

**PROFESSIONAL ISOLATION & INDEPENDENCE OF
BUSH NURSES IN TASMANIA 1910–1957**

'We were very much individuals on our own'

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This thesis is submitted in fulfilment of the requirements
for the Degree of Doctor of Philosophy

School of History and Classics
University of Tasmania

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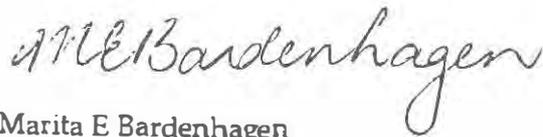
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Marita E Bardenhagen

15 October 2003

AUTHOR'S STATEMENT

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Marita E Bardenhagen

15 October 2003

ABSTRACT

This is a thesis about the lives and roles of women who were Tasmanian Bush Nurses, who engaged in a facet of nursing that originated in 1910 and eventually was renamed District Nursing in 1957. The Bush Nursing Service provided nursing care to the populations of rural townships, the surrounding countryside and bush in a period of Tasmanian history when road transport and communications necessitated the nurse to operate with little day-to-day supervision and support. From a variety of public and private sources and in-depth interviews this thesis explores the twin themes of female professional isolation and independence. It demonstrates the dynamic nature of lived experience as the society in which the nurse lived and worked changed.

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² In all maps, unless otherwise noted, the orientation of the map follows the convention that the top of the map is north.

ABBREVIATIONS

AANS	Australian Army Nursing Service
ABNS	Australian Bush Nursing Scheme
ADB	Australian Dictionary of Biography
AGM	Annual General Meeting
AHRR	Australian Historical Records Register
AIF	Australian Imperial Force
ALP	Australian Labor Party
AMA	Australian Medical Association
ANF	Australian Nursing Federation
ANA	Australian Natives' Association
ANU	Australian National University
AOT	Archives Office of Tasmania
ATNA	Australasian Trained Nurses' Association
AWNL	Australian Women's National League
BC	British Columbia
BMA	British Medical Association
BN	Bush Nurse
BNA	Bush Nursing Association
BNC	Bush Nursing Centre
BNH	Bush Nursing Hospital
BNS	Bush Nursing Service
CRANA	Council of Remote Area Nurses of Australia
CWA	Country Women's Association
CQU	Central Queensland University
Devon PH	Devon Public Hospital
DPH	Department of Public Health
EZ	Electrolytic Zinc Company of Australasia
FINA	Flinders Island Nursing Association
GMO	Government Medical Officer
GMS	Government Medical Scheme
HDNA	Hobart District Nursing Association
HEC	Hydro Electric Commission
HGH	Hobart General Hospital
HPH	Hobart Public Hospital
HRA	Historical Records of Australia
LBNA	Lilydale Bush Nursing Association
LCC	Launceston City Council
LDNA	Launceston District Nursing Association
LGH	Launceston General Hospital
LPH	Launceston Public Hospital
LTO	Lands Titles Office (Hobart)
MBE	Member of the British Empire Order
MHA	Member of the House of Assembly
MN	Master of Nursing
MRT	Mineral Resources Tasmania (previously Mines Department)
NAA	National Archives of Australia
NBT	Nursing Board of Tasmania
NCW	National Council of Women
NESMH	North East Soldiers' Memorial Hospital
NSW	New South Wales
NTBNA	Northern Tasmanian Bush Nursing Association

NZ	New Zealand
PHAT	Professional Historians Association of Tasmania
PHN	Public Health Nurse
Qld	Queensland
QVMAG	Queen Victoria Museum and Art Gallery
RHH	Royal Hobart Hospital
RNSH	Royal North Shore Hospital
RSSILA	Returned Servicemen's and Sailors' Imperial League of Australia
RS	Royal Society of Tasmania
SN	Supervisory Nurse
STBNA	Southern Tasmanian Bush Nursing Association
Tas	Tasmania
TBNA	Tasmanian Bush Nursing Association
TBNO	Tasmanian Bush Nursing Order
TCMCW	Tasmanian Council for Maternal & Child Welfare
THRA, PP	Tasmanian Historical Research Association, <i>Papers and Proceedings</i>
TJP&PP	<i>Tasmanian Journals Papers and Proceedings of Parliament</i>
TPHD	Tasmanian Public Health Department
TSO	Tasmanian School of Nursing
UTAS	University of Tasmania
VBNA	Victorian Bush Nursing Association
Vic	Victoria
VON	Victoria Order of Nurses
WA	Western Australia

IMPERIAL MEASUREMENTS

The focus of this study is prior to 1966 and imperial weights and measures usually have been retained.

Area

1 acre = 0.4 hectare

Currency

1 pound = 20 shillings

1 shilling = 12 pence

Approximate Conversions from Pounds to 2003 dollars³

1910: £1 = \$200.00

1920: £1 = \$125

1930: £1 = \$105

1940: £1 = \$105

1950: £1 = \$71

Distance

1 mile = 1.6 kilometres

1 yard = 0.9 metre

1 foot = 30 centimetres

1 inch = 2.5 centimetres

Mass

1 pound (16 ounces) = 0.45 kilograms

Temperature

32 degrees F = 0 degree C

50 degrees F = 10 degrees C

100 degrees F = 37 degrees C

³ Damien Bardenhagen, Commonwealth Bank, Personal Communication, August 2003.

DEFINITIONS & A NOTE ON SPELLING

In this thesis the names of Bush Nursing Centres, Hospitals, Associations or Orders are capitalised, as are terms 'Bush Nurse' and 'Bush Nursing' although Bush Nurse is abbreviated to BN. This is to provide consistency, (although there is inconsistent capitalisation in the sources used). The pronoun 'she' is used when referring to Bush Nurses as all Bush Nurses were women.

Bush Nurses referred to their centre with a variety of labels that included Bush Nursing Centre, Bush Nursing Hospital, Clinic, and Surgery. These places of work did have official differences which are described in the text. In this thesis I have maintained the nurse's terminology where quoting the nurse but otherwise have differentiated between BNC and BNH as appropriate based on my understanding of the centre's official status.

Most records referred to BNs as Sister. I have included first names where known and have used maiden names when those were the names under which they worked.⁴ However if once married, they continued to work but under their married name I have chosen to identify them in the text with this name for the relevant period, i.e. after marriage. In the first instance I have given their full name and thereafter referred to them as 'Sister' and their surname. Footnotes refer to BNs with their current name and maiden name in brackets. Where I have interviewed a BN or have had access to personal papers I have included a brief biography at first mention. Where available I have listed the BNs' Tasmanian General Nursing Registration Numbers as contained in the Register of General Nurses.⁵

Some place names (such as Storys Creek) have dual spellings. The official spelling is Storys Creek but written records have referred to it as Storeys Creek. I have maintained the spelling where quoting original documents or when referring to the 'Storey's Creek Medical Union'. Marrawah and Redpa, actually two distinct communities, are used synonymously in nearly all records. Originally Redpa was known as East Marrawah. I have kept the BN's usage as recorded if quoting but, in general, use the term Marrawah to refer to the district. The BNC was located at Redpa with an annexe at Marrawah. The Chappell Islands group

⁴ It has not been possible to find first names for each BN. These names are not recorded in all official documents which refer to them, and in exploring with ex-patients of BNs and with sources such as the Furneaux Museum it was clear that for many BNs 'their first name was Sister'. Not even women whom BNs delivered of babies knew the first name of their BN. By 'losing' their first name it appears that BNs gained a measure of professional anonymity and thus maintained their role boundaries. Dr Trevor C Beard recalls at Campbell Town that his own and Sister Clark's English background clearly prohibited the use of first names. Trevor C Beard, Personal Communication, September 2003.

⁵ AOT, Register of General Nurses, (AD 448).

comprises Mount Chappell, Goose and Badger Islands. In Department of Public Health records the identification of the BNC is recorded as Chappel Island, although the spelling on contemporary maps is Chappell. Where quoting source material I have kept the spelling as quoted.

'Half-caste' is a term used in historical documents and by a number of past and present white communities. The term will be used in this paper when quoting or paraphrasing others, but is not a term accepted in current use. The Aboriginal people of Cape Barren Island regarded themselves as 'Islanders' during this period.⁶

To create boundaries for this thesis a series of working definitions have been established as included in the following glossary:

Bush Nursing: refers to a service that originated as the Bush Nursing Order, constituted in Tasmania in 1910 and by 1920 became known as the Bush Nursing Service as part of the Department of Public Health (DPH). It was renamed the District Nursing Service in 1957 as part of the new Tasmanian Nursing Services.

Bush Nurse: refers to the nurse who worked within that service. Today there are no official Bush Nurses in Tasmania although the term is still used by older residents when referring to nurses working in rural areas.

Rural: refers to the functional characteristics of a geographic area.⁷ The direct consequences of factors such as distance to, and travel time from, other centres, the population density, total population, and resource availability create for the community and their health care providers a necessity to alter their life choices and opportunities.⁸ During the time frame of Bush Nursing in Tasmania, all areas outside Hobart and Launceston were deemed rural.

Isolated: The concept of 'isolated' refers to more than distance. This study focuses upon a number of aspects of isolation experienced by BNs. These are professional concepts of isolation which includes physical isolation from facilities, and isolation from peers; personal isolation from family and friends, and social isolation within the community.

⁶ 'It [the term half-caste] is considered by the contemporary Tasmanian Aboriginal people as derogatory and dehumanising.' Patsy Cameron, Interview, 2 August 1994.

⁷ Commonwealth, Department of Human Services and Health. Rural and Remote Area Classification Canberra: Statistical Services Section, 1994, in Roger Strasser, 'Rural General Practice: is it a distinct discipline?' *Australian Family Physician*, vol. 24, no. 5, May 1995, pp. 870–876.

⁸ For additional reading on definitions of 'rural' see Michael Reid & Shane Solomon, *National Health Strategy, Improving Australia's Rural Health and Aged Care Services*, Background Paper no. 11, September 1992, Treble Press, 1992, pp. 26–27.

Furthermore the physical isolation of a community with respect to other (larger) communities, such as urban areas, required the nurse to factor such isolation into her nursing practice. At a conference in 1995, in Canberra entitled 'Beyond the Black Stump', on the theme of rural and isolated nursing many papers delivered recounted the experiences of nurses in outback mainland Australia. In this context speakers were describing conditions in central Queensland and Western Australia that made distances in Tasmania seem inconsequential. This raised questions about what should be the definition of 'isolation' for Tasmanian BNs. In the course of the research for this thesis it became clear that isolation was more than distance. Photographs of heavy snow and mountainous terrain on the Tasmanian West Coast were powerful images of isolation. Lack of transport, facilities, peers and support are all factors included in the definition of isolation. The BN although situated within a community was isolated emotionally, professionally and socially. This study will focus upon these various aspects of isolation experienced by BNs.

In modern resource-management-based terminology, isolation is defined by an algorithm described in terms of its 'varying demographic, ethnic, economic, and occupational characteristics'.⁹ Nursing in rural areas necessitates a degree of isolation which can be both physical and professional. Physical isolation has been defined as 'physically remote from peers' and professional isolation as 'professionally remote from opportunities to develop and extend own knowledge and to apply this'.¹⁰

Most rural nurses today do not have the same scope or diverse roles as their BN counterparts. Remote Area Nurses of the Australian outback would be the closest to BNs of the 1910–1956 period. Remote area nurses are defined by Ann Kreger as 'a registered nurse employed as the health care provider on a 24 hour basis in a community that is isolated from hospital and medical facilities'.¹¹

The remote area nurse has to combine the knowledge and skills of both community health nursing and advanced clinical nursing. In the absence of any other health, welfare or specialist services, the remote area nurse is required also to practise beyond the normally accepted limits of the nursing profession. Put simply, as the sole medical representative in

⁹ Michael Reid & Shane Solomon, *National Health Strategy*, p. 11. 'The approach adopted in this respect has been initially to classify rural communities according to three variables, namely population size of the locality; the characteristics of the Statistical Local Area in which the locality is situated; and distance from the locality from a hospital.' Reid & Solomon, p. 27.

¹⁰ G Gray & P Buckley, *What can be done to assist RNs working in Remote and Rural Australia (across the Spinifex)*, Flinders University SA, 1990, npn, in Robert N Thornton, 'Rural Nursing Practice' in Genevieve Gray & Rosalie Pratt, (eds), *Issues in Australian Nursing vol. 3*, Churchill Livingstone UK, 1992, p. 121.

¹¹ Ann Kreger, *Report on the National Nurse's Committee Project*, National Nursing Consultative Committee Project Steering Committee, December, 1991, p. xv.

an isolated area, the remote area nurse might be called upon to perform roles normally fulfilled by doctors and other medical and welfare specialists.¹²

Roger Strasser comments that 'in very small communities, local services are provided by nurses. These nurses are generally supported by doctors who are some distance away and might provide a visiting service'.¹³ These nurses are the modern equivalent of the BNs and it can be argued that this thesis is relevant for those grappling with rural health delivery looking at the historical roots of problems still unresolved today.

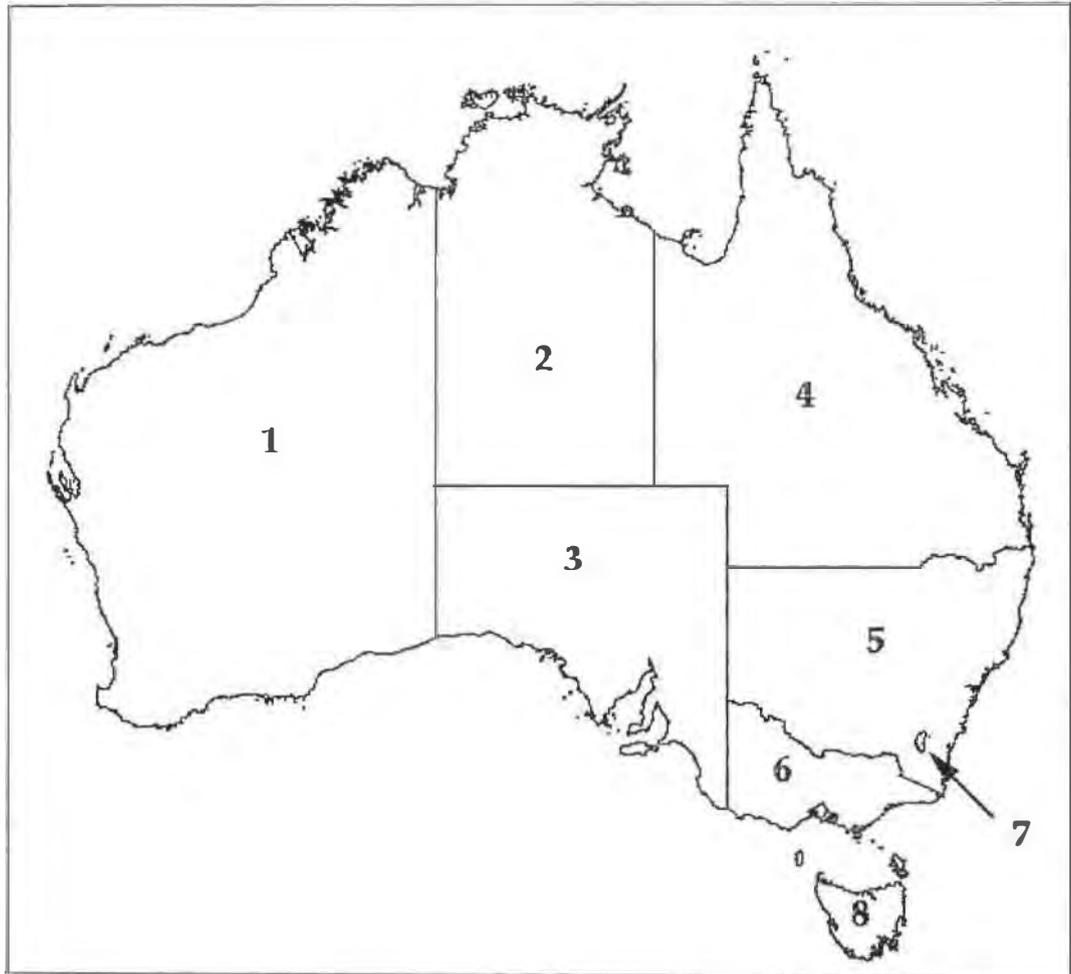
Professional Independence: While no professional is divorced totally from professional control or the influence of others, the BN was required to practise without recourse to immediate supervision and without close readily-available professional support---even, as shall be seen, when working in a close relationship to doctors the BN was still, in many cases, in independent nursing practice.

The definitions I have outlined, and the modern definitions I have included, show how complex the terminology can be especially when the definitions are blurred continually and vary according to circumstance. Although debate about the nature of rurality and rural practice still exists in Australia, I have focused on the practical experience of BNs and their communities using their terms and words rather than resorting to arbitrary or current definitions.

¹² Ann Kreger & Jennifer Cramer, *A Crisis in Remote Area Health Care Delivery: Remote Area Nurses' Perspective: Background Paper for the Council of RAN of Australia Incorp for the Northern Health Minister's Conference*, Broome, Western Australia, November, 1990, p. 2. Definition of Remote Area Nursing from Report of the 3rd National Remote Area Nurses Conference, Townsville, September, 1985, p. 2.

¹³ Strasser, pp. 871-2.

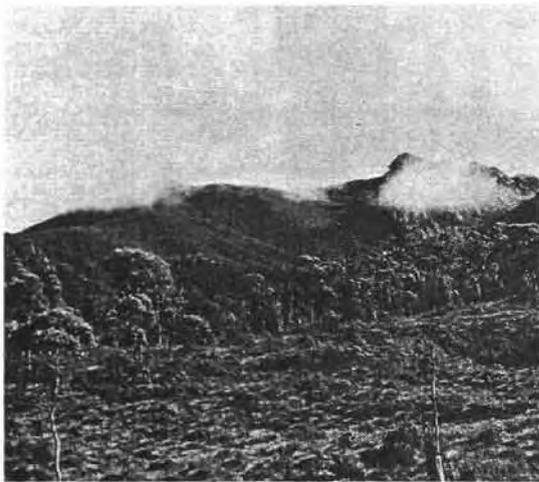
Map P.01 Australian States and Territories



- | | | | |
|---|---------------------------|---|-------------------------------------|
| 1 | <i>Western Australia</i> | 5 | <i>New South Wales</i> |
| 2 | <i>Northern Territory</i> | 6 | <i>Victoria</i> |
| 3 | <i>South Australia</i> | 7 | <i>Australian Capital Territory</i> |
| 4 | <i>Queensland</i> | 8 | <i>Tasmania</i> |

Photograph P.01
The Tasmanian 'Bush'

While the Australian outback and desert is the typical image conjured up in most people's minds when the term 'the bush' is used, Tasmania provided a challenging environment for its pioneers and for those like Bush Nurses who served the health needs of the State's settlers.



The Thumbs, near Adams field.
Source: Barbara Tweedie (née Hazelwood),
Private Collection.



Rossarden looking towards Ben Lomond.
Photographer: Alex Thomson.
Source: Author's collection.



Stepped Hill, near Clear Hill, near Adamsfield.
Source: Barbara Tweedie (née Hazelwood),
Private Collection.



Tasmanian Rainforest.
Source: Postcard, Waratah Local
Museum.

PREFACE

I grew up in isolated Hydro towns throughout the Tasmanian bush.¹⁴ I did not feel totally isolated because I grew up within a tight-knit community and when I went to boarding school, so did everyone in my class and street. The people who felt the isolation most were the single people who came into the town from outside to work, such as the teachers and young men (tradesmen or professionals) who were separated from their family and friends. They travelled out of the community as often as they could to go home. I spent my school holidays with grandparents in a small rural community centred around the township of Lilydale, in Tasmania's North East. One person who was an integral part of my grandparents' lives was the BN, Sister Mary Walsh. I have focussed on Lilydale in previous publications because even though I have never lived there, it seemed an important part of my life and part of my roots.¹⁵ Whilst researching the local government records of the Lilydale Council, I discovered a list of returned servicemen from World War I which had been used to justify the need for the services of a BN in the area.¹⁶ I also found a wealth of information referring to the Lilydale Bush Nursing Association. Memories flooded back of Sister Walsh, a woman who was a central figure in the town and who had devoted her life to caring for the health needs of this rural community for 34 years. I began to wonder why she had become a BN and what that really meant within the community. How did she fit into the community, what was her status and role? Was Mary Walsh typical of other BNs? How did she cope with the isolation? Was isolation the key to her independence? In 2002 I attended the renaming of the Lilydale Community Day Care Centre (previously the Lilydale Bush Nursing Centre). The building is now named 'The Mary Walsh Centre' in honour of the longest-serving Bush Nurse. This thesis is dedicated to Sister Mary Walsh, who provided the initial inspiration for the thesis, the women who became BNs, and those who provided the supportive communities on which BNs relied.

¹⁴ Hydro Electricity Commission (HEC) towns were situated in remote bush areas throughout Tasmania.

¹⁵ Bardenhagen, Marita E, *Lilydale—A German legacy: An Examination of Nineteenth Century German Immigration to Northern Tasmania*, Launceston, 1987 and Bardenhagen, Marita E, *Lilydale—Conflict or Unity 1914–1918: An Examination of a Tasmanian Rural District during the Great War*, Launceston, 1992.

¹⁶ Since amalgamated with Launceston City Council (LCC). Records are held in the Queen Victoria Museum and Art Gallery (QVMAG) and it was museum staff who encouraged me to pursue this topic.

Photograph P.02 Sister Mary Walsh, Bush Nurse, Lilydale c1940¹⁷



Photographer: Monteath.
Source: Eunice Finan, Private Collection.

¹⁷ Mary Walsh, MBE was born in Strathalbyn, South Australia, on 13 August 1914 and died 7 September 1998 aged 84. She did her general nursing training at the Royal Adelaide Hospital and her midwifery training at Queen Alexandra Hospital in Hobart. She was registered in Tasmania on 15 March 1940, Registration Number 1085. She was the longest-serving BN at Lilydale, Bush Nursing there from 1940 to 1974. *The Examiner*, 15 September 1945, and 6 October 1998, p. 19, 'Life dedicated to community care', Obituary (based on records of M Bardenhagen).

CHAPTER ONE

Introduction, Historiography & Methodology

Bush Nurses are legendary amongst Tasmanian rural and community nurses, and extant histories celebrate them with good cause. Bush Nurses also feature as local heroines, an integral part of isolated communities throughout the state as they cared for generations of families. They provided nursing care from 'womb to tomb'. There are other sides to this story, mostly untold, which, while not diminishing the value of the celebratory histories, place these stories into context. There has not been any definitive study of Tasmanian BNs' clinical work and collectively-lived experiences, an analysis that would provide insights into the history of Tasmanian rural women. Women's history, particularly rural history, is often invisible as rural women were too busy to keep records, or the records did not survive.

In this introduction the existing historiography has been divided into the micro and macro histories of nursing from a state, national and international level; the position of nursing within the health systems and social developments of the time; and finally studies about the critical issues such as isolation, professionalism, gender and power. These will be explored to position this thesis within the literature.

The only history of Tasmanian Bush Nursing is the pamphlet, *A History of Bush Nursing in Tasmania* written in 1947.¹ Published ten years prior to the demise of the Bush Nursing Scheme in Tasmania, it provides a brief description of services from 1910 to 1947.² The emphasis and orientation might reflect its origin as a history written for an association (especially one under threat of being lost through incorporation into another service). It focuses on the founders and supporters of the scheme, such as office bearers and benefactors. It also provides a list of BNCs, identifies some of the women who were employed as BNs, and reproduces extracts from the reports of a few centres. Bev Davis has written the only specific Bush Nursing history for a Tasmanian district. *Bush Nursing on Bruny Island* is a pamphlet produced c1985. A local retired nurse and resident of Bruny

¹ *History of Bush Nursing in Tasmania 1910–1947*, Mercury-Walch, Hobart, 1947. This publication appears to have been commissioned by the Bush Nursing Association. It was published in leaflet form with the author unknown, although most likely the author was Sister Noller, the Supervisory Nurse (SN). Document held in Bruny Island Museum. Sister Doris Kathleen Noller was trained at the Adelaide Public Hospital and was a triple-certificated Bush Nurse. She was registered in Tasmania on 6 June 1933, Registration Number 526. She worked in many busy BNCs throughout Tasmania before being appointed to the position of SN. After 21 years work for the DPH, she resigned in 1961 owing to bad health.

² A similar unpublished document, 'A Short History of Bush Nursing in Tasmania', written by Sister Doris Kathleen Noller, SN, in 1952 was located in the Bush Nursing records at the AOT.

Island, Davis has extracted carefully from Minute Books and municipal records a chronology supplemented with some personal accounts.³ This kind of publication provides the minutiae that help describe the scheme at a local level. Neither pamphlet provides analysis of BNs' experiences but together they provide important data for the historian.⁴

Oral histories have captured the memories of BNs. There are several BNs' recollections that have been published locally, for example the *Tasman Peninsula Chronicle*.⁵ The Royal College of Nursing (Tasmanian Branch) has undertaken an oral history project interviewing retired nurses throughout Tasmania.⁶ Some of these interviews are with nurses who practised as BNs during their careers. This project, which is ongoing, forms an important contribution to the history of nursing in Tasmania. At the time of writing this thesis one interview included details about nurses who had spent time as BNs on Flinders Island. These histories fail to highlight the Bush Nursing Service as an independent nursing profession in its own right and do not include nurses who were solely BNs. Although oral histories have the reputation of being celebratory, these interviews provided some 'warts and all' information about experiences that were relevant to my study.

General Nursing histories contribute to Bush Nursing historiography. Beatrix Kelly's *A Background to the History of Nursing in Tasmania* devotes a chapter on Bush Nursing and describes the scheme and duties of the nurses.⁷ This publication, funded by the Graduate Nurses' Association and the Florence Nightingale Committee, was written from Kelly's perspective as a retired nurse with many years' experience. The history provides extracts of nursing regulations and rules but does not analyse the data collected or displayed. The author does comment on the paucity of Tasmanian nursing histories. To date this publication remains the basis for Tasmanian nursing historians to build upon and for nursing students who want to investigate the history of nursing organisations in Tasmania.

³ It contains some authors' notes to contextualise the listed events. These include the perceived important events for the district such as the official opening of the centre in 1936. Also listed are the nursing staff, including relief nurses and Red Cross supporters. The fund-raising events for the BNA are explained more fully in Chapter Four based in part on an interview with Miss Stirling. Several brief interviews and accounts from previous nurses and residents also are included. The documentation of a particular local history such as this helps the district to appreciate the past contributions of health carers and provides the reader with a glimpse into one particular community.

⁴ Other Tasmanian work-in-progress includes at least two local histories. Maurice Hallam, President of the Tasman Peninsula Historical Society, has commenced research on the Peninsula BNs and Olga Steele currently is writing a biography of her mother (a ex BN in Tasmania).

⁵ Mrs Clarice Mildred Clark, (née Mainwaring), 'Bush Nurse' in *Tasman Peninsula Chronicle*, Tasman Peninsula Historical Society no. 3, December, 1967, Item 5 and Maurice Hallam, 'Sister Barricoat—The Peninsula's Friend' in *Tasman Peninsula Chronicle*, no. 5, March 1990, p. 4.

⁶ Royal College of Nursing (Tasmania Branch) Oral History Project.

⁷ Beatrix Kelly, *A Background to History of Nursing in Tasmania*, Davies Brothers Ltd, Hobart, 1977.

Social Histories of Tasmanian communities usually include Bush Nursing, albeit briefly, as the BN was an integral part of the history of most districts.⁸ Suzanne Lester's *Spring Bay Tasmania—a social history* is an excellent example of a thorough social history of a country district that includes the local BN.⁹ AC Hearn's *Somerset the Cam* provides extracts from the only known diary of a BN, Sister Agnes Clara 'Nessie' Mackenzie, MBE.¹⁰

An Australian national perspective is included in John Wilson's 'Bush Nightingales'. It provides an overview of the nurse's role in the Australian Cottage Hospital industry, and traces the development of Bush Nursing in the outback. Wilson suggests that the lack of Bush Nursing histories or the:

relegation of nursing to the background of official history ... may be blamed ... [on] the traditional male dominated perspectives of the past.¹¹

The brevity of Wilson's work precludes it addressing in detail many aspects of Bush Nursing, such as independence and isolation. Within Australia, there are many state-based studies of Bush Nursing. Interstate Bush Nursing histories range from comprehensive books to pamphlets and journal articles, but these usually concentrate on Victoria.

Celebrative publications had the dual role of lauding of the BNs as well as promoting the service (even before it had begun). One early example, a pamphlet about the Victorian Bush Nursing Scheme produced in Victoria c1909, is a fine example of propaganda romanticising the bush.¹² It probably was sponsored by the *Age* and supported by Lady Rachael Dudley.¹³ A section outlining the proposed Australian Bush Nursing Scheme is

⁸ Development in web-based technology has seen local communities such as Bruny Island and Rossarden setting up district homepages which include information on BNs.

⁹ Suzanne Lester, *Spring Bay: A Social History*, Artemis, Hobart, 1994. Her sources are based mainly on oral interviews with past BNs and other community members.

¹⁰ Agnes Clara 'Nessie' Mackenzie MBE came from a family of diarists. She first started writing a diary when she was nine years old. The diary relating to her nursing career in 1955 only was made available to me from her family. It provided information on her social engagements, nursing visits, clinics, mileage and time spent working at the local hospital. Insights into her clinical practice, thoughts and opinions were not evident in this edition but her daily, weekly and monthly routines could be mapped out such as visits to the CWA, local Liberal Branch, family, etc. Agnes Clara Mackenzie was born in 1900. She trained at the Launceston General Hospital graduating in 1919 and went on to complete her midwifery and child welfare training. She was registered in Tasmania on 20 February 1929, Registration Number 174. In 1971 she was awarded the MBE. She died in 1973 aged 73 years.

¹¹ John Wilson, 'Bush Nightingales, A view of the Nurse's role in the Australian Cottage hospital industry', in John Pearn, (ed), *Health History and Horizons*, Amphion Press, Brisbane, 1992, p. 28.

¹² Donald Macdonald, *Australian Bush Nursing Scheme*, Atlas Press, Melbourne, c 1909 in Anthea Hyslop 'The Social Reform Movement in Melbourne 1890 to 1914', (PhD Thesis), LaTrobe University, 1980. See also a poem by Louisa Lawson, 'The Flight of the Nightingales', in *Australian Bush Nursing Scheme* quoting the *Argus* 9 December 1909.

¹³ It contains extracts from Lady Rachel Dudley's speech, romantic illustrations by Ida Rentoul, reproduced bush scenes such as 'The Pioneer' by Frederick McCubbin and 'A Bush Track' by Paterson and others, illustrations of the ideal nurse entitled the 'the Quality of Mercy', poetry by O'Dowd and a poem entitled 'A Woman's Work' by Oriel.

included.¹⁴ Caroline Andersen's brief overview of Bush Nursing in Victoria, similar to the Tasmanian pamphlet *A History of Bush Nursing in Tasmania*, celebrates BNs and the founders of the organisation.¹⁵ It outlines the beginning of Bush Nursing in Victoria in 1911, with the establishment of the first centre at Beech Forest, through to 1951.¹⁶ Victorian BNs' long hours, poor facilities, inadequate transport and isolation parallel the conditions of Tasmanian BNs. Andersen describes three stages with developments in Victoria—from the scheme's inception to 1920 by which time there were 28 centres throughout Victoria; the development of BNHs, and finally consolidation and the establishment of Supervisory Nurses and management by a Central Committee.

The major contribution to the history of Bush Nursing in Victoria is Susan Priestley's *Bush Nursing in Victoria 1910–1985*, published by the Victorian Bush Nursing Association.¹⁷ It places the Victorian BN in her environment but provides only some detail of her daily life and work. Priestley shows that this scheme, unlike the Tasmanian scheme, was mainly hospital based and independently funded for the majority of its existence. Underpinning the scheme's success was Sir James W Barrett who was crucial in its formation and longevity, but the basic ingredient of Bush Nursing's success is the story of those who did the nursing.¹⁸ Their conditions and stories parallel the Tasmania experience. Priestley's work is a well-written story of an Association and its members. It also includes a chapter briefly outlining 'interactions' between the States.¹⁹ Elizabeth Burchill also details the origins of the proposed national scheme and the formation of the Victorian scheme.²⁰ Like Kelly's Tasmanian publication, this gives a general overview of the hardships faced by nurses and allows comparison with the Tasmanian experience.

¹⁴ *Australian Bush Nursing Scheme*. This contains two separate pamphlets reproducing addresses by Lady Dudley and Lady Carmichael, and a copy of remarks made by Her Excellency the Countess of Dudley and Lady Carmichael to the Members of the Royal Trained Nurse's Association, at Government House, 'The Ideal District Nurse' and Australian Bush Nursing Scheme, Address by Her Excellency the Countess of Dudley at Government House, Melbourne, 8 December 1909. Additional information relating to Lady Dudley's scheme is contained in Christopher Cunneen, *Kings' Men, Australia's Governors-General from Hopetoun to Isaacs*, George Allen and Unwin, Sydney, 1983, pp. 86–7, 92.

¹⁵ Hyslop, 'The Social Reform Movement in Melbourne', p. 352. Hyslop also refers to Caroline E Andersen, *The Story of Bush Nursing in Victoria*, Renown Press Carnegie, Melbourne, 1951 pp. 3–5, 18 and Donald Macdonald, in 'Bush Nursing' in *Australian Bush Nursing Scheme*, pp. 8–11.

¹⁶ Andersen.

¹⁷ Susan Priestley, *Bush Nursing in Victoria 1910–1985*, VBNA and Lothian Publishers Co. Pty Ltd, Melbourne, 1986.

¹⁸ For additional information about J W Barrett's career refer to Michael Roe, *Nine Australian Progressives, Vitalism in Bourgeois Social Thought 1890–1960*, University of Queensland Press, St Lucia, 1984.

¹⁹ Priestley, pp. 72–75.

²⁰ Elizabeth Burchill, 'Nurses on Horseback: The Bush Nursing Association', a chapter within her general nursing history, *Australian Nurses since Nightingale 1860–1990*, Spectrum Publications, Richmond, 1992.

Richard Trembath and Donna Hellier's *All Care and Responsibility, A History of Nursing in Victoria 1850–1934*, traces the history of nursing (including Bush Nursing) in Victoria over that period.²¹ It gives credit to previously unsung heroines of the nursing profession and documents the achievements of the profession as a whole. Although in part celebratory, the emergence of nursing as a profession is addressed specifically together with an analysis of the economic independence of nurses and their growing assertiveness. While Tasmanian BNs gained economic independence through nursing, as a group they were not industrially organised or active.

Queensland is best served by the edited oral histories of J Klotz, and by Glenda Strachan's work which provides an emphasis on the working conditions of nurses.²² There are no similar works in Tasmania. The majority of studies in New South Wales are community or hospital-based anecdotal histories which add to local knowledge of BNs. In Western Australia, Noel Stewart has written a celebratory history of the Silver Chain, a nursing organisation that eventually incorporated Bush Nursing.²³ By far the most thorough of the publications about South Australian rural nursing experience is Rob Linn's work.²⁴ District Nursing in South Australia predated the Bush Nursing Scheme in providing nurses to remote communities. This 'rural' nursing service was not a distinct 'rural' entity. Where South Australia District nursing *included* rural nursing, District Nursing in other states usually referred to metropolitan nursing services. In Central Australia the Inland Mission Nurses, although identified as 'BNs' were a service distinct from Bush Nursing. These nurses were part of the provision of an overall 'mantle of safety' for the people of the Outback. Stationed at prominent centres like Alice Springs, the nurses travelled if needed.²⁵ Ellen Kettle provides a comprehensive summary of health services

²¹ The Royal Victorian Trained Nurses' Association became the Royal Victorian College of Nursing in 1934. Richard Trembath & Donna Hellier, *All Care and Responsibility, A History of Nursing in Victoria 1850–1934*, Florence Nightingale Committee, Melbourne, 1987.

²² Jennifer A Klotz, *Remote Area Nurses: Stories to be Told—A Collection of Oral Histories* CDROM and Glenda Strachan, *Labour of Love—The History of the Nurses' Association in Queensland 1860–1950*, Allen & Unwin, St. Leonards, NSW, 1996. As well Klotz has written about Birdsville and other remote areas of Queensland. Unfortunately her thesis was unavailable for interlibrary loan.

²³ This is an illustration that the scheme reached every corner of Australia in some shape or form. Noel Stewart, *Little but Great: Saga of the Silver Chain (1905–1965)*, np, 1965.

²⁴ Rob Linn, *Angels of Mercy: District Nursing in South Australia 1894–1994*, Royal District Nursing Society of South Australia Inc, Norwood, 1993; Joan Durdin, *They Became Nurses: A History of Nursing in South Australia 1836–1980*, Allen and Unwin, North Sydney, 1991. Bush Nursing was incorporated into the South Australian scheme and title in 1938.

²⁵ According to Rob Linn the Inland Mission Nurses had a dual role to assist the deserving poor, and also the isolated. For further information see Ivan Rudolph Flynn's *Outback Angels, Casting the Mantle: 1901 to World War II*, Rockhampton, Queensland, Central Queensland University Press, 2001 and also Flynn's *Outback Angels—Fulfilling the Vision: World War II to 2002*, Central Queensland University Press, Rockhampton, 2002. 'Their vocation was similar to that of South Australia's District Nurses. There was definitely a spiritual calling in both'. Rob Linn, Personal Communication, 2003.

across the Northern Territory.²⁶ Differences between states in the organisation of rural nursing shall be mentioned briefly in Chapter Two.

While Bush Nursing has featured in a variety of studies, usually these have been focussed on one state, one hospital or one municipality. As a collective history, the separate accounts and stories help piece together the history of Bush Nursing throughout Australia. However none of these publications includes Tasmania as a focus and none provides comprehensive analysis of nurses' work and lived experiences. This thesis will integrate a wide range of written sources with oral histories to provide a detailed analysis of Bush Nursing in Tasmania focussed on the independence of the women who provided the service and their experiences of isolation.

International Roots and Parallels

Australia was not alone in developing rural and remote nursing services to isolated communities. Throughout the dominions of the British Empire and beyond there was a quest to improve the health of 'the race' and a concern about high infant mortality rates. Rural areas were a particular focus of attention. Australian Bush Nursing Schemes arose as a uniquely Australian response to the delivery of health services to 'the bush'. The Australian scheme was modelled on, or adapted from, the British District Nursing services that provided services to rural areas as well as the city. Similar needs were being addressed in other countries, such as Canada and New Zealand.

Canada has a particularly rich historiography of rural, remote and frontier nursing.²⁷ Canada was earlier than Australia in its identification of the needs of isolated communities. It saw that specific preparation for rural work was required, and accordingly set up special training programmes in various provinces.²⁸ Canada, like Australia, is a federal nation. Consequently there was a proliferation of different schemes across the provinces.²⁹ These

²⁶ Ellen Kettle, *Health Services in the Northern Territory—a history 1824–1970, vol. 1 and vol. 2.* Australian National University, Northern Australian Research Unit, Darwin, 1991.

²⁷ Much of this work has been carried out and published since I commenced work on this thesis some ten years ago. Useful collaboration with researchers doing similar work in Canada has allowed detailed exploration of the similarities and differences between the two countries. This is outside the brief of this thesis. Canadian authors writing in this field include Cynthia Abeele Comacchio; Johanne Daigle; Kari Dehli; Dianne Dodd; Jayne Elliott; Florence H M Emory; Georgina Feldberg; Deborah Gorham; A M Jeffrey; Molly Ladd-Taylor; Alison Li; Jutta Mason; Laurie Drees Meijer & Lesley McBain; Kathryn McPherson; Sheryl Nestel; Anne Anderson Perry; Sharon Richardson; Nicole Rousseau; Irene Stewart; Meryn Stuart; G M Weir; Maude Wilkinson; and Judith Zelmanovits.

²⁸ Various provincial Divisions of the Red Cross provided funding for five universities to start Public Health Nurse programs with the first in 1920. Jayne Elliott, Personal Communication, 2003.

²⁹ The developments in child welfare similarly were based on United Kingdom models and although the cultural heritage was seen as derived from this environment, the differences in physical size

schemes included Public Health Nursing, District Nursing, Red Cross Outpost Nursing, and Medical Services to Settlers.³⁰ As in Australia, Canada had no national overview or coordination of these nursing schemes and, probably because of this, there is no national history of rural nursing.

Issues of gender and power, particularly as they affected isolated nurses, are the subject of a growing collection of essays and much work-in-progress. Kathryn McPherson has published extensively about women in remote Canada, and of particular relevance is her research on nurses in the rural prairie west in Canada in the 1920s and 1930s and on nurses in northern Manitoban Native communities from the 1950s to 1970s.³¹ For McPherson nursing history is moving away from a study of established institutions to 'investigating more marginalised places of work (such as public health centres and rural areas) and from examining elites to exploring grass roots workers'.³²

Meryn Stuart's study of Public Health Nurses in Ontario's hinterland in the early 1920s explores gender and professional conflict between nurses and physicians, and the 'tightrope that nurses had to walk' to avoid alienating doctors by trespassing on their

and political structures between Australia and the United Kingdom required 'translation' of the models. Each state in Australia developed different models of child welfare provision. See Philippa Mein Smith, *Mothers and King Baby: Infant Survival and Welfare in an Imperial World: Australia 1880–1950*, McMillan Press, London, 1997.

³⁰ The terms 'station' or 'outpost' nurses often are used to describe nurses in these schemes. Run by the Department of National Health and Welfare as part of the Indian and Northern Health Services, this was the only federal nursing scheme in Canada. It provided a health service to indigenous people.

³¹ Her publications include: Kathryn McPherson, 'Nursing and Colonization: The Work of Indian Health Service Nurses in Manitoba 1945–1970' in Gina Feldberg, Molly Ladd-Taylor, Alison Li & Kathryn McPherson, (eds), *Women, Health and Nation: North America Since 1945*, Montreal, McGill-Queen's University Press, 2003; 'The Country is a Stern Nurse': Rural Women, Urban Hospitals and the Creation of a Western Canadian Nursing Work Force, 1920–1940', *Prairie Forum*, Fall, 1995, pp. 175–206; 'Was the Frontier 'Good' for Women? Historical approaches to women and agricultural settlement in the prairie west, 1870–1900' *Atlantis*, Fall, 2000, pp. 75–86; 'Why Borders Matter: Comparative Perspectives on Canadian and American Women's Health Care' co-authored with Georgina Feldberg, Molly Ladd-Taylor & Alison Li in Gina Feldberg, Molly Ladd-Taylor, Alison Li & Kathryn McPherson, (eds), *Women, Health and Nation: North America Since 1945*, Montreal, McGill-Queen's University Press, 2003; 'Nurses, Archives, and the History of Canadian Health Care' in *Archivaria* 41, Spring 1996, pp. 108–120; *Bedside Matters: The Transformation of Canadian Nursing, 1900–1990*, Oxford University Press, Toronto, 1996; 'Carving Out a Past, The Canadian Nurses Association War Memorial', *Histoire sociale/Social History*, special issue on Spectacle, Monument, and Memory vol. XXX, no. 58, November, 1996, pp. 417–29; 'The Prairie Wife: Gender, Colonization and Agricultural Settlement in Southwestern Manitoba, 1880–1920' paper presented at the Northern Great Plains Historical Conference, September, 1996; 'The Lessons of Ethel Johns', Hannah Lecturer, Manitoba Medical History Society, April, 1997; 'Rethinking Professional Boundaries: Co-operation and Conflict between Medicine and Nursing, 1870–1990', Margaret Hart Lecturer, University of Manitoba Faculty of Nursing, November, 1997.

³² Kathryn McPherson & Meryn Stuart, 'Writing Nursing History in Canada: Issues and approaches' *Canadian Bulletin of Medical History*, 1994, 11, pp. 3–22. See also Kathryn McPherson, *Bedside Matters*.

jealously-held territory.³³ Stuart emphasizes Public Health Nurses rather than the 'policy makers' as the 'central actors' in rural health, as I will do for BNs.³⁴ Canadian Public Health Nurses were 'hoping for autonomy, independence and a chance to use their skills in a new way—to prevent illness rather than [to] heal it'.³⁵ Work within the community presented them with an opportunity to give of themselves in a way that was not possible in hospital nursing.³⁶ Public Health Nursing in Canada was considered a prestigious job and better paid than hospital nursing. In Australia Bush Nursing was also prestigious, although in Tasmania was less well remunerated than hospital work. In contrast Alexandra McKegg argues that in New Zealand rural nursing was a low status area of nursing practice.³⁷

Gender, class and power were as central to Canadian rural nursing as the Australian experience.³⁸ Like BNs, Public Health Nurses worked under a 'professional protocol that warned against "diagnosis, prescription or treatment" [and] requir[ed] that they deferred to physicians or covertly used strategies to get around the rules'.³⁹ Public Health Nurses were encroaching on the medical turf. Inter-professional boundaries shifted and blurred especially where the nurse had no access to medical advice or where she had better and more up-to-date skills than the resident doctor. These instances parallel the experiences of the Tasmanian BNs where in oral histories they describe having more knowledge of childhood diseases than did young and inexperienced doctors. Institutionalised power imbalance influenced nurse-doctor communication. The nurses carefully played 'the doctor-nurse game', communicating recommendations without appearing to do so.⁴⁰ By playing this game Canadian Public Health Nurses and Tasmanian BNs reinforced medical domination of rural health care, but this was the price paid for greater autonomy in the absence of the doctor.

³³ Wendy Mitchinson, University of Waterloo, Review of Dianne Dodd & Deborah Gorham, (ed), 'Caring and Curing: Historical Perspectives on Women and Healing in Canada' in *Canadian Historical Review*, vol. 76, no. 2, June 1995, Ottawa, University of Ottawa Press 1994, pp. xii, 218. See also Meryn Stuart, 'Ideology and experience: Public Health Nursing and the Ontario Rural Child Welfare Project, 1920–25', *Canadian Bulletin of Medical History*, vol. 6, no. 2, Winter, 1989, pp. 111–131. In footnote 32 Stuart states 'For an informative discussion of British origins of Public Health Nursing (called 'health visiting') and the debate about its functions, see Celia Davies, 'The Health Visitor as Mother's Friend'".

³⁴ Meryn Stuart, 'Shifting Professional Boundaries: gender conflict in Public Health, 1920–1925', Chapter 3 in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Dianne Dodd and Deborah Gorham, (eds), University of Ottawa, Ottawa, 1994, pp. 49–70.

³⁵ Stuart, 'Shifting Professional Boundaries', pp. 49–70.

³⁶ Stuart, 'Ideology and experience', p. 123.

³⁷ Alexandra McKegg, 'Ministering Angels: the government back-block nursing service and Maori health nurses, 1909–1939', MA thesis, University of Auckland, 1991.

³⁸ Stuart, 'Shifting Professional Boundaries', p. 50.

³⁹ Stuart, 'Shifting Professional Boundaries', p. 50 and Meryn Stuart, "Half a loaf is better than no bread: public health nurses and physicians in Ontario, 1920–1925", *Nursing Research*, vol. 41, no. 2, pp. 21–27.

⁴⁰ Stuart, 'Shifting Professional Boundaries', p. 56.

Jayne Elliott's doctoral study of the Red Cross Outpost Nursing in Ontario, Canada (1922–1984) looks at 'the outposts as a slice of the development of rural health/hospital services in the province'.⁴¹ Elliott's study has strong parallels with this thesis. Drawing on the oral histories of surviving nurses and on central records, the study illustrates that nurses in opposite hemispheres shared a culture of isolation and autonomy. Anne Perry's description of Outpost Nursing Service Centres in Ontario in the 1930s shows that they resemble Tasmanian BNCs both in size and in distance from doctors, although by 1930 others boasted hospitals of 23 beds—more akin to the Victorian Bush Nursing Association.⁴² Jayne Elliott's study shows that a number of these small hospitals in Ontario continued to grow, the largest reaching 140 beds. By 1970 all the nursing stations were closed, and by 1984 only ten hospitals ranging from 15 to 22 beds remained. Like the Tasmanian Bush Nursing Association, the Red Cross in Canada acted as arbitrator and determined location of centres based on need and the capacity to be self-supporting. Bush Nurses in Tasmania and Outpost Nurses in Canada attended accidents, did prenatal, postnatal, and midwifery work, visited schools and homes. Elliott's work builds on the work of Cynthia Comacchio Abeele who argues that Public Health Nurses were the 'foot soldiers of the crusade' for the child and maternal movement in Canada.⁴³ Elliott shows that Outpost Nurses usually had recourse to some physician advice—even if only by telephone or telegraph in the earliest days—although sometimes a doctor would be practising nearby or even would move into the community. She looks at both sides of the autonomy of nurses' work—it gave them freedom to arrange their own work as they saw fit, but they also undertook tasks for which they had little training—delivering babies for instance, since those trained in Canada could not get advanced midwifery education.

Sheila Penney's work on the Victorian Order of Nurses (VON), a Canadian District Nursing Service, demonstrates that middle class women promoters were behind its establishment. Promoted as a service to 'save the mothers and babies', its formation closely

⁴¹ Queens University, Kingston, Ontario, Canada. Completion date 2004. Jayne Elliott, Personal Communication, 2003.

⁴² Anne Anderson Perry, 'Guarding Settlers on Outposts of North: how Railway Red Cross Hospitals and Hospital Car on Canadian National System watch over our welfare of pioneer families', *Canadian Railway Magazine*, vol. 16, no. 3, March, 1930.

⁴³ Cynthia Comacchio Abeele, 'The Mothers of the Land Must Suffer'; Child and Maternal Welfare in Rural and Outpost Ontario, 1918–1940', *Ontario History*, Ontario Historical Society, vol. 80, no. 3, September, 1988, p. 184–6. Concentrating on Ontario, she talks about the most isolated areas being served by the Red Cross who 'operated a 'Hospital on wheels' which supplied hospital and home nursing care to the sick, conducted clinics, made school inspections and attempted to carry on health education in the homes', as well as carrying out prenatal supervision and attending confinements in the absence of doctors. Canadian doctors, like Tasmanian doctors, could not be enticed to take up practice in the most isolated areas. Unlike the Tasmanian or even the Australian experience, in Canada nursing demonstrations were carried out in an attempt to encourage communities to employ nurses. Nurses were allowed only to conduct 'well baby' clinics.

parallels the later Australian experience.⁴⁴ Although the initial focus was the plight of isolated women and children, the scheme quite soon became urban-based. However the early period with its cottage hospital development is comparable with Bush Nursing, and Penny details the working conditions of these early VON nurses.⁴⁵ Rural visiting by VON nurses soon ceased because of funding problems and the establishment of rural centres that clients were expected to visit. Later, travelling nurses were appointed to re-establish this service. In contrast rural visiting was at all times an important part of the Tasmanian Bush Nursing Service.

Nicole Rousseau and Johanne Daigle explore rural nursing services in Quebec based on an analysis of the annual reports of the provincial Ministry of Health and the archives of the Medical Service to Settlers.⁴⁶ They argue that the service was a tool of government in a 'project of colonisation'. Their analysis demonstrates that services have a complex series of reasons for their existence, reasons which lie behind the humanitarian face of the local implementation of the service.⁴⁷ Although doctors were not providing adequate local services they opposed this nursing service which trespassed on their professional territory.⁴⁸ Rousseau and Daigle argue that their conditions mirror what was happening in at least three other provinces (Alberta, Saskatchewan and Newfoundland).⁴⁹

⁴⁴ Sheila Penny, *A Century of Caring, The History of the Victorian Order of Nurses for Canada*, VON, Canada, Ottawa, 1996. 'Initially, women of the National Council asked Lady Aberdeen to consider promoting district nursing services for the 'outlying districts of the country' as Canada's 'memorial' for Queen Victoria's June 1897 Diamond Jubilee, no doubt in emulation of the British Institute of Queen's Nurses which had been founded at her Golden Jubilee'. See also Charlotte Madeod, 'Victorian Order of Nurses', in *Women of Canada*, p. 264.

⁴⁵ VON also staffed the hospital... in a converted hotel furnished as a hospital by the Council of Women. The usual arrangement was two nurses per hospital... These little hospitals, though often makeshift and lacking in the most basic comforts, were cherished in their communities. Where rural visiting had been tried on a small scale, notably in Quebec and Nova Scotia, it had petered out due to lack of funds or the establishment of alternatives, such as hospitals, nearby. Support from Women's Institutes, Homemakers' Associations and others was sought. DeWey, p. 83, 85.

⁴⁶ Nicole Rousseau & Johanne Daigle, 'Medical Service to Settlers: the gestation and establishment of a Nursing Service in Quebec, 1932-1943', in *Nursing History Review*, vol. 8, 2000, pp. 95-110.

⁴⁷ Rousseau & Daigle, p. 96.

⁴⁸ Rousseau & Daigle, p. 97. These nurses undertook activities such as (1) maternal hygiene, (2) infant hygiene, (3) school hygiene, (4) contagious diseases, (5) tuberculosis, (6) vaccinations/immunisations, (7) general medicine, (8) minor surgery, (9) dental care, (10) obstetrics, (11) doctor's visits and (12) hospitalisation. p. 105.

⁴⁹ Rousseau & Daigle, p. 110. Judy E Mill & others look at the different and overlapping roles of District Nurses and PHNs in Alberta and British Columbia. PHNs in BC were responsible for the delivery of nursing services to urban and rural communities and focused on health promotion and illness prevention. PHNs in Alberta in the 1920s 'assisted physicians with immunizations for smallpox, diphtheria, pertussis and scarlet fever, and district nurses in rural communities administered immunizations independently'. Judy E Mill, Beverley D Laspert, & Susan M Duncan, 'A History of Public Health Nursing', in *Canadian Nurse*, vol. 98, no. 1 January, 2002, pp. 20-22. Social and physical isolation are recurring themes in Canada and Tasmania. See also Marjorie M Green, *Through the Years with Public Health Nursing in the Provincial Government Jurisdiction British Columbia*, Canadian Public Health Association, Ottawa, 1984.

Judith Zelmanovits demonstrates that northern Canadian nurses had greater autonomy and professional authority than their counterparts in the less isolated south. Similarly in Tasmania BNs' levels of autonomy were higher when, and where, they were more isolated from medical support. Zelmanovits' nurses often practised alone, and thus they 'were forced to make diagnostic and prescriptive decisions often without the benefit of advice' not only from a doctor but also without any input from nursing colleagues.⁵⁰ For rural nurses, lack of collegial support can be a critical factor in increasing the sense of isolation.⁵¹ Tasmanian BNs also said that isolation from colleagues was a critical part of their experience.

Unlike Australian and British nurses, Canadian nurses in this period were not offered specialist training in midwifery.⁵² The medical profession strongly opposed nurse involvement in midwifery. Nevertheless midwifery was part of the job description of the Canadian rural nurse, although, except in Newfoundland, the regulations construed this as an emergency service only. With midwifery care as a central focus of Bush Nursing, this is one of the main differences between BNs and their Canadian counterparts.

In Canada as in Australia significant social pressures had prevented upper and middle class married women from working prior to World War II.⁵³ Nurses

were structured within a heterosexual matrix, as the symbolic 'wife' to the doctor 'husband' tending the patient 'child'. Yet that heterosexual position for nurses was figurative not literal ... [they] were expected to be single and heterosexually inactive.⁵⁴

⁵⁰ Judith Zelmanovits, 'Midwife Preferred': Maternity Care in Outpost Nursing Stations in Northern Canada, 1945–1988', in Molly Ladd-Taylor, Alison Li & Kathryn McPherson, (eds), *Women, Health and Nation: Canada and the United States since 1945*, Georgina Feldberg, McGill-Queen's University Press, Montreal and Kingston, 2003, p. 163. Her focus is on station or outpost nurses employed after World War II who were practising alone or with one other nurse (who was often absent because of visits and leave). She includes some nurses in small hospitals within the federal Indian Health Services zones who, although providing a service for indigenous people, also serviced a wider community. See also Mary-ElLEN Kelm, *Colonizing Bodies, Aboriginal Health and Healing in British Columbia 1900–50*, Vancouver, University of British Columbia Press, 1998. Kelm states that 'the work of the field matrons in midwifery [in the first half of the twentieth century] seems to have been the main money-saver.'

⁵¹ 'Nursing in the small community islands carries increased emotional pressure ... isolation is minimised by the close relationship between nursing staff on the Isles of Scilly and those on the mainland.' L. Dopson, 'The islands: the Isles of Scilly' Part 2, *Nursing Times*, vol. 80, no. 12, 1984, pp. 40–42.

⁵² With the exception of Alberta where a training programme in advanced practical obstetrics was set up at the University of Edmonton in 1943. Jayne Elliott, Personal Communication, 2003.

⁵³ Janet C Ross-Kerr, *Prepared to Care, Nurses and Nursing in Alberta 1859–1996*, University of Alberta Press, 1998, p. 59. 'The proceedings of the Jubilee Congress of district nursing held at Liverpool in May 1909 revealed that Australia, Britain, Canada, Finland, Germany, Holland, Norway, Sweden, Switzerland and the United States had developed various forms of district nursing'. p. 90.

⁵⁴ McPherson & Stuart, 'Writing Nursing History in Canada', pp. 3–22. See also K McPherson, Chapter 5 'The case of the Kissing Nurse': femininity, sociability, and sexuality, 1920–1968' in *Bedside Matters: The Transformation of Canadian Nursing, 1900–1990*.

Nurses themselves helped maintain the culture which saw nurses being required to resign on marriage. Nursing shortages after World War II, and the social changes brought about by the war, led to the potential for married nurses to be employed in Canada and Australia. The complexity of the social and sexual environment in which nurses lived and worked, the role of marriage, and the impact of social change are explored in this thesis in the context of Tasmanian BNs. This thesis stands alongside the extensive research by Canadian historians to contribute to a trans-national and comparative history of nursing.

Similar needs existed for nursing services to rural communities in New Zealand, but the organisational response was different from that developed in Australia and Canada. In New Zealand no one nurse provided a comprehensive service including general, midwifery, and child health nursing. Public Health Nurses were the closest equivalent to the BN as in some rural areas they provided both general and child health nursing. Government funding provided home-based (general) nursing care through District Nursing services,⁵⁵ and nursing services to indigenous clients through Public Health Nurses.⁵⁶ Plunket Nurses, working within a community-based organisation with some Government funding through grants, provided Child Health nursing services but usually only within cities and towns.⁵⁷ Public Health Nurses in cities worked primarily with indigenous children and did administer immunisations. In rural areas their role included more general nursing, often focused on indigenous needs. Some rural areas had services from District and Public Health Nurses, and at times also from Plunket Nurses.

Patricia Sargison collates an extensive collection of sources for nursing history.⁵⁸ Some of the most relevant works in the history of nursing in New Zealand pertinent to

⁵⁵ Administered through Hospital Boards.

⁵⁶ Administered directly through a government department.

⁵⁷ The Society for Promoting the Health of Women and Children, incorporated in 1908, has some parallels with Bush Nursing in Australia. Lady Victoria Plunket, the wife of the Governor of New Zealand, was instrumental in arranging the Society's various local branches to form the New Zealand Society for the Health of Women and Children. This became known as the Plunket Society, and within six months the nurses became 'Plunket Nurses'. Members of Plunket committees were recruited from prominent women in society. See Linda Bryder, *A Voice for Mothers, The Plunket Society and Infant Welfare 1907–2000*, Auckland University Press, 2003, pp. 17–23, 35–35. Bryder argues these NZ women were maternalists rather than feminists. Dr Valentine of the NZ DPH wished to combine the work of District Nurses and Plunket Nurses, but this became an area of long standing dispute between the government department and the Society. District Nurses were seen as being of lesser status as they cared for the sick poor. Later, in 1911, the Native Health Nursing Service was set up to care for Maori mothers and babies. Plunket Branches were spread throughout NZ by 1914, whereas in contrast Bush Nursing and Child Welfare Nursing in Tasmania were slower to spread. Again in contrast with Plunket Nursing, BNs did not have a specialised training course nor a specific uniform.

⁵⁸ Patricia A Sargison, *From Candles to Computers, A bibliography of printed sources on the history of nursing in New Zealand*, 1986. See also Patricia Sargison, *Victoria's Furthest Daughters*, Alexander Turnbull Library, Endowment Trust, New Zealand, 1984; Patricia A Sargison, *Notable Women in New Zealand Health Te Hauora ki Aotearoa: Ona Wahine Rongorui*, Longman Paul, Auckland, 1993.

Bush Nursing include those by Philippa Mein Smith, Linda Bryder,⁵⁹ Patricia Sargison and Alexandra McKegg,⁶⁰ and the research of Margaret Tennant, such as her work on health camps and in women's studies. According to Sargison the 'only serious study of backblocks nursing' (as rural nursing was called in New Zealand) is McKegg's 'Ministering angels—the government backblock nursing service and Maori Health Nurses, 1909–1939'.⁶¹ Its major focus is the indigenous nursing service, but its section on District Nurses demonstrates that the New Zealand situation was closely allied to the Australian experience. Her discussion of indigenous health is also relevant. Maori health was transferred to DPH control in 1911 and a district nursing service was incorporated into the Native Medical Service.⁶² According to McKegg, the Native Health Nursing Service was a tool of assimilation.⁶³ Although some Maori women were trained for the service, the majority of nurses were Pakeha (Caucasian) women.⁶⁴ Unlike New Zealand, there was never a separate nursing scheme for indigenous people in Tasmania nor efforts to train indigenous people in nursing during this period.⁶⁵ In Tasmania a BNC was established on Cape Barren Island where a 'Half Caste Reserve' was established under government control. The social environment on Cape Barren Island was perhaps the closest equivalent to McKegg's isolated indigenous settlements. The proposed guidelines for New Zealand rural District

⁵⁹ Linda Bryder, *Regional History of New Zealand's Infant Welfare Organisation: Not Just Weighting Babies. Plunket in Auckland, 1908–1998*, Pyramid Press, Auckland, 1998; *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, (ed), B. Williams Books, Wellington, New Zealand, 1991; 'Maori and the Plunket Society, 1907–1960' in *Health and History*, vol. 3, no. 1, 2001; 'We shall not find salvation in inoculation: BCG Vaccination in Scandinavia, Britain and the USA, 1921–1960' in *Social Science and Medicine*, vol. 49, no. 9, 1999, pp. 1157–68; 'Sex, Race and Colonialism: An Historiographical Review' in *The International History Review*, vol. 20, no. 4, 1998, pp. 806–22. Linda Bryder's recent *A Voice for Mothers* is a history of the Plunket Society and traces the history of New Zealand's most successful voluntary organisation from 1907 to 2002. Plunket was organised around three dominant strands: 'the mixed economy of welfare; maternal and infant health; and mothercraft and parenting.' The work of Plunket provides a useful good comparison with the Child Health component of the BN's work.

⁶⁰ Unfortunately NZ universities and some Australian universities have a policy of not lending theses and therefore various MA and doctoral works were unavailable to me.

⁶¹ Alexandra McKegg, 'Ministering Angels: the government backblock nursing service and Maori health nurses, 1909–1939', (MA thesis), University of Auckland, 1991. (I was able to access a copy of a chapter of this thesis through the kindness of Pat Sargison). See also McKegg's work on the Maori Health Nursing Scheme, *New Zealand Journal of History*, vol. 26, no. 2, October 1992, pp. 145–160. In another article on the Maori Nursing Scheme, P Wood, 'Efficient preachers of the gospel of health', *Nursing Praxis in New Zealand*, vol. 7, no. 1, March 1992, pp. 12–21, notes that in one isolated place on the east coast the community supplied the nurses with a cottage with an emergency ward. Although the nearest doctor was 50 miles away the nurses had access to a phone. p. 20.

⁶² A McKegg, 'The Maori Health Nursing Scheme, An Experiment in Autonomous Health Care' in *New Zealand Journal of History*, vol. 2, October 1992, pp. 145–60.

⁶³ McKegg, 'Ministering Angels', p. 180.

⁶⁴ There are some historical articles, published in *Kai Tiaki* from 1909 and along with oral histories these appear to have been used extensively by McKegg.

⁶⁵ Tasmania did not have a Native Department. The Tasmanian Aboriginal population did not have formal status and did not gain suffrage until 1962. Their cultural and political identity is still controversial today. For additional information on recent interpretations of Tasmanian Aboriginal History see Henry Reynold's *The Other Side of the Frontier: Aboriginal resistance to the European Invasion of Australia*, Penguin, 1995.

Nurses in 1909 which provided Maori and Pakeha nursing states that 'in no sense of the word would the district nurse be expected to prescribe, use instruments, or in any way to take the place of a doctor' and that the nurses' role in midwifery was, as in Canada, in cases of emergency only.⁶⁶ Despite this these nurses had 'an independence unable to be achieved working in the hospitals'.⁶⁷ Bush Nurses in Tasmania describe a much broader clinical role than this reference suggests was the experience of New Zealand District Nurses.

Derek Dow quotes a contemporary description of backblocks nursing, inaugurated in the same year as Bush Nursing, as 'noble, as unselfish, yes, and as Christian-like, as the missionary calls to heathen lands'.⁶⁸ McKegg also characterises the nurses as special: 'as women they were atypical, as nurses they were unusual'.⁶⁹ Joan Rattray refers to Hester Maclean's call for nurses possessing 'a strong will, character, physical stamina, courage and adaptability'.⁷⁰ Web-based resources on rural nursing in New Zealand include biographies of various 'special' women such as Amelia Bagley (who founded the backblocks system), Nurse Maude, Robina Cameron, Janet Gillies, Ellen Anderson, Akeneni Hei, and Mabel Mangakahia.⁷¹

While Canada and New Zealand both had rural nursing schemes that were contemporaneous with, and parallel to some aspects of Australian and Tasmanian Bush Nursing, neither country had schemes that were identical in character and organisation to Tasmanian Bush Nursing.⁷² Bush Nurses were a small, but clearly-defined group, within Australian nursing but in common with other nurses they received their training and usually spent their early careers within hospitals. Most BNs trained in Australian hospitals, many travelling interstate to undertake additional training. Some gained further experience and training in overseas hospitals. Hospitals were formative environments for BNs' skills and attitudes, and hospital histories provide a background to this environment.⁷³ Several

⁶⁶ *Appendices to the Journals of the House of Representatives, NZ, 1909, H22, pp. 5–6.*

⁶⁷ McKegg, 'Ministering Angels', p. 149.

⁶⁸ Derek A Dow, *Maori Health and Government Policy 1840–1940*, Victoria University Press, Wellington, 1999 p. 132.

⁶⁹ McKegg, 'Ministering Angels', p. 147.

⁷⁰ Nurse Bilton inaugurated the service by visiting her first patient in Uruti...'. Joan Rattray, *Great Days in New Zealand Nursing*, AJ1 & AWReed, Wellington, New Zealand, 1961, p. 39.

⁷¹ See also the following in the *Dictionary of New Zealand Biography*, URL: <http://www.dnzb.govt.nz/dnzb/>, updated 4 April 2003, Elizabeth Leila Ralsto Fergusson, 1867–1930; Hester Maclean, 1859–1932; Maude, Sibylla Emily 1862–1935; Mabel Te Aowhaitini, Mangakahia, 1899–1940; Mabel Te Aowhaitini 1899–1940'.

⁷² 'The proceedings of the Jubilee Congress of District Nursing held at Liverpool in May 1909 revealed that Australia, Britain, Canada, Finland, Germany, Holland, Norway, Sweden, Switzerland and the United States had developed various forms of district nursing.' Ross-Kerr, p. 90.

⁷³ Most notable are Linda M Brown, *History and Memories of Nursing at the Launceston General Hospital*, General Hospital Ex-trainees Association, Launceston, 1980 and John Wilson, *A century of caring: Latrobe's Hospital 1887–1987: an illustrated history of the Devon Cottage Hospital in northern Tasmania*,

early Tasmanian hospital histories are commissioned histories and have a male medical and chronological focus.⁷⁴ An unpublished work, *The Coming of Medicine to Launceston and The History of the Launceston General Hospital 1804–2004*, promises to be more inclusive and will examine the interface of BNs with the hospital.⁷⁵

Influencing my use of sources was Janet McCalman's recent history of the Royal Women's Hospital in Melbourne. Patient case studies were an integral part of the work.⁷⁶ This study encouraged me to persevere in my search for the daily patient records that BNs were required to keep. Anthea Hyslop's history of Ballarat Base Hospital also models a new way of writing a hospital's history.⁷⁷ She presents a social statement as much about the community and its people as about the institution. Nurses are afforded names alongside their medical colleagues whereas in most previous histories they are portrayed as nameless women. These two histories have paved the way for innovative approaches to the history of institutions and their communities which meld oral and written sources. Similarly Henry Reynolds postulated that a history of a hospital potentially was a history of the surrounding community.⁷⁸ As a focal point of the community, hospitals provide insights into every aspect of that community and reflect values and attitudes. This thesis will provide insights into the values and attitudes of the community, as the lived experiences of BNs within the Tasmanian Bush Nursing Service are examined.

Bush Nurses generally were required to be trained in a range of sub-specialisations within nursing and to be triple-certificated.⁷⁹ Thus the histories of the various divisions within nursing are relevant to this study. In addition, BNs were employed either in other areas of nursing at some time during their careers or worked in tandem with such services.

Graduate Nurses' Association Centennial Celebrations Committee, Mersey General Hospital, 1988. Both publications are written by nurses, and investigate the training environment of nurses. The first is more a chronological history of an institution and nurses whereas the latter has a greater social emphasis and has a rural setting.

⁷⁴ Clifford Craig, *Launceston General Hospital First Hundred Years 1863–1963*, Board of Management of the Launceston General Hospital, Launceston, 1963 and WG Rimmer, *Portrait of a Hospital: The Royal Hobart*, Royal Hobart Hospital, Hobart, 1981.

⁷⁵ Paul Richards is coordinator of this publication. At a lecture at the Launceston General Hospital in 2002, Professor Henry Reynolds stressed that hospitals influenced life within the community. Anthea Hyslop also encouraged the adoption of a broader social emphasis for hospital histories. Anthea Hyslop, 'Writing a History of a Hospital', The Historical Committee, Launceston General Hospital Symposium, 1995.

⁷⁶ Janet McCalman, *Sex and Suffering, Women's Health and a Women's Hospital*, Melbourne University Press, Carlton South, 1999.

⁷⁷ Anthea Hyslop, *Sovereign Remedies, A History of Ballarat Base Hospital 1850s to 1980s* Allen & Unwin, Sydney 1989.

⁷⁸ Henry Reynolds, Address to Launceston Hospital History Group, 2002.

⁷⁹ The term Single Certificate referred to a certificate in General Nursing only; Double Certificate to General and subsequent Midwifery training; Triple Certificate to certificates in General, Midwifery and Child Welfare in that order. Certificates in Eye and Ear or Psychiatric nursing were not included in the nomenclature 'Triple Certificate'. All qualifications were gained in training hospitals (unless gained overseas).

Diane Snowden's history of Hobart District Nursing is strictly confined to District Nursing.⁸⁰ Despite Bush Nursing being a forerunner of, or parallel scheme to, the District Nursing scheme, and later becoming subsumed under the same banner, there is just a single mention of Bush Nursing. This is in the context of the work of Emily Dobson who was 'at the head and front of nearly all philanthropic and education movements in Tasmania' including Bush Nursing.⁸¹ Rob Linn's history of District Nursing in South Australia, previously mentioned, provides a more comprehensive history. Midwifery in Tasmania has been the focus of two Honours theses in History.⁸² Both briefly mention Bush Nursing although midwifery was considered a substantial part of BNs' duties. These two works provide important background about the registration of midwives and the political structures within which midwifery was placed.⁸³

In a recent study devoted to the child welfare specialisation within nursing, Sheryl Brennan examined the history of the child welfare movement in Tasmania between 1918–1930 and specifically analysed the prevailing construction of motherhood.⁸⁴ Although child welfare was included in the duties of BNs, and many BNs completed training in child welfare, BNs were not included as a separate group within this study. The study highlights the progressive ideology which saw mothers as needing to be checked and controlled by health professionals. The urban trained nurses were the agents by which this ideology was put into practice in the city and the bush. Anthea Hyslop looks at the child as a focus of social reformers in Australia, focussing on Victoria. Hyslop describes these reformers 'as essentially preventative in purpose', but unlike in Canada a comprehensive Public Health Nursing service did not develop in Australia.⁸⁵

⁸⁰ Diane Snowden, *Caring for the Community, One hundred Years of the Hobart District Nursing Service Inc 1896–1996*, Printing Authority of Tasmania, Hobart, 1996.

⁸¹ For biographical details and an extensive list of Emily's activities see Alison Alexander, 'The Public Role of Women in Tasmania 1803–1914', (PhD Thesis), University of Tasmania, 1989 pp. 323–326. Emily Dobson, (née Lempriere) was married to Henry Dobson, the Tasmanian Premier during that time. *Tasmanian Mail* 30 March 1911 in Snowden, p. 13.

⁸² Dusanka Sabic, 'Turning Full Circle', (BAHons Thesis), University of Tasmania, Hobart, 1986, and Sharon Smith, 'Unveiling the Science of Childbirth', (BAHons Thesis), University of Tasmania, Launceston, 1993.

⁸³ Lorraine Larcombe RN, (MA Thesis), La Trobe University, also has researched midwifery in Tasmania.

⁸⁴ Sheryl Brennan, 'Nurses and Constructions of Motherhood: scientific motherhood and the rise of the child welfare services in Tasmania 1918–1930', (MN Thesis), University of Tasmania, 1995. Sheryl Brennan is currently the Clinical Graduate Studies Co-ordinator, School of Nursing, University of Tasmania, specialising in the Family and Child Health Nursing stream of the Graduate Diploma of Nursing.

⁸⁵ 'Children and the Nation's Future (1): Variations on a racial theme', in Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. 204. For information pertaining to the introduction of the federal Baby Bonus refer to TH Kewley, *Social Security in Australia 1900–72*, Sydney University Press, 2nd edn, 1973, pp. 64–143 and also Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. 239.

Bush Nursing was much of the time under the auspices of the DPH and the nurses' role included aspects of public health.⁸⁶ Public health histories are of relevance to this thesis. Stefan Petrow's history of public health in Launceston and Hobart specifically examines these two urban centres while ignoring the rural areas of Tasmania.⁸⁷ He provides a background to the relationship between the Tasmanian Health Department and the city councils in the delivery of public health. Philippa Martyr contends that Petrow's study is a 'comprehensive—some may say exhaustive—analysis of the role of municipal councils in Tasmania in the late nineteenth century'.⁸⁸ Histories of the public health in Tasmania which extend beyond the urban areas have yet to be written. The Tasmanian Health Department controlled public health delivery in urban and rural Tasmania through legislation and regulation. Country municipal councils were the agents of the Health Department in Public Health, and BNs worked closely with the councils and their municipal health inspectors in promoting public health.

Bush Nursing was established during a period of major public health crises within the Australian community,⁸⁹ and the Australian Department of Health was established in 1921 as a reflection of 'a universal concern for health issues'.⁹⁰ Michael Roe emphasises that community health came to the fore during the early twentieth century. Roger Wettenhall provides a contemporaneous context for the administrative structure of the Public Health Department which took over the administration of the Bush Nursing Scheme in 1920.⁹¹

The national population debate, including that on the use of contraception, coincided with the early period of Bush Nursing in Tasmania. Jillian Waters discusses the population

⁸⁶The DPH was set up in Tasmania under the *Public Health Act* of 1903. The Department initially comprised a director, a part-time secretary, three clerks, and three caretakers for potential depots for quarantine or infectious disease hospitals. It controlled local boards of health until they were absorbed into local government in 1907. It was not until 1929 that the *Act* was amended and the DPH was given enforcement power. AOT, TA19. In this thesis the DPH is described as if this bureaucracy had a single voice. The DPH files in the AOT provide no evidence that there was ever confusion or conflict in the public face presented by the department.

⁸⁷Stefan Petrow, *Sanatorium of the South? Public Health and Politics in Hobart and Launceston 1845–1914*, Tasmanian Historical Research Association, Hobart, 1995. For a NZ comparison see Derek Dow, *Safeguarding the Public Health*, Victoria University Press, Wellington, 1995.

⁸⁸Philippa Martyr, *Electronic Journal of Australia and New Zealand History: Book Review of Petrow's Sanatorium of the South? Public Health and Politics in Hobart and Launceston 1845–1914*, Tasmanian Historical Research Association, Hobart, 1995.

⁸⁹Specific Public Health issues which the BN faced are dealt with in several publications. Anne Killalea's *The Great Scourge*, confined to 1937–1938, deals with the Infantile Paralysis epidemics. Anne Elizabeth Killalea, 'The Great Scourge The Tasmanian Infantile Paralysis Epidemic of 1937–38', (MHum Thesis), University of Tasmania, 1992 and also same title published by Tasmanian Historical Research Association, Hobart, 1995. Anthea Hyslop's work examines the influenza epidemic in Australia and Tasmania. BNs recalled these epidemics in their interviews.

⁹⁰Michael Roe, 'The establishment of the Australian Department of Health: Its background and significance', *Historical Studies*, vol. 17, no. 67, October, 1976, pp.76–192.

⁹¹Roger L Wettenhall, *A Guide to Tasmanian Government Administration*, Platypus Publications, Hobart, 1968.

debate in the early part of the twentieth century when a need to increase the population was politicised, and marriage, family and children took on new significance.⁹² Reproduction had become a social concern. The women's movement saw this debate as about promoting a healthy baby for a healthy society, while the male-dominated power elite saw this quite differently, and more in terms of racial defence, development, racial purity and colonisation.⁹³

Anthea Hyslop includes Bush Nursing in her examination of women and social reform in Victoria, but there is no equivalent study of women in Tasmanian history.⁹⁴ She contends that Bush Nursing was heralded by one local newspaper as a 'life-saving movement, intended primarily for the relief and education of mothers'.⁹⁵ Bush Nurses were to be agents of social reform that would 'improve the health of country people', 'reduce infant mortality' and thus 'raise the general standard of public health' and 'increase the population'.⁹⁶

Kerreen Reiger has analysed the construction of the Australian family from 1880 to 1940, the critical period in Bush Nursing's growth and one of considerable change in Australian society.⁹⁷ The progressive ideology saw the housewife as needing to become 'modern' or 'efficient', domestic technology had become available, and through public propaganda and professional control the state intervened in child bearing and rearing practice.⁹⁸ There is contradiction as the reforming attempts were initiated by 'an emergent class of professionals, technocrats or experts' among whom BNs are numbered.⁹⁹ This group worked 'hand in hand with ... the dominant class in Australian society' but, while promoted by and in the interest of the dominant class, the ideas 'represented a fundamental threat to some deep-seated social arrangements'.¹⁰⁰ Reiger sees the 'dilemma presented by the operation of quite different models of home and family is of much greater significance than has generally been recognised'.¹⁰¹ Bush Nurses reflected some of the dilemma presented by the operation of quite different models of home and family as they modelled societal values which were at odds with the progressive ideology they promoted. There is a coherence across nations to the ideologies which drove social reform in the late nineteenth

⁹² Jillian C Waters, 'To Help the Mothers and Save the Babies: an episode in Tasmania's population debate', (BA Hons Thesis), University of Tasmania, 1983.

⁹³ Mein Smith, *Mothers and King Baby*.

⁹⁴ Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. 345.

⁹⁵ Hyslop quotes extensively from the *Argus* in 1909–10.

⁹⁶ Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. 346.

⁹⁷ Kerreen M Reiger, *The disenchantment of the home*, Oxford University Press, Oxford, 1985.

⁹⁸ Reiger, pp. 2–3.

⁹⁹ Reiger, pp. 212–213.

¹⁰⁰ Reiger, pp. 2–3.

¹⁰¹ Reiger, pp. 2–3.

and twentieth centuries although the actual implementation of these reforms differed¹⁰² This thesis will contribute to the knowledge of how these reforms were implemented at the grass root level by BNs in Tasmania.

Similarly, in the context of Bush Nursing there are local and international differences in the implementation of rural nursing services but there are critical parallels in the services' underlying aims, in the fluidity of inter-professional boundaries, and in the influences of gender and power relationships. Midwifery was the battleground for social control. Not only was the midwife in a position of power over her patients, but the medical profession made childbirth an area of territorial dispute and was to battle midwives for patients' confidence and support. The male takeover of women's work and knowledge perhaps was supported paradoxically by the majority of women. Although doctors profited from female grassroots support and networks, women reformers and nurses were advantaged by access to male power structures.¹⁰³

As in all wars there was, and still is, some shifting of the frontline of this battle. More so in Canada than in Australia the medical profession was successful in taking over childbirth. In this thesis it will be demonstrated that in the latter period of Bush Nursing the medical profession gained increasing control of midwifery and BNs were to become more providers of ante-natal care than of intra-partum care. Childbirth became described in terms suggesting the need for intervention rather than as a 'normal process' requiring facilitation. Barrington stated that:

The public should be taught that it is just as necessary to go to hospital for childbirth as for a surgical operation.¹⁰⁴

The medical profession as self-styled experts wielded great influence at all levels of government. This was supported by skilful use of propaganda, through the media and education, which underpinned progressive change. The 'message' was promulgated with missionary fervour using religious terminology.

Bourgeois women led the way in many areas, such as with the development of Bush Nursing. For Bush Nursing's founders changes were to be achieved while keeping the social order intact. Perhaps this tension helped promote (male) medical control of health initiatives if not of nursing practice within the community. While at organisational level (male) medical control of nursing was institutionalised, this control did not manifest itself

¹⁰² Reiger, p. 4.

¹⁰³ Sandra Lee Barney 'Maternalism and the Promotion of Scientific Medicine During the Industrial Transformation of Appalachia, 1880-1930' in *NWSA Journal*, vol. 11, no. 3, 1999, pp. 68-92.

¹⁰⁴ F Barrington, 'Presidential address to section of obstetrics and gynaecology', *Transactions of the Australasian Medical Congress*, 1920, p. 156.

at the level of practice within the community. The interaction between BNs and doctors is dealt with in this thesis through official correspondence records and oral histories. No other research has explored interpersonal and inter-professional relationships between doctors and nurses in Tasmania. There have been no histories written about the Tasmanian Government Medical Officers or General Practitioners in Tasmania.¹⁰⁵

At a more theoretical level MJ (Mike) Hazelton addresses the relationship between medicine and nursing, a relationship important for, but not central to, this thesis.¹⁰⁶ He looks at it from the standpoints of class and gender analysis. A key concept is that of medical dominance, defined by Eliot Freidson as the 'authority to direct and evaluate the work of others without in turn being subject to formal direction and evaluation by them'.¹⁰⁷ Evan Willis argues that task allocation in health occurs as a result of informal negotiation between providers and imposition from above,¹⁰⁸ and that medical dominance over the work of others comes from 'medical authority' and 'medical sovereignty'.¹⁰⁹ The relationship between two health care groups can be categorised then as one in which there is 'exclusion', 'subordination', 'limitation', and 'incorporation'.¹¹⁰ Nurses are seen by Willis as 'subordinated' with their work largely directed by doctors. This analysis might be true for hospital nursing but will be challenged by the practice of BNs. Mike Hazelton argues that

Nurses simply have not always acquiesced under medical or patriarchal authority. Rather, they do, and have, actively negotiated and contested the social relations that constitute the health systems within which nursing has been conducted.¹¹¹

This view of the health system as an area of contested social relationships reinforces the dynamic nature of health boundary issues. This thesis will show how BNs navigated such relationships.

Nursing as an occupation during the late 1800s and early 1900s was undergoing substantial change, as has been described well in numerous nursing histories. The attempts to improve standards of practice through enhanced training and then through registration

¹⁰⁵ No single data source provide an accurate listing of doctors of the period and their places of practice and residence.

¹⁰⁶ MJ Hazelton, 'The History of The Present': Nursing and Critical Historiography' in Susanne Atkins et. al., (eds), *Outpost Medicine, Australasian Studies on the History of Medicine*, University of Tasmania and the Australian Society of the History of Medicine, 1994, pp. 227–228.

¹⁰⁷ Eliot Freidson, *Professional Dominance: The social structure of medical care*. Chicago, Aldine, 1970, p. 135 quoted in Hazelton.

¹⁰⁸ Evan Willis, 'Sister Elizabeth Kenny and the evolution of the occupational division of labour in health care'. *Australian and New Zealand Journal of Sociology*, vol. 15, no. 3, 1979, pp. 30–38 quoted in Hazelton.

¹⁰⁹ E Willis, *Medical Dominance: the division of labour in Australian health care* (rev. edn), Allen & Unwin, Sydney, 1989 quoted in Hazelton.

¹¹⁰ Willis, *Medical Dominance*, p. 32.

¹¹¹ Hazelton, p. 223.

saw many nurses claim professional status, while others used religious metaphors to describe an occupation which was 'above' the more worldly concerns of mere professions. Conflicts between gender-specific nurturing roles and the male scientific theory-based view of health care activity, increasingly embraced by the medical profession, added to the internal conflicts as nurses struggled to position themselves within the health system.¹¹² Bush Nursing developed during this period of professional turmoil for nurses.

The hospital itself was also the site of changing focus and role definition from a charitable to more socially inclusive and curative role. Public health was coming to the fore with its focus on social engineering based on progressive ideology. Nurses' claims to professional status in the context of these dynamic changes were debated within and without nursing then as now. Trembath and Hellier note that the use of the term 'profession' to describe nursing is seen in a variety of contemporaneous documents such as those which describe the value of the registration of nurses,¹¹³ the status of nursing,¹¹⁴ the challenges of nursing,¹¹⁵ and conditions of work and remuneration.¹¹⁶ They argue that the case for professional status for the late nineteenth century nurse is not established. Woods, from an American viewpoint, counters a number of their arguments and notes that it was not until the 1920s that the subordinate relationship of medicine and nursing was consolidated, to a large extent because nursing was not the equal of medicine in the political or economic spheres of activity.¹¹⁷ In Australia during the 1880s it was thought that nurses 'exhibited tendencies towards diagnosing and prescribing of a very free description' and in this period Australian doctors were well organised politically and able to influence the way in which nursing was to develop.¹¹⁸ This influence was expressed even through the attitudes of nurses in key positions who saw nurses as subservient to doctors, thus consolidating gender-based roles.¹¹⁹ Concern about clinical independence surfaced at times during the Bush Nursing era, and has continued since that time. Within New Zealand, Linda Bryder shows that relationships between Paediatricians and Plunket (Child Health) Nurses shifted from combative to supportive between the 1930s and the 1950s, perhaps because doctors, by that time, could support an organisation that they felt they could

¹¹² Alison Bashford, 'Domestic Scientists: modernity, gender and the negotiation of science in Australian nursing, 1880–1910', *Journal of Women's History*, vol. 12, no. 2, 2000, pp. 127–146.

¹¹³ Royal Commission on Charitable Institutions of the Colony. P.P. (L.A., Vic), vol. 6, p. 19, 1891, in Trembath & Hellier.

