photographs have been included, both as illustrations for the text and source material for analysis.

The documents provided an official picture of the development of aged care in Tasmania, and an indication of what was considered important or at least interesting to those in authority. They did not give much indication of the day-to-day practices in the Homes, or any description of the personal relationships between carers and cared-for. It was therefore necessary for me to find another source to 'fill the gaps', and this has been accomplished through the use of oral history.

Oral history

> …the past does not speak for itself — instead it speaks for those who published their observations or put archival records together.[81]

Oral history gives voice to those invisible in the documents. Details of the lives of the ordinary man and woman can be preserved and their contributions made visible; lives and contributions which would otherwise disappear with the person dies, or forgets, and be lost to us forever.[82] Such narratives conjure up more than simple statements of actions taken or events experienced. They also yield ephemera that do not get written down: emotions, moods, goals, motivations, perceptions, attitudes and personal meanings, which allow a much more detailed picture of the past to be collated than a simple assemblage of facts. They can reproduce the nuances of experience—the tastes, the sounds, the colours. They bring freshness and immediacy to the past, and can give a new perspective: as Narelle Biedermann suggests, 'few can describe the past with more passion and articulation than those who were there'.[83] The oral historian asks questions that might not have been considered at the time of the events being discussed, and the cushioning of

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[81] Hamish Maxwell-Stewart, 'Crime and health: an introductory view', in PAC Richards, *Effecting a Cure,* page 36

[82] Gwyn Prins, 'Oral history; in *New Perspectives on Historical Writing,* (Cambridge, 1991); one of the criticisms of oral history is the fear that by being caught up in the trivial, the larger picture will not emerge; but quite frequently it is the trivial that reveals some of the most important historical details.

[83] Narelle Biedermann, 'The voices of days gone by: advocating the use of oral history in nursing', in *Nursing Inquiry*, 8(2001), 61-62, page 61

time can make subjects that were once hurtful or forbidden a little easier to talk about. Oral history narratives also help us to understand written documents, let us glimpse the unwritten motives and assumptions, and importantly, fill in the gaps left in the official records with the only evidence still available. It has been argued that oral history may be *more* valid than histories based on written materials, because the source is the person who has actually lived the experience, and the historian can check her interpretation with the person who provided the history.[84] I believe this is particularly important in a field where the subjects—nurses, women, old people—have rarely been members of the elite, and whose voices have therefore rarely been heard.

Whilst history is concerned with both change and continuity, it is the latter that is especially useful when examining an ongoing phenomenon such as aged care, allowing us to see not only the differences but also the similarities to the present situation. Whilst the written records tend to emphasise change—new policies and new procedures are more likely to be documented than continuance of the old—oral history allows us to trace those traditions and rituals that remain stable, particularly in an oral culture.[85] This is particularly pertinent for research into nursing practices. Not only has the profession developed many rituals due to the hands-on apprenticeship training system that prevailed throughout much of its history, but it has a strong oral tradition, incorporating such common practices as spoken handovers and the taking of patient histories. This oral tradition has led in part to the scarcity of written sources.

For this study, oral history interviews were conducted to gain both the personal viewpoint of the participants and an insight into the day-to-day operations of aged care, to fill in the minutiae that do not appear in the official records. Sometimes oral history interviews unearth personal memorabilia—diaries, photographs, artefacts—but little material of that nature was uncovered during these interviews, apart from a few press clippings, some letters and a few photographs (most of which belonged to a single participant, with a high local profile in the profession). Several participants mentioned that they had 'recently' culled files and thrown away information because it 'wasn't important'. What a person

[84] K Roberts and B Taylor, *Nursing Research Processes*, (Southbank, Vic, 2002)
[85] Prins, 'Oral History', page 137

keeps and discards can be illuminating, and it is clear that no-one believed that records of their nursing past were worth keeping for posterity.

The participants

The specific nature of oral history research requires purposive or 'typical case' sampling of participants, to ensure that the experiences related are representative, rather than generalizable.[86] The collegiality of the nursing community and the small size and interwoven nature of Tasmanian society enabled me to identify a good cross-section of suitable interviewees across a wide variety of settings and locations, which led to 'snowball' sampling, where one participant introduces another. The effect of the personal introductions was beneficial; although some people expressed reluctance to participate at first, they became more amenable to being interviewed when they knew I came with the recommendation of a friend, and very few of those people approached declined to participate. When sources ran dry, I turned to the media.[87] An interview on ABC Radio and a letter to the major state newspapers attracted broader interest and the final participants were chosen. Most participants had worked in Hobart or Launceston, where the majority of Homes were located, but two nurses from regional areas were also interviewed.

Participants were given an Information Pack containing an Information Sheet, a Consent form, and a Personal Data form. The Consent form gave the option of using their real name or choosing a pseudonym, and this was discussed at the beginning of each interview to ensure the participants understood and were comfortable with their choice. I also requested permission to place both the taped recordings and the transcripts in a permanent oral history archive for future research purposes, and those participants who consented to this signed a Release & Deposit Agreement (all forms can be found at Appendix 1).

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[86] Geertja Boschma et al, 'Oral history research' in Sandra Lewenson and Eleanor Herrmann, (eds), *Capturing Nursing History*, (New York, 2008)

[87] An interesting insight into the gendered nature of aged care was suggested by the fact that no men were identified as possible participants by the 'snowball sampling' method. I had almost given up hope of speaking to male nurses/attendants, but the general media broadcasts discovered three men, all of whom had worked in the public sector.

In all, twenty-one women and three men took part in the research, with involvement in aged care ranging from months to several decades in the sector.[88] Their experience covered both public and private institutions, large and small, religious and secular, and the specialized peripheral areas of community nursing and geriatric assessment. Some continue to work in aged care today, others have moved into different fields of nursing and health care, and a few are long retired.

Ethical concerns and confidentiality

Tasmanian society is quite small and close-knit, and there are many and varied links between the people who live here. It is important for people to be able to continue their relationships with others without feeling embarrassment or shame, and without the possibility of offending or upsetting other people. For this reason, the oral history participants were given the choice of using their own names or choosing another. Most were happy to be identified, one chose a pseudonym and two others asked that only their first names be used. Some interviewees requested that certain sections of their interviews be deleted, although some of these sections have in fact been used, with permission, after de-identifying both third party and narrator. Some other stories have also been de-identified, as they might have legal and/or social repercussions for the teller.

The personal nature of oral history did raise ethical considerations about distress to the participants. In the event, most people appeared to enjoy their interviews, whether the feelings expressed about the subject were negative or positive. Many spoke with great warmth and affection of the residents they had cared for and their colleagues, and took pleasure in committing their memories to posterity; others took the opportunity to put on record their disillusionment and dissatisfaction with conditions they had experienced. Two participants became quite tearful, and one revealed a personal trauma long hidden from all but her closest family; all three were contacted after the interview to ensure they had recovered from the experience and all declined the offer of counselling.

[88] See Appendix 2 for details of participants by role, gender, locality, type of home, and period of employment. A more personal description of each participant and their experience is included in the postscript.

The interviews

Interviews were conducted in settings chosen by the participants, and the duration of the interviews depended on their interest and stamina; most lasted between one and two hours, although several were far longer. At the outset of each interview, participants were invited to tell their story in whatever way they chose. Some did this chronologically, others thematically, and several participants had prepared written statements, which they read into the recorder. When these statements were finished, the interviews proceeded on a question and answer basis using open-ended questions to guide the interviews. These questions were developed from the documentary evidence already gathered, information from other interviewees, and my own experience as an aged care nurse.

During the interviews I noted the participants' body language, level of interest and involvement, and emotional responses to the stories they were telling. Afterwards, I transcribed the interviews myself. This allowed me to immerse myself in the material, to inform both the following interviews and my simultaneous archival searches, and also to analyse the meta-language of the participants as well as their words. The transcript was then cleaned to remove repetition and extraneous words (such 'um', 'ah', and 'you know'), personal non-relevant details, and outside interruptions, and a copy sent to the interviewee to read and edit for accuracy of information. Expletives, grammatical errors and vocal mannerisms were not changed, to preserve the authentic voice of the participant.

At this stage, participants were permitted to delete any information that they felt uncomfortable sharing. As they are identified by name in the thesis, I believe this was an important step to ensure that nobody was embarrassed by disclosing more than they had intended, and they were more willing to be open when they knew they had some control over the finished product. In the end, very few asked for deletions of any kind, and these sections usually involved information about a third party who was not part of the research or comments that were particularly negative or possibly slanderous. The transcript was then coded for analysis.

Analysis, interpretation and theory

> The historian without his facts is rootless and futile; the facts without their historian are dead and meaningless. [History] is a continuous process of interaction between the historian and his facts, an unending dialogue between the present and the past.[89]

My initial analysis was cyclical. Each interview sent me back to the archives for verification or to explore another avenue, and each archive visit gave me new questions to ask at the interviews. Once the interviews were concluded and the chronological framework was completed, I carried out an iterative thematic analysis of both interview and archival data using the NVivo software package for qualitative analysis. Nodes for various sub-themes were set up and the textual material coded into these, along with note links to archival material and photographs. The various nodes were then categorised into sub-themes, which were then synthesised into the main themes which run throughout this thesis under the overarching concept of 'in safe hands'. These themes were 'keeping control', 'making do and good enough', 'the ennursement of aged care', 'for their own good', and 'home and family'.

This thesis is not heavily dependent on theory, because as Janet McCalman points out, history is shaped by ideas rather than theory, as 'events which happen in different times cannot be bound too closely together, because contexts and actors are themselves unique and bound in a particular time'.[90] However, I have drawn on Erving Goffman's concept of the 'total institution'[91] to describe and explicate the ways in which control has been exercised over the residents of nursing homes during the last two centuries in order to keep them 'in safe hands'. I have also adapted the principles of affect control theory in an attempt to interpret the events and actions of the past by examining changing social identities.

Affect control theory

Affect control theory gives us a way of understanding how actions, identities and emotions are linked in order to control social interactions and maintain culturally-based meanings. The basic principles of affect control theory are that affective meanings are

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[89] EH Carr, *What is History?*, (London, 1990/1961), page 30
[90] Janet McCalman, 'Histories and fictions: reclaiming the narrative', *AHA Bulletin*, 84(1997), 31-37
[91] Erving Goffman, 'On the characteristics of total institutions', *Asylums* (Harmondsworth, 1968)

linked to labels for identities and actions. These meanings are derived from one's culture and encompass three dimensions: evaluation (how good), potency (how powerful), and activity (how lively). People 'expect, enact, and interpret actions that will *maintain* these culturally given meanings for the social identities and actions that occur in the situation'.[92] When a person encounters a 'deflection', an event that does not maintain the expected cultural identity, they alter their actions to restore the meaning and minimize the deflection. If the meaning cannot be restored by the action, then the person redefines the meaning of the interaction in order to make sense of it, and this may involve a change in the way the person perceives the event, the identity or the action. The greater the deflection, the higher the stress for the person involved, and the more important to find an alternative interpretation of behaviour to minimize the deflection and return the situation to the culturally accepted norm.

Emotions are affected in two ways. In the first, they are a direct result of the identity held; people with high-status, powerful identities will feel positive emotions, those in stigmatized or low-status identities will feel powerless and negative. In the second, when a person's identity is challenged by events or actions that differ from his or her own expectations, negative or positive emotions will be evoked that will change the way they see their identity and control the way in which they act in the future. For example, a woman might identify herself as a 'nurse' who is therefore 'very good, quite powerful, and very lively', and may see a resident of the Home in which she works as a 'grandfather' and therefore 'good, powerless, and quiet'. If he conforms to these expectations, she will tend to him in the manner that she expects a nurse to act—for example, with kindness and concern. If, however, he is demanding, loud and physically aggressive, the nurse may alter her expectations by re-identifying him as a 'troublemaker', and therefore justify her chosen action of avoiding or even restraining him. In turn, her changed actions affect the way she sees herself and her own identity, and the contrast between the care she feels she should be giving and the actual treatment meted out may cause negative feelings about her role and actions. It is this contrast between expected and enacted reactions and the ways in which they are interpreted that will be discussed in the following chapters.

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[92] Lynn Smith-Lovin, 'Affect control theory' in George Ritzer, (ed), *The Encyclopaedia of Social Theory*, (Thousand Oaks, 2004), page 3

Reflexivity and the interviewer's influence

> Sense-making… is colored by the questions the historian asks. Ask 'what did the experience mean to the informant', and also 'why am I asking these questions?'[93]

Janet McCalman reminds us that oral history is in fact the product of *two* historians, and that the researcher is secondary to the interviewee, who has 'complete and exclusive control of the evidence and has already selected and interpreted the story…'[94] But when the interview finishes, the interviewee's control ends; once the researcher begins analysis and interpretation it becomes their story, so it is important that the researcher's viewpoint and assumptions are clearly understood by both themself and their readers.[95] The researcher chooses what information is collected, what is left out, and how it is analysed, according to their own interests, philosophies and academic purposes.[96]

I am not a neutral party, nor a historian. I am a Registered Nurse, and this has shaped the history I have written. My experience in aged care influenced the questions I asked, how I interpreted the answers and my attitudes towards to the subject.[97] It also affected my relationship with the people I interviewed. On several occasions, my background made the interview possible. Some participants were reluctant to speak to me and could not understand why such a study was being done until I revealed this shared experience, after which they displayed a far greater willingness to share personal memories, both negative and positive.[98]

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[93] Barbra Mann Wall, Nancy Edwards and Marjorie Porter, 'Textual analysis of retired nurses' oral histories', *Nursing Inquiry*, 14:4(2007), 279-288

[94] Janet McCalman, *Struggletown: Portrait of an Australian Working-Class Community*, (Ringwood, Vic, 1988), page182

[95] Boschma et al, 'Oral history research'

[96] Schafer, *A Guide to Historical Method,* (Chicago, 1980); Wall et al, 'Textual analysis'. Post-modernist historians go so far as to suggest that the story is an artistic interpretation that reveals more about the author than the past.

[97] Janet McCalman points out that a person's story might 'be different if told to a member of the opposite sex, of a different age and a different social class' ('Translating social inquiry into the art of history', *Tasmanian Historical Studies,* 5:1(1995-6), 4-15) My background might have encouraged some confidences but also prevented other memories from being shared, and still others overlooked.

[98] Sherna Gluck suggests that this reluctance to be interviewed 'comes from being socialized female in this society'; because women have become accustomed to being sidelined and therefore cannot understand the importance or relevance of their experiences unless this is made explicit to them by the interviewer: 'What's so special about women? Women's oral history' in David Dunaway and Willa Baum, (eds), *Oral History: An Interdisciplinary Anthology*, 2nd edition, (California, 1996). This viewpoint was shown in many of the interviews through such comments as "I don't know if I'm helping at all", "this is probably no use to you", and "it's probably not important".

Assessing the validity of historical research

Central to the veracity of historical research are two concepts: external criticism, which establishes validity, and internal criticism, which establishes reliability by looking at possibility and probability of truth. The nature of the evidence used for this study makes a judgement of authenticity quite simple. The Parliamentary Papers and official departmental records are unlikely to be counterfeit, I conducted the interviews myself, and although the content of the newspaper articles, publicity brochures and advertising materials may be open to question, their provenance is undoubted. As for content credibility, it is suggested that to determine a historical 'fact' either two independent primary sources must agree, or one independent primary and one independent secondary, with no conflicting evidence.[99] In particular, the oral evidence of individuals is not strong evidence in itself (*testis unus, testis nullus:* one witness is no witness). It is true that oral history poses specific problems, relying as it does on reminiscence. A person creates their own version of the past, specific to the time of asking—'not the past as it exactly was, but the past as it seems now'[100], and this must be taken into account.

To address this limitation and strengthen the evidence, I used several approaches. Firstly, I collected the documentary and oral evidence simultaneously, with each source informing the other. Comments made by interviewees were checked against documentary records where possible, with items such as dates, staffing and resident numbers often available in the archives. I also tried to locate participants whose experiences overlapped, either in location or timeframe, to enable corroboration of details.[101] At the same time, activities and actions mentioned in the documentary evidence were discussed with the participants to illuminate details, confirm events and fill in the gaps in the official records. I paid particular attention to accounts that appeared to contain inconsistencies or contradictions, either within one interview or compared to other testimonies or archive material. I found these differences were often simply a matter of opinion (one person's 'safe refuge' is another person's 'closed prison'), or due to the subjectivity of memory

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[99] John Sweeney, 'Historical research: examining documentary sources', *Nurse Researcher*, 12:3(2005), 61-73. Tuchman illustrates this with Aesop's fable about the lion: a lion tells a man "there are many statues of men slaying lions, but if only the lions were sculptors there might be quite a different set of statues" (Barbara Tuchman, *Practising History*, (New York, 1981), page 19

[100] Elizabeth Tonkin, *Narrating Our Pasts: The Social Construction of Oral History*, (Cambridge, 1992)

[101] Participants did not always agree with each other, but such divergences can represent 'two perfectly valid accounts from different standpoints, which together provide vital clues towards the true interpretation': Paul Thompson, *The Voice of the Past: Oral History*, (Oxford, 2000), page 240

rather than a rendering of empirical fact. Such disparities have been made explicit in the discussion chapters where relevant.

In addition, much of the information in this thesis was gleaned from incidental details in records made for other purposes. This adds to their reliability; they are less likely to be distorted or falsified when they are not the main focus of the record, and often cast light not only on the official practices but also give insight into personal and unofficial viewpoints and opinions.[102] Scribbled notes in the margins of official documents can give a piercing insight into the opinions and attitudes of the man (it was usually a man) behind the official title.

Language and discourse

Language is not merely an expression of our understanding of the world, it *creates* that understanding and constructs the way in which we think about ourselves and others.[103] This is so whether the words are written or spoken, but it is particularly illuminating in oral histories. English is a rich language with many diverse elements of speech which convey subtle nuances of tone and meaning. When a person chooses a word from the many possibilities available, whether consciously or unconsciously their choices are shaped by the culture in which they live and the mores of the day.[104] Oral history therefore reveals more than memories about past practices; the language that nurses of different generations use to describe and discuss the same aspects of nursing care are quite revelatory about the changing philosophy behind this care.[105] This is also reflected in the participants' 'moral language'[106], the self-evaluation that takes place as a person realises the gap between what they have just said and what they believe is acceptable to say, expressed in terms such as "isn't that terrible?". Almost every interview included at least one of these moments.

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[102] Jim Sharpe, 'History from below'

[103] M Crowe, 'Discourse analysis: towards an understanding of its place in nursing', *Journal of Advanced Nursing*, 51:1(2004), 55-63; J Smith, 'Critical discourse analysis for nursing research', *Nursing Inquiry*, 14:1(2006), 60-70

[104] Linguist Ferdinand de Saussure speaks of the difference between la parole (speech) and la langue (the language itself); when we speak, we survey the many elements of the language such as words and parts of grammar available to us, and make a usually unconscious decision of which to use to convey our meaning.

[105] Helen Sweet, 'Establishing connections, restoring relationships: exploring the historiography of nursing in Britain', *Gender & History*, 19:3(2007), 565-580

[106] K Anderson and D Jack, 'Learning to listen: interview techniques and analyses' in Sherna Gluck and Daphne Patai, (eds), *Women's Words: The Feminist Practice of Oral History*, (New York, 1991); Sherna Gluck, 'What's so special about women? Women's oral history' in David Dunaway and Willa Baum, (eds), *Oral History: An Interdisciplinary Anthology*, (Walnut Creek, CA, 1977)

Throughout this thesis I have given consideration to the word choices made by the participants, and also to the official language used in the documentary sources. I have avoided changing any nomenclature when quoting from primary sources, whether written or oral. Some of these terms may be considered offensive by today's standards, but they are historically accurate and give insight into prevailing attitudes. Equally, it may be confusing to use multiple descriptive terms for the same phenomenon, but it is necessary to do so to understand the changing culture over the decades. Thus, in this study, invalid depots become benevolent asylums, infirmaries, homes for invalids, homes for the aged, rest homes, nursing homes, and finally residential aged care facilities. Warders become attendants or nurse's aides, then personal carers, then extended care assistants. Inmates turn into patients, then residents or clients. Each of these changes has echoed a change in attitude towards older people and the type of care they deserve to receive, and they will be discussed as they occur throughout the thesis.

A brief background to the 'total institution'

> First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time to the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution.[107]

A 'total institution' is a place in which the barriers that usually separate the different spheres of an individual's life—sleep, play, and work—are removed for the inmates, who live in a world clearly segregated from that of the staff and the outside community. Goffman's original taxonomy identified five groups of total institution: those for work purposes (such as barracks and boarding schools), those for seclusion (monasteries and kibbutzim), those to protect the public from people seen as threats (prisons), those for people seen as threats but who are also incapable of caring for themselves (lunatic asylums, hospitals and leprosariums), and those established to tend to the needs of persons felt to be both incapable and harmless, such as homes for the aged. Goffman

[107] Goffman, 'On the characteristics of total institutions', page 17

admits that the categories are not 'neat [or] exhaustive', but all are characterized by a reliance on formal administration—bureaucratic authority.[108]

It may be difficult to see how institutions as different as prisons, asylums, hospitals and Homes can all be classified as 'total', but can there be varying degrees of 'totality'? Christie Davies proposes a clarification of the concept by differentiating on three aspects: how 'open' or 'closed' the institution is, its official purpose, and how compliance is elicited by the staff of the institution.[109] Each of these three aspects may be further separated into three sub-categories. In a closed institution, the inmates are kept against their will and prevented from leaving; in an open one, they enter voluntarily and are relatively free to come and go; and those in an 'intermediate' category have their freedom severely curtailed but not removed completely. The purpose of the institution may be an end in itself, it may be concerned with some external utilitarian task, or it may seek to transform the inmates. Lastly, the mode of eliciting compliance may be coercive, remunerative, or normative.[110]

In the last two hundred years, Tasmanian Homes have shown characteristics that cross several of these categories, in differing permutations. These varying aspects will be examined in the following chapters, as the model of care for the aged shifts from punishment to welfare in the later 19th century and, in the 20th century, to medicine, and finally, 'Home as home'.

The structure of the thesis

The thesis is thematic rather than chronological, although most chapters follow a chronological course. The chapters overlap in time periods, but each concentrates more heavily on a particular period, showing the changing emphasis of models of care as the decades and centuries pass.

Chapter 2 introduces the theme of 'keeping control', exploring how Homes developed from the early institutions built to house the destitute of the colony, many of whom were

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[108] Goffman, 'On the characteristics of total institutions', pages 11-18
[109] Christie Davies, 'Goffman's concept of the total institution: criticisms and revisions', *Human Studies,* 12:1/2(1989), 77-95
[110] Davies, 'Goffman's concept of the total institution', pages 85-90

aged and infirm, and keep them separate from society. In this chapter, the 'safe hands' were protecting the Tasmanian populace from the threat of pauperism, social disconnectedness and moral degeneracy. The occupants of the institutions were 'inmates', the method of control coercive, and the model of care was firmly rooted in the English Poor Law institutions for social control: the workhouse, the poorhouse, and the asylum. The emphasis in this chapter is on the colonial era. The legacy of the Poor Laws extends into Chapter 3, where the 'rule of less eligibility' governed the institutions, causing them to 'make do' with conditions and practices that were 'good enough' for inmates who deserved or were perceived to need no more, and for the staff who worked within them. In this chapter, it is the budget that is being kept 'in safe hands', and the focus is on the early 20th century.

Chapter 4 examines the stepped progression of the ennursement of aged care, from the introduction of a limited number of trained nurses into the institutions at the beginning of the 20th century, to the renaming of the public Homes as 'geriatric hospitals' and improvements in nurse training and treatments in the middle decades of the century, to developments in the care of patients with dementia in the 1970s and 1980s. The chapter considers the change in the institution from workhouse to hospital, the transition of the inmate to 'patient', and the role of the nurse in this process. The nurse's role is further explored in Chapter 5, which follows the daily routine in the Homes, concentrating on the second half of the 20th century. It was now the patients who were 'in safe hands', as they were bathed, fed, and exercised 'for their own good'. The nurses exercised normative control but could face ethical dilemmas as they provided protective and paternalistic care.

The concept of the Home as 'home' is examined in Chapter 6. This ideology was first mooted in the late 19th century and made official in the 1950s, with the passing of the *Aged Persons Homes Act 1954.* The provisions for funding in this Act caused a blossoming of the sector, and affected both the physical appearance of Homes and their care ethos. Whilst the previous chapters have concentrated on the government-run public institutions, in this chapter the private Homes come to the fore. Patients became 'residents', and in the next few decades the care staff often took on the roles of surrogate family, for each other as well as those they looked after. This chapter reveals in more detail the often concealed or overlooked positive side of aged care.

The final narrative chapter, Chapter 7, revisits the concept of 'keeping control'. It examines the growing weight of paperwork — policies and procedures, rules and regulations, standards monitoring and accreditation systems — that came into practice in the 1980s and 1990s, and that act to control the keepers themselves. Whilst chapter 2 was concerned with how people were kept *inside* the Homes, this chapter explores how they are kept *out*: the assessment teams that have evolved to control the gates to the Homes and regulate who is allowed to enter, and the domiciliary nursing services which serve to keep people in the community for as long as possible. The thesis proper concludes with Chapter 8, which examines the evidence and answers the questions posed at the beginning of this chapter.

A postscript gives more details about the participants in the oral history, placing their aged care experience in the context of their entire working lives, to show the importance and effect of working in an area that brought both great satisfaction and great frustration.

Tasmania

Location of institutions mentioned in text

Outline map of Tasmania © University of Melbourne, 2001

Chapter 2

Keeping control

> Consider the helpless pauperism of improvidence, constitutions ruined by vice and profligacy, asylums and hospitals overflowing with degraded and wretched outcasts, descending to the grave without respect and without sympathy, quitting a world which they had only dishonoured and abused.[1]

The penal colony of Van Diemen's Land began in 1803 when a small contingent of convicts from the colony in New South Wales and the soldiers who guarded them arrived in Sullivan's Cove, in what would become Hobart Town. These first settlers were followed by more convicts, more soldiers, and a small number of free citizens, who began to spread across the island, farming and exploiting the natural riches of the land. The convicts were not held in central penitentiaries, but were sent out into the communities to work as unpaid labour in building public and private infrastructure for the nascent colony. In many ways, Van Diemen's Land was in itself a closed total institution, isolated from the rest of the world and run on strict bureaucratic lines as 'a gaol for the entire British empire'.[2]

The prisoners were housed in convict stations in the various settlements, and small invalid wards were built within these to accommodate those too old, ill or weak to work. Even in those earliest days many of the convicts were advanced in years and suffered from infirmities. The first Lieutenant Governor, David Collins, lamented that he had been burdened with a 'collection of old, worn-out and useless men'[3], some of whom served their entire sentences within these invalid barracks.[4] When their sentence ended, so did this support, and the new emancipists were left to fend for themselves in the community.

The great majority of the newly free were men. Four times as many men as women were transported to Van Diemen's Land, and most of the female convicts found homes and families; no matter what their crime, their scarcity made them desirable as wives and

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[1] John West, *History of Tasmania*, (Launceston, 1852), Vol I, page 306
[2] Babette Smith, *Australia's Birthstain,* (Crows Nest, 2008), page 138
[3] WA Townsley, *Tasmania: From Colony to Statehood,* (Hobart, 1991): the quotation is from a letter written by Captain David Collins, the first Lieutenant Governor of the colony.
[4] Andrew Piper, *Beyond the Convict System: The Aged and Institutionalised in Colonial Tasmania,* unpublished PhD thesis, School of History & Classics, University of Tasmania (Hobart, 2003)

mothers and few ended their sentences alone. It was far more difficult for the men, who had little chance of marriage and family in such a gender-imbalanced society, and even more difficult for old men, who had few opportunities to find work enough to support themselves in old age and little ability to carry it out.[5] Prisoner became pauper.

The large number of convicts sent to Van Diemen's Land resulted in a population with a very different demographic profile to that of New South Wales. Sydney Town had far more free settlers in ratio to convicts, and whereas most of the paupers in New South Wales were poor migrants, the great majority of Hobart Town's impoverished population were emancipists. Although 'free by servitude', they were still considered part of the convict system, and this had a fundamental effect on both the type of support that was considered appropriate for them, and the way in which it would be provided.

In the country they had left, the English Poor Law gave indigent people a right to basic accommodation and care in the poorhouse within their own parish, but there was no Poor Law in the new country, and no formal provisions for shelter or accommodation for the needy. In Sydney Town, the Benevolent Society opened an asylum in 1818 to cater for the destitute, but Van Diemen's Land had a far smaller and less affluent society and could not support a similar charitable body. The government itself had to provide support to all those in need, free settler and emancipist alike,[6] but the small amount of outdoor relief was not sufficient for those with no home or prospects and many old men ended up on the streets. The sick or disabled might be lucky enough to find a bed in one of the small hospitals opening across the island[7], but many homeless and frail old people were arrested, charged with vagrancy and sent to gaol. As the number of homeless and destitute grew, it became increasingly apparent to the public and authorities alike that something more needed to be done.

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[5] Approximately 20% of the 73,500 convicts transported to Van Diemen's Land were female (Alison Alexander, 'The legacy of the convict system', *Tasmanian Historical Studies*, 6(1998), 48-59). Piper states that "three quarters of male convicts were unable to form traditional roles of father, husband and head of household', and that they likely lacked the incentive to work hard and save for old age: 'Admission to charitable institutions in colonial Tasmania: from individual failing to social problem', *Tasmanian Historical Society*, 9(2004),49-53, page 55

[6] RA Cage, Poverty Abounding, Charity Aplenty, (Sydney, 1992)

[7] The largest of these, the general hospital in Hobart Town, housed around seventy old people, mainly women, in its invalid wards until the opening of the New Town Charitable Institution in the 1870s.

This chapter will examine the early institutions set up to accommodate infirm and elderly paupers with no family and nowhere to go. It will show that these were originally intended to be an extension of the penal system, to reform or punish the indigent: closed institutions, controlling the inmates in a coercive model, to keep them in safe and secure hands away from society. It will also trace the legacy of this system in the 20th century, beyond the end of pauperism, showing how the often harsh and punitive conditions continued into later Homes and coloured social attitudes to aged care even up to the present day.

The 19th Century: 'institutions for the necessitous classes'[8]

> The [total institution] is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests or moors.[9]

In the 19th century, the inmates of the pauper institutions were controlled principally through the physical fabric of the buildings and where they were located, as there were very few staff employed to provide supervision or care. In England, the workhouses tended to be built on the outskirts of towns, surrounded by high walls and locked gates to segregate the inmates from the surrounding community. In Van Diemen's Land, although these features were also utilized, they were often reinforced by natural features of the wild and unpopulated landscape. Even when the institutions were moved into the towns they remained separate from the community, the men and women kept behind locked gates, barred windows and a rampart of rules to prevent the mingling of inmates and townspeople. The motivation was twofold: to deny the paupers easy access to contraband, particularly alcohol, in order to facilitate a reformation of sorts, and to protect the respectable citizenry from being importuned by the paupers.

The imperial institutions: New Norfolk and Impression Bay

The earliest accommodation for destitute invalid paupers was opened in 1827 in the old convict invalid barracks at New Norfolk, twenty-four miles away from Hobart Town. The isolated location met with general approval.[10] Using the three dimensions of affect

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[8] TLC, 3, 1858, Paper 37, page 1
[9] Goffman, 'On the characteristics of total institutions', page 16
[10] But not universal; the Deputy Inspector General of hospitals believed that New Norfolk was too far away from the town to allow 'constant observation and surveillance'. Bowden, *The Blind, the Paralytic, the Aged and the Destitute.*

control theory, this is hardly surprising: emancipists were not good (proven by their convict background), they had no power to demand or request comfort and support, and many were very active indeed, despite their infirmities—begging, drinking in public and generally causing trouble. Even those who did not carouse created trouble; their visibility on the streets reminded the respectable citizenry of the presence of the criminal classes among them, and held the threat of moral contagion.[11] Their removal to a safe distance would help prevent the spread of this disease, and was therefore a welcome solution.

The insane and infirm paupers lodged in the various hospitals across the colony or living on the streets were gathered together and moved to New Norfolk. It housed both the free and the free by servitude, who were by far the majority.[12] The original building had accommodation for thirty men only, and it was soon replaced with a new hospital which could house more than a hundred, including a small number of women. The two sexes were carefully kept apart, an arrangement that would continue to be the norm in Tasmanian institutions for the next one hundred and thirty years.[13]

> The ward for the reception of females afford excellent accommodation for about 20 patients, and the Board much approved of the arrangement by which all communication between the sexes is effectively guarded against.[14]

The New Norfolk Hospital took in chronic cases—the sick, invalid and mentally ill. Whilst it was not strictly a home for the aged, a large number of the inmates were in fact of advanced years; the admissions book shows many diagnoses of 'debilitas', or weakness, often used to describe old age.[15] The Hospital was run by a medical officer, but this was the limit of the care provided. There were no paid staff to tend to the invalids. Attendants were chosen from the more able-bodied inmates, often the mentally retarded, who tended to be younger and stronger, and this set something of a precedent for future institutions, as will be seen in the next chapter. But no matter how basic the

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[11] Hamish Maxwell-Stewart, 'Crime and health—an introductory view', in Paul Richards (ed), *Effecting A Cure,* (Launceston, 2006), page 35

[12] Caitlin Bowden, *The Blind, the Paralytic, the Aged and the Destitute: the New Norfolk Colonial Hospital in Van Diemen's Land*, unpublished Honours thesis, School of History and Classics, University of Tasmania (Hobart: 2007)

[13] This was the standard arrangement in the English and American workhouses of the time, which separated inmates only by gender; so old and young, prostitute and orphan, beggar and conman would be housed together: Doreen Norton, *The Age of Old Age*, (Harrow, 1990); David Rothman, *The Discovery of the Asylum*, (Boston, 1971)

[14] From a 1833 report on the New Norfolk Hospital, quoted by Ralph Gowlland, *Troubled Asylum*, (New Norfolk, 1981),page 21

[15] Bowden, *The Blind, the Paralytic, the Aged and the Destitute*

care, for many paupers it offered a far better chance than living a hand to mouth existence in town or country. The hospital filled rapidly with voluntary entrants and many desperate people were refused admission.

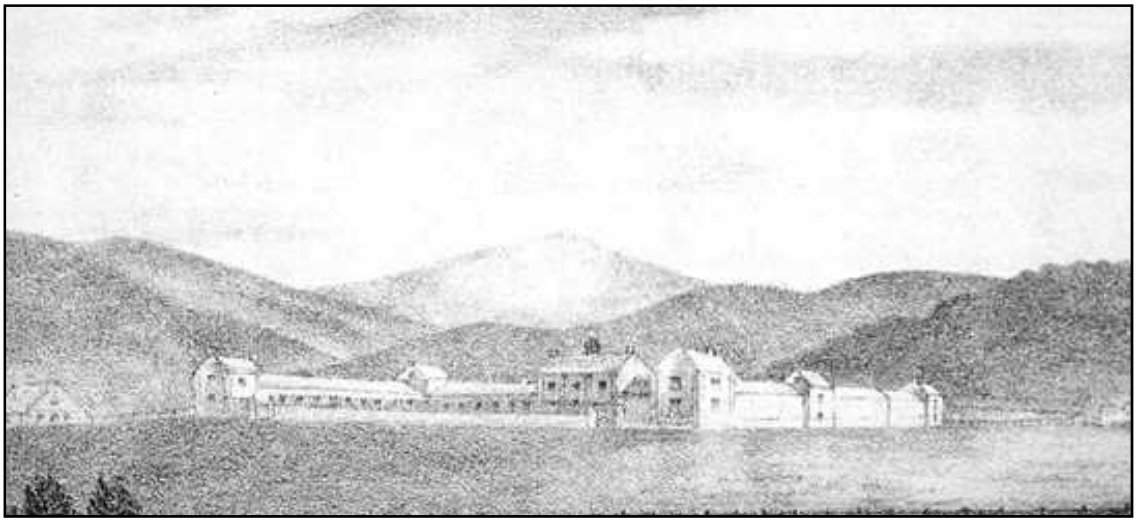

Plate 1: 'Invalid Hospital, New Norfolk' by Henry Melville, 1833[16]

Even those lucky enough to be accepted were not guaranteed of a place indefinitely, as all but the most debilitated inmates were expected to labour in return for their keep. Those who could not but who were nonetheless considered physically capable (such as the blind and the senile) were discharged back into the community when the overcrowding became too great. Here, they often lived and died on the streets, sometimes by their own hand. The *Hobart Town Courier* reported the suicide of one such old man in 1842,

> found … hanging to one of the cross-beams of the creek, below Campbell-street. He was 75 years of age, and had been in the colony since 1818. Necessity is supposed to have been his prompter to the rash deed; and numerous are the instances which daily occur in this town of men—some lame, some blind, some in second childhood by accumulation of years—who, unable to gain a subsistence by labour, are tottering from door to door… Sixty of these unfortunate beings are now adrift on the community…[17]

The newspaper added that whilst it was acceptable to expect people who were able to work to either do so or leave the establishment, they thought that forcing out men who were blind and had lived in New Norfolk for more than ten years 'savours rather of harshness'. The ethical argument of whether a pauper's sinful past could be ameliorated by his or her current infirmity, if weakness could outweigh wickedness, would continue

[16] From the WL Crowther Library, Tasmanian Archive and Heritage Office: item no AUTAS001126077064
[17] The Hobart *Courier*, 4th March 1842, page 3

for the rest of the century, for as long as the ex-convicts made up the bulk of the institutional population. Throughout the 19th century and into the 20th, there would be those who championed the 'poor creatures' and those who dismissed them as 'vicious and dissolute', no matter how frail.

New Norfolk Hospital remained the sole institution for invalids and paupers until 1848, when the chronic overcrowding became too much. The Hospital became a dedicated insane asylum, and the 'general' cases were removed, the women to the Hobart Colonial Hospital and the men to the Impression Bay Convict Station on the Tasman Peninsula.[18]

Impression Bay was even more remote than New Norfolk, being some sixty miles from Hobart Town and cut off by natural barriers of wilderness and sea. The only land connection to the main island was the isthmus of Eaglehawk Neck, a narrow band of land traversed by the Dog Line, a row of guard dogs installed to prevent the convicts from the Port Arthur penitentiary settlement further down the peninsula from escaping on foot.[19] The barracks at Impression Bay accommodated up to 500 people, and the invalids, 'blind, maimed, infirm and debilitated from age, accident and disease', shared the site with probationary convicts (who made up around three-quarters of the total population of the station) and later, an 'overflow of lunatics' from New Norfolk. There was no public protest against sending men who had served their time to live once again with those who were still under sentence, and the arrangement strengthened the link between convict and pauper in the public view.[20] As at New Norfolk, there was medical attention but no nursing care; the men continued to look after themselves.

Van Diemen's Land became 'Tasmania' in 1856, when the colony gained self-government and proclaimed its separation from its imperial past. Transportation had ended three years earlier, and the convict population of the island was dwindling. The various convict stations across the island were closed and the last of the imperial prisoners were consolidated into a single group at Port Arthur, where a new prison

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[18] Dr Garvin Crabbe, *History of Lachlan Park Hospital* (Hobart, 1950); RW Gowlland, *Troubled Asylum* (Hobart, 1981)

[19] Port Arthur commandant James Boyd wrote: 'many of [the dogs] have not been off the chain for years and are consequently very savage': Margaret Harman, 'Dog line at Eaglehawk Neck', *Companion to Tasmanian History*, (Hobart, 2005)

[20] Piper, *Beyond the Convict System;* Ralph Gowlland, *Troubled Asylum*, (New Norfolk, 1981), page 43

building was waiting to accommodate them. They were joined in 1857 by the prisoners and paupers of Impression Bay. Although Impression Bay ceased to be a permanent invalid depot, it continued to be used occasionally as a quarantine hospital (or 'dumping ground', as Piper bluntly puts it) for aged emancipist patients of Hobart Town's General Hospital when space was required for more deserving free citizens during various disease outbreaks during the late 1850s and 1860s.[21]

The Pauper House, Port Arthur

The Port Arthur pauper house was possibly the nadir of the colonial government's efforts to support the old and destitute. Throughout its existence, Port Arthur had been the penal establishment *ne plus ultra*, a place for 'the dyed-in-the-wool offender and those found guilty of the gravest criminal offences or persistent bad conduct'.[22] It had a fearsome reputation in the colony, and was regarded with dread by convict and free citizen alike for both its isolated location and its reputation for cruelty and deprivation.[23] Few of the invalids would have ever set foot there previously, and some still did not want to, disappearing during the journey there or soon after arrival.[24] Their places were taken quickly by others, whose desperate straits made even this 'place of misery' a welcome alternative to the streets and starvation.

In her history of Port Arthur, Weidenhofer describes the arrival of 'pathetic, confused old men … not understanding the reason for the move because they had not committed a crime'[25], but technically, they had; an 1859 newspaper article strongly criticized the fact that 'before the destitute can be relieved they must be transformed into felons'.

> The aged, the infirm, the blind, the halt and the lame, each take their turn at the bar of the Police Office and plead guilty to the heinous offences of sleeping in the open air, of being under sheds, and of having no visible means of subsistence; and for these crimes, the Bench is *compelled* to sentence them to imprisonment with hard labour in order that they may obtain the food necessary to keep their bodies and souls together.[26]

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[21] Piper, Beyond the Convict System, page 40
[22] Lloyd Robson, *A Short History of Tasmania,* (Melbourne, 1997), page 16
[23] Piper points out that the fact that this remote and forbidding site was considered a suitable place to send aged and infirm men demonstrates the harsh attitude held by the authorities towards paupers at that time: *Beyond the Convict System*, page 58
[24] This was particularly so for men from the north of the island, who resented being sent so far from friends and familiar surroundings. In his chapter on 'The care of the aged', BW Griffiths tells of one man, 'Diddie' Slater, who made his way back to Launceston from Hobart twice on foot—a distance of 126 miles. In Clifford Craig, *Launceston General Hospital: First Hundred Years 1863-1963,* (Hobart, 1963),pages 85-6.
[25] Maggie Weidenhofer, *Port Arthur: A Place of Misery*, (Port Arthur, 1990), page 112
[26] The *Mercury*, Thursday, 19th May 1859, page 2

The old men took up residence in the old penitentiary buildings, which had been vacated by the prisoners due to their advanced dilapidation. These proved to be too decrepit even for paupers, and a new Paupers' House was built on the site in 1858. This corralled the men into large open dormitories, the walls lined with beds separated by an eight foot passage.[27] More than 120 men shared four water closets and two urinals, and there was no provision for dining or a day room; but there were fireplaces, which would be sorely needed in the cold and damp of a southern Tasmanian winter (and summer, at times).[28] The whole House was enclosed within a yard, and whilst it might not have been a prison—the men were free to leave, unlike the prisoners—it was certainly carcerative in nature.

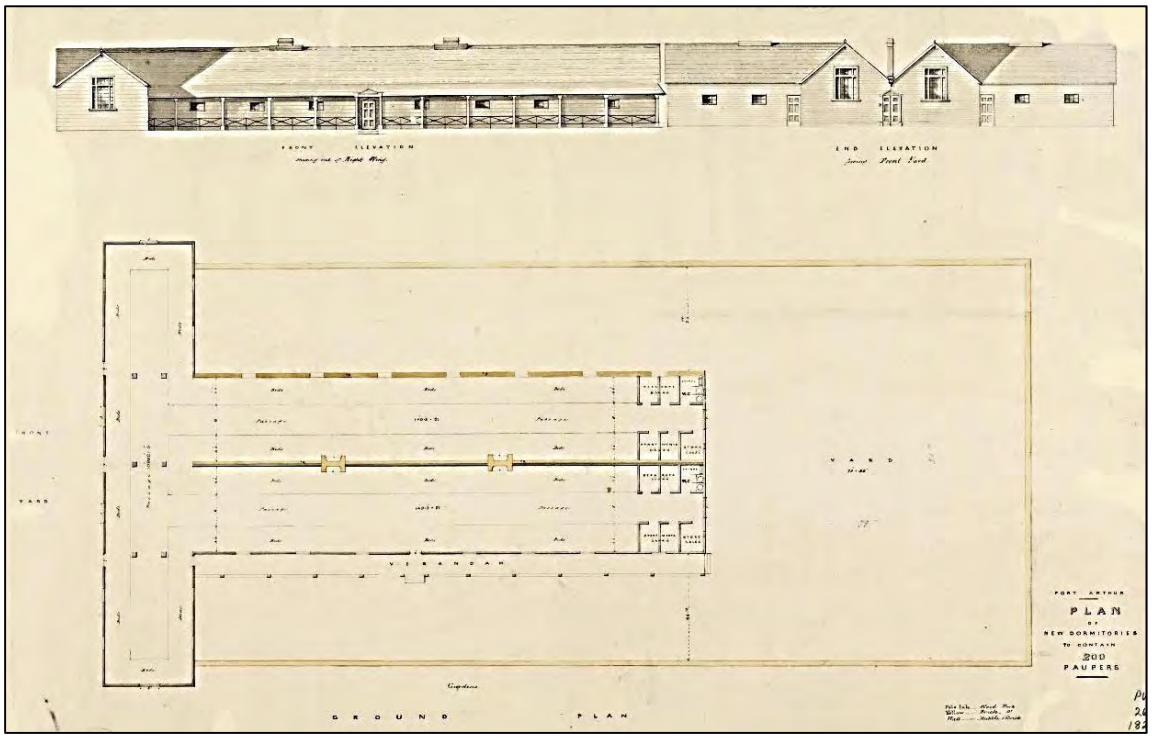

Plate 2: The Pauper House, Port Arthur[29]

[27] Piper states that the use of large dormitories as opposed to smaller, more private accommodation, was instigated at Impression Bay to prevent 'unnatural crime'—homosexual activity—between the men. Presumably this was also the motivation for their continued use in future institutions.
[28] Port Arthur temperatures average around 15°C (59°F) during the daytime and 8° (46°F) at night: see http://www.weatherzone.com.au/climate/station.jsp?lt=site&lc=94157
[29] AOT, PWD266-1-1827: Plan, Port Arthur, Dormitories for Paupers

Not everyone believed Port Arthur to be appropriate for the purpose, or that complete separation of the men from society was beneficial. A Joint Committee of the Legislative Council and the House of Assembly in 1858 reported that the inmates were kept

> under regulations too nearly approaching to those of a Penal Establishment, at the same time cutting off the inmates from the view of nearly all society, and placing them beyond the reach of such sympathy and kind attention as the well disposed might be desirous of offering.[30]

With the completion of the transfer of administration from imperial to colonial rule, there were now a number of buildings in the main town that were no longer needed for convicts or soldiers, and it was suggested that the 'almost unused' Brickfields Convict Hiring Depot, on the outskirts of Hobart Town, would be a suitable replacement. A further recommendation that a similar facility be set up in Launceston to accommodate the destitute from the north of the island, rather than send them south, was ignored. In 1859 most of the men were moved from Port Arthur to the newly adapted Brickfields Invalid Station (Brickfields). The Port Arthur Pauper House continued in use for some years, however, taking the overflow of emancipist men who applied for admission to the general hospital and could not be accommodated at Brickfields.[31] Despite being semi-closed, a Royal Commission into Charitable Institutions in 1871 noted that there were 169 men in the Pauper Asylum at that time[32], and in 1876 more than one hundred men were transferred there when the Cascades Invalid Asylum became overcrowded.[33] When it was finally closed in 1877, there were one and twenty six old men still living in the Pauper House.[34]

The Brickfields Invalid Station, Hobart

> An asylum for the decrepid [*sic*] and cast away, who know not where to lay their heads…[35]

Brickfields appeared to be an ideal solution to the accommodation problem. It was closer to town, making it easier for those of a charitable bent to visit regularly, but still distant

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[30] TLC, 3, 1858, Paper 37, pages 5-6
[31] The *Mercury*, Monday, 8th October 1860, page 2; report from General Hospital Board of Management
[32] TLC, 17, 1871, Paper 47
[33] The *Mercury*, Friday, 28th July 1876, page 2. The newspaper report noted that the move had not been announced, and no provision had been made to care for the 'old and incapable fellow beings'. In the same paper, the Benevolent Society reported that '100 inmates of the Cascades and 23 of the Brickfields had been forwarded to Port Arthur'.
[34] Maggie Weidenhofer, *Port Arthur: A Place of Misery*, (Port Arthur, Tas, 1990), page 121
[35] The *Mercury*, Saturday, 30th May 1874, page 2

enough to keep the invalids isolated from the community. The building was well designed to control the inmates; apart from high surrounding walls, it had two internal quadrangles which could be pressed into service as holding yards to contain the men on Sunday, the superintendent's day off. This close confinement was too much for several local citizens, who complained to the Colonial Secretary and requested that the men be allowed some freedom. The Superintendent of Brickfields, John Withrington, refused this request, on the grounds that the men would go out, get drunk and cause trouble.[36] The notion that another person could oversee them in his absence did not appear to have been entertained by anyone in authority.

Withrington's contention was proven correct when some men found their way into town whilst on leave passes, begging from the populace, spending the money on alcohol and causing 'much trouble and annoyance to the Government'.[37] The authorities naturally bore the brunt of public disapprobation for this misbehaviour; as Goffman points out, when the inmates of a total institution are given access to the outside world, then ' the mischief they may do in civil society becomes something for which the institution has some responsibility'.[38] It was determined that men who went out and returned intoxicated should not be readmitted. Later changes limited town access further, allowing inmates to go out for the day, six at a time, once a month during the summer only, and the superintendent recommended that no leave at all should be granted in the first six months of an inmate's arrival.[39] This prolonged separation from the community after admission to a total institution serves to ensure a 'deep initial break with past roles'[40], a method of depersonalizing the inmate and emphasizing the total control of their new existence by institution rules.

Once again the men were expected to work for their board, either in the depot or its grounds or out in the community. Those who were able engaged in hard labour, breaking stone, making roads and laying footpaths, and twenty were employed at the Public

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[36] Kim Pearce, *Historical Study: North Hobart*, (Hobart, 1992). The Sunday confinement was only one of a series of complaints made by Philip Smith, a long-time advocate for the invalids, and for the convicts before them. He and his daughter, Marian, were both regular visitors to the charitable institutions of Hobart, and he wrote many times to the Colonial Secretary about various aspects of the conditions within: see the *Mercury*, Saturday, 8th January 1876, page 3, for copies of his correspondence.
[37] TLC, 11, 1865, Paper 9
[38] Erving Goffman, 'On the characteristics of total institutions', *Asylums* (Harmondsworth, 1968), page 78
[39] TLC, 17, 1871, Paper 47, page 87: evidence of John Withrington, question 455.
[40] Goffman, 'On the characteristics of total institutions', page 24

Cemetery in nearby New Town.[41] When two visitors suggested that easy entry to Brickfields allowed many of the inmates (who had an average age of seventy-one) to be idle, the superintendent assured them that those inmates 'considered capable of work who refuse to do so are dismissed from the Depot'.[42] Dismissal was the ultimate form of punishment—the fear of losing their place in the only shelter available was enough to keep most of the inmates compliant with the rules—but there were other punishments, too. These included solitary confinement, imprisonment 'with or without hard labour'[43], and loss of privileges: meal rations were cut, the supply of tobacco was stopped, or extra workloads imposed.

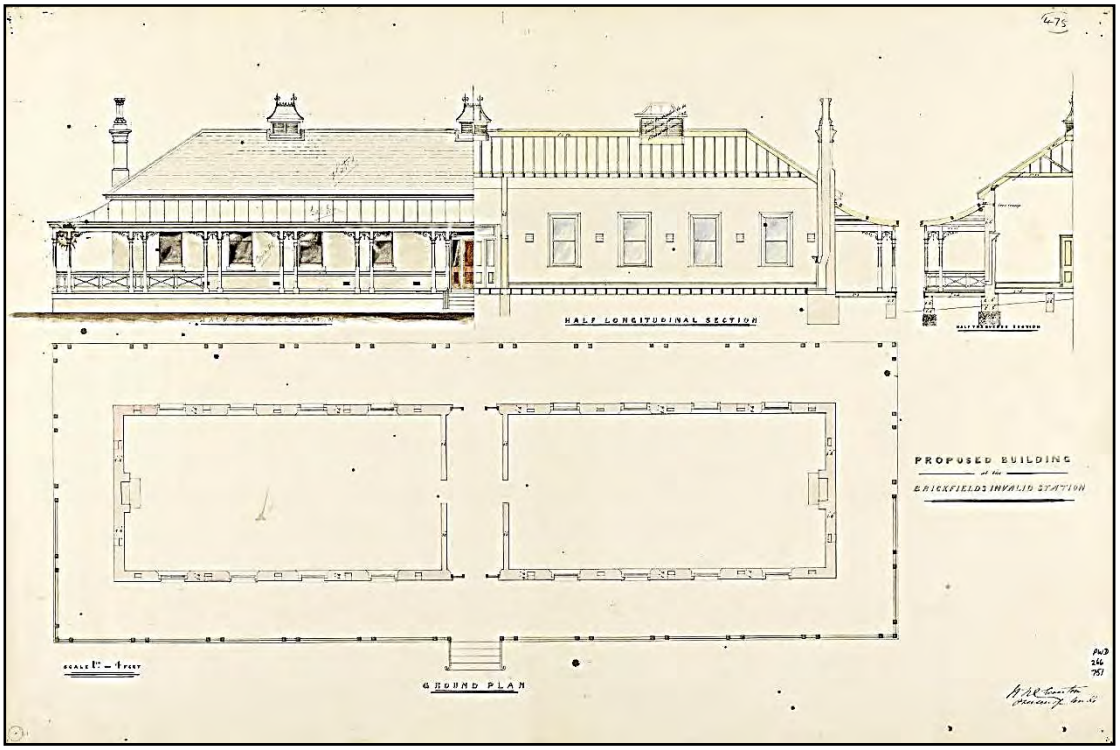

Plate 3: Plan for Brickfields Invalid Station, c1859, showing the inner quadrangles[44]

Life within a total institution depends a great deal on the character of the superintendent, who wields power over inmates and staff alike. Superintendent Withrington was a strict authoritarian, controlling the inmates of Brickfields with the help of a head warder and several wardsmen, chosen from the inmates themselves as a reward for good behaviour and obedience. Although a newspaper report states he did this 'without exercising more

[41] TLC, 28, 1879, Paper 5
[42] TLC, 29, 1880, Paper 8
[43] Regulations for Brickfields Pauper Establishment for Males in the *Hobart Town Gazette*, Tuesday, 25th August 1874, page 880
[44] AOT, PWD266-751: Plan, Brickfield buildings, Hobart

coercion than is necessary to preserve decency and order'[45], it is clear than discipline was his major concern; in 1869 two of the wardsmen were appointed as 'special constables for the purpose of good order and discipline', and an attempt to save money by reducing the meat ration was abandoned not for health concerns but because it was discovered that 'obtaining a sufficient and good diet is the most efficient way of preserving discipline amongst the inmates…'[46] The annual reports regularly extolled the cleanliness of the establishment and the contentment of the inmates, which was 'entirely attributable to the disciplinary arrangements of the Superintendent, and the very efficient manner in which his duties are at all times discharged'.[47]

Another efficient disciplinarian ran the Invalid Depot in Launceston (the IDL), which opened in 1868 in the disused imperial military barracks in Royal Park; the north finally had its own institution for destitute men.

The Invalid Depot, Launceston

> The Superintendent shall have the custody and control of the inmates…[48]

The Board of the Launceston General Hospital administered the IDL but failed in their bid to appoint the superintendent; instead, day-to-day management was taken on by John Cox, the superintendent of the Launceston Penal Establishment.[49] This decision is significant, as an important distinction between types of institutions is their emphasis on the custodial or remedial/therapeutic aspects of care.[50] This is usually dependent upon the relative power position of the staff; an administrator is usually in charge in custodial organizations, and a medical professional in the remedial type. The fact that the government chose to install the prison superintendent rather than a medical man suggests that the foremost purpose of the IDL was correction rather than care.

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[45] The *Mercury*, Thursday, 4th August 1859, page 3
[46] TLC, 13, 1867, Paper 4
[47] TLC, 20, 1874, Paper 6 Report by the Board of Management
[48] Rules and regulations for the Male Invalid Depot, Launceston, in *The Hobart Town Gazette*, Tuesday, 25th August 1874, page 882, rule 1. The rules for all government invalid institutions at that time were substantially the same, with adaptations for local differences such as gender of inmates and staff levels.
[49] Piper, *Beyond the Convict Legacy*, page 81
[50] Nick Perry, 'The two cultures and the total institution', *The British Journal of Sociology*, 25:3(1974),pages 345-355. This mirrored the situation in the English workhouses, where the 'master' was frequently a former prison or army officer, emphasizing discipline and control: John Adams, 'The last years of the workhouse, 1930-1965' in Joanna Bornat et al, (eds), *Oral History, Health and Welfare*, (London, 2000). Superintendent Withrington was an ex-soldier.

The first annual report noted that a paid warder and head wardsman, assisted by five of the most able-bodied inmates, were tending to eighty-nine men, some bedridden, with an average age of sixty-three.[51] The IDL provided accommodation for men from the northern half of the island, 'all districts north of Campbell Town, and from all parts of the coast'.[52] North was better than south, but it was still too far from home for men from the outlying districts, and some inmates absconded or chose to discharge themselves to return to their rural communities. This choice was not appreciated by the Board of Management; emancipists could not expect automatic entitlement to the benefits of charity, but should pay for these with subservience, obedience and gratitude, not rebellion and independence. The Board made it clear how they believed such rebels should be treated:

> Where a man persists in leaving the Institution in spite of the opinion of the Medical officer … he should be … treated as a vagrant, and sent for a term to the House of Correction, where he would learn to appreciate the comforts of the Depot.[53]

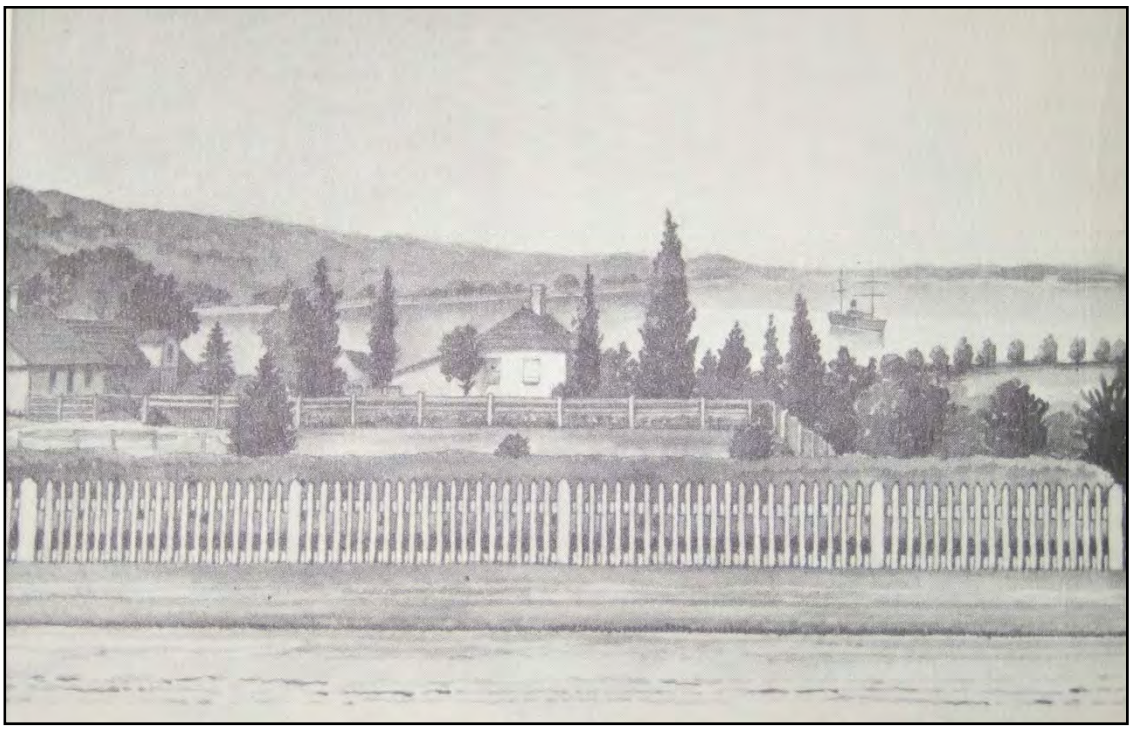

Plate 4: Painting of the Launceston Invalid Depot, Paterson Street, c1868[54]

[51] TLC, 15, 1869, Paper 5
[52] TLC, 17, 1871, Paper 47, page 48, question 66. The map of Tasmania on page 36 indicates this area.
[53] TLC, 17, 1871, Paper 5
[54] From the Launceston General Hospital Annual Report, 1978, page 44

In both Brickfields and the IDL, discipline, order, and regimentation were emphasised, and control overshadowed comfort. The men had to hand over any 'private clothing or other property they may possess' to the overseer[55], and were given a uniform to wear on the premises. This is part of the process that Goffman calls the 'mortification of the self', whereby the person is dispossessed of the trappings of their former life role and becomes an 'inmate' of the total institution, with personal belongings replaced with clearly identifiable institutional items.[56] The *Mercury* reported disapprovingly that the Brickfields uniform had a 'penal aspect[57], made from grey tweed and serge ('in this colony the prevailing garb of convictism') and marked with the letters 'B.I.D.' and the 'broad arrow'[58], also a familiar symbol of the convict system. The similarity of the institutional uniform to that worn by prisoners was indicative of the parallels drawn by the authorities between the two states of convict and pauper. IDL inmates were later allowed to keep their own clothes, providing they were clean and tidy, but this was for reasons of economy rather than the inmates' choice.[59]

The depersonalization process involved other stages: inmates had their hair cut, and were washed and disinfected, although Brickfields had no running water and the IDL did not even have a bath—the superintendent begged for one to be installed, as the 'dirty state' of the inmates on admission made it almost impossible to keep the premises vermin-free.[60] They were examined by a doctor, not just to judge their health status but also to ascertain their ability to work; those who were deemed capable but refused were denied admission. They were also subjected to the routine of the institution around the clock, leaving them with no choice of when to get up, wash, dress, eat, work or rest, and they did all these things together. Goffman states that the 'key fact' of total institutions is 'batching'—the handling of whole blocks of people as single entities without needs or desires—and this was certainly the case in the invalid depots.[61] The men followed a strict routine, regulated by the sound of the bell. They rose at 6am (7am in winter); ate breakfast at 8am and dinner at 1pm, tea at 5.30pm (4.30pm in winter), and went to bed, in complete

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[55] Rules and regulations for the Male Invalid Depot, Launceston, in *The Hobart Town Gazette*, Tuesday, 25th August 1874, page 882, rule 36; again, this rule appears in the regulations for all invalid institutions.
[56] Goffman, 'On the characteristics of total institutions', page 28
[57] The *Mercury*, Thursday, 4th August 1859, page 3
[58] The *Mercury*, Saturday, 20th May 1874, page 2
[59] Piper, *Beyond the Convict System*, page 409
[60] TLC, 18, 1872, Paper 8
[61] Goffman, 'On the characteristics of total institutions', pages 17-18

silence, at 9pm (8pm in winter), when the lights were extinguished and the gates were locked.[62] The gatekeepers had strict orders that they were not to 'on any account allow any Inmate to leave the institution without an order from the Superintendent'.[63]

Prior to the establishment of the IDL, those pauper men who could not make the journey south had been accommodated in the dormitories of the debtors' prison at the Launceston Penal Establishment. Within two years of opening, demand for beds outstripped supply and the male wards in the Launceston gaol were re-opened, to be used by the inmates for sleeping purposes only; they re-joined their fellows during the day for meals, work and recreation.[64] For many theses sleeping arrangements would have been a return to familiar surroundings, and some may have wondered at the difference between being an 'invalid' and a 'disorderly person' imprisoned for vagrancy.

The pauper women of Launceston were also housed in the gaol, in the infirmary ward. They had been there since 1860 and would remain in those quarters until the closure of the IDL in 1912.[65] Whilst these arrangements might be acceptable for ex-convicts, the idea that a woman of good character or gentle birth who had fallen on hard times should be forced inside the gaol was abhorrent to the citizens of the city. In 1879, the Launceston Benevolent Society launched the Launceston Alms Houses Trust, to build two houses to provide shelter for

> …the relief of those infirm and aged women, whose respectable antecedents make them shrink from the Invalid Depot, and who through circumstances over which perhaps they have no control, have been reduced to the lowest depths of poverty and distress...[66]

The houses were to be erected on land donated by a wealthy merchant and devout churchman, Mr Henry Reed, who also provided a large sum of money to the fund for their erection.[67] But despite the fact that the almshouses were intended for respectable old

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[62] The *Mercury*, Saturday, 20th May 1874, page 2
[63] The *Hobart Town Gazette*, Tuesday, 25th August 1874, page 879, regulation 17 (Brickfields),and page 882, regulation 28 (IDL)
[64] TLC, 17, 1871, Paper 5. The gaol cells continued to be used until the IDL closed in 1912.
[65] TLC, 5, 1860, Paper 45. There were ten women in residence there in 1871; one was 'an old servant of Mr Theodore Bartley', who contributed 4s a week to her upkeep in the gaol (TLC, 17, 1871, Paper 47, question 77). This ignominious end after faithful service was not uncommon; Davidoff et al state that 'elderly servants without kin or friends were disproportionately represented in the workhouse' in England: *The Family Story: Blood, Contract and Intimacy, 1830-1960*, (London, 1999), page 166
[66] The *Examiner*, Tuesday, 18th February 1879, page 2
[67] From the obituary of Henry Reed in the *Examiner*, Monday, 11th October 1880, pages 2-3

ladies who had fallen on hard times, in a society that saw pauperism as a 'contagion', their presence aroused some public consternation. Fears were raised that the alms houses would 'disgrace the neighbourhood and depreciate … properties', and the owner of the adjoining land requested that the Benevolent Society pay for half of the expense of a substantial boundary fence.[68]

In the south, pauper women were also accommodated in a penal establishment. They had occupied the Infirmary at the Hobart General Hospital until 1867, when they were moved to a section of the Cascades Female Factory, separate from the female prisoners and their children.[69] They were joined by male paupers from the Hospital and Port Arthur in the same year[70], and by the overflow from Brickfields in 1869. The Cascades Invalid Depot (Cascades) became the third dedicated institution for paupers in the colony.

The Cascades Invalid Depot, Hobart

A misplaced, gloomy old prison…[71]

Cascades was situated just outside Hobart Town at the foot of Mount Wellington, in a dank basin with little sunlight known locally as 'shadow of death valley'.[72] It was a cheerless place, cold and damp, surrounded by high walls made necessary by its close proximity to the city. Whilst the women occupied dormitories, the men slept in the old gaol cells of the old gaol at first, until larger wards were built for them. The cells continued to be pressed into service at times when overcrowding made it necessary.

There was no rest from labour here, either; although frailty and an inability to work were actually prerequisites for admission, inmates were still expected earn their keep. The men, with an average age of sixty-nine, were engaged in 'cultivating the land, carpentry, shoemaking, broom-making, coopering, picking oakum, stone-breaking', whilst the women made and repaired the clothing and bedding and did the washing for the institution.[73] If they refused, they were faced with solitary confinement, imprisonment

[68] The *Examiner*, Thursday, 22nd August 1878, page 3
[69] TLC, 14, 1868, Paper 2, page 3
[70] Piper, *Beyond the Convict System*, page 110
[71] TLC, 17, 1871, Paper 47, pages 83-84: evidence of Dr ES Hall
[72] Pearce, Historical Study: North Hobart
[73] TLC, 16, 1870, Paper 6. This was no different, of course, to the lot of many old men and women in the community; without state pensions, those without means had no choice but to work until they could do so no longer.

'with or without hard labour', or dismissal from the depot.[74] This was still seen as a fitting punishment for pauperism; in 1871 the Tasmanian Parliament placed on record that indigence was entirely due to personal character defects such as 'idleness, intemperance, immorality, extravagance, and a determination … not to work'.[75]

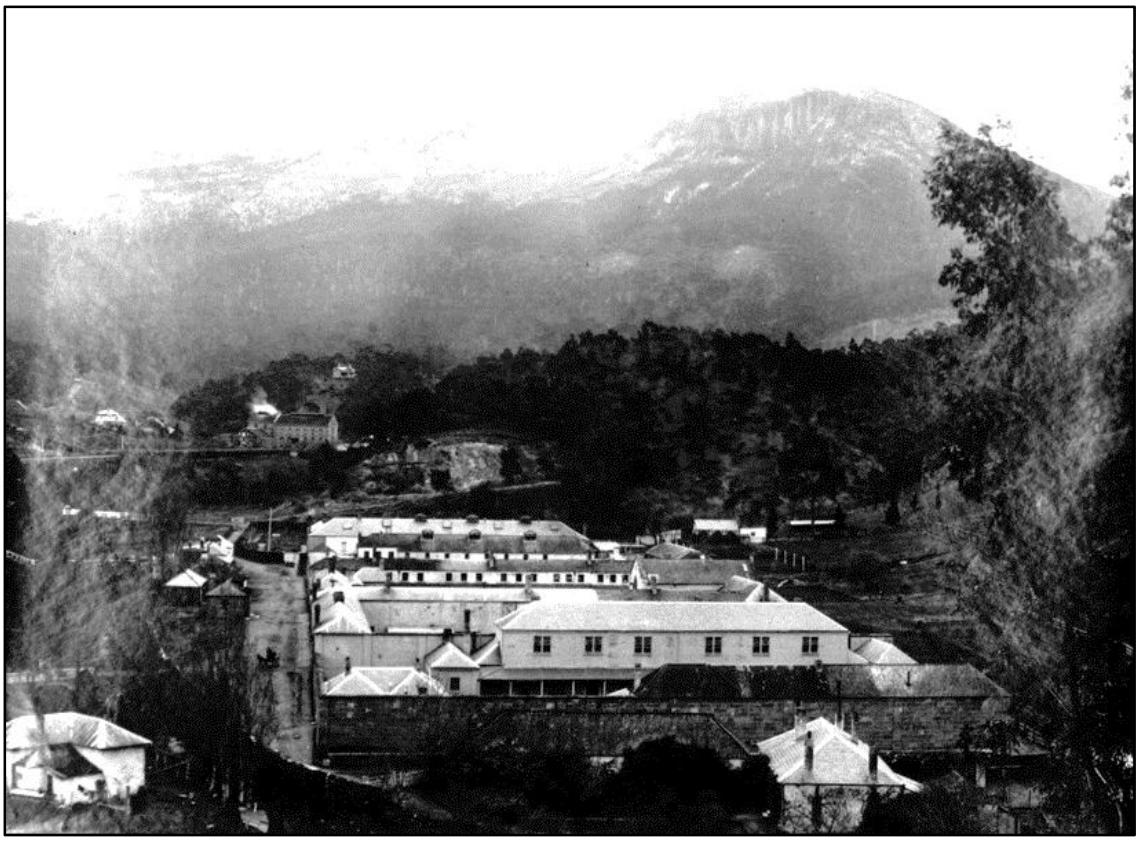

Plate 5: The Cascades Invalid Depot, c1900. The imposing bulk of Mt Wellington and the high walls surrounding the site give the institution a cheerless and forbidding aspect.[76]

Not everyone was quite so harsh in their opinion. In England, there were moves afoot to improve conditions in the workhouse infirmaries in which impoverished elderly people were accommodated, and to afford them some comforts in what was to be their last 'home'. Reformers called for better care and milder discipline. Of course, the English workhouse inmates were not primarily ex-convicts, as they were in Tasmania[77], but still these ideas also gained ground in the colony, softening the public view towards paupers. The annual reports of the institutions, which had previously been almost entirely

[74] Rules and regulations of the Cascades Invalid Depot for Males, *Hobart Town Gazette*, Tuesday, 18th August, 1874, page 871, rule 40
[75] TLC, 17, 1871, Paper 47, page 105: evidence of Mr FS Edgar, Hobart resident, question 637
[76] Pictorial works collection, Tasmanian Archive and Heritage Office: item NS1013-1-45
[77] For example, in 1874, only 25 of the 248 Brickfields inmates were 'free to the colony': the *Mercury*, Saturday, 30th May 1874, page 2

concerned with financial details, began to mention comforts and treats provided to the inmates by charitable citizens. In 1873 the *Mercury* published a lengthy article describing life at Cascades in some detail; the reporter wrote approvingly of the 'substantial' diet, 'ample' clothing and 'comfortable' beds:

> [W]hether their presence in such an institution is due to their misfortunes or their faults, it must not be forgotten that most of them … will ere long depart for "that bourne from which no traveller returns;" and … there is some satisfaction in knowing that many poor old fellows, whose lives may have been misspent, have found an asylum at last…[78]

Ex-convicts, yes, but now 'poor old fellows', a different social identity. Although undeniably bad when younger, now they were weak and quiet, and could therefore be afforded some pity and even kindness in their declining years. Not too much, of course; the reporter also highlighted the very basic nature of the accommodation and the lack of amusement to 'take away from the monotony' of the inmates' lives, but there was no suggestion that such surroundings should be changed materially, and no comment on the fact that, as at Port Arthur and Impression Bay previously, the invalids shared the institution with convicted prisoners still serving their sentences. The link between crime and poverty, prison and pauperism, was clear; but this link was about to be challenged.

The Tasmanian economy had boomed since the end of transportation, and this had brought wealth and more free settlers to the colony. During the 1870s a larger and more powerful middle class began to rise and take charge, bringing a renewed interest in social policy. Respectability was paramount in their concerns, and welfare, education and charity became the weapons of choice to impose their mores and morals on those below them in the social pecking order. Children were a prime focus of the reformers, and orphan children of particular concern.[79] It was decided that they would fare better under the care of foster families than in an institution; as a result, the children from the largest orphanage in the colony, the Queen's Orphan School in New Town, were boarded out and the school was closed.[80] The buildings thus vacated were far more suitable to house old

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[78] The *Mercury*, Hobart, Wednesday, 1st January, 1873, page 3

[79] The argument was that neglected children might become socially destructive and therefore dangerous adults: Tamara Hareven, 'Changing images of aging and the social construction of the life course', Mike Featherstone and Andrew Wernick, (eds), *Images of Aging: Cultural Representations of Later Life*, (New York, 1995)

[80] It is interesting to note that a similar scheme was suggested for old people in 1896 when discussions were being held regarding the introduction of old age pensions. The idea did not gain approval, as the experts

men and women than the dark, damp stone yards of Cascades, and in 1874 the female paupers were transferred there, followed a few years later by the men.

The New Town Charitable Institution, Hobart

> …an idyllic scene concealing the harsh reality of institutional life.[81]

The women were given new accommodation in what had been the Infant Orphan School, but was now renamed the New Town Charitable Institution for Indigent Females (New Town). They were supervised by a matron and a head nurse, and there was some care provided by eighteen of the fittest invalids who were paid two to fourpence a day as 'helpers, or Nurses'.[82] Although there were no high walls surrounding this institution, it was still segregated from the outside community, encircled by extensive parklands, and inmates were prevented from leaving the building by a female doorkeeper. She acted under similar orders as the gatekeepers at the male institutions[83], although she protected only the interior of the building itself, and not the grounds as in the male depots, a reflection of the traditional female domain. To ensure their schism from society, new inmates were not permitted to leave for three months after admission, after which those who wanted to leave for the day were 'occasionally permitted to do so'.[84]

In 1879, the men from Cascades arrived, together with most of the men from Brickfields, taking up residence in two more of the Orphan School buildings, now the New Town Charitable Institution for Indigent Men. These flanked St John's Church, which was dominated by a clock tower, and admission to the institution quickly became known as 'going behind the clock', a term which remained in use until the Home closed in 1994.[85] The phrase suggests a disappearance from society, with connotations of control and subjugation, and this may in fact have been the intention. Graeme Davison suggests that

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believed that no one would be willing to take on the job. Graeme Davison, ''Our youth is spent and our backs are bent': the origins of Australian ageism', *Australian Cultural History*, 14(1995),40-62

[81] Kim Pearce, 'The Queen's Orphan Asylum—New Town', in *Hobart's History: The First Two Hundred Years*, papers and proceedings of the conference held by the Professional Historians' Association of Tasmania, 4th October, 1997, page 19

[82] TLC, 21, 1875, Paper 9

[83] Rules and regulations for the New Town Charitable Institution for Indigent Females, in the *Hobart Town Gazette*, Tuesday, 18th August 1874, page 874, regulation 24

[84] TLC, 23, 1876, Paper 9. This was in line with other charitable institutions, which also enacted a period wherein inmates were confined within the establishment: Piper, *Beyond the Convict System*, page 188.

[85] John Hargrave, 'St John's Park', *The Companion to Tasmanian History; St John's Park Strategic Options*, 'A Report to the Secretary, Tasmanian Department of Health', (Hobart, 1990); interview with Peter Sweeney

'public' time was used in the 19th century as a controlling and disciplinary structure to produce social order, and notes that this 'time-based discipline' was pioneered by former Van Diemen's Land Governor George Arthur, 'the strongest disciplinarian of them all'.[86]

New Town was certainly more comfortable and the location more salubrious than any of the old ex-penal sites, but daily life for the inmates did not change greatly. The stern and penny-pinching John Withrington was superintendent here now, and conditions were still custodial, with no privacy, strict routine and monotonous diet ('ample in quantity, but always the same'[87]), as the daily timetable demonstrates:

8am	breakfast (tea and half a pound of bread)
9am	work commences
12pm	cease work
1pm	dinner (a pint of soup, ¾ lb of both meat and potatoes, ½ lb bread)
2pm	work recommences until 4.30pm
5pm	tea (a pint of tea and half a pound of bread)
7pm	muster bell rung; head warder makes rounds
9pm	silence bell rung[88]

Plate 6: The approach to St John's Park Church and the Queens Orphans Schools, 1872[89]

[86] Graeme Davison, 'Navigating Australia's past', *Tasmanian Historical Studies*, 7:2(2001), 4-15, page 12
[87] TLC, 30, 1881, Paper 9, page 5: excerpt from visitors' book by JH Lefroy
[88] TPP, 15, 1888-9, Paper 50, pages 38-40: evidence of Mr Frederick Seager, Assistant Superintendent and Storekeeper, New Town
[89] Pictorial works collection, Tasmanian Archive and Heritage Office: item no PH30-1-6284

This prison-like routine seems incongruous when set against some of the excerpts from the visitors' book included in the annual reports. These tended towards the warmly congratulatory, with writers expressing themselves delighted with the comfort, cheer and cleanliness of the establishment. These judgements were no doubt relative rather than absolute, the visitors' opinions coloured by the standards they believed to be suitable and appropriate for paupers. Piper points out that the claims of cleanliness, for example, were far removed from reality.[90] For paupers, no matter how weak and quiet, were not 'good', and were therefore still less deserving than other members of the community. Superintendent Withrington made this abundantly clear during an inquiry into conditions at New Town in 1884, when he described the 'nurses' who attended the invalids:

> *Do you find that the nurses who are themselves inmates, meet all requirements*? Yes, with the class of people.
> *Are the inmates principally made up of the criminal class*? Yes.
> *Have you tried any other nurses besides the ones now employed*? Yes; about eight years ago we tried other nurses, but we had to get rid of them, for they were worse than the inmates.
> *Would it not be possible to get a class of nurses who would not fall into the ways of those you had before*? Yes; but it would not be doing justice to bring higher class nurses amongst the class of people in the institution-at present at any rate.[91]

The inmates themselves did not appear to disagree with the official opinion. One visitor who quizzed the old men reported that they were 'not only thoroughly satisfied and comfortable, but much better cared for than their own or their friends' circumstances would admit of procuring outside the Institution'.[92] It is true that with no welfare support beyond the meagre provisions of the government's newly re-established outdoor relief provisions, life on the outside would have been difficult; overcrowding, basic food and strict routine were far better than homelessness.

As in England and America at that time, the government institutions were becoming *de facto* aged care homes.[93] In the final decades of the century, between eighty to ninety per

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[90] Piper, Beyond the Convict System, pages 225-226
[91] TPP, 6, 1885, Paper 154: Administration of charitable grants: report from the select committee with minutes of proceedings and evidence; evidence of John Withrington, questions 231, 232, 234, and 235
[92] TPP, 11, 1887, Paper 10.
[93] Lavinia Dock, 'A neglected field of nursing: the county almshouse', *The American journal of Nursing*, 6:8(1906), 25-26; Doreen Norton, *The Age of Old Age*, (Harrow, 1990); Dieckmann, 'From almshouse to city nursing home: Philadelphia's Riverview Home for the Aged', *Nursing History Review*, 1(1993), 217-22; Ellen Schell, 'The origins of geriatric nursing: the chronically ill elderly in almshouses and nursing homes, 1900-1950', *Nursing History Review*, 1(1993), 203-216.

cent of the inmates were aged fifty-five or more, and a great many were living beyond eighty.[94] They were also still overwhelmingly emancipists, but this fact now cast a different light on the situation. Whereas previously a criminal background had removed any public sympathy and made destitution a natural consequence of their sins, it was now recognized that the convicts were 'often treated in such a manner as to unfit them, when given their freedom, to provide for their declining years…'[95] This opinion was not shared by all, of course; old attitudes die hard. At the First Australasian Conference on Charity held in Melbourne in 1890, Alderman Crouch from Hobart somewhat uncharitably identified the cause of the pauperism of the men and women in New Town as

> Drink; unhesitatingly drink… It makes men lazy, wretched, quarrelsome, crazy, and criminal. … Drink fills our gaols and hospitals, and crowds our benevolent and lunatic asylums. Can anyone deny that drink is not the principal cause of pauperism and the helpless condition of the poor?[96]

Alderman Crouch was about to discover that poverty was not always alcohol-related. The final decade of the 19th century saw the end of the economic boom that had boosted Australia's fortunes and population, and depression swept the country. The Tasmanian government felt the effects of this severely, and began to search for ways to economize. The charitable institutions were a substantial drain on government finances, and in Launceston, the positions of Under-Gaoler at the Penal Establishment and Resident Overseer of the IDL were amalgamated to save money, showing the correlation between pauper house and gaol was still strong.[97] A decline in the number of inmates at New Town suggested one solution: close the IDL and transfer everyone in it to New Town to take up the empty beds. This suggestion was strongly resisted by Northern citizens:

> …there are many who have relatives and friends living in or near Lton [*sic*]and who visit them and occasionally take some few comforts which the depot does not provide… I admit there are many of these old men who have been very bad in their day ... but none too bad for the 'Lord Jesus Christ' to own … these poor old people ought not to be treated unkindly, now they are helpless…[98]

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[94] Andrew Piper, 'Admission to charitable institutions in colonial Tasmania: from individual failing to social problem', *Tasmanian Historical Studies*, 9(2004), 43-62 The statistics in Appendix 3 show that the percentage of the population aged 80 or more almost doubled between 1871 and the turn of the century, and women nearly tripled.
[95] TPP, 15, 1888-9, Paper 50, page xxi: Report of the Royal Commission into Charitable Institutions
[96] Ronald Mendelsohn, *The Condition of the People*, (Sydney, 1979), pages 88-89
[97] TLC, 23, 1891, Paper 15
[98] AOT TRE1/1/2406 4670 Proposed removal of the Invalid Depot from Launceston to Hobart. Letter from Mr EL Ditcham to the Treasurer, Sir Philip Oakley Fysh, 15th June 1894. Mr Ditcham had been Chairman of the Launceston Benevolent Society, and a member for over forty years.

The Treasurer replied that it was the duty of the government to 'study economy in every possible way' and that closing the IDL would save £600 a year. Others agreed, and could not see why ex-convicts should be mollycoddled in this way; the gulf between 'deserving' and 'undeserving' poor was still unbridged.

> …whilst our poor, who by unfortunate circumstances have become indigent in their old age, should not be bundled to the other end of the island against their wish, sentiment is thrown away on men … who have led vicious and dissolute lives. They should have no say in where they should be kept from starvation at the expense of the saving and industrious.[99]

In the end, the northern protesters won; the decision was made instead to hand the day-to-day management of the institution to the Launceston Benevolent Society.

The Launceston Benevolent Asylum

The Benevolent Society took over on the first of January 1895 and the IDL became the Launceston Benevolent Asylum. Despite dropping numbers, there were still more inmates than beds and some men continued to sleep in the gaol. This drew some impassioned indignation from at least one member of the public:

> …this state of affairs should no longer be allowed to exist in our midst. It is inhumane. It is a mockery to Christianity. It is a disgrace to the authorities. Is it possible to find a parallel state of affairs existing in any part of her Majesty's vast dominions as free men housed in unhealthy cells in HM gaol, not for crime … but on account of their poverty and infirmities?[100]

The writer called on the government to finalise the problem by building a new and suitable Benevolent Asylum in Launceston, and his was not the only voice crying out for change. On the brink of a new century, it seemed that a turnaround had been achieved; no longer banished from society, 'out of sight, out of mind' and held solely responsible for their own sad circumstances, penurious old people were now increasingly being recognized as having a right to be part of the greater community, and worthy of some consideration and care. A new generation was rising to power that had not experienced the convict era, and did not have their attitudes towards the destitute coloured by the old perceptions of the 'convict stain'.[101] The local newspaper expressed approval that the days when poor old people

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[99] Letter from 'Diogenes' to the *Examiner,* Friday, 12th April 1895, page 3
[100] Letter from Mr WC Wilson to the Launceston *Examiner*, 21st September 1900, page 3
[101] Joan Brown, *Poverty is Not a Crime*, page 152

> …who were no longer able to maintain themselves were treated like so many dumb, driven cattle, are fortunately gone forever. We may not be able to do more than supply them with the bare necessaries of life, but if their lot can be lightened by the companionship of those they knew in brighter days so much the better.[102]

It was the beginning of a social upheaval that would continue to build over the next few decades and bring great changes to the provision of care to the aging population of the island; but it was, after all, only a beginning. There was a long way to go.

The 20th century

Inmate numbers at both Tasmanian institutions continued to fall. By the turn of the century the Launceston Benevolent Asylum had an average of one hundred and forty people in residence, and New Town sheltered around four hundred inmates.[103] This did not mean that the government could make great savings, however; the majority of the inmates were between seventy and ninety years old, and costs were rising because more help was needed to care for these frail people. Once again the argument was made for amalgamating the two institutions into one, in the South, and once again the people of the North fought against it.

In 1902, seventy-two inmates were removed from Launceston to New Town, although fifteen were returned to the IDL soon afterwards due to public outcry.[104] A smallpox epidemic in 1903 brought some small benefit; an outbreak amongst the Launceston inmates brought any further talk of closure to a halt for the time being, as the local *Examiner* gleefully reported.[105]

> We kept our old and halt and lame
> Within the city wall,
> That they might end their days in peace
> And see their friends withal.
> It broke our hearts to think that they
> Down south should have to pack,
> And so we did our level best,
> And got them all brought back.
>
> And now the small-pox we have had,
> A-going it full bat,
> You may be quite surprised to hear
> Down south they don't want that.

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[102] The *Examiner*, Thursday, 20th September 1900, page 4
[103] TPP, Vol 43, 1900, Paper 22
[104] TPP, Vol 49, 1903, Paper 37
[105] The Launceston *Examiner*, 13th August 1903, page 7

It's got among the invalids,
No man can well say how,
But this is Hobart's chance to shine;
Does it want the Depot NOW?

A compromise was made; current inmates would be allowed to remain at the IDL, but new admissions would be sent to Hobart. In the meantime, the institution had proven to be financially impossible for the Benevolent Society to manage; in 1905 the state government resumed responsibility and it officially became the Invalid Depot once again.

Both public institutions now came under the supervision of the New Town superintendent, Frederick Seager. Seager was a more compassionate man than his predecessors, less affected by the influence of the convict system. A long-time employee at New Town, as a junior officer he had strongly advocated for proper nursing care and greater comforts for the inmates of New Town, and he was able to achieve many of these aims when he assumed authority. Those inmates who needed nursing care now received it from paid employees, and those who could care for themselves were granted '[m]uch freedom'[106]; the men were allowed to go out after 'cease labour' at 4.30 and at weekends, and all inmates were encouraged to go out with friends one day a week.[107]

This was a great paradigm change; never before had 'freedom' been mentioned in relation to the inmates of the state institutions. This change in attitude regarding the running of these establishments may in part have been due to the age and frailty of the inmates (more than half were over seventy), but it probably also stemmed from the fact that the majority of them were now free-born; by 1908 only a quarter of the New Town inmates were ex-convicts, and in Launceston, the figure was even lower at just over eighteen per cent.[108] Without the convict stain to colour their character, care could be more compassionate. This did not mean that control was to be relaxed entirely, of course. When Matron Biggs of the IDL died in 1909, she was fêted as 'a most efficient officer, a good disciplinarian, and highly respected by all'[109], and despite the nod to freedom, Seager's second-in-

[106] TPP, 57, 1907, Paper 26
[107] TPP, 53, 1905, Paper 53
[108] TPP, 61, 1909, Paper 23 (IDL) and Paper 30 (New Town)
[109] TPP, 63, 1910, Paper 31. When her successor, Matron Baker, died in 1926, the annual report eulogized her 'devotion to duty and kindly disposition' (TPP, 97, 1927-28, Paper 49, page 4),and the she was praised in the local newspaper as a woman of 'many sterling qualities', but not as a disciplinarian: the *Examiner*, Thursday 30th September, 1926, page 7

command received a change of title in 1912 from 'head warder and storeman' to 'head warder and discipline officer'.[110]

By then there were only thirty-one men and twelve women left in the IDL, and numbers continued to fall. The extremely dilapidated building finally closed its doors in 1912, and a smaller scale Home for Incurables was planned, with two wards for eight patients each.[111] It opened in May the following year as the Home for Invalids.

Plate 7: The inmates of the Launceston Invalid Depot with Matron Biggs, c1905[112]

The Home for Invalids, Launceston

The Home for Invalids (HFI) was distinctly different from its predecessors, being built on a domestic rather than institutional scale and design, but it was still a total institution. The change of name from 'depot' to 'home' might suggest domesticity, but the occupants were still 'inmates' and there were still barricades to keep them from the outside world: a

[110] TPP, 69, 1912-13, Paper 56
[111] AOT, PWD18/1/9937 Letter from Chief Secretary to Minister of Land and Works, 10/5/1911
[112] Pictorial works collection, Tasmanian Archive & Heritage Office: item no LPIC144-1-115

'new 6 ft paling fence with 21 chains' was erected around the property.[113] This was still in place in 1948, when Eleanor started work there as a semi-trained nurse:

> There was barbed wire on top of the fences and big gates with chains around them. I don't think anybody could have escaped![114]

Although housed under the one roof, the male and female inmates were carefully separated, in this case by a central block housing the kitchen, offices and Matron's quarters. In later years, this segregation even extended out into the grounds, where a fence 'of the cyclone type' was erected to divide the male and female sections. There is no record of what those in authority thought was going on at the Home, but they took things seriously; the Director of Public Works recommended that a

> …chain mesh wire fence and gate be erected at [the] lower end and a 6 ft paling fence be erected across [the] near lawn…[115]

Apart from the name, there were other changes to the institution. Gone were the male overseer and warder; now the matron, who had previously only supervised the female inmates of the IDL, was in charge of the entire establishment. This move from male figure of authority to female suggests a shift in focus from correction to care; matrons were usually in charge of the domestic sphere within institutions—housekeeping, nursing—whilst administration and discipline were the forte of the male superintendents. At the HFI, the Matron fulfilled both roles, supervising the domestic and nursing staff and managing the day-to-day routine of the Home. Matron Baker was 'most assiduous in her duties', running the Home and carrying out all the clerical duties efficiently, although she did have access to a little male assistance when necessary:

> The arrangements made last year for a responsible male officer to visit the institution periodically, and assist the Matron in any cases of discipline, has proved very satisfactory, and the Matron has rarely found it necessary to requisition his services.[116]

The low number of disciplinary issues was probably due to the differences between the inmates of the HFI and those who had been accommodated in the old IDL. Not only were numbers evenly divided between men and women (the men had far outnumbered the

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[113] AOT, PWD18/1/9937 Letter from Chief Secretary to Minister of Land and Works, 10/5/1911
[114] Interview with Eleanor
[115] AOT, HSD1/1/5175 99.16.39 Memo from Director of Public Works to BM Carruthers, 6/12/1939
[116] TPP, 81, 1919-1920, Paper 40

women in the previous century), but practically no-one was an ex-convict.[117] They were from the lower classes, certainly, but they were no longer tarred with the brush of moral degeneracy—unless it suited the authorities to do this in order to justify poor conditions and ill treatment, as would occur periodically over the next few decades.

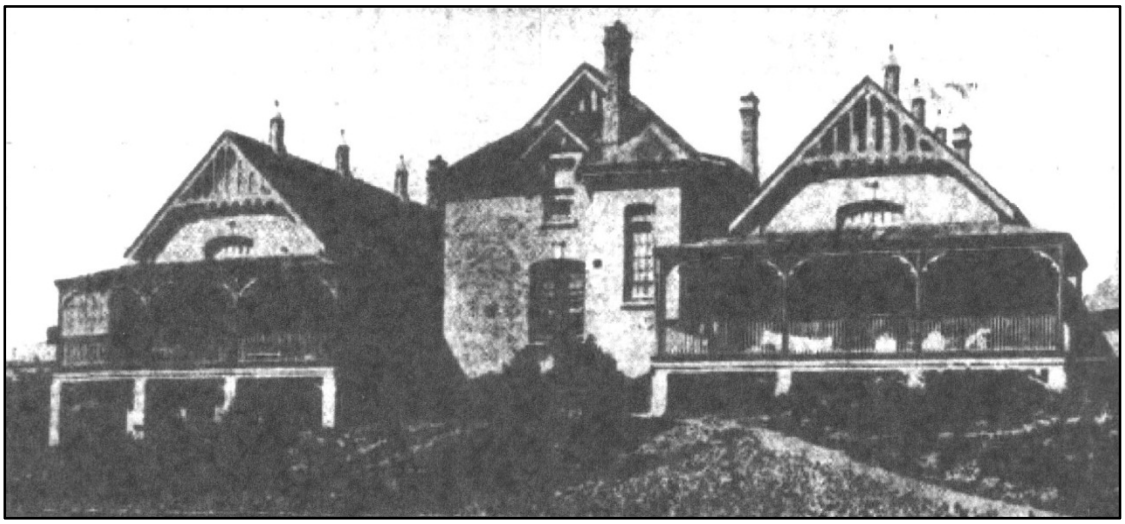

Plate 8: The Launceston Home for Invalids[118]

The inmates were still subject to a certain amount of organizational discipline, however, including the continuation of practices associated with mortification of the self, a characteristic of the total institution wherein 'parts of the body [which] may conflict with efficient management … may be resolved in favour of efficiency'.[119] After one man resisted the removal of his moustache, the Department of Public Health issued an edict that 'patients shall have their moustaches and beards removed as soon as possible after admission, unless special representations are made to retain the same'.[120] It was easier for staff to wash a clean-shaven man, and staff convenience outweighed inmate preference.

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[117] Alison Alexander states that the last remaining imperial convict, Catherine Kean, died in 1925 at the age of 93: *Tasmania's Convicts* (Crows Nest, 2010),page 202

[118] The *Examiner*, 2nd August, 1928, page 5. Despite intensive searches in the archives and other official records, this photograph is the only one found of the HFI; no official photograph appears to exist of the building or its staff or inmates. Similarly, there are no interior shots of the 20th century New Town/St John's Park buildings, whereas there are many photographs in the archives of other government health care institutions such as the general and rural hospitals, and their wards, nurses, and patients. Megan Davies noted a similar lack of images of the Vancouver Old People's Home, and suggests this is an indication of the poor regard in which the institution was held: 'Renovating the Canadian old age home: the evolution of residential care facilities in B.C., 1930-1960', *Journal of the Canadian Historical Association,* 12:1(2001), 155-175, page 158.

[119] Goffman, 'On the characteristics of total institutions', page 77

[120] AOT, HSD1/1/5416

The two government institutions continued to provide for the island's elderly poor throughout the First World War and the Great Depression, but as the 1930s dawned, the notion of 'charity' began to carry a sizeable stigma. It seemed condescending, suggesting an image of the great and wealthy doing good to the less fortunate, who were perhaps not wholly deserving of this beneficence.[121] This attitude was now seen as Victorian, out-dated, and the Tasmanian government reacted accordingly. The Charitable Institutions Department, which ran the HFI and New Town, became the Social Services and Children of the State Department in 1934, and New Town became the New Town Rest Home. The superintendent noted that this name change was 'greatly appreciated by the inmates and the public generally, and is more in keeping with the work which is being carried on in the home'.[122]

New Town might now officially be titled a 'rest home', but there was little rest for the inmates, who were still expected to carry out many tasks around the buildings and grounds.[123] The custodial atmosphere also lingered; this was partly due to the buildings, many of which were unchanged from the 1830s, but there were also many rules and regulations still in place to depersonalize the inmates. They continued to be issued with institutional clothing to replace their own garments, which were packed away in storage on admission, and although the women were now wearing more modern and attractive dresses, their feet were still encased in 'heavy lace-up boots of a very old fashioned and obsolete type', made by prisoners at HM Gaol for ten shillings a pair.[124] Rules were rigorously enforced when necessary; Henry Coleman, aged ninety-three and 'living alone in a hut in Zeehan', was brought in

> almost blind and very feeble, … in an advanced state of senility, and very dirty, and only able to get about with great difficulty … owing to his unstable mental condition he is very resentful of various offices which the staff have to perform for him, such as trimming his beard, and cutting his hair, which can only be done by one officer restraining him whilst the other uses the clippers.[125]

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[121] Ronald Mendelsohn, The Condition of the People: Social Welfare in Australia 1900–1975, (Sydney, 1979), page 120
[122] TPP, 113, 1935, Paper 43, page 3
[123] As late as the 1960s, male inmates were expected to wash up, mop floors, stack wood, and fill wood boxes: AOT, HSD222/2/2
[124] AOT, HSD1/1/5141 98.7.39 Memo from L Woodhouse to Director of Public Health, 27/1/1939 Approval was requested and granted to supply them with shoes instead, which had the added advantage of being two shillings cheaper. At least their clothing was made for them; Megan Davies notes that some Canadian Homes in the 1930s issued their inmates with clothes donated from local funeral parlours 'not required by the undertaker': *Into the House of Old*, (Montreal, 2003), page 117
[125] AOT, HSD1/1/5144 98.11.39 Memo from Supt Woodhouse to BM Carruthers, 13/3/39

Lack of privacy remained an issue, and there were no provisions made to allow personal belongings, which might have made it more home-like. In fact, inmates were positively discouraged to bring anything in with them, as the Department made it clear upon admission that they would 'accept no responsibility for any articles which are retained by the patients in their rooms.'[126]

Towards the end of the 1930s the new field of geriatric medicine began to influence the way in which care was provided to old people throughout the Western world[127], and Tasmania was no exception. As the model of care changed from welfare to medicine, control of both state institutions passed from Social Services to the Department of Public Health. In a final attempt to cast off all the stigma of charity that tainted the public institutions, the Director of Public Health suggested that a new name be found for the HFI[128]; this was not approved, but New Town was given yet another new identity. It adopted the title of the church at its heart, and became St John's Park.

St John's Park, Hobart

St John's Park was now officially designated a 'geriatric hospital', but it still retained many of the prison-like characteristics of the total institution, including the use of the term 'inmate' for the occupants of the non-medical wards ('patients' was reserved for those people in the hospital wings, to differentiate them from the others). The inmates continued to be carefully supervised by the staff, who followed an official set of *General Instructions* which contained one hundred and nine regulations, many multi-layered, setting out their duties. Amongst other things, the Chief Attendant and the Matron were responsible for 'the discipline and cleanliness of the staff employed, and patients housed'; the Senior Officer for inspecting, once a month, 'patients' private belongings … with a view to preventing hoarding of institutional clothing' (interestingly, there was no similar rule for the women's division); and the attendants and nurses were enjoined to use persuasive means when a patient refused to obey the rules, requesting the assistance of other attendants if necessary 'so that the patient may see the futility of resistance and thus

[126] AOT, HSD6/1/5190 98/5/1 Memo from Superintendent Trebilcock to Minister for Health, 28/1/60
[127] John Grimley Evans, 'Geriatric medicine: a brief history', *British Medical Journal,* 315(1997):1075-1077; John Morley, 'A brief history of geriatrics', *The Journals of Gerontology,* 59A:11(2004) 1132-1152. The development of geriatric medicine as a speciality will be further explained in chapter 4.
[128] AOT, HSD1/1/4048 99.13.38 Memo from BM Carruthers to Minister for Health, 1/11/38

avoid a struggle.'[129] No such printed guidelines existed for the HFI, where rules and routines were set by the matron, and this was to cause a great many problems.

'More like a gaol…': the Public Inquiry into the HFI

A public furore erupted in 1947 when local politician RJ Turnbull claimed that the HFI was 'more like a gaol than a home for the infirm'. In an incendiary article in the Hobart *Mercury*, he stated that inmates were 'subject to harsh discipline [and] petty punishment for infringing rules'.[130] As the person making the rules and inflicting the punishment, Matron McClymont was clearly in the spotlight as the villain of the piece.

An inspection visit revealed long-standing and ongoing problems between the Matron, her staff and many of the residents.[131] This precipitated a Public Inquiry, in which the committee heard that the inmates were subject to all manner of rules and regulations devised by the Matron ('there are no printed rules … whatever Matron says goes'[132]), and that punishment was meted out for even minor transgressions of these rules. Mrs Clark claimed to have been put to bed early for five days after coming back from an outing ten minutes late, and said she was not allowed to speak to any other patients. Attendant Boley told of Mr Coleman, a 'very clean gentleman', who had irritated the Matron and was put in the 'dirty ward' on an old mattress, which upset him greatly. When another patient died, Boley asked if he could exchange the mattresses; Matron said no, but he did it anyway. This caused a great deal of discussion by the Committee, who were universally condemning—not of the patient's treatment or the matron's attitude, but of Boley's disobedience.[133]

Boley's action might have been motivated purely by a wish to help the 'very clean gentleman', but it was seen by those in charge as a deliberate act of defiance, an assault on the matron's authority—and it may very well have been so. The Inquiry found there was no love lost between the matron and her staff. Dr Turnbull said that Matron McClymont dealt out arbitrary punishments based on her personal likes and dislikes of

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[129] *General Instructions for the Efficient Working of St John's Park,* Public Health Department, (Hobart, 1948)
[130] The *Mercury*, Saturday, 7th June, 1947, page 7: 'Home for Invalids "Like Gaol"'
[131] AOT, PSC2/1/83 7C/47 Memo from Mr Parry to Public Service Commissioner, 15/5/1947
[132] AOT, PSC2/1/83 7C/47 Evidence of Mrs Clark, inmate
[133] AOT, PSC2/1/83 7C/47 Evidence of Attendant Boley

patients; he suggested that the staff 'apparently have human instincts'[134] (the implication was that Matron did not), and this led to conflicts due to her 'too zealous' administration of the Home. The nurses and attendants appeared to agree that their superior was too harsh; Nurse Lee attested that Matron 'has [the patients] crying pretty often, two or three of them at a time sometimes. She won't let them get together to have a laugh or chat. She does not like hearing people laugh or enjoy themselves'.[135] Cook believed that the patients were suppressed by the matron; she said she would not have come to the HFI 'if I had known how the atmosphere was here … I did not realise it was a bad as it is'.[136]

There were some voices raised in defence of Matron McClymont. Dr Roberts, the HFI's official doctor, was firm in his support, stating that he 'knew of no instance where the matron was vindictive or harsh towards the patients, in effect she was most kind and he had received no complaints from any patients.'[137] But Dr Roberts was rarely there; he visited once a week (or less—Dr Turnbull said darkly, 'he is supposed to but does he'[138]), and he was firmly on the side of the authorities rather than the inmates. One of the longest resident inmates agreed with him, telling the Committee that the HFI had improved one hundred per cent in the twelve years he had been there, and he was 'very happy … and well looked after'.[139] This may have been the case, or it may not; Mrs Damien, a regular visitor to the HFI, mentioned that inmates had told her 'about being unhappy but won't let their names be mentioned because they are afraid they will be punished'.[140] This is always a difficulty in a total institution; how can you complain about those who hold such power over your entire existence?

The results of the Inquiry demonstrate how people maintain the meaning of identities, actions and events, re-assigning social roles to avoid deflections. Mr Parry had suggested in his original inspection that 'Matron may be a little vindictive', but despite a great deal

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[134] AOT, PSC2/1/83 7C/47 Evidence of Dr RJ Turnbull, MHA. Goffman suggests that getting too close to inmates is a problem for staff in total institutions, as 'there is always the danger than an inmate will appear human' ('On the characteristics of total institutions', page 79). This has long been an excuse for keeping a distance between staff member and inmate, and was possibly the root of the difficulty at the HFI, where Matron preserved the distance and the nurses did not.
[135] AOT, PSC2/1/83 7C/47 Evidence of Nurse Lee
[136] AOT, PSC2/1/83 7C/47 Evidence of Mrs Bussey, cook
[137] AOT, PSC2/1/83 7C/47 Evidence of Dr Roberts, medical officer
[138] AOT, PSC2/1/83 7C/47 Evidence of Dr Turnbull
[139] AOT, PSC2/1/83 7C/47 Evidence of Mr Higgins, inmate
[140] AOT, PSC2/1/83 7C/47 Evidence of Mrs Damien, visitor

of evidence from both inmates and staff that she was divisive, unfair at times, and did not treat some inmates very well, the Chairman of the inquiry was reluctant to find fault. Instead, he made excuses for her severity, based on the type of people she worked with: 'her task is not easy, the patients are not like ordinary patients. They are old and if we did not have a fairly strict disciplinarian the place would soon get into a degenerate state'. Mr Parry then concurred with him, agreeing that she 'has a very hard time with them. They are untrustworthy and dishonest'. A regular visitor offered a different explanation; she did not quibble with the need for control, but did suggest that the inmates' aberrant behaviour was not always due to bad character:

> These people are very trying and I don't say they don't need discipline but they have to rise so early of a morning and it is a very long day for them. … I understand they are not allowed to lie on the beds during the day and don't go to bed until after tea at night.[141]

The differences in opinions about the character of the inmates suggest a disparity in the way in which staff and public on the one hand and management on the other saw the HFI inmates. Most of the nurses believed their charges were old and frail people who needed help; this explained their 'human instincts' to be kind and lenient, which put them at odds with the matron. Members of the public thought the inmates 'should have a certain amount of liberty…'[142] and that the 'poor old folk' needed kindness and 'some freedom'; after all, they were not prisoners, they had done nothing wrong except grow old and helpless. Excuses for misbehaviour could be made that related to their treatment rather than their character. But the Matron, the doctor and the management committee had to reconcile the sometimes harsh and neglectful treatment meted out, and justify the increasingly dilapidated and rundown environment. This was achieved by branding the inmates 'untrustworthy' and 'dishonest', although there was little evidence proffered to suggest that these terms were in any way appropriate. Those inmates who did complain were labelled 'troublemakers', their social identity changed to demonstrate that they did not deserve better, and turning attention on their actions rather than on the way in which they were treated.[143] In the parameters of affect control theory, good, weak and quiet 'old

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[141] AOT, PSC2/1/83 7C/47 Evidence of Mrs Phillips, visitor. This also shows the lack of autonomy and rights of the inmates; to not be 'allowed' to lie on one's own bed during the day suggests that the bed did not belong to the person but the institution, and an inmate could not expect to exercise choice in its use.
[142] AOT, PSC2/1/83 7C/47 Evidence of Mrs Damien, visitor
[143] Piper notes similar behaviour in the 19th century institutions, such as at Brickfields in 1879, where an inmate who complained about poor conditions and mismanagement was dismissed as a 'disturber' and 'great Drunkard': *Beyond the Convict System*, page 280

people' became bad, weak and lively 'troublemakers', who therefore needed discipline and control rather than care and consideration.

It was agreed by the Inquiry in the end that Matron McClymont needed disciplinary powers, but 'in a place like a Home for Invalids punishment needs to be administered sympathetically and with great discretion'; they recommended that an official set of Rules be drawn up and issued to staff and patients to allow the establishment to run more appropriately.[144] Whether this occurred is unknown; Eleanor was not given one when she began work there the following year, and there is none in the records.

A state election in September 1948 brought a change in government, and Dr Turnbull, the instigator of the Inquiry and the HFI's chief critic, took the portfolio of Minister for Health. One of his first acts was to announce that a new HFI was the top priority in the Health Department's building plans[145], but the months passed with no further activity. This did not pass unnoticed by the public, and a flurry of letters to the local newspaper demanded action. One writer stated 'I cannot for the life of me see why the place is called a home, as any place less like a home would be hard to find'.[146] Another was even more scathing:

> Hitler was branded a callous murderer when he ordered the use of a lethal chamber for the permanently sick, but even that was much more humane than worrying them to death in small doses. … I suggest that as there is no security, protection, or accommodation for invalids, …the act [be] amended empowering doctors to administer to us an overdose of POISON.[147]

At last Dr Turnbull acted, calling for tenders in 1949 for the building of a new Home.[148] It took five years to eventuate, but it would change the face of aged care in Tasmania dramatically, not least because it was the first state-run institution that was intended as a dedicated 'home for the aged', opened exclusively for people over the age of retirement.[149]

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[144] AOT PSC2/1/83 7C/47: Covering memorandum reporting on Inquiry, 17/6/47 from the Public Service Commission to the Minister for Health: recommendation number 10
[145] The *Examiner*, Saturday, 9th October 1948, page 3: 'No 1 Priority on Home for Invalids'
[146] Letter from M. Humphries to the *Examiner*, Tuesday, 30th August, 1949, page 2
[147] Letter from 'Poison' to the *Examiner*, Saturday, 27th August, 1949, page 20
[148] The *Examiner*, Thursday, 11th August, 1949, page 3
[149] St John's Park also included buildings accommodating crippled children, delinquent boys, and mentally deficient patients not severely enough affected to be sent to Lachlan Park, the psychiatric hospital. The HFI had also had younger inmates, some 'mentally defective' and some physically handicapped.

Cosgrove Park, Launceston

Cosgrove Park opened in 1954, with room for 108 people. It was built on the top of a hill overlooking the town, with large windows to take advantage of the 'superb' view. Unlike the HFI it had no high fences, although it was separated from the surrounding community by large gardens, as at St John's Park. The inmates were now officially 'patients', and they were divided into two categories: those who required a degree of nursing care, who lived on the main floor of the Home and made up the majority of the residents; and more self-sufficient people who resided on the lower floors, in 'hostel' style accommodation with limited support and supervision, coming and going as they chose.

Plate 9: The east façade of Cosgrove Park, early 1960s[150]

Despite the agreeable surroundings and the bright, modern interiors, there was still a strong undercurrent of control about Cosgrove Park, and the public view of its function would not be changed very easily. Some members of the community still conflated the function of old age home and prison; one man requested that his ninety-one year old wife be admitted, citing her alcoholism and violence towards him:

> I could go on reciting her wickedness ad infinitum but I feel I have given you sufficient details to justify her detention under discipline…[151]

[150] Pictorial works collection, Tasmanian Archive and Heritage Office
[151] AOT, HSD6/3/2211

There was even some confusion as to the status and role of the Home within the Department itself. When several hostel residents went out and returned intoxicated, the Director General of Health Services stated that the police should have been called and the men 'charged with a breach of the peace in a public institution'. The administrator of Cosgrove Park, Mr Griffiths, explained that the police would not arrest anyone at Cosgrove Park as it was classed as a private residence.[152] The Superintendent of St John's Park was called upon for advice; he explained that inmates there were given three chances, with increasing punishments: in the first instance, reprimand and removal of all privileges; in the second, reprimand, removal of privileges and stoppage of pensions; and finally, discharge or, if old and infirm with nowhere to go, to be 'put into bed and kept there'.[153] It is interesting to note the reappearance of the word 'inmate' in this missive, despite its lack of official sanction for some years. It would appear that when a person caused trouble, they were no longer seen as a deserving 'patient', but regressed to the status of the prisoner or pauper, in which role they could be suitably punished.

The Crown Solicitor was moved to point out that whilst institution management could 'enforce early bedtime or withhold … leave passes'[154], they could not legally withhold pensions, which were the residents' own property. But in a total institution, the line between personal and institutional belongings becomes blurred at times; the official records suggest that this was in fact common practice at St John's Park, amongst other punishments. Several years after that initial warning, for example, Mr Kerslake was denied his pension, pass and privileges (no pictures, sports or entertainment), ordered to work for seven days in the kitchen, and sent to bed 'without wireless' by nine o'clock each evening.[155]

These remnants of the punitive past were diminishing, however; in the years to come, such punishments would disappear and new methods to manage undesirable behaviour would take their place. Society in the second half of the 20th century was very different to society before the war. People were living longer, and as the baby boom took hold and housing shortages loomed, there were now a significant number of middle class elderly

[152] AOT, HSD6/3/2211 Memo 19/8/1958, Memo 20/8/1958
[153] AOT, HSD6/3/2211 Letter, 24/10/1958. He does not explain how this should be done.
[154] AOT, HSD6/3/2211 Letter from Crown Solicitor, 15/4/55
[155] AOT, HSD 221/1/1 File A10/1 (12/12/62), File B6/1 (9/9/1963)

people with accommodation needs[156]. This demographic shift in the type of person requiring admission to aged care brought many changes to the sector, and the coercive method of control lessened in importance as the target clientele became more respectable. Although some aspects of Goffman's 'mortification of the self' would continue to be seen (the removal of personal possessions and the instruction in the rules of the Home, the following of strict and inflexible routines, and the 'batching' of residents), these were gradually whittled away by changing opinions of what was acceptable, and the concept of residents' rights.

Residents' rights and the language of control

The move towards resident freedom and autonomy reached its culmination in 1989, when the Australian Government released its Final Report on *Residents' Rights in Nursing Homes and Hostels.* This set out a draft Charter of Residents' Rights and Responsibilities, which stated, *inter alia*, that 'every resident or a nursing home or a hostel has the right to be treated as an individual'; and 'the rights of a person are not reduced by the capacity of the person to exercise them on their own behalf'.[157] The Report looked at all aspects of nursing home life, including moving beds or rooms without consultation, provision of storage space and personal possessions, clothing, building design (with a majority of single rooms), and required Homes to

> …examine methods to promote a homelike environment by removing, adapting or minimising institutional characteristics and consult with residents to find out their ideas or concepts of improving the ambience of the environment.[158]

One of the requirements was the removal of institutional terms such as 'wards'.[159] This was a clear acknowledgement of the power of language to create reality, examples of which have been seen throughout this chapter. From the overtly penal nomenclature of the early days ('inmates', 'overseers', 'warders', and 'superintendents') to the broader institutional terms used in the later records ('muster', 'rations', 'dormitories', 'mess hall'), the language used in official documentation helped to uphold the custodial nature of aged care until well into the 20th century. Even when the old custodial terminology

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[156] The elderly population of Tasmania had nearly doubled between 1901 and the introduction of the *APHA* in 1954. Appendix 3 shows that the percentage of the population aged 60 and over increased from 4.07% in 1901 to 7.56% in 1954, and the equivalent figures for those over 80 were 0.64% and 1.12%.
[157] Chris Ronalds, *Residents' Rights in Nursing Homes and Hostels: Final Report,* Department of Community Services and Health (Canberra, 1989)
[158] Ronalds, *Residents' Rights,* page xxix
[159] Ronalds, *Residents' Rights,* page xxix

was replaced with less contentious language, it continued to be used on occasion by members of the public, those in authority, and the occupants of the Homes themselves; Judith, one of the participants in this study, used the word 'inmate' several times whilst describing her work at Cosgrove Park despite the fact that the residents had been designated as 'patients' from that Home's inception.

The Charter of Residents' Right and Responsibilities was passed in 1990, and would have great repercussions throughout the aged care sector for both public and private institutions. By that time, the private Homes far outnumbered the public, but they were relatively recent arrivals on the scene.

Plate 10: Derwent Court Nursing Home, as it appears today.[160] It is no longer a Home.

Few private Homes, either philanthropic or proprietary, existed in Tasmania prior to the 1950s, and when they did appear, the residents were of a different type to those in the public institutions—middle class, respectable, with money to pay for services and a different expectation of conditions and care. Coercive control was rarely used within these establishments, and they did not exist to keep their occupants sequestered from society; they have subsequently played no part in this chapter. Nevertheless, many instigated rafts of rules and regulations that were reminiscent of those within the public institutions: for example, the fifty-one residents of the Derwent Court Nursing Home, in

[160] Photograph taken by Elaine Crisp, May 2011

Sandy Bay, Hobart, were not permitted to bring in jewellery or money, as it was against the Home's policy, and could only leave the premises with the approval of both the doctor and Director of Nursing, and had to return by 4pm.[161]

On the whole, however, the private Homes placed more emphasis on care and less on custody. Even where ostensibly coercive methods were used to control resident behaviour (such as locked doors and physical restraints), the intention was therapeutic rather than punitive—for the resident's 'own good', rather than to protect society. These measures will be discussed further in Chapter 5.

This chapter has shown that the roots of the Tasmanian aged care sector were firmly embedded in the custodial model of the convict system that dominated the state so strongly throughout the 19th century and beyond. The earliest institutions were closed total institutions, coercive and custodial. The inmates were locked in at night, and granted day leave only by the favour of those in charge. Although technically they could leave if they chose, there was nowhere else to go; they might find the gates closed against them, with only the gaol cell or beggary to fall back upon. Only the most desperate would enter, and that was entirely satisfactory as far as the authorities were concerned; even without a Poor Law, the government had achieved its aim to set up a system that no-one would want to use unless they had little choice. The public did not mind, either; the conflation of prisoner and pauper as members of a 'criminal class' made control the main imperative, and there was little consideration of care.

In the 20th century, as the emancipists died out, their place was taken by the impoverished lower classes, a group that still had little claim on public sympathy, particularly when the populace as a whole were suffering the exigencies of the First World War and the Great Depression. It was not until after World War Two, a time of social upheaval and regeneration, that new solutions were sought to better answer the problem of a growing aging population; the opening of Cosgrove Park and the blossoming of the private sector would change aged care a great deal in the following decades. But no matter how hard

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[161] Derwent Court Nursing Home: Information Booklet (Hobart, 1986). Jenny Hockey notes that this 'compulsory shedding of possessions, responsibilities, and personal space' not only erodes aspects of the resident's social identity, but also reminds them of the impending reality of death; 'Residential care and the maintenance of social identity: negotiating the transition to institutional life', *Growing Old in the Twentieth Century*, (London, 1989)

the new Homes might try to cast off the past, the legacy lingered; particularly for St Johns' Park, which provided a direct link back to convict days. Is it any wonder that even in the 1990s people still spoke forebodingly about 'going behind the clock'?

The custodial nature of Tasmanian aged care for much of its existence also affected the image of those who worked within the sector, who were seen as custodians rather than carers. Even when nurses were finally employed, it was not seen as necessary to find technically accomplished or highly knowledgeable nurses to give appropriate care. Whilst coercive control might be deemed acceptable by the public and the authorities, it often caused discomfort to those nurses and attendants employed in the Homes who were forced to treat their patients in a way that contradicted the accepted social identity of the 'kind and caring' nurse. It may also gave free rein to the few who enjoyed exercising their power over the weak and powerless in their charge, giving rise to the stories of ill-treatment and abuse.

Goffman specifically identifies asylums, prisons, army barracks, and boarding schools in his examples of 'total institutions'; it is interesting to note that in Tasmania, each one of these was utilized by the government as homes for the aged after they outlived their usefulness for their primary purpose. The use of second-hand buildings was to set a precedent for another aspect of aged care in Tasmania: that of 'making do' and 'good enough', and this will be examined in the next chapter.

Chapter 3

'Good enough' and 'making do'

> …we would deprecate as pernicious any attempt to make institutions designed for the relief of pauperism more attractive than the home which the honest self-denying workman can hope to secure for himself in old age by the observance of temperance and economy. … Public charity should not be so much a boon, as a mitigation of the consequences of the neglect or violation of wholesome general laws.[1]

Despite the lack of a Poor Law in the Colony of Tasmania, it was clear that the public institutions for paupers were modelled on the English workhouses: isolated from the community, gated and walled to keep the inmates away from respectable society. But unlike the mother country, the colonial government did not build new forbidding edifices to house the poor. They did not need to. The end of transportation created a wealth of disused and obsolete imperial buildings to be pressed into service by the government to house the old and infirm: convict barracks (Impression Bay), convict hiring depots (Brickfields), prisons (Port Arthur and Cascades), military barracks (the Launceston Invalid Depot), and an orphanage (The Queen's Schools at New Town).[2]

It was not just the buildings themselves that were 'good enough' for their inhabitants; the records reveal that furnishings, food, clothing and care for the elderly inmates were often basic at best and sometimes considerably less than adequate, and in this, too, the Tasmanian government was clearly influenced by its English counterpart. In 1834, the English Poor Law was amended to include the principle of 'less eligibility', which ruled that the relief given to paupers should not allow them to live in conditions 'really or apparently as eligible as the independent labourer of the lowest class'[3]; in other words, life in the workhouse should not be as attractive as life in the community. The reasoning behind this principle was to deter all but the most desperate people from seeking

[1] TLC, 17, 1871, Paper 47, page xxiii

[2] The latter remained a Home until 1993 in its incarnation as St John's Park, and there is still an aged care facility on its site. Although the oldest original buildings no longer house old people, the Infant's School, which became the female division of the New Town Charitable Institution, is still in use as the head office of the current operators, Southern Cross Aged Care.

[3] Bernard Harris, *The origins of the British Welfare State: society, state and social welfare in England and Wales, 1800-1945*, (Basingstoke, 2004); direct quotation from Ronald Mendelsohn, The Condition of the People: Social Welfare in Australia 1900–1975, (Sydney, 1979), page 87.

admission to the workhouse, and its effect was to subject those desperate people to conditions of misery and harshness that affected the image of the entire British welfare sector for decades to come. The quotation at the start of this chapter, from the 1871 Royal Commission into conditions in the Tasmanian charitable institutions, shows that the Tasmanian government had adopted the principle even without an enacted Poor Law.

Over the first decades of its existence, the overseers of the nascent Tasmanian welfare sector made sure that the occupants of the invalid depots were given less than the poorest community dwellers. Even when the institutions became old age homes, their inmates did not automatically enjoy an improvement in living standards. Until the second half of the 20th century, the government Homes were second hand and second rate, but 'good enough' for people with no other choice. That this situation was considered acceptable for so many decades is partly explained by the fact that it was not just the inmates of the institutions who were forced to endure some hardships. There were many lean times amid the boom years for all Tasmanians, and the population as a whole was not wealthy; the 'labouring class' made up more than forty per cent of the population until the second half of the 20th century.[4] The government, too, struggled financially, and economies were essential to ensure that all necessities were covered. Nevertheless, there is evidence that the elderly inhabitants of the charitable institutions were intentionally well down on the government's list of priorities until the mid-1950s. This lack of status also affected the nurses who cared for the elderly inmates. They endured sub-standard working conditions, low wages, a lack of training, and a lower standing and reputation than workers in other health care settings. Many of these factors continue to affect the sector to the present day.

This chapter will explore how the need for thrift combined with a disdain for the lowest classes to create Homes that were 'good enough' for old folk and the people who looked after them.

[4] Shayne Breen, 'Class', *The Companion to Tasmanian History*, (Hobart, 2006)

‘Quite adequate for the class for whom it is provided…’

> …two apartments, which during the rain are inundated both from above and below, in which cooking, washing, and all other necessary operations are performed, and in which the patients are all huddled together…[5]

The Vandemonian invalid depots were basic indeed. Even when a new Invalid Hospital was built at New Norfolk to replace the original old and leaking convict barracks, inmates were provided with only the bare necessities. As overcrowding became a problem, sometimes they did not even have that: in 1836 there were only enough bedsteads for half the occupants, no sheets on those that were provided, and insufficient furniture and utensils to go around. The meals were badly cooked, and inmates’ clothing was ‘motley … varied in colour, kind and condition’.[6] When the invalids were moved to Impression Bay and later Port Arthur they enjoyed less crowded conditions, but their surroundings were little better. The buildings at Impression Bay were ‘generally dilapidated’[7] and the old penitentiary buildings of Port Arthur had been considered too decrepit even for prisoners, but were considered suitable for impecunious old men for a few years until a new paupers’ house was built.[8]

Perhaps the remoteness of the early institutions kept their inhabitants out of mind as well as out of sight, but this changed when depots were opened in more central locations in both Hobart and Launceston. Townsfolk were now able to visit and inspect the premises, and the newspapers began to publish articles about life within the depot walls. Both visitors and the Press occasionally decried the poor conditions, but very little was done about them. With an inmate population almost entirely consisting of ex-convicts, it was difficult to arouse much concern in the public mind, and it is likely that the newly christened Tasmanian government believed that they were doing enough. After all, they had a new colony to run, a new parliament to establish, a new economy to build, and these remnants of the old imperial convict system were almost certainly deemed less worthy than the many other calls on the public purse.[9]

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[5] Ralph Gowlland, *Troubled Asylum*, (New Norfolk, 1981), page 4
[6] Report to the Lieutenant Governor from the Principal Medical Officer, 3rd October 1836, quoted in Kelly, *A Background to the History of Nursing in Tasmania*, page 52
[7] Piper, Beyond the Convict System, page 46
[8] Maggie Wiedenhofer, *Port Arthur: A Place of Misery*, (Port Arthur, 1990)
[9] As part of the ‘criminal classes’, they were not considered to be ‘deserving’: David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, (Boston, 1971)

The new government had started well enough, it seems. The opening of the Brickfields Invalid Depot (Brickfields) in Hobart Town in 1859 was greeted with approval by the *Mercury*, which had been advocating for some time for a refuge for invalids within the town environs. The 'remarkably clean' premises included a paddock 'laid down with English grass' for the leisure activities of the inmates, a small library and 'perfectly new' bedding, and the inmates were reported to be contented and happy.[10] This pleasant state of affairs appears to have deteriorated quite quickly, however. Only four years after the opening, Dr E Swarbreck Hall, a long-time member of the Hobart Benevolent Society and a keen advocate for the destitute, protested about the conditions in the hospital ward:

> …the beds are straw only, not even a hair mattrass [*sic*] or an air-cushion or a water-bed; for men, many bed-ridden for months, with backs mortified from long constant pressure. … There are some half-dozen arm-chairs with wooden seats, and the only other sitting provision for these aged sufferers are forms without even backs … a short time since, a poor man 108 years old, died on one of these comfortless straw beds…[11]

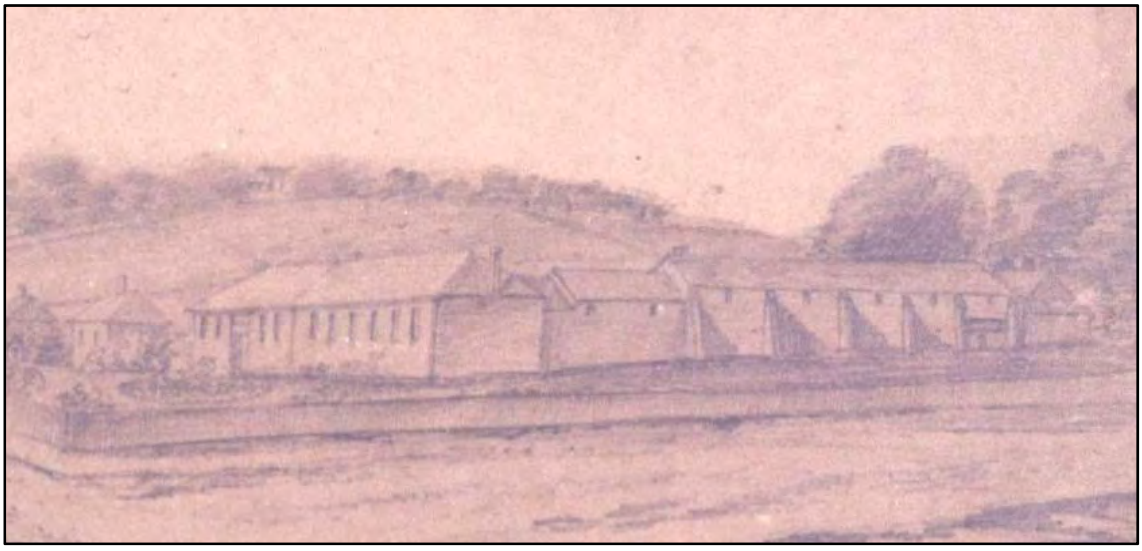

Plate 1: 'Brickfields Invalid Depot' by Miss Shoobridge, 1865[12]

In reply to a suggestion that the 'comfortable quarters' of Brickfields had made men seek admission 'without necessity', he ridiculed the idea that people capable of working—or even begging—would try to gain admission to such an unpleasant place if they did not

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[10] The *Hobart Town Daily Mercury*, Thursday, 4th August 1859, page 3
[11] Letter to the *Mercury*, Saturday, 15th August, 1863, page 5 Straw mattresses were common in the hospitals, where they could be burnt after the patient was discharged (see Janet McCalman, *Sex and Suffering*, (Carlton South, Vic, 1998), page 79), but here the men were forced to lie on them perpetually.
[12] WL Crowther Library, Tasmanian Archive and Heritage Office: item no AUTAS001125294660

need it. (This, of course, demonstrates that the rule of 'less eligibility' was in fact succeeding in its goal.) Dr Hall claimed that the condition of the men within the depot made it an infirmary and as such, it should have 'all the comforts and requisites' of a hospital, including medical care.[13] Instead, the bed-bound men lived in a 'bare, gloomy barrack room' and subsisted on half-rations[14], being cared for by their fellow inmates. This latter situation was not in itself unusual; the official government policy was that able-bodied inmates would provide care in all medical and charitable institutions in the colony, as a cost-cutting measure.[15] The difference was that in the invalid depots, there were very few able-bodied inmates at all, and most were too old and infirm to be of much use to their fellows.

The second Hobart institution, the Cascades Invalid Depot (Cascades), did not enjoy even a brief period of approbation. Cascades was infamous for its unpleasant setting, being dark and damp all year around, and questions were raised almost immediately about its suitability for frail old people. Dr Hall went so far as to say it was 'a positive cruelty' to banish invalids there:

> The accommodation … is altogether insufficient. … For bed-ridden old men, some nearing their hundredth year … to have only straw beds and pillows, and those who can sit up no easy reclining chairs …is a condition I am sure that any feeling person … can readily appreciate and deplore. [Their] sufferings ought to be mitigated by every appliance and comfort that human skill and Christian kindness can devise.[16]

But there was little Christian kindness to be found. Dr Benson, the medical officer of Cascades, agreed that the place had been build 'on a morass' and was 'not cheerful', but protested that many inmates were dirty or incontinent, and that

> the bedding is suitable and clean, and can easily be changed. There is always an abundant supply of dry straw on hand, and I have witnessed no ill effects which could possibly be attributed to the use of such for filling mattresses.[17]

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[13] Robson, *A Short History of Tasmania,* page 46

[14] This meant they received only half a pound of meat a day, rather than the one pound given to other inmates of the institutions, and of the gaols and armed forces. Whilst this might sound quite a lot, it was 'inclusive of bones', which could dramatically lessen the amount of edible matter.

[15] AOT, CON74/1 *Instructions for the Management of Convict Hospitals,* (Hobart, 1845) Similar arrangements existed in the other colonies, and, indeed, in England, where trained nurses were still some decades away.

[16] TLC, 17, 1871, Paper 47, pages 83-84: evidence of Dr ES Hall

[17] TLC, 17, 1871, Paper 4, page 99: evidence of Dr WM Benson, question 604

It seems clear that the two gentlemen ascribed very different social identities to the invalids, and this could explain their opposing views. To the charitable doctor, the men were 'sufferers'—weak, inactive and basically good—and the conditions in which they lived did not correspond to the way in which he believed such people should be treated. To Dr Benson, they were reprobates—weak, yes, but actively difficult and basically bad. He was therefore content to accept the situation. The members of the Commission agreed to a great extent with Dr Benson. Whilst they admitted that they would not have recommended the Cascades site for selection, they believed that the inmates were not in such a state of health as to require their removal to another location. Besides, economy was a major consideration, and this was managed in a 'remarkable' manner, with accommodation that was 'as commodious, cleanly and comfortable as could be reasonably expected [and] quite adequate for the class for whom it is provided…'[18]

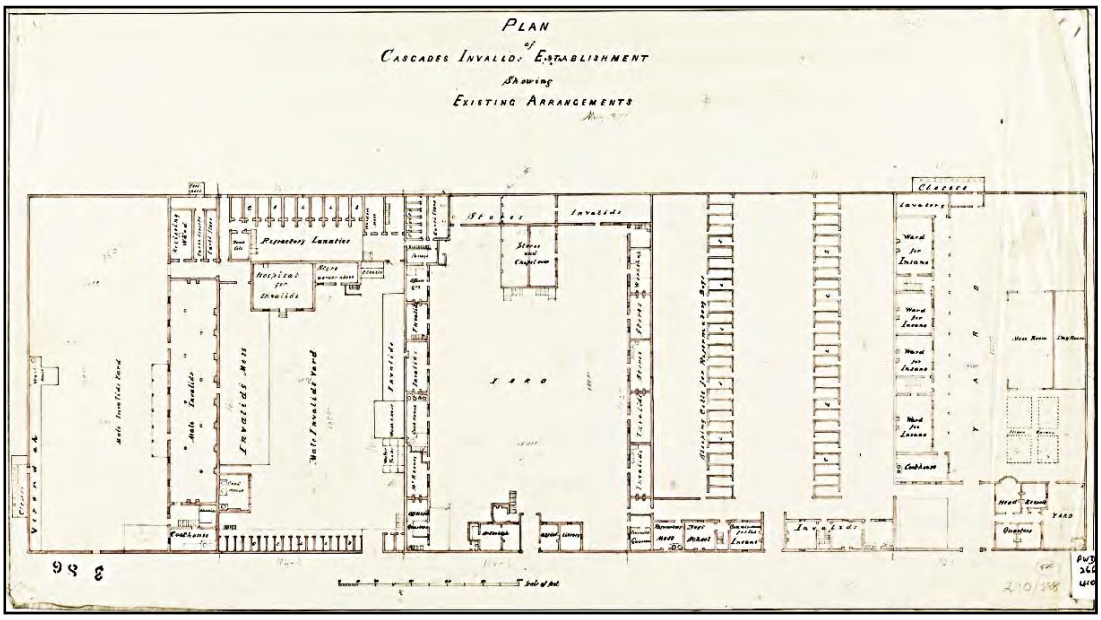

Plate 2: Plan of Cascades Invalid Establishment, 1877.[19] The old prison cells can be seen in the second yard from the right, used when necessary to house the old people.

Conditions improved when the paupers were moved into the defunct Orphan School buildings at New Town, the women in 1874 and the men five years later. The female accommodation at the New Town Charitable Institution for Indigent Females (New Town) was far better than Cascades. The building was only twelve years old, erected in 1862, and was 'capacious and airy, consisting of five dormitories, dining-hall, kitchen,

[18] TLC, 17, 1871, Paper 47, page xxiii
[19] ATO, PWD266-1-410: Plan, Cascades Factory Hobart, Invalid Establishment

and several other rooms, including a bath-room'.[20] Even so, there was no hot water in that bathroom, the outside woodwork was 'quite bare of paint, and perishing', and there was no day room, so the women had to sit on the verandahs if they wanted to leave their beds, not the most comfortable situation in Hobart's often cold and windy climate.[21] The men's division, which opened in 1879 in the original Orphan School buildings erected forty years previously, also needed 'a considerable expenditure before it can be placed in that state of repair which should be maintained'.[22] Costs were minimized by having the renovations carried out by the inmates themselves.

> The wards and hospitals have been thoroughly cleansed, lime washed, painted, and effectively renovated by inmates, thus saving a large amount in the expenditure.[23]

Plate 3: The Women's Division, New Town Charitable Institution, c1900[24]

The inmates saved the government even more expenditure by providing their own domestic and nursing care as well. The women continued to make their own clothes and do all the mending, washing, and 'general sanitary requirements of the Institution'.[25] While Tasmanian hospitals began to employ professional nurses from the end of the 1870s, the charitable institutions continued to use inmates as attendants. The New Town

[20] TLC, 21, 1875, Paper 9
[21] TLC, 24, 1877, Paper 8
[22] TLC, 30, 1881, Paper 9
[23] TPP, 35, 1885, Paper 9
[24] Pictorial works collection, Tasmanian Archive and Heritage Office: item no PH30-1-7641
[25] TLC, 29, 1880, Paper 9

women did have one nurse (who doubled as cook) to care for the sick and 'in every possible way help the infirm'[26], but the men had no equivalent help, and continued to care for themselves, as did the men of the Invalid Depot in Launceston (IDL).

This staffing policy might have been financially prudent, but it brought other problems for the institutions, causing great difficulty as the inmates aged and the already small number of able-bodied among them diminished sharply. Successive annual reports from all the public institutions bewailed the unsuitability of the inmates for the task, growing louder as the years passed; they were 'too infirm' at Cascades in 1878, 'very feeble' at the IDL in 1879, and 'totally unfitted from age and their own infirmities' at New Town in 1884.[27]

The IDL inmates did have a cook, a 'well-behaved' prisoner from the nearby gaol[28] who was paid two shillings a day. The government had originally offered one shilling but no well-behaved man would accept for less than two; in contrast, the inmates who acted as wardsmen were paid fourpence a day. The accommodation at the IDL was not quite as comfortable as at New Town. Although the buildings had been 'thoroughly repaired and adapted to the use of the invalids'[29] when the IDL opened fifteen years earlier, there was no mess-room for the men, and the roof leaked. Despite this, the local newspaper article called the arrangements 'admirable, but only when the number and class of the inmates were taken into consideration[30]; in other words, 'good enough' for the paupers within, given their ex-convict backgrounds.

By the end of the 19th century, the IDL was in a truly parlous state, with its buildings becoming increasingly dilapidated and inadequate. This was partly due to the fact that the Launceston Benevolent Society, which now ran it, was reluctant to ask for funds for improvements in case this strengthened the government's long-running case for closure. By now, not even the pauper status of the inmates could be used as justification for the squalid conditions, particularly as the number of emancipist inmates dropped, and its

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[26] The *Hobart Town Gazette,* Tuesday, 18th August 1874, page 875: Regulations for New town Charitable Institution for Indigent Females, rule 22
[27] TLC, 26, 1878, Paper 9; TLC, 28, 1879, Paper 10; TPP, 2, 1884, Paper 9
[28] TLC, 17, 1871, Paper 47, page 48: evidence of John Cox, Superintendent, IDL, question 61.
[29] TLC, 15, 1869, Paper 5
[30] The *Examiner,* Saturday, 28th October 1893, page 3

central location made the establishment a visible source of shame and embarrassment. One critic labelled it a 'plague spot of our beautiful city'[31], damning the inadequate diet, the lack of recreational facilities and the abysmal sanitary provisions, which included the burying of inmates' excreta in a shallow trench next to the buildings,[32] which were

> …in an advanced state of decay, cold, damp, and cheerless… the walls are dadoed inside with coal tar … to keep the damp out and the vermin down [and] outside … to keep the water out.[33]

He called for the IDL to be shut down. This prompted an impassioned disagreement, as the inmates and their supporters continued to resist the move. The core of their argument was that the physical environment in which a person lives is only part of the story, and other elements that affect a person's happiness should be taken into consideration.

> The couple of hundred old people in the Asylum have been drawn mostly from the north. What few remaining friends they have are northern residents, and they rightly regard as nothing short of exile their removal to New Town, where from month to month they would never see a friendly face. The days … when those who were no longer able to maintain themselves were treated like so many dumb, driven cattle, are fortunately gone for ever. We may not be able to do more than supply them with the bare necessaries of life, but if their lot can be lightened by the companionship of those whom they knew in brighter days so much the better.[34]

Sometimes 'not good enough' *is* good enough, if the alternative is worse.

The impasse continued for some years, as the authorities deliberated on how much support the elderly inmates deserved, and where and how this should be provided. This was not a purely Tasmanian debate, of course; old people were now becoming a focus of the new federal government, culminating in the introduction of a national old age pension in 1908. Graeme Davison points out that although the pension seemed to enshrine the idea that old people had a right to support, it was not for their innate qualities as old people but for the service they had contributed to the colony, and the country, when they were young. [35] There was still a strong religiously-based belief that people enjoyed the

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[31] Letter from Mr WC Wilson to the Launceston *Examiner*, 21st September 1900, page 3
[32] Letter from Mr WC Wilson to the *Mercury*, Thursday, 28th July 1898, page 3
[33] Letter from Mr WC Wilson to the *Mercury*, Tuesday, 19th July 1898, page 3
[34] The Launceston *Examiner*, 20th September 1900. A letter to the editor in the same edition claimed that 'removal to the New Town Asylum … to some of these poor old creatures would be like transportation.': the *Examiner*, 20th September 1900, page 3
[35] Graeme Davison, ''Our youth is spent and our backs are bent': the origins of Australian ageism', *Australian Cultural History*, 14(1995), 40-62. Davison states that the exception was those people whose penury was the result of sacrifice, such as soldiers and the pioneers, who had relinquished the chance of a

old age they deserved, as God would reward virtue and punish immorality.[36] With this view, it was clear that the inmates of the institutions must have been less virtuous than their healthier, wealthier fellow citizens, and therefore still be less deserving of comfort than the elderly in the community.

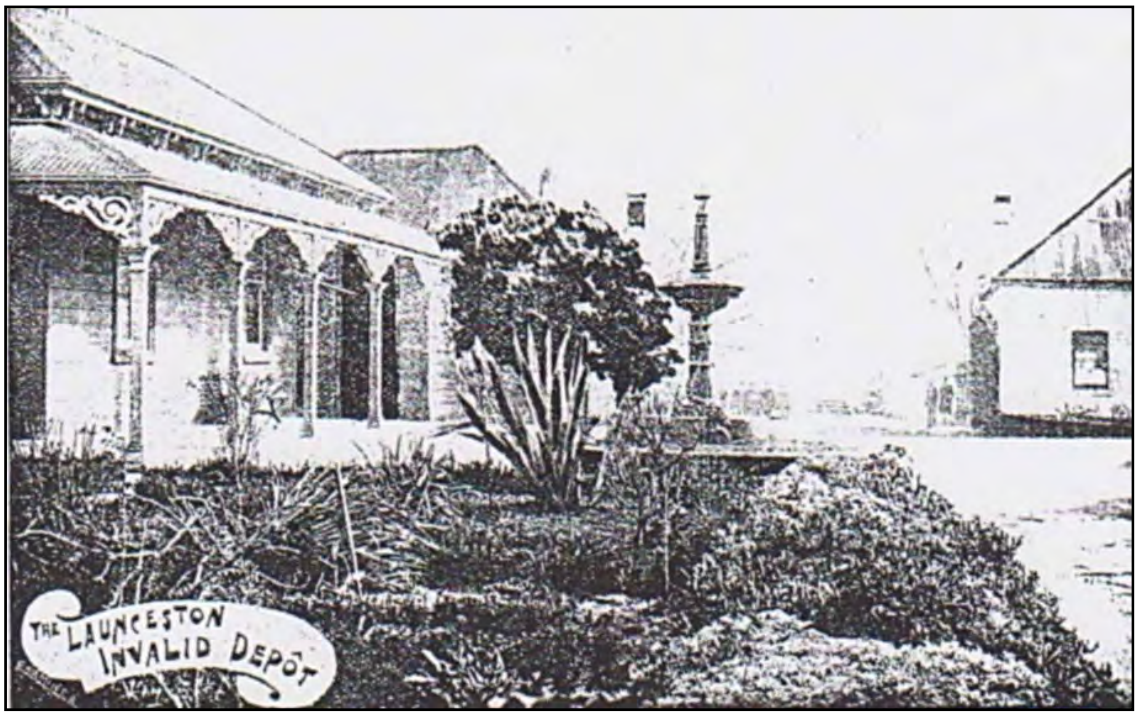

Plate 4: An illustration of the Launceston Invalid Depot in 1895.[37] The beauty of the grounds was in stark contrast to the conditions within, a dichotomy noted in a newspaper article that stated there was perhaps 'no more lovely spot in Australia' but that the buildings were 'far from being in keeping with their surroundings … old and need constant repair'.[38]

The IDL was finally closed in 1912. Some of its equipment, including blankets, bedding and utensils, were retained to furnish the new Home for Invalids (HFI) that would open the following year. The rest was returned to Government stores, except for those items deemed 'unsuitable', which were handed on to other charitable institutions.[39] These items were no doubt well worn, as nothing was wasted; until its final days, IDL

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healthy old age for the good of the country. This attitude would be exemplified when a new Home was built at New Town in 1939 for returned servicemen from the Great War. Gellibrand House had 'two spacious lounge rooms', a dining room and 'two luxuriously equipped bathrooms', electric radiators and comfortable furniture to give the men what was described as 'all the comforts and amenities of a private home' (the *Mercury*, Friday, 3rd June, 1938, page 3: "Home for War Veterans")

[36] Davison, "'Our youth is spent and our backs are bent'"

[37] Illustration from the *Launceston Examiner*, 18th May 1895, page 25

[38] The *Launceston Examiner*, Tuesday, 10th November 1891, page 4

[39] AOT PWD 18/1/9937 There is no detail of which institutions received this largesse.

correspondence was written on forms printed with an '18—' date, with the '8' struck through and a '9' inked in by hand.

The new HFI had originally been planned as yet another refurbishment of an existing property, this time a derelict domestic dwelling, but after the building was destroyed ('set on fire by someone no doubt'[40]), a new one was erected in its place. This was something of a milestone. For the first time in the history of Tasmania, old people were to be provided with a new building to live in rather than being moved into a redundant government edifice.

Whilst still total institutions, the HFI and New Town were no longer 'closed', as they had been in the19th century. Inmates entered willingly, and could leave the premises on occasion, with permission. They were also cared for by professional (but not trained) nurses, rather than tending to themselves under the supervision of an overseer or warder.

'Only the most feeble and helpless are left…'

The introduction in 1909 of a national old age pension had been a boon for able-bodied inmates of the state institutions, but brought new problems for management.[41] Those who were fit enough to look after themselves took the pension and were discharged, leaving the superintendent of New Town to report to state parliament that

> …only the most feeble and helpless are left, whom the nurses and warders have to attend to like so many children, and I very much fear it will yet be necessary to have further paid labour to assist in the hospital wards, as the very greatest difficulty now exists in having the work performed in a satisfactory manner.[42]

It was necessary. In the following years, more male warders were employed, and several women were hired as nurses. They were not trained nurses, but they were good enough to care for old people, and being younger and able-bodied, they were almost certainly an improvement on the inmates themselves. They faced very different conditions to the nurses who were now staffing the state's general hospitals. Whilst both groups learned

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[40] AOT PWD 18/1/9937 Letter from Chief Secretary to Minister of Land and Works, 10/5/1911

[41] The old age pension entrenched the split between 'deserving' and 'undeserving' poor, as only the deserving were eligible to receive it. Drunkards, deserting husbands and past prisoners were ineligible, and any criminal activity resulted in cancellation. John May, 'Social welfare', in John Henningham, (ed), *Institutions in Australian Society*, (South Melbourne, 1999); Margaret Conley, 'The 'undeserving' poor: welfare and labour policy', *Australian Welfare History*, (South Melbourne, 1982)

[42] TPP, 63, 1910, Paper 29, page 2

their skills on the job, the New Town nurses received no formal training or qualification, and whilst the hospital nurses had dedicated quarters, the New Town nurses actually slept in the wards next to the inmates they tended. This arrangement continued until 1913, when lower inmate numbers enabled them to move into one of the now empty wards in the female division.[43] The room was divided into cubicles by curtains which afforded little privacy, but at least the nurses could now take some time away from their charges.

The New Town nurses were also paid at a lower rate than the hospital nurses, and the new superintendent found it difficult at times to fill vacant positions. He pressed for parity, and in 1915 the state government substantially increased the nurses' salaries, in light of the 'arduous duties performed.[44] Those salaries were covered in part by the old age pension given to all eligible inmates of the state institutions, paid directly to the state government, but here too the institutions received inequitable treatment. Whereas a pensioner in the community received ten shillings a week, the institutionalised elderly were only worth eight shillings. In 1915, the state government requested that this inequity be amended[45], and the commonwealth agreed to pass on the extra two shillings—but directly to the inmates, which did not help state coffers. Two years later, the pension for community dwellers was increased by two shillings and sixpence, but again the institution inmates were forgotten.[46] Another request was made for the additional funds. The government hoped to use the money to install electricity at New Town, but this would have to wait.

In 1920, the southern institution found a new way to raise money when a new laundry was opened at New Town. The Home took charge of their own linen and also that of other state institutions, including the Hobart General Hospital. The increased income allowed the installation of electric lights in parts of the building, and fly screens were installed to the 'great benefit of the inmates, as the fly nuisance has been very much in evidence of late years'[47], which could not have been helped by the pan lavatory system in

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[43] TPP, 69, 1913, Paper 54 In contrast, the nurses at the New Norfolk mental hospital (also untrained) had been given their own quarters in 1886: Gowlland, *Troubled Asylum*, page 97
[44] TPP, 71, 1914-15, Paper 34 Frederick Seager died in 1913, after forty-four years at New Town.
[45] TPP, 73, 1915-16, Paper 54
[46] TPP, 79, 1918-19, Paper 41. This was to be an ongoing battle; by 1927 the pension was £1, whilst the Homes and their inmates received a combined amount of 14/6 (TPP, 97, 1927-28, Paper 49)
[47] TPP, 83, 1920-21, Paper 56. Hydro-electric power had been available in Hobart since 1916; Launceston installed its first domestic electric lighting in 1895 (Robson, *A Short History of Tasmania)*

use at the time. It was suggested that some new buildings might be needed to house the occupants of the old Men's division, as the original Orphan School buildings, now ninety years old, were now in a 'bad state of decay', but nothing came of this.[48]

In the north, the HFI was also struggling to accommodate those who appealed for entry. By 1924 the Home housed thirty-one old people, eleven more than it had been built to accommodate. The local newspaper mentioned the overcrowding in an otherwise glowing article which described the HFI as 'a haven, where [incurable cases] can end their lives amidst pleasant surroundings and in comfortable circumstances'.[49] The reporter waxed lyrical about the Home's views, its sunny position, and 'spacious verandahs', but ten patients were now sleeping on those same verandahs. They were less than suitable for the purpose. Originally built on to the Home to allow the inmates some daytime escape from their shared wards, they were unlit and protected from the elements only by canvas blinds. This made nursing difficult at night, and also exposed the occupants of those beds to drenching rains and freezing cold in winter. There were also problems inside the HFI. There was no day room for the women, and nowhere to dry washing on wet days apart from the 'already overcrowded sitting rooms'. Fires were inevitable; a quilt caught alight one cold afternoon, although no-one was injured.[50] Outside was little better than inside.