¹¹⁴ Greta Lyons in *Una*, vol. 11, June 1913, p. 83 quoted in Trembath & Hellier.

¹¹⁵ *Argus*, 7 October 1912 quoted in Trembath & Hellier.

¹¹⁶ Jessie McBeth in the *Herald*, 20 May 1922 quoted in Trembath & Hellier.

¹¹⁷ CQ Woods. Chapter 10, 'From Individual Dedication to Social Activism: Historical Development of the Nursing Profession' quoted in C Maggs, (ed), *Nursing History: The State of the Art*, Croom Helm, London, 1987.

¹¹⁸ *Australian Medical Journal*, vol. 2 (New Series), October 1880, pp 468–470 quoted in Trembath & Hellier.

¹¹⁹ Isabella Rathie, Matron, Melbourne Hospital; 'we are in great measure the handmaid of the medical man' quoted in Trembath & Hellier, p. 19.

control; and Philippa Mein Smith shows the shifting balance of power between midwives and doctors over the twentieth century.¹²⁰

This thesis will demonstrate that, in Tasmania, the boundaries between areas of professional practice were contested territory and in constant flux. Furthermore, professional boundaries varied over time and place, based on the qualities of individual players, the constraints of the environment, and changes in technologies within and without the health care sector. Rural areas were not the preferred practice location of the medical profession in Australia, a situation little changed today and well-explored in current literature. Rural needs for health care were highlighted within progressive ideology, and particularly by progressive women espousing the needs of rural mothers and babies. Bush Nurses were the 'foot soldiers' in this campaign. In Tasmania, BNs became the key health providers for rural communities. Initially these BNs essentially were unchallenged independent health professionals, working in an environment which was significantly different from nursing practice of that period. Nevertheless contemporary attitudes would not allow women personal or social freedom, and marriage required resignation and the loss of professional status. Their registration and training bodies also were heavily male influenced, if not male controlled.¹²¹ Moreover while Tasmanian Bush Nursing was initially community-based and promoted primarily by middle class progressive women, it was not long before organisational control was handed by the Bush Nursing Association to the medically-dominated DPH.¹²² The independence of the BN became, at least in theory, progressively more constrained. This thesis will show that, despite the climate of increasing official control, the practical constraints of the environment in which they practised ensured that Tasmanian BNs valued and retained independence of practice. Trembath and Hellier argue that:

[A] nurse in 1900 could not seriously expect to be regarded as a professional ... [as she did not] enjoy the power of independent decision making ... [but rather was] taught during her period of training to obey without question the instructions of the doctor attending the case. A nurse did not initiate; she responded.¹²³

¹²⁰ Bryder, *A Voice for Mothers*, p. xiv; Philippa Mein Smith, 'Midwifery Re-innovation in New Zealand', pp. 169–187 in J Stanton, (ed), *Innovation in Twentieth Century Medicine and Health*, London, Routledge, 2002.

¹²¹ Trembath & Hellier's analysis of the development of nursing in Victoria highlights well the medical dominance over nursing development in the State. The influence of Barrett in Bush Nursing in Victoria also underlines the influence of male medical models. Hyslop's *Sovereign Remedies* also demonstrates that male-based gender structures dominated women in the health field, whether those women were nurses or doctors. Not only were nurses seen as being responsible for female, nurturing, work but female doctors tended also to do 'women's work'.

¹²² Within rural communities, informal power structures were often female and thus local committees still had an important supportive, if not controlling, role. BNs were from a variety of class backgrounds, but in their work espoused middle class values.

¹²³ Trembath & Hellier, p. 42.

It is in this latter area that the experience of the BN is different from that of the majority of nurses of that period. The development and consolidation of the hospital as a key component of the health service required a strengthening of systems of control within hospitals. This control became medicalised and led to a decrease in the autonomy of hospital nurses.¹²⁴ There was less need to develop within community practice the tight systems of control which were seen within hospitals, and thus less need to control the autonomy of nurses.

The BN did enjoy the power of independent decision making, albeit a power that varied by location and over time.¹²⁵ If a doctor were in attendance the BN still was subject to his orders, but a doctor was in attendance in a minority of the cases nursed. The evidence for the increased control over their autonomy towards the end of the Bush Nursing era might reflect the trend towards tighter control within the health system coming but late to an area where its need was lower (and where, for practical reasons in the early 1900s, such control could not be exerted). By the 1940s BNs, although a small group within nursing and without a political or social structure, had established a clear sense of identity. For rural communities the BN was seen as a person of special qualities, at times almost saintlike. The DPH needed to demythologise the Bush Nurse to gain control over this group. Through the skilful use of nomenclature change as a way of blurring the nurses' identity the department worked to reduce the nurses' independence and power.¹²⁶

Robert Dingwall describes the modern situation of the midwife in the United Kingdom where he argues that the medicalisation of reproductive services has seen the midwife transformed into a maternity nurse.¹²⁷ For Dingwall the nurse has become merely an extension of the doctor. While there is a substantial zone of discretion in which she takes responsibility for her practice she functions within rules defined by modern (medical) obstetric practice. Nevertheless Dingwall's argument, based on the fact that the nurse has to function within rules defined for her, is weakened as close examination shows this is also true for the general practitioner and the obstetrician. The midwife's lack of ongoing supervision, the requirement to make her own decisions when faced with new or unexpected problems, and her management of whole obstetric care must make her independent. For the BN we will see that independence of practice did exist, but that the regulatory and management framework in which this occurred was somewhat unclear.

¹²⁴ Maggs, (ed), *Nursing History: The State of the Art*.

¹²⁵ Discussions about autonomy are relevant to this thesis as are the debates about professionalism. While these are intersecting concepts, there are important semantic distinctions. See for example: P Anne Scott, 'Morally autonomous practice?' *Advances in Nursing Science*, vol. 21, no. 2, pp. 69-79.

¹²⁶ Changes in nomenclature occurred from about 1945 as will be detailed in Chapter Two.

¹²⁷ Robert Dingwall et al, *An Introduction to the Social History of Nursing*, Routledge, London, 1988, pp. 171-172.

While many see the impact of doctors on midwifery as an example of inter-professional conflict, others see this as a result of market forces.¹²⁸ The role of market forces in creating conflict in midwifery will be demonstrated in this thesis as rural doctors tried to maximise their income from private practice.

Another framework through which to understand inter-professional boundaries and concepts of independence and autonomy is from exploration of complaints about practice where boundaries appear to have been transgressed. Detailed research by Mary Chiarella has explored the concept of nursing autonomy based on a Coronial Inquiry, and its aftermath, following the death of an Aboriginal in custody of police in 1987.¹²⁹ This detailed exploration of autonomy, while not based on events in the Bush Nursing era, is still relevant to much of the experience of Bush Nursing. The BN worked within guidelines which probably were deliberately unclear. This provided an environment in which disputes might be expected, but there are few complaints by doctors against nurses, or nurses against doctors, recorded in the archives. Analysis of these in the thesis has provided some insight into official views of the role of the BN. Conversely, the absence of identified complaints about practices which contravened the strict letter of the regulations are strongly suggestive of an environment in which such behaviour was accepted tacitly.

The twentieth century saw the medical profession gain legal control over the new technologies in health care which were to revolutionise health care delivery. Nurses and doctors differed little in their access to therapeutics in the early 1900s, but by the mid-twentieth century nurses no longer had equality of access to effective treatment modalities. Changes in accessibility of medical care for rural dwellers reduced the centrality of the BN within rural health care, and this thesis places BNs within this environment of diminishing rural isolation. This thesis will develop the theme of the shifting boundaries between nursing and medicine and the implication for nursing autonomy. J Shoebridge sees the relationship between medicine and nursing in a strategic fashion and focuses on areas of contestation, collaboration and co-operation.¹³⁰ This view perhaps reflects that there is not *one* medical nursing relationship but a series of relationships between individuals. Each relationship might change over time dependent on circumstance, experience or attitudinal shifts. Bush Nurses will be seen to work within such

¹²⁸ Enid Fox, 'An Honourable Calling or a Despised Occupation: licensed midwifery and its relationship to District Nursing in England and Wales before 1948', *Social History of Medicine*, vol. 6, no. 2, 1993, pp. 237–259.

¹²⁹ Mary Chiarella, *The Legal and Professional Status of Nursing*, Churchill Livingstone, London, 2002.

¹³⁰ J Shoebridge, 'Co-operation, collaboration or confirmation; the insubordination of Australian Nursing', quoted in G Gray and R Pratt, (ed), *Issues in Australian Nursing 2*, Churchill Livingstone, Melbourne in 'The History Of The Present: Nursing and Critical Historiography' p. 222.

a system, where, while it is possible to characterise a general professional situation, significant variation in this general relationship is seen between individuals and over time.

There are distinct differences in practice between hospital and community, and more so between urban and rural practice. Robert Dingwall notes that this was recognised by Florence Nightingale in 1859 when she commented that, while in hospital, the nurse's work was constrained by an elaborate system of discipline and control, but that within the community the nurse must rely on her personal qualities and skills. Nightingale saw the community-based nurse as the doctor's 'staff of clinical clerks, dressers and nurses'.¹³¹ As Dingwall notes, 'This list is revealing. The clerks and dressers were apprentice doctors, so that the boundary between medicine and nursing in the community appears to be rather different from that in the hospital'. The hospital nurse is subordinate to the doctor, while the nurse in the community 'is much closer to the doctor, as a treatment assistant'.¹³² Bush Nurses will be seen as 'closer to a doctor' and to use Nightingale's terminology as more of an 'architect' than a 'builder'.

Notions of what it is to be rural are increasingly the subject of modern research, and much of this is relevant to understanding the Bush Nursing experience. Rurality is seen as a complex phenomenon which incorporates variables such as population, isolation, economic activity and social systems.¹³³ Significant variability exists within the experience of rurality. This variability, as experienced by BNs in Tasmania, is highlighted within this thesis. For the BNs, as for modern nursing professionals in rural areas, such an environment leads directly to consideration of the influences on practice of isolation and distance, self-reliance, and lack of anonymity. Rural social structures make concepts of outsider/insider and old-timer/newcomer of particular importance as is the need for the nurse to work through established informal power structures within the community.¹³⁴ For the nurse arriving from an urban environment this requires the development of new skills as the psychology and sociology of rural communities are markedly different from the cities.¹³⁵ For health planners this also was challenging as service delivery models that might be effective in cities might not be so in rural areas and vice-versa.¹³⁶ The rural environment in Australia in

¹³¹ Dingwall et al, p. 178 refers to Florence Nightingale in 1876, as quoted in Baly *On Trained Nursing for the Sick Poor*, 1986, p. 128.

¹³² Dingwall et al, p. 178.

¹³³ M K Zapf, 'Notions of rurality', *Rural Social Work*, vol. 6, no. 3, 2001, pp. 12–27.

¹³⁴ KA Long & C Weinert, 'Rural nursing: developing the theoretical base', *Scholarly Inquiry for Nursing Practice*, vol. 3, no. 2, 1989, pp. 113–27.

¹³⁵ Strasser, pp. 870–876.

¹³⁶ District nursing services in the United Kingdom, on which Bush Nursing was based, worked more smoothly in rural than in urban areas because of less complex social structures and smaller more manageable organisational structures. See Enid Fox, 'Universal Health Care and Self-Help: paying for District Nursing before the National Health Service', *Twentieth Century British History*, [Great Britain], vol. 7, no. 1, 1996, pp. 83–109.

which BNs were to practise was conceptualised in a unique Australian way as 'the bush'. This term, by 1826, had 'achieved a currency as a conventional reference to the country in general outside a capital'.¹³⁷ It is a complex concept that is inherently contradictory. Seen as 'no place for a woman', the bush is simultaneously 'the terrain on and against which both Australian men and women symbolically measure their identity'.¹³⁸ It is both a place of 'purity and innocence' and an environment which is 'hostile, desolate and resisting efforts to humanise it'. Cameron Richards sees the dominant narrative of the bush as being 'prototypically white, Anglo-Celtic' and 'male' with the hero 'confronting and mastering the Other'.¹³⁹ Bush Nurses challenge this dominant narrative. We see them take their nursing care into the most remote areas of Tasmania, but in other ways they reinforce this masculinist view as the skills they had to master in conquering the challenges of their environment often were those not traditionally seen as female.

Jane Barnett and Jeri Bigbee examine modern rural nursing in the United States and reinforce the view that nurses can provide broad-based health care to rural communities in the absence of a doctor.¹⁴⁰ Nurse practitioners provide services and refer, when required, in a model of health care again surfacing in areas with physician shortages in Australia and in the United States. These experiences have distinct parallels to those of the BNs of the early part of the twentieth century.

The literature review has highlighted an apparent paucity of recorded lived experiences of BNs. There might be a number of reasons for this state of affairs. It may be that rural history has not been seen as the history of health or the history of women; that these nurses, practising in isolated areas, were invisible to the general urban populace; that they were not part of the elite about which history is written; that the diversity of their roles and long hours prevented BNs from writing journals and diaries, or that because of the transitory nature of their positions, letters were not hoarded but discarded with every move.

I did for a long time [keep a diary], but when I moved around it got thrown out. I often wished I'd kept them but I just didn't have that much room, because I reckoned to travel in two suitcases and that's it.¹⁴¹

¹³⁷ Cameron Richards, 'Bush Frontier Rhetoric', *Journal of Australian Studies*, vol. 49, 1996, pp. 81–89.

¹³⁸ Kay Schaffer, 'Women and the Bush: Australian national identity and representations of the feminine', Working paper 46, Sir Robert Menzies Centre for Australian Studies, 1989.

¹³⁹ Richards, pp. 81–89.

¹⁴⁰ Jane Stallard Barnett, Jeri L Bigbee 'Nursing Centers: One Approach to Rural Health Care' in Angeline Bushy, (ed), *Rural Nursing, Volume 2*, Sage Publications, Newbury Park, California, 1991, Chapter 13, p. 168.

¹⁴¹ Evelyn Mellish, Interview, Musselroe Bay, 1994. Sister 'Dorothy' Evelyn Dorothy Elizabeth Mellish was born in England in 1914 and began her nursing training, in her 30s, at Southampton after she had cared for her invalid mother. She came to Australia as a tourist and completed her general training at St John's Hospital, Hobart, midwifery at Calvary Hospital, Hobart, and child welfare in Hobart. Soon after she became District Nurse at Gladstone although was known always as a BN.

Bush Nurses were generally sole practitioners. There is no evidence that they were politically active as a group but does this mean they were oppressed? They functioned as members of a general nursing profession and gained their professional education from within general nursing. In their role as BNs they mostly functioned as isolated individuals. This has isolated them from historiography, and in their working lives will be seen to have worked both for and against them. This will be the focus of this study. In summary, the literature has provided an incomplete outline of the history of Bush Nursing as an organisation; an occasional brief insight into the lives of BNs; a background to the training environment from which BNs were recruited; a description of other areas of specialisation in nursing; the place of Bush Nursing within the context of hospitals and public health in Australia and Tasmania, and an insight into some of the major public health issues facing BNs.

Methodology

This thesis explores the professional isolation and independence of BNs in Tasmania. The period of Bush Nursing was one of significant social change. It includes the two World Wars of 1914–1918 and 1939–1945, the Great Depression of the 1930s, revolutions in transport and communication, changes in the acceptable roles for women in society, and substantial changes in health care.¹⁴² Bush Nursing reflected these changes, and this study assesses the impact of the changes on both the isolation and the independence of the BN.

The time frame for this thesis is the entire Tasmanian Bush Nursing era from the inception of the Tasmanian Bush Nursing Association in 1910 to the incorporation of Bush Nursing into the PHD District Nursing Service in 1957. This thesis is based on the examination of existing information and new oral histories.¹⁴³ The study is necessarily selective—not all the data in the public record for each nurse or each centre were used, the study focussing on data of relevance to the research questions. The study does not focus on the nurses who were employed by the Hydro Electric Commission (HEC) as they were employed and practised in working conditions different from those of nurses employed

She retired to Musselroe Bay where she continued to administer First Aid, and died at Scottsdale on 3 September 1998.

¹⁴²This included formalisation of nursing qualifications, State registration of nurses in 1927, and developments in immunisation and antibiotics.

¹⁴³Ethical approval for the study and its collection and use of data were gained from the University of Tasmania Human Studies Research Ethics Committee, and informed consent governed all data collected and used. Confidentiality of source has been maintained where requested. Clinical data about individuals exist within DPH files in the AOT archives. These individuals are not identified by name within the thesis.

under the Bush Nursing Scheme.¹⁴⁴ Since isolation would have been an important issue for the HEC nurses as for the BNs the story of these HEC nurses is of potential interest.¹⁴⁵ One major difference was the mobility of the HEC village populations. These villages were dismantled and moved to the next site as new dams and power stations were constructed. The HEC archives therefore would indeed be of great value to any future researcher in this field or as a comparative study with Bush Nursing.

This thesis focuses on a small number of BNCs particularly those where it was possible to combine data from a number of primary and secondary sources. This includes BNCs, which provide contrasting environments such as islands (Furneaux and Bruny Islands); isolated mining towns (Waratah and Adamsfield); a forestry and farming area (Marrawah) and a farming district within 20 kilometres of a major city (Lilydale).¹⁴⁶ The thesis examines in some detail BNCs which were amongst the most difficult environments for the BNs. These provide critical tests for the thesis. An organisation's strengths, weaknesses and attitudes are judged best by exploring the ways in which they deal with most disadvantaged or difficult environments. If BNs were to demonstrate professional independence it should have occurred in these areas, and the organisation would have to develop ways of supporting or controlling that development. Contrasting these environments with less isolated environments provides the opportunity to assess the degree to which these findings can be generalised.

¹⁴⁴ Currently HEC personnel records are not available for research purposes. Although there is an extensive archive of HEC material it remains unindexed and unavailable. Several theses have dealt with the hydro scheme without dealing with women, families or nurses. Roger Lupton, *Lifeblood—Tasmania's Hydro Power*, Focus, NSW, 2000 neglects the role of women, using only approximately seven references. Tim Jetson in *The Roof of Tasmania, A History of the Central Plateau*, Pelion Press, Launceston, 1989, includes health under the heading of 'social infrastructure' but women, and in particular the unnamed nurses who served the area for the period under study, do not rate a chapter. Sally Rackam's three volumes of *Hydro Construction Villages* remain the only social histories to include women's and children's experiences in the hydro and contain a brief mention of the health needs of the communities. Perhaps these historians are reflecting the HEC's archival policy which focuses on maintaining construction records rather than a record of the social history of their schemes. As with the Bush Nursing Service the HEC relied on migrant nurses to fill some of their positions. Sister MJ Bloomfield (Field Hospital, Bronte Park) and HM Summerford (Waddamana) were two such migrant nurses working in 1949. Sister May Pierce was also an early BN in the HEC villages.

¹⁴⁵ HEC nurses were referred to by the HEC as Bush Nurses. Hydro Tasmania, Personal Communication, 2003.

¹⁴⁶ These centres were chosen for several reasons. The Furneaux Islands and Bruny Island had extant daily work journals; three former BNs that had worked at Waratah were available for interview; two midwifery journals existed for Marrawah and one of the BNs listed in the journals was available for interview. Adamsfield was in a particularly harsh and remote environment, written reminiscences of the first BN were available and a later BN was available for interview. At Lilydale comprehensive data were available readily and the BNC boasted one of the longest serving BNs.

Bush Nurses were required to keep records of their work. The main body of BNs' records of their daily work and written case histories have not survived.¹⁴⁷ The only case-based records available were for general nursing care over short periods on Babel, Chappell and Bruny Islands, and two daily midwifery journals from Marrawah. The daily journals from Bruny Island were located on Bruny Island, the remainder of the work records were in the AOT archives. Statistical descriptions of the work of the BNCs are recorded in monthly and annual reports which survive in the Tasmanian Parliamentary Papers. Descriptions of the BN's work are included also within the correspondence between BNs, the DPH, and its Supervisory Nurses.¹⁴⁸

Given the years since the inception of Bush Nursing in Tasmania, exploration for information about the early period of Bush Nursing necessarily has depended on secondary sources or written primary sources. Unfortunately many of the early records, such as the Bush Nursing Association records up until 1920 when the DPH took over, have not been located. Some data pertaining to this period have been found in Municipality Minutes and records, or newspaper reports of general local council business.¹⁴⁹ Sources of data included the DPH files in the Archives of Tasmania (AOT), Municipal and Parliamentary records, personal archives, published and unpublished works, newspaper archives, a large collection of photographs, hospital and local museum archives. These were supplemented with oral histories, most collected specifically for this thesis but a small number were identified from previous research examining Lilydale records. All living and known BNs were identified and 17 interviewed.¹⁵⁰ The data from these various sources were integrated and analysed to allow the themes of the thesis to develop through the lived experience of the nurses.

¹⁴⁷ For a recent example of the use of case histories refer to Janet McCalman, *Sex and Suffering*, where case histories from an institution have produced a rich source of primary material to uncover the everyday lives of women through a hospital.

¹⁴⁸ The range of records required to be maintained by the BN included '1. Day Report Book entered daily; 2. Midwives Record Book entered daily; 3. Midwifery Bookings Book entered as necessary; 4. Antenatal Visits Book entered as necessary; 5. Child Welfare Visits Book entered as necessary; 6. Drugs Book entered as necessary; 7. Patients Account Book (small) entered as necessary; 8. Patients Receipt Book entered as necessary; 9. Patients Accounts Monthly Book entered first day of each month; 10. Requisition Book entered first day of each month'. AOT, DPH, Information regarding Bush Nursing in Tasmania, 1947, (HSD 6/10). Although there are index cards relating to the various items associated with Bush Nursing many of these records do not exist in the AOT. They might never have been lodged with the Archives. The staff of the AOT are aware that these gaps exist.

¹⁴⁹ Some Councils' records have been searched in the course of collecting data for this thesis, for example Flinders Island and Lilydale. Bev Davis *History of Bruny Island*, c1985, also had noted meticulously the references to BNs which appeared in the Bruny Island Council Minutes.

¹⁵⁰ Of the 23 identified two were uncontactable, and one was too ill to interview. Three were located in late 2003 and were contacted by telephone.

Interview data and existing recorded sources inform each other. Recollections are enhanced by substantiation and sometimes clarification. Existing sources were used to refine the parameters of the interviews. The interviews themselves led to a renewed examination or interpretation of other source material. Most retained documents have been created as part of an official transcript, but oral histories are not part of this transcript. The oral history's power becomes a guided communication event, or as I like to call it, 'a dance of intimacy and distancing' between the interviewer and interviewee. Interviews were conducted with BNs, their families, peers, patients, employers and friends, and formed a new primary source that contextualised the place of BNs in rural and remote Tasmanian communities. Each nurse told unique tales of her Bush Nursing career. While none of the earliest BNs were alive, the living BNs covered a wide span of the period under study from approximately 1925 to 1957 and a wide range of Bush Nursing postings.¹⁵¹ The interviews became part of a collective history with converging evidence validating themes of independence and isolation.

Three Tasmanian nurses who worked at Waratah provide a continuous chronological perspective for a remote mining town on the west coast.¹⁵² These women's lives share a parallel in that they came to live and work at a town situated on Tasmania's 'wild' west coast. These three oral histories, supplemented by other primary sources, form a collective memory of a place. Their period of service spans the years between 1941 to 1982 although the thesis deals only with the period up to 1957. These women provide a unique opportunity to examine a facet of the life of a remote mining and timber town. Their stories validate each other and form a strong basis for gaining an understanding of isolated nurses in Tasmania over a substantial period.

Many women worked as BNs on the Furneaux Islands. Those interviewed for this thesis included one former Cape Barren Island BN. Her husband, formerly employed as the local teacher, participated in the interview providing an insight into his role in supporting the BN. Two freelance Tasmanian nurses who worked on Babel Island during the mutton-bird season in the mid to late 1930s were interviewed also. They had special and unique relationships with the Aboriginal community. In addition I had access to an interview with another BN who had been stationed at Whitemark on Flinders Island. These interviews

¹⁵¹ Unfortunately all former Supervisory Nurses are deceased.

¹⁵² In 1871 tin was discovered at Mt Bischoff and within ten years a community was established that was to become the town of Waratah. After the mining collapse the focus changed to timber milling. Today it is a small town with only traces of its heyday. Most would consider a visit to Waratah, even today, as a trip to 'Beyond the Black Stump'—the title of a Nursing History conference in Canberra in 1995. Although the main Municipal Offices were based at Wynyard, some unique data still were available at Waratah. Information collection was facilitated by the local Councillor and Museum caretaker.

provided the only nurses' voices to document the health care provided to Tasmanian Aborigines during this period. Former BNs interviewed provided opportunities to explore the work of relieving nurses; married and single nurses; and British, interstate and Tasmanian BNs. With interviewees often aged and in poor health, interviews were semi-structured to provide maximum flexibility. A network of people who worked and lived with BNs allowed additional perspectives to be gained. These interviewees included a former matron of a city hospital who remembered receiving patients referred to hospital by BNs, two Medical Officers who worked with BNs; those who accommodated BNs as boarders; housekeepers of BNs; Council and fund-raising committee contacts, such as a Council Clerk who worked with BNs, members of fund-raising committees and one who participated in the Bush Nursing Queen competitions as a young girl; families and friends of BNs; husbands and boyfriends of BNs; members of the Tasmanian Aboriginal community from the Furneaux Islands who worked and lived with BNs; and people who had used the services of BNs. This inclusion in the study of a wide range of people has lessened the impact of bias in recollection when interviews are restricted to a selection of people with similar value systems. The identification and selection of these interviewees has not been systematic. Usually they have been located by advertising the study within historical societies/organisations, academic departments, the community at large, family, friends and friends of friends—a process which can be described as a snowball effect.

Triangulation of all sources is crucial to provide the sophisticated layered interpretation of lived experiences. Daily work journals, departmental correspondence and regulations did not concur always. The oral recollection provided a way of understanding the differences in written archives and at times provided a challenge to previously recorded history, for example an understanding of the apparent tension between written organisational rules and individual practice, between the public and the private.

A number of written sources are used in the thesis in conjunction with the oral histories. These allow different voices to speak, provide different viewpoints, substantiate details such as dates, and determine the verifiable statement as opposed to the exaggeration. Printed official reports can 'authenticate' a story and either support or expose a myth. Conversely such written primary sources provide administrative and official histories illustrating how the system of Bush Nursing was supposed to work according to the rules and regulations. The voice of BNs comes through within their correspondence with the DPH and, although part of the official transcript and reflecting the story that the BN wanted the organisation to know, often is both clear and evocative. In the thesis where the words of the key players, the BNs, their patients, and the officials within the organisation are available to tell the story, and where their words are able to say much

more than can be conveyed in a mere paraphrasing of the words, the quotation is included verbatim.

Tasmanian Parliamentary Papers provided a short concise chronological report of Bush Nursing in Tasmania; municipal records such as Minute Books of Council Meetings reported the official decisions and municipal correspondence files provide a wealth of information that fills in the details such as fee collection, purchase of equipment, vehicle and fund-raising events.¹⁵³ An almost complete set of Annual Bush Nursing Reports have been located for the Lilydale district.¹⁵⁴ Public Health Reports include Annual Reports, correspondence and reports from individual centres (these include insurance papers, lists of BNs applying for positions, fragments of medical details of patients, and complaints about a range of issues).¹⁵⁵ Hospital archives include the records of the Hospital Auxiliary which was a major influence on the financial viability of the Bush Nursing Schemes.¹⁵⁶ Bush Nursing often had to rely on the Auxiliaries' fund-raising energies. Private collections have included photographs and certificates of individual nurses and several details of training, experiences and dates (that are sometimes elusive in an oral history) and one diary.¹⁵⁷ Identified newspapers supplied details and descriptions of local district fund-raising events in the social pages as well as monthly reports from Bush Nursing Committees.¹⁵⁸ Although not always accurate, newspaper reports have filled the gaps where Minutes are unavailable. A thorough search has been made of the early period of Bush Nursing through to the end of the Second World War in *The Examiner*, *The Daily Telegraph*, *The Weekly Courier*, *The Illustrated Tasmanian Mail*, *Mercury*, and *North Eastern Advertiser*. Several private collections contained newspaper clipping files.¹⁵⁹

¹⁵³ TPPs provided the statistical data used for many of the graphs throughout the thesis. Not all Council Minutes for every municipal council in Tasmania were studied. These sources provide potential data for future studies of non-metropolitan centres.

¹⁵⁴ Lilydale and Avoca were the two longest-serving local council-controlled centres. The set of documents available for Lilydale provides a mass of data that help explain the success of this particular centre. The local council took on the male leadership role of administering its own centre in true progressive style, but it was the grass-root support from across the municipality with its fund-raising and focus of community energy which made Lilydale self-supporting for so long. For example it was not unusual for local meetings to attract up to 30–50 residents.

¹⁵⁵ The majority of the DPH reports can be found in HSD 1 and 6 where there are many boxes of data from all over the state.

¹⁵⁶ Hospitals kept some records and a thorough search of every hospital throughout Tasmania may divulge more records, particularly those hospitals which were previous BNHs.

¹⁵⁷ Private collections are valuable primary sources because they usually provide the personal level of documentation that often fills the elusive gaps of history, such as revealed by photographs of the BN and her personal surroundings outside the gaze of the official cameras.

¹⁵⁸ Newspapers tell us several versions of the history--editorials which convey the political agenda of the time (for example, the romanticising the bush in order to attract BNs and the turning of BNs into heroines by celebrating their work in an effort to recruit more BNs and encourage public support), the publicreaction through letters to the Editor, and the reporting of meetings which allow one to fill the gaps left by missing minutes! Tasmanian newspapers are also generous reproducers of photographs that bring the BNs out from our imagination and into view.

¹⁵⁹ For example the family of Sister Connors and also Mr W Wilson.

Pictorial data in maps, plans and photographs have provided much useful information. These existed in many archives and personal collections. A photograph album of BNCs throughout Tasmania held by the Nursing Board of Tasmania, supplemented by photographs collected privately, give a pictorial history particularly of the 1930s and 1940s. The collection for this thesis numbers some 350 images, some taken by the researcher to document the current state of former BNCs and the environment in which the BNs lived and worked. Photographs provided forgotten or undocumented details of the past, were used in oral histories/interviews to jog memories or to inspire a recollection, and also provided clues to further research.

A small selection of my photographic archive is included within the thesis to provide a dramatic sense of isolation of BNs within the unique Tasmanian context. Photographs allow the reader to form a mental picture which avoids the trap of interpreting the written word through current experience and understandings. Photographs were used as an analytic tool revealing meaning or values. As Lucy Frost sums up: 'Photography is clearly akin to writing of letters and diaries. All record the immediate and draw their power directly from experience'.¹⁶⁰ The evidence from photographs might be complementary or might reverse or change the interpretations made from other data. For example, the album from the Nursing Board of Tasmania mainly documented the BNCs and probably formed the basis for a survey or record of buildings. Nevertheless the photos reveal more than just evidence that a BNC existed. The photographs show the state of disrepair of the buildings, whether or not the building was recycled from another use, location within the community, gardens, signage of functions, and in some cases the current BN and even former patients.

Modern maps of Tasmania tend to obscure the isolation for rural Tasmanians in the period 1911 to 1957. Maps from contemporary sources have been used within the thesis where available, and new maps have been generated to highlight features of the environment where no contemporary maps have been found. On occasion hand drawn maps have been located which provide unique views of local conditions. Building plans of some BNCs exist and these aid the interpretation of descriptions and stories from oral histories, written archives and photographic evidence. Few organisational plans are in existence, but where present these allow additional understanding of formal relationships and theoretical lines of responsibility. The discovery of a BN's kit allowed the researcher to supplement written records of medications and equipment available, and to raise questions about the ability of the BN to assist in 'forbidden' and 'secret' activities such as abortion. The Public Health Reports provided most of the quantitative data, and some analysis was

¹⁶⁰ Lucy Frost, *No Place for a Nervous Lady*, University of Queensland Press, St Lucia, 1995, p. 12.

carried out on the BNs' daily work records and maternity records.¹⁶¹ This provided an additional source of information for triangulation with case or incident-based information from oral histories and other sources.

The challenge for historians is to evaluate all the available data and to make a judgement or interpretation of the past that can be justified and supported at the time of writing. This thesis has included and analysed a wide a range of data in order to explore the research questions. But this thesis can only be part of the story of Bush Nursing. I have collected and analysed much data which reflects on other aspects of Bush Nursing, and within the various archives considerable other material exists which was not relevant to the thesis. Other data may exist as yet undiscovered, and no archaeological studies of Bush Nursing have been undertaken. With so much more to tell and find, this thesis was designed to address two aspects of the Bush Nursing history. Perhaps others may search further or perhaps reinterpret in another time with another set of values and perspectives.

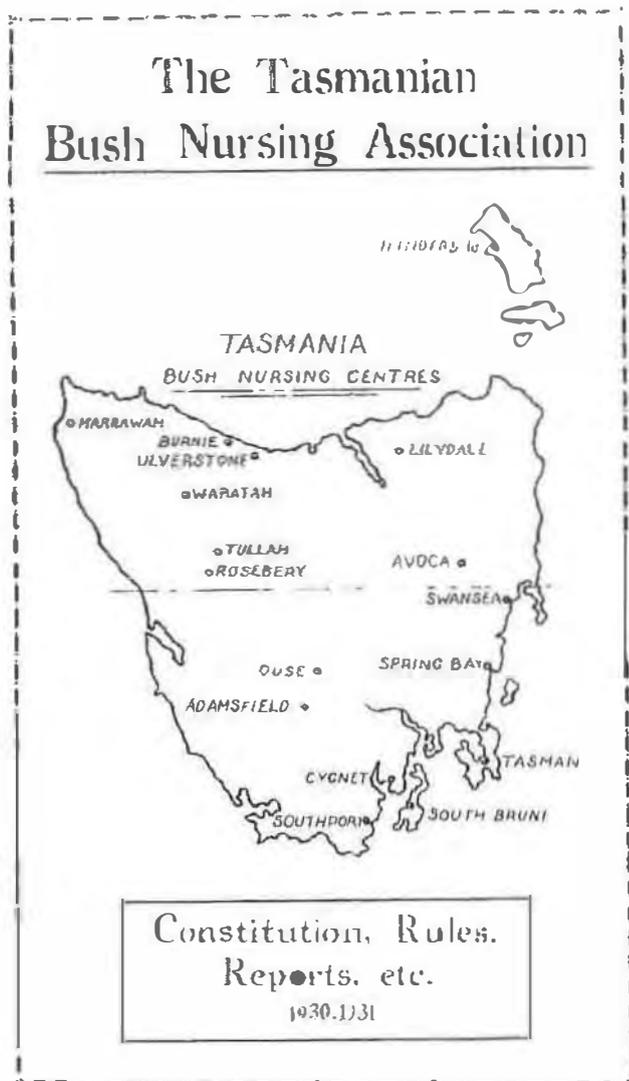
The literature suggests that BNs might have functioned as both professionally independent and isolated women. This thesis examines the lives of Tasmanian BNs, mainly utilising unpublished primary sources supported by secondary sources where they exist. It will explore the dual themes of professional independence and isolation to shed new light on the nature of Bush Nursing, and will give a new perspective on women's lives in rural and remote areas through their lived experiences. This resonates with the growing body of work exploring international experiences especially in Canada and New Zealand.

The methodology is integrative, examining many different women in a range of places at various times. It used multiple sources rather than a single data source. However the focus of this integrative approach is on women who became special because they were placed in extraordinary circumstances. This thesis reconstructs their lives within their remote communities through their experiences and voices. Through the examination of the work and lives of Tasmanian BNs, it develops the dual themes of professional isolation and independence. Chapter Two briefly describes the development of Bush Nursing and its relationship to other developments in health, particularly in nursing. The professional isolation of BNs will be explored in Chapter Three by examining the work environment. The relationship between BNs and the communities they served forms the subject of Chapter Four. These three chapters set the scene for the analysis of the work of BNs in Chapter Five. This chapter will demonstrate the independence of the professional practice

¹⁶¹ Nursing and medical comment and advice were sought during this analysis. Dr Sheryl Brennan provided comment on this analysis from a nursing perspective. Professor Alex Thomson & Dr John Morris provided similar input but from a medical perspective.

of BNs. These chapters underline the achievements of one small group of rural and isolated women in the first half of the twentieth century.

Map 1.01 Bush Nursing Centres in Operation 1930-1931



This map forms the frontispiece of the TBNA's Annual Report for 1930-1931.

CHAPTER TWO

A Brief Overview of Bush Nursing

Before exploring the isolation and independence of BNs it is useful to place Bush Nursing, and BNs, both in the context of their time and in the context of the health services. Bush Nurses were not merely isolated women working in isolation—they worked within the context of their organisation, and had collegial support and organisational supervision even if this was of a minimal nature. The philosophic and political roots of the Bush Nursing Service provided the framework in which they worked. The thesis therefore briefly explores the public history of the organisation before focussing in depth on the private history of BNs. This adds another layer of meaning to the BN story. It is the marriage of public and private histories that best lets us fully understand their experiences.

The development of Bush Nursing occurred within the context of a progressive movement. Public health was coming to the fore and some women were active participants, in their roles as nurses or as members of organising committees, in the promotion of regulation and control of health issues. Bush Nursing evolved in Tasmania in response to the energetic work of Lady Rachel Dudley.¹ During her short sojourn in Australia the Countess observed the isolated conditions under which many women in the outback lived, and suggested that some form of trained nursing service be provided in the more remote areas to meet cases of sickness and other emergency.² The proposal for a Bush Nursing Service was developed from these concerns, and Lady Dudley promoted Bush Nursing throughout Australia in her capacity as wife of the Governor General. She described the scheme as a patriotic and national duty.³ Her rhetoric encapsulated the essence of progressivism when she said:

we venture to appeal to you to support this project, and by so doing to recognise once more the great principle of corporate responsibility for all that affects the welfare of the individual, which is also the corner-stone of social progress and development.⁴

¹ B Cronin, 'The Bush Nurse', *Walkabout*, March 1 1953, pp. 7–10. Cunneen includes a section on Lady Denman (Gertrude née Pearson) who continued the work of Lady Dudley supporting the Bush Nursing project. According to Cunneen 'some measure of operational success between 1911 and 1914 [was] largely due to her efforts'. This was through her zealously visiting outback towns to install nurses in the Victorian or NSW Bush Nursing Scheme, but there is no mention of visits to Tasmania.

² AOT, DPH, 'A Short History of Bush Nursing in Tasmania', DK Noller, (HSD 6/59) and Cunneen, *Kings' Men*.

³ Australian Bush Nursing Scheme, Address by Her Excellency the Countess of Dudley at Government House, Melbourne, 8 December 1909.

⁴ *Australian Bush Nursing Scheme*, Address.

In understanding the cultural or political environment in which Bush Nursing developed it is important to recognise that issues of control and regulation were as significant for Bush Nursing as were the moves for assistance to the needy and the development of personal responsibility through education. Jillian Waters argues that, with the help of women's organisations, professionals secured their hold on maternal and child welfare services.⁵ Michael Roe asserts that for John SC Elkington, first Head of the newly formed DPH, 'such voluntary groups were an essential part of the progressive syndrome'.⁶ Professional groups also played an important role, and the regulation of midwives in 1901 and nurses in 1927 served to normalise and control childbirth practices.⁷ This regulation however placed significant control of nursing and midwifery in the hands of the male dominated medical profession. Furthermore Waters sees this environment in class and gender terms as she states that:

Bourgeois women in their capacity as voluntary social workers and members of organisations ... were agents of state hegemony while from their point of view fulfilling their conception of 'civic duty'.⁸

The Bush Nursing Association with its strong community-based roots can be seen as such an organisation, although its committee also included a number of influential men.⁹

For Bush Nursing, control extended beyond childbirth into child rearing practice. Some BNs worked in areas serviced by Child Welfare Nurses, others were expected to carry out child welfare activity.¹⁰ Just as Child Welfare Nurses were 'used as vehicles to help bring the new scientific knowledge to women',¹¹ Bush Nurses became the

⁵ Waters.

⁶ See Michael Roe, *Nine Australian Progressives*, p. 96 and also M Roe, *Life over Death, Tasmanians and Tuberculosis*, Tasmanian Historical Research Association, Hobart, 1999, p. 47.

⁷ Waters, p. 31.

⁸ Waters, pp. 14, 23, 26. Waters argues that the government was consciously promoting motherhood and maternalistic principles, as a national movement. The *Mercury* used the slogan of 'Make Motherhood Worthwhile' in an article reporting on the establishment of the Tasmanian Council for Maternal and Child Welfare. (17 July 1941) This Council had representation including Women's Non Party League, Child Welfare Association, Woman's Christian Temperance Union, Australian Women's National League, CWAs, Mothers' Clubs, Salvation Army, Women's Branches of the ALP, Girls' After Care Committee, Queen Alexandra Hospital, Sunshine Homes Committee, Women's Auxiliary of the Royal Hobart Hospital, Mothercraft Home and Bush Nursing Associations. The Council changed its name soon after to the Tasmanian State Council for Mother and Child.

⁹ It was aligned with the Women's Non Party League; and affiliated with the Australian Women's Suffrage League, Child Welfare Association, State Council for Mother and Child, Women's Christian Temperance Union, CWA and the Australian Women's National League. Brennan, p. 44.

¹⁰ The term 'Child Welfare Nurse' is used in this thesis for consistency, although the term 'Child Health Nurse' often is used also to refer to a nurse in the same service. Over time the latter became the usual term to avoid confusion with the role of the Department of Child Welfare. Child welfare encompassed both the social and the health aspects of the child's life from the pre-natal period through childhood.

¹¹ Brennan, p. 30.

professionals to instruct rural women in the art of mothering.¹² Beatrix Kelly notes that the Bush Nursing regulations required BNs to 'visit the home of every mother as soon as possible after birth, but not before the mid nurse in attendance has finished the case'. They were to

obtain the confidence of the midwifery nurses and through them to get in contact with the expectant mothers with the object of advising as to the methods of life and hygiene of pregnancy.¹³

In many cases the BN carrying out the child welfare activity was the same person as the midwifery nurse. Thus in areas where the BN was the sole health professional she would be aware already of many of the mothers with new babies. Where babies were born out of area in a larger centre, we shall see in Chapter Five that this posed particular problems for the BN. The nurses were responsible for running monthly clinics that mothers with infants could attend. Mothers were eligible for the federal government Maternity Allowance only if their children received 'appropriate' infancy care.¹⁴ Dedicated Child Welfare Nurses were usually city based, and BNs provided that service to country areas. They contacted pregnant women at the earliest possible stage to ensure women knew 'the importance of diet, adequate rest and relief from mental and emotional strain'.¹⁵ This maternalist ideology was seen as needing to be inculcated in women as early as possible, and nurses assisted with, or conducted, childcare/mothercraft classes in the schools.

JSC Elkington, the Head of Public Health in Tasmania, argued strongly for improved services to infants in a speech in 1909. This was an argument as much from the perspective of eugenics as from that of health improvement through skilled health intervention. According to Michael Roe, Elkington stated that high levels of health problems in infancy threatened 'the very heart of racial efficiency' and thus the survival of Australians as a people. 'Expertise and eugenics joined together' as a potent force for societal change.¹⁶ Sheryl Brennan claims that Child Welfare Nurses, and by inference BNs, were potentially powerful reinforcers of scientific constructions of motherhood.¹⁷ Kerreen Reiger contends that social developments in domestic science, family planning and infant welfare sprang 'directly from a belief that the application of science would find answers to society's ills',

¹² So too was district nursing used: 'district nursing was linked with the solving of social questions'. Amy Hughes, *Practical hints in district nursing*, The Scientific Press, 3rd edn, London, nd, pp. 2-3 quoted in Linn, *Angels of Mercy*, p. 244. JSC Elkington, Chief Health Officer of Tasmania blamed ignorant mothers for high mortality rates.

¹³ Kelly, p. 148.

¹⁴ Waters, p. 25.

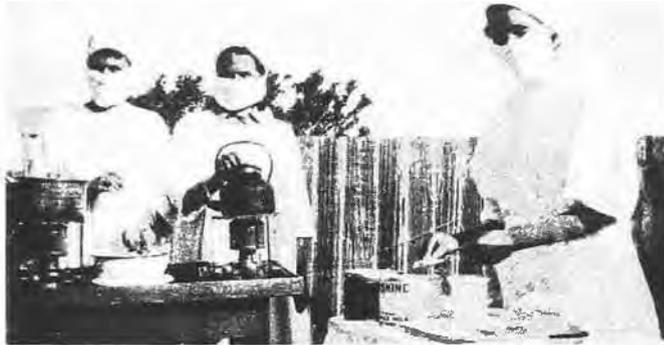
¹⁵ Waters, p. 25.

¹⁶ Roe, *Nine Australian Progressives*, p. 96.

¹⁷ Brennan, p. 12.

and C Knapman asserts that the dominant themes of scientific motherhood were an emphasis on 'training, supervision, efficiency and reliance on expert scientific knowledge'¹⁸

Photograph 2.01 Aboriginal Girls on Cape Barren Island—learning to prepare milk and sterilise utensils at the Bush Nursing Centre



The photograph demonstrates the emphasis on 'Scientific Motherhood' with the preparation of infant formula carried out with strict asepsis much as might be the case with a surgical operation. This also reflects the significant impact of gastroenteritis as a cause of infant death and the concerns with addressing this loss of life.

Source: DPH, Bush Nursing Album, NBT.

This was a national development and is referred to by McCalman as 'the management of middle-class experts'.¹⁹ Jillian Waters argues that there was both direct and indirect 'state coercion for motherhood' designed to maintain social roles and to keep women out of the workplace.²⁰ Waters and Brennan both see Tasmanian nurses as propagators of government ideology and of the 'construction of motherhood'. The Bush Nursing Service started in a period which could be described as one dominated by policies of 'soft eugenics'. The BN's major activities in midwifery and child health ensured that she was very much an agent of this social movement. Her role was important in the translation of Federal Government initiatives, such as the Maternity Allowance Scheme, physical fitness campaigns and the improvement of standards in milk and foodstuffs, into practical outcomes for the bush.²¹

¹⁸ Brennan, p. 8, refers to Reiger, and C Knapman, 'Reconstructing Mothering; Feminism and the Early Childhood Centre' in *Australian Feminist Studies*, vol. 18, Summer, pp. 11–131.

¹⁹ Janet McCalman, *Public and Private life in Richmond, 1900–1965*, Melbourne University Press, Melbourne, 1984, p. 210 and also Bashford.

²⁰ Waters, pp. 11–12.

²¹ At the same time many other reforms were being instituted such as the creche and kindergarten movement, district nursing, institution of children's courts, protection of child labour, and organisation of children's guilds and clubs. *Australian Bush Nursing Scheme*, p. 4.

Michael Roe gives an insight into the progressive nature of the health professionals in Tasmania and Australia during the early period of Bush Nursing.²² He also discusses the Country Life Movement, part of the progressive framework, that was placing greater emphasis on the rural instead of the urban lifestyle. Roe does not look specifically at Bush Nursing or women as contributors or players to the health trends (although there is mention of the role of the Country Women's Association). Positions of influence remain the province of male politicians or public administrators. This work demonstrates that progressivism was an ideology that was sweeping the country in public health and education. Although considered idealistic, the men identified by Roe as 'Progressives', were also men who held power, prestige and ultimately control.²³ One cannot underestimate the importance of their work leading the way for health initiatives which improved the general standard of living for society as a whole. These men, and their usually unnamed wives (with the exception of Emily Dobson),²⁴ were the activists for such schemes as Bush Nursing.²⁵ Women were the agents implementing these changes at grass roots level.

Progressivism in Australia embraced a rural ideology. Rural life offered particular strengths—the 'austere, even aesthetic, lifestyle' and the supposed rural virtues.²⁶ The Country Movement section of the progressive movement in America similarly saw agrarian society as better than urban life 'because it was more stable and less strife-torn'.²⁷ Consistent with this eulogisation of the rural life, Richard White's view of Australian nationalism and its future was that it lay in the 'role of the "bush" or the countryside as a nursery for Australia's children'.²⁸ Lady Dudley similarly stated that 'those splendid bush families are the bone and marrow of this country'.²⁹ Judith Bessant argues that

The Australian bush assumed a central role in professional discourses about modernity and its ills ... An elaborate discourse about the beneficial, heroic, health

²² Roe, *Nine Australian Progressives*, p. 67. Emphasis is mainly on the VBNA.

²³ From their work they reaped personal benefits such as satisfaction and public esteem. In regard to their motivation it appears that they were rewarded with more power. Michael Roe, *Personal Communication*, 2003 counters this argument by stating that 'the essential view of the progressives was that ideals were pretty pointless unless backed by power. They were proud to be powerful!'

²⁴ AR Taylor, 'Mrs Henry Dobson; Victorian 'Do-Goooder' or sincere social reformer? An analysis of her Charitable and Public welfare Work in the 1890s', (BA Hons Thesis), University of Tasmania, 1973.

²⁵ For example in Grant W Rodwell, 'The Country Life Movement and Australian State Schools' in RC Peterson & GW Rodwell, (eds), *Essays in the History of Rural Education in Australia and New Zealand*, William Michael Press, Darwin, 1993. In Chapter 5 Rodwell refers to 'Progressivism' as an offshoot of the 'American Country Life Movement' and like Roe comments on the middle class of this period looking to rural Australia. For example Barrett in Victoria was a driving force behind the development of Bush Nursing in his State. Refer p. 76.

²⁶ Roe, *Nine Australian Progressives*, p. 11.

²⁷ Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. 353.

²⁸ Judith Bessant, 'Ferrets to look after and rabbits to chase: the rural myth and experiences of young country Australians', Chapter Six in RC Peterson & GW Rodwell, (eds), pp. 102–128.

²⁹ *Una*, vol. 7, December, 1909, p. 151 in Trembath & Hellier, p. 68.

and welfare conferring benefits of rural life became a significant component of our collective culture.³⁰

Within this context BNs became the 'intervening experts'. This role was foreshadowed by Donald Macdonald in his pamphlet which predated Bush Nursing and wrote of BNs as the 'the missionaries of health, of sanitation, of cleanliness and of comfort all over Australia' in remedying 'this defect [skilled aid for bush dwellers] of our civilisation'.³¹ For Anthea Hyslop, as state intervention became socially acceptable, women became the experts in fields such as child welfare and the environment. The national wave of Progressivism sought to 'increase population ... make it healthier and to preserve racial purity'.³² Similarly, the loss of a child's life was seen by Seddon in New Zealand as of particular significance in demonstrating 'decadence' in the nation.³³ The needs of children were central to the activity of the progressives, were the focus of wider public concern, and this was the environment from which Bush Nursing's focus developed.

Bush Nursing developed as a response by women to the plight of rural women and children in particular. Lady Dudley's appeal in the first instance was to the National Council of Women, and they were subsequently active in driving the establishment of Bush Nursing.³⁴ Organisations such as the Women's Health Association³⁵ of Hobart corresponded with local government and encouraged the adoption of the scheme.³⁶ Alison Alexander contends that these groups comprised predominantly middle class women who had time to participate in philanthropic activities.³⁷ Jordan, in her examination of the National Council of Women, supports this claim.³⁸ The lists of committee members of such groups add further substantiation as it is the wives of doctors, aldermen and governors who appear regularly. The Women's Sanitary Association not only supported the adoption of Bush Nursing but also was 'stressing personal responsibility for health and cleanliness

³⁰ Refer to 'The future of the Race', in 'The Marcus Clarke Memorial Volume', Melbourne, 1988, p. 264 cited in Stephen Murray-Smith, (ed), *The Dictionary of Australian Quotations*, Heinemann, Melbourne, 1984. Bessant, 'Ferrets to look after and rabbits to chase', Footnote 4, p. 124, and p. 105.

³¹ *Australian Bush Nursing Scheme*, Atlas Press, Melbourne, c 1909, pp. 8-11.

³² Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. v.

³³ New Zealand Premier Richard Seddon, Midwives Bill, *New Zealand Parliamentary Debates*, vol. 128, 1 July 1904, pp. 70-1 quoted in Philippa Mein Smith, 'Midwifery re-innovation in New Zealand', Chapter 8 in J Stanton, (ed), *Innovations in Health and Medicine. Diffusion and resistance in the twentieth century*, Routledge, New York, 2002.

³⁴ The NCW in Canada also were influential in assisting the wife of the Canadian Governor General, Lady Isobel Aberdeen, to establish the Victorian Order of Nurses in 1898. Ross-Kerr, pp. 74, 81.

³⁵ Previously known as The Women's Sanitary Health Association, established in 1891, *Tasmanian Mail*, 3 October 1891 in Alexander, pp. 225-6.

³⁶ Davis, p. 2.

³⁷ Alexander, pp. 283-294.

³⁸ Renee Jordan, 'Hobart's leading women 1885-1914', 'Living and Working in Hobart: Historical Perspectives', PHAT Conference October, 2002 and also MA in progress.

believing that education was crucial to reform'.³⁹ Consistent with progressive thought, perhaps women saw the bush as a particularly important site of service, just as CEW Bean was to idealise the bush background of the diggers.⁴⁰ This action by women for women is reflected in the work of the BN. Whilst not exclusively caring for women, data from official records and oral history demonstrate that Bush Nursing work was directed towards the needs of women and families.

Bush Nursing required women who were special. Not only were they to work in areas isolated from immediate collegial support, they would require skills different from those provided to them within their training. Initially the scheme recruited older and experienced nurses:

Not only must their standard of efficiency cover the requirements of the lonely districts where they may be sent, and should represent the three divisions of medical, surgical and midwifery training, but they should be dowered with plenty of personal experience. It is a field of work perhaps suited to older Nurses than to those but recently trained.⁴¹

In addition to wanting nurses of 'thirty to forty' years old, it was desired that they would 'have the confidence of the district, have been brought up in the country, and prefer country to city life'.⁴² Furthermore the nurses should be unmarried and without children, and of temperate disposition (being required to sign declarations that they used no alcohol).⁴³ In the first DPH Report that included Bush Nursing, the success of the scheme was said to be 'inseparably bound up in the personality of the nurse'.⁴⁴ This view was supported in local newspaper and Bush Nursing Committee reports. The ideal BN was to be capable of relying on her resources in a great many emergencies; have the physical strength to enable her to ride or drive to distant country calls and to remain on duty for long hours; be professionally well trained; have skills in riding horses and driving buggies; be able to fit into the conditions, and be endowed with missionary spirit!⁴⁵ Furthermore Bush Nursing was seen as self-sacrifice. In 1911 Lady Dudley visited Gunbower in Victoria over Easter for the installation of a new BN. In her speech she linked the Easter sacrifice to the sacrifice expected of the BN.⁴⁶ Bush Nurses were isolated both as individuals and as

³⁹ Their platform additionally included the conditions of female factory workers, better conditions for the poor, and the health of children. Snowden, pp. 11–12 and see also Petrow, p. 111 and Alexander, p. 227.

⁴⁰ G Davison, 'Bush' in G Davison, J Hirst, S MacIntyre, (eds), *Oxford Companion to Australian History*, Oxford University Press, Melbourne, Australia, 2001 p. 99 and also M Roe, Personal Communication, 2003.

⁴¹ *Australian Bush Nursing Scheme*, Address by Her Excellency the Countess of Dudley at Government House, Melbourne, 8 December 1909.

⁴² *The Examiner*, 10 September 1910, p. 9.

⁴³ Being an abstainer also meant that she received a 10 per cent discount on her insurance policy.

⁴⁴ *TJPP&P*, 1921–22, p. 24.

⁴⁵ *TJPP&P*, 1921–22, p. 24.

⁴⁶ Installation by Lady Dudley at Gunbower. *The Age*, 17 April 1911.

Bush Nurses were required to keep records of their work. The main body of BNs' records of their daily work and written case histories have not survived.¹⁴⁷ The only case-based records available were for general nursing care over short periods on Babel, Chappell and Bruny Islands, and two daily midwifery journals from Marrawah. The daily journals from Bruny Island were located on Bruny Island, the remainder of the work records were in the AOT archives. Statistical descriptions of the work of the BNCs are recorded in monthly and annual reports which survive in the Tasmanian Parliamentary Papers. Descriptions of the BN's work are included also within the correspondence between BNs, the DPH, and its Supervisory Nurses.¹⁴⁸

Given the years since the inception of Bush Nursing in Tasmania, exploration for information about the early period of Bush Nursing necessarily has depended on secondary sources or written primary sources. Unfortunately many of the early records, such as the Bush Nursing Association records up until 1920 when the DPH took over, have not been located. Some data pertaining to this period have been found in Municipality Minutes and records, or newspaper reports of general local council business.¹⁴⁹ Sources of data included the DPH files in the Archives of Tasmania (AOT), Municipal and Parliamentary records, personal archives, published and unpublished works, newspaper archives, a large collection of photographs, hospital and local museum archives. These were supplemented with oral histories, most collected specifically for this thesis but a small number were identified from previous research examining Lilydale records. All living and known BNs were identified and 17 interviewed.¹⁵⁰ The data from these various sources were integrated and analysed to allow the themes of the thesis to develop through the lived experience of the nurses.

¹⁴⁷ For a recent example of the use of case histories refer to Janet McCalman, *Sex and Suffering*, where case histories from an institution have produced a rich source of primary material to uncover the everyday lives of women through a hospital.

¹⁴⁸ The range of records required to be maintained by the BN included '1. Day Report Book entered daily; 2. Midwives Record Book entered daily; 3. Midwifery Bookings Book entered as necessary; 4. Antenatal Visits Book entered as necessary; 5. Child Welfare Visits Book entered as necessary; 6. Drugs Book entered as necessary; 7. Patients Account Book (small) entered as necessary; 8. Patients Receipt Book entered as necessary; 9. Patients Accounts Monthly Book entered first day of each month; 10. Requisition Book entered first day of each month'. AOT, DPH, Information regarding Bush Nursing in Tasmania, 1947, (HSD 6/10). Although there are index cards relating to the various items associated with Bush Nursing many of these records do not exist in the AOT. They might never have been lodged with the Archives. The staff of the AOT are aware that these gaps exist.

¹⁴⁹ Some Councils' records have been searched in the course of collecting data for this thesis, for example Flinders Island and Lilydale. Bev Davis *History of Bruny Island*, c1985, also had noted meticulously the references to BNs which appeared in the Bruny Island Council Minutes.

¹⁵⁰ Of the 23 identified two were uncontactable, and one was too ill to interview. Three were located in late 2003 and were contacted by telephone.

Bush Nursing was more than a calling. As 'intervening experts' BNs were raising the status of nursing, and in particular that of Bush Nursing, as a profession. The development of professionalism was relevant to the role of BNs. Bledstein describes the process of professionalisation in terms that usually fitted occupations which were the province of white Protestant males from at least middle-class backgrounds.⁴⁷ Over the period of Bush Nursing there was debate in some nursing circles about whether or not nursing was in fact a profession but, while not Bledstein's middle-class males, nurses were becoming recognised as professionals.⁴⁸ The use of the term 'profession' to describe nursing is seen in a variety of contemporary documents. The value of the registration of nurses was that it would 'impart a "professional character to nursing."⁴⁹ Private (non-hospital nurses) were 'the grandest branch of our noble profession'.⁵⁰ The challenges of nursing went beyond the 'romance of nursing the sick' to developing a 'love for the scientific side of their profession'.⁵¹ These professionals were 'above commerce' accepting low pay and conditions as the burden of the role.⁵² There remains a historiographical debate about the professional status of the late nineteenth century nurse. Richard Trembath and Donna Hellier state that professional status can be assessed in three ways. Firstly a profession had to mark out its territory through having a unique body of knowledge and theory; secondly a profession had to limit the practice of the profession to those with the right training or professional conduct, and thirdly the nature of the professional-client relationship should be one where the only responsibility for the professional opinion was that of professional to client. For them nursing failed to meet these criteria.⁵³ Judith Bessant and Bob Bessant, however, argue that this view of professionalism is but one way of conceptualising the issue. A profession can be seen as a group with 'integrity', a group that has a

strength and belief in its values, standards and codes of behaviour, which in turn may result in public recognition and acknowledgment ... Becoming professional in

⁴⁷ Burton J Bledstein, *The Culture of Professionalism, The Middle Class and the Development of Higher Education in America*, WW Norton and Co, New York, 1976, p. xi. Bledstein views professionalism as a 'cultural process by which middle class in America matured and defined itself'.

⁴⁸ Alexander claims that Miss Harriet Munro 'established nursing as a career for women' by her organisational skills in providing nurse training. Alexander, p. 34 and also Kelly, p. 44. This ties in with Bledstein's discussion of the role of the university as being integral to the development of professions in America. 'Nursing had risen in the general esteem, and the public provided gifts for patients and subscribed to the Nurse's Recreation Fund.' Alexander comments further that 'In 1896 nurses' accomplishments were described as well known—of their merits 'it is unnecessary to write'—and their services were in great demand.' *Tasmanian Mail*, 18 April 1896. 'It had taken two decades, but by the 1890s nursing was accepted as a professional career for women and middle class names appear in the list of nurses.' Alexander, p. 34. Within this context of the raising of the social class of nursing, it is understandable that these women would take their values with them to the bush.

⁴⁹ Royal Commission on Charitable Institutions of the Colony, PP, (LA, Vic), 1891, vol. 6, p. 19 in Trembath & Hellier.

⁵⁰ Greta Lyons in *Una*, vol. 11, June, 1913, p. 83 quoted in Trembath & Hellier.

⁵¹ *Argus*, 7 October 1912 quoted in Trembath & Hellier.

⁵² Jessie McBeth quoted in the *Herald*, 20 May 1922 in Trembath & Hellier.

⁵³ Trembath & Hellier, p. 31.

this sense does not rest on receipt of a blue-print from others. Nor does it rest on the approval of others, particularly 'superiors'. It depends on the self-assurance of the group or individuals concerned.⁵⁴

They argue that from this standpoint the work of private nurses in the early twentieth century 'comes close to this type of professionalism', and this thesis will argue that the BN would also be an exemplar of a professional in this sense. In contrast with private nurses, BNs were a small group. Even though BNs as a group had no political or social structure they had a sense of themselves as BN with a particular role to fill. They had a calling to rural service, and a role as 'intervening experts' in the implementation of progressive ideas and policy.

The early years of the twentieth century were marked by an increased role for women in teaching as well as in health. While the experiences of women BNs and rural teachers are in some respects comparable, there are equally important differences.⁵⁵ Nursing was viewed essentially as a female occupation. Bush Nurses were all women. At least until late in the Bush Nursing era, almost all BNs with substantive appointments were single women. There was no other rural professional group that was female only, although teaching had a significant proportion of women in its workforce. As with nursing, it was considered inappropriate for a married woman to be a teacher. The nurse's role involved her in the more intimate details of the community, and for many nurses this tended to isolate them. Bush Nurses usually lived and worked within the BNC, and this added to a sense of isolation from the community—while paradoxically providing her with an unusual level of independence for a single woman in a male dominated community.

Women teachers were generally younger and less experienced than BNs, boarded in the community, and potentially were less isolated by the nature of their work. Often single women were preferred to men as teachers. They were easy to accommodate in private homes as they had 'few possessions and no dependents'.⁵⁶ Nurses, as older women, had more trouble fitting into private board. Additionally, BNs' workload and hours increased the difficulty in meeting the constraints of living within such board. While women's roles as teachers and nurses primarily were in seeing to the needs of women and children, these roles required them to 'learn skills and undertake tasks considered unwomanly, putting a

⁵⁴ Judith & Bob Bessant, *The Growth of a Profession—Nursing in Victoria 1930s–1980s*, La Trobe University Press, Melbourne, 1991.

⁵⁵ For a discussion on rural teachers see DV Selth, 'The effect of poverty and politics on the development of Tasmanian state education 1900–1950', (MA Thesis), University of Tasmania, Hobart, 1969, p. 19. Selth identifies a number of characteristics of rural teachers and their work conditions which have some comparability with BNs.

⁵⁶ Grant Rodwell, 'The influence of Progressivism on Tasmanian State Primary Education 1904–1920', (PhD Thesis), University of Tasmania, 1987, p. 266.

cloak of cool professional distance over their supposed emotionality'.⁵⁷ As with Reiger's women both teachers and nurses experienced the inherent contradiction in being 'natural' women and being 'modern, organised and efficient managers'. This is true particularly of the role of BNs and their experience will highlight this contradiction.

There is evidence also that the community viewed the BN as a special person with expertise and a special role to play within the community. Bush Nurses had a unique set of responsibilities different from the nursing profession as a whole and therefore had a different set of values. In this thesis the expanded role of the BN and the community's expectations of her will be explored. Bush Nurses were the forerunners of independent nurse professionals.

Lady Dudley's argument for the establishment of a new nursing service was based on identified health needs within rural Australia. Other dominions of the British Empire had identified similar needs and had implemented nursing schemes to address these. After reviewing these schemes it was decided to model the Australian scheme on both the British District Nursing Scheme which had been implemented into the country districts, and on the Canadian scheme.⁵⁸ Lady Dudley used media coverage effectively in her campaign and Tasmania was the first State to respond enthusiastically to her call.⁵⁹ In 1910 the first Bush Nursing Order was formed in Launceston.⁶⁰ The south of the State initially was less convinced of the need for such a scheme. According to Lloyd Robson, the Northern Tasmanian Bush Nursing Order was established by Mrs Sarah Alice (Lallie) Keating (née

⁵⁷ Reiger, pp. 215-216. This cloak can be visualised also as the nurses' uniform. This is discussed more fully in Chapter Four of this thesis where uniform is used as a tool by the BNs to create distance between them and their patients and communities.

⁵⁸ David Boorer contends that the Bush Nursing Scheme was based on England's Metropolitan District Nurses but does not provide a reference. Boorer, p. 844 and *Australian Bush Nursing Scheme*, Address by Her Excellency the Countess of Dudley at Government House, Melbourne, 8 December 1909. Shiela Penney argues that the Canadian Scheme was needed to 'fill the gap left by medicine as it retreated from rural practice and chronic care,' as the Scientific medicine' movement entailed a shift to hospital-based practice. Penney, pp. 16-17.

⁵⁹ Anthea Hyslop contends that the BNA in Victoria was founded in Melbourne in 1910. Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. 285. She further argues that it was the efforts of the National Council of Women that played an important role in extending the ideas of Lady Dudley in Victoria. Refer to the *Age*, 25 August 1909, 1 December 1909; the *Argus* 9 December 1909. Lady Dudley also spoke at a regional conference of the NCW in Brisbane on 21 August 1909. Wilson, 'Bush Nightingales', p. 39. Unfortunately the records in Tasmania for the NCW do not include the correspondence records up to 1930 and the Minute Books are missing for the period 1910-1920.

⁶⁰ Kelly, p. 144. Kelly notes that the Northern Tasmanian Bush Nursing Order was formed in 1911 but in 1910 *The Examiner* quotes a letter to the Editor from Mr Alf C Mathers, as Chairman of the Committee of the Northern Tasmanian Bush Nursing Order, calling for subscriptions. *The Examiner*, 3 August 1910, p. 7. The Northern Order held its first fund-raising ball at Albert Hall in 1911, the *Daily Telegraph*, 6 September 1911, p. 4. Priestley, p. ix, refers to the VBNA being formed in September 1910 and the appointment of a BN at Jindabyne, NSW, in July 1911 and at Banana, Queensland in 1917, pp. 72-73.

Monks).⁶¹ The scheme was set up as a memorial to the late King Edward VII, and its rationale, constitution and means to be adopted are as shown in *Appendix A*.⁶²

Bush Nurses originally were known as King's Nurses. The first Tasmanian meeting was organised jointly by the Australian Natives' Association and the Australian Women's Association with strong support from the local members of the National Council of Women following on from the national impetus.⁶³ Sarah Keating, as a member of the National Council of Women in Tasmania, sought the support of the Australian Natives' Association and doctors statewide for the Bush Nursing Service. A committee of fourteen members, including one Queen's Nurse,⁶⁴ was formed and was headed by the Australian Natives' Association president.⁶⁵ Local country doctors were canvassed by the fervent Mrs Keating who enthused:

The doctors all over Tasmania have been splendid. I have sent letters all over the north end of the island, and have not yet received one refusal of help and interest.⁶⁶

David Boorer asserts that across Australia there had been 'intense opposition from doctors (who feared an inferior kind of Sarah Gamp)' and there is evidence that there was significant concern about the potential for nurses to act independently from doctors.⁶⁷ They were reassured by Lady Dudley that this would not be the case, although given the locations in which it was proposed to locate nurses it is hard to see how nurses could be supervised routinely by a doctor.⁶⁸ These issues were to give rise to friction as Bush Nursing developed and some of the tensions that developed between doctors and nurses are explored later in Chapter Five within the thesis.

⁶¹ Lloyd Robson, *A History of Tasmania, Volume 2, Colony and State from 1856 to the 1980s*, Oxford University Press, Melbourne, 1991, p. 249. He notes that Bush Nursing began in 1909 but this is unsupported by references. He also notes that Emily Dobson was a life patron of the BNA of Tasmania. Sarah Keating's husband was Senator John Henry Keating. See also Kelly, p. 144, and *The Examiner* 10 September 1910. According to the *Australian Dictionary of Biography* entry for her husband, John Henry Keating, Sarah Keating 'inaugurated the BNA in Tasmania under the auspices of Lady Dudley and was a principal in the Tasmanian child welfare movement,' p. 542. A photograph is included on p. 9 in *History of Bush Nursing in Tasmania*. As well as being a member of the National Council of Women in Tasmania, Sarah was also instrumental in the Tasmanian Child Welfare Movement and the World War I Comforts Fund. Refer to Robson, p. 249.

⁶² *The Examiner*, 3 August 1910, p. 7.

⁶³ John Henry Keating was leader of the ANA. Refer to B Nairn & G Serle, (ed), *ADB*, vol. 9, Gil Las, Melbourne University Press, 1983, p. 542. Records of this first meeting were not located.

⁶⁴ Queen's Nurses were Nurses from the Queen Alexandria Royal Army Nursing Corp and were veterans of war service. John Wilson, Personal Communication, Launceston, 2003.

⁶⁵ *The Examiner*, 10 September 1910, p. 9, quoting an interview with Mrs Keating and a Reporter from the *Melbourne Herald*, 6 September 1910.

⁶⁶ *The Examiner*, 10 September 1910, p. 9.

⁶⁷ Boorer, p. 844.

⁶⁸ 'Experienced nurses would work under the supervision of a qualified doctor where available, forming a chain of professional help in their areas.' Burchill, *Australian Nurses since Nightingale*, p. 79.

The records of the Bush Nursing Association show that the first BN was appointed in 1911 to Weldborough and the second to Flinders Island the following year.⁶⁹ Sarah Keating refers to a nurse being employed for the Deloraine district as early as 1910.⁷⁰ Sponsored by local government, the north of the state led the way in establishing centres. By 1913 there were three BNs employed in country areas.⁷¹ Southern localities such as Bruny Island had begun discussions about the establishment of BNCs as early as 1910 in response to circulars distributed to municipalities.⁷² It was not until 1914 that Tasmania's second scheme was established after a public meeting of Hobart residents with the *Mercury* reporting a 'fairly good' attendance.⁷³ An apology from Dr Samuel Alexander McClintock, the Chief Health Officer, expressed 'perfect accord with the movement, and an earnest wish for its success'.⁷⁴ The Tasmanian Bush Nursing Association was formed soon after and it actively promoted the Bush Nursing Service to local councils. The advent of World War I created a difficult environment for the Tasmanian Bush Nursing Association, but after a shaky beginning the momentum increased. Centres were established rapidly. In most cases, Municipal Councils initiated the clinics and paid the BN's salary. Mining companies funded schemes such as those at Adamsfield, Waratah, Rossarden, Storys Creek, Rosebery, Tullah and King Island. Most local communities established Bush Nursing Committees that helped raise additional funds. On occasions, as in the case of Bruny Island, the Tasmanian Bush Nursing Association offered the services of a BN free of charge for the initial three months.⁷⁵ At least one northern community initiated the development of a BNC as a response to the RSSIL requesting assistance for returned soldiers. This facilitated Red Cross funding. The number

⁶⁹ Nurse Collier was sent by the Bush Nursing Order to nurse an 'appeal case', and the first BN at Flinders Island was Nurse Adams. In the early years of Bush Nursing it appears that BNs work was case-based rather than BNC (geographic) based. According to Mrs Iola Fowler, Interview, Flinders Island, 1994, Nurse Julia B Adams was also the teacher and later missionary. Other sources refer to two sisters noting Julia B Adams was the teacher. Noted as the BN in Municipal Minute Books, 23 September 1912, p. 244 and p. 255 and in Bush Nursing records, Miss JB Adams is referred to also in the Launceston District Nursing Papers. The District Nursing Service was a distinctly different organisation from Bush Nursing. The Flinders Island Nursing Association was formed in 1911 by ratepayers of Flinders Island with a Committee of five. It subsidised the salary of Nurse Adams with assistance from the Governor of Tasmania. Correspondence is addressed to the District Nursing Association, Launceston, LDNA, Bundle 10, September, 1911, Correspondence to LDNA from Alf J Jones, Honorary Secretary, FINA, QVMAG. BNs and District Nurses were both known as 'King's Nurses' as both were part of the King's Memorial movement—one for the country and one for the city. See *The Examiner*, 10 September 1910, p. 9. See also Flinders Island Road Trust Minute Book, 1 July 1903–12 December 1903, p. 244 and 23 September 1912, p. 255.

⁷⁰ *The Examiner*, 10 September 1910, p. 9 and article on the formation of the Northern Tasmanian BNA, Interview with Mrs Keating, *The Daily Telegraph*, 10 September 1910.

⁷¹ Alexander, pp. 212–3.

⁷² Davis, p. 2. There is no reference to the author of these circulars.

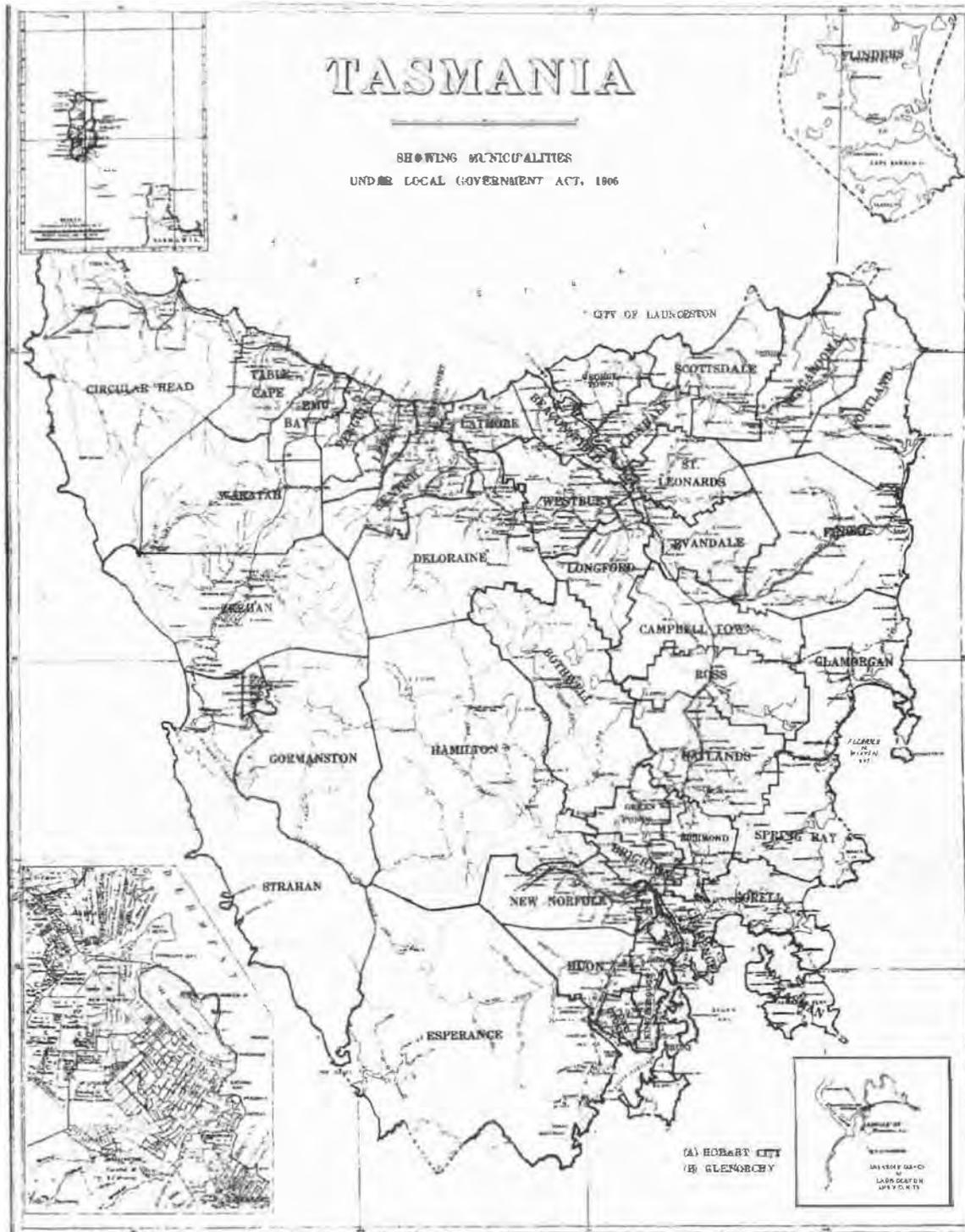
⁷³ This meeting was called by the Women's Health Organisation in July 1914.

⁷⁴ AOT, DPH, 'A Short History of Bush Nursing in Tasmania', DK Noller, (HSD 6/59).

⁷⁵ Davis, p. 3.

of BNCs steadily increased over the period of the Bush Nursing Service as is demonstrated in Figure 2.01.⁷⁶

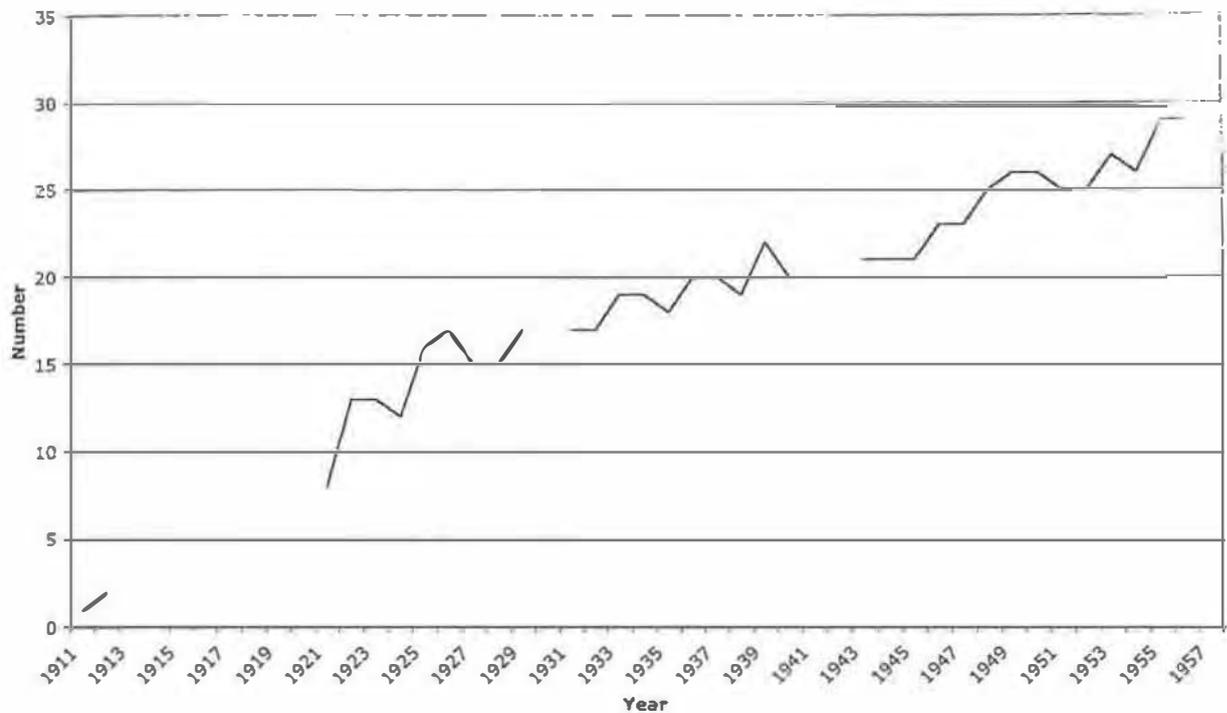
Map 2.01 Tasmanian Municipal Boundaries, 1906



Municipalities were the geographic bases on which needs for Bush Nursing Centres were determined, and were responsible for part of the costs of the Bush Nursing Service.
Source: *Walch's Tasmanian Almanac, 1925.* J Walch and Sons, Hobart, Tasmania

⁷⁶ The data used in this graph are a compilation of data from DPH Annual Reports, and from other documents which list the operation of BNCs.

Figure 2.01 Number of Bush Nursing Centres by Year

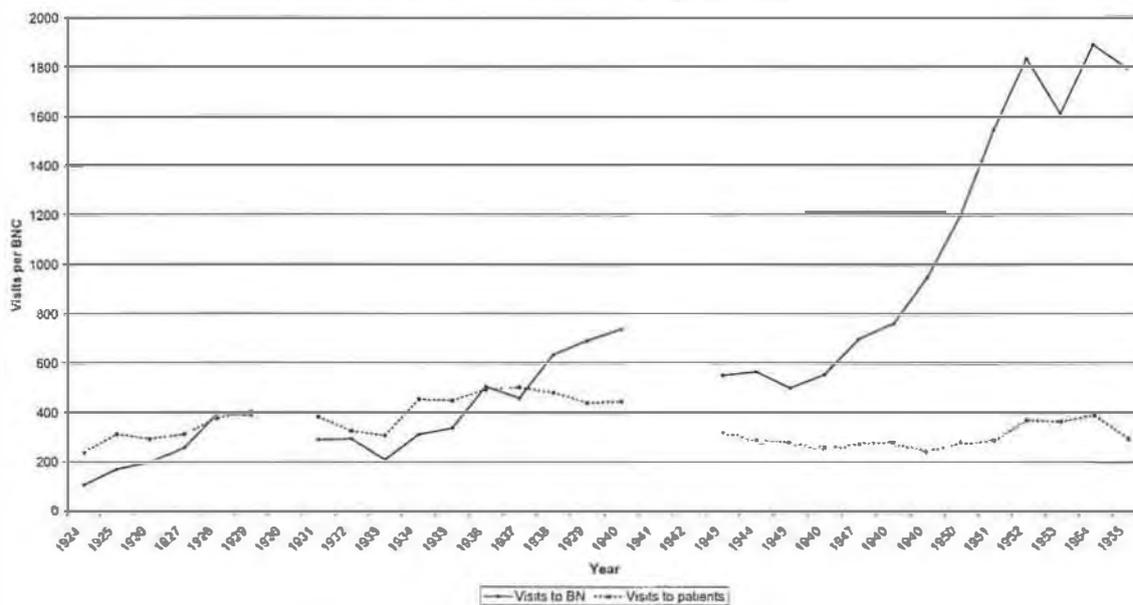


Source: Collated from the *Tasmanian Journal of Parliamentary Papers and Proceedings* and *Tasmanian Bush Nursing Records*.

The record of which BNCs were open at any time is incomplete. Records of the period before 1921 do not list active BNCs, but once the DPH took over administration of the scheme Annual Report data usually list centres that were in operation over the previous twelve months. No Annual Report has been found for the year 1930. Annual Reports during World War II are brief and do not list active centres. In any one year some centres might have opened or closed, occasionally for short periods because of an inability of the Bush Nursing Service to recruit nurses or because of holidays and illness. It was during this period that Manpower Authorities controlled the movements of BNs. Satellite or sub-centres were operated from some centres and are not included in these totals. Despite the gaps in the information available, the data demonstrate that the Bush Nursing Service continued to grow right up to the time it was subsumed into the District Nursing Service. The last new BNCs were opened at Westbury and Dover in 1955.⁷⁷ A total of 51 different BNCs operated during the scheme and a dozen other centres were proposed but never realised. Table 1.01 lists the BNCs by their known dates of operation. The workload at each BNC increased rapidly, and the characteristics of that work changed over the Bush Nursing era.

⁷⁷ There was a BN appointed at Dover as early as 1925 but this position did not last and eventually a BNC was established at Southport *Huon Times* 17, 27 March 1925 in N Beechey and D Baker, *A History of Dover & Port Esperance—Tasmania*, vol. 2, Dover, 2000, p. 125.

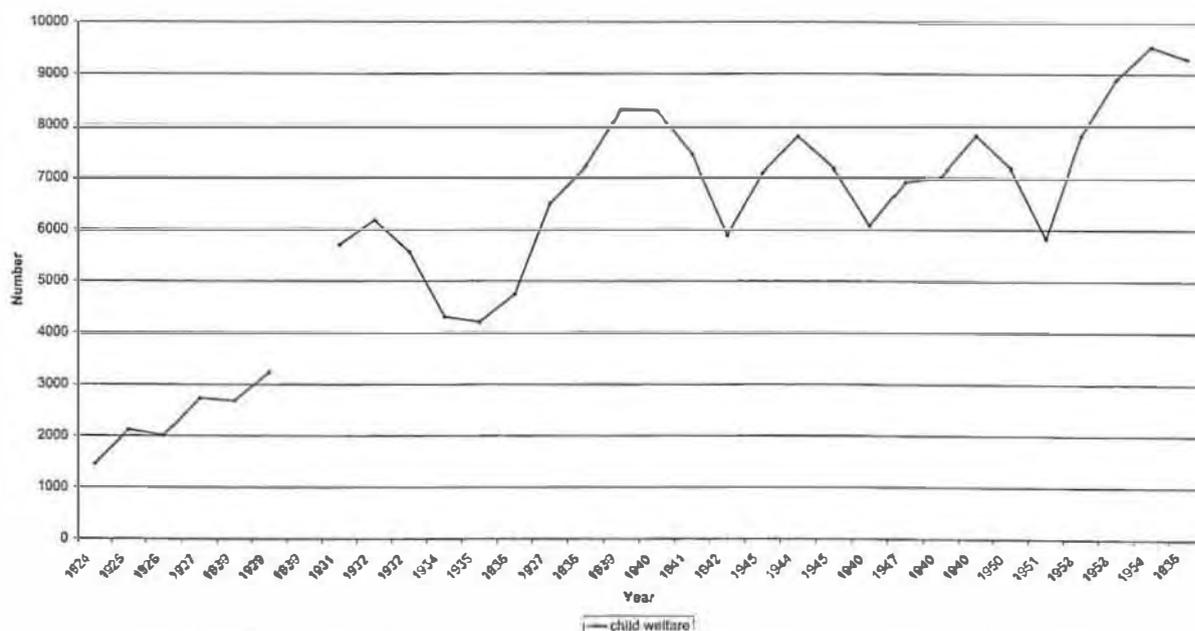
Figure 2.02 Visits per Bush Nursing Centre per annum—patient visits to Bush Nurse and Bush Nurse visits to patients



Source: Collated from the *Tasmanian Journal of Parliamentary Papers and Proceedings* and *Tasmanian Bush Nursing Records*.

Figure 2.02 shows that the workload for each BNC increased particularly after World War II. The growth in visits patients made to the BNC was the primary area of growth, increasing almost fivefold over the years. Visits by BNs to patients, however, show minimal change. In the early years of Bush Nursing the visits by the BN were greater in number than visits to the BN, although this changed in the late 1930s. This was in part a consequence of the increased access by patients to transport.

Figure 2.03 Number of Child Welfare Visits by Bush Nurses per annum



Source: Collated from the *Tasmanian Journal of Parliamentary Papers and Proceedings* and *Tasmanian Bush Nursing Records*.

Child welfare visits increased in importance over the Bush Nursing era (Figure 2.03). We shall see that BNs believed that the increased child welfare work reduced the need for other visits to children and this might have been responsible for the reduction in the visits to patients noted in Figure 2.02. Workloads related to mileage travelled, maternity work, and in-patient care, and are detailed, in Figures 3.01 5.01, 5.02, and 5.03, later in the thesis. Bush Nursing in Tasmania spans a period of substantial changes in society and in health technologies. Bush Nursing and BNs reflected many of those changes, particularly as they influenced rural communities and the lives of rural people. This thesis will explore the interaction between Bush Nursing and the evolving rural society in which it functioned.

Bush Nursing Centres developed from and within local communities, and the Bush Nursing organisation was in large part community controlled. The initial proposal was for a centralised or Federal scheme, and Tasmania was included in the scheme's provisional Federal Council. This did not meet with political approval, with a number of states opposing Lady Dudley's initiative for an 'Australian Order for Bush Nursing'. Dr Lendon, President of the South Australian 'District Trained Nursing Society', publicly opposed the implementation of the Bush Nursing Service in South Australia. Primarily this was a consequence of fears that centralisation of control would result in the loss of medical control of nurses. He believed that 'the strict control of the nurses ... and their efficient functioning within the medical hierarchy could only be maintained locally'.⁷⁸ According to Linn the District Trained Nursing Society already felt they were serving the needs of families in the South Australian bush.⁷⁹ In Tasmania concern was raised that a Federal scheme would see local money being lost to fund Federally-based management. Mrs Keating stated that: 'Tasmania is too small, and not wealthy enough for it'.⁸⁰ Additionally Tasmania decided that the Federal proposal for a training centre could be dispensed with as a way of minimising the expense of the scheme.⁸¹

Lady Dudley eventually succumbed to the pressure of state rivalries and conceded in 1910 that the States would need to operate independently.⁸² Even in local implementation, separate north and south Tasmanian schemes were developed, adapting the Federal

⁷⁸ Linn, *Angels of Mercy*, pp. 71–74. Dr Lendon was instrumental in securing Lady Dudley as joint Patroness of the DTNS.

⁷⁹ R Linn, Personal Communication, April, 2003.

⁸⁰ Article in the formation of the Northern TBNA—Interview with Mrs Keating. *The Daily Telegraph*, 10 September 1910.

⁸¹ The Canadian nurses had distinct training schools.

⁸² Wilson, 'Bush Nightingales', p. 40. See also Cunneen, p. 86. Apart from lack of Federal funding the final cause of failure for the Federal scheme was noted as 'opposition from the Australian medical profession.'

scheme to fit parochial local needs. These two committees later standardised their rules and conditions of employment. Mrs Sarah Fraser, Secretary of the Tasmanian Bush Nursing Association for thirty years,⁸³ described the scheme:

We took our constitution from the constitution of the federal scheme selecting those parts of it which seemed essential to the successful working of the scheme in Tasmania; [we] were careful to make it elastic.⁸⁴

The Bush Nursing Service in Victoria started in 1910, just slightly later than in Tasmania, and also appointed its first BN in 1911.⁸⁵ The Victorian scheme differed somewhat from the Tasmanian scheme. In Victoria BNHs, as distinct from BNCs, were the principal element of Bush Nursing.⁸⁶ Substantial private endowments enhanced their funding base. Victoria had James Barrett, a dominating figure in the state's social debate, as its champion of Progressivism and he was instrumental in making the Victorian Bush Nursing Scheme successful.⁸⁷ In South Australia Alan Campbell was a potent force for the District Trained Nursing Society.⁸⁸ Other states also had successful independent schemes.⁸⁹ Despite the strong local organisation and control, during the 1920s there were two Federal conferences held where the majority of the states met to agree on matters such as maximum salaries; government help for midwifery shortages; general support for the movement; a Federal Maternity Bonus to support maternity wards in hospitals, and encouraging the greater participation of country centres.⁹⁰ The Victorian scheme of a minimum of 100 subscribers in each district was adopted, the subscription being £1 a year. This scheme was not found suitable for Tasmania, as the centres in the state were not so closely settled as those on the mainland. Nor were the Tasmanian centres as wealthy as those in Victoria.⁹¹

⁸³ AOT, DPH, Letter To Dr Turnbull from the Bush Nursing Association, 1 March 1950, (HSD 5).

⁸⁴ *The Examiner*, 10 September 1910, p. 9.

⁸⁵ In Tasmania the Northern Bush Nursing Association was formed in approximately July 1910, and the VBNA was formed in November 1910. Hyslop, 'The Social Reform Movement in Melbourne 1890 to 1914', p. 351. The VBNA amalgamated with Aged Care Victoria in 1999. 'The BNCs rather than the hospitals, although diverse, still identify most closely with the label of 'bush'.' Alison Beckett, VAHEC, Personal Communication, April, 2003. Today the scheme is funded through HAC a Federal initiative but there are also other additional sources of funding. See <http://www.vahec.com.au>.

⁸⁶ NAA Series A 1928/1 Item 690/39/2, Section 1—NHRMC—Program of reconstruction on Public Health—Progress after War. Bush Nursing Hospital.

⁸⁷ With support from Barrett, Bush Nursing grew faster in Victoria than in any other area of the country. Barrett was for some time President of the VBNA. He inspected centres regularly throughout the state and was politically active in achieving his goals. Even overseas trips became recruiting drives for BNs. When Bush Nursing was under threat from a National Health and Medical Research Council report he was a strong advocate for the service. (NAA Series A 1928/1 Item 690/39/2 Section 1—NHRMC—Program of reconstruction on Public Health—Progress after War. BNH.) He saw Bush Nursing as requiring special training, and advocated virtually tertiary level training for them while he saw a much lower level of training was required for ordinary nurses. Roe provides a detailed critique of Barrett's contribution. Roe, *Nine Australian Progressives*, pp. 57–88.

⁸⁸ For further information on Alan Campbell refer to Linn, *Angels of Mercy*.

⁸⁹ Previously mentioned in Chapter One.

⁹⁰ Priestley, p. 72.

⁹¹ *Mercury*, 9 December 1922, p. 11

The Tasmanian Bush Nursing Association was administered by a State Council and the State was divided into Northern and Southern Divisions, each with a central committee.⁹² The State Council included representation from the two Divisions and the British Red Cross.⁹³ It met annually, alternately at Hobart and Launceston.⁹⁴ The statewide Bush Nursing Service was administered by the Tasmanian Bush Nursing Association for only six years, and in 1920 the Southern Division was taken over by the DPH at the Division's request.⁹⁵ The Southern Division wanted to achieve uniformity of administration across the State in order to achieve better co-ordination with the DPH and enhanced access to funding. They approached the Northern Division requesting that the North also come under DPH administration, and this was agreed to in 1922.⁹⁶ This shifted the overall control of the scheme from a community base to one of government control, unlike Victoria. The Bush Nursing Association remained active as the adviser to the DPH on the administration of the Rules of Bush Nursing until the 1950s when the Southern Division was dissolved and the Northern Bush Nursing Association continued headed by Mrs Fraser.⁹⁷ A State Bush Nursing Trust Fund continued to operate providing funding assistance to centres.

The DPH administered the Bush Nursing Service on behalf of the Bush Nursing Association. While some centres were under the control of the DPH, others were under day-to-day control by a local committee, whether it was the Municipal Council, Medical Union or a special committee constituted for the purpose.⁹⁸ Even where they did not have day-to-day control, the DPH often mediated in disputes between the local Councils and Medical Unions and the BN, and between BNs and clients. The DPH regulated professional practice through controlling the availability of equipment and drugs, and the rights of BNs to prescribe and dispense. This thesis will highlight the way that levels of control over issues such as prescribing varied over the Bush Nursing era, and in some ways this control increased as the availability of potent antibiotics in the 1930s and 1940s increased.

⁹² Kelly, p. 151. The British Red Cross Fund of £10,000 bequeathed to the Bush Nursing Service in Tasmania was allocated by the Governor General. AOT, DPH, 58.28.8, Letter to Director of Hospitals and Medical Services from Miss K White, Secretary Australian Red Cross, Tasmanian Division, Ref 14/10, 4 September 1956, (HSD 5).

⁹³ References include Priestley, *History of Bush Nursing in Tasmania, 1910–1956* and Kelly.

⁹⁴ *History of Bush Nursing in Tasmania, 1910–1956*.

⁹⁵ The DPH was established on 6 January 1904, replacing a Government Board of Health. AOT, Agency Registration, DPH. Another source claims that the request came from the State Council. *History of Bush Nursing in Tasmania, 1910–1956*.

⁹⁶ NAA, BN in Tasmania, Series A2486, Item 1922/8480. Letter from Darling, Central Committee, Southern Division TBNA, to Earle, 22 May 1922.

⁹⁷ QVMAG, Lilydale Council records, Appointment of Mr W Wilson to replace Mr Von Alwyn, BNTF, Folio 21, 10 July 1961–26 November 1964. The Bush Nursing Trust Fund assisted centres previously part of the BNA. Mr John Alexander Von Alwyn, OBE, was President of the State Bush Nursing Council for many years. See *The Australian Traveller*, 6 February 1947, p. 2.

⁹⁸ AOT, DPH, c1956, Information re Bush Nursing in Tasmania, (HSD 5).

The initiation of BNCs, in most cases, was at the behest of local Municipal Councils with local community support. Councils raised funds through membership subscriptions, rating, and nursing fees. Communities supported the Councils and the Bush Nursing Association for their region through fund-raising activities.⁹⁹ Through a mix of donations, entertainments, bazaars and annual Button Day appeals, the support of local committees remained critical throughout the life of the centre. While the scheme was based on a system of strong local participation and ownership, in many cases local funding difficulties eventually led to the responsibility for the BNC being taken over by State Government. The local Council or Medical Union remained responsible for much of the day-to-day organisation of the centres. This Governmental assistance included taking over the ownership of Bush Nursing residences, and some of the equipment, from the Council or Medical Union.¹⁰⁰ The loss of local control at the level of the BNC had been foreshadowed some years before in the shift of the control at State level from a community-based to governmental control. As local ownership decreased, eventually the Bush Nursing local Committees ceased activity, but most local Auxiliaries and CWA Branches continued to assist the Centres.¹⁰¹ Exceptions to this general rule were that in areas controlled by Medical Unions no local funding mechanisms were in place. At Lilydale and Avoca the BNCs retained their local Bush Nursing Committees.¹⁰² The move from community ownership and control was a gradual one, and by 1949 there were 11 committee centres including medical unions, councils or general committees and 14 public centres.¹⁰³ By 1952 it was reported that of a total of 25 BNCs only seven retained the local committees. Nineteen of the centres were 'wholly controlled and administered' by the DPH as 'in most cases owing to financial and other reasons, the local Committees found it difficult to administer the Centres'.¹⁰⁴ Map 2.02 shows the location of all BNCs that operated in Tasmania. Reference to Table 1.01 will demonstrate the years of operation of each of those BNCs.

⁹⁹ Local Council support will be discussed further in Chapter Four.

¹⁰⁰ AOT, DPH, 28.28.8, Re Use of Red Cross Trust Fund, staffing levels and conditions etc from Sister DK Noller, (HSD 5/8) (HSD 3/12).

¹⁰¹ The CWA was founded in Tasmania in 1936 in Launceston. Ena Miles, *Glimpses of Gold, A brief history of the Country Women's Association in Tasmania (Inc)*, CL Richmond and Sons, Tasmania, 1986. Although several small histories have been published of the CWA in Tasmania, none of these have documented the active role of the CWA in supporting BNs.

¹⁰² AOT, DPH, Memo to Minister of Health from SN, 20 January 1949, (HSD 1). As a local Council controlled BNC, the BNs at Lilydale and Avoca were appointed by the local committee and had benefits provided by Council, such as superannuation and insurance. These BNs had particularly long tenures in their area, tenures which could be modified only by the agreement of Council and BN. In contrast, BNs appointed by the DPH were usually placed in any one location for relatively short periods before being transferred to other centres.

¹⁰³ AOT, DPH, 58.01.49, (HSD 6/34).

¹⁰⁴ AOT, DPH, 'A Short History of Bush Nursing in Tasmania', DK Noller, (HSD 5/8).

As Government assisted one BNC it had almost a snow-balling effect as other BNCs questioned 'why should we fund our centre when the government funds the BNCs in the neighbouring municipality?' The introduction of the Free Government Medical Scheme (a state government initiative) in 1938 decreased local willingness to fund-raise. Added to this was the impact of increased DPH control leading to a decrease in willingness to pay for a service no longer community controlled.

The seven Medical Union Centres generally were less well equipped than the other BNCs. Situated in more remote districts, they were usually without sewerage or septic sanitation. It was the Medical Unions' responsibility to equip and maintain their own Centres. Funding for these Centres was mainly from membership subscriptions, patients' fees, and government help, but the DPH subsidised the salaries and all the travelling expenses of appointees.¹⁰⁵ The centres received no financial assistance from the Bush Nursing Association. Medical Unions functioned in the following towns: Queenstown (Queenstown Medical Union); Zeehan (Zeehan Medical Union); Rosebery and Tullah (Montagu Medical Union); Strahan (Strahan Cottage Hospital Union); Waratah (Mount Bischoff Medical Union); Story's Creek (Storey's Creek Medical Union);¹⁰⁶ Rossarden (Rossarden Medical Union); Boyer, New Norfolk (Australian Newsprint Mills Medical Union);¹⁰⁷ and Grassy, King Island (Grassy Medical Union).¹⁰⁸ Adamsfield was the exception to the mining towns as it did not have a Medical Union. It set up a Vigilance Committee made up of miners who administered the collection of fees to fund and maintain medical services on the field including the establishment of a small hospital.

While local communities had responsibility for and control over the centres, the control over nursing practice was through a professional mechanism. In 1920 the first Supervisory Nurse was appointed by the DPH and eventually in 1946 a northern

¹⁰⁵ AOT, DPH, 28.28.8, Re Use of Red Cross Trust Fund, staffing levels and conditions etc from Sister DK Noller, (HSD 5/8) (HSD 3/12).

¹⁰⁶ Note explanation of various spellings of Storys Creek in 'Definitions and a note on Spelling.'

¹⁰⁷ No Bush Nursing records were found for Boyer but there was a BNC at Maydena funded from Australian Newsprint Mills Medical Union.

¹⁰⁸ Also there were Medical Unions connected with the Associated Pulp and Paper Mills, Burnie, Electrolytic Zinc Co. of Australasia, Ltd, Risdon, and with the Cornwall Coal Co., St Marys. AOT, DPH, 60.92.49, Letter from Dr BM Carruthers to Commonwealth Medical Officer, Medical Unions Other than Friendly Societies 29 April 1949, (HSD 6/37). See also Geoffrey Blainey, *The Peaks of Lyell*, St. David's Park Publishing, Hobart, 1993, pp. 197-198 for the weakening of the AMA, and also Alison Alexander, *A heritage of welfare and caring: the EZ Community Council, 1918-1991*, Pasmenco Metals EZ, Hobart, 1991, pp. 22-23. I have not been able to locate any published history of Medical Unions in Tasmania and the only reference to annual reports was the Queenstown Medical Union Papers lodged with the DPH in 1949. Medical Unions were established by Mining Companies to provide for the health care needs of their workers and in some cases set up their own hospitals. I have not pursued this area of research as this thesis does not focus on organisations and administrations but rather on the women who were BNs.

Supervisory Nurse was appointed.¹⁰⁹ The role of these women in inspecting the centres dispersed around the state and in reducing the professional isolation of the BN is explored in Chapter Three.

The Supervisory Nurse was responsible to the Director of Public Health for advice on Bush Nursing issues. Associated with changes in Bush Nursing structures and control there developed, initially subtle, changes to the way Bush Nursing was described. In 1947 the DPH decreed that 'in future the title "Bush Nurse" will not be used. The officer will be "Sister—Bush Nursing Service"'.¹¹⁰ Bush Nursing was being moved a distance away from its historic roots. In 1952 the Southern Division of the Tasmanian Bush Nursing Association was dissolved, but the Northern Division continued.¹¹¹ In 1957 Bush Nursing was renamed officially the 'Government Nursing Service—District Nursing Centres Division' as the Bush Nursing Service itself became the casualty of the changed times.¹¹² The DPH rationalised this change in a letter which stated:

The Hon. the Minister for Health (Dr. R.J.D. Turnbull) and I have for some time now been devising means where the present Country Nursing Services can be made more effective and be move [sic] economically administered. We have now reached the final stages of planning, which will entail the abandonment of the title 'Bush Nursing Service' and its substitution by the title 'District Nursing Service'. The plans, aims, and present arrangements of the Bush Nursing Service will be retained in toto and will not be altered in any respect, but will be included in a larger service which will take in other forms of nursing service.¹¹³

Bush Nursing had ceased to exist as an entity in its own right. During its tenure, it had provided services across much of Tasmania. On the following page, Map 2.02 shows the Bush Nursing Centres that existed in Tasmania over the period of Bush Nursing. This map may be read in conjunction with Table 1.01 which gives the operational dates of each BNC.¹¹⁴

¹⁰⁹ *History of Bush Nursing in Tasmania, 1910–1956*.

¹¹⁰ QVMAG, Box 10–10 November 1947, Minutes LBNC. The following year there is at least one instance of a GMO complaining of communications and goods still being addressed to the BN, BNH Cygnet instead of Sister-in-Charge, Health Centre, Cygnet. AOT, DPH, Letter to Secretary DPH, dated 28 October 1948 but stamped 29 October 1946 and reply noted 30 October 1946, (1/92).

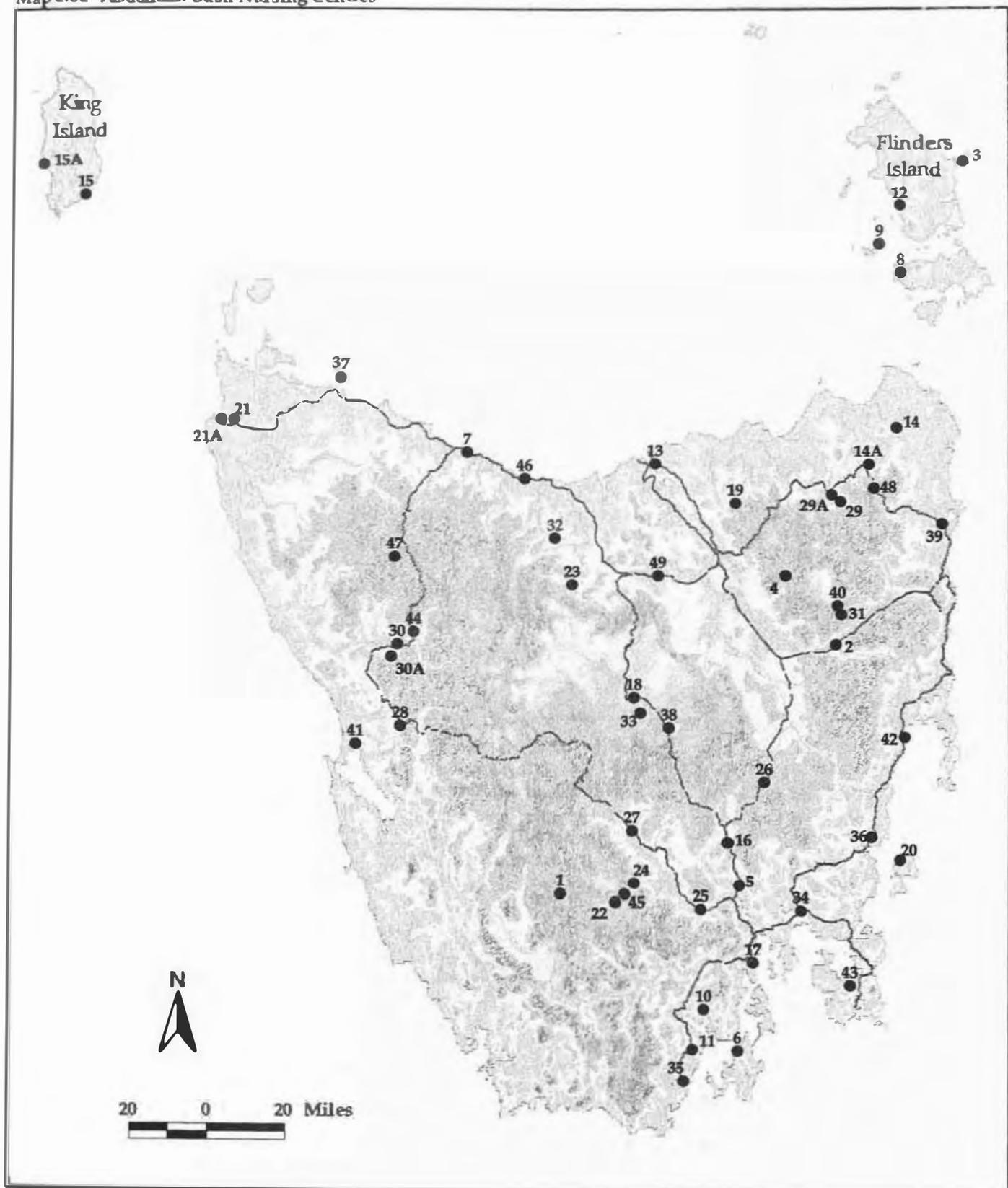
¹¹¹ *TJPP&P*, 1952.

¹¹² AOT, DPH, 58.1.1, Letter to Sister Atkinson, Burnie, from Director of General Health Services, 2 October 1957, (HSD 5).

¹¹³ QVMAG, Box 10, Letter Director General Medical Services to JA Von Alwyn re name change of Bush Nursing, 26 July 1956, (HSD 5).

¹¹⁴ Sven Rand assisted with the production of this map, September 2003.

Map 2.02 Tasmanian Bush Nursing Centres



Legend for Map 2.02

BNC Number	BNC Name	BNC Number	BNC Name
1	Adamsfield	23	Mole Creek
2	Avoca	24	National Park
3	Babel Island	25	New Norfolk
4	Blessington	26	Oatlands
5	Brighton Camp	27	Ouse
6	Bruny Island	21	Redpa
7	Burnie	29	Ringarooma
8	Cape Barren Island	30	Rosebery
9	Chappell Island	31	Rossarden
15A	Currie, King Island	33	Shannon
10	Cygnet	32	Sheffield
11	Dover	34	Sorell
12	Flinders Island	35	Southport
13	George Town	39	St Helens
14	Gladstone	37	Stanley
15	Grassy	38	Steppes
16	Green Ponds (Kempton)	40	Storys Creek
14A	Herrick	41	Strahan
17	Kingborough	42	Swansea
43	Koonya	36	Triabunna
18	Lakes	44	Tullah
29A	Legerwood	45	Tyenna
19	Lilydale	46	Ulverstone
28	Lyell (Queenstown)	47	Waratah
21A	Marawah	48	Weldborough
20	Maria Island	49	Westbury
22	Maydena	30A	Williamsford

The BN had become changed into Sister—District Nursing Service. She was now quite different from the Tasmanian BN of the early 1900s. In this thesis we shall see that the professional isolation had lessened because of social and environmental changes, and with this went the professional independence—perhaps because it was needed no longer and no longer tolerated. It was claimed that the deletion of the word 'Bush' was needed as it 'conjured up the misleading picture of work under the old conditions, in isolated wild areas with no conveniences or amenities.'¹¹⁵ The nursing work continued, and nurses continued to be labelled by the community as BNs for some time after the scheme was subsumed. Some local Bush Nursing Committees continued their work under the banner of Bush

¹¹⁵ *History of Bush Nursing in Tasmania, 1910–1956.*

Nursing.¹¹⁶ Nurses in rural Tasmania today continue to be referred to as 'the Bush Nurse' by older residents.

Bush Nursing developed because of the broad-based health needs in rural communities. While its primary focus was on midwifery and child health, it also had responsibility for the provision of 'first contact care' over the full range of what are now termed 'primary health care' needs. Traditionally it was the medical profession who had the responsibility for meeting these needs, but in general its members had abrogated responsibility for the health needs of those in the bush. Most isolated communities had no resident, and often no visiting, doctor. The 'rudimentary' transport and communication infrastructure further reduced the access of the rural population to doctors. Bush Nurses thus were to be placed in areas in which no local services existed. While conceptually BNs were not independent from doctors, by virtue of their isolation we shall see that independent practice was a feature of Bush Nursing.

The advent of BNs and BNCs was not the first attempt to address the health needs of the bush. Other developments occurred in parallel or overlapped the development of Bush Nursing. The BNs therefore worked at times in parallel or cooperation with these services. Some schemes were attempts to provide a comprehensive local health service, for example Government Medical Officers (GMOs),¹¹⁷ while others addressed specific health needs or interest groups to the exclusion of others, for example HEC Nurses, Midwives, Child Welfare Nurses, the School Medical Scheme, Tasmanian Tourist Nursing Scheme, and Dental Services. Each of these schemes will be described briefly in turn. The development of these schemes, and the problems of funding and staffing them, significantly increased the level of professional isolation of the BN and her level of professional independence. Often, as will be noted, it was the Bush Nursing Service that filled the holes in health care delivery created by the unequal or inequitable geographic focus of 'parallel' services or filled service gaps created by 'focussed' or single problem health services. Bush Nurses also assisted when these services were unable to obtain staff or funding. The Bush Nursing Service provided a generic nursing service, or more correctly a generic health service, that could be termed a comprehensive primary care service in today's terminology.

Prior to BNCs being established in rural and remote Tasmania there were cottage hospitals operating in some rural districts, with a doctor who, if able, would employ a

Lilydale
¹¹⁶ QVMAGBush Municipality Records, Receipt for hire of the hall for a dance for \$4 from the Lilydale Nursing Committee, 9 October 1968. Other receipts in the same year refer to the Lilydale District Nursing Ball.

¹¹⁷ Details of the Government Medical Scheme are contained in *Appendix B*.

nurse to assist him.¹¹⁸ Three examples of cottage hospitals include Lilydale, King Island and Flinders Island. Alison Alexander notes that Tasmania's first regional hospital was established at Campbell Town in 1855. As would be expected with the difficulty in getting health professionals into the bush, the hospital was run by a 'series of untrained couples' until 1912. The State's mining areas, with workers operating in hazardous conditions and usually in remote locations, were 'quick to establish hospitals'. The first of these was at Mt Bischoff, and here a nurse was employed from 1881.¹¹⁹ The growth in country hospitals was quite rapid from 1900, and by 1914 there were 12 hospitals. Five of these (Beaconsfield in 1890; Zeehan in 1891; Strahan in 1893; Queenstown in 1895; and New Norfolk 1910) trained nurses.¹²⁰ Bush Nursing and the BNCs and BNHs operated differently from cottage hospitals, thus cottage hospitals are not discussed in detail within this thesis. This thesis is not a comparative history of organisations but rather has its focus on individual women who were BNs.

The Great Depression caused substantial hardship in the Tasmanian community. The Government was concerned about access to medical care for people in remote country districts, and the impact of the cost of medical attention reducing the ability of people to access services where those services existed. In 1930 for budget reasons the DPH had terminated the (infrequent) rural visits from Departmental Medical Officers and in 1931 terminated rural dental visits.¹²¹ Medical Officers now were concentrated in the two main cities, Hobart and Launceston, with only occasional visits to the country. The effects of the Great Depression on access to services was in part moderated by a reduction in the salary paid to the BN, but the Government remained concerned about accessibility especially to medical care. Where medical care could be accessed by rural communities, the cost of this care was substantial. In 1937 an out-of-hours BN home visit at Marrawah would cost 5 shillings whereas a doctor's visit, with the doctor coming from Smithton, cost £10 (Table 2.01).

¹¹⁸ In Victoria even today the terms 'cottage hospitals' and 'BNH' are used synonymously. Refer to Boorer, p. 945.

¹¹⁹ Alexander, p. 37.

¹²⁰ Alexander, p. 37 and 42 and Kelly, pp. 114–116. According to J Wilson these country hospitals would have trained Auxiliary Nurses only. Personal Communication, 2003. Many hospitals began as privately-owned cottage hospitals (usually owned by doctors) such as the Darwin Hospital (maternity only) at Burnie. These were not training hospitals. Edith Collis past Sub Matron and Deputy Matron at the Spencer and Devon Hospitals, Personal Communication, August, 2003.

¹²¹ Selth, p. 24.

Table 2.01 Fees at Bush Nursing Centres

FOR THE GUIDANCE OF MEDICAL AND NURSING STAFFS AND PATIENTS, BUSH NURSING HOSPITALS	
Consultations Free of charge at Hospital—Monday to Friday between 9 am and 6 pm, and Saturday between 9 am and 12 noon.	
Emergency Visits to Homes	
Hours as per above	Fee of 5/- plus mileage.
After-hours	Visits to Centre 5/- per patient.
Visits to Patient's home	7/6d plus mileage.
N.B. Unless otherwise directed by DPH, no exceptions to be made.	

Source: AOT, DPH, Guide for Nursing Staffs and Patients.

The cost of medical services was therefore a more urgent priority than was the cost of nursing services. In 1938 the Government instituted the Government Medical Scheme, a free medical service designed to increase affordable access to medical care for Tasmanians. During the investigation of the need for such a scheme and a review of the State's health services, the Director of Public Health noted that

initial action should be tempered with the utmost caution, in order to avoid alienating the co-operation and support of the community in general and, in particular, the members of the medical profession and ... Bush Nursing ... Association.¹²²

In some instances medical practitioners are opposed to the idea of co-operating with the BN on the grounds that she interferes with his living'.¹²³ Similar sentiments had been expressed in Victoria and a local doctor, under contract to a Friendly Society, described the BN as 'a constant source of friction'.¹²⁴ Not only might the GMO interfere with the earnings of the doctor, the Director of the DPH was concerned that the Government Medical Scheme might interfere with the Bush Nursing Service: 'If consultations by medical officers serviced by the State be free, there is little likelihood of patients paying for the services of the Bush Nurse'.¹²⁵ He recommended that all GMOs charge a fee for service. The Director was concerned further that a free Government Medical Scheme would create demand for such a service in towns, a loss of income in hospital fees, and a loss of membership of Friendly Lodges.¹²⁶ His recommendation that the Government Medical Scheme operate on a fee for service clearly was overruled as the Scheme was implemented.

¹²² AOT, DPH, Memorandum from Director DPH, 3 August 1937, (HSD 1/36).

¹²³ *TJPP&P*, 1930.

¹²⁴ Priestley, p. 28.

¹²⁵ AOT, DPH, Memorandum from Director DPH, 3 August 1937, (HSD 1/36).

¹²⁶ The Friendly Lodges were private health insurers and an important component of the health-care funding mix. A free medical service might reduce the need for such Lodges and thus reduce the

The duties of the GMO included satisfactory sanitation of individual homes and of the community; investigation into problems of sanitation, such as the disposal of human and household waste, and the protection of water supplies; control of infectious diseases, active immunisation and detection of carriers; prevention and control of tuberculosis, by encouraging the use of chest clinics and sanatoria; the regular and systematic inspection of all school children for physical diseases and dental defects; 'Maternity hygiene', including the supervision of pre-natal and post-natal clinics; child welfare; control and protection of food supplies, including meat inspection; supervision of private hospitals; industrial hygiene, such as the prevention of sickness and accident in industry; and educating the public in the principles of public health and personal hygiene.¹²⁷ A charge for out-of-hours calls was levied so that the doctor's services would 'not be imposed on', and 'so that the doctors would not be required to render a 24 hour a day service, involving, in many instances, excessive travelling'.¹²⁸ Eventually this strategy was implemented for BNs.

After a survey of the State's health services, the DPH chose the initial sites for the Government Medical Scheme. Where the Government determined that a GMO should be placed, it negotiated with the local Council. If the Council were prepared to strike a rate as set by the DPH to subsidise the scheme, the local doctors, if any, were offered the opportunity to become GMOs. If they did not want to do so, the DPH advertised a position and placed a GMO in the area in competition with him.¹²⁹

The scheme provided for 'free access of all persons to medical advice' and was heralded 'as one of the most effective branches of the Public Health Service'.¹³⁰ By the end of the first year of operation of the Government Medical Scheme there were GMOs located in 11 municipal districts.¹³¹ Bush Nursing Centres were in operation in nineteen centres at that time. Only three of the nineteen BNCs had GMOs appointed to the area (Flinders Island,

income within the health service. For more information see *Tasmanian Historical Research Association, Friendly Societies' Registrar, 33/16 and Friendly Society Movement, 40/109*. Eric R Guiler, 'The Oddfellows at New Norfolk', *Tasmanian Historical Research Association, Papers & Proceedings*, 8 September, 1993, pp. 109–117.

¹²⁷ AOT, DPH, 1.1.39, Miscellaneous General—GMS, (HSD 3/2).

¹²⁸ AOT, DPH, 1.1.39, Miscellaneous General—GMS in Country Districts and AOT, DPH, 1.24.41, Miscellaneous, Letter to J Walch & Sons from DPH re queries of GMS, 1 August 1941, (HSD 3/2).

¹²⁹ AOT, DPH, 1.3.40, Letter from 'Frank' Gaha (Minister of Health) to Warden, Circular Head, 25 January 1940, (HSD 1/79).

¹³⁰ *TJPP&P*, no. 16, 1939, p. 15.

¹³¹ GMS Districts in operation to 30 September 1939. Esperance, Flinders Island, Glamorgan-Spring Bay, Hamilton, Kingborough-Bruny, Penguin, Portland, Sorell, Scottsdale, Tasman. AOT, DPH, 1.13.39, Miscellaneous General, Number of patients inception to September 1939, (HSD 3/2). BNCs in operation in Tasmania in 1939—Adamsfield, Avoca, Bruny Island, Burnie, Cygnet, Flinders Island, Lilydale, Marrawah, Ouse, Ringarooma, Rosebery, Rossarden, Southport, Spring Bay, Swansea, Tullah, Tasman Peninsula, Ulverstone, Waratah.

Kingborough-Bruny, and Tasman). In other areas like Ouse and Ringarooma, the G.M.O was placed in relative proximity at Hamilton and Scottsdale respectively. Nurses such as those at Adamsfield, Tullah, and Rossarden, remained as isolated as ever. Government Medical Officers worked in their areas only 10 months of the year, the remainder being allocated for study and holiday leave, and this combined with recruitment and retention difficulties added to the BN's isolation. During World War II medical staff shortages caused stress for the Government Medical Scheme as this memorandum attests:

If the Military Authorities persist in calling up further doctors from Tasmania, not only will our Medical Service be jeopardized, but generally we will not be in a position to maintain the highest community standard consistent with the policy of the Government. Moreover, in the event of an epidemic of disease of any serious character arising, a definite health hazard may ensue.¹³²

Even by the 1950s it was said 'there are still a number of isolated Centres, which receive only periodical medical visits' from G.M.Os.¹³³

On the following page, Map 2.03 shows the location of hospitals and 'District Nursing Centres' within Tasmania in 1956.¹³⁴ This map is produced from information contained in the Nurses' Year Book and Hospital Directory 1956. At this time, although Bush Nursing was still officially in existence, in many official documents BNCs had already become retitled as District Nursing Centres. The detailed key to this map is contained in *Appendix I*. Red Crosses denote large hospitals with medical consultant services; Blue Crosses denote smaller hospitals with general practitioner services supplemented by consultant services 'available through the Emergency Specialist Services'; Red Circles denote District Nursing Centres with beds, some with medical practitioners attached; and Blue Circles denote District Nursing Centres without beds and without attached medical practitioners.¹³⁵

¹³² AOT, DPH, 1.15.41, Shortage of Medical Staff due to war military service, Memo to Premier, 4 April 1941, (HSD 1/80).

¹³³ AOT, DPH, 'A Short History of Bush Nursing in Tasmania', DK Noller, (HSD 6/59).

¹³⁴ Sven Rand assisted with the production of this map, September 2003.

¹³⁵ AOT, DPH, *Nurses Year Book and Hospital Directory, 1956*, Greendale Pub Co., Appendix A and Appendix B, (HSD 6/92). Sven Rand assisted with the production of this map, September 2003.

The Government Medical Scheme was designed to be a free scheme, in contradistinction from the Bush Nursing Service which, for most of the period, in most cases required a patient payment for service.¹³⁶ Thus, in areas where the BN and the GMC worked together to provide medical services to communities there was the potential for the development of tension based on issues of fees and costs, in addition to the tensions related to control and responsibility.¹³⁷ The Government had re-assured those concerned that the Government Medical Scheme would not harm the viability of Bush Nursing, but was prepared to accept a greater role in contributing to BNCs.¹³⁸ Soon after the start of the Government Medical Scheme the expected claims of adverse impacts on Bush Nursing Centre profitability were made and were one reason for a call for centres to be taken over by the DPH.

With the free medical services operating throughout the district, thus reducing the earning power of the nurse, the committee of the Southport Bush Nursing Association deem it advisable to suggest that the Public Health Dept take over the entire financial liability of the Southport Hospital on the condition that should the Free Medical Scheme lapse, the institution revert to a Bush Nursing Hospital. The committee, on their part, agree to raise as much funds as possible to assist in the general maintenance of the hospital.¹³⁹

In situations where it was approved, the DPH accepted taking over the BNC but continued to expect some contribution from local fund-raising to the operating costs of the BNCs.¹⁴⁰ In the mining areas, funds for the BNC were raised from weekly contributions from employees, but in 1939 a National Insurance Scheme was proposed. Miners were to be required to contribute to this and therefore the mining-based BNCs foresaw the loss of a major part of their income. Once again the DPH was obliged to consider taking over the liability for BNCs.¹⁴¹

¹³⁶ Maternity services, other than home deliveries, were free. There was no fee for service at the Medical Union Centres.

¹³⁷ An example of such a problem was in response to a patient complaint in 1940 about medical treatment where the DPH reiterated that since the Government Medical Scheme started that Dr George Arthur Jones was able to 'make use of the BN and BNC for any minor operation' or dressings. Although the medical service was free, there was a charge, 'the usual bush nursing fee', for the services of the BN and BNC. Dr Jones was not allowed to use the BNC for consultations with patients, but nevertheless was requested to provide 'all possible assistance to the nurse, in order to facilitate her work.' Such tensions over control and responsibilities will be discussed in Chapter Five. AOT, DPH, 13.10.40, 31 September 1940, and 1 August 1940, (HSD 3/5).

¹³⁸ QVMAG, Box 10, Lilydale Bush Nursing Meeting 23 September 1937, re interference of Bush Nursing by Free Medical Service, and Newspaper File held by D Wilson—*North Eastern Advertiser*, 21 September 1937, Chief Secretary's Visit to Lilydale Council.

¹³⁹ AOT, DPH, 58.14.38, BN Southport—Letter from Southport BNA re terms for taking over financing, 13 May 1938, (HSD 1/53).

¹⁴⁰ AOT, DPH, 58.14.38, BN Southport—Memo to Minister for Health re taking over Southport BNC, 14 July 1938, (HSD 1/53).

¹⁴¹ AOT, DPH, 58.12.38, BN Rossarden—Letter from Rossarden Medical Union re inability to finance further the BN Centre because of proposed National Health Insurance Scheme, 19 August 1938 and AOT, DPH, 58.12.38, BN Rossarden—Letter to Tasmanian Council on Maternal & Child

The medical service did not remain totally free. Levies were put in place to reduce the potential for the GMO to face excessive after-hours work because of the free nature of the scheme. This mirrored the arrangement for Bush Nursing Service where BN could retain after-hours fees as compensation for her long working hours. It was also a strategy to reduce demand.¹⁴² There became the potential for confusion and complaint—if a patient were treated by a doctor the treatment was free. If a BN assisted there was a fee charged on behalf of the BN and BNC.

At some centres the BN's workload was said to have decreased as a result of the GMO service, and in Cygnet the Supervisory Nurse noted that 'this centre is not so busy since the advent of a GMO to the district'.¹⁴³ The GMOs however were not providing a service in simple competition against the BNs. They saw their role as different from that of the BN:

Dr Walker, GMO at Snug, complained to the Kingborough Council yesterday ... He did not consider it right for him to be expected to attend maternity cases by himself as he had recently been called upon to do ... he refused to attend confinements in people's own homes, without any help.¹⁴⁴

Although home deliveries posed significant challenges and were discouraged by the DPH, there is no evidence that BNs were unprepared to carry out home-based confinements unless they had additional help. It seems that the doctor would carry out such tasks only with BN assistance, whereas the BN was expected to be able to cope alone.

Bush Nurse's prescribing became controlled more rigidly by the DPH through the GMOs particularly during the 1940s. In 1955 a further inroad was made into the control of BNs by GMOs. Prior to that date BNs controlled admission of all patients to BNCs and BNHs. This policy at least in part was to ensure that the BN maintained the necessary control to prevent potentially infectious cases from coming into contact with maternity cases, the latter being the rationale for the BNC. It also allowed the BN to have some control over her workload as in-patient care created particularly high demands on a one or two-nurse environment. In 1955 the situation was reversed. At that time the Director

Welfare re Rossarden centre & insurance. The National Insurance Scheme proposed by the Federal government never came to fruition, (HSD 1/53).

¹⁴²The BN had to invoice the DPH and wait for the money to be reimbursed; the GMO was able to retain his receipts directly. AOT, DPH, 58.14.3, Letter BN Ringarooma from Director of Hospital Medical Services, 29 August 1950, (HSD 5).

¹⁴³AOT, DPH, 58.5.41, BNC Cygnet Letter re SN's visit to Cygnet Centre, 19 August 1941, (HSD 1/79).

¹⁴⁴AOT, DPH, 58.35.43, BN Kingborough District—proposed BNC, (HSD 1/87).

General of Medical Services determined that the GMO should be the Superintendent of the hospital and that all decisions about admission would forthwith become his.¹⁴⁵

This thesis will explore through the eyes of BNs, and some of the other players, the relationship between the GMO and BNs over the Bush Nursing era. This must be seen in the light of the prevailing doctor-nurse/medicine-nursing relationship, interactions based on professional and gender power relationships. Almost all the doctors with whom the BNs interacted were male. The exceptions to this were most of the School Medical Officers, and an occasional female rural general practitioner. There is a record of one female rural general practitioner, Dr Fanny Croaker Robertson Klausen, at Swansea in 1938 who declined the 'opportunity' of becoming a GMO when the DPH intended to place a GMO in her area. She later that month started private practice at Sorell. Dr Carol Mary Kingsmill provided St Helens with service as a Medical Officer of Health for half a day a week in 1938, until moving to reside at St Marys.¹⁴⁶ The Council was happy to pay for the service to encourage a 'resident doctor in the Municipality'. Dr Heather Gibson, a former School Medical Officer, believes that there was only one female general practitioner working in rural Tasmania in the 1950s, a Dr Marcia Blackburn who was married to the local GMO at Snug.¹⁴⁷ The BN at Lilydale referred patients to Dr Geraldine Archer, an unmarried female general practitioner in Launceston, and this is the only female doctor-BN relationship about which any data are available.

It will be seen that, for all the difficulties, there were effective working relationships between some BNs and GMOs and that despite systems of formal control the BN often remained isolated and independent in her practice. In the early years of Bush Nursing it will be shown that doctors had minimal impact on the lives and work of many BNs. Even after the advent of the Government Medical Scheme, this scheme and the Bush Nursing Service had little impact on each other except in a few areas. This might have been in part the intervention of World War II creating significant demands for medical manpower in other fields, and thus lessening the potential growth of the Government Medical Scheme. It will be seen that the major impact of the medical profession on Bush Nursing occurred after this period—a period where affluence and improved transport and communications infrastructure eased access to doctors, potent new drugs became available but were restricted to prescribing by medical professionals, and shortages of nurses created much

¹⁴⁵ AOT, DPH, 58.2.3, Director General Medical Services to all GMOs, 22 February 1955, (HSD 5). A warning was given by the Director that care should be taken to ensure that the BN was not overloaded with hospital work otherwise staff would be lost and difficult to replace.

¹⁴⁶ QVMAG, Box 10—Newspaper Article, 22 July 1938. St Helens Council deciding on doctor or BN. As no doctor was available, a BNC was established in St Helens in 1939.

¹⁴⁷ Dr Heather Gibson, (née Morris), was appointed School Medical Officer in 1951.

difficulty in filling vacancies in Bush Nursing with any nurse, let alone an unmarried nurse.

The group most similar to the Tasmanian BNs consisted of the nurses employed by the Hydro Electric Commission (HEC). While starting later than the Bush Nursing Scheme, the HEC scheme was set up to address particular local needs.¹⁴⁸ Its nurses operated in isolated areas, often in new villages set up specifically for the HEC's construction program. They provided a broad-based nursing service to the employees of the HEC during the construction of the network of dams, power stations and electricity distribution systems for the State. In 1920 the HEC first employed Dr Albert William Shugg who was based at Waddamana. The following year Dr 'Frank' John Francis Miena Gaha, later Minister for Health in Tasmania, took over this role on the resignation of Dr Shugg.¹⁴⁹ As the scheme grew the doctor travelled around the various Hydro sites each week. By January 1949 Dr Lloyd Wallis Bryant, formerly the GMO at Hamilton, was given the position of doctor responsible for visiting all the villages, each with its own nursing centre staffed by one or two nurses. While in many ways similar to Bush Nursing, the HEC Scheme started from commercial necessity rather than from local community action and was under the control of the HEC rather than the Bush Nursing Association or DPH. The overall scheme was considerably smaller than the Bush Nursing Service in numbers of nurses and population served.¹⁵⁰ Given that the HEC Scheme operated independently from the Tasmanian Bush Nursing Service, and that there are differences in the years in which the two schemes commenced and finished, this thesis focuses solely on the latter scheme and its nurses.

¹⁴⁸ The BNC at Lakes (this was a term to describe Great Lake in the Tasmanian Central Plateau) in 1925 was funded by a private hydroelectric company to provide nursing services in its area. The BNC was within the Tasmanian Bush Nursing Scheme and closed in 1928.

¹⁴⁹ Minister for Health 9 April 1959 to 19 September 1961. Colin A Hughes 'Australian Federal and State Portfolio Lists 1855-1982', Tasmanian Parliamentary Library.

¹⁵⁰ Information about the HEC nurses is in part available in Sally Rackham, *Hydro Construction Villages, Volume One, Waddamana, Shannon, Tarraleah*, HEC, Tasmania, 1981. HEC Personnel files are not available to the public.

Photograph 2.03 Dr L Bryant, Hydro Electric Commission Doctor and Government Medical Officer



Dr Bryant worked with both BNs and the HEC nurses. This photograph demonstrates that travel conditions for the doctors were also often difficult, and this, together with the fact that their areas did not coincide with those of the BNs, reduced contact between doctors and BNs.

Source: Dr Lloyd Bryant, Private Collection.

The care of maternity patients was seen as the priority for Bush Nursing, consistent with the progressive view of the role of motherhood in the wellbeing of the nation. In 1901 the first Act to register midwifery practices was passed in Tasmania bringing the practice of midwifery under the control of the Court of Medical Examiners.¹⁵¹ This prevented some women from practising and caused a further shortage of midwives in rural areas. Some women continued to practise despite the regulations but the general populace was encouraged not to trust untrained and unregistered midwives. Prior to Bush Nursing, both registered and unregistered midwives, i.e. traditional midwives, practised throughout Tasmania and travelled to the homes of women. Alternatively, for women to access medical care in labour they called a doctor from the nearest town or otherwise needed to travel to town or city hospitals. Unregistered and registered midwives might have continued to practise alongside or in competition with BNs but there is no evidence of such interaction.

The need for midwifery services was the impetus for the majority of BNCs to be set up across Tasmania. The establishment of the Weldborough BNC in 1911 was a direct result of the need for a midwife. The 1921 Royal Commission into Public Hospitals found a need to establish maternity wards in all country hospitals and felt that if the Bush Nursing Service were assisted and encouraged it would assist mothers in remote areas.¹⁵² The appropriate location for delivery, and health care professional to 'take charge of labour', were contested fiercely during the Bush Nursing era. Bush Nursing started with the

¹⁵¹ Sabic, p. 1.

¹⁵² Sabic, p. 64.

premise that it would carry out and support home deliveries. We shall see that quite rapidly there was pressure for deliveries to be performed at the BNC. An increasing proportion of women were persuaded that hospital-based deliveries and doctor involvement was appropriate. Dusanka Sabic contends that in Tasmania it was not until the 1950s that the majority of births took place in public hospitals under the care of a doctor.¹⁵³ Prior to that, especially in the 1920s and 30s, deliveries in the small 'lying in hospitals'¹⁵⁴ and at home constituted the majority of deliveries.¹⁵⁵ For Bush Nursing the data suggest that the majority of confinements were within the BNCs rather than patient homes by at least the 1930s. The changes that occurred over the Bush Nursing era must be seen in a context of wider and ongoing change. In New Zealand from the 1920s a similar debate ensued, a debate that saw a constant shifting in the power relationships between midwifery and medicine. Philippa Mein Smith outlines the changing power balance over the twentieth century, a description which reinforces that the health care environment can be conceptualised as an ever changing system as it tries to achieve balance.¹⁵⁶

Equally as important for Bush Nursing was the provision of services to children. Bush Nurses provided child health services from the inception of the Bush Nursing Scheme, but in 1917 the Tasmanian Child Welfare Nursing Services were established in response to the perceived 'high infant mortality rates and to improve the health and well being of children'.¹⁵⁷ Care to children was styled 'child welfare' or 'child health' and was a significant part of the BN's duties. At its inception, Child Welfare Services had close contact with the New Zealand Plunket scheme and Dr Truby King.¹⁵⁸ By 1918 'specialised' Tasmanian Baby Clinics and Child Welfare Association's clinics were established and the Child Welfare Nursing Service ran in parallel with the Bush Nursing Scheme. These initially serviced only the urban areas of Hobart and Launceston, and BNs provided Child Welfare Services in areas where no dedicated Child Welfare Nurse was available.¹⁵⁹ The nurses working within the Tasmanian Baby Clinic and Child Welfare Associations were paid by the DPH. The independent Child Welfare Association, established in 1917, met the cost of leasing and maintaining premises.¹⁶⁰ Child Welfare Nurses' services were free to

¹⁵³ The Queen Victoria Hospital had opened in Launceston in 1897 and the Queen Alexandra in Hobart in 1907. Kelly, p. 122.

¹⁵⁴ BNCs and BNHs are included in this category of small lying-in hospitals.

¹⁵⁵ Sabic, p. 30.

¹⁵⁶ Mein Smith, 'Midwifery re-innovation in New Zealand'.

¹⁵⁷ Brennan, p. 13.

¹⁵⁸ Kelly, p. 153.

¹⁵⁹ In January 1918 Laura Richardson commenced work in Hobart as the first Child Health Nurse in Tasmania (*JPP&P*, 1918–19, p. 13). Myrtle Serle was appointed by the DPH to the position of Child Welfare Nurse at Launceston. Brennan, p. 33.

¹⁶⁰ *TJPP&P*, 1918–19, no. 26, p. 13, quoted in Brennan, p. 33.

their clients. In 1926 it was stated that government funded BNs should complete training at the Mothercraft Home to ensure they were trained properly in this area.¹⁶¹

Map 2.04 Child Welfare Clinics, 1950



Mapping Branch,
Lands and Surveys Dept. Hobart

This map is from 'Mother', published by the Public Health Department, Tasmania, in 1950.¹⁶²

This later was reflected in the requirement that BNs possess a certificate in Child Welfare. Bush Nurses without such training were encouraged and financially supported to take time away from their Bush Nursing post to undertake the training.¹⁶³ An added incentive for such activity was a subsidy that was paid by the DPH towards the salary of a BN engaged in 'child welfare work, and supervis[ion of] the physical condition of school children'. There is one example of a subsidy being paid to a Bush Nursing Committee upon receipt of

¹⁶¹ TJP&P, 1927.

¹⁶² Stanley, Burnie, Ulverstone, StHelens, Strahan, Maydena, Sorell and Dover were all sites of BNC at some time. In the Preface the Director of Public Health and Maternal Welfare and Child Health (Dr C L Park) states 'What better immigrant is there than a healthy, Tasmanian-born infant?' showing that Progressive ideology was still to the fore. This was at a time of significant post-war immigration to Tasmania.

¹⁶³ AOT, DPH, 58.24.37, BN Mothercraft—letter to Sister Brook, Tullah re her wish to train, 2 February 1937, (HSD 1/36).

a satisfactory report from the local police on the Child Welfare Services to the DPH. This demonstrates an integrated approach to services in small communities, and perhaps implies that in this area of her activity the nurse was in some way accountable to the police. There is, however, no other evidence for such accountability.¹⁶⁴ In Lilydale the BN and the local police cooperated in activities relating to the care of 'crippled children' in the Municipality.¹⁶⁵ Generally the police and the BN collaborated over issues such as deaths, injuries associated with crime such as assault, rape and child molestation.

Child health care was delivered also within schools, and a School Medical Service was developed in 1907, under the control of the Education Department.¹⁶⁶ Dr Gertrude Halley of Melbourne was appointed as the first Schools' Medical Officer in that year.¹⁶⁷ The following year two part-time officers, Dr William Goodwin Chadbourne Clark and Dr Hogg, and later Dr Isobel Ormiston, were appointed and were responsible for hygiene in schools as well as the health of the children in Hobart and Launceston.¹⁶⁸ This medical service soon was to be augmented by the appointment of nurses to assist in its delivery.¹⁶⁹ The first two School Sisters were appointed in 1911 to supplement the work of the Medical Officers.¹⁷⁰ Bush Nurses will be seen to have substantial work within school health programs as the School Sisters and School Medical Officers were not able to service the rural schools adequately. The BN's role in school health appears to have been ignored in Rodwell's study of the progressive health movement within the education system.¹⁷¹ Bush Nurses' roles not only were in the schools but were also in the homes of children as they visited to reinforce instructions parents might have been given, and to educate the parents about the 'general need to seek medical attention whenever necessary'.¹⁷²

In 1939 the DPH had responsibility for the School Medical Service and stated in a report that 'four School Sisters and 21 Bush Nurses also made a valuable contribution to the

¹⁶⁴ AOT, DPH, 58.5.38, BN Cygnet, Memo re to Director Social Services re remuneration of charges, 27 May 1938, (HSD 1/53).

¹⁶⁵ Newspaper File held by D Wilson, *North Eastern Advertiser*, 7 February 1936, Lilydale Council Meeting.

¹⁶⁶ Selth, p. 40.

¹⁶⁷ See G Rodwell, *The influence of Progressivism on Tasmanian State Primary Education 1904–1920*, p. 204 for personal details of Dr Halley and details of her brief.

¹⁶⁸ See Rodwell, *The influence of Progressivism on Tasmanian State Primary Education 1904–1920*, p. 213. Dr Hogg possibly was Dr Gustave Heuze Hogg. See also Selth, p. 40. The School Medical Scheme was the first scheme of its kind in Australia.

¹⁶⁹ The School Medical Service contrasts in organisation and style with the Child Welfare *Nursing Scheme* (My emphasis).

¹⁷⁰ In 1945 School Sisters were renamed School Nurses. Selth, p. 95.

¹⁷¹ G Rodwell, *The influence of Progressivism on Tasmanian State Primary Education 1904–1920*, p. 213.

¹⁷² Selth, p. 95.

health of the school child'.¹⁷³ Bush Nurses were the primary providers of the school nursing service. During the period of this report (1941) a full-time medical officer was appointed and the work in schools was performed by GMOs, School Sisters and School Dental Inspectors in addition to the BNs. Nurses operated alone in schools and included home visits in their work. By 1951 there were five full-time School Sisters and one part-time in the south, three in the North West, one at Queenstown and three at Launceston.¹⁷⁴ The location of these dedicated School Sisters suggests that even in 1951 BNs provided school health services in the more remote areas. Official statistics of Bush Nursing list these school visits as one of its reportable activities as shown in *Appendix C*.

Dr Heather Gibson argues that the BNs would have considered the school work as a significantly less important component of their duties than other clinical work such as midwifery. Dr Gibson stated that she rarely had contact with BNs, suggesting that if her recollection is true she seldom visited schools in the more remote rural areas. On the one occasion when Dr Gibson had contact with a BN engaged in school work, she found her less prepared than her trained School Sister counterpart.¹⁷⁵ According to Dr Gibson, by the 1950s, when the staffing of the School Medical Service had significantly expanded, small rural schools might have been visited three times by the School Sister—the first time was to do a general health check, the second accompanied by the School Medical Officer to follow up identified cases, and the third to check that treatment recommendations had been carried out.¹⁷⁶

The majority of School Medical Officers listed in the health reports was female.¹⁷⁷ Dr Gibson substantiated that most School Medical Officers were women. She believed it to be because the sessional and part-time nature of the work suited mothers with children and allowed work to fit around family commitments.¹⁷⁸ She remembers one or two men were employed. An alternative reason for females predominating as School Medical Officers is that school visiting was seen as a female role.¹⁷⁹

¹⁷³ *TJPP&P*, 1942–1943, no. 8, p. 11.

¹⁷⁴ *TJPP&P*, 1952, no. 59, p. 12.

¹⁷⁵ Dr Heather Gibson, Personal Communication, Lindisfarne, January, 2003.

¹⁷⁶ Dr Heather Gibson, Personal Communication, Lindisfarne, January, 2003. Sister Beaudinet, Sister Lamprill, and Sister Kent at Queenstown were some of the School Health Nurses remembered by Dr Gibson as practising in rural areas.

¹⁷⁷ For example, School Medical Officers include Dr Heather Gibson, Dr Pauline Stanbury, Dr Diana Starr in the NW (she also conducted Child Welfare Clinics), Dr Dorothy Long, Dr Audrey Officer, Dr Margaret Wilson, Dr Mary Young, Dr Joyce Park, Dr Valerie Davenport, Dr Betty Batt at Scottsdale, and Dr Mona Hatherley at Circular Head and Burnie. *TJPP&P*, various reports.

¹⁷⁸ Dr Heather Gibson, Personal Communication, Lindisfarne, January, 2003.

¹⁷⁹ In New Zealand the School Medical Service was established in 1912 and also was predominantly staffed by women. See Patricia A Sargison, *Notable Women in New Zealand Health Te Hauora ki Aotearoa: Ona Wahine Rongonui*, Longman Paul, Auckland, 1993, p. 27 'School doctors were expected to combine a 'social and missionary role' with regular medical inspections, combating

In contrast with the BN, the School Medical Officers generally did not live within the communities they visited and serviced. In addition their role was a narrowly focussed service rather than a comprehensive one. By 1953 retention of School Medical Officers was becoming a problem. GMOs were supplementing this work at Scottsdale, George Town, Cygnet and Dover.¹⁸⁰ At this time there were 13 School Sisters and they expanded their service into remote areas such as King and Flinders Islands and the east coast.¹⁸¹ This was not easy to resource and Dr Gibson, School Medical Officer reported:

an attempt has been made to relieve school sisters of the burden of supervising scattered country districts by inviting the assistance of sisters holding positions at Bush Nursing and Child Welfare Centres. This has proved most satisfactory and in many isolated districts has saved school sisters much tiring travelling. As a result of this help it has been possible to extend the school health programme to every part of the state and we feel that a better service has been given to the whole community.¹⁸²

By mid 1956 the School Medical Service reported that for the first time since its inception they were fully staffed.¹⁸³ Where the School Sister visited the BN's district, she was a parallel professional employed on a part time basis. More often however the BN, once again, operated alone. Dr Gibson's recollection differs from her official report and she sees the 1950s as a period of successful expansion for the School Medical Service with Dr Murray, the new head of the department taking a keen interest in the area. She accepts that BNs were involved in the School Health work particularly during the war time period of staff shortages, but argues that in the 1950s their services were required no longer.¹⁸⁴ It is likely that her contemporaneous report is a more accurate reflection of the true situation. Even where BNs were not working in schools, brief contact was maintained between the School Sister and the BN but usually it would be a courtesy call where the School Sister would drop in for a cup of tea to let the BN know she was in the other's district for a short time. If these nurses were friends they might have lived together in the BNC for the duration of a short overnight visit.

Dental care was another area that was difficult to provide in the bush. While not a core function of the BN, many recall carrying out dental work including dental extractions and providing advice on oral hygiene in the absence of the formal dental services. Over the Bush Nursing era dental services to the bush were at best patchy in outreach, and were inconsistent and often expensive. Dental clinics were set up in Tasmania in 1916 after

parental ignorance and raising the national consciousness about health, hygiene and nutrition. They were not expected to treat children, but diagnose, advise, lecture and carry out research,' p. 27.

¹⁸⁰ *TJPP&P*, 1953, no. 52, p. 15

¹⁸¹ *TJPP&P*, 1953, no. 52, p. 13.

¹⁸² *TJPP&P*, 1954, no. 70, p. 31.

¹⁸³ *TJPP&P*, 1956, p. 35.

¹⁸⁴ Dr Heather Gibson, Personal Communication, Lindisfarne, January, 2003.

medical officers had commented on the 'extremely poor dental health' of the children they had seen. Initially, one officer in Hobart visited the west coast and a second officer was stationed in the north.¹⁸⁵ In 1931 the travelling dentists were dismissed as a consequence of budget cuts. The majority of dental clinics were held in urban areas. Private dentists visited rural areas running occasional clinics at the BNCs or even travelling with a vehicle set up as a mobile surgery. Children attended clinics for dental treatment.¹⁸⁶ In 1947 there were plans once again to expand Government-funded dental services as the remoteness of the rural population reduced accessibility, and many families were unable to pay for needed dental treatment. It was planned to base this service in hospitals and generally require the client to travel to the service.¹⁸⁷ Individual schools were visited in country areas. By 1953 the State was divided into school dental districts, and school children throughout Tasmania were provided free dental treatment.¹⁸⁸

No study has been completed on public health activity in rural areas of Tasmania although a wealth of information can be found in local municipality records, usually within the health inspector's reports. Bush Nurses were not Public Health Nurses, and thus in this respect their roles were quite different from those of the Canadian Public Health Nurse. Tasmanian BNs did work which can be conceptualised as public health but their primary tasks were in relation to individual clients. There were two health professionals within public health in addition to the BN, the Medical Officer of Health and the Health Inspector. While the BN worked in parallel with the Health Inspectors she would co-operate on many issues. This was especially the case during outbreaks of infectious diseases. On Babel Island the BN was authorised to act as health inspector during the mutton-bird season. While immunisations were carried out in schools, this was an area initially not covered by the School Sister. Immunisation was the responsibility of the local Councils and the GMO, and documents from the DPH frequently stress that immunisation was not nursing work. In conjunction with the GMO or private doctor, the BN assisted with immunisation and on occasion she gave immunisations without medical supervision. In the 1950s the School Medical Service staff organised and administered the immunisation programme in schools.¹⁸⁹

District Nursing was a nursing service 'formed for the special object of providing skilled nursing for the sick poor in their own homes'.¹⁹⁰ The Launceston District Nursing

¹⁸⁵ Selth, p. 112.

¹⁸⁶ *TJPP&P*, 1942-1943, no. 8, p. 1.

¹⁸⁷ *TJPP&P*, 1942-1943, no. 8, p. 11.

¹⁸⁸ A list of districts is included in *TJPP&P*, 1954, no. 61, p. 32.

¹⁸⁹ *TJPP&P*, 1954, p. 31.

¹⁹⁰ *Launceston District Nursing Association*, Stephenson & Sons, Launceston, 1985, Launceston District Nursing, QVMAG Files.

Association was founded in 1893 as a non-sectarian organisation and 'concerned with nursing pensioners and people on low superannuated incomes who [were] confined to their homes'.¹⁹¹ Services were free of charge. Initially the scheme was funded by subscriptions and donations. Treatment provided included sponging, bed-making, dressings, injections and other treatments ordered by the doctor.¹⁹² The Hobart District Nursing Association, with the same objectives as the Launceston District Nursing Association, was formed in 1896 after a public meeting was convened by Lady Georgina Gormanston.¹⁹³

District Nursing essentially was urban-based, and thus was not designed to meet the needs of rural isolated women.¹⁹⁴ Its emphasis was on treatment in the home and did not have physical infrastructure like the BNCs. Its role was also narrower than that of Bush Nursing. The By-Laws of District Nursing stated that 'No nurse shall attend a case of midwifery or of infectious disease'.¹⁹⁵ Child Welfare Services were also outside their role. In contrast Bush Nursing had a particular focus on midwifery and, when possible, on the treatment of infectious disease. This latter however was subject to restrictions because of the risk of infection in midwifery practice. With its urban base allowing close contact between nurse and doctor, District Nurses had a relationship with doctors which was fundamentally different from the relationship between BN and doctor. Although Bush Nursing was, in Tasmania, a scheme distinct from District Nursing it must be remembered that elsewhere in Australia the two schemes were often synonymous (for example, in South Australia and in Western Australia).¹⁹⁶

Other organisations also provided nursing services. The St John Ambulance Association was established in Launceston in 1887 and in Deloraine in 1890.¹⁹⁷ In 1892 Lady Hamilton formed an 'Amateur Nursing Band' of approximately eight women to nurse the

¹⁹¹ Extract from First Annual Report, LDNA, QVMAG Files.

¹⁹² Launceston District Nursing Association, 2 pages of notes, c1959, Launceston District Nursing, QVMAG Files.

¹⁹³ Kelly, p. 74 and Snowden, p. ii: Lord Gormanston was Governor of Tasmania.

¹⁹⁴ 'This organisation [Melbourne District Nursing Society] pioneered district nursing in Australia and had convinced many politicians and others of the evils of poor housing and the lack of sanitation, and of the foolishness of not taking enough care with cases of contagious diseases.' Linn, *Angels of Mercy*, p. 24.

The South Australian District Nursing Society was not formed until 1894.

¹⁹⁵ *Launceston District Nursing Association*, Stephenson & Sons, Launceston, 1985, Launceston District Nursing, QVMAG Files.

¹⁹⁶ Linn, *Angels of Mercy*. In 1938 the DTNS officially changed its name to 'the District and Bush Nursing Society (hereafter DBNS) as an indication of the wider tasks of the Society and the expansion of its services.' p. 112. In South Australia the nursing service was initially called the District Trained Nursing Society and later the District and Bush Nursing Society. In Western Australia the Silver Chain was established, later incorporated Bush Nursing.

¹⁹⁷ Alexander, p. 212.

sick poor, and this was the forerunner of the Hobart District Nursing Service.¹⁹⁸ The Evangelical Nursing Association began in Launceston in 1896 and was a missionary organisation mainly financially supported by subscriptions.¹⁹⁹

A service closely associated with Bush Nursing was the Tasmanian Tourist Nursing Service, introduced in 1952 and administered by the DPH.²⁰⁰ The Tasmanian Tourist Nursing Service's role was to provide trained nurses to fill critical vacancies in hospital nursing positions and in BNCs. It paid the fare to Tasmania for interstate nurses who stayed six months, and after twelve months paid their return fare.²⁰¹ The DPH Report noted that 'Tasmania had quite a lot to offer nurses from the Mainland who want a short break, but not a complete holiday'.²⁰² In 1957 the service came under the control of the DPH Services and was renamed the 'Tourist Nursing Division' in the same restructure of health that saw Bush Nursing cease.²⁰³ The Bush Nursing Service was supplemented regularly with Tourist Nurses especially to cover BNs' annual and sick leave. Appointments at BNHs usually were confined to two months but periods of service could extend between three and fifteen months.²⁰⁴ For the DPH, this pool of Tourist Nursing staff proved invaluable. It allowed it to keep centres open and provided BNs with their annual leave that on some occasions had accrued for years. These nurses were a partial solution to the vexed problem of nursing recruitment and retention, particularly in some remote areas. These issues shall be discussed further in the chapter that includes retention of BNs.

¹⁹⁸ *Walch's Almanac* 1889, p. 287; 1890, in Alexander, pp. 294, 317.

¹⁹⁹ According to *Walch's Almanac* the last date of operation of the Evangelical Nursing Association was February 1974. See also *Cyclopedia of Tasmania*, vol. 11, p. 49.

²⁰⁰ *TJPP&P*, 1952, no. 59, p. 267.

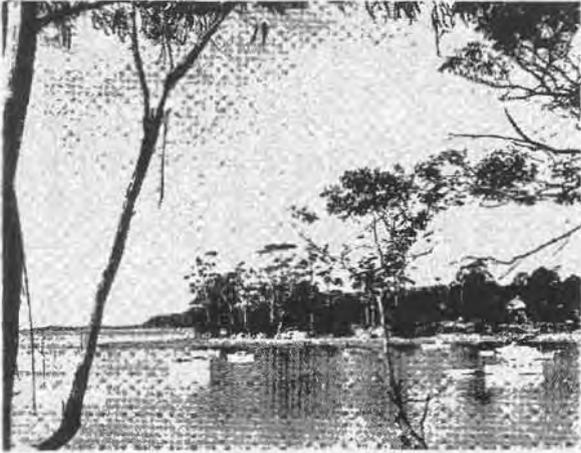
²⁰¹ *Our Pioneers Interview 6*: 'Sister Dorothy Eleanor Simpson', p. 2.

²⁰² *TJPP&P*, 1952, no. 59, pp. 26–7.

²⁰³ *TJPP&P*, 1957.

²⁰⁴ *TJPP&P*, 1956, no. 63, p. 14.

Photograph 2.04 Advertisement for Bush Nursing Position



ST BELLENS, where we have one of our many small modern all-electric country hospitals.

This is only one of thousands of beautiful views you will see in

TASMANIA

DOUBLE and TRIPLE CERTIFICATED SISTERS can be called on a very welcome and largely unobtrusive in the DISTRICT NURSING SERVICES including the TOURIST NURSING SERVICE.

SALARY at 1st July, 1956, £15/6/9 to £16/6/6 weekly.
UNIFORM ALLOWANCE of 4/- weekly.
AIR FARES from Melbourne to Hobart returned after an annual service and RETURN FARE after 12 months.
RETURN AIR FARES from place of engagement refunded after two years service.

Inquiries to
DEPARTMENT OF HEALTH SERVICES
Nursing Section,
Dovey Street, Hobart

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Bush Nursing advertisements stressed the benefits of Tasmania, in this case the lovely environment within which nurses would work. This idyllic scene is a far cry from the mud and snow which nurses had to endure in some BNCs particularly in winter. Note that in this 1956 advertisement the term Bush Nurse had been replaced by the term District Nurse.

Source: AOT, DPH. Nurses Year Book and Hospital Directory, 1956, Greendale Pub Co., (HSD 6/92).

Bush Nursing was a new service, distinct from this range of seemingly parallel or competing services. Although the BN frequently filled in the gaps in other services this was a reflection of the breadth of her role and the narrow focus of the other services. It was only the BNs who were seen to have the ability and willingness to tackle such a broad based

role.²⁰⁵ Operating mostly in remote areas, BNs usually worked as solo practitioners and thus as isolated health professionals. Priestley argues (of the Victorian scheme):

It was the isolation of the Bush Nurse ... which made her role distinct from that of the hospital, visiting private or district nurse. She was called on to exercise high levels of initiative, independence and often ingenuity.²⁰⁶

Equally important was her clearly defined role as the 'health professional of first contact'. These aspects of her role will be explored in depth in later chapters.

There was no special training for the challenges of Bush Nursing practice. Nurses preferred for appointment as BNs were triple certificate trained (General, Midwifery and Child Welfare) but double certificates also were accepted in some instances.²⁰⁷ At least two full-time BNs were single certificate nurses although these were exceptions. The 1927 Nursing Act identified three categories of nurses that included general, midwifery and mental [psychiatric] nurses.²⁰⁸ Some BNs also held a six month certificate in ear and eye specialisation. Salaries were structured so that triple certificate sisters were paid at the highest rate. In 1953 the minimum rate of pay for a triple certificate sister in her 4th year after graduation was £13 9s 3d a week when the basic wage was £12 2s 0d a week.²⁰⁹

Women who became BNs perhaps by personality were more suited as independent nurses than as nurses specialising in theatre or hospital work. Some BNs were local women but there were nurses recruited from interstate and overseas. In many cases they were well-travelled and experienced nurses. As one BN recalls:

When I got back to Tasmania and was relieving in a hospital it made me frustrated! You couldn't give an aspirin without a doctor ordering that you give one, and I thought I'll do a bit of Bush Nursing and a bit of relieving in Child Welfare work; just to see the country.²¹⁰

²⁰⁵ AOT, DPH, Sunning up of Sisters' qualifications, 15 September 1953, (HSD 5).

²⁰⁶ Priestley, p. 34.

²⁰⁷ A single certificate was general nursing trained; a double certificate was general and midwifery trained; triple was general and midwifery as prerequisites for certificate in child health. 'While other specialist qualifications were regarded as valuable no qualifications other than general, midwifery and child health could make up a "triple certificate". At the time these qualifications were seen to encapsulate the range of knowledge and experience a nurse reasonably could be expected to acquire. They also provided a career pathway.' Dr S Brennan, Personal Communication, 2003.

²⁰⁸ See Kelly.

²⁰⁹ State of Tasmania DPH, Bush Nursing Service, *Information Relating to Standing Orders of the Bush Nursing Service August 1953*, p. 2.

²¹⁰ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1995. Sister Isyabell Ann Weir was born 6 January 1914 at Hanroyd, west of York Plains, Tasmania. She completed her nursing training at Melbourne, Midwifery at Prince Henry's Midwifery Hospital, and child welfare in Hobart. During World War II she nursed in Brunei, Africa and New Zealand. She was in her early 50s when she became a relieving BN as a war widow. She nursed at St Helens, Mole Creek, Otlands, Avoca, Flinders Island, King Island (Currie and Grassy), and Koonya. She also did relief child welfare nursing at St Marys.

This is the voice of an independent woman speaking of her need to escape the frustration of closely supervised hospital work where her every move seemed under scrutiny.²¹¹ Bush Nursing and Child Welfare Nursing were two types of nursing that provided unsupervised work environments.

Bush Nursing was a vibrant and busy health service that arose out of the concerns and ideology of the progressive movement and was embraced by female political activists. The Bush Nursing ideology tapped into perceptions of community need and the failure of the medical profession to deliver adequate services to the bush. While Bush Nursing overlapped the period of some antecedent services, and was associated with a range of parallel and sometimes competing services, it was a major force in rural health care delivery. Its nurses operated to a large extent as autonomous professionals with medical authority belatedly being asserted in the last years of the Bush Nursing Service. Its eventual subsumption under the District Nursing umbrella, a topic outside the brief of this thesis, was in no way a reflection of its lack of success, but more likely a rationalisation of services and responsibility. The conditions under which the BNs worked were a major factor in promoting their autonomy, and is the subject of the next chapter prior to an analysis of their work practices in the final chapter.

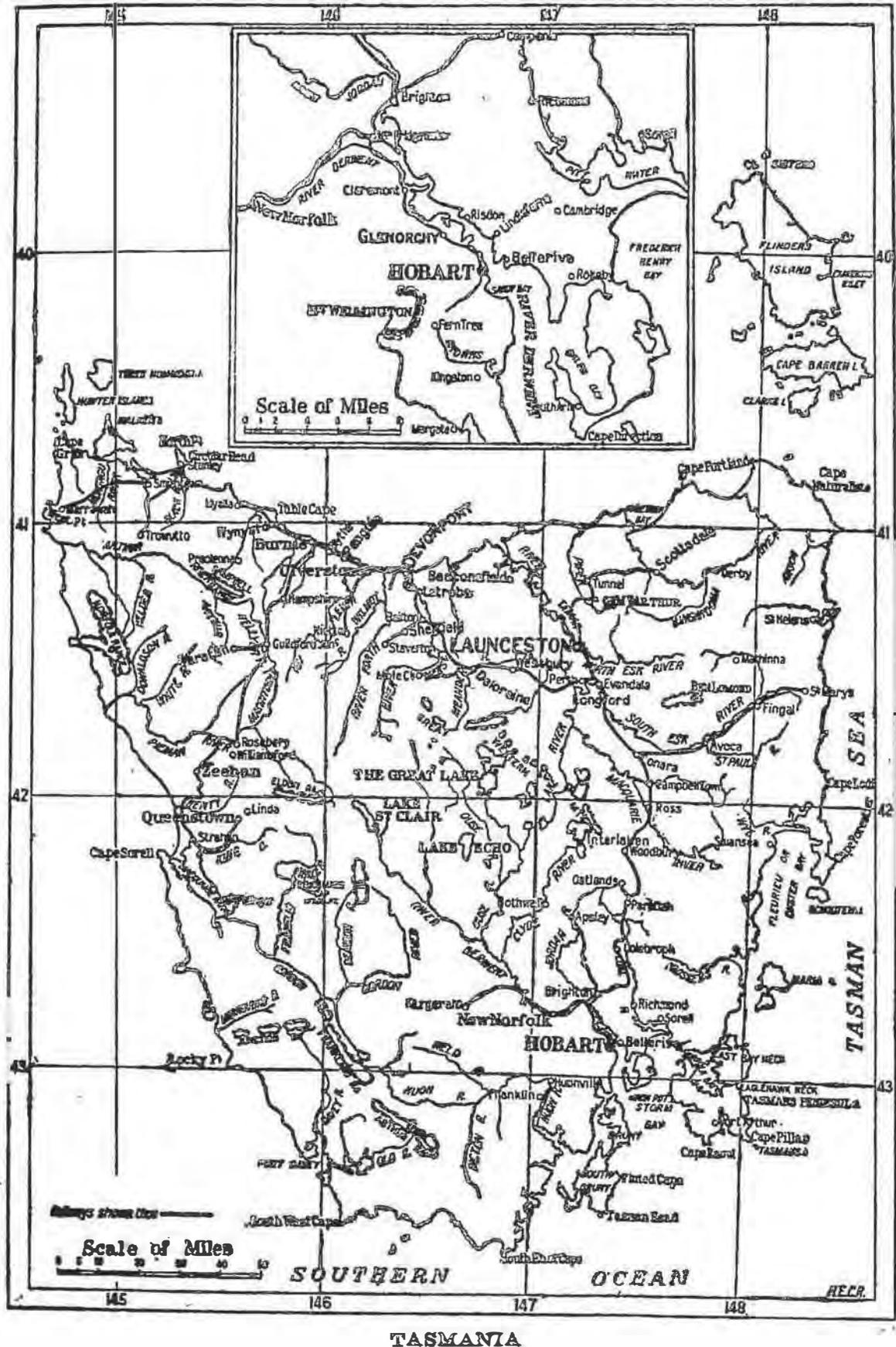
²¹¹ Another area of future study would be to compare the military backgrounds of nurses who became BNs such as 'Maisie' Rayner, Isyabell Williams, Vi Millington and Eleanor Burbury. These women would have practised autonomously during World War II and therefore were attracted to the independent nature of Bush Nursing. John Wilson, Personal Communication, 2003. Sister Viola Clarice Millington (previously Thompson and née Liersch) was born on 13 November 1912 at Port Pirie in South Australia from a farming family. She did her General Nursing training at Adelaide Hospital, completing this in 1936. Vi came to Tasmania in 1945 after serving in the Army and then as a Red Cross Nurse in NSW. She took a position as a theatre sister at St John's Hospital, Hobart. From there she went to the Mothercraft Home and gained her Child Welfare Certificate. Soon after she married a Triabunna local who was the publican's son. At that time although the BNC at Triabunna was closed she persuaded the DPH to appoint her as BN.

CHAPTER THREE

Bush Nurses as Isolated Professionals

Isolation was a central part of the Bush Nursing experience and included separation from fellow health professionals and from other community members within their rural communities. This chapter explores the issue of professional isolation and the theme of 'isolated women' is explored in Chapter Four. The professional isolation of the BN had many contributing factors, and changed over the period of the Bush Nursing Service. The distance from other centres was compounded by the harsh climate and by difficulties with transport and communications. Nursing required access to appropriate facilities, equipment, and where necessary to local or regional hospitals. As a consequence these factors influenced the experience of isolation. Bush Nursing operated over a period of 45 years in which tremendous societal change occurred, particularly in the development and availability of transport and communications infrastructure. This chapter details how changing access for BNs and their communities to transport and to communication technologies influenced their isolation. The level of actual or perceived collegial support, and supervision from, and interaction with, other health care workers such as doctors were central also to the nurse's sense of professional isolation. The personal living arrangements of BNs, a consequence of the physical isolation, provided environments different from hospital nurses' homes and contributed to both professional and personal isolation. This chapter has as its primary focus the experiences of individual women rather than a detailed analysis of the development of rural infrastructure. It is through the eyes of the lived experience of BNs that isolation will be explored and, although transport and communication technology, together with increasing affluence, would in time substantially lessen rural isolation, it will be seen that BNs remained isolated over the entire Bush Nursing era.

Map 3.01 Railways and Towns, Tasmania, c1930



Source: E T Emmett, *A Short History of Tasmania*, Angus and Robertson, Sydney, Australia, 1937.

Physical Isolation

The Bush Nursing Service was designed to provide for the needs of isolated and rural communities, thus by definition BNs worked in environments more isolated than those experienced by their colleagues in other branches of nursing.¹ Working conditions varied significantly according to geography, funding sources and the level of technology in the area in which they worked. Variation in working conditions was reflected in a system of bonuses, the so-called 'isolation bonuses'.

Isolation bonuses applied to several areas early in Bush Nursing history but these were exceptional. Fairly late in their history the differences between Bush Nursing environments were reflected in a more generous and more commonly available system of bonuses. The bonuses were designed to attract, and retain, nurses to areas perceived as unpopular, and the need for bonuses was compounded by the dramatic increase in the number of BNCs. Adamsfield, a small osmiridium mining town, was one of the most remote parts of the Tasmanian south west.² Costs of living were high as the charge for packing stores to the field over the bush track was 10/- per 100lbs weight.³ By 1931, the BN at Adamsfield received the highest wage for BNs in Tasmania to compensate for the high cost of living and her isolation.⁴

The harsh conditions experienced by some BNs are indisputable. The Inspector, appointed by the Department in 1934 to vet the mutton-birding industry, felt that the

¹ Even in 2003 parts of Tasmania and its islands are classified as rural and remote within the Federal Government's classification designed to characterise health needs and the impact of rurality.

These areas include those in which the Bush Nursing Service operated, and reinforce that within the Australian context Tasmania still offers experiences in remote and rural health care.

² Osmiridium is a hard non-reactive alloy of the platinum family used for the tips of fountain-pen nibs and some medical equipment such as balance scales. At one time the price reached £40 an ounce according to O'Reilly. Michael J O'Reilly, *Bowyangs and Boomerang: Reminiscences of Forty Years Prospecting in Australia and Tasmania*, Mercury Press, 1984. Elsie Bessell recalls that 'It was 1925 and Hobart in the grip of an icy winter, that the news leaked out that a rich new field of Osmiridium had been discovered by a lone prospector in the almost inaccessible far west of Tasmania. There now ensued an almost unprecedented rush of men from all parts of the state, even from the Mainland, deserting their farms and orchards and their properties with the main object of "get rich quick" in view. The price then was £32.15 shillings an ounce and is extensively used in industry and engineering for machines etc and parts needing great resistance'. Elsie G Bessell Papers, Private Collection. Elsie Grace Bessell (later Mrs Matthews) was born at Lisle in 1884, a small gold-mining town, in the north east of Tasmania. One of twelve surviving children she was the daughter of a miner and boot-repairer. She trained at Melbourne Royal Hospital and she started Bush Nursing in Victoria but later came to Tasmania for domestic reasons. She served the areas of Adamsfield, Tullah, Marrawah, and Ouse, and was Matron of Zeehan Hospital for three years. Elsie married Stuart Matthews whom she met at Adamsfield at the age of 50 and had no children. They returned to his farm on Flinders Island where she continued to nurse on an unpaid relief basis.

³ AOT, DPH, 58.1.36, Letter to Sister Evans, BN Adamsfield, 20 January 1936, (HSD 1/24).

⁴ Receiving £215 per annum. *TJPP&P*, Report for 1927-28.

environment on Babel Island was too bad for a woman to endure and the Bush Nursing Service on the Island should be abandoned.⁵ These sentiments presumably related to 'cultured white women'. They obviously did not extend to the mainly Tasmanian Aboriginal women working in the industry alongside their families.

Photograph 3.01 Babel Island Mutton-bird Huts, 1930



Life on Babel Island was particularly harsh as the island was only occupied for the short period each year associated with the mutton-bird season. Conditions of work were dangerous and dirty.

Source: DPH, Bush Nursing Album, NBT.

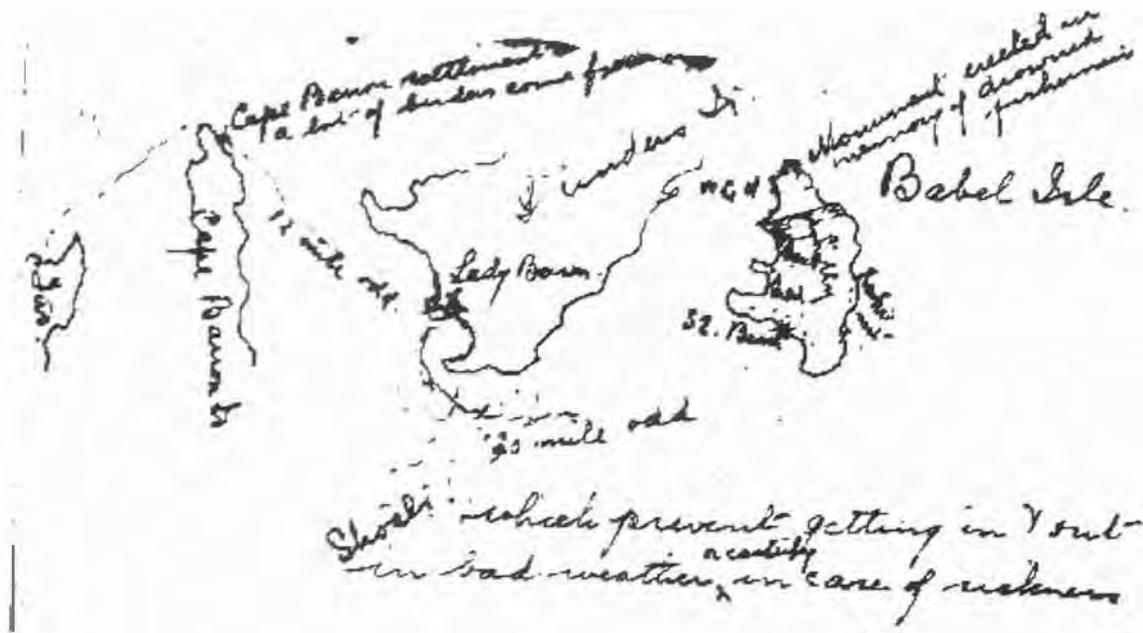
The Director of Public Health was well aware of the isolation of BNs after inspections of the various centres in 1936. He reported that the surroundings were often 'uncongenial' and that the nurses lived in 'isolation'. He believed that, in order to retain nurses, attention had to be given to safeguarding their welfare. He suggested the following guidelines—nurses should stay in any BNC for a maximum of only two years; where meetings were held by Local Committees in the BNC or nurse's quarters that permission be obtained from the nurse; that the nurse not be expected to clean up after others held such meetings; that the nurse be 'permitted, with the sanction of the Local Committee, to have a friend or family visitor in residence occasionally, providing accommodation be available', and that the nurse 'be given permission to rest at the discretion of the committee' for a few days if she had been on continuous 24-hour service for 'any period'—provided that her services were not required for urgent work.⁶ These recommendations reflect in the first instance the conditions of service and rules under which BNs lived characterised by long

⁵AOT, DPH, Babel Island Mutton Bird Season Report from Inspector, 28 April 1934, (HSD 1/5-1/6).