> …no one has had the nous to have planted a break-wind of trees right around the grounds, and a few shelter trees for the inmates to sit under in hot weather. Except for a few rows of vegetables in front, the place is still the cow-paddock that it was when Launceston was first settled.[51]

The garden was extremely steep, as was the approach to the Home. Despite the fact that the HFI was no longer a 'closed' institution, this isolated the inmates from the outside world very effectively. It was difficult for visitors to access and almost impossible for the elderly inmates, very frail and many in wheelchairs, to be taken out. It was only after a petition from the inmates that arrangements were made to grade the grounds.[52]

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[48] TPP, 83, 1920-21, Paper 56
[49] The *Examiner*, Thursday, 2nd August, 1928, page 5: 'Home for Invalids: A Useful Institution'.
[50] HSD 1/1/5175 99.16.39 Letters from Matron Campbell to Secretary of Public Health, 28/4/1939, 23/6/1939
[51] AOT, HSD1/1/5167 99.8.39 Report by RJ Parkes on the Home for Invalids, Launceston, to the Director of Public Health, 24/7/39
[52] AOT, HSD1/1/5172 99/13/39 Petition from inmates, 30/1/1939; correspondence between BM Carruthers and Minister for Works, March 1939

Meanwhile, in Hobart, the old Orphan School buildings continued to decay and the staff was finding it ever more difficult to carry out their duties efficiently without modern conveniences. In 1928, the new superintendent was surprised to find that unsafe, expensive gas was still being used for cooking in the outmoded kitchens, particularly as the state government ran the Hydro-Electric Department and advertised its benefits widely to the public. The institution was also still using the unhygienic pan lavatory system, which was 'not only obnoxious, but a source of grave danger to health', and the walls needing painting as they were 'past the soap and water stage'. It was suggested that it might be better to demolish the old Home and start afresh in another location with new, modern buildings, but the one hundredth anniversary of the Orphan School in 1935 saw them still in use.[53] But the shift in focus in that decade from a custodial to a therapeutic model of care would bring some improvements inside, if not out.

'To make the few remaining years … comfortable and enjoyable'

> …the future of the Institution would be different from that in the past, inasmuch as formerly it was used only as an asylum for the aged, and now it was being utilised as a hospital for chronic cases…[54]

Whilst the HFI continued its downhill trajectory for the duration of World War Two and beyond, the newly re-christened St John's Park enjoyed a brief revival of fortune. In 1938, extensive building work was carried out: a new kitchen block, a day room, dispensary, store and barber's shop, and a new dining hall to seat the 160 inmates of the men's division, who until then had been forced to disperse over several old and unsuitable rooms.[55] Once again, plans were mooted to demolish the old Orphan's School buildings altogether and erect four new ward buildings, two on either side of the church, but again these did not come to fruition. Instead, the interiors of both divisions were renovated and redecorated.[56] The management declared their 'earnest desire … to make the few remaining years of the inmates comfortable and enjoyable', and to this end, the old

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[53] TPP, 99, 1928-29, Paper 46 This did not occur, to the benefit of posterity. The buildings were less than suitable as an old age home, but beautiful examples of colonial architecture. A great deal of Tasmania's built heritage exists today because of budgetary restrictions in early decades.
[54] TPP, 119, 1938, Paper 3: Parliamentary Standing Committee on Public Works: Proposed Additions to St John's Park, New Town (Formerly Known as the New Town Rest Home)
[55] TPP, 119, 1938, Paper 3
[56] AOT, HSD1/1/5147 99.12.39 Although, as Megan Davies points out, 'new names, new paint, and soft sofas … do not alter the institutional reality': Renovating the Canadian old age home: the evolution of residential care facilities in B.C., 1930-1960', *Journal of the Canadian Historical Association,* 12:1(2001), 155-175, page 174

vegetable gardens were removed and new parklands laid out.[57] Unfortunately, these could only be enjoyed by the ambulant inmates, as there were insufficient staff members to enable hospital patients to be taken outside into the sun.[58]

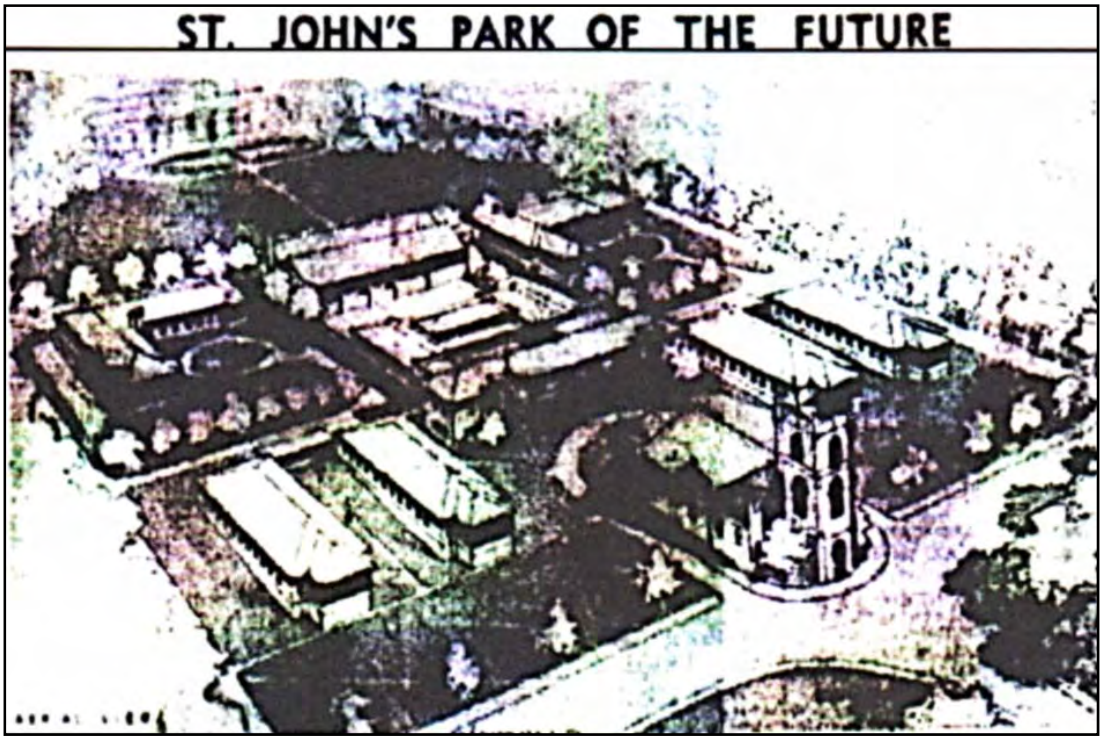

Plate 5: Artist's impression of the planned changes to the St John's park site, showing four new wings on the site of the to-be-demolished Orphan School buildings.[59]

Although it was now officially classified as a 'hospital for chronic cases', the majority of the staff were still untrained. Whilst the male employees lived in the community, or in cottages in the grounds, the female nurses continued to sleep in their curtained cubicles in the old women's ward. The 1938 refurbishments did include a new nurses' home, but tragic circumstances prevented the female staff from taking up residence. A serious outbreak of poliomyelitis led to the conversion of a section of the women's division into a polio ward, and the newly opened nurses' home was filled by nurses from the Royal Hobart Hospital[60] who moved out to St John's Park to care for the polio victims. The superintendent accepted the necessity for this, but requested plaintively that if a home for crippled children was established at the site, then 'consideration be given to the question

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[57] TPP, 119, 1938, Paper 8, Appendix VIII (pages 33-34)
[58] AOT, HSD1/1/5144 98.11.39 Memo from Supt. Woodhouse to BM Carruthers, 13/3/39.
[59] From the *Mercury*, 20th March 1939, page 9
[60] The Hobart General Hospital became the Royal Hobart Hospital in 1936: Kelly, *Background to the History of Nursing in Tasmania*, (Hobart, 1980), page 28

of providing similar facilities for our own nursing staff'.[61] A permanent Home for Crippled Children was indeed opened the following year, their nurses retained the nurses' home, and the St John's Park nurses began another long wait for suitable accommodation.

In Launceston, too, the staff endured difficult conditions. The matron's accommodation on the first floor of the Home was extremely cramped, as her cupboard and floor were used as storage space for the Home's linen.[62] Given that Matron Campbell spent every night and almost every day in the establishment, this must have been less than ideal. Quarters for other staff were also limited, and an attempt to find outside lodgings for the nurses was unsuccessful, meaning only local women could be employed.[63] The lack of accommodation extended to the inmates, as demand for beds continued to outstrip supply. A question was asked in Parliament in December 1938 regarding the situation:

> Question 1: Is it true that several old people have been refused admittance to the Home for Invalids due to a lack of accommodation?
> Question 2: If so, what is going to be done about it?
> Answers: No. See answer to question 1.[64]

This was deliberate obfuscation. The HFI was in fact badly overcrowded, with an average of thirty-five residents and a long waiting list, and many more were turned away. Matron Campbell was instructed not to admit any further patients, except with the endorsement of Dr Fulton, the medical officer.[65] But although this problem was recognized in the internal departmental records, it was strongly denied in public, and was not even mentioned in the annual report for 1938, which instead painted a rosy picture of life within the Home: the wooden benches that had previously been the only seating had been replaced by leather chairs, bed-tables and garden seats were donated, and the inmates were taken on outings and even to the theatre on occasion.[66]

In reality, conditions at the HFI were not quite as pleasant as the official report suggested. When Mary Howard (who had previously worked as a wardsmaid at the Launceston

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[61] TPP, 119, 1938, Paper 8, Appendix VIII, page 34
[62] AOT, HSD1/1/5178 99.8.39 Report from RH Parkes to BM Carruthers, 24/7/1939
[63] AOT, HSD1/1/5175 99.16.38 Memo from BM Carruthers to Minister for Health, 18/9/1939
[64] AOT, HSD1/1/4051
[65] AOT, HSD1/1/5181 99.22.38 In his chapter on the history of aged care Launceston, BW Griffiths states that the HFI had 'a bed capacity of 35' upon opening, and that there was 'no record of there being any particular shortage of beds'. It appears he was following the official line, rather than the evidence in the archives. 'Care of the aged' in Clifford Craig, *Launceston General Hospital: First Hundred Years,* (Hobart, 1963), page 88
[66] TPP, 121, 1939, Paper 16, Appendix X

General Hospital where her work was 'outstanding') arrived to take up similar duties at the HFI, she took one look at the interior of the building and 'decided to seek employment elsewhere'.[67] Six of the inmates were sleeping on beds that had previously been in use at Port Arthur, which had closed seventy years earlier, on mattresses, many stuffed with straw, which were very old and 'particularly unsuitable for rheumatoid cases and bed patients'.[68] Much of the furniture and equipment was also second rate, where it existed at all. Despite a donation of china from the local Apex Club, there was a shortage of crockery and kitchen equipment, including dishes, spoons, plates, forks, bowls, cups and pudding dishes. The nurses often used their own money to purchase items which were desperately needed, for various reasons:

> There are only two tumblers in the institution. Seven of the patients take communion frequently. One of this group is syphilitic. This leaves one tumbler for the remainder of the inmates and none at all for the staff.[69]

Matron Campbell requested permission to buy a new wireless, as the 'present set was bought, I believe, in 1929 [and] is now a trial to the inmates rather than a pleasure'. She was given permission to buy one using money from the HFI's 'Treats' account.[70] Other necessities were requisitioned from the Department, but many of her requests were refused by the head of the Health Department, still counting the pennies. Mr Carruthers struck off orders for mattresses, quilts and lockers (thirteen women shared a single locker and five had no locker space at all), explaining that a certain sum was provided by Parliament each year and this sum could not be exceeded, so requisitions should be restricted to those 'of an urgent nature only.[71] So Matron raided the 'Treats' account again, and bought cupboards to store the inmate's belongings—a treat indeed.

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[67] AOT, HSD1/1/5165 99.1.39 Memo from Matron Campbell to BM Carruthers, 6/3/38

[68] AOT, HSD1/1/4050 99.1.38 Memo from Matron Campbell to BM Carruthers, 3/10/38 This is reminiscent of the complaints made by Dr Hall more than sixty years earlier regarding the conditions at Brickfields and Cascades. In her *Background to the History of Nursing in Tasmania,* (Hobart, 1977), Beatrix Kelly claimed that 'a number of beds in the Port Arthur Hospital were those originally used during the Crimean War in the military hospital staffed by Florence Nightingale and her nurses' (page 50). Given the government's propensity for recycling, it is a possibility that some of these might have ended up in the IDL or at New Town after Port Arthur closed.

[69] AOT, HSD 1/1/4050 99.1.38 Memo from Matron Campbell to BM Carruthers, 22/8/1938

[70] AOT, HSD1/1/4050 99.1.38 Letter from Matron McClymont to BM Carruthers, 24/7/38. The 'treats' account was made up of donations from benefactors, such as Owen Jarman of Golconda, who left the Home £15-11-5 in his will. Mr Carruthers approved the purchase of an 'airzone' wireless, which at £6/6/- was the most expensive quotation received. For once, the inmates were not making do!

[71] AOT, HSD 1/1/4050 99.1.38 Letter from Matron Campbell to BM Carruthers, 3/10/1938; memo from BM Carruthers to Matron Campbell, 10/10/1938

The residents also made do with bad food at times, as quality was dictated by economic measures. Mr Figgis complained that the meat 'is so tough that we cannot cut it much less eat it as the majority of us are toothless … the sausages are apparently stuffed with sawdust'.[72] Even when the food was suitable, the cooks were not always up to the work they were employed to do. One cook was so incompetent that the inmates were moved to protest in writing, with the Matron's blessing:

> I am not a professional grumbler but am asked by the Inmates to bring under your notice that the food supplied us is not properly cooked as an instance a number of fine geese were killed for Xmas dinner but were so badly cooked that most … of them had to be thrown away.[73]

In 1939 an independent inspector was sent to investigate conditions at the HFI. Mr Parkes' report was scathing, three closely typed pages describing squalor and disorder:

> The whole place is in a state of chaos owing to inadequate storage and other facilities. … Kitchen safes and drawers are filled with a miscellaneous collection of trading accounts, books (official) and newspapers. Pots and pans are hidden in dark recesses under sinks and other inaccessible places. Conditions in the detached storeroom at the rear of the building almost baffle description. …groceries, bundles of patients private clothing, and other belongings, suitcases, relics of last Xmas' decorations, new clothing and linen, and a disused bedroom commode (Victorian era design, by the look of it). …the laundress flounders about amongst mountains of washing stacked on the ground inside and outside the laundry… The ironing board is about the side of a small coffin lid, supported at the free end by a low trestle. It is so low that persons using it must be in danger of burning their shins (or at any rate their knees) with the iron. … Under the building there are stored about twelve wooden bedsteads recently received from the L'ton Public Hospital. These should be cleaned from dried vomit etc, varnished or painted and dismantled till required for use. …tea is poured out on the open verandah space outside the kitchen. This verandah is swept by Arctic gales… It is regrettable that … they have to eat under conditions similar to those that would obtain at the top of Mt Wellington.[74]

Mr Parkes made suggestions for improvements, and added that these would make this 'Cinderella of Government Institutions more in keeping with the ideals of "Tasmania's Humane Government"'. The quotation marks around the last three words are Mr Parkes' own, and suggest it is a direct citation of a government slogan of the day; given the tenor of his letter, it is apparent that he found the description ironic. Apart from the long list of inadequacies given in this report, there is other evidence that the culture of 'making do'

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[72] AOT, HSD1/1/4050 99/1/38 Letter from W Figgis, 3/3/1938

[73] AOT, HSD1/1/4037 99.3.38 Letter from BJ Figgis to Director of Public Health, with covering letter from Matron Burris, 30/12/1937

[74] AOT, HSD1/1/5167 99.8.39 Report on the Home for Invalids, Launceston, to the Director of Public Health, 24/7/1939 Mt Wellington is on the outskirts of Hobart, 1270 metres (around 4,000 feet) tall and frequently the coldest and windiest spot on the island.

and ‘good enough’ was strong. Memos and letters from the Matron to her departmental superiors detailing the shortcomings and difficulties with which she grappled were handwritten on ruled pages of paper torn from an exercise book; similar missives from St John’s Park in the same era were typewritten, on letterhead. It appears that the HFI was not given the consequence by the Department of Health that St John’s Park enjoyed. Although there is no clear reason for this in the records, there are several possibilities that may be considered. First, there had long been a north/south schism in Tasmania. Despite its dominant economic role through much of the 19th century, Launceston was very much the secondary city in the state, and Hobart was the seat of legislative and regulatory power. The Launceston establishment may simply have been overlooked. Secondly, the HFI was run by a female matron rather than a male superintendent and housed more women than men, which might have led to its being seen as more of a domestic abode than an official institution. In contrast with St John’s Park, which was seen as a hospital, the HFI did not need to aspire to the same standards.[75] Thirdly, St John’s Park also housed younger inmates: delinquent and ‘mentally defective’ boys, and polio victims. Perhaps their presence made it more important to maintain a more official and formal atmosphere more important to the establishment. Or maybe, as young people, they were simply worth more in the eyes of the authorities.

In 1948, the mentally defective boys were transferred from St John’s Park to a new Home, and the nurses from the female division moved into the building that had accommodated them. Once again, the aged (or their nurses, in this case) benefited from new arrangements made for youth. The new nurses’ home turned out to be a mixed blessing. Some of the rooms were so damp that their occupants had to dry clothing and mattresses in front of the fire before they could be used. There was nowhere for visitors to sit, nowhere for the nurses to study (they now received some formal training), and only twenty-six out of seventy-six nurses now on staff could be accommodated. The remainder lived in the community, and the Matron herself continued to live within the women’s division, which made it almost impossible for her to get away from her patients.[76] Approval was given for a new home, but it would be a few years yet before

[75] Megan Davies noted that Homes in British Columbia, with their ‘middle class domestic architecture’ and female staff, were never seen as anything more than ‘second-rate medical institutions’, well below general and psychiatric hospitals in the health care hierarchy: *Into the House of Old*, (Montreal, 2003), page 174
[76] TPP, 165, 1961, Paper 33, page 3

the nurses would see any change. The first site chosen was refused (it was the only suitable space for a sports oval, which was considered more important, in view of the crippled children on site), and no money was forthcoming, and the nurses continued to make do.[77]

So did the residents of the HFI. Eleanor painted a dismal picture of the Home as it was when she started work there in 1948.

> There was no decoration. The women's ward was one long ward, holding twelve beds, and the men's was the same, and the back wall had a door through to a lavatory, which people went out to. There were beds right along the wall. The beds were paillasses, hard old things. I can't remember any curtains between. No personal possessions, just a little locker. There were two lean-to rough rooms, very old, built outside the back wall of the large house. The back wall of the Home was brick, and the lean-tos were quite primitive, they weren't even painted or anything. There were two beds in each shed, which accounted for four more residents. The layout of the men's accommodation was similar, except there was a sunroom at the front of the house which housed six residents. I don't remember there being any flowers at the Home for Invalids, but the gardens were nice. No-one used them, but it was nice to look at as you walked through.[78]

As at the IDL before it, a pleasant street frontage masked a less than ideal interior. There had been talk throughout the previous decade of extending the HFI, or even building an entirely new Home.[79] In 1940 the government had contemplated buying Newnham House, a large and impressive Launceston property with extensive grounds[80], but they had more pressing calls on the public purse. A new general hospital was being built to replace the old, built in 1863[81], and other wartime concerns meant that the proposal was shelved. By the end of the war, it had become widely known that conditions within the Home were a disgrace. Nineteen female patients shared one bathroom, and fifteen men the other ('there is no privacy at all, people coming in and out all the time'[82]), the day-room could only accommodate ten patients at once, and there was no dining room—the

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[77] They made do until 1963, when they were moved out of their damp and derelict accommodation and into the Royal Hobart Hospital nurses' home, and the old home was torn down (TPP, 169, 1963, Paper 72). A new one was finally built in 1965.
[78] Interview with 'Eleanor'
[79] The *Examiner*, Wednesday, 19th July 1939, page 6 'Inadequate Space: Extending Home for Invalids'
[80] The *Examiner*, Wednesday, 11th September, 1940, page 4; the *Mercury*, 11th September, 1940, page 2. In the *Mercury*, the term 'Invalid Depot' is used, although this had fallen out of official use at the end of the previous century.
[81] Paul Richards, 'History of the Launceston General Hospital', in *Effecting a Cure*, (Launceston, 2006)
[82] AOT, HSD6/1/557 Letter from Mrs Emma Clarke, 5/4/1946

patients ate from trays on their knees.[83] A Parliamentary Standing Committee agreed that something needed to be done.

> The matron and staff were working under considerable difficulty owing to the obsolescence of the building and its inadequate and inefficient equipment. The institution is on several levels, which means that there are steps in various parts of the building which prevent bedridden patients from being wheeled from one portion of the building to another or to be taken outside in their beds to enjoy the fresh air and sunshine … the wards or dormitories are seriously overcrowded…[84]

Although the Committee approved plans for a new home, no further action was taken, and two years later, the 1947 Public Inquiry into the Home revealed that there was still a great air of 'making do'. There was no medical sterilizer ('the staff have to boil all their surgical dressings on the stove. We try to do it when it is not being used for cooking'[85]), no sink in the kitchen, and the utensils were so old that the cook complained they discoloured the food.[86] She had gone out and bought serving spoons with her own money. There was still a shortage of crockery and cutlery, and inmates often had to use the same spoon throughout their meal. The stove was wood-fired, and the only electrical equipment was 'a jug and a very old toaster', although a Frigidaire had been provided a little while before. Whilst St John's Park patients were bathed daily, the HFI inmates had a bath once a week in the cramped and inadequate bathrooms, which caused some difficulties as the lavatory was in the same room. There were only two bedpans for the women, one of which was broken, and Matron put out a new roll of toilet paper twice a week, and "as a rule it lasts".[87] Scarce medical supplies were also made to last, as Eleanor remembered:

> The bandages that I did up the ladies legs with varicose ulcers, I had to scrub them and then boil them in a paint tin, and you'd cut up Velvet soap and put them in and bring it to the boil. The bandages were hung on a gooseberry bush to dry.

Despite the frailty of the inmates, there were no handrails in the bathrooms, no radiators in the rooms, only wood fires, and no floor coverings on the wooden floors. Linoleum would 'be a great asset', Matron McClymont believed, both for comfort and ease of cleaning. Worst of all were the two lean-to rooms at the back of the HFI, which were unpainted and had earthen floors. A bug infestation had taken hold in the old rotting

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[83] TPP, 135, 1946, Paper 12, page 4
[84] TPP, 135, 1946, Paper 12, page 1
[85] AOT, PSC2/1/83 7C/47 Evidence of Matron McClymont
[86] AOT, PSC2/1/83 7C/47 Evidence of Mrs Bussey, Cook
[87] AOT, PSC2/1/83 7C/47 Evidence of Nurse Lee

timbers, as the Matron explained: 'the nurse called me in and a patient's bed was black with bugs. Fortunately the patient was blind'.[88] Blind, but surely not without her other senses—even the Commissioner appeared to find this situation completely unacceptable, reporting on it directly to the Minister for Health rather than including it in his final report for the Inquiry.

> I believe the only cure would be the removal of the two wards, but I hesitate to make this suggestion in view of the scarcity of the accommodation and the heavy demands being made for admission to the Home. I feel, however, that the matter calls for some drastic action…[89]

Once again, no action, drastic or otherwise, eventuated. Four women, two of them blind, continued to occupy the rudimentary bedrooms.[90] The surrounding houses may have had similar insect infestations (the Launceston General Hospital, just around the corner, certainly experienced problems with cockroaches at times[91]), so it is not so much the conditions that shock but the fact that the Matron could speak about them so lightly and with so little apparent concern. Possibly she had become inured and desensitized; after all, she shared the Home and rarely escaped its confines. The HFI was a total institution for her as well as for her charges. The inquiry came to the conclusion that the building was totally unsuitable as a Home for Invalids. Although it was found to be 'scrupulously clean', it was poorly equipped, uncomfortable and outdated. Recommendations were made to repaint and brighten the interiors, to install ceiling fans, lay linoleum over the wooden floors, install additional heaters, and reupholster the dilapidated easy chairs.[92]

Both state Homes owed their 'scrupulously clean' interiors to physically strong but mentally weak female inmates rather than paid domestic staff. At the HFI, Rossie Taylor and Jean Nunn rose at 6am to report to Matron for orders, starting work before the nurses came on duty, seven days a week: scrubbing floors, cleaning, washing, and ironing. The Public Inquiry heard from several witnesses that Rossie was particularly badly treated,

> …well and truly driven. Matron is always at her… You can hear Matron roaring Miss Taylor up over in the womens section when you are in the mens section.[93]

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[88] AOT, PSC2/1/83 7C/47 Evidence of Matron McClymont
[89] AOT, PSC2/1/83 7C/47 Memo to Minister for Health from Public Service Commissioner, 19/6/1947
[90] Interview with 'Eleanor'
[91] Interview with 'Eleanor': "we had to make forty slices of bread first thing, and in those breadbins it was absolutely full of cockroaches. Absolutely running miles of them, on the bottom! And being a junior, you didn't like… We thought, well, if the senior nurse doesn't tell the matron, who am I to tell her?"
[92] AOT, PSC2/1/83 7C/47 Memo from Public Service Commissioner to Minister for Health, 17/6/1947
[93] AOT, PSC2/1/83 7C/47 Evidence of Attendant Boley

She was forced to work seven days a week, and sometimes denied the few pleasures afforded the other inmates, such as attendance at parties given by charitable visitors. Despite this treatment, Rossie did not want to leave the HFI, and the matron took advantage of this fact to ensure her compliance.

> [Matron] threatens to send Miss Taylor away if she does not do her work. Said she would send her to Hobart. She does that to scare her. She likes being here. [*Chairman: In spite of all the work she has to do she still likes to stay here?]* Yes. Sometimes she is crying till 4 o'clock in the morning.[94]

Once more, the threat of exile to the south was brandished to instil discipline and keep control. Dr Turnbull found Rossie's treatment unacceptable. He suggested that if she was a servant she should be paid at award rates, and if she was not, she was worked excessively hard. Matron McClymont disagreed: 'I don't work her very hard. She is very trying and never does anything unless I am with her. …none of her people have ever complained.' It is possible that Rossie's family did not want to complain in case they found themselves burdened with her. When Jean Nunn's aunt protested against her niece's treatment , she was told to take Jean home, which she could not do.

> I think it is a terrible thing to have to get up at 6 o'clock and scrub these cold dark mornings. If they were being paid to do it it would be bad enough. But my niece is being paid for and she is made to do all that for nothing… When I complain to the Matron she says why don't you take her out. I can't take her. I am out in the bush.[95]

When asked by the Inquiry whether these two inmates were ever allowed to stay in bed past 6am if they wanted, Matron McClymont replied, "It is not a matter of how they feel. Work comes first." Facing a lack of alternative accommodation, combined with the social stigma attached to mental weakness, the two women were for all intents and purposes prisoners of the Home, with no choice but to carry out the required duties in return for bed and board. Rossie Taylor was still doing the work when Eleanor started at the HFI.

> There was one female resident who slept in a bed in the passage with a screen around it; she was slightly mentally retarded but seemed to be washing the floors and cleaning most of the time, which she did very well.[96]

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[94] AOT, PSC2/1/83 7C/47 Evidence of Nurse Lee
[95] AOT, PSC2/1/83 7C/47 Evidence of Mrs Christmas
[96] Interview with 'Eleanor'

Even now, sixty years later, Eleanor did not question the arrangement. She surmised that Rossie "could have been homeless, [or] someone might have rejected her", and did not seem surprised at either possibility. Rossie had a bed, and a roof over her head, and that was good enough. Similar housekeeping arrangements existed at St John's Park, as Claire discovered in 1951. But as with so many aspects of life in the southern institution, the contract was more formal and the 'mentally defective' women more strictly supervised than in Launceston.

> When I started work, all the cleaning was done by patients out of Royal Derwent, the mental asylum. There was no employed domestic staff at St John's Park. They had their own big dormitory where they would all sleep, and the nurses at night time would have to see that they were all in their dormitory by 9 o'clock at night and then the door was locked and we carried the key. They weren't prisoners, but they were … it was a safety thing on their behalf, to keep *them* safe. I never ever knew them to attack a nurse or be violent in any way … they used to hand out medication to keep them—the ones that needed it—just to keep them subdued. They got their keep, I don't suppose they got paid, but then I suppose they were all on some sort of government money, so they'd get a little bit of money somewhere. They had their own dining room.[97]

This delineation between nursing and housekeeping staff was highlighted by several other participants in this study, who told me that they ate in separate dining rooms from the housekeeping staff ("we had an RN's dining room and a housemaid's dining room. The ENs ate with us—nursing's different to the housekeeping"[98]). It was an important distinction for them, stemming from the birth of the modern profession. Prior to the establishment of modern trained nursing in the second half of the 19th century, there was little difference between domestic servants and nurses. It was not until the rise of science-based medicine and the resultant increase of clinical technology that the trained nurse began to occupy a very different area to her domestic sisters. For untrained and semi-trained nurses, with no qualifications and very little specialized or technical knowledge, the difference was even less distinguishable. Throughout the 20th century both groups did somewhat similar work, neither held educational qualifications, and the domestic servant often earned a comparable wage.[99]

Matron McClymont certainly saw the two groups as interchangeable. She pushed for female nurses rather than male attendants to be employed at the HFI, and her rationale

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[97] Interview with Claire Paynter
[98] Interview with Pat Job
[99] In 1946, for example, the nurses were paid £3 per week, from which 12s 6d was deducted for weekly board, whilst the cook received £3 15s but did not live in: TPP, 135, 1946, Paper 12, page 4

was not entirely to do with the fact that the females were paid half as much as the men. They were also twice the value:

> …when things are slack and there is nothing further to be done … the nurses will do the mending & other tasks and duties too numerous to mention, and no time whatsoever is wasted.[100]

The use of mentally defective women as domestic staff at St John's Park came to an end in 1955, when a new superintendent, Mr Trebilcock, started a push to employ paid domestic staff to replace the Lachlan Park inmates:

> For some time Matron has been very unhappy with the necessity of having to use mentally defective women to work in the Hospital wards in lieu of wardsmaids. The types of certified mental defectives we are caring for here are practically all of a very low grade mentally, and incapable of anything like adequately carrying out the duties which would be required of wardsmaids. At times their behaviour in the wards is very bad as they quarrel amongst themselves quite a lot using very disgusting language on these occasions, which is very irritating to the old ladies who frequently complain of their conduct.[101]

Mr Trebilcock's words reveal a hitherto unseen attitude to the inhabitants of a public Home: his occupants are now 'old ladies', quite a turnaround from 'paupers', 'poor creatures', or even 'old folk'. This signals a real qualitative change in attitude towards the aged people within the Homes, a change that had been made clear when the newest state institution opened the previous year. Cosgrove Park had patients, not inmates, and housekeeping staff, not Rossie Taylor and Jean Nunn. Nobody slept in corridors, and there were finally enough cups and spoons to go around. It was definitely 'good enough'.

'One of the most advanced homes of its kind…'[102]

> When it was first built, it was very glamorous, oh yes! My aunt's mother was one of the first ladies to go in there, she was one of the first residents. It was quite sought after, everyone was waiting to get there, there was a long waiting list.[103]

The lives of the inmates of the dreary and unsuitable HFI were made immeasurably more pleasant when they moved into Cosgrove Park in 1954. The new Home seemed to signal

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[100] AOT, HSD6/1/1975 Letter from Matron McClymont to Director of Health & Medical Services, 3/6/1948

[101] AOT, HSD220/1/1 1171/35 File 1B: Memo from Superintendent Trebilcock to Public Service Commissioner, 1/6/1955. 'Mental defectives' continued to labour at St John's Park in other roles, however; in 1962 a job advertisement for a Laundress in Charge noted that previous experience 'in the handling of mental defects' was most desirable, suggesting their continued employment: AOT, HSD221/1/1 1171/42 File C3 Advert 29/5/1962

[102] BW Griffiths, 'The care of the aged', in Clifford Craig, *Launceston General Hospital: The first 100 years*, (Launceston, 1963), page 92

[103] Interview with Kay Joyce

the end of the era of making do for the old people of Launceston. The patients were cared for by a professional staff that included a cook, kitchen maids and domestics. Trained nurses ran the divisions, and the Launceston General Hospital provided a Board of Management, interrupting the direct chain of command between matron and the Health Department.

The state government had provided for a 'magnificent, all-electric' building, with linoleum floors (Matron McClymont would have been pleased), an extensive use of 'chrome and laminex fittings', and central heating to augment the fire places. There were four large lounge rooms and two day rooms, and a promenade deck outside the dining room gave a sheltered area for gentle exercise and relaxation, in contrast to the steep and unused gardens of the HFI.[104] This uncharacteristic generosity only extended to the building of the new Home, however. The Board of Management was informed it would need to raise funds to furnish Cosgrove Park, as there was no more money available.[105] A public appeal was launched to raise funds.

A brochure was printed to promote the new Home and explain how the donations would be used to cover both necessities and luxuries, from £100 to purchase a bed and accessories to £1,000 to furnish a four-bed ward. Donors were promised 'a place of honour on the Donation Board', and appropriate organizations were encouraged to provide finance for recreational items such as a piano, a library, a billiard table and even a bowling green. Churches were asked to supply furnishings for the chancel. Even occupational therapy facilities were on the wish list.

> By giving whatever you can, in goods, services, or money, you are giving to these aged people, a fulfilment of their hopes…. Yours is the task and yours the joy of knowing just how much your assistance means.[106]

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[104] Department of Health, appeal brochure, *For the Aged – Security Care Comfort: Cosgrove Park Home for the Aged*, (Hobart, c1953)
[105] The *Mercury*, Wednesday, 2nd July 1952, page 17: 'Hospital will control Invalid Home'
[106] Department of Health, *For the Aged – Security Care Comfort.* The local newspaper reported that the children of Glen Dhu School raised £100: The *Examiner*, 5th August 1954. The Launceston Apex Club established a public appeal, which helped to fund a bowling green and a subsequent 'modern and elaborate occupational therapy centre': BW Griffiths, 'The care of the aged', page 90. A similar arrangement with the Eastern Shore Apex Club in Hobart resulted in the St John's Park holiday home in Carlton Beach, Hobart; there, the members not only raised money but also donated materials and labour: TPP, 169, 1963, Paper 72

Plate 6: Cover of brochure for Cosgrove Park financial appeal[107]

Both government institutions were now seen more as geriatric hospitals than welfare institutions. Cosgrove Park was the exemplary Home, providing the most up-to-date nursing and medical care to its patients. It was the subject of a television documentary, and visitors came from across Australia (and even internationally) to inspect it.[108] St John's Park, too, built new facilities and implemented innovative policies and services, as will be seen in the next chapter. The days of making do seemed far behind, at least for the residents. For the staff, however, it was a little different; one way in which the government could save money was in their accommodation and working conditions.

Whilst Cosgrove Park provided improved accommodation for the residents, the nurses received no such upgrade; if anything, they were less well catered for. At the HFI, four

[107] Department of Health, For the Aged – Security Care Comfort
[108] AOT, HSD6/3/2216 109/8/1 Documents 5, 12, 21, 24. The high status of Cosgrove Park is also indicated by a large collection of photographs in the government Archives, showing the buildings, residents, special events, concerts, and the attached bowling club, used for publicity purposes during the 1950s, 1960s and 1970s.

nurses had received board and lodging in a small house at the rear of the property[109], but no such arrangements existed at the new Home. The original plans had included a nurses' home, with twenty-one single bedrooms and a separate matron's flat. Dr Craig, the Surgeon Superintendent of the Launceston General Hospital, had seen this as an important part of the new development. He was aware of the difficulties that had been experienced in finding suitable staff for the HFI, which was he knew was 'not regarded as one of the "plums" of the nursing profession':

> One of the factors which must be considered in the erection of new hospital institutions was the provision of good accommodation and the improvement of nursing conditions generally, in order to make the profession more attractive.[110]

His concerns went unheeded, however; economy prevailed and the nurses' home was never built. When Cosgrove Park opened, only the matron was given rooms, but these were in the lower level of the men's wing. This was hardly satisfactory, and she came 'restive … due to the noise factor, which is … unavoidable as her bedroom is in such close proximity to the male wards and toilet facilities'.[111] The lack of privacy and the inability to get away from the patients might also have affected her satisfaction with this arrangement. She was given accommodation in one of the new 'twilight cottages' in the grounds on a temporary basis, and the other staff lived off the premises altogether.[112]

The St John's Park nurses finally received a new nurses' home in 1966[113], but their conditions at work were less than adequate. The staff rooms were in a building that was one hundred and twenty years old, small and cramped, badly lit and ventilated, and very damp. The female dining room was so small that the nurses had to eat in three sittings, and the male attendants had no dining room at all but used the men's division room after the patients had finished. They shared washroom facilities with the male patients, too, and used those sinks to wash up their teacups. The twelve senior male staff did have their own dining room, a twelve foot by twelve foot room in the old Orphan School building that had been built in 1831. Superintendent Trebilcock was troubled that the men were 'compelled to eat and wash in conditions worse than those used by the convicts', and a Parliamentary Standing Committee agreed:

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[109] Interview with 'Eleanor'
[110] TPP, 135, 1946, Paper 12, page 3
[111] AOT, HSD6/1/6020 104/4/6 Letter from BW Griffith to Dr J Edis, 23/6/1954
[112] Interview with Judith Beard; confirmed in AOT, HSD6/1/6020 104/4/6
[113] TPP, 175, 1966-67, Paper 54

> It is surprising that such good work has been carried out at this institution, and it would appear that this can be attributed to the loyalty of all members of the Staff, from the Superintendent down.[114]

A new amenities block was built, which greatly improved the working environment,[115] Some staff seemed so pleased that they even came in on their days off—with their families, much to the superintendent's dismay.

> …eight off-duty nurses … were partaking of morning tea … when they were not on duty. I might add that some of these Nurses had their children with them and were causing congestion in the general dining room.[116]

But even free morning tea did not address the difficulties of being overworked and underpaid.[117] Insufficient staffing numbers meant that employees often worked beyond the hours of their shifts and above their set duties, as Superintendent Trebilcock acknowledged in several annual reports in the early 1960s:

> I cannot speak too highly of my staff, many of whom have given hours and hours of overtime without any reward whatever, except the knowledge that they have contributed to the comfort and happiness of the patients…[118]

It was not a new story. At St John's Park in 1936, there were not enough staff to take the inmates outside into the garden, and at the HFI in 1939 the Matron was 'almost entirely confined … to the institution' as there was no-one to whom she could delegate her duties.[119] Ten years later, her successor had been unable to have a day off for several weeks and many of the nurses had postponed their annual leave for many months.[120] The situation did improve at Cosgrove Park, which had a good staffing ratio, at least during the day. In the 1980s this improved still further, but Peter D doubts that these higher staffing levels were motivated by beneficence. He believes they were used to inflate costs to prove that the Home was financially unviable for the state government to

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[114] TPP, 165, 1961, Paper 34, page 3
[115] TPP, 171, 1964, Paper 70
[116] AOT, HSD6/3/2494 Memo from Superintendent Trebilcock to J Edis, 29/1/1964
[117] This situation is not unique to Tasmania, of course. In Linda Olson's edited collection *The Graying of the World: who will care for our frail elderly'*, chapters on conditions in fourteen countries all found that understaffing was a problem (Binghampton, NY: 1994). Other studies have linked understaffing and low quality of care in nursing homes: see Meridean Maas, Janet Specht, Kathleen Buckwalter, Josephine Gittler and Kate Bechen's review of this literature in 'Nursing home staffing and training recommendations for promoting older adults' quality of care and life: part 1. Deficits in the quality of care due to understaffing and undertraining', *Research in Gerontological Nursing*, 1:2(2008), 123-133
[118] TPP, 165, 1961, Paper 62, page 30
[119] AOT, HSD1/1/5165 99.1.39 Memo from BM Carruthers to Minister for Health, 11/7/1939
[120] AOT, HSD6/1/550 Memos from Matron McClymont to Secretary for Public Health, Feb/April 1946

continue to operate, to bolster their case for sale to a private company. He still feels indignant about his perceived manipulation.

> I was a union steward, and they'd give us anything we wanted. They were letting me get away with murder, by employing extra people, bringing in anyone on overtime, to prove that it was too costly. That was wrong, but that was just to prove their point. Because RNs were getting into trouble at the hospital—'oh, we can't put any more on', or 'you've go to work less', and they were letting us work with more! We thought they were afraid of the 'big bad union', but they were letting me fall in the fishpond by claiming it was too costly to run, so it improved their case to get rid of it. Hindsight's a wonderful thing![121]

By the 1980s, the public institutions had deteriorated greatly from their heyday twenty years earlier. They now faced a great deal of competition from private Homes, and people with the ability to choose their accommodation chose these; the public Homes once again became the last refuge for those with little money and few options. They lost staff, facilities, status, and reputation, and those in charge lost patience with the government. In 1981, the superintendent of St John's Park, Dr Ginsberg, resigned early from the position, his farewell letter setting out his disgust and despair.

> My intention had always been to retire at 65 … but circumstances have made it impossible for me to continue. My policies here were to develop SJP into a proper geriatric hospital for the disabled elderly and the chronic sick, whose needs have always been rather neglected in our society. I had hoped to provide a place where people could be looked after with kindness, and where they could live out the remainder of their lives with dignity and some sort of happiness. … It is a decision that I have made with great sadness, because I feel that I am letting down the elderly sick, whose interests have always been so dear to me. However, the frustrations I have been suffering, and the sense of outrage provoked by this recent decision … are undermining my health.[122]

Dr Ginsberg spoke of difficulties communicating with the Head of Department, a lack of consultation, a lack of money, and a lack of courtesy. His departure made little difference to the situation, it seems. In 1990, a strategy report for St John's Park included Dr Ginsberg's letter as part of a litany of damning evidence as to the Home's regained 'poor relation' status in the Tasmanian health care sector. The Superintendent of Nursing, Norm Clarke, reported that once again the nurses were on a different pay Award to nurses in the hospital system, and were never included in discussions on department policy. Their equipment orders were ignored (there was one photocopier in the entire complex), their furniture orders left unfilled, and funding was inadequate to staff the Home safely and efficiently. He stated bluntly, 'We appear to be victims of a long history of

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[121] Interview with Peter Davy
[122] *St John's Park Strategic Options*, Appendix: resignation letter from SA Ginsberg, 11/11/1981

inaction'[123], and his grievances would have sounded familiar to Matron Campbell at the HFI fifty years earlier. Once again, the staff and inmates of the public Homes were making do.

Plate 7: The North Orphan School building, St John's Park, c1966.[124] The men's division occupied this building until the 1950s, after which it was used for offices, storage, staff rooms, and a picture theatre.

It is interesting to note that an appendix to the report included a suggestion that the Department 'consider the recycling of large buildings, such as primary schools, as elderly persons housing'. In the end, the state government resisted the temptation to follow this suggestion and return full circle to repurposing obsolete government properties. This was almost certainly due to the amount of money it would cost to make such conversions satisfy the raft of new standards and policies for aged care being enacted by the federal government at that time. In fact, these requirements were making the Homes they did have even more of a financial liability, and in 1993 they gave them up altogether. Both Cosgrove Park and St John's Park were sold to private operators in the early 1990s.[125]

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[123] *St John's Park Strategic Options,* Report from Superintendent of Nursing, Mr NV Clarke
[124] Pictorial works collection, Tasmanian Archive and Heritage Office
[125] The Australian government introduced legislation that removed the obligation to pay benefits for nursing home beds run by the states (TPP, 207, 1982, Paper 36). The resulting freeze in funding meant that the public institutions were no longer financially viable, and plans were made to transfer the beds to private ownership over a period of years (TPP, 225 Part 3, 1991, paper 70). A privately owned company,

The 1990s saw an influx of corporations into the aged care sector, as it became more business-like and regulated. A number of new Homes were built, and a number of old Homes were taken over and renovated. Most of these were large, and many were quite luxurious; the residents certainly found them good enough. But a small number of Private Homes had already existed for several decades, and for much of this time their residents had definitely made do.

'Matron tries hard': philanthropic and proprietary Homes

> Matron tries hard, the patients appear well cared for, unfortunately a tremendous amount of maintenance work is required. Matron says she can't afford at the moment but will do the best she can.[126]

A few small Homes had opened in Tasmania during the inter-war period and post-World War Two, catering mainly for genteel old ladies who could afford to pay a little for their accommodation. These were often owned and run by trained nurses, but most offered little more than basic assistance in everyday tasks in a domestic setting.[127] Following the Second World War, a great increase in the number of Australians over the age of sixty-five made it necessary for the federal government to find new ways of providing support for the growing number of 'aged and chronics' filling expensive beds in the general hospitals.[128] At first, they made financial grants available to philanthropic groups to build new Homes, but this was not enough to solve the problem. In1962 the National Health Act was amended to allow the payment of twenty shillings a day per resident to all approved nursing homes, new and existing, philanthropic and private-for-profit, which in return would provide a degree of nursing care to their residents.[129] This new payment made the smaller proprietary Homes more viable. Those already in existence, such as the Mary Ogilvy Home and St Ann's in Hobart, were able to expand, and new establishments began to open their doors.

Tasmanian Nursing Homes, bought Cosgrove Park for $3 million in 1992, causing a furore when they were approved to buy it with a 10% deposit and a ten-year payment plan, with no further payments for five years. In 1994, Southern Cross Care took over St John's Park, renaming it Rosary Gardens (Department of Community and Health Services Annual Report, 1994-5)

[126] AOT, HSD6/2/1002 96/27/9 Inspection report, 26/2/1976

[127] These include Alison Alexander, Mary Ogilvy: The Evolution of a Grand Lady: The Mary Ogilvy Homes Society, 1946-2006 (New Town, 2006); Victoria Rigney, Many Doorways, One Journey, (Hobart, 2005)

[128] The proportion of the population aged over sixty-five increased by 50% between 1947 and 1961, with a proportionally larger increase in the older groups: RA Parker, *The Elderly and Residential Care: Australian Lessons for Britain*, (Aldershot, 1987), page 10

[129] Parker, The Elderly and Residential Care, page 12

Many of these private Homes took advantage of the large number of old, many-roomed houses in the suburbs, which were unsuitable for the post-war nuclear family without servants and therefore inexpensive to acquire.[130] The houses were chosen for convenience of location, their large size, or pleasant grounds, rather than suitability in layout or design, and they could be difficult to adapt appropriately.

Plate 8: Bethshalom Home for Aged Christians, as it appears in 2012.[131]

Bethshalom was a typical example. Opened in 1964 as a 'home for aged Christians', it occupied a house that had been built in the 1920s by the wealthy Von Alwyn family of Launceston.[132] Over the years it was extended several times, but the facilities were never luxurious and there was never much room, or much money. St Margaret's Home, also in Launceston, had similar problems:

> There is only one room available for the purposes of dining-room and lounge. Most wards are too crowded to be used as bed-sitting rooms. The result is that unless a resident is confined to bed, there is no chance of her getting away from the same people all day and every day. Toilets also present problems. There are only two on the residents' floor: one of these is within the bathroom; the other within a three-bed ward, within which is also the only shower cubicle. There is no room available for looking after noisy or disturbed patients. … There have been occasions when deafness has had to be a qualification for admission,

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[130] The pattern of private home run by a former nurse in a large old house was seen across Australia: Parker, *The Elderly and Residential Care*, page 14

[131] Once again a private residence, the present owners have named the house 'Bethshalem'. Photograph taken by Elaine Crisp with permission from owner, April 2012

[132] Interview with Dorothy Morse. The Gospel Hall Church was described by Lloyd Robson as a "fringe religion' in *A Short History of Tasmania*¸ (Melbourne, 1990), page 115

> depending upon the condition of others sharing the room in which a vacancy has occurred.[133]

Even with the government subsidy, it was not easy to make ends meet, particularly in the smallest Homes. Many had fewer than a dozen residents—Bethshalom started with eight, Sunny Brae with six, and Abbeyfayle had eleven[134]—and even with fifteen beds at St Margaret's, Sister Brokken found it difficult at times.[135] Although the private Homes charged fees, it was hard to increase prices, competing as they did with the free accommodation offered by the state institutions. This was particularly difficult in Launceston, where the relatively new Cosgrove Park enjoyed a good reputation and carried little of the stigma that still overshadowed St John's Park in Hobart. Sister Brokken admitted pensioners to fill her beds when necessary, but their contributions did not cover her costs and her Home deteriorated, requiring 'considerable maintenance' which she could not afford. She sold to the Methodist Church in 1976.[136] Dorothy Morse kept costs to a minimum at Bethshalom by doing much of the work herself, with the help of her family, including her three children. She also kept a cow and chickens,

> …so we had milk, cream and butter, and plenty of eggs and chickens, so we had meat—the basics were there. We had vegies in the garden. I can remember one Board member, he said "I wish my housekeeping was as low as that!" Well, of course, if you've got those basics it makes a lot of difference.

She also "did the laundry and everything, just as you would in your own place". She continued these arrangements when she opened her own Home, Sunny Brae, in 1969. It was not unusual for the matron of a private Home to do much of the housework, as Alex found out when she went to work as a domestic at Abbeyfayle.

> Matron did a lot of the hands-on work too, I didn't do all the washing up by myself, she'd be washing and I'd be drying. She would have gone round during the day giving whatever medications they would have had to have, and then she'd

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[133] AOT, HSD6/2/1002 96/27/9 Letter from RE Hingston to Director, Dept of Social Security, 21/5/1982
[134] AOT, HSD6/3/2651 537/13/10 Approval schedule for Bethshalom 25/3/1964; AOT, HSD6/3/2665 537/79/10 Application for licence for Sunny Brae 28/7/69; AOT, HSD6/3/2653 536/30/10 Inspection reports for Abbeyfayle.
[135] In addition, it is likely that very few of the private operators would have had business or management training or experience to assist them in running their Homes efficiently, as in a British study which found that many nurses wanted the freedom and autonomy of running their own business but rarely had the knowledge and skills to do so: Gavin Andrews and Sally Kendall, 'Dreams that lie in tatters: the changing fortunes of nurses who left the British NHS to own and run residential homes for elderly people', *Journal of Advanced Nursing*, 31:4(2000), 900-908
[136] AOT, HSD6/2/1002 96/27/9 Inspection report, 26/2/1976. A change in federal funding arrangements in 1973 had given religious and charitable organizations a $4 for $1 capital subsidy to buy private nursing homes that were for sale, and many smaller Homes were swallowed up by the larger and wealthier church-run bodies after that date: Parker, *The Elderly and Residential Care*, page 40

> be bustling around cooking. Come to think of it, running a home for ten people and having to look after them all, it must have been quite a lot of work.[137]

Even at the larger Homes, some domestic chores were often done by the operators rather than employees, to save money. At Nazareth House, with a hundred residents, the aides did quite a lot of the cleaning, but the nuns did the cooking.[138] Nazareth House was far bigger than most of the private Homes and with so many mouths to feed, the Sisters had to find ways to stretch the funding they received from the federal government. Throughout the 1970s and 1980s they relied a lot on donations.

> I can remember these friends of my parents, their mother was in there and they brought meat for the place. And the nuns used to go around asking for food and different things. The orchards would drop off boxes of apples, and people with gardens would drop off food.[139]

This could lead to a certain amount of making do, as far as meals were concerned.

> … one of the fellers said "I'll have a sausage, and I'll have an egg". Nobody told me that they were supposed to have *either* a sausage *or* an egg, not both. The sister in the kitchen was a pretty stroppy sort of a nun, particularly when you asked her for more sausages and eggs! "What did you do with the other ones?" And I said, "Well, I fed the residents with them", and there weren't any left to take to feed the other ones who were in bed. So I learned that you had to give them *half* a breakfast instead of a full one.[140]

Medical supplies were also at a premium. As late as 1990, Margaret remembered eking out the meagre stocks, and improvising when necessary:

> The nuns had such a tight budget that they didn't allow for luxuries like sterile dressing packs and things like that. You did the best you could—you'd rinse out a kidney dish with boiling water, and get some gauze out of a packet, make up some steri-strips out of Elastoplast to cover a wound. And of course we re-used bandages—they were washed and rolled. At the end of a shift, if you had nothing to do, you sat and rolled bandages.[141]

At least they did not need to dry the bandages on the gooseberry bushes, as Eleanor had done forty years before at the HFI. But other practices still echoed those old days; few of the smaller Homes could afford to hire many nurses or aides, and this meant long hours for the live-in matrons. Dorothy had one afternoon off a week, and took one holiday in

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[137] Interview with Alex Myers. Andrews and Kendall found that when RNs started their own Homes they 'immediately have had to double their average working hours': 'Dreams that lie in tatters', page 905. This stress is exacerbated by the fact that for the live-in matron, the shift never ends.
[138] Interview with Barbara Allen
[139] Interview with Judy Wall
[140] Interview with Barbara Allen
[141] Interview with Margaret

the thirty years that she ran Bethshalom and Sunny Brae.[142] Sister Farley worked forty hours a week on duty and another twenty on call at St Margaret's; when the Inspector suggested a second RN was necessary, this apparently came as something of a revelation to the Methodist Church-run Board of Management:

> Matron had shown signs of tiredness and lessening enthusiasm (certainly not devotion to duty), but their committee had not previously given thought to examining the reasons why.[143]

The aides at Nazareth House accepted that their work could not be accomplished within the hours they were formally employed, and their employers appeared to recognize and perhaps rely on the knowledge that they would work until finished.

> When I used to do seven till three, it was very seldom that I'd finish at three o'clock because there was only a couple of staff coming on then and you couldn't turn around and leave them to do it, you'd just finish off what you were doing.[144]

> If you were supposed to knock off at seven o'clock and someone needed something, you didn't go, you just stayed there and did whatever had to be done. Sometimes I wouldn't be home until half past eight![145]

Diana Gibson noted in 1998 that unpaid overtime was widespread in the aged care sector, with many staff staying on after their shifts to finish the 'back round', or run errands outside the Home. She states that they were willing to do this because such activities are seen as a 'normal' extension of the female caring role, and therefore not 'work'.[146] It certainly appears that many Homes relied on such devotion, and this did not always go unnoticed by the staff themselves.

> We'd come in before the shift officially started, because we never had time to do the work. Which I don't believe in, because if you come in early and do two or three residents before the time you're supposed to start, well naturally you'll be finished within a certain time. But if you came in at the right time and did your shift and there's some left over at the end, like a few who hadn't had their bath or shower or whatever, then the establishment get to know that there's not enough staff on or time to do these things.[147]

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[142] Interview with Dorothy Morse. Similar conditions existed at other small Homes; see, for example, Peter Yule, *Lyndoch: The First 50 Years*, (Warrnambool, 2002); Alison Alexander, *Mary Ogilvy: The Evolution of a Grand Lady*, (New Town, 2006)

[143] AOT HSD6/2/1002 96/27/9 Inspection Report, 22/9/1982 Both Sister Farley and her predecessor, Nellie Brokken, had been RNs at Nazareth House before moving on to St Margaret's. Another ex-Nazareth House RN, Joan Schneirer, opened Springslade Nursing Home in Legana in 1971 (HSD6/3/2550 Inspection report 7/7/1971). It was later bought by the Park Group, which also purchased Cosgrove Park, and is still run today as Tamar Park Aged Care Facility.

[144] Interview with Barbara Allen

[145] Interview with Nancy Langley

[146] Diana Gibson, *Aged Care: Old Policies, New Problems*, (Cambridge, 1998), pages 76-77.

[147] Interview with Barbara Allen

But still they carried on, making do with conditions that might not have been accepted so willingly in any other workplace, to ensure that things were good enough for the residents they cared for.

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No matter how difficult things were in the Homes, and how basic the surroundings, it was still a step up on the life that many residents had left behind. A file of admission applications for Cosgrove Park in the 1960s reveal the conditions in which the elderly person with no assets might be forced to live.[148] Mrs Brown was boarding and caring for two aged pensioners and an invalid pensioner and his mother, and finding the task increasingly onerous, being seventy-six herself. Mr Green, seventy-three, rented the lower floor of a terrace, and had been physically threatened by the family upstairs when he asked them to close the gate. Miss Violet, seventy-one, rented a bedroom and kitchen but feared this would soon cease as her eighty-nine year old landlady 'was not expected to live much longer'. Mrs Pink had been moved from family member to family member as no child had room for her permanently, and she 'could no longer tolerate these frequent moves'. Mrs and Mrs Rose's house was very damp, the Olives had no modern conveniences, and Miss Lemon's roof leaked. Mr and Mrs Plum rented a small weatherboard cottage with an outside lavatory, but 'its poor access completely debarrs [*sic*] [Mr Plum] from its use'. Miss Peach, an eighty-three year old lady, lived in

> …an old cottage in James Street … not fit for occupation, particularly by an elderly person. It is damp throughout, access to the kitchen is by an inadequately covered verandah, there is no bathroom. It has been condemned and will be demolished when Miss [Peach] leaves.[149]

As late as 1972, applications for admission to Cosgrove Park were being received describing slum-like living conditions: one woman's ill brother was sleeping in a hut on her property, and she had no car, no phone and a one and a half mile walk to her nearest neighbour. Another lady lived in a house with an outside toilet, no bathroom and no 'facilities'.[150] Conditions like these make it clear why such people would seek admission

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[148] AOT, AD203/1/1850: pseudonyms used as file has restricted access. These conditions were not unique to Launceston; in her history of Hobart district nursing, Dianne Snowden interviews nurses who remember visiting people living in 'almost primitive conditions, lacking even electricity' during the 1960s: *Caring for the Community: One Hundred Years of the Hobart District Nursing Service*, (Hobart, 1996), page 76. They are also widespread across Australia, as revealed by John Stubbs in *The Hidden People: Poverty in Australia* (Melbourne: Lansdowne Press, 1966)

[149] AOT AD203/1/1850 8/5/1 Excerpts from applications for entry to Cosgrove Park, 1960–1968

[150] AOT HSD6/3/2212 109/5/2 Hospitals – Cosgrove Park – Application for Entry – Individual

to a Home, whether a cramped room in a converted house or in the public institutions, and why they might accept conditions that might be less than ideal. Whether a Home is good enough depends on how well it answers the needs and expectations of the inhabitants; the opinions of the public, whether family or outside community, are not as important. This was seen clearly when the paupers in Brickfields expressed themselves content with a roof over their head and food in their bellies, when the inmates of the IDL fought so strongly to remain in a dilapidated and run-down building, and when the waiting lists for the later institutions ballooned enormously despite the falling reputations and decaying conditions of the Homes. Even a run-down and somewhat stigmatized St John's Park would be heaven in comparison to many of the houses, offering a solid roof, warmth, running water and the help of nurses, even if untrained.

This chapter also makes it clear why those with more money, more choice, and higher expectations would find the prospect of entering a Home less than appealing. From the charitable institutions providing conditions 'less eligible' than those of the poorest people in the community, to the run-down and publicly vilified public Homes in the first half of the twentieth century and the old-fashioned private Homes in the 1960s and 1970s, there was little to appeal to an increasingly well off and discriminating middle class. For the nurses, too, there was little attraction to the sector. Not only did they often endure poorer conditions and lower wages than their colleagues in other branches of the health care sector, but the domestic nature of much of the nursing care—bathing, feeding, dressing and soothing—made it seem to be a simple extension of the natural work of women, needing no training or special skill. Whilst the untrained nurses, with no other qualifications or experience, might be satisfied with working in a Home, to the trained nurse it was often seen as a waste of knowledge and expertise.

But there were always a number of old people in the Homes who were not simply aged but also ill, and who needed some level of medical treatment. The 19th century institutions addressed their needs in small 'hospital' wards, where they received bed rest and medicines but little else in the way of nursing care. It was not until the 20th century and the development of a new medical speciality—geriatrics—that the Homes began to provide therapeutic treatment on a grander scale, through the ministrations of nurses. The next chapter will examine 'Home as hospital', and the ennursement of aged care.

Chapter 4

Home as Hospital: the ennursement of aged care

Senectus enim insanabilis morbus es' (old age is an incurable illness)
Lucius Annaeus Seneca, 5BC–65AD

For at least two thousand years, the practitioners of western medicine considered the morbidities of old people as the natural progression of age, for which little could be done. In around 161BC, Roman playwright Terence wrote that '*senectus ipsast morbu'* (the illness is old age itself), and as late as the early 20th century medical texts still quoted Terence and did not disagree with him.[1] With such a view, the lives of old people were seen as less valuable than those of the young, and little time, effort, or money were expended to treat the illnesses of old people or to provide nursing special care. Although Jean Charcot discussed the particular medical conditions of old people in his *Clinical Lectures on the Diseases of Old Age* in 1867, he did not pursue therapeutic treatments for these. It was not until the 20th century that geriatric medicine developed.

The term 'geriatrics' was coined in 1909 by Ignatz Nascher, a Viennese-born American physician who pioneered medical treatment for the elderly, working extensively with the inmates of the New York City almshouse. Geriatrics remained a purely clinical discipline until 1922 when Granville Stanley Hall suggested that psychological treatments as well as physical ones should be employed to treat the elderly. The speciality came of age in the mid-1930s, when Dr Marjory Warren's work in the English poor law infirmaries brought geriatric medicine to international prominence.[2] The medicalization of old age meant that hospitals began to include dedicated geriatric wards, and Homes, too, began to be seen as geriatric or chronic hospitals rather than as welfare institutions.[3] This brought many changes to conditions for both nurses and inmates (who were now called 'patients'), and a more clinical view of the environment in which their needs would be met.

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[1] Daniel Schäfer, 'That senescence itself is an illness': a transitional medical concept of age and aging in the eighteenth century', *Medical History,* 46(2002), 525-548

[2] John Grimley Evans, 'Geriatric medicine: a brief history' in *British Medical Journal*, 315(1997), 1075-1077; John Morley, 'A brief history of geriatrics' in *The Journals of Gerontology*, 59A:11(2004), 1132-1152

[3] The term 'medicalization' 'describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders': Peter Conrad, 'Medicalization and social control', *Annual Review of Sociology,* 18(1992), 209-232, page 209.

These changes were felt as far away as Tasmania. The public Homes changed their function from carcerative to therapeutic, from custody to care, and doctors took over from the old bureaucratic administrators. By the 1950s both state institutions were officially classified as 'geriatric hospitals'. This did not mean that they stopped controlling the inmates; a hospital is still a total institution, albeit a more open one, and those in charge still wield power, even if their intention is beneficent. Although the doctors were in charge, they were not *in situ*; unlike the general hospitals, the Homes did not have resident medical officers. Their power therefore devolved upon the nurses, who were there twenty-four hours a day to keep the patients in safe hands. From the 1960s, the private Homes were also affected by these changes, as federal government funding arrangements became linked to nursing care. Even the smallest Homes were enjoined to offer trained nurses and skilled treatment. The ennursement of aged care was complete.

This chapter will trace the growing dominance of the nurse in aged care in the 20th century, from the replacement of the 19th century institutions' 'pauper nurses' with paid employees supervised by trained nurses, to the establishment of the 'geriatric hospitals' and the implementation of specialized training for the nurses who worked in them. The particular case of dementia care will be examined, as this area is one in which the carcerative and therapeutic functions are combined, even to the present day. The chapter will also explore the effect that ennursement had on the private Homes, small and large, which moved from domestic-style homes to 'private medical establishments'. It was a move that would bring about great benefits for the residents, but bring its own disadvantages too.

Pauper nurses and tired old men

> Each year increases the difficulty of finding … fit persons to act as wardsmen and attend upon the sick. I fear the day is not far distant when paid nurses will have to be employed…[4]

The inmates of the early invalid depots were, by definition, unwell. The commandant at Port Arthur noted that a large number of the Impression Bay inmates who were transferred to his penal settlement in 1857 were 'perfectly helpless, having been bed-ridden for years', and the Brickfields Invalid Station records showed 'numerous cases [of]

[4] TLC, 5, 1885, Paper 10

cancer, paralysis, ulcers, heart and chest diseases' amongst the inmates, yet they received little medical attention unless acutely ill.[5] At these establishments and at the Cascades Invalid Depot too, the frailer men and women were tended by stronger inmate nurses and wardsmen, supervised by government officials: superintendent, head warder, and a matron for the women's division. As in the hospitals, the matron was usually a woman drawn from the respectable classes, and her sphere of responsibility was domestic rather than therapeutic.[6]

When the women of Cascades were moved to the New Town Charitable Institution for Indigent Females (New Town) in 1874, the pauper nurses were supported by a head nurse, who ministered to the sick when she was not busy in her additional duties as cook.[7] She was not a trained nurse[8], but at least she was a frail and invalid inmate. She may even have been a professional nurse, a woman who made her living by caring for the better-off citizens in their own homes (the hospitals, like the invalid depots, were for the poor, and the more prosperous and respectable citizens avoided them). Professional nurses were not formally trained but were often highly skilled, gaining their knowledge from life experience.

The men at Cascades had no such assistance, and the Cascades superintendent himself complained to the government about the conditions and the poor quality of nursing care.

> I found the Hospital patients much neglected, from the want of proper attendance; the attendants were selected from amongst the Paupers, a class, as a whole, totally unsuited for such work,—being too infirm, and otherwise quite incapacitated from rendering the assistance required by the unfortunate old men placed under their care.[9]

Even when they, too, moved to New Town, they continued to be cared for by their fellow inmates. In the north, invalid women, accommodated in the hospital ward of the gaol, were tended by female prisoners under the supervision of a free woman. The female

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[5] Piper, *Beyond the Convict System*, page 183
[6] A practice long-established in England; see Brian Abel-Smith, *The Hospitals 1800-1948*, (London, 1964)
[7] TLC, 21, 1875, Paper 9
[8] There were no trained nurses anywhere in Tasmania at that time. Even the Hobart General Hospital required their able-bodied patients to assist in nursing the more seriously ill. In 1875, a Nightingale-trained nurse took over as matron of the Hobart General Hospital and opened a school there, the second in Australia. The Launceston General Hospital followed suit in 1881. Bartz Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia, Vol 1: Foundation to Federation 1788-1900*, (South Melbourne, 1991)
[9] TLC, 26, 1878, Paper 9

prisoners looked upon this service as an 'indulgence for good conduct'[10], and of course they were unpaid, saving the government money. This arrangement ceased in 1886, when the old women came under the wing of the Launceston Invalid Depot (IDL), and a professional nurse was engaged to attend to them.[11] The male attendants at the IDL were also chosen from the inmates themselves, and similar problems arose here as at the other institutions. By 1878 the average age of the inmates was seventy-one, and the Launceston superintendent also complained that

> the majority of inmates have become very feeble; it is with difficulty that Wardsmen capable of performing the duties can be selected from among them.[12]

Similar problems were being experienced in England, where the workhouse inmates also provided their own care, but in that country great changes were underway. In the 1860s a campaign led by social reformers and medical men[13] had resulted in the division of workhouses into two sections: the workhouse proper, and the workhouse 'infirmary' for the frail and ill, almost entirely populated with people in their dotage. There was a growing recognition that these people needed—and deserved—suitable nursing care, although it would be thirty years before an Act was passed to deal the 'death blow to pauper nursing' in 1897.[14] From then on, the Poor Law infirmaries were staffed with paid nurses, under the supervision of a trained nurse. Over the next few decades, these institutions gradually became the public hospitals of the United Kingdom.[15]

The Tasmanian government began to experience similar pressure to provide professional care, and it was not just from the superintendents who found it difficult to find suitable inmates to do the job. A visitor to New Town in 1886 commented on the nursing care (or lack of it) for old and frail inmates, with no night staff at all and 'the sick and dying …

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[10] TPP, 15, 1888-9, Paper 50, page xxiii The Report states that 'sentimental objection may be raised that it is unfair to the inmates to place [the old women] in the same building with prisoners; but we understand they raise no objection to being placed there.' One wonders what choice they had.
[11] TPP, 11, 1887, Paper 11. They remained in the gaol wards until the whole site was closed in 1913.
[12] TLC, 28, 1879, Paper 10
[13] See, for example, 'Report on the Northleach Workhouse and Infirmary', in the *British Medical Journal*, 16th Nov 1867, page 458
[14] A Local Government act was passed forbidding inmates to be employed as nurses: 'At last: the death blow to pauper nursing', *British Medical Journal*, 21st Aug 1897, page 493
[15] Doreen Norton, *The Age of Old Age*, (Harrow, 1990). A similar pattern occurred in the USA, where some of the oldest hospitals still extant started as institutions for the 'chronically ill, disabled, elderly, and diseased': Clifford Bennett, *Nursing Home Life: What It Is and What It Could Be*, (New York, 1980), page 18

left to the tender mercies of attendants of about 70 years of age'.[16] He suggested a trial of six or eight paid nurses, 'to control and instruct such of the inmates as are fitted for the duty and arduous task of nursing', which was refused on the grounds of economy. The following year, a Royal Commission was held to investigate conditions within the Charitable Institutions. The New Town Ladies' Committee complained that the 'nurses' (their quotation marks) were unfit for the job of caring for their patients, and asked that two trained nurses be engaged. The medical officer, Dr Barnard, agreed with them:

> The majority of [the men] are old and decrepid, [*sic*] and, as one very important part of the treatment of the aged is good nursing, I would recommend the appointment of two good nurses… I do not think there is anything objectionable in that; [the men] are lying in bed all the time. [The nurses] should be of a mature age, and married women. I think the sick there should receive as much comfort as if they were men of more refined habits; and if this suggestion were carried out, the Institution would be as near perfect as possible.[17]

The superintendent did not agree, however. He did not believe it possible to ask respectable women to attend to men of 'very dirty habits' and 'filthy actions'.[18] Neither did the matron, who 'would rather be without them. It would be introducing an uncontrollable element into the establishment, and they would jar with existing arrangements'.[19] Matron Hurst was not a trained nurse, and she may have felt that she would be unable to prevail over women with experience and skills that she did not possess; they might assume control and whittle away her authority. Superintendent Withrington may also have feared that the introduction of permanent staff with nursing experience would lead to his losing some control over the inmates, who might defer to them in preference to him (he was an ex-soldier, not a medical man). Or he may have simply been more concerned with the financial implications of such a move. The Commission certainly was, claiming that the patients were 'for the most part incurable,

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[16] TPP, 11, 1887, Paper 10. Night nurses were not employed in the general hospitals either at this stage.
[17] TPP, 15, 1888-9, Paper 50, page 32: evidence of Dr CE Barnard, Medical Officer, NTCI, questions 787-8
[18] TPP, 15, 1888-9, Paper 50, page 34: evidence of John Withrington. In fact, nursing staff of the Hobart General Hospital had already indicated to Frederick Seager, the Assistant Superintendent, that they were quite happy to provide necessary nursing care (Paper 50, page 38). The phrase 'dirty habits' was frequently used to indicate incontinence, suggesting this was seen as a moral failing rather than a medical condition. The term continued in use for many decades; Patricia Shaw stated that 'the expression 'dirty habits' should not be used' as late as 1963: Patricia Shaw, *Old People in Homes: A Handbook for Matrons*, (London, 1963), page 121
[19] TPP, 15, 1888-9, Paper 50, page 36: evidence of Mrs Louisa Hurst. This attitude was seen in other Homes, too. Judith Godden reports that a Ladies Board was appointed by the Select Committee investigating conditions at Sydney's Newington Asylum for old women, and their investigation resulted in the death rate falling from an average of eleven a month to three, 'despite the determined opposition of the Matron': 'The work for them, and the glory for us!': Sydney women's philanthropy, 1870-1900' in Richard Kennedy, (ed), *Australian Welfare History*, (South Melbourne, 1982)

and no amount of skilled nursing would be of avail', and therefore the additional expense could not be justified.[20] This was not enough to halt the campaign, however, and members of the community continued to call for professional nurses to be employed, particularly the hospital wards, as can be seen from excerpts from the Visitors' book for 1889:

> It is a matter of regret the continual absence of professional nurses in the hospital wards. (WH St Hill)
>
> The ward attendants seem very kind and attentive, but the employment of two skilled nurses to guide and superintend would be a great improvement. (A Young, MHA and JM Dooley, MHA)
>
> [It is suggested] that (say two) respectable middle-aged women as nurses be provided for each division, and with control over the supplementary nurses. (J Hamilton) [21]

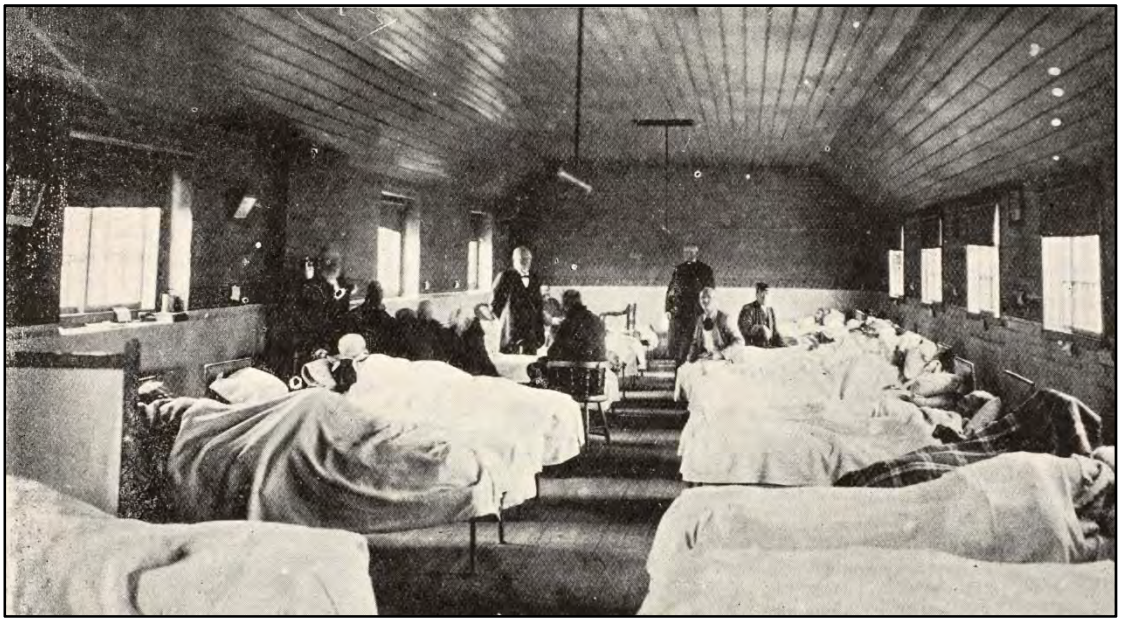

Plate 1: The men's hospital ward, New Town, c 1895[22]

A new superintendent was appointed to the IDL in 1890, and he expressed similar sentiments to these visitors. For the first time these complaints were about the quality, not simply the quantity, of the attendants:

> I am decidedly of opinion that an attendant other than a pauper should be appointed as a responsible officer, as the sick and dying require more care and attention than can be expected from fellow inmates…[23]

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[20] TPP, 15, 1888-9, Paper 50, page xxii
[21] TPP, 20, 1890, Paper 11
[22] Image from The Friends of the Orphan School and St John's Park Precinct, accessed at http://www.orphanschool.org.au/20century1.htm

His concerns were not addressed, but the New Town superintendent was allowed to employ four able-bodied paid wardsmen to look after the hospital inmates, which improved the cleanliness of the ward and allowed for 'better nursing'.[24] Several more years would pass before any trained nurse set foot in the institution, with the coming of a new superintendent and a new century.