⁶AOT, DPH, 58.29.36, Visit by Director Public Health to Centres and his recommendations to benefit nurses 4 December 1936, (HSD 1/24).

hours of work, hard living conditions, a lack of privacy, and isolation from peers, friends or family. The impact of these factors on retention was seen as of sufficient import to merit a relaxation of the rules which governed their lives and work. By today's standards even the 'relaxed rules' would seem inappropriately harsh.

Map 3.02 Babel Island



This map was drawn by Dr Ick, GMO at Flinders Island, and included in a letter to the DPH. It shows the relationship of Babel Island to Flinders, highlighting the navigation difficulties.
Source: AOT

Service on Chappell Island and Babel Island also attracted isolation bonuses early in the history of Bush Nursing. Even though the BN was stationed on these islands only for the six weeks' duration of the mutton-bird season, the bonus was argued for by the Supervisory Nurse who stressed the isolation of the islands.⁷ No doubt this was to compensate the BN for living in a tent on a snake-infested isolated island.⁸ The description of Chappell Island used to justify the need for a BN makes it clear how difficult life was to be for the BN:

...two men were snake bitten there again last year & one lost his life. We have no nurse & often it is impossible to reach Flinders Is on account of rough weather. Some years we have been there without even a boat. The snakes are the worst there of any island used for the mutton birding & we have no assistance of any kind.⁹

⁷AOT, DPH, 58.71.39, BN Chappell Island Memo from Minister of Health. An allowance of £1 per week was paid in 1939, in addition to salary at the rate of £190 per annum, (HSD 1/70).

⁸AOT, DPH, 58.7A.39, BN Chappell Island, Letter to Sister Evans, 10 March 1939, (HSD 1/70).

⁹AOT, DPH, 58.7A.39, BN Chappell Island, Letter from VLE Virieux requesting a BN from the coming mutton bird season—March 1939, 19 December 1938, (HSD 1/53) and (LSD 51).

By 1951 four areas were identified for isolation bonuses.¹⁰ The conditions for eligibility underscored that the rationale for the bonus was concern about staff retention. The bonuses were paid only after a period of continuous service.¹¹

Sister Helen Elizabeth Gwladys Davies on Cape Barren Island made many complaints to the Department about her working conditions and in particular her isolation.¹² One complaint centred on a delivery. In the early hours of a stormy morning the patient gave birth to a son, then started to bleed 'profusely'. The patient was said to have 'collapsed ... pulseless for more than two hours'. Sister Davies never in her 31 years of midwifery, had 'seen anyone nearer dead and go on living'. Clearly feeling alone and somewhat helpless she wrote:

In my opinion I earned the isolated places bonus in one night. Do you wonder that I asked to be moved away? In my opinion no woman should be expected to stay alone without any help at all. I have no one within call. No telephone. I knew it was too rough to send a boat for Dr. No one even to keep the fire alight.¹³

The Department empathised with her.¹⁴ The isolation bonus was not enough to keep her on the island. Sister Davies was appointed to Cape Barren Island in 1939 and served there intermittently until 1951. Her account, written in 1951, tells of her frustration with inadequate facilities and supplies but overwhelmingly conveys a sense of deep loneliness and frustration.

I am fond of the house and it is a real home to me, but the isolation is felt much more since the boats do not come.

You speak of that extra £22 a year you give that to Flinders. Well they have electricity, they are sewered, they have white people around them, they have a Dr in the back yard. They can get to Tasmania twice a week at least.

I am my own sanitary contractor, a frig, here for the passed two summers out of action and is still, the lighting plant never been properly installed. I asked for an adequate water supply to kitchen, 'no' I was told. I ask for a carpet square Flinders I got theirs 'no' I was told. Every bit of comfort in the place and it is very nice and very comfortable I have put in myself.

¹⁰ Flinders Island, Cape Barren Island, Marrawah and Waratah. By 1953 other centres attracted similar allowances including Strahan, Tullah and King Island and even later this was extended to other centres. State of Tasmania DPH, Bush Nursing Service, *Information relating to and Standing Orders of the Bush Nursing Service*, August, 1953, p. 2.

¹¹ £52 was paid on completion of one year of service and £104 at completion of a second year of service. AOT, DPH, 58.28.3, 15 October 1951, Letter from Secretary Public Health PA Driscoll re bonus to Sisters in isolated centres: Sister FL Herbert, BNC, Marrawah, Sister DM Ride, BNC, Whitemark, Sister HE Davies, BNC, Cape Barren Island and The Secretary, Mr Bischoff Provident Hospital, Waratah, (HSD 5).

¹² Sister Helen Elizabeth Gwladys Davies was born c1892. She trained in the Austen Hospital NSW where she was registered in 1936. She worked as a Bush Nurse in Western Australia, Victoria, South Australia and Tasmania, notably on Cape Barren Island. She was registered in Tasmania in 1940, Registration Number 1152. Upon retirement, she married late in life to George Heywood Hills. She died in 1978 at Launceston in her 86th year.

¹³ AOT, DPH, Letter to Secretary Health from Sister H Davies, Cape Barren Island, 15 December 1951, (HSD 5).

¹⁴ AOT, DPH, 28.4.3, Letter to Sister Davies Cape Barren Island from Acting Director Hospital Medical Service, 28 November 1951, (HSD 5).

You know no one else will come here at all. Well, I told T. [Kit' Kathleen Jessie] Widdicombe [SN] and I will tell you I cannot stay here for 12 more months. The bonus cuts no ice with me at all ... I requisitioned for kerosene on Nov 1st also other supplies they have not arrived. Until Xmas Eve there was no kero at the shop for over a month and I wired to Whitemark for it but it did not come ... As I have decided against returning to this centre after my holidays ... I find I can no longer endure the isolation, the inconveniences and disadvantages.¹⁵

Frustration, loneliness and powerlessness were the key to Sister Davies' complaints. She was physically and racially isolated on an island administered by the government as a Half-Caste Reserve from 1912 until 1951.¹⁶ Isolation was clearly the product of many factors, several of which are explored in this chapter. Isolation played a big part in whether a BN stayed at a particular centre or whether she committed herself to permanent staff. This sense of isolation was felt even in BNCs which (at least nominally) had two nurses:

I do not think that I will join the permanent staff yet. I feel very unsettled here although I like the hospital and the work. It is far too lonely.¹⁷

The climate at some of the BNCs was harsh and made it difficult for the BN to work efficiently. High rainfall, mountain climates and heavy snows combined with a 'rudimentary' transport infrastructure, made access to patients within the area difficult, and increased the isolation from the outside world. Additionally, climate affected decisions about the transfer of seriously ill patients to medical or hospital care. In response to a telegram message from Cape Barren Island dated 17 June 1944, '*Have premature infant 16 days desperately ill unable to get transport or medical aid. Davies.*',¹⁸ the Flinders Island BN was asked to arrange a police launch to travel to Cape Barren Island and transport the baby to Whitemark Hospital, which had the advantage of telephone access to Launceston-based medical advice. As the town had an airstrip, it would be possible to arrange rapid transport of the infant to the Launceston Hospital. It was more than three days before the weather abated sufficiently to allow the police launch to reach the island. The baby died some four days later, after a seven and a half hour trip from the patient's home to Whitemark Hospital. The twin handicaps of isolation and climate, combined with rudimentary

¹⁵ AOT, DPH, Letter to Sister Noller from Sister Davies Cape Barren Island BNC, 27 December 1951, (HSD 5). Sister 'Kit' Kathleen Jessie Widdicombe trained at the Hobart Public Hospital and was registered in Tasmania on 12 January 1930, Registration Number 353.

¹⁶ *Cape Barren Island Reserve Act, 1912*. 'Half-caste' is a term used in historical documents and by a number of past and present white communities. The term will be used in this paper as quoted in context. The Aboriginal people of Cape Barren Island regarded themselves as 'Islanders' during this period. For the history of the end of the Reserve see Lyndall Ryan, *The Aboriginals of Tasmania*, Allen & Unwin, NSW, 1996, p. 258.

¹⁷ AOT, DPH, 58.23.1, Letter to Director General Medical Services from Sister Blair, Koonya BNC, 23 July 1952, (HSD 5).

¹⁸ AOT, DPH, 58.7.44, BN Cape Barren Island, Sister Davies, Miscellaneous Correspondence, Reports, etc, (HSD 1/8C).

communications, had created a stressful experience for the nurse and sad outcome for the baby and its family.

Even within the BN's own area, climate had a substantial impact on ease of travel. The local Bush Nursing Committee's role was to assist the BN. In many cases they lobbied the DPH on her behalf. At Queenstown, after her car had been withdrawn because of light mileage, representations to reinstate the car included the following:

homes to be visited often entail opposite areas of the town ... [and] are quite numerous ... If Sister has to combat weather & fatigue at the same time it isn't in the best possible interests to any one.¹⁹

and from Tom D'Alton, Leader of Government in Council:

the Sister ... either has to hire a car or trudge around the roads and hills of Queenstown to visit patients at home.²⁰

They pointed to the rainfall at Queenstown being between 10 and 11 feet per year. With the dirt roads and tracks of a mining town, and the heavy rainfall, carrying the Bush Nursing kit by foot was not always pleasant or easy. Such conditions could undermine the BN's health. In 1944 Sister Erica Breta Hollingsworth resigned her position as BN at Waratah, another mountainous mining town, on the advice of Dr James Henry Russell Tremayne as the 'climate ... was too stringent for her health'.²¹ In 1953 a climatic allowance for the BN at Waratah was belated recognition of this hardship.²² This allowance (additional to the isolation bonus) was not provided for other areas in which BNs also worked often in equally harrowing conditions. It can be assumed that Waratah was singled out for the climatic allowance because of the problems of retention rather than the climate alone.

Access to patients was not always easy. Road conditions were varied, most often rough and sometimes impassable. Marrawah was 40 miles from the nearest doctor at Smithton over what maps of the period denoted as a track.

¹⁹ AOT, DPH, Letter to Director of DPH, from Child Welfare Committee Queenstown, 14 July 1954, (HSD 5).

²⁰ AOT, DPH, Letter to Minister of Health from Tom D'Alton Leader of Government in Council, 7 October 1954, (HSD 5).

²¹ AOT, DPH, 58.23.44, BN Waratah, Letter from Basil Plummer, Deputy Director of Man Power, (HSD 1/89). Sister Hollingsworth was either Sister Erica Breta Hollingsworth (trained in the Devon Public Hospital and registered in Tasmania on 27 January 1941, Registration Number 1211), or Sister Elizabeth Maud Hollingsworth (trained at Mater Misericordae Hospital, Rockhampton, and registered in Tasmania on 1 November 1945, Registration Number 1782).

²² An additional £15 per annum 'climatic allowance' was paid to the nurse at Waratah. State of Tasmania DPH, *Bush Nursing Service, Information Relating to Standing Orders of the Bush Nursing Service*, August,

Map 3.03 Marrawah to Smithton



A sand track ran from Marrawah to Smithton (a straight line distance of 22 miles), the other roads in the area were but horse tracks. Redpa was situated several miles east of Marrawah on the loop track that serviced the farms and sawmills.
Source: Anonymous

Photograph 3.02 Road from Marrawah to Smithton



Marrawah to Smithton Road: 'deep sand in summer and deluged with water in winter ... Many lives had been lost by patients having to be conveyed over the tortuous road of sand'.²³
Source: DPH, Bush Nursing Album, NBT.

This road was the route out of the area for patients that the BN could not handle without assistance. It was substantially better than the roads within the area serviced by the BN at the Marrawah BNC when it opened in 1922. The sand track from Smithton to Marrawah

²³ QVMAG, Box 10, Newspaper Article, 16 January 1923, Visit of politicians to Marrawah Bush Nursing Home.

was completed with blue metal in 1937 but travelling conditions remained difficult.²⁴ In 1950 the BN at Marrawah wrote:

The bus has not yet been fixed after my smash on April 22nd. Hope they soon do some thing as it has rained solidly for nearly 10 days & one has to practically swim any where one wants to go, the mud is so deep.²⁵

Even where BNs had access to a vehicle, poor roads sorely tested both BN and vehicle. Sister Clarice Mildred Mainwaring, an early BN at Koonya,

did her best, trundling over dirt roads at night, trying to cope with gashed legs, amputated toes and difficult births ... The nurse's car, a Waley's Whippet, was always breaking down despite the ministrations of a mechanic who kept his false teeth in his toolbox.²⁶

Poor roads, the mechanical breakdowns and travel at all hours and in all weathers, required of the BN courage and fortitude. Often no roads existed and nurses used bush tracks or railway lines to gain access to patients or their community.

Photograph 3.03 Access to Adamsfield, c1928



At Adamsfield, with a population of some 60 persons in 1936, there were not even dirt roads into the field. Located over 20 miles from the nearest township, it was reached only by a track. Sometimes even this track was impassable on horseback.²⁷

Source: Mineral Resources Tasmania, Fred Smithies Collection, AOT.

²⁴ AOT, DPH, 58.9.37, BN Marrawah—Letter to Director Public Health from Chief Health Inspector, (HSD 1/36).

²⁵ AOT, DPH, Letter to Sister Noller from Sister Doreen Herbert, Marrawah Centre, 21 May 1950, (HSD 5).

²⁶ Dr Margaret Scott, 'The Essayist, The Sisterhood', p. 59 in *40 Degrees South Tasmania & Beyond*, no. 3, 1995-6. Dr Scott recalls that her references are drawn mainly from locally-published *Peninsula Chronicles* and local memories of the BN that have been conveyed to her over the years. Personal Communication, 26 February 1997. Sister Clarice Mildred Mainwaring was trained at the Devon Public Hospital and registered in Tasmania on 20 February 1929, Registration Number 188.

²⁷ AOT, DPH, 58.1.36, BN Adamsfield—Letter to Sister Evans, 20 January 1936, (HSD 1/24). It was not until December 1948 that the first vehicle, a Jeep, successfully reached Adamsfield. Mines Department Photography Files, April, 2003.

Proposals for establishing BNCs reinforced the difficulties created by poor roading particularly on the vulnerable women and children. The Tasmanian Council for Maternal & Child Welfare was concerned about the situation of women at Rossarden. In their request for a BN they wrote:

There are at the time of writing 16 expectant mothers, as well as some young babies ... it would be a terrible thing to leave these people in this isolated place without trained assistance ... the road to Avoca (the nearest town) is a very rough one & accentuates the difficulty of obtaining or reaching a doctor's attention.²⁸

The conditions described which isolated the women of the district were precisely those which created for the BN an environment in which she became isolated in both her personal and working life.

This situation was not only a feature of the early period of Bush Nursing. Even by the 1950s access to patients could be difficult. Tasmanian roads remained bad, particularly in the rural areas.²⁹ Many roads were at best narrow and winding, others just dirt tracks. Road maintenance was poor and this, together with the Tasmanian weather, tested the BN's mettle. One BN was given a warning about the St Mary's Pass on the east coast prior to taking up her appointment in the 1950s. She remembered driving very carefully in second gear all the way through the steep and narrow winding gorge road.³⁰ The BN at Gladstone was required to visit Mrs Nicholls at Eddystone Point lighthouse on several occasions during a pregnancy in which the patient was too unwell to travel.³¹ Ringarooma BN, Sister Ruth Bartels, had to make a night call by hire car to Tarranah.³² Almost at her destination she found the bridge was down and had to walk up and down a slippery hill to reach the patient. On this occasion she luckily had assistance from Mr Kid, a volunteer driver.³³

²⁸AOT, DPH, 58.12.38, Letter to BN Rossarden from TCMCW, 12 July 1938, (HSD 1/53). The nearest doctor was at Campbell Town.

²⁹Evidence for this can be seen in rural municipality Road Trust's Minutes or Council Minutes.

³⁰Eileen McManus, (née McMenamin), Interview, Falmouth, 1994. Sister Eileen McManus, (née McMenamin) was born on 1 March 1931 in Liverpool, England. Her father was a headmaster and her mother a clerk. She undertook a pre-nursing course at the Royal Liverpool Children's Hospital then completed her General training. She was at Koonya, Dover, Swansea, and finally St Helens where she met her husband, Tim McManus.

³¹Mrs Nicholls contributed this information during a conversation with Elvie Richardson, (née Green) at James Scott Wing, NESM Hospital, Scottsdale, January, 2003. This was a long trip over a road that is still a four-wheel-drive track.

³²Sister Ruth Bartels, (née Holmes) was born in 1924. One of 3 children she was raised on a farm at Ringarooma, in north east Tasmania. The Holmes family were traditionally professional people--chemists, doctors and dentists. Ruth trained at the Launceston General Hospital and upon completion of her General Nursing certificate on 22 July 1946 returned home and married a local, P Bartel. As a married nurse Ruth relieved other local nurses in the area in between having her own children. Finally she was appointed to a position at Ringarooma where she was the Bush Nurse for 12 years. Tasmanian Registration Number 1939.

³³AOT, DPH, Letter to Sister Noller re Ringarooma BN, 11 July 1952, (HSD 5).

Map 3.04 North East Tasmania



The numbers on this map refer to BNCs as also shown on map 2.02. (The straight line distance from Scottsdale to St Helens in 39 miles).
Source: Sven Rand, 2003.

Prior to taking up positions, many BNs, particularly from interstate or overseas, were not aware of the isolation of Tasmania:

I didn't realise how vast Tasmania was really ... and I just didn't realise it was so difficult to get from place to place in those days.³⁴

Although the BNCs appeared to be close to major centres on the map, the nature of the terrain and climatic conditions made the communities more isolated than perceived initially. Distances travelled by the BN were substantial. Patient visits were a significant part of the work of the BN, at least in part because transport difficulties also were experienced by her patients. Furthermore the BN was located within a country area and serviced patients who were scattered over a considerable area. The distances travelled also need to be viewed in light of the modes of transport and the difficult roads or other access.

³⁴ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

Photograph 3.04 Marrawah Bush Nurse on Horse



This photograph of an unidentified Bush Nurse (on right) show her in jodhpurs rather than uniform. The Bush Nurse was accompanied by two women, presumably the Supervisory Nurse and the representative of the Bush Nursing Association.

Source: DPH, Bush Nursing Album, NBT.

Although travel distances were not always great for Sister Hazel Bird, at Marrawah, the conditions were harsh and her work busy. Riding her horse on the dirt tracks in the area she would work regularly around the eight mile circular track from the hospital onto which many farms, as well as four or five timber mills, converged.³⁵ The farthest she had to travel was a return trip to Temma (three hours on horseback), a distance of approximately 18 miles, which required crossing the Arthur River by punt.³⁶ (Map 3.03). She also visited people farming inland from Temma. Tasmania even at this time provided BNs with challenging conditions which isolated both BNs and patients. (See Map 3.05 for relief map of Tasmania).³⁷

³⁵ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994. Hazel Bird was born on 28 April 1908 in South Australia and lived on a small farm at Encounter Bay. She graduated from Adelaide General Hospital, and then nursed at Northfield Infectious Diseases Hospital and later specialised in Surgical and General Nursing. She completed Midwifery training in 1933, and also a course at the Victorian Eye and Ear Hospital in the same year. She was registered in Tasmania on 18 March 1935, Tasmanian Registration Number 646. Her first post in Tasmania was at Marrawah. After four years of Bush Nursing at Marrawah she completed her Child Welfare Certificate in London while on holiday in 1938. In 1939 she returned to Marrawah, and later after marrying Len Gaffney retired from nursing. She died on 30 June 1998.

³⁶ The road to Temma, on the West Coast of Tasmania, is today still accessible only via four-wheel-drive vehicle. There was also a farm located a few miles slightly inland from Temma called Kaywood Farm. Harry Wells, Interview, Smithton, March 2003. For further descriptions refer to HA Lane, 'Since the White Man Came', in *Proceedings of Seminar Arthur to Pieman River Area*, Municipality of Circular Head, Area Development Consultative Committee, Smithton, 1973.

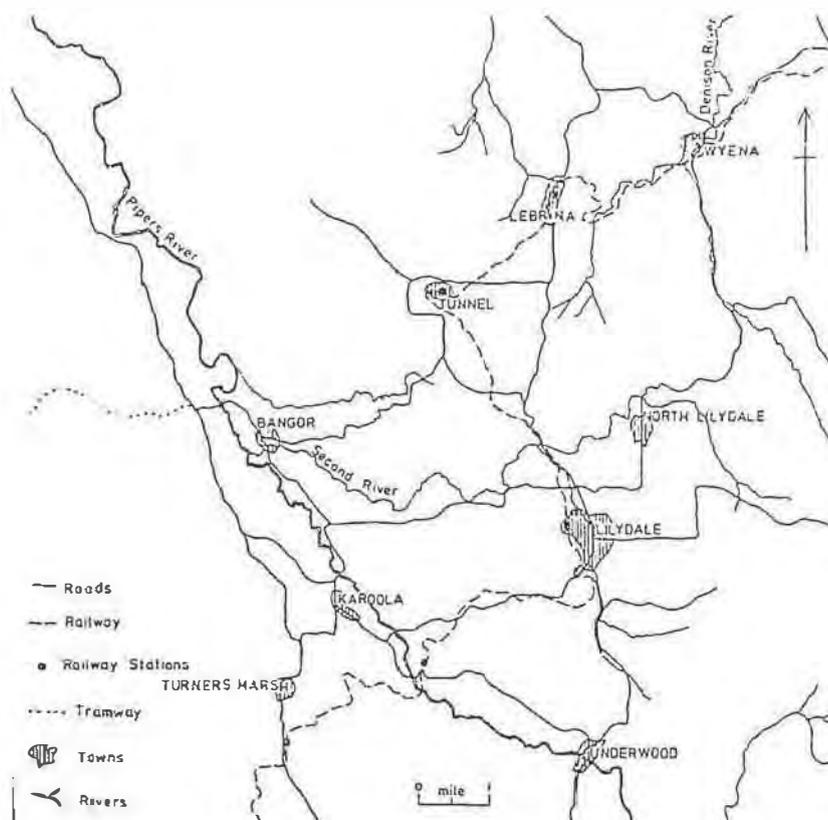
³⁷ Source: Sven Rand, September 2003.

Map 3.05 Tasmanian Towns and Terrain



Sister Pitt, a BN at Lilydale, had travelled 3,985 miles in the year ending June 1938.³⁵ She covered a wide area and a single day might involve long hours and travel. One day she is recorded as having a night call to Nabowla, a round trip of 46 miles. She did not arrive home until 11 pm, but then had another call out at midnight and yet another at 1am.

Map 3.06 Lilydale



Source: BJ Kelp, 'Evolution of a Land Settlement Pattern in Tasmania: The Lilydale District 1840-1923'. BA(Hons) Thesis, University of Tasmania, 1971.

Compounding the difficulty was the need to travel in any weather and at any hour of the day. For her safety, local married men often volunteered to accompany her on night calls.³⁹

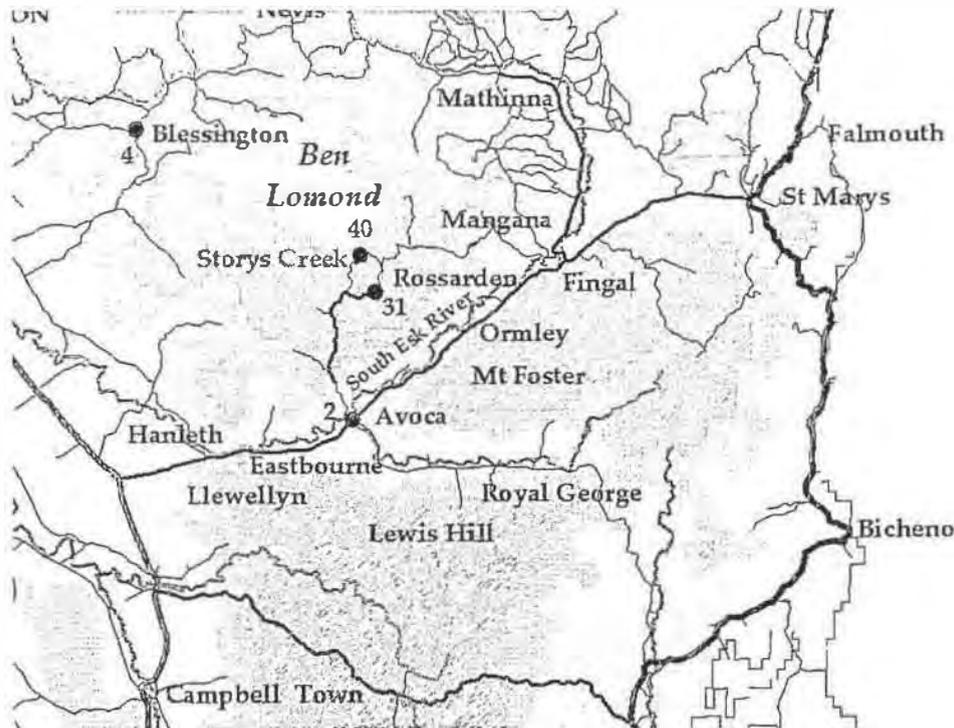
While for some BNs travel distances might be short, the onset of World War II and the consequent war shortages increased travelling difficulties. Fuel shortages compounded the isolation of distance. Storys Creek was only 18 miles from Avoca, and eight miles from Rossarden. Petrol shortages had reduced trips to 'essential travel' only. The BN, as with

³⁸ She would need to make visits to Lower Turner's Marsh, Tunnel, Lebrina, Wyena, Nabowla and sometimes to the neighbouring municipality. Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

³⁹ Volunteers included Messrs M Kelp, JH Manzoney and LG Darling. *North Eastern Advertiser*, 12 August 1938. Despite the large mileage travelled by the BN, the Lilydale Council (unlike many other communities) did not charge mileage fees, its policy designed to ensure equality of care to all residents.

locals, now was limited to travel on the store's lorry which went from Avoca to Storys Creek. Medical assistance was available only 39 miles farther at Campbell Town.⁴⁰

Map 3.07 Fingal Valley



The mountainous roads between Avoca, Rossarden and Storys Creek were made more treacherous by snow and rain. If the BN's vehicle broke down on the road she might have a prolonged wait until help could arrive, or if she were unlucky enough to go off the side of the road she might not be seen for the thick bush. Travel routes were chosen carefully with safety in mind rather than economy. (Numbers on this map refer to the BNCs as also shown on Map 2.02). (Avoca to St Marys is a straight line distance of 28.4 miles.)

Source: Sven Rand, 2003.

It became necessary to plan travel routes so that help could be obtained if trouble arose. Having to contend with roads treacherous with rain and snow⁴¹ it made sense for the Avoca BN to travel via the longer route as little traffic passed along the shorter route.⁴² As BNs gained access to cars, the distances travelled became a potential area of dispute.⁴³

⁴⁰ AOT, DPH, BN, Storys Creek—Enquiry re establishment of a Centre Re GMS—see file GMS 1.12.h, (HSD 3). In 1941 Storys Creek was a mining village of about 180 people, of which 100 workers were in the mine, AOT, DPH 58.36.43. and 58.33.41, (HSD 1/80).

⁴¹ AOT, DPH, BN, Storys Creek—Enquiry re establishment of a Centre Re GMS—see file GMS 1.12.h, See also file 58.36.43, 58.33.41, (HSD 1/80).

⁴² AOT, DPH, BN, Storys Creek—Enquiry re establishment of a Centre Re GMS—see file GMS 1.12.h, See also file 58.36.43, 58.33.41, (HSD 1/80).

⁴³ Even in 1946 nurses were not necessarily provided with a vehicle. The BN at Mole Creek had to travel to areas including Liena (12 miles), Mayberry (6 miles), Caveside (6 miles), Chudleigh (5 miles), South Mole Creek (4 miles), and to two large timber mills in the district (one 14 miles, the other 20 miles). The Bush Nursing Committee was unable to provide a car. AOT, DPH, Letter to the Minister of Health from Mole Creek BN Committee 27 August 1946, (HSD 6/34).

Cars increased the BN's ability to travel, but were seen as more costly than travel on foot or by horse. At Waratah the BN drove to many localities including Guilford Junction, situated 10 miles away, and Parawee, a similar distance. When necessary, she accompanied patients to the North West coast, either to Burnie or Wynyard, approximately 45–50 miles away. The Bush Nursing Committee expressed concern about excessive travel in a letter to the DPH.⁴⁴

Map 3.08 Waratah to North West and West Coast



Waratah, in the centre of the map, is in the mountains and almost equally distant from the West and North West Coasts. Distances to medical assistance, and travel times in particular, made it essential that the Bush Nurse accompany her most seriously ill patients on this journey. Mountain climates at times made travel impossible and curtailed communication with the outside world. The map predates the establishment of Tullah (now located on the Mackintosh River north east of Rosebery), Williamsford (probably shown as Ringville), and Guildford Junction in the Surrey Hills to the east of Waratah.

Source: John G Bartholomew, 'Victoria and Tasmania' in *Times Survey Atlas of the World*, Edinburgh Geographic Institute, The Times, London, 1922, (From the David Rumsey Institute).

⁴⁴ AOT, DPH, 58.26.1, Memo for Director Hospital Medical Service from Sister Widdicombe Waratah, 17 May 1951, (HSD 5).

Table 3.01 Monthly Mileage of the Bush Nurse at Waratah, July 1950—April 1951

Month and Year	Mileage
July 1950	140
August 1950	100
September 1950	250
October 1950	160
November 1950	70
December 1950	nil
January 1951	400
February 1951	152
March 1951	144
April 1951	312

This table is compiled from data submitted to Supervisory Nurse.⁴⁵
 Source: AOT, DPH

The data in Table 3.01 do not support the claim that travel was excessive given the nature of the BN's area and her work demands. We shall see that complaints about excessive travel reflected not only costs but also community values and beliefs about cars. No attempt was made to assess the value of the mileage in terms of improved access to health or improved health outcomes for patients or nursing time saved from non-nursing duties. Travel became a source of tension between nurses and the Bush Nursing Committees and nurses often felt the need to justify their mileage. Sister Evelyn Petrina Locher at Maydena felt she needed to justify a monthly mileage of 400 miles:

I hope this does not sound too fantastic, but I had three patients: 1 hand crushed in machinery, 1 cut artery of leg and another with part of finger cut off, all of whom I was worried about haemorrhage and went with them to the hospital. Two of them had to go straight on to Hobart.⁴⁶

Occasionally BNs had to accompany patients to allow their condition to be monitored. Sister Locher's explanation implies that she accompanied the patients to New Norfolk to the GMO who then referred them on to the hospital another 20 or so miles distant.

⁴⁵ AOT, DPH, 58.26.1, Memo for Director Hospital Medical Service from Sister Widdicombe Waratah, 17 May 1951, (HSD 5).

⁴⁶ AOT, DPH, 58.28.7, Letter to Sister Noller from EP Locher Maydena, 1 September 1952, (HSD 5).

Transport

The BN's services to patients were dependent on her access to them or their access to her. The level of support or supervision of her activities by her organisation or by doctors similarly depended upon ease of access. The BN was based in isolated communities and served other communities which were isolated from her by distance or difficulty in accessibility. The perils of poor roads and the distance between towns throughout Tasmania contributed to the sense of isolation, geographically and psychologically, both for the BNs and for the local populace. The nurses needed to gain access to patients and also to transport critical cases to hospitals. This became a constant concern in their working lives, as recollected by Eileen McManus:

I was a bit shocked, mainly because there was no transport. I couldn't get any transport when I first went to Koonya; I couldn't get out of Koonya. I had to travel on the truck to get out of there [for two days] and that did horrify me.⁴⁷

Lack of transport not only created a sense of isolation but also a feeling of entrapment. For the nurse to live and work in isolated communities she required access to transport. The isolation of these communities also affected the extent of road development, the quality of roads, and the availability of transport.⁴⁸ In the early period of the Bush Nursing Scheme, the BN carried out her daily visits to patients on foot, on bicycles, on horses, in a jinker, or on the local train. Later came cars, motor-bikes (although these were an uncommon mode of transport), and a variety of other vehicles from bread carts to coal trucks. Access to remote island locations required travel by sea and later by air.

Particularly in the early period of Bush Nursing many women had little or no experience in the independent use of transport. The challenges for BNs included learning to use transport, and coping with community reaction to the BN taking on roles and activities usually conceived as men's work. It was not until after the social changes wrought by World War II and the increased availability of motor vehicles, that activities such as driving cars were seen as usual or suitable for women. The focus of this section is the impact of rural isolation and the availability of transport for BNs, and it deals but peripherally with

⁴⁷ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

⁴⁸ For example, while there was a road from Queenstown to Hobart in the late 1930s it was not until the 1960s that there was a road through to the west coast towns such as Tullah. For additional information relating to road construction refer to *Bush Track to Highway, 200 years of Australian Roads*, NAASRA, Sydney, 1987, p. 66: 'One of the most significant road developments in the state was the completion in 1963 of 54kms section of road from Rosebery to Fingerpost, near Waratah, on the west coast. This road, now part of the Murchison Highway, was built through probably the most harsh and rugged country in the nation.' p. 71. See also MS Wilson, *Report on Tasmanian Transport Problems*, Parliament of Tasmania, 1938; and Michael Sharland, *Once Upon a Time. Some Tasmanian Tales*, 1976, pp. 9–10.

the access to transport of Tasmanian rural women. This is an area which merits future research.

Transport raised many challenges for the BN. Once she arrived in their area often she needed to learn to ride a bicycle, or a horse or to drive a car. Patient health needs required that the nurses travelled. Many patients were not fit to travel. Many others had less access to transport than did the BN. The central importance of travel, and the practical difficulties inherent in such travel, combined to make this an area of ongoing debate and tension. Local committees were concerned about mileage, costs, personal use and damage to vehicles. For the BN, lack or poor availability of transport, abuse of the nurse's transport by patients, payment, safety and security were all of concern. There was no single standard for transport provision within the Bush Nursing Association. Some centres were provided with transport by the government, others by the local committee or the Red Cross, and in others the BN owned and used her own transport.

Occasionally sick patients required transport to hospital or doctor. While eventually the transport of sick patients was the responsibility of the ambulance services, such services usually were not readily available to the BN during the early period of the Bush Nursing Service and the nurse often improvised as she met the need to transport patients.⁴⁹ The provision of ambulances and how she improvised will be discussed later in this chapter.

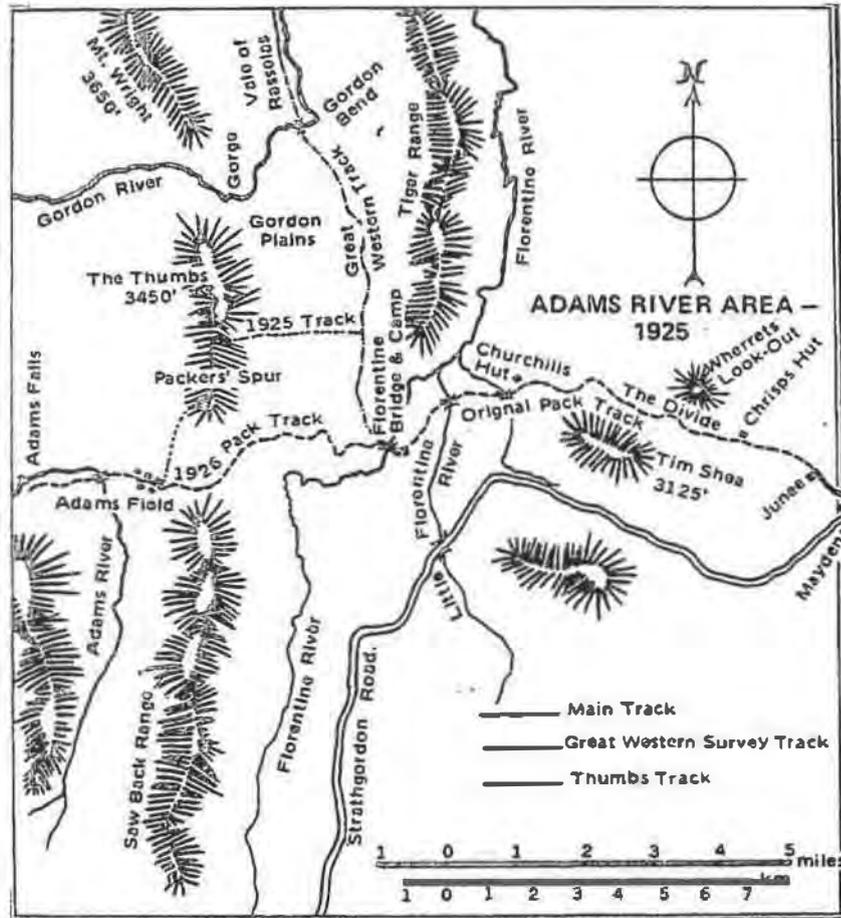
Walking was initially, and remained, the primary method by which BNs travelled to see patients. The BN could require substantial physical fitness even to get to her community. To reach Adamsfield, the BN was required to travel by train to Fitzgerald, situated 56 miles from Hobart, then to undertake a walk of 22 miles to Adamsfield. The trials and tribulations of this route are described well.⁵⁰ The original track was via the Thumbs and involved a climb of over 2200 vertical feet. The journey was not easy. Pack horses could go only part of the way. From there everything had to be carried over the Thumbs. With over 75 inches of rain each year, the mud on the track was often over two feet deep. Snow was also a frequent occurrence. Later when the track was re-routed south

⁴⁹ I have been unable to locate any published reliable sources on the provision of ambulance services in Tasmania apart from a small section in Wettenhall, pp. 292–294, and P Forster, 'Administration of Ambulance Services in Tasmania', (Diploma Public Administration Thesis), University of Tasmania, 1964. Today, other than for the Swansea and Oatlands services which remain administered locally, ambulances are administered by the State Ambulance Service. They are staffed by professional ambulance officers. Wettenhall notes that there was no central Authority until 1959.

⁵⁰ Kathryn, Ralph and Timothy Gowland, *Adamsfield: The Town that Lived and Died*, CL Richardson & Sons, Devonport, Tasmania, 1973, pp. 21–22, and Fay Peterson, 'Adamsfield—Then and Now', *The Tasmanian Transport* no. 12, 1955, p. 4.

via Packers Spur, it became possible to take horses all the way to Adamsfield.⁵¹ Eric French and his aunt, Sister Elsie Grace Bessell, arrived at Adamsfield by packhorse and foot.⁵²

Map 3.09 Adamsfield



Adamsfield area showing 1926 locations.

Source: Barbara Tweedie (née Hazelwood), Private Collection.⁵³

Thurza Hazelwood, another BN, remembers it would take three-quarters of a day to walk into Adamsfield. 'You had to be fit living in those sorts of places'.⁵⁴ Fitness also was required once the BN arrived at the centre.

⁵¹ Fay Peterson, p. 4.

⁵² Sister Elsie Grace Bessell.

⁵³ June is shown on old maps and now is known as Fitzgerald, near Maydena. Source: Barbara Tweedie, 'Adamsfield', unpublished paper, 83 Lord Street, Sandy Bay, Personal Communication, 13 September 1998.

⁵⁴ Thurza Hazelwood, (née Cox), Interview, Prospect, 1998. Thurza Hazelwood was born in 1905 at Staverton near Sheffield and grew up on a farm. She was one of twelve children. She trained and completed her general nursing of five years at St John's, Hobart. As well as Bush Nursing, her career included private nursing. Thurza married in 1930 at the age of 25. She met her husband at a convalescent hospital at Claremont. His war injuries prevented him from living in the city and so they went to Adamsfield where he was lured by the mining fever. She was 25 at the time of her first arrival at Adamsfield. She later assisted a nurse while living at Storys Creek and Butler's Gorge. However she was to return to Adamsfield three times. As well as being the BN, Thurza was also the post mistress and SP bookmaker using the battery wireless for race results.

Photograph 3.05 Access to Adamsfield, c1928



The Thumbs

Source: Mineral Resources Tasmania. Fred Smithies Collection, AOT.



Corduroy Track

Source: Mineral Resources Tasmania, Fred Smithies Collection, AOT

The starting point ... was at the end of the railway line at Fitzgerald and it was only a mere 29 miles to the new field ... (the track) had been roughly and hastily prepared through dense bush, about 9 feet wide barely enough for 2 pack horses with panniers to pass each other at close quarters. The country was so swampy and boggy corduroy slabs had to be laid in many places, with not even the edges [spurred or defined?] so that the diggers had to struggle to get themselves and their mules and packs to the distant field.⁵⁵ Through the lovely Florentine valley with its wonderful timber, then and lush growth. The men had to work knee deep in the slush and mud. Ruffe hut built for an early surveyor was a halfway house and proved a godsend to the weary men as here they rested and had a meal before proceeding to the formidable 'Thumbs' which was then the only possible [route] to the field. Thick snow hampered their efforts.⁵⁶

⁵⁵ [C]orduroy tracks were made by cutting six foot to eight foot saplings of eight to twelve inches in diameter and splitting them in halves. The split sides were faced alternately upwards and downwards and nailed close together on two stringers, 4 feet to 5 feet apart. These stringers, which could be logs of up to 18 inches or more, were placed across gullies and the corduroys (the split saplings) were nailed to the top. It was quite a satisfactory method, but the sappy surface of the corduroys at times became slippery, and it was quite possible for horses to slip over the side. Often small spars were put on the ends of the corduroys to prevent this happening.' A Farquhar, *The Autobiography of BA Farquhar, Bert's Story*, Regal Publications, Launceston, 1990, p. 4.

⁵⁶ Elsie G Bessell Papers, Private Collection.

Visiting patients on foot was the normal practice in many BNCs, and was still common in the 1950s. Walking to visit patients, even short distances, created hardship. Sister Bartels at Ringarooma recalled walking with her case every day to do dressings or to see patients in 'rain, hail or sunshine'.⁵⁷ If the distance was over a mile the BN was supposed to be collected by the patients, but this was also often on foot. It was at times frightening walking alone and in the dark through the bush on her patient visits. Even when using a car she might have to get out and walk.⁵⁸ The shadows and shapes of the bush at night created in this BN feelings of dread and soon she would go out at night only if she were accompanied.

Photograph 3.06 Bush Nurse and Nursing Kit, Tasman Bush Nursing Centre



When the BN walked to see patients she needed to take all the instruments, dressings and medications that she might use. Carrying this some miles, at times in difficult conditions or at night, would not have been an easy task. Photographs of the contents of her Bush Nursing kit, in Chapter Five, demonstrate that this kit would have been quite heavy.

Source: DPH, Bush Nursing Album, NBT, c1936.

Sister 'Nessie' Agnes C Mackenzie in the North West serviced a large farming community and recalled problems of muddy accesses and other dangers as she carried her Bush Nursing kit on patient visits.⁵⁹ The journey often would be fraught with more than one danger:

One house I had to visit was up a mud track well off the road, through the cow yard to the house. This day it was raining heavily, so donning my gumboots I set off with scales. When I got to the cow yard I found it impossible to get through, so I climbed

⁵⁷ Ruth Bartels, (née Holmes), Interview, Bridport, 2002.

⁵⁸ Ruth Bartels, (née Holmes), Interview, Bridport, 2002.

⁵⁹ Sister 'Nessie' Agnes C Mackenzie trained at the Launceston Public Hospital, and was registered in Tasmania on 20 February 1929, Registration Number 174.

up the cattle loading ramp. I got the scales up and one foot, when I brought the other one up there was no gumboot, so I had to feel around until I located it, step down into it and draw up my leg carefully.⁶⁰

She described visiting houses up to 20 miles in the bush, getting bogged in mud, chased by dogs and avoiding bulls. Through all her description comes a sense of satisfaction and professional value as she overcame these obstacles.

It generally became expected that the BN would be escorted on night calls to patients' homes. When a patient's family escorted the BN on foot to her patient it did not reduce the physical struggle but usually it provided a sense of security. At times the BN might have been uneasy in the presence of her usually male 'escort' as issues of personal safety were of concern to some BNs. In later years when vehicles were more readily available it was not unusual to use a hired taxi or the family's own vehicle.

Other hazards lurked for the walking nurse. At Adamsfield, Sister Hazelwood's husband always would walk in front of her carrying a large stick to hit the button grass tussocks as the 'whip' snakes would lie across the tops of these plants. Snakes also were frequent on the mutton-bird islands off the coast of Flinders Island. To access Babel Island, arguably the most isolated area in which BNs worked, the BN would have to travel on three different boats, and finally be carried from the boat to the island.⁶¹ Once on the island there were only tracks winding around the rookeries. The visiting Health Inspector reported that walking was tiring and difficult because of the sandy nature of the soil, thick undergrowth, hidden rookeries and the many snakes.⁶² Some of the sheds she visited were over four miles from her hut, a distance made difficult and hazardous by the conditions underfoot, the adverse weather and by walking alone.⁶³ Despite this harsh environment one BN returned to the island four seasons in a row and in Chapter Five it shall be shown she took over the Health Inspector's duties in addition to her own. Walking remained part of the BN experience in many areas of Tasmania even in the later years, although by that time it was seen as inefficient. In 1953 Sister Doris K Noller, the Supervisory Nurse, requested that the Director of Medical Services provide cars for at least four centres

⁶⁰ AC Hearn, (Fuzzy), *Hearn's Somerset The Cam*, Somerset, 1992, taken from notes written by Agnes Mackenzie held in Family Collection of JR and EM Mackenzie, 'Glendessie', Wynyard.

⁶¹ Aboriginal men would walk from Babel Island to Flinders Island across the spit with their clothes tied to their heads and then walk to Whitemark to procure supplies of formula milk. Patsy Cameron, Personal Communication, July, 1994.

⁶² AOT, DPH, Babel Island Mutton Bird Season Report from Inspector, 28 April 1934, (HSD 1/5-1/6).

⁶³ AOT, DPH, (HSD 1/5-1/6).

including Avoca, Ringarooma, Maydena, and Mole Creek as 'a good deal of time was wasted where ... visiting is done on foot'.⁶⁴

Photograph 3.09 Babel Island Access



The photograph has been enhanced to make visible a boat anchored some distance offshore and the boat that the passengers are alighting from. This photograph also shows the young children who lived and worked on the island with their parents, and comprised a significant part of the BN's work.

Source: DPH, Bush Nursing Album, NBT.

Cycling could replace walking if allowed by the conditions of the roads. Some nurses provided their own bikes while others had bikes provided by the local committees.⁶⁵ Former BNs at Waratah, Sisters Ruby and Lois Kelly, used to walk or cycle to do their rounds on a 'really bad little road, full of pot holes and it was wet and it was cold'.⁶⁶ When she first arrived at Waratah, Ruby had to walk because she was unable to ride a bike.

⁶⁴ AOT, DPH, 58.2.4, Memo for Director General Medical Services from Sister DK Noller, 13 April 1953, (HSD 5). Sister Doris KNoller trained at the Brisbane General Hospital and was registered in Tasmania on 6 June 1933, Registration Number 526.

⁶⁵ AOT, DPH, Report BN Rossarden. Proceeds from a dance organised by the local Women's Auxiliary Committee paid for the bicycle, 21 July 1948, (HSD 5).

⁶⁶ Sister Ruby Kelly, (née Elphinstone) Interview, Wynyard, 1994. Ruby Kelly, (née Elphinstone), Interview, Launceston, 1994. Ruby Elphinstone was born in 1916, at Burnie on the North West coast of Tasmania. She was one of four children and finally completed school up to Merit level at 14 years. At 21 years of age she trained at the Launceston General Hospital. She was registered in Tasmania on 24 April 1942, Registration Number 1374. Later she completed her midwifery at the Queen Victoria Maternity Hospital. Schooling and nursing were interrupted with caring for an invalid sister. Ruby nursed at Campbell Town, Wynyard and then chose Bush Nursing at Waratah so she would not be manpowered too far away from her family. At Waratah, where she stayed for several years, she met her husband, Bill Kelly. Lois Kelly, (née Rockliff), Interview, Launceston, 1994. Lois Rockliff, one of five children, was born at a farm at Penguin in 1917. After completing her education she trained at the Devon Hospital at Latrobe. She was registered in Tasmania on 2 October 1940, Registration Number 1156. She did midwifery at Launceston. It was too expensive to undertake further child welfare training. After nursing at St Marys and being employed as a private nurse in several positions Lois was manpowered to Waratah, where she stayed for four months. Most midwifery nurses had enlisted, creating a shortage throughout Tasmania. It was here that she met and married her husband, Bert Kelly.

Photograph 3.07 Waratah Bush Nursing Centre in Snow



The Mt Bischoff Hospital is the substantial building in the centre and the Bush Nursing Centre is located to its right.

Source: DPH, Bush Nursing Album, NBT.

Photograph 3.08 Walking in the Snow



Even when cars were available, climatic conditions might make their use impractical. Bush Nursing Centres situated in the highlands, the south west, and the west coast, regularly experienced snow every winter. At Waratah it snowed about three or four times every year and then the nurses would have to walk.

Source: Mercury, 1922

In the early years of Bush Nursing horseback or 'horse and sulky' were a frequent means of transport. Horseback travel, while faster than walking, was still fairly slow and this limited the number of cases which could be nursed at one time. Nevertheless the horse allowed the nurse to cope with more adverse conditions than did riding a bicycle.

Photograph 3.10 Sister Barnicoat in Trap



Sister Harriet Barnicoat at Koonya on the Tasman Peninsula, one of the earliest Bush Nurses, travelled in a trap or chaise.⁶⁷ Horse transport created practical difficulties and Sister Barnicoat had local assistance with harnessing or driving the trap.⁶⁸
Source: Maurice Hallam, Private Collection.

In 1921 Sister Daisy Richmond, Supervisory Nurse of the Southern district, attended a local council meeting at Bruny Island and stated that a 'horse and trap for the nurse was absolutely necessary'.⁶⁹ At Lilydale in 1923 the Council purchased a first-class jinker for the use of the BN.⁷⁰ By 1931, transport was considered a necessity and the Bush Nursing Association advised that 'every effort should be made to place it on a satisfactory basis in order to facilitate the work of the Nurse'.⁷¹

⁶⁷ Hallam, p. 4. Harriet Barnicoat, (née Badham), was born in 1860 at Bromyard, a small village near Blackpool in England. She migrated with her family to Tasmania in the 1890s. Prior to arriving in Tasmania, Harriet had completed her nursing training in England. Her family settled in the Saltwater River area and she married a local carpenter and wheelwright. She resigned from Bush Nursing in 1917 after 12 months as the conditions were too demanding. She died in 1924. Notes from M Hallam, November, 1996.

⁶⁸ Sister Kolosque on Flinders Island would be driven about in a jinker by Mrs Isobel Bailey. Olga Henwood, Interview, Flinders Island, April, 1994. Sister Barnicoat had occasional assistance from Ethel Wiggins to harness the horse. Hallam.

⁶⁹ Davis, p. 6.

⁷⁰ At the cost of £30 with the Northern Bush Nursing Association contributing £7. QVMAG Lilydale Council correspondence, 29 June 1923.

⁷¹ *The Tasmanian Bush Nursing Association, Constitution and Rules of 1930–1931*, p. 9.

Not all nurses had jinkers; many rode horses. Sister Mary Johanna Treahy in the 1930s at Marrawah recalled she had to visit, on horseback, patients who through illness were unable to journey to the BNC.⁷²

One night, after a severe storm, Mrs Burnley [Treahy] had to find her way across flooded creeks to reach a sick man at Temma. With a man on horseback acting as her guide as far as Arthur River, she rode her horse through water which was so deep in places that it went over the top of her riding boots.⁷³

Distances travelled on horseback were substantial. The BN at National Park in 1922 recorded her mileage for March and provided a breakdown of the reasons for the travel. Up to 64 miles were travelled each day, on one day travelling 32 miles on two occasions to visit the same patient. The majority of visits were for maternity work and for child welfare visits.⁷⁴ The *Mercury* published an article with the headline: 'Bush Nursing in Tasmania: Devoted Women engaged in arduous Task, Stray peep into isolated homes, The work as it is and must be':

A drive in a spring cart over the roughest of unformed roads, through the thickest of that kind of bush which alone can be seen in totally undeveloped country, has to be undertaken. The road is absolutely dangerous, even for the most experienced male driver in a heavy cart, and for a woman to traverse it for many miles on horseback, alone, is an ordeal the contemplation of which might well daunt the heart of the most self sacrificing and courageous gentler sex, particularly if the journey has to be performed in the blackness of night.⁷⁵

In less than 12 months a 'Tasmanian Bush Nurse' travelled 3,446 miles and in one month alone travelled 479 miles.⁷⁶ The BN obviously needed significant confidence and skills in horse riding. Little sympathy was offered those who had difficulty. At Bruny Island Sister Janice Fenton fell from her horse and broke her ankle but the reaction of the Bush Nursing Association office was 'Oh, if you could ride a horse it wouldn't be broken'.⁷⁷ Soon afterwards she contracted pneumonia, collapsed and left the BNC.⁷⁸

⁷² Sister Mary Johanna Burnley, (née Treahy) was appointed first to Burnie BNC and later became a Child Health Nurse at Smithton where the clinic today bears her name. Born in 1899, she graduated from Roma Hospital, Queensland, and commenced nursing in 1920. She was registered in Tasmania on 24 November 1928, Registration Number 152, and she was awarded the MBE for 50 year's service to the nursing profession. She died on 3 January 1990 aged 93.

⁷³ *The Weekender*, 20 July 1985.

⁷⁴ NAA, Bush Nursing in Tasmania, Series A2487, Item 1922/8480, Letter to Earle from Ethel F Darling and attached appendices.

⁷⁵ *Mercury*, 9 December 1922, p. 11.

⁷⁶ *Mercury*, 9 December 1922, p. 11.

⁷⁷ Janice Flora Barnes (previously Brooks and née Fenton), Interview, Devonport, 1999.

⁷⁸ Janice Flora Fenton was born in 1906. One of ten children, Janice lived in various locations along the North West coast of Tasmania from Forth to Smithton as her father was a contractor and moved around. Janice had only 4 years of formal schooling from the age of 8 years old. She trained at the Launceston Public Hospital, and her training included some nursing in the TB wards. She was registered in Tasmania on 12 July 1933, Registration Number 535. Afterwards she did some Bush Nurse relieving and then completed her midwifery course at Hobart. While nursing in the Western Districts of Victoria she married Will Brooks and they had a son. As a married Bush Nurse she was manpowered and eventually came back to Tasmania as a single parent and did some private nursing. Janice then married Alan Barnes. Janice relieved BNs in

Many BNs without prior skills in riding or driving were willing to learn. Sister Hazel Bird, another former BN at Marrawah, had to learn to ride quickly as there was no car.

I'd [laughs] I'd only ridden a horse, there was a pony there—six, sixteen feet—called Peg. Well I'd never had to put a bridle or saddle on horse in my life, but somebody turned up—I think it was the policeman—and showed me what to do and how to do it and ... at Redpa ... He said, 'Put your bridle on first and then tie her to the fence and then put your saddle on and make sure you've got it adjusted properly'. And then he put me on it. He said, 'You go round the yard and see how you go'.⁷⁹

Her description of the horse reinforces her lack of horse experience. The 16 foot horse was only (presumably) 16 hands—although it might well have seemed 16 feet to someone with no background in horses. After this rapid introduction, every day she would make a round trip from Redpa to Marrawah. Her lack of experience as a rider was potentially hazardous given the conditions. Even after the arrival of motor cars, skills in horse riding remained essential in areas which were inaccessible to vehicles.⁸⁰ The DPH recognised that the BN at Marrawah should be a 'horse woman'. To Sister May Leah Evans, a prospective BN for Marrawah, they offered the reassurance that the horse was one which 'travels well and has no vices'.⁸¹ By 1940 the horse at Marrawah was a source of complaint. Sister Louie Edith Green complained bitterly to the DPH about the horse but was unsuccessful in her efforts to be rid of it. The horse 'without vices' might not have been so 'tame' for a different rider.

The conditions of this Centre are most unjust; the riding alone is excessive, to say nothing of the 'risk of life' in riding the horse 'provided', which shies at all motor traffic!—and badly! I am a good horse woman—but do not enjoy these tricks!⁸²

Not only accessibility, but also, and now perhaps more significantly, economic factors saw horses retained after the introduction of the car. Now Sister Green and her horse shared the road with cars, adding to the danger of horse transport. Although motor cars were available in the area they were not necessarily seen as the appropriate transport for the nurse. A horse provided cheap transport for the BN. Few people within the community had vehicle transport or could afford to pay the cost of such transport when requiring the services of the BN. Until the mid-1940s horseback thus remained a frequent mode of travel for BNs in the remote areas and only women with riding experience (often women from

several districts including Bruny Island, Marrawah, and Storys Creek. Janice died at Devonport 6 September 2000.

⁷⁹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

⁸⁰ Sister Mulligan felt that she could not work at Marrawah in 1931 because while she could drive a car she could not as yet ride or drive a horse. AOT, DPH, 48.6.34, BN Flinders Island, 16 December 1933, from Sister Mulligan re transfer, (HSD 1/5-1/6).

⁸¹ AOT, DPH, 58.1.36, BN Adamsfield, Letter to Sister Evans, 20 January 1936, (HSD 1/24)

⁸² AOT, DPH, 58.11.40, BN Marrawah Letter of complaint from Sister Green, 6 June 1940 and AOT, DPH, 58.11.40, BN Marrawah Letter 19 June 1940 from SN, (HSD 1/79). Sister Louie Edith Green trained at the Royal North Shore Hospital in Sydney and was registered in Tasmania on 8 May 1940, Registration Number 1116.

rural backgrounds) usually were considered eligible for such positions.⁸³ That reliance on horses persisted into the 1940s, highlights the level of isolation of much of rural Tasmania. Sister Hazelwood at Adamsfield felt she was lucky even to have a horse. Most of the miners and their families used 'shank's pony' despite the harsh weather.⁸⁴ The horse alleviated the BN's isolation by aiding her mobility but the care of the animal also added to her daily workload.

Bush Nurses practised in some areas before roads into, or within, the region were formed. In at least two areas railway access was the only means of transport available.⁸⁵ At one point in 1934 the train from Zeehan to Burnie was out of action, and the Montagu Medical Union acknowledged that the BN had to walk carrying her case for five miles every time she made a trip between Tullah and Rosebery.⁸⁶ The North Farrell tram ('Wee Georgie Wood') operated daily, four days a week, between Tullah and Rosebery, and at Marrawah the community had access to a rail car which came three times a week from Smithton to Redpa.⁸⁷ While these services were not frequent enough to be useful for urgent transport, the railway tracks could be used to gain access to patients even when trains were not available.⁸⁸ One particular incident illustrates the resilience of the nurses:

Now she was a widow and she lived in the bush ... near the rail line ... along that line there was a creek. It was fairly wide ... she became ill and somebody came bounding in to me and they said ... 'Come at once. She's very ill'. And she was in this isolated spot. And there were two men there ... [who] came at once and they said to me, 'Now, what are you like walking sleepers?' And I said, 'I've never walked sleepers in my life'. Well, one took my first aid kit and ... tied it around his neck, one took one hand and one took the other and they said, 'Now don't look down, look at the sleeper'. And they took me for quite a distance on these sleepers and it was a horrible feeling, but they were used to it ... And when I saw the patient ... she had a very nasty haemorrhage and I knew I was out of my depth, so I said to these two men, 'Please go straight to the Post Office and tell them to get one of the doctors ... and to come as fast as he could because it was a real emergency'. [It] must have been an hour before he could get ... [to the place] where they met up with him, and then they had to bring Doctor over the ... sleepers and he came in the door and he said to me, 'You don't want to be a nurse or a doctor here', he said, 'you want to be a bloody mountain goat'. [Laughter.] It was so funny.⁸⁹

⁸³ Edith Collis was offered the BN position at Waratah in 1944 but, because she could not ride, was manpowered to the position of matron at the Mothercraft Home, Roope St, New Town, Hobart. The Mothercraft Home trained Double Certificate Nurses in child welfare along the New Zealand Truby King system. Edith Collis, Personal Communication, August, 2003.

⁸⁴ Thurza Hazelwood in *The Sunday Examiner*, June 17, 1990, p. 18, 'On the Road Again with Eddie Kerfoot and Geoff Willson: "Tale of three Sisters! Trip back to Adamsfield"'.

⁸⁵ Tullah to Rosebery (and Williamsford) and Redpa to Smithton.

⁸⁶ AOT, DPH, 58.15.34, BN Tullah, Montagu Medical Union letter of thanks to DPH for special grant of £75 to re-establish the Tullah BNC, 31 March 1934, (HSD 1/6).

⁸⁷ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

⁸⁸ See map of Marrawah tramway in Jack G Branagan, *Bush Tram-Ways and Private Railways of Tasmania c1850-1960*, Regal Press, Launceston, 1992, p. 134.

⁸⁹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

Most BNCs challenged their nurses with similar and extreme conditions. Hazel Gaffney's description illustrates the fitness required of the BNs and underlines their independence and sense of courage. They rose to the adventure, risk and dangers of the bush environment just as the early calls for the establishment of the Bush Nursing Service had predicted. They were not afraid of the extreme conditions under which they worked, not glorifying it but describing it in matter-of-fact terms as a job that had to be done and so you did it.

Nurses on Tasmania's offshore islands needed to use sea or air transport but the weather that affects these islands is often stormy.⁹⁰ Access required good weather. At Bruny Island in the 1930s, patients needing urgent medical treatment often were transported to Hobart on a local fishing boat.⁹¹ To attract the fisherman's attention they would light a series of small fires on the foreshore, the message's content being conveyed by the number of fires lit. Steamers which made regular but infrequent trips up and down the channel, and on rare occasions barges carrying timber from the island, would be used to transport patients. When all other means of transport failed, a dinghy would be rowed across the channel to Gordon.⁹²

On one occasion the BN on Cape Barren Island was called out to a young man—certain that he had appendicitis, she called for medical advice because she had 'very little experience other than [her] training'. It was after 9 am on a Sunday, and there was no further scheduled radio contact that day. Deciding to evacuate the patient to Flinders Island, where medical advice could be sought and the patient flown to Launceston if necessary, she faced another problem. Tides and 'roaring forties' winds needed to be right before one could sail across the strait from Cape Barren Island to Flinders Island. After waiting for the right conditions she then had to entrust her patient into the hands of the local owner of the sailing boat,⁹³ and was concerned that he might not know how to care for him properly. Although worried, the situation was now out of her hands.⁹⁴ Eventually the

⁹⁰ Flinders Island, King Island, Maria Island, Bruny Island, Cape Barren Island, Chappel Island and Babel Island were all especially isolated.

⁹¹ Recollection of Sister Jane Finn, refer to Davis.

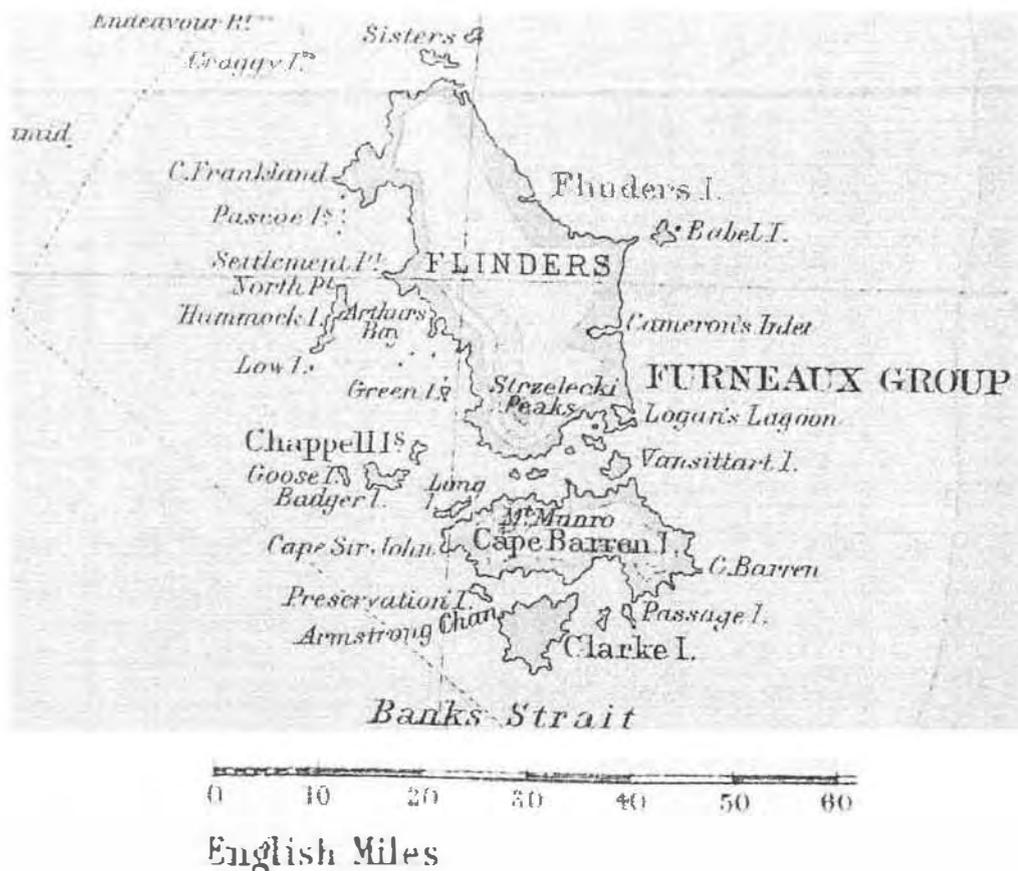
⁹² Davis.

⁹³ Motorised boats were not available.

⁹⁴ Una Saville, (née Nicholls), Interview, Devonport, May, 1999. Sister Una Josephine Saville, (née Nicholls) was born in 1924 at Wynyard and grew up on a farm at Table Cape on the North West coast of Tasmania. Following a family tradition of nursing she trained at the Launceston General Hospital graduating in the 1940s, and registering in Tasmania on 26 November 1946, Registration Number 2010. She did midwifery at the King Edward Hospital in Perth Western Australia, undertook a some midwifery at the Mersey Hospital at Latrobe and finished her training in child health in Hobart. She took up a position of BN at Cape Barren Island for six years, and later at the hospital at Whitemark on Flinders Island.

patient arrived at Flinders Island, the nurse's diagnosis was confirmed and the patient flown out to Launceston. It had been a stressful time for the BN.

Map 3.10 Furneaux Islands



Source: John G Bartholomew, 'Victoria and Tasmania' in *Times Survey Atlas of the World*, Edinburgh Geographic Institute, The Times, London, 1922, (From the David Rumsey Institute).

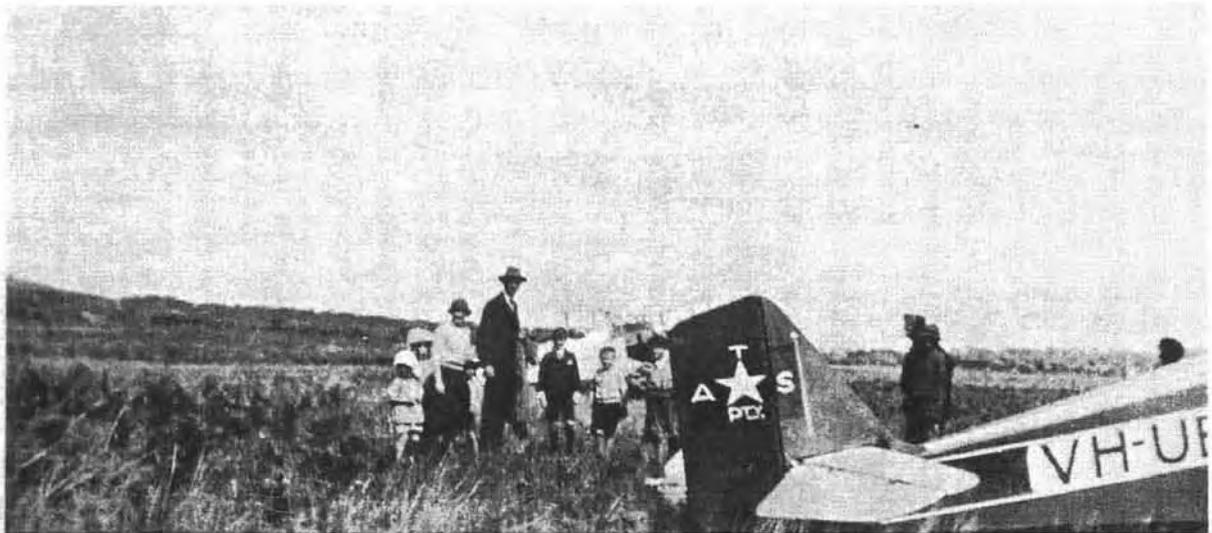
Gaining access to, and egress from, the Furneaux group of islands was not easy. The journey was tortuous and often there were delays. Ensuring that adequate supplies were available for the BN's personal needs and her nursing duties was not easy. The BN travelled to Chappell Island by steamer as Sister May Leah Evans was instructed in 1939:

You should proceed by 'plane from Launceston to Whitemark on Thursday next, the 23rd instant, and join the steamer there for Chappel Island. The equipment required by you, viz. tent, bedding, furniture, nursing requisites etc., is being provided by the Government, and will be consigned to you at Chappel Island, and forwarded from Launceston by steamer on the 22nd idem. If it should happen that such equipment is not on the boat when you are joining it at Whitemark, it will be necessary for you to remain there until it arrives, as there is no accommodation in the island. It will be necessary for you to take food supplies with you, but cooking utensils, etc., will be provided. I would also suggest that you take gum boots, on account of the prevalence

of snakes. Orders are attached, to enable you to travel by 'plane and boat, and send your luggage by boat.⁹⁵

This was an exercise in logistics. The BN needed to travel with everything required for personal and patient care (including nursing such patients in her BNC if required). If necessary supplies were missed the next opportunity to remedy this would be many days hence. On one occasion blankets were forgotten and the next boat was 10 days away.⁹⁶

Photograph 3.11 Aerial Link to Cape Barren Island, 1933



Cape Barren Island was only accessible by sea until an airstrip was built in the 1930s.⁹⁷ Small planes could then land as here in 1933. To leave the island the Hawkins' family required two planes. Before this, with total reliance on boats for external access, if the weather was not good they were inaccessible.⁹⁸ Aeroplane access was never achieved for Babel and Chappell Islands. Source: Mrs June Gee, (née Hawkins), Private Collection.

The Furneaux Group remained isolated by the sea, the weather and navigation difficulties even in 1947. This isolation was compounded by the unsophisticated communication technology and facilities. Dr Edwin Theophilus Jesse Ick and later Dr SJ Rumbold acknowledged the isolation of Cape Barren Island in reports to the DPH:

[T]he Police boat should endeavour when possible to catch the tide as the navigation of the Sound is both difficult and dangerous.⁹⁹

[A]n adequate medical service is impossible because all through the year there are days when boats cannot reach or leave the Island to deal with serious cases, and no

⁹⁵ AOT, DPH, 58.7A.39, BN Chappel Island Letter to Sister ML Evans re travelling to Chappel Island, 17 March 1939, (HSD 1/70).

⁹⁶ AOT, DPH, 58.7A.39, BN Chappel Island Mutton Bird—Letter from Dr Ick re blankets, water etc for nurses on Island, (HSD 1/70).

⁹⁷ The 'Miss Flinders' and 'Miss Currie' landed on Cape Barren Island in the early 1930s after Mr Hawkins organised a group of locals to construct a rough airstrip at the back of the local school house. Mrs June Gee, (née Hawkins), Private Collection and Interview, Kings Meadows, 2003.

⁹⁸ Una Saville, (née Nicholls), Interview, Devonport, May, 1999.

⁹⁹ AOT, DPH, 5.15.47, Flinders Island re Dr SJ Rumbold's report on conditions (malnutrition) on Cape Barren Island, (HSD 3/15).

continuous communication is possible. Radio transmission is conducted twice daily—morning and evening for a few minutes.¹⁰⁰

The Cape Barren Island BNC was one of the most difficult for the BNs to maintain without complaint. Even in the Annual Reports it was singled out as a place where many hardships were experienced owing to 'isolation and irregularity of shipping supplies'.¹⁰¹ Not only was navigation difficult but the boats required very short turnaround times. Loading and unloading were rushed 'often under very difficult circumstances and weather'. Shortages of supplies occurred from time to time as the conditions prevented the boats from travelling across the narrow strait from Flinders to Cape Barren Island.¹⁰² These shortages, and the weather and navigation-related difficulties in leaving the island, hampered the delivery of care for the population.

Map 3.11 Cape Barren Island to Flinders Island



This passage from Flinders to Cape Barren Island was a treacherous channel, and despite the fairly short distance served to completely isolate the BN.

Source: EA Counsel, Surveyor General Tasmania, 1904.

As had Sister Davies before her, Sister Una J Saville (née Nicholls) wrote to the DPH outlining a case where resource constraints, even in 1952, were the primary problem affecting access to care off the island. A seven year old boy had severe cuts to his fingers, including severed ligaments. This required medical attention but it was too late in the day

¹⁰⁰ AOT, DPH, 5.15.47, (HSD 3/15).

¹⁰¹ AOT, DPH, Bush Nursing Annual Report 1946–1947 Northern Centres, (HSD 1/91).

¹⁰² AOT, DPH, Flinders Island, *Cape Barren Island Act*—Proposed amendment and investigation re living conditions of 'half-castes', 14 January 1945, (HSD 1/91).

to attempt the trip to Whitemark Hospital on Flinders Island. The next day the police boat was unavailable and the child's grandfather was unwilling to make his boat available to transport him. Finally, a further day later, the police boat travelled to Cape Barren Island and picked up the injured child. Transport off the island had taken 41 hours.¹⁰³ The isolation of the BN meant that considerable difficulty and expense could be incurred in carrying out the nurse's decision to evacuate a patient. It was crucial that her decisions were made not only in the best interests of the patient but also in full recognition of these difficulties and costs. All the evidence points to a high level of trust by the doctors and communities in the BN's ability to make such decisions. This confidence in the BN's abilities grew from necessity because of the isolation but also was deserved as BNs' skills were proven and vindicated. On occasion the decision by a BN to treat, rather than evacuate, a patient was the subject of criticism as will be highlighted later in the thesis, but such criticisms were rare.

The BNs on the islands were not the only ones constrained by water,¹⁰⁴ or having to use boats to reach or move patients. Tasmania's mountainous terrain, and occasionally torrential rains, meant that BNs on the Tasmanian mainland had to contend with floods and rivers. At Marrawah the BN needed to use a punt to cross the Arthur River; Sister Janice Barnes recalls having to row across a flooded river to get to Storeys Creek; Sister Margaret Ross once carried a patient across the same river; and Sister 'Lexie' Alicia Jean Burns (née Laird) used a flying fox to cross the river to Corinna.¹⁰⁵

¹⁰³ AOT, DPH, Letter to Director General Medical Services from Sister Saville, Cape Barren Island re transport to Flinders Island, 5 July 1952, (HSD 5).

¹⁰⁴ Supplies were irregular also in other locations which depended on sea transport. Problems in shifting supplies from the dockside to the Centres also created difficulty at the Tasman Centre. The Sister-in-Charge reported the lack of proper facilities for carting goods from the jetty to hospital, a distance of approximately one and a half miles. AOT, DPH, 58.23.7, Report re Tasman BNH, 7 August 1950, (HSD 5).

¹⁰⁵ Janice Flora Barnes, (previously Brooks and née Fenton), Interview, Devonport, 1999. Emma Jessica Dineen, (née Smith), Interview, Swansea, 2003. Sister Emma Smith graduated from the Launceston Public Hospital and was registered in Tasmania 22 February 1931, Registration Number 427. Alexia Jean Laird (known as 'Lexie'), was born in 1923, at a farm, Troopers Track, near Lefroy and Pipers River in Tasmania's North East. Nursing was a career Lexie had always wanted to do. Lexie was attracted to the pioneering spirit of Bush Nursing. The independence of working alone attracted Lexie who resented the patronising attitude of matrons, doctors and the general hospital hierarchy and referred to bush nurses as being country women who were 'their own people'. Lexie completed her schooling and then undertook her general training at Launceston General Hospital graduating in 1946. She was registered in Tasmania on 22 July 1946, Registration Number 1937. She then went to Queensland to train in midwifery at the Women's Hospital in Brisbane which included child health but this was not accepted as the third certificate in Tasmania. After relief nursing in hospitals throughout Queensland she applied to do Bush Nursing back in Tasmania and was posted to Waratah for two years. Later she nursed at Wynyard, returning to Waratah in 1952 after she married a Waratah local, Matt Burns. 'Lexie' was awarded an Australia Day Honour in 1977. She retired from nursing while at Waratah where she resides in the renovated BNC.

Photograph 3.12 Flying Fox over the River at Tullah



River crossing by flying fox was required at times in several areas. This picture shows a patient in a stretcher being evacuated over the Pieman River.

Source: DPH, Bush Nursing Album, NBT.

Map 3.12 Corinna and Tullah



For the BN at Tullah, the Pieman River created a potential hazard. It could flood rapidly as the river drained the mountainous West Coast area.

Source: E A Counsel, Surveyor General, Tasmania, 1904.

Motorbikes were not a normal mode of Bush Nursing transport. Cape Barren Island offers an exception. In the 1950s Sister Una Saville's husband, Charles Saville, was the local Special Constable and teacher, giving Una access to the Harley Davidson motorbike with a side car that was used as the police bike. Even then her primary method of transport was a

Photograph 3.13 Sister Una Saville and Motorbike



Sister Una Saville, Bush Nurse, with daughters Ellen and Jillian c1956 in police motorbike on Cape Barren Island
Source: Una Saville, Private Collection.

'horse and cart, an old dray'.¹⁰⁶ The motorbike was not seen as suitable transport for the BN. Official reaction to motor cycle use can be gauged from the Supervisory Nurse's comment: 'out of the question' when one BN sent a newspaper clipping to the DPH showing two BNs from Devon Hospital, Latrobe, with motor cycles. The DPH did not object to the BNs utilising trucks, lorries, bread carts or a number of other conveyances. By 1945 a motor truck was made available to the Bruny BNC, and a utility truck replaced the bicycle at Marrawah.¹⁰⁷ Some BNs had to be content with whatever vehicle was available. The following account is from the Supervisory Nurse after her inspection of the Avoca BNC:

This Centre is increasingly busy. The Nurse visits within a radius of 15 miles, using whatever conveyance is available, usually a lorry or bread-cart. She is happy in her work, and popular with the people.¹⁰⁸

¹⁰⁶ Una Saville, (née Nicholls), Interview Devonport, 1999. At this time there was only one motor vehicle on the island owned by a family living on the other side of the island. Personal Communication, June 2003.

¹⁰⁷ AOT, DPH, 58.42.45, Bush Nursing Annual Conference, BNA, (HSD 1 /91).

¹⁰⁸ AOT, DPH, 58.2.41, BN Avoca SN's Inspection Report of Avoca Centre, 30 July 1941, (HSD 1 / 83).

Photograph 3.14 Motorbikes—'out of the question'



This clipping was sent to the DPH in 1951 to argue that BNs should be allowed to use motorbikes. In response to the suggestion that a two stroke motor bike might be a solution to overcome transport problems the Supervisor's hand written file note stated 'out of the question!'¹⁰⁹

Source: AOT, DPH.

On King Island a panel van had been donated by the Red Cross enabling Sister Rita Eugenie Risby to access the outlying areas and conduct welfare and school visits.¹¹⁰ In 1951 Sister LF Hurnall resigned from Waratah because of the lack of appropriate transport and the harsh conditions. Her description was not encouraging for others who might follow in her footsteps:

The Transport System consists of a 3 ton timber lorry in which I travelled about 60 miles in all and that was only available for urgent cases to which one visit only could be paid, alternatively I used an empty School Bus or walked to anything within a mile over rough unmade roads.¹¹¹

Motor vehicles eventually superseded the horse for most BNs. In Tasmania, the availability and use of cars generally increased rapidly from the 1920s.¹¹² It was not long before some BNs gained access to cars. At Burnie in 1928 Sister Mackenzie purchased her own car and was reimbursed for using it on urgent visits.¹¹³ In 1930 on her arrival at Ulverstone, Sister Thelma Rose Amelia Connors had two weeks to learn to drive a small

¹⁰⁹ AOT, DPH, undated and unidentified newspaper article. The clipping was sent by Sister LF Hurnall, c1951, (HSD 5).

¹¹⁰ AOT, DPH, Bush Nursing Annual Report 1946–1947 Northern Centres, (HSD 6/10).

¹¹¹ AOT, DPH, Letter to SN from Sister LF Hurnall, 10 July 1951, (HSD 5).

¹¹² Robson outlines the rapid increase in motor vehicles in Tasmania in the early 1900s. From a mere 152 motor vehicles in 1909 the number of vehicles increased to 1387 in 1914–15; 2023 in 1918–9; 3965 in 1922–23; 6676 in 1924–25 and by 1939 there were 28000 motor vehicles (including motorbikes) on Tasmanian roads. Robson, p. 377 and p. 468. The *Report of the Transport Commission on the Operations, Business and Affairs of the Transport Department during the year ended 30th June 1948*, no. 46, notes that by 1949 the number of vehicles had increased to 41507, representing one vehicle for every 6 persons of the population.

¹¹³ A 1928 single seater Chevrolet for £218. The Council paid her six pence per mile for car expenses. Hearn, p. 59.

one-seater Chevrolet Roadster.¹¹⁴ It was serviced carefully for the demanding journeys and is reputed to have had only one puncture in five years.¹¹⁵ The car had a somewhat closeted existence, and 'whenever the vehicle was not being used for duties, it was locked away'.¹¹⁶ Other cars had a harder life. In 1932 the Lilydale Bush Nursing Committee balked at paying £34 for a horse and jinker and agreed to the provision of motor transport instead.¹¹⁷ Two years later the Lilydale Council complained to the LBNC about damage to the car from the poor roads and they suggested the residents assist with funds.¹¹⁸ The Lilydale public was particularly supportive of the Bush Nursing Association, in 1941 purchasing a sedan car through the generosity of a member of the local committee and a 50 per cent Government subsidy.¹¹⁹ In 1949 when a new Holden was being considered the Health Minister was lobbied by the local committee to contribute towards the cost.¹²⁰ Motor vehicles were still beyond the financial reach of most centres and often had to be subsidised by the government.

Not all areas provided the nurse with a car but in many isolated regions there were one or two vehicles in the community which, when required and available, were utilised by the BN as a taxi service. At Marawah Sister Bird, in emergencies, hired or borrowed a car to use as 'the ambulance'.¹²¹ At Rosebery the BN was provided with a car for special trips such as when she was to travel to Williamsford some five miles away. The car also was available for limited travel within Rosebery itself. In many BNCs the BN and GMO shared

¹¹⁴ *Advocate* newsclipping, undated private collection. Thelma Rose Amelia Connors was born in 1894 in Hobart. Thelma left home at fourteen years of age to take up employment as a housemaid in Geeveston and later Hobart. She commenced nursing in 1918 at 22 years of age at Highbury Private Hospital, a training school operated by three retired nursing sisters. She graduated from there and was registered in Tasmania on 18 April 1928, Registration Number 36. Prior to Bush Nursing on the north west coast Thelma worked at Vaucluse Infectious Disease Hospital and completed a six month midwifery course at the Queen Alexandra Hospital. The midwifery course required trainees to complete three 'outdoor' maternity cases with a Sister and no doctor in attendance, and three cases with sister and a doctor attending—this highlights that newly-trained midwives had a little training for independent practice in isolated areas. She completed a Child Welfare Certificate at the Mothercraft Home at New Town. She was the Bush Nurse for five and a half years at Ulverstone from 1930, at Burnie for eighteen months and Deloraine for 12 months. Later she did Child Welfare Clinic relief work throughout the state in areas such as Smithton, Scottsdale, Queenstown and Hobart, finally undertaking child welfare work in Launceston, retiring in 1954. She died 2 October 1989.

¹¹⁵ Family notes from interview with T Connors, 1990, Private Collection.

¹¹⁶ Family notes from interview with T Connors, 1990, Private Collection.

¹¹⁷ QVMAG, Lilydale Council Records, Annual Meeting of the LBNC, 18 July 1932.

¹¹⁸ QVMAG, Lilydale Council Records, Letter to WC Sulzberger from Council Clerk W Wilson, 29 September 1934.

¹¹⁹ This replaced the Tourer car that had been in use for eight and a half years and was 'much more comfortable, particularly during cold and wet weather.' Other residents helped by providing free petrol, and loaning a car when the BN's car was being repaired. QVMAG, Lilydale Council Records, Minutes AGM, LBNC 22 September 1941 and 9 October 1943. Mr Fred Kelp and Mr CK Smith. QVMAG, Lilydale Council Record, Report of Annual Meeting of the LBNC, 1941.

¹²⁰ QVMAG, Lilydale Council Records, Minutes AGM, LBNC 26 September 1949. Holdens were introduced to Australia in 1948.