'A great blessing': the advent of the trained nurse

> It is my pleasant duty to report another very considerable advancement in the nursing and comfort of the sick inmates. The obsolete system of inmates being employed as attendants has happily passed away, and outside female nurses are presiding over and caring for the sick and afflicted in both the male and female divisions.[25]

As assistant superintendent of New Town, Frederick Seager had long advocated for trained nursing staff to care for the ailing inmates.[26] In 1905 he became superintendent of both public Homes, and he finally succeeded in his aim. The new matron was a 'certificated nursing sister', and she supervised a staff of professional nurses rather than untrained and unpaid inmates. She and her nurses were only employed in the hospital wings of New Town (the inmates of the 'welfare' wards continued to fend for themselves), but this was a major step forward. A trained nurse was now also available to the men of the IDL, as the Launceston District Nursing Association sent Nurse Tole on a daily basis to attend the sick.[27] Superintendent Seager noted the advanced age of inmates in both Hobart (where more than half were over seventy), and Launceston (two-thirds over sixty-five):

> With such a number of poor human creatures now in the Institution, … the introduction of female nurses to care for and attend upon the sick continues to be a great blessing … but I fear the day is not far distant when consequent upon old age and the helpless condition of the inmates, further able-bodied help will be required to cope with the large number of sick people…[28]

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[23] TPP, 23, 1891, Paper 15, page 4
[24] TPP, 25, 1892, Paper 14
[25] TPP, 55, 1906, Paper 22. Female nurses had been employed in the general hospitals for over twenty years; since 1876 in Hobart and 1879 in Launceston.
[26] Mr Seager started work at New Town in 1869, spending forty-four years there in total. This long ervices was not unique; a later superintendent, Arthur Trebilcock, was there for thirty-five years, and Leonard Woodhouse started work in 1918 and was still there in 1954. John Withrington spent twenty years at Brickfields and another decade at New Town. This is in direct contrast to the men who ran the benevolent asylums in Victoria, who according to Robert Cage, rarely stayed for long and caused a great loss of continuity: *Poverty Abounding, Charity Aplenty: The charity network in Colonial Victoria*, (Sydney, 1992). Perhaps the fact that they were government employees made this longevity possible.
[27] TPP, 61, 1909, Paper 23
[28] TPP, 57, 1907, Paper 26

Inmate numbers dropped after the introduction of the old age pension in 1909, but this did not reduce the need for nurses, as those who remained were the weakest and in need of most attention. The nurses not only provided this attention but took over other aspects of the running of the Home, particularly those traditionally seen as the female preserve. They presided over the 'culinary department', and even arranged musical entertainments to 'make glad the hearts of the poor old people'. Superintendent Seager made his appreciation clear:

> Very great credit is due to the matron and nurses for their untiring energy in the cause of the poor specimens of suffering humanity now unfortunately found in such numbers in the various wards, but cared for and attended to as only women nurses can.[29]

Plate 2: The women's hospital ward, New Town Charitable Institution, c1905[30]

Superintendent Seager was not alone in his high opinion of female nurses. Florence Nightingale had famously said 'every woman is a nurse'[31], and it was a common belief at that time and for many decades to come that women were superior caregivers: kinder, more virtuous, more sensitive, more patient and more nurturing than men, and also more

[29] TPP, 63, 1910, Paper 29, page 1
[30] Image from The Friends of the Orphan School and St John's Park Precinct, accessed at http://www.orphanschool.org.au/20century1.htm
[31] Florence Nightingale, *Notes on Nursing: What it is and what it is not*, (New York, 1860/1969), page 3

likely to carry out instructions reliably and with dedication.[32] This moral superiority allowed women to gain influence and even power in areas traditionally seen as within the women's sphere of domesticity. In the parameters of affect control theory, a woman was powerful within her own sphere of influence; she was also good and quiet, an ideal role model for the still morally questionable inmates of the charitable institution. Thus, the professional nurses became agents of governmentality, ideally suited to reforming the socially deviant and returning them to the fold of respectable society.[33]

Perhaps this belief in the moral superiority of womanhood lay behind the decision to place the new Home for Invalids under the supervision of a matron rather than a male administrative superintendent. This action, together with the new name, signaled a different purpose for the new establishment, distinct from the IDL that it replaced: domestic rather than custodial.[34] The matron was assisted by another paid nurse, and although neither was trained, this ratio was a great deal better than the previous institution and even better than the hospitals—the Hobart General Hospital at that time had one nurse to 57 patients.[35] The two nurses lived in, so the inmates had nursing care around the clock.

New Town also began to provide its inmates with twenty-four hour nursing care in the same year, employing night nurses and changing its name to the New Town Infirmary and Consumptive Home. This new medical focus was echoed in the 1915 annual report, which called the inmates 'patients', a title previously restricted only to those in the hospital wards of the two institutions, but this was an aberration and the old term remained in common usage and in the official records for several decades to come. The majority of the work continued to be done by untrained nurses and attendants, who often had no experience at all before they began, and learned on the job. Minnie Lang was one such staff member. She had been hired as a laundress in 1936, and was made a nurse

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[32] See, for example, the words of Dr Balls-Headley of the Women's Hospital in Melbourne, quoted in McCalman, *Sex and Suffering*, page 78

[33]See, for example, Siobhan Nelson, 'Pastoral care and moral government: early nineteenth century nursing and solutions to the Irish question', *Journal of Advanced Nursing*, 26(199), 6-14; David Holmes and Denise Gastaldo, 'Nursing as means of governmentality', *Journal of Advanced Nursing*, 38:6(2002), 557-565

[34] Matrons were usually in charge of domestic settings, whether in schools, hospitals, or institutions, taking charge of housekeeping and nursing functions. In the institutions, the matron had previously had charge of domestic management and care of the female inmates only, as in other Homes; see CJ Cummins, *The Development of the Benevolent (Sydney) Asylum*, (Sydney, 1971)

[35] Alison Alexander and Marita Bardenhagen, 'Nursing', *The Companion to Tasmanian History*

shortly thereafter, on the same salary.[36] She did not prove entirely satisfactory, and during an inquiry into her conduct the requirements for a nurse were made clear:

> A nursing qualification was not necessary for a position of Nurse at the Rest Home. The nurses appointed to the Institution were trained there, and it was not necessary for them to have had previous experience.[37]

Although the staffing policies remained the same for many years, other administrative arrangements were about to alter. A paradigm change was occurring in the provision of care to the old and frail, originating once again from the Poor Law infirmaries in England. In 1935, Dr Marjorie Warren had taken over the West Middlesex Hospital, an institutional infirmary, and noted that the 500 patients were far from a homogeneous mass with the same care needs. She classified them into five groups and commenced a program of treatment and rehabilitation in order to restore as much function to each group as possible.[38] The results were so successful that her methods were adopted by infirmaries across the country and eventually across the world, including Australia, where she lectured during a world tour. Geriatrics became a recognized medical speciality, and the elderly became suitable subjects for treatment.[39] Health care was now seen as important at every stage of life, and the medicalization of old age began in earnest.

Home becomes 'hospital': the influence of geriatric medicine

> …the future of the Institution would be different from that in the past, inasmuch as formerly it was used only as an asylum for the aged, and now it was being utilised as a hospital for chronic cases…[40]

Although Miss Lang and the other untrained nurses continued to staff the Tasmanian institutions, the two public Homes ceased to be the responsibility of Social Services and were placed under the aegis of the Department of Public Health. It was also decided to put the New Town Rest Home in the charge of a medical officer as superintendent, and in

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[36] This is reminiscent of the conditions in the English workhouse infirmaries in the 1860s, where 'often a scrubber or laundress would be promoted to paid nursing duties': Abel-Smith, *The Hospitals,* page 56
[37] AOT, HSD1/28 98.29.36, Document 6
[38] The five groups were chronic up-patients, chronic continent bed-ridden patients, chronic incontinent patients, senile but quiet patients, and those with senile dementia, who required segregation. Marjorie Warren, 'Care of chronic sick', *British Medical Journal,* 25th December 1943, pages 822-823
[39] Morley, 'A brief history of Geriatrics'; Barton and Mulley, 'History of the development of geriatric medicine in the UK'; Megan Davies, 'Renovating the Canadian old age home: the evolution of residential care facilities in B.C., 1930-1960', *Journal of the Canadian Historical Association,* 12:1(2001), 155-175. Articles on the care of aged patients began to appear in the *American Journal of Nursing* in the 1930s: for example, Evelyn Pettee, 'The care of the aged', 39:2(1939), 145-155
[40] TPP, 119, 1938, Paper 3, page 2

1938 it changed its name again, to St John's Park, and was officially designated as a geriatric hospital.[41] The death of the Matron of the HFI in the same year brought an opportunity to upgrade the medical credentials of the Launceston establishment as well. Matron Burris had been ill for some time, and a week before her death, the hospital employees' union took the opportunity to press for the appointment of a trained nurse into the expected vacancy.

> It has been suggested by Members of the above Union that when consideration is being given to making an appointment a woman who has the qualifications of a trained nurse should be appointed. I am given to understand that it is frequently necessary in this Institution to have professional attendance to these old people; hence the desire to have a trained nurse, who is capable of rendering this service.[42]

The Director of Public Health agreed, and Sister Bernice Campbell, who was 'well qualified both professionally and personally to carry out the duties of the office', was appointed to the position.[43] It was recommended that Matron Campbell have another trained nurse to assist her, but this almost certainly did not happen, as similar recommendations were made ten years later when her successor was still the only fully trained nurse working at the HFI.[44] Both Homes faced particular difficulties in finding staff as they were not training hospitals and could not produce their own nurses. The general hospitals were staffed with student nurses, girls in training, who provided patient care in return for their instruction, lived on the premises and were paid a very small wage. The public institutions did not have access to this inexpensive, well trained, and dutiful workforce; they had to pay full female wages and the nurses were free to come and go—and unfortunately, many of them went.

After the forty-hour week was introduced in 1948, the Homes began to accept practically anyone willing to do the work.[45] At the HFI, where a second male attendant was

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[41] TPP, 117, 1937, Paper 9 Davies noted a similar round of name changes in British Colombia at this time, as the word 'old' was removed from the titles and names more redolent of hospitals or places 'for recreation or as a quiet place for the last stage of life', such as gardens: 'Renovating the Canadian old age home', pages 159-160

[42] AOT, HSD1/1/4037 99.3.38 Letter from Mr Barnard, Branch Secretary of the Dispensary and Asylum Employees' and Allied Government Officers' Federation, to BM Carruthers, 28/2/1938

[43] AOT, HSD1/1/4037 99.3.38 Memo from BM Carruthers, 23/5/1938

[44] AOT, HSD6/1/1975 Memo from Public Service Commissioner to Minister for Health, 17/5/1948; AOT, HSD6/1/562 Inspection Report, 11/11/1946 shows 'Matron (general trained), 5 semi-trained, 1 attendant'

[45] In his survey of aged care homes published in 1950, Bernard Hutchinson found it 'noteworthy' that a 'medical' establishment should be run by non-trained personnel rather than nurses: *Old People in a Modern Australian Community*, (Melbourne, 1954). One explanation is that the medicalization occurs 'on the conceptual and institutional levels [rather] than on the interactional level of patient treatment'; the doctors

desperately needed to cover the male division, a fifteen-year-old girl was helping to look after the elderly men. The Minister of Health found this unacceptable, declaiming that '…such duty should not be allotted to a young girl'.[46] It is not clear whether his objections were due to her lack of experience or skill, or to the moral niceties of such a situation, but it is likely to have been the latter.

The perfect answer was the 'semi-trained' nurse, a woman who had started her training as a hospital nurse but had not completed her qualification. These nurses brought whatever level of skill and knowledge that they had already gleaned in the hospital ("we were allowed to do anything which we had done during our little bit of training"[47]), but did not command a trained nurse's salary. Government regulations prevented semi-trained nurses working in other health care areas without further study, but they could find work easily in the government-run Homes. Both Eleanor and Claire were semi-trained, having completed a few months of nursing at the general hospitals before leaving when they became engaged to be married.[48]

> [The HFI] was the only place available in Launceston for a partly-trained nurse. I rang the Matron and she said she would like me to come, and I just had to wait a couple of weeks until there was a vacancy and she rang me.[49]

> I got a job at St John's Park and I was there for three years. They were always crying out for staff there. I didn't have any trouble getting a job. I simply went there are asked 'is there any work?' [and the Matron said] 'when can you start?'[50]

Eleanor received no further training, but Claire did; from 1949, St John's Park nurses were given the opportunity to upgrade their skills, and improve their salaries. A syllabus

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(and in this thesis, RNs) manage the care rather than providing it: Peter Conrad, 'Medicalization and social control', page 215

[46] AOT, HSD6/1/1975 Memo from Minister for Health to Director of Health & Medical Services, 7/6/48

[47] Interview with 'Eleanor'. The use of semi-trained and untrained nursing staff in the institutions was a pattern repeated throughout Australia. Wendy Madsen's examination of the use of untrained nursing staff in Queensland showed that as hospital standards improved and registration of nurses became mandatory, untrained nurses moved from private duty nursing, lying-in hospitals and the community into institutions catering for chronic ill and aged patients, which did not have the same requirements for trained and skilled staff. Wendy Madsen, 'Early 20th century untrained nursing staff in the Rockhampton district', *Journal of Advanced Nursing*, 51:3(205), 307-313. It is worth noting that in many American public institutions still using unpaid inmates to provide the majority of care as late as the 1940s, a practice that had ceased in Tasmania several decades earlier: Raymond M Hilliard, 'The emerging function of public institutions in our social security structure', *The Social Service Review*, 20:4(1946), 479-493

[48] Marriage put an end to a nursing career, so there was little point in continuing. The Public Service, which employed hospital nurses, did not allow married women to hold permanent positions until after 1966. Jill Conway, 'Gender in Australia', *Daedalus*, 114:1(1985), 343-368

[49] Interview with 'Eleanor'

[50] Interview with Claire Paynter

of lectures and examinations was provided to both male and female employees, who attended on separate days—the gender segregation applied even to the classroom. Six lectures in the first year covered both theory (anatomy and physiology) and practical topics, such as first aid, dressings and bandages, treatment of fractures, artificial respiration, routine examination and 'transport of injured persons, including practical instruction on hand-seats and, for males only, stretcher exercises'.[51] This syllabus was revised two years later, to include more practical subjects, including:

- Definition of Home Nursing, qualities of the nurse, advice to nurses
- The sick room, choice, preparation, cleaning, lighting, ventilation and heating
- The bed, bed-making, bed-making in special cases, aids to comfort in bed
- Observation of the sick, temperature, pulse, respiration etc., signs and symptoms to be noted, Doctor's visits
- Daily nursing routine, washing the patient, bed-sores, care of the mouth, care of the hair
- Invalid diet, serving of food, milk, liquid and light diets
- Methods of treatment, removing or neutralising the cause, promoting favourable conditions, rest, aiding nature's efforts, medicines and their administration, external applications—cold, heat, counter-irritants
- Treatment of certain symptoms and of special diseases—paralysis, cardiac diseases, renal diseases, respiratory diseases, rheumatic fever
- Infection and its prevention, disinfectants
- Specific infectious diseases
- Surgical nursing, wounds and their care, asepsis, wounds, burns and scalds, fractures [52]

Staff members with more than five years' experience were initially exempt from the lectures, although they were examined on various practical skills, including sponging, bed-making, taking of vital signs, urine testing, preparation and use of enemata, catheterisation, bandaging, feeding and giving injections. Those with less than five years' experience had to attend, but this was also a privilege—one could only gain admittance to the training after successfully completing twelve months' probation.

Passing the course did not give the nurses a recognized nursing qualification outside the Home, but it did bring monetary reward. The successful nurses, both male and female, received a £26 nursing efficiency allowance, which brought their salaries into line with the psychiatric nurses at Lachlan Park Hospital.[53] It also altered the nomenclature used

[51] AOT, HSD6/1/2814 98.7 Examinations for Improvement of Staff
[52] AOT, HSD6/1/3340
[53] AOT, HSD6/1/3340 98.5 Memo from Supt Woodhouse to Director of Public Health, 30/7/51. Staff members who completed a First Aid Certificate received an increment of £13 per annum: Memo from Supt

for the female staff: the senior sister became the 'assistant sub-matron', the junior sister 'senior sister in charge' and the nurses who had passed examinations became 'staff nurse' or 'senior nurse', to distinguish them from the 'nurse assistants' who had not completed their training. The staff nurses controlled the wards during the day shift, but were in complete charge of the female division on afternoon and night shifts, as were the charge attendants in the men's division.[54]

St John's Park was run very much like the general hospitals, with an organized and disciplined hierarchy and formalized rules and regulations. In contrast, the HFI retained a more domestic atmosphere, and the nurses continued to receive no formal training. When plans were being finalised in 1952 to replace the HFI with a larger Home, the Director General of Health Services, Dr Edis, did not envision the need for much nursing care in the new establishment either.

> It is proposed to house approximately 100 old people at Cosgrove Park. Some of these cases will be ambulant, some will be bedridden. Of the bedridden ones practically all will be beyond any medical treatment. … As there will be very little medical treatment in an institution such as this, very little trained nursing staff will be required. I suggest one matron and one sister, who could be known if necessary as Sub-matron. … staffing will have to be carried out by people of the nature of Blue Girls or [auxiliary nurses]. These people … will work a 9-5 forty-hour week, or something similar.[55]

It appears that Dr Edis still subscribed to the notion of old age as an incurable illness that needed little treatment other than 'tender loving care in a clean, warm environment'[56], and rationed care at that.

Care was not the only thing to be rationed. Although many new drugs were coming on to the market in this post-war period, few of these were prescribed for the patients in the Homes. Eleanor knew about penicillin, but never saw it ordered at the HFI, and Claire agreed that "there wasn't a lot in the way of drugs… That wasn't the idea."[57] New drugs were often expensive, and this was a problem when the state government had to foot the

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Woodhouse to Public Service Commissioner, 12/11/1951. Claire remembered receiving an extra fifteen shillings a week after completing her First Aid Certificate.

[54] AOT, HSD6/1/3341 98.6 Memo from Supt Woodhouse to Public Service Commissioner, 25/2/52

[55] AOT, HSD6/1/6021 109.4.8 Letter from Director General of Medical Services, 11/7/1952

[56] A widely accepted belief historically: MF Cullen, 'Nursing care', in Michael Denham, (ed), *Care of the Long-Stay Elderly Patient*, (London and Canberra, 1983), page 42

[57] Interview with Claire Paynter

bill. When it was suggested that a new anti-inflammatory drug, butazoladin[58], be trialled to treat two of the HFI's arthritic patients, a sum of ten pounds was requested from the Home's 'Treats' fund, which stood at the not inconsiderable sum of £439/14/7. The Departmental accountant thought it unlikely that 'any donor would offer the slightest objection if any expenditure were incurred which would have the effect of relieving the suffering of rheumatoid arthritis patients', and Dr Edis reluctantly agreed to a one-off payment, but he did have qualms about the wisdom of the move:

> …should the drug prove successful, then the cost of further treatment cannot be borne by this fund. It would seem, therefore, that unless financial arrangements can be made for continued treatment, it would be unwise to commence the initial treatment.[59]

Despite Dr Edis' belief that there would be 'very little medical treatment' at Cosgrove Park, it was officially described as a 'hospital for the aged sick' by the Minister for Health.[60] The Home was to be managed by the Launceston General Hospital (LGH), which would enable the hospital to transfer 'disposal problems'—long-term patients with chronic illnesses—to the institution immediately when acute beds were needed.[61] As he laid the foundation stone for the new Home which was to be named after him, Tasmanian Premier Robert Cosgrove declared

> Old people are living longer and becoming more numerous and it is the responsibility of the community to ensure them comfort, security and happiness in their declining years.[62]

And despite Dr Edis' reluctance, they received medical treatment too.

'A hospital for chronic diseases plus old age'

A year after it opened, Cosgrove Park's role as a 'hospital for chronic diseases plus old age'[63] was made even clearer when a dedicated medical officer was appointed, as at St

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[58] A trade name for phenylbutazone, a non-steroidal anti-inflammatory drug released in 1949. It is no longer used for humans.
[59] AOT, HSD6/1/4296 99.5.2 Memo to Sister Widdicombe, 20/08/1953
[60] RJ Turnbull, Minister for Health, 'Foreword', in Department of Health, appeal brochure, *For the Aged – Security Care Comfort: Cosgrove Park Home for the Aged*, (Hobart, c1953)
[61] The *Mercury*, Wednesday, 2nd July 1952, page 17: 'Hospital will control Invalid Home'; AOT, HSD6/3/2216 109/8/1 Report by Dr AJ Foster, 13/6/1961
[62] The *Examiner*, Thursday, 12th October, 1950, page 3 The decision not to call the new Home the 'Home for Invalids' after all, but to name it instead after a respected public figure, indicates that the new Home was regarded as being superior in status to the old, 'an indication of the growing respectability of old age homes': Davies, 'Renovating the Canadian old age home', page 160. The fact that the Premier agreed to this naming suggests he saw no stigma in being associated with such an institution.
[63] AOT, HSD6/3/2192 109/1/2 Letter from CC Petrovsky, Gen Superintendent of the LGH, 6/9/56

John's Park. Dr Ick was eighty-six years old, a retired GP with a good reputation in the local area. In a somewhat unusual twist, he was actually a resident of the Home. The Director General justified his choice of the venerable physician by explaining that 'being himself an old man, [he] had more insight into psychological aspects of old age than one can expect from a young doctor'.[64] This may have been true, but it could also be argued that the old tradition of 'making do and good enough' was still in play. In any case, the situation was mutually beneficial to the two parties: it provided the Home with a doctor at a very low cost, and it allowed Dr Ick to move into Cosgrove Park as a resident without embarrassment, giving him 'a reason, other than an economic one, for being there.'[65] This comment suggests that the stigma of the charitable institution still affected the new improved Cosgrove Park in the eyes of the middle classes.

The ruse was not entirely successful. Judith worked as an RN at the Home during Dr Ick's residency, and was unaware that he was officially appointed to the position. She believed him to be simply a resident, to whom she could go to for advice if she was "really in trouble".[66] His professional colleague and successor, Dr Welsh, also lived in, and was also of advanced age[67], and this could sometimes be confusing for the staff:

> …the doctor was in the kitchen one night and one of the nurse's aides went in and found this old man in the kitchen and she said to him, "come on, Pop, it's time to go to bed!" and she took him by the hand, took him down to the main wing, for him to go to bed! And it was the doctor![68]

This exchange demonstrates the artifice of the social world in a total institution, a reality that is constructed rather than natural. Goffman explains that staff and inmate groups can often be close in 'function and prerogatives' and that in many cases reverse roles and play on the other side'.[69] Davies further elaborates on this by pointing out that the openness of the total institution plays a part in this; whilst a prisoner and his warder cannot change sides in a 'closed' gaol, in an 'open' institution 'all positions in the hierarchy are at least theoretically open to everyone'.[70] At Cosgrove Park, this was clearly the case, and the

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[64] AOT, HSD6/3/2191 109/1/2 Letter from J Edis, 29/8/56
[65] AOT, HSD6/3/2192 109/1/2 Letter from J Edis, 29/8/56
[66] Interview with Judith Beard and Elaine Sturzaker
[67] AOT, HSD6/3/2192 Letter from John Edis, 23/12/1958; interview with Judith Beard
[68] Interview with Kay Joyce
[69] Erving Goffman, 'On the characteristics of total institutions', *Asylums* (Harmondsworth, 1968), pages 104-5
[70] Christie Davies, 'Goffman's concept of the total institution: criticisms and revisions', *Human Studies*, 12:1/2(1989), 77-95, page 86

Homes were also repositories for older nurses, too. Several participants mentioned RNs who were as old as the people they were looking after. Claire exclaimed that her staff nurse was "quite old …getting on for sixty!"[71], and Helen thought one RN she worked with at Cosgrove Park in the 1980s

> was one of the patients, she was so old!—she had grey hair pulled back in a bun, and she must have been in her sixties, well and truly in her sixties. There was another elderly sixty-odd year old woman who had been there for yonks. There were a lot of staff who were like that. I think they were waiting to get their [own] bed, working as long as they could![72]

Plate 3: Staff of Cosgrove Park, c1960[73]

Notwithstanding the advanced age of its resident doctor, Cosgrove Park was a great leap forward for aged care in Tasmania, and for a while it led the country as a state-of-the-art geriatric facility. The day-to-day operations were supervised by the highly qualified matron, Sister Hogarth, assisted by several certificated nurses sourced from the LGH itself. Judith started work there when it first opened in 1954, immediately after completing her training at the LGH:

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[71] Interview with Claire Paynter

[72] Interview with 'Helen'. In 1950, Ollie Randall found that many nurses went into aged care at the end of their careers, thinking that 'if they should become ill or incapacitated, they would be in a place where they could be cared for, [wanting] protection for themselves quite as much as a job': 'Wanted: a nurse for a home for the aged—must have a genuine liking for old folks', *American Journal of Nursing*, 50:7(1950), 428-420, page 428

[73] AOT, AB644: Photographs of Cosgrove Park

> I remember Dr Morris, a Resident [at the LGH], and there was a big joke that he was going around with a little book saying who needed to go to Cosgrove Park and would they like their names put down. The day I got there there was nobody else there—Sister Hogarth was in hospital with a back problem. So here was me in all my glory, with this lovely veil hanging down, feeling terribly important.[74]

Judith *was* important, despite her youth and inexperience. Dr Edis had prevailed and there were very few RNs on staff, two on morning shift (one in each wing), and a single RN on both afternoon and night shifts.[75] They supervised both the male attendants and the female nurses' aides, who unlike the unqualified 'nurse assistants' at St John's Park were still given the title 'nurse'.[76] Judith worked on the morning shift in the men's wing. In her absence, the three senior male officers ran the wing, supervising the attendants and administering the drugs. She found them 'experienced and responsible', but there is no detail in the records to show where this experience came from; possibly they had previously worked at the HFI or St John's Park. The Cosgrove Park staff learned how to care for their patients by watching their fellow workers, and with the help of the RNs. At St John's Park, however, another forward leap was about to occur.

'A special branch of training'[77]: the Geriatric Auxiliary Nurse

In 1956, the Tasmanian Nurses Registration Board (NRB) approved a new branch of training under the Tasmanian Auxiliary Nursing Service Act, to be known as the 'Geriatric Section'.[78] The St John's Park Geriatric Training School for Auxiliary Nurses opened the following year, and the number of staff undertaking nursing training grew quickly, from fourteen women and seventeen men in 1958 to forty-two women and thirty-seven men two years later.[79] In recognition of their new professional status, the male attendants became 'Male Nurses-in-Training', although female staff remained 'nurse assistants' throughout their course.[80] The NRB expressed its hopes that the training school would not be unique:

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[74] Interview with Judith Beard. When I questioned her about the term 'inmate', she said they were still called that, but 'patient' was coming in, as Cosgrove Park was 'a hospital, not a home'.
[75] Interviews with Judith Beard, Elaine Sturzaker, and Kay Joyce
[76] 'Geriatric Attendants Cosgrove Park and Evandale', staff handout given to Kay Joyce on commencement of work at Cosgrove Park, 29th May 1961
[77] TPP, 157, 1957, Paper 76, page 18
[78] TPP, 157, 1957, Paper 76, Appendix III, page 18
[79] AOT, HSD6/3/2492
[80] AOT, HSD 220/1/1 File 1B Memo from Superintendent Trebilcock to Public Service Commissioner, 15/1/1961

> As plans are being made for other institutions for the aged in other parts of the State, it is to be hoped that the lead thus given will encourage other institutions to implement similar training schemes.[81]

St. John's Park Name: ALLEN William Charles

Instruction	Date	Remarks
Ethics of Nursing	3.12.57	Attended Geriatrics Training classes of 3 hrs daily at St John's Park. From – 3.12.57 to 20.12.57 inclusive. – Instructed by Male Nurse Hamilton.
Care and Administration of Drugs	7.12.57	
Asepsis—Setting up of Trays	12.12.57.	
Catheterisation and Bladder Washout (Prac. demon.)		
Enemata	10.12.57.	
General Care of Patient	5.12.57	
Examination of Urine, Faeces and Sputum (Prac. demon.) Theory	18.12.57.	Instructors Remarks. –
Preparation and Administering of Drugs by Injection	7.12.57	Displays an intelligent
Temperature—Pulse and Respiration in Health and Disease	7.12.57	interest in all phases of
Last Offices	19.12.57	Nursing, both practical &
Ward Cleaning and Care-Hospital Equipment	3.12.57	theory :– Ideally suited,
Elementary Hygiene	13.12.57	
Bedmaking—Various Types	6.12.57.	
Inhalations, Fomentations and Poultices		
Elementary Dietetics	12.12.57.	
Revision of First-Aid to Standard of St. John Ambulance	16.12.57.	
PREPARATION & SERVING OF MEALS – FEEDING	4.12.57	
HELPLESS PATIENTS.	"	
MOUTH TOILETS.	"	
20177 BEDSORES.	"	

Plate 4: An example of a training card, St John's Park, 1957[82]

Suggestion was made that the School might provide training for staff at some of the other Homes now opening across the state, both public and private. Dr Edis agreed that these would be 'best staffed largely by persons trained in geriatrics', but although he was happy for such a course to go ahead, he suggested that it be as short as possible, 'as these Auxiliary Nurses are primarily employed … to look after old people'.[83] It appears that he still did not fully subscribe to the idea that caring for old people required anything more than basic training. Despite the agreement of the School, no training course was developed and St John's Park remained the only institution in the state to offer its staff a certificated training course. Cosgrove Park aides continued to be taught by the RNs, with occasional lectures from the doctor in charge.[84]

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[81] TPP, 159, 1958, Paper 74, page 20
[82] AOT, AE744/1/1 St John's Hospital training cards A-Z
[83] AOT, HSD6/3/2494 Memo from J Edis to Superintendent Trebilcock, 6/7/1960
[84] Interview with Kay Joyce

From 1961 that doctor was the newly appointed geriatrician, Dr Alan Foster, who took over the medical supervision of Cosgrove Park after the death of Dr Welsh.[85] The Home would never again have a live-in doctor. As part of his new role, Dr Foster made a comprehensive assessment of the Home and its operations and found the standard of nursing of a 'high order of efficiency', despite the lack of qualified staff. Although he was generally pleased, he did note the beneficial effect that training had on the employees:

> The bed-side teaching of nursing-aids in such matters as care of the skin, care of the feet, simple physiotherapy, and general promotion of conscience towards patients, showed a marked improvement in morale and general interest in those so instructed.[86]

Some of the female staff were semi-trained, but many of the other aides, both male and female, had no training or experience at all. To address this lack of knowledge, Dr Foster again raised the possibility of the aides training towards a formal certificate in geriatric nursing, as at St John's Park. Again, it was refused.

The inability of the non-hospital trained staff to gain any official credentials was to cause some problems in the smooth running of the Home. With no qualifications, the male attendants could never achieve the highest level of authority—that belonged to the RNs. And in the male-dominated workforce of the 1950s and 1960s, that meant trouble.

Hospital hierarchy and power struggles

At St John's Park, the male division was run by male officers; the chief attendant was a certified psychiatric nurse and his underlings were 'male nurses-in-training'.[87] At Cosgrove Park, there were no male RNs, so this gender segregation was impossible, and female RNs ran both divisions.[88] Some of the male employees found it difficult to accept

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[85] Dr Foster was apparently a popular and appointee; Elaine Sturzaker called him a 'lovely, lovely man', and Judith Beard and Kay Joyce all used the same descriptive when talking about him. Dr Foster made regular weekly visits to Cosgrove Park, but when he moved on this role was gradually taken over by other doctors from the LGH, who also attended to emergencies. This situation that continued until the Home was sold into private hands, when residents were finally granted their own choice of medical practitioner: interviews with Judith Beard, Elaine Sturzaker, Kay Joyce, and Helen

[86] AOT, HSD6/3/2216, Document 2: Report by Dr AJ Foster, 13/6/1961. Dr Foster was later Minister of Health, and a keen advocate for community care for aged people.

[87] HSD6/1/3340 Memo from Superintendent Woodhouse to Chairman, Classification Board, 29/5/1951

[88] Male nurses were not trained in Australian general hospitals until the 1940s, and no men at the LGH until 1944; by 1960 fewer than half a dozen had qualified: Linda M Brown, *History and Memories of Nursing at the Launceston General Hospital*, (Launceston, 1980), page 63. St John's Park had access to a larger pool of male nurses, as Lachlan Park Psychiatric Hospital had been training men for many years.

female supervision, and when Matron Hogarth terminated the employment of three male attendants in 1959, they complained to their union. A letter was sent to the Board of Management outlining their grievances:

> We would request that serious consideration be given to the … question of whether or not women can satisfactorily supervise men. A skilled manager [should] be employed, preferably a male nurse. … The position is that attendants have three bosses—Matron, Sisters and head attendants. This only leads to confusion. Sisters should have their special duties to perform and not be in charge of attendants.[89]

On the copies of this correspondence in the files of the Department of Health, it appears that someone in that department had sympathy with these views, pencilling in the notation 'I agree 100%' next to the paragraph. There is no evidence to show who this was, but the Board did not concur anyway. Their reply was in the RNs' favour.

> If women possess the greater knowledge and experience then, naturally they should be in a position of supervision. … The position is that the best person available should be appointed, irrespective of whether that person be male or female. … The chain of authority is no different to that in any other institution and it exists at this hospital. There have been no complaints here [at the LGH]. It must be remembered that the men have had little or no training, and therefore it is necessary for their work to be supervised…[90]

Another pencilled notation again appears on the copy in the Department's records, underlining the second sentence above and adding 'not the point'. The presence of this correspondence in the Department files suggests that the matter was taken further than Board level, but there is no evidence that Department officials made any attempt to overrule the Board's decision. The chain of command stood, and the female RNs continued to run the male division. Relations improved between management and staff the following year when Matron Hogarth left and was replaced by Bill Elmore, one of only five male RNs in the north of the state at that time.[91] The RNs were all still women, however, and they continued to face intermittent resistance from their male subordinates.

> *Judith*: There might have been a little bit of resentment occasionally, with a few of them, but they knew that we were in charge, and that was it.
> *Elaine*: That's right. They knew we were trained nursing sisters, and they were not. And if they wanted their job they did as they were told. …every RN up there

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[89] AOT, HSD6/3/2191 Letter from Charles Lamp, Secretary, HEF to Board of Management, LGH
[90] AOT, HSD6/3/2191 Reply to Charles Lamp, 31/8/1959
[91] Interviews with Judith Beard, and Peter Davy; LGH Annual Report 1960. One of the other four, Bernard Harding, would fill the same position from 1965: Brown, *History and Memories*, page 64. In her chapter 'Women and health' in Victoria Robinson and Diane Richardson, (eds), *Introducing Women's Studies*, (Basingstoke, 1997), Jenny Hockey points out that this situation was common in the 1960s, when despite the fact that less than 10% of nurses were men, they held more than 50% of elite nursing positions.

> ran a tight ship, and you were respected for that. You put your stamp on your standards and parameters, and that was it—they just respected it. I don't remember having any problem at all with the male staff.[92]

There is an overtone of the power struggle in these comments, and this appears to have occurred to Elaine, too; in a subsequent conversation she modified this to deny that any 'insurmountable' problems existed.

As an annexe of the LGH, Cosgrove Park took on a hospital-style hierarchy, with junior staff members expected to stand with hands behind backs when the Matron entered a room, and Sisters addressed with their official titles.[93] The RNs sometimes struggled to instil hospital etiquette in the untrained staff they supervised, both male and female. They had to "quickly adjust to working with people who were friendly to the point of familiarity"[94], and whilst Elaine hastened to say that "it was a much nicer way to work", that may not have always been so at the time. Despite happy memories of his work and workmates at Cosgrove Park, Peter D remembered the RNs as "haughty, treating a lot of us as inferior".[95] This is an interesting contrast with Kay's memories:

> The RNs shared the duties, they worked with us. They'd do what we were doing, and help. They'd give out tablets, and do the dressings, and then they'd come along and help us if we had lots of people we had to feed, or… they just used to come along and do things in general, just like we were. We did have a good relationship with them, yes, very good. There was no division.

These contradictory perceptions could be explained by the differing social identities adopted by the RNs, Peter D, and Kay, and the expectations they had of themselves and the people with whom they worked. The RNs were used to the hospital hierarchy. By the time they finished their training, they expected to take on positions of authority within the hospital, to be obeyed by their underlings, and to receive the respect and obedience that their position warranted. They were strong, active, and good, and they made this clear by 'running a tight ship' and ensuring the staff came up to their standards. For Kay, this was quite acceptable; she had thought of 'doing nursing' herself, admired the women who had succeeded in their career, and was pleased and grateful to receive their help. Her submission and obedience would have been met with approval, and even friendliness.

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[92] Interview with Judith Beard and Elaine Sturzaker
[93] Interview with Kay Joyce
[94] Interview with Elaine Sturzaker
[95] Interview with Peter Davy. Peter's supervising RN was Judith Beard.

For Peter, however, it was not so clear cut. Although they were professionals, the RNs were also women, who in that pre-feminist era could be expected to be quiet and weak.[96] But they were not—they were in charge, and they were quite unequivocal about it. He and his fellow male colleagues chafed under the yoke, calling the RNs 'battleships'[97], an interesting choice of words when one considers that when Judith was Peter's supervisor, she was only in her mid-twenties.

There may have been difficulties behind the scenes, but to the public, Cosgrove Park was a great success, even by international standards. In 1961 the distinguished British geriatrician, Dr Lionel Cosin[98], visited Cosgrove Park to give the opening speech at the first Tasmanian Geriatric Conference. He praised Tasmania as being well ahead of the British Commonwealth in matters of aged care and expressed his 'pleasurable surprise on the obvious efforts being made to provide the elderly with the most suitable accommodation and care possible' at the two government institutions.[99] In Britain, the prevailing philosophy of care was to provide a complete package of facilities, combining residential Homes with independent living units, both under the aegis of a hospital for acute care. The Tasmanian government adopted a similar policy, declaring that 'so far as possible, accommodation should be attached to general hospitals'.[100]

Cosgrove Park followed this model exactly. Not only did it include a 'Twilight Cottage' scheme, with twenty-four unit in the grounds of the Home, but its association with the LGH gave it direct access to diagnostic and treatment facilities. Similar administrative arrangements were in place at Spencer Wing, a third and much smaller public institution which opened in 1958 in the now-disused maternity hospital at Wynyard, in the north-west of the island. The medicalization of old age had brought the Tasmanian government another selection of second-hand buildings to re-purpose, and Spencer Wing would be the first of several Homes to occupy superseded or superfluous medical establishments across Tasmania.

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[96] See, for example, Vern Bullough, Brenda Shelton and Sarah Slavin, *The Subordinate Sex: A history of attitudes towards women,* (Athens, GA, 1988)
[97] Interview with Peter D
[98] Dr Cosin was a founder member of the British Geriatrics Society and a specialist orthopaedic surgeon. He was a pioneer in the surgical treatment and rehabilitation of elderly patients with fractured femurs, enabling them to regain independence and even return to the community. (Norton, *The Age of Old Age)*
[99] LGH Annual Report, 1961: Address by Dr L Cosin, at the opening of the Geriatrics Conference
[100] TPP, 161, 1959, Paper 59, page 6: Official opening of Spencer Home for the Aged, Wynyard

One result of the closer association between Home and hospital was the use of a wider range of medicines. Antibiotics and sulpha drugs were now being used regularly, along with cardiac drugs such as digoxin, analgesics, vitamins ("nearly everyone had a vitamin tablet up there, every day, B1 or B6"[101]), antacids, and what Peter D described as "breathing medicine"—many of the men had been miners and most were heavy smokers.[102] Diuretics were common, as were laxatives:

> …they were very big on making sure everyone had a crap every day. We had the old Shaw's cocktail, senokot, coloxyl, and if you hadn't had your bowels open for a few days, you got a suppository.[103]

This increase in drugs was necessary, as the patients were now more likely to be chronically ill and very frail. The growing number of private Homes were providing an alternative for elderly people who needed some help, but they did not as a rule take in anyone who needed a great deal of nursing care, or was bedridden. Those people had no choice but to enter the 'geriatric hospitals' in Launceston, Wynyard, or Hobart. This posed particularly difficulties at St John's Park, where by 1962 around two thirds of the Home's five hundred-plus patients needed ongoing medical treatment. Superintendent Trebilcock could see that that their care needs would soon exceed the scope of practice of the auxiliary nurses who made up the majority of his staff. It was time for another great leap forward for Tasmanian aged care nursing.

'First class nursing…': the Geriatric Registered Nurse

> There is no doubt that the type of patient being admitted … today requires hospital attention which demands first class nursing. I do feel the standard of nursing must be elevated … and a suggested curriculum has been forwarded to the Nurses' Registration Board for its consideration.[104]

In 1963, the *Nurses' Registration Act* 1952 was amended to include a 'course of training for geriatric nursing and for the registration of geriatric nurses', to be offered at St John's

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[101] Interview with Kay Joyce
[102] Interviews with Peter Davy, and Pat Job
[103] Interview with Peter Sweeney. Similar practices were noted by Vera Green and Michael McKean in Ward H and at Allambi respectively. Eileen O'Leary remembered one nun at Nazareth House who saw laxatives as the answer to all patient ills: "anytime somebody had a pain, she'd give them laxatives! It got to be a bit of a joke – if anybody complained of anything, 'it's the bowels'! and you'd get some laxatives." It appears this practice was widespread, not only in Australia. Patricia Shaw stated that regular aperients for all residents was a 'relic of the past' and 'should never be countenanced', suggesting it was a common practice in the UK in 1963: Patricia Shaw, *Old People in Homes: A Handbook for Matrons*, (London, 1963), page 121
[104] TPP, 167, 1962, Paper 56, page 30

Park.[105] Graduates would be recognized as RNs with the same standing as nurses from the three-year training course offered by the general hospitals, and upon successful completion of the final exams, they became Registered Nurses (Geriatric Section) with the NRB.[106] This was not only a first for Australia, but a first for any country in the British Commonwealth.

Both male and female nurses were taught a curriculum designed by the Tutor Nurse, Clive Hamilton, as a two-tier program.[107] The first year comprised the Auxiliary Nurse course, with classes in the theory and practice of nursing, including etiquette, ward management and cleaning, and general care of the patient, including admission and discharge procedures, bathing and bed-making, physical examination, observations and charting, and last offices. There were also six lectures on 'care of the aged'. At the end of the first year, trainees sat an examination and, if successful, were registered with the NRB as Auxiliary Nurses (Geriatric Section). They then moved on to the higher level of the course. The second year included eight lectures in basic anatomy and physiology, six lectures in basic pharmacology and pharmacy, at least twenty-four lectures on Practical nursing, as per the General Nursing training course, and classes in surgical nursing. The third year focussed on geriatric nursing: lectures, discussions and study of the social and medical problems of the aged, including specific nursing care of common diseases of the aged, including senile dementia.

As all St John's Park nursing staff would now be expected to undergo the training to the highest level that they could achieve, all new applicants for nursing posts were given two tests to determine their suitability: Raven's Progressive Matrices No 38 to measure their IQ, and a writing exercise to test their grasp of written English. Not all were successful. Mr Mills ('a very young 17') took two hours to write two short letters, and told them he was 'not keen on study—just wants a job'. He did not get one.[108] There were others already on staff who were just as unenthusiastic about the new study regime, and complaints were made regarding onerous hours and expensive textbooks. Superintendent

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[105] TPP, 171, 1964, Paper 70, page 6
[106] TPP, 179, 1968, Paper 73, page 6
[107] AOT, HSD6/3/2494 Details of curriculum for three-year course of training, 11/10/1962
Clive Hamilton had trained at the Royal Hobart Hospital, graduating in 1956 and undertaking a post-graduate course in geriatric nursing in 1964: Beatrix Kelly, *A Background to the History of Nursing in Tasmania*, (Hobart, 1977), page 71
[108] AOT, HSD 221/1/1 File C2

Trebilcock lamented that 'there are on the nursing staff a small minority who are quite prepared to work here as 'Male Attendants' and 'Nurses' Aides' without any training and thus impede the raising of nursing standards and efficiency'.[109] He believed he knew where the complaints originated:

> Unfortunately there are some married women employed on the staff who are only here for a 'job' and have no intention whatever of training. In fact, some of them have been two or three years endeavouring to obtain the [Auxiliary Nurse] certificate and to date have failed to do so through lack of interest and non-attendance at lectures.[110]

Although they tried to employ only single women, a shortage of suitable applicants meant married women sometimes had to be accepted, particularly as the requirements of the three-year course meant that the old system of employing 'tourist nurses', travellers from other states or overseas, was no longer a possibility. Applications from people who wished to find short-term work were refused:

> I am not employing persons who are not prepared to stay three years … and I am not interested in persons who are only wanting to see Australia and will stay only a few months.[111]

The Geriatric Training School flourished and 1966 the first graduation ceremony for fully-trained geriatric RNs took place, but Nurse Tutor Clive Hamilton was not there. He had died the previous year, and the school was named in his memory. Five students—three men and two women—passed the final exams and were registered with the NRB.[112] The Royal Australian Nurses' Federation granted the new geriatric RNs full membership, seeing this new branch of nursing as an opportunity to address the gender imbalance of the profession.

> …geriatric training will bring into nursing practice an increased number of male nurses. It is considered that the appointment of male nurses to public hospitals, rest homes and other institutions accepting male patients is very desirable, and this service … is appreciated by the patients concerned. …encouragement is being given to the employment of geriatric nurses in rest homes.[113]

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[109] AOT, HSD6/3/2494 Memo to J Edis, 25/1/1963
[110] AOT, HSD6/3/2494 Memo to J Edis, 29/1/1964
[111] AOT, HSD 221/1/1 File C2 Letter from Superintendent Trebilcock, March 1962. 'Tourist nurses' were nurses from other states who took work at the Homes and hospitals whilst travelling. The Nurses' Registration Board had noted in 1947 that tourist nurses 'kept open many of our country hospitals' as well (TPP, 137, 1947, Paper 55). These short-term staff members had been common previously; Claire worked with a lot, "probably more from the mainland than in Tasmania". Some married local men and settled down but most of whom were only there for a brief time (interview with Claire Paynter)
[112] AOT, HSD6/3/2494 Tasmania was the only state to have a geriatric nurse register, so they could only register as auxiliary nurses in other states.
[113] AOT, HSD6/3/2494 Letter from Beatrice Kelly, Secretary, RANF Tasmania, to Dr A Foster, Minister for Health, 30/9/1966

Plate 5: Students and nurses outside the St John's Park Training School[114]

Throughout the modern incarnation of the profession, there had been an emphasis on the 'female' nature of nursing, and the necessity for a feminine sensitivity to be able to give good nurturing care. But men had always been employed as nurses in psychiatric hospitals and asylums, and had played a major role in the public institutions of the 20th century. It is probably no coincidence that both asylums and Homes were primarily custodial for much of their history, making men more appropriate employees than in the general hospitals.

Peter S enrolled in the course in 1971. He had originally sought entry to the Royal Hobart Hospital nursing school, but they had a limit on the number of male nurses accepted in each intake. St John's Park Geriatric Nursing School had no such limitations, and Peter S was employed immediately.

> I walked up the avenue and started there the following Monday. They put you on as students, but the course didn't start until the January. You did nursing blocks, same as they did at the hospital. You went in for six weeks training PTS, but I'd already got up and done some before the actual training stage. I did three years training, from '71 through to qualifying in 1974. [115]

[114] St John's Park Hospital information brochure, Department of Health, Hobart, c1972
[115] Interview with Peter Sweeney

Despite its initial success, enthusiasm for the School proved to be short-lived. Student nurses were hard to recruit, as the Home could not compete with the 'glamour of a general hospital'[116], and entry standards inevitably began to drop. Many of those who began did not finish their training, and the head of the NRB believed this was due to a lack of suitable students, as St John's Park enrolled 'all humans who were warm, breathing and mobile'. She expressed her doubts that the course could continue.

> From my appointment eight years ago, at the commencement of this course, I fully believed that this course would gradually disappear, and gave it a span of approximately 10 years. I was very surprised that the Board had introduced such a course. … A geriatric course will only interest a certain type of person, and they are much in the minority. Most students prefer to do general training, which is of more value to them.[117]

The twelve-month auxiliary nurse course was augmented to two years in 1974[118], and the three year RN course was dropped altogether. Peter S was one of the last to graduate. The unattractiveness of geriatric nursing is indicated by the fact that a 1977 career brochure (plate 6) for the two-year auxiliary nurse course does not even specify that St John's Park was a geriatric hospital. For Peter S, the real end of the era of geriatric nursing as a valued speciality came in June 2003, when the classification was dropped from his registration certificate. Although he had been working as an RN in the acute sector for some years (he gained his Bachelor of Nursing degree in 1998—"I went from being an RN to being an RN!"), he still felt regret that he was no longer credited with that special knowledge.[119]

The 1970s saw another area of aged care begin to take on more prominence, as the aging population caused a rapid rise in the number of people suffering from dementia. Although there had always been some cases among the old and infirm members of the Tasmanian community, even in the earliest decades of the colony, they were not common. By the mid 20th century, the increasing number of people living to old age meant that more people were in need of care, but it was not until the 1970s that real change took place, with the recognition of dementia as a condition apart from other mental illnesses, needing particular care and treatment.

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[116] AOT, HSD6/3/2494 249/4/150
[117] AOT, HSD6/3/2494 249/4/150 Memo from Registrar/Secretary, NRB, to Director General of Health Services, 11/11/1971. Only 47 of 230 students commencing the course had graduated.
[118] TPP, 191, 1974, Paper 82
[119] Interview with Peter Sweeney

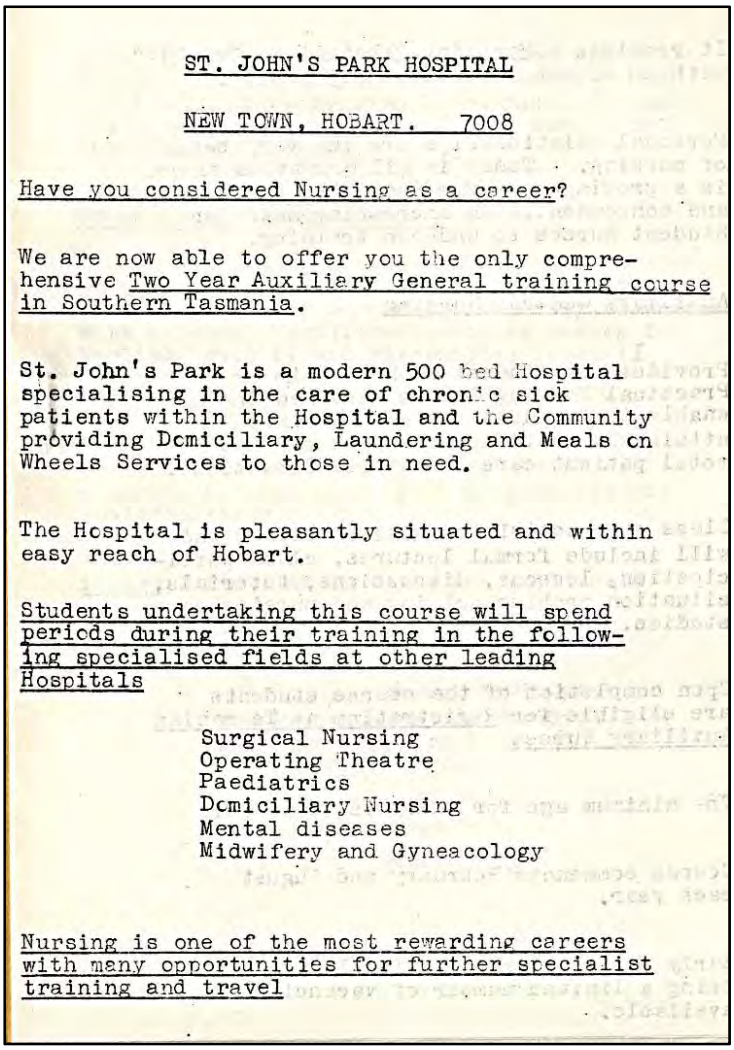

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Plate 6: Page from the 1977 St John's Park career brochure[120]

'Chronic brain failure': care for people with dementia

> You are no doubt aware the literature indicates that chronic brain failure is, and will become increasingly so, a very dominant problem among the elderly.[121]

For most of Tasmania's history, sufferers of advanced dementia were sent to the lunatic asylum at New Norfolk[122], but there were few options for less severe cases. One of the earliest references to specific arrangements is in the records of the HFI for 1920, when a new 'refractory ward' was built in which 'noisy patients' could be separated from the

[120] St John's Park, *Could this be your career? Student nurses: a 2 year comprehensive auxiliary general training*, (Hobart, 1977)
[121] AOT AA1/1/559 16/6/8
[122] Andrea Vreugdenil, 'Out of sight, out of mind: senile dementia in nineteenth century Launceston', in Paul A Richards, (ed), *Effecting A Cure: Aspects of Health and Medicine in Launceston*, (South Launceston, 2006)

other inmates.[123] Inmates with troublesome behaviours such as wandering were usually sent south, as St John's Park was better suited due to its location and the larger and more secure buildings. Due to the stigma of mental illness existing at the time, it was not quite as hard to get families to agree to the move for these patients as it was for other elderly relatives:

> …a patient at [HFI] is causing a lot of trouble by continually absconding … Senility is the cause of the trouble he is giving, and I am wondering if this patient could be transferred to St John's Park, where proper control could be kept over his movements. His children are unable to look after him, and are quite agreeable to his transfer…[124]

The Tasmanian government missed a golden opportunity to provide for people with dementia when they designed Cosgrove Park. A dedicated dementia facility, Woodhouse, had opened at St John's Park in 1954 to separate the demented patients from the merely physically frail and elderly. But no separate facilities were available at Cosgrove Park when it opened in the same year, although there were some farsighted people who had foretold the need. Alderman Edwards had requested a soundproof room to be built and there were public calls for a dedicated facility, but the Minister of Health did not agree:

> If the public feels that there should be a special reception house for senile dementia, we should look into the question of building such mental homes, but this appears absurd to me.[125]

Dr Edis concurred wholeheartedly, stating that building accommodation at Cosgrove Park for 'cases which are considered insane … would simply turn the institution into a Mental Home'.[126] The lack of separate facilities made life difficult for the rest of the patients. People with dementia might be good people and powerless, but they are often quite badly behaved and very loud. They caused continual disturbance in the shared bedrooms and living spaces, rifling through cupboards, taking belongings, climbing into the wrong bed, and making a great deal of noise. Those patients whose behaviour made them particularly difficult were certified insane by the Home's doctors and transferred to Lachlan Park. Arguments arose when one of the patients transferred to Lachlan Park was subsequently certified sane by her own doctor, who requested that she be moved back to Cosgrove Park. He was informed that

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[123] TPP, 85, 1921-22, Paper 53
[124] AOT, HSD6/1/559 Memo from Matron McClymont to Asst Secretary for Public Health, 29/7/46
[125] AOT, HSD6/3/2211 Memo from Minister of Health to Director General of Health Services, 1/4/1955
[126] AOT, HSD6/3/2211 Memo from DG of HS to M of H, 4/4/1955

> …the institution's medical officers will be the sole people to determine what cases are admitted, and what cases are discharged… Outsiders cannot overrule these officers in matters concerning the institution.[127]

The message was clear: the gates of this total institution were strictly controlled, and no arguments would be brooked.

By the 1970s, continued improvements in medicine meant that people were living longer, and the longer a person lives the more likely he or she will develop dementia.[128] The situation became more problematic, particularly for patients in the earlier stages of the disease. Very few private Homes would accept such residents, as they lacked both the facilities and staff to care for them. St John's Park could accommodate people in the south of the state in Woodhouse, but Launceston had nowhere for them to go. The idea of a special facility for patients with senile dementia did not seem so absurd now, as the beds of the public hospitals began to fill with old people who were not advanced enough to be certified insane and sent to Lachlan Park. In 1976 a solution was finally found, and once more old people found themselves in an environment that had once housed the young. Another maternity hospital was put to a new use.

The Australian birth rate was in decline in the 1970s, and Tasmanian hospitals were experiencing a decrease in maternity and obstetric cases.[129] Ward H, on the top floor of the Queen Victoria maternity hospital, now stood empty whilst the medical wards in the LGH bulged with geriatric cases, many with some degree of dementia. Ward H was converted to accommodate 'convalescent and medical female cases of LGH in the longer term period'[130], and the old ladies moved in. In what was almost an echo of the old days of the invalid depots, the old and weak were removed from the community and locked away, out of sight and almost out of mind. The RNs in the other wards were reminded of their presence occasionally, as a common characteristic of the old age home made its presence felt—or smelt.

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[127] AOT, HSD6/3/2211 Memo from Director General of Medical Services to Minister for Health, 4/4/1955
[128] Around 5% of the population over sixty-five years old suffers from some form of dementia; this rises to over 20% in the over-eighties: CMC Allen and CJ Lueck, 'Neurological Disease', in *Davidson's Principles and Practice of Medicine,* (Edinburgh, 2002), page 1172. Pat Job told me, 'When I trained, we didn't do geriatrics, because we didn't have old people in those days! They all died at 60!' Pat trained in the 1940s : interview with Pat Job
[129] TPP, 201, 1979, Paper 35
[130] Annual Report of the Queen Victoria Hospital, 1976

> I did mid[wifery] there, and there were the oldies on the sixth floor. Well, you got out of the lift, and it nearly took your breath away! The smell was just so bad. Especially if you'd been down on the first, second and third [floor] doing mid, and all the people were ambulant and washed and whatever, and you'd go up there and… ugh. Everybody complained about it—nurses, staff, visitors—it would hit you, you know, the acetone in the urine would just about knock you flat.[131]

> I worked in midwifery, and every so often, we'd see a poor old lady walking down the corridor [with] a sign on her back saying 'please return me to Ward [H]', and into the lift we went to return this lady. I used to think 'oh, fancy working up there'. I only went up there to return people who were lost, and you'd get out of there as fast as you can! Isn't that sad? It was lots of old people, sitting around looking blankly at each other, or moaning… It was a bit whiffy.[132]

Plate 7: The Queen Victoria Hospital as it looks in 2012. Ward H occupied the top floor.[133]

Vera was certainly not impressed with her first glimpse of the ward and its occupants when she arrived to take up the position of staff nurse in 1979.

> I just came out of the lift doors and the smell hit you—the smell of urine. The patients were over-medicated, sitting in chairs on incontinence sheets, in their nighties, just looking like zombies. It felt like I'd gone back to Bedlam, it was just awful. Forty-one women trapped up there. The windows were very high, so you couldn't see out unless you stood on tiptoe, and it was a prison, and people were *living* up there for ever! The other floors were just the same, but you don't mind, do you, when it's just for a few days.[134]

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[131] Interview with 'Helen'
[132] Interview with 'Margaret'
[133] Photograph taken by Elaine Crisp, May 2012
[134] Interview with Vera Green

Other patients were restrained, with sheets wrapped around them and tied at the back of the chair. Whilst this was sometimes done to prevent a frail patient from attempting to get up, falling over and hurting themselves, it was also used to stop the more active ones from wandering and upsetting the routine of the ward. Vera recognized this could be attributed to the nurses' desire to keep the ward 'shipshape and tidy and everybody in their place', but she tried to alter it nonetheless, together with another aspect of hospital life, the dominance of routine and timetables.

> Night staff started getting everybody up for breakfast around half past six, and the day staff came on at seven and they proceeded to have everyone out by eight o'clock, sitting in a chair with a table over their knees so they could eat breakfast. And they were still drugged from the Mogadons and all the other things they'd had, trying to eat their breakfast. I said, "From now on, it's breakfast in bed, and you have until twelve o'clock to get them showered and dressed. It's their home—they *live* here, just think about that!"[135]

The medication regime was another target. The routine administration of sleeping pills was ceased ("the falls were horrendous"), as was the regular dosing of patients with laxatives ("the night staff … felt that they had to make sure the patients were having their bowels open every day—a real bowel fixation"). It was harder to change ingrained mind-sets, particularly those of the medical staff and older nurses. Being part of a teaching hospital helped a little, as the student nurses brought new attitudes.

> We had a change of personnel coming through all the time, which made a difference. A lot of the student nurses had good ideas, were fun—acted silly, danced for the patients, dressed up—we had a lot of fun! We made an effort to make life more enjoyable.[136]

Some of the patients were 'normal', in Vera's words—sufferers from strokes or other chronic illnesses that had led to their long-term admission. One of her major goals was to separate them from the demented patients. She enlisted the help of the hospital welfare officer, Sister Corrick, who approached the local private Homes and arranged to take their more difficult patients, particularly those who were inclined to 'escape', and send them the physically frail but mentally competent Ward H patients. But no matter what cosmetic and routine changes she could instigate, it was still a hospital ward, and the growing knowledge of dementia made it clear that different arrangements were needed.

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[135] Interview with Vera Green. In their 1991 examination of nursing rituals, Mike Walsh and Pauline Ford noted that 'getting all the work done by lunchtime' was a major preoccupation of the hospital-trained nurse: *Nursing Rituals, Research and Rational Actions,* (Oxford, 1991)
[136] Interview with Vera Green

In 1988, Ward H was closed and the patients were transferred to Allambi, a dedicated Geriatric Unit. This was yet another second-hand medical building, the old Launceston Infectious Diseases Hospital, but it was a great improvement on the hospital ward. It was a single story building, with open space and access to the fresh air, and it proved to be a much more suitable place to house patients with dementia. A number of philanthropic Homes also began to build dementia-specific wings, to provide their residents with comfortable but secure surroundings in which they could kept for their 'own good', as will be seen in the next chapter.

'Private medical establishments': the private Homes

The number of private Homes in the state grew rapidly from a handful of 'rest homes' in the 1920s to twenty by 1967, fifty by 1978[137] and more than seventy by the end of the century. These were classified as 'voluntary non-profit' (the majority, run by church and charitable organizations), or 'private gain' (run by the proprietors, often nurses).[138] Many were established with funding under the Commonwealth Government's *Aged Persons Homes Act 1954*, and further legislative changes during the 1960s offered extra benefits if a trained nurse was present on the premises at all times, allowing them to be licensed as 'private medical establishments'.[139]

As mentioned in the previous chapter, many of the early private Homes were operated by RNs. Mrs Hodges, the ex-Matron of the Beaconsfield Hospital, opened a 'Rest Home for invalids and convalescents' at Beauty Point in 1917.[140] RN Barbara Bennett opened the Carlisle Rest Home in the 1920s, offering 'comforts and attention for the aged, convalescent and chronic patients'.[141] Sister Bennie operated the St Helena Rest Home, and Mary Ogilvy had trained as a nurse before opening her house as a 'guesthouse for women of small means'.[142] All of these were intended to be domestic settings rather than hospitals, and nursing care was more of a side attraction than the main intent.

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[137] AOT HSD6/2/513 96/6/(3) Report of Federal State Coordinating Committee for Nursing Home Accommodation, Tasmania, 14th meeting, 23/8/1978

[138] This is in great contrast to the American sector, where the vast majority of Homes were run on commercial lines by for-profit operators.

[139] Diane Gibson, *Aged Care: Old Policies, New Problems*, (Cambridge, 1998)

[140] From classified advertisement in the *Examiner*, Saturday, 20th October, 1917, page 11

[141] From classified advertisement in the *Mercury*, Saturday, 30th May 1925, page 2

[142] Alison Alexander, *Mary Ogilvy: the evolution of a grand lady*, (Hobart, 2006)

Perhaps the first private Home to emphasise nursing care was Eskleigh Memorial Home, which opened in 1947 in a converted mansion financed with the help of £15,000 raised by the public. It offered accommodation for thirty chronically ill people, rather than those who simply could not cope at home, and it was not specifically an aged care facility although the elderly made up the majority of its 'guests'. Prospective patients were offered 'comfort and cheer amid surroundings of almost breath-taking loveliness', but management found difficulty in procuring nursing staff to assist the Matron and the opening was delayed until a nurse and a sister could be found.[143] The Home filled quickly filled, and the Board noted that 'probably a dozen Eskleighs' would be needed to cater for future demands.[144]

Plate 8: Eskleigh Memorial Home, in its setting of 'almost breath-taking loveliness'[145]

The Sisters of Nazareth arrived on the scene in 1950, opening a Home for seventeen residents in the old homestead on the Mount Esk estate in Launceston.[146] This was

[143] The *Mercury*, Saturday, 23rd August 1947, page 6; the *Mercury*, Friday, 19th September 1947, page 2
[144] WR Rolph, *Eskleigh Memorial Home*, (Perth, Tas, 1949)
[145] Pictorial works collection, Tasmanian Archive & Heritage Office: item no AB713-1-5694
[146] 'New Wing at Nazareth House', the *Mercury*, Thursday, 12th April 1951, page 7. The Sisters opened the first Nazareth House in 1857 in Hammersmith, London, and ran Homes in several countries, including the UK, America and Africa.

replaced with a much larger building in 1952, and by the end of the decade Nazareth House accommodated more than a hundred residents. The conditions of the licence for the newly extended Home required two trained nurses at all times during each day and 'in residence and on call during each night'[147], and as two of the nuns were also RNs, their permanent residence within the establishment enabled the Home to fulfil these requirements without hiring trained staff from outside the order. The ratio of just two RNs to more than one hundred residents was considered sufficient because the majority of the Home's occupants were not classified as 'ill'. The department inspector may not have realized that she was echoing two thousand years of medical tradition when she declared in her yearly report that:

> Old age is not in itself an illness—only a natural phenomenon of nature.[148]

The lack of RNs meant that untrained aide Nancy worked alone at night when she began in 1966, and although few of the residents were chronically unwell, she did find herself undertaking clinical procedures that would have been carried out by RNs in other Homes and in the hospitals.

> I was taught to give injections by one of the nursing nuns, because there were a few people there who had to have certain injections through the night—insulin and things like that. We did blood sugar tests, blood pressures. If someone took really, really sick we had to put them on oxygen, suck them out. We had two people with trachys that we had to clean. We had to do the dressings.[149]

She enjoyed this on the whole, except for administering penicillin ("real thick stuff, those were horrible to give, I *hated* those"), but the increasing regulation of the aged care sector towards the end of the 1970s brought such practices to an end. The dwindling number of nuns in the order made it necessary for the religious sisters to employ RNs around the clock. Roz started work there in 1980, and she found that whilst the RNs were needed by the nuns, they were not necessarily welcome.

> I think they resented us RNs a bit—they probably felt they could do it themselves, but they were *obliged* to employ RNs, so … so they felt that they knew it all, and they actually didn't. But they still had a presence, and their word was *law*! They supervised the staff, and there was a sort of a hierarchy involved—it was them, then it was us. They ran the place, basically.[150]

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[147] AOT, HSD6/3/2680 559/50/10 Licence conditions, 27/1/1966
[148] AOT, HSD6/3/2680 559/50/10 Inspection report, 22/2/1966
[149] Interview with Nancy Langley. This use of untrained staff was not unique to Nazareth House. In her private Home in Melbourne in the late 1970s, Ellen Newton writes in her diary of being given a morphine injection by 'an inexperienced nursing-aide of twenty': *This Bed My Centre*, (Melbourne, 1979), page 188
[150] Interview with Roz Wilson

Other Homes were also providing more technical nursing and medical care. The Queen Victoria Home for the Aged in Hobart had eighty residents and four RNs, and although primarily aimed at the more ambulant resident, there were facilities for those who needed greater nursing care. In 1965 the Home went so far as to install 'equipment for the benefit of rehabilitating fractured femur cases and hemiplegics' which proved of great benefit.[151] Pat was sub-matron, and a photograph taken that year shows her looking every inch the professional hospital nurse.

Plate 9: Sister Pat Macready (now Job) on the terrace at the Queen Victoria Home, Hobart. 1965[152]

Other philanthropic Homes installed hospital wards, or even entire wings. The Mary Ogilvy Home installed a sick bay in 1962, which expanded to sixteen beds by the end of the decade. The Board of St Ann's Home bought the adjoining property in 1968 and converted it to a geriatric hospital (although a Superintendent of Nursing was not appointed until 1984), and the Lillian Martin Home opened fifteen hospital beds in 1972 to provide 'intensive care nursing … until the end'.[153]

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[151] AOT HSD6/3/2562 508/670/10 Inspection Report, 10/3/1965
[152] Photograph courtesy of Pat Job
[153] Alexander, *Mary Ogilvy*; Victoria Rigney, *Many Doorways, One Journey*, (Hobart, 2006); Bell Thompson, *The Key of the Door*, (Hobart, 1977)

Many of the smaller private Homes also provided some level of nursing care, particularly those which were run by RNs. As part of their licensing conditions, they were required to send acutely ill residents to hospital unless the doctor in charge certified that the patient could be nursed adequately in the Home[154], and some were able to do this. When Sister Lees applied for a licence for Abbeyfayle in 1961, the purpose of the establishment was listed as 'medical nursing and treatment'.[155] To this end, the Home was equipped with equipment such as 'surgical scissors, artery forceps, dissecting forceps, hyperdermic [*sic*] syringes, aural syringe, thermometers, mixture glasses, enema apparatus, kidney dishes and galipots', and resuscitation oxygen equipment and a sterilizer were added later.[156] Sunny Brae was also equipped with sterilizers, along with forceps, sterile dressings, kidney dishes, and enema apparatus.[157] Both were able to accommodate residents until they died. Alex remembered a room in the otherwise pleasant house that she tried to avoid.

> …there was one particular room that I felt quite uncomfortable about going into; it had a lino floor and there was a bed in the middle of it, and I think there must have been someone in that room who was very near death. The other rooms were what I'd call more comfortable, more home-y, so that peculiar room with the lino must have been the 'hospital' part of the home … very squeaky-clean … medical-feeling—it was clean, and it was well-kept, and the light was bright enough, but it gave me the creeps.[158]

* * * * *

There has been much debate in recent years about the effect that medicalization has had on old age and thus on aged care. Some believe it to be beneficial, as without it aged care becomes social care and old people become unimportant, 'warehoused' rather than treated.[159] Others argue that it has been identified as a major source of the more negative valuation of old age in modern times, encouraging society to see aging as 'pathological or abnormal'.[160] In the same way, the ennursement of the Homes could be seen as a mixed

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[154] AOT HSD6/3/2651 537/13/10 Approval schedule for Bethshalom, 25/3/1964
[155] AOT HSD6/3/2665 537/79/10 Application for licence 21/6/61
[156] AOT HSD6/3/2653 536/30/10 Inspection Report 14/2/1972
[157] AOT HSD6/3/2665 537/79/10 Application for licence for Private Medical Establishment, 28/7/1969
[158] Interview with Alex Myers
[159] Shah Ebrahim, 'The medicalization of old age: should be encouraged', *British Medical Journal*, 13th April 2002, 861-863. The term 'warehouse' has been used in several studies on aged care; it suggests that the elderly are removed from the community and placed in storage, untreated and ignored, until they die: see, for example, Daniel Baum, *Warehouses for Death*, (Ontario, 1977)
[160] Christopher Conrad, 'Old age in the modern and postmodern Western world', in Thomas Cole et al, (eds), *Handbook of the Humanities and Aging*, (New York, 1992), page 80; Carroll Estes and Elizabeth Binney, 'The biomedicalization of aging: dangers and dilemmas', *The Gerontologist*, 29:5(1989), 587-596

blessing. On the one hand, the trained nurses brought with them expertise, skills and knowledge that undoubtedly benefitted the people they cared for, and conditions in the Homes improved greatly under their supervision. On the other, their professional training could also have less welcome results. Some wanted to keep the strict standards they were used to in the hospitals: the starched uniforms, the discipline, the order and the cleanliness, and sometimes the authority.[161] This could make them unapproachable, turning otherwise pleasant young women into authoritarian 'battleships', and the Homes into clinical facilities. Barbara recognized this when she discussed the uniform she wore:

> We used to wear a white nurse's uniform, white cap, white shoes. We didn't like those white dresses. The uniforms have changed a lot since them. I think the navy and white looks smart. They have had different colours, different shirts. One of the residents said to me once, when I had a shirt on that I'd bought, navy with spots on, "I love that shirt, I like seeing the girls in different types of blouses, not all uniforms". I think it changed the way residents see you, I think they're happier with you just in navy and white, not a white nurse's uniform. That would probably make them feel like they're in a hospital, I guess!

There were other aspects of the Homes that might make the residents feel they were in a hospital. Many of the newly built facilities included hospital-like features, such as treatment rooms, offices for medical consultations, and floor plans that clustered resident bedrooms around a central nurses' station. These new room arrangements allowed the nurses to take centre stage and employ their panoptic gaze upon their patients, as they did in the hospitals.

The ennursement of aged care had a major effect upon the treatment of the old people who lived in the Homes, whether 'patient' or 'resident'. Whereas control had previously been kept primarily through punitive measures, now the aged care nurse became a powerful instrument of governmentality, exercising normative control through the use of professional expertise and paternalistic concern. The residents would be organized and kept safe, 'for their own good'. This will be examined in the next chapter.

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[161] Ollie Randall, 'Wanted: A nurse for a home for the aged: must have a genuine liking for old folks', *American Journal of Nursing*, 50:7(1950), 428-430; Peter Townsend, *The Last Refuge*, (London, 1962), page 45-6. At Lyndoch, Sister McKenzie continued to wear her veil 'well after most people had given them up', showing her commitment to 'the ideals of the nursing profession': Peter Yule, *Lyndoch: The First 50 Years*, (Warrnambool, 2002), page 46

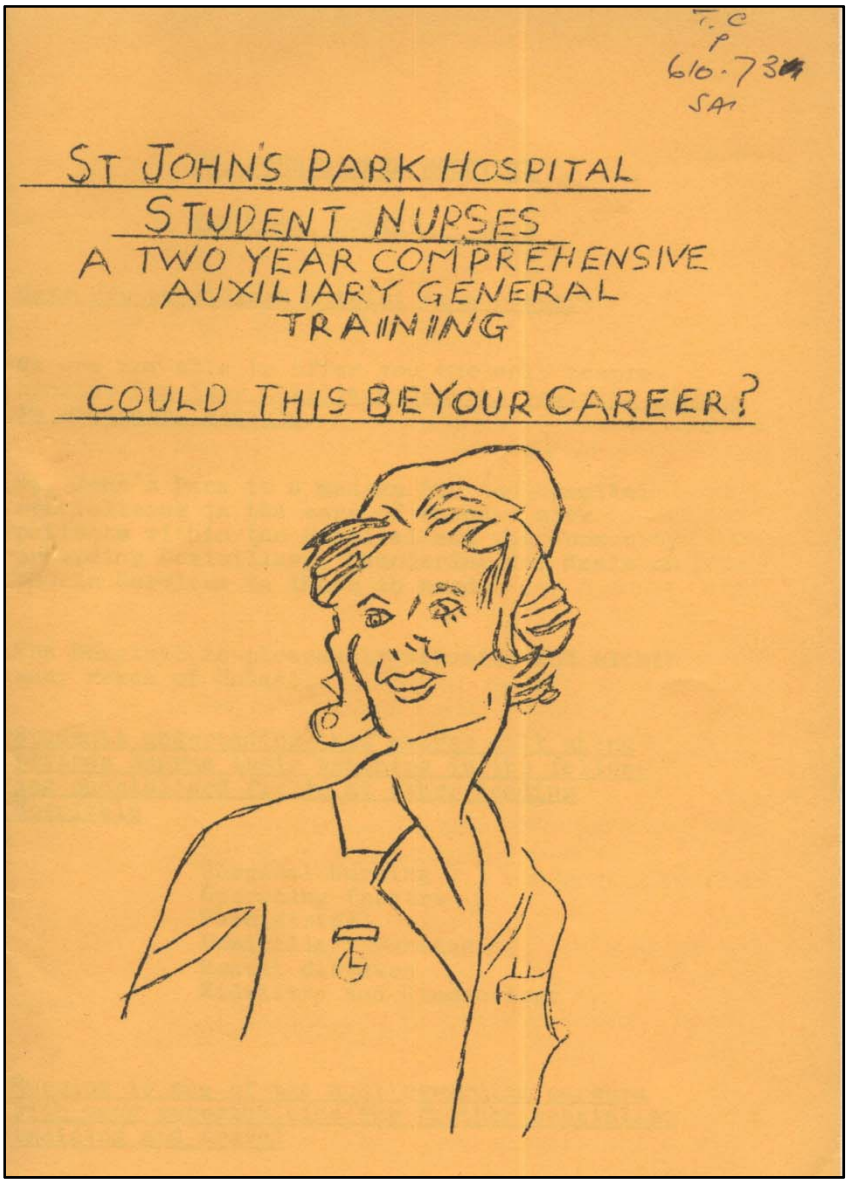

Plate 10: The cover of the St John's Park Hospital career brochure.[162] The quality of the hand drawn illustration and lettering suggest that the course did not carry much prestige within the hospital system.