¹²¹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

resources including transport. In 1937 the local Bush Nursing Committee on Bruny Island purchased a 1927 touring model Morris Cowley as the first hospital car. Within months it was out of action and it is questionable if it ever eased the BN's isolation for the short time it was available. The following is an account from the local Health Inspector:

The self starter is not working, car having to be cranked by hand on each occasion starting is required. Steering is difficult. The lights are disconnected, the brakes inefficient, front leaves in spring broken and body generally in disrepair. No side curtains, or spare tyres are in existence. On Monday last the stub axle broke rendering driving impossible.¹²²

The car was a shared resource with the local doctor from Snug. In 1944 the DPH empathised with the difficulties vehicle sharing created, and during this period of war shortages tried its best to provide centres with transport.¹²³

Other districts borrowed cars from the closest hospital. At Ringarooma there was a car provided from Scottsdale Hospital. Once a week the Ringarooma BN also travelled to Derby, Gladstone, Moorina and Herrick, and Pioneer, sometimes utilising the bus. The BN would be on the road over 10 hours a day doing these rounds. Driving alone, particularly at night, was often unsettling with the isolation and the poor roads:

I used to be frightened, especially when I had to get in the car and go right up to Trenah ... nine miles up in the bush out of Ringarooma ... I used to be terrified. I was really ... yes, I was frightened. I can remember one night, I really was a mess by the time I got home.¹²⁴

Although access to vehicles was frequently difficult and costs of transport were an often expressed concern, BNs' mileage related to patient visiting was steadily increasing until the late 1930s (Figure 3.01). From that time the petrol rationing of World War II was to have a great impact on the duties of the BNs. Mileage dropped significantly. Petrol rationing compounded the already difficult access to patients by the nurse and to the nurse by patients. In 1942, after approaches to the government, petrol ration tickets were made available to those motorists who brought urgent cases of sickness or accident to the surgery of the BN.¹²⁵ War-time blackout restrictions made vehicle lighting at night inadequate, particularly so in rural areas where roads and conditions required better levels of lighting than were required in city areas. It was dangerous to navigate in darkness with the precarious road conditions. Sister Mary Walsh received at least one reprimand over an incident where she uncovered the headlights during an emergency call out one evening. Obtaining a first vehicle or a replacement vehicle was also difficult as the war consumed

¹²² AOT, DPH, 58.3.38, Letter to Director of Public Health from HH Parker, Health Inspector, Bruny Island, 14 July 1938, (HSD 1/33).

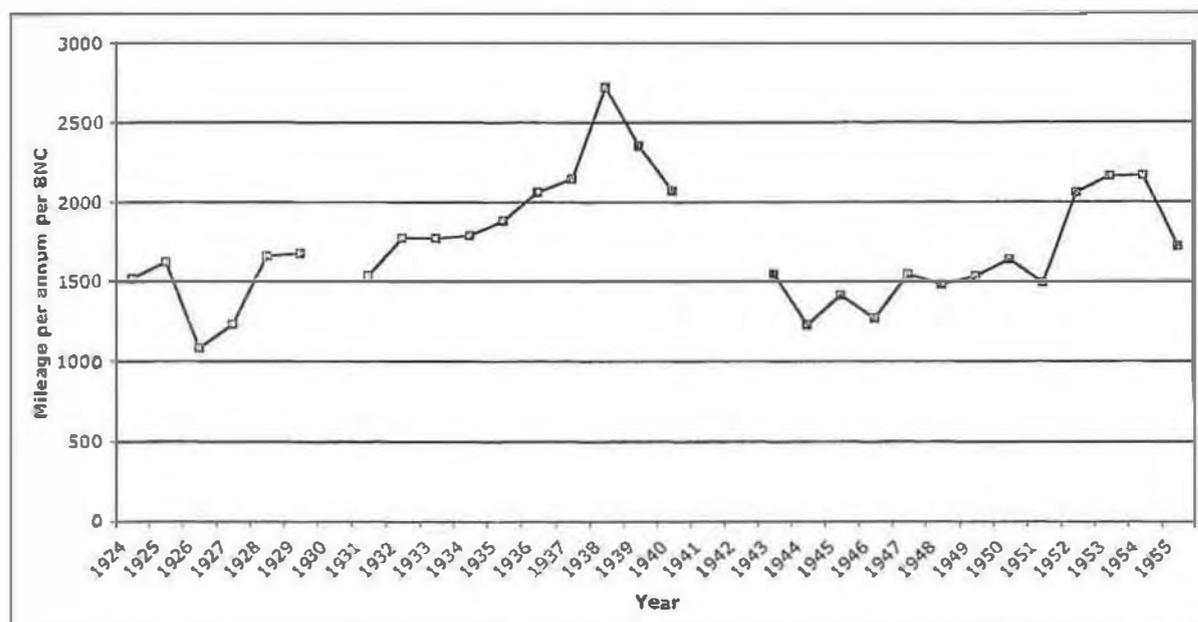
¹²³ Davis, p. 13 and AOT, DPH, 3.8.44, Kingborough-Bruny re transport for BN & GMO, army vehicle being considered, 14 November 1944, (HSD 1/89).

¹²⁴ Ruth Bartels, (née Holmes), Interview, Bridport, September, 2002.

¹²⁵ QVMAG, Lilydale Council Records, Annual Report of the LBNC, 30 June 1942.

Australia's productive effort. The war marked a turning point in the BN's work patterns. Travel mileage never again was to reach the levels of the late 1930s, presumably as patients themselves had better access to vehicles in the post-war period.

Figure 3.01 Mileage per annum per Bush Nursing Centre



Source: Statistics from the *Tasmanian Journal of Parliamentary Papers and Proceedings* and Tasmanian Bush Nursing Records.

Vehicle security was an issue for Centres. Sister Mabel Margaret M Hall was forced to hire a car for visiting patients. Her vehicle had no petrol because it had been pilfered from the car and from stored drums at night.¹²⁶ Garaging was not always conveniently located. Often the car was garaged at a different location from the BNC or from where the BN resided. In Gladstone in 1949 the nurse lived in rented rooms in a private house, the clinic was held in a room of the school house, and garaging for the car was about 200 yards distant. Such a situation was difficult particularly for night calls and in inclement weather. Vehicles were not always maintained in good order, thus safety was a concern. The car allocated to Sister Connors at the Ulverstone BNC handicapped her work to a certain extent. She remembered it as a small English baby Austin car and recalled locals remarking: 'You are not going to Toiberry in that, are you?!'¹²⁷ She completed the journey 'safely' on that occasion but lost the roof in the process. At Marrawah, the Foreman at City Motors, Smithton, stated that the BN's car was 'in his opinion, besides ... being not weather-proof

¹²⁶ AOT, DPH, Letter to Secretary for Public Health from BN Bruny Island, (HSD 6/10).

¹²⁷ Family notes from interview with T Connors, 1990, Private Collection. Toiberry is a tiny hamlet of farms near Gunns Plains, NW coast of Tasmania. Sister Connors might have been stationed at Mole Creek at this time.

... was also unsafe'.¹²⁸ At Bruny Island the nurse was reputed to need to open the car door with a pair of scissors.¹²⁹

Vehicle provision in terms of absolute availability, conditions of use and accessibility was not uniform across Centres. Dr Bruce Maitland Carruthers, Director of the DPH, argued that the BN would be served best with a vehicle for her use rather than the ad hoc approach to transport provision.¹³⁰ He argued that this was necessary, in the best interests of Bush Nursing, to reduce dissatisfaction with working conditions and was important given the problems in retaining BNs' services.¹³¹ The unavailability of vehicles when required for urgent work was a frequent source of nursing concern. It was a problem for nurses over the whole of the Bush Nursing era. At Bruny Island the BN and the local GMO were obliged to rely on service cars which were located over eight miles away. This resulted in 'distressing delays'.¹³² Sister Lilian Elizabeth Allen of Waratah complained that at times she had long waits for transport when called out a case.¹³³ This was countered by pointing out that she need not wait for an official car. She had her own car, and her husband drove one of the Wells Hire Cars.¹³⁴ Married BNs were less likely to be supported by the local Committees over issues such as car usage.¹³⁵

By 1947 'proper motor transport' was the rule for most centres but it is not clear what 'proper' actually meant.¹³⁶ There were almost as many varieties of transport supplied to BNs as there were centres and even if they had transport it was not always available when needed. Despite this stated improvement in transport provision, in 1949 the Ringarooma BNC still did not have a car for the BN and in other centres vehicle location remained a

¹²⁸ AOT, DPH, 58.13.3, Report for Director Hospital Medical Services from Widdicombe re Marrawah, 2 August 1951, (HSD 5).

¹²⁹ Davis, p. 13.

¹³⁰ Dr Bruce Maitland Carruthers, OBE was born 23 April 1892, Maitland NSW and died 29 November 1951 aged 59 years. See Obituary, *Walch's Almanac*, 1959 and also *Australian Medical Journal*, March 22, 1952 pp. 421-422, and in *Mercury* and *The Examiner*, 30 November 1952. Upon completion of his studies at Sydney University he enlisted in 1915. He was a Lieutenant Colonel in the Australian Army Medical Corps, and an Officer of the Order of the British Empire, AWM Army Record, Service Number TX2157. He was associated with the Public Health Department for approximately 16 years and was appointed Director on the 15 June 1936 and later to the combined position of Director General of Hospital and Medical Services. He was instrumental in setting up the Tasmanian Free Medical Scheme. For additional biographical detail see AOT PSC35/3, in WG Rimmer, *Portrait of a Hospital: The Royal Hobart*, Royal Hobart Hospital, Hobart, 1981, p. 277.

¹³¹ AOT, DPH, 58.10.37, 16 February 1937, Letter to Ouse BN from Dr BM Carruthers re transport, (HSD 1/49).

¹³² AOT, DPH, 3.7.45, Kingborough-Bruny request by Bruny Council to Minister of Health for transport for Nurse/DMO on Bruny Island, (HSD 3/12).

¹³³ Sister Lilian Elizabeth Allen graduated from Royal Prince Alfred Hospital in Sydney, and was registered in Tasmania on 30 June 1940, Registration Number 1205. It is possible that Sister Allen was Sister Beryl J Allen, rather than Sister LE Allen.

¹³⁴ AOT, DPH, Report for Director Hospital Medical Services re Waratah BN, 26 April 1951, (HSD 5).

¹³⁵ The different treatment of single and married BNs will be noted in Chapter Four.

¹³⁶ *History of Bush Nursing in Tasmania 1911-1947*, pp. 4-5.

problem.¹³⁷ While in the 1930s the DPH argued that the BN should have a vehicle for her use (when the cost of cars was met at least 50 per cent by the local community), in the 1950s the DPH was arguing that vehicles were necessary for the nurse only in certain circumstances.¹³⁸ By now the DPH would have to meet the full cost of vehicles as it had taken over the funding of the Bush Nursing Scheme. Additionally the official view of the role of BNs might have been changing, and this reduced the 'need' for transport. The Council Clerk at Bruny Island wrote to the Department as the BN had problems in accessing a car in emergency. The response from the Minister for Health was that the nurses' activities 'should be confined to the BNC' as a resident Medical Officer was situated at Lunawanna. Later it was argued that, 'if the doctor was absent, transport for the nurse should be provided by the patient'.¹³⁹ This clearly indicates that by this time, and perhaps because of the location of a doctor near a Bush Nursing Hospital, the BN at a Hospital was not expected to have the same focus on house calls as did the BN located at a Centre.

In 1953 Sister Dorothy A Clark at Avoca BNC wrote a lengthy document to the DPH setting out her grievances about inadequate transport. This document, and its description of her work and her area, allows one to see the need for good access to transport and the substantial mileage that could be required of the nurse. It rebuts the DPH's argument that the transport available to nurses was adequate for their activities. It reinforces that the nurse's role was not merely to wait for patients to come to her, and was broader than was expected of the resident medical officer (where he existed). She described the distances from her quarters to the various localities she was to visit. These included Mount Foster 20 miles; Ormley 14 miles; Lewis Hill 18 miles; Llewellyn 14 miles; Royal George 11 miles; Hanleth 10 miles; Benham 5 miles; and Eastbourne 6 miles. Additionally within Avoca itself patients could be two miles from her. Each of these areas had a small population (approximately 600), with an apparently significant proportion of children.¹⁴⁰ There were schools, where she conducted mothercraft lectures, located at Avoca, with 86 pupils, and Royal George, with 30 pupils. She averaged one midwifery patient each month and made an average of 20 visits to each.¹⁴¹

¹³⁷ AOT, 58.32.49, letter 30 August 1949, (HSD 6/34).

¹³⁸ AOT, DPH, 58.10.37, Letter to Ouse BN from Dr BM Carruthers re transport, 16 February 1937, (HSD 1/49).

¹³⁹ AOT 58.1.49, Various letters to and from Council Clerk and DPH April 1949, (HSD 6/34).

¹⁴⁰ 'The population of each district is roughly: Avoca-300 with 40 children under 2 years; Lewis Hill-30 with 4 children under 2 years; Mount Foster-50 with 10 children under 2 years; Royal George-120 with 20 children under 2 years; Ormley-20 with 4 children under 2 years; Llewellyn-18 with 2 children under 2 years; Hanleth-12 with 3 children under 2 years; Eastbourne-10 with 1 child under 2 years; Benham-100 with 8 children under 2 years'. AOT, DPH, 58.2.4, Letter from Sister D A Clark, Avoca, 10 March 1953, (HSD 5).

¹⁴¹ AOT, DPH, 58.2.4, (HSD 5).

The area as described would require significant travel, particularly as while some people owned cars the majority did not. She complained that, despite the characteristics of her work and area, her means of transport was very irregular. There was one taxi, which was seldom available when needed. If she were needed at Mount Foster, Royal George or Lewis Hill, she had to travel in a coal lorry, and wait for another lorry to return. She wasted half a day in travelling, and was so covered in coal dust that she carried it on her person into the houses she visited. Weekends were even more difficult for most people with cars went out of the district and obtaining transport for urgent cases who needed to go into hospital was impossible. Referral to hospital involved significant travel—'medical cases' could be sent to hospitals at St Marys, 25 miles away, and Campbell Town, also 25 miles away. Any surgical case or road accident had to be referred to Launceston, a distance of 54 miles.

Sister DA Clark then went on to detail instances where a car was needed, and could not be obtained:

[A] small boy ... had fallen, and sustained a fractured femur. I sent his mother to find transport. There was nothing ... an hour later, we put a very weary and miserable little boy into the taxi and took him to Launceston.

[A] patient came to me from Mount Foster. She had travelled in an ancient car which refused to move again. She was very ill, and I had to get her to hospital ... there was a delay of nearly 2 hours before we found someone with a car ... On reaching the ... doctor [he] admitted her to hospital as a poliomyelitis suspect.

Last September and October, I was very busy—and only managed to have 4 undisturbed nights. At the end of this time, I was extremely tired, and at 8 o'clock one night, was preparing to go to bed. The phone rang, and a patient from Bona-Vista—a property at the extreme corner of Avoca—2 miles away, asked me to go and see her little girl—promising to send a car. At 11.00 pm the car arrived, and I was taken to the house. The parents had been trying since 8.00 pm to get a car. I finally got to bed at 1.00 am—only to be called out again at 3.00 am. Had I a car of my own, this sort of thing would not happen, and I would not be so tired as I was then.¹⁴²

A car for the use of the sister would have saved delay in transferring critically ill patients to hospital, and also prevented needless fatigue resulting from waiting for transport to a patient's house.¹⁴³ This account highlights the travel-dependent nature of the BN's work and how, even in the 1950s, the lack of transport for both nurses and patients affected access to health care.

Bush Nursing Committees would often state their preference in relation to the skills expected in a new BN. In the early years of Bush Nursing horse riding skills were

¹⁴² AOT, DPH, 58.2.4, (HSD 5).

¹⁴³ AOT, DPH, 58.2.4, (HSD 5). On the 7 May 1953 Sister Dorothy A Clark resigned from Avoca and left the state.

particularly sought after. In the later years driving skills became of considerable importance to the Bush Nursing Committees. It was the scattered nature of settlement in Tasmania that made mobility of such high value from the inception of the Bush Nursing Service.¹⁴⁴ The Lilydale Council's concern about poor roads and their impact on their vehicle led them to stress that any relieving nurse should be an experienced driver. This was not an easy criterion to fulfil. Bush Nurses were generally inexperienced drivers. The Council had available to them Mrs Doris Theresa Hudson (née Hetherington), a retired BN.¹⁴⁵ For the Lilydale Council she was an ideal choice. She was readily available as she remained living in the area. Although she was now married, thus 'disqualified' from nursing, she would be only a temporary appointee and she 'knew the district from end to end'.¹⁴⁶ Furthermore the Council was able to use her services at no cost. There is no record of her ever being paid for the relieving work, perhaps justified because her marital status meant she did not fit the criteria required of a nurse.¹⁴⁷ This episode from 1932 highlights the potential value of ex-nurses who lived in rural communities and the way in which their services were used often but not formally recognised. Most arrangements in this period with married ex-nurses were private and local arrangements given the unacceptability of married women as nurses.

The Tasman Peninsula Council provides another clear example of the community's preference for nurses with driving skills in order to meet the needs of providing health services to the isolated community. There were different consequences of that preference in a time when many women were unable to drive. The Council's stated primary concern was that those with little driving experience were detrimental to the well-being of the car. Appearing as an afterthought they added 'there is the risk of injuring or perhaps worse to the patient being conveyed therein'. The Council consequently ruled that 'if the next nurse appointed cannot drive a car, she will have to put up with a horse and trap'.¹⁴⁸ The DPH was not sympathetic with this argument. It felt that as BNs were in such short supply teaching them to drive was not an onerous responsibility, and furthermore was the Council's financial liability. In 1936 when Sister Agnes Gartside's driving abilities were an

¹⁴⁴ AOT, DPH, 3.7.45, Kingborough-Bruny request by Bruny Council to Minister of Health for transport for Nurse/District Medical Officer on Bruny, (HSD 1/19).

¹⁴⁵ Sister Doris Thersea Hetherington was BN at Lilydale from 1 June 1932 to 22 June 1935.

¹⁴⁶ AOT, DPH, 58.7.36, BN Lilydale 4 June 1936, (HSD 1/24).

¹⁴⁷ By the late 1950s Mrs Philomena Wilson, (née Lewis), who was married to the local Council Clerk, did receive payment for her relief work which included emergency calls, immunisation work, daily visits to attend dressings, and on at least one occasion delivering a baby en route to Launceston. She was a single certificate nurse who retired upon marriage. QVMAG, Lilydale Council Records, Letter to DPH from Council Clerk, 28 March 1957 and other correspondence during Sister Walsh's extended leave in 1956-1957 and David Wilson, Personal Communication, 2003.

¹⁴⁸ AOT, DPH, 58.16.36, Bush Nursing Tasman Letter from Warden Nubeena re need for Sister with driver's licence, (HSD 1/24).

issue the Department stated that, as considerable difficulty was experienced in securing the services of BNs, it was unlikely that a properly trained nurse could be found who also had driving experience.¹⁴⁹ They pointed out that Sister Gartside had 'rendered excellent service for several years at Waratah so clearly was able to carry out similar work at Tasman.'¹⁵⁰ In the same year Sister Bird was the focus of a similar discussion when the Council was 'disappointed' to learn that she was not an experienced driver.¹⁵¹ Driving was an issue for the Tasman Committee again in 1937 when its members objected to the costs of driving lessons for Sister O'Brien.¹⁵² While these accounts demonstrate that over the period 1936–7 driving capabilities were an important local issue, more importantly there was a turnover of at least four different BNs. The problem with retention of staff was perhaps a reflection on the characteristics of the location itself and the attitude of the Council to 'driving expertise'.

Bush Nurses overcame their inexperience with local help as this example at Storys Creek illustrates:

I remember one case I had was he chopped his toe open. I was driving a utility to his house. I got my bag to stitch it up. I always carried these things, needles, put sutures in, first aid things. So I parked the car, I wasn't used to driving a utility. I got off the road. It was only a narrow road so cars could pass. I must have hit a gum tree. I remember a man ... people working on the hydro, when I came back from fixing up the man's foot, 'You'll be all right Sister. You always choose the right tree!' They got it out for me. People used to help each other in those places, it was a good life. You always had some one generally wanting to help.¹⁵³

Many communities were happy to drive the BN to her destination particularly on long trips.¹⁵⁴ Sister Kathryn Isobel Alston at Cygnet was unable to drive a car but the Secretary was 'prepared to convey her to cases at any time required'.¹⁵⁵ Doctor Bryant recalled that before the Ouse nurses learnt to drive, the ambulance driver would take the nurses on their rounds.¹⁵⁶ At Lilydale in 1935 appreciation was expressed to those who kindly had driven Sister Rita Pitt at night time until she became used to the car and the district.¹⁵⁷

¹⁴⁹ Sister Agnes Gartside trained in the General Hospital Melbourne, and was registered in Tasmania on 25 April 1931, Registration Number 372.

¹⁵⁰ AOT, DPH, 58.16.36, BN Tasman Letter to Warden Nubeena, (HSD 1/24).

¹⁵¹ AOT, DPH, 58.16.36, BN Tasman Letter from SN. The SN noted that: 'They expressed their opinion in front of Sister, thus making her feel rather uncomfortable. In other respects Sister was favourably impressed with the Centre and hopes to give satisfaction and content herself there for a long time,' (HSD 1/24).

¹⁵² AOT, DPH, 58.16.37, BN Tasman Letter from Nubeena Council Clerk to PDH, (HSD 1/36).

¹⁵³ Janice Flora Barnes, (previously Brooks and née Fenton), Interview, Devonport, 1999.

¹⁵⁴ AOT, DPH, 58.26.1, Report for Director General Medical Services from Sister Widdicombe re Waratah BN, 8 May 1952, (HSD 5).

¹⁵⁵ Sister Kathryn Isobel Alston graduated from the District Hospital, Cowra NSW, and was registered in Tasmania on 8 September 1936, Registration Number 778.

AOT, DPH, 58.5.39, BN Cygnet—Transport, (HSD 1/70).

¹⁵⁶ Dr L Bryant, Interview, Bellerive, 1994.

¹⁵⁷ QVMAG, Lilydale Council Records, Annual Meeting of the LBNC, 31 July 1935.

Driving was at this time primarily a male rather than a female skill or role responsibility. The BN, by accepting a position in an isolated community, was not only in an unusual role of an independent unmarried female professional in the community but also at the forefront of women embracing 'male' tasks. New or relieving BNs often were not able to drive. They frequently had to learn on the job, much to the annoyance and fear of the local communities. Cars were expensive to repair and, as the local municipalities had to pay for repairs to cars damaged by BNs, the nurses' driving capabilities were always a concern. On her arrival at Lilydale, Sister Walsh was given an old car, a Chev Ford, but she could not drive. Various gentlemen of the district took her on driving lessons. Learning to drive on the job, initially her driving was less than expert:

I remember one occasion when I got the car bogged on those rough roads. I had taken a short cut. There I was in my white uniform, veil and stockings and an elderly woman (patient) with me. Luckily a young man got us out.¹⁵⁸

Photograph 3.15 Sister Mary Walsh and Car



The photograph of Sister Walsh, in 1953, demonstrates her obvious pride in the car. The Mercury wrote 'Sister M Walsh pictured here has been in charge of the Lilydale Bush Nursing Centre for 13 years. She travels more than 800 miles a month to care for her patients'.

Source: The Mercury, 1 October 1953.

¹⁵⁸ Mary Walsh, Oral History Tape, Interviewer: Dr Philip Mahnken, SA.

Her driving experience and ability increased with time as many years later the local Council Clerk remembered an incident:

[S]he was out to the Mt Arthur school hut ... in the middle of the night because there was something wrong there with one of the boys. At one stage the paths turns up quite steep and there is a little fork there. Well, she turned the car there in the middle of the night ... I'm glad I didn't see it, how she did at that time, how she managed to turn the car I don't know. Yes she did it ... she must have been hanging over the cliff there.¹⁵⁹

Perhaps the driving manoeuvre was helped by her inability to see the steep cliffs because of night and the war-time driving light restrictions.

Some relieving BNs optimistically considered that driving was a skill that could be learnt quickly and easily on the job:

So far I have not had time to learn to drive a car ... will probably be able to get a lad from the garage in Lilydale to teach me to drive one without danger to the general public.¹⁶⁰

'Local lads' were not the only men enlisted to teach BNs to drive. Often Council Clerks were used as driving instructors as Sister Kit J Widdicombe reported:

The Council Clerk (Mr Nicolson) accompanied Sister who drove the hospital car on Saturday, they travelled through Port Arthur and Nubeena back to Koonya, a distance of over 25 miles. I went out with her yesterday and she managed fairly well, especially when the narrow hilly roads are taken into consideration. Sister intends to practice reversing the car and backing in the hospital yard, without any instructor.¹⁶¹

Driving lessons were brief. The new BN at Marrawah, Sister Leslie D Meredith, learnt to drive from locals after two weeks of lessons.¹⁶² Nurses were not ready for the difficult road conditions with which they would have to cope. The combination of poor driving skills, at least initially, and the difficult conditions made life stressful for some nurses. Sister Mabel Helen Smail at Bruny Island was so upset by her inadequate driving and many mishaps that she tendered her resignation:¹⁶³

As the Bush Nursing car seems to have been so ill used during the time of my residence as BN at Alorunah, & sincerely regretting all the accidents, & feeling very responsible for same, I hereby tender to you my resignation, as BN of the Alonah BNC.¹⁶⁴

She could not carry out her role adequately unless she continued to drive and with her confidence in her ability shattered, she saw no option except resignation. Sister Margaret

¹⁵⁹ A Van Der Hek, Interview, Norwood, 1994.

¹⁶⁰ AOT, DPH, 58.29.36, BN Lilydale, 27 June 1936, (HSD 1/24).

¹⁶¹ AOT, DPH, 58.16.36, BN Tasman Secretary Public Health from SN re Sister Gartside's driving 9 November 1936, (HSD 1/24).

¹⁶² AOT, DPH, 6.6.47, Letter to SN from BN at Marrawah, (HSD 6/10).

¹⁶³ Sister Mabel Helen Smail trained at the Brisbane Hospital, Queensland, and was registered in Tasmania on 21 October 1940, Registration Number 1170.

¹⁶⁴ AOT, DPH, 58.3.41E, BN Alonah Resignation of Sister Mabel H Smail, 15 March 1941, (HSD 1/80).

Ramsay had a car accident at Marrawah, turning the car upside down. Such accidents were made more dangerous by difficulties in gaining help once an accident had occurred because of the low traffic volumes. She was too nervous to drive again and was transferred to Oatlands, a hospital centre, where she could remain located within the centre rather than driving around isolated country roads.¹⁶⁵

Even as late as the 1950s driving skills were not universal and the community, including the patients themselves, were still coming to the rescue of 'stranded' nurses.

The other thing that I had never seen before was a car with steering with column gears ... so I didn't know how to drive the car. And, of course, we had to go for the mail and the shopping every day and the milk and so one of the patients came out to the hospital grounds and showed me how to drive the vehicle ... Well, fortunately, she [the patient] was on the road to recovery so she showed me how to manage it and I drove off to the Post Office ... coming back I got a little bit stuck in one of the gears and I couldn't change it and I went past the hospital drive and so here I was in the middle of the road with a water truck careering towards me and luckily the driver was very nice and he got out and pushed it into the correct gear and I got back to the hospital.¹⁶⁶

It is perhaps surprising that the low level of driving preparedness, combined with the difficult driving conditions, did not lead to more accidents and accidents with serious injury. The poor roads would have ensured that driving speeds were generally limited and this might have been the saving grace. Sister Charlotte Mary Lloyd, a relief BN at Lilydale, was injured in an accident on a straight piece of road on Brown Mountain, Underwood. The Council Clerk recommended to the DPH that 'it is not desirable that Sister Lloyd should drive it [Holden sedan] in the future as she is used to driving a low powered Morris Minor car'.¹⁶⁷ One wonders how the BN, upon recovery, was to carry out her duties without a car.

Car-related conflict between BNs and the local committees was an added problem. Restrictions on car use, perhaps as much related to gender bias where cars were seen as 'male' objects, and difficulties in coping with driving on the poor roads would have created a sense of powerlessness. Nurses without transport were literally isolated in their district. Furthermore as many people considered it a luxury to own a car, and some were envious that a woman (albeit a young BN) would have access to a vehicle, the BN's use of the car was under close scrutiny. While the presence of a car could reduce the physical isolation of the nurse from her patients, the presence of a car could place her apart from, or socially isolate (or alienate) her from, the community and in particular from other women. There

¹⁶⁵ The Bush Nursing Hospitals did not require BNs necessarily to travel, in contrast with the BNCs without in-patient beds where substantial travel was required.

¹⁶⁶ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

¹⁶⁷ QVMAG, Lilydale Council Records, various letters to DPH and Insurance Co re accident from Council Clerk, 4 February 1957.

was always one person in the community who would notice if there was the slightest misuse of vehicles. The DPH records show that complaints of misuse were numerous but usually dismissed as petty. Some disputes spilled out into the public arena. By 1938 the Ulverstone Committee had been complaining for over two years about Sister Lilian Iles' car usage. By now Sister was airing her grievances openly. The Supervisory Nurse investigated the case for the Director of Public Health and noted that:

Sister Iles said that she does stay with country mothers whenever there is accommodation; the reason for the mileage being so high was that she frequently had to travel from one end of the district to the other. Regarding the use of the car for private purposes, Sister said that her rooms are a mile from the township, and that she uses the car to save time. I also advised Sister to refrain from writing letters in the Press. After some discussion, she promised to do so.¹⁶⁸

The records available suggest that the mileage travelled was justifiable. The complaints were in part at least a reflection of the status and cost of car provision rather than being truly based on the grounds of inappropriate use. That the debate spilled into the public arena reflects that the problem had become somewhat heated and that personality issues might have added complications. Two years later a local person wrote to the Department independently supporting the BN:

[I]f Sister Iles were to comply with all the requests & directions of the president, she would soon be an inmate of the Lachlan Park Hospital.¹⁶⁹ For instance, I believe she is forbidden to take any passengers in her car either for company or for help, and forbidden to attend the Red Cross sewing meetings, although she may have to come down 20 miles from Nietta to do so.¹⁷⁰

While Sister Jean Isles was criticised for attending Red Cross Sewing Meetings in the BNC car, such activities were crucial to the maintenance of public support for the BN and BNC.

The car had become a critical resource for BNs as their work mileage rapidly increased. However, it did little to ease their personal isolation. They were not to use the car for private purposes and thus still were confined to their isolated communities by the nature of their responsibilities and the geography. A few complaints about private use of cars were justified although if the BN used the car she was more immediately available to respond to urgent health needs in the community. This might be, at least in part, the reason the DPH tended to dismiss such complaints.

¹⁶⁸ AOT, DPH, 58.18.38, BN Ulverstone, Transport, Letter from SN re Sister Iles use of car & letters to press, 12 September 1938, (HSD 1/53). Sister Lilian Iles was trained at the Devon Public Hospital and registered in Tasmania on 18 April 1928, Registration Number 23.

¹⁶⁹ A mental institution located at New Norfolk.

¹⁷⁰ AOT, DPH, 58.18.38, BN Ulverstone, Letter from JM Edwards defending Sister Iles over Red Cross complaints, 17 April 1938, (HSD 1/53).

Map 3.13 Ulverstone



Source: John G Bartholomew, 'Victoria and Tasmania' in *Times Survey Atlas of the World*, Edinburgh Geographic Institute, The Times, London, 1922, (From the David Rumsey Institute).

There were often concerns about the nurses' use of provided cars for personal use. In 1936 the Red Cross at Ulverstone objected to the BN's personal use of the car. The instance was dismissed by the Supervisory Nurse as occasions when Sister 'sometimes calls on friends when returning from patients homes'.¹⁷¹ Concern was expressed similarly by the Bruny Council at the use made of the BN's car to transport picnic parties during a time of war restrictions.¹⁷²

Patients in many cases were required to pay for the cost of a hire car or petrol for the nurse to attend sick cases in the home or for out-of-hours work. Many patients resented paying such costs. The complaints about the BN's private use of the car were perhaps in part sublimated anger at transport-related costs for which patients were liable. One such complaint from Marrawah stated that:

¹⁷¹ AOT, DPH, 58.18.36, Letter to Director Public Health from SN re complaints of Sister Iles BN Ulverstone, (HSD 1/24).

¹⁷² AOT, DPH, Letter to Secretary for Public Health from Council Clerk Bruny Island, 13 January 1947, (HSD 6/10).

When we require attention here, we have to pay for the car to bring the Nurse in; which we are quite willing to do but is the car allowed for private transport, such as a trip to Burnie, Smithton and the beach for pleasure?¹⁷³

Conversely, on some occasions the BN was reprimanded for using her own transport to convey patients to city hospitals.¹⁷⁴ Such a situation arose for a range of reasons, and in some circumstances was encouraged actively.

It is also recommended that the nurse be instructed that on no account is she to convey patients in her car to Hobart for treatment, unless any individual case is unfit to travel by service car or is so ill that she may need some nursing assistance during transit. This procedure, however, may be departed from in connection with the transport of cases of infectious disease, which of course should not be sent to Hobart by a conveyance utilised by the public.¹⁷⁵

If the BN could, and in fact perhaps should, transport in her car those who were significantly ill or who might be infectious, she indeed would have grounds for transporting the majority of sick patients who were sent out of area. The lack of access to an ambulance also might make the option of using a private car attractive to the nurse. While cars still were considered a luxury item, from the 1930s some BNs began to own cars privately and might use these as patient transport. Even in the late 1950s, Sister 'Maisie' May Eileen Rayner at Ringarooma used her car to drive patients to the Scottsdale hospital as there was no ambulance provided by the local committee.¹⁷⁶

Even at BNCs where vehicle transport was provided, issues of cost required the BN to use the car within strict guidelines. Sister Widdicombe's use of the car at Waratah was governed by rules set out by The Mt Bischoff Provident Society about which persons and what type of cases could access transport paid for by the Society. This complex set of rules reflected the funding basis of the scheme. It was necessary for the nurse to notify the Secretary before using transport to ascertain whether or not the transport costs were

¹⁷³ AOT, DPH, letter to Sister Noller, 20 November 1949, (HSD 6/34).

¹⁷⁴ AOT, DPH, 58.16.36, BN Tasman Letter to Nubeena, Authority re nurse transporting patients to Hobart, (HSD 1/36).

¹⁷⁵ AOT, DPH, 58.16.36, (HSD 1/36).

¹⁷⁶ In 1956 there was an ambulance at Scottsdale (17 miles away that was available for the BN at Ringarooma. AOT, DPH, 51.13.19, Memo for Director General Medical Services from Transport Officer, 6 September 1956, (HSD 5). May Eileen Rayner (later Mrs Hooper) known as 'Maisie' was born in 1912 and her family lived at Strahan and later at Latrobe where her father was an engineer employed by the government Shale Export Company. Maisie began her general training in 1932–1933 aged 22 at Devon Public Hospital, Latrobe. She gained Tasmanian registration on 20 October 1939, Registration Number 1047. Later Maisie went to Melbourne for six months of specialist training at the Victorian Eye and Ear Hospital. She enlisted and served in the Australian army nursing service, A.I.F. from 6 August 1941 to 22 May 1946. See *Leatherwood* for further details. In 1948 she worked as a member of the permanent staff of the Public Service as a clerical assistant in the Navy Department at Auckland. Maisie worked at Cooma District Hospital, NSW, from 12 January 1951 to 23 September 1951. Maisie returned to Tasmania after the war and with ambitions of becoming a matron at the Toosey hospital at Longford, finally completed her midwifery at the Women's [Hospital] in Melbourne and then returned to Tasmania to take up the position of matron. Maisie eventually became a BN around 1958 with an appointment to Ringarooma in Tasmania's far North East in the late 50s to 1965.

covered by the Society. This added to the BN's difficulties as her responsibilities included care for those not covered by the Society. An additional problem was managing patient confidentiality given that she needed to provide significant detail in order to justify her use of Society-paid transport. In 1951 Sister Allen requested a car to make six visits but 'Mr Wells rang to say he wished to cart wood for the afternoon, and would she drive herself?' in her own car.¹⁷⁷ Clinical need was not the pre-eminent factor in the availability of vehicles which were hired on a casual or an 'as needed' basis for nurses' transport.

Table 3.02 Rules of Car Hire at Waratah

1.	A car is hired ... for General Outpatient-Subscribers only.
2.	Obstetric Cases ¹⁷⁸ , Non subscribers and Injury through acts of violence are responsible for their own transport.
3.	Visits by Sister to subscribers at Guilford Junction, Parawee and scattered parts of Waratah, the Society provides Hire Car.
4.	Welfare visits by Sister to Guilford Junction and Parawee, Society provides Hire Car. ¹⁷⁹

Source: AOT, DPH, 1951

The concerns of the Bush Nursing Committee for the Ouse Bush Nursing Hospital highlight the lack of private and public transport in some rural and isolated communities.¹⁸⁰ It was argued that the BN's car was exploited by relatives who allegedly used it to obtain a free trip to town, ostensibly justified as accompanying the patient. The committee stated that: 'It is evident that fares for transport of patients are even more difficult to collect than nursing fees are'.¹⁸¹ Any means of transport was eagerly made use of, but in this case there were ramifications for the whole community as the committee withdrew the BN's access to transport to Hobart hospitals.

A schedule of fees applied where the BN was required to travel to patients, or conduct after-hours work. These were not popular, were difficult to collect, and varied somewhat by Centre. For example, in Marrawah rules 4, 9, 10 and 11 of the '*Rules and Regulations of The Marrawah Bush Nursing Centre*', related specifically to charges for transport and after-hours visits.¹⁸² These rules were often the source of complaints to the

¹⁷⁷ AOT, DPH, 58.26.1, Memo for Director Hospital Medical Services from Sister Widdicombe re Waratah Mileage, 23 May 1951, (HSD 5).

¹⁷⁸ These were seen as a 'self inflicted' condition.

¹⁷⁹ AOT, DPH, 58.26.1, (HSD 5).

¹⁸⁰ AOT, DPH, 58.9.36, BN Ouse re poor nurse's quarters, unsatisfactory committee, from SN Nurse (HSD 1/36).

¹⁸¹ AOT, DPH, 58.16.36, BN Tasman letter from SN re purchase new vehicle for BN, (HSD 1/36).

¹⁸² [rule] 4. Persons requiring the Sister at night must accompany her to and from the patient. [rule] 9. Calls to Salmon and Arthur Rivers carry an extra charge of 5/- . [rule] 10. Residents beyond Arthur River are required to meet Sister at the river with conveyance. [rule] 11. Any patient requiring Sister to accompany them to Smithton or elsewhere must pay an extra fee of 7/6 for her services.

Department as were the rules at Waratah. At Waratah subscribers to the Mt Bischoff Provident Society were covered by the Society for transport expenses necessary other than where specifically excluded, such as cases of pregnancy or injuries from violence.¹⁸³

The isolation of the BNCs and the community they served required that a proportion of the BN's patients would need to be evacuated from the area to the nearest doctor or base hospital for more specialised treatment. Few people owned cars. The rural communities were isolated by their geography from treatments requiring medical intervention, and by the poor roads and lack of transport from accessing the treatment available outside of the community. The charging of fees for transport further isolated those who could not pay, and increased the need for the BN to practise her clinical skills rather than seeking advice from or referring on to a doctor.

Ambulances

The BN herself faced considerable constraints on her use of transport. There were thus many problems faced when BNs needed to convey patients to base hospitals. Ambulances—although bearing little resemblance to today's vehicles—were one solution to the transport needs. Ambulances came in many shapes and sizes. The vehicles used as ambulances were not always appropriate for patients. There was much variation between centres in the availability and suitability of vehicles. Some municipalities were generous in their support whereas others, particularly the poorer rural communities, could not always provide the appropriate vehicle for the use of the BN.

For the period of the story of Bush Nursing in Tasmania, ambulances (where they existed) were administered by local municipalities. The majority of rural ambulances were operated by volunteers, usually on a roster basis. Additional information on ambulance services is referred to in *Appendix D*. Many early BNs did not have access to formal ambulance services. Local communities would improvise to provide the BN with the necessary transport to send patients to town or city hospitals.

'They are also responsible direct to Sister for her board and lodging whilst away, or any travelling expenses, and her earliest return to the district.' AOT, DPH, 58.8.36, BN Marrawah Rules & Regulations for Marrawah BNC, (HSD 1/36).

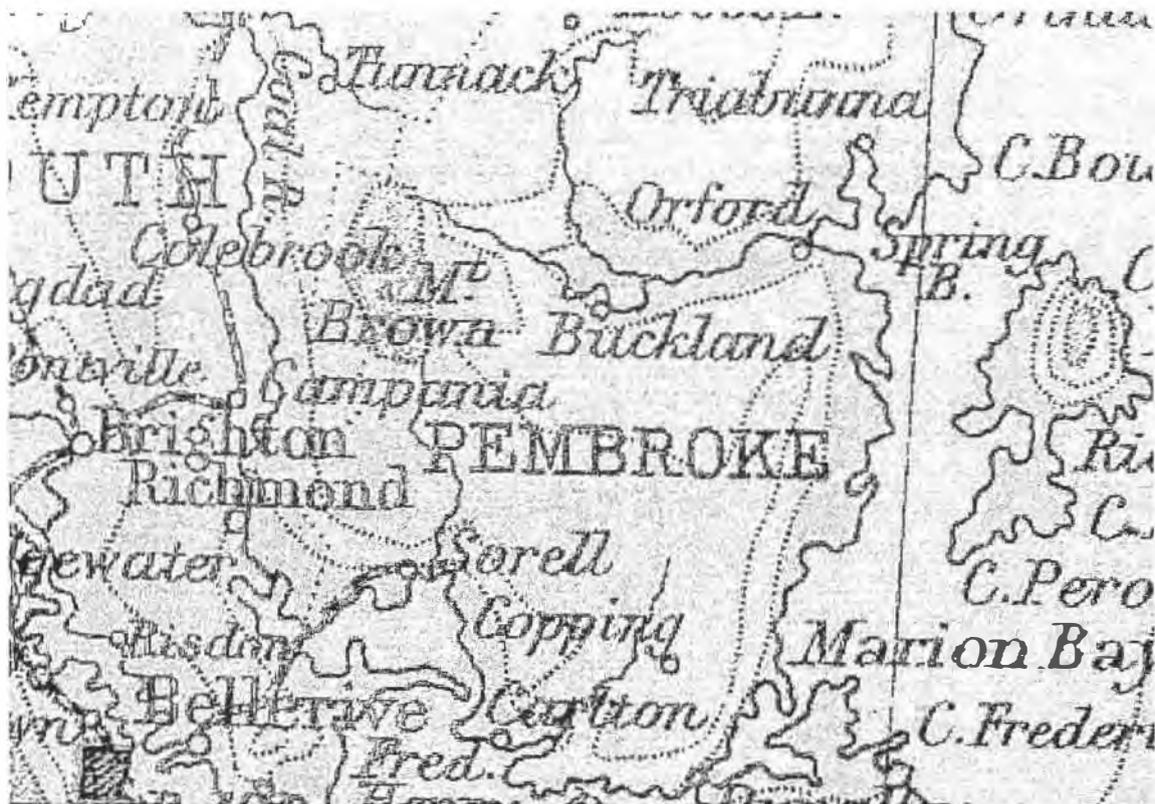
¹⁸³ AOT, DPH, Report for Director Hospital Medical Services re Waratah BN, 26 April 1951, (HSD 5).

Lester provides a picture of the range of 'ambulance services' that might be used in one transfer at Spring Bay:

About 1915, Mr Press who had been injured in an accident at Wielangta, was put on a flat rail truck and the loco pulled it to Rheban. Teams of men carried him 8 km to Orford on a make-shift stretcher of a bag between two saplings where he was transferred to a stretcher on wheels and towed behind the doctor's car to Richmond.¹⁸⁴

Innovation was clearly required. With inadequate or non-existent roads in many areas a range of patient transport methods was adopted.

Map 3.14 Spring Bay



0 10 20 30 40 50
English Miles

Wielangta is a hill approximately halfway between Copping and Orford, and Rheban is on the coast about halfway between Wielangta and Orford. The island to the right of the map is Maria Island.

Source: John G Bartholomew, 'Victoria and Tasmania' in *Times Survey Atlas of the World*, Edinburgh Geographic Institute, The Times, London, 1922, (From the David Rumsey Institute).

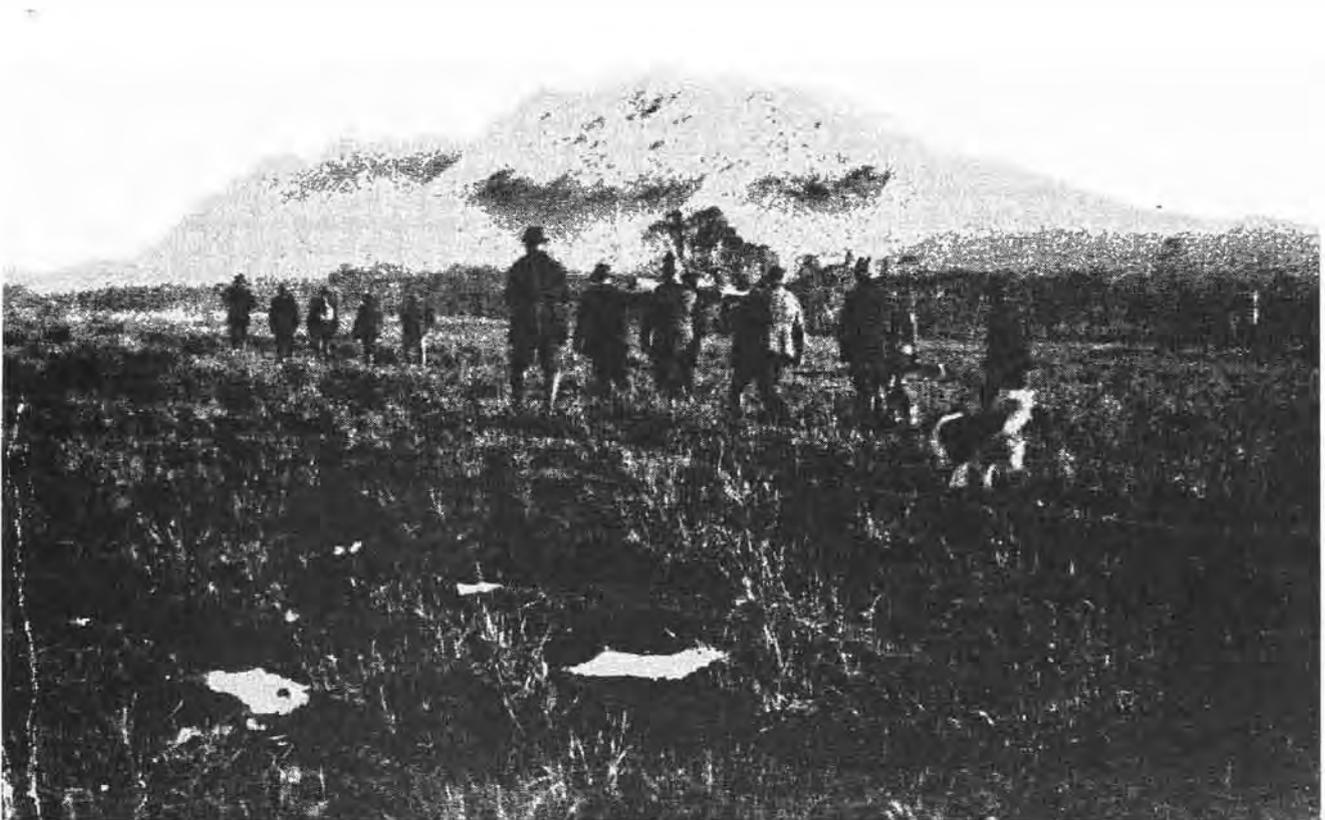
¹⁸⁴ Lester, p. 188.

While conditions might be primitive there was consideration of propriety as shown by this account at Adamsfield:

[W]hen a patient had to be carried out for special treatment ... the nurse would call for volunteers and if the patient was a woman married men would be given preference. A stretcher would be improvised by stretching chaff bags between two long poles upon which the patient would be placed. Four men would then shoulder the poles and with the relief of ten or twelve more and the nurse in attendance, the procession would start.¹⁸⁵

Just as the BN might at times be chaperoned by married men when requiring companionship while travelling, the often intimate problems of women that might lead to their being shifted to the BNC or hospital disqualified single men from helping with such a task.

Photograph 3.16 Carrying-out Patient from Adamsfield



The mountains which ring Adamsfield are clearly visible in the background of this enhanced image of a stretcher party carrying a patient out of Adamsfield.
Source: DPH, Bush Nursing Album, NBT.

¹⁸⁵ MJ O'Reilly, *Bowyangs and Boomerangs—Reminiscences of Forty Years Prospecting in Australia and Tasmania*, Mercury Press, p. 162.

The isolation of the BNC and weather-related complications meant that it was often imperative to get the patients transported out of the area as soon as was physically possible. At Adamsfield Sister Elsie Bessell recalled:

Many exciting incidents occurred from time to time. On one of the coldest days and nights icicles hung from inside some tents. A young digger was lost in the bush and with the spirit which never failed in an emergency, many of the men turned out in that bleakest of nights. Eventually he was found nearly frozen under a log in heavy fog where he had taken shelter, unfortunately his feet and legs had not been protected. It was a slow and difficult task that lay ahead, I did all I could to help and ease the poor fellow. I could see from the start that it would be hopeless to save his feet and that it was imperative that he reach hospital as soon as possible. I sent the word around that I needed men and horses, so we carried the patient slung between two horses. It was an arduous journey for all and we arrived foot sore and weary and anxious for the poor lad who sad to say had to have both feet amputated.¹⁸⁶

Bush Nurses were placed in situations for which their training did not prepare them, and where appropriate facilities were not available. Improvisation was always evident. At Marrawah a woman was transported out of the bush on a 'sled thing'. In labour and needing the BN, the patient was dragged through trackless bush on a sled. It was not possible to carry her through that terrain so 'they had to get her out the best way they could'.¹⁸⁷ Sister Bird recalled another incident at Marrawah in 1939 where an immediate response was required. A boy swallowed a sausage which had become stuck in his throat. He was brought by car immediately to see the BN but she did not have anything to grab the sausage with. So she decided to transfer him urgently to the doctor at Smithton:

But I didn't know whether we'd get him there or whether he'd choke. He had his head on the floor; he had his feet up over the back ... his feet up in the air, sort of leaning on the back of the car ... every breath he took, he was fighting to breathe. [Imitates gasping] ... and I was dead scared he was going to stop; every breath would be the last one.¹⁸⁸

This was an emergency trip and sister described the trip as the fastest ever between Marrawah and Smithton. Once at Smithton the doctor successfully removed the impacted sausage with a pair of forceps. When emergencies presented themselves the communities usually would respond, as in this case, by providing the transport and a driver.

The Montagu Medical Union at Rosebery was attempting to purchase an Ambulance in 1941. Funding was to come from 'the loyal co-operation and sympathetic assistance of the Government, the DPH, and subscribers'.¹⁸⁹ This vehicle proved not to be an outstanding success as was also the situation at Rossarden:

¹⁸⁶ Elsie G Bessell Papers, Private Collection.

¹⁸⁷ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994. This was a maternity case.

¹⁸⁸ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

¹⁸⁹ AOT, DPH, 58.14.41, BNC Rosebery Annual Report from MMTU, 30 June 1941, (HSD 1/79).

The ambulance here is a wicked vehicle—I consider it an insult to ask nurse to ride in it—more so in this cold climate. To ride in the front with the driver is almost as bad as riding in an open sidecar. I made two trips—and had cold sores on my nose and mouth for weeks after. Sister [Ada Gladys] Donald said she rarely went out in it and I don't wonder. Am thinking in the middle of winter, I'd be inclined to let the patient take its chance rather than risk pneumonia myself.¹⁹⁰

A more ambitious ambulance service, the Sorell District and Peninsula Ambulance Service was subsidised by the Tasmanian State Government and opened in 1944. It was dedicated for 'Christian Service in the cause of Humanity' supplying two ambulances 'ANYWHERE in Tasmania 24 hours a day, 7 days per Week'.¹⁹¹ By 1946 in the Southern part of Tasmania the Southern Tasmanian Transport Service provided ambulance services to the south of the state, including Oatlands. With just two ambulances, areas outside Hobart were serviced in cases of extreme emergency only.¹⁹² The service was of little assistance to the BNs. Soon, however, ambulance services were established in other locations.¹⁹³

Ambulances were not always located conveniently or close to the BN. In later years the BN at Koonya recalled that although there was an ambulance it was not kept at the hospital but located at the ambulance station, some distance away.¹⁹⁴ Sister Evelyn Dorothy Elizabeth Mellish at Gladstone remembered the ambulance but found it was usually difficult to locate:

[T]here used to be one at Derby in those days and one at Scottsdale ... Before the Scottsdale Hospital took it over, we had to use the Derby ambulance. Well, you can imagine if you wanted it now, it could be out at Gladstone, it could be at Musselroe, so you couldn't really rely on that.¹⁹⁵

¹⁹⁰ AOT, DPH, BN Rossarden, Sister Tilley to Sister Noller, 30 May 1949, (HSD 6/34). Sister Ada Gladys Donald, (née Jeffrey).

¹⁹¹ AOT, DPH, Letter to DPH from Sorell District & Peninsula re ambulance charges, 9 March 1950.

¹⁹² Hobart serving all districts south of and including Oatlands, controlled by the Southern Tasmanian Ambulance Transport Services Board, fees charged for hire; Sorell serving Sorell, Richmond and Tasman controlled by Sorell and District Ambulance Service, fees charged for hire. AOT, DPH, 60.64.46, Miscellaneous File, Ambulance Services in State—data supplied to Commonwealth Health Dept, (HSD 6/2).

¹⁹³ Launceston serving Launceston and surrounding districts controlled by the Northern Ambulance Association, fees charged for hire; Scottsdale serving north eastern districts controlled by the North Eastern Soldier's Memorial Hospital Scottsdale, fees charged for hire; Latrobe serving Latrobe and surrounding districts controlled by the Devon Public Hospital, Latrobe, fees charged for hire; Burnie serving Burnie (no other data available); Wynyard serving Table Cape and Circular Head controlled by the Spencer Hospital, Wynyard, fees charged for hire; Rosebery and Tullah serving Zeehan following portions: Rosebery and Tullah, where rail and motor ambulances are provided, controlled by Montagu Medical Union, fees charged for hire; Queenstown servicing Queenstown, Strahan, Gormanston and if necessary the Smithton serving the Circular Head Municipal district and controlled by the local authority, fees charged for hire; Glenorchy serving Glenorchy municipal district and controlled by the local authority, fees charged for hire. AOT, DPH, 60.64.46, Miscellaneous File, Ambulance Services in State—data supplied to Commonwealth Health Dept, (HSD 6/2).

¹⁹⁴ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

¹⁹⁵ Evelyn Mellish, Interview, Musselroe Bay, 1994.

In 1936 the Tasman Council debated the most suitable type of vehicle for the BN's transport needs:

[T]here is a diversity of opinion as to the most suitable vehicle. Many suggestions have been made, such as an ambulance; a sedan car with half the back of the front seat to be adjustable in the same manner as the car already in use. A single seater car or a utility truck with a special cover under which patients can be placed on a stretcher¹⁹⁶

The concept of the BN driving the ambulance was not favoured. A driver might be procured when sick patients were being driven to the doctor so that the BN could give attention to the patient. As the ambulance would be the only vehicle for use in attending to the health needs, at other times the nurse would need to drive the ambulance herself when visiting patients in the district. The solution that seemed best was for the BN to have a single seater car to which could be attached a stretcher if required.¹⁹⁷ Often cars were used as ambulances and BNs improvised patient transport arrangements. Nurses describe cases where cars were employed as ambulances and patients would be laid on the back seat, babies born on back seats, and planks used within the cars to lay the patients straight on their backs.

At Strahan a panel van was provided 'to serve as an ambulance for transporting patients to the Lyell District Hospital at Queenstown'.¹⁹⁸ Often at the BNCs hire cars were used as there was no vehicle designated as the ambulance. At Southport hire cars provided the 'ambulance service':

We had no ambulance in that time. Just a car. A hire car ... I didn't ever drive patients to the city. We'd get the hire car man [to take]... the very sick ones to the city¹⁹⁹

By using hire cars provided with a driver the BN could give the patient her every attention as Sister Burns (née Laird) at Waratah described. This hire car, which doubled as the mail service, was:

a big taxi with a lot of space in it that was what I used when I needed wheels. I could get that for emergency things and you would lay your patient on the back seat. You'd sit a little box there beside them and sit on that and look after them while you brought them down the coast.²⁰⁰

Sister Burns always managed to acquire a vehicle when needed. In 1952 the Bush Nursing Association supplied a Holden sedan car for the BN at Waratah. The stretcher would be placed through the boot. There was a roster of ambulance drivers including the Council Clerk and members of the Mt Bischoff Hospital Board.

¹⁹⁶ AOT, DPH, 58.16.36, (HSD 1/36).

¹⁹⁷ AOT, DPH, 58.16.36, (HSD 1/36).

¹⁹⁸ *TJPP & P*, 1950–1951.

¹⁹⁹ Viola C Millington, (previously Sister Thompson and née Liersch) Interview, Sandy Bay, 1994.

²⁰⁰ 'Lexie' A J Burns, (née Laird), Interview, Waratah 1994.

Country towns like Lilydale operated taxi services which became the regular transport for midwifery cases being sent to Launceston. At times the baby did not wait until its mother reached Launceston, so volunteers and taxi drivers became recruited as attendants at birth assisting the BN. The general proximity of vehicles and the high costs involved in driving considerable distances were features of the isolation and the state of development of motorised road transport. The cost of hiring privately owned or, in the case of mining companies, the company car, was sometimes a source of contention as we have seen previously where maternity cases were considered self-inflicted and therefore not covered under the rules for usage.²⁰¹ The hire cars were not always available and had other priorities and competing demands for their use, so the sister had to fall back on alternative transport options. All Tasmania's islands required similar improvisation using a range of water-craft as 'ambulances'. At Bruny Island the challenge included improvising communication when urgent access to boats was required. During the period when there was no resident BN at Maria Island, the Southport BN used to travel by fishing boat to the island. Patients needing to be transferred off the island would be taken off by boat.²⁰²

Photograph 3.17 Ambulance, Tarraleah



Sammy Watson in front of the ambulance. Dr Bryant remembered the central highland ambulances as 'converted one tonne panel vans which had room for the driver and nurse in the front, if necessary and you had a stretcher in the tray part at the back and there was a sort of seat you could let down if the nurse had to be beside the patient all the way'.²⁰³ These vehicles, provided at HEC sites, were generally more suited to purpose than those described by Bush Nurses.

Source: Dr Lloyd Bryant, Private Collection.

²⁰¹ An ambulance finally was procured for the community in 1963.

²⁰² Viola C Millington, (previously Thompson and née Liersch) Interview, Sandy Bay, 1994.

²⁰³ Dr L Bryant, Interview, Bellerive, 1994.

Ambulances were often a source of conflict between the BN and the local Committee. Significant restrictions on their use were in place. At Rossarden in 1952 the Chairman (Mr Roper) would not allow the BN's husband to use the ambulance to drive her to patients nor to teach her to drive although it had been approved by the DPH. The Union attempted to relieve the BN of her authority for use of the ambulance and a charge was made for transporting patients to hospital.²⁰⁴ At Brighton Camp the ambulance was not to be used outside of the camp 'except for accidents or in extreme emergency, and a fee of 30/- should be charged'.²⁰⁵ On King Island ambulance drivers were volunteers and available only during working hours on weekdays. After-hours and on the weekend the nurse had to drive the ambulance herself as well as attending to other duties. This created work priority conflicts. In applying for assistance to employ a driver, if required, Hazel Gaffney stated that:

Wednesday a child of 18 months was drowned here about 11 am. I was quite a long while attending to her, & later to her mother. Finally after the police enquiry here, I had to take the child's body to the morgue in Currie (by the ambulance). I should have taken Child Welfare Clinic here that day, but had to postpone it ... I would like to know if I could be relieved of (ambulance driving) ... if I want to be.²⁰⁶

In reply the DPH could offer little assistance, advising that this 'is the best arrangement we can make with the Company'.²⁰⁷

Many Centres had better rail than road access. Rail rolling stock were also used as ambulances when road ambulances were unsuitable or unavailable. The Maydena and Adamsfield BNCs utilised the local rail also, but were not happy with this service as trains were 'too slow and uncomfortable'.²⁰⁸ When Sister Bird at Marrawah looked after her haemorrhaging patient in the bush we saw that 'walking the sleepers' of the railway and tram tracks was the only practical route in and out. Later when the patient improved somewhat she was placed on a little trackmen's truck and taken to the BNC for treatment as required.²⁰⁹

²⁰⁴ AOT, DPH, Letter to Director General Medical Services from Sister DK Noller re Rossarden, 4 July 1952.

²⁰⁵ AOT, DPH, 58.3.3, Letter to Sister Welch, Brighton Camp Secretary Public Health re ambulance use, 14 April 1950, (HSD 5).

²⁰⁶ AOT, DPH, 58.8.3, Letter to PHD from Sister Irma I Welsh, Grassy, re driving ambulance, 31 November 1952, (HSD 5).

²⁰⁷ AOT, DPH, 58.8.3, Letter to Sister Irma I Welsh, Grassy Centre, from Director General Medical Services re ambulance drivers, 26 November 1952, (HSD 5).

²⁰⁸ AOT, DPH, Letter to Director Public Health from Maydena Progress Association re consulting room and transport, 18 September 1952, (HSD 5).

²⁰⁹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

Photograph 3.18 Tullah Rail-based Transport



*The Tullah Bush Nursing Centre utilised the local 'Wee Georgie Wood' train to transport patients, while sometimes relying on horse drawn rail cars.*²¹⁰

Source: DPH, Bush Nursing Album, NBT.

²¹⁰ AOT, DPH, Bush Nursing Annual Report 1946-1947 Northern Centres. It will be remembered that for a time this was the only transport, (HSD 6/10).

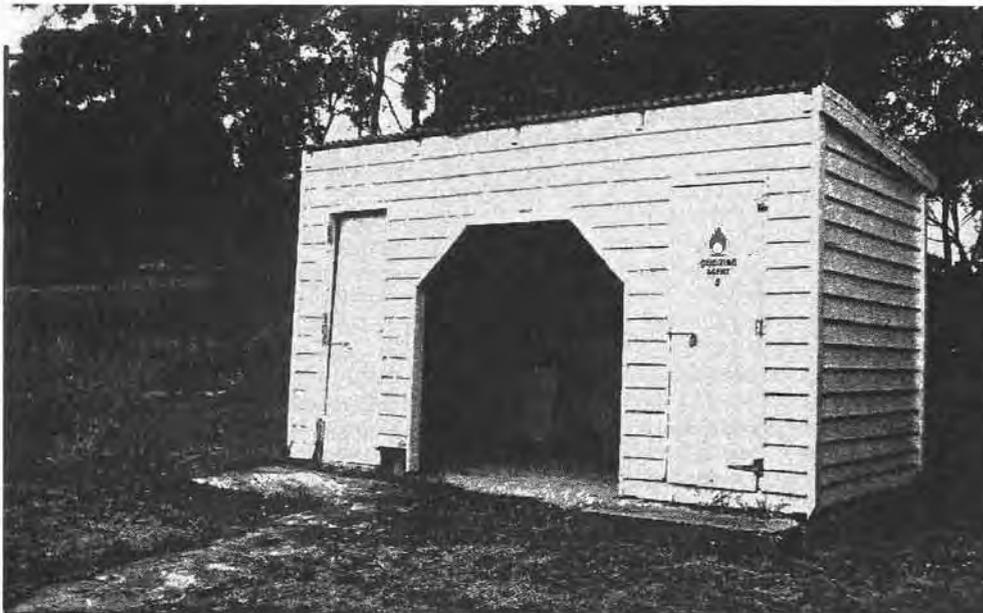
As well as the emergencies, ambulances (or their equivalent) would be used to transport the dead to the morgue. Just as with transporting the sick, transporting the dead required ingenuity:

... an elderly person died at home and I was asked to go and see to the person. Well I found the dear old lady was dead and they said, 'Well, can you fix her up?' I went in and there were little children there and I said to them 'Sorry I can't do this here. We must get her to the mortuary'. Well, there was no transport, so we did sit up the little old lady and put a hat on her and drove her to the mortuary where we did manage to fix her up ... so that she would look like an ordinary person while we drove around the town to the mortuary.²¹¹

With lack of appropriate transport, and the lack of purpose-designed facilities transportation of patients to the mortuary from the hospital was fraught with practical dangers:

The mortuary was some distance away from the hospital and I can remember having this person on the trolley and we had to go across a cattle ramp and, of course, one of the trolley wheels got stuck in the cattle ramp and the wheel came off and this whole body was sliding, so it was quite horrific. We just managed to save it and get over to the mortuary ... and there was no lifting apparatus in those days. It would have been really difficult to manage.²¹²

Photograph 3.19 Mortuary at Bruny Island



The mortuary at Bruny Island was a small unlined wooden shed at the back of the Bush Nursing Centre. The area in which bodies were kept was inside the open area in the middle.

Photographer: Alex Thomson.

Source: M Bardenhagen, Personal Collection.

²¹¹ Eileen McManus, (née McMamin), Interview, Falmouth, 1994.

²¹² Eileen McManus, (née McMamin), Interview, Falmouth, 1994.

The BN could not have carried out her duties given the climatic conditions and the geographic spread of her work if walking had been the only way to move around her area. Transport services were distributed unevenly, unreliable, often slow, and not always safe. Transport difficulties affected the nurse's access to patients, their access to her, and the choices of treatment made by the nurse. The situation slowly improved over the years and by the late 1940s it was stated that:

Proper motor transport for the staff is now the rule, with facilities for the transfer of patients to hospital, when necessary, by means of 'plane, boat, motor or rail.'²¹³

Even by the end of the Bush Nursing era access to vehicles was unequal and responsibility for transport and costs remained a disputed issue. It was not only transport issues which served to isolate the nurse and to create an environment in which she needed to become autonomous and flexible. Her work environment and the communications infrastructure both affected her professional practice and moulded her into a unique health professional.

Communications

Geographic isolation today is lessened substantially by communications technology. Bush Nursing, however, commenced at a time when for rural Tasmanians the postal service was in general the only way to communicate to those outside their area other than face-to-face meetings. Communications were to play an increasingly important part in the lives of BNs. Advances in communications gradually allowed isolation to decrease, and provided an environment in which control of practice could be implemented more easily.

As the telephone infrastructure was expanded it became possible to consider connecting subscribers to the network. Lilydale was one of the first BNCs to recognise the importance of the telephone for the BN. On 25 July 1934, a telephone to BN's quarters was on the local committee's agenda. It was decided to ask the Postal Department to put in a direct telephone line from the residence of the Postmaster to the rented quarters of Sister Doris Hetherington.²¹⁴ This provided the BN with the opportunity to discuss problems with the hospital or doctor. As most of the local community did not have telephones its use within the area was more limited.

²¹³ AOT, DPH, 'A Short History of Bush Nursing in Tasmania', DK Noller, (HSD 6/59).

²¹⁴ QVMAG, Box 10, Lilydale, 25 July 1934, Annual Meeting Bush Nursing Notes.

A telephone cable across Bass Strait opened in 1935, but this was not extended to connect the small islands in the Furneaux group.²¹⁵ Bruny Island was serviced better than the Furneaux Islands and a telephone was installed at the Bruny Island BNC in 1936.²¹⁶ Where telephones were not available, such as at Cape Barren Island, the community generally relied on the telegram. This, however, was an expensive service and communication between the BN on Cape Barren Island and the doctor on Flinders Island based at Whitemark was restricted because of these costs. In 1941 the DPH took over responsibility for telegraphy costs, from the Lands and Surveys Department, and telegrams were no longer subject to strict control.²¹⁷

More flexible and personal than telegraphy, radio services were utilised also with radio transmission to and from Cape Barren Island being available in 1947. Radio transmission was based on scheduled call times and no continuous service was provided. The local doctor considered that this was still inadequate and the combination of lack of continuous communication and the weather restrictions on boat access to and from the island made a medical service impossible.²¹⁸ The lack of communication and difficult access were used as reasons during an unsuccessful attempt to close the Cape Barren Island Reserve in 1947.²¹⁹ The radio remained unreliable and the telegram continued to be the primary means of communicating between doctor and the BN on the island. The radio limped on and in the 1950s the BN's husband maintained it in a semblance of serviceable life by judicious use of matches stuck here and there. This combination of unreliable radio services, difficult transport, and isolation, made health-care delivery difficult. This was highlighted when in June 1952 there was a gap in BN services on the island. In response to a query about the lack of a BN and the poor services and access, the Minister of Health replied but was not reassuring. The difficulties in communication were recognised but appeared beyond solution. He stated:

I am aware of the fact that there is an unreliable pedal wireless, an unusable air strip, no medical officer and no BN on Cape Barren Island and that the distance from Flinders Island is roughly three hours and sometimes it may be very rough. With regard to the question of wireless, this matter has been taken up with the department concerned to see whether a new type of wireless could be installed. Apparently not.

²¹⁵ Robson, p. 468.

²¹⁶ Davis, p. 13.

²¹⁷ AOT, DPH, 58.7.41, BN Cape Barren Island—Radio communication service between Cape Barren Island and Flinders Island, (medical messages)—payment for, memo 26 November 1941, (HSD 1/80). 'This Department will meet the cost of any telegrams of a medical nature which may pass between Dr Connell and Sister Davies.'

²¹⁸ AOT, DPH, 58.6.41A, (HSD 1/80).

²¹⁹ AOT, DPH. Letter to Dr BM Carruthers Director of Medical Services from Dr SJ Rumbold GMO, 20.8.47, 'The suggestion of dispersal of the CB Island population is supported by the fact that an adequate medical service is impossible because [of access to and from the island and the lack of] ... continuous communication,' (HSD 6/10).

As regards the airstrip, I have also asked this matter to be investigated for the purpose of clearing the track but was informed that the cost would be too great.²²⁰

Isolation was to continue. It was not always an inevitability, but was maintained by the attitude of the DPH to the use of transport and communication technologies. Isolation was politically acceptable despite the obvious difficulties in attracting BNs, and the stresses on BNs created by the occasional poor health outcomes resulting from that isolation.

The DPH's cost based decisions were not always logical. At Southport Sister Louie Green had a pedal and a battery operated radio set, but both had poor reliability: 'the "set" refuses to function; this is its "chronic state" and never in any year have we had more than six months use of it!' She was frustrated by the false economy of the DPH. A switch already had been installed for an electric radio set but the DPH was spending almost as much each year for replacement batteries as it would have cost to have installed a reliable radio. Because of the poor reliability of the old battery she was 'tortured with the unrelieved loneliness of this awful, unusual desolation. A young nurse would have been given one at once.'²²¹

The mutton-bird islands off the coast of Flinders Island were also a source of concern as one of Tasmania's most remote corners. The importance of reliable and speedy communication was highlighted by the Council Clerk on Flinders Island in a letter to the Premier:

My Council desires to stress the necessity for wireless communication with Babel Island in the Mutton-birding season. Last year a woman suffered from a poisoned hand and was fortunate to be able to get off the Is and proceed to Launceston for surgical treatment in which he [*sic*] lost her middle finger. The previous year a young man who had his hand poisoned, owing to rough weather, was unable to leave the Is in time and so died shortly after admission to Hospital at Launceston. Had wireless been installed a large fishing boat could have been sent out to Babel to get this young man in time to save his life.²²²

The lack of adequate communication required BNs to improvise methods of communication. Fires were used as signals on Bruny Island, gunshots to summon help on Babel Island, and towels left on gates at Triabunna. Without such improvisation lives would have been lost.

The presence of a telephone infrastructure into an area did not guarantee access to a telephone. Even on the Tasmanian mainland where telephone services became available

²²⁰ AOT, DPH, 58.4.3, Letter to Minister for Health from John Steer, Member of the House of Assembly re BN needed on Cape Barren Island, 25 June 1952, (HSD 5).

²²¹ AOT, DPH, 58.18.47, (HSD 6/11).

²²² AOT, DPH, 146.3.52, Letter to Premier, Tasmania, from Council Clerk Flinders Island, re wireless mutton bird Islands, 27 October 1952, (HSD 5).

early within the history of the Bush Nursing Service, access to telephones was not always easy for the BN.²²³ Telephone lines usually were shared and thus telephone calls were not particularly private. Few BNs had a non-party line. The nature of local telephone services meant that the telephone exchange operated only in normal working hours. In Waratah the BN was not considered the highest priority in the town for telephone services. The only after-hours connection was located at the local police house. On weekends and every day from 10 pm–8 am the police had the only usable telephone. Ruby Kelly remembered:

I couldn't ring up on my phone ... even though I had the hospital phone there, it was like everybody else's private phone. It stopped Friday night. Urgent things went through the police station.²²⁴

This system was not without advantage as 'if they couldn't get me they rang the policeman and asked if he knew where I was. They knew the routine'.²²⁵ The small size of the community allowed the police to know, or quickly ascertain, the BN's whereabouts.²²⁶

The BN was the person the community initially called upon in situations of domestic violence, suicide and accidents. In many cases she arrived prior to the police, even though the police was the only group with continual access to the telephone. It was not only BNs who had problems obtaining adequate telephone access. Government Medical Officers, such as the doctor at Southport in 1938, also were concerned about inadequate after-hours telephone access. He complained to the DPH that the arrangements for telephone communication between the BNH and the doctor could break down when most needed. As an example he noted that:

a maternity case which was worrying the Sister—was delivered about 5 am & the message called me was not received till 6.10 am—it was brought by car to me from Southport.²²⁷

His telephone access problems served further to isolate the BN. The same problem existed at Avoca when the postmaster was absent on sick leave. Even in emergency the BN could not 'ring the Campbell Town Hospital, between the hours of 10 pm and 9 am on week days, Saturday afternoons, and Public Holidays'.²²⁸ The solution to the communication problems for the BN at Southport was that she became the telephone operator in the absence of the

²²³ Unlike in Victoria where good telephone access was earlier than for Tasmania: 'In the 1920's many BNCs in Victoria were linked to telephone exchanges. This was a much-needed development, enabling the nurse to contact the doctor and to have the support of his advice and instructions in emergencies, thus lessening her heavy responsibilities', Burchill, p. 85.

²²⁴ Ruby Kelly, (née Elphinstone), Launceston, Interview, 1994.

²²⁵ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²²⁶ There is potential for further research into the comparison between the rural male police force and the BNs that may illuminate gender inequalities. Both were full-time sole 'professionals' from outside the community, working in isolation.

²²⁷ AOT, DPH, 58.14.38, BN Southport—Letter re poor telephone communication between hospital & Dr, 23 October 1938, (HSD 1/53).

²²⁸ AOT, DPH, 58.2.6, Letter to Post Master General, Hobart from Secretary Public Health re isolation, telephone calls, 8 January 1951, (HSD 5).

postmaster.²²⁹ While an ingenious solution, this clearly would have increased the BN's out-of-hours workload as the trade-off for access to a telephone at all times.

In Tullah a similar system operated where 'for a period of many years, the postmistress (non-resident) has plugged the switch to sister's residence during non-operational times of the Post Office, e.g. nights and weekends'. This gave the BN continued telephone access, until in 1949 the system was changed and a coin-operated call box was installed. Her access to telephone services decreased:

In the event of Sister wishing to consult Doctor re a patient at the Surgery, she has to produce coins and go three hundred yards to the call box and await the call being put through to Zeehan or Rosebery, as the case may be.²³⁰

While it was not uncommon for the BN to have to cope with no telephone access to medical advice when visiting a patient's home, now this was also the case when attending patients admitted to the BNC. If the BN had difficulties with the care of a patient she would have to leave the patient's bedside to walk to the telephone box to place her call. Clearly this was not a satisfactory state of affairs. Consequently this reduced telephone access was of more concern than was the out-of-hours workload that had been created by the BN being the defacto out-of-hours postmaster. Other BNs also had no after-hours telephone access. At Maydena in the early 1950s the BN could not even take the first step to achieving telephone access:

Also I have been informed that there is no-one here I can enquire about the telephone. No one seems to know whom I should contact. It would be a great help if I could get it. The doctors have been commenting on how useful it would be as it is extremely difficult to make a phone call after-hours here.²³¹

In 1952 the Secretary for Public Health made a request to the Post-Master General to try to make communication more accessible for BNs in the North East, in particular for Storys Creek and Rossarden.²³² As before, the mere fact that a facility existed did not mean it was always available and operating. At Adamsfield the only access to telephones was via the Post Office. No-one had private phones. The telephone could be out for weeks because of the heavy snow falls. When lines were cut because of snow, other access was hampered also. Sister Hazelwood described a three week period without contact with the outside world as a consequence of such an event.²³³

²²⁹ AOT, DPH 58.14.39, BN Southport re Telephone Service, 5 June 1939 (HSD 1/70).

²³⁰ AOT, DPH, Report to Director Hospital Medical Services from Sister Widdicombe re Tullah Centre, 15 November 1949, (HSD 1/70).

²³¹ AOT, DPH, 58.28.7, Letter to Sister Noller from EP Locher Maydena re mileage and need of telephone, 1 September 1952, (HSD 5).

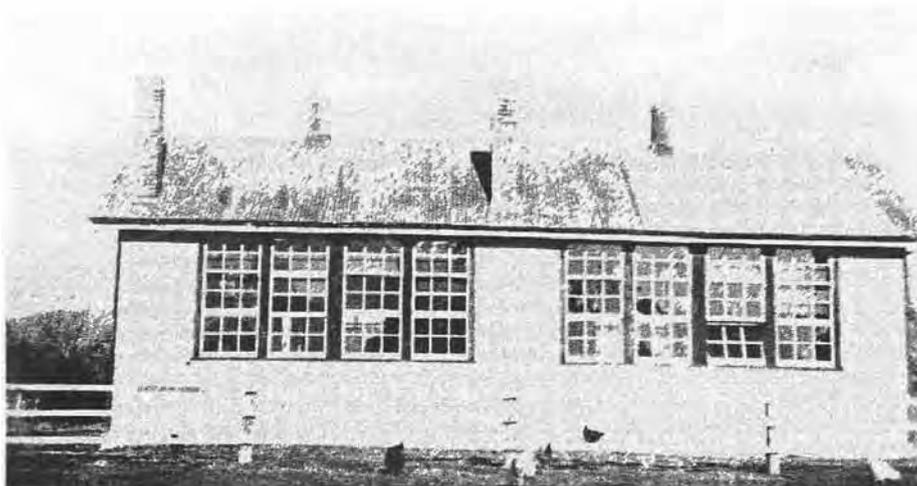
²³² AOT, DPH, 58.2.6, Letter to PMG Hobart from Secretary Public Health re isolation, telephone calls, 8 January 1951, (HSD 5).

²³³ AOT, DPH, 58.4.3, Letter to Minister for Health from John Steer MHA re BN needed on Cape Barren Island, 25 June 1952, (HSD 5).

As years went by the telephone became of paramount importance to BNs, the technology lessening some of the impact of their physical isolation from other health care workers. Direct contact with doctors was possible. For example the BN at Marrawah would ring the nearest doctor at Smithton, and the BN at Waratah would have contact with doctors at Penguin or Wynyard. Contact with hospitals was also an integral part of the BN's work. Instruction over the telephone, if and when possible, was a welcome innovation for the BNs. In some centres community or local groups recognised the value of telecommunications and supported the request for better telephone access. Communities lobbied for services to be extended to both the BNC and the BN's residence.²³⁴

While the BNs appreciated their telephone link to the outside world, communication by telephone could not obviate all aspects of their isolation. By the mid 1940s, BNs in most cases could contact, eventually, a hospital or GMO for advice. Nevertheless they were alone when making the initial decision that led to the telephone call, and in carrying out that advice. The doctor could advise based only on the information that had been collected and interpreted by the BN, and conveyed to him. In her work she was hampered by a lack of equipment. The nursing equipment she had available was not as extensive as she had been trained to use, and in many instances, if it existed, it was often outdated or unmaintained. How BNs worked in such isolation now will be explored by examining their workplace—the Bush Nursing Centre.

Photograph 3.20 Legerwood Bush Nursing Centre



The Legerwood Bush Nursing Centre was a satellite operated from Ringarooma. Using a vacant local school, it was not used for admission of patients or for accommodation for the Bush Nurse.

Source: DPH, Bush Nursing Album, NBT.

²³⁴ One group of rural women who lobbied for assistance was the CWA at Legerwood, with the support of the local doctor. The CWA offered to pay for all calls if they could have the telephone installed at the Legerwood School for the use of the Doctor (on his once-weekly visits) and the BN.

Bush Nurses' Workplaces

There is a range of consequences that resulted from the isolation described so far and which impacted on the professional nursing practice of the BN. The physical isolation of BNCs influenced their design and the available resources. Some centres were based in makeshift premises such as tents or garages, while others were 'purpose built'. Still other centres were set up in temporary facilities because of the seasonal nature of the work, such as centres in the Furneaux Islands for the mutton-birding industry. Generally the centres began as small cottages that were added to over the years. While some developed into small hospitals, other municipalities established BNHs from the outset. Across the Bush Nursing Service in Tasmania there was no uniformity in the provision of the building in which the centre was housed, the resources provided, or in the accommodation facilities. In remote areas of Tasmania, facilities such as electricity and telephone or telegraph links did not exist. Medical equipment was too expensive for poorer communities to supply. Some communities provided independent accommodation for the BN while others combined living and working space in the one building. (See *Appendix E*).

To a large extent BNCs varied according to the level of community support and the success of fund-raising. No matter how well resourced, BNs, particularly when first arriving from the urban centre hospitals where they had trained and worked, usually considered the centres to be ill equipped. The working conditions impacted on personal and professional isolation. The former is discussed in the next chapter. The proximity to, and relationship with, base hospitals and with other health professionals, in particular GMOs, shall be dealt with in Chapter Five. Consequences of isolation included a lack of facilities and a range of difficult circumstances. These led BNs to improvise and display a characteristic inventiveness. This section sets the context in which BNs operated and provides the background in which to gauge their clinical work as independent practitioners.

The BNC was referred to variously as surgery, clinic, a health centre and at least in two instances 'a clearing station' or 'annexe'.²³⁵ There was an inconsistent distinction made between Hospitals and Centres based on the availability of beds for the admission of patients. Such categorisation was not static and often a centre would become a hospital and vice versa. While the needs of the community at that time were an important factor, the availability of adequately trained staff was the primary reason for a change in the

²³⁵ One was Lilydale after World War II, where a 'modern Home and Clearing Station' was opened officially at Lilydale on 10 January 1948, and another at Babel Island.

designation. The terms 'Centre' and 'Hospital' often appear to be used interchangeably for the same location at the same time.

According to the regulations the BNHs were facilities with 'usually three or four beds' and their primary purpose was 'for cases of uncomplicated midwifery' and the 'temporary care of accident cases' prior to their transfer to a base hospital.²³⁶ Bush Nursing Centres were to have no hospital beds, or only one bed for 'emergency temporary care of accident cases prior to transfer to the nearest hospital'. Some BNHs employed one nurse, but others employed two nurses if they could attract and keep them. One BNH employed three nurses for a short period. Generally BNCs were staffed by one BN. As well as the discrepancies between the designation as a centre or a hospital there was great variation in ownership and control of the facilities as was outlined in Chapter Two.

The 1940s and 1950s were times of expansion for the Bush Nursing Association within the DPH. Ouse was one centre that eventually was lauded as epitomising what a modern BNC should be like and was featured on the cover of a pamphlet, *History of Bush Nursing*.

Photograph 3.21 Ouse Bush Nursing Centre



Opened in January 1940 this was described as 'the first all-electric Bush Nursing Hospital'. This purpose-built centre was extended over a period and became one of Tasmania's busiest Bush Nursing Centres.
Source: DPH, Bush Nursing Album, NBT.

²³⁶ State of Tasmania DPH Bush Nursing Service, *Information Relating to and Standing Orders of the Bush Nursing Service*, August 1953, p. 5.

Additions to the Ouse BNC soon meant it had hospital status as noted in 1936:

By adding a general ward we hope to make the work easier and more congenial to the Sister in charge, by saving her often long rides in all weathers, and at the same time offer patients the comfort of hospital and more or less her constant attention in preference to hurried visits. Whenever a patient is admitted, the committee allow sister to engage a maid for so long as the said patient is in the Home.²³⁷

The Ouse BNH officially comprised a five bed delivery ward, two wards with two beds and a single room for maternity.²³⁸ The capacity to admit more patients and to employ more staff might have saved the BN from travelling long distances in difficult conditions but it added to her responsibilities with the supervising of staff and in caring for patients 24 hours a day. Ouse soon became a two-nurse centre. In 1952 it attracted a third nurse because of the high workloads. The Director General of Medical Services wrote to the Minister of Health bringing his attention to the stresses the centre was under, stating:

The state of affairs at this hospital has been giving rise to some concern lately. There are at present only 2 Sisters on duty and the work there is very heavy. Furthermore, there are only two domestics for whom there is living-in accommodation. Apparently it is difficult, if not impossible, to get domestic help unless board is made available ... In order to correct the immediate situation, I have asked Sister Noller to appoint a third Sister temporarily, and a permanent one as soon as possible, and as soon as accommodation can be made available for her in the town.²³⁹

The Ouse BNH was a busy small hospital environment. Recruitment and retention problems affected BNHs which meant they were not always able to maintain their two-nurse staffing. In the more fortunate times when a BNH had two nurses working within it, the professional isolation of the BN arguably was diminished. Unlike her city counterparts the BN had significantly less support from other staff, and her long working hours would have decreased the contact between the nurses. Generally two nurses equated with double or triple the workload. Even within BNCs with two BNs, BNs often felt isolated from all collegial support and interaction. In providing 24-hour care, seven days a week, there was little useful overlap and little rest, let alone leisure.

Satellite or Annexe Centres were established in at least four municipalities. This meant that the BN had an equipped facility in which to practise in at least two locations within her municipality. Given the geographic spread of her patients, and the low level of community access to adequate transport, this provided significant improvement in the

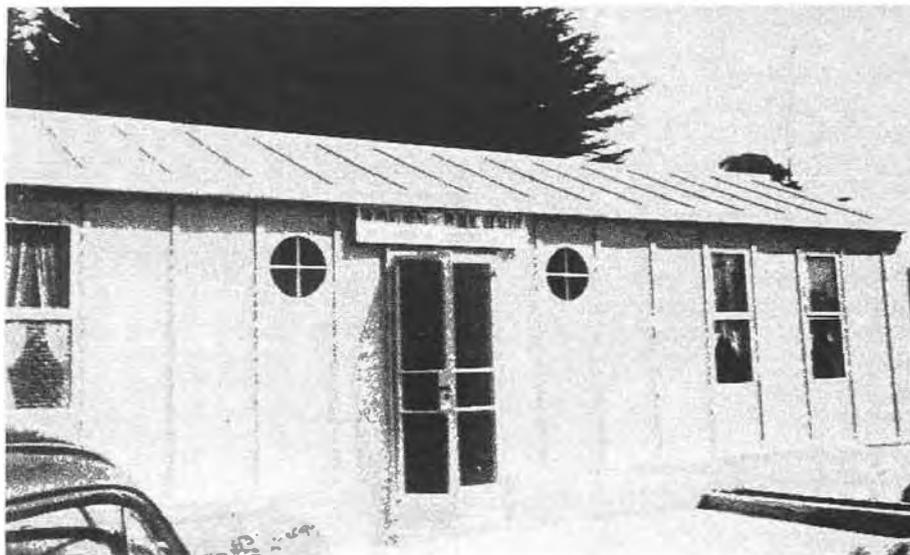
²³⁷ AOT, DPH, 58.8.36, BN Marrawah, Letter Secretary Public Health, from Marrawah Committee adding general ward, (HSD 1/24).

²³⁸ Dr L Bryant, Interview, Bellerive, 1994.

²³⁹ AOT, DPH, 58.12.3, Memo to Minister Health from Director General Medical Services re Ouse Hospital, 27 November 1952, (HSD 5). A significant feature of this period was the expansion of the HydroElectric Commission Scheme in Tasmania. The increase and cultural diversity in population from the hydro villages, as well as the service industries locally created higher demands on the BNs' time at Ouse. One BN recalled there were seven different nationalities in the Ouse BNH at one time. L Shoobridge, Personal communication, 2003.

convenience of services for the BN's patients. The BN at Redpa had a satellite centre at Marrawah, Ringarooma had an annexe at Legerwood, and the BN at Gladstone maintained the Herrick centre.²⁴⁰

Photograph 3.22 Herrick Satellite Bush Nursing Centre



Bush Nursing Centres display a variety of architecture which reflects the various origins of the premises (purpose built or converted), the ability of the local community to raise the necessary funds, level of in-patient care offered, and the period in which it was constructed. No standard for design appears to have been adopted. Floor plan variations are demonstrated in the Appendices.

Source: DPH, Bush Nursing Album, NBT.

On King Island there was the BNC at Grassy and the annexe at Currie. As time passed it became increasingly difficult for the Bush Nursing Service to maintain staff. Many centres were amalgamated and small satellite centres closed. Others operated special clinics at various locations within their districts in rooms not specifically set aside for the BN. In contrast with annexes which were listed formally in DPH reports, used only for the BN's work, and 'properly equipped', rooms in special clinics changed according to the needs of the community. The BN carried her equipment to these locations.²⁴¹ Child Welfare Clinics especially were operated in rooms such as vacant school rooms, as at Legerwood. These rooms also were shared or made available to the visiting GMO.²⁴²

Where a significant demand for nursing services could be established for a short period of time, seasonal centres, such as on Babel and Chappell Islands, operated for the

²⁴⁰ Redpa was known as East Marrawah until April 1925. S Marshall et al, *One Hundred Years On—A History of Marrawah-Redpa 1889–1989*, Circular Head Chronicle, p. 63.

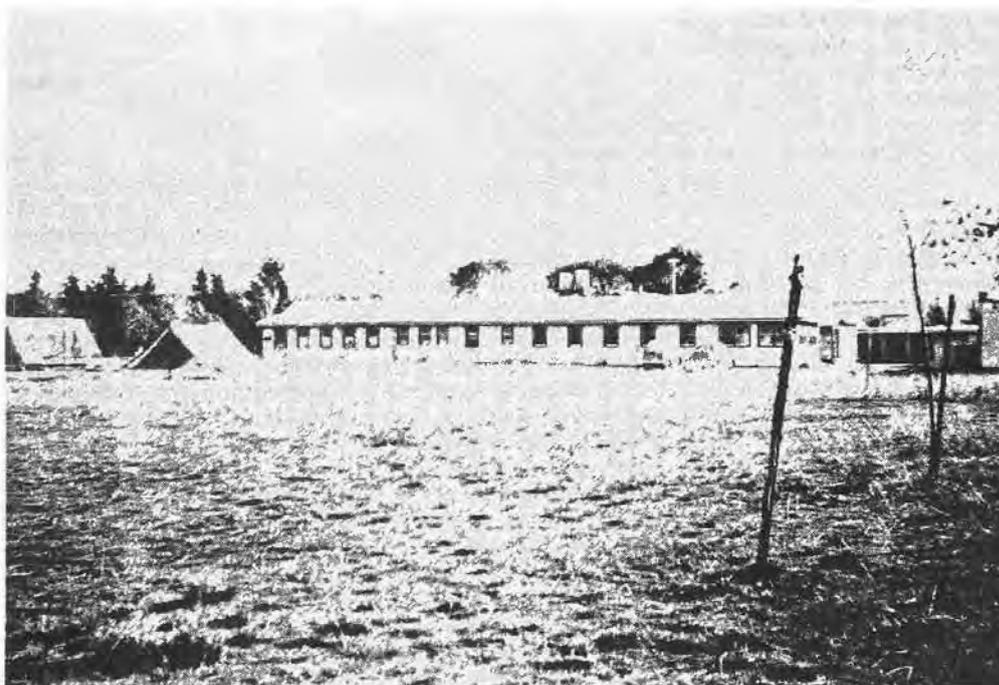
²⁴¹ Ruth Bartels, (née Homes), Interview, Bridport, 2003. These rooms later were taken over by the Child Health Nurse.

²⁴² AOT, DPH, 58.35.45, BN Legerwood School Building. Use by CWA Legerwood as BNs Surgery, Letter from E L Singline, Honorary Secretary, Legerwood Branch CWA, (HSD 1/91).

duration of the mutton-bird season. The establishment of these centres resulted from strong lobbying by the local community and from pressure placed on the Minister of Health through the press. At one point conditions on Chappell Island were worse than those on Babel Island and so primitive that they were considered unfit for a nurse.²⁴³

In 1949 a special-purpose centre was established at Brighton primarily to assist displaced persons. The BNC was established to cater for the needs of some 400 displaced persons who were admitted to Brighton Camp in addition to 400 to 500 Australians already situated there. With the closely-confined geographic region (the camp only) served, and the specific purpose behind the establishment of the Brighton Camp BNC, the centre was an anomaly that is not analysed separately within this thesis.²⁴⁴ A study of the Brighton Camp BNC as well as the HEC camps would provide insights into how the BN coped with diverse cultures and languages in the health setting, as well as highlighting Tasmania's multicultural roots.

Photograph 3.23 Brighton Bush Nursing Centre



This Centre was completely funded by the Government because of the nature of its work.

Source: DPH, Bush Nursing Album, NBT.

²⁴³ AOT, DPH 58.7A.39, BN Chappel Island Mutton Bird—re living conditions at Chappel Island not fit for nurse, 24 February 1939, (HSD 1/70),

²⁴⁴ The BNC at Brighton operated between 1949–1952. Sister JL Folder and her family lived on site. AOT, DPH, 58.48.49, Report Brighton Camp, 22 September 1949, (HSD 6/34).

The Medical-Union-operated Centres usually needed to be pressured by the DPH to upgrade facilities for the BN. They were the least supportive of supplying the telephone for the use of the BN and also were generally less likely to fund needed nursing equipment. The DPH intervened at Tullah in 1943 when it was deemed Sister Heather Lynch's accommodation was unsatisfactory. The outcome of this intervention was that the DPH recommended that she 'provide her own quarters and live with her husband, attending the surgery during surgery hours'.²⁴⁵ This arrangement was at a time when the concept of married nurses only just was becoming acceptable, and when their living with their husband was not considered usual. The intervention most likely was welcomed very much. The situation of Medical Union Centres worsened with the impact of a falling income from the subscription base. It became a justification for the DPH to take over the administration of some centres and by the early 1950s the number of Medical Union BNCs had dwindled. It was increasingly difficult to attract staff to these centres.²⁴⁶ In *Appendix F* is a list of BNCs, as at June 1949, illustrating the various controlling bodies.

Bush Nursing Centres and BNHs varied in their construction, the size and configuration of the work and residential space, and in the ways in which they operated. This situation reflected the isolation and difficulty of access to an area, the financial viability of a community, and the degree of support from that community. The presence or absence of residential accommodation in the BNC affected the BN's isolation. The location of the BNC and its availability for the Bush Nursing Committee meetings and other community gatherings affected her centrality in the community. The number of beds within the centre influenced the provision of domestic support and the potential for this support to reduce isolation.

When the Bush Nursing Service first came into operation Bush Nursing Sisters certainly had to 'rough it'. The primitive conditions contributed to the BN's sense of physical and personal isolation. Bush Nurses at Green Ponds and Adamsfield initially operated from tents.²⁴⁷ The harsh conditions at Adamsfield included the BN's 'large tent with a camp oven and very little else'. To reach her tent she had to 'wade knee deep in mud and avoid dozens of prospecting shafts uncovered for the most part'.²⁴⁸ Even as late as 1939 tents and flies also were supplied as accommodation for Sister Evans, the BN on Chappell Island.²⁴⁹

²⁴⁵ AOT, DPH, BN Tullah, Re relieving BN—see also file 87.7.43, 58.20.43, (HSD 1/87).

²⁴⁶ AOT, DPH, Memo to Director General Medical Services from Sister DK Noller re Rossarden BNC, 20 February 1952, (HSD 5).

²⁴⁷ Various sources.

²⁴⁸ Elsie G Bessell Papers, Private Collection.

²⁴⁹ AOT, DPH, 58.7A.39, BN Chappel Island Mutton Bird, Memo re Sister Evans camping equipment, 6 June 1939, (HSD 1/70).

Sister Bessell recalled that after a period of using a tent as the BNC at Adamsfield she decided 'something more comfortable was needed'. Using the materials available at hand she improvised and constructed a crude hut:

so with a rough framework and a few yards of hessian I contrived quite a homely building and treated a great many diggers with cuts, bruises and those disabilities which so often occur in such a large community.²⁵⁰

Eric French remembers the hut as having two rooms, one of which was used for patients.²⁵¹ One assumes that Sister Bessell had improved on her living quarters and swapped her tent for the one other room—cooking, living and sleeping in that room. Conditions continued to improve and Sister Bessell noted that 'a little later a temporary hospital was built of slabs and there I took up duty'.²⁵²

Photograph 3.24 Adamsfield Bush Nursing Centre, c1928



The Bush Nursing Centre at Adamsfield improved from a small tent to a slab hut which was, for all its primitivity, better than the accommodation lived in by most mining families.

Source: CA Bacon, *Notes on the History of Mining and Exploration at Adamsfield*, Mineral Resources Tasmania Report 1992/20, p. 29. Fred Smithies Collection, AOT.

²⁵⁰ Elsie G Bessell Papers, Private Collection.

²⁵¹ Nephew of Elsie G Bessell who spent time with her on the fields. Eric French, Personal Communication, Newnham, 2002.

²⁵² Elsie G Bessell Papers, Private Collection.

By 1936 conditions at Adamsfield had improved still further. Sister 'Maisie' Evans accommodation was:

a cottage or perhaps I should say hut, containing four rooms one of which is for emergency cases, or if the nurse thinks it necessary to have a patient under her personal care. I do not say that it very up-to-date, but is the best place on the Field. Furniture, linen, crockery, etc. are provided. Sometimes nurses take some of their own personal belongings to a Centre, to give an intimate touch to the place. It is not necessary to take nursing equipment as that is always provided.²⁵³

Thus the BN at Adamsfield now had a small purpose-built hospital and separate accommodation, but she would sleep within the hospital when required.

Crude huts were the only accommodation on Babel Island. The Supervisory Nurse wanted assurance that suitable accommodation would be provided for the BN before sanctioning the placement as she noted: 'I understand that living conditions and general surroundings, are to the least of it, primitive.'²⁵⁴ An advertised pledge in *The Examiner* stated that the Mutton Birders' Association was prepared to put up a proper permanent dwelling for the Nurse, however on her arrival at the Island Sister Risby was informed that she might board with the Holloways.²⁵⁵ She was welcome to avail herself of any other arrangement she could make. Holloway's offer was presumably the most attractive available as 'after visiting a number of dwellings, Sister decided to stay at Holloway's.' That this offer was the most attractive raises speculation about her alternatives since the following description of her shared accommodation in this dwelling underlines the basic nature of life on the islands:

To say the least of conditions, these were extremely rough and primitive. Her accommodation consisted of a room in a paling structure, the walls of which were lined with old newspaper. The room measuring 9' x 6' was separated from another bedroom, in which two female mutton birders slept, by means of a counterpane hung over a beam. A sheet held in position over another beam sufficed for privacy between her room and the kitchen, where at times up to 20 persons were dining from 4 am onwards, so one can imagine how much sleep was obtainable. The floor of the room was an earthen one, covered with semi dry grass. A bunk was provided as a bed, while several petrol cases acted for wardrobe, dressing table and chairs.²⁵⁶

The conditions were the epitome of the hardships experienced when working in isolated environments and must have contrasted strongly with any conditions the BN hitherto had experienced. Sister Risby did not return to the island for a second term. The following year

²⁵³ AOT, DPH, 58.1.36, BN Adamsfield, Letter to Sister Evans outlining Adamsfield & Marrawah conditions, 20 January 1936, (HSD 1/24).

²⁵⁴ AOT, DPH, 58.23.34, BN Babel Island Mutton Bird Season 14 March 1934, re Sister Risby willing to go to Babel, (HSD 1/5). AOT, DPH, 30 March 1935, Babel Island, Arrival of Sister Burbury for duty, (HSD 1/13).

²⁵⁵ *The Examiner*, 10 March 1934.

²⁵⁶ AOT, DPH, Babel Island Mutton Bird Season Report from Inspector re appalling living quarters for nurse, 28 April 1934, (HSD 1/5-1/6).

Sister Eleanor Christina Burbury expressed her willingness to go to Babel Island.²⁵⁷ Finally, a building was erected specifically for the BN in 1936 and this was both her home and her workplace.²⁵⁸ It provided a substantial improvement on earlier conditions:

The quarters consist of two rooms constructed of galv. iron and lined with plywood water is connected to interior of dwelling, and a medicine chest has been built in the bedroom. Blinds have been provided to the four windows. A locked lavatory has been provided and equipped with a kerosene tin.²⁵⁹

While conditions were not 'overly comfortable', the idea of living in a crude hut did not deter all nurses. Sister Edna Olive Foster was prepared to return to Babel Island for four seasons.²⁶⁰ An attraction was that, particularly in locations and conditions such as these, the BN had complete autonomy of practice. Also there might have been an element of the challenge and excitement of working on the 'last frontier' as evidenced by the BN's paternalistic attitude towards Aborigines that will be illustrated in later chapters. Not only were these nurses going out to isolated areas but also they were civilising 'half-castes'.

Even in less-isolated environments BNCs were often in improvised facilities. At Lilydale from 1924, the BNC was operated from a building which had been a garage until a custom-built BNC was opened in 1948. The garage was unlined and had provided an inadequate work environment, but the BNs endeavoured to make do and improved the garage as they were able:

Sister [Pitt] has made some small improvements in the Surgery. She has a small stove for heating the place and boiling water on. She is also colouring the walls with a water paint.²⁶¹

Even when the BN was provided with independent living quarters and a surgery these were not always appropriate or satisfactory. In 1934 the local Council provided accommodation and a surgery for Sister Linda Weeks on Flinders Island in a building located near the Whitemark Post Office and Stores. It was considered by Sister Weeks as quite comfortable.²⁶² This was her impression on arrival during winter, before she had experience of the place and without the onslaught of summer flies. It consisted of three rooms, including a kitchen, in a four-roomed building. The fourth room was used as a butcher's shop. It was not long before a subsequent BN complained bitterly about the same

²⁵⁷ Sister Eleanor Christina Burbury was a double-certificated nurse trained at the Launceston General and the Queen Victoria Hospitals. Registered in Tasmania 18 March 1933, Registration Number 509. AOT, DPH, Babel Island re Sister Burbury, 21 March 1935, (HSD 1/13).

²⁵⁸ AOT, DPH, 58.6A.36, Report, (HSD 1/24).

²⁵⁹ AOT, DPH, 58.6A.36, BN Babel Island re quarters built for Nurse, 20 April 1936, (HSD 1/24).

²⁶⁰ Sister Edna Olive Foster trained at Devon Public Hospital and was registered in Tasmania on 7 May 1931, Registration Number 378.

²⁶¹ AOT, DPH, 58.7.34, BN Lilydale, re Sister improving surgery, 30 July 1934, (HSD 1/36).

²⁶² AOT, DPH, 58.6.34, BN Flinders Island, re accommodation for Sister Weeks, 5 March 1934, (HSD 1/36). Sister Linda Weeks was trained at Devon Public Hospital and was registered in Tasmania on 27 April 1928, Registration Number 54.

building and her complaints might explain Sister Week's departure. In 1939, Sister Sylvia J Singleton, an experienced nurse, described vividly the main cause of complaint:

[B]ut the conditions under which I have to work here are most harassing to myself and moreover unsanitary in the extreme. The butcher's shop which is built on the room in which I live has a wooden floor, the odour of meat pervades the place, there is no protection from flies, when the door is opened they invade the house.²⁶³

In such an environment privacy became an issue. The butcher was able to overhear the BN's conversation with patients. Women particularly, given the intimate nature of many of their problems, found this a concern. Lack of sound insulation also meant that the noise from the garage/blacksmith's shop on one side and the butcher on the other made life for the BN trying. The butcher in particular chopped meat at 'all hours during the day and night'. The BN's sleep at night was broken by the noise, and even more disturbed if she attempted to sleep late the day after working at night. She pleaded:

I feel that I cannot go on indefinitely. If the hospital is likely to be started soon I could manage but otherwise I shall be compelled to resign, or ask for a transfer to another centre.²⁶⁴

The combination of a lack of privacy and constant flies would not have made a satisfactory or appropriate work space. Such conditions would not have been tolerated in an urban environment. Flies were often a source of complaint and at Waratah a relieving BN gathered up several hundred dead flies and carefully mailed them to the DPH to make a point about the lack of screens on the windows.²⁶⁵ The incumbent BN had tried in vain for years to obtain funding.²⁶⁶ The DPH's reaction is not recorded. Other commercial premises also were used as BNCs. Until 1952, when a residence, surgery and child welfare clinic was built for the Strahan BN, she resided at, and presumably practised from, the local hotel.²⁶⁷ In other remote areas hotel rooms sometimes were made available to the BN and the visiting GMO but were not the usual place of practice.

A feature of working in an isolated area was that support staff, to which nurses were accustomed in a city hospital environment, was not available to them. It was not uncommon for BNCs to begin as renovated cottages where the BN would live and work alone. These buildings were often old, were not built or altered specifically for their new use, and were often characterised by odd quirks. One nurse recalls that 'most of the buildings were a little bit old and there were steps in funny places and things like that'.²⁶⁸

²⁶³ AOT, DPH, 58.6.39, BN Whitemark. Nurse Sylvia J Singleton complaining of her living quarters near butcher's shop, 4 January 1939, (HSD 1/70). Sister Singleton trained at St Vincent's Hospital in Sydney and was registered in Tasmania on 9 March 1938, Registration Number 883.

²⁶⁴ AOT, DPH, 58.6.39, (HSD 1/70).

²⁶⁵ 'Lexie' AJ Burns, (née Laird), Personal Communication, 2003.

²⁶⁶ 'Lexie' AJ Burns, (née Laird), Personal Communication, 2003.

²⁶⁷ *TJPP&P*, 1952.

²⁶⁸ Eileen McManus, (née McMenamin) Interview, Falmouth, 1994.

Upkeep and maintenance of cottages were often problems for the Nurse. She seldom had the time or energy to undertake the necessary jobs herself, but only some centres provided caretakers and gardeners. It was not always easy to find others able to do the work, as Sister Gwendoline Tilley at Rossarden noted:

It has been a very pleasant stay here. The committee or Board are very helpful and have done much to make life more cheerful. There is still room for improved conditions in the cottage—but they are dependent on carpenters at the mine for most of this work.²⁶⁹

A few centres were fortunate in having new premises purpose-built and specifically designed as BNCs.²⁷⁰ The political and developmental processes involved in establishing a purpose-built BNC could take many years. Starting in 1934, the local Bush Nursing Association worked in conjunction with the local council to lobby for a new centre at Lilydale. The BN herself initiated discussions with the Council Clerk and enlisted the support of the Supervisory Nurse.²⁷¹ After the community purchased land for the erection of the BNC the Government promised assistance towards the cost of the building when the local Committee was in a position to commence work. The DPH was confident that the local community had the resources to succeed in bringing the project to fruition.²⁷² In 1937 the proposal seemed to be less viable as, although supportive in principle, the DPH was not willing to provide financial assistance for a facility for the accommodation of the BN only. The DPH stated that while

Grants [£100 each] were certainly made to the Southport and Bruny BNCs, towards the cost of erecting a BNH ... each of these centres ... include accommodation for a maternity case. The matter of providing a cottage for a BN seems to me to be entirely a domestic one, the responsibility for which should devolve upon those immediately concerned.²⁷³

This however was countered with the argument that, while it was not appropriate to erect a cottage hospital in Lilydale, the BNC would be both the BN's home and her workplace. They planned an inexpensive cottage for the BN to live in, and one room would be used as a minor dressing room and a clinic for baby welfare work. There would not be any provision made for patients to stay at the cottage.²⁷⁴ It was not until 1945 that a tender was accepted for erection of a new cottage at Lilydale for the BN at a price of £1,996 and the

²⁶⁹ AOT, DPH, 58.7.49, Letter from Sister Tilley—Rossarden, 30 May 1949, (HSD 6/34). Sister Gwendoline Tilley, (née Jessop) trained at Hobart Public Hospital, and was registered in Tasmania on 12 August 1933, Registration Number 537.

²⁷⁰ A new building, at the Burnie BNC comprising a clinic and quarters for the nurse, was placed in commission in 1940. AOT, DPH, 58.26.40, (HSD 1/79). In 1953 a new BNC at Gladstone was being planned to serve South Mount Cameron, Moorina, Weldborough and Pioneer districts. AOT, DPH, 58.16.3, Memo to Minister for Health from Rossarden Centre, 27 October 1953, (HSD 6/34).

²⁷¹ AOT, DPH, 58.7.34, BN Lilydale, re Sister improving surgery, 30 July 1934, (HSD 1/5-1/6).

²⁷² AOT, DPH, 58.7.36, BN Lilydale, re erecting cottage for BN, 2 September 1936, (HSD 1/24).

²⁷³ AOT, DPH, 58.8.37, BN Lilydale, re cottage for Lilydale BN, 23 October 1936, (HSD 1/24).

²⁷⁴ AOT, DPH, 58.8.37, BN Lilydale, proposed erection of cottage, 10 August 1936, (HSD 1/24).

local Council accepted responsibility for ongoing maintenance.²⁷⁵ Finally the official opening of the Lilydale BNC was held on Saturday, 10th January 1948 some 18 years after the start of the political process.²⁷⁶ The BN finally could leave behind her the difficulties of working and living in unsatisfactory conditions.

Photograph 3.25 Lilydale Bush Nursing Centre



Mrs Richardson in front of her garage, used as the Bush Nursing Centre, at Lilydale c1945.
Source: Anne Richardson.



Initially the Bush Nurses at Lilydale used a garage which was improved progressively by the nurses to make it more suitable as a Bush Nursing Centre. The purpose-built Bush Nursing Centre eventually constructed essentially is unchanged today and is used as a community centre.

Photographer: Alex Thomson, 2002.
Source: M Bardenhagen, Private Collection.

Visiting Medical Officers also needed rooms from which to practise. At Ouse the doctor used one of the rooms of the BNC, but while working in the surrounding district he

²⁷⁵ AOT, DPH, 58.42.45, BN, Annual Conference, BNA, (HSD 1/91).

²⁷⁶ QVMAG, LCC Records, Invitation card.

operated his surgery from the front room of a hotel or in a room hired from locals. On Flinders Island a more unusual co-operative relationship developed between the BN and Dr Evett Gordon Allport, the local doctor. In 1934, before the hospital was built, the doctor allowed the BN access to his private rooms for maternity cases whether he was engaged or not.²⁷⁷ Later BNHs, such as the hospital at Cygnet, were designed to meet the needs of the doctor and the nurse. Here the BNH was designed to accommodate four maternity cases and one emergency general case, and also included a doctor's surgery.²⁷⁸ This arrangement had the potential to reduce the isolation of the BN but also to reduce her independence of practice.

The medical equipment available to the BN also varied among centres. Many nurses would arrive directly from urban facilities where they had been accustomed to access to a full range of equipment and drugs only to find that they would need to improvise in the bush. Their training hospital environments, and their initial post-training experiences, were generally in facilities that were well-resourced and well-embedded in a medical hierarchy with significant support for their nursing practice but with low levels of autonomy. The BN environment was a substantial contrast with the prior experience of the first-time BN.

Equipment provision depended on factors such as donations and the financial viability of the BNC and the community. Without the donations of a camp bed, miscellaneous medical equipment and a tent, one wonders how the first nurse at the Green Ponds BNC would have functioned.²⁷⁹ The lack of equipment was a reason some BNs resigned. Upon the resignation of the BN at Rosebery in 1947 a resident of the community, a married nurse, was approached to help out with the nursing shortage. She forwarded a report to give the DPH an insight into the conditions the previous BN had to endure. The following is an extract:

The instruments are ancient and rusted with not enough forceps to do a dressing in the specified manner. The furniture in the home quarters is in need of renovation.²⁸⁰

The inequality between centres was huge and there was much variation in the availability of equipment. This was especially the case if one compares DPH administered centres with the committee-controlled centres which were dependent on subsidies from the local community. Medical Union-funded centres were equipped even more poorly as they received no Departmental funding. While the DPH might advocate the supply of equipment it could not guarantee that it would be available:

²⁷⁷ AOT, DPH 58.6.34, BN Flinders Island, re accommodation for Sister Weeks, 5 March 1934, (HSD 1/5).

²⁷⁸ AOT, DPH, 58.42.45, BN Annual Conference, BNA, (HSD 1/91).

²⁷⁹ *History of Bush Nursing in Tasmania 1910–1947*.

²⁸⁰ AOT, DPH, 13.5.47, Letter to Director Hospital and Medical Services from Sister Doreen Herbert, Rosebery, (HSD 6/10).

Cylinder of Oxygen with fittings. This department is supplying to all its BNCs the above apparatus. It is suggested that those Centres, controlled by Local Committees, consider purchasing them for their centres.²⁸¹

Here, though, the DPH clearly saw that such equipment should be available at all centres, it could but suggest 'politely' that local committees would consider such purchase. Not only were these committees less able to fund the equipment, it would be fair to assume that they were less able to judge the value or necessity of the equipment than would be a body such as the DPH. Nevertheless a mandatory equipment list was not developed at any time in Bush Nursing history. The DPH's failure was surprising. The DPH at times subsidised Medical Union Centres to allow them to purchase additional equipment.²⁸²

Without access to the equipment she was trained to use, the BN learned to improvise and often the outcomes were not measurably inferior. At Ringarooma the BNC purchased a griller for sterilising.²⁸³ Waratah facilities were very primitive on Sister Laird's arrival:

I remember Doctor asking me to set to remove a fingernail and didn't have any equipment. He said, 'You have to improvise in these places, Sister'... I mean I had all my settings up and everything like that we used to do in the hospitals and that's what I thought he'd want, but he didn't. We just managed and we managed all right. We only used a fraction of the things but the fingernail came off and everything was all right.²⁸⁴

There were no facilities for the doctor to operate—no theatre, no equipment or anaesthetics at Waratah during this time. At Adamsfield in 1943 the BN, Sister May Leah Roach, had clashed with the Secretary of the Committee about the adequacy of the equipment provided.²⁸⁵ As fate would have it he later required the services of the BN and learnt first hand of the centre's inadequacies:

It was rather unfortunate for him that last Monday he should have a fall and lacerate his arm rather badly. However he was down here with some very rusty blunt suture needles and dressings from the Hospital, but the needles were too hopelessly blunt to use so I snapped it up hoping for the best. Fortunately it healed up without any trouble.²⁸⁶

²⁸¹ AOT, DPH, Letter to Mt Bischoff Hospital re supply of oxygen cylinders to all BNCs, 23 September 1951, (HSD 5).

²⁸² AOT, DPH, 58.26.40, BN, Summary of Receipts and Expenditure—Centres controlled by Dept, Annual Reports, Returns & Requests to centres including forms issued for compilation, annual meeting—BNA, State Conference—Annual Report, (HSD 1/79).

²⁸³ AOT, DPH, 58.13.37, BN Ringarooma Letter from SN, re surgery improvements, 28 June 1937, (HSD 1/36).

²⁸⁴ 'Lexie' AJ Burns, (née Laird), Interview, Waratah, 1994.

²⁸⁵ Sister May Leah Roach, (née Evans) trained at Melbourne General Hospital and was registered in Tasmania on 4 September 1933, Registration Number 540.

²⁸⁶ AOT, DPH, 58.26.43, 58.1.43, BN, Adamsfield, Correspondence with local committee re accommodation of visitors in Hospital, Transfer of control of centre to DPH, Instructions of BN re fees, re application of Sister ML Roach, (HSD 1/87).

One can only hope that this experience made it easier for the BN to equip appropriately her BNC from then on. Even in 1948 the Gladstone BN had no illusions about what equipment would be missing as she was required to supply all she might need:

BNs are required to supply and wear their own uniforms, and it would be appreciated if you would bring your own instruments etc., which would obviate the necessity of purchasing others for your use.²⁸⁷

Equipment became a focus for fund-raising with many BNs encouraging locals to help support the purchase of new equipment such as wheelchairs.²⁸⁸ By the late 1950s Sister Evelyn Mellish remembers the centre at Gladstone being ill-equipped and having no wheelchair. She soon had a good relationship with the Bush Nursing Committee whose members began to provide equipment upon her requests. 'I only had to ask ... and they got it'.²⁸⁹ Soon after Sister Eileen McMEnamin arrived at Koonya she also found that no wheelchair was available:

I can remember arriving there [at Koonya] and the first thing that happened, a man came in and he had had a heart attack. And I said, 'Oh, where's the wheelchair?' There was no wheelchair and I can remember vividly what happened. The other Sister who was there just beckoned to some men who were working in a paddock nearby and said come and help. And they came over and carried the man into the hospital. But he did die and that was my first experience at Bush Nursing.²⁹⁰

Such experiences quickly brought home to the BN the isolation from the environment they had come to expect. By the late 1950s and early 1960s Eileen recalls 'generally they had adequate equipment for those days. You could deliver a baby and you would have everything there'.²⁹¹ This view is reinforced by the Public Health Reports which state that most centres had been equipped with anaesthetic machines and X-ray apparatus by 1947.²⁹² Nevertheless, as late as 1948 BNCs facilities for sterilisation were at times described as primitive.²⁹³ By 1950 gas and oxygen machines and infant resuscitators had been supplied to centres with hospitals. In 1952 darkrooms were provided to some centres.²⁹⁴

We have seen that in the bush there was no guarantee that even the most basic supplies and furniture would be provided. The lack of specific medical equipment which the BN had taken for granted in the city hospital working environments exacerbated the BN's already inadequate working conditions. It was often a source of complaint to the BN

²⁸⁷ AOT, DPH, Report on proposed BNC at Gladstone by SN, 30 August 1948, (HSD 6/34).

²⁸⁸ Fund-raising will be dealt with more fully in Chapter Four showing how this activity helped integrate the BN into the community.

²⁸⁹ Evelyn Mellish, Interview, Musselroe Bay, 1994.

²⁹⁰ Eileen McManus, (née McMEnamin) Interview, Falmouth, 1994.

²⁹¹ Eileen McManus, (née McMEnamin) Interview, Falmouth, 1994.

²⁹² *TJPP&P*, 1948.

²⁹³ AOT, DPH, 58.26.49, Letter to Department of Health from Sister Noller, 26 May 1948, (HSD 5).

²⁹⁴ *TJPP&P*, 1950 and 1952.

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²⁹⁰ Eileen McManus, (née McMenamin) Interview, Falmouth, 1994.

²⁹¹ Eileen McManus, (née McMenamin) Interview, Falmouth, 1994.

²⁹² *TJPP&P*, 1948.

²⁹³ AOT, DPH, 58.26.49, Letter to Department of Health from Sister Noiler, 26 May 1948, (HSD 5).

²⁹⁴ *TJPP&P*, 1950 and 1952.

committees and to the DPH. It was not easy for the BN to pressure the relevant groups for equipment particularly without a system-wide list of mandated or recommended equipment. Sister Clarice Marjorie Hussey's experience at Rossarden in 1952 demonstrates the difficult position in which the BN could be placed.²⁹⁵ She wrote to the Supervisory Nurse for assistance saying:

[W]hen I first came here, I asked them for the following—a F.H. stethoscope, tongue depress with torch attached, Sphygmomanometer and an auriscope and the fuss and arguments that went on at the meetings (I attended the meeting, as they have asked me to). At first they said it was too expensive, then they asked me to write & ask you, & if you did not supply me with them, that they would get them for me if they weren't too expensive.²⁹⁶

The reply she received from the Supervisory Nurse must have been cold comfort and she would have realised quickly that to obtain even the basic equipment she requested would take a long and tedious argument:

Further advice for you is to first approach your local secretary for new equipment, replacements, repairs, etc. It would be his duty, per his Committee ... If ... supplies of new equipment or replacements are delayed or refused, then you need to write officially to the Secretary of Public Health, Hobart, giving details and advising if you are being hindered in your work from lack of them. That is the procedure for your future help. No Sisters should need to be distressed unnecessarily, as you imply, or hindered in their work.²⁹⁷

While 'no Sisters should need to be ... hindered in their work', the process of obtaining appropriate equipment was clearly bureaucratic and lengthy and must have contributed to a feeling of professional isolation. There was little guarantee that any satisfaction was likely by the end of the drawn-out process the BN was to follow. The Supervisory Nurse at that time considered that all centres were 'reasonably well equipped' but in her list justifying this appellation she outlines what might be described these days as hotel amenities:

Such electrical equipment as refrigerators, floor polishers, vacuum cleaners, washing machines (with boiling attachment), drying cupboards, wireless for staff (as apart from one for patients) and other amenities including lounge carpets, armchairs and sewing machines, are provided in most of the Hospital Centres, and partly to other Centres.²⁹⁸

This is not a list of the types of equipment that allow the core nursing functions to be carried out, as equipment requested by Sister Hussey, and that impacted on her sense of professional isolation.

²⁹⁵ Sister Clarice Marjorie Hussey, (née Kapper) trained at the Madran State Hospital in India, and was registered in Tasmania on 19 December 1950, Registration Number 3153.

²⁹⁶ AOT, DPH, Letter from Sister Clarice Marjorie Hussey, re repairs/supplies Rossarden, 1952, (HSD 5).

²⁹⁷ AOT, DPH, Letter to Sister Clarice Marjorie Hussey, Rossarden from SN, re repairs/supplies, 21 February 1952, (HSD 5).

²⁹⁸ AOT, DPH, 28.28.8, Re Use of Red Cross Trust Fund, staffing levels and conditions etc, from Sister DK Noller, (HSD 5/8) (HSD 3/12).

As well as lacking equipment isolated BNCs did not always hold adequate supplies of medicines and drugs. This was exacerbated by the problem of refrigeration. 'The medicine cabinet held nothing beyond aspirins, antiseptics and a few dressings'.²⁹⁹ There were also problems with supplies being sent to the country from the city. Urban areas were not always keen to share with the country. When Sister 'Maisie' Rayner had a patient with a snake bite she moved the patient to Scottsdale, following which the Launceston General Hospital was approached to send antivenin. The hospital staff member who replied stated that, as there was in stock only one vial which might be needed in Launceston, it could not be sent to Scottsdale. From Scottsdale the response was, that while you might need it to use it, we have a patient with a snake bite and need to use it. 'So you had better send it!'³⁰⁰

Sources of medication varied by the type of BNC, as we have seen for other supplies and equipment. Until 1943 the Vigilance Committee at Adamsfield provided medicine for the BN out of funds raised by monthly subscriptions. The DPH took over the administration in 1943 with the arrival of Sister Roach.³⁰¹ Some BNs might have sought supplies of drugs and medical supplies from travelling salesmen because their usual supplies took so long to arrive. While restrictions on the holding and dispensing of drugs developed particularly in the 1940s, at this time the DPH and the GMO were still willing for BNs to hold responsibility for drugs especially in the more remote areas such as Babel Island.

The DPH sent very different instructions to the BNH staff at Flinders Island in 1941 pointing out that as there was now a resident GMO 'who is authorised to order all drugs required, there is no need for the BNH to carry a stock of medicines'.³⁰² Regulations surrounding the supply and use of drugs became more strict by the 1950s. The following case shows that 'essential' drugs were withdrawn from the BNCs:

It is desired to inform that further consideration has been given to the range of medicaments which may be ordered and supplied by BNCs and similar organisations ... it has been decided to withdraw the list of life-saving and disease preventing drugs recently forwarded to you and to revert to those drugs and medicaments which were permitted to be ordered and supplied under the terms of the authorisation originally granted to each Centre.³⁰³

²⁹⁹ Scott, p. 59.

³⁰⁰ Margaret Spark and Dawn Coffey, Interview, Beauty Point, 1994.

³⁰¹ AOT, DPH, 58.26.43-58.143, BN Adamsfield, Correspondence with local committee re accommodation of visitors in Hospital, Transfer of control of centre to DPH, Instructions of BN re fees, re appointment of Sister ML Roach, (HSD 1/87).

³⁰² AOT, DPH, 58.6.41A, BN Flinders Island Equipment, Stores SN to Sister Green re ordering drugs, 9 October 1941, (HSD 1/80).

³⁰³ AOT, DPH, Letter to Sisters-in-Charge from Director Hospital Medical Services re Pharmaceutical Benefits Act, 5 July 1951, (HSD 5).

The proposal to withdraw 'life-saving and disease preventing drugs' was consistent with the erosion of Bush Nursing autonomy. The BN's use of medications and drugs and the way this changed over the Bush Nursing era, will be explored in Chapter Five.

The boundary between the BN's home and surgery was blurred and was based around the health needs of the community rather than the BN's needs. As early as 1927 the Public Health Report was calling for 'uniformity [to] be brought about in the matter of the domestic conditions of the BN'.³⁰⁴ (*Appendix E* details some of the lack of uniformity that concerned the DPH.) The 'ideal' BNC was a cottage, with maternity and emergency wards attached 'to help decrease the isolating conditions'.³⁰⁵ As the Bush Nursing Association and the DPH began to assist with the provision of buildings the majority of BNCs incorporated living quarters for the BN in the centre. The DPH clearly identified that autonomy and privacy were two essential ingredients to make a successful BNC. Despite their concerns, even when living and working space were combined in the one facility, often comfort, autonomy and privacy still were lacking and this contributed to the BN's sense of isolation.

Initially the BNC's domestic facilities and nursing equipment were primitive. These conditions had to change to retain staff. It is in the more remote BNCs that conditions were at their most difficult. Nevertheless, any organisation's attitudes and goals can be judged by the degree to which it manages the more difficult tasks, and the degree to which it manages an equitable distribution of the support or resources it supplies. It is also these different environments that generate the majority of the official correspondence and records as problems occur, and the difficulties highlighted demonstrate the essence of the BN experience.

Initially neither hot nor cold running water, and neither septic tanks nor sewage, were available for many BNs. Even by the 1930s conditions were primitive, and not just for the BNs. Complaints from BNs were common and descriptions of conditions contrast strongly with those that the BN would have accepted as normal in the city:

[T]he drainage system of the whole township—soap suds and waste from houses lie all over the so called footpaths and roads. Fingal council don't seem at all alarmed at the state.³⁰⁶

The mutton-bird islands had no adequate natural water source. The only water supply on Babel Island was from collection into water tanks, and the toilets were crude. Prior to a nurse arriving the Health Inspector was to visit the island to ensure that amenities were in order. In 1936 the report was not promising, as the water tank had not been delivered. In

³⁰⁴ *TJPP&P*, 1928-1929.

³⁰⁵ *TJPP&P*, 1928-1929.

³⁰⁶ AOT, DPH, 30 May 1949, (HSD 6/34).

addition neither the oven nor the nurse's bed had arrived.³⁰⁷ Domestic water for Chappel Island had to be carted to the island and the difficulties with access did not make this easy. Doctor Ick was charged with the duty of ensuring the BN had ample supplies of approximately 200 gallons of water.³⁰⁸ This became an onerous task for the GMO who had great difficulty in transporting the water to Sister Evans on Chappell Island. 'It is quite impossible to take more than 40 gallons at a time'.³⁰⁹ Forty gallons at a time, with intermittent opportunities for delivery, combined with the isolation of the island and its access problems, hampered efforts to meet the minimum requirements identified by the DPH for the seven-week season. At Ringarooma running water became available in 1937, with improvements including a wash basin, a tap and 'an electric jug for boiling water in. This will dispense with the necessity of obtaining hot water from the landlady'.³¹⁰ In 1946 renovations were planned for the BNC at King Island that included the surgery being transferred and attached to a new cottage. Several minor alterations were suggested and it was proposed to have an electric stove and hot water system installed.³¹¹

Toilet facilities remained primitive even in the 1940s. In 1949 the Director of Hospitals and Medical Services requested in writing to the local Medical Union in Waratah that as:

[T]he Sanitary contractor has resigned his post. I would be glad if you could arrange for someone to be appointed to take his place as soon as possible, and, in the meantime would you provide a spade for the sister's use.³¹²

Even when the toilet facilities consisted of more than a spade, going to the toilet might mean becoming quite dirty. At Marrawah the toilet was some distance from the main building and, when the ground was ploughed, a very muddy pathway had to be negotiated. By 1950s equipment and facilities were improving in an effort to attract and to retain staff. Septic tanks and hot water were becoming requirements that most BNs began to take for granted but there were still exceptions to the rule even in respect of the most basic provisions such as water.

Electricity was first connected to urban areas in Tasmania as early as 1895 in Launceston and somewhat later in Hobart.³¹³ Rural areas acquired power much later. Some BNCs were never to receive the electricity that we now take for granted. Many BNs remember the professional disadvantages such as operating in the dark as well as the

³⁰⁷ AOT, DPH, 58.6A.36, BN Babel Island re quarters built for Nurse, 20 April 1936, (HSD 1/24).

³⁰⁸ AOT, DPH, 58.7A.39, BN Chappel Island Mutton Bird, Memo to Dr Ick to arrange water for Chappel Island BN, 17 March 1939, (HSD 1/70).

³⁰⁹ AOT, DPH, 58.7A.39, BN Chappel Island Mutton Bird, Letter from Dr Ick re blankets, water etc for BNs on Island, (HSD 1/70).

³¹⁰ AOT, DPH, 58.13.37, BN Ringarooma Letter from SN re surgery improvements, 28 June 1937, (HSD 1/36).

³¹¹ AOT, DPH, Letter from K Widdicombe re King Island, 30 October 1946, (HSD 1/92).

³¹² AOT, DPH, 58.26.49, Letter to the Chairman Mt Bischoff Provident Hospital Committee 26 January 1949, (HSD 6/34).

³¹³ Robson, p. 294.

practical personal ones. In the 1930s the four-bed BNH at Koonya as yet did not have electricity 'and was sometimes invaded by snakes' according to Sister Clarice Mainwaring.³¹⁴ In 1946 the nearest HEC lines were still 18 miles from Redpa and Marrawah in the North West.³¹⁵

Sister Walsh, the Lilydale BN, boarded with the Richardson family who lived opposite the Council Chambers. Initially there was no electricity, and even the BNC (garage) had only a hurricane lamp for lighting. Electric light and power were installed by 1941.³¹⁶ Some centres had their own, or shared local, generation plants. Cape Barren Island had a 2.5 horse-power petrol engine that supplied power.³¹⁷ Later, generation capacity improved but the electricity supply was still fraught with problems. The BN's husband, who had to be a 'jack-of-all-trades', recalled getting assistance from an unexpected source. When the diesel generator broke down and they were without power the visiting dentist fortunately had been a diesel mechanic before becoming a dentist. He soon had the generator running again.³¹⁸ Usually however if the BN's husband had not been able to fix it they would have needed to wait until a mechanic could make a special trip to the island. Isolation required broad-based skills.

By 1952 most centres had electricity supplied through the statewide network although several still relied on local generation plants.³¹⁹ A report written by a Supervisory Nurse and published by the DPH makes it clear that even then an electricity supply was not universal:

Working and living conditions for this staff have much improved from the early days, and electrically equipped hospitals and residences are the rule where power is installed. Other Centres have their own power plants for generating their electricity. Very few places have neither.³²⁰

Obviously some centres had no power—it is unclear which centres were without electricity at that time, but it would seem that Koonya, Alonnah, Southport and Triabunna were still without electricity. Babel Island and Chappell Island were seasonal centres and therefore are not included in this report, but they never were connected to an electricity supply. Adamsfield also never received power, but by this time its BNC had been closed. Not only

³¹⁴ Scott, p. 59.

³¹⁵ AOT, DPH, Bush Nursing Annual Report 1946-1947 Northern Centres, (HSD 6/10).

³¹⁶ QVMAG, Box 10, Report 1941-1942, Re immunisation work by BN and electric light & power installation, (HSD 6/10).

³¹⁷ Charles Saville, Interview, Devonport, 1999.

³¹⁸ Una Saville, (née Nicholls), Interview, Devonport, 1999.

³¹⁹ *TJPP & P*, 1952.

³²⁰ AOT, DPH, 58.28.52, 'A Short History of Bush Nursing in Tasmania', DK Noller, 'The earlier portion of this History has been compiled with the kind help of Mr. R Parkes—deceased, and formerly of this Department. Grateful appreciation is accorded to him for this and all the help he continually gave to Bush Nursing. Sister DK Noller, February 1952,' (HSD 6/59).

was the provision of power slow to arrive, but also there were problems with the reliability of supply and always there were some services not maintained well. Electricity was at times unavailable through blackouts or through other resource rationing. At Waratah Sister Burns recalls that in the 1950s the privately-owned electricity scheme would be turned off at midnight and switched back on at 6 am. During the night the BN had to work by lamplight:

I can remember trying to suture. An old chap came in and he'd fallen down and split his head open and I'm trying to stitch it up in the middle of the night in the dark. I mean I had a lamp. I had to dodge his hand all the time. Funny old fellow. I got it stitched up.³²¹

The rhetoric continued from the DPH as it later claimed that the last two full-time centres were provided with an electrical supply.³²² In contradiction to this report as late as 1958 the Southport BNC reported that preparations were 'now' underway for installing electricity and that the poles were going up.³²³

Not only were essential services often lacking or unreliable, food, food storage and cooking facilities were also frequently substandard. Given that the BN was required to cater fully for any in-patients, this could cause her significant difficulties. On the Fumeaux Islands the BN not only needed to ensure sufficient food and water for her entire stay, but at one stage she also had to transport her accommodation (tent and bed) and all medical supplies that might be required. There was a small shop operating on Babel Island at one time but there were no facilities for fresh food and the boat visited the island only once in seven weeks.

As the staple food for the season consists chiefly of fresh mutton birds, for which one has to possess an acquired taste, Sister had of necessity to become a vegetarian.³²⁴

Cooking facilities were provided in the form of an old Peters oven that was fuelled by wood. There was no electricity, only kerosene and candles. While Babel and Chappell Islands were perhaps the most difficult situations, many other BNCs had similar problems.

On Cape Barren Island Sister Ruby Amy Gittus still was cooking on an open fireplace in 1947, although there was a stove on the premises which she stated she could not arrange to have installed.³²⁵ Eventually she submitted her resignation from the Cape Barren Island

³²¹ 'Lexie' AJ Burns, (née Laird), Interview, Waratah 1994.

³²² AOT, DPH, 28.28.8, Re Use of Red Cross Trust Fund, staffing levels and conditions etc from Sister DK Noller, (HSD 5/8) (HSD 3/12).

³²³ AOT, DPH, Bush Nursing Annual Conference, BNA, 58.42.45, (HSD 1/91).

³²⁴ AOT, DPH Babel Island Mutton Bird Season Report from Inspector re appalling living quarters for nurse 28 April 1934, (HSD 1/5).

³²⁵ Sister Ruby Amy Gittus trained at Stowell Private Hospital and was registered in Tasmania on 8 March 1939, Registration Number 996. After her time as a BN at Bruny Island she retired from the

BNC because of this.³²⁶ Furthermore there were 'wars' over space with a portion of the BN's quarters and clinic in the hospital building being occupied by a Miss 'Ada' Adah Marior Hudson, the local missionary. Even the local doctor wrote to the DPH to support the BN's case: 'Sister Gittus could use and needs the space occupied by Miss Hudson and it is not fair that she has to suffer the present set up'.³²⁷ The next BN did not fare much better on the island:

I am continually having to throw away food which would keep quite well under ordinary circumstances. Food here is most expensive and most difficult to get ... You will think I have a refrigerator, yes, but I cannot spare the kerosene to use it ... The boats are very irregular. The copper stand in the wash house is only just holding together and it is impossible to stay out there while the fire is burning for it bellies out smoke like the kitchen stove ... Winnie (my Maid) says she cannot endure the smoke, and is talking of leaving. There is no other suitable girl here.³²⁸

Miss Hudson continued to haunt the island, and in 1944 still her belongings were stored in the large well-equipped kitchen in the BNC making this space unavailable to the BN.³²⁹

By the 1950s the centre at Cape Barren Island finally had some equipment which previous BNs had requested continually. Most importantly the centre now had a fridge. 'Well it was equipped, we had a kerosene fridge, that sounds funny for equipment but at least you could have all your things in the fridge'.³³⁰ Refrigeration was seen as a need at other centres as well. The BN at Rossarden could not see how she might get a refrigerator from the Medical Union and hoped that the DPH might supply one. Without a fridge it was hard to store food and thus catering for herself and her patients was difficult.³³¹ The need for basic domestic equipment was made pressing because of the sheer load that domestic tasks added to the burden of BN duties.

Sister Louie Edith Green, an elderly BN on Flinders Island, had reached the limit of her endurance in 1941 as she was obliged to cope alone with the tasks of nursing and providing for her patients. Her description of her domestic tasks reinforces the desirability of domestic help, household labour-saving devices and other basic equipment:

I cannot possibly nurse, wash, chop sticks, pump, cook, & clean seven rooms! also go up to 1/4 mile for milk, bread, vegetables, and also for all stores, fruit, mail etc, as nothing is delivered; food is either burnt black and wasted, or the fire goes out, & food is uncooked at meal times. All patients ordered into hospital require some night-

DPH and operated her own private maternity hospital at Sorell selling it to the DPH for conversion to a BNC in 1946. AOT, DPH, 58.39.46, (HSD 1/92).

³²⁶ AOT, DPH, Letter to Dr BM Carruthers from SN Noller, 11 November 1947, (HSD 6/10).

³²⁷ AOT, DPH, GMO 20.8.4&, Refer to Dr Ick Letter to Dr BM Carruthers Director Medical Services from Dr S J Rumbold, (HSD 6/10).

³²⁸ AOT, Letter to Dr BM Carruthers, 8 August 1949, (HSD 6/34).

³²⁹ AOT, DPH, 58.7.44, BN Babel Island, Sister Davies—Miscellaneous Correspondence, Reports etc, (HSD 1/89).

³³⁰ Una Saville, (née Nicholls), Interview, Devonport, 1999.

³³¹ AOT, DPH, Letter from Sister Clarice Marjorie Hussey re repairs/supplies Rossarden, (HSD 5).

nursing. I am much too busy to look for help, or write or answer letters! except perhaps after 10 pm or even 11 pm when I am too tired to be exact, & therefore unwittingly make errors.³³²

Not only did the BN cater for the in-patients, but many BNs also did washing for the centre or hospital as well as for themselves. The DPH had to write on behalf of the BN at Waratah to pressure the Mt Bischoff Committee to provide her centre with a clothes wringer. There had been many delays yet the DPH considered it a matter of urgency.³³³ Without such basic equipment the task must have seemed impossible indeed especially when the weather was inclement. Gladstone finally received a refrigerator in 1950 supplied by the Southern Branch of the Bush Nursing Association.³³⁴ These delays, lack of domestic support, equipment in disrepair, and the lack of help with tasks such as chopping wood must have led the BN to feel abandoned by the bureaucracy, increasing her loneliness, helplessness and ultimately her isolation.

Sister M L Roach was not impressed with the conditions at Adamsfield in 1943. While the Vigilance Committee had:

wholly maintained the Hospital Building in the way of a new roof, new fence, chimney, alterations to windows ... and an extra door ... the linen is in a pitiable condition and the blankets are filthy, the pillows likewise.³³⁵

She was 'astounded' at the filthy condition of the hospital with its dirty scrim and paper on the walls blowing in and out with the breeze. There was no china 'except for odd cups, saucers and plates and the cutlery and silver has practically disappeared'. While the conditions were poor Sister Roach and her husband decided that staying in the hospital was better than having to 'drag up and down in the snow' during winter, but could not see how they could renovate the hospital by themselves.³³⁶ They saw renovation, at least in some sense, as their personal responsibility. Bush Nurses developed a sense of ownership of their BNC and as a consequence of the isolation had little choice but to take on responsibility of maintenance.

Throughout all the years that records exist for Bush Nursing as part of the DPH, Sister Davies remained the consistent complainant. In all fairness to her she was situated in the most ill-equipped and least-maintained centre on an isolated island. Other BNs stationed on this island, such as Sister Green and Sister Gittus, had complained in similar

³³² AOT, DPH, 58.6.41B, BN Flinders Island re domestic assistance for Nurse EL Green who is overworked, 11 June 1941, (HSD 1/80).

³³³ AOT, DPH, 58.26.49, Letter to the Chairman Mt Bischoff Provident Hospital Committee, 26 January 1949, (HSD 6/34).

³³⁴ AOT, DPH Annual Meeting Report re Gladstone BNA, 25 July 1950, (HSD 5).

³³⁵ AOT, DPH, 58.1.43, BN Adamsfield Centre, Correspondence with local committee re accommodation of visitors in Hospital, Transfer of control of centre to DPH Instructions of BN re fees, re appt of Sister ML Roach—see file 58.26.43, (HSD 1/87).

³³⁶ AOT, DPH, 58.1.43, (HSD 1/87).

vein. Although the Department became accustomed to Sister Davies' letters both her complaints and their responses provide evidence of isolation and the consequent frustration for BNs:

I really do not think the game is worth the candle. Please cannot better arrangements be made immediately. I feel unable to carry on.

Really things are so difficult I feel like giving up. I have been out of a number of essential goods for months, not weeks. I have wired repeatedly. I have asked Dr to enquire but nothing happens anywhere. Will you please repeat those orders and see I get at least drugs, phingle, kerosene, cleaning materials and dressings on the next boat. I am tired of nagging for all these things The place is extremely difficult and there is no cooperation anywhere.³³⁷

The DPH requested assistance from Dr John Archibald Waddy, GMO on Flinders Island, stating that the present position was 'chaotic' and that 'it is a dull day now when we do not receive a letter from Sister Davies asking for equipment, stating equipment has not arrived, and complaints in general.'³³⁸ The response from the GMO on Flinders Island to the Director of Public Health stated that he did not consider Sister Davies required additional assistance as she already had daily domestic assistance and her workload was light. This however did not deal with her frustration about delays in obtaining needed equipment, frustrations experienced by many other BNs.

Isolation led to stress for BNs. By 1950 the dispute on Cape Barren Island with Sister Davies became so difficult that the Supervisory Nurse eventually wrote to the BNs stationed at Flinders Island BNH to see if they could provide some of their time for relief work. In her request it can be seen that she accepted that the problems over the availability of even basic supplies such as foodstuffs at Cape Barren Island were reality rather than merely a reflection of a BN under stress:

[T]he food position at Cape Barren Island is most difficult. Fresh fruit and vegetables arrive there over ripe or bad. Tinned fruit is unprocurable. If we sent a relieving Sister there for a month or longer the food difficulties and others would present such a problem to her that she would most likely want to leave. This has happened before. On the other hand, if you three could take a week at a time there, taking supplies of food from your own hospital stock, it seems to me it might solve the relieving problem.³³⁹

³³⁷ AOT, DPH, 58.4.49, Letters to DPH from Sister Davies, Cape Barren Island, 28 July 1949 and 11 November 1949, (HSD 6/34). 'Phingle' may be a misspelling of 'phenol' which was a popular cleaning and sterilising product until the 1950s, Peter Mercer, Personal Communication, 2003. Dr Anthea Hyslop suggests 'phingle' is a misspelling of 'phenyle', the trade name of a phenol solution, Personal Communication, 2004. Dr J Wilson alternatively suggests that 'phingle' may be a misspelling of shingle, a fuel that was burnt in small heaters.

³³⁸ AOT, 58.4.49, Letter to and from Dr Waddy, (HSD 6/34).

³³⁹ AOT, DPH, Letter to Sister Burke, Flinders Island from SN re relieving at Cape Barren Island, 27 February 1950, (HSD 5).

Isolation contributed to inadequate facilities, equipment and basic necessities of life. The slowness of organisation response and unwillingness to spend money further contributed to the hardship under which BNs lived and worked. The consequence of these combined factors increased the sense of frustration and isolation and was the direct cause of problems in BN recruitment and retention. The conditions within BNCs lagged substantially behind those experienced by city nurses as we shall see was true also for the remuneration of BNs. Furthermore, the combination within the same BNC of home and work tended to isolate the BNs although it provided them with independence as 'single women with accommodation'.

Although the DPH recognised the importance of personal privacy it was not a luxury afforded to BNs in isolated communities. Privacy for the BN became an issue of concern for the DPH when conditions at Southport were identified by the Supervisory Nurse in 1935 as intolerable:

An awkward arrangement has been brought to my notice. The nurses have no privacy whatever. As there is no accommodation for a maid ... she has to sleep in sister's room ... Sister said she would have to go right round the verandah for hot water from the kitchen each time she wanted it.³⁴⁰

At Marrawah Sister Bird recalled the BNC:

It was a small place. It had four decent rooms: there was a bedroom, a living room, a kitchen, and then there was this fairly small bedroom for a maternity patient. It'd take one maternity patient at a time ... Well, when I first went, the surgery was in part of our living room, like the dining living room, and there was one corner that had a couple of chairs and big cupboard with all drugs and everything I needed in that.³⁴¹

Appendix F provides floor plans and details of a number of BNCs which illustrates the difficulties that the physical design of the BNC created for BNs. By 1951 conditions at Marrawah had deteriorated and the BN kept enough room only for herself and even that was in disrepair: 'The sleep-out which sister herself uses, is very untidy, with "pieces" nailed up for blinds'.³⁴² In many cases BNs ensured that improvements in the BNC went into patient services, and thus put themselves and their personal comfort last. Bush Nurses made the Centres their homes and took time to develop gardens and decorate interiors.³⁴³

Although within their BNC/home BNs lacked privacy, some BNs did not perceive privacy as an issue. At Gladstone Sister Evelyn Mellish commented: 'It didn't worry me,

³⁴⁰ AOT, DPH, 58.14.38, BN Southport. Letter re committee will not hire permanent maid and privacy for nurse, 25 July 1938, (HSD 1/53).

³⁴¹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

³⁴² AOT, DPH, 58.13.3, Report for Director Hospital Medical Services form Widdicombe re Marrawah Hospital conditions, 2 August 1951, (HSD 5).

³⁴³ 'I still like being here, although it is an out of the way place we find plenty to do in the spare time, as soon as the weather improves I am going to try and grow a few flowers they will make it more home like I hope', Letter to SN from Sister A Laird, 12 July 1949, Waratah, AOT, DPH, 58.26.49, (HSD 6/34).

because I had always lived in a nurse's home from the time my mother died'.³⁴⁴ Personal space was not something that many nurses had grown to expect. When a BN was on leave, the relieving BN could feel keenly that she was invading the home. Perhaps this was most reinforced when in one case a relieving BN was expected to housekeep for her predecessor's husband. The local BN left to go on leave but as the Centre was her home, her husband remained. The BNC was the only accommodation available for the relieving BN. It became a very difficult situation for the relief BN.

She was married ... and she went off away on holidays and left me the husband and the double bed and the flats, you see, and I had meals and everything to get. Yes everything, Oh dear! ... Well I was expected to [cook for the husband]. I was very indignant about that, very, and I had to buy all the food. So I had to go and sleep out the back of the clinic, [in the] baby health clinic room and make myself a bed out there. Everybody used to laugh, you know, but I didn't laugh.³⁴⁵

With many BNCs and BNHs being overloaded it was not uncommon for BNs to give up their bed for a patient, the BN then sleeping in a chair or on a couch. This not only adversely affected their working conditions but most likely their health from lack of rest. At Koonya while there were three beds for the staff, four for patients, and a cot, it was noted that: 'Recently there were eight patients in residence. One was in sister's bed and one on the floor in her room. A cot was borrowed for a child'.³⁴⁶ At Southport it was not recorded where the BN slept as:

It was necessary to put one of the maternity patients in sister's bed while she slept on the couch in the sitting room. Another time the mattress from the couch, though it is too long and narrow, had to be used in the cot.³⁴⁷

At Marrawah the Supervisory Nurse reported that the BN 'had to give her room up to patients four times during the present year'.³⁴⁸

While BNCs might be primitive they still were often better than the accommodation in which the community lived. At Adamsfield only the basic requirements of living were available to all residents. The BN felt privileged because she had obtained a tiny stove whereas most of the other women in the town had only camp ovens. She was happy to share her facilities and home and on some days the women would come to her kitchen and have a baking day. This somewhat mitigated the BN's isolation. Even the beds in the BNCs were shared with visitors as these were the only place to accommodate visitors such as Mrs Dwyer Gray, President of the Bush Nursing Association, who came once a year to make an

³⁴⁴ Evelyn Mellish, Interview, Musselroe Bay, 1994.

³⁴⁵ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

³⁴⁶ AOT, DPH, 58.17.39, BN Koonya, Letter from Sister Stammer re too many patients at Koonya Hospital, 3 October 1939, (HSD 1/70).

³⁴⁷ AOT, DPH, 58.14.38, BN Southport, Letter re committee won't hire permanent maid and privacy for nurse, 25 July 1938, (HSD 1/53).

³⁴⁸ AOT, DPH, 58.8.36, BN Marrawah, Letter Secretary Public Health from Marrawah Committee adding general ward, (HSD 1/24).

inspection of the facility. According to Sister Hazelwood she always would obtain permission to use the premises for accommodation purposes.³⁴⁹ After her departure the DPH sent new instructions:

It has come to the notice of this Department that the BNH at Adamsfield is used as an accommodation house by visitors etc., to the district. I wish to inform you that this practice must cease and the Hospital be used only for the purpose for which it was erected.³⁵⁰

The community dismissed the comments in the main as petty and supported heartily the actions of the previous BN.³⁵¹ The ruling of the DPH would have further increased the BN's isolation.

By combining the centre and the home of the BN, the Department and community saved on several different levels.³⁵² Firstly the BN was always near her work and therefore always on call. 'We had to live in the hospital because, of course, we were on call at night as well, so we had to be there'.³⁵³ Secondly the combined home and work was more financially viable as only one building was required, one cleaner, one set of rates and one central location for the community focus. According to Jennifer Cramer the situation for today's remote area nurses is similar to that of the BN:

For remote area nurses, home is part of the work place. Hodgson (1980a) in a study of Canadian outpost nurses, noted that this form of housing serves the employer as a convenient and economical way of accommodating nurses but it is a dilemma of the outpost nurse to create a private life while working in a public place, job and living in an essentially public building. The nurse lives within the domain of the community.³⁵⁴

Remote Area Nurses and BNs share the problems created by the mixing of living and working, and private and public roles. While privacy was a cause of concern for many BNs, the DPH saw privacy issues in a different light. While paying lip service to the problem of privacy for the BN, their major concern was the privacy of patients.³⁵⁵ Because of that BNs, if married, were not allowed to have their husbands living on the premises. Male visitors of any sort were discouraged. Even the children of BNs were seen as a problem although the DPH usually tolerated them while they were young. There is no record of older or teenage

³⁴⁹ Thurza Hazelwood, (née Cox), Personal Communication, Prospect, January 2003.

³⁵⁰ AOT, DPH, 58.26.43–58.1.43, BN Adamsfield Centre, Correspondence with local committee re accommodation of visitors in Hospital, Transfer of control of centre to DPH, Instructions of BN re fees, re appt of Sister ML Roach, 26 February 1943, (HSD 1/87).

³⁵¹ AOT, DPH, 58.26.43–58.1.43, (HSD 1/87). Sister Roach, (née Evans), married a local miner Bill Roach, T Hazelwood, Personal Communication, 2003.

³⁵² On Cape Barren Island the BNC was not only the old school room but also housed the BN and her husband the local teacher, Una Saville, (née Nicholls), Interview, Devonport, 1999.

³⁵³ Eileen McManus, (née McMenamin) Interview, Falmouth, 1994.

³⁵⁴ Jennifer Cramer, 'Dilemmas of remote area practice' in G Gray and R Pratt, (ed), *Issues in Australian Nursing* 3, Churchill Livingstone UK 1992, p. 134. Cramer refers to C Hodgson, 'Sitting on an island: nurses in Canadian north', MA Thesis, McMaster University, Ontario, 1980. (Un sighted).

³⁵⁵ As identified from the sheer volume of documentation about the issue.

male children living with BNs, and therefore no record as to what reaction the DPH would have had to this situation.

An additional problem with the combining of home and work place was the potential for cross infection. In many instances BNs were prone to infections from their contact with patients and then passed these onto their own families. This was potentially more a problem where the BN's children lived in the BNC with her. Sister JL Folder at Brighton expressed her concerns for her child from outbreaks of infectious diseases.³⁵⁶ The obverse also caused concern when the BN was boarding within the community, particularly at times of serious epidemic illness:

Mrs Weeks, the occupier of the house where the BN boards, was nervous about having Sister there while there is any likelihood of her being called to a case of Infantile Paralysis. In view of this, and Sister's dissatisfaction with her quarters, arrangements were made for her to go to the hotel.³⁵⁷

With the prominence of infectious diseases as a health problem during the Bush Nursing era it is perhaps surprising that this issue does not feature more strongly in the official Bush Nursing correspondence.

Where the BN lived in private board the living arrangements were at times even less satisfactory than when she lived in the BNC. Sister Gwen Tilley, a relief BN, who boarded with her child with locals at Gladstone wrote that she:

is housed in a bed sitting room where she sleeps, bathes herself in a dish (I have use of the bathroom where the wind whistles wildly) cooks her breakfast and tea and keeps her food. The bed is comfortable and warm—and there is a good supply of wood. I keep my bread in a billy can in an attempt to prevent it drying—and I eat the most easily prepared foods in an attempt to minimise preparation of food in the bedroom. The lady of the house supplies the midday meal—and this costs me 25/- weekly for myself and child. Mrs Richardson is very kind—but my wretched independence prevents my intruding on her any more than is absolutely necessary. The bathroom has a chip heater—but is serviced by a very small tank—the smallest I've ever seen. There is no running water over the basin—and I wash my teeth in water from a cup. To get to my bed sitting room I either have to go through their living room or make a wide detour right round the house. All the water used in the laundry work has to be carried from another very small tank. The Lavatory is about half way to Hobart and the wood heap is about the same distance away. The surgery (a room in the school house) is about a quarter of a mile away. There is no water in this room—and again one has to intrude in peoples' private lives when on duty at the surgery. The car is garaged still further away. When the Sister is wanted on the phone, the PM does a trek to find her whereabouts and then the Sister (if found) does another trek to the PO and often waits for a long interval till the caller is located. No blame is due to the Committee—they are a very helpful body—it has been a real pleasure to work with them. They are untiring and self sacrificing in their effort to

³⁵⁶ AOT, DPH, 58.48.49, Report Brighton Camp, 22 September 1949, (HSD 6/34).

³⁵⁷ AOT, DPH, 58.13.37, BNC Ringarooma, Letter from SN re accommodation for Sister, 6 December 1937, (HSD 1/36).

keep the centre going. It is for this reason alone I stayed on—despite my husband's advice to quit.³⁵⁸

Sister Tilley vividly described the grossly inadequate facilities she and her child were forced to endure. But endure it she did. She dismissed her comments as showing 'wretched independence which prevented her asking for 'privileges' but nevertheless she asserted herself in making the complaint to the DPH. In an earlier letter written soon after arriving in Gladstone from Rossarden, Sister Tilley opined that she could last only a week in these conditions, but despite this remained in board for some five months.³⁵⁹ Upon receipt of this outpouring, Sister Noller, the Supervisory Nurse, wrote to Dr Carruthers expressing her grave concerns about retention of staff under such difficult conditions.³⁶⁰

Problems associated with BNs sharing accommodation was a common concern for many centres even where there was strong committee support. Whereas Sister Tilley at least felt she was living in an environment of goodwill, in 1934 Sister Pitt at Lilydale was less happy 'as the family with whom she is boarding is not very well disposed towards her'.³⁶¹ Such concerns were part of the impetus that led to the provision of a purpose-built BNC at Lilydale, and in a number of other centres. While the DPH had identified autonomy and privacy as key concerns, BNs either in private board or residing within the BNC still lacked comfort, privacy and autonomy.

The history of the development of Tasmanian BNCs is rich with correspondence between local communities and the DPH. Records of additions, renovations, improvements, complaints and strong lobbying for funding, can be found in files for most centres. Some centres were more successful than others; some were destined to be the source of conflict and complaint for years. The examples in this chapter are but a sample of the rich sources that each community could access to provide a complete and thorough history of these buildings and their inhabitants. This also is worthy of a social history of

³⁵⁸ AOT, DPH, 58.7.49, Letter to Sister Noller, SN, from Sister G Tilley, 23 June 1949, (HSD 6/34).

³⁵⁹ AOT, Letter to Sister Noller, 8 August 1949, Sister Tilley wrote: 'In regard to Gladstone I'll be very surprised if I last a week. The bed sitting room set up is a most inconvenient and uncomfortable arrangement. I didn't leave a modern up to date home with all conveniences to come to this prehistoric Florence Nightingale set up. Why do you people allow these committees to start a centre under these conditions beats me. Bath once a week if you are lucky seems the order of my new home. I couldn't live a week without a bath—and don't intend to. Have no idea where my dinner is coming from today and have no intention of cooking a meal in my bedroom—we could manage with bread and butter until after the weekend—when I expect to be well rid of the place. I shall return to Rosebery—and before I take another job in Bush Nursing will have fuller details before I leave home,' (HSD 6/34).

³⁶⁰ AOT, DPH, 58.7.49, Letter to Sister Noller from Sister Tilley. Note, written by Sister Noller to Dr Carruthers, 17 October 1949, attached to this letter: 'What shall be done regarding staffing this centre? I feel we will lose Sisters to Bush Nursing if sent out to these conditions. Sister Tilley leaves on 1 December 1949. Shall we leave it unstaffed until the new residence is built? I have interviewed one Sister re the vacancy and she has been put against it,' (HSD 6/34).

³⁶¹ AOT, DPH, 58.7.34, BN Lilydale, re Sister improving surgery, 30 July 1934, (HSD 1/36).

domestic and health-related architecture. Many of these buildings are under threat of demolition, or already have disappeared, as new health facilities are built and thus part of our social fabric and heritage has been lost or is in danger of being so.³⁶²

In this chapter the voices of a small number of women have illustrated the environment in which BNs lived and worked. Their home and work environments were the locations in which they experienced the personal and professional isolation that became the culmination of their frustration, deprivation and lack of privacy, leisure and freedom. The experiences described were not experienced by all BNs, although undoubtedly conditions were more difficult in the early years of Bush Nursing. The characteristics of the centre influenced BNs' work, as did access to adequate domestic and nursing equipment. Her life was shaped by geographic factors, including climate and transport, but modified somewhat by her access to communication technology. Isolation was a universal experience for these women, but conditions and facilities were not uniform and not supported by agreed minimum standards. The hardships of their environment were not expected by many BNs, and in Chapter Four and Five it shall be seen that the level of their responsibility, and the complex nature of many of the health problems with which they were to deal, was equally unexpected. The rules of the organisation implied that they were to work in well-supported clinical environments, but they remained isolated. The improvement of transport and communication had the potential to reduce isolation, but these resources also were not uniformly distributed. Bush Nurses had, at most times, inadequate access to such facilities. Their patients, in the main, were disadvantaged more. As a consequence, BNs generally lacked the ability to gain access easily to professional support for problems that arose as they worked within the community. Organisational responses to the BNs' needs were critical to their feeling of isolation. Many communities, and Bush Nursing Committees, welcomed and supported the BNs. Some communities placed obstacles in the BN's way or responded to her pioneering role as an independent female professional with restrictions or complaints that were strongly gender-based. The DPH appeared slow or reluctant to act to support the BN if this were potentially expensive, although the Supervisory Nurses were generally powerful advocates for the interests of the BNs. The Medical Unions were similarly reluctant to support BNs as willingly as committee-controlled BNCs. The next chapter explores the BN's personal isolation within her community, and the subsequent chapter will explore the issues of professional practice and autonomy.

³⁶² *The Examiner*, 28 April 2003, describes outrage over private purchase of Brighton Camp buildings. All previous BNCs, if existing, are not included on any current Tasmanian Heritage Register.

CHAPTER FOUR

Bush Nurses as Isolated Women and Community Members

'I felt I had arrived at the end of the world!'

Rossarden I think is positively a loathsome place—I have never been to worse ... Here I haven't any neighbours so to break the monotony of a quiet life 'at home' I am contemplating climbing gum trees, which are directly opposite the cottage, in search of an opossum, if such animals exist in gum trees!—Must have company of some kind!¹

I used to go out and sit with the ducks in the afternoon, I was so lonely. Ah ha!! Strange company but better than no one. The ducks and I would sit on the wood heap together. They were quiet and seemed to like me.²

These are the words of isolated women experiencing deep personal loneliness. Many BNs expressed such loneliness in interviews and in their correspondence with the DPH. These descriptions were the voices of women and were not necessarily the expression of Bush Nursing experience. They could have been those of any women living in these areas. Life for men and women was lived differently particularly in the early years of Bush Nursing, but one of the problems with examining the isolation of BNs as women is that each had a life which was unique. How did these women, sent as BNs into isolated communities, cope as women in isolation? Did they climb trees or go mad? What mechanisms allowed them to cope with their predicament? Some BNs married in contravention of the rules; some immersed themselves in their work and some resigned; and some complained bitterly and consistently.

The focus of this chapter is personal isolation. After detailing this isolation I will explore the impact of marriage on Bush Nurses and Bush Nursing. On the whole single women were more isolated than their married counterparts. It was not unusual for the BN to marry a local lad thus gaining integration into the community through family networks and support. Although through marriage, according to the rules of Bush Nursing, they automatically would lose their formal status as a BN, marriage had obvious attractions for many BNs. Bush Nurses like Thelma Connors, 'Nessie' Mackenzie, Ruby Gittus, Evelyn Mellish and Eleanor Burbury remained single. Mary Walsh at Lilydale remained in the same area longer than most BNs yet never married. Despite being single she appeared to be well-integrated into the community. Personal isolation is difficult to characterise. Is it an attribute of the relationship between an individual and those in the community around her or is it inextricably bound within the personality of the individual? It is a cliché to say that

¹ AOT, DPH, 58.14.44, BN Rossarden letter from Sister Hélène Bonhôte at Rossarden, 5 January 1945, (HSD 1/91).

² Isyabell Ann Weir, (née Williams), Interview, Westbury, 1995.

some people are lonely in a crowd. Was Bush Nursing a profession that attracted loners or explorers?

Bush Nurses were isolated women as well as being isolated professionally. In many cases these nurses were leaving their family and friends to travel to remote areas that they had never visited prior to their appointment. Bush Nurses lived alone or, in some cases, alone until they married. Even when some official acceptance was accorded to married BNs, isolation could deepen. Further, the general requirement was that the BN must live at the BNC away from her husband. Sexual activity on the premises was prohibited. The BN had to remain at least visibly 'the virgin on the hill'.

Their vivid impressions of their journey to, and arrival at, the BNCs can give an insight to the shock that awaited many. As single women without transport, and in many cases without prior knowledge of the community, these women quite literally were trapped on arrival. The isolation of the community, and lack of transport and modern communications infrastructure, meant that they could only reduce personal isolation within the context and confines of their new community. Their work allowed them to interact with the community during their 'opening hours' but what was it like at other times? How did they fit into the community outside of this work, especially in areas where the population was predominantly male and where the few women were married?

Despite the initial drawbacks many saw their appointments and a new way of life as a challenge and all have commented that they never regretted their career choice.³ The majority of BNs interviewed enjoyed the independence that came from living alone but the physical isolation was daunting initially. Sister 'Lexie' Alicia J Laird recalls arriving in Waratah:

The fellow said this is where you're stopping. It was in the middle of Parawee and there was this little hut there in the middle of the trees, and I thought, 'Oh God, where have I come?' [Laughter], and then we seemed to come fifty miles on a rough road, it was a gravel road and I thought, 'Oh, where am I going to?' But I liked it once I got there. I never did like towns much.⁴

³ Professor Michael Roe raised the issue that the unanimity of endorsement of the BN's life choices could be an indicator that oral history tends to be an indicator only of the affirmers, not those who defected or were desolated. Although it can be argued that women labelled and identified as BNs for a long period of time were part of the cohort of women interviewed and can be considered the 'stayers', there also were women identified and interviewed who were in their nursing careers. As well I have documentary evidence of the 'non-stayers'. Retention problems point to the dissatisfaction with the conditions but the women who stayed in positions overcame these drawbacks. They did not seek to hide the problems but usually gave what I describe as 'warts and all' type interviews.

⁴ 'Lexie' A J Burns, (née Laird), Interview, Waratah, 1994.

Sister Laird was one of the lucky ones as she had a family connection within the community. She was met on arrival by her cousin with a wheelbarrow in which to carry her luggage to the Bush Nursing quarters. The family ties helped facilitate her acceptance by the locals. She eventually married a local timber worker.

Sister Hazel Bird, an earlier BN from interstate recounts her journey. On arrival at Burnie en route to Marrawah, even the locals thought that she was going to the 'end of the world':

Well, when I came to Tasmania, we came in on the little trading ... ship or boat ... from Melbourne to Tasmania. We came into Burnie. We came in at four o'clock in the morning and everybody had to leave the boat, and just across the road was the Bayview Hotel, and I said to a man ... 'I've got a fairly big case. Could I get a taxi and get the big case up to the hotel?' And the man was there with a horse and dray and he took it up for nothing. So when I went into the hotel there was a night porter on duty, and he asked me what I wanted and he said, 'What are you doing out this hour of the morning?' And I said, 'I've just come from Melbourne'. I said, 'Could I have a single bedroom, please?' He said, 'You're not going to bed now, are you?' And I said, 'Yes'. And he said, 'What've you come over here for?' And I said, 'I'm going to Circular Head, Marrawah, Redpa nursing'. 'Oh ... You don't want to go there ... That's the end of the world! ... It's a terrible place!' And I said, 'Oh, I'll go and have a look at it'. 'Oh dear', he said, 'you don't want to go there'.⁵

The BN's sense of adventure, or of venturing into the last frontier, comes across strongly in many similar comments. They went from an environment in which they shared their work and personal lives with other nurses, to one in which they would be alone. Although alone, many BNs perceived their life as independent rather than lonely. Others such as Sister Evelyn Mellish did not mind the loneliness even though it was a new experience for her:

No, I liked that, it didn't worry me. Most of the time I've lived where there were people, and houses. The first time I lived on my own was when I came to Gladstone. I was never scared of the dark when I was a kid.⁶

She said she never regretted choosing Bush Nursing as a career. Despite the isolation of personal life, BNs were too busy to dwell long on this. As single independent women they stood out in rural isolated areas as possessing 'a freedom' long before most other rural women who were engaged in other aspects of work.⁷

⁵ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

⁶ Evelyn Mellish. Interview, Musselroe Bay, 1994.

⁷ There has been work published about rural teachers as previously noted in Chapter 1. Parallels may be drawn from these studies suggesting that Bush Nursing and teaching had somewhat similar experiences.

Loneliness—the price of life on a pedestal

Bush Nurses were given high status in the community and often were 'placed on pedestals'. This in turn affected the community's expectations of them and their position within the community. The local Council Clerk at Lilydale held the BN in high esteem and described her as being on a 'pedestal', 'married to her profession'.⁸ Other locals saw her similarly:

They looked to her to cure them rather than waiting for the doctor. No-one ever said a bad thing about her personally or professionally. She was the favourite Bush Nurse because all the others had lives besides but she was always there—dedicated to nursing.⁹

The Headmaster at Lilydale School saw her as 'the unofficial Medical Officer always ready and willing to care' for all in need.¹⁰ The nurses themselves felt the communities' high regard and respect, and dependence upon them:

They did have a lot of respect for the Sister, there was no doubt about that, and they were very dependent and they really thought the Sister could fix everything.¹¹

Sister N Jean Bryan (later Sister Isles) at Oatlands felt that the community respect was only second to that accorded to the local doctor.¹² At Strahan Sister Elaine Mary Macguire (née Morris) diagnosed a case of whooping cough that was disputed by the young locum visiting at the time.¹³ 'If Sister Macguire says it's whooping cough, it's whooping cough!' asserted the parents.¹⁴ The young locum later confided that he had never seen a case of whooping cough. The confidence entrusted in the nurse was accompanied by her sense of professional self-assurance and competence. This came not only from experience but perhaps also from youthful enthusiasm and overconfidence as expressed by Sister Ruby Elphinstone (later Sister Kelly):

I suppose I felt like all the people who lived there the Sister will fix it and I felt pretty confident then. I was young and green in the world. I didn't feel I couldn't fix anything really as long as they called me in time.¹⁵

⁸ Art Van Der Hek, Interview, Norwood, 1994.

⁹ Dina Bardenhagen, (née Chick), Personal Communication, 2003.

¹⁰ QVMAG, Lilydale Council records, Letter from Mr W Thornton to the Warden, Lilydale Council, 30 July 1974.

¹¹ Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

¹² Jean Isles, Personal Communication, 24 April 2003. She was an interstate nurse who married a local farmer and remained in the district nursing until her retirement with only time out to care for her young family. Her connection with the local community made her 'feel like part of a big family'.

¹³ Sister Elaine Mary Macguire trained at Devon Public Hospital and was registered in Tasmania on 9 July 46, Registration Number 1963.

¹⁴ Dr John C Morris, Personal Communication, Windmill Hill, April, 2003. Dr Morris was the brother of Sister Macguire and recounted this incident from her recollections to him. Sister Elaine Macguire, (née Morris), was a relief BN at Tullah and also at Strahan.

¹⁵ Ruby Kelly.

The respect in which she was held placed the nurse in a privileged position in the community, trusted in her work, with access into any home, and entrusted with community secrets. Bush Nurses were aware of holding this position of high esteem as these comments collectively illustrate. Vi Millington recalled, 'I was always allowed to come there, [into their homes] I was one of the privileged people. If they were sick they'd call on me or they'd write letters [asking] for advice ... The nurses ... were very well respected ... that's one thing, it didn't matter what you did you were never criticised'.¹⁶ Evelyn Mellish stated that, 'As long as they trusted me, that was all I cared about'.¹⁷ Eileen McManus also recalled that, 'We were very respected ... People were wonderfully kind there; they really looked after me'.¹⁸ Ruby Kelly summed up the situation: 'You were their doctor, their nurse and their friend'.¹⁹

Not all BNs saw the relationship between them and the community in such terms. Sister Laird felt that people in the community 'were kind to me ... were all very good, they'd do anything for a BN' but conversely she recalls that she was treated as one of the community with no special status.²⁰ Her interpretation might be more a reflection of her modesty when describing herself rather than a true assessment of the situation, or it might reflect the complexity of the interwoven public and private roles.

While the oral evidence above confirms the respect the community held for the BN and for her role in the community there is a tendency to view the past through 'rose tinted glasses'. The official records detail many complaints from various centres about individual BNs or particular aspects of Bush Nursing (such as we have seen with transport-related issues). Others saw the nurse as 'merely a paid worker'. These views, however, do not detract from the thesis that the BN was seen by the majority of the community as a special and valued person fulfilling a special and much-needed role in the community.

We have seen that Bush Nursing demanded 'women with a calling' and through their actions earned their special status in their communities. Many BNs subsidised the BNC from their own salaries if the need arose, and as has been noted earlier even gave up their own beds to accommodate additional patients. In arguing for the support of retired BNs by the Red Cross Trust Fund, the Supervisory Nurse, Noller recalled that:

During the depression of 1928 and for many years afterwards, the salaries of Bush Nursing Sisters were so reduced as to be barely a living wage. Also, such items as

¹⁶ Viola C Millington, (previously Thompson, née Liersch), Interview, Sandy Bay, 1994.

¹⁷ Evelyn Mellish, Interview, Musselroe Bay, 1994.

¹⁸ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

¹⁹ Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

²⁰ 'Lexie' AJ Burns, (née Laird), Interview, Waratah, 1994.

firewood and other things, were being purchased by them for their patients' comfort. In some cases, where premature infants or others needed fires night and day, the Sisters concerned paid for the wood themselves, as the Committees could not meet the cost. The babies had to be fed and tended sometimes 2-hourly in the 24 hour day, and the fires kept stoked. Daytime duties were fitted in just the same. These nurses could have been placed in the Home Missionary category. It is these older nurses, now retired, on reaching retiring age—the pioneers of the service—whom the Trust Fund has helped in the past, and it is hoped will be able to continue to help in the future.²¹

A position on a pedestal, associated with the power inherent in a knowledge-based calling, isolated the BN as it restricted personal behaviour and created high community expectations. The BN's behaviour became constrained by the highly public role she had to play. Furthermore role expectations led to a lack of personal freedom and a loss of privacy. She was usually the only health care professional in her area. She was an 'unusual' woman by virtue of her education and her independence as a salary earner. She had a centrality in the community as a direct result of her multi-functional role as midwife, general nurse, school nurse, child health clinic nurse, and doctor. She was often the first person with health knowledge on the scene of accidents, she was ambulance driver and undertaker, she was called to emergencies if the police were unavailable or by the police if women were to be arrested, she might be the after-hours telephone operator, and she even acted as the vet on many occasions. The local community had total confidence in the nurse.²²

The increased expectations of the BN by the community were a direct result of the isolated nature of the town. The BN's expanded role (both official and unofficial) resulted in a broadened perspective of what it was to be a nurse in the community but paradoxically while it increased her 'visibility' it also served to broaden her apartness from, or isolation within, the community. There was variable success in socialisation of BNs into the communities in which they were sent to serve. This in turn influenced the longevity of the nurse's service within the community, and how she coped with the personal and professional isolation. The independence of the BN would not have developed if she were not isolated, but isolation and independence had a human cost.

²¹ AOT, DPH, 28.28.8, Re Use of Red Cross Trust Fund, staffing levels and conditions etc from Sister DK Noller, (HSD 5/8) (HSD 3/12).

²² 'I am directed to convey to you the appreciation of the Warden and Councillors for your untiring work in all parts of the district which has been of great value to the community.' AOT, DPH, 58.8.38, BN Lilydale—Letter to Sister Pitt from Council in appreciation of hard work during paralysis epidemic, (HSD 1/53). The local Bush Nursing Committee's Minutes and reports published in the local newspapers were a continued testament to the BN at Lilydale.