[162] St John's Park Hospital, *Could this be your career? Student nurses: a 2 year comprehensive auxiliary general training*, (Hobart, 1977); from State Library of Tasmania catalogue collection

Chapter 5

'For their own good'

> Curtailments of the self occur … even where the inmate is willing and the management has ideal concerns for his [or her] wellbeing.[1]

It could be argued that the earliest institutions for the old and infirm—New Norfolk, Impression Bay, Port Arthur, Brickfields and Cascades— were set up for the inmates' own good. After all, they were taken from a hand-to-mouth existence, sometimes on the streets, and given food and shelter. But this was not done for reasons of kindness or beneficence; it was to remove these rootless and destitute people from society, to control the contagion of poverty and criminality in order to safeguard the community. In return for their bed and board, the inmates were expected to submit to the rules, and strict discipline was enforced with punishment or dismissal. But as the model of pauper care changed from custody to welfare, in the third quarter of the 19th century, the institutions began to move from punitive to paternalistic discipline.[2]

The birth of geriatric medicine in the 1930s affected the way in which old people were treated, changing the institutions into hospitals, the warders into nurses, and the inmates to patients. Nurses, initially engaged only in the infirmary wards of the public institutions, gradually became the principal employees in all the Homes, and their professional ethos and customary work practices greatly influenced the way in which the Homes were run. They occupied a position of trust and responsibility, and also held a great deal of power over the people they tended. Unlike general hospitals, which have doctors on site and in command, in the Homes it was the trained nurses who wielded authority on a day-to-day basis, and the untrained nurses who carried out the daily routines and enforced the rules. Just as hospitals gave doctors 'a new authority over the

[1] Erving Goffman, 'On the characteristics of total institutions', *Asylums*, (Harmondsworth, 1968), page 50

[2] Paternalism is the notion that those in authority have a right to interfere in the life of others 'for their own good', the inference being that they know what is in a person's best interests better than the person him- or herself. It has been a characteristic of all welfare provisions made in Australia since white settlement, as centralized governments conceived policies, formulated practices and oversaw their implementation. Ronald Mendelsohn cites historian Sir Keith Hancock, who wrote, 'Perhaps it is a fraud to assert that there is such a thing as Australian Socialism. It would be truer to speak of Australian paternalism': *The Condition of the People: Social Welfare in Australia 1900-1975*, (Sydney, 1979), page 36

patient'[3], the Homes gave nurses a new authority over the elderly people they cared for. The trained nurses brought with them expert knowledge of what was best for the health and wellbeing of their charges, and in expressing this professional concern, they often exercised a considerable degree of paternalism.

The power of paternalism might not be wielded consciously in aged care settings, but it is there each time a resident in a Home is forced to ask for help, or for permission to do things that in ordinary life would be their choice, or made to wait for assistance.[4] Often, however, it is more overt, as those in charge make it clear that they know best, and the resident has little choice but to agree. This was particularly so in times before the concepts of autonomy and resident choice became part of the accepted dialogue surrounding aged care.

The medicalization of old age changed the way in which society looked at old people, at the type of care it was felt they should receive, and how much autonomy and self-control they should be allowed to have. By the 1950s, the decision to align accommodation for the aged with hospitals[5] helped to recast aging as an illness rather than a stage in life. It fostered the view that anyone going into a Home must be infirm and unwell, incapable of caring for themselves physically and, by extension, incapable of making decisions about anything that concerned their wellbeing. It also changed the way in which old people saw themselves, as they entered the Homes and adopted the role of 'patient'. Whilst this term might have fewer negative connotations than 'inmate', it still denoted a particular social identity: a patient was expected to be good, to stay quiet and inactive, and to relinquish power, being obedient to the doctors and grateful to the nurses.[6] Patients were kept compliant by assuring them that everything was for their ultimate benefit, and many willingly surrendered their independence, becoming docile partners in their own helplessness. Those who were less cooperative faced a new form of control, as normative discipline compelled them to accept the rules: good behaviour was rewarded with

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[3] Janet McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, (Melbourne, 1999), page 15

[4] Goffman, 'On the characteristics of total institutions', page 45. In *Culture Against Man* (London, 1966), Jules Henry noted that in one Home he studied, requests were written down by the nurse in charge and then forgotten, as though the act of writing down the request actually satisfied it.

[5] TPP, 161, 1959, Paper 59, page 6: '…departmental policy [is that] accommodation for the aged should be attached to general hospitals…'

[6] Bruce Ford, *The Elderly Australian*, (Ringwood, Vic, 1984)

approval, whilst recalcitrance brought disapprobation and displeasure. At times, they could even experience physical force—but always, of course, for their own good.

There is little information in the documentary records about daily routines within the Homes, so this chapter will concentrate on practices during the second half of the 20th century, using the oral histories gathered from the study participants. Where possible, these oral accounts will be contrasted with what *should* have been occurring by looking at official instructions to staff and the literature of the day, to show how well official procedures and real practices meshed. The chapter follows the pattern of a day's routine, from getting up to going to bed, and examines change and continuity in particular aspects of daily life over the decades. It will highlight the role played by the nurses in that routine, and explore their attitudes towards the work, both positive and negative, as they kept the residents 'in safe hands'.

'No flexibility': the daily routine

> I wouldn't like to move into a nursing home. …there are times when you have your cup of coffee, and times when you go to the toilet, times when you get dressed. There's a routine. I always think that, well, you're told all your life what to do, when you're a baby, when you go to school, when you leave school and you're working, when you get married! And then, at the end of your life, when you should be able to stay in bed until 10 o'clock if you want to, what happens? You get pulled out at 7 o'clock. No flexibility.[7]

Goffman states that the micromanagement of a person's daily life—when to get up, get washed, get dressed, eat, play, work, sleep—is necessary for the smooth and efficient running of a total institution.[8] But whilst some level of cooperation is necessary, and rules are needed to allow people to know what is acceptable and what is expected, it is the level of flexibility within this micromanagement that can contribute to the resident's quality of life.[9] This depends on two things: how much consultation and choice the residents have in the practices that affect them, and how much the practices are aimed at their benefit as opposed to the convenience of the staff. Before the adoption of the

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[7] Interview with Barbara Allen
[8] Erving Goffman, 'On the characteristics of total institutions', *Asylums* (Great Britain, 1971)
[9] Social Welfare Commission, *Care of the Aged* (Canberra, 1975). Some aspects are more flexible than others. A 1986 survey of Australian Homes found that whilst 86.3 per cent of Homes allowed flexible visiting hours, only 63.7 per cent allowed a choice of bedtime, 35.5 per cent a choice of bath time, and 18.5 per cent a choice of mealtimes. Dr Catherine Rhys Hearn, *Quality, Staffing and Dependency: Non-Government Nursing Homes*,(Canberra, 1986), page 81

Charter of Residents' Rights and Responsibilities in 1990, the routine in most if not all Homes was arranged by those in authority without any consultation with the residents, who had little say in when or what activities occurred.

> There was very little attempt to personalise things for residents. There might have been a little, but on the whole things had to be done this way really. And there were limited numbers of staff on, so from a practical point of view having an institutional sort of process there made it possible for the few people that were there to actually get the work done.[10]

The nurses might do their best to give individual attention to residents, but often the job simply became a push to get through the list of tasks necessary to assist a large number of residents—frail, often immobile, frequently confused, sometimes uncooperative—to achieve at least the basic activities of daily living.[11] The residents were coaxed out of bed, kept fed, hydrated, clean, and dry, and put back to bed, following an often strict routine. They received nursing care to address the infirmities and diseases of old age and, where possible, were encouraged in the pursuit of exercise and recreation. And they received this attention whether they wanted it or not, 'for their own good'.

The day begins

> They were all gotten out of bed at some ungodly hour, unless they were really sick. It sounds terrible, doesn't it, but it's the truth. You'd have to have a reasonable proportion of them up before you did breakfast.[12]

The 'ungodly hour' was officially around 7am in most Homes. The precedent was set in the colonial institutions, when the rising bell sounded at 6am in summer, 7am in winter, and all inmates were expected to get up and ready themselves with little assistance.[13] In the 20th century, the less mobile inmates had nurses to help them bathe and dress, but this dependence meant the day could in reality begin much earlier than 7am. At the Launceston Home for Invalids (HFI) in 1948, Eleanor would begin sponge-baths at 4am.

> It's a wonder the people didn't complain, but they never did. It wouldn't take much of anybody's time in the daytime. But you did what you were told to do.[14]

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[10] Interview with Roz Wilson

[11] Almost all the participants expressed disappointment in their inability to give more time and individualized care to the residents they had worked with over the years, the exceptions being Joan Mutimer, who worked as an assessor, and Marguerite Bramble, who only worked for a few weeks on the geriatric wing of the RHH, on night shift.

[12] Interview with Roz Wilson

[13] The *Mercury*, Saturday, 20th May 1874, page 2; Rules and regulations for the Male Invalid Depot, Launceston, in the

[14] Interview with 'Eleanor'

The inmates of the HFI probably realised there was little point in complaining, with management holding the reins of power and the ever-present threat of discharge or removal to Hobart. Perhaps it was simply the end result of the depersonalization process, wherein the inmate accepts unthinkingly the rules of the total institution.[15] Eleanor only questioned the practice because of an incident during her training at the Launceston General Hospital (LGH), where the 4am sponge bath was an established routine. One of her patients there had asked plaintively, "Why do they do me in the night? I'm so tired and I'm here only to rest".[16] But in a total institution, routine overrides individual preferences, and the 4am sponge-baths continued, even after the HFI was replaced with Cosgrove Park. Until the 1990s, Elaine and her aides would wake everybody up at 4am for a wash.[17] Patients at Vaucluse, the long-stay ward at the Royal Hobart Hospital, were also subjected to the same inflexible routine as the patients in other, more transient, wards when Marguerite worked on the night shift there in the late 1960s.

> …breakfast would arrive *really* early, about 5 o'clock in the morning, and we used to start feeding and washing the patients then! We used to have to get three or four of them sponged and up before we left at 7.30 in the morning, and I remember this one particular lady, we used to get her up and dressed, she'd be in her dressing gown and nightie, and we used to put pigtails in her hair, sitting up like [antennae]—they actually used to do their hair like little children! And I still have a vivid memory of that, that wouldn't happen now—because that was just the culture, it wasn't her choice.[18]

Marguerite felt uncomfortable about this infantilization of the patients, but she was a student nurse at the time and she did not feel confident enough to question her superior about it. In an environment where the patients lay in bed for most of the day and were dressed, fed and toileted like infants, it is possible that the RN, who had been there for many years, no longer saw her charges as autonomous adults and had slipped comfortably into the role of 'mother'. Marguerite, as an outsider, believed that removing choice from the patients in this way was not so much maternal as paternalistic.

The private Homes started the day in a more relaxed fashion, probably due to a lack of staff during the early hours. Dorothy was on call overnight at Bethshalom and Sunny Brae, but had no other help until the aides began work at 7am[19], and it is likely that most

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[15] Goffman, 'On the characteristics of total institutions'
[16] Interview with 'Eleanor'
[17] Interview with Elaine Sturzaker
[18] Interview with Marguerite Bramble
[19] Interview with Dorothy Morse

of the other proprietary Homes had similar arrangements. At Nazareth House, the residents were also allowed to sleep until after 7am until the early 1970s, because night nurse Nancy worked alone. But once a second aide joined her on the night shift, each of them had to shower or wash four residents before they finished their shift. They were often joined by a day shift aide, coming in early to work unpaid to get a head start on the day's routine, until the nuns put a stop to it.[20]

Plate 1: Excerpt from information brochure for St John's Park[21]

Whatever the morning routine, getting up was quite rigidly enforced in most Homes. Residents were rarely allowed to sleep in or have a day in bed. Whilst this was for disciplinary reasons in early times—idleness was not to be tolerated—by the mid-20th century it was becoming recognized that staying in bed could be detrimental to a resident's health.[22] At the HFI public inquiry in 1947, Matron McClymont explained that she got an inmate up against her wishes because 'it was essential from a nursing point of view to get her out of bed where possible'.[23] She quite rightly pointed out that it would have been far less trouble and work for the nursing staff if she had remained in bed. But

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[20] Interviews with Nancy Langley, and Barbara Allan. Barbara believed this was because of insurance concerns, as employees coming in before their shifts would not be covered by workers' compensation.
[21] St John's Park Hospital information brochure, Department of Health, (Hobart, c1972)
[22] Bed and staff shortages in hospitals during the Second World War led to early mobilization of patients, and an unexpected consequence of this was the discovery that they recovered more quickly. Consequent studies found that 'virtually every organ and body system promptly and progressively deteriorates when inactivated', and this greatly affected both acute care practices and long-term rehabilitation care: Paul J Corcoran, 'Use it or lose it—the hazards of bed rest and inactivity', *Western Journal of Medicine*, 154:5(1991), 536-538, page 536
[23] HSD6/1/1975 Memo from Minister of Health to Director of Health and Medical Services, 7/6/1948

the patients did not always rise willingly. Judith remembered that some of the Cosgrove Park residents were "very disgruntled" when they had to get up and go to the day rooms; perhaps they assumed that as 'patients', they should be nursed in bed, as in the general hospitals.[24] By the 1970s, sitting out of bed was accepted as best practice in both hospitals and Homes, and St John's Park even used this fact for positive publicity in their brochure, as seen in plate 1.

It is probable that many residents of the Homes did not mind the early start, as old people are often early risers. But willingly or not, the residents were roused and readied for the day, by nurses who brooked no dissent. This ongoing conflict between what was best for the residents and what they actually wanted was seen even more clearly when it came to bath time.

Cleanliness and hygiene

> There is a receiving room for the female paupers, where they are cleansed before they enter the other portions of the establishment.[25]

The colonial institutions used the bath on entry as a rite of passage, symbolic of the removal of the pauper from their immoral past and their entry into a more respectable present. Those who refused this ritual were refused admission.[26] Whilst it was obviously beneficial to cleanse the inmates and remove insect life from their bodies, it was also part of the process of depersonalization and 'mortification of the self' necessary to instil discipline in a total institution.[27] After admission, the inmates were bathed fortnightly, in batches, to allow the small number of overseers to supervise a large group of inmates.[28] The male inmates of New Town were bathed in 'lots of 12' (although the water was changed between bathers), they were shaved twice a week, their linen was changed

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[24] Interview with Judith Beard. Social worker and aged care expert Ollie Randall noted in 1965 that the size of nursing homes was always described in terms of bed numbers, 'the traditional concept of nursing care being that of service rendered to persons *in bed*' [italics in original]: 'The situation with nursing homes', *American Journal of Nursing*, 65:11(1965), 92-97, page 93

[25] 'The Cascades', the *Mercury*, Wednesday, 1st January 1873, page 3

[26] TPP, 6, 1885, Paper 154, page 19. Chapter 7 of Andrew Piper's thesis is an in-depth exploration of the link between cleanliness and morality during the convict era and the role of cleanliness in the control and reformation of inmates: *Beyond the Convict System: The Aged Poor and Institutionalization in Colonial Tasmania*, PhD Thesis, University of Tasmania (2003)

[27] Goffman, 'On the characteristics of total institutions', page 28

[28] Batched inmates are 'treated alike and required to do the same thing together: 'Goffman 'On the characteristics of total institutions', page 17

weekly, and they were issued with clean clothes when necessary.[29] If they refused, their tobacco ration was withheld, a measure that soon ensured compliance.[30] IDL inmates were also subjected to regular bath days.

> Mr Daniels believes cleanliness to be one of the main essentials of Depot life. Therefore the old men have, willy-nilly, to submit to the operation of bathing. They are submitted to this treatment in batches. At first there was a difficulty; various excuses were given to prevent the operation from being performed; but Mr Daniels was adamant, the men gradually grew accustomed to the water and soap, and as plenty of both is used they are always clean, and visitors are not averse to approaching them.[31]

Although the punitive and reformative nature of the institutions changed in the 20th century, bathing was still a requirement, and one to be enforced if necessary. Until the 1970s, the primary duty of the St John's Park nursing staff was personal hygiene[32], and it also loomed large in the routine of other Homes. Whilst the state institution requirements might have been a remnant of the old institutional desire to instil the discipline and values of the respectable middle class upon the lower class inmates, there was also a strong nursing imperative behind the practice. Florence Nightingale had said that an unwashed skin would interfere 'injuriously with the natural processes of health just as effectually as … slow poison'[33], and the bathing of patients featured strongly in nurse training at least up to the transfer of nurse education to the tertiary sector. In the Homes, the nurses vigorously applied soap and water, or ensured their aides did so.[34] Most residents submitted more or less willingly, accepting their wash as part of the routine of the Homes, but others were not so acquiescent. Pat remembered

> [one] old lady had an umbrella, or a stick, and every time we tried to bath her, she'd be hitting us. She hated having a bath, we had to force her in.[35]

In the 21st century, one does not 'force' a resident to do anything, but up to the 1980s and the introduction of accreditation and residents' rights, physical coercion was accepted

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[29] TPP, 15, 1888-9, Paper 50, page 37: evidence of Mr Simon Murphy, Head Warder
[30] The *Mercury*, Thursday, 25th March 1886, page 4
[31] The *Launceston Examiner*, Saturday, 28th October 1893, page 3
[32] HSD222/2/2 Instructions for Deputy Charge Male Nurse, 1957
[33] Florence Nightingale, Notes on Nursing: what it is and what it is not, (New York, 1860/1969), page 93
[34] Evelyn Pettee recommended baths to keep the aged patients' skin soft: 'The care of the aged', *American Journal of Nursing*, 39:2(1939), 145-155. It was sometimes noted that these ministrations might meet with protest, but no suggestion these protests should be heeded: see Edith Marsh, 'The care of the chronically ill at the Cuyahoga County Nursing Home', *American Journal of Nursing*, 41:2(1941), pages 161-166; Mildred Hainsworth, *Modern Professional Nursing*, (London, 1956), pages 92-94
[35] Interview with Pat Job

tacitly if not officially as a necessity at times. The nurses knew best, and the residents had little choice in if or when they had their wash, as Peter S explained.

> Things are different as society goes now; you've always got to ask permission. People have the right to say no. Back then it was different: "Want a bath?" "No!" "In you go!" [laughs] But it didn't hurt them anyway, really—if you can smell them from two paces back they probably need a bath, really! So yes, there was a little bit of scruffin', but if they hadn't had a wash, and stunk, what else could you do? You had to clean them up.[36]

Peter's charges, the old men of St John's Park, were mainly from the lower socio-economic stratum, a group with a long tradition of being treated with a minimum of consideration for personal preferences. Pat's patients lived in a private Home, with single rooms and ensuites, and came from a higher social class. The fact that both groups of residents were treated in similar fashion and that both nurses found this quite normal suggests that the practice was widespread and widely accepted by nursing staff, if not by the residents themselves.

The installation of showers in the 1960s and 1970s made hygiene practices easier and faster, and the Homes were able to implement more than one bath day a week. Whilst this was easier for the staff, it may have made things less pleasant for the residents, as the process assumed a conveyor belt-like routine.[37]

> You'd be working with a colleague, you'd be in the shower room and your colleague would be in the room where there'd be four ladies. She'd get them out of bed, and she'd put them on to a shower chair, and they'd still have their singlet and pants on. She'd open the door and push them in, and then I'd be in the shower room and I'd take off their singlet and pants and push them into the shower, shower them, and then dry them off. There'd be talcum powder flying in all directions—between the steam and the talcum powder, it's a wonder we weren't all suffocated! And then you'd put on their fresh underwear and you'd push them out the door again, and your colleague would finish off the dressing. And then you'd get the next one in. They didn't get showered every day—they probably got three or four showers a week, and on other days they'd get face, hands, between the legs, maybe under the arms—a freshen-up, that was about it. They were all washed in the morning, whatever kind of wash it was. It was terrible, actually, when I think about it, but at the time it seemed very practical—they were getting washed, very efficiently! Whether they wanted to get washed or not was another matter… We'd often hear "I don't want to", "well, you are!" It's awful![38]

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[36] Interview with Peter Sweeney

[37] In *Nobody Ever Died of Old Age*, (Boston, 1972), page 146, Sharon Curtin noted the conveyor-belt nature of the shower routine as being like 'two sisters doing dishes: lift, scrub, rinse, dry, put away.'

[38] Interview with Eileen O'Leary

It is clear that looking back on it, Eileen is aware of the lack of concern that she and her fellow aides displayed for the residents' autonomy and dignity. Her moral language ("it's awful", "it was terrible, actually") shows her recognition of these breaches by today's standards, but at the time the practice was quite acceptable. The RNs arranged the bathing rosters, and the aides followed them; the residents were given no choice in the time of the shower or who would carry it out. The routine was efficient, the showers were effective, and the residents were clean.[39]

There were other grooming issues: nail cutting, hair brushing, and teeth-cleaning—or, more commonly, denture cleaning. Many of the residents had complete dentures, as it was cheaper to have teeth extracted than filled.[40] The ubiquity of the denture has given rise to what I suspect may be an urban myth. Several participants told me the story of the mass false teeth collection, never seen but always heard about second-hand:

> I wasn't a witness to this, it was before I went there, a new attendant came. And you know how you go round with the trolley and you have dishes and that and clean people's teeth? This bloke went round and collected everyone's teeth, and cleaned them, and didn't know whose they were![41]

That an item as personal and intimate as a set of false teeth could be treated as casually as any other common belonging, to be batched together for convenience or efficiency, seems unlikely. I have also heard the tale in the context of hospital wards, again always second hand. But true or not, the story illustrates Goffman's contention that the inmates of a total institution are seen as a homogeneous mass rather than as individuals to be given personal attention. This homogeneity can also be seen in the catering arrangements that the residents faced on a daily basis.

Breakfast

> They used to wheel the trolleys—you know, the hot boxes, they were around then—with the porridge and milk and whatever they were having for breakfast. They always did have something hot on toast for breakfast, can't remember what

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[39] A 2006 study showed that showering could be particularly unpleasant for residents with dementia, being cold, noisy and intimidating, and unless there was a compelling health reason for it, it constituted abuse. The authors stated that 'bathing people routinely against their wishes—'for their own good'—should become part of nursing history': Joanne Rader, Ann Barrick, Beverly Hoeffer, Philip Sloane, Darlene McKenzie, Karen Talerico, and Johanna Glover, 'The bathing of older adults with dementia', *American Journal of Nursing*, 106:4(2006), 40-48, page 40

[40] Even today, a large proportion of Australians over forty-five have no teeth of their own: Humphrey McQueen, *Social Sketches of Australia 1888-2001*, (St Lucia, 2004)

[41] Interview with Peter Davy

> it was but I remember there was always porridge and cornflakes. And some mornings they'd have a little bit of mince on toast or something. The food wasn't too bad. We had a tray and we'd all line up at the hot box and the senior nurse would put the porridge out, and the milk, and then you'd run it to the patient and come back and get another tray.[42]

Breakfast time was usually around 8am, although some Homes started earlier. Nazareth House residents broke their fast at 7.30, and St Margaret's residents ate at 6.45am.[43] With the evening meal at around 5pm, this left a very long period between meals, but those who would have liked a cup of early morning tea were often disappointed. Miss Hogarth, one of the first hostel residents at Cosgrove Park, took her lamentation to the Minister for Health himself. She was informed:

> …although we try to make it as much like home as possible you will realise that this is not quite possible in an institution, and I can quite understand that you cannot get a cup of tea at 6.30 in the morning as this might be too much strain on the staff.[44]

The Minister suggested to management that a kettle be provided in a small pantry to allow her and like-minded residents to make their own tea, but this was quickly quashed by Mr Griffiths, the administrator, who believed that 'access to boiling water … would represent a potential danger to them'. This concern was no doubt sincere but clearly paternalistic, arising from the view that because a person finds it necessary to enter a Home for one reason, they are therefore considered incapable of making any decision or carrying out any task, even those that could easily be done without help. This requires the person to request assistance, removing their autonomy and putting them in a 'suppliant' or childlike role, emphasising their weakness.[45] For Miss Hogarth, the story ended happily. She wrote to the Minister again two years later to say that she could now 'make a pot of tea and have a snack of biscuits and butter at 6.15 (in bed)'[46], but this appears to have been a temporary aberration. Tea-making facilities disappeared in the 1960s, and

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[42] Interview with Claire Paynter
[43] AOT, HSD6/2/1002 Inspection report 16/8/1974
[44] AOT, HSD6/3/2211 Letter to Miss Hogarth, from the Secretary, Department of Health, 6/6/1955. This was no doubt a widespread reaction: Ellen Newton writes of requesting a cup of tea at 3am when sleepless due to illness. The night nurse replies, 'No dear, you couldn't possibly have a cup of tea at this hour' and quickly departs. She finally received the longed-for drink at 7.30am on her breakfast tray. *This Bed My Centre*, (Melbourne, 1979), page 92
[45] Goffman, 'On the characteristics of total institutions, page 76. Goffman points out that in general society, only children usually face this lack of personal choice. The 'parent-child' relationship between the aged care nurse and the Home resident can been seen in several exchanges in the interviews discussed in the following chapters.
[46] AOT, HSD6/3/2211 Letter from Miss Hogarth to Mr Turnbull, Minister for Health, July 1957

few other Homes attempted such arrangements. It was tried briefly at Nazareth House, but there again the paternalistic concern won through:

> Years ago, they put facilities in so everyone could make themselves a cup of tea, but then you had to think about what residents you got, because they could burn themselves. So we couldn't let certain residents do things, and most of them weren't allowed to because of the boiling water.[47]

The concern was not unfounded, of course. The Queen Victoria Home in Hobart allowed each resident to have "a toaster and kettle in their room, but then some silly old biddy set fire to something", according to Pat[48], and the practice was stopped. With the added fear of litigation in recent years, this decision is understandable, but it does show the tendency to reduce residents to a homogeneous mass. Rather than assessing each individual for their abilities, it is easier to impose a blanket decision that affects everybody, no matter what their capabilities.

Breakfast itself was often a hearty affair, mirroring the traditional choices that the residents would have made at home.[49] The 19th century institutional gruel gave way to porridge, an option much favoured by the nuns of Nazareth House for its suitability as an invalid diet, much to Eileen's dismay.

> Porridge—bucket-loads of it, over the years, I've shoved down people's throats! And I absolutely *hate* porridge. But somehow I used to shut off from my own discomfort and thought well, they're enjoying it—and they did, by and large! It was good for people with swallowing problems.[50]

The words 'by and large' suggest that not everybody enjoyed it, but they had little choice in the matter. It was for their own good. Most Homes provided some sort of cooked breakfast in addition to the porridge, like Claire's "something hot on toast": baked beans, mince, sausages, eggs and bacon, or even the occasional chop.[51] Mealtimes usually coincided with medication times, and the food gave the staff a useful vehicle in which to administer drugs, whether the resident wanted them or not.

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[47] Interview with Judy Wall
[48] Interview with Pat Job
[49] In *Nursing Home Life*, (Berkeley, CA, 1990), Clifford Bennett notes that '[b]reakfast is the meal that receives the fewest condemnations' (page 99). Possibly this is because it is the meal that has the fewest variations, and therefore is the least likely to disappoint.
[50] Interview with Eileen O'Leary
[51] Interviews with Kay Joyce, and Claire Paynter

Medication administration is an increasingly fraught area of practice in aged care today. The requirements of autonomy and consent mean that a resident cannot be made to take medicines against their will, which can cause an ethical dilemma for the nurses: how to balance the resident's autonomy of choice over what they ingest against the knowledge that without the medication, they will possibly deteriorate in health or even die. This is particularly difficult when the resident is suffering from dementia and does not understand the seriousness of their actions. This is one situation where the nurses really can claim to 'know best', and in the days before regard for autonomy became paramount, they endeavoured to ensure that they prevailed—by subterfuge, or force if necessary.[52]

> If a patient didn't want to take their tablets, sometimes we would crush them up and put them in their meal. If we knew they were going to carry on about it, they'd smash them up and put them in with their mashed potato or whatever.[53]

It is likely that in reality such stratagems are still used today, as the ubiquity of pureed food makes clandestine drug administration easy. Homes are still total institutions, and the RNs are still the experts.

Once bathed, fed, and medicated, the residents were ready to begin the day's activities.

'The bread of idleness is not good for any person'[54]

> Every officer and employee shall encourage patients to occupy themselves, and no effort must be spared to induce them to take exercise, and to promote cheerfulness among them.[55]

In the 19th century, there was no question about how the inmates of the early institutions would spend their time. They were expected to do any work for which they were capable, in an effort to instil a middle class work ethic and combat idleness. In the earliest days, this had been akin to hard labour, and by the later years of the 19th century it amounted to at least the housekeeping, gardening and tending to the needs of other inmates. The employment of paid nurses brought an end to this latter activity, but the inmates of the

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[52] Goffman, 'On the characteristics of total institutions', page 35
[53] Interview with 'Helen'
[54] TPP, 1, 1885, Paper 12, page 3: Annual report of the Hobart Benevolent Society
[55] *General Instructions for the Efficient Working of St John's Park*, Public Health Department, (Hobart, 1948), rule 68

two public institutions continued to carry out 'light duties for their own good'[56], such as peeling potatoes and washing up, well into the 1950s.

Studies have shown that this idea in fact true. Helping with chores gives people a sense of purpose and usefulness, preventing dependence and increasing self-esteem.[57] What really matters, however, is how much choice the resident has in what work they do and how often they do it. At St John's Park the inmates were expected to carry out daily chores in return for their keep, whereas some of the private Homes allowed their residents to choose whether or not they helped. At the Queen Victoria Home, for example, residents chose their own tasks, peeling vegetables, washing up and managing the kiosk.[58] Barbara and Nancy remembered Nazareth House residents willingly helping out.

> One of the residents would go around and he used to delight in picking up the cutlery, and then two of them would dry it up. And they used to love peeling apples or potatoes, or chopping up carrots, folding up serviettes. I think it made them feel as if they were wanted.[59]

Some were a little too enthusiastic, perhaps:

> … there were two elderly ladies who used to come down at five o'clock every morning and set up the things and cook the toast—of course, it would be cold before anybody got there![60]

A change to funding arrangements in the 1970s meant that the Homes began to receive greater financial subsidies for high-care patients, so the more dependent the resident, the higher the payment.[61] Self-sufficiency began to be discouraged, and newly admitted residents tended to be older and frailer and less able to contribute in such a way. Concerns about safety were also raised, and although these were sometimes used as an excuse to prevent the slower and less agile residents from interfering in the fast and

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[56] PSC2/1/83 7C/47 Public Inquiry into conditions at HFI, quote from evidence of Matron McClymont
[57] Mary Zahrobsky, 'Recreational programs in homes for the aged in Cook County, Illinois', *The Social Service Review*, 24:1(1950), 41-50; Hutchinson, *Old People;* Helen Bartlett, *Nursing Homes for Elderly People*, (Chur, Switzerland, 1993); Stephen Abbott, Malcolm Fisk, and Louise Forward, 'Social and democratic participation in residential settings for older people: realities and aspirations', *Ageing and Society*, 20(2000), 327-340
[58] AOT, HSD6/3/2562 508/60/10 Inspection report 13/3/1968 Shaw noted that suitable residents should be given odd jobs to keep them involved in the Home's routine (*Old People In Homes*, page 51)
[59] Interview with Barbara Allen
[60] Interview with Nancy Langley
[61] A similar change occurred in the USA at that time, with funding linked to care needs; Robert Kane and Rosalie Kane, 'Care of the aged: old problems in need of new solutions', *Science*, 200:4344(1978), 913-919

efficient routines of the employees, the practice died out.[62] Nowadays, no Home expects a resident to work, whether they would like to or not, but they are expected to keep busy in other ways—whether they would like to or not.

'The busy person has no time to grow old'[63]

> …boredom, inactivity and disinterest are the greatest enemies of the aged'.[64]

The idea that activity could keep a person cheerful and therefore healthier was not entirely new even in the 1950s. The Brabazon Employment Society had been started in England at the end of the 19th century, and a branch opened at New Town in 1900 'to provide interesting occupation for those who … are forced to pass the weary hours idly' in the infirmary wards.[65] The Annual report for that year reported that inmates had produced basket work, Turkish mats, bent iron work and knitting, but there is no further mention of this society in later reports so it is not clear how successful the group was in the long run. The HFI had no similar society. During the four decades of its operation, there were no organized recreational facilities at all and Matron did not think them necessary.

> They have the wireless. The men seem to want to read and doze most of the time. … I don't think the men would appreciate facilities for recreation. The women have their knitting and fancy work and they are quite content.[66]

In the 1950s social welfare groups began to push for more activities for old people, to prevent boredom and to ensure they remained socially engaged.[67] A new Handcraft Centre was opened at St John's Park[68], and occupational therapists were employed to help the inmates and patients engage their time more productively. Some inmates took up

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[62] Interview with Barbara Allan; Pauline Payne, *Helping Hand Aged Care 1953-2003*, (North Adelaide, 2003), page 72
[63] Elizabeth Black, 'Nursing home care', *ANJ*, 50:5(1950), 289-291, page 289
[64] AOT, HSD6/1/4395 109/8/1 'The problem of the aged', press release, undated but c1959
[65] TPP, 45, 1901, Paper 9
[66] PSC2/1/83 7C/47 Public inquiry into conditions at the HFI: evidence of Matron McClymont etc
[67] Cecily Hunter points out that this was a very middle-class attitude, as for the average working class person who had worked hard all their life, the chance to sit and do nothing would be greatly appreciated: 'The concept of successful ageing', *History Australia*, 5:2(2008), 42.1-42.15. American Homes were also recognizing the benefits of regular exercise and activity: see Marsh, 'The care of the chronically ill'; Zahrobsky, 'Recreation programs'; Lydia Merritt, 'Young ideas for elderly patients', *American Journal of Nursing*, 52:6(1952) , page 713
[68] TPP, 161, 1959, Paper 59, page 20

these activities with great enthusiasm, but not everybody was keen to join in. The men were particularly resistant[69], but even the women were reluctant at times.

> I have endeavoured to get [Mrs P] to take up handcraft work … but she persists in sitting and doing nothing. An effort is being made … to take her down to the Handcraft Centre in a wheelchair to see if it is possible to get her interested.[70]

Like the matron of the HFI before her, Judith found that the old men of Cosgrove Park "seemed to be happy to just sit and talk", and Elaine agreed that most residents did not want to do much. The nurses were expected to encourage them to do so, but this was one aspect of daily life that they did not spend a great deal of time or effort upon. The endless routines of physical care took precedence.

> It takes a lot of effort to motivate people, and I don't think the nursing staff had the time, because you were flat out doing all the back toilets, and the hygiene. You didn't have the time to sit there and try and encourage somebody to go to the Day Therapy Centre. [71]

By the early 1960s, a clear link between health, happiness and psychosocial activity began to emerge.[72] The government instigated a wider program of recreational and rehabilitation activities in the public Homes, led by diversional therapists and physiotherapists. As with the handcrafts programs, these sessions appear to have had mixed success. Judith did not remember the ladies of Cosgrove Park joining in with any great enthusiasm in 1965.

> I remember Margaret used to try and do callisthenics in the day room, and that used to be a circus—she was the only one who would do it, all the old ladies would just sit there and look at her in amazement![73]

But Kay enjoyed helping out with the activities.

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[69] AOT, HSD221/1/1 1171/42 File B6/1 Minutes of Gellibrand House Board meetings. Megan Davies suggests that many men find the 'make-work' of handcrafts and occupational therapy distasteful, as it ignores their past knowledge and skills and therefore gives them no satisfaction in a real job well done: *Into the House of Old*, (Montreal, 2003), page 123

[70] AOT, HSD6/1/5190 98/5/1 Memo to Minister for Health from Superintendent Trebilcock, 14/3/1960

[71] Interview with Judith Beard and Elaine Sturzaker. Dr Catherine Rhys Hearn noted that achieving resident participation took a great deal of time and skill, neither of which were readily available in most Homes: *Quality, Staffing and Dependency: Non-Government Nurisng Homes*, (Canberra, 1986), section D3.3.

[72] Robert Havighurst posited the influential 'activity theory' of aging in 1963, which claimed that high levels of social activity produced high morale and life satisfaction, and that people could deny old age by maintaining middle age activity patterns. Carroll Estes, *The Aging Enterprise: A critical examination of social policies and services for the aged*, (San Francisco, 1979), page 8, Nursing articles began to address psychosocial as well as physical benefits; see, for example, Michael Miller, Dorothy Keller, Eduard Liebel, and Irene Meirowitz, 'Nursing in a skilled nursing home', *ANJ*, 66:2(1966), 321-325

[73] Interview with Judith Beard

> We used to do arm and leg exercises to music, and we used to play records—'Bill Bailey won't you come home' or something! [laughs] That was always about 11 o'clock before lunch, we'd have them all in the day room, and some of them used to get up and dance.[74]

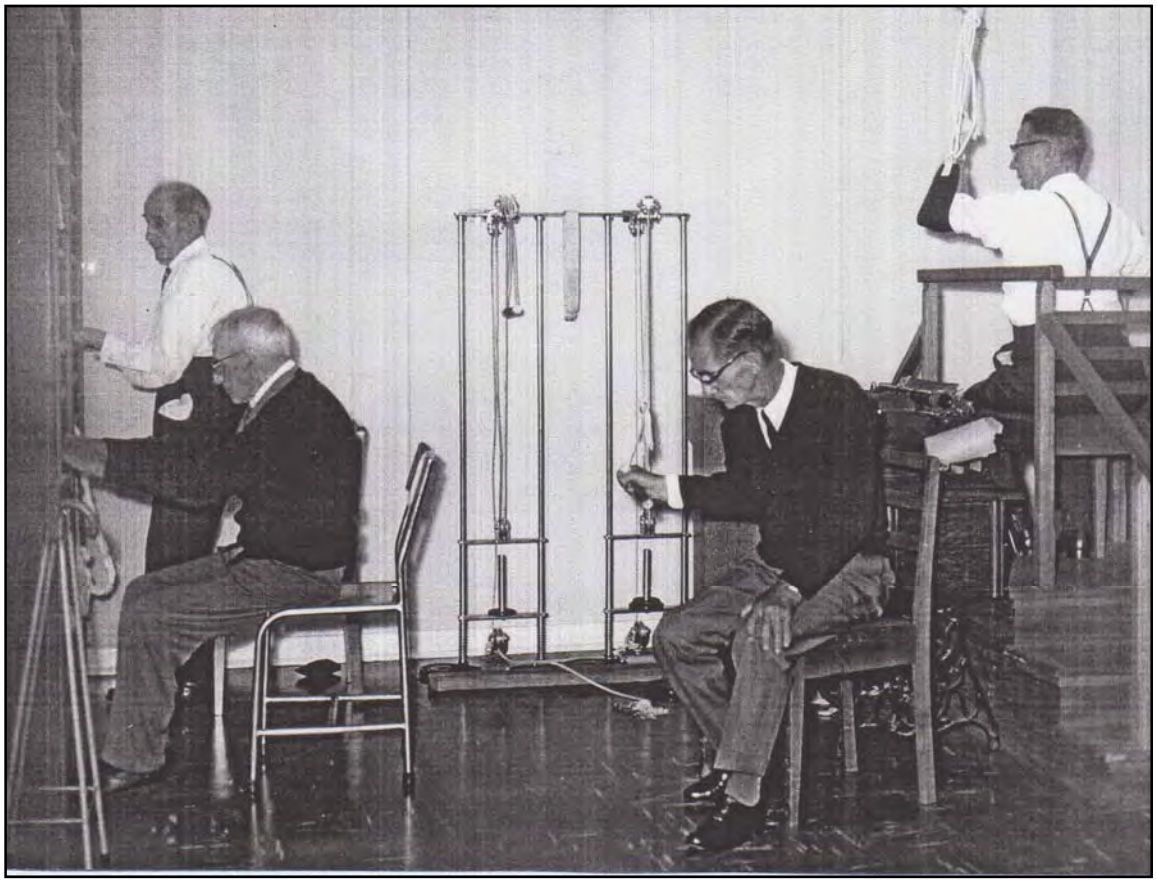

Plate 2: Residents take their daily exercise in the physiotherapy room at Cosgrove Park, c1966[75]

A physiotherapy centre had opened at Cosgrove Park in 1958, and during the next few years the services expanded to include exercise classes, occupational therapy, speech therapy and a hydrotherapy pool.[76] The residents were encouraged to attend regular sessions with qualified physiotherapists, as well as taking part in the informal activities arranged by the nurses. St John's Park patients also had access to physiotherapy

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[74] Interviews with Judith Beard and Elaine Sturzaker, and Kay Joyce

[75] AOT, AB644/1/9: Photographs of Cosgrove Park: therapies

[76] This emphasis on rehabilitation was a growing phenomenon across Australia and around the world. Cecily Hunter discusses the introduction of 'restorative treatment' into the benevolent homes of Victoria and their reclassification as 'geriatric hospitals' in 'Nursing and care for the aged in Victoria: 1950s to 1970s', *Nursing Inquiry,* 12(2005), 278-286. Articles in the *American Journal of Nursing* also looked at the importance of rehabilitation, for example Miller et al, 'Nursing in a skilled nursing home', 66:2(1966), 321-325, who stated that nurses should use rehabilitation skills in combination with other therapies to maintain and improve residents' health. Megan Davies found physiotherapists on the staff of several Canadian Homes from the 1940s in 'Renovating the Canadian old age home: the evolution of residential care facilities in B.C., 1930-1960', *Journal of the Canadian Historical Association,* 12:1(2001), 155-175, page 170

facilities, which had been installed at the Wingfield Home for Crippled Children some years earlier.[77] The physiotherapists assumed a central position in the Homes, superior even to the RNs. When the third Geriatrics Conference was held at Cosgrove Park in May 1965, its theme was 'the practical side of caring for the aged', and despite the undoubtedly practical nature of nursing, the attendees were geriatricians and physiotherapists.[78]

The private Homes did not enjoy such facilities, and rarely employed diversional therapy staff until the 1990s, when the introduction of standards and outcomes for accreditation required that residents be 'encouraged and supported to participate in a wide range of interests and activities'. But whether snoozing, knitting, reading, or dancing, the one thing that many residents looked forward to most was lunch—the main meal of the day.

Lunchtime

> In old age, food is often the main pleasure of the day, [and sometimes] it may be the only one.[79]

The records show that the early institutions provided their inmates with the standard rations issued to prisoners and hospital patients, a diet calculated to sustain life but provide little pleasure.[80] The Parliamentary papers reported regular improvements in dietary arrangements throughout the first half of the 20th century, but as has been shown in previous chapters, these official records did not always mirror reality. The Public Inquiry into the HFI in 1947 certainly brought to light many inadequacies in the diet of the inmates, from poor quality ingredients to poor quality cooking, but apart from these complaints there is little evidence of what was served in the Homes on a day-to-day basis.

This changed in the late 1950s, when the Homes began to receive government funding and food became a focus of official inspections. These reports show that the Homes

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[77] TPP, 161, 1959, Paper 59. As with nursing, it was hard to attract physiotherapists to work in aged care, which was 'arduous and ... not as rewarding' as acute care: AOT, HSD6/3/2378 241/2/41 Memo from Dr Edis to Public Service Commissioner, 18/7/1962; letter from Superintendent Ginsberg to Director General of Health Services, 27/6/1972

[78] AOT, HSD6/3/2216, Document 20. Four RNs were permitted to attend another conference the following year, however: AOT, HSD6/3/1729 Wynyard Geriatric Conference, 13/2/1966

[79] Patricia Shaw, *Old People in Homes*, (London, 1963), page 38

[80] The rules and regulations of the charitable institutions all include a 'scale of rations' which include meat, vegetables, bread, butter, salt, pepper, barley, tea, and sugar; see, for example, regulations for New Town in *The Hobart Town Gazette*, Tuesday, 18th August 1874, page 875

provided their residents with meals similar to those they would have eaten at home in earlier years. At St Margaret's, lunch was usually a meat dish with three vegetables and a pudding.[81] It was the same at Abbeyfayle, where the matron prepared "standard home cooking of the time, good food, prepared from scratch".[82] The government inspector declared that the Nazareth House kitchen produced 'beautiful food'[83], but given the age of the residents and their state of health (and dentition), there was a certain amount of pragmatism in the choice of dishes.

> Lots of mincemeat, because a lot of them couldn't chew very well, stews, you never saw chops—lots of soup. It wasn't fancy food, but it was what they probably would have eaten at home! *Lots* of vegetables, because they used to have they own vegetable garden. And milk used to come in big buckets. You'd let the milkman in every day, and he'd bring these big tins of milk in, not in cartons, and sit it in the fridge. They had huge fridges down there. The meat used to come in in bulk, you didn't have it all chopped up in those days.[84]

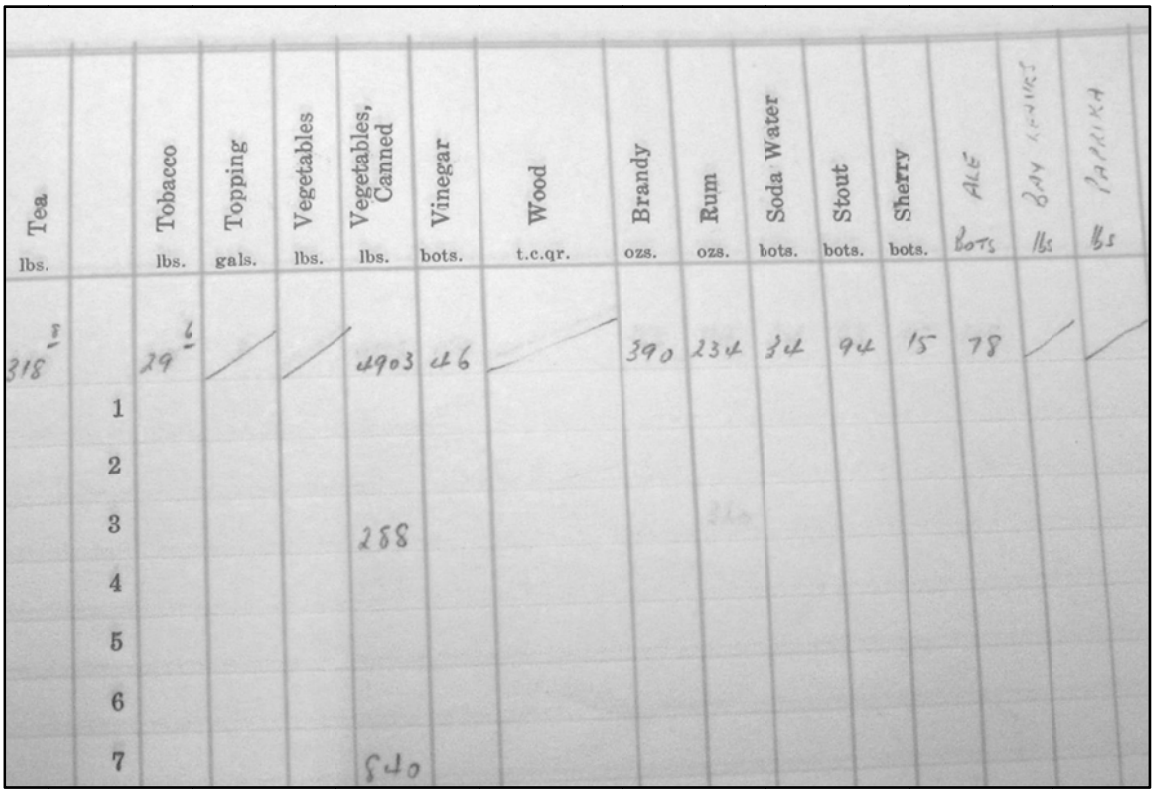

Plate 3: Part of the printed ledger for St John's Park, July 1967[85]

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[81] AOT, HSD6/2/1002 Inspection report 16/8/1974
[82] Interview with Alex Myers
[83] AOT, HSD6/3/2680 559/50/10 Inspection report 18/11/1966
[84] Interview with Nancy Langley
[85] Archives Office of Tasmania. The inventory ledgers for St John's Park in the 1960s show stout as a standard stock item, along with bottles of rum, sherry, stout and brandy. Brandy was also used as a pick-me-up, and not always for the patients. Peter Sweeney remembered being given brandy after taking a body to the morgue, but it was possibly only the men who received this, as Claire Paynter did not mention it.

In all the Homes, the nurses served the meals and fed those residents who could not feed themselves. Those who did not want to eat were cajoled and persuaded by various means. At St John's Park, they received a medicinal glass of stout.

> …all the patients got a little glass of stout at lunch. Stout's supposed to give you an appetite—if you're down in health and you're heading for rock bottom, they always maintain that stout picked you up, gave you a lift… a tonic, that's the word.[86]

Another method of persuasion was to withhold desserts until the main meal was finished, a paternalistic reminder of childhood discipline (if you don't eat your greens, you can't have pudding!). The other side of the coin was the placing of residents on enforced diets because they were 'too fat', a practice that did not always go down well:

> I remember one lady, Mrs James, she was [at Nazareth House] for years. They thought she was getting too fat, so they cut down her meals. And she sent for Reverend Mother, and she said she wanted a cut in her rate because they were only giving her one potato instead of two![87]

When both the underweight and the overweight resident can be used as evidence that care is not of the highest standard, a person's appetite ceases to be a personal choice and becomes the business of the Home, and a legitimate concern for the nurses in charge of that care.[88]

Once lunch was over, the residents were again encouraged to take part in a variety of activities. Whilst exercise was recognized as being good for a person, fresh air was also paramount, so on a fine day, these might take place outside.

Fresh air and the 'health-giving qualities of sunshine'

> It is the unqualified result of all my experience with the sick, that second only to their need of fresh air is their need of light… And that it is not only light but direct sun-light they want.[89]

Even before Florence Nightingale espoused the importance of fresh air and sunlight, their benefits had been recognized. The inmates of Brickfields Invalid Depot were 'allowed to take a book or paper from the [reading] room, so as to enjoy a read in the sunshine'[90], and

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[86] Interview with Claire Paynter
[87] Interview with Eileen O'Leary
[88] John Braithwaite, 'The nursing home industry', *Crime and Justice*, 18(1993), 11-54, page 43
[89] Nightingale, *Notes on Nursing*, pages 84-5
[90] The *Mercury*, Saturday, 30th May 1874, page 2

the major complaint against the use of the Cascades Invalid Depot was its location in damp and dark 'shadow of death valley'. The old ladies of New Town were encouraged to sit on the balcony or in the garden of the women's division, whilst the men enjoyed a 'copious supply of air' through their wards and sat out on the verandah on hot days.[91] Even at the run-down Launceston Invalid Depot, the men could take advantage of sunlight on 'broad stretches of lawny grass'.[92]

In the 1920s and 1930s, sun-bathing became more popular as a recreational activity for the public in general, and solaria were built on to several wards at St John's Park in 1938 to enable even the chair-bound patients to enjoy the benefits of sunshine.[93] Verandahs were added to the Home for Invalids, and the windows flung wide; a complaint that the men's room was draughty was denied: it was 'only the fresh air going through'.[94] And it was not just the residents who benefitted. When the new nurses' home at St John's Park was opened in 1960, it included a flat roof to be used as a sundeck,

> …having in mind the health-giving qualities of sunshine, particularly for those persons who spend so much of their time indoors.[95]

Cosgrove Park took sun-worship to even greater heights. The Home was designed with a great many floor-to-ceiling windows, particularly on the eastern side, to give 'ample provision for sunlight', and the residents were encouraged to sit on the large promenade deck outside to enjoy the view and the sunshine. In many Homes, residents would be taken outside into the sun, to soak up the health-giving rays. At Nazareth House, they had a pergola in the garden for the residents to enjoy. Even the bedridden were not forgotten as sunlight was employed as a therapeutic treatment, to prevent and heal bedsores.

> When they had sore bottoms, we used to open up the blinds, with the doors closed, and the sun would shine in on their bottoms. We didn't really have that many sore bottoms like you have nowadays, so it worked! Just lying on their beds with their bottoms laying towards the sunshine![96]

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[91] The *Mercury*, Thursday, 25th March 1886, page 4
[92] The *Launceston Examiner*, 10th November 1891, page 4
[93] The *Mercury*, Friday, 3rd June 1938, page 3
[94] PSC2/1/83 7C/47 Inquiry into conditions at the Home for Invalids, Launceston, 5th and 6th June 1947 Evidence of wardsman Cooper
[95] TPP, 165, 1961, Paper 33, page 3
[96] Interview with Barbara Allen, confirmed by Eileen O'Leary

Plate 4: The promenade deck of Cosgrove Park, with an 'unforgettable view [and] ample sunshine'[97]

Outdoor activities were encouraged. In 1957, a bowling club was built at Cosgrove Park to serve the local community, and the residents were made honorary members.[98] St John's Park followed suit in 1963.[99] In that same year, the residents of the southern Home began to enjoy regular trips to the seaside, thanks to their farsighted and innovative superintendent. Mr Trebilcock had mooted the idea of a holiday home in 1959, and thanks to the efforts of the Eastern Shore Apex Club, a dormitory block and several chalets for the more able residents were built at Carlton Beach, on Hobart's eastern shore. Regular day trips and longer stays saw the patients returning 'more contented and happier in their outlook'.[100] Carlton Beach was renamed the Arthur Trebilcock Holiday Home in 1972, after the superintendent's death, but it did not remain a holiday home for long afterwards. In the following year it became an annex of the main Home, when the

[97] Department of Health appeal brochure, *For the Aged – Security Care Comfort: Cosgrove Park Home for the Aged*, (Hobart, c1953), page 5
[98] TPP, 157, 1957, Paper 76, page 7. Shaw (*Old People in Homes*, page 30) notes that 'bowls, croquet and putting' were beneficial exercise for old people.
[99] TPP, 169, 1963, Paper 72, page 22
[100] TPP, 169, 1963, Paper 72; TPP, 171, 1964, Paper 171, page 33

overcrowding at St John's Park became too great.[101] It was finally sold into private hands in 1986.[102]

Plate 5: The dormitory accommodation at Carlton Beach Holiday Home[103]

Apart from the exercise and recreational activities, the public Homes also provided regular excursions into the community, to encourage the more active residents to take an interest in the world outside the Homes.[104] The acquisition of buses by the public facilities in the 1960s meant that more of the residents could take part in these activities, but they did not always do so willingly. Some had to be persuaded, sometimes quite persistently, to join in. When Vera instituted regular outings for the patients of Ward H, the long-stay geriatric ward of the LGH, she was keen to press even the most reluctant on to the buses. She was compelled to reassess her belief that the nurse always knows best when one of the student nurses complained.

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[101] TPPs: 187, 1972, Paper 82, page 17; 189, 1973, Paper 88, page 22

[102] *St John's Park Strategic Options*, Report from Superintendent of Nursing, Mr NV Clarke, page 1. It was brought by the Salvation Army.

[103] St John's Park Hospital information brochure, Department of Health, (Hobart, c1972)

[104] This, too, following Havighurst's activity theory of aging, which advocated social inclusion as necessary to a healthy old age: Estes, *The Aging Enterprise*, page 8. The activities are described in more detail in Chapter 6, pages 212-3.

> I remember one student nurse went back and complained that I was forcing people to go on a bus outing when they didn't want to go. And I said, "well, we didn't *force* them, we just encouraged them, because they enjoyed it once they got there." There might perhaps be one or two who were reluctant to go… but she made me think, well, maybe we should relax a bit and not be so intense about it, being bossy! So that was a good thing in the end. When I went to the Special Care Unit I tried to teach this, that we shouldn't be saying "this is good for you and you will do it" if they don't want to do it. It's a fine line between being encouraging and being bossy. [105]

Despite the increase in activities and facilities, the majority of residents in the majority of the Homes spent their days sitting quietly in day rooms and lounges, waiting for the next meal. The final meal of the day, tea, was usually followed quite quickly by bedtime; the early start to the day was mirrored by an early end.

Teatime, suppertime, and bed time

Tea was typically served around 5pm in most Homes, and although the main meal of the day was usually served at lunchtime, tea was often quite substantial too: perhaps shepherd's pie, fish fingers, or eggs and bacon.[106] It had to see the residents through until breakfast the next morning, although many Homes served 'supper' to help bridge the gap. This usually consisted of a hot drink and a small snack; at Nazareth House, the supper shift aide would take around the trolley "with tea and coffee and water and milk, and a plate of biscuits", starting at 7pm.[107] Peter S remembered a similar round at St John's Park, wheeling a trolley with coffee, tea, and ninety cups around the men's division.[108] Most residents were given their supper in bed, to which they began to move soon after tea was finished.[109] For some of the frailer residents, this move began even before that meal.

> In the afternoon, you'd start off by putting the really old patients to bed first, as a routine. This lady first, then this lady, then that one. So by the time the evening shift came on, so many were in bed and some still had to go to bed. I guess the sicker ones would have been put back to bed first. It was very routine.
> Some of them went to bed after lunch! Probably not by choice… They wouldn't have had much choice in anything.[110]

By 9pm most residents were in bed, if not asleep, but this did not mean that the nurses could relax. Immobile and incontinent residents needed regular attention throughout the

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[105] Interview with Vera Green
[106] AOT, HSD6/2/1002 Inspection report 16/8/1974
[107] Interview with Judy Wall
[108] Interview with Peter S
[109] Interview with 'Helen'
[110] Interview with Eileen O'Leary

day and night, and the regular 'back round' was the major weapon in an ongoing battle against bedsores. There would be no real rest for anybody.

Incontinence care and the fight against bedsores

> Bedsores are patches of gangrene which form over the bony prominences of the buttock in bedridden cases. The following are the chief factors in their causation: (1) Old, feeble, or thin patients. (2) Any hardness or roughness of the bed. (3) The keeping for a long time in one position...[111]

Decubitus ulcers, commonly known as bedsores, appear to have been a perennial yardstick to measure the standard of nursing in aged care.[112] They are a critical concern in chronic hospitals and aged care facilities, as the bedridden and the immobile are highly prone to skin breakdown, particularly if incontinent, and once developed a bedsore can be impossible to cure. It is hardly surprising, then, that their incidence is often reported in records where no other health condition gains mention, and their presence or absence seen as a measure of the nursing skill and care given to the patients.

The high importance of bedsore prevention is seen in the *General Instructions* given to the staff of St John's Park; of the twenty-one regulations for attendants and nurses, only four apply to physical care of the patients (as opposed to administrative and supervisory duties), and two of these concern the prevention of bedsores, and the cleaning of the incontinent patient.[113] In 1949, the head of the Health Department cited the complete lack of bedsores on 'old and senile' bedridden patients at St John's Park to be evidence of the nurses' outstanding attention and care.[114] Unlike some other positive reports in the official records, there is evidence that this was true. When Eleanor started at the HFI in 1948 she was surprised to find there were fewer patients with bedsores there than at the LGH, where she had previously worked.[115] Even the public used bedsores as a benchmark of care standards:

> …the fact that our dad spent approximately seven years in bed (the most of which time he was quite helpless) and up until the last his back remained sound, this alone we feel speaks for the attention he received…[116]

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[111] EW Hay Groves, *Groves & Birchdale's Text-Book for Nurses*, (London, 1936)
[112] Mary O'Brien noted that bedsores were a repeated motif of nursing home 'scandals' mentioned in the American press: *Anatomy of a Nursing Home*, (Maryland, 1989), page 209-10
[113] *General Instructions for the Efficient Working of St John's Park*
[114] AOT, HSD6/1/2814 98/7 Memo from BM Carruthers to Public Service Commissioner, 31/8/1949
[115] Interview with 'Eleanor'
[116] Interview with 'Eleanor'; AOT, HSD6/1/5190 98/5/1 Letter from CW Pott to Superintendent Trebilcock, 14/6/1960

There are no details in the records of methods of skin care in the 19th century institutions, although there are allusions to bedridden patients with unpleasant wounds and ulcers.[117] Presumably in those days before antibiotics and good ward hygiene, the 'poor creatures' would not have suffered for long as infection and fever took their toll. As new treatments were developed and more staff were brought in to care of the bed-ridden, conditions improved. By the 1930s, a favoured method of preventing pressure sores was the use of methylated spirits 'or some other strong preparation of alcohol' rubbed briskly into the skin to dry and harden it, and this practice endured for several decades.[118] Sometimes other elements were added to increase efficacy. At St John's Park in the early 1950s, Claire used to mix:

> …methylated spirits and … what was it, some white powder. Boracic, was it? Johnson's Baby Powder? We put the powder in our hand, then we tipped some methylated spirits on to make a paste, and it was very hard on our hands. We'd go around, doing a back round, rubbing people's bottoms with it. That was done every hour, you'd go around and give them a back toilet. You had to look after their backs because you'd be in trouble if the backs were neglected, especially people who were incontinent all the time.[119]

Lanoline became popular in the 1970s, although the nurses were not entirely satisfied ("it used to get on to your hands, and you couldn't wash it off"[120]), and Kay remembered using mercurochrome. Whilst Nazareth House aides exposed the bottoms of their residents to the sun, at Cosgrove Park they employed ray lamps to promote healing.[121] Methylated spirits even enjoyed a brief resurgence at Nazareth House in the 1970s, but it did not prove popular or long-lasting:

> There was a time when the residents were sprayed with methylated spirits in place of the cream! That was terrible! I don't know why, they said "instead of using the creams now, used the methylated spirits, it's better for them". That was for a while, then they went back to the creams.[122]

At one stage the Home experimented with water beds, but the test was short lived as the bladders kept bursting, leaving the patients wet and causing a great deal of extra work for

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[117] Dr ES Hall, that indefatigable advocate for the destitute, decried the lack of comfortable bedding for the invalids even 'though [their] flesh may be rotting for the want of it': TLC, 17, 1871, Paper 47, pages 83-84: evidence of Dr ES Hall; recommendations for improvements

[118] Anonymous, *The Illustrated Family Doctor*, (London, 1934), page 79; Hay Groves, *Text-Book for Nurses*, page 232; Mildred Hainsworth, *Modern Professional Nursing*, (London, 1956), page 296

[119] Interview with Claire Paynter

[120] Interview with Nancy Langley

[121] Interview with 'Helen'

[122] Interview with Barbara Allen

the aides.[123] But no matter what treatment was used, it was used regularly. Until the invention of pressure mattresses, the back round was accepted nursing practice for all bedridden patients, who received four-hourly 'back toilets', night and day.[124] Anyone seen to be at risk of a bedsore was moved on to the two-hourly list. For the nurses, it was a matter of personal pride, as "having a patient with a bedsore was really bad nursing—it was a disgrace".[125]

> All night, you went around and you did your pressure area care, and changed anybody who was incontinent, and then you'd start again. They were just changed every two hours. You did pressure area care every two hours, because they didn't have special beds—that was the only way they could try and prevent all sorts of pressure areas, excoriation and things happening. And it was successful, we didn't see many bedsores. In terms of what we now call 'quality of care', that was the main driver.[126]

By the 1990s, research had found that there is nothing that can be applied to the skin to reduce the incidence of bedsores, and the only really effect method is removal of the pressure and shearing forces.[127] Pat showed herself to be far ahead of her time at the Queen Victoria Home in the early 1960s, where she favoured constant movement to prevent pressure areas developing in the first place:

> I made the girls pull the drawsheets just a little bit—"every time you walk past that room, pull the drawsheet a bit, and then pull it the other side next time". I had them all trained to do that.[128]

The main cause of bedsores was incontinence. Long accepted as a 'natural' part of aging, there was little done to remedy the condition[129]; instead, the nurses dealt with the results. The days and nights were a constant round of changing linen, four or more times a shift. The mattress was protected with drawsheets and mackintoshes, "thick, dark red waterproof things" which did not really work.[130] When asked about the most important change in aged care over the past few decades, the participants almost without exception nominated continence pads, which enabled the residents to not only be kept dry and

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[123] Interview with Barbara Allen, confirmed by Nancy Langley
[124] See, for example, A Millicent Ashdown, *A Complete System of Nursing*, (London, 1940); *The Illustrated Family Doctor;* Hay Groves, *Text-Book for Nursing*, Pugh, *Practical Nursing*
[125] Interview with Judith Beard. Studies have found that nurses manifest a 'guilt phenomenon' about patients' bedsores, denying or underestimating their existence: Walsh and Ford, *Nursing Rituals*, page 71
[126] Interview with Marguerite Bramble
[127] Walsh and Ford, *Nursing Rituals,* page 75
[128] Interview with Pat Job
[129] Walsh and Ford write of the acceptance of this situation: 'Of course the ward smells of urine. It's a geriatric ward, what do you expect?': *Nursing Rituals*, page 93
[130] Interview with Claire Paynter

therefore at less risk of bedsores, but also to finally get a good night's sleep. They also saved a great deal of linen washing, but that does not mean that they were adopted eagerly when they first became available in the 1980s. They were expensive and not every Home could afford them. At Nazareth House the nuns had little money to spare for such luxuries, and the aides continued to 'make do' for several more years.

> We'd make a pad—the old sheets were cut up and hemmed, and you'd fold those up and put them in between their legs, and then wrap a drawsheet around underneath their day clothes, if they were out in their chairs. I think that made it a bit smelly, really… They were washed, laundered and reused.[131]

Marguerite noted that incontinence pads, whilst unquestionably beneficial for both residents and staff, also had one effect that might be considered detrimental. Whilst the constant back rounds were disturbing, they also meant that the residents had far more attention from the staff than they do today.

> Nowadays they don't even walk around at night and check on them, and the residents are *really* lonely and anxious, because there's nobody around. Care has become standardised, there are rules and regulations, policies, but to be honest, the care that they get now compared to the care that they got in the 1960s when there was nothing but they were all looked after…

There is no doubt that a good night's sleep is necessary for the mental and physical wellbeing of a person. The continual disturbances in the days before continence aids meant that residents were perpetually tired, which could lead to 'bad' behaviour: "they'd get crabby and upset, and swear at you, and try and hit you".[132] They could also become distressed and restless, particularly when suffering from some degree of dementia, and this behaviour was often treated with physical means: restraints, both mechanical and pharmacological, and doors locked against the outside world.

'For their own safety': restraints and safety measures

> They used restraints did for people who were constantly getting out and wandering. They used to sit them in the chair and they had a band thing that went around their tummy and across their shoulders too, and they were tied to the chair so they couldn't actually get up.[133]

There had always been a few people with dementia in the Homes; 'senility' was a not uncommon diagnosis among the admissions to the New Norfolk mental hospital even in

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[131] Interview with Barbara Allen
[132] Interview with Marguerite Bramble
[133] Interview with 'Helen'

the earliest days of the colony, and for a long time that was the only place for people with dementing illnesses. But by the 1950s there were many more old men and women developing these conditions, and New Norfolk could not take them all. As geriatric hospitals aligned with the general hospitals, St John's Park and Cosgrove Park often admitted old people who had been abandoned by families who could no longer cope, and others came in directly from the community. There was little medical treatment available, apart from tranquilizing drugs, and even less knowledge about methods to address problem behaviours such as wandering.[134] It was up to the nurses to find a way to control their charges, and this often involved some form of physical restraint.

This was a topic that was avoided by most of the participants in this study, particularly those who demonstrated a positive attitude towards their job and the area of aged care. There has been an enormous amount of research and discussion about the subject of restraint in recent years, with the consensus of opinion being strongly against the practice: it is clear that restraints cause physical and mental damage, as well as being an assault on residents' dignity and autonomy.[135] For this reason, it might be difficult for a person who used restraints in the past to admit to doing so, even though they were then an accepted method of control; it is certainly politically incorrect to admit to approving of their use. I was therefore not surprised when several participants denied outright that restraints were ever used in the Homes where they worked. Others admitted to having seen them used but only occasionally, and always applied by other people. Some nurses talked freely about their use but reclassified them as 'safety measures' or did not recognize that the methods they had used were actually restraints.[136]

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[134] 'Wandering' is one of the most common behavioural disturbances in early and mid-term dementia, and causes the most concern to care staff because of its association with falls and increased mortality: Donna Algase, 'What's new about wandering behaviour? An assessment of recent studies', *International Journal of Older People Nursing*, 1:4(2006), 226-234, page 1

[135] See, for example, C Gastmans and K Milisen, 'Use of physical restraint in nursing homes: clinical-ethical considerations', *Journal of Medical Ethics*, 32(2006), 148-152; D Evans, J Wood et al, 'Patient injury and physical restraint devices: a systematic review', *Journal of Advanced Nursing*, 41:3(2003), 274-282; R Gallinagh, R Nevin, et al, 'Perceptions of older people who have experienced physical restraint', *British Journal of Nursing*, 10:13(2001), 852-859; R Neufeld, L Libow et al, 'Restraint reduction reduces serious injuries among nursing home residents', *Journal of the American Geriatrics Society*, 47:10(1999), 1202-1207

[136] In 'Stabilization instead of restraints in the care of elderly patients', in the *American Journal of Nursing*, 44:11(1944), 1049-1050, Edith Marsh makes the same reclassification; she suggests that 'stabilizing does not bring to mind any suggestion of force', but her stabilizing methods include bedrails and paraldehyde.

This was particularly so for the use of pharmacological restraints. Kay said that at Allambi in the 1980s and 1990s, "You never restrained the people. They kept them sedated… medicated".[137] Sedatives and tranquilizers were among the more common medications prescribed, even when the residents received far fewer medicines than they do today, and most participants agreed that the majority of residents that they had tended, over all the decades, had been given some form of sedating drug. Helen shuddered when she told me of the awful smell of paraldehyde, a strong hypnotic sedative used for the more violent and aggressive patients in the 1960s, and Vera was horrified by the 'zombies' of Ward H, created through an excessive use of tranquilizers.[138]

During the day, it was more common to use physical measures. Methods included "seat-belt things"[139], slide tables[140], body straps, being tied to bed rails[141], and the application of bedrails alone, a practice still used widely today, albeit only with doctors' orders and family consent. At Nazareth House residents might be undressed and put to bed[142], or more frequently, tied into their chairs

> …if there was a danger they'd fall out of their chair in the lounge room. You'd put a drawsheet across a person and tie it in a knot at the back, so they couldn't slump, or get up and try to walk. It sounds awful, but they didn't fall out of their chairs, so it worked![143]

Whilst most of the RNs who discussed restraints were quite negative about their use, some of the aides were more ambivalent. Whilst they understood that restraints are no longer viewed with approval, their concerns were primarily with the physical bodies of the residents, and in this respect the restraints were effective. Using restraints allowed the aides to go about their work without worrying where the residents were or what they were doing. They were safe—physically, if not psychologically.[144] Nancy was positive enough about restraints to actually request that they be used for her own mother when she entered the Home.

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[137] Interview with Kay Joyce
[138] Interviews with 'Helen', and Vera Green
[139] Interview with Nancy Langley
[140] Interview with Michael McKean
[141] Interview with Judy Wall
[142] Interview with Judy Wall
[143] Interview with Eileen O'Leary
[144] An early proponent of removing restraints pointed out that this was a fallacy. Immobile residents became helpless very quickly, so that although they would not be able to fall and break a hip, they would be 'helpless in 30 days and crippled … safely': Julia Blakeslee, 'Untie the elderly', *American Journal of Nursing*, 88:6(1988), 833-834

> We had seat-belt things that we used to put on [which] stopped them falling, but now you're not allowed to do that. I wanted a seat belt for my Mum, but they wouldn't allow it. And I said, not even if I sign it and the doctor signs it? And they wouldn't have it. And she kept falling, because she had dementia and she didn't know she couldn't walk properly.[145]

Even before the evidence mounted against physical restraints, other solutions to the problem were explored. Some Homes addressed the problem with new environmental designs: the multi-storey Woodhouse and Carruthers buildings at St John's Park (built in 1954 and 1961 respectively) and Ward H (opened in 1976) brought the added security barriers of lifts and stairs.[146] These were seen as a step forward at the time, but for some residents (and some participants), conditions were too much like a return to the old days of custodial institutions:

> A patient called me a prison warder. She was imprisoned on the top floor of the QV Hospital Ward H. Because the design of the accommodation is unsuitable, patients have to have medication and restraints to enable staff to control them…[147]

The successor to Ward H, Allambi, was more suitable for residents and staff alike. The floor plan was somewhat reminiscent of the Brickfields building of so long ago, being a rectangular layout around an internal, enclosed courtyard, and it served a similar purpose—to control the occupants and seclude them from the community. But unlike Brickfields, the courtyard contained a garden, and the new facility was considered vastly superior to the old Ward H.

> Oh, it was 100% better. Beautiful. You had the corridors going all the way round and in the centre they had a nice big garden outside, and all the bedrooms looked into the garden. They'd go out into the garden and wander around and enjoy themselves. They used to sit out on the verandah on hot summer days, and they'd have their lunch out on the verandah. It was really nice for them.[148]

The new facility was a 'secure' unit, equipped with 'electro-magnetic and manual door locking control systems', and the staff were issued with keys to let themselves out.[149] Because of this high level of security, physical restraints were not widely used and

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[145] Interview with Nancy Langley
[146] Interviews with Michael McKean, and Peter Sweeney.
[147] Vera Green, script of speech given to press conference, ADARDs, 1983
[148] Interview with Michael McKean
[149] Interview with Michael McKean; 1988 Annual Report of the LGH

occasionally a resident managed to 'escape', despite the high windows and a long drop to the ground.[150]

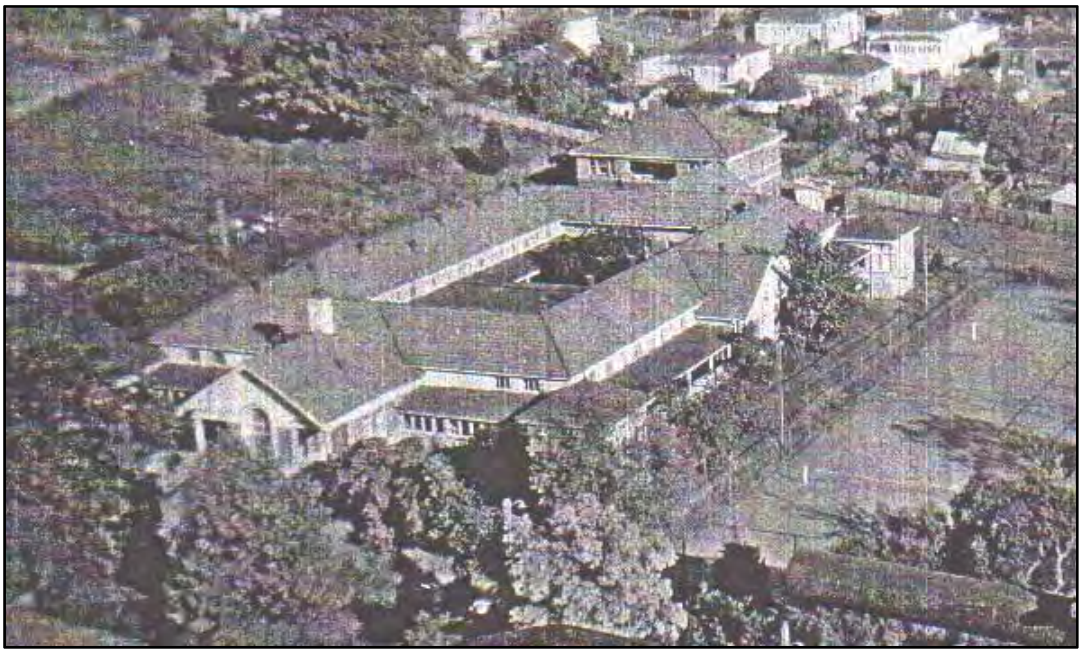

Plate 6: Aerial view of Allambi, showing the open central courtyard[151]

Secure units became more common as the 1980s and 1990s wore on. Vera was involved in the planning of the facility opened by Masonic Peace Haven in 1986.

> We wanted a secure courtyard and gardens, [and] we had doors that were only able to be opened by staff—the [residents] couldn't get through, they'd try the doors but they couldn't get through.[152]

Vera's Special Care Unit is still operating, and has been joined by similar secure units in many other private Homes across the state. They all continue to offer care in a closed environment, where control is still exercised for the residents' own good, and very few now use any form of physical restraint. This does not mean that all restraints have gone, however; a 2010 study found that Tasmanian Homes used sedative drugs at three times the rate of those in Sydney.[153] It is a continuing area of debate and ethical dilemma.

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[150] Interview with Kay Joyce
[151] From Photographs collection, Local History section, Launceston LINC
[152] Interview with Vera Green
[153] Juanita Westbury, Karin Beld, Shane Jackson and Gregory Peterson, 'Review of psychotropic medication in Tasmanian residential aged care facilities', *Australasian Journal on Ageing*, 29:2(2010), 72–76

Being tied up might not be pleasant, but even restraints were probably better that the treatment meted out to some old people in the decades before new knowledge brought understanding of dementia. Mental illness was highly stigmatized, and the demented and mentally deficient were sometimes kept hidden by families who were ashamed of their condition.[154] Nancy described how one family dealt with their elderly mother, who had Alzheimers:

> …they kept her in a shed in the back of the house! And [her son] who was mentally retarded and so violent … this was the shed they put *him* in … he didn't have a bed, he had bales of hay to sleep on because he used to wet everything. This is what happened then. Because [they were] mentally deficient, they hid [them] away. It was shameful.

Shameful *for* the family, not shameful for the way they treated their demented mother. The son ended his days at Nazareth House, sleeping in a warm and comfortable bed with regularly changed sheets rather than on bales of hay.

Whilst many of the practices that we might look upon as unacceptable today were well-intentioned, for the person's 'own good', it is clear that sometimes these crossed the line into ill-treatment and abuse.

'A degree of bullying...'

> Some of the residents were subjected to a degree of bullying. It came from both the top and the bottom. I mean, even this dragging them out of bed at some ungodly hour of the morning, whether they wanted to or not—that's a form of bullying, isn't it? It was just institutional stuff—you were in an institution and you had to conform to the rules, that's basically where a lot of it came from. And if you were a bit different, well, look out! But a few of the carers could occasionally be cruel to them. If the residents hit out or something, some of them might get a reciprocal one in return occasionally. It was partly lack of training or understanding, but I think some of it was lack of supervision—not being pulled up the first time it happened, so it had become a bit of a habit, almost accepted.[155]

There is no doubt that ill-treatment of residents occurred in the early institutions. Oppressed people will use what little power they have to gain ascendancy over those who

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[154] Mentioned in interviews with Nancy Langley, Eileen O'Leary, and Pat Job. The stigmatized nature of mental illness is well documented, both in Australia and internationally; see, for example, RW Gowlland, *Troubled Asylum: The History of the Royal Derwent Hospital*, (New Norfolk, 1981); GN Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill*, (New York, 1994)

[155] Interview with Roz Wilson

fall even lower in the hierarchy[156], and the inmates of the institutions were certainly oppressed. The fact that the official Rules and Regulations of all the 19th century male invalid depots specifically instructed warders to refrain 'from using harsh or irritating language, and … striking or ill-using an inmate', suggests that the potential for such abuse was officially recognized.[157] It is interesting to note that the female establishment did not include any similar rule for its staff; perhaps the authorities thought it unlikely that the 'gentler sex' could ill-treat each other. They were wrong, of course. The Ladies' Committee at New Town reported that the 'nurses' were 'ignorant, harsh, and neglectful'[158], and nurses only existed in the women's division. Even when inmate warders and nurses were replaced with paid staff, there was no guarantee that the inmates would receive kind or gentle treatment.[159] At the HFI in 1938, Nurse Ryan appears to have achieved some level of infamy in the town, as Matron Campbell reported to her superiors:

> Mrs Pike, a frequent visitor to the home, reported that Nurse Ryan had been unkind to Jane Harris, an inmate, locking her in the morgue as punishment and that her personal belongings had been burnt for the same reason. Mrs Christmas, a relative of Joan Nunn, an inmate, … said she was cruel to the helpless inmates, and stated that Clare Harris had been strapped to a chair, thrashed, and left in that position for some time. She and Nurse Ryan had had a quarrel about the matter and [Nurse Ryan] said that if she had any outside interference, Joan Nunn would be sent to New Town. …the laundress … said that she "had heard down town about Nurse Ryan doing a lot of hitting". … I have repeatedly had to tell her about her rough and insulting manner to the inmates.[160]

The 1948 *General Instructions* to staff of St John's Park also expressly forbade ill-treatment of the patients. The Charge Attendants were ordered to 'ensure that all … attendants carry out their duties efficiently and treat all helpless patients with gentleness and care', and the attendants were given even more specific instructions, in not one regulation but five, covering both physical and psychological abuse. By the time Kay

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[156] Jules Henry noted that inmates of a Home who received bed and board in return for helping out tended to be 'callous and harsh to the weak and disoriented': *Culture Against Man*, (London, 1966), page 420. Other studies have seen similar power plays between untrained nurses and patients: see, for example, Lori Jervis, '"Working in and around the chain of command": power relations among nursing staff in an urban nursing home', *Nursing Inquiry*, 9(2002), 12-23; Suzy Gattuso and Celia Bevan, 'Mother, daughter, patient, nurse: women's emotion work in aged care', *Journal of Advances Nursing*, 31:4(2000), 892-899

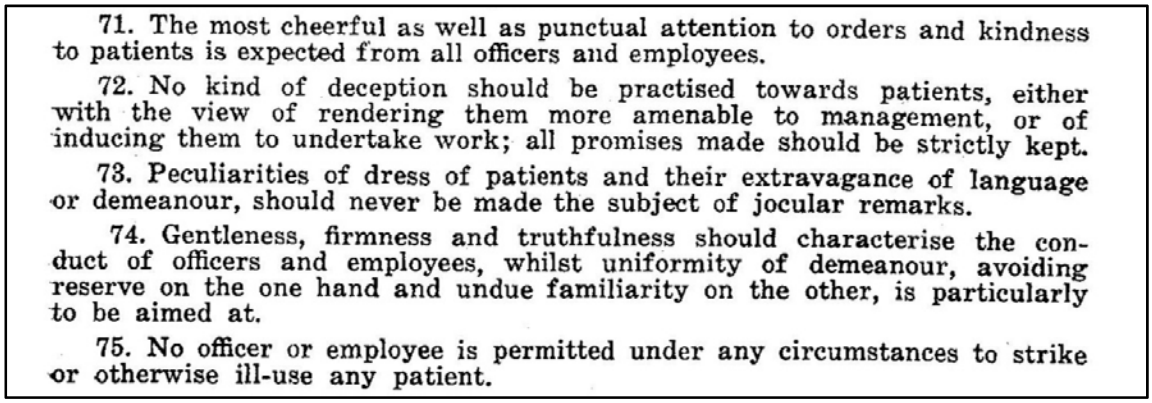
[157] The *Hobart Town Gazette*, Tuesday, 18th August 1874, page 871, regulation 30 (Cascades); the *Hobart Town Gazette*, Tuesday, 25th August 1874, page 879, regulation 15 (Brickfields) and page 882, regulation 26 (IDL).

[158] TPP, 15, 1888-9, Paper 50

[159] Megan Davies notes that many staff showed 'callous disregard, even cruel behaviour' towards the inmates, and could be mean-spirited and rough: *Into the House of Old*, page 134

[160] AOT, HSD1/1/4047 99.12.38 Report from Matron Campbell to ES Tudor, 22/12/1938

started at Cosgrove Park in 1960, these rules were no longer so bluntly stated, but the staff were told to be 'courteous and kind at all times', and 'to treat everyone how you would personally like to be treated'.[161]



71. The most cheerful as well as punctual attention to orders and kindness to patients is expected from all officers and employees.

72. No kind of deception should be practised towards patients, either with the view of rendering them more amenable to management, or of inducing them to undertake work; all promises made should be strictly kept.

73. Peculiarities of dress of patients and their extravagance of language or demeanour, should never be made the subject of jocular remarks.

74. Gentleness, firmness and truthfulness should characterise the conduct of officers and employees, whilst uniformity of demeanour, avoiding reserve on the one hand and undue familiarity on the other, is particularly to be aimed at.

75. No officer or employee is permitted under any circumstances to strike or otherwise ill-use any patient.

Plate 7: excerpt from official instructions to staff of St John's Park[162]

If a nurse was caught ill-treating a resident, the penalty was usually instant dismissal—but first they had to be caught. Helen was unhappy with some of the aides at Cosgrove Park, but without direct proof of abuse she found it difficult to difficult to persuade those in charge that changes should be made ("it was always put in the 'too hard' basket, it was very frustrating"[163]). Peter D heard stories about one of his co-workers, although he "never saw anything"[164], and Michael admitted he saw things that upset him at Allambi.

> I've seen people hit patients… Sometimes it's because of frustration, and sometimes it's because they shouldn't be in the job. I'd think, do you say something to someone? I didn't, and I should have done. What made me not do that was, I wanted my job. If I'd said something, I'm the lower end of the chain… there would be repercussions, so you just… you learn to bite your tongue, or you'd make sure you didn't work with them so you didn't see it.[165]

Helen was a temporary staff member, and the two men were aides, 'at the lower end of the chain'. They all felt impotent and even at a remove of several decades their discomfort was still palpable. But others were in positions of authority and were able to make a difference. As the RN in charge at Peace Haven special dementia unit, Vera sacked several members of staff when they were caught mistreating the residents. Ill-

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[161] Instructions to Cosgrove Park Staff, c1961, courtesy of Kay Joyce.
[162] *General Instructions for the Efficient Working of St John's Park,* (Hobart, 1948)
[163] Interview with 'Helen'
[164] Interview with Peter Davy
[165] Interview with Michael McKean

treatment was not always intentional, however. Vera understood why accidents sometimes happened.

> I was bathing an ex school teacher, and we were in the shower and she was struggling and fighting and I'd just taken over from the nurse, because the nurse was saying she had difficulties and I thought "well, I'll see what sort of difficulties she's having". And this lady, she hit me so hard across the head, that before I'd realised—you know, I'd just got such a whack—before I connected brain to anything else, I hit her back. I just went "don't you do that to me!"—oh, my… I thought, yes, it's so easy to do, so easy to do when you're under stress, under pressure. She was covered in faeces, and she didn't want to be changed, and she didn't want to be showered, a big, strong woman, very, very difficult. So I was always sympathetic when these people have problems.[166]

The resident had breached acceptable patient behaviour, and her violence had suspended Vera's usual norm prohibiting physical abuse. For a moment she had ceased to be a resident—good, weak, inactive—and had become 'difficult'—active, bad, and very strong. If an experienced RN of Vera's principles could snap and fight back, it is likely that the aides, with less understanding and very much less recompense for an unpleasant job, would have also felt released from the rules against retaliation and force.[167] The abuse of staff by residents is the other side of the coin, rarely spoken about or acted upon.[168] In most cases, the nurses were expected to accept it as part of the resident's condition, to exercise patience and forbearance. But sometimes it became too much, even for the nuns of Nazareth House

> I can remember there was an old lady called Mrs Brown, she socked me one night and knocked me across the room. If anything like that happened, you had to report it, and of course I had a black eye, which I couldn't hide next morning when the nun came round and said 'what happened to you?' She was gone, next day. When I went back on shift next time she was gone. It wasn't acceptable. The nuns particularly wouldn't accept it—to hit your staff was a no-no. A lot of people thought the nuns would say 'that's too bad', but that wasn't the way it was. If they did something to the staff, that was it, they were gone.[169]

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There is no doubt that daily activities in the Homes were carried out for the residents' own good. They were kept clean, fed, warm and dry, and as far as possible, safe. There is also little doubt that these activities were arranged in such a way that the staff could

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[166] Interview with Vera Green

[167] This was the case in an American study by Charles Stannard, 'Old folks and dirty work: the social conditions for patient abuse in a nursing home', *Social Problems*, 20:3(1973), 329-342

[168] Joel Savishinsky noted that many old people in the Home he studied would curse the nurses or hit out at times, but there was nowhere for the staff to go to 'chill out' when this had occurred: *The Ends of Time: Life and Work in a Nursing Home*, (New York, 1991), page 172

[169] Interview with Nancy Langley

carry them out in the most efficient and convenient manner. The residents had no choice or input into the way in which they were cared for; the micromanagement of their day was total.

It was this aspect of their work that many of the participants in this study found the most difficult to square with how they believed a nurse should act. For some, the necessity to balance their identity as 'caring professional' with the responsibility of controlling and ordering the routines and rigours of nursing home life created an ethical predicament. This was particularly so when they were compelled to carry out actions that they felt were wrong, or conflicted with the traditional mission of the nurse to alleviate suffering and give comfort, such as administering restraint and other forms of overt control. Overall, the aides found this less problematic than the RNs, who were inculcated by their training with a doctrine of safety and the Nightingale pledge of devotion to one's patients. But although several looked back and judged their work practices through today's moral lens, admitting that certain actions or attitudes were 'terrible' or 'awful', they pointed out that this had not been the case at the time; for the most part, their motives had been beneficent and they had simply been administering care in the best way possible at that time.

> I think we made a difference for the residents. They might have got the extra wash that they didn't particularly want, and an extra few laxatives, but it was better than being stuck in a shed![170]

The metaphor of paternalism is the relationship between the father and his child, and Halper points out the irony in the fact that the people most often subjected to paternalistic endeavours are old people.[171] This is not surprising, however, when one considers that the concept of age as 'second childhood' is as old as written history itself. But Halper also states that the father should be 'wise and loving', and that could also be a description of the ideal nurse. Perhaps benign paternalism does not deserve the poor image it has attracted in recent years. Perhaps, in view of the highly gendered nature of both the nursing profession and the old age home, it should be renamed 'maternalism'[172] and accepted as a natural result of the relationships that often flourish in the Homes. Because

[170] Interview with Eileen O'Leary
[171] Thomas Halper, 'The double-edged sword: paternalism as a policy in the problems of aging', *The Milbank Memorial Fund Quarterly: Health & Society*, 58:3(1980), 472-499
[172] Megan Davies, 'Renovating the Canadian old age home', page 171

for residents and staff alike, the aged care setting could provide both extended family and a real home, as will be seen in the next chapter.

Plate 8: Another scene of sunbathing, this time from the St John's Park brochure, c1972[173]

[173] St John's Park Hospital information brochure, Department of Health, (Hobart, c1972)

Chapter 6

'Home as home', and the surrogate family

> [Home] is both a place and a state of mind, homely and mundane and, as such, closely associated with family. Home implies warmth—both physical and emotional—ease, comfort and love.[1]

In the aftermath of the Second World War, Australia experienced a housing shortage. Demand far exceeded supply, and this particularly affected older people on pensions who had little disposable income and had never been able to afford to buy their own homes.[2] In response to a pressing need for suitable accommodation for the growing numbers of people reaching old age and with nowhere to go, the Commonwealth Government passed the *Aged Person's Home Act* (*APHA)* in1954, which gave financial assistance to philanthropic groups, such as churches and charities, to enable them to build new Homes.[3] This Act passed responsibility for the growing welfare needs of the older population from the then conservative federal government to the private sector, and thus led to the birth of the Australian aged care 'industry' as we know it today.[4] It also implied a new focus for aged care, suggested by the Act's title: the new Homes should be *homes*, not institutions.

The *APHA* stated that new Homes should provide aged persons with 'conditions approaching as nearly as possible domestic life, and, in the case of married people, with proper regard to the companionship of husband and wife'[5]. This was not a new idea, and nor was it uniquely Australian. In the UK, the Local Government Act of 1929 had proclaimed that workhouses should be replaced with smaller, more home-like

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[1] Lenore Davidoff et al, *The Family Story: Blood, Contract and Intimacy 1830-1960*, (London and New York, 1999), page 83

[2] Social Welfare Commission, *Care of the Aged* (Canberra, 1975), page 39; Bruce Ford, *The Elderly Australian*, (Ringwood, Vic), page 89

[3] It is interesting to note that in the same year, the US government enacted changes to the Hill-Burton Act (which governed funding to hospitals) to provide funding to 'public and non-profit entities to construct nursing homes', although these had to be in conjunction with a hospital. This led to the introduction of standards in staffing and facility design but is also why 'most nursing homes look so much like mini-hospitals': Bruce Vladeck, *Unloving Care: The Nursing Home Tragedy*, (New York, 1980), page 42-43

[4] RA Parker, *The Elderly and Residential Care: Australian Lessons for Britain*, (Aldershot, 1987), page 3; John May, 'Social Welfare' in John Henningham (ed), *Institutions in Australian Society*, (South Melbourne, 1999)

[5] *Aged Persons Homes Act 1954*, section 3(1)

establishments, 'old people's hotels' with no rules and regulations and no stigma of charity.[6] In the same year as the *APHA* was passed, Bernard Hutchinson published a report on old age Homes in Victoria, and found it 'desirable that old people should not be accommodated in institutions, but in homes of a much smaller and more intimate type'.[7]

The change in philosophy was possibly brought about by a change in demographics. Old people were no longer a tiny minority of the population[8], and they were no longer held to be entirely responsible for their own difficulties in old age.[9] In the second half of the 20th century, Homes were no longer just for the poor working classes, although the majority of residents were not well off, or for those without family, although the majority were still single or childless. The Homes improved in reputation and standards, and by the 1960s residential care had become a more acceptable option than it had been in earlier times. Some old people actively sought admission, making arrangements to enter before they really needed much assistance.

> You had sixty-five year old women coming in still wearing high heels and helping in the kitchen. Now, it's funny, if somebody comes into the facility and they're around say seventy-six, you say, that's a young one! I don't think today's sixty-five year olds would think of taking a room at an aged care facility—they're out there still enjoying life. They were much more long term then. There's one particular resident at Mount Esk, she's been there since 1975 or something. She was one of the high-heels and stockings girls who used to help with the washing up back then. She's just over a hundred now.

Most homes provide shelter to a family, and this is true for many Homes, too. The social roles of the family—parent, grandparent, child, mother, father—are often taken on by the residents and staff. As seen in the previous chapter, this can result in paternalistic care, where the 'parent' nurse knows best and the 'child' resident is given little choice in care or participation in activities, for their own good. But it can also result in the formation of a 'surrogate family bond'[10], a close bond that mimics that normally shared between biological family members. The nurses might see the residents as cherished grandparents

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[6] Josephine Gaman, 'Homes for the aged in Britain', *The Social Service Review*, 22:1(1948), 101-2
[7] Bernard Hutchinson, *Old People in a Modern Australian Community*, (Melbourne, 1954), page 151
[8] In Tasmania, the percentage of the population aged over sixty-five had almost doubled, from 4.07% in 1901 to 7.56% in 1954: ABS, 3105.0.65.001 Australian Historical Population Statistics, 2008, Table 4.15
[9] Although there were some who still felt that way. John Stubbs claimed that there was still a widespread belief amongst Australians that poverty was the victim's fault when he published his study on poverty in *The Hidden People: Poverty in Australia*, (Melbourne, 1966)
[10] Isabel Sumaya-Smith, 'Caregiver/resident relationships: surrogate family bonds and surrogate grieving in a skilled nursing facility', *Journal of Advanced Nursing*, 21(1995), 447-451. This study found that 92% of respondents reported surrogate family bonds.

or respected parents, and themselves take on the role of caring child or firm but loving parent. Control is still exercised, of course, but as in a domestic setting it is normative, and intended to allow the smooth running of the family unit.

> [Residents] will be expected to behave as members of a well-brought-up family and, as such, will not, for instance, disorganize meals by being late or go out.[11]

This chapter will explore some of the ways in which a home-like atmosphere was attempted, if not always successfully, in the public and private Homes both before and after the passing of the *APHA* in 1954. It will also examine the development of the 'surrogate family' and the affect this had on the attitudes of the nurses and their feelings towards both the residents and the job itself. Again, this chapter draws heavily on the oral histories from the study participants, particularly to explore the emotional aspects of aged care—a topic rarely broached in the official documentation. It also reveals some of the positive aspects of residential aged care, a side rarely seen or celebrated.

Home as 'home'

> Home is an expression of one's personality through furnishings, decorations, memorabilia, ambience, plants, pets.[12]

The idea that a Home should also be a home for those who lived within began in the second half of the 19th century in England, as social reformers such as Louisa Twining and Florence Nightingale began to attempt the separation of the 'deserving' from the 'undeserving' poor massed together in the workhouses. The campaigners recognised that sometimes age *could* be a just reason for poverty, and that the old people were deserving of some care and comfort in their accommodation, rather than custody:

> …workhouses are no longer penitentiaries for able-bodied idlers and lazy vagrants, but *homes* in which the declining years of most of our labouring population *must* be spent, and in which it is but simple justice that they should find no inconsiderable amount of home enjoyments.[13]

A home gives a person shelter, a roof over their head, a room in which to live, but it is also a lot more than that. Home is a place in which a person should feel emotionally secure, safe, and cared for. It is a place of security, of familiarity, of independence. A person in their own home has control of their own life, and those who enter must

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[11] Patricia Shaw, *Old People in Homes: A Handbook for Matrons*, (London, 1963), page 55
[12] Robert Butler, *Why Survive? Being Old in America*, (Baltimore, 1975), page 103
[13] 'Report on the Northleach Workhouse and Infirmary', *British Medical Journal*, 16th Nov 1867, page 458

negotiate with them in order to carry out any activity that involves the person. When a person leaves their own home and enters a Home, they lose this ability to control their environment.[14] They cannot continue with customary routines, they cannot make their own choices. How, then, could 'home' be created in a Home? The answer appeared to lie in those 'home enjoyments' mentioned above. Although the workhouses themselves could not be altered, within those large and often forbidding edifices, conditions improved greatly for the elderly inhabitants. By the beginning of the 20th century, they enjoyed new freedoms: to come and go, to get up and go to bed when they chose, and to wear their own clothes. They ate better food, and they were provided with the wherewithal to make their own drinks 'without permission'.[15]

Similar changes were occurring in the Tasmanian public institutions around the same time. Although the inmates did not receive all the concessions granted to their English counterparts, they did enjoy a great many improvements to their conditions. At New Town, Superintendent Seager brought in comforts unseen before: woollen shawls for the women, and soft pillows and fine woollen blankets for the beds.[16] The diet was upgraded, and the inmates given more liberty to leave; both men and women were encouraged to go out with friends on one day a week.[17] Mr Seager reported to Parliament in 1907 that

> …very great efforts are made to make the Institution a home for all who avail themselves of its friendly shelter.[18]

Like those English workhouses, no-one could have seriously thought of New Town as 'home'. It was far too large, too institutional, too forbidding, too stigmatized, to ever engender the feelings of warmth and comfort conjured up by that word. Still, attempts were made: a name change to St John's Park in 1938 was aimed at reducing the stigma, and the buildings also received a thorough renovation to make the interiors more comfortable. Wooden benches were replaced with leather chairs and settees, curtains were hung and lamp shades provided, and the old scripture texts and religious prints upon the walls were replaced with 'high class pictures'.[19] Whilst officials were pleased to

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[14] Sheila Peace and Caroline Holland, 'Homely residential care: a contradiction in terms?', *Journal of Social Policy*, 10:3(2001), 393-410
[15] Doreen Norton, *The Age of Old Age*, (Harrow, 1990), page 17
[16] TPP, 47, 1902, Paper 18, page 3
[17] TPP, 53, 1905, Paper 53
[18] TPP, 57, 1907, Paper 26
[19] AOT, HSD1/1/5145 98/12/39 Alterations, Renovations, Repairs & Others (1935-38)

claim that the wards had 'quite a homely and non-institutional appearance'[20], this was presumably a relative rather than an absolute evaluation. Claire certainly did not think the women's division was particularly 'homely' where she started work in 1951:

> There was three big long wards, and I think there was about sixteen beds to a floor. Eight down one wall and eight down the other wall. Each big long ward had a big open fireplace at each end, with big wood boxes either side of the fire place, and the men down at the men's division each morning would come up and fill the wood boxes to keep the fires going. That was the only means of heating that there was. The floors were wooden, no carpet at all. They were old metal beds, and there were no curtains between, just big open wards! They didn't have any day clothes there. None. There was nowhere to go anyway.[21]

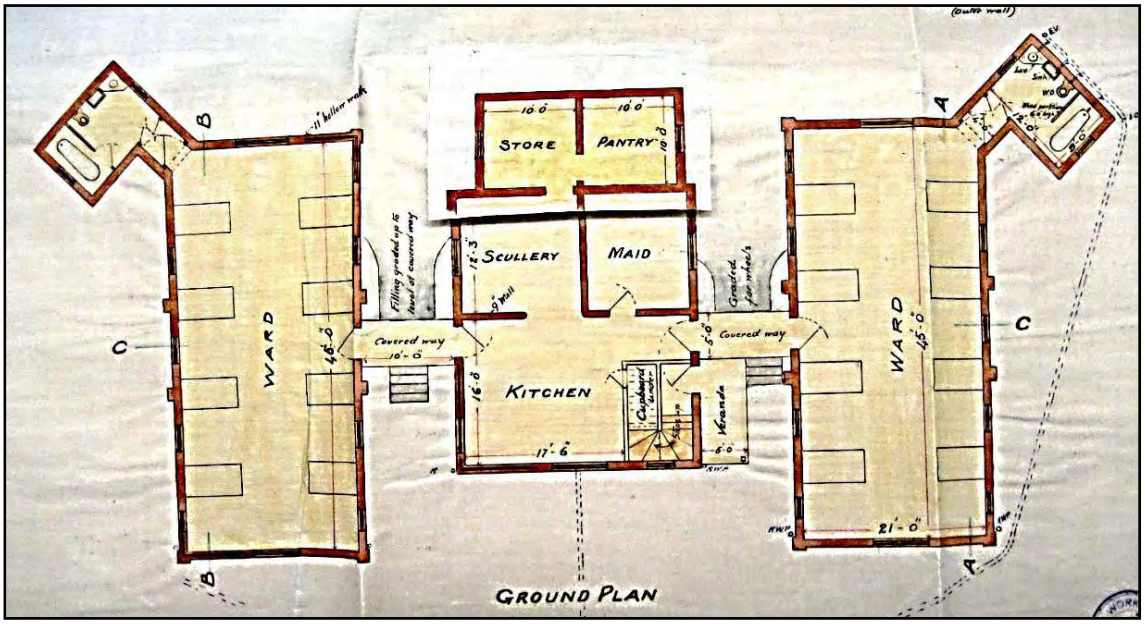

Plate 1: Original floor plan of the Home for Invalids, Launceston, c1912.[22] It shows the multi-bed wards with shared bathroom, separated by the central domestic block. There were soon far more than eight beds in each ward, and verandahs built on the ends of the wards held more beds.

The Home for Invalids (HFI) in Launceston was not particularly homely either, with its dormitory-style wards and cramped conditions. But it did at least look like a house, and it was located within a residential suburb rather than removed from the local community like St John's Park, surrounded by parkland. It was also less formal in management and daily routine, and the smaller number of residents meant that the staff could build more

[20] AOT, HSD6/1/2814 98/7 Memo from BM Carruthers, Director of Health and Medical Services, to Public Service Commissioner, 15/9/1949
[21] Interview with Claire Paynter
[22] AOT, HSD1/1/5175

personal relationships with them. This might not always be seen as a good thing by management[23], but it was pleasant for the workers. Eleanor became

> …very fond of them all. When I said goodbye to them all, I went round and kissed every one of them, and my husband said "I don't know how you could do that!", but you sort of got to love them.[24]

The HFI's replacement, Cosgrove Park, was far brighter and spacious than the old Home, but in some ways it was a step backwards. It was built to house more than one hundred residents, and the large communal spaces for living and eating resembled hotel lounges or mess halls rather than domestic living and dining rooms. There was also an emphasis on cleanliness and modernity, with 'over a mile' of rubber linoleum laid on the floors[25], making it resemble a hospital more than a home.

Plate 2: Outside a 'garden ward' at St John's Park, c1972[26]

Five new 'garden wards' which opened at St John's Park in the early 1970s were a little more successful in achieving the warmth and intimacy of a domestic house. These long, single-storey buildings, named Boronia, Waratah, Melaleuca, Camellia, and Fuchsia,

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[23] See Chapter 2, pages 64-66
[24] Interview with 'Eleanor'.
[25] Department of Health, Appeal brochure, *For the Aged – Security Care Comfort: Cosgrove Park Home for the Aged*, (Hobart, c1953)
[26] St John's Park Hospital information brochure, Department of Health, (Hobart, c1972)

were built on a more human scale than the old dormitory-style accommodation in the old buildings.[27]

> The garden wards were more like homes. They had a couple of single rooms with bathrooms—they weren't actually attached, you had to go out of the door into the hall, but that was considered their bathroom. And also they had a sliding door so you could go straight out to the verandah, one at either side, and quite a good courtyard and things. You'd either push [the residents] out in their bed, or they could go out and feed the birds, whatever. They had a kitchen, dining area, then quite a reasonable sized lounge.

Many of the purpose-built Homes that sprang up after the passing of the *APHA* were built along similar lines to the garden wards, but they too could be quite institutional, catering for a large number of residents with the necessary large communal spaces. It was the smaller proprietary Homes, in converted domestic houses, which came closest to fulfilling the Australian Government's vision. These Homes were intended to be just that—homes—providing their residents with shelter, food, a warm bed, and companionship.

Even those proprietary Homes which provided some nursing care and were designated 'private medical establishments' were still more home than hospital, replicating the atmosphere of a family house where possible. Abbeyfayle was a typical example. Sister Cora Lees opened Abbeyfayle in 1959, in a large Federation house in Launceston. As with many of the small Homes, it catered for women only, middle-class ladies from a higher socio-economic group than the average patient in the two public Homes.[28] Neither Matron Lees nor her staff wore uniforms, and the surroundings were domestic rather than institutional: regular beds, easy chairs, curtains and carpets (as at Cosgrove Park, most institutions had linoleum—so much easier to clean), and very little equipment. The government inspector, Sister Widdicombe, declared it to be a 'particularly cosy home'.[29]

Abbeyfayle might have been cosy, but it did have some shortcomings. The old ladies spent their days in close proximity to each other. They shared their bedrooms, and the house had a single bathroom. There was only one living area, in which they spent the

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[27] TPP, 191, 1974, Paper 82; TPP, 193, 1975, paper 79; TPP, 201, 1979, Paper 35; interview with Peter Sweeney. They are still in use today, as part of Rosary Gardens, owned by Southern Cross Care.
[28] Interview with Alex Myers. Most of the smaller private Homes catered for women only, at least until the 1970s when the occasional married couple would enter.
[29] AOT, HSD6/3/2653 536/30/10 Inspection report, 4/6/1960. Someone underlined this typed line several times with ink, to emphasize the opinion.

entire day, eating their meals sitting in their chairs as there was no dining room.[30] In fact, there was nowhere else for them to go at all, no solitude, and no privacy. This was true of most of the smaller establishments, and it was also a problem in the large ones, too. There is no doubt that privacy is one of the most vexed aspects of institutional living.

Privacy

> …conditions are very difficult. There is only one room available for the purposes of dining-room and lounge. Most wards are too crowded to be used as bed-sitting rooms. The result is that unless a resident is confined to bed, there is no chance of her getting away from the same people all day and every day.[31]

Privacy was not even considered in the 19th century invalid depots, where large dormitory-style wards were the only option. The floor plan of the Port Arthur Paupers' House shows three large connecting wards lined with beds, Brickfields had 'seven large dormitories [with] no less than 66 beds'[32], and Cascades had wards for forty men or women as well as the 'old cells, which could be used if required'.[33] New Town also provided large communal wards, and similar arrangements existed at the IDL. The HFI was the first institution to provide smaller rooms, with a dozen beds or fewer, but only because the whole establishment was on a smaller scale.

This sharing of accommodation would not necessarily have concerned the inmates, as privacy was not of the same import then as it is today. The working classes would rarely have experienced solitude at any stage of their lives[34], and this would have been particularly so for those who had been part of the convict system, as most of the 19th century inmates had been. In the first half of the 20th century, the large size of the average family meant that few people enjoyed the luxury of a bedroom to themselves. Even poorer families often had a maid, and many households took in boarders, either on a formal or informal basis, to help make ends meet. In a book of oral histories about life in

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[30] Interview with Alex Myers. This was a very common characteristic of the smaller private Home, where space was at a premium: Dr Catherine Rhys Hearn, *Quality, Staffing and Dependency: Non Government Nursing Homes*, (Canberra, 1986), Section D3.3 Nursing Home Layout

[31] AOT, HSD6/2/1002 96/27/9 (1) Letter from RE Hingston to Director, Department of Social Security, 21/5/1982

[32] The *Mercury*, Saturday, 30th May 1874, page 2

[33] The *Mercury*, Wednesday, 1st January 1873, page 3

[34] Philippe Ariés, 'The Family', in Bert Adams and Thomas Weirath (eds), *Readings on the Sociology of the Family*, (Chicago, 1971)

20th century Australia, Lillian Gollan reminisced about her home life in the inter-war years, a story that would have been common throughout the country:

> We were fortunate indeed that we had Alice (our maid) living with us from the age of seventeen years for fourteen years. We all loved her and she was very good to us. She slept in the boys' room, as there were only three bedrooms—grandma's, mum dad Enid and May's, and the boys'. From age twelve to twenty-four years I slept on the balcony.[35]

Prior to World War Two, many of the class of people who would later move into private Homes lived in boarding houses. Single older ladies in particular often chose to live in such places—not only were they safer than on their own, but they did not have to pay for household accoutrements, and expenses could be kept to a minimum.[36] In these boarding houses, privacy was almost totally lacking: meals were communal, a single sitting room meant almost compulsory socialising, and even the bedrooms might be shared.

Single bedrooms were therefore not seen as a priority for the new purpose-built Homes that arose in the 1950s and 1960s across Australia. The large dormitories of old were replaced with smaller rooms, but these usually contained two, four, or six beds.[37] Nazareth House had a majority of four-bed rooms, as did Cosgrove Park. Umina Park in Burnie had eight beds in each room.[38] The Queen Victoria Home in Hobart was an oddity well ahead of its time, with a majority of single rooms and several doubles when the new building opened in 1961[39], but it was located in a middle-class suburb and its Board was made up of wealthy and influential businessmen. The intended clientele would probably have expected more privacy. In the smaller proprietary Homes, particularly those in adapted domestic dwellings, larger bedrooms were usually filled with as many beds as would fit inside and stay within licence conditions[40], and most rooms

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[35] Lillian Gollan (born 7/2/1908), in *Memories of the 20th Century: A Social Snapshop of Life Before 2000*, (Lowood, 2001), page 23

[36] Seamus O'Hanlon, '"All found" they used to call it": genteel boarding houses in early twentieth century Melbourne', *Urban History*, 29:2(2002), 239-253, page 247. The boarding house owners sometimes provided meals to local non-residents who were unwilling or unable to cook for themselves, an early precursor of the type of service later provided by Meals on Wheels.

[37] This was common across Australia: Chris Ronalds, *Residents' Rights in Nursing Homes and Hostels: Final Report*, (Canberra, 1989), page 46

[38] Interview with Elizabeth Barron

[39] AOT, HSD6/3/2562 508/60/10 Inspection report 28/8/1963; interview with Pat Job.

[40] Eighty square feet of floor area and 800 cubic feet of air space; see, for example, AOT, HSD6/3/2680 559/50/10 Licence for Nazareth House, 27/4/1964, condition 2b. This appears to be a standard requirement in other countries, too; the American standards also required 'a minimum of 80 square feet per bed': Bruce Vladeck, *Unloving Care: The Nursing Home Tragedy*, (New York, 1980), page 152

were utilized for beds, including verandah spaces and dining rooms, as at Abbeyfayle. It was a matter of economic viability, and the Homes provided some privacy with the judicious use of screens or curtains for visual privacy, if not aural.

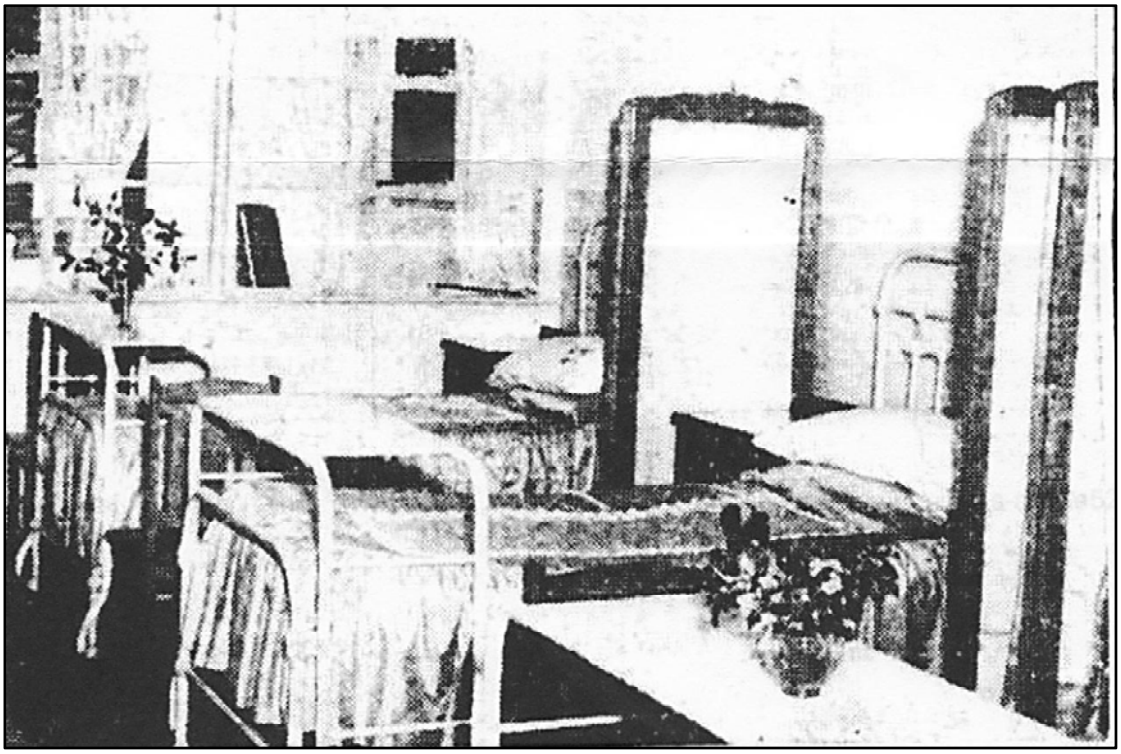

Plate 3: A room at Nazareth House. There are multiple beds with hospital-style bed tables, but frilled counterpanes and flowers are home-like and the screens provide some privacy.[41]

There has been much debate over the years about the advantages and disadvantages of shared accommodation, particularly bedrooms.[42] There is evidence that many residents of the Homes actually welcomed the shared rooms. That generation had rarely been alone, and some enjoyed the company of compatible roommates, particularly if they had been lonely before entering the Home.[43]

> We do have a few people who *hate* to be on their own—they're frightened to be in by themselves. Shared rooms can be beneficial. I can think of one elderly lady who shares a room with a lady who doesn't talk any more, and doesn't move much. But because the old lady can see this other woman in there, she's quite

[41] The *Examiner*, Tuesday, 1st July 1952, page 6
[42] The debate began in England as early as 1946, when aged care reformer Lord Amulree stated that many old people felt frightened at night and needed the presence of other people, so not all rooms should be private ('Care of the chronic sick and aged', *British Medical Journal*, 20th April 1946, page 617). This was supported by later studies, such as Mary O'Brien, *Anatomy of a Nursing Home*, (Maryland, 1989), and Shaw, *Old People in Homes*, page 22. Shaw noted, however, that more than four beds stopped the room feeling 'homelike'.
[43] Interview with Judy Wall

> happy. If you put her in a room by herself, she gets quite anxious—"ooh, don't shut the door, don't go, don't leave me in here". But if she's in with the other darling old thing, just lying there, not talking to her, she's quite happy!

As with the question of restraints in the previous chapter, the RNs and the aides did not always agree about the benefits of single rooms, and once again, this difference often involved expediency.[44] For the aides, shared rooms made it quicker and easier to carry out their daily routines, and the private rooms were inconvenient.

> It took us twice as long to do our work and that's when we had to ask for some extra staff because we couldn't cope. Because you could go into a room where there were four people, and you could put four people on to a commode and watch them, do that room and then move on. But when you started having to do rooms singly, it took much longer. You couldn't leave anybody, you had to wait with them.[45]

Barbara felt that they were a good thing, on the whole.

> There was a lot going for having four beds, because if you had one person on a commode, you could keep your eye on that person while you were attending to another. And it did help when you were feeding them, because while one was enjoying their meal, you'd give them a mouthful and they wouldn't have to swallow straightaway. I think it's too rushed nowadays. And I think it was good for the residents, for the simple reason that if somebody needed assistance, there was always somebody there to give you a yell.[46]

RN Roz was not quite so sure. Not only was there the problem of *in*compatible roommates, but there was a privacy issue.

> It was a mixed blessing, I think. In terms of the residents, I think sometimes it was good—they could interact with some of the other people in their room—but in other ways it wasn't and there was certainly no privacy. They all seemed to know everybody's business in the room, so from that point of view it was *awful*. It was possibly easier for the carers, because the residents were all more contained in one area and if you were working in a room on one side and something happened, or if someone fell over or someone was crying out, you could hear what was happening, so you probably had better ability to respond.[47]

It was not until the introduction of the Nursing Home Outcomes and Standards in 1987 that privacy became more of a consideration. Many of the older Homes began to make changes to the structure of the buildings, dividing larger wards into smaller, single or

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[44] This was also seen in a British study which found that whilst senior staff had more 'progressive', resident-oriented views, care staff were more likely to express views that sprung from 'organizational needs for routine': Dianne Willcocks, Sheila Peace & Leonie Kellaher, *Private Lives in Public Places* (London, 1987), page 56

[45] Interview with Judy Wall

[46] Interview with Barbara Allen

[47] Interview with Roz Wilson

double rooms. At Umina Park, Liz oversaw the conversion of the old eight-bed wards into single bedrooms with ensuites[48], and the nuns of Nazareth House also divided the four-bed wards into single rooms. Some older buildings that did not lend themselves to conversion were replaced entirely; Cosgrove Park, that once shining star, was demolished in 2008 and replaced with a brand new Home. New Homes are built with single-occupancy rooms as a norm. Now there is little choice in the matter for residents; apart from a few double rooms, they are on their own. But whatever the arguments for and against shared bedrooms, there is one great benefit of the single-occupancy room: it allows the resident to engage in intimate activities.

Sex and intimacy

> …there seems little justification for the rigorous segregation that is apparent almost everywhere. It seems unreasonable to expect those who have been accustomed to association with both sexes throughout their lives to adjust easily to association exclusively with members of their own sex.[49]

The notion that residents in aged care facilities should be able to pursue sexual relationships is a very modern one, and even today, many people view the idea with ridicule or disgust.[50] Until the last quarter of the 20th century there were no provisions made in the Tasmanian Homes to enable elderly couples to enjoy such activities. In fact, men and women were actively kept apart, married or not.

There had been limited contact between couples at New Town since 1890, when wives from the female division had been allowed to visit their husbands in the male block, creating 'an air of contentment', according to one visitor.[51] From 1903, this improved still more as the falling numbers of inmates allowed for some flexibility of space and married couples were occasionally able to remain together.[52] As a general rule, however, in every Home with mixed occupancy, male and female residents spent their days apart.[53] Even when men and women gathered together for mutual activities, such as film screenings at St John's Park, they were carefully separated and propriety was

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[48] Interview with Elizabeth Barron
[49] Bernard Hutchinson, *Old People,* pages 118-119
[50] Rhonda Nay, 'Sexuality and older people', in Rhonda Nay and Sally Garrett (eds), *Nursing Older People: Issues and Innovations,* (Sydney, 2004)
[51] TPP, 20, 1890, Paper 11
[52] TPP, 51, 1904, Paper 12
[53] AOT, HSD6/3/1729 60 CO 9 Address to Wynyard Geriatric Conference, 13/2/1966. Most of the smaller private Homes accommodated ladies only, so the problem did not arise.

maintained.[54] At Nazareth House, there was complete segregation of the sexes, to the extent of separate dining rooms for men and women.[55] Cosgrove Park had a shared dining room, but men and women dined in separate sittings, and had separate day rooms in each gender segregated wing. This segregation meant that married couples could not enjoy the 'companionship of husband and wife' mandated in the *APHA*, as wives were accommodated at one end of the building and husbands at the other.[56] It was not until 1965 that two bed-sitting rooms were provided for elderly couples[57], although this small number meant that some couples were still accommodated in the separate divisions. For unmarried couples, the wait would be much longer.

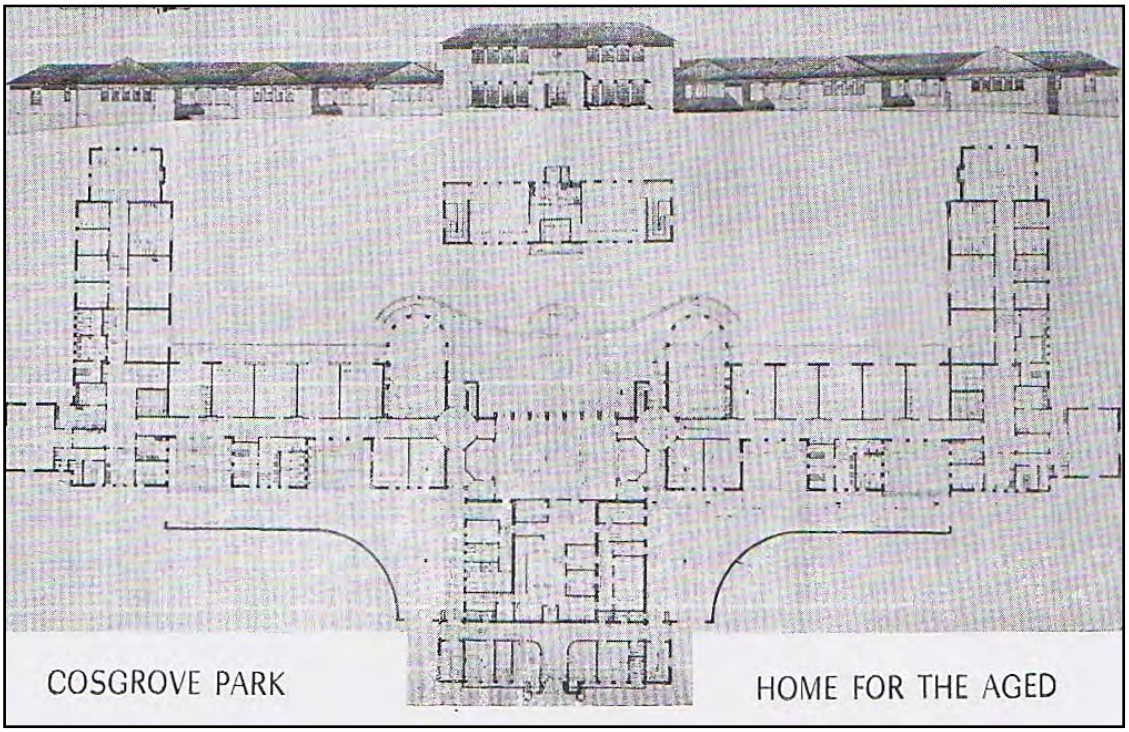

Plate 4: Floor plan for Cosgrove Park, showing the male and female wings either side of a central block, with 'sun terraces and verandahs for separate use for both male and female patients'[58]

Changing social mores and the sexual revolution of the 1960s meant that segregation of the sexes was no longer so vital for respectability in the Homes. Men and women were at last allowed to share the communal areas. Eskleigh Memorial Home built a new lounge

[54] AOT, HSD222/2/2 Statement of Deputy Charge Male Nurse duties, 1957
[55] AOT, HSD6/3/2680 Inspection Report 22/3/1963
[56] Interview with Elaine Sturzaker
[57] Launceston General Hospital Annual Report, 1965
[58] Illustration from Department of Health appeal brochure, *For the Aged – Security Care Comfort: Cosgrove Park Home for the Aged,* (Hobart, c1953). Quote from TPP, 135, 1946, Paper 12

room to connect the previously used Ladies and Gents lounges in 1971[59], and other Homes also relaxed their rules, at least during daylight hours.

> We had the odd couple who were lovers! You know, they had to sit together, and spend the day together, and then night time come they'd kiss one another goodnight. It was just wonderful. The sleeping quarters were separate, but they could mingle during the day. We had one lady, we always used to find her down in the men's day room with her friend, it was gorgeous.[60]

By the end of the 1980s, the old men's and women's divisions of the larger Homes were a thing of the past, but naturally the multiple occupancy bedrooms continued to be devoted to either men or women. Helen remembered one couple who overcame the difficulty, with the help of family.

> There was a husband and wife and the husband was in one room and the wife was in another, so their relatives would come and take them home for the day. I don't know whether the relatives knew, but they used to just pop Mum and Dad in the room and go away for a few hours, so I think they probably had an idea.

Towards the end of the 20th century, it became clearer that sexual relationships continue to be important to older people. Some Homes began to provide 'honeymoon suites', where couples could retire to enjoy each other's company[61], and the modern requirement for single occupancy rooms allows residents far greater privacy for intimate dealings.

Single rooms also have another beneficial effect, as the residents now have the space to bring in more personal possessions, and the ability to keep these safe.

Belongings and belonging

> Familiar objects provide a sense of continuity, comfort, security and satisfaction. They contribute to a maintenance of orientation, especially if one's world is quickly changing.[62]

The public Homes allowed their inmates to keep very few personal belongings, citing lack of space and security in the large communal wards. At St John's Park, as late as the 1950s, even the clothing a person owned was removed and put into storage. When Cosgrove Park opened in 1954, each patient was provided with an 'individual wardrobe

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[59] AOT, HSD6/3/2669 Inspection report 12/5/1971.
[60] Interview with Kay Joyce
[61] Cosgrove Park provided such a room in the first decade of the 21st century. There was a wide range of reactions to this on the part of staff, from disgust and shock, to amusement, to acceptance of the right of the elderly residents to express a still-important aspect of their lives.
[62] Butler, *Why Survive*, page 414

and locker'[63], but there was no room for other personal possessions. It appears that the patients themselves may not have expected to be able to bring anything with them.

> It was a hospital, not a home. I can't remember anyone even suggesting that they bring a photo, or something of their own. If you went into hospital you didn't take them, so you didn't take them into Cosgrove.[64]

By the 1960s there was a growing recognition that personal items give people a sense of ownership and belonging in an otherwise impersonal situation.[65] The public Homes began to allow residents to bring in mementoes of their past to augment and soften the institutional surroundings.

> They still had the same government quilts, but they were trying to encourage more and more people to bring their own crocheted blankets in, and they were allowed to have photos of their family on the walls, and anything else that they needed.[66]

Nazareth House residents could also bring in photographs and small items, and a pair of wealthy sisters who shared a room even brought in some of their own antique furniture.[67] In the smaller Homes, lack of room still limited personal belongings, although the security aspects seemed to have been less of a concern in these establishments. This is possibly due to the different class of people who were admitted, or perhaps because the private Homes were more private altogether, being closer to a domestic dwelling and less likely to admit visitors off the street without checking their credentials. Derwent Court residents could bring in small items such as writing materials, knitting, clocks, and even television and radios 'provided they are fitted with earphone attachments so that their use does not disturb other residents'.[68] The residents of Sunny Brae

> …each had their own little corner and their own chest-of-drawers, and anything that they wanted to bring that we could fit. If they wanted to bring their own chair, if it was suitable, they could do that. In the single rooms, if they wanted to, they furnished their rooms with their own furniture. [69]

The 1990 Charter of Residents' Rights and Responsibilities made provisions for personal belongings a legal requirement, and as single rooms have become the standard, the rules on belongings have relaxed. All Homes now expect residents to bring in personal

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[63] Department of Health, *For the Aged – Security Care Comfort*, page 5
[64] Interview with Judith Beard
[65] Shaw, *Old People in Homes*, page 37
[66] Interview with 'Helen'
[67] Interview with Eileen O'Leary
[68] Derwent Court Nursing Home: Information Booklet (Hobart, 1986)
[69] Interview with Maureen Battese

possessions, and furnishing one's own room has become quite common. Some Homes even allow the resident to choose their own wall colours and accessories, such as carpets and curtains.[70] But there may have been some advantages in the old system; institutional furniture is a great leveller, diminishing the differences between the different socio-economic groups. Now, when people can use their own objects, a lack of possessions may be seen as a sign of penury, and bring a stigma of its own.

Reducing a lifetime of memories to items that can be housed in a single room can be difficult in itself, but of all the possessions a person leaves behind, perhaps the most emotionally charged and hardest to part with is the family pet. For many old people, 'the greatest sorrow at leaving their old home is parting with a much loved animal'.[71] The logistics of keeping pets in communal living spaces, together with the question of hygiene, has made this aspect of domestic life particularly difficult to address to everyone's satisfaction. Nevertheless, some Homes made provision for pets, and some even had resident animals—birds, cats, and dogs.

Pets

> …there might be detected solitary old veterans innocently passing away the time in caressing cats … "Pussy" is quite at home in these quarters; she is a general pet, and her presence may be detected in every corner of the buildings.[72]

Pussy lived at Brickfields in 1874, but she appears to have been an aberration at this early stage. Whilst domestic animals might have been found in the other public Homes, I have been unable to find any record of them, although Judith and Elaine remembered how Dr Foster, the state geriatrician during the 1960s, interceded on behalf of a Cosgrove Park patient who came from the bush with his dog. The dog was allowed to live at the old Ainslie House, at the edge of the property, where his owner could visit him daily.[73] Peter S remembered a St John's Park resident who had a guide dog[74], but that is not really a pet.

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[70] One resident of a Home in which I worked briefly in 2005 had decorated her room in a symphony of purples: vivid lavender walls, mauve curtains, deep plum bedspread, bright lilac bed linen, and an abundance of accessories decorated with violets. It was headache-inducing for the staff, but she loved it, and that was the important thing. It would never have happened in earlier times.
[71] Shaw, *Old People in Homes*, page 79
[72] The *Mercury*, Saturday, 30th May, 1874, page 2
[73] Interview with Judith Beard and Elaine Sturzaker
[74] Interview with Peter Sweeney

In the 1980s, Nazareth House began to allow small dogs to come in with their owners, which the aides found to be a mixed blessing as they ended up caring for the dogs too.[75] Other Homes followed suit in the 1990s, and some even acquired their own. St John's Park had a dog and cat[76], and Cosgrove Park adopted 'Tiger the wonder dog', a black Labrador, who was rescued from the RSPCA and took up residence in June 1990. In Hobart, the Mary Ogilvy Home had birds, several cats, and Tess, a black Labrador so spoiled and overfed that she 'could only waddle'.[77]

● Cosgrove Park resident Mr Lewis Lee with Tiger ... 'he's a wonderful dog.'

Picture — PAUL SCAMBLER

Tiger the wonder dog is residents' best friend

Plate 5: Front page news: 'Tiger the wonder dog' takes up residence at Cosgrove Park[78]

[75] Interviews with Nancy Langley and Eileen O'Leary

[76] From oral history of Desi Dean, resident from c1953 to 1993, in *No More Bread and Milk: Stories from St John's Park*, (New Town, 1993), pages 16-17

[77] Alison Alexander, *Mary Ogilvy: The Evolution of a Grand Lady*, (New Town, 2006), page 49 The operators of the Home clearly did not follow Patricia Shaw's advice that 'a dog in the dining room is always overfed and should not be allowed there': *Old People in Homes*, page 81

[78] The Launceston *Examiner*, 14th June 1990, page 1

The benefits of animals for people with dementia was also recognized at that time, and the ground-breaking ADARDS nursing home in Hobart, which opened in 1991, kept dogs, cats, chickens, and an aviary.[79] Today, twelve Tasmanian Homes have in-house pets.[80] Mrs Cat was a popular resident at Cosgrove Park when I worked there in 2006, with the pick of the beds to sleep on, and the verandah at Mount Esk (formerly Nazareth House) today accommodates an array of bowls to feed several feline tenants. These animals provide companionship, and entertainment too—an important aspect of the homely Home.

Entertainment

> Quite often people from town would come to Cosgrove Park, concert groups and so on, and a group used to come up every Sunday and show a film in the dining room. Any film that was going, just ordinary cinema…every week, or very nearly every week.[81]

One of the few criticisms levelled at the public institutions during colonial times had been the monotony of life for the 'poor old fellows' within. Although there were some diversions, these were provided almost exclusively by outsiders, members of the public doing charitable works. They were not official activities and there was little provision for amusement or pleasure made by the authorities or the staff of the Homes themselves. When the invalid depot was moved from the inaccessible Tasman Peninsula to Brickfields, its proximity to Hobart town made it possible for visitors to come and visit the men, and to give readings and concerts, using a piano bought through public subscription.[82] There was also a small library, which was stocked with donated periodicals, books and newspapers, including a regular supply from the Governor.[83] This tradition continued when the men moved to New Town, and the IDL also received reading matter from private benefactors, bookshops and publishers.[84]

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[79] Interview with Vera Green. ADARDs was one of the first Homes in Australia to cater exclusively for residents with dementia, utilizing a range of behavioural treatments and eschewing the use of heavy medications: John Tooth, 'ADARDS Nursing Home', *The Companion to Tasmanian History*, (Hobart, 2005)
[80] www.agedcareguide.com.au
[81] Interview with Judith Beard
[82] TPP, 16, 1870, Paper 4
[83] The *Mercury*, Saturday, 30th May 1874, page 2
[84] TPP, 17, 1871, Paper 5

Many of the early entertainments were possibly more for the inmates' own good than their amusement. The annual reports record numerous visits from religious ministers and lay preachers, giving sermons and playing sacred music. But there were other more secular diversions; several ladies visited regularly to chat with and read to the invalids, particularly those in the hospital wards, and others provided musical evenings and afternoon tea meetings, at which the inmates were 'liberally supplied with dainties'. Local girls formed the Flower Mission, which came on Fridays to give each Hospital ward patient 'a tastefully-made bouquet'.[85] Similar amusements occurred at the IDL, where the largest ward was decked out with 'a stage and other accessories for entertainments'.[86]

The new century brought more visitors and a wider variety of amusements to the Homes. A vaudeville company performed at New Town in 1911, as did Mr Foley in 'one of his inimitable entertainments'.[87] Mention is made in 1927 of Mr McCann, who 'has been visiting for over 20 years to put on entertainments for the inmates'.[88] The HFI inmates were also visited by community groups and entertainers, and this continued when Cosgrove Park took its place. There was more room there, and the residents were regaled with full concerts given by school groups, the CWA and church organizations, on a large stage in the dining room.[89] The archives hold a great many photographs of these productions: children in tutus and tap shoes, groups of dancers, solo singers, and that perennial mainstay of amateur comedy, men dressed as women with enormous false bosoms.[90]

Whether these performances were entirely to the taste of all the residents is doubtful, as tastes differ greatly. It is also immaterial; the records suggest they were well attended and well received, or they would not have continued. Goffman points out that the inmates of

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[85] TPP, 5, 1885, Paper 9
[86] The *Examiner*, Tuesday, 10th November 1891, page 4
[87] TPP, 65, 1911, Paper 11. To my great disappointment I cannot find any further description of these, to explain their inimitability.
[88] TPP, 97, 1927-28, Paper 49
[89] Interview with Kay Joyce
[90] AOT, AB644/1/2: Photographs of Cosgrove Park. This large cache suggests that this was one aspect of the Home of which the government was particularly proud, evidencing the care they took to provide the residents with entertainment, and the involvement of the community in the workings of the Home. It is interesting that there are very few photographs of the residents themselves, however; most depict performers and visiting dignitaries.

a total institution will go to anything to escape the dreary monotony of their everyday lives (even unamusing amusement is better than boredom), and will be charitable in their reception even if they are not delighted, as they cannot risk the cessation of events:

> The institution provides a stage and guarantees an appreciative audience; the performers contribute a free show. There can be such a compelling need of each for the services of the other that the relationship may pass beyond the matter of personal taste and become almost symbiotic.[91]

Plate 6: The Village Glee Club perform at the HFI at Christmas, 1948.[92] The players appear to be more enthusiastic about the entertainment than their elderly audience.

There were also diversions outside the Homes. When the Prince of Wales visited Tasmania in April 1920, the inmates of both institutions were driven around their respective cities to view the illuminations put up in his honour.[93] From the 1930s, the proprietor of the Moonah theatre allowed the inmates of New Town free entry to the pictures each week[94], and two local theatres in Launceston donated tickets to performances to the inmates of the HFI.[95] Both Homes took their inmates on annual outings. The HFI residents went to the seaside and into the country, and St John's Park inmates also explored the beauties of the local area, visiting Mount Wellington, Salmon

[91] Erving Goffman, 'On the characteristics of total institutions', *Asylums*, (Harmondsworth, 1968), page 100
[92] The *Examiner*, Friday, 24th December 1948, page 5
[93] TPP, 83, 1920-21, Paper 48 and Paper 56
[94] TPP, 111, 1934, Paper 37, page 3
[95] TPP, 121, 1939, Paper 16, Appendix X, page 36

Ponds, National Park, and enjoying an annual river trip in the MV 'Cartela'.[96] When a new fifteen-seat bus was acquired in 1968, trips were made even further afield, to destinations such as Port Arthur. The residents not only saw the sights but dined at local motels, enjoying 'community singing and whistling along the way'.[97]

These trips were welcome, but they were only occasional, and they were also only for the ambulant. The bedridden and chairbound patients had few distractions. In 1951 this was addressed when part of the ground floor of the old Orphan School building at St John's Park was converted into a cinema/concert hall, complete with tip seats.[98] The coming of television also made a great difference, bringing entertainment and diversion for everybody. Sets were placed in the dayrooms in 1960[99] and the beneficial effects of these on resident behaviour were noticed immediately, as the superintendent noted.

> Matron has received many reports from the patients complaining that Mrs Harper had used filthy language and made malicious remarks about them, but when questioned by Matron, she emphatically denied everything. … Since Television sets have been installed at the Women's Division the conduct of Mrs Harper has improved considerably…"[100]

As psychosocial activity grew in importance during the 1960s[101], the entertainment schedules became more crowded. The superintendent of St John's Park submitted a calendar of events each month to the Department which show activities on almost every single day. These included an eclectic array of films (in 1968, these included 'Who's Afraid of Virginia Wolf', 'The Singing Nun', Disney cartoons, and several Elvis Presley movies), afternoon teas and suppers, bowling, musical recitals, and concerts. The residents received visits from members of the RSL, Mothers' Unions, the Red Cross, church groups, and schoolchildren, and professional entertainers such as the cast of *Snow White and the Seven Dwarfs* and 'Television Celebrity Mr Jack Gunn'.[102]

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[96] TPP, 171, 1964, Paper 70, page 34
[97] AOT, HSD6/1/6594 Memo from Acting Superintendent Langdale re social activities, 16/12/1968
[98] TPP, 145, 1951, Paper 68, Appendix V
[99] Television was only introduced to Hobart in May of that year (the *Examiner*, Saturday, 19th May 2012, page 38), so this very prompt response to this new technology shows the government's willingness to supply the residents of St John's Park with the latest entertainment resources.
[100] AOT, HSD6/1/5190 98/5/1 Letter from Mrs Harper to Premier Reece, 22/3/1961; memo from Superintendent Trebilcock to Minister for Health, 30/3/1961
[101] Chapter 5, page 165
[102] AOT, HSD6/1/6594. In 1966, the film operator, Mr Quinn, had carried out this task for over thirty years.

Without the resources of the state government behind them, few private Homes offered any activities that fell outside the usual domestic arrangements, such as television.[103] Nazareth House residents had more than most, with a billiard room and a library, as well as television, a piano and a radiogram.[104] In the 1970s, the staff began to organize other activities. Judy and Barbara would go in once a week when they were off-duty, to take Bingo, and there was "music, and a few games".[105] They also took out the more active residents to the theatre occasionally. Barbara remembered a particularly lively evening at a Foster and Allen performance when one resident loudly demanded a cup of tea throughout the performance.[106] The voluntary Homes also received visits from community groups, who put on concerts and musical evenings, and Eileen remembered one very welcome guest, for the nuns if not for her.

> Daniel O'Donnell—do I *hate* that man! The nuns *loved* him. He was on the television morning, noon and night! He came and visited there, and there was *great* excitement![107]

In the 1980s, the nuns even instituted a 'happy hour', with drinks handed round to the residents who had not yet gone to bed. They were not the first to relax the long-standing ban on alcohol in the Homes. At the Queen Victoria Home in the 1960s, Pat got into the habit of visiting 'Aunt Mary', a long-time resident, for a nightly sherry and a chat.[108] Even the public Homes, which had banned liquor completely due to the long held belief that poverty and drink were irrevocably intertwined[109], began to soften their stance. In the late 1960s St John's Park residents were allowed a drink in the evenings, distributed and carefully controlled by the nurses.[110] At Cosgrove Park, the male residents were given a glass of beer quite regularly, and relatives brought in the occasional bottle, which was kept in the drug cupboard for safekeeping by the RNs.[111] Residents who came in the

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[103] Television was the only entertainment option at Abbeyfayle: interview with Alex Myers. Eskleigh residents were given classes in handcrafts from 1965, but not all that Home's residents were elderly; many were younger people with chronic illnesses: HSD6/3/2669 Inspection report, 14/7/1965
[104] AOT, HSD6/3/2680 559/50/10 Inspection report 22/3/63
[105] Interview with Judy Wall
[106] Interview with Barbara Allen
[107] Interview with Eileen O'Leary
[108] Interview with Pat Job
[109] Apart from medicinal purposes; the use of brandy and stout at St John's Park was detailed in chapter 5, page 169. Rum was on the list of 'medical comforts' at the IDL, given to the men instead of milk if they were unwell. The men did not complain, and it was cheaper than milk, so everyone was happy: TPP, 15, 1888, Paper 50, page 37
[110] Interview with Peter Sweeney
[111] From personal knowledge, this was still the routine in 2006. I was told it was because the rooms were shared and it was difficult to ensure a resident's supply would not be taken by others, but there were some

worse for wear were no longer threatened with deportation to St John's Park, or kept in bed as punishment, as they had been in 1958.[112] Judith fondly remembered Reg:

> He was a *dear* old fellow, but he had a little bit of a problem with the drink. He'd be alright all the week, but Saturday—poor Reg! The police would bring him home *every* Saturday night. Eventually, he used to come up on Saturday morning and apologise to me for what state he'd be in when he came home Saturday night![113]

The proximity of the bowling club gave Cosgrove Park residents a chance to continue the social routines of their younger days, and the aides were there to assist the residents in this activity as in others:

> When they had the bar over there in the [bowling club] pavilion, the residents just used to walk over there and have their beer every night, like they're coming home from work! Time and time again we had to go over and bring somebody back drunk. We used to have a lady that drank heavily, and she'd be over there in a wheelchair. We'd have to wheel her over and then we'd have to wheel her home, she'd be so drunk! It was just as if they were living in their own home.[114]

The only time that the inmates of the charitable institutions had been allowed to drink alcohol for pleasure was on special occasions. When Edward VII was crowned in 1902, the New Town inmates were 'regaled with a full diet of baked meat and potatoes', washed down with dandelion and ginger beer, and beer as a special treat.[115] And then, of course, there was Christmas. Christmas festivities have a high profile within the records of the state institutions, and the celebrations described match well the characteristics of what Goffman calls the 'institutional ceremony'.

Christmas

> Once a year inmates will decorate the establishment with easily removable decorations partly supplied by the staff, in this way banishing from the living quarters what an extra-special meal will then banish from the table. Small gifts and indulgences will be distributed among the inmates; some work duties will be cancelled; visitor time may be increased and restrictions on leave-taking decreased. In general, the rigours of institutional life for the inmates will be relaxed for a day.[116]

RNs who refused to allow any resident more than a half-glass of sherry per night, for the resident's 'own good' of course.

[112] See chapter 2, page 69

[113] Interview with Judith Beard

[114] Interview with Kay Joyce

[115] TPP, 49, 1903, Paper 11

[116] Goffman, 'On the characteristics of total institutions', page 93

Even at Port Arthur in 1860, Christmas was a special time, with no work, no 'scarcity of roast-beef, plum-pudding, and tea', and a relaxation of discipline for the inmates of both the penitentiary and the Pauper House.[117] These arrangements continued and even became more elaborate in the later Homes. A special feast was always served at both the IDL and New Town, washed down with beer and ginger beer donated by the breweries and other benefactors[118], and in 1915 the first Christmas tree arrived in the women's wards of New Town, donated and decorated by the matron and nurses. The following year Father Christmas visited and gave each inmate a gift, which 'was the cause of much merriment and enjoyment'.[119] At both institutions, townspeople would come to put on concerts and entertain the inmates. A radio appeal began in 1929 to provide the New Town residents with presents[120], and this tradition continued for many years. Other donations of gifts were made, and the local newspapers published articles each Christmas showing groups of school children and charitable groups distributing gifts and putting on musical soirees.

In later years, the Homes themselves provided their residents with presents: records for the St John's Park men's division in 1961 show gifts of shirts, slippers, belts or braces, pipes and tobacco, wallets, pocket knives, fountain pens, and the traditional socks, ties, and handkerchiefs.[121] Each person also received a parcel of toiletries and necessities for the coming year, with such items as toothpaste and brush, comb, face washers, underclothing, and shaving brush, cream and razor blades for the men.[122] There was some effort made to personalize these gifts and give the men something they really wanted. Mr Alexander (aged eighty-five) received a Western novel; Jimmy Ah Sow (eighty-two) requested a cardigan; Mr Woods (seventy-five) a cigarette lighter; Mr Button (seventy-eight) a hot water bag; but Mr Neal (eighty-four) did not want a present

[117] The *Mercury*, Friday, 28th December 1860, page 3
[118] TPP, 23, 1891, Paper 14. Beer was forbidden at other times, as alcohol of any kind was prohibited.
[119] TPP, 75, 1916-17, Paper 43
[120] TPP, 101, 1929-30, Paper 35
[121] The publication of an article in the *American Journal of Nursing* describing similar present-giving in an American Home in 1955 suggests that this practice was relatively new and quite innovative: Bernice Coleman, 'The holiday season in homes for the aged: Chanukah', 55:12(1955), 1462-1464
[122] AOT, HSD222/2/8 Christmas gift suggestions.

at all.[123] The gifts were wrapped in gaily coloured crepe paper, which was also used to make garlands to decorate the wards.[124]

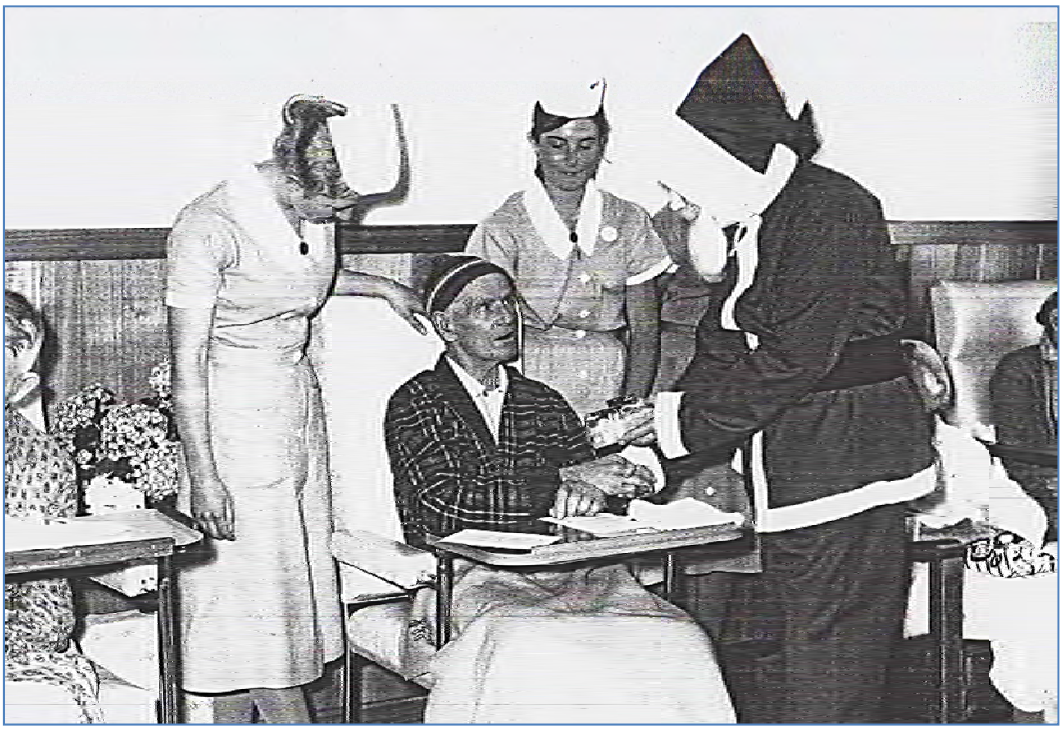

Plate 7: Santa visits Cosgrove Park, c1966[125]

Father Christmas also visited Cosgrove Park, where the residents received chocolates and toiletries, and Kay recalled a particularly successful year when wind-up toys were a hit.[126] But while Santa and presents were great fun, the highlight of the day was Christmas lunch. The meal was traditional, and plentiful, and accompanied by festive libations.

> A salubrious Christmas dinner was held consisting of turkey, ham, green peas, beans and new potatoes, plum pudding, brandy sauce, etc. Liquid refreshment was provided for all male and female patients requiring same in the afternoon.[127]

Elaine's grandfather, a resident at Cosgrove Park in the 1960s, always stayed for lunch at the Home because the food was so good, joining his family for tea instead.[128] The staff were well catered for, too.

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[123] AOT, HSD222/2/8 No records could be found for the female division, but presumably similar arrangements would have been made for them.
[124] AOT, HSD222/2/9
[125] AOT, AB644: Photographs of Cosgrove Park
[126] Interview with Kay Joyce
[127] AOT, HSD6/1/6594 Memo from Superintendent Trebilcock to J Edis: activities for December 1965

> The nursing staff used to have a lovely Christmas—we had a *beautiful* Christmas dinner, and there was always lots of alcohol there! We all dropped tools on Christmas Day for Christmas dinner—when I think back now, I don't know who kept an eye on the ward! But everyone was in the dining room, and there was all this grog, not stubbies of beer, big bottles of beer—wine wasn't a drink that was drunk much going back then—and sherry, that awful, sweet sherry. And I [asked], "do they —the St John's Park people—do they supply all this alcohol for the nurses?" And they said, "no, no, all the undertakers in Hobart throw in at Christmas time and the money is all spent on alcohol for the nurses at St John's Park, because *we* are keeping *them* in business!"[129]

Gift-giving was often reciprocal, at least at the private Homes where the residents were better off. Nancy remembered that "at Christmas time you couldn't carry home the presents you'd get", a situation that changed in the 1980s as new rules and regulations came in regarding the permissibility of such exchanges.[130]

Judith mentioned that she'd been surprised at how few residents left Cosgrove Park at Christmas Day to spend the day with relatives. But of course, many had no relatives, or no close ones. Across the decades, the majority of people in Homes have been the never-married, the widowed and the childless, who have no one to turn to for support. For them, the Home became their world and the staff their family.

'Detached atoms': the 'family' Home

> The inhabitants of an old country are usually surrounded by kindred. Those of a colony are detached atoms.[131]

The inmates of the colonial charitable institutions were certainly 'detached atoms'. Most of the destitute invalids were ex-convicts, never-married or widowed, and few had families. With no-one to provide support or help them with daily life, they had no choice but to enter the invalid depots. The authorities believed that as this 'criminal class' died out, the need for the institutions would end, and for a while it appeared they were right. The population of the two government Homes was dwindling rapidly by the beginning of

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[128] Interviews with Barbara Allen, and Elaine Sturzaker. This would have met with the approval of Patricia Shaw, who believed that 'if any relations wish to take a resident out for Christmas Day it may be necessary to agree but it is a pity, because it does not help the resident to feel he is a member of the Home: *Old People in Homes,* page 64

[129] Interview with Claire Paynter. The donations from the undertakers were a long-standing arrangement, as Peter Sweeney, who worked there throughout the 1970s and 1980s, corroborated.