The Bush Nurse's Uniform—manipulated or controlled isolation?

The professional identity of the nurse and the community expectations of the nurse can be examined through the way in which the nurses wore their uniform.²³ The wearing of an apron and veil was a means of signifying status as a registered nurse.²⁴ Bessant and Bessant accord great significance to the wearing of uniforms in hospitals:

The uniform had become the most important piece of paraphernalia associated with the nursing ritual. It defined status and responsibilities. Its upkeep and appearance were subject to constant perusal and close inspection. The state of the uniform was not only important for the hospital's public image, but was seen by those in authority to measure the worth of the wearer.²⁵

By donning a uniform the hospital nurse was able to assume her role and establish boundaries which distanced herself from the community in a professional sense, an act which can be seen as a form of manipulated or controlled isolation. At least for a nurse in an isolated community, 'defining actions' such as the BN removing her uniform and participating in the community in civilian dress could not always succeed in keeping separate her work and private life. Unlike hospital nurses who could remove their uniforms and themselves from their place of work, the BN was trapped within her community.

Metaphorically it could be argued that the BN was trapped within her uniform whether she donned it or not. Nevertheless the uniform provided a tool by which she attempted to define social roles. According to the rules and regulations, she was required to wear her uniform while on duty. The uniform was not always practical clothing for the BN, and there is no record that a distinct Bush Nursing uniform was developed or specified.

²³ Debates about nurses' uniforms are scattered throughout the nursing journals across the world but generally there is agreement that uniforms instilled respect, authority and confidence around the nurse. Bush Nurses interviewed support this view. Nurses today now question the symbolism of the uniform in the relationship between nurse and patient and nurse and doctor. For some examples see M Richardson, 'The symbolism and myth surrounding nurses' uniform' in *British Journal of Nursing*, vol. 8, no. 3, 1999, pp. 169–175; ME Macfarlane, 'The Professional Nurse: with or without a uniform' in *Canadian Journal of Nursing Administration*, vol. 3, no. 3, pp. 14–17; Chris Mahoney, 'Hemmed In', in *Nursing Times*, vol. 95, no. 15, 1999, pp. 24–5.

²⁴ Bessant & Bessant, p. 40. 'The caps were the most significant part of the uniform. They designated the status of individuals in the nursing hierarchy, so particular care had to be taken with them.' **Note** Uniform code, including caps, was not a universal nursing code, and it varied by training environment. For a summary of arguments about the utility of nurses' uniforms see also A Pearson, H Baker, K Walsh, M Fitzgerald, 'Contemporary nurses' uniforms: history and traditions' in *Journal of Nursing Management*, vol. 9, no. 3, 2001, p. 147.

²⁵ Bessant & Bessant, p. 39.

Rather the dictum was to wear 'some' nursing uniform: 'BNs have no special uniform, so those worn by you at present would be quite satisfactory'.²⁶

Photograph 4.01 Bush Nurses in Uniform—a formal statement

These two posed photographs show the nurses in full uniform, a statement of their identity as nurses.



Unidentified Bush Nurse at Grassy (possibly Sister Mavis Elizabeth Abel), note she is wearing her full uniform including veil and cape.

Source: DPH, Bush Nursing Album, NBT.



Sister Lillian Stella Perkins, Cape Barren Island BNC.

Source: Furneaux Island Museum

²⁶ AOT, DPH, 58.15.39, BN Spring Bay, Letter to NSW Sister wanting details of BN work offer of Triabunna, 30 November 1939, (HSD 1/70).

The visiting doctors and the Supervisory Nurse expected the nurse to wear a uniform, and many BNs recall putting their uniforms on 'only when the matron was coming down'.²⁷ The veil was considered, by the nurses, as a part of uniform more easily omitted in day-to-day work, but 'when the Doctor was coming up I'd put my lid [veil] on, while we did surgery . . . as long as your veil was 'a small' you'd have no trouble'.²⁸ Dr L Bryant at Ouse remembered that he 'had a ruling about that', and thus the nurses always wore their veils.²⁹

At various times BNs were allocated a Uniform Allowance, and BNs wore the uniforms from their previous, usually hospital, employment.³⁰ Sometimes the BN was 'caught' out of uniform and was advised officially to wear her uniform whenever attending patients and when on duty.³¹ Sister Jean E Fraser at Avoca and Sister Bryan at Oatlands were instructed 'to wear uniform when attending patients'.³² 'Discarding the uniform' was part of a complaint against Sister Iles at Ulverstone.³³ Residents complained to the Supervisory Nurse about Sister Amy Maud Storey at Bruny Island getting 'about in such awful rags' such as on one visit where she was attired 'in strides and a very worn out jumper'.³⁴ The Tasmanian Bush Nursing Association wrote to the DPH recommending Sister Storey's services be terminated for various reasons and concluded that the BN must also 'keep up the dignity of the Nursing profession and the Bush Nursing Scheme by wearing the regulation uniform'.³⁵ Despite such examples, generally a blind eye was turned on non-wearing of uniforms other than on 'formal' occasions. The uniform was an effective tool used by BNs to evoke trust and confidence.³⁶ While not all nurses wore full uniform all of the time, and other nurses did not wear uniform in situations where it was impractical (such as on Babel Island), the BNs did not object to wearing the uniform.

²⁷ Evelyn Mellish, Interview, Musselroe Bay, 1994.

²⁸ Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

²⁹ Dr L Bryant, Interview, Bellerive, 1994.

³⁰ In lieu of the provision of uniforms (four shillings a week in 1953). AOT, DPH, 58.9.2, Letter to Sister Noller from Sister Anne Elizabeth Hammett, Lilydale Centre, 13 February 1951, (HSD 5) and State of Tasmania DPH BN Service, 'Information relating to and standing orders of the BN Service August', 1953, p. 2, (HSD 5). Sister Hammett was an English-trained Sister, double-certificated and additionally trained as a physiotherapist. She became a BN reliever while in Tasmania on holiday, relieving the Matron at Queenstown, and the BNs at Lilydale and Oatlands.

³¹ AOT, DPH, 58.2.49, Report by SN for Avoca, 2 August 1949, (HSD 6/34).

³² AOT, DPH, 58.2.49, (HSD 6/34). AOT, DPH, 58.28.5, Report on Inspection of Oatlands Hospital by DK Noller, 25 January 1952, (HSD 6/34).

³³ AOT, DPH, 58.18.36, BN Ulverstone, Letter to Director Public Health from SN re complaints about Sister Iles (HSD 1/24).

³⁴ AOT, DPH, Letter to the Secretary for Public Health from SN Clara Alice Stammer, 14 August 1934 (HSD 1/5). Sister Amy Maud Storey was trained in the Christchurch Public Hospital and registered in Tasmania on 24 November 1928, Registration Number 150.

³⁵ AOT, DPH, Letter to Mr EJ Tudor Secretary DPH, from Ellie Baxter TBNA, 25 August 1934, (HSD 1/5).

³⁶ Pat Grimshaw and others refer to women enlistees during World War II: 'Donning uniforms symbolised women's bid to be taken seriously ...'. P Grimshaw, M Lake, A McGrath and M Quartly, *Creating a Nation 1788-1900*, Mc Phee, Gribble, 1994, p. 256.

Photograph 4.02 Floral Dress and Veil



Sister Lilian Green with Dr Royden Herbert Minton Connel at the opening of the Flinders Island Bush Nursing Centre on 8 February 1941. Sister Green 'stylishly' mixes her floral dress with her veil, a delightful statement about Island informality. As it is a formal occasion she is wearing high heels!

Source: Furneaux Museum.

Photograph 4.03 Sister Foster on Babel Island, 1936



Sister Edna Foster did not wear her uniform on Babel Island, and the informality on the island is evident as she poses with a stake of mutton-birds across her shoulders.

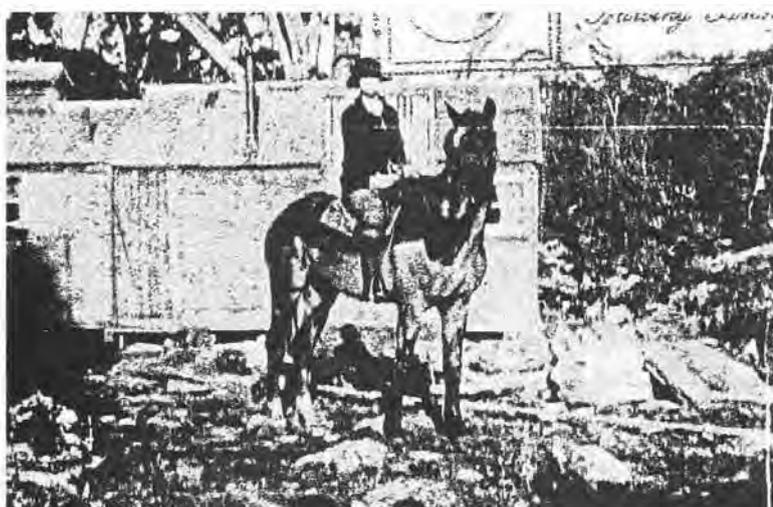
Source: Private Collection.

Bush Nurses saw the uniform as defining their status within the community—a professional badge. The uniform was used in this way to give patients confidence in the BN. Hazel Gaffney remembered:

At the home I always wore a uniform, if I didn't have my jodhpurs on. I had grey linen with a little white collar and when I did my maternity cases I always wore a white gown, gloves and a mask. Without fail, I got into my uniform because if you do that, they feel safer. If you blew in there in a dress that you'd been out in you're one of them, but you put your uniform on and there's that barrier. You see, there's the difference. You're then back on your professional status.³⁷

Here she draws the distinction between a dress and jodhpurs, the latter while not uniform in the strict nursing sense was still a sign of the nurse's activity in a way in which a dress was not. 'When I went on the pony I wore jodhpurs and a shirt and my riding breeches because I was on the pony every day'.³⁸ More importantly is her clear statement that the private and public personae of the BN were delineated by a professional code of dress.

Photograph 4.04 Sister Storey, Shannon Bush Nursing Centre, 1925



Sister Amy Maud Storey's use of jodhpurs was practical and also a formal expression of her role as a Bush Nurse.
Source: Nursing Archives of Australia.

This view of uniform as a tool of control was not just an isolated instance. Sister Lois Rockliff wore her uniform at all times whilst visiting patients but did not wear her veil except in the surgery.³⁹ Sister Rockliff conducted surgery if anyone came and wanted their fingers dressed and then would wear her veil. 'Yes, you'd dress up. It sort of gave people more confidence you know'.⁴⁰

³⁷ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

³⁸ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

³⁹ Lois Kelly, (née Rockliff), Interview, Launceston, 1994.

⁴⁰ Lois Kelly, (née Rockliff), Interview, Launceston, 1994.

Photograph 4.05 Sister Lois Rockliff (later Kelly), 1943



Source: Private Collection

With no uniform designed to meet the conditions under which the nurse worked, the uniform was discarded when climatic conditions, working conditions, or other activities, rendered it impractical (regardless of rules).

Oh I'd leave my veil behind because the blooming thing would get blown away if it rained, especially if it was a windy day. I used to carry it in the car, but I never put it on.⁴¹

Sister 'Lexie' Laird always wore her uniform when she was delivering babies but did not wear the nursing uniform at all times, especially in the wet weather: 'You couldn't wear a veil. I mean, you imagine a starched veil, you get one drip of water on it! [Laughs]'.⁴² Although she discarded the veil Sister Laird drew the line at informality or even practical dress. She never wore trousers even in the snow. While some wore jodhpurs for riding, trousers were not a common form of dress. Eric French cannot remember his aunt, Sister Elsie Bessell, ever wearing her uniform at Adamsfield but he does remember that she never wore slacks. Sister Thurza Hazelwood also recalls that they did not have uniforms at Adamsfield but that most nurses wore a white apron. She wore dresses in the town, but did wear trousers in the bush for walking. Even when wearing a dress often she would wear thigh boots in which to tuck her dress.⁴³ Similarly, on Babel Island, trousers were a practical form of dress because of the terrain and working conditions.

⁴¹ Evelyn Mellish, Interview, Musselroe Bay, 1994.

⁴² 'Lexie' AJ Burns, (née Laird), Interview, Waratah, 1994.

⁴³ Nick Evers & Robert Ingpen, *Tasmania—Paradise and Beyond*, Adelaide, 1978, p. 40.

Photograph 4.06 Sister Elsie Bessell, c1927



Source: Eric French, Private Collection.



In the first photograph Sister Elsie Grace Bessell is nursing a baby at Adamsfield, the conditions in which she is working making the wearing of the uniform impractical. In the second photograph, the uniform and pose show this to be a formal portrait which says to the viewer, 'I am a Bush Nurse and this is my centre'. Note that she is wearing her full uniform including the veil. This is the Adamsfield Bush Nursing Centre which eventually replaced the slab hut that is illustrated in Photograph 3.24.

Source: DPH, Bush Nursing Album, NBT.

Some nurses would wear their full uniform even when it might have caused practical difficulties. Sister Eileen McMenamin shifted a dead patient to the mortuary (a shed some distance out the back of the BNC) on a trolley at night and described:

We used to wear the veils and everything in those days. The white veil. So there you would have been going across the cattle ramp with a body on it, in the full veil.⁴⁴

Other nurses donned uniform when called out at night to go visiting patients' homes,⁴⁵ and Kathryn McPherson's analysis of sexuality and the nurse similarly describes nurses using the uniform as 'a sexual' barrier to protect themselves when travelling alone on night calls.⁴⁶ In contrast Sister Ruby Kelly (née Elphinstone) at Waratah did not wear her uniform very often whilst nursing during the day let alone on night calls.

I was having to get out of bed at all hours of the night to go to people. They'd knock on the door, 'Come to get you Sister' ... That was the stage they'd get frightened and they would come. 'Quick Sister I think they've got appendicitis, their stomachs are sore and they are vomiting' ... and I got the same thing you see and I had no hope of getting it better, because I'm out all hours running around the country. So in the end ... I had all the clothes I had, nearly, on and Bill's overcoat on top of the lot, my overcoat and his overcoat.⁴⁷

Often the uniform was supplemented to enhance practicality. At Waratah Sister Rockliff remembered she always wore a raincoat because 'it rained all the time'.⁴⁸ At Cape Barren Island, Sister Saville wore a gown over her uniform such as is worn in hospitals during theatre or surgery, or on occasion over her ordinary clothes, as patients would call into the centre at any time of the day or night. 'The uniform wasn't used a lot. It really wasn't necessary'.⁴⁹ This was especially the case when she travelled the island in a horse and dray. If conducting a routine clinic or delivery she always would wear uniform.

The uniform as a way of defining roles and boundaries was at best only partially successful. It was difficult for the BN to have time to herself. Although 'available times' were advertised on the doors of clinics, the BNs were available 24-hours a day. Communities were not always sympathetic to the BN enjoying a private side to her life and considered her public property.

⁴⁴ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

⁴⁵ Janice Flora Barnes, (previously Brooks and née Fenton), Interview, Devonport, 1995.

⁴⁶ Kathryn McPherson, *Bedside Matters — The Transformation of Canadian Nursing 1900–1990*, Oxford University Press, Toronto, 1996, p. 181.

⁴⁷ Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

⁴⁸ Lois Kelly, (née Rockliff), Interview, Launceston, 1994.

⁴⁹ Una Saville, (née Nicholls), Interview, Devonport, 1999.

Photograph 4.07 Sister Una Saville, Cape Barren Island



Sister Una Saville on Cape Barren Island wore a 'hospital' gown over clothes. Here she treats an Aboriginal boy. Despite the semiformal pose, the wearing of the gown suggests that this was treatment conducted outside a routine clinic time.
Source: Una Saville, Private Collection.

Doffing her uniform did not allow her to doff her nursing persona. Even when out at dances or public functions people would assume she was available:

I can remember going one night to ... some sort of a turnout and they said, 'Oh, we knew you were coming out tonight so we thought we'd leave it until tonight'.⁵⁰

This blurring of boundaries might have been the reason for some blurring of dress codes as when Sister 'Ruby' Christina Ruby May Sutherland (née Edmonston) at Gladstone wore a pink nylon dress over her uniform.⁵¹

⁵⁰ 'Lexie' AJ Burns, (née Laird), Interview, Waratah, 1994.

⁵¹ Elvie Richardson, (née Green), Interview Scottsdale, January 2003. Sister 'Ruby' Christina Ruby May Sutherland trained at Edmonston District Hospital, Victoria, and was registered in Tasmania on 9 March 1938, Registration Number 886.

Alan Pearson and others note that the dominant view in the literature is that the uniform enhances professionalism.⁵² For D Smith the uniform enhances legitimacy although suppresses individuality.⁵³ This might have a negative effect by creating a social barrier that for Pearson is the 'very antithesis of the nurse-patient relationship'. C Flint and S Szasz see uniforms as entrenching the power that nurses have over their patients.⁵⁴ D Little also views the uniform as a symbol of power.⁵⁵ Kim Walker argues rather that while nurses wear uniforms as 'unequivocal signifiers of their difference ... in reality they efface her being' making her anonymous.⁵⁶ For Bush Nursing there is no evidence that the uniform made the nurse anonymous. While such anonymity might have occurred for a hospital nurse working as one of many nurses dressed alike, this was not the context for BNs. She was usually the sole nurse in an area, and her uniform provided a class or professional identity. Despite the BN conceptualising and using the uniform as a definer of professional boundaries, the uniform could not mask individuality. The uniform might have increased the isolation of the BN but this was through reinforcement of her role, not through loss of personal identity. Years later, locals can remember still the various names and actions of individual nurses. Bush Nurses did not see the uniform in terms of emphasising the power of the professional over the patient, although by reinforcing the nurse role the use of uniform might have contributed to the personal safety of the nurse as an isolated and single woman.

Kim Walker further argues the impracticability of the uniform and contends that the uniform was 'designed to constrict their movements and desexualise their bodies' and to implement a 'hierarchical encodement'.⁵⁷ The imposition of the uniform would seem by this analysis to be something that nurses might rebel against. For Walker, the nurses' belief that their uniform defines their status is false and the nurses are deceived by an 'illusory visibility'. Once again this analysis does not seem to fit the context of Bush Nursing where only in exceptional circumstances most nurses did abandon the uniform totally. The sight of a sole individual in the community in uniform would seem to have enhanced her visibility. While the uniform might have been imposed by regulation, BNs worked with minimal supervision. Their election to wear uniform suggests that the uniform was a tool that they used consciously and to good effect and at other times chose to discard.

⁵² Pearson, Baker, Walsh, Fitzgerald, p. 147.

⁵³ D Smith, 'Uniforms: worn out', *Nursing Times*, vol. 86, 1990, pp. 32-35.

⁵⁴ C Flint, 'Symbols of Servility', *Nursing Times*, vol. 80, 1984, pp. 51-52, and S Szasz, 'The Tyranny of Uniforms', in J Muff, (ed), *Socialisation, Sexism and Stereotyping*, St Louis, CV Mosby, 1982.

⁵⁵ D Little, 'The "strip tease" of nurse symbols or nurse dress code: no code', *Imprint*, vol. 31, no. 1, 1984, pp. 49-52.

⁵⁶ Kim Walker, 'On What it might mean to be a nurse: A discursive ethnography', (PhD), LaTrobe University, 1993, pp. 65-6, discusses in his thesis the issue of the uniform in a section entitled 'A paradoxical discourse: The visibility/invisibility dialectic'.

⁵⁷ Walker, pp. 65-6.

Gender Isolation

Bush Nurses as agents of progressive ideology espoused the principles of scientific motherhood. Within this ideology motherhood was not merely a role which needed to take into account contemporary theories of child rearing, but also it was the ultimate destiny of most women and seen as the pinnacle of female achievement.⁵⁸ The BN's position in the community was therefore somewhat ambiguous as she preached one theology yet role-modelled another. Her role was acceptable as a high calling for womankind only if she was within a monastic tradition. Here her service was to 'medicine' (if not to the doctor), but this tradition required the sacrifice of any (or, at least, personal) life as an individual.

At least until the social changes in women's status and expectations of women occurred within the context of World War II, the BN's power as a proponent of Progressivism was intertwined with the view of her as part of a monastic order. In this context the BN by role definition required no life of her own. The code of conduct of BNs as set out within Standing Orders reinforced this view of them—their home was public property and any visitor to that home required official approval. Certainly male friends were not encouraged as visitors, and forbidden as overnight guests. A public life without the freedom of a private life perhaps would have been acceptable where the nurse lived within a community of peers (such as a nurses' home). For the BN there was no community of peers, and in fact no peers, in her daily life. Thus she was personally isolated by virtue of her role.

Bush Nurses were single women—we shall see that even when marriage eventually was allowed they were usually expected to live in isolation from their husbands. As single women this placed a particular social role upon them, both in the personal and professional sense. In many areas in which BNCs were located the majority of inhabitants were male. As members of a gender-based minority group, BNs' single status reinforced this minority

⁵⁸ Strachan, p. 25. Marriage was the ultimate destiny of most women. Although by the 1890s young women worked longer and married later in life than their mothers had, 'the majority still looked to marriage as their prime goal and to the home as their natural and proper sphere', Ronald Lawson, *Brisbane in the 1890s*, University of Queensland, St Lucia, 1973, p. 129. It was clear that 'social pressures ... set marriage as the prime female goal; and a majority of women accepted that only widowed or deserted married women should work', Eddie Clarke, *Female Teachers in Queensland State Schools: a history 1960–1983*, Queensland Department of Education, Policy and Information Services, Queensland, 1985, p. 6. 'It was universally assumed at the beginning of the twentieth century that most girls would get married within about a decade of leaving school. Not all girls got married, but the great majority did, and the assumption of the growing girl was that she would marry', Elizabeth Roberts, *A Woman's Place*, Basil Blackwell, Oxford, 1984, p. 81. In this comment she refers to the UK—central and northern Lancashire.

position. As a single female member of the workforce the BN was often unique. This placed constraints on acceptable social relationships. At Adamsfield:

There is not much social life as there are only about six women and six children on the Field, but the nurses appear to have been very happy in spite of this.⁵⁹

This, combined with the muddy conditions, saw Sister Hazelwood go to her first dance in long boots. 'The floor was uneven and the women were outnumbered ten to one'.⁶⁰ Being female in a male-dominated remote community had advantages in small things such as being in high demand at dances—a pleasurable bonus. The same status could result in social disharmony.

At Ouse often there were complaints about men 'hanging around the hospital'. One complaint in particular was made about married men, perhaps underlining the concern that an unattached single woman might cause problems for other women in the district. In 1950 questions were asked about visitors (married men) to the Ouse BNH in response to complaints from a Hamilton resident.⁶¹ On investigation the BN in charge dismissed the complaint and reported that:

The only married man I know of, who has visited the hospital, is a carrier who has been on business trips different times and offered to take different members of the staff, when off duty to Tarraleah and Butler's Gorge on his rounds. To my knowledge, six different members of the staff have gone on these trips and generally in pairs, and speak well of him. Only occasionally has he called in and had a cup of tea on his way home. I am very surprised indeed for anyone to see any harm in it, but I will certainly make it my business to see it does not occur again.⁶²

While the nurse as a single woman could be seen as a danger to community stability or morality there is no evidence that she acted inappropriately.

Conversely it might be postulated that for the nurse there would be dangers in working, living and travelling alone. As a highly-valued professional, her status became part of her protection but this was an inadequate safeguard. There were times when one BN noted that she was frightened, but references to this were somewhat obscure and related to 'shadows' rather than statements of personal vulnerability. Another nurse described getting a dog for her protection:

⁵⁹ AOT, DPH, 58.1.36, BN Adamsfield, Letter to Sister Evans outlining Adamsfield & Marrawah conditions, 20 January 1936, (HSD 1/24). Sister 'Maisie' Lillian M Evans was at Adamsfield from 1936-38. *Tasmanian Post Office Directories*.

⁶⁰ Thurza Hazelwood quoted in *Sunday Examiner*, 17 June 1990, p. 18, 'On the Road Again with Eddie Kerfoot and Geoff Willson: "Tale of three Sisters! Trip back to Adamsfield"'.
⁶¹ AOT, DPH, 58.12.5, Letter to Sister Adcock, Ouse from Director Hospital Medical Services re married men visiting staff, 25 May 1950, (HSD 5).

⁶² AOT, DPH, 58.12.5, Letter to Director Hospitals from Sister Adcock, Ouse re married men visiting staff, 26 May 1950, (HSD 5).

[I] purchased a dog because of the people who had kept coming late at night before they went to sea and, of course, I was on my own at the centre so I had a dog for a bit of protection at night.⁶³

Yet, as noted previously, another BN jokingly referred to a patient's 'frisky hands' while she sutured a head laceration by lamplight. Only the latter was clearly sexual harassment. In one interview a BN described an 'overfriendly' doctor in a BNH, again a reference to possible sexual harassment perhaps further complicated by the doctor's position of power.⁶⁴ Despite these examples the interviewees in this study did not see themselves as vulnerable or sexually harassed.

Travel, particularly at night, was seen as a concern probably because of the risk of accident or breakdown. There was acceptance on many occasions that the nurse should travel accompanied. Volunteers provided this service but obtaining volunteers was not always easy given the unpredictability and unsociability of night calls.⁶⁵ On Cape Barren Island the task appeared to fall primarily on the shoulders of one volunteer as Sister Saville recalled, 'There was one chap in particular. He was very very helpful and he'd drive with his dray. That was only at night time ... Lewis Mansell'.⁶⁶ As appropriate to the sense of morality of the times, if the BN were a single woman the driver would be a married man. Thus while safety was not discussed explicitly by most nurses interviewed in this study there is clear evidence that as single women, living by themselves for the most part in remote male-dominated communities, precautions were taken which reflected a concern for personal safety.

Gender issues also became prominent once it were possible for a BN to be married. Sister Bird, at Marrawah, ceased work as soon as she was married despite offers of work. Her attitude is indicative of the prevalent attitudes of, and to, middle-class working married women at that time in Tasmania:

Stopped dead. Stopped dead. When I got married, Matron from the Ulverstone Hospital came and she said, 'I'd like you to go on night duty', ... And Lennie [the newly-wed's husband] was sitting there ... I said, 'Ask Len'. And did he answer. He said, 'Don't you think I can afford to keep my wife?' And she said, 'Yes, I know you can'. 'Well', he said, 'I'm keeping her'. And I never had one day's nursing that I got one cent for from the day I married. But I often helped people. I often went and gave people that needed injections.⁶⁷

⁶³ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

⁶⁴ In this case when I queried the incident the BN dismissed the incident as inconsequential because everyone knew what he was like and took precautions when working alone with him.

⁶⁵ QVMAG Box 10—Newspaper Article, nd, re Sister Hetherington's resignation and volunteers for night calls.

⁶⁶ Una Saville, (née Nicholls), Interview, Devonport, 1995.

⁶⁷ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994. Hazel was 32 years old when she married Len Gaffney. 'We were late, you see, late getting married, but it didn't worry us. We were very happy. Been married for forty-nine years and couldn't have been better.'

The DPH could find itself in conflict with the BN's husband, one making it clear that he should be consulted when it offered employment to his wife at the Tasman BNC:

I understand that my wife has been appointed relieving BN. I have not received any notification or been consulted by the local authorities in any way ... I wish to state emphatically, that I will not agree to my wife holding the position temporarily.⁶⁸

The DPH tried not to upset the status of the husband as head of the house and breadwinner. In the later Bush Nursing period there were strenuous attempts to gain employment for the BN's husband. Unless he was employed gainfully it would be harder to retain the BN. Sister Ruby Kelly's husband ran out of work and, although she had secure employment as a BN, it was time for her to move as well. The DPH started working with local communities to identify work opportunities for BNs' husbands.

Whether single or married, gender issues affected the BN's life in the community. Particularly for single women gender was a source of isolation rather than an assistance in helping them integrate into the community. As members of isolated communities we shall see that they participated in local activities such as fund-raising, leisure and social events. Despite this involvement we have seen that the uniqueness of their role placed them on a pedestal, and made them as much *apart from* as a *part of* the community. In trying to integrate with the community and reduce isolation many nurses developed relationships that led to marriage.

Bush Nursing, like general nursing, was officially a vocation for single women. Nurses in many senses were married to their profession, a relationship with close parallels to the position of females within religious orders. The community saw and appreciated this selfless service and somewhat reluctantly accepted the idea of a BN married to an individual rather than to a career. Through an exploration of marriage and the BN we gain some insight into the integration of the nurse into the community. In some places the communities were a 'sure marriage mart' for single BNs, but as marriage was not part of the official vision of the BN this created significant difficulties for the Bush Nursing Association and DPH.⁶⁹ For isolated women, marriage was often a solution to the isolation.

⁶⁸AOI, DPH, 58.16.36, BN Tasman Letter from Mr Locke re not agreeing to wife's temporary position, (HSD 1/24).

⁶⁹Marilyn Lake in *Getting Equal, the history of Australian Feminism*, Allen & Unwin, Sydney, 1999 refers to the 'Married Women Teachers and Lecturers Dismissal Act' that was passed in 1932 but vehemently opposed by Jessie Street; 'the legislation denied women teachers the right to marry, but Street added 'it also deprives a woman teacher who marries of the right to work'. 'It was not until 1966 that the marriage bar was removed within the Commonwealth Public Service' according to Jill Julius Matthews, *Good and Mad Women, the Historical Construction of Femininity in Twentieth Century Australia*, George Allen & Unwin, Sydney, 1985, p. 85. Edith Collis remembers King Island having the reputation as the surest place for teachers and nurses to find a marriage partner. Edith Collis, Personal Communication, August, 2004.

For the BN this created the difficulties of 'marrying' her new wedded status to her Bush Nursing career. For much of the Bush Nursing era this required 'divorce' from her career (although there were exceptions to the rule). While a husband and family decreased the sense of personal isolation for the BN and helped integrate her into the community, marriage also brought with it complications and problems.⁷⁰

According to the regulations BNs were not permitted to be married. During this period it was the usual policy for nurses' employment to be terminated immediately upon their being married.⁷¹ One BN at Triabunna recalled that, 'No they were very, very much against [marriage] ... once the girls who were in the Bush Hospital married, they had to retire, resign'.⁷² In some Centres the BN stayed within the community but in others the BN and her husband left the district.

At Adamsfield marrying the BN became a tradition.⁷³ With the preponderance of single men, it became impossible for Adamsfield to maintain a BN service staffed by single women. Sister Thurza Hazelwood who lived in Adamsfield in the 1930s saw the field as a 'marriage bureau'. There was a shortage of women and nurses would usually only last two months or so before marrying a local.⁷⁴ The DPH could not keep sending and losing more BNs to marriage. The solution was to agree that in those exceptional circumstances a married BN was acceptable reluctantly. Sister Inez Elsie Raphael married a local miner and tendered her resignation in June 1934 but was allowed to continue work at Adamsfield until a successor was secured. She then became Tasmania's first married BN. Several months later the committee protested her appointment, angered at an overheard telephone conversation to the Supervisory Nurse where Sister Inez Elsie Howard (née Raphael) had reported that:

[I]t was essential for a married Sister be stationed at the Adamsfield Centre and not a single Sister owing to the loneliness and need of protection in case of night calls.⁷⁵

⁷⁰ Alison Bashford refers to the process of modernisation suggesting we need to 'examine the contradictions and negotiations, investigating the modes and strategies by which women resisted, accommodated, and were displaced by modern scientific and professional imperatives' in Bashford, 'Domestic Scientist' p. 128. So too can the BNs' marriage be seen to be contradictory and one which BNs needed to balance carefully. Kari Dehli states that 'motherhood and marriage were incompatible with wage work' and that married women were automatically excluded as visiting nurses. As well she discusses the conflict between being professional and upkeeping her 'natural feminine traits which elicited mother's trust and confidence'. Kari Dehli, "Health Scouts" for the State? School and Public Health Nurses in early Twentieth-Century Toronto', in *Historical Studies in Education Review*, vol. 2, no. 2, 1990, p. 258.

⁷¹ Bush Nursing Procedures and Instructions, Part II, no. 27, nd, p. 9: husbands.

⁷² Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

⁷³ Boorer quotes a nurse who summed up the marital status of nurses: 'The majority of those who come here end up getting married'. Boorer, p. 845.

⁷⁴ Thurza Hazelwood, (née Cox), Interview, Prospect, 1998.

⁷⁵ AOT, DPH, 58.1.35, G A Prescott, Copy of motion posed by Adamsfield Vigilance Committee, 28 September 1934, (HSD 1/13). Sister Inez Elsie Howard trained at Sydney Hospital and was registered in Tasmania on 31 May 1932, Registration Number 453.

The Committee members now insisted that they were against married women being employed because 'many single Sisters are seeking appointments' and they also resented the implication 'that a single Sister would need protection from the class of men that we have in this community'. It is of significance that these sentiments coincided with Sister Howard reporting a case of child abuse. Her replacement, Sister Audrey Elizabeth Harrison, arrived in November 1934 but by December 1935 the committee once again was needing to seek the services of a BN.⁷⁶ Sister Hazelwood was already married and living in Adamsfield when she was employed as the BN in 1938. Despite her nursing qualifications being lower than the stated minimum, the DPH appointed her at a salary of £100 per annum.⁷⁷ Sister Hazelwood saw her appointment as unpopular because of her married status, thus depriving the community of a new bride.⁷⁸

Marriage was considered to be one of the main reasons for the loss of BNs. While it was possible for a community to try to make the BN feel part of the community, with resignation being the price of marriage it was difficult for any area to make the BN feel at home while simultaneously keeping her services in the community. The two needs were almost mutually exclusive.

The ladies take personal interest in the staff too, socially. This is considered mainly responsible for retaining staff happily here longer. Honorary membership to sporting bodies has been included, for staff. One Sister has been nearly 3 years at Oatlands. The domestic assistant has been there nearly 5 years. The other Sister has done nearly a year and has relieved several times previously. Sister Bryan is to resign next March to be married. It is the main cause of resignation in this district.⁷⁹

The substantial loss of BNs to marriage was of course no surprise. If marriage were the ultimate destiny of women, and marriage were incompatible with service as a BN, the Bush Nursing Service needed to plan for Bush Nursing as a high turnover occupation. During the latter years of Bush Nursing recruitment of nurses became extremely difficult. It was necessary to relax the rules against marriage. This was a progressive process. It was marked by some variability and inconsistency among centres and across time as the DPH and others struggled to assess and respond to the changes in workforce availability and societal mores. It was in the more remote West Coast regions that rules initially were relaxed, particularly in regard to the employment of married temporary staff. Married

⁷⁶ Sister Audrey Elizabeth Harrison, (née Hall) trained at Hobart Public Hospital and was registered in Tasmania on 31 August 1928, Registration Number 109.

⁷⁷ AOT, DPH, 58.1.38, BN Adamsfield re Married Nurse—appointment of Sister Hazelwood, 19 May 1938, (HSD 1/53).

⁷⁸ Thurza Hazelwood, (née Cox), Interview, Prospect, 1998.

⁷⁹ AOT, DPH, 58.11.3, Report for Director General Medical Services from Sister DK Noller re Oatlands Hospital, 7 December 1953, (HSD 5).

sisters were appointed as relieving sisters, and in many cases were allowed to be accompanied by their husbands or family.⁸⁰

In 1936 married nurses relieved in Lilydale and Tasman BNCs but clearly in a bridging capacity. At Lilydale an arrangement was made for Mrs Doris Hudson (the ex BN) to carry on the Bush Nursing work until the arrival of Sister Edna Foster.⁸¹ As has been noted previously Mrs Hudson was not paid for her services, acting in a voluntary capacity, and perhaps while it was grudgingly acceptable for a married woman to relieve as a BN, it was not acceptable to pay her as a BN. At Tasman a similar situation arose: 'owing to our inability to secure the services of a permanent nurse ... Mrs IA Locke was asked to act in the position in a temporary capacity'.⁸² Married nurses were also useful in filling difficult gaps in the service, such as those caused by conflicting clinical commitments. Mrs Hudson also assisted in Lilydale when Sister Pitt, attending a maternity case, thus was unable to visit and nurse scarlet fever cases in Golconda.

The War Years (1939–1945) saw many married women in relieving positions. It is clear that these years put more stress on the DPH's efforts to fill BNC vacancies and married nurses often helped. This still was construed as acceptable only as a temporary measure:

A BN is required to resign her appointment on marriage, but it is the practice of the Department to retain her services in a temporary capacity during the period of acute shortage of nurses owing to war conditions, providing she is willing to act and has no children.⁸³

Even if the BN had children the Department was happy to waive the marriage rules on the condition that the nurse find someone else to take over responsibility for the children. Mrs Lynch, the BN at Tullah prior to her marriage, was approached with the offer of a paid position:⁸⁴

Would [you] help us by taking the Tullah BNC for one month during Sister Allen's annual leave before Christmas ... The staff of BNCs is a problem at present, owing to war conditions, and the married nurses are doing this service for us in some centres. You may have a young family, but perhaps it might be possible to get someone to take over these responsibilities for the month.⁸⁵

⁸⁰ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

⁸¹ Another married reliever at Lilydale was Mrs Arnold, previously Sister D M Stuart. AOT, DPH, 58.8.37, File Docket BN Lilydale, letter to Council Clerk, Lilydale from EJ Tudor, 13 August 1937, and letter to Secretary of Health from Council Clerk, 11 August 1937, (HSD 1/36). AOT, DPH, 58.7.36, BN Lilydale re married relief, 19 June 1936, (HSD 1/24).

⁸² AOT, DPH, 58.16.36 BN Tasman, Letter to Mr Locke re temp position of Mrs Locke as BN, (HSD 1/24).

⁸³ AOT, DPH, BN Tullah, Re relieving BN, see also file 87.7.43, 58.20.43, (HSD 1/87).

⁸⁴ The salary would be at the rate of £4.4.0 per week.

⁸⁵ AOT, DPH, 58.21.41, BN Tullah, Request Mrs Lynch to relieve at Tullah (where she nursed before marriage) from Mr EJ Tudor, (HSD 1/79).

Many nurses married during the war years but, although resigning as required, continued to carry out Bush Nursing duties in a temporary capacity. After five and a half years of service in Tullah, Sister Minnie Windsor married in 1943 but was permitted to work in a temporary capacity.⁸⁶ The DPH stated: 'I feel I should accept her offer, in the absence of any valid reason why she should not so act'.⁸⁷ Sister AM Vernon at Swansea was to be replaced in 1944 'owing to her approaching marriage' but was permitted to continue nursing in the North afterwards on a 'temporary basis'.⁸⁸

With the serious shortage of nursing staff during the war years, and the requirement that marriage required resignation from Bush Nursing, it is not surprising that maintaining BNs in the isolated areas was difficult. Man Power regulations constrained the freedom of BNs to marry or to move, thus making things somewhat easier for the DPH. Approval was required for marriage:

Man Power require the name of proposed husband, date of marriage, and name of officiating clergyman before release is granted for marriage⁸⁹

and with 'Bush Nursing Rules require[ing] 1 month's notice of termination of service' it was not possible legally to obtain a quick marriage and release from contract. ⁹⁰

Man Power helped lead social change. In 1945 Sister Alwyn Amy Adcock was asked to resign from her position at Ouse with effect from the date of her marriage.⁹¹ Her request for temporary work was noted 'for future reference, in the event of a suitable vacancy arising'. She had not requested a *temporary* position and had made it clear that she did not want to resign. It was necessary for her to be the breadwinner as her husband was expected 'to remain a Repat patient for several years to come'.⁹² Furthermore she noted that she had not 'applied for my release from the Army yet' (presumably under wartime Man Power regulations). While the DPH was attempting to secure her resignation 'Man Power authorities offered (her) a position as BN at King Island'.⁹³ It would seem that the wartime Man Power authority was less concerned about the implications of employing married staff

⁸⁶ AOT, DPH, BN Tullah, Re relieving BN—see also file 87.7.43, 58.20.43, (HSD 1/87).

⁸⁷ AOT, DPH, BN Tullah, Re relieving BN—see also file 87.7.43, 58.20.43, (HSD 1/87).

⁸⁸ AOT, DPH, 58.5.42, (HSD 1/86).

⁸⁹ AOT, DPH, 58.23.44, BN Waratah, (HSD 1/89). Under the National Security (Man Power) Regulations of the *National Security Act 1939* women were able to be 'manpowered', and their employment directed as deemed necessary for the war effort.

⁹⁰ AOT, DPH, 58.23.44, BN Waratah, (HSD 1/89).

⁹¹ AOT, DPH, 58.24.45, BN, Appointments, Resignations (Permanent Dept Staff), (HSD 1/91). Alwyn Amy Adcock was born 18 March 1923 in Victoria. She was a probationer at the Bencilla BNH in Victoria for 18 months and then completed her general training at Bairnsdale District Hospital and her midwifery at Mildura. She arrived in Tasmania in 1949, and was sent to Ouse BNH on her first day in the state. She married Mr Hills in 1951, and resigned from Bush Nursing in February 1956. AA Hills, Wynyard, Personal Communication, 2003.

⁹² AOT, DPH, 58.24.45, (HSD 1/91).

⁹³ AOT, DPH, 58.24.45, (HSD 1/91).

than was the DPH, and that in this case they over-rode the DPH's wishes or advice and appointed a married BN.

Even after the end of the war, in 1946 and 1947, official records show that the DPH still preferred single to married staff. It was the more isolated areas which continued to lead the way in the acceptance of married BNs. Sister Ruby Elphinstone met her husband elsewhere, but consciously chose to work at Waratah. Her husband, Bill Kelly, came from Waratah and he had family there. Married for a year on arrival at Waratah in 1946, Sister Ruby Kelly (née Elphinstone) previously had visited the town during her engagement. She believed that the authorities thought her very suitable because she had married a local man and thus would be more likely to stay in Waratah, and 'of course they couldn't get anybody [else]'.⁹⁴

When Sister Greta Victoria Bristowe married and transferred to Storys Creek, Sister Ada Gladys Donald (née Jeffrey) at Storys Creek took over her position at Rossarden.⁹⁵ This was brokered by the two Medical Unions involved.

Now I understand then by what you said that the department would have no objections if I stayed on nursing after marriage and knowing of the terrific shortage of nurses throughout the state would be glad to do so—Frank, as I think I told you has only one arm to work with and his employment is at Storeys Creek.⁹⁶

The transfer was designed to allow Sister Llewellyn (née Bristowe) and her husband to reside at the BNC at Storys Creek. Furthermore Sister Donald was married with a son. She desired to move from the Storys Creek BNC as it was located on a busy road.

Sister Donald is very keen to come here—prefers to be here on account of Jeffrey's safety which believe me, is jeopardised many times daily on account of the Storey's Cottage being directly on the road.⁹⁷

While in many ways the Medical Unions rightly were criticised for their lack of equipment and poor facilities, they were able to work flexibly and, with the DPH's approval, to ignore the 'rules' in order to secure stable health care for their remote communities.

Nursing shortages were still a significant problem for the Bush Nursing Service at war's end and the Annual Reports offered 'a word of gratitude to our married nurses who

⁹⁴ Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

⁹⁵ AOT, DPH, BN Annual Report 1946-1947 Northern Centres, (HSD 6/10). Sister Ada Gladys Donald, (née Jeffrey) trained at Huddersfield Royal Infirmary in Yorkshire, England. Sister Greta Victoria Bristowe (later Llewellyn) was trained at Castlemaine, Victoria, and registered in Tasmania on 8 July 1946, Registration Number 1930.

⁹⁶ AOT, DPH, Correspondence relating to Transfer of nurses at Storys Creek and Rossarden, 1947, (HSD 6/10)

⁹⁷ AOT, DPH, 1947, (HSD 6/10).

on so many occasions have filled the breach, owing to the continued shortage of trained nurses'.⁹⁸ Changes were afoot. By the middle of 1947 the DPH was making the case to employ married women 'in emergency' and no longer was arguing this as a temporary appointment. It quoted the British example of employing married women where 'many hospitals in Great Britain are staffed up to forty to fifty per cent by married women'.⁹⁹ Nevertheless numerous examples show that a married nurse still was considered the second best option. Sister Gwendoline Tilley lost her employment as a relieving nurse when Sister Ross, a single nurse, became available. The following consolation was sent by the DPH: 'You will appreciate the necessity of appointing an unmarried sister, who can be resident at the centre'.¹⁰⁰ We have seen that the DPH gained substantial value from combining the BN's home and work. Married women and their families were more difficult to accommodate in the BNC and they thus were of lesser value than unmarried staff. Conversely, because the Medical Union believed that a married nurse would provide them a more stable employee, Sister Laird lost her relieving position at Waratah in 1951 when a married nurse became available to fill the position. This exception to the general rule is understandable in the context of the historic difficulty in maintaining single nurses within isolated mining communities but illustrates the variability between centres.

The BN's isolation severely constrained her social contacts. This together with the 'over representation' of men in many of these communities not surprisingly resulted often in the marriage of the BN to one of her patients. Sister Bird at Marrawah met her husband Len Gaffney 'over his infected cut thumbs'.¹⁰¹ Sister Lois Rockliff met Bert Kelly at the local dance hall, and Sister Eileen McMenamin married the local vet.¹⁰² Many of the BNs who married locals believed that their marriage helped them to become accepted into the community by gaining a 'foot in the door'.¹⁰³ Despite having to resign as a BN they retained at least some sense of identity as a nurse within the community, some helping the new BN (formally or informally) while others kept their identity merely by the appellation of former BN.

⁹⁸ AOT, DPH, BN Annual Report 1946–1947 Northern Centres, (HSD 6/10).

⁹⁹ AOT, DPH, 13.5.47, Letter to the Chairman BN Centre Ringarooma from Secretary for Public Health, (HSD 16/10). Meanwhile here in Australia campaigners like Jessie Street were involved in protesting the rights of nurses and teachers to marry. See Judith Godden, 'The unionisation of nurses' in Heather Radi, *Jessie Street Documents and Essays*, Women's Press Inc, NSW, 1990, pp. 94–103.

¹⁰⁰ AOT, DPH, 58.15.49, Correspondence, March 1949, (HSD 6/34).

¹⁰¹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

¹⁰² Eileen McManus, (née McMenamin), Interview Falmouth, 1994.

¹⁰³ Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

Married Bush Nurses were the Reserve Army of Relievers

Marriage into the community was a frequent occurrence for bush teachers as well as the BN. Retention rates were a problem for the Education Department as for the Health Department. Marriage also required the resignation of the female teacher.¹⁰⁴ The Education Department had an advantage. If an area developed a reputation for continued loss of female teachers through marriage a male teacher simply would be sent next. Male teachers, like the police, were allowed to marry without prejudicing their employment. The lack of male nurses meant that the DPH lacked the Education Department's flexibility. Government policy was clearly sexist but even more evidently so when male teachers married female BNs (as was common) and she would have to resign.

As married nurses were used as temporary, or sometimes permanent, staff, precedents were being created. In 1949 Sister Jean Elizabeth Fraser requested leave to be married. She informed the DPH that she hoped to stay on at Avoca if her husband were allowed to reside at the BNC, and quoted the precedent of Sister Greta Llewellyn's husband staying at the Storys Creek BNC.¹⁰⁵ The local council was supportive of her request, and the following year it is noted that her husband was staying with her, but only at weekends. The Sister at the Avoca BNC wrote:

Just a note to tell you that I was married on 7th January, and returned to Avoca on 13th Jan. The council clerk notified me that the council were quite agreeable for me to marry, and remain here, and he was going to confirm it with you. So I took it for granted that everything is in order. At present my husband is only coming down from the mine for the weekends.¹⁰⁶

Many BNs took the safe option and did not notify the DPH until after their marriage. Notice after the event became commonplace as BNs realised that their services were indispensable and they were thus in a position of power. In 1950 eight of the 35 BNs employed throughout the state were married, but some were living apart from their husbands.¹⁰⁷ Men who were not patients were not allowed to sleep in the BNC. At Waratah these strictures were to crumble as the DPH tried to ensure that this remote centre was staffed adequately. In the 1953 rules it is noted that the wont of husbands living in a hospital was:

¹⁰⁴ Alexander, Footnote 2, p. 1, 1910, notes that the Education Department announced that married women would no longer be employed. In the past it had been customary for women to resign upon marriage. *TJPP&P*, 1909, no.1, p. 22.

¹⁰⁵ AOT, Letter to DPH 6 November 1949, (HSD 5).

¹⁰⁶ AOT, DPH, 58.2.2, Letter to Sister Noller from Sister Fraser, Avoca Centre re her marriage to Mr Lejnicks, 18 January 1950, (HSD 5).

¹⁰⁷ *TJPP&P*, 1950.

considered an objectionable practice, and therefore prohibited in Hospitals where maternity cases are admitted, and is only permitted at other Centres, with the written permission of this Department.¹⁰⁵

In contrast when Sister Laird married in 1952 at the age of 29 her husband was allowed to reside in the BNC. She met her husband 'Matt' at Waratah, and did not notify her employers until after her marriage, recognising that 'They couldn't get anyone so they had no choice'.¹⁰⁹ She retained her permanent staff status. Sisters Ruby and Lois Kelly and 'Lexie' Burns (née Laird) were aware of the desperate need for nurses on the West Coast and all realised that their skills outweighed the strict enforcement of regulations. The retention of nursing services also remained reliant on the working opportunities of spouses. On Cape Barren Island the BN was employed because she was already a resident as the local teacher's wife. She had married upon completion of her nursing training but her husband subsequently was transferred to Cape Barren Island for a year by the Education Department. They stayed six years. 'It was difficult to get people there', she said.¹¹⁰

While the more remote and unpopular BNCs led the social change, in more popular centres stricter rules applied. At Ouse in 1951, Sister Alwyn Adcock was planning to be married and her husband was waiting on a repatriation land grant. Even though she had an excellent record of service and wanted to continue Bush Nursing the recommendation from the DPH was that 'she should be given permission to remain on until such time as her husband-to-be has a farm allotted to him'.¹¹¹ The DPH was bending the rules but this flexibility did not extend to offering Sister Adcock a permanent position.

Although the DPH might be seen as conservative, the community at times lagged behind the DPH in recognising the new reality. Small rural communities were insular and traditional. The two World Wars saw large numbers of young men leave the area for war service, but many people had never travelled from their small communities. Social change was slow to affect rural communities. Traditional rural views on women's work and marriage needed to be challenged by the only slightly less conservative DPH which saw that it needed to advocate for a changed perspective on nurses and marriage. At Swansea in 1954 the Department was aware that local residents sometimes objected to married BNs:

This department would like to have your Councillors' opinion on the appointment, if necessary, of a married nursing Sister with perhaps husband and child resident, to fill the above vacancy. It is becoming increasingly difficult to retain single Sisters in

¹⁰⁸ AOT, DPH, 58.28.3, Circular to all BNCs from Director General Medical Services and see also Procedures and Instructions Part II, no. 27, p. 9—husbands, 3 June 1953, (HSD 5).

¹⁰⁹ 'Lexie' AJ Burns, (née Laird), Interview, Waratah, 1994.

¹¹⁰ Una Saville, (née Nicholls), Interview, Devonport, 1999.

¹¹¹ AOT, DPH, 58.12.3, Memo to Sister Noller from Director General Medical Services re Ouse BNC, 14 June 1951, (HSD 5).

BNHs, unless two are appointed together ... The appointment of married, or widowed Nursing Sisters at Triabunna and other Centres, has proved successful in that it has retained them longer and more contentedly. It would be appreciated if you could ascertain whether residents, as a whole, are likely to concur, or raise objections, as it seems the only solution to the problem.¹¹²

Barely 11 days later the DPH was to keep pressure on the Council both to accept a married BN and to ensure stable employment for her husband to avoid closure of the BNH.¹¹³ The DPH's actions contradicted its own rules about the marital status of BNs. The success of the new BNC that opened in George Town in 1955 was acknowledged openly as resulting from the endeavours of the married BNs.¹¹⁴ The 1956 Annual Health Report acknowledged that remote areas now were relying on married staff to overcome staffing shortages.¹¹⁵ Restrictions on accommodation of BNs' husbands continued. In this respect it seems that Tasmania might have been less flexible, and perhaps slower to change, than in Queensland. There, husbands were employed as wardmen in at least some outback hospitals which meant that they could reside in the hospital even where in-patient beds were in use.¹¹⁶

Bush Nursing Families

Marriage necessarily did not reduce personal isolation. Usually for the BN, regulations about residence required her husband to live elsewhere. Often work opportunities might require him to live outside the area. Isolation might have worsened even as a consequence of marriage. Unless the BN's husband had local employment there was an increased risk of the community losing the services of the BN. Recognising this, finding employment for her husband was a concern of both the DPH and the local community. In some DPH responses to prospective BNs in the 1950s there is the suggestion that although they no longer were concerned about the fact of a BN's marriage, they would

¹¹² AOT, DPH, 58.28.1, Letter to Warden Glamorgan Council from Director General Medical Services re married Sister, 11 January 1954, (HSD 5).

¹¹³ AOT, DPH, 58.1.1, Letter to Swansea Council Clerk from Director General Medical Services re married Sister appointment, 22 January 1954, (HSD 5).

¹¹⁴ T/PP&P, 1955.

¹¹⁵ T/PP&P, 1956. By 1958 after the subsumption of Bush Nursing into District Nursing the debate was still in progress. Rules were being slowly relaxed but the onus was now on the individual to find work for the spouse: 'At some of the Centres without in-patients beds it is permissible for the Sister's husband to reside there with her. He is not employed by the Department, and makes his own arrangements about obtaining work locally, if he wishes'. AOT, DPH, 58 January 1, Letter to Sister Warren, Victoria from Director General Health Services re employment, 2 October 1958, (HSD 5). Things remained difficult for married nurses even in later years as the former BN from Cape Barren Island discovered when contemplating re-employment to where her husband was employed as a teacher: 'Should your husband be transferred to Strahan or any other town with a District Nursing Centre having a vacancy we would be grateful if you could help out temporarily pending a more permanent appointment being possible. Avoca centre is expected to be vacant too, but neither could accommodate your family'. AOT, DPH, 58.1.1, Letter to Sister Saville from Sister DK Noller re possibility of Strahan appointment, 18 September 1958, (HSD 5).

¹¹⁶ AOT, DPH, Letter to Hospital & Charities Committee from Sister Warren, Queensland, re employment. Referring to Hospitals with First Aid Out Patient and/or Medical In-patients, 29 September 1958, (HSD 5).

prefer that the husband be employed outside the area. This presumably was to avoid the conflict between home and work obligations and the complications created by normal marital relations for the operation of BNCs. It might be that the apparent contradiction in accepting marriage but not husbands was moderated according to the 'level of attractiveness' of a Bush Nursing post. Positions which were the hardest to fill were likely to be those where the DPH was more inclined to be 'helpful'.

Sister Hussey, married to a teacher, reasonably requested that as her husband had been transferred to a school 25 miles from her BNC at Ringarooma, he be allowed to stay with her on occasions.¹¹⁷ This request was noted on file records as 'approved' but the occasional conjugal visits soon became permanent. The relief BN, Sister Bartels, found the situation somewhat awkward. She recalled that when Sister Hussey wanted leave the whole family would need to move out of the BNC. If they were not going away on holidays they usually rented another local house. On a few occasions the Hussey family remained in the BNC. This constrained access to the inside toilet for Sister Bartels and her patients, requiring them to walk around the back of the centre to use an old outside toilet.¹¹⁸ How toilet access for patients was achieved when Sister Hussey was in residence with her family can be but conjectured. This problem highlights that BNCs were designed for a single nurse who shared her resources with her patients. Once husbands or families were in residence the operation of the BNC became much more difficult. Issues about privacy, bathroom access and toileting, and the difficulties of operating a normal family life in the constrained physical environment were of concern. Furthermore we have seen that the BN traditionally gave up her bed to patients whenever this was required—would this also be expected of the BN's husband?

In some areas where the BN had a long tenure, slowly changing rules about marriage gradually reduced her isolation. In Triabunna, initially Sister Vi Thompson lived at the hospital and her husband lived with his family who owned the local hotel. Not only did the regulations stop her husband living with her but, as BN, she was not allowed to live away from the BNC whilst on duty. Thus she and her husband lived separately for years but later, when regulations allowed her to live away from the BNC, she bought a house in the area.¹¹⁹

The changes in the regulations reflecting or recognising the changing nature of Bush Nursing family relationships had been slow in coming. Furthermore the actual practice in

¹¹⁷ AOT, DPH, Letter to Director General Medical Services from Sister Clarice Marjorie Hussey, Ringarooma, 8 June 1953, (HSD 5).

¹¹⁸ Ruth Bartels, (née Holmes), Personal Communication, Bridport, January 2003.

¹¹⁹ Viola C Millington, (previously Thompson and née Liersch), Sandy Bay, Interview, 1994.

relation to enforcement or leniency was variable. While marriage was no longer a necessary reason for resignation, marriage led some BNs to resign because the Bush Nursing Regulations made marriage untenable.¹²⁰ The situation was becoming somewhat muddy and inconsistent across the Bush Nursing Service.¹²¹ By 1952 Sister Noller stated that husbands had been allowed to reside in Medical Union-owned BNCs but not DPH-owned BNCs. The DPH had allowed the BN's children to reside in its centres.¹²² In 1956 husbands could reside in DPH-owned BNCs if the centre had no in-patient beds.¹²³ Where husbands lived in BNCs they were required to pay rent although the DPH gained value from the maintenance and repairs that the BN's husband might carry out.¹²⁴ In this confusing and changing environment even as late as 1957 some BNs were prepared to live separately from their families in order to secure work. On King Island Sister Mavis Elizabeth Abel declared: 'My husband is agreeable to live at the Single Men's quarters provided by the Scheelite Mine, if my application is accepted'.¹²⁵

Not only were married nurses seen to be a 'threat' to the culture of Bush Nursing, a culture based on the employment of single women married to their profession, and accepted only reluctantly by the DPH, but equally they were able to upset the delicate

¹²⁰ Sister Dorothy Grace Vaughan resigned from Triabunna because her husband was not allowed to live with her at the centre. AOT, DPH, 28.5.47, Correspondence between Sister Noller, SN, and Dr BM Carruthers, and Note from Sister D Noller 3 February 1947, (HSD 6/10). See also King Island correspondence, AOT, DPH, 58.8.49, (HSD 6/34).

¹²¹ In 1952 the Australian Newsprint Mills Ltd had a new staff member arriving from England. His wife, Sister Locher, was a trained nurse and the company requested that the couple and their two young children be allowed to live in the cottage in Maydena which was two streets from the clinic itself. She would be employed as the BN. It was seen that Maydena had trouble attracting single nurses so a married nurse was a satisfactory arrangement. Although she had two young children who might restrict her capacity somewhat, the company justified the decision by the additional value of increased availability leading to 'neighbourly assistance in the event that it is necessary for her to visit in the district or being called out on urgent cases'. Rent would be charged for her husband's accommodation. Difficulties arose when Sister Locher wanted leave to go to hospital and her family wanted to remain in the cottage rather than leave the district. While initially she was to make a room available at the cottage for the relieving nurse and the family were to find board in the community, the relieving nurse eventually had to stay at the clinic itself which was not equipped adequately with cooking facilities, heating or furniture, AOT, DPH, 58.28.2, Various correspondence, 8 April 1952, 14 February 1952 and 12 June 1953, (HSD 5).

¹²² AOT, 58.8.49, (HSD 6/34).

¹²³ AOT, DPH, 58.AL, Letter to Sister Allen, WA, from Director General Medical Services, 6 January 1956, (HSD 5).

¹²⁴ The rental deducted from the BN's salary was at a rate of £1.5.0 each week AOT, DPH, 58.8.3, Letter to Sister Welsh, Grassy from Secretary Public Health, 30 July 1952, (HSD 5). 'Yes, my husband is still here. He came over to spend Christmas holidays with Peter & I... He has built the cupboard in the kitchen you gave me permission to have built, besides numerous small items needing repair. What gardening has been done, he has been able to do. I have cut down the domestic help I am allowed, to 8 hours per week, because my husband helps me when possible, particularly, with regards meals etc. This Centre is worked from 9 am to 6 pm week days & 9 am to 12 midday Saturday. People come along any time during those hours which does not always fit in with preparing meals without some help'. AOT, DPH, 58.8.3, Letter to Secretary Public Health from Sister I Welsh Grassy re husband staying, 12 July 1952, (HSD 5).

¹²⁵ AOT, DPH, Letter to Director General Medical Services from Sister Abel, King Island, 22 July 1957, (HSD 5). Sister Mavis Elizabeth Abel was a BN from 1945 to 1963 and worked at Rosebery, Waratah and Grassy.

balance of community relationships which supported the BN and the BNC. In Tullah in 1943 problems arose between the BN and the Medical Union after her husband wanted to live with her. The DPH had no objection to the husband living in these premises (despite the fact that it appeared to have owned the building) but the BN was finding living conditions intolerable.¹²⁶ If the BN's husband carried out care-taking duties a Board Member's wife might lose employment and housing. The BN's marriage upset the status quo and the Medical Union noted that the arrangement had been satisfactory until the BN married.¹²⁷ The final resolution of this standoff at Tullah is uncertain, but the case serves to reinforce that the success of BNCs depended on supportive communities, and that in each community the web of support was unique. If community support broke down the BN could find herself even more isolated within her community.

Married BNs usually desired to take leave when their husbands also had leave available to them. For example both at Tullah¹²⁸ and Storys Creek¹²⁹ the incumbent BNs desired to take holidays during mine shut-downs. Thus for the DPH scheduling holidays became more complex. Finding relieving staff became more difficult for the DPH as there were constraints on the timing of the leave. Once again the impact of marriage could lead to enhanced isolation for the BN when the DPH could not provide her with much needed holidays.

Marriage also had an isolating effect on single BNs who worked in tandem with married BNs. The presence of husbands led to complaints when, in several cases, relieving

¹²⁶ 'As you know this is a Government building for the BN with a caretakers residence, and a door dividing the two residences, the caretakers part has all the cooking facilities which has made it impossible for a nurse to cook her own meals, and if she only gets one meal a week there the M.M.U. has made the rule she still has to pay £1.1 a week. Am I justified in wanting to be able to cook for myself so that my husband could be with me at times instead of him having to get all his own meals and live by himself? The caretaker's husband is one of the board members who receives the benefit of the subscribers money by house rent free, wood, light and sanitary fees which is worth about [£75] a year ... Yesterday I thought I would like to cook my husband a pie, preparing everything in my bathroom on the wash stand and only wanting to take it in oven with a few biscuits as well, was literally ordered out of the kitchen by this child of 17 [the nurse's assistant] and ask why I did not get a home of my own ... and when [the caretaker's] ... husband came home from the board meeting, he walked straight through the dividing door and removed the key from my side of the door and said I had no right in that part of the house at all ... Am I justified in that, also in wanting my husband to be here with me, does it rest with the PHD or the M.M.U whether he resides here with me or not (have not put this before the board) but he can chop the wood as well as supply it for me without using the subscribers money and the care-taking at present is only a farce from my point of view, and my husband would do more for me than the caretaker and not any impudent children to contend with, and I can easily see to the doctor's meals if cooking apartment is available for his fortnightly visits'. AOT, DPH, BN Tullah, Re relieving BN—see also file 87.7.43, 58.20.43, (HSD 1/87).

¹²⁷ AOT, DPH, BN Tullah, Re relieving BN—see also file 87.7.43, 58.20.43, (HSD 1/87).

¹²⁸ AOT, DPH, 87.7.43, 58.20.43, (HSD 1/87).

¹²⁹ AOT, DPH, 25.7.47, Letter from the Storys Creek union to the Director of Hospital and Medical Services, (HSD 6/10).

BNs were accompanied by their husbands or family without notifying the DPH or the incumbent BN who had made the BNC her home. In 1954 Sister Nicholl complained that:

Sister [Dorothy A] George has just left ... I did not know she was bringing a child, nor ... her husband here for the long week-end. I think, since this is reckoned to be my home, to be shared with another Sister, you might have informed me.¹³⁰

Sister Nicholl, an unmarried BN, did not appreciate the invasion of a family rather than a single colleague. In fact permission had been sought and given by Sister Nicholl prior to the appointment, but presumably relationships and living conditions deteriorated over the course of the stay.¹³¹

Widowed BNs, with or without children, were more acceptable to the DPH than were married women. Similarly we have seen that married BNs with children, but whose husbands lived away from home, were also more acceptable to the DPH than were 'complete' family units. Children were seen as less disruptive than the presence of an adult male. While there was a recognition that her children might have consumed some of the BN's energies, the need for BNs sometimes outweighed the complication.

There were still concerns about the impact on work where BNs with children might not have the support of another parent with child rearing. Bush Nurses were asked frequently if they intended sending their children off to boarding school.¹³² There was an assumption that children would interfere with their ability to care for patients as well as their children. It was difficult for the BNs to balance families and their work. As working mothers this had the potential to alienate them from other mothers in the community. The combination of mother, wife and nurse workloads was so great that it contributed to their isolation from the community from sheer exhaustion. It was a complex balancing act that was aided by the community because they valued the BN so highly and were desperate to keep her at all costs. Many BNs recall experiences of community support.

When Sister Vi Thompson had her baby the BNH at Triabunna had to close until she was able to restart work. After two weeks she went back to work with the baby.¹³³ Without

¹³⁰ AOT, DPH, Letter to Sister Noller from Sister Nicholl Cygnet BNC, 25 February 1954, (HSD 5).

Sister AM George was an English trained nurse working as a reliever.

¹³¹ AOT, DPH, 58.2.54, Letter to Director General Medical Services from husband of Sister DA George, 7 March 1954, (HSD 5).

¹³² AOT, DPH, 58.11.56, Letter to Sister Flett, NSW from Director General Medical Services re vacancies, 7 September 1956, (HSD 5).

¹³³ 'I had him at Swansea and the hospital [BNC Triabunna] was closed. They couldn't get anybody to relieve me so it was closed while I had him. I came down to the Mother Craft Home with him for about a fortnight and I stayed with someone for two or three days and I went back to Triabunna and I worked again. [Laughs.] That was my home.' [Laughs] Viola Millington, Interview, Sandy Bay. At Cape Barren Island, the BN left the island to have her babies at nearby

community acceptance the BN would have been lost to the community as in this period maternity leave was unheard of.¹³⁴ In many cases the BNs continued working up until the baby was born and commenced duties immediately after the lying-in period particularly if there were emergencies or other patients were needing to be seen. Most BNs were obliged to leave the area for their own maternity care and most chose not to work after having their children. Sister Eileen McMenamán returned to nursing only for some night duties and ceased active maternity care once her children were born: 'I delivered my last baby when I was expecting my first'.¹³⁵

Sister Ruth Bartels at Ringarooma recalls taking her baby with her except when the visiting doctor did his rounds and then the babe would be cared for by a local neighbour. Child care was not easy to arrange and early boarding school became the solution for some BNs. Having a family might have decreased some aspects of personal isolation, but itself created a new form of isolation experienced when young children left their home in the country to attending city boarding schools. While nursing at Triabunna, Sister Vi Thompson's son initially lived with her at the hospital but later she sent him to Hutchins, a private boarding school in Hobart.¹³⁶ Other BNs tried to select BNCs where local 'good schools' were situated, thus reducing the need for boarding school. Sister Janice Brook (née Fenton) refused a position in 1947 when her son, Bill, was seven years old because of concerns about schools. It was not just her concerns that dictated the places in which she might work. Some centres would not allow children to stay with their BN mother.

The Bush Nursing Committee at Ringarooma does not approve of the Sister stationed there accommodating members of her family. Sister [J] Brook's application can only be considered if she places her child at a boarding school or with some other relative.¹³⁷

It was not easy for children living with a BN mother, and without a father at home. According to his widowed mother, Bill often would wake up in the morning to find that his mother was not there. She would have been called out to a case and although she would leave him sleeping she could not always guarantee to return in time. 'He had a very insecure life'.¹³⁸ Later she sent her son to Launceston Church Grammar,¹³⁹ although he spent some time living with her at the BNCs, especially for holidays. When Janice remarried she brought him home.

Flinders Island, and 'came straight home' to Cape Barren and continued nursing. The community were supportive of the new babe as it meant that they retained their BN.

¹³⁴ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

¹³⁵ Eileen McManus, (née McMenamán), Interview, Falmouth, 1994.

¹³⁶ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

¹³⁷ AOT, DPH, Memorandum 4.6.47 to SN, (HSD 16/10).

¹³⁸ Janice Flora Barnes, (previously Brooks and née Fenton), Interview, Devonport, 1995.

¹³⁹ A private Anglican Preparatory School with boarding facilities for boys (now co-ed).

Clearly it was much easier for children to be cared for adequately when the father lived at home. The BN's workload would have required of her husband significant help within the home and with the children.¹⁴⁰ Other centres also were unhappy with the concept of the BN's children living with them and in 1949 a condition placed on a relieving BN position at Strahan was that the four-year-old child live at the local hotel away from his mother. This posting, not surprisingly, did not eventuate.¹⁴¹ The lack of adequate child care created difficulties for the BN and led to understandable but impossible requests by the Supervisory Nurse:

Sister's child (aged 4 years) allowed in Surgery. Strong disapproval was voiced from various quarters regarding Peter being in Surgery during treatments etc. The fact is known that Peter is an extremely undisciplined child, and Sister Welsh has been requested to observe this legitimate cause, and limit the child to living quarters.¹⁴²

Another concern of the DPH raised via a general memorandum in 1956 was the potential for 'destruction' of departmental property.¹⁴³ That this was raised in a general memo suggests that it was becoming common for families to live with BNs. For the BN, having her children in residence with her lessened her isolation, for the DPH there seemed little to commend the practice other than the recognition that recruitment and retention were enhanced. Where BNs had family assistance life became much easier for them as noted by Sister Ole at Avoca:

I am finding that so far I am able to manage the work and baby quite well ... since we arrived. I changed her to cows milk immediately and she has gained a pound and a half in three weeks. My mother and Sister have managed to get out for their days off every week which as you can guess is quite a help.¹⁴⁴

The level of workload at the BNC and the age of the child(ren) would have been important factors in determining the ability of the BN to cope with the competing demands of child-rearing and Bush Nursing coupled with little child-care assistance. Bush Nurses had to balance life and work and the DPH sometimes wanted reassurance and to know the details of how the nurse could achieve both of her conflicting tasks. Sister Abel applied for a full-time Bush Nursing position on King Island in 1955 on the proviso that she could live at the BNC with her two children.¹⁴⁵ She was not prepared to be isolated from her children. The DPH had concerns about her ability to take on a full-time position and wrote querying

¹⁴⁰ Elizabeth Roberts discusses patterns of women's employment and notes that this 'cannot be ignored in the study of role-relationships within marriage', Roberts, p. 118.

¹⁴¹ AOT, DPH, 58.21.49, (HSD 6/34).

¹⁴² AOT, DPH, 58.8.3, Report for Director General Medical Services from Sister Widdicombe re Grassy BN, 3 September 1952, (HSD 5).

¹⁴³ AOT, DPH, 58.2.3, Memo for BN from Director General Medical Services re Nurses' children damaging buildings, 8 June 1956, (HSD 5).

¹⁴⁴ AOT, DPH, Letter to Sister Noller from Sister EN Ole, Avoca, 23 July 1953, (HSD 5). It is unclear whether or not Sister 'Nola' Ole's husband was living with her during this period at Avoca. Sister Elizabeth Nola Ole was registered in Tasmania on 11 November 1954.

¹⁴⁵ AOT, DPH, Letter to Director General Medical Services from Sister Abel, King Island, 22 July 1957, (HSD 5). Previously she was working part-time and lived away from the BNC.

the amount of work she would be able to undertake at both Grassy and Currie 'since you have a husband and small children to be considered'.¹⁴⁶ The female role of wife and mother was seen to be pre-eminent although she had a husband who could provide substantial household assistance. Even when married or with children the BN's role was not the traditional gender-based role.

It was not just children of the BN who stayed at BNCs, but on occasion BNs had nieces, nephews, or other relatives, staying with them. On Babel Island a sister took a nephew 'for company' and Elvie Richardson, the cleaner at Gladstone BNC, remembers that Sister Ruby Sutherland very occasionally had interstate nieces to come and stay with her at the BNC.¹⁴⁷ Bush Nurses used family ties as tools to reduce personal isolation.

Some BNs married late in life. Although an individual choice, this was in part because of the nature of the work. Sister 'Maisie' Rayner, according to her friends, 'never had time to be married because she was so busy'.¹⁴⁸ 'Maisie' finally married at 57 having left nursing to look after her sick mother, later her father and finally her husband whom she had met while nursing at the Repatriation Hospital.¹⁴⁹ 'I'd rather nurse an elderly man than a ward full of men who couldn't care less about me'.¹⁵⁰ Sister Rayner's predicament reinforces the personal isolation of BNs, despite their busy and productive life in the community. She reflects that caring for patients does not provide the personal feeling of being cared for, and this undoubtedly underlines the high rate of loss of BNs to marriage.

Single Bush Nurses

Not all BNs eventually married. The few who never married did not prefer female company necessarily but remained single for different reasons. Some BNs such as Eleanor Burbury 'lost' their men in the war which of itself had reduced the number of eligible men available. Sister Evelyn Mellish notes that 'I never got married ... No, no reason at all. Probably because I wasn't asked!'¹⁵¹ Alternatively Sister Mary Walsh at Lilydale had many admirers but chose to remain committed to her position and profession. Sister Walsh's best friends always remember her going to dances with them and enjoying herself. She was considered very popular always. They would all go in a group of young women and they would return home in the same group. On some occasions Dina Chick and Eunice

¹⁴⁶ AOT, DPH, 58AB, Letter to Sister Abel, King Island from Director General Medical Services re child welfare Currie, 1 November 1955, (HSD 5).

¹⁴⁷ Elvie Richardson, Interview, Scottsdale, January, 2003.

¹⁴⁸ Margaret Spark, Interview, Beauty Point, 1994.

¹⁴⁹ 'Maisie' May Eileen Rayner married William James Hooper 15 February 1969.

¹⁵⁰ Margaret Spark, Interview, Beauty Point, 1994.

¹⁵¹ Evelyn Mellish, Interview, Musselroe Bay, 1994.

Cameron would stay the night at the BNC to keep Mary company and to save themselves a walk home.

Community connections were important factors for the integration into the community of health workers who needed to gain the trust of locals. Interaction within the community could lead to marriage, and marriage-based family networks provided 'complete' assimilation into the community—but usually at the cost of resignation from the position as BN. Ending isolation was often synonymous with ending one's career. Nevertheless social acceptance did not solely depend on, or lead to, marriage. The nurse was one of a small number of professionals in a small and isolated town and participation in community activities was another fundamental aspect of integration.

The Bush Nurse as a Community Member

Fund-raising, both local and state, was an important activity for the Bush Nursing Association. The success or demise of most BNCs depended upon local fund-raising. Not only were such monies needed for essential equipment, but also the nurses' salaries were dependent on raised funds. For example, the salary of the BN by 1934 was £160 per annum. Of this sum, £90 came from the Red Cross Bush Nursing Trust Fund, the Bush Nursing Association and the Government. The balance was from the local council. Fees charged to patients for nursing services were not sufficient to cover such costs. As well as the local Bush Nursing Committees, local organisations such as Red Cross, Salvation Army, and CWA were active in motivating communities to fund-raise.¹⁵² The level of funding required, and the success in raising funds, varied across communities and over time. The level of fund-raising and its success affected the isolation of the BN through its impact on the provision of medical equipment, transport and home comforts. Additionally, through her participation in fund-raising activities, the BN's social activities extended well beyond the confines of the nursing role. Committees were set up, and events were advertised in newspapers publicising the funds raised, people attending and the enjoyment of the event. At Spring Bay functions included concerts, fancy dress balls, sports and raffles.¹⁵³

¹⁵² In 1956 at the close of the BN Scheme the following organisations were acknowledged for their voluntary help: The Red Cross Fund, the Northern Division of the BN Association, Northern local BN committees, Medical Unions, Local Auxiliaries, CWA Branches, Apex Clubs, Young People's Organisations and individuals. *TJPP&P*, 1956.

¹⁵³ Lester, p. 182. Ted Vaughan, Len Bresnehan, Bob Allanby and Mrs Keo formed a BN Committee.

Bush Nursing Queen Carnivals were a popular way to raise funds. Each contestant represented a BNC and the carnivals were based on a competition between the contestants to see how much funding they could raise within their own communities. Ronda Stirling, a participant representing Bruny Island, recalled the event vividly:

The night of the crowning we would be dressed up in our nurses uniform, little cape and that ... it was at the Hobart Town Hall and we would march on to the stage to Country Gardens ... I remember getting a gold armlet and a bangle top and a nice crown to put on my head and you just sat in the middle of the two lines and they just crowned you and that was it ... It was one big thing in my life.¹⁵⁴

The event in c1930 raised £120 for the Bruny Island BNC.

Photograph 4.08 Bush Nursing Queen



Bush Nursing Queen Carnivals had a high profile and mobilised the community around the Bush Nursing Centre and self responsibility for community health needs. This photograph shows Ronda Stirling in the Bush Nursing Queen's costume, standing beside Sister Storey and Mrs Baxter.
Source: Bruny Island Museum.

Sister Walsh recalls that her happiest experiences at Lilydale were the fund-raising events such as dances, the annual carnival, fancy dress parties and parades. Dances were a popular form of fund-raising. They promoted social interaction within the community and for Sister Walsh lessened the isolation from family and friends in South Australia. The Bush Nursing Committee organised an annual nursing ball.¹⁵⁵ Lilydale enjoyed a reputation as

¹⁵⁴ R Stirling, Interview, Bellerive, 1994.

¹⁵⁵ Every year there was definitely the district nursing ball and Sister Walsh played a very important part in it. Oh Sister Walsh was so popular she was tremendous, popular and the ball was always

having the most active and supportive Bush Nursing Committee but its members in turn attributed its success to the personality of the BN. The Grand Parade was held in the main street. There was broad-based community support for the various events organised by groups.¹⁵⁶ Fund-raising was not without its tribulations and Mary Walsh got into trouble one night at a Catholic Ball:

It was illegal to raffle wine and [the winner of the prize] was very drunk. He was so pleased he won the prize that he was boasting to everyone, including the police. There was a hell of a row because I had to admit that I had allowed the wine to be raffled on the premises.¹⁵⁷

Photograph 4.09 The Bush Nursing Ball



Events such as this were not only the highlight of the rural community's social activity, but served to cement the centrality of the Bush Nurse and the Bush Nursing Centre as expressions of community spirit and self reliance. (Pictured from left: Mary Weston (later Gunyan), Mary Muckridge (later Stops), Mena Mitchell (later Kelp), Hazel Kelp (later Harding), Corrie Green (later Coghlan), Dina Chick (later Bardenhagen), Mary Walsh (Bush Nurse), Eunice Cameron (later Finan)).

Source: Dina Bardenhagen, Private Collection.

A particularly novel method of fund-raising was introduced by Councillor Gerald E Archer at Lilydale in which he asked for a donation of silver for the Bush Nursing Association for every hunting permit he issued on his property.¹⁵⁸ At Bruny Island regular Euchre card parties were held where locals would give donations. Even children's groups were

... packed, a packed house let's say and they always raised quite a bit of money and then that was put aside again in the account held by council because there was a committee.' Art Van Der Hek, Interview, Norwood, 1995.

¹⁵⁶ Such as 'the Younger Set' at Karoola and at Lilydale, Karoola Sports Club, RSSILA, CWA, Bangor residents, Lebrina Progress Association, and the Underwood Progress Association.

¹⁵⁷ Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

¹⁵⁸ *The Examiner*, 8 May 1939.

involved in fund-raising. The local Junior Red Cross groups raised money to supply a tea service, and to assist with the installation of a telephone, in 1936.¹⁵⁹

The central Bush Nursing Association raised funds with its annual button appeal. Buttons would be sold in the major cities and towns as well as in the BNCs. Children were involved actively, and Ronda Stirling recalled: 'I would go down to the ferries and sell buttons. I would say I was nearly eleven ... in 1930'.¹⁶⁰ Ronda also remembers that her mother, on behalf of the Bush Nursing Association at Bellerive, ran stalls in Hobart:

Mostly my mother used to have stalls. She was a very good cook and she used to make a lot of cakes. She would get plants and pot plants from Chandlers ... My father used to supply her with vegetables and food and she would sell them. We would have a stall outside the Town Hall.¹⁶¹

In some localities, whether by lack of community support or a result of community financial impoverishment, raising funds was not easy. This placed substantial stress on the viability of the BNC. In 1937, Rossarden depended on contributions from the Northern Branch of the Bush Nursing Association'.¹⁶² At Ringarooma Sister Nora Louise Fry complained that the local committee had not organised any functions to raise funds for the BNC since its inception.¹⁶³ While there was strong community support in most regions, the mining company towns were the exception. There was no Red Cross Association or CWA at Waratah. Occasionally there was the Florence Nightingale Appeal and the nurses would sell badges. Waratah did not participate in serious fund-raising activities. Not only were the majority of the families on a low income but also the local schemes instituted, and subsidised, by the mining companies had a different 'funding culture'. The impact of this lower level of community support resulted in fewer facilities for the BNs in these centres.

Community support was vital for successful fund-raising and, if the BN were not outgoing in personality, such support was more difficult to achieve. As with mining company subsidy, Government assistance was a further disincentive for local fund-raising. When Government made up the shortfall in funds at Waratah the following comment was made, 'As the Government makes up the deficit in financial affairs the people of the district don't feel disposed to struggle to raise funds'.¹⁶⁴ This was seen in 1949 also as BNCs became

¹⁵⁹ Davis, p. 13.

¹⁶⁰ R Stirling, Interview, Bellerive, 1994.

¹⁶¹ R Stirling, Interview, Bellerive, 1994.

¹⁶² AOT, DPH, 58.12.37, BN Rossarden, Letter, 15 October 1937, Rossarden Medical Union re funding, (HSD 1/36).

¹⁶³ AOT, 58.14.49, Letter to Sister Noller from Sister Fry Ringarooma, 8 November 1949, (HSD 6/34). Sister Nora Louise Fry trained at the Launceston Public Hospital and was registered in Tasmania on 17 July 1942, Registration Number 1398.

¹⁶⁴ AOT, DPH, 58.23.44, BN Waratah, (HSD 1/89).

more under the control of Government.¹⁶⁵ Reduction in community ownership of their facility reduced the closeness of the BN to her community.

Payment in kind was common, especially in the poorer districts where produce or goods were home-grown and income was minimal. It became an important part of the funding and support mix. In Marrawah this tradition was used as an argument against a request for financial assistance to the BN, describing it as 'an unjust imposition, as up to the present, it has cost the sisters very little for food, gifts of various kinds, keeping them well provided'.¹⁶⁶ Payment in kind was a very personal method of payment, as were gifts, and might have enhanced and cemented the relationship between the BN and the community, lessening isolation. One local resident at Marrawah supplied the nurse with a *Women's Weekly* every week during her stay at the centre: 'It came. I never paid for it, I'd never asked for it, but it was there'.¹⁶⁷

Gifts for the BN were more a reflection of appreciation of the BN's services than truly a payment in kind. Gifts from locals eased the isolation for BNs. The people of Lilydale were extremely generous to Sister Walsh and often would give her donations of food, including cases of pears and apples. A wide range of other produce also was offered to BNs such as barrels of potatoes and crayfish from a grateful fisherman at St Helens.¹⁶⁸ Some donated produce needed to be consumed in moderation and only when time away from work allowed.¹⁶⁹

Some of the families were very good to us ... Bruce Lyon at Swansea—had the most wonderful cellar with gooseberry wine and plum wine and he used to take me down to sample some ... but there weren't too many of those [outings] because really you had to be about for people and to deliver the babies and look after the patients.¹⁷⁰

Other produce arrived in a less-than-ideal state like the wild duck that needed cleaning.¹⁷¹

¹⁶⁵ 'You will remember I gave you my personal assurance that my Committee would without doubt carry on as usual providing that your Government would not Gazette the fact that they were taking over the whole of the BNCs. I gave you my reason if you did so I would get no the support of the business people for donations each year as this was the only source of revenue we had.'

AOT, DPH, Letter to Dr BM Carruthers from TBNA Launceston, 1 March 1949, (HSD 5). Despite this concern the Launceston Branch of the BNA continued to provide grants towards the salaries of the BNs in local council-operated BNCs of Avoca, Lilydale, Mole Creek and Ringarooma and made a new commitment to provide money so that the BNs in these centres received free electricity. AOT, DPH, Letter to TBNA Nthn Division from Director Public Health re fuel/light payments, 4 April 1949, (HSD 5).

¹⁶⁶ AOT, DPH, 58.11.40, BN Marrawah Letter, 26 July 1940, Marrawah Committee re can't afford maintenance of maid, (HSD 1/79).

¹⁶⁷ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

¹⁶⁸ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

¹⁶⁹ In addition to needing to stay sober to be able to carry out their work, the BNs were required to sign a temperance pledge.

¹⁷⁰ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

¹⁷¹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

Community support for Bush Nursing was strong from the inception of the organisation. The development of Centres came from grass-roots action which needed to continue to sustain the service. Groups active in the support of Bush Nursing included the Returned Sailors and Soldiers Imperial League of Australia (RSSILA). In Lilydale they formed a committee to 'assist the BN'¹⁷² and donated funds to furnish the BN's quarters.¹⁷³ The RSSILA was concerned particularly with the transport difficulties faced by BN. On Flinders Island the RSSILA ran an annual ball with the entire proceeds going to support Bush Nursing, and to fund a 'Diggers Bed' at the hospital.¹⁷⁴

At Koonya 'there was a local Red Cross group and they were very supportive of the Bush Nursing scheme and regularly supplied library books etc to the patients'.¹⁷⁵ The Apex Club provided support by donating Singer Sewing machines to BNCs.¹⁷⁶ The Bush Nursing Association itself was active in fund-raising also and the results of these activities were reported regularly in the daily newspaper. For example *The Examiner* reported in 1941 that in Lilydale they had raised '15 bags of potatoes, 72 dozen eggs, 56 bottles of jam, sauce and pickles, honey, butter and other sundries and £2 12s 6d in cash'.¹⁷⁷ This was particularly generous as it was during a time of war restrictions.

Photograph 4.10 Gift of Sewing Machine—community support



*The community supported the Bush Nursing Centre in many practical ways. This photograph provides formal documentation of such support, and the purpose behind the photograph is suggested by the image of the Sister Marjorie Joyce Kelly, Sister in Charge of Sorell Bush Nursing Hospital, in full uniform whilst seated at the sewing machine mending hospital sheets.*¹⁷⁸

Photographer: Sister Anna Mary Diment
Source: DPH, Bush Nursing Album, NBT.

¹⁷² QVMAG Lilydale Council Correspondence, 23 March 1923. The committee consisted of 3 ladies, 2 RSA members and 2 Council representatives.

¹⁷³ £20 of the total 61 required.