[130] Interview with Nancy Langley

[131] TPP, 17, 1871, Paper 47, page xxxvi; from Commissioners' report, Royal Commission into Charitable Institutions

the 20th century, but it was a temporary hiatus. Medical advances and improvements to sanitation during the next decades meant that more people were reaching old age, and the emancipists were simply replaced with other old people needing help and support. The institutions were still necessary, and in this new century the gender balance would be reversed. Old women, particularly the unmarried and childless[132] were to become the main occupants of the Homes, a situation that continues today as women continue to outlive men.

Although the Homes were needed, they were not greeted with approval by everyone. When the Archbishop of Melbourne came to open the extension to Nazareth House in 1951, expanded it from seventeen to one hundred beds, he was scathing about young people in society and their "tendency … to shirk their natural duty" towards elderly relatives, thus making the extension so necessary.

> It is a regrettable feature of our times that so many people, in the evening of their lives, must look for comfort and kindness to a benevolent state. … Here in this Nazareth House in St Leonards, … many people will experience, perhaps for the first time, the real impact of Christian charity.[133]

The Archbishop's exhortation was neither original nor unusual. In the eighteenth century, preacher Samuel Willard told his listeners, "Children that have been the charge of their parents to bring them up … should not presently … desert their helpless parents … and [leave] them shift as they can".[134] The belief that families were 'shirking their natural duty' was a common one, and there is still a widespread belief that an extended family system once existed 'whereby successive generations of kin lived together, the younger ones caring lovingly for the oldest', and that these ties no longer exist.[135] Each generation hears that the generations before them have cared for their elderly relatives, taking them

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[132] Childbirth was a high cause of death for women, so those who did not give birth were far likelier to live to old age. This was also the case in other countries and across the time span: see Peter Townsend, *The Last Refuge*, (London, 1962); Robert L Kane and Rosalie A Kane, 'Care of the aged, old problems in need of new solution', *Science*, 200:4344(1978), 913-919, page 914; Michael Katz, 'Poorhouses and the origins of the public old age home', *The Milbank Memorial Fund Quarterly*,62:1(1984), 110-140; Margot Jefferys and Pat Thane, 'An ageing society and ageing people', *Growing Old in the Twentieth Century*, (London, 1989). Elizabeth Roberts cites an early twentieth century study that found only 16% of workhouse inmates had any relatives who might have given them shelter: 'The recipients' view of welfare', Joanna Bornat et al, (eds), *Oral History, Health and Welfare*, (London, 2000), page 213

[133] The *Examiner*, Monday, 7th July 1952, page 3: Tendency to Shirk Duty

[134] Pamela Doty, 'Family care of the elderly: the role of public policy', in *The Milbank Quarterly*, 64:1(1986) 34-75

[135] Margot Jefferys and Pat Thane, 'An ageing society and ageing people' in Pat Thane, (ed), *Growing Old in the Twentieth Century* (London, 1989)

in and looking after them within the bosom of the family, even though research has shown that this is not actually the case.[136] But such public castigation by influential church figures made people feel guilty about letting their elderly parents enter the Homes, even if the elderly person actually wanted to.[137] Sixty years later, Peter D remembered the Archbishop's speech:

> I didn't know many people who had grandparents living with them. Which, you know, pox on us—we should be looking after our own, shouldn't we. We don't, though. I remember Archbishop Young, he was saying we shouldn't have to do this, Nazareth House, we shouldn't have to extend it, if people took their responsibilities seriously. You know, you have children and then they disown you.[138]

Some old people who were forced to enter a Home against their will took advantage of this suggestion that families were deserting their duties, and would pass on horror stories to upset the relatives who could not care for them, particularly daughters.

> When I went to work at Nazareth House my mother-in-law was *horrified*, because 'they do terrible things to people there'. She'd be telling me these things and I'd think, oh my God, what have I got myself into? But after I'd been there for about a fortnight, I realised, no. She had a friend whose mother had gone there, and she told her daughter what supposedly used to happen. And it didn't at all! I mean, I've seen patients down there tell their families the most atrocious lies, and I think it's to get back at them—you know, 'you've put me in here'.[139]

Whether the Archbishop was right or not, the fact is that many of the people entering the Homes were still detached atoms. In the 1950s, an entire generation of women reached old age who had never had the option of marriage and family at all. The depression of the 1890s and the massacre of young men in the Great War had left them husbandless and alone. Nancy pointed out the irony of the situation for these women.

> Lots of them didn't have family to visit. Ironically, the 'misses' were probably the ones who'd looked after *their* parents in their home; they were the last of the girls in the family, and they had minded their parents.

But whether they had a family outside or not, residents developed other relationships within the Home, with each other and with the men and women who cared for them.

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[136] Peter Laslett, 'The significance of the past in the study of ageing' in *Ageing and Society'*, 4:4(1984), 379-389

[137] Peter Davy recalled hearing the Archbishop's speech when he was a child of ten, and

[138] Interview with Peter Davy. It was actually Archibishop Tweedy, but as Peter was only eight at the time, the mistake is understandable. The fact that he remembered it at all is an indication of the influence the Archbishop's words had on the community at that time.

[139] Interview with Nancy Langley

Unlike their blood relatives, this surrogate family could be with them day and night, through good times and bad, right until the end.

'They were like grandmothers to us': the surrogate family

> After you'd been there for a little while, it was really lovely, because you had a bit of rapport with your patients and you were treated like their daughter. And really, I guess they loved us to a certain degree, because some of them had no-one else to love… We used to get a lot of 'misses', and 'misters', who had no family.[140]

Enforced living with other people can have two effects: it can drive people to introspective solitude, or it can make them bond, creating their own 'family' groups with the people with whom they spend their days.[141] Alex remembered that the ladies of Abbeyfayle were in the former group, sitting in silence, watching television.[142] But in many of the Homes, small groups would form, particularly amongst those residents who had few visitors from the outside world. Michael saw it a lot at Allambi:

> It came more of a family for them. They'd take a liking to [another patient], and let them sit beside them at the meal table. They had their own meal table, and you had to be careful, cos they were pernickety—they'd like to sit in their one spot, besides *that* person. It was a routine, like their own little families, I suppose.[143]

The shared sleeping quarters in many of the Homes also encouraged this. The James Scott Wing at Scottsdale was a case in point. It serviced a small rural community, and many of the residents knew each other before admission.

> …a lot of them quite liked the four-bed rooms, and they got to know the other people quite well and they sort of became a little family. It's always been fairly family-orientated and very friendly, being a country area.[144]

Now that single rooms with private ensuites are *de rigueur*, it is perhaps more difficult for people to make and maintain these friendships, particularly as residents become more frail and less ambulant, and more likely to be suffering from a dementing illness. But

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[140] Interview with Nancy Langley
[141] Joel Savishinsky, *The Ends of Time;* Stephen Abbott, Malcolm Fisk, and Louise Forward, 'Social and democratic participation in residential settings for older people: realities and aspirations', *Ageing and Society*, 20(2000), 327-340; Maria Vesperi, 'The reluctant consumer', in Jay Sokolovsky, (ed), *Growing Old in Different Societies*, (Belmont, CA, 1983); Dianne Willcocks, Sheila Peace & Leonie Kellaher, *Private Lives in Public Places* (London, 1987); Jules Henry, *Culture Against Man,* (London, 1966)
[142] Interview with Alex Myers. Watching television, even uninteresting programs, is a way of avoiding eye contact and therefore unwanted social interaction: Willcocks, Peace & Kellaher, *Private Lives in Public Places*, page 92
[143] Interview with Michael McKean
[144] Interview with Maureen Nichols

they still have access to the most common surrogate family bond: the one that exists between the resident and the nurse.[145]

This bond can be both beneficial and detrimental. Beneficial, because the nurse will do more for the resident and the resident will be more grateful to and compliant with the nurse, making the lives of both more pleasant and easy. Detrimental, because the resident can becoming more demanding, more jealous for attention, and when they die, the nurse suffers more emotionally. The benefits clearly outweigh the disadvantages, however, as attachment to the residents was cited by most of the participants in this study as the main reason for staying in the job, or its best part at least.[146] Many of the participants told me they were treated as a 'daughter', and saw the residents as 'grandmothers' (these close relationships appeared to be more common with the ladies rather than the men they tended). This probably reflects the nature of the intimate and domestic tasks they undertook for the residents, as well as the natural bond between an older person and a younger one, giving the aides a submissive identity as 'daughter'.

It is often said that home is not home without a mother.[147] She plays a crucial role as the person who anchors the family, establishes its culture, and determines its values. She provides the warmth and security, but she is also a figure of authority, setting standards and ensuring that familial discipline is upheld. As authority figures, the RNs or the matron often assumed the maternal role, and in the smaller Homes it was usually the matron, as at the Lillian Martin Presbyterian Home in Hobart:

> On one occasion I heard Matron referred to by a male patient as "Mother Cato". That aptly describes her, for she exerts that loving consideration, yet controlled discipline, necessary in any large family.[148]

The literature shows the importance of the matron in making a Home a home.[149] Her authority means that her attitudes are the main influence on staff and residents, and a

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[145] Sumaya-Smith, 'Caregiver/resident relationships': this study found that 92% of respondents reported surrogate family bonds.
[146] And in other studies; see Sumaya-Smith, 'Caregiver/resident relationships', page 449
[147] See, for example, the popular song 'What is home without a mother', written by Alice Hawthorne (Septimus Winner) in 1854, a sentiment echoed by many in art and music.
[148] Bell Thompson, *The Key of the Door: The story of the Lillian Martin Presbyterian Home*, (Hobart, 1977), page 7
[149] See, for example, 'Care of the aged', *Monthly Labour Review*, 30:1(1930), 100-105, page 101; Helen Bartlett, *Nursing Homes for Elderly People: Questions of Quality and Policy* (Chur, Switzerland, 1993), page 135; Shaw, *Old People in Homes*, page 17, pages 155-6; Davies, *Into the House of Old*, page 132

caring matron could make a great deal of difference, particularly before the implementation of government accreditation and the monitoring of standards and outcomes in the Homes. In the smaller Homes, the matron would also be a constant presence, living on the premises and always being on call. At Nazareth House, the nuns fulfilled this role.

> The nuns would go around and say goodnight to everybody, and check on them. I think most of the residents got to trust the nuns, because they were like a mother to them, I suppose. [When the nuns left], they missed them. There was nobody there—the DON only works till 5.30pm, so there was nobody there to do that, but the nuns were there twenty-four hours a day.[150]

Dorothy was also there for her residents twenty-four hours a day, seven days a week, sacrificing family life and leisure time to look after the residents of first Bethshalom and then Sunny Brae for over forty years.[151] Dorothy's situation was quite unusual, in that her real family and the surrogate 'family' lived together in the one house to begin with, a situation more common in the UK, where many very small Homes were run by ex-nurses in conjunction with domestic arrangements.[152] She said that having the children there "made it homely for the residents", but she knew it was a difficult situation for them and they struggled at times with a lack of privacy and space. The family eventually moved into the house next door, but they continued to help at the Home until she sold it in 1998. There were other children around at Sunny Brae, too. Maureen B took hers in when they were babies.

> I worked up until I had a caesarean—the day before, I think! And then I went off and had [my son], and then I went back to work. I was only doing a few hours a week, and I took him with me when he was little, because I was feeding him. He used to sleep in the side room, and I'd duck in and feed him when I needed to. He was a Sunny Brae baby, and so was my daughter. I had her the following year, and pretty much the same scenario.[153]

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[150] Interview with Judy Wall, corroborated by Barbara Allen. Nazareth House was sold to Southern Cross Care in 2006, which renamed it Mount Esk.

[151] On the wall of Dorothy Morse's living room is a picture executed by a family member of one of the residents of Sunny Brae. It shows the old ladies sitting in their chairs in the living room of the Home, with Dorothy bustling around bringing afternoon tea. They are all depicted as Beatrix Potter-style rabbits, with Dorothy is the matriarch of the warren.

[152] Gavin Andrews and Sally Kendall, 'Dreams that lie in tatters: the changing fortunes of nurses who left the British NHS to own and run residential homes for elderly people', *Journal of Advanced Nursing*, 31:4(2000), 900-908. In the US, small family-style Homes had been common before World War II, but these disappeared in the 1950s when new regulations made it difficult to satisfy legal requirements, and new funding provisions made aged care a potentially profitable industry for larger players. Bruce Vladeck, *Unloving Care: The Nursing Home Tragedy*, (New York, 1980), page 104-5

[153] Interview with Maureen Battese

As they grew up, Maureen B continued to take her children in to visit and later, her grandchildren, too. They became part of the family. Other staff also developed close relationships with the residents: one nurse chose to hold her wedding in the lounge room at Sunny Brae, with the residents as guests.[154] The staff at Nazareth House also took their children in to work with them occasionally. Eileen's daughter went to sing for the residents, and Margaret found the nuns very flexible when family responsibilities arose.

> When I had to start work at 8 o'clock and my last child was still at primary school, the nuns said "oh, you can bring in your little boy in with you! He can sit in the nice warm lounge and watch a bit of television." So he would come with me until about twenty past eight, and he had a lovely time because one of the old ladies loved playing marbles with him. "Do you play marbles?" she said to him. "Oh, yes, I'd love to play marbles"… so he'd play marbles with Adeline, who was about eighty, I suppose.

Most of the aides in the Homes had children. In fact, bringing up those children was often the only qualification they had to carry out their work, which was similar to the domestic duties with which they were familiar. Despite their lack of training or specialized knowledge, they found themselves welcomed and even courted by the Homes. Although the work could be heavy and, at times, unpleasant, the sense of being needed and 'making a difference' meant that many stayed in the job for many years. The personal and caring nature of the work also appealed to the less educated and qualified man, too. Both Peter D and Michael were working in unskilled manual jobs before finding work in the Homes and realizing that this made them feel worthwhile.

> I *loved* Cosgrove Park, it was wonderful. It gave you a sense that you were … were *doing* something, you were achieving, helping other people, which was something that a person with grade eight education wanted to do. You know, to do something that was important—or that *you* thought was, and helping older people live comfortably *was* important. Helping people is the most wonderful thing you can do, I think.[155]

It appears the major reward of the job was not monetary; it was the social relationships the nurses developed with the residents and also their co-workers. Judy was typical:

> I was [at Nazareth House] for thirty-one years, and our workmates were always our very best friends. We all got on so well together, and everybody cared for everybody else. When I first retired, I didn't miss the work but I missed the people I worked with, the friends.[156]

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[154] Interview with Dorothy Morse
[155] Interview with Peter Davy
[156] Interview with Judy Wall

Kay went further, seeing her workmates at Cosgrove Park as 'one big happy family', and Eileen, a recent arrival from Ireland, found a second home at Nazareth House.

> The staff became like an extended family, and it was a very supportive environment. We worked really hard, but somehow you felt like you belonged there. The nuns really cared for the staff as well as the residents, and even though you'd complain about them sometimes, they took an interest in you. They'd ask about your family, and they'd remember things. They took an interest when I was going to do nursing, and they were very proud when I graduated.[157]

Clearly, surrogate family relationships were important, to residents and staff alike. These bonds could be particularly strong at the end of a resident's life, particularly if he or she had no family to share their final hours.

> I remember one lady, she was a Catholic and she wasn't expected to live long, and the priest came up to give her the last rites. I took him into the ward and he said "would you like to stay?" and I said, "oh, I'd love to", and she passed away in my arms… Because, as I say, they were just like grandmothers to all of us. We were very close to our patients in them days.[158]

Kay wept a little as she told me this story, the emotion still strong despite a thirty-year interval. Peter D also shed tears over the remembered death of a resident for whom he had cared many years earlier, a workmate of his father's. Both worked at Cosgrove Park, and they were able to spend the last moments with these residents because they died during the day. At night it was far more difficult, when fewer staff were rostered. Claire remembered busy nights at St John's Park in the 1950s, when five or six deaths a night might keeping her running backwards and forwards to the mortuary.159 But at Nazareth House, the nuns made sure that no-one ever died alone. No matter what time of the night or day, someone from the order would sit with the person until the end. At Sunny Brae, too, Dorothy would always stay with a dying resident. When she retired, Maureen B (who had been there as long as she had, and who took over her position) kept up the tradition, but this personalized service finished when the Home was bought out by the management of the much larger Aldersgate in 1998.

> They didn't approve of that, they just thought that whoever was on duty could cope. And fair enough too, I understand that, but it was just something special that I could do, the last thing I could do for the resident and for their family. Just to be there and be able to talk with them, just let them know that we really cared.[160]

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[157] Interview with Eileen O'Leary
[158] Interview with Kay Joyce
[159] Interview with Claire Paynter
[160] Interview with Maureen Battese

For many residents, the deathbed was the only time they saw their real family.

> Some of the families, you didn't see from one year's end to the other, and then when it came time, when they were passing on, the family'd come out of the woodwork—you couldn't get through the door for people![161]

> Some of them had families but they didn't visit. I remember one lady, she was dying and she kept calling out for 'Stephen, Stephen'. She hadn't been married, and he was her nephew; he lived in Hobart. And I know they tried to get Stephen to come up, but Stephen *never* came. My colleagues would say 'bastard'. But Stephen turned up when she was dead, didn't he![162]

Others saw them more often, and this could be a mixed blessing.

The real family

> It was open slather on visiting hours—they could come any time of the day or night.[163]

Throughout the 20th century, most Homes, both public and private, had very flexible visiting hours, and friends and family could come at almost any time. [164] Despite this, the majority of the residents received few visitors. Many had no family to visit, of course—that is why they were in the Homes in the first place. This might seem sad, but sadder still is the evidence that their situation might have been preferable to what some people who did have families had to endure.

Families are not always protective and nurturing. Some are neglectful, and some may even be a 'source of suffering and hardship'[165], as in the case of one couple who applied for admission to Cosgrove Park to get away from their adult sons, who were unemployed and 'responsible for many of their parents' debts'.[166] Once within the Homes, the residents could be sure of continuing care and attention, but they were not always completely safe from importuning relatives, at least not at first. At Cosgrove Park in the early 1960s, the residents paid part of their pensions for their care and received the balance in cash, and some family members took advantage of this face.

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[161] Interview with Kay Joyce
[162] Interview with Eileen O'Leary
[163] Interview with Judith Beard
[164] Interviews with Judith Beard, Kay Joyce, Peter Sweeney, Claire Paynter, Barbara Allen, Nancy Langley, Eileen O'Leary, Dorothy Morse, Maureen Battese, Maureen Nichols. Even in the more 'closed' institutions such as St John's Park in 1957, visitors were admitted at all hours with the permission of the officer in charge of the shift: AOT, HSD222/2/2
[165] Scott Coltrane, *Gender and Families*, (Thousand Oaks, 1998), page 78
[166] AOT, AD203/1/1850 8/5/1 Reports on prospective residents, 24/8/1964

> I remember one little old lady there, she used to be given her little bit of pension, and the only time she ever saw her son was that night, and she'd give him the money.[167]

> One week was tobacco week, and the other week was pension, and there was always half a dozen people who'd see their family twice a fortnight—on tobacco day and pension day.[168]

One of the benefits of living in a Home is that the resident is not alone and therefore not as vulnerable. Senior staff noticed the pattern, and pressed for change to the arrangement. The money began to be paid into the residents' bank accounts, and their small savings were kept safe.

Sometimes the workers in the Homes preferred it if families stayed away. The literature shows that the relationship between families and caregivers is an ongoing source of tension in Homes. This is because real families have expectations of the standard of care that is given to their relatives, and these cannot always be fulfilled to everyone's satisfaction. The families may see the Home employees as too narrowly focussed on practical care, neglectful and difficult, a situation not helped by the constant reminders in the media about abuse and neglect in Homes.[169] In turn, the staff may see relatives as fussy, demanding and interfering, and a challenge to their authority.

> They weren't encouraged to come in, they really weren't. They were probably seen as unwelcome intrusions if they tried to be part of it, which is terrible, isn't it? It depended a little bit on the individual staff members' attitude, but certainly a lot of the staff found them to be a bit of a nuisance if they interfered! The nuns had a bit of the same attitude, really. *They* were there to care for them now.

But there were also warm and mutually respectful relationships, and several participants in this study spoke affectionately of particular family members who came in to visit their relatives regularly and with whom they developed strong bonds. The families occasionally bonded with each other, too. Maureen B remembered one group of women whose association was strong enough to even withstand the death of their relatives:

> The six single rooms were filled with six delightful ladies, all with delightful families, daughters or nieces, and they all got to know each other and they all

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[167] Interview with Kay Joyce
[168] Interview with Peter Davy. Peter and Kay Joyce explained that the majority of the male residents were war veterans, and were supplied with tobacco once a fortnight by charitable bodies such as the Red Cross.
[169] See, for example, Barbara Bowers, 'Family perceptions of care in a nursing home', Emily Abel and Margaret Nelson, (eds), *Circles of Care: Work and Identity in Women's Lives*, (Albany, NY, 1990)

> interacted, and some of them are still friends now, years later, and still meet up occasionally. And that was just really special, a real community.

* * * * *

Ironically, it was the government itself that began to undermine its own 'Home as home' philosophy, when they introduced an Intensive Care Nursing Home Benefit in 1968. This gave extra money to bedridden patients, and allowed the Homes to hire more staff and give higher care, but in return those in charge were required to fill in more paperwork and spend an increasing amount of time on administration. They also had to provide higher standards of accommodation and living conditions, far beyond those of a domestic home. It was the start of the era of 'Home as business', and it was the beginning of the end of the small proprietary Home, many of which could not afford to provide the required facilities. The introduction of the Nursing Home Standards and Outcomes in 1987 increased the administrative burden still further, and a new funding instrument, the Resident Classification Instrument (RCI) introduced in 1988, made care plans and paperwork all-consuming. The few small Homes that had weathered the storm gave up, closing their doors and selling their beds to the larger companies and organizations that dominated the sector. Now the small domestic-style home has gone forever, replaced by increasingly larger buildings that hark back to the institutional roots of the sector.

Some of the homely touches have remained. The strict formality of the past has disappeared, replaced with familiarity and equality between staff and residents. The residents are given a say in their own care, and first names are customarily used now. It might be hard to imagine a warm and intimate friendship between 'Mrs Clarke' and 'Matron McClymont', let alone a surrogate family bond, but 'Nancy' and 'Elsie' can certainly be friends. The décor of the Homes is more attractive, the furniture more domestic (although hospital beds are still necessary for the increasingly frail residents), and there has been a move towards providing more and smaller living areas, to allow for more privacy for visits with family and friends. The staff uniforms, too, are less hospital-like in many Homes, but most Homes still have them. The white nurse's dress and veil has gone, to be replaced with a corporate uniform, often with the company logo prominently displayed upon the shirt or jacket. Such a dress code only reinforces the

difference between inmate and staff member, as uniforms create a barrier that no amount of nurturing care can neutralize.[170]

Nursing homes are the only welfare institutions that still exist in a similar form to their earliest design—large, group-living houses that provide shelter to a great number of people with nothing in common except a single demographic factor, in this case, age. The other mass-care institutions of the early welfare state have gone: orphanages replaced with foster care, lunatic asylums and homes for the disabled with community care and small group houses. But except for the brief interval in which smaller, domestic-style Homes were both encouraged and feasible, large-scale nursing homes continue to be the norm, spread widely throughout Australia and the industrialized world. And they operate under an increasing number of rules, regulations, policies and standards, which keep the residents in safe hands—and the operators too, as the next chapter will explore.

Plate 8: A publicity picture from St John's Park emphasizing the 'home atmosphere' of the facilities, c1972[171]

[170] Mike Walsh and Pauline Ford, *Nursing Rituals, Research and Rational Actions*, (Oxford, 1991)
[171] St John's Park Hospital information brochure, Department of Health, (Hobart, c1972)

Plate 9: Liz Barron, as DON of Umina Park Nursing Home, with one of the residents in single-occupancy, individually decorated bedroom, c1995[172]

Best Friend (for May)

I have come all this way
to find a best friend.
That's her there,
In the next chair.[173]

[172] Photograph courtesy of Elizabeth Barron
[173] Emma Saunders, 'Best friend', in Robyn Friend, (ed), *Fancy Seeing You Here: A Collection of Writing by Residents of Nursing Homes in Launceston and the Tamar Region*, (Launceston, 1989), page 113

Chapter 7

Home as Business: control revisited

> Southern Cross do a good job, but it's really a business, isn't it. Look how many homes they've got—they've got quite a monopoly now. I mean, Glenara [Lakes, a new five-star aged care facility], it's beautiful, but it's not a home. Nazareth House has never been the same since the nuns left. The nuns saw the residents as people, whereas the business sees the residents as dollars.[1]
>
> The nuns weren't business people, and they had run Nazareth House into the red in a big way. It's run by a Board now, and there were some changes which involved cutting hours and some services, fine-tuning a whole lot of things so that the place was actually viable. Without them, we would have all lost our jobs.[2]

When the Australian federal government began to provide grants and subsidies to organizations to build and run Homes for the elderly in 1954, they also began to keep a closer eye on how those Homes were run. During the second half of the 20th century, they introduced a series of policies to monitor and control residential aged care.[3] Homes were required to hold a licence to operate, and regular inspections became necessary in order for them to receive government financing. By the end of the century, the somewhat *ad hoc* provisions of the earlier Homes have been replaced with a carefully structured and well-organized industry.

The operators of Homes are now compelled to provide facilities and conditions that reach a standard determined by a statutory body, the Aged Care Standards and Accreditation Agency Ltd. The staff who work within the Homes have become more accountable, and require more qualifications. These changes have improved the quality of the Homes and enhanced the lives of the residents in many ways, but they have also had less beneficial consequences. More rules, more paperwork, and less room for individuality in service provision have meant that the Homes have become more businesslike, with an increased emphasis on both quality and efficiency. The smaller, more homelike Homes have disappeared altogether, conquered by an avalanche of regulations with which they could not comply. The large organizations that have replaced them often own multiple

[1] Interview with Nancy Langley
[2] Interview with 'Margaret'
[3] Francesca Beddie, Putting Life into Years: The Commonwealth's Role in Australia's Health Since 1901, (Canberra, 2001)

properties with standardized facilities and a corporate mentality. Homes have become 'aged care facilities', the residents are 'clients', and financial considerations have attained a higher priority than in the past. These changes have affected not only the residents but also the staff, and as the opening quotes suggest, opinions are varied as to their benefit.

This chapter will explore how the growing web of policies, rules and regulations introduced during the second half of the 20th century affected the Homes and the people who lived and worked within them. It does not consider the policies themselves; as explained in Chapter 1, there are many publications that do this in far more depth and detail than is possible within the scope of this thesis.[4] The first section of the chapter examines how an increased requirement for accountability to government and Agency bodies affected the routines and practices within the Homes for the RNs and the aides. The second section explores the ways in which the government sought to limit access to the Homes to control the burgeoning demand for beds, through the development of community care services and the introduction of assessors to guard the gates. The final section shows how the Homes, in fulfilling their responsibilities, have used the regulations put in place to keep *them* controlled to once again gain control over the residents and keep them 'in safe hands'.

Controlling the Homes

> The nursing homes and hostels industry is one which is in receipt of significant amounts of government funding. It is also one where facilities and individual staff are able to exercise considerable control over the lives of residents. In the general societal climate where greater accountability is being sought in a number of ways, it is appropriate that these issues will be reflected in changing requirements of the industry itself.[5]

Before 1954, the Australian government played little role in the provision of formal aged care services. In Tasmania, the state government ran two public institutions, one in each of the two main cities, and a number of private Homes were operated by charitable and religious groups, and by smaller proprietary operators. Apart from compliance with Fire Brigade and building regulations, there were few bureaucratic requirements to run a home. This changed in 1954, when the federal government passed the *Aged Persons' Homes Act* in 1954 to fund the building of new Homes by approved philanthropic groups,

[4] See Chapter 1, literature review, page 10
[5] Chris Ronalds, *Residents' Rights in Nursing Homes and Hostels*, (Canberra, 1989), page 7

and again in the 1960s when they began to provide a number of subsidies to all Homes, as long as these delivered an increasing variety of services and a greater level of care. In return, the government assumed increased control over the Homes, and regular inspections became a condition of licence. The inspectors reported on the condition and cleanliness of the rooms, kitchen and bathroom arrangements, hygiene, the state of the grounds, emergency equipment, and the number of staff members and their qualifications.

A further level of control was introduced in 1987, when it became necessary for Homes to gain official accreditation to operate. They achieved this by proving compliance with a series of thirty-one standards and outcomes, covering management and staffing, health and personal care, resident lifestyle, and physical environment and safety. The inspections became more detailed, and other more ephemeral aspects of the Homes, such as atmosphere, privacy, and staff knowledge, came under scrutiny. To gain accreditation, a Home had to satisfy the criteria in all four areas, and ongoing monitoring inspections involved the latter three.[6] The monitors were no longer satisfied to judge the Homes on the visual evidence of a single visit; the Homes were now required to provide proof of compliance with these standards on an ongoing basis. The answer was a vast increase in paperwork, to provide an enhanced level of accountability. This section will examine three key aspects of that accountability: patient care records, medication management, and staff training.

Patient care: nursing notes and care plans

> When I was in charge of the shift I had to write a report, and that was just, 'so-and-so had tablets' and 'so-and-so played up', and sign it. Then later on, in the eighties or nineties, it was something for every patient, which took a lot more time. And that takes away from the time you can spend with patients. The nurses didn't have much to do with the patients later on because they had that much bloody book work, it was ridiculous.[7]

Before the 1980s, patient records were minimal in the Homes. The HFI did not even keep patient files, although the nurses would write a brief report in a notebook to let their replacements know what, if anything, had happened during the shift.[8] These notes were

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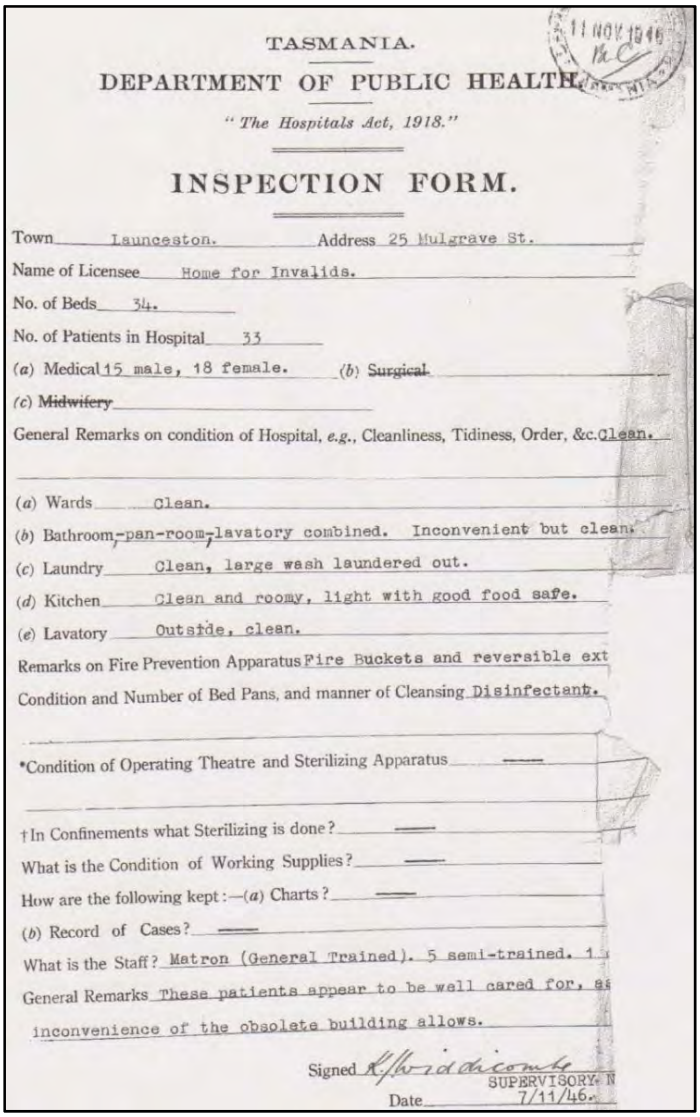
[6] Commonwealth/State Working Party on Nursing Home Standards, *Living in a Nursing Home: Outcome Standards for Australian Nursing Homes*, (Canberra, 1987). These have increased over the years, and there are now 44 outcomes which need to be addressed.
[7] Interview with Peter Davy
[8] Interview with 'Eleanor'

probably informal and transient, as the Inspection Report shows that no charts or case records were kept at the HFI in 1946 (see plate 1 below).[9]



TASMANIA.

DEPARTMENT OF PUBLIC HEALTH.

"The Hospitals Act, 1918."

INSPECTION FORM.

Town Launceston. Address 25 Mulgrave St.

Name of Licensee Home for Invalids.

No. of Beds 34.

No. of Patients in Hospital 33

(a) Medical 15 male, 18 female. (b) ~~Surgical~~

(c) ~~Midwifery~~

General Remarks on condition of Hospital, *e.g.*, Cleanliness, Tidiness, Order, &c. Clean.

(a) Wards Clean.

(b) Bathroom-pan-room-lavatory combined. Inconvenient but clean.

(c) Laundry Clean, large wash laundered out.

(d) Kitchen Clean and roomy, light with good food safe.

(e) Lavatory Outside, clean.

Remarks on Fire Prevention Apparatus Fire Buckets and reversible ext

Condition and Number of Bed Pans, and manner of Cleansing Disinfectant.

*Condition of Operating Theatre and Sterilizing Apparatus ——

†In Confinements what Sterilizing is done? ——

What is the Condition of Working Supplies? ——

How are the following kept:—(a) Charts? ——

(b) Record of Cases? ——

What is the Staff? Matron (General Trained). 5 semi-trained. 1

General Remarks These patients appear to be well cared for, as

inconvenience of the obsolete building allows.

Signed [signature] SUPERVISORY N

Date 7/11/46.

Plate 1: Inspection report for the Home for Invalids, Launceston, 11th November 1946.[10]

St John's Park also used a report book in each ward, which was completed by the senior staff nurse to hand over to her replacement on the next shift. Communications rarely extended beyond the ranks of the senior staff, however, as the nurses followed their customary routines.

> Every now and then we used to get an oral report from the matron. We'd all have to meet in her office and she'd have a talk to everybody. The senior nurse on

[9] AOT, HSD6/1/562 Inspection report, 11/11/1946
[10] AOT, HSD6/1/562

> each shift did a handover, the senior nurses used to have a chat between themselves. They'd pass on to us what to do, but not to any great extent.[11]

By the 1960s, the government funding for 'private medical establishments' meant that Homes were required to have a qualified RN on staff and to keep more comprehensive patient documentation. At Bethshalom, Dorothy "had to keep the same records as you did in any hospital, files for each person and a daily record."[12] Most Homes had a diary in which the RN in charge would note briefly any incidents or treatment needs arising during the shift, with a particular emphasis on bowels, and bedsores.[13] Nazareth House was a little more informal, as the nuns were in charge and they were not so hospital-oriented as the trained nurses who ran most of the other Homes. Before RNs were employed in the 1970s, the aides would hand information on orally to the aide on the next shift, rather than to the nuns, especially if they were on retreat, "which meant they weren't allowed to talk to you".[14] Very little was reported; Roz remembered that handover for the whole Home, for one hundred and six residents, took about 'ten minutes' and was almost entirely concerned with physical changes or problems.[15] At the smaller Homes, there was little need for formal handover either, as the matron was on the premises twenty-four hours a day and therefore knew the residents' state of health without notes.[16]

The use of a single reporting book was widespread until the 1980s, when individual care plans began to be formulated for residents in order to address their needs more comprehensively. At first these were still quite short and focussed on physical needs.

> They had care plans for anybody who needed dressings on wounds, or if they had impacted bowels and needed manual removals or bowel preps, but a lot of them didn't really have a care plan because they didn't need a care plan.[17]

The introduction of a Resident Classification Instrument (RCI) in 1988 made care plans and paperwork all-consuming, as psychosocial and cultural aspects of care also began to gain prominence alongside the customary physical measures. Whilst the aides continued

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[11] Interview with Claire Paynter
[12] Interview with Dorothy Morse
[13] Interviews with Kay Joyce, Peter Sweeney, Peter Davy, and Pat Job
[14] Interview with Nancy Langley, corroborated by Judy Wall
[15] Interview with Roz Wilson
[16] Interviews with Dorothy Morse, Maureen Battese, and Alex Myers
[17] Interview with Helen

to provide the hands-on care, the RNs found themselves more and more caught up with these time-consuming reports, affecting the time they could spent with the residents and thus the quality of care that they felt they were able to provide. The increasing load of paperwork was commented on by most of the participants in this study, many of whom declared it to be the worst aspect of their job.

> It made things much more difficult, because we had to spend as much time with paperwork as we did with our residents, so it was so rushed and you didn't have time as you used to do.[18]

Although no-one liked doing the paperwork, there were differences in the opinions held by the aides and the RNs regarding the value of care plans. Aide Barbara believed that they were completely unnecessary ("you used your common sense—everything was just done by common sense"[19]), but Maureen N, who was Director of Nursing at the Scottsdale hospital and its attached Home wing, disagreed. Although she admitted that the extra requirement did take a great deal of time, she also acknowledged that the lack of documentation in the past had probably contributed to poor or negligent care at times.

> …it's making sure that all these things are done. We do have to have these check points. There'll always be nurses that are super-duper competent and efficient and compassionate, and there'll always be those who are slack and lazy—nurses are human! And *anybody* can make a genuine mistake, too—a lot of mistakes are fairly simple and don't do any harm, but others, you know, you could kill somebody. [The paperwork is] making it safer. Mistakes were made in the past, and I guess they'll still be made, but you've got your checklist and you're ticking more boxes and trying to make the system more fool proof. I think that's got to be for the better.[20]

I have been unable to gain access to any old nursing notes for any Home, public or private, to illuminate the practices within the Homes. Privacy requirements and a lack of understanding of the importance of such records have probably contributed to their destruction or disposal, but there is evidence that they could not necessarily have been relied on completely anyway, for several reasons. First, it has been suggested that as funding for the Homes depends on the level of resident care needs, there is a temptation to falsify the records and report a resident to be sicker or more dependent than he or she

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[18] Interview with Judy Wall. Bruce Vladeck noted that 'no complaint is more frequently voiced by nursing home staff, nor more worthy of sympathy, than that the backbreaking load of regulation-induced paperwork can only detract from the quality of care', but that they were carefully kept as the gave the inspectors 'something to look at.': *Unloving Care: The Nursing Home Tragedy*, (New York, 1980), page 153

[19] Interview with Barbara Allen

[20] Interview with Maureen Nichols

really is, in order to receive more money.[21] Whilst no participant in this study admitted to such misrepresentations, Peter D hinted at such practices at Cosgrove Park[22], and it is highly likely that other Homes also did so, particular as there is strong evidence that this practice is still carrying on.

> A 77-year old man who cannot speak and can only move his eyebrows has been labelled physically threatening and verbally disruptive by his aged-care home on government funding applications. … A similar assessment was given to another [resident], a 76-year-old woman who has multiple sclerosis. [Her children] were horrified to discover that their mother, who can only move one hand, was described as being constantly physically agitated … verbally refus[ing] care and verbally disrupt[ive to] others…[23]

There is also a tendency for those in charge to report what should be done rather than what is done[24], particularly when the RN writes the report about work done by staff lower in the hierarchy. One RN who participated in this study admitted that on night duty, she would sleep "nearly all night, and let the nurse's aide do all the work", filling in her report in the morning based on what she was told.[25] But even when the RNs were not taking unauthorized breaks, they were often still gathering information at second hand. As an attendant at Allambi, with no nursing qualifications, Michael could take care of a patient's nursing needs but not write the report on his actions or observations.

> I could pass it on and they could check it and confirm it. You'd tell them what you've done, and they'd go and write it down but they haven't actually done it. They'd go and check, but sometimes they didn't even check, they just assumed you'd done it.[26]

There is one aspect of care, however, that must be carried out and documented by the RN in person. This is the administration of an increasingly large and diverse range of

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[21] John Braithwaite, 'The Nursing Home Industry', *Crime and Justice,* 18(1993), 11-54; Timothy Diamond, *Making Gray Gold,* (Chicago, 1992); Nancy Foner, *The Caregiving Dilemma,* (Berkeley, CA, 1995)
[22] Interview with Peter Davy
[23] The *Australian,* October 3rd, 2011: 'Immobile mute Melbourne man a 'threat', carers claim on funding application'. This is another example of the type of negative publicity that the aged care sector attracts.
[24] Victor Minichiello points out that "informal practices of an organisation may be excluded from the records because they can contradict officially expressed policies" in 'Admitting nursing home residents: a case study in policy implementation', in Hal Kendig and John McCallum, (eds), *Grey Policy: Australian Policies for an Ageing Society,* (Sydney, 1990), page 170
[25] Valerie Yow claims that people are more rather than less willing to be candid with the passage of time; this shows the strength of oral history to elicit those details that would never end up in the official records for fear of reprimand: *Recording Oral History* (Walnut Creek, CA, 2005). Several participants talked about 'other nurses' who did similar things on night duty, but this RN was the only one to admit to taking advantage of her senior position to get some extra rest. She approved the use of the story, but I have not given her name as the practice would have been subject to disciplinary action, and even with the passage of time there may be repercussions.
[26] Interview with Michael McKean

medications to a resident population with a greater number of illnesses and chronic conditions. The paperwork associated with the drug round, and the drug round itself, have become an increasingly important and laborious aspect of the aged care RN's daily routine.

Charts, trolleys and locked doors: drugs and the drug round

> In 1982-83 Departmental officers have made a determined effort to improve the standard of drug storage and dispensing within private medical establishments. New stationery and measures to protect the nursing staff have been introduced with apparent success.[27]

It is interesting to note that when the state government decided to instigate new rules to regulate the administration of medications in Tasmanian Homes, it specified that these measures were taken to 'protect the nursing staff', rather than the residents. Prior to 1982 the Homes had kept minimal drug records, and the arrangements for medication administration and storage were basic at best. The lack of formal paperwork was of little import in the 19th century and in the first few decades of the 20th, as there were very few drugs used in the Homes anyway.[28] As an increasing number of medications became available after the Second World War, the Homes began to keep lists. At Cosgrove Park in the 1960s and 1970s, these were handwritten by the nurses, and pinned up in the 'mixture cupboard', and there was no record of when, or if, these were administered:

> Drugs were given according to the general medication list—there were no individual charts in those early years. It was just accepted that if the drugs were ordered, they were given on time. We were permitted to administer non-dangerous drugs at our discretion, and anything that was given without an order, like [cough mixture], analgesics or antacids, were noted in the general report.[29]

Even where drug charts existed, such as in the long-stay wards attached to general hospitals, they were also written up by the nurses, who wrote down the doctors' prescriptions but did not need to have them signed.[30] It was not until formal drug charts were introduced in the early 1980s that the doctors themselves were required to write up the charts. This ensured that they took full responsibility for the drugs prescribed, thus providing the nurses with that protection mentioned earlier.

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[27] TPP, 211, 1984, Paper 9, page 23
[28] See Chapter 4, pages 125-126
[29] Interview with Elaine Sturzaker; confirmed by Judith Beard and Peter Davy
[30] Interview with Maureen Nichols

The drug charts required nurses to give out medications on a stricter schedule, and to sign that they had been given. But sometimes doctors would prescribe new drugs and not 'un-prescribe' the previous ones, which led to a great deal of over-medication. Another safeguard was put in place during the 1990s and early years of the 21st century, to monitor the doctors' actions—the pharmacist review.

> We have accredited pharmacists who go through the drug charts and look at what people are on, and if they think somebody's on too much, or it could be improved with another drug, they write to the doctor. So there's another little checking system. That's mostly been happening in about the last eight years, and it's an annual thing.[31]

The administration of medicines was another area that came under increasing control. Prior to the employment of an RN on every shift in the Homes, unqualified staff would administer medications, as no restrictions existed on such practices. At Cosgrove Park, Judith supervised the day shift in the men's division, but she was not replaced when she finished at 3pm and the senior attendant gave out the evening drugs. If she was unwell and there was no-one to relieve her, they stood in then as well.[32] At Nazareth House, the medications for the day were prepared by the nuns and given out by the aides. Even when RNs were employed, the day shift RNs and aides still handed out medications that had been put into pill trays by the RN on night shift. Roz fought against this practice, but it was not until the accreditation process began in 1987 that things really changed. The Home acquired a "proper medication trolley and dispensed from the charts, as you should do".[33] The aides were no longer allowed to give out pills at all, which Barbara found frustrating.

> When the RNs took over the medications, we weren't allowed to do it anymore. Now we're not allowed to even give a Panadol, or something—it seems silly when an RN has got to stop what she's doing and give someone a Panadol.[34]

Most Homes had a room in which the drugs were kept (few allowed the residents to keep their own—for their own safety), but there was very little security. At St John's Park in the 1950s, even the junior staff members had a key to the cupboard[35], and at Cosgrove Park the drug trolley was unlocked, and covered with a towel when not in use, a practice

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[31] Interview with Margaret
[32] Interviews with Peter Davy, and Kay Joyce
[33] Interview with Roz Wilson
[34] Interview with Barbara Allen. Panadol is a brand name for paracetamol (acetaminophen), available in supermarkets and pharmacies with no prescription and few restrictions on sale, and commonly used by the general public without any need for nursing supervision.
[35] Interview with Claire Paynter

that continued until the introduction of the new regulations in 1982.[36] Dangerous drugs such as morphia were the only medicines that were carefully monitored in the Homes, and this meant that staff could sometimes take advantage of access to lower schedule medications. Pat remembered one staff member at the Queen Victoria Home who was caught taking a resident's sedative tablets, to feed an addiction. She also admitted that she and her fellow nurses frequently took the residents' chlotride, a diuretic tablet, to try and lose weight.[37]

Some participants mentioned drug administration errors in the days before documentation: the wrong tablets given, the omissions, the close calls which could have had tragic results.[38] Whilst such errors still occur even with more comprehensive regulation and documentation, there is no doubt that the controls have helped to reduce mistakes. The new regulations might have been intended to protect the nurses, but they assuredly protected the residents too.

Nurses' aides to PCAs: the transformation of the untrained nurse

> There was no training [in the 1980s], and no way of knowing who was good. Now they go through a proper interview, police check, references, all that. And they start under the condition that they get their Certificate III, if they don't already have it. Most of the carers who are employed have been to [college] and have done one of their certificates, and then they go on and do Certificate 4 and become trained carers.

One of the major changes that occurred in the fourth quarter of the 20th century was the instigation of official training for care staff. Once, aides learned on the job and were given no formal training in any aspect of tending to an elderly resident. The majority of these untrained staff members were women with children, and they relied on common sense and domestic experience. Their duties were often wide ranging and they sometimes carried out nursing care that went well beyond the simpler activities of personal hygiene, toileting, and feeding that might commonly be associated with the job.[39]

In the 1970s, many Homes began to run formal education sessions for the aides, although most of these concentrated on two activities only: manual handling and fire drill. Whilst

[36] Interview with Judith Beard and Elaine Sturzaker
[37] Interview with Pat Job
[38] At the request of the participants no specific examples will be given, due to possible legal ramifications.
[39] See Chapter 4, page 143

both of these are important for the safety of the residents, it could be argued that those in charge were more concerned with protecting themselves against compensation claims from injured workers or bereaved families than resident wellbeing. It was not until the beginning of the 21st century that formal certification became a legal requirement for staff within the Homes, with aides required to attend classes at accredited tertiary education schools and colleges. The implementation of scope of practice and certification has meant that all aides now have some level qualification, and they are not allowed to carry out activities or treatments that they are not qualified to do. Barbara and Nancy both expressed their frustration with no longer being able to carry out what they had seen as 'their' responsibility for many years. Nancy now works as a volunteer in the Home she worked in for over thirty years, and was surprised by the limitations she faces:

> I'm not allowed to feed a patient or anything like that, because I'm not a member of staff, and I'm not 'trained', even though I worked there for years! I said to [the Director of Nursing] a few weeks ago when they were crying out for staff, "I'll come down and do a shift for you", and she said, "You'll have to go and do the course first". I said, "You're joking!" I couldn't be bothered. I worked there for thirty-three years, and did most of it on my own, but I didn't have that bit of paper…[40]

But whilst the aides might find the restrictions to their activities frustrating, again the RNs tend to disagree. As in other areas of care such as restraints and drug administration, the trained nurses weighed up the benefits to residents rather than convenience for the staff, and supported the need for these restrictions and regulations. And of course, as they are responsible for the practice of the aides who are subordinate to them, they are also protecting themselves.

The RNs are also subject to ongoing training now. In the twelve months before we spoke in 2009, Margaret, who works at one of the newest and best appointed Homes in the state, had undergone in-house training courses in fire drill, manual handling, elder abuse, chemical competency, cardio-pulmonary resuscitation (CPR), legal responsibilities of medication management, behaviour assessment education, and safety awareness.[41] Drug calculations, CPR and fire training are carried out yearly, and the aides also undergo many of the same education classes. Whilst the provision of staff training and the

[40] Interview with Nancy Langley
[41] Interview with 'Margaret'

increase in documentary requirements have certainly benefited the residents and the staff, there is also a more cynical reason for their existence, as Maureen N suggested.

> It *is* really frustrating that you've got to document everything—'if it's not written, it's not done', but that's as it is, people sue these days and how do you prove the care was given if it's not written down. [Nurses say] there's no longer time to do the patient care, it's all paperwork. And it is frustrating, but if you haven't got the form, ticked all the boxes, you can't prove that it was done.[42]

Training courses provide that vital piece of paper to prove that something has been done, but training is not in itself a guarantee that the person will provide good care. Some of the study participants believed that the certificate courses have in fact had a negative effect on care in some ways, as they remove the 'family' relationships of old:

> Things have changed dramatically. Attitudes have changed. The attitude then was, it was how I would want *my* parents treated, and you did everything in your power to make them comfortable, and did everything that they asked of you. The elderly were more like a family then; it's become more like a hospital now. The [staff] who are coming in now, they think it's easy. They go and do the eight-week course and they think it's an easy job. And it's the hardest job in the world, to look after elderly people. I'm not saying that in a nasty way, but it's the hardest job because you have to do so many things that are unexpected. It's not a hospital, it's their home and you need to be able to differentiate between clinical and non-clinical.[43]

Just as Homes became 'aged care facilities', for 'clients' rather than 'residents', 'aides' became 'carers', and more recently, 'ECAs', or 'PCAs'.[44] The changing titles indicate a change in focus for these staff members. When RNs were not employed in the Homes at all, all female staff were called 'nurses', a title which was commonly used by any person giving personal care to the sick or dying. This practice continued until the 1960s, when the increasing importance of geriatric medicine made it more important to differentiate between those staff members who had expert knowledge and those who did not. The untrained nurse became the 'nurse's aide', a clear indication of her subservience to her more qualified superior. As the patients they cared for became 'residents', the aides became 'carers', showing a shift in focus towards the work they did for the residents rather than their position in the management hierarchy. Now, the acronyms of PCA or ECA are more commonly used; they describe the same job but sound more professional, more businesslike.

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[42] Interview with Maureen Nichols
[43] Interview with Nancy Langley
[44] ECA stands for 'extended care assistant', PCA for 'personal care assistant', but the acronyms are used almost exclusively.

This increased professional standing for staff in the lower echelons is important in the modern aged care sector, as the RNs are once again disappearing, their higher salaries making them less attractive to employers who are concerned with the bottom line. Whilst the PCAs become more qualified, there are fewer highly qualified RNs in the system, and moves are afoot to reduce their presence further. The disappearance of the name 'nursing home' reflects this change, as do new laws and policies introduced to allow a return to the days when staff members other than RNs were permitted to administer medications.[45] It is this aspect of 'Home as business' that concerns many who work in the sector, as they believe the quality of care given to today's 'client' will suffer.

The methods put in place to ensure quality—the paperwork, the training, the accountability—can only go so far. The charts do not show how care is given, just that it has been given. The PCAs may have learned practical techniques, but they do not necessarily carry them out in the most appropriate fashion, as Nancy mentioned in the quote above. But one aspect of quality control can be carefully monitored, and that is the built environment in which the residents live.

One of the results of the entry of corporate business into the aged care sector was the renovation or remodeling of many older Homes, or even total demolition and the erection of new buildings. This was beneficial in many ways, as the old multi-bed wards finally disappeared and shared bathrooms became a thing of the past. The floor plans often provided a number of smaller public spaces rather than a single large communal living area, enabling the residents to receive visits from family and friends with a degree of privacy. The sleek and sometimes lavish decoration of the new Homes gave the residents luxuries that they had never had before. But even in this respect, some participants in this study questioned who was really benefitting from the changes:

> A friend of mine who works at [Sandhill], with the chandeliers and everything, said that one of the old men said to her, "Cor, we were lucky to even have a light globe in our house!" And now they've got chandeliers! I think a lot of residents think it's ridiculous. They don't want that; that generation didn't go in for all that sort of thing. Most of them went through the Depression; they probably think it's obscene extravagance. They're quite possibly building them for the baby

[45] Poisons Regulations 2008, *Regulation 95EA: Administration of certain substances by aged-care workers in residential care services*, at http://corrigan.austlii.edu.au/au/legis/tas/consol_reg/pr2008230/s95ea.html

> boomers, but do we baby boomers want to go in? No! I think we want to think we'll never get old...[46]

If baby boomers do not want to go into Homes, they will receive more help now to stay at home than at any time in the past. In fact, they might not get into a Home even if they want to—the gates to the new and improved aged care facilities are carefully controlled.

Controlling the gates

For several decades, the Tasmanian government has worked to find ways to solve the problems of a growing ageing population and a finite budget. This section will examine the two main solutions that they found, both of which emerged in the 1960s: providing services to people in their own homes, and assessment of prospective residents, to determine need and limit access to an increasingly attractive alternative lifestyle in the Homes.

Care in the community: domiciliary services

> Taking into account the difference in the cost of custodial care and the domiciliary and ancillary services, it is quite clear that the policy adopted by the Board in introducing these services was a right and proper one. In other words, the future policy in regard to the aged should be 'assistance at home instead of homes of assistance'.[47]

By the early 1960s, despite the opening of a number of private Homes across Tasmania to take up some demand, waiting lists for the public institutions numbered in the hundreds. To address immediate needs, the Department of Health set up state-run domiciliary services to provide care and assistance to people in their own homes. Although district nurses had existed for some decades, they worked for privately operated services and looked after the sick. These new domiciliary services would also look after the well, in an effort to keep them that way.

In July 1963, Cosgrove Park began to provide such ancillary services as linen exchange, cleaning services and meals-on-wheels to sixty people a day in the surrounding suburbs of Launceston. Seventy more local residents were brought into the new Day Centre each

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[46] Interview with 'Margaret'. Sandhill was built to replace Cosgrove Park, which was bought in 2006 by Aged Care Services Australia Group, a large mainland corporation which operates 34 Homes in four Australian states, and demolished to make way for the new five-star facility.
[47] AOT, HSD6/3/2216 109/8/1 Document 26

day for a substantial lunch, gentle activities, and afternoon tea, and in the following year, twenty-five non-ambulatory patients were admitted to the Day Hospital daily for physiotherapy, bathing, chiropody, hairdressing and meals.[48] These arrangements were beneficial for the Departmental budget as well as for the patients, and the government determined to expand the services to include nursing care, and to extend them across the island.

> It was hoped that in the future some form of domiciliary geriatric nursing service might assist in reducing the waiting list by enabling more old people to maintain a standard of fitness which would enable them to remain ambulatory and live in their own homes. ... a very successful service which operates in the United Kingdom … works in conjunction with charitable organizations such as "meals on wheels", who assist with feeding these people, and trained personnel who give assistance in other directions.[49]

The hopes of the government were fulfilled until 1968, when state-run domiciliary nursing services began in Hobart, Launceston, Longford and Burnie.[50] Joan was one of the first RNs employed as a domiciliary nurse. When she joined the Launceston service in 1969, she was one of three, although one left almost immediately, as she did not like the work.[51] Working in the often chaotic and sometimes dirty environment of a domestic dwelling could be confronting at times, particularly for a nurse trained in the order and cleanliness of a general hospital, but Joan did not find this a problem. She had been a Queen's Nurse in England (that 'very successful service' mentioned in the quotation above), and she was aware of the problems she would face. [52]

In Launceston, two full-time and two part-time RNs carried out around 230 home visits a week.[53] They rode bicycles at first, but were soon driving cars, donated by local service clubs, and the demand for their services grew quickly once the doctors realized how useful their services were. The domiciliary nurses were originally based at the

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[48] AOT, HSD6/3/2216 109/8/1 Document 26
[49] TPP, 173, 1965, Paper 12: Standing Committee: St John's Park proposed extensions to women's block
[50] TPP, 179, 1968, Paper 73, page 15
[51] Interview with Joan Mutimer
[52] The Queen Victoria Jubilee Institute for Nurses began in Britain in1888 with funding from Queen Victoria, to provide trained nurses to go into the houses of the poor and nurse them back to health. It became the Queen's Institute for District Nursing in 1928, and trained district nurses until 1967, when local authorities took over this responsibility: Monica Baly, *Nursing and Social Change*, (London, 1995)
[53] Even in the late 1960s, official assessment reports on prospective residents noted that many old people lived in rental accommodation with outside lavatories, no conveniences, no bathrooms, and no running water (AOT, AD203/1/1850) Kay Joyce also mentioned that many houses in the area had no bathrooms and she would often bathe and change day patients during their visits to Cosgrove Park.

Launceston General Hospital, but as more were employed and the number of cars donated to the service grew, they moved out to Cosgrove Park, where there was more room to park. Kay, who worked at Cosgrove Park as an aide, went out with the domiciliary nurses occasionally, if their workload was particularly heavy. She was horrified by some of the cases she saw:

> I can remember the first time I went, we went to this house up Prospect, which I've never *ever* forgotten. It was this little old man, and he had an ulcer on his leg and she had to do the dressing on it, and it was just *atrocious*. I don't know how he walked. The floor of his house was dirt—I don't know whether the floorboards had rotted away or whether he'd burnt them in his fire. He just sat there by his big open fire… I could not believe that someone could live like this! Cosgrove was a palace compared to that.[54]

Plate 2: The domiciliary nurses outside the Cosgrove Park chapel, next to their donated cars, c1969[55]

Relations between the Cosgrove Park nurses and the domiciliary RNs were not always completely amicable, as issues of status arose.

> The Cosgrove Park staff didn't like us, because we went out and we had cars and we didn't have someone breathing down our necks! It was a higher status job. Most of the people who worked at Cosgrove Park were either orderlies or only geriatric trained, after they brought in geriatric training.[56]

The relative prestige of the aged care nurse and the domiciliary nurse is an interesting question. Joan was quite dismissive of the Home nurses, even the RNs who were 'only

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[54] Interview with Kay Joyce
[55] AOT, AB644/1/16: Photographs of Cosgrove Park: domiciliary vehicles
[56] Interview with Joan Mutimer

geriatric trained'. She believed her own position had higher standing due to the autonomy and relative freedom she enjoyed. And yet that disgruntled RN who left when Joan began had complained that as a domiciliary nurse, "You're just anybody's maid … and you have to scrub the bowl that you wash them in". A domiciliary nurse carried out treatments that were not far different from those within the Homes, or even the hospitals ('giving of injections, renewing dressings, bathing and sponging'[57]), but her words reveal two main differences in their work. RNs did not usually do cleaning; the junior nurses, the aides, or housekeeping staff carried out those domestic duties. But perhaps more importantly, there is a loss of authority engendered by working in someone else's territory. Rather than dealing with quiet, good and weak patients, who are submissive and obedient to the nurse's expertise, the domiciliary nurses could instead be faced with people who were sometimes demanding and not always compliant with the nurses' orders. The nurses might be welcome visitors, but they were visitors nonetheless; the householder chose whether they entered or not.[58] This made the other RN feel like 'a maid', but Joan felt her autonomy outweighed the necessity to perform tasks that would have been delegated to those below her in the hierarchy. Her long experience in the English domiciliary service probably served to buffer her against the possible loss of authority, as well; she was the expert, and what's more, she was usually made very welcome indeed. The domiciliary nurses were often greeted with particular warmth by family members, usually daughters, struggling to cope with elderly parents and relatives in their own homes.

> They didn't have any respite places for people that were looking after mum and dad. There was always the daughter or someone looking after mum or dad—there was a case, out Youngtown, we used to go to a lady out there and her mother was bedridden, and she nursed her for years, the daughter did. And there was no home help then. So the RN'd go out and she'd do little things, like make the bed or wash up the dishes, give them a bath, or wash them in bed or whatever.[59]

Liz also began working as a domiciliary nurse in 1969, and also found herself welcomed with open arms. Her territory took in a large rural area in the north west region of Tasmania. Like Joan, she was a recent immigrant from the UK and a qualified Queen's

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[57] AOT, HSD6/3/2216 109/8/1 Document 26

[58] Their welcomeness was demonstrated by the speed with which their services were taken up by the public, as evidenced in the rapid and quite sizeable expansion in the provision of district nursing services in Tasmania and in Australia generally; see Diane Snowden, *Caring for the Community: One hundred years of the Hobart District Nursing Service Inc, 1896-1996* (Hobart, 1996); XXXX

[59] Interview with Kay Joyce

Nurse, and she brought skills and knowledge that were in short supply in Tasmania at that time. She was initially employed for twenty hours a week, driving her own car between appointments, which might be half an hour apart. Starting with four patients, she had fifty in no time.

Welcome wherever she goes

She's an expert on pensions, claim forms and drainage.

She's a domiciliary nurse, and she's welcome wherever she goes!

SHE KNOWS THE LOT!

by JILL Bourne

She knows when to call in the plumber, get the carpenter to fix a step and arrange for a dangerous branch to be pruned from a tree. She bandages, gives injections helps with diet, and SMILES, knowing that she may be the only person to step inside the house that day.

The flourishing Coastal domiciliary nurse service takes the nurse out of the hospital to the patient in the home.

She deals with elderly people needing specialised care, the handicapped and people straight out of hospital who need post-operative care.

As well as making a lot of people much happier by nursing them in their own secure surroundings. the service frees beds in the hospital and leaves them free for patients requiring more specialised care.

Sister Liz Barron of Burnie started domiciliary nursing for the N.W. General Hospital five years ago when the service along this stretch of the coast first began.

Then she had four patients and worked part time for two days each week.

Today with an average of 60 patients, she, and an assistant, work a five day week covering an area from Somerset to Boat Harbour and inland to Elliott, Yolla and Flowerdale.

Two more nurses cover Penguin and Burnie.

That's how fast the service is expanding.

"Rewarding"

"It's really most rewarding work," Liz says "I get so much pleasure from seeing an old lady come to her door to greet me, knowing that she is a valued member of the community and doesn't need to be in dire distress before help comes. In hospital so many elderly people lose

domiciliary nurse's job is to create a good relationship with her patients and liase between them and their doctor That means not hurrying people, but taking time to find out all their problems, big and small.

Apart from nursing and

Sister Liz Barron greets one of her regular patients, Mrs. Bertha Kemp of Bass Hwy., East Wynyard, with a big SMILE.

Plate 3: Liz, domiciliary nurse, makes headlines in the local newspaper[60]

[60] The *Advocate*, Wednesday, 16th January 1974, page 17

Liz found the conditions she worked in very different to those she was used to in the UK. First, there were the living conditions in which many of her rural clients lived, which she found more akin to the 1920s than the 1970s:

> And oh, the houses, some of the houses were terrible! You know, everything happening in one room, the bed in the room, the food, everything. Very primitive —no water—they had a pump way up the garden. No bathrooms, no toilets—dunny out the back. Imagine going to a house with an elderly person with a whopping great sore on her leg, no proper water, you had to wash everything before you started to do her dressing. You had to get a pan from somewhere and boil up the instruments in the pan, boil them for about ten minutes to get them as good as you could get it. Cool that, work with your instruments, clean up the dressing and then go from there. Even washing your hands—you did the best you could. I always had rubber gloves with me, so I'd discard the gloves and wash my hands at the next place.[61]

Liz also faced difficulties in acquiring enough and suitable equipment to treat her home-based patients, as the matron in charge of the hospital where she was based struggled to understand this new service.

> Miss Williams was very much 'old school' (she was a real battle-axe, inflexible was the word) and she knew *nothing* about community nursing, didn't understand it. I went to see her because I needed to give someone in the community an enema, they were so bunged-up and so ill, and I asked if I could take a bedpan and an enema apparatus. "What?" she said. "You want a *bedpan* to take out into the community? You don't take things out into the community!" I'd been a district nurse in Aberdeen, where you had *all* the equipment under the sun, even an IV infusion. But, "you can't take bedpans out of the hospital!" And I said, "Miss Williams, why?" And she said "because it's not the done thing to take hospital equipment. What about contamination?" I said "what about sterilisation?" Bedpans don't need high-tech sterilisation, they just need to be thoroughly washed and used again. So I said "if they're properly washed in the home they can be used just as well." She said "and where are you going to get the equipment from to do an enema?" I said, "Again, from the hospital. You can dedicate one for the community, so it doesn't have to go back into the hospital. Then it becomes the responsibility of the district nurse to look after the equipment, and it's on *her* shoulders if there's any cross-infection or whatever you're worried about."

Despite these teething problems, by 1972, all Tasmanian public hospitals provided a home nursing service. Across the island, the domiciliary nurses were making 21,740 visits a year and 2,600 people were receiving home help.[62] Four years later, there were 106 RNs employed in the service across the state, and the St John's Park nurses alone visited 1,100 patients a year.[63] This rapid increase was partly due to the new Community

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[61] Interview with Elizabeth Barron
[62] TPP, 187, 1972, Paper 82
[63] TPP, 197, 1977, Paper 19; TPP, 199, 1978, Paper 33

Health program which began in 1973 with funding from the federal government.[64] Unlike the other Australian states, which established Community Health Centres, the regional nature of Tasmanian settlements meant that domiciliary services were more suitable to address the needs of the population. By the tenth anniversary of the setting up of the division, there were 300 nurses and the division also offered meals on wheels, physiotherapy, social work, occupational therapy and chiropody services, mainly to elderly clients.[65]

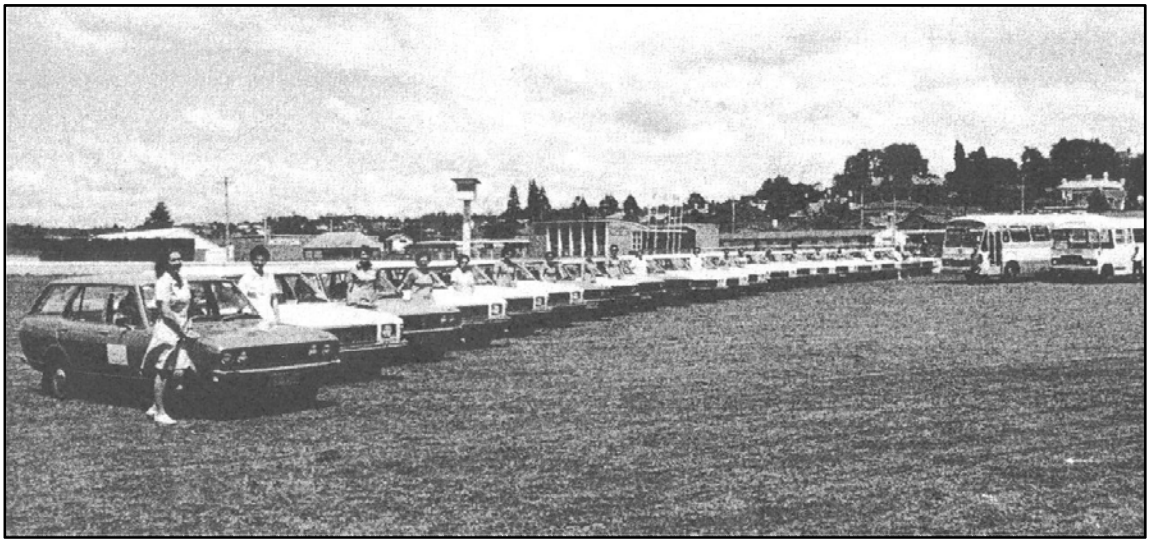

Plate 4: The Launceston domiciliary service fleet, c1972[66]

Whilst the domiciliary service was a resounding success, it became clear quite quickly that it was never going to be able to completely replace residential care. The advances made in medical treatment continued to lengthen lives, as people survived illnesses and lived with medical conditions that would have killed them in earlier times. Now, there were just too many people needing help, spread over too great a distance, and the state government did not have the financial capacity (or the workforce strength) to give everyone the services they needed. The 1988 annual report included a farewell message from the Director General of Health Services, who acknowledged this.

> When I moved to the Department I had expectations of changing the emphasis from institutional to community services… I have envisaged that the day would come when there would be a transfer of funds from institutional services to domiciliary home care services, on the basis that people would be kept out of institutions. Not only would there be better 'quality of life', but there would also

[64] TPP, 213, 1985, Paper 14: report on 10th anniversary of Community Health division
[65] TPP, 213, 1985, Paper 14: report on 10th anniversary of Community Health division
[66] Launceston General Hospital Annual Report, 1978, page 45

> be financial benefits. But technological development has been dramatic, and has resulted in the need for more institutional services…Improved and increased home care services have been achieved, but by an increase rather than a transfer of funds.[67]

The Australian government has continued to provide for care in the community. Funding packages were introduced in 1992 and the ratio of nursing home beds per capita of population has gradually dropped. But there comes a time when care in the community is simply not enough. Nancy saw the problems first hand, as her mother aged.

> I know for a fact [home care] doesn't work. We tried to keep my mother in her home. We had home help every day, people came in to shower her, but then she got dementia and she wasn't eating, and she wouldn't shower at all. The girls would come there and she'd get aggressive at them. She used to fall over, and she would fall when there was no-one there. I mean, they were there for an hour, but what about the other twenty-three hours? Because the staff used to come between ten and eleven in the daytime, we had Meals on Wheels which came at twelve, and after that there was nothing and she spent all the rest of the time on her own. Our biggest scare was that she'd go outside and fall, and be there all night. It's a wonderful idea, but it doesn't work unless you've got people who could pop in every hour! At least in a nursing home, there's someone always there.

Not everyone can stay at home: physically disabled, chronically ill and demented old people need more than occasional help. Even for the reasonably healthy, good community support is sometimes less than ideal: meals-on-wheels can be rushed or not to the recipient's taste (and who will check that they are eaten?); infrequent visits from social workers and health visitors can miss problems; volunteer visitors can be irregular and patronising; and old people can remain lonely, friendless and isolated. The service hours are inflexible, and there is also the continuing trouble of maintaining a house and garden. In this context, Homes can be seen as 'therapeutic communities', in contrast to the squalor, deprivation and apathy of living in the community.[68] Staying at home alone can be depressing when you only cook for and look after yourself, as one resident of a northern Tasmanian Home explained in poetry:

> Living Alone
> You get to be an introvert.
> You might have a cat or a dog or a canary.
> But I'd rather be with human beings who can still
> teach me something.[69]

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[67] TPP, 219 Part 2, 1988, Paper 59
[68] Roger Clough, *Old Age Homes*, (London, 1981), page 12
[69] Nell Gardiner, 'Living Alone', in Robyn Friend, (ed), *Fancy Seeing You Here: A Collection of Writing By Residents of Nursing Homes in Launceston and the Tamar Region*, (Launceston, 1989), page 7

But wanting to go into a Home is no longer enough. Now there are new gatekeepers guarding the doors, and they are very particular about who they let inside.

The rise of the assessors

The domiciliary services provided by the government were certainly a boon to those who wished to remain in the community, but there were still many who sought admission to the Homes. Thanks to federal government funding, the public institutions were joined by a number of voluntary and proprietary Homes to help address this demand, and by the late 1960s Tasmania had more aged care beds per capita than any other state.[70] Every one of these beds appeared to be needed; waiting lists were long and growing longer, and the government struggled to regain control. In 1969 a state-wide assessment of aged care accommodation was carried out, which found that sufficient beds existed and gave an explanation for the waiting lists:

> The Commonwealth nursing home subsidies are paid through the patient, not direct to the nursing home. This means … that nursing homes tend to maintain a 100% bed occupancy sometimes without due regard to the actual needs of patients in order to gain a maximum income. If a 100% bed occupancy is maintained, there must be difficulties in meeting acute needs, there must be waiting lists and finally an artificial 'shortage' of beds is created.[71]

One-fifth of the state's nursing home population and more than one-third of the welfare (hostel) occupants were deemed to be fit to live at home, with help. It was decided that the most appropriate approach was to develop properly coordinated home care services, rather than invest in yet more beds in an environment which already exceeded international standards.[72] To ensure that only those people who genuinely needed residential care would be admitted to nursing homes, an assessment procedure would be instigated to investigate the patient's needs.

Cosgrove Park already required an assessment of prospective residents before their admission. These assessments were initially carried out by Child Welfare Officers from the Department of Social Services, but this was putting an excess pressure on these

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[70] TPP, 177, 1967, Paper 74: 3.9 per 1000 of the population over 65, compared to 2.9 in New South Wales, 1.2 in Victoria, 2.2 in Western Australia, 2.1 in South Australia and 1.7 in Queensland

[71] TPP, 183, 1970, Paper 105, page 14

[72] TPP, 185, 1971, Paper 83: Tasmania had 43.4 nursing home beds per 1000 of the over-65 population compared to the international standard of 25, and 20.2 welfare beds compared to 15 internationally.

already overworked personnel, and it was decided that an RN would be appointed to take over this task.[73] Joan became an assessor in 1971.

> A lot of the nursing homes didn't have what I'd call real nursing home patients (I mean, they did after a while, because the residents deteriorated), but the ones coming in, they were going out, shopping, and everything. And that wasn't what they were supposed to be for. So I was approached and asked, would I go into the nursing homes and inspect them and write down who's in there, what abilities and disabilities they had, etc. etc. And I found that there were so *many* in there that should *never* have been in there, they got in because they knew people, not because they needed help. You see, they didn't want to do housework, the cooking. You had people waiting on you, your meals were cooked and washed up. They played bingo, and cards, and people came in to entertain them. I mean, it was a life worth having! A lot of them thought it was more like a hotel.[74]

As an assessor, Joan wore no uniform, and had an unmarked car. She would drive to the address of a person who had applied for admission, and interview them to see if they really needed nursing home care or if they just wanted what she called "an easy time". She found many applicants who were quite fit and healthy, cleaning their own houses, doing their own gardening and shopping and living independently. She removed them from the waiting list. Other names could also be deleted quite quickly.

> I found out that there were people who had died *years* ago, but had never been taken off the list, or people would go round to different nursing homes and put their name down on so many waiting lists. All the homes had individual lists, there was no central organization, and I got more than half the names off those waiting lists.[75]

She met with resistance from some other health professionals, who felt that the decision about admission should be theirs. The physiotherapists posed particular objections to her authority. They had been uppermost in the hierarchy of care professionals in the Homes throughout the 1960s, and were used to being in charge. There was "a lot of politics":

> It was a real battle between the physios and OTs and the Department of Health, wanting to keep control of the nursing homes and who goes in and who doesn't. I was the one who said who had to go in, and they thought *they* should. We had quite a tussle.[76]

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[73] AOT, HSD6/3/2211 109/5/1 Letter from Director of Social Welfare, 20/9/1970; memo from Minister for Health, 25/1/1971

[74] Interview with Joan Mutimer

[75] Interview with Joan Mutimer

[76] Interview with Joan Mutimer. The tussle continued when a federal assessment program was mooted in 1975. Whilst social workers, occupational therapists, physiotherapists, nurses and doctors all agreed that all old people 'should have the opportunity to have [their] needs assessed', they could not agree on who should actually do the assessment. The Social Welfare Commission recommended that a team should carry out these assessments, headed by a geriatrician, but it was not until 1985 that a pilot program began at Commonwealth level to establish guidelines for assessment. See Social Welfare Commission, *Care of the Aged* (Canberra, 1975); Diana Gibson, *Aged Care: Old Policies, New Problems* (Cambridge, 1998)

In the end, Joan won the tussle, and was able to reduce the waiting list for Cosgrove Park quite substantially. But despite these checks and the success of the public domiciliary service, waiting lists continued to grow throughout the 1970s. At the end of that decade the Tasmanian government decided to amalgamate the waiting lists of every Home in the state, public and private, into a single list for each region.

> A permanent position has been created for a Senior Nurse to maintain this list and to assess the patients on it. The scheme has had the enthusiastic acceptance of all the private and voluntary organizations. A waiting list of the North West region is currently being compiled and it is hoped to extend the service to the Southern area in the near future.[77]

The combined waiting list meant that a clear picture could be seen of the real state of demand, and people on the list could be prioritized according to their need. The northern waiting list was quickly declared a "resounding success", with virtually no patient in need left in the community, but there was no start on the Southern list.

> It appears that there may well be a social attitude problem in the South… In the North of the State it was found that having a common waiting list and greater cooperation between the voluntary, private and State nursing home organisations, that the waiting list was rapidly brought under control. We are trying to achieve this in the south, although there has been quite a bit of resistance in some quarters.[78]

There had in fact been 'quite a bit of resistance' in the north as well. Liz had been promoted from domiciliary nurse to running the Community Health department in her region, and she found herself on one of the first of the Geriatric Assessment Teams (GATs) that were set up by the state government to assess the Homes and their waiting lists. She found the going difficult.

> That was hard work setting that up, let me tell you. …it was the [Home] administrators who were the real problem—they were very protective of their environment. You know, "how *dare* you come in as an assessment team and give us lists and tell us what we're going to do. *We* will decide who's going to come in to *our* nursing home". They wouldn't tell us half the time how many people were on their list. "You're not having *my* list, it's private and confidential." I had to get Dr Curran [the state director of the geriatric division] to write to all the nursing homes in the region … and say that the assessment teams are here to stay, they're going to become mandatory whether you like it or not, you do not admit anyone unless it's through the assessment team.[79]

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[77] TPP, 203, 1980, Paper 18, page 17
[78] AOT, AA1/1/559 Letter from Director General of Health Services to Medical Commissioner, Mental Health Services, 13/7/1981
[79] Interview with Elizabeth Barron. Dr Curran was Senior Medical Officer, in charge of the government's Community Health and Geriatrics section: TPP, 197, 1977, Paper 19

Three regional GATs were set up, aided by specific purpose grants from the Australian government, to service the north, the north-west and the south of the island.[80] By 1985 they had established an assessment register of 1,350 clients[81], and this declined rapidly as they were removed from the list or placed in suitable accommodation. The GATS became permanent in the mid-1980s, when they were adopted throughout Australia and were renamed Aged Care Assessment Teams (ACATs). Home admission approvals across Australia dropped by around fifty percent.[82] Entry to a nursing home was no longer the choice of the individual or the decision of the Home's management; it was now entirely up to the authorities as to whether a person was deemed 'suitable' for aged care. Whereas in the past, a person could put down their name at the Home (or Homes) of their choice and be admitted as soon as a bed became available, this was no longer the case. Another layer of control was added, and this could be particularly annoying for the operators of the proprietary Homes, such as Dorothy at Sunny Brae.

Plate 5: Sunny Brae today, showing the proximity to the road. The front door, the main access to the house, opens on to the street. The house is now a private dwelling again, divided into eight units.[83]

Dorothy had always assessed potential residents herself, visiting them in their own homes to assess their mental state and behaviour. Sunny Brae was close to a busy road, and she believed it was unsuitable for people with dementia, who might wander into the street and

[80] TPP, 213, 1985, Paper 14, page 26
[81] TPP, 215 Part 2, 1986, Paper 39, page 41
[82] Warwick Bruen, 'Aged care in Australia: past, present and future', *Australasian Journal on Ageing*, 24:3(2005), 130-133
[83] Photograph taken May 2012 by Elaine Crisp

be hurt by a passing car. She also had personal reasons for wanting to make her own selection of residents. Sunny Brae was her family home as well as a Home, and she resented having the choice of who she admitted taken out of her hands.

> I didn't like the Geriatric Assessment Team, I didn't like them at all. There was a sister there, and she was really very nice, but… When they took over, they decided who could come in. We had to agree with that, otherwise we wouldn't get the subsidy. It was the subsidy that made [the Home] pay or not pay. They would assess people before they came in, for Commonwealth benefits, where before we didn't need to have that done, I could do that myself. I could have in the people I wanted.[84]

Maureen B did not have the same antipathy to the assessors, but then she was an employee, not the owner.

> I think on the whole they did a pretty good job. I had very good relations with everyone that I spoke to on the ACAT team, and if I needed help, if I was looking for people to fill beds, they would be helpful and I certainly didn't have any dramas with them.[85]

In safe hands: residents' rights and the safety net

> The assessors would be there all day—for a day and maybe two days. They'd go into everything, they'd look at the medication charts, and all the documentation, and they'd talk to the residents, they'd talk to the families if they were available.[86]

The Standards monitoring inspections introduced in 1987 were not just quantifiably different to the old licence inspections; they also changed in quality. The new standards were judged on subjective rather than absolute measures, and the residents themselves were given a greater say in how well they believed the Homes satisfied requirements.[87] To gain this insight, the inspectors conducted interviews with a number of key staff and 'capable' residents, a judgement which is not always easy to make in an aged care facility.

> I'll never forget, there was this dear old lady who 'lived in the past' but could be very plausible, and one of the visiting people was having this really serious conversation with this dear lady, and taking on board everything that she said, and then after a little while she started to talk about going home to her mother now…

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[84] Interview with Dorothy Morse
[85] Interview with Maureen Battese
[86] Interview with Maureen Battese
[87] For example, a 'home-like environment' was measured by how happy the residents were with the atmosphere rather than by the appearance of the Home and how the inspector believed it should look, as had been the case in the past: see Diana Gibson, *Aged Care: Old Policies, New Problems*, (Cambridge, 1998), pages 87-88

> And then they realised the lady suffered from dementia and she didn't really have a clue what she was talking about![88]

The Standards guaranteed the privacy and dignity of the resident and the ability to 'exercise choice over his or her lifestyle'.[89] In 1990 a Charter of Residents' Rights and Responsibilities was passed by the federal government, and together these two pieces of legislation made great changes to aged care. Whilst they reduced the freedom of the providers to run the Homes in their own way, they increased the autonomy of the residents. From the aides' point of view, this new authority brought a difference in resident attitude that could be difficult to accept.

> When I first went there, you were like an angel to them. They treated you that way, especially the men patients. There were several elderly men there who just thought you were something out of this world. Like, if you were running late with something when I was there on my own, it was, "never mind, darling, that's alright, I'll wait till you get round". But now, and in later years, if you weren't there straight away… the patients changed in the way they looked at *us*, and they also changed in what they demanded to be done. The ones that were there when I went there in the 1960s were different type of people altogether, and they appreciated what they had. They've got more demanding and they want more for their money, and it's a business now.[90]

The greatest reward of a lowly paid, sometimes difficult and frequently unpleasant job is often the gratitude of the recipient of these services. Nancy liked being seen as an 'angel', and many of the other aides mentioned this change in attitude as an upsetting development. Some addressed it by moving into areas of the Home where the residents are less active and vocal. Barbara told me that her sister-in-law, who is still working at Nazareth House (now Mount Esk) as an aide, prefers to work with the high-care patients, as "they're dependent on you, whereas the [low care] ones can move around and drive you crazy, yelling for you all the time".[91]

Legislation has mandated freedom and rights for residents, and the corporate nature of many Homes has encouraged the residents to see good service, comfortable surroundings, and modern facilities as their due. No longer powerless and quiet 'old dears', they are

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[88] Interview with Maureen Battese

[89] Commonwealth/State Working Party on Nursing Home Standards, *Living in a Nursing Home: Outcome Standards for Australian Nursing Homes*, (Canberra, 1987)

[90] Interview with Nancy Langley

[91] Interview with Barbara Allen. Erving Goffman noted that in total institutions, some staff preferred to work with 'regressed' people because they made fewer time-consuming demands than those who were more *compos mentis*: 'On the characteristics of total institutions', *Asylums*, (Harmondsworth, 1968), page 75

now powerful 'seniors', with a voice to demand what they want and the legal backing to receive it. The controlled have become the controllers.

Or have they? Despite the Charter of Residents' Rights guaranteeing residents their own choices and even the 'right to take risks'[92], paternalism has resurfaced, if it ever really went away. An increasing number of 'safety measures' are now enforced, to ensure the resident is not harmed in any way, and to guard the Home operators against litigation. This was demonstrated clearly in a recent newspaper article, which castigated many current practices that the residents are forced to endure 'for their own good', including compulsory activities, restraints on wandering residents, and restrictions on diet, all to keep the residents 'in safe hands'.

> The food authority does not say you can't serve a poached egg, just that it should be cooked at 62 degrees for 17 minutes. That's not a poached egg; that's kiln-fired organic pottery.[93]

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The businesslike footing of the aged care sector has had mixed results for both residents and staff. Some feel that paperwork has become the main goal of the Home, rather than a by-product of care. Funding arrangements have encouraged dependency, the instigation of unnecessary treatments, and the privileging of physical over psychosocial care. But the rules also help to guard against abuse or neglect by staff, and the assessors have shortened waiting lists and enabled people to receive the level of service they need as quickly as possible.

> Although you think sometimes it's gone too far with all this paperwork we do, it *has* concentrated on the rights of the resident. When [the assessors] come around they ask the resident when they prefer to have their bath, do they get the meals they want to eat—they have to have a choice of meals, a choice of when they do things. So I think that has done a lot towards thinking about the residents, and making life as comfortable for them as we possibly can. I do think some of it has gone overboard, but, striking a happy medium is the tricky thing.[94]

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[92] Commonwealth/State Working Party on Nursing Home Standards, *Living in a Nursing Home: Outcome Standards for Australian Nursing Homes*, (Canberra, 1987)

[93] Stephen Judd, 'When I'm old I'll still want soft poached eggs', The *Sydney Morning Herald*, July10-11, 2010, News Review: page 7. Stephen Judd is chief executive of HammondCare, an independent Christian charity which specializes in dementia and aged care.

[94] Interview with Maureen Nichols. Nancy Foner points out that since the USA government brought in stricter regulations in the 1990s, vulnerable residents are less likely to be abused and neglected by 'greedy providers [who] cut corners to save money': *The Caregiving Dilemma*, page 55

Aged care Homes have improved greatly in many ways, even if some developments have not been entirely successful, and some appear to be a step backwards. No-one would suggest that the 19th century institutions were in any way preferable to today's Homes. Now there is privacy, a choice of diet, entertainment. But some *might* suggest that the less regulated and bureaucratically controlled Homes of the pre-accreditation era were better than today's highly regulated, businesslike establishments.

> If I had been able wave a magic wand and do things differently then, they've done a lot of that now. Single rooms and such. But I wonder, have they lost that friendliness? Too much documentation—has that taken away from the family atmosphere that was there?[95]

Many of these changes have undoubtedly protected the residents and improved their lives, but not every effect has been positive. The residents often find their days even more regimented and their safety even more guarded, for their own good. The demands of administration and bureaucracy can eliminate the individuality of the Homes and take away any domesticity and warmth. And people also find it more difficult to become residents in the first place, as the government carefully guards entry to the Homes: where once the authorities exercised control to keep the inmates *inside*¸ now their efforts are aimed at keeping them *out*.

Aged care began in Tasmania as an overt form of social control. The aged inmates of the charitable institutions who were kept isolated, confined, and strictly disciplined to protect the public from the 'contamination' of pauperism and the criminal classes. In the 21st century, aged care is still concerned with control, but now it runs throughout the sector and everyone involved is affected in some way. The government controls the Homes by providing funding, and the accreditors control them with the granting or withdrawing of approval to operate. The Homes control their staff, making them account for every moment of every day, every change in the condition of their residents, in order to maximize the money they receive from the government. The nurses control the residents, ensuring they are kept 'in safe hands', whether they want to be or not, whilst at the same time paying lip service to their rights to choice and risk. And the residents, too, now have some control, as their rights are protected by law and their complaints are heeded.

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[95] Interview with Eileen O'Leary

At the beginning of my study, I asked why, despite the many safeguards put in place and the efforts of the government, the industry regulators, the administrators and the staff, does aged care still engender such negativity from the public? My answer to this, and my other questions, will be explored in the final chapter.

Chapter 8: In safe hands?

> It wasn't a terrible place. It wasn't a terrible place. That's what a lot of people thought, because [the Homes] were the sort of 'end of the road' places. But it wasn't… nobody was treated cruelly or anything like that. They were clean and warm and fed… I have very happy memories of St John's Park.[1]
>
> Over the twenty-nine years that I worked and cared for the aged, I think back on it as a very happy and rewarding time. It's nice, isn't it, to think that you're helping people. You get involved in so many people's lives.[2]
>
> I was the one who admitted the residents, and talked with their families, and got to know them. That was good, I really enjoyed that part of it. Trying to write a care plan that would be individual and meet their needs, and getting to know them well enough to know what their needs were. I really enjoyed that bit of it. I did enjoy it. I guess I wouldn't have stayed that long if I hadn't![3]

Here we are at the beginning of the 21st century. The last two hundred years have seen an enormous number of changes to the way in which old people have been cared for in Tasmania. They have changed from inmates to patients, to residents, to clients. The people looking after them have transmuted from overseers and warders, exercising coercive discipline and enforcing punishments, to nurses and attendants looking after patients 'for their own good', to RNs and PCAs following care plans and monitoring outcomes to keep the residents (and the Home operators) in safe hands. Depots became institutions, institutions became nursing homes, and now nursing homes have become aged care facilities, with no nurse in the title, and a dwindling number of them in the Homes. The model of care has changed from punitive to welfare, to medicine, and now to business. Where two public Homes existed in 1912, in 2012 there are sixty-nine, none of which are operated by the government.

This chapter will answer the questions I posed myself in Chapter 1, albeit in a slightly different order, and offer an explanation for the negative image of aged care so prevalent in today's society.

[1] Interview with Clare Paynter
[2] Interview with Barbara Allen
[3] Interview with Maureen Battese

The Homes

Why did the Homes begin in the first place? Who went into them?

The Homes began because they were desperately needed. In 19th century Van Diemen's Land / Tasmania, those aging 'detached atoms' with poor health, little money, and no kith or kin were taken off the streets, given a roof over their head and food in their bellies. For unmarried and unmarriageable ex-convicts, aging single men living solitary lives in mining towns and rural huts, and destitute and childless widows and spinsters, the public Homes could quite literally be the difference between life and death. In return, society was protected from the perceived moral degeneracy of these emancipists and paupers.

In the 20th century, the Homes continued to shelter the single and the childless, and they were joined by a growing number of people who did have families. Changing social conditions—earlier marriage, earlier and smaller families, smaller houses, geographical mobility, and an increasing number of women entering the workforce[4]—meant less support for elderly people to remain in the community. In the first half of the century, the inmates of the institutions were still overwhelmingly from the working class, and there was still a preponderance of men, but by the 1950s, an aging population and the social changes mentioned above meant that more middle class people were entering the Homes, and more private homes were opening to take them. Even the wealthy would occasionally seek admission, as servants and large families disappeared.

The majority of inmates in the colonial institutions were men, reflecting the imbalance in gender caused by transportation and the pioneering past of the island. In the 20th century, more women began to enter the Homes, too, as the childless and never-married were joined by a growing number of widows. Nowadays, the Homes cater for all classes of people, from all socioeconomic groups, and due to their longer average lifespans, the women far outnumber the men.

What social function did the Homes fulfil?

Homes have fulfilled several different functions over the last two hundred years: prison, reformatory, protective asylum, hospital, home, and now business. Modern day Homes

[4] WD Borrie, 'The population', in Keith Hancock, (ed), *Australian Society,* (Melbourne, 1989)

are expected to fulfill many different functions, all at the same time: medical care, rehabilitation, palliation, a pleasant social environment, a protective environment for the demented, a place in which a person can find the support and assistance necessary to live out their final years. They are also increasingly expected to be financially viable, to pay their own way and even at times to make a profit for their corporate owners. It could be argued that the attempt to carry out all these functions at the same time is doomed to failure: accomplishing all, but none very well.

Had conditions in the Homes been far worse in the past?

The obvious answer is yes. The principle of less eligibility meant that the 19th century institutions were certainly worse, with conditions purposely made inferior to even the lowest labourer's domestic arrangements. The early invalid depots were cold, damp, dirty, and uncomfortable, and the food was less than appetizing. Even in the early 20th century, life in the Homes could still be unpleasant. The oral histories from residents of St John's Park in the 1950s tell stories of hard work, boring food and daily tedium, and the Public Inquiry into the Home for Invalids in Launceston in 1948 revealed a climate of distrust, conflict and unhappiness in surroundings that were only just 'good enough'. The situation in the private Homes was probably better, as their residents had more choice in which Home to enter and whether they stayed, but financial constraints and under-staffing meant that the Homes were rarely well-decorated and up-to-date, and the service could be slow, even neglectful at times.

But 'worse' is relative. Nursing homes were certainly worse than today's bright and modern aged care facility, but they were better than struggling alone in often substandard housing[5], and probably no worse than the conditions in ordinary domestic dwellings at that time. In some ways, they might even have been better—homely and familiar, providing friendship and accustomed activities rather than regimentation and safety. Consider life at the Trevallyn Convalescent and Nursing Home, an eleven-bed proprietary Home in Launceston. Opened in 1960 by an RN, from 1962 it was owned and run by a succession of semi-trained nurses, who provided basic care to the residents, and kept costs down by limiting staff numbers. The Home was in an old weatherboard house on a

[5] See Chapter 3, page 110

steep hillside, was not very well run and not very clean, but the residents did not appear to mind. In 1972, the inspector reported that:

> All patients are ambulant here and appear very contented. They had all been to the … races at Longford on Tuesday and were very pleased with themselves.[6]

Life at Trevallyn was probably very similar to the life the old ladies would have led in their own houses, albeit less lonely. But even so, the ladies did not enjoy that life for much longer; increasing costs and stricter regulations forced Trevallyn to close soon after this inspection, and most of the other small Homes followed soon after. The new aged care facilities that have taken their place certainly offer improved conditions, but they can come with less freedom. There is no longer a choice.

Had there ever been a time when going into a Home was a good thing?

Yes, and not just relative to the alternative of starvation on the streets or struggling in a leaking room with no heating and no bathroom. It was definitely a good thing in the middle of the 20th century, when medical advances and a booming economy allowed for comforts and facilities in the Homes unseen before. Cosgrove Park was a desirable address for a time; so desirable that Joan had to be employed to weed out those applicants who thought of it as a hotel, where they would have 'an easy life'. But even when the desirability *was* relative to a difficult life outside, aged care was still a good thing when the residents received warm shelter, sufficient food, and around-the-clock care and attention. Unfortunately, however, they sometimes did not. As I searched the records and spoke to the participants, it became plain quite quickly that many of the negative tales I had heard were based on fact.

Were the negative stories real, apocryphal, or simply exaggerated?

All three, it seems. The story of George's suicide by gunshot was certainly real, although the reasons provided for his actions had altered somewhat in the intervening decades. My meeting with the RN who had been on duty that night was serendipitous, a result of the close-knit, interwoven nature of Tasmanian society. Elaine had not been one of my direct contacts, but came along to the interview I had set up with Judith, who had been recommended by Kay, who had worked with her forty-five years earlier. Elaine's story made me even more committed to finding out if the other tales were also true.

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[6] AOT, HSD6/3/2666 Inspection report, 22/3/1971

The old lady who was tied to a chair for hours on end, sitting in a puddle of her own urine because the staff wouldn't take her to the toilet? Also real. Such treatment was possibly quite common when restraints were an accepted and widespread method of controlling wandering residents. Helen saw this several times at Cosgrove Park in the 1980s:

> They did use restraints for people who were constantly getting out and wandering. They used to sit them in the chair and they had a band thing that went around their tummy and across their shoulders too, and they were tied to the chair so they couldn't get up. Some of the nurses (not nurses, I shouldn't say that, it was the aides), they'd just tie them in their chair and leave them there. And I heard them even telling patients off who'd become incontinent, you know "oh, why did you make such a mess?"[7]

The bedridden old man who was left to lie in his own excrement until all the skin came off his bottom? Probably apocryphal. The bedsore *motif* appears time and time again in both official records and in the oral histories, showing the long-time status of their prevention as the benchmark by which the quality of care was judged. Not only was it a matter of personal pride for the nurses that their charges were bedsore-free, but it was also one of the aspects of treatment that could be measured very easily, and all staff knew that they would be held accountable. Bedsores happen, but the weight of evidence suggests it is unlikely that they were ever allowed to develop intentionally through neglect.

The sadistic nurse who hit her frail, defensive charges and scalded them with boiling hot baths? Unfortunately, real again, although the extent of such abuse was probably exaggerated. Physical abuse was more likely to occur in Homes with untrained staff and a lack of supervision, a pattern also seen in the American literature. But while the majority of ill-treatment was perpetrated by aides, there were cases where trained nurses were responsible. Vera remembered one male nurse at the dementia care unit who

> …practised water torture on his patients, and I caught him and got him sacked. He had worked sixteen years in various nursing homes. I'd been suspicious of him when a very demented man called him a 'cruel bugger'. To talk to him, you'd have thought he was the light of the world. He'd say "oh, I *love* old people, Sister Green", yet behind your back… He came to us from [another Home] with a glowing reference, and then I found out that they'd had suspicions about him there but they wanted to get rid of him, so they gave him a good reference.[8]

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[7] Interview with 'Helen'
[8] Interview with Vera Green

It is rare for such outrages to occur in Australia today, thanks to regular inspections, residents' rights, and the legal ramifications that would ensue to any Home that allowed them to happen. The public release of accreditation information and the eagerness of the media to expose shortcomings have made the sector far more accountable. But the fact that they did would no doubt have coloured public perception of life in the Homes, even when they no longer occur.

What of the lesser complaints? The smell of cabbage and urine (especially urine) was definitely real; almost every participant mentioned it, and most pointed out that the development of continence pads had dramatically reduced it.[9] The rest are probably exaggerated. Cold baths had certainly been common at the 19th century institutions, but I found no evidence of them in the later Homes.[10] Cold food, inedible food, and insufficient food were all mentioned at the Public Inquiry into the HFI in 1947, but the emphasis on quality and quantity of food in the official inspection reports after the 1960s make it less likely that residents suffered from anything more than a lack of choice and variety.[11] There was certainly a lack of entertainment in the proprietary Homes, apart from television, but there would have been little more than that in the homes of the average Tasmanian, and more than in many, particularly in the early 1960s when the cheapest television set cost around five weeks' wages for the average worker.[12] The records show a great deal of effort to amuse and divert the residents of St John's Park and Cosgrove Park. Perhaps it is only when people are grouped together that it becomes obvious that they have little to do, and as pointed out in Chapter 5, sometimes old people *like* to just sit and do nothing , preferring it to the compulsory activities that the resident is often forced into 'for their own good'.[13] Lack of privacy was widespread before the 1990s, but whilst we might now consider this to be completely unacceptable, it was not

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[9] Bruce Vladeck noted that 'there is always some odour of either urine or disinfectant' as a high percentage of nursing home residents are incontinent: *Unloving Care: The Nursing Home Tragedy*, (New York, 1980), page 8.

[10] The replacement of baths with showers, however, might add to this aspect: see Chapter 5, page 159

[11] A 'voice at afternoon tea' in the oral histories of St John's Park residents says, "We used to get sick of stew. We had it every day. They ask us now what we'd like for supper." Elizabeth Dean and Annie Reynolds, *No More Bread and Milk: stories from St John's Park*, (New Town, 1993). This story was true in America, however; Jules Henry reported starving inmates licking their plates, eating other people's leavings, begging for food, and hiding bread in their lockers in *Culture Against Man*, (London, 1966), page 418

[12] The *Examiner*, Saturday, 19th May 2012, page 38: the most inexpensive set cost around £99, the equivalent of about $105 when the average wage was $22 a week.

[13] See Chapter 5, page 165

necessarily so to residents in the past; this would have depended on what they were used to prior to admission, and possibly on how lonely they had been.

The accusation of lack of care is the hardest to establish or debunk. Inspection records can show staffing ratios, patient health statistics, dietary provisions, the condition of the Homes, and even the treatments provided, but they cannot expose the *way* in which the care was given or the attitudes of the carers. For this, the residents themselves must be asked. There is evidence of this nature in the records, and much of it is positive; the resident gives a glowing report, or at least, does not complain. The visitors' books of the colonial institutions mention contented inmates, and the Public Inquiry into the HFI in 1947 heard from residents who were "very happy in being there and well looked after".[14] When standards monitoring was introduced in the 1980s, the inspectors began to speak to the residents as part of the accreditation process, and the majority of reports were positive. This is no proof, of course, that the residents really had nothing to complain about; residents are very dependent on nurses, and are unlikely to criticize in circumstances where reprisals might make their lives even less pleasant.[15] But stringent inspection routines and the increasing scrutiny of the sector, coupled with the media's delight in exposing neglect, ill-treatment and poor conditions, makes it likely that the reports were reasonably truthful.

Most of the participants in this study also told positive stories about the standard of care in the Homes, but this is not surprising given that most of those who chose to participate did so because of their fond memories and their wish to counterbalance the negative stories they hear from the public and in the media. Others did include some tales of indifferent and apathetic staff, particularly amongst the aides. Helen recalled a number of long-time employees at Cosgrove Park who "would go out and smoke at every opportunity—they didn't really care, all they were there for was to do their however many hours and get out and get paid".[16] But whatever the truth, it cannot be denied that

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[14] AOT, PSC2/1/83 7C/47

[15] For example, a 1986 survey found that 29.5% of residents were 'very happy', 35.4% 'generally happy' and only 16.4% 'not happy' with life in the Homes, but warned that these results should be interpreted cautiously as 'most residents are reluctant to criticize the home or voice criticism of nursing or other staff and their activities': Dr Catherine Rhys Hearn, Quality, Staffing and Dependency: Non-Government Nursing Homes, (Canberra, 1986), Section 6.6

[16] Interview with 'Helen'

all residents in all Homes at all times received more care than they would have done at home, in the community, on their own, particularly after the introduction of trained nurses.

The nurses

> Nurses are the backbone of services caring for the aged. … But nursing is also the Achilles' heel of services for the aged. Nursing the bed- and chair-ridden elderly is often heavy and unrewarding work. The tasks are more domestic and hygienic than technical or exciting. … The grand old ladies of the nursing profession have been, if anything, even more disdainful towards the care of the aged as a profession and as a source of training than the grand old men of the medical profession.[17]

Why were the nurses so negative about their work? Is aged care nursing 'real' nursing?

Not one of the twenty-four people with whom I spoke for this study actually planned or chose a career in the area, whether aide or RN, as can be seen in the postscript.[18] This does not mean that no-one ever set out to work in aged care as a career choice, but the evidence suggests they were few and far between, at best. The official records contain numerous mentions of the difficulty in recruiting nurses, and the literature from other countries where nursing homes proliferate suggests this is not an Australian oddity. There is little doubt that nursing home work has a low status in the nursing hierarchy, a fact acknowledged by several participants. [19]

One reason for this is the similarity between the work done by aged care nurses, particularly the untrained aides, and the domestic staff in the Homes.[20] In the 1970s, in

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[17] Bruce Ford, *The Elderly Australian*, (Ringwood, Vic, 1984), page 108

[18] This was noted in other studies, too; see Joel Savishinsky, *The Ends of Time: Life and Work in a Nursing Home*, (New York, 1991) where only one RN in the Home had chosen aged care; and Renee Shield, *Uneasy Endings: Daily Life in an American Nursing Home* (New York, 1988)

[19] Interviews with Marguerite Bramble, and Roz Wilson. For confirmation of this, see, for example: Rhonda Nay, 'An ageing society: implications for nurses', in Genevieve Grey and Rosalie Pratt, (eds), *Issues in Australian Nursing 3*, (South Melbourne, 1992); Brendan McCormack, 'Gerontological nursing—the state of the art', in Malcolm Johnson, (ed), *The Cambridge Handbook of Age and Ageing*, (Cambridge, 2005); MF Cullen, 'Nursing care', in Michael Denham, (ed), 'Care of the Long-Stay Elderly Patient, (London and Canberra, 1983); Charles Stannard, 'Old folks and dirty work: the social conditions for patient abuse in a nursing home', *Social Problems*, 20(1973), 329-342; Mary O'Brien, *Anatomy of a Nursing Home*, (Maryland, 1989); Katherine Carr and Mary Kazanowski, 'Factors affecting job satisfaction of nurses who work in long-term care', *Journal of Advanced Nursing*, 19(1994), 878-883. Doreen Norton mentions that the geriatric wards were seen as 'punishment wards' for nurses in the English hospitals (*The Age of Old Age* (Harrow, 1990).

[20] See Chapter 3, page 97

addition to caring for the residents of Nazareth House, Barbara and her fellow aides were responsible for cleaning bathrooms, making beds, and even washing and polishing the floors.[21] Even the RNs, in supervisory positions, did very little clinical nursing and used very little technology, a situation that continues today. Although the Homes improved dramatically throughout the second half of the 20th century, introducing rehabilitation and physiotherapy services and allowing the RNs to provide an increasing array of treatments and drugs to the residents, they still lagged far behind the scientific and medical discoveries that kept the hospitals at the cutting edge of health care. Perhaps the reason that the traditional nurse's uniform was retained for so long was due to this desire to make their professional position clear to all. Not everyone took things so seriously, however:

> When the Matron was away, one of the housemaids (who was a good friend of mine), she'd put my veil on and I'd put her cap on, and I'd get the vacuum cleaner out and be rushing around, and she'd be taking the pills around![22]

Another reason for the low status of aged care nursing within the profession is due to its identification with geriatric medicine. If the goal of medicine is to cure, geriatric medicine is a speciality of failure, as patients cannot be 'cured' of old age. The nurses who work in the area are therefore also failures, second-best to their hospital-based colleagues who have the potential to help their patients recover and leave. The lack of technological and advanced clinical care in the Homes prompted a perception that looking after old people is unchallenging, at least from a technical point of view. No-one doubts that the people themselves can be difficult—that statement appears time and time again in the official records, usually as an excuse for neglect or less than perfect treatment—but the work is not. Aged care nurses carry out repetitive, unexciting tasks, involving 'basic' body work rather than the medical-allied technical work of the hospital.[23] This leads to the view is that it does not matter if the RNs who work in aged care are not of the highest calibre; they cannot achieve any great improvements and they cannot do too much harm. Aged care nursing is not 'real' nursing. Pat summed up this belief in our interview, and her attitude was not unusual.

> I knew I couldn't work at the Royal, because things were changing and I wouldn't be able to keep up—even in 1960 things were different to when I'd been there in the 1940s. When Dr Young said to me 'I'll get you a job at the Queen Vic,

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[21] Interview with Barbara Allen
[22] Participant's name withheld
[23] John Stevens and Jan Herbert, *Ageism and Nursing Practice in Australia*, RCNA Discussion Paper No. 3, (Deakin, 1997)

> they're needing people there', I took that because I knew it wouldn't be real nursing.[24]

This opinion appears to have prevailed amongst the medical men who held positions of authority over the aged care sector for much of the 20th century. In 1946, the Medical Officer of St John's Park turned down an offer for his nursing staff to attend lectures at the Royal Hobart Hospital in order to qualify for registration with the NRB, because he believed that not only were the staff unlikely to have the 'necessary educational standard required', but that their experience in the Home would be too limited in nature.[25] The advances made in the sector during the next decade were not sufficient to change the views of the Director General of the Health Department, who in 1960 wanted the staff to have some training, but not too much, as they were 'primarily employed … to look after old people'.[26] The introduction of specialized geriatric RN training at St John's Park did little to change these views; even the head of the NRB, which registered the graduates, did not believe the qualification to be of much value, and the public agreed.[27]

> You did nursing blocks, same as they did at the hospital. You went in for six weeks training PTS. I did three years training, from '71 through to qualifying in 1974. We got exactly the same pay as the nurses at the Royal, it came under the Public Sector awards, and the training wasn't much different … we covered an awful lot. We did everything; you got to do all the procedures and that. I think the public saw us as different to general trained, and the status wasn't as high. There was a few people that used to say St John's Park was the PBW—'public bum washers'.[28]

Such evaluations made it clear to the nurses that aged care was not an area for the ambitious or even professionally proud RN, and it became seen as an area for the superannuated, the de-skilled, and the prospective retiree. Several participants mentioned the advanced ages of some of the nurses they worked with in the Homes[29], and studies have shown that many aged care RNs work in the sector because they are 'too old' or no longer have the necessary skills and knowledge to work in an acute care environment.[30]

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[24] Interview with Pat Job
[25] AOT, HSD6/1/2814 98.7 Letter from Director of Health and Medical Services to Dr J Tremayne, Medical Officer, 21/5/46; letter from Dr Tremayne to Director of Health and Medical Services, 28/5/46
[26] AOT, HSD6/3/2494 Memo from J Edis to Superintendent Trebilcock, 6/7/1960
[27] See Chapter 4, page 139
[28] Interview with Peter Sweeney. Interestingly, Humphrey McQueen notes that when hospital nurses went on strike in the 1970s, they had been put down by doctors for a hundred years as 'expert bum washers': *Social Sketches of Australia 1888-2001,* (St Lucia, 2004), page 279
[29] See Chapter 4, page 128
[30] Dr Catherine Rhys Hearn, *Quality, Staffing and Dependency*, (Canberra, 1986). A participant in one American study said, "When I looked for employment … they suggested, well you've been out for a while,

Affect control theory can offer yet another explanation for why some aged care nurses are so negative about their work. If a trained nurse sees herself (or himself) as a person who provides therapeutic care, who is good, powerful, and active, then working in a Home can disrupt this image. First, the parameter of evaluation can be affected. The RNs who worked in the Homes before the introduction of standards monitoring spoke of their dislike of some of their duties: restraining wandering residents, coercing others out of bed at 'some ungodly hour', forcing them into the shower, making them join in activities they did not want to do, tricking them into taking medications or undergoing treatments against their will. Even today, the RNs expressed the view that they were not doing the best by their charges, denying them psychosocial care and the dignity of autonomy even as they upheld their physical health and safety. When a person is forced to do something that he or she feels is not right, then that person cannot see themselves as 'good', and a negative deflection occurs. Some of the participants in this study addressed this by attempting to make a difference, and others justified it to themselves by arguing that the actions were for the residents' 'own good'. Others simply left the sector altogether.

Secondly, the potency of the nurse can be decreased. An aged care RN is in a curiously ambivalent position where power is concerned. Although the RN is usually in complete charge of the Homes, he or she cannot heal the patient. In the healthcare context, where cure is better than care, the aged care nurse's therapeutic skills are therefore found lacking and this can leave the RN feeling weak instead of powerful. Thirdly, the parameter of activity may be compromised. Whilst there is no doubt that nurses were extremely busy in the past and continue to be so today, the nature of that activity has changed. The nurses at New Town worked long hours and had little time away from work, sharing a room with their charges until well into the 20th century. The matrons of the Homes were often on call twenty-four hours a day, and were as much captives of the total institution as the inmates they supervised. Eleanor "never stopped" when she was on duty at the Home for Invalids in 1948, Claire was "too busy" to listen to the radio on the wards at St John's Park in 1954, and Roz remembered that at Nazareth House in the 1980s, "You ran, from the minute you got there to the minute you left". Even today,

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you know, you'll do less harm if you go into gerontology because they're old and they're going to die anyway": Geert Boschma et al, 'Oral history research', in S Lewenson and EK Herrmann (eds), *Capturing Nursing History,* (New York, 2008), page 94

Margaret loves the fact that she is "always busy". But whereas Eleanor, Claire, and Roz were physically active, doing injections and dressings, now they mainly fill out the never-ending paperwork. Pat noticed this change in focus:

> You have to write everything down, and you have to account for everything … there's much more regimentation, and rules, rules, rules. You don't see many trained staff, I mean they're there, they give out the pills obviously, but you see the carers. There are so many more carers and ENs, and they do most of the work. The RNs are doing the paperwork, sitting in the office, reams of paper. [In the 1960s] we did everything, making the beds, and the bedpans, and making sure their bowels were working, and absolutely everything that all the aides and carers do now. It's a pity for the nurses, because they don't know what nursing is.[31]

So maybe aged care nursing *was* 'real' nursing after all.

Are RNs really necessary in aged care?

'Real' nurses or not, the RNs were definitely needed. The residents suffered from a range of chronic illnesses and there were also acute emergencies, such as "a pulmonary oedema attack in the middle of the night, or if they fell over and fractured their femur, those kind of things".[32] Even without this clinical expertise, there is evidence that the majority of abuse and neglectful treatment of residents comes from the untrained staff members in the Homes. A number of recent studies have shown that the better trained the nurse, the better the outcomes.[33]

> On the staff depends the happiness and efficiency of the hostel. Even if the buildings and equipment are perfect, the hostel will be an unhappy place if the staff are unworthy. Conversely, a devoted staff, united in high ideas of service, can make the most unpromising buildings into contented peaceful homes.[34]

Aged care and the status of old people

> …the test of a civilization is the way that it cares for its helpless members.[35]

What does aged care reveal about the status of old people in our society? Their status has certainly changed throughout the period of white settlement in Tasmania. The inmates of the 19th century institutions were overwhelmingly emancipists—ex-convicts, with all the

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[31] Interview with Pat Job
[32] Interview with Roz Wilson
[33] See, for example, Jane Bostick, 'Relationship of nursing personnel and nursing home care quality', *Journal of Nursing Care Quality*, 19:2(2004), 130-136
[34] Patricia Shaw, *Old People in Homes*, (London, 1963), page 150
[35] Pearl S. Buck (1892-1973), *My Several Worlds* [1954]

baggage of moral degeneracy that that social identity implied. They had a very low status, but it was not because they were old people, it was because they were those *particular* old people. In the first three or four decades of the 20th century, the inmates were no longer emancipists but the majority of them were still drawn from the lower classes. They continued to hold a low social status but again, this was reflective of the low status of working class people in general. Within society, the status of the elderly was determined by their social status; a rich old man was held in as high regard as a rich younger man.[36] There is no doubt, however, that elderly people had a lower status than the young, with far more done to ameliorate the conditions for orphans and schoolchildren than the old and frail. But as explained in Chapter 2[37], this was not necessarily because children were regarded more highly, but rather because they were seen as a greater risk to society and therefore needing more attention to ensure their continued good behaviour.

It was only in the 1930s that the elderly began to be seen as a discrete demographic group, with particular characteristics and particular needs.[38] The fact that St John's Park was upgraded and efforts made to improve the lives of the inmates is evidence that their status as old people was improving, and the uproar about the sub-standard conditions at the Home for Invalids supports this. The passing of the *Aged Persons Homes Act* in 1954 and the building of Cosgrove Park is indication that, at least in the eyes of federal and state governments, the status of old people was increasing. Providing therapeutic and medical treatment to the residents of the Homes showed that age was no longer seen as a disease in itself, and old people were no longer considered unworthy of efforts to ameliorate their ailments.

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[36] Until the development of old age as a discrete demographic group, this was the norm in most societies; wealth brings power, no matter what the age of the person: see, for example, James Dowd, 'Social exchange, class, and old people', in Jay Sokolovsky, (ed), *Growing Old in Different Societies*, (Belmont, CA, 1983); Pat Thane, (ed), *The Long History of Old Age*, (London, 2005)

[37] Chapter 2, page 52

[38] Frederic Zeman's article, 'The medical and social problems of old age: a critical bibliography for nurses and social workers', 44:11(1944), 1046-1048, includes entries such as an article from *Harper's Magazine* entitled 'Old people: a rising national problem', published in October 1939, and *The problems of aging*, a volume 'devoted to the study of the aging process', also published in 1939. Other publications about the new 'problem' demographic include IM Rubinow, 'The modern problem of the care of the aged', *The Social Service Review*, 4:2(1930), 169-182; and John J Griffin, 'The growing problem of the aged', *The Social Service Review*, 19:4 (1945), 506-515

The willingness of the wider community to become involved with the Homes also suggests that they could command some sympathy at every stage. The visits to inmates of the colonial institutions and the provision of treats, not only on feast days but every day, is testament to this. Community involvement gradually increased throughout the 20th century, and by the 1960s, community groups even went so far as to fund and help build extra facilities for the residents of the Homes, such as the Carlton Beach holiday home, indicating that old people had achieved a greater measure of importance in the eyes of society.

What is the status of old people now? From the evidence in this study, I think they enjoy a higher status now than at practically any stage in the past. There is a great deal more attention paid to their needs and a significant amount of public pressure to provide safe and suitable care. Some may disagree with this, suggesting that old people are devalued, unwanted, living in Homes rather than with families who have abandoned them, but the fact that we even argue about this shows that they matter. In the 19th century, few people questioned if an old person was comfortable and happy. Old men died in the streets, old women were left to lie on straw paillasses, covered in flies, in converted prisons, with no one to care for them. Now, we care. Now, we have in place a carefully formulated and strictly monitored structure of standards and outcomes that ensure old people are sheltered in comfortable accommodation, fed properly, and treated well.

So why, despite the many safeguards and improvements put in place and the efforts of the government, the industry regulators, the administrators and the staff, does aged care still tend to engender negativity from the public?

The negative image of aged care: an explanation

There are several possible reasons for the continued negative image of aged care. In Tasmania in particular, the legacy of the past is hard to overcome. The fact that aged care here began as part of the convict system, as an overtly disciplinary mechanism to control the outcasts of the nascent colony, has coloured the sector ever since. St John's Park, that relic of the transportation era, was used as a Home continually for over a hundred years from the 1870s, and no amount of outside beautification and inside renovation could remove the stigma and negativity of 'going behind the clock' for the people of Hobart. The public outcry against the conditions within the HFI cannot have helped the northern

population of the island to look upon Homes with much approval. Though elements of the townsfolk did their best to make the lives of the inmates more pleasant, with donations of treats and visits to entertain, the era of 'making do and good enough' is a clear original for many of the stories of neglect, unhappiness, and monotony.

The amount of exposure that Homes receive from the media whenever things go wrong and the lack of it when they go right is another factor. The newspapers are more than willing to expose a Home that is doing the wrong thing, whether by keeping the resident too safe, or not safe enough. Several participants told of their frustrations with such negative reporting.

> The newspapers, they never put anything good in. When my mother passed away, Judy and Barbara came to see me and we were saying that. There was some big report about a home in Victoria that had done something dreadful, and Barbara said, "Can't they ever put anything *good* in the paper?' And it's true, they never do. They never put anything nice that happens.[39]

This kind of publicity is extremely influential, not only for the public who receive a skewed picture of the sector, but also for the staff in the Homes, who feel attacked and devalued, and become stigmatized as neglectful and abusive.[40] There is also the social stigma directed towards families who are perceived to have 'abandoned' their elderly relatives to the 'unloving care' of the Homes, which continues to this day.[41]

Ironically, the growing raft of rules and regulations, meant to improve the sector and ensure the safety and security of the residents, may also have contributed in some ways to the lack of desire to enter a Home. Once a person is admitted, they may find themselves sheltered from the outside world, protected from the dangers of soft cheeses and the three-minute egg, woken at seven in the morning and cajoled out of bed to join in the activities indicative of 'successful aging'. The Homes themselves must conform to

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[39] Interview with Nancy Langley. This is not a phenomenon unique to aged care, of course. For the media, 'good news is no news', and there is scientific evidence that this 'negativity bias' is hardwired into the human brain, which 'reacts with far more electrical activity to the stimuli of bad news than to good [so] our attitudes are more heavily influenced by downbeat than good news': Angela Neustatter, 'Good news is no news', *The New Statesman*, 28th August 2008

[40] 'The quality and quantity of mass communications pertaining to nursing strong influences the course of the nursing profession by shaping the nature of nursing's relationship with the public it serves': Beatrice Kalisch & Philip Kalisch, *The Changing Image of the Nurse*, (California, 1987)

[41] See Chapter 6, pages 214-215. Of course, 'family' usually means 'daughter'; Nancy said "when we had to put Mum in [Nazareth House], my brother said "this wouldn't have happened twenty years ago". I said, "well, come on David, come over and get her and take her home with you", and he wasn't interested."

accepted standards, producing documented evidence of this compliance that makes paperwork all consuming in search of the funding dollar. And the nurses, too, find themselves even further away from 'real' nursing as they spend their days producing that paperwork rather than caring for the old people they have been employed to serve.

I began this study with the assumption that aged care had always been a 'bad thing', and that I would find the reasons for this in a historical examination that would unearth horrifyingly bad conditions, ageist policies, uncaring bureaucrats and disdainful medical men. I was not surprised when I found evidence to support the truth of these beliefs, but I was surprised to discover that they were far from the whole truth. The history of aged care in Tasmania, like most histories, is far from a straight line of triumphal progression. The image of the Homes has been good and bad, and the treatment of the residents has been approved and castigated, sometimes both at the same time. How can this be explained?

Once again, the parameters of affect control theory can help to explain these seemingly paradoxical findings, and suggest a reason for the prevailing negativity of the image of aged care. Over the last two hundred years, old people in the Homes have variously been invalids, emancipists, old lags, old boys, pathetic creatures, paupers, old folk, old ladies, sufferers, troublemakers, patients, old gentlemen, veterans, grandmothers, grandfathers, residents, clients; sometimes more than one of these at any given time, depending on the observer. These changing social identities and the emotions they evoke have affected the way in which aged care has been viewed over the years—accepted, embraced or decried.

When the care provided, no matter how basic or substandard to modern eyes, corresponded with expectations of what *should* be provided, aged care was acceptable. Throughout much of the 19th century, the inmates of the government-run institutions lived in overcrowded, sometimes dirty, often uncomfortable conditions, yet there was little outcry against their treatment from the public or by the inmates themselves. The majority were ex-convicts—bad, powerless but active—and therefore 'undeserving' poor, and in the eyes of Tasmanian society they were not deemed to merit much care at all. When honest labourers struggled to make ends meet, the inhabitants of the charitable institutions were lucky to have a roof over their head and prison rations. It was only a few of the

more charitable and enlightened citizens, like Dr Hall of Hobart, who saw them instead as 'pathetic creatures' or 'poor old fellows'—not really bad, inactive, and weak— and decried their conditions, but these people were in a minority. Only the overtly sub-standard conditions of Port Arthur and Cascades attracted any sizeable criticism, the first because of its extreme penal connotations and the latter because of its unpleasant location. These two institutions could not even be justified in light of the convict stain borne by the paupers within, and their use was limited. New Town was more suitable, and the inmates themselves did not often see themselves as deserving of more comfort or attention than they received under its roof. Even the increasingly rundown Invalid Depot in Launceston had its supporters. A few complaints were made, and a few men absconded to chance their luck on the streets, but the majority of inmates were grateful for a bed and followed the rules laid down to allow them to stay.

As the 20th century dawned, the Homes began to attract more widespread condemnation. As the emancipists died, the removal of the convict stain meant that the inmates took on more deserving social identities. The Launceston Invalid Depot was replaced with the more suitable Home for Invalids, and the New Town buildings were renovated to bring conditions up to a standard suitable for 'poor old men' and 'old dears' who were weak, powerless and almost good. As the Homes aged and conditions deteriorated, this did not marry well with the improved social identities of the inmates, and over the next few decades there were several public outcries about standards of living and the care—or lack of it—provided to the 'old gentlemen' and 'old ladies'. But whilst the public protested, the authorities adjusted the identities of the inmates to excuse the shortcomings; the 'poor old people' became 'difficult', and even 'troublemakers', and this was excuse enough not to make any great changes.

By the middle of that century, however, even the authorities had to change their tune. An increasing number of studies into social conditions showed that it was unreasonable and misguided to blame old people for their own hardships. Now they were 'old ladies' and 'old gentlemen', most definitely good, and they deserved more. The Homes as they stood were no longer acceptable in the view of a majority of people, and new arrangements were called for. The emergence of a strong private sector and the opening of Cosgrove

Park helped to address these issues, and demonstrated that when conditions exceeded expectations, aged care was viewed very favourably, as Elaine and Judith remembered.

> *Elaine:* The public attitude to nursing homes was very positive in those days, wasn't it?
> *Judith*: Yes, I think so!
> *Elaine:* I don't remember any negativity, at all. There was a lot of support.[42]

Most of the residents of the new public Home were still from the lower socioeconomic classes, and the conditions they were provided with were far better than they could expect in the community. Cosgrove Park was 'glamorous', and its rapidly expanding waiting lists were testament to its popularity. St John's Park, on the other hand, with its aging buildings and links to the old convict system, was not. 'Going behind the clock' was something to be avoided, despite the efforts of various superintendents to provide bigger and better facilities. The majority of the private Homes occupied a more middle ground. Providing conditions similar to those that the residents would have experienced in their own homes, they avoided the stigma of the public institutions but never attained any accolades, and now they are no longer an option.

In the 1980s, the introduction of residents' rights brought a new found power to the inhabitants of the Homes. Now they have taken on a social identity that is almost the exact opposite of that held by the old people in the charitable Homes in the 19th century. Where the 19th century inmates had been bad, undeserving of comforts, kindness, and the ministrations of 'respectable' nurses, modern day residents are now good, deserving and demanding gentle care, consideration, and expert nursing care. Where the inmates were powerless, kept subjugated by punitive control measures and strict discipline, the residents now have the power to complain and the authorities have the power to ensure they receive suitable care. The only parameter which has remained similar is that of activity, but here also there are changes. Where the inmates were required to work for their keep, the residents today are expected to play for their health. And yet, despite these vast improvements, still few people want to enter a Home and few nurses want to work in one.

[42] Interview with Elaine Sturzaker and Judith Beard

The negative image that I carried into this study is understandable in the light of the historical evidence. The dreadful reputation of the early Homes, combined with continued publicity for scandals and the reflection of the American nursing home industry, prepares the public to think badly of aged care. The application of affect control theory can even offer an explanation of why ostensibly good service and conditions can still engender a negative response. The modern resident is truly in safe hands, cocooned from the outside world and protected by legislation and regulations that are often used by the Homes to restrict choice and deny individuality, but this paternalistic control is unattractive to the younger generations. Whereas old people were once willing, or acquiescent at least, to place themselves in the 'safe hands' of the nurses 'for their own good', the prevailing social identity of an old person as an autonomous, responsible adult makes this paternalism problematic. No matter how beautifully decorated the Home, how lovely the garden, how considerate the care, we do not want to enter those doors and lose our freedom. Depot, rest home, geriatric hospital or aged care facility, they are all still total institutions.

> …the basic reason for deficient nursing home care lies in the conflict *between the purpose for which these facilities should exist and the regulatory system used to operate them.* First and foremost, these institutions should be *homes*, with living arrangements which permit patients to enjoy life as much as possible.[43]

This is the dilemma facing Homes today. They need to be big enough to be financially viable, but the bigger they are, the less personalized the service, the less home-like the surroundings. To gain accreditation, they must adhere to the many rules and regulations put in place to guard the wellbeing of the residents, but this often results in the imposition of restrictions which prevent the residents from really enjoying life. This study has shown that simply legislating for improvements to please those in authority is not the answer. What is important is that the care provided coincides with what is wanted by the resident. When a Home is a home, the positive side of aged care emerges.

Despite the negativity that has overlain the aged care sector for much of its existence, the Homes have been and still are the preferred choice for many people. They offer security, companionship, assistance, comfort, and even some comparative independence for their residents. And I believe that the residents deserve the last word.

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[43] Clifford Bennett, *Nursing Home Life*, (New York, 1980), page 63; italics in original.

I lived with my daughter for quite a while—
well, I couldn't live at home after my sister died—
they wouldn't let me stay there alone.
They have a lot of interests and go out and about.
And that's how it should be—but my interests are not the same.
I decided I might as well go to Aldersgate
where I'd be independent, and have a bit of company.
My daughter had a talk to the matron.
She had a nice little room all ready for me.
Wasn't that lovely.[44]

[44] Excerpt from Lillian Cairns, 'Independence', in Robyn Friend, (ed), *Fancy Seeing You Here: A Collection of Writing by Residents of Nursing Homes in Launceston and the Tamar Region*, (Launceston, 1989), page 3

Postscript: the participants

Eleanor (interviewed 3rd November 2009) was half way through nursing training at the Launceston General Hospital in 1948 when she met the man of her dreams and left to be married. She took a position as a semi-trained nurse at the Home for Invalids during her engagement, regularly escaping over the high fence at midnight to meet her fiancé without the matron's knowledge ("The silly things you do when you're young!"). Although she never returned to nursing, her daughter became an RN and worked at Bethshalom, with Dorothy Morse.

Helen (interviewed 13th March 2009) worked at Cosgrove Park in 1988, filling in for an RN who was on long service leave. She found the experience frustrating and depressing, and quickly moved on to a permanent position in a surgical ward at the Launceston General Hospital, where the patients 'got better and went home'. She spent the rest of her nursing career there, and is now happily retired.

Margaret (interviewed 18th June 2009) 'detested the thought of aged care', but was coerced (her word) by the nuns of Nazareth House to take up an RN position in 1985 when her children attended the Larmenier School next door. Despite her initial distaste for the work, she found the aides so friendly and encouraging that she grew to like it, and stayed for six years. After working as a midwife for four years, she returned to the Home and still works in the sector today, at another Home owned by the company that bought Nazareth House.

Barbara Allen (interviewed 5th May, 2009) was offered an aide's position at Nazareth House in 1977, when her youngest child enrolled at Larmenier School, the primary school attached to the Home and also run by the Sisters of Nazareth. She remained there for twenty years, retiring in 1997. Two years later she came out of retirement and returned to the Home on permanent night shift, finally leaving for good in January 2009, at the age of 73. She found it 'a very happy and rewarding' twenty-nine years, and made many long-lasting and deep friendships with co-workers and residents alike.

Elizabeth Barron (interviewed 18th November, 2009) became the first domiciliary nurse in the rural north-east of Tasmania in 1968. An experienced Queen's Nurse from Scotland, she had an extremely successful career in the service, finishing her public career in 1990 as Director of Nursing for Community Health. After retiring, Liz was appointed to the Board of Umina Park Nursing Home, and agreed to become their Director of Nursing in 1991. Over the next eight years she supervised the upgrading and expansion of the Home, and finally retired—permanently—in 1999. She was awarded a Medal of the Order of Australia in June 1998, and inducted into the Tasmanian Honour Roll of Women in 2008, for services to health.

Maureen Battese (interviewed 11th February, 2010) trained as a midwife, and worked as an RN at Bethshalom for a few hours a week during her first pregnancy in 1969 to make some pocket money. Although she had no intention of staying, she remained with matron Dorothy Morse for the next thirty years, moving with her to Sunny Brae and taking over as Director of Nursing when Dorothy retired. She is now retired herself, but retains a little part of the Home she worked in for so long: a green chair that once graced a room at Sunny Brae and holds 'lots of memories' of the past.

Judith Beard (interviewed 14th April, 2010) started at Cosgrove Park as an RN when it opened in 1954, fresh from completing her nurse training. She was only there for six months that time, leaving to get married, but returned in 1958 and stayed for seven years. She was in charge of the men's division, supervising Peter Davy and the other male attendants, and is friends with Kay Joyce. She trained with Elaine Sturzaker at the Launceston General Hospital, and they both have lunch on a regular basis with some of the other ex-nurses they trained with sixty years before.

Dr Marguerite Bramble (interviewed 5th January, 2010) did not particularly enjoy her student nurse rotation to the long-stay geriatric ward of the Royal Hobart Hospital in the early 1970s, and she moved into other areas when she graduated as an RN, and then out of nursing altogether. In 2004, she returned to nursing, undertaking an Honours degree in a nursing home, and continuing with doctoral research in the area of dementia care. Marguerite is now an academic at the University of Tasmania and a research associate for the Wicking Dementia Research and Education Centre, Hobart.

Peter Davy (interviewed 10th March, 2010) was given a job as a cleaner at Cosgrove Park in 1964 by Bruce Griffiths, the administrator, who was 'great friends' with his mother. He fell in love with the job and made it his life's work, remaining there until 1993 when the stress he felt from the sale of the Home to private operators brought on a series of heart attacks. Peter then went to university and took his BA, but he still feels that helping old people live comfortably is one of the most important things a person can do.

Vera Green (interviewed 2nd April, 2009) went to work at Ward H in 1980 because she wanted a permanent day-shift job, as she had three small children. Despite her initial lack of interest in geriatric nursing, she became a keen and outspoken advocate for dementia sufferers, and played a key role in the foundation of ADARDS and the first private special dementia care unit in Launceston. She left the aged care sector in 1989, suffering from depression and stress arising from constant financial constraints placed upon her by the 'business' model of management adopted by the Home's administrators.

Pat Job (interviewed 23rd January, 2010) took an RN position at the Queen Victoria Home for the Aged after her divorce in 1960, as the flexible hours made it possible to look after her young children whilst working full time. She stayed at the Home for five years, becoming sub-matron, and left in 1965 when the heavy lifting work took its toll on her back, already weakened by polio she had contracted during the 1953 outbreak. She became a Radiology nurse at the Royal Hobart Hospital for ten years, and later worked casually at two other Homes for short periods. Pat, now long retired, lives near to the Queen Vic, and has no fears about going to live there some time in the future.

Kay Joyce (interviewed 24th March, 2010) was visiting an aunt at Cosgrove Park in 1960 when she was asked if she would like a job as an aide. She agreed, and apart from some short breaks to have her children, stayed at the Home until it sold to private operators in 1992. She became an EN in 1990, and after leaving Cosgrove Park she moved to Allambi, where she worked until 1997, when it too 'went private'. Preferring to stay in the public sector, at the time of her interview Kay was running the Occupational Therapy Department at the Launceston General Hospital.

Nancy Langley (interviewed 10th June 2009) worked as an aide at Nazareth House from 1965 until 1999. She spent much of this time on the night shift, which allowed her to care for her children before and after school, and made many firm friends, including Barbara, with whom she enjoyed the occasional game of toilet roll football in the corridors when the nuns were asleep. Nancy loved her surrogate family at the Home, and for a while it even included her real family, when her mother was admitted in her last months. Like Barbara, she still visits the Home as a volunteer.

Michael McKean (interviewed 18th March, 2010) was working as a cleaner at Evandale Hospital, an annexe of Cosgrove Park, when he was offered a position as a geriatric attendant at Ward H in the early 1980s. Michael's mother had been an RN at a nursing home and he was comfortable with old people, but he took the job mainly because it was much closer to his home. He moved to Allambi when the special dementia unit opened, and stayed for several years until personal circumstances forced him to move interstate. He has since worked in both public and private hospitals as an attendant, but has never returned to aged care

Dorothy Morse (interviewed 19th November, 2009) ran Bethshalom Home for Aged Christians for the Gospel Hall Church from its opening in 1964 until 1969, when she left to open her own Home, Sunny Brae. She and her family operated Sunny Brae for thirty years until increasing regulation and her failing eyesight made it necessary for her to sell. Sunny Brae is closed now, converted to private flats, but Dorothy still has some mementoes. Now in her eighties, she uses a shower chair that she bought for the Home from Abbeyfayle when it closed in 1972, and there are still a great many people to whom she will always be 'Matron Morse'.

Joan Mutimer (interviewed 6th November, 2009) had been a Queen's Nurse in England before immigrating to Tasmania with her husband and children in 1969. She started working as a domiciliary nurse in Launceston in 1969, because the regular hours were more convenient for her young family. She left Launceston in 1975 to take up a position running the Cook Hospital in the Nullabor, and although she returned to the island some years later, she never returned to community nursing.

Alex Myers (interviewed 10th March 2009) worked at Abbeyfayle Nursing Home in 1968, after she finished high school. Her mother knew the matron, and arranged the job for her. As child of immigrant parents she had no elderly relatives of her own, and knew no old people at all. She found the Home a little disturbing and rapidly discovered that she didn't have a nursing bone in her body. She left to go to university, and has since made a successful career as an artist and musician.

Maureen Nichols (interviewed 25th May, 2010) spent twenty-four years at the Scottsdale Hospital, in the north-west of the state, where she was Director of Nursing until her retirement in 2008. The rural hospitals are the source of government-run aged care in Tasmania today, and Maureen was responsible for the operations of the James Scott Unit, the long-stay aged care wing attached to the hospital. She was invaluable in providing a balanced view of policy and regulation requirements, as both a practitioner and an administrator.

Eileen O'Leary (interviewed 8th August, 2009) found a 'second family' at Nazareth House, where she started work in 1982 as a cleaner soon after her arrival from Ireland. She became an aide quite quickly, and one of the RNs with whom she worked suggested that she go to college and become an RN herself. Eileen worked at Nazareth House part-time throughout her nursing training, but left after she graduated in 1991 because she was 'sick to death of people dying'. She now works in the Orthopaedic Outpatient Clinic at the Launceston General Hospital, and is still good friends with the RN who persuaded her to change career.

Claire Paynter (interviewed 12th March, 2010) worked as a semi-trained nurse at St John's Park for three years from 1951. Like Eleanor, she had left her training at the general hospital upon her engagement, but unlike Eleanor she returned to nursing after her marriage. She became an enrolled nurse, and spent the final twenty years of her career at Toosey Public Hospital at Longford, a country town about 18 kilometres from Launceston. Although Toosey had an aged care wing, she preferred to work in the acute hospital wards, finding it less stressful than geriatrics.

Elaine Sturzaker (interviewed 14th April, 2010) went to Cosgrove Park after Judith had left, taking the job in 1966 because of the convenient hours, and to help pay for some new tyres for the family car ("my husband said 'you can go to work until the tyres are paid for!' and thirty years later…"). She discovered that she loved geriatrics, and stayed at Cosgrove Park for twenty years as the night shift RN. She moved on to run the Day Therapy Centre at a private Home for another ten years, until she retired, and is still great friends with Judith.

Peter Sweeney (interviewed 21st May, 2010) enrolled in the St John's Park Training School for Geriatric Nurses in 1971, becoming one of the last four students (and the only male) to graduate in 1974, when the Geriatric RN course was dropped. He worked his way up through the ranks at the Home, becoming a Charge Nurse before leaving in 1983 to move to a country town, where he continued to work in aged care. He took his Bachelor of Nursing degree in 1998, and has worked at the Launceston General Hospital since then.

Judy Wall (interviewed 7th June 2009) was recruited as an aide for Nazareth House by a friend who worked in the office there. Like Margaret and Barbara, her children went to the school next door. She started in 1976 and stayed for thirty-one years, because of the 'wonderful people' she met amongst the staff and residents. She left because of increasingly long hours on a less flexible roster, and a surfeit of paperwork, but stays in touch with the many friends she made at the Home.

Roslyn Wilson (interviewed 14th October, 2009) worked at Nazareth House as an RN from 1982 to 1992. She had no experience in aged care, but took the position because the hours were flexible and she had a small child. Despite feeling that it was 'good to make a difference' in the lives of the residents, she did not really enjoy aged care, and she undertook a Bachelor of Nursing with a speciality in child health and parenting, an area in which she continues to work today.

Appendix 1

Participant Information Sheet
Consent Form
Release and Deposit Agreement
Informant Profile

PARTICIPANT INFORMATION SHEET

In Safe Hands: A history of aged care nursing in Australia 1950-2000

Invitation
You are invited to participate in a research project involving the history of aged care nursing practices in Australia. The study is being conducted by Elaine Crisp, PhD Candidate, Dr Sheryl Brennan, Associate Professor of the School of Nursing and Midwifery, and Dr Tom Dunning, Head of School, School of History & Classics, University of Tasmania.

What is the purpose of this study?
The purpose of this study is to record the experiences and practices of nurses who have provided care to older people, whether in nursing homes, day centres or in the community, during the 20th century. Although nurses are the backbone of the aged care sector, their voices are rarely heard and they are almost invisible in published histories of nursing. This study aims to redress this imbalance.

Why have you been invited to participate in this study?
You have been invited to participate in this study because you are its focus; without your memories and experiences this history cannot be written. Your recollections of day-to-day routines, regular chores, and the occasional disaster (or triumph); your happy memories and your regrets and disappointments are all important in painting a picture of the work you carried out.

What does this study involve?
You will take part in a taped interview which will last approximately one to one-and-a-half hours, during which you will speak of your experiences of aged care nursing – these might include your training, your everyday tasks, your feelings about your work and the changes that you saw during the period. The information you give will be at your discretion, and you will be free to withdraw any information from the study when you receive a copy of the interview for your approval, if you change your mind about its use. After the interview, the tape will be transcribed and a copy will be given to you for you to ensure that it is a true reflection of the interview. You will be free to make any necessary changes or elaborate further in another interview, should you desire.

It is important that you understand that your involvement is this study is voluntary. If you decide to discontinue participation at any time, you may do so without providing an explanation. Oral history is a special type of research; unlike many research methods, people's real names are usually used in the work, and the information you give is saved for posterity, to provide help to future historians and researchers. It is possible, however, to provide you with a false name if you prefer.

Are there any possible benefits from participation in this study?
Whilst we cannot claim any direct benefits to you from this study, it is certain that you will be providing a great service to others by your participation. So much knowledge is only to be found in the memories and minds of the people involved; once they have gone, that knowledge is also gone. Your contribution to the sum of knowledge about this topic will be invaluable. It is also true that reminiscence can be a pleasurable experience. It is hoped that benefit will also be derived for the nursing profession; in particular those nurses working in aged care. By establishing the importance of the nurse in providing care to the older person, it is possible that nurses will become more prominent in discussions about the future directions of aged care.

Are there any possible risks from participation in this study?
There are no specific risks anticipated with participation in this study. However, if you find that you are becoming distressed at your recollections, you will be advised to seek support or alternatively, we will arrange for you to see a counsellor at no expense to you.

What if I have questions about this research?
If you would like to discuss any aspect of this study, please feel free to contact either Elaine Crisp on 03 63943101, or Associate Professor Brennan on 03 6324 3976.

This study has been approved by the Tasmanian Social Science Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote [*HREC project number*].

Thank you for taking the time to consider this study. If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.

CONSENT FORM

In Safe Hands: a history of aged care nursing in Australia 1950-2000

1. I have read and understood the Information Sheet for this project.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves participation in an interview for approximately one hour to one-and-a-half hours, and a possible follow-up interview of a similar duration. During the interview I will be discussing my past experience involving the nursing care of older people.
4. I understand that I have the option to have a pseudonym used in place of my name. It has been explained to me that I have the right to withhold the use of any material from the transcripts and tape.
5. Any questions that I have asked have been answered to my satisfaction.
6. I agree that research data gathered from me for the study may be published.
7. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish may request that any data I have supplied to date be withdrawn from the research.

Name of Participant:_____

Signature:_____ Date:_____

I have explained the project and the implications of participation in it to this person and I believe that the consent is informed and that he/she understands the implications of participation.

Name of Investigator:_____

Signature:_____ Date:_____

RELEASE AND DEPOSIT AGREEMENT

In Safe Hands: a history of aged care nursing in Australia 1950-2000

I, ……., grant permission to Elaine Crisp to tape record an interview with me and agree, subject to my ongoing involvement, that:

1. I will have the opportunity to comment on and edit the transcript, on request.

2. The tape and transcript of the interview will be:
   a. returned to me; or
   b. placed in the oral history collection of [*organisation to be negotiated*]; or
   c. deposited in another place of my choosing: (*please specify):*…….
      …….

3. The tape and transcript can be copied and edited by staff of the University of Tasmania.

4. Material from the interview can be published in a book, article or other format, with acknowledgement of the source.

5. I agree the transcript may be used as part of a research thesis subject to the following conditions: *(please specify)*
   a. No conditions
   b. Confidentiality be preserved; I wish to remain anonymous and will be for the purposes of this and any subsequent research, referred to under an agreed pseudonym only in the text and in the accompanying footnotes and references.
   c. Public access to tapes and transcripts to be limited for a specific period of time: *please specify*:.....……
   d. Other conditions:…..……
      ……
      ……

Signature: ……

Name: ……..……. Date: ……..

Statement by Researcher:
I have explained details of release and deposit to this person and I believe that the agreement for placement of tapes and transcripts to be informed.

Signed: …… Date: ……..

INFORMANT PROFILE

Personal information

Name: ……. Sex: M / F

Address: ……..……..……

……..…….

Phone: …….. Email: ……..……...……

Date of Birth: / / Place of birth: …….....

Education: (*highest level of education and date achieved)*

.....……..……

Professional qualifications *(please list all qualifications and date achieved):*

……

……

……..…. ……

Why did you start working in aged care?

……

……

……..…….

Why did you stop?

……

……

……..…….

Have you worked in any other area of nursing?

……

……

……..……..

Do you have any artifacts such as photographs, diaries, journals, text books or personal papers relating to your work in aged care that you would be willing to lend to the researchers for study or reproduction, that may be included in the study? (These would be returned to you as quickly as possible.)

……

……

……..…….....

Appendix 2

List of participants in oral history interviews by role, gender, locality, type of home, and period of employment

Name	Role	Gender	Area	Home	Time Span
Eleanor	STN	female	North	Public	1940s
Claire	STN (now EN)	female	South	Public	1950s,1990s
Judith	RN	female	North	Public	1950s-1965
Pat	RN	female	South	Private Voluntary	1960-1965
Alex	Domestic	female	North	Private Proprietary	1960s
Helen	RN	female	North	Public	1960s,1980s
Dorothy	Matron	female	North	Private Proprietary	1960s-1998
Kay	Aide (now EN)	female	North	Public	1961-1997
Peter	Attendant	male	North	Public	1964-1993
Elaine	RN	female	North	Public/Private	1965-1994
Nancy	Aide	female	North	Private Religious	1965-1999
Joan	RN	female	North	Community	1969-1973
Elizabeth	RN DON	Female	North West	Community/Private Voluntary	1969-1990 1990-1999
Maureen B	RN/DON	female	North	Private Proprietary	1969-2001
Marguerite	RN	female	South	Public	1970
Peter	RN	male	South	Public	1971-1985
Judy	Aide	female	North	Private Religious	1976-2007
Barbara	Aide	female	North	Private Religious	1977-2009
Roz	RN	female	North	Private Religious	1980-1990s
Vera	RN	female	North	Public/Private Vol.	1980s
Michael	Attendant	male	North	Public	1980s
Eileen	Aide (now RN)	female	North	Private Religious	1982-1991
Maureen N	DON	female	North East	Public	1984-2008
Margaret	RN	female	North	Private Religious	1985-2011

STN Semi-trained nurse

EN Enrolled nurse

RN Registered nurse

DON Director of Nursing

Appendix 3

Tasmanian population statistics

Census Year	Population over 60 years								
	Men	Women	Total	Men pop	% of pop	Women pop	% of pop	Total Pop	%
*1841	711	207	918	27285	2.61	16738	1.24	44023	2.09
*1870	4758	1842	6600	52853	9.00	46475	3.96	99328	6.64
1881	3882	1741	5623	61162	6.35	54543	3.19	115705	4.86
1891	4298	2629	6927	77560	5.54	69307	3.79	146867	4.72
1901	3829	3194	7023	89624	4.27	82851	3.86	172475	4.07
1911	3848	3993	7841	97591	3.94	93620	4.27	191211	4.10
1921	5015	5014	10029	107743	4.65	106037	4.73	213780	4.69
1933	8152	7867	16019	115097	7.08	112502	6.99	227599	7.04
1947	9402	10078	19480	129244	7.27	127834	7.88	257078	7.58
1954	10852	12499	23351	157129	6.91	151623	8.24	308752	7.56
1961	11844	15164	27008	177628	6.67	172712	8.78	350340	7.71
1971	13718	18332	32050	199915	6.86	198158	9.25	398073	8.05
1981	18184	24331	42515	212565	8.55	214659	11.33	427224	9.95
1991	23852	31512	55364	231466	10.30	235336	13.39	466802	11.86
2001	28632	36253	64885	232470	12.32	239325	15.15	471795	13.75

Census Year	Population Over 80 years old								
	Men	Women	Total	Men pop	% of pop	Women pop	% of pop	Total Pop	% of Pop
1841	Figures not given			27285		16738		44023	
1870	271	89	360	52853	0.51	46475	0.19	99328	0.36
1881	453	189	642	61162	0.74	54543	0.35	115705	0.55
1891	610	293	903	77560	0.79	69307	0.42	146867	0.61
1901	658	449	1107	89624	0.73	82851	0.54	172475	0.64
1911	548	541	1089	97591	0.56	93620	0.58	191211	0.57
1921	567	736	1303	107743	0.53	106037	0.69	213780	0.61
1933	839	968	1807	115097	0.73	112502	0.86	227599	0.79
1947	1286	1654	2940	129244	1.00	127834	1.29	257078	1.14
1954	1522	1924	3446	157129	0.97	151623	1.27	308752	1.12
1961	1730	2508	4238	177628	0.97	172712	1.45	350340	1.21
1971	1994	3669	5663	199915	1.00	198158	1.85	398073	1.42
1981	2304	5018	7322	212565	1.08	214659	2.34	427224	1.71
1991	3726	7012	10738	231466	1.61	235336	2.98	466802	2.30
2001	5524	10446	15970	232470	2.38	239325	4.36	471795	3.38

Statistics compiled from ABS: 3105.0.65.001 Australian Historical Population Statistics, Tables 4.13, 4.14 and 4.15

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Claire Paynter

Dorothy Morse

Eileen O'Leary

Elaine Sturzaker

'Eleanor'

Elizabeth Barron

'Helen'

Joan Mutimer

Judith Beard

Judy Wall

Kay Joyce

'Margaret'

Marguerite Bramble

Maureen Battese

Maureen Nicholls

Michael McKean

Nancy Langley

Pat Job

Peter Daley

Peter Sweeney

Roz Wilson

Vera Green

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HSD1/1/1984 99.4.36 Home for Invalids – staff – appointment and resignations

HSD1/1/4037 99.3.38 Home for Invalids – staff – appointments and resignations

HSD1/1/4047 DPH 99.12.38 Home for Invalids – patients – miscellaneous

HSD1/1/4048 Home for Invalids – proposed alteration of name of institution

HSD1/1/4050 99.1.38 Home for Invalids – equipment Stores

HSD1/1/4051 Questions to parliament

HSD1/1/5141 98.7.39 St John's Park – shoes – issue to female patients (instead of boots)

HSD1/1/5144 St John's Park – patients – enquiries, reports, complaints

HSD1/1/5145 St John's Park – alterations, renovations, repairs & others (1935-38)

HSD1/1/5165 99.1.39 Home for Invalids – staff appointments – resignations

HSD1/1/5167 99.8.39 Home for Invalids – equipment, stores

HSD1/1/5168 99.10.39 Home for Invalids – visit JC Ackers

HSD1/1/5171 Home for Invalids – patients – miscellaneous enquiries, complaints etc

HSD1/1/5172 Home for Invalids – grading of institution grounds – request from patients

HSD1/1/5175 Home for Invalids – buildings – repairs, alterations, etc

HSD1/1/5177 99.18.39 Home for Invalids – request for enquiry – HEF

HSD1/1/5179 Home for Invalids – excess number of inmates – instruction to Matron

HSD1/1/5181 99.22.39 Home for Invalids – admission – endorsement by Dr Fulton

HSD1/1/5416 Home for Invalids – male patients – removal of moustaches and beards

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HSD6/3/2494 249/4/150 St John's Park – staff training – courses – geriatrics

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HSD6/3/2653 536/30/10 Abbey Fayle [*sic*]

HSD6/3/2665 537/79/10 Sunny Brae

HSD6/3/2666 537/85/10 Trevallyn Nursing Home

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