¹⁷⁴ AOT, DPH, 58.6.38, BN Flinders Island Letter from RSSILA re donating 'Diggers Bed' at hospital, 20 June 1938, (HSD 1/53).

¹⁷⁵ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994. The Red Cross also provided funding at a state level as previously noted in Chapter 2.

¹⁷⁶ AOT, DPH, 58.34.19, Mr J Northey 12 April 1949, (HSD 5).

¹⁷⁷ *The Examiner*, 11 October 1941.

¹⁷⁸ AOT, DPH, 58.28.6, Letter to Apex Club from Sister DK Noller SN, 12 June 1950, (HSD 5).

Sister Connors remembered the people of the North West coast as being particularly friendly and helpful when she arrived in Ulverstone from Hobart in 1930.¹⁷⁹ She felt that the community worked well together and she did not need to ask them for assistance. The local Council, Red Cross and Salvation Army all helped to ensure the smooth operation of the BNC. At Gladstone Sister Mellish recalls similar levels of community support with the community doing 'all sorts of things to raise money for the Centre' and providing anything she felt she needed for the centre.¹⁸⁰ Sister Millington at Triabunna also received help from the Ladies Auxiliary. Members provided linen and helped to equip the centre.¹⁸¹

The level of equipment which characterised the early BNCs was seen as no longer being adequate in the face of changes in community expectations. Consequently, community fund-raising support was required not only in the early establishment phase of a BNC, but in an ongoing fashion. The Supervisory Nurse recommended that the Strahan BNC open a Special Bush Nursing Auxiliary Fund to provide non-essentials such as a wireless 'to compete favourably with advancing amenities provided in cities and larger towns'.¹⁸² The level of support from such groups was substantial.¹⁸³ Sister Adcock at Ouse wrote to her Supervisory Nurse to illustrate how the Hospital Auxiliary was continuing to keep local interest in the Bush Nursing. The examples of assistance included a diverse range of donated gifts and services.¹⁸⁴

¹⁷⁹ Family notes from interview with T Connors, 1990, Private Collection.

¹⁸⁰ Evelyn Mellish, Interview, Musselroe Bay, 1994.

¹⁸¹ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

¹⁸² AOT DPH, 58.21.49, Letter to Mrs V Littoral, Strahan, (HSD 6/34).

¹⁸³ AOT, DPH, Note only—Oatlands BN Hospital Women's Auxiliary Annual Report, 19 March 1952, (HSD 5). 'I desire to express the thanks and appreciation of this department to your Committee for its continued interest in and valuable support to Oatlands BNH. Gifts for the year ending 19 March 1952 are gratefully acknowledged with thanks, as follows: Annual subscriptions @ 12/- each from 31 members £53/18/6 raised during the year 22 1/2 doz. Eggs from Paratta School, 40 doz. eggs from Oatlands school, Flowers, cakes, jams and books etc. from members and non-members, Establishment of a hospital library. £60/18/- spent on amenities as follows: 2 bed lamps—Sisters' Bedroom 5 Velvet cushions—lounge, 6 trees, Cake tins, Bowls, Curtains and rod, Baby gowns, Paint etc. Making of kitchen curtains, mending etc. £25 donated towards a lawn mower (including £10 from Council), Shrubs, Glass Dishes etc.' AOT, DPH, 58.11.3, Letter to Oatlands Hospital Aux from Director General Medical Services appreciation, 25 March 1952, (HSD 5).

¹⁸⁴ AOT, DPH, 58.12.3, Letter to Sister Adcock, Ouse Hospital from Sister DK Noller re hospital auxiliary, 28 March 1951, (HSD 5): The auxiliary has assisted 'By working bees, or paid labour, keeping hospital grounds beautiful. Planting of ornamental trees or shrubs and sowing lawns. Keeping garden beds tidy; Purchasing baby clothing and replacements (including napkins) and making of same; Nursery furnishings—curtains and quilts; Stainless steel nipple bowl sets for in-patients and Baby Clinic; Fancy curtain material (and labour) for some wards or staff rooms, and loose covers for arm-chairs and couches; Fancy house linen and crockery, for staff or patients, such as tray covers, trays, tea sets, or individual tray ware for patients; Wirelasses for staff or patients or both; Extra electric equipment not already provided, such as a large toaster or electrolux.'

Even after BNCs were placed under State Government control, the Auxiliaries and fund-raising committees were integral to the maintenance of the Bush Nursing Scheme. Over the years they provided considerable non-essential goods but which made living conditions easier.¹⁸⁵ Reports continually praised them highly, never underestimating their worth. This worth must be appreciated not only in material terms but also in the way in which it responded to the needs of the BN. The various activities served to give the BN a sense of her value to the community and to integrate her into the community. This in turn eased her sense of isolation not only in a material way but also psychologically.

Fund-raising was not the only avenue for community participation. Bush Nurses became members of clubs and organisations within the community for purposes of leisure as well as participating in events linked to fund-raising. All these pursuits were opportunities to help integrate the BNs into the community, and through their social life they were able to relax and become part of that community. These activities, while not linked explicitly to fund-raising, enhanced the nurse's profile and helped to foster the fund-raising climate. Their professional roles kept them somewhat separate, as always they needed to be ready to respond to calls for the services of a nurse. Sister McMenamain noted the restrictions that 'being on call' placed upon her:

Well, one of the difficulties was that you couldn't go too far away because you were the only person there, or at least I was the only person there at Swansea, and you couldn't go too far away because if somebody needed you, you had to be there.¹⁸⁶

She also found it was possible to balance social activity, such as going to the local picture theatre, with being on call by leaving a note on the door to allow people to track her down when needed.¹⁸⁷

Where a nurse was away from the Centre, and a note on the Centre door was not practical, other innovative methods might be employed to catch the attention of, or to contact, the nurse when need arose. Sister Vi Thompson used to enjoy going fishing at Spring Bay, but stayed within sight of the hospital in order to see the 'white towel' hung on the hospital gate which signified an emergency.¹⁸⁸ She also attempted a regular game of golf where she would 'steal time' to 'sneak off' but only if she knew there were no cases pending.¹⁸⁹

¹⁸⁵ *TJPP&P*, 1950–1951: 'equipment and amenities such as wireless sets, electric polishers, sewing machines, electric vacuum cleaners, bed lamps, pressure cookers, staff and patient crockery, infants' clothing, curtain furnishings and other miscellaneous items.'

¹⁸⁶ Eileen McManus, (née McMenamain), Interview, Falmouth, 1994.

¹⁸⁷ Eileen McManus, (née McMenamain), Interview, Falmouth, 1994.

¹⁸⁸ Lester, p. 184.

¹⁸⁹ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

On Cape Barren Island, boats became a form of relaxation for Sister Saville and her teacher husband. They owned their own little boat and 'if things got too much ... you would just hop in that boat and off you'd go and anchor it out there and there you'd sit'.¹⁹⁰ This was a solitary activity and would not have served to integrate a BN into the community. Cape Barren Island was, however, an environment different from that of most BNs. The community of non-Aboriginal people was small. Attitudes at that time would have precluded significant social activity between racial groups and this is borne out by records relating to the BN on Cape Barren Island.¹⁹¹ Thus racial isolation added to the isolation of the BN on this remote island.

Sister 'Lexie' Burns at Waratah had a group of friends who together would go on outings, including bush walks. Despite her position as a single professional person, she saw no social distinctions. Many of her social acquaintances worked for the local saw miller, Joe Fagan. Sister Ruby Kelly felt that she was treated like one of the community. She would go bushwalking and attend the pictures and dances at the local hall. Sister Janice Fenton also recalled that she was 'a great one for getting around and enjoying the country and the bush'.¹⁹² Sister Mary Walsh at Lilydale remembered the social activities including tennis, badminton, cards, and fishing, at seaside resorts such as Bridport. Lilydale was a lively place where the young people always had something to do on weekends. Bands travelled from Launceston to play at functions. Marrawah was also a socially active area:

We had a dance every fortnight. One fortnight it was Redpa ... and next it'd be Marrawah and the man from the shop, he had a little van and he went round the road and picked the people up, you know picked us all up. And I didn't always go, but I liked going. I enjoyed the dances. But I was very fortunate.¹⁹³

While Sister Eileen McMenamin was in the socially 'quiet' area of Dover, she used to play badminton, go to the beach or go swimming in the summer.¹⁹⁴ Sister Evelyn Mellish in Gladstone relied on simple pursuits as there was 'not much [social life] ... we had a very good radio. It was a darn good set'.¹⁹⁵

Holidays were the only times when the BN would have a real break from her work. Usually a relieving nurse was appointed, if available, or the BNC would close. The reliever would stay in the BN's accommodation and thus the BN on holiday normally would leave the area. This period served as respite from the locality rather than as an opportunity to integrate further into the community. Occasionally, particularly where the nurse was

¹⁹⁰ Una Saville, (née Nicholls), Interview, Devonport, 1999.

¹⁹¹ Exceptions to this rule were the football matches organised by the teacher.

¹⁹² Janice Flora Barnes, Interview, Devonport, 1995.

¹⁹³ Hazel Gaffney, Interview, Ulverstone, 1994.

¹⁹⁴ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

¹⁹⁵ Evelyn Mellish, Interview, Musselroe Bay, 1994.

married and her husband did not have leave at the same time, the nurse might stay in the community while being on leave.

Sometimes the BNC was the social centre for a very isolated community. There seems to have been no impediment to people casually dropping into the BNC for a chat and a cup of tea:

Everybody visited me socially, because nine out of ten, if they saw me, you know, they'd stick their heads in the door or something and say, 'Hello Sister. How are you?'¹⁹⁶

On Cape Barren Island many locals (regardless of race) just dropped into the BNC: 'A lot a folk used to come in and sit down and have a cup of tea with us, morning tea and so forth—they don't just come and knock'.¹⁹⁷ The social role of the BNC was both a consequence of the nurses' integration into the community, and served to cement that integration.

In the social milieu of the times single women needed to be cautious about social, or even work-related, contact with men. As we saw when a complaint was made at Ouse about married men dropping in to visit the (single) BN, this type of social interaction was unchaperoned and thus 'less safe' than a group-based social setting. The complaint reflects this concern, as does the care in selecting married men as the chaperone/driver when the BN was accompanied on visits. The BN ideally restricted her social activity to group settings, particularly settings where women were the main or sole participants. By virtue of her full-time work, the BN did not have the opportunity to participate fully in the activities of (non-working) women's groups. Her range of social activities, although broad, was constrained by her work, her single status and her gender.

Where the BN married and continued to work there were a number of complicating factors for her. We have seen that the Bush Nursing organisation was only reluctantly supportive of married BNs, and even then, through their attitudes and rules, created a number of difficulties for her. The local populace (usually the women), at times also appeared to be less accommodating towards the married BN. In one particular BNC, the BN normally would approach the Auxiliary to help fund-raise for essential or time-saving equipment. Its members refused to assist with the purchase of a washing machine (used also for laundry of patient-related items at the BNC) on the basis that her husband should

¹⁹⁶ Hazel Gaffney, Interview, Ulverstone, 1994.

¹⁹⁷ Una Saville, (née Nicholls), Interview, Devonport, 1999.

provide such items—even though her husband, because of the regulations, did not live with her at the BNC.¹⁹⁸

While we have seen that most communities were supportive of the BN, and that she was integrated into the community, this was not always the case. Official records document examples of relationship breakdowns between BNs and the community, or with the local Bush Nursing committee. At Ouse in 1936 it was noted that working conditions were inadequate, and that: 'No special effort has been made to raise funds for this work during the time that Sister Elsie Mary Westcombe has been in the District'.¹⁹⁹ On the Tasman Peninsula the Supervisory Nurse detailed a poor working relationship between nurse and community. The nurse stated that 'she could not remain in a place where everybody told such lies, and that no one seemed able to speak the truth'. The Supervisory Nurse saw that 'Sister [E] Roche has been unfortunate enough to create a bad impression among [the people of the district]'.²⁰⁰ The Supervisory Nurse did not recommend her for further BN work. In Ulverstone complaints about Sister Iles continued for some time, and 'the Committee for some reason is very anxious that a transfer of nurses should be made'.²⁰¹ In Rossarden relations were even worse, and the Supervisory Nurse reported that some residents including members of the Bush Nursing Committee 'made Sister's life a misery, bullied and spied on her', and that she was 'treated by them as a menial'.²⁰² Despite this, the nurse felt most residents appreciated her work and she hoped to be able to remain in the area as it was near to her husband's school.²⁰³ She refused a transfer to another area because of her husband's position.

The drinking of alcohol by Sister Nora Fry was the primary basis of a complaint in Ringarooma in 1937. Her version of events suggests no serious misdemeanour:

I am reasonably young and very fond of dancing, I do not indulge in sport and actually my greatest off time pleasure is to attend a Ball etc. Before I go any further I must stress the fact that I'm not a drinker and have never been drunk in my life but I usually have a spot or two before attending a ball or party and so the occasion of the Bachelors Ball July 15th at Legerwood I attended in a party; arrived at Legerwood about 9.45 pm went into the hotel lounge had a few spots, consequently was caught in a lightning raid along with 150 other people. I didn't feel at all criminal like, but I

¹⁹⁸ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

¹⁹⁹ AOT, DPH, 58.9.36, BN Ouse re poor nurse's quarters, etc from SN, (HSD 1/24). Sister Elsie Mary Westcombe trained at Devon Public Hospital and was registered in Tasmania on 21 April 1933, Registration Number 515.

²⁰⁰ AOT, DPH, 58.16.36, BN Tasman Letter from SN re Sister E Roche's resignation/recommends not to hire her for further BN work, (HSD 1/24).

²⁰¹ AOT, DPH, 58.18.37, BN Ulverstone letter from SN re Committee complaint (HSD 1/36).

²⁰² AOT, DPH, 4 July 1952, Letter to Director General Medical Services from Sister DK Noller re Rossarden BN, (HSD 5).

²⁰³ AOT, DPH, Letter to Director General Medical Services from Sister DK Noller re Rossarden BN, 4 July 1952, (HSD 5).

believe Mrs Styles could barely get to pen and paper quickly enough to report me to the Public Health Department.

Although the complaint related to a social gathering, she felt somewhat isolated from her community:

Regarding the people of Ringarooma—actually not very friendly—and never regard a Sister in a social light—I have my own relatives here and am reasonably contented but I think Sisters strange to this district must find it lonely as an invitation to their homes is very hesitant, they lack the spirit, i.e. the greater majority. The previous bank manager I believe made a remark in front of my uncle about 'Sisters are only paid servants'.²⁰⁴

The alcohol-related offence was at worst trivial, but acted as an 'excuse' or focus for complaint by the Bush Nursing Committee. Integration into the community usually was seen in a positive light but, as in this case, could lead to problems. Similarly, the BN at Flinders Island, Sister Constance Catherine Walker, had difficulties which demonstrate the obverse of the advantages that come from family ties to an area. Whereas in Marrawah, Sister Ruby Elphinstone found that family ties opened doors, on Flinders Island considerable feeling existed against Sister Walker, 'owing to her being related to so many of the families on the Island'.²⁰⁵

The success of the BN was tied inextricably to her ability to make positive relationships both with individuals and the various organisations with which she interacted. Without substantial community support the scheme could not survive financially. Without a feeling of personal support the isolation took its toll and, if frank hostility developed, the situation was not viable. The balance between community membership and professional detachment was a difficult one. It was necessary for the BN to ensure that her social relationships were sufficiently superficial not to interfere with her professional function, and to maintain the community support necessary for fund-raising. Additionally she needed sufficient community interaction to balance the isolation brought upon her by her professional role and personal circumstances.

The BN, as the sole member of an occupational group, was fulfilling a role of responsibility in her community, in a similar position to the school teacher and police officer where they existed. Bush Nurses were always women and, like women teachers, expected to remain single. It might be expected, therefore, that a BN might gain some social support from a female school teacher where she existed in that community. There were

²⁰⁴ She further stated: 'That remark was made when Sister [Clarice Irene] Philbey was here and I believe upset Sister Philbey—my aim in telling you that is to prove that it is not one Sister in particular but generally speaking.' AOT, DPH, Letter to Sister Noller from Nora Fry & postscript from Sister Noller, 11 October 1949, (HSD 5).

²⁰⁵ AOT, DPH, 58.6.37, BN Flinders Island, (HSD 1/36).

inevitable parallels in their social circumstances. Certainly the role of BNs encompassed school health, and therefore they visited schools. Where BNs had outlying clinics these at times were based within school facilities. There is little evidence that mutually-supportive social relationships developed. There were some BNs married to school teachers, but these were exceptions and provide no evidence of mutual social support between isolated professionals. Single BNs and teachers did not share residential accommodation.

In Lilydale in the mid-1940s the school teacher, Miss Mavis Bessell, developed a close rapport with the BN, Sister Walsh. This was based in part on the need for Miss Bessell to send many children from the school to the nurse for attention. They also went to card evenings and fund-raising events together. Despite this they did not see themselves as special friends. This was perhaps because Sister Walsh had been in the area for some seven years prior to Miss Bessell's arrival, and because the BN in particular was so busy with her work.²⁰⁶ This story raises the possibility that mutually-supportive relationships might not have developed generally because of high nursing workloads and long hours of work, different residential or living arrangements, and because of different timings in the appointment of nurses and teachers.²⁰⁷ The lack of time to form women's networks meant that the BN was isolated further.

Bush Nurses worked co-operatively with the police in a number of ways. Police often had the only after-hours telephone access, and in some areas accompanied the nurse on after-hours calls. This arrangement had its disadvantages. Sister Hazel Bird had the support of policeman Trevor Long who would come:

a lot with me at night when I was called out, but then in the end I wrote to Hobart and I said, 'The person requiring my attention at night, could they be responsible for an escort for me?' because see it wasn't fair to drag the policeman out at three o'clock in the morning ... The night calls went down tremendously when they knew somebody had to come to pick me up and take me. They'd ring up and say, 'Could you come?' And then I had to say, 'Yes, but there's got to be somebody with me at night'. And that put a stop on a lot of it. The unnecessary ones, anyhow.²⁰⁸

There is no evidence that close social arrangements or even marriage existed between BNs and police. Generally the police were married men.

The Council was involved closely in funding and supporting Bush Nursing. In Lilydale Sister Walsh would be invited by the local Council to all formal functions, thus cementing her relationship as a central part of the community's fabric: 'Oh definitely, oh yes, you couldn't have anything without inviting Sister Walsh, that's a standard every

²⁰⁶ Mavis Chick, (née Bessell), Personal Communication, 2003.

²⁰⁷ Many single teachers, like BNs, went on to marry locals.

²⁰⁸ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

time'.²⁰⁹ The relationship with Council was crucial. Council had a role in ensuring that the BN was accepted as a part of the community, and in supporting her nursing endeavours through control or influence over facilities, equipment and funding. At Waratah Sister Laird's cousin, Darrell Laird, was the Council Clerk.²¹⁰ This gave her family support and a point of reference within the community. It eased her transition into the community by allowing the local people to accept her more easily through family introductions and inclusion into family events and activities.

The BN often was isolated from her religious or faith supports, particularly if the small community was predominantly of one faith. Priests and ministers visited some of these areas even less frequently than did the doctor. At Swansea there was a Catholic church but no resident priest. A BN recalled a priest visiting the area while on holidays and performing a Mass. This was the first Mass in three months.²¹¹ Ensuring work-free time to worship was also difficult but the BN was fortunate on this occasion as a doctor relieved for her while she attended church. Where worship required leaving her BNC, travel to attend to faith needs was no easier than travel for holiday purposes.²¹²

The Marrawah area was a close-knit community. It was difficult for Sister Hazel Bird to follow her own religious denomination. She had been a member of the Congregational Church in South Australia but adopted Presbyterianism because her church was not represented locally. Religious affiliation was important for many nurses but had the potential for division based on faith. At Lilydale, although Sister Walsh was an active member of the Catholic Women's League, residents did not see that this affected her relationship with patients. 'Religion wasn't a division for her either. She treated every one the same whether they were Methodist, or Presbyterian or Church of England'.²¹³ Religious life offered BNs the opportunity to use other talents, enhance interests and quality of life, and lessen isolation. Sometimes BNs' hidden talents came to the fore such as Sister Elsie Bessell's singing voice. She was very popular with the miners at Adamsfield because of her beautiful voice:

In those days I possessed quite a good singing voice and was always in great demand for the concerts which the diggers later organised and which were much appreciated by the community. The hall which was erected for this purpose was also used in part

²⁰⁹ Art Van Der Hek, Interview Norwood, 1999.

²¹⁰ One of the key Waratah community contacts was Mr Egan, chairman of the Mt Bischoff Hospital Board, a company to which the local residents paid subscriptions. 'He was the chairman, yes he thought he was king of Waratah. He'd wave his butcher's knife about and tell you a few things.' Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

²¹¹ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

²¹² Eileen McManus, (née McMenamin), Interview Falmouth, 1994.

²¹³ Art Van Der Hek, Interview Norwood, 1999.

as a billiard room and on Sunday a courageous minister made his way to the field and gave a service to the few men and women who attended.²¹⁴

This was clearly an asset that helped her, a single BN at that time, to mix with the miners.

Religious affiliation provided the nurse with opportunities for social contacts based on a shared faith. From this came a form of social integration which, because of its formality and constraints, had less danger of blurring professional boundaries. Sister Vi Thompson recalled that general social relationships were difficult and potentially dangerous:

I never mixed, and they never mixed with me. I mean I did belong to the Church Guild, [that] helped. You see you were so restricted, you were so tied you couldn't [make long-lasting friendships] ... you didn't because it wasn't safe.²¹⁵

The maintenance of appropriate professional boundaries was a concern of many BNs, and the small communities in which they lived made it hard to achieve professional distancing without exacerbating personal isolation. For Ruth Bartels her friendship networks were established by her lifelong connection with the community. Her policy was not to talk about anybody's business. Even so she found it very hard to balance friendships. She recalled that most of her friends respected her dilemma and co-operated without interfering in her work, but it was still a challenge.²¹⁶

The Australian climate and culture could add to feelings of isolation through experiences of cultural dislocation. For BNs from urban backgrounds, rural attitudes and culture created some challenge. Dislocation from family rituals such as birthdays, Christmas and other important cultural events, was a common experience. Bush Nurses easily recalled their feelings of isolation from family: 'Oh, I did miss my family, especially around Christmas time'. Some BNs were from the Northern Hemisphere and the cultural dislocation was enhanced further by the difference in climate: 'I was used to a cold Christmas and here I was in the middle of Australia with the hot weather'.²¹⁷

It was not easy to reduce isolation from family. A few BNs were fortunate in that they could have occasional visits to or from their families but, for most, family contact was a luxury. They could return home only if a relief nurse could be found to cover their absence. Sister 'Maisie' Rayner's family travelled regularly to Ringarooma to visit her and thus she had a sympathetic family network. Often complaints were made about the frequency or duration of visits to the BN, or about the gender of visitors. Permission was required to

²¹⁴ Elsie G Bessell, Private Collection.

²¹⁵ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

²¹⁶ Ruth Bartels, Personal Communication, August, 2003.

²¹⁷ Eileen McManus, (née McMenamín), Interview, Falmouth, 1994.

have visitors stay, but was not sought always. The Supervisory Nurse reported that at Ulverstone one of the many complaints included that:

Sister had staying with her for six months, a visitor who was suffering or had been suffering from Tuberculosis. This person went with Sister in her visits to country districts. Sister's landlady complained about her having a visitor, and among other things said too much electricity was used at the time.²¹⁸

Usually there was no problem over female or child visitors especially for weekend visits.²¹⁹

Friends in Melbourne, they sent me *Smith's Weekly*. It was a terrible paper, but they sent it to me every week, and Mum in South Australia sent me the *Weekend Whole News of South Australia*. That came every week. That came in this little old train thing, and Mother wrote to me every week and I got a few letters from other people, but not many. But see, the papers kept me going.²²⁰

Communication with families primarily was by letter. While physical isolation and distance might reduce visitors, it did not stop the mail. Unfortunately the mobility of BNs has meant that family letters did not survive. Bush Nurses often boarded with a local family until independent accommodation was available.²²¹ The restrictions of private board made it difficult for the BN to have friends or family stay with her. Conflict often resulted between the BN and the family with whom she boarded because of this.

The BN had responsibility not only for the clinical or health services provided at the BNC but also for the catering and cleaning services. Many BNs had domestic or medical aides to assist with operating their centre. Domestic aides provided a relatively stable personal contact for the BN within the BNC. Clearly such a contact had significant potential for reducing personal isolation, but in many ways this was of minimal benefit. The domestic aide was usually a young single girl, and there was little commonality of background or interest between BN and aide. Aides did not have to live at the BNC, although many did so, and were allowed to marry. The live-in aide provided some relief from the night-time isolation, but this was balanced by a loss of privacy. Some aides provided at best a 'fleeting acquaintance' for the BN, while adding to her responsibility by requiring her to provide staff training and to be a manager of staff.²²² Other aides became significant helpers, carrying out duties as diverse as housekeeping, nurse aide, driver, or

²¹⁸ AOT, DPH, 58.18.36, BN Ulverstone Letter to Director of Public Health from SN re complaints of Sister Iles, (HSD 1/24).

²¹⁹ 'In reply to your letter of the 5th instant, approval is herewith granted for your girl friend to reside with you on Saturday and Sunday night next.' AOT, DPH, 58.12.5, Letter to Sister Sproule, Ouse, from Director Hospital Medical Services re friend staying, 12 April 1950, (HSD 5).

²²⁰ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²²¹ Selth, p. 19.

²²² 'One is always at the mercy of the domestic staff in such matters and of the domestic staff which is provided here the least one could say is that they are an added responsibility.' AOT, DPH, Letter from Sisters Girot & Watts Cygnet re too much work, not enough funds to feed patients, 3 January 1951, (HSD 5).

receptionist.²²³ Some went on to do training in basic Red Cross and emergency procedures. Usually the instruction was completed by the BN but occasionally these women attended structured courses.²²⁴ Some aides developed into lifelong friends. The relationships that developed between the BN and her domestic helpers gave her another link into the community by providing local knowledge. This assisted the BN's work by providing a context for her patients. Some accounts show that the price of help and companionship often meant conflict with the local committees.

Photograph 4.11 Ivy Hennessey and Sister Hélène Bonhôte²²⁵



Ivy Hennessey (on right) is seen here acting as driver for Sister Hélène Bonhôte.

Source: Bruny Island History Collection, Bruny Island Museum.

²²³ Mrs Elvie Richardson, (née Green), was the cleaner at the Gladstone BNC for many years before Sister Evelyn Mellish became the BN. She recalled several BNs including Sister Tilley, Sister Manson, and Sister Sutherland. She became close friends with Sister Ruby Sutherland, a widow, and they would share lunch regularly. They exchanged letters for many years after the BN had left the centre and returned to the mainland. Elvie also acted as chauffeur on occasion and would drive all the way to Winnaleah to keep Sister company and also to share the burden of driving as the BN would often be tired from attending patients the night before. On one occasion Elvie rode in the back of the ambulance with a patient while the Sister drove to Scottsdale. Elvie Richardson, Interview, James Scott Wing, NESM Hospital, Scottsdale, January, 2003. At Bruny Island, Ivy Hennessey worked at the hospital for many years and was a jack-of-all trades for the BNs. She drove Sister Gittus and Sister Crawford all over the island as they could not drive. She was also the cook, and the cleaner. Ivy Hennessey commenced at the hospital as Sister Finn's assistant in 1937 when 18 years of age and acted as driver for Sister and doctor's visits, employed by the Council, then by the Health Department and subsequently by the Royal Hobart Hospital until 1972 when she retired after 34 years of service to the hospital. Davis, p. 14.

²²⁴ Choice of domestic help usually was negotiable and at the nurse's discretion. 'I wrote down to Hobart and I said, "Please, could I train a very nice person—she had no children and her husband was an invalid". And I said, "Could I train her as an assistant?" And I did the maternity work, because, I said, "it was too much. Too, too much". I couldn't help them as much, by being one person and they said, "yes". They gave that permission. And I trained ... Freda Jackson ... she became a wonderful assistant.' Hazel Gaffney, (née Bird), Ulverstone, Interview, 1994. At Triabunna Viola had a local girl helping who also had her St John's Certificate. Viola did her own cooking. 'You always had a domestic there you could leave and take messages.' Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

²²⁵ Sister Hélène Bonhôte graduated from Launceston Public Hospital and was registered in Tasmania on 26 February 1939, Registration Number 1082.

Sister Hazel Bird had both a midwifery assistant and a local girl employed as domestic help.²²⁶ Some of the time Sister Bird would pay these girls from her own funds suggesting that the local committee was not supporting the BN and that Department had not authorised the additional help. Employment of domestic staff was often a source of conflict with the local committees.²²⁷ Sister Bird's replacement, Sister Louie Edith Green from Sydney, strongly objected to the situation:

I feel that I have been cheated and deceived! and I am thoroughly upset and dissatisfied! I understood that I had to pay my own board, but I am not prepared to pay the board of the 'maid provided for my help', as the local committee expects! if their work is too heavy for one, I have to pay for help!²²⁸

The Supervisory Nurse, just as surprised as the new incumbent, addressed the local committee accordingly stating that under no circumstances was the BN expected to provide sustenance for staff or patients out of her own pocket.²²⁹

Not all BNs were supported initially with housekeeping or cooking but the majority of nurses recall recruiting local domestic help.²³⁰ It was not always easy to find adequate

²²⁶ 'I think she got sixteen shillings a week or something and her care and accommodation ... but it was busy, there was no doubt about it. There was not a lot of free time by this time. I not only had two extra rooms on it, I had a nursing aid, because I couldn't do the work, I couldn't handle it. And I taught the nursing aid how to do simple dressings and put on splints and various odds. Toward the end of the session I had a nursing aid all the time.' Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²²⁷ 'Sister Hingston said that, with the exception of one week, patients have been in residence during the whole period of her employment at Southport. In spite of this the Committee does not wish the appointment of a maid to be permanent. It was suggested that someone could be procured when the necessity arose. This appears undesirable as the nurse would have to take anyone who happened to be free at the moment, irrespective of her suitability, and Sister would have to spend a lot of unnecessary time in explaining the work and trying to train each new maid. AOT, DPH, 58.14.38, BN Southport—Letter re committee won't hire permanent maid and privacy for nurse, 25 July 1938, (HSD 1/53).

²²⁸ Additionally 'I never would have left Sydney, had I known the "truth" about this place: I realise why you cannot get any Tasmanian nurses to take these centres! they know them! and I cannot say that I feel much admiration for any nurse who would allow herself to be so imposed on!' AOT, DPH, 58.11.40, Bush Nursing Marrawah, Letter of complaint from Sister Green re maid charges and horse, 6 June 1940, (HSD 1/79).

²²⁹ 'Apparently it has been the practice for the BN to pay for the maintenance of a maid, and for some of the patients accommodated in the hospital. In no case should the nurse be expected to provide sustenance from her own salary, and it is regrettable that she has been called upon to do this in the past. When BNs are appointed they are informed that lodging is provided, but that they are responsible for their own board. It is not unreasonable, therefore, for a nurse to feel aggrieved when she finds that she is expected to meet expenses which should be the responsibility of the Committee.' AOT, DPH 58.11.40, BN Marrawah Letter 25 June 1940 to Marrawah Committee re Sister having to pay for maid, (HSD 1/79). AOT, DPH, 58.11.40, BN Marrawah Letter from SN re nurse paying maintenance of maid, 19 June 1940, (HSD 1/79).

²³⁰ At Avoca there was no allowance made for any domestic assistance but according to the SN's opinion 'a Nurse should not have to do the polishing and cleaning, as she is then not able to keep her hands in the condition essential for her work.' AOT, DPH, 58.2.41, BN Avoca SN's Inspection Report of Avoca Centre, 30 July 1941, (HSD 1/80). Sister Mellish at Gladstone did her own housekeeping and cooking. She was able to procure the services of a gardener who was a local woman who came twice a week.

domestic help. Because of the isolated location of the BNCs domestic staff also were expected to be multi-skilled.²⁷ Melba Henwood (Mrs Dunstan) gave up her nursing training to marry and consequently became the nurse's aide on Flinders Island. She assisted Sister Green cutting firewood for the slow combustion stove. Melba Henwood and Sister Green 'did everything on their own. They had no handymen or anyone to help them.'²⁸ Melba Henwood not only cooked and cleaned but also was called upon to assist with deliveries.

At least two BNCs from Cape Barren Island recruited Aboriginal girls from the island even after they were stationed elsewhere. In December 1948 Sister Gittus requested that Miss Beverley Mansell of Cape Barren Island be employed to relieve the local domestic help at Alannah on Bruny Island. She held a schoolgirl elementary Mothercraft Certificate and was interested in nursing. The department paid for the travelling costs. In July 1949, six months later Sister Gittus requested that she be allowed to have Deborah Maynard, a young girl she brought off Cape Barren Island, to come and live with her permanently at the Alannah BNC.²⁹ Permission was granted on condition that this arrangement did not restrict admissions to the hospital. It is unclear what eventually happened to these two Aboriginal girls who had developed close friendships with Sister Gittus, but they did not remain with her permanently.

On Cape Barren Island, local Aboriginal women were employed by BNCs.³⁰ While Sister Una Saville, the BNC in the 1950s, developed a special relationship with her Aboriginal aide not all such relationships were positive.³¹ Sister Davies was desperate for additional help in 1960 and wrote three times within one month. She stated that she would prefer a middle aged white woman domestic who would (also) be a companion. Sympathy without relief is futile.³² Racial isolation was an important part of the Cape Barren Island experience and racial conflict appears to have exacerbated Sister Davies' isolation:

For instance, I saw a man and he promised to come and cut some wood for the stove. I saw him some four or five times, 'Oh yes I will come tomorrow Sister'. As soon as I moved away, he laughed and said 'Let the old white convict cut her own wood'. As

²⁷ At Adamsfield there was a set routine for collection of fees and maintenance of the BNC for which Sister Roach was happy to continue. The custom was for Mr FL Gony to collect the monthly fees for which he received 2/6 in the EI collected. He was employed also for 2 days to clean up the hospital and wash blankets etc. for which he charged 15/- .AOT, DPH, BN Adamsfield Centre, Correspondence with local committee re accommodation of visitors in hospital, transfer of control of centre to Dept, Instructions of BNC fees, (re appointment of Sister ML Roach—see file 58.26.43) 58.145, (HSD 1/87).

²⁸ Olga Henwood, Interview, Flinders Island, April 1994.

²⁹ AOT, 58.149, Letter to DPH from BN, 30 June 1949, (HSD 6/34).

³⁰ Viola C Millington, (previously Thompson and née Liersch), Sandy Bay, 1994.

³¹ Una Saville, (née Nicholls), Interview, Devonport, 1999.

³² AOT, DPH, Letter to Secretary Public Health from Sister Davies Cape Barren Island, 6 March 1960, (HSD 5).

there is no other man available at present I am still without wood cut. This is only an instance. I could tell many.²³⁷

The help she did get from Aboriginal girls often was labelled as incompetent and they frustrated Sister Davies with their unreliability, especially during the birding season. 'Winnie just announced she was going birding knowing I had 4 midwifery cases booked, and quite regardless of any help being available or otherwise'.²³⁸ Sister Davies could not understand the familial bonds and cultural practices of the Aboriginal community. It was not part of Sister Davies' brief and her work ethic and expectations were loaded onto the Aboriginal girls in vain. The cultural gap was insurmountable.

On Flinders Island also domestic help was provided by the local Aboriginal community but appears to have been judged more successful according to the white BNs.

Bernice Armstrong—the half caste lass I have here is an excellent girl, I think. She is only sixteen but a very clean, thorough girl, and a good little worker. At present I have her sleeping in one of the back wards.²³⁹

Implicit in this remark is the separatist nature of the work and colour of people. It was at the back of this hospital that the 'half-castes' were located with grey blankets; the white patients slept at the front with the white blankets. Bernice Armstrong would not have eased the social loneliness of the BN. With her youth and race she would have been viewed only as a worker rather than as a companion.

Domestic aides increased the BN's responsibilities and were an additional source of conflict at times. Nevertheless the aides in many cases did reduce the personal isolation of the BN within her BNC. Furthermore the aide provided an additional window into the local community with its secrets and values, and provided advice even about local geography. The BN for the most part still lived alone as most aides were, or became, married.

²³⁷ AOT, 58.4.3, Letter to DPH from Sister Davies Cape Barren Island 16 April 1951, (HSD 5).

²³⁸ The following account depicts a different story of overwork and abuse: Miss Winnie Maynard, Cape Barren Island For the last 8 years since the Cape Barren Island BNC has been open, it has employed the services of the above named and at the present time she is being paid the sum of £3.0.0 per week. Unfortunately the Sister in charge has been making this girl work from approximately 6 am in the morning to 7 pm or 8 pm at night without any time off. Kindly instruct the staff of the Cape Barren Island Centre that this girl is only to work 40 hours a week. Furthermore, the mother has complained to me that during the eight years the girl has been at the Centre she has not had any holidays on full pay, to which I understand she is entitled. She is now going on two months holiday I believe, and I think she should be given payment whilst she is away.' AOT, DPH, 58.4.6, Memo to Secretary Public Health from Minister for Health re Cape Barren Island Centre, 16 March 1950, (HSD 5) and AOT, DPH, Letter to Secretary Public Health from Sister Davies Cape Barren Island, 25 March 1950, (HSD 5).

²³⁹ AOT, DPH, Letter to Miss Noller SN from Flinders Island Bush Nursing, 12 December 1948, (HSD 5).

Retention and Recruitment—outcomes of professional and personal isolation

A critical outcome of the demanding work of the BN, combined with personal and professional isolation, was that Bush Nursing, throughout its history, faced difficulties in recruitment and low retention rates. Recruitment difficulties made it hard to obtain even relief nurses which in turn influenced retention. Problems with retention and recruitment reduced leave opportunities and decreased the opportunity to increase the number of BNCs with more than one BN. These factors all increased the BNs' isolation. Furthermore there were social changes such as expectations about working conditions, and about marriage and family, hence Bush Nursing was forced to respond to these changes to enhance retention and recruitment. Finally as new modalities of treatment changed the BNs' roles and responsibilities the character of Bush Nursing itself slowly changed.

From as early as the late 1930s difficulties in recruiting BNs was of concern to the DPH. In a paper to Cabinet it was argued that a major contributor to the shortage was inadequate salaries. From 1926 to 1931 the salary for BNs was £200, but 'owing to the Depression it was reduced as low as £150, rising again in 1934/35 to £170'.²⁴⁰ This reduction was a consequence of the Government grant towards Bush Nursing salaries being reduced by 44 per cent from 1930–31 levels in the 1932–33 year.

In this regard, it would seem that the position of a Bush Nurse is not sufficiently attractive financially to induce nurses to apply for appointment. The present salary is £170 per annum, from which a nurse is required to provide for her own keep.²⁴¹

Allowances provided to the BN to cater for patients also were seen as insufficient. The shortage of applications for positions led to a 'softening' of the requirement that BNs be triple-certificated. Sister Thurza Hazelwood's appointment to the position of BN at Adamsfield in 1937, despite her only qualification being a training certificate from the St John's Homeopathic Hospital in Hobart, was a direct consequence of the failure to find qualified staff willing to work in Adamsfield. There is evidence that there was some discomfort in the DPH about her position and its implications for quality of care. A letter in 1938 from the DPH to a Mr Clark advised him that:

In the circumstances, I would strongly urge that you make arrangements for your wife to be confined at either the Cottage Hospital, New Norfolk, or the Queen Alexandra Hospital, Hobart.²⁴²

²⁴⁰ AOT, DPH, 58.26.37, BN, Memo from Director of Public Health stressing need of wage rise for BN, 13 April 1937, (HSD 1/36).

²⁴¹ AOT, DPH, 58.26.37, (HSD 1/36).

²⁴² AOT, DPH, 58.1.38, BN Adamsfield shortages, Letter to Mr Clark, Adamsfield re wife's confinement, 11 January 1938, (HSD 1/53).

After some delay the Cabinet finally approved a salary increase of £20 (with the exception of Sister Hazelwood²⁴³) in October of that year. In 1937 Dr Carruthers, the Director of Public Health, wrote to his Minister about the extreme shortage of BNs in the State. He recommended that the Government increase its contribution to each BN's salary to £50 per annum per nurse salary. This would enable a salary of £190 to be offered to BNs.²⁴⁴

The demands of World War II also created a shortage of nurses which in turn placed stress on local community services. At Burnie the BNC closed after 20 years of operation because of the war, but new Centres continued to be opened, sometimes only for a brief period of time.²⁴⁵ Not all applications for new Centres could be entertained although the need might be justified. In response to a proposal for a new centre at Grassy the DPH replied:

No Departmental objection can be offered to the establishment of such a centre but, unfortunately, at the present time it is difficult to obtain services of Bush Nurses. As a matter of fact, for this reason some of our existing centres are not functioning.²⁴⁶

In 1939 there was an attempt to increase nursing qualifications by financial incentives for holders of Child Welfare Certificates but often advertisements for nurses failed to result in any applications and in 1940 the issue of salaries was considered again.²⁴⁷

²⁴³ She was to be paid only £100 per year because of her lack of qualifications.

²⁴⁴ He noted that the present salary was £170 per annum with the nurse providing her own keep. In the past it had been as high as £200 from 1926-27 to 1930-1931. 'In subsequent years owing to the depression, it was reduced as low as £150 rising again in 1934/35 to £170. The Government grant had been reduced from £900 in 1927/8 down to £500. AOT, DPH, 58.26.37, BN Salaries—Proposed increase to £190 owing to scarcity of applicants for vacancies, (HSD 1/36).

²⁴⁵ AOT, DPH, 58.4.45, BN Burnie, Letter from A Macfarlane, Hon Secretary, 24 October 1945, (HSD 1/91). 'During the course of the year, [1940] the number of BNCs was increased by three; the new centres being Triabunna, Cape Barren Island and St. Helens. The last mentioned centre, only functioned for a few months, owing to the difficulty of obtaining a nurse after the resignation of the first appointee.' AOT, DPH, 58.26.40, BN, Summary of Receipts and Expenditure—Centres controlled by Dept, Annual Reports, Returns & Requests to centres including forms issued for compilation, annual meeting—BNA State Conference—Annual Report, (HSD 1/79). 'During the course of the year (1945), new centres were established at Oatlands and Strahan ... The Centre at Waratah could not be serviced owing to shortage of nursing personnel. This factor also presented a problem at other locations.' AOT, DPH, 58.42.45, Bush Nursing Annual Conference, BNA, (HSD 1/91).

²⁴⁶ AOT, DPH, 58.45.45, BN Grassy (King Is) Proposed Centre, (HSD 1/91).

²⁴⁷ From 1 January 1939, the salary of any nurse holding a Child Welfare Certificate, in addition to possessing Certificates for General and Midwifery Nursing, was increased from £190 to £220 per annum; the added liability being met by the Government.' The issue of qualifications of appointees was the subject of concern in Ringarooma in 1947 when the committee was unhappy that their relieving nurse was only a single certificate Sister. A letter of explanation was sent from the DPH to the Committee explaining that it was not their policy to appoint such nurses but owing to the extreme shortages of nurses it was a temporary solution.' AOT, DPH, 58.28.39, Report of Ringarooma BNC by SN 27 May 1947, BN, State Council Meeting & annual report, (HSD 16/10). Letter to the Chairman BNC Ringarooma from Secretary for Public Health, 13 May 1947. AOT, DPH, 58.31.40, BN, Scarcity of applicants for BN positions—Meeting of State Council to discuss position, Suggestion to Minister for Health re increased salary, Data re financing of BN Scheme—submitted to Premier, (HSD 1/80).

By 1941, as shortages of nurses in Australia 'reached critical proportions', Bush Nursing vacancies increased.²⁴⁸ Military Service claimed some BNs and local and national advertisements for new nurses remained largely unsuccessful.²⁴⁹ Retired and married nurses were now acceptable for Bush Nursing positions:

As army requirements will absorb qualified nurses for some time to come, would it be possible to make use of retired nurses to attend clinics in towns where the time is only a few hours per week and the work light, to relieve nurses for service in centres like Redpa.²⁵⁰

The DPH needed to consider innovative ways to fill its vacancies, ways which would change the social structure of Bush Nursing. Not only was nursing in crisis but doctors were equally scarce. The GMO positions were not able to be filled as vacancies arose.²⁵¹ This further increased the necessity of a well-functioning Bush Nursing Service and added to the professional isolation and independence of the BN. Resource shortages affected the ability of BNCs to provide nurses with satisfactory facilities.²⁵²

The advent of Man Power, with its controls over work and even private lives, reduced the freedom of nurses to shift from a needed nursing position, made marriage and the subsequent loss of the nurse through required resignation more difficult, and led to compulsory postings of nurses to positions in BNCs.²⁵³ The DPH, perhaps reluctantly at first, accepted and then encouraged married nurses as relieving BNs.²⁵⁴ The DPH's stance against marriage was softening but it is clear that they were concerned that the community was not ready to accept married nurses. As the war went on, and in the social aftermath of

²⁴⁸ Linn, *Angels of Mercy*, p. 135.

²⁴⁹ AOT, DPH, 58.18.40, BN St Helens Letter to St Helens Committee re lack of nurses for vacancy, 5 March 1940. AOT, DPH, 58.11.41, BN Marrawah Letter to Marrawah Committee, (HSD 1/80).

²⁵⁰ AOT, DPH, 58.11.41, BN Marrawah, War time—request to Secretary for Public Health for retired nurses to fill vacancies, 30 June 1941, (HSD 1/80).

²⁵¹ AOT, DPH, 51.28.42, Departmental, Review of Activities of Department—Statement submitted to Premier for ALP Conference, Conference resolutions re: Provision of hostels for women travelling to maternity hospitals and care of young children; Extension of GMS; Maternity treatment in Public Hospitals, (HSD 1/86).

²⁵² 'The reason why the erection of the residence is so urgent is that the Sister is very busy, and is very tired so there appears to be some little friction where she boards. She informed me she would not go back to the same place after her annual leave. You may be able to do something to expedite the work, (W. Wilson) Council Clerk.' AOT, DPH, 58.42.45, Bush Nursing Annual Conference, BNA, (HSD 1/91).

²⁵³ '29th September, 1944. Advice has been received from the Man Power Directorate that it is anticipated Sister Butler will be released from the Devon Public Hospital at the end of the current month, for the purpose of taking over the appointment of BN at Waratah', AOT, DPH, 58.23.44, BN Waratah, (HSD 1/89).

²⁵⁴ 'During recent years, the difficulty which has presented itself in securing nurses for Bush Nursing appointments has been accentuated by the prevailing national emergency, so much so that the Department has had to depart from established practice by employing married nurses to act in a temporary capacity'. AOT, DPH, 58.26.40, BN, Summary of Receipts and Expenditure—Centres controlled by Dept, Annual Reports, Returns & Requests to centres including forms issued for compilation, annual meeting—BNA State Conference—Annual Report, (HSD 1/79).

the war where the shortage of nurses across Australia continued, more and more married nurses were seen as a necessary part of the solution to the nursing shortage.

A number of married women are now employed, and their services are much appreciated in the more distant areas. If it were not for them about half of the Centres would need to be closed ... Where quarters and surgery only comprise the Centre, many are staffed by married nurses, having husbands or families resident, or these places could not be kept staffed. In the earlier days, nurses handed in their resignations when they married, but now they may elect to continue in the service.²⁵⁵

There was a renewed effort to make Bush Nursing financially attractive with additional salary increases. Some Centres used creative bonuses. Medical Unions were not tied to DPH conditions of service and provided their BNs with additional leave with pay at times of mine shut-downs.²⁵⁶ Salaries and conditions continued to improve:

Double cert BN earned £365 per annum plus cost of living allowance of 15/- per week and a climatic allowance of £15 ... in most cases all homes were electric, Residence fuel and lighting supplied and also dom help but Sister to provide her own board. Arrangements for special leave for child welfare training if desired.²⁵⁷

but despite these significant changes the nursing shortages continued.

Competition for the scarce nurses was fierce. In March 1947 a Public Health Memorandum noted that Redpa and Marrawah districts had been without the services of a BN for some time:

Most trained nurses, at present, are unwilling to take up positions in remote country areas when there are ample positions available in the city and towns of larger population.²⁵⁸

Nevertheless the number of BNCs increased, as despite some closures other centres opened. In 1946 many BNCs were staffed by relievers for part or even the entire year. Some had to close for short periods.²⁵⁹ In 1947 the problems continued. In September 1947 there was no BN at Southport or Triabunna, St Mary's Hospital had been forced to close its general wards, and the nursing shortage was critical in Queenstown as well as in nearly all

²⁵⁵ AOT, DPH, 28.28.8, Re Use of Red Cross Trust Fund, staffing levels and conditions etc from Sister DK Noller, (HSD 5/8) (HSD 3/12).

²⁵⁶ AOT, DPH, 58.15.49, Letter from SN, 8 December 1949, (HSD 6/34).

²⁵⁷ AOT, DPH, 58.26.49, Letter to applicant Miss A J Laird in Queensland, 17 February 1949, (HSD 6/34).

²⁵⁸ AOT, DPH, 21.3.47, Memo from Secretary for Public Health, (HSD 6/10).

²⁵⁹ In 1946 a hospital opened in Cygnet and the workload was stated to have increased such that the child welfare work was proving excessive for two Sisters. Swansea had a succession of relievers, an increasing workload, and hoped for two permanent BNs. Triabunna required relievers but despite this had to close for short periods. Ringarooma also provided a service through relievers and with some breaks in the continuity of the service. Marrawah was unattended for four months but reopened in May. Adamsfield BNC closed when Sister Roach resigned. The local population was falling, the Centre was in a poor condition, and no one was available to replace her. AOT, DPH, Bush Nursing Annual Report 1946-1947 Southern Centres. AOT, DPH, Letter to Director Hospital & Medical Services from Sister DK Noller re Adamsfield, 1 November 1946, (HSD 1/92).

hospitals.²⁶⁰ Bush Nursing vacancies were noted at Triabunna, Koonya, Marrawah, Mole Creek, Sorell, Cygnet, Strahan, Waratah and Tullah.²⁶¹ In 1948 the situation was no better. Triabunna Hospital closed again in May 1948. The Ringarooma BNC was closed for four months in 1949.²⁶² The nursing shortages appeared to have deepened and the DPH advised that this was a problem 'throughout the Commonwealth and other countries of the world'.²⁶³ Not only was it difficult to recruit BNs, but as always retention of nurses was equally difficult. The DPH noted that:

As a rule, Bush Nursing Sisters do not serve for very lengthy periods. Other more congenial positions claim them after two or three years, or less. The life is lonely and social attractions are usually few. However, they gain experience from their extra responsibilities and we are appreciative of their services, even for one or two years.²⁶⁴

There were of course notable exceptions to this rule as previously noted. These women remained in one area for a substantial period of time despite the guideline requiring that nurses stay in any one area only two years.²⁶⁵

Apart from marriage, isolation and the difficult working conditions were perhaps the primary reasons for the loss of nurses from the service:

Sisters [Edna] Anderson and [Beatrice] Ferguson resigned from the Sorell BNC intending to take up positions in drapery stores in the city for regular work hours and more social opportunities.²⁶⁶

However interpersonal relationship breakdowns played their part. Conflicts occurred on occasion between BNs in Centres where more than one nurse was stationed, and in others between BNs their communities.²⁶⁷

The DPH and the local organisations realised that facilities needed to be upgraded to encourage nurses to stay and to lessen isolation. From the 1950s the DPH planned the provision of modern equipment and renovations with the stated aim of providing country

²⁶⁰ AOT, DPH, 25.9.47, Letter to Secretary of Southport BNC from Director of Hospitals and Medical Services, (HSD 6/10).

²⁶¹ AOT, DPH, 23.1.47, Letter to Nurse in Victoria from Dr BM Carruthers Director of Hospital and Medical Services, (HSD 6/10).

²⁶² AOT, DPH, 58.14.49, Letter to Sister Noller from Sister Fry Ringarooma, 8 November 1949, (HSD 6/34).

²⁶³ AOT, DPH, 58.24.49, Letter to Council Clerk at Triabunna, 28 January 1949, (HSD 6/34).

²⁶⁴ AOT, DPH, 'A Short History of Bush Nursing in Tasmania', DK Noller, (HSD 6/59).

²⁶⁵ The two-year rule was to prevent BNs becoming too familiar with their community, particularly with the high rate of marriage to locals in some areas. Edith Collis, Personal Communication, August, 2003.

²⁶⁶ AOT, DPH, 58.17.49, Report of the SN, Sorell, 19 January 1949, (HSD 6/34). Sister Edna Joan Anderson.

²⁶⁷ AOT, DPH, 58.28.4, Memo to Sister Widdicombe re King Island staff resignations—find out reason re Sister George, 24 August 1950. AOT, DPH, 58.13.40, BN Rosebery, Letter to Montagu Medical Union, 9 May 1940 re Sister Rushton resignation & vacancy, (HSD 1/79).

centres with all the amenities of city institutions.²⁶⁸ In 1951 and 1952 the focus was not only on salaries but also on conditions of work and the impact of this on recruitment and retention of nurses. It was argued that the conditions of work and salaries lagged behind other Public Service and Hospital awards. The Supervisory Nurse argued to the DPH that 'salaries be ... raised to at least the equivalent of Hospital Award rates and annual leave be raised from 28 days to 32 days as allowed in other Public Service Institutions'.²⁶⁹ Staff were resigning because of salaries and conditions. Sister Mary Loveland Watts at Cygnet argued that:

We will find it impossible, with the present day cost of living, to provide adequately three meals, [and] morning and afternoon tea to patients and staff, at six shillings per day, without encroaching upon our own salaries

and that this, combined with the long working hours each week, meant that Sister Watts wished to resign as soon as possible.²⁷⁰ Recognising the impact of isolation and the changing social climate, innovative ideas were being floated by Sister Noller to attract and keep 'young, enthusiastic, [and] well-qualified, unmarried girls in the Service'. These ideas included free travel to the nearest city or large town for weekly time away from work, and free travel to the nearest city when going on annual leave.²⁷¹

In the 1950s there was an increasing tendency for applications to be from married nurses who wanted their husbands and children to be resident with them, and 17 of the 40 current BNs were married women. The Supervisory Nurse commented that the large proportion of married and elderly sisters attached to the Bush Nursing Staff made transfers impracticable.²⁷² Despite the attempts to make Bush Nursing more attractive to potential or current BNs, in the 1951–1952 year (the year that the Southern Tasmanian Bush Nursing Association was dissolved) 14 of the 25 operational BNCs had to be closed or partly closed for periods of a few weeks to a few months over the year. Salaries for nurses in Tasmania

²⁶⁸ *TJPP&P*, 1956. Lists of equipment included 'washing machines, drying cupboards, convection heaters and other miscellaneous modern household equipment.'

²⁶⁹ 'with allowances, that is, 10/- weekly increase' especially given that 'one cannot quote a 40 hour working week for them, overtime rates, or a compensating salary attraction.' AOT, DPH 58.28.3, Memo from Sister DK Noller re salary increase & longer annual leave for BN due to shortage, 14 July 1950, (HSD 5).

²⁷⁰ AOT, DPH, Letter from Sisters Girot & Watts, Cygnet, re too much work, not enough funds to feed patients, 3 January 1951, (HSD 5). Sisters Leonie Alice Girot & Mary Loveland Watts stated their working hours to be '70 hours full-time duty for each Sister, plus 32 hours on call each at night ... the daily duties are often too much for one Sister'. Sister LA Girot was trained at St Joseph's Hospital, Auburn, and registered in Tasmania on 19 December 1950, Registration Number 3160.

²⁷¹ AOT, DPH, 28.28.8, Re Use of Red Cross Trust Fund, staffing levels and conditions etc from Sister DK Noller, (HSD 5/8) (HSD 3/12). It was noted that the Bush Nursing Association of New South Wales provided its staff with free travel to the nearest city when going on annual leave and an additional week's annual leave. AOT, DPH, 58.45.41, BN Nurse shortage, Letter from TBNA, to encourage girls to do nursing, 10 November 1941, (HSD 1/83).

²⁷² AOT, DPH, Memo to Director General of Medical Services from Sister DK Noller re Nursing Shortages, 2 November 1953, (HSD 5).

were not competitive, between 8 shillings and 26 shillings a week lower than those in Victoria and New South Wales.

Attempts were made to fill vacancies by sponsored migrants, but these efforts were not always successful, cultural dislocation being one reason for this lack of success.²⁷³ Some additional support for immigrant nurses, and an attempt to understand the difference between their nursing practices, was necessary if sponsored migration was to work:

There are a great many immigrant nurses on my various staffs now, and I have tried to give them a little bit of extra private consideration and encouragement when possible, because they are strangers in a strange land. Their methods are different sometimes, but usually as good as ours.²⁷⁴

These BNs would feel even more isolated than those used to Australian rural life. The shortage of nurses and the impact of this on community services was of concern to the community. The DPH continued to lobby the Minister of Health for authority to increase BNs' salaries as 'everything has been done so far as advertising, posters and propaganda are concerned, but not with any great measure of success'.²⁷⁵ While the Minister had agreed to parity with Tasmanian Hospital nursing, the Department argued that this was insufficient.²⁷⁶

Table 4.01 'Characteristics' of Bush Nurses, 1954

Married or widowed with children	19
Past retiring age and single or widowed	4
Permanent staff with 'full faculties'	6
'Middle aged - heavy- limited'	1
Casual staff	4
Vacancies	6
Total	46

Source: AOT, DPH, 58/29²⁷⁷

²⁷³ The fact that you were nominated by this Department to Tasmania would mean that you were under a moral obligation to remain a reasonable time on our staff, and at least a year. Some immigrants arrange a two years' service. After the first year you will find the country less strange and providing you give it a good trial, are quite likely to settle happily for a longer or permanent period, although not necessarily at Flinders Island all the time. We have a number of English, Scotch and Irish Sisters and ... other nationalities on the Bush Nursing and other hospital staffs. Some have been with us quite a time. Once you get to know some of the people it makes all the difference, speaking from experience'. AOT, DPH, 58.6.3, Letter to Sister Winder, Flinders Island Centre from Sister DK Noller, 3 April 1951, (HSD 5).

²⁷⁴ AOT, DPH, 58.24.3, Letter to Sister Thompson Triabunna from Sister DK Noller re SN, 16 April 1953, (HSD 5).

²⁷⁵ AOT, DPH, nd, Report Cygnet Health Centre shortage of staff, (HSD 5).

²⁷⁶ 'Bush Nursing Sisters are not covered by the determination of any Wages Board, nor are they members of the Public Service, their rates of pay being fixed by this Department. Recently you approved of their being paid at the same rates as those fixed by the determination of the Hospitals Wages Board. So far as these hospital awards are concerned, there is a certain amount of discrepancy between our award and those of other States, which is outlined in the attached statement. In an attempt to encourage Nursing Sisters to this State, would you please approve that their rate of pay be fixed at the highest rate of those operating on the mainland? I feel that unless we do something such as this, there is the danger of one or two Bush Nursing Hospitals having to close down.' AOT, DPH, 58.28.1A, Memo for Minister for Health from Director General of Medical Services re Nursing Shortage, 10 November 1953, (HSD 5).

²⁷⁷ AOT, DPH, 58/29, Bush Nursing Staff Changes planned as at 1 July 1954, (HSD 5).

In 1954 the Bush Nursing Service was still dependent on temporary staff for its survival. Of a total staff of 46 nurses only six were noted as 'permanent staff with full faculties', an expression suggesting the bureaucracy had developed a real sense of frustration with current staffing. Vacancies were 'filled for a few weeks at a time' by Tourist Nurses. Advertising continued to be used in an attempt to fill the vacancies and this included the rather unusual step of radio advertising. This was successful at least in one case, attracting a nurse in Western Australia who had nursed previously at Waratah.²⁷⁸ While it was difficult for the Bush Nursing Service to retain staff it was even harder to arrange and organise relief. In lieu of adequate relief, rotation was seen as good as a rest. A particularly useful strategy allowed solo BNs to be relieved by BNs from a Bush Nursing hospital with more than one nurse on staff.

Photograph 4.12 Advertisement for Bush Nurses

C.E.S. ^{was} advised that Bush Nursing salaries were not award rates. Asked if they could advertise such vacancies under a professional heading.

John

13/5/49.

11/5/49
COMMONWEALTH EMPLOYMENT SERVICE

MOTOR MECHANIC
Good type Tradesman required.
AWARD WAGES

BUILDERS' LABOURERS
Both experienced and inexperienced men required.
Good Wages

BUSH NURSE
for North-East Coast. Must have general and obstetric certificates.
Award Wages

For the above and many other positions apply to the District Employment Office.

75 MURRAY STREET, HOBERT
Phone 7191

THIS SERVICE IS ENTIRELY FREE.

The placing of this advertisement in the body of an advertisement for tradespersons created concern at the DPH. It did not create the right impression — Bush Nurses were seen as responsible professionals, not tradespeople.

Source: AOT, DPH, 558.28.49, 11 August 1949.

²⁷⁸ AOT, DPH, 15.12.55, Letter to DPH from Beryl Allen, WA re employment, (HSD 5).

Bush Nurses occasionally would relieve each other during annual or sick leave. Although many knew of each other, it was not usual practice to form friendships or to meet regularly. Isolation from colleagues was the norm as travel out of the area was difficult. Leisure time was brief and seldom without an on-call responsibility. No active organisation of BNs worked to link them together or foster their interests. Many nurses originally came from interstate and never met BNs out of their district. Occasionally some local BNs met if their visits to Hobart coincided and sometimes nurses would be rotated to give one BN a week off for 'a spell and a change'.²⁷⁹ These strategies could not meet the leave requirements. Sister Mellish remembered in her first year at Gladstone that the DPH could not find anyone to relieve her and so her leave accumulated. She finally took leave when approximately three months had accrued. She stayed in the area for 14 years, retiring aged 68, three years after official retiring age, as replacing her on retirement was even more difficult than finding a reliever.²⁸⁰

Bush Nursing could be arduous and the breaks were minimal. Some nurses made a career out of relieving, and relief BNs did not require the same qualifications as a permanent BN. Sister Elizabeth Nola Ole, midwifery trained only, was one such reliever.²⁸¹ Other relievers might be recruited with no midwifery training if there was no pending midwifery case. Some relievers were nurses having a break between training courses or at the end of their training.²⁸² Relief nurses were recruited from BNs who had retired on marriage but still lived in the area, or from other nurses who had shifted into the area 'fortuitously' and were persuaded to take on the role. This was the case on Cape Barren Island.²⁸³ The lot of the reliever was not easy, coming into an area with which she was not familiar, and where the regular nurse was regarded with special affection. This experience

²⁷⁹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994 and Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

²⁸⁰ 'They couldn't keep anyone. The longest they ever kept anybody there was four to six weeks. They had about half a dozen. They didn't like living in the country. And the ones who lived in the district didn't want to come out to Gladstone. For fourteen years. I liked it ... I think it was the district I travelled in. Because I used to go to Anson's Bay and down here. [Musselroe Bay] I loved it down here, I thought it was beautiful ... they couldn't get anybody to replace me ... I got at least three years extra.' Evelyn Mellish, Interview, Musselroe Bay, 1994.

²⁸¹ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

²⁸² In 1933 Sister Janice Fenton relieved a few weeks at Marawah because there were no maternity cases pending. She was in between training courses and they had to have someone as there was no doctor. Sister Fenton then went to Hobart to do midwifery training and after a break because of travel and marriage, returned to Tasmania, filling vacancies as part of the Man Power scheme during World War II. Barnes Janice Flora, (previously Brooks and née Fenton) Interview, Devonport, 1995.

²⁸³ 'There was a little hospital there and there was another Sister there when I got there a Sister Davies—but she left very shortly after. I didn't take on the hospital, in fact I wasn't going to do it all—see I hadn't had any experience as a Sister in any hospital. I had done my training and I just did a little bit [of midwifery] up at the Mersey [Hospital], just waiting to get into child health ... and it was pushed onto you a little bit. But it was an experience.' Una Saville, (née Nicholls), Interview, Devonport, 1999.

made them even more isolated than substantive BNs, but at least the experience was short-lived. At Lilydale there were occasional relieving nurses who according to Mr Art Van Der Hek, the Council Clerk, were not held in the same esteem as Sister Walsh:

Well, I don't think you could expect that, I mean Sister Walsh lived there and all right, that was her dedicated job you know, she lived for it. Whether it was the middle of the night, if you called Sister Walsh she would say, 'Yes, all right, I'll be there'.²⁸⁴

Relieving required 'extra tact and understanding' to avoid upsetting the community.²⁸⁵ Going beyond nursing, the reliever's duties included taking care of the BN's home, as well as her patients. 'Often they left their pets behind, or their garden and their pot plants and one would care for them with pleasure'.²⁸⁶

Nurses who had travelled to, or within, Australia on working holidays were recruited into the Tourist Nursing Service. They often travelling in pairs to lessen the isolation.²⁸⁷ Some Tourist Nurses actively sought relief work. 'I asked to be a relieving nurse so I could get around to see the country'.²⁸⁸ In 1947 an Emergency Nursing Service was created to fill critical vacancies including those within Bush Nursing.²⁸⁹ This pool of temporary staff was critical for the operation of the BNCs. In 1949 more than 90 per cent of sisters in country hospitals were nurses from interstate or overseas. Most were on short contracts although many extended these contracts.²⁹⁰

The personal isolation experienced by the BN was shared to varying degrees by all the women employed as BNs. Bush Nurses worked within isolated, male-dominated and conservative, rural communities. The loneliness of the BN was not only a problem for the BN but also for the DPH. If BNs were not integrated into the community and made welcome they did not stay. Retention was an ever-present problem for the DPH. Community expectations were a double-edged sword. As BNs became revered they became isolated through their professional status. The uniform became a tool consciously used to provide a professional distance between the BN and her patients and to provide a barrier between public and private life. Forming close friendships among patients in the

²⁸⁴ Art Van Der Hek, Interview, Norwood, 1995.

²⁸⁵ AOT, DPH, 58.24.3, Letter to Sister Viola C Thompson Triabunna from Sister DK Noller SN, 16 April 1953, (HSD 5).

²⁸⁶ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1995.

²⁸⁷ Sister Bird recalled a tourist nurse from Canberra, named Flemming, relieving her at Marrawah. Dr Bryant recalled in 1949 two English tourist nurses, Sister Sunniford and Sister Bloomfield, who relieved at Ouse. Many would take up positions only in pairs. Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

²⁸⁸ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1995.

²⁸⁹ AOT, DPH, 58.26.49, (HSD 6/34).

²⁹⁰ AOT, DPH, 51/9, Letter to King Island Hospital Board from Director Hospital Medical Services re Emergency Nursing Service, 12 January 1949, (HSD 5).

small communities could lead to perceived loss of confidentiality. Community dependence lessened the BN's privacy and time away from work responsibilities. Living within the BNC further isolated the BN although domestic aides could provide some personal contact—where the aide was unmarried, or socially equal, but normally the aide was in a mistress/servant relationship to the BN. Relief for holidays or illness was difficult, and contact with relievers was fleeting. Contact with other nurses essentially was limited to occasional contact with a Supervisory Nurse, and BNs never gained any organisational framework for peer support or advocacy. Isolated from family, friends, and often their social and religious culture, marriage was one key to overcoming loneliness but the price paid was often loss of career and professional status. Married BNs did not retain the 'position on the pedestal'. As the BN gained 'a provider' in her husband the community support lessened. In most of the Bush Nursing era, married woman had relieving and unpaid positions only. When paid positions became available for married nurses, the conditions of appointment often meant separation from husband and children, reinforcing the isolation of the BN's position. Bush Nurses were thus at all times isolated women living and working in isolated communities.

CHAPTER FIVE

Independent Professionals

The concept of professional independence is complex. No professional is totally divorced from professional or regulatory control, or the influence of others. Whilst hospital nurses worked within a clearly-defined hierarchical structure and were subject to a level of control that made nursing subservient to medicine, this was not the experience of the BN. In this chapter we shall see that the BN was required to practise without recourse to immediate supervision and most often without close readily-available collegial support. Even when working in close relationship with doctors, in many cases, she still was working independently, at least in respect of her nursing practice.

There is debate within and without nursing about its professional status.¹ Nevertheless, regardless of whether or not Bush Nursing was a profession, occupation or vocation, this thesis argues that BNs were independent from doctors. There are gender-based arguments about the relationship between nursing and medicine. Bush Nurses were female and the doctors with whom they interacted were mostly male. The primary examination in this thesis is related to whether or not there is evidence that BNs in some senses were free from medical domination, rather than examining the reasons for the domination of nursing by medicine. This chapter will explore the work of BNs and demonstrate this independence through examining their actions such as diagnosing, instituting treatment including dispensing drugs, ascertaining deaths, and referring to hospitals, together with their work relationships, the availability of doctors and the role of the Supervisory Nurse. Other aspects of their work practice, beyond that necessarily seen as part of the 'official workload', will be included to illustrate the scope and diversity of their work.

Officially at least BNs were not to work as independent health professionals. In Lady Dudley's original argument for nurses in the bush it was stated clearly that 'such a nurse will work in close touch with the medical men of the district and with the nearest general hospital' and that she will 'carry out the work with the co-operation of the medical profession'.² It was proposed that Bush Nursing committees provide oversight to see that the nurses operated within their boundaries.

¹ Refer to Chapter One Literature Review.

² *The Sydney Mail*, 27 July 1910, p. 34.

Bush Nurses' roles within nursing and relating to the medical profession were as complex as they were contradictory. Bush Nurses' activities were constrained officially by the regulations pertaining to nursing which demonstrated a clear divide between the roles of nurse and doctor. In practice, nurses worked in an isolated clinic or small hospital environment. In many instances they would have been unable to contact a doctor within hours or in some cases days. This professional isolation helped to shape their role, status and duties. In their hospital training and practice prior to becoming BNs, nurses' contact with patients was primarily from work generated by doctors. Patients arrived in hospital for treatment as a consequence of a decision by the doctor to admit them for treatment. The work of BNs was in the main generated directly by the patients themselves or by the activities of the BNs rather than by doctors. This might have been true in part for private nursing and for Child Welfare nurses, but the BN's role was more akin to the way in which doctors' work was created.

Supervisory Nurses visited infrequently. The Tasmanian Bush Nursing Association was sometimes over 200 miles away as was the DPH. Communication with these was by letter, no substitute for minute-to-minute professional contact. Contact with other nurses was fleeting, such as briefly seeing their holiday reliever and in later years the occasional School Nurse or Child Welfare nurse. It was expected that nurses would use their initiative, improvise with basic equipment and refer patients to the urban doctors, or to hospital, if necessary and appropriate. They would mainly act independently. This independence of the BN was by default and as a consequence of her isolation. Nurses delivered health care to a community scattered over a wide area with minimal, if any, assistance. Within this context their confidence grew and they felt extremely capable:

You'd just have to do the best you could because if it was an emergency, if you didn't hop in and do what you could, they could die before they could get proper treatment. You had to be independent and you had to be ready to make up your own mind in an emergency. You couldn't panic. You just had to say, well its up to me.³

They recognised that, particularly in emergency, they had to be able to assess the problems and institute treatment without the benefit of advice from others. They were 'more than nurse'; 'You were their doctor, their nurse, their friend'. The Bush Nursing role demanded of them skills and independence greater than those usually associated with the nursing role.⁴

This was especially the case in the early period of Bush Nursing and at all times in remote areas such as Adamsfield, Cape Barren Island and Babel Island. Separation from

³ Thurza Hazelwood, (née Cox), Interview, Prospect, 1998.

⁴ Joan Woolley, Interview, Longford, 1994 and Ruby Kelly, (née Elphinstone), Interview, Wynyard, 1994.

medical advice or support was through physical distance and transport difficulties, geographic barriers such as mountains or passages of water, poor communication technologies, and as a consequence of workloads, membership of different groups, and personality differences.⁵ Without a medical professional at close hand, and as the health-care worker of first contact for the patient, there was potential for the 'clear demarcation' between doctor and nurse to blur, and for the nurse to act as an independent practitioner. The actual relationship between the BN and the doctors with whom she came in contact was therefore a complex one—officially a hierarchical relationship with substantial power differential—the nurse was at times hand maiden, at times assistant, at times colleague or back up, and at times competitor with the doctor. This relationship will be discussed within this chapter. Issues of behaviour in the doctor's absence, such as autonomy of practice, and deference in his presence or in communication with him will be explored.

The rules regarding the duties of the BN and her relationship with the medical profession were set out explicitly. Nurses were to act only under medical direction, except in 'cases of emergency, trivial cases and normal midwifery'. In districts without a resident doctor the nurse could act outside this guideline if in 'the absence of a BN, no skilled aid would be sought'.⁶ The nurse was to go to any part of the district as required by a doctor to attend the sick and was obliged to keep 'records for medical inspection'.⁷ Furthermore, if the BN were required to leave the BNC for any reason connected with her work she first should receive approval from 'the officer of the local controlling body', usually the local Bush Nursing Committee.⁸ This chapter will investigate the degree to which such rules were practical and to which they were followed.

⁵ Doctors and nurses both covered large and not necessarily overlapping geographic areas. Doctor versus nurse, salaried versus fee for service, different routes of professional accountability, different philosophic bases for the services.

⁶ AOT, BNA, Bush Nursing Regulations, Rule 2, (HSD 5).

⁷ AOT, BNA, Bush Nursing Regulations, Rule 6, (HSD 5).

⁸ AOT, BNA, Bush Nursing Regulations, Rule 20, (HSD 5).

The Bush Nurse as a Sole Practitioner

We were very much individuals on our own. We didn't hear of anyone unless you happened to have been working with them and then you learned about them.⁹

Bush Nurses in Tasmania generally were socially and professionally isolated and worked in areas as sole health professionals. This professional isolation was a direct consequence of the isolation of rural communities from all other health facilities. Nurses working in other countries which undertook similar approaches to the delivery of health care, for example the early Public Health Nurses in British Columbia and Alberta, were professionally isolated also.¹⁰ The Albertan District Nurse was to be found in any district up to 60 miles from the nearest doctor or hospital. The distances involved required her in the 'course of her duties to assume the role of doctor'; similarly the Klondyke Victorian Nurses were to act under the direction of doctors but only 'when such direction is available'.¹¹

In Tasmania, most BNs were sole practitioners. Not only did they work apart from nursing colleagues, but normally they were isolated from the doctors to whom they were, in theory at least, subservient. Most BNCs were located in areas without resident doctors, and some areas seldom if ever were visited by a doctor. While Sister Thurza Hazelwood was at Adamsfield the doctor never visited the area. Additionally, at times the BN had no communication whatsoever with the doctor or hospital as the telephone lines could be down for several weeks at a time because of snowfalls.¹² Nurses frequently understated their level of independence. Sister Hazelwood would not admit to taking the role of a doctor, but did state that she was faced with incidents that usually a doctor would face rather than would a nurse. She saw that the strict nursing controls which set out the boundaries between doctors and nurses did not operate at Adamsfield saying 'We just had to cope as best we could'.¹³ Similarly, at Gladstone and Marrawah some of the BNs do not recall the areas being visited by doctors.¹⁴ In other areas the doctor might visit occasionally but because he also serviced a large area, and was based many miles away from the BNC, he was seldom available to assist in person.¹⁵ At Dover the doctor covered the area from Dover to Triabunna and to Bicheno:

⁹ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

¹⁰ Mill, Leiper, Duncan, pp. 18-23.

¹¹ Deputy Minister of Public Health, 1935 in Ross-Kerr, p. 88 and JM Gibbon & Mary S Mathewson, *Three Centuries of Canadian Nursing*, Macmillan, Toronto, 1947, p. 258.

¹² Thurza Hazelwood, (née Cox), Interview, Prospect, 1998.

¹³ Thurza Hazelwood, (née Cox), Interview, Prospect, 1998.

¹⁴ Evelyn Mellish, Interview, Musselroe Bay, 1994, and Janice Flora Barnes née Fenton, Interview, Devonport, 1999.

¹⁵ For example the BNC at Ouse was nine miles from the nearest GMO, and it was 35 miles to the nearest doctor from Marrawah.

He covered quite an extensive area and in the meantime we did everything else. We did the X-rays, we stitched people up and delivered babies; whatever happened we could manage it.¹⁶

It took special qualities to cope with the professional isolation. Maturity often was seen as an advantage.

There is only one Sister on staff who is 'on call' for 24 hours per day for 7 days weekly ... [and is] relieved for five days per month by a Sister sent from Hobart ... In my opinion Sister Gittus is the right person in the right place. She is nearing middle age and I feel no younger Sister could be persuaded to accept the position, owing to isolation of the Centre.¹⁷

Sister Gittus was of a mature age, she had had previous experience of working on Cape Barren Island, and thus had a track record of coping successfully with isolation. At Storys Creek there were about 800 persons in an area which was isolated by its altitude and its harsh climate.¹⁸ Frequently telephone services and electricity were affected by the environment, no doctors visited, and Annual Reports reiterated that 'the work here is often dependent on the decision of the BN'.¹⁹ The area included two metal mines (tin and wolfram), a coal-mine, and, in the St Paul's Valley, a sawmill. These, together with local farming activities, made the area one in which serious accidents and injury were highly likely. Despite the nature of the area almost half of the inhabitants were children. At Strahan, a town on Tasmania's West Coast, the population was similar, and the area similarly was isolated with a scattered population. For the same period no doctor visited.²⁰

Even when a doctor was located close to a BNC, it was not always possible for that doctor to provide assistance to the BN. The GMO was prevented frequently from travelling from Flinders Island to Cape Barren Island because of the weather. Poor telecommunications made this isolation more profound. Epidemics could take their toll and at Rossarden the BN had to cope with whooping cough and influenza epidemics on her own.²¹ At Rosebery the BNs were unable to communicate with the local doctor when he was visiting the Tullah area or the Zeehan Hospital.²² At Tullah, the loss of a river bridge prevented the transfer of a patient out of the area to the base hospital, and also prevented

¹⁶ Eileen McManus, (née McMenamain), Interview, Falmouth, 1994.

¹⁷ AOT, DPH, 58.1.3, Memo for Director General Medical Services from Sister DK Noller re CWA Complaint Alonnah Hospital, 22 September 1952, (HSD 5).

¹⁸ AOT, DPH, 1.13.41, Letter from Storys Creek Medical Union medical needs of area/population. 24 March 1941, (HSD 1/80).

¹⁹ AOT, DPH, Bush Nursing Annual Report 1946-1947, Northern Centres (HSD 6/10).

²⁰ AOT, DPH, Letter to Dr BM Carruthers from Sister H Davies, Strahan, 1947, (HSD 6/10).

²¹ AOT, DPH, BN Centre, Rossarden, 21 July 1948, (HSD 5).

²² AOT, DPH, Report to Director Hospital and Medical Services from Sister Widdicombe re Tullah BNC, 15 November 1949, (HSD 5).

the local doctor from getting in to assist the BN.²³ The death of local doctors also had its impact on the nurse by increasing her work and reducing her clinical support²⁴

Bush Nursing Hospitals were special cases as in some of these BNCs nurses had, at most times, the potential for collegial support from another nurse. Working hours and the necessary division of labour (for example because of infection-control guidelines) reduced the practical value of this support and rendering them de-facto 'sole practitioners'. Additionally BNs did not always find it easy to work with the one other nurse they were alongside. Personality issues were potentially more troublesome in a small isolated workplace like a BNC than in a large hospital environment.²⁵ Many relieving BNs and especially Tourist Nurses from overseas often would request a Centre where two nurses who were friends could work together. This provided them at least some opportunity to gain collegial support as well as to reduce personal isolation. When BNs were relieved, the incoming reliever usually needed to stay in the BN's accommodation. So while 'Sisters in charge of Centres, [were] required to hand over personally to the relieving Sister before leaving for holidays or on transfers etc'this handover was necessarily brief.²⁶

Some BNs were fortunate in that, although they were in single nurse BNCs, they had forged effective links with other BNs in adjacent areas. Where the travel distances and travel times allowed they could arrange to relieve each other and thus gain some free time. In this situation BNs had to leave the area if they were not working as it was 'awkward' if the neighbouring (relieving) BN had to travel a considerable distance over the difficult roads, especially after-hours, while the nurse on leave was living in close proximity to the patient in need.²⁷ Rossarden and Storys Creek stand out as the two centres where co-operation and mutual support were most effective. These relationships achieved no mutual support in a personal or professional sense other than for time off. Supervisory Sister Noller cautioned that:

This staff—by reason of its scattered and isolated nature of work and 24 hours daily 'on call' service given its patients—is unable to meet in conference.²⁸

This isolation not only hampered their professional work but also their ability to be active in a political sense in an attempt to change their work conditions. In addition to providing

²³ AOT, DPH, 15 November 1949, (HSD 5).

²⁴ AOT, DPH, 58.5.38, BNC Cygnet, letter from Committee desiring extra nurse for Cygnet after Dr Wade's death, 17 May 1938, (HSD 1/53).

²⁵ AOT, DPH, 58.22.3, Report for Director General Medical Services from Sister DK Nollerre Swansea Sisters, 19 December 1952, (HSD 5).

²⁶ AOT, DPH, Circular to BNCs re Rules to be observed, 1953, (HSD 3/22).

²⁷ AOT, DPH, Letter to Secretary for Public Health from the Storeys Creek Medical Union, 26 March 1947, (HSD 6/10).

²⁸ AOT, DPH, 'A Short History of Bush Nursing in Tasmania', DK Noller, (HSD6/59).

relief, BNs from adjacent areas might cover vacancies by providing occasional visits to the vacated areas.²⁹

In a minority of Centres retired BNs lived in the area and provided assistance in special circumstances such as to cover periods of leave. In the main this provided no relief from the challenge of working as a sole practitioner, but on some occasions collegial support was forthcoming. In Lilydale during one epidemic Sister Rita Pitt was assisted by Mrs 'Doris' Mary Arnold (formerly Sister Stuart) because of the high workload, and similarly assisted when infected patients needed nursing but a midwifery case was pending.³⁰ While some sisters retired through marriage, often were retained in the community, and were supportive of the BN, such support was uncommon. In fact retired BNs could pose significant problems for the BN. In 1935 the BN on Bruny Island resigned because of conflict with the former BN, Sister Storey. Sister Storey had established a private hospital and nursing service on the island and competition between the BNC and the private service created tension. Later, when Sister Storey set up a hospital near Penguin, there were similar tensions. On Flinders Island Olga Henwood recalls that, even after Sister Kolosque retired and another BN had been appointed, Mrs Margaret Cecily Blundstone, (ex Sister Kolosque) provided care for Olga's sick baby.³¹ These examples suggest that the potential for professional support from ex-BNs in the community was realised rarely. The potential was not encouraged by the DPH or the TBNA. Living within many communities were former nurses who provided no real relief from the sole practitioner status.³² Sister Betty Harvey retired from School Nursing to marry and live in the Oatlands district. Although not socially or professionally involved with the BN, the local people called on her if the doctor or BN were unavailable.³³ Just as BNs were isolated from medical officers so too were they isolated from the central Bush Nursing Association. Visiting from a Supervisory Nurse was the official link between the BN and the Bush Nursing Association.³⁴ The Supervisory Nurse took on an advisory and facilitating role for the BN

²⁹ AOT, DPH, 58.2.41, Bush Nursing Avoca SN's Inspection Report of Avoca Centre, 30 July 1941, (HSD 1/80).

³⁰ Sister 'Doris' Mary Arnold, (née Stuart), graduated from the Public Hospital Hobart, Tasmanian Registration Number 226.

³¹ Sister Margaret Cecily Kolosque, (later Blundstone), trained at the Public Hospital, Launceston, and was registered in Tasmania on 1 July 1930, Registration Number 337.

³² Lilydale provides an exception as, in that community, retired BNs at times provided holiday relief and at others assistance during epidemics.

³³ She trained as a general nurse and midwife, and with mothercraft training, and had worked for some years as a School Nurse. One particular instance she recalled was when the local doctor's wife called her one day to ask her to attend a sick patient at Paratta, four miles south of Oatlands. Betty White, (née Harvey), Personal Communication, April 2003.

³⁴ Initially the SNs were termed 'Organising Nurses', reflecting perhaps a different view of their function.

and the local bodies.³⁵ They usually would introduce the BN to the community, make sure she was settled in, and then make a further visit within six to twelve months.

Photograph 5.01 Supervisory Sister Kit Widdicombe and Sister Winifred Leaver, Gladstone Bush Nursing Centre.³⁶



Source: DPH, Bush Nursing Album, NBT.

During the 1920s the Supervisory Nurse travelled by horseback across the State. Occasionally in later years her visit would coincide with a visit from the Minister of Public Health, Director General and members of the Bush Nursing Association:

Sister Beauglass and Kit Wittingcombe [Widdicombe], and Sister Noller ... Oh they'd come to see if everything was all right and if you were running the hospital right and what not, you know.³⁷

Not all visits were formal and well-orchestrated. Some were more ad hoc and appeared more social than supervisory:

Sometimes she'd come down and sometimes not. She'd only come down about twice a year. I'd give her a nice tea and we'd chat about this, that and the other.³⁸

These visits played an important supportive role. The Supervisory Nurses were held in high esteem by the BNs. Sister Clara Alice Stammer, a Supervisory Nurse, was described in

³⁵ AOT, DPH, Letter to Secretary DPH from the Storeys Creek Medical Union, 26 March 1947, (HSD 6/10).

³⁶ Sister Winifred Leaver was a migrant nurse, trained at St George's Hospital, Bombay, India. She arrived in Tasmania in 1949 and gained Tasmanian registration on 1 February 1950, Registration Number 2852.

³⁷ Evelyn Mellish, Interview, Musselroe Bay, 1994.

³⁸ Evelyn Mellish, Interview, Musselroe Bay, 1994. This task would be taken on by the Matron if the local hospital was in charge of the BNC.

terms of both endearment and efficiency. She travelled around the State checking up on all BNs especially where nurses were having trouble handling the work or if there were local disputes.³⁹ Visits were generally fairly brief, but at least annual:

the visit should not be a hurried one, but equipment, etc. should be checked against the inventory and all records thoroughly examined, and the work of the centre thoroughly investigated.⁴⁰

Where physical access into an area was more difficult it might be visited less often. Mrs Barker and Mrs Gray from the Bush Nursing Association in Hobart would travel on horseback to Adamsfield to check on the BNs. In 1930 Mrs James Smith, President of the Northern Bush Nursing Association, travelled around the BNCs. Even when 'sophisticated' travel was possible it could be slow. On her visit to Marrawah she took over four hours to travel the 30 miles from Smithton on the Marrawah Tramway.⁴¹ Over a six-year period Sister Widdicombe, the Supervisory Nurse, visited the BNC at Cape Barren Island once or twice only during the BN's stay.⁴² The role of Supervisory Nurse was an important one, and many Supervisory Nurses were BNs prior to their promotion.⁴³ Supervisory Nurses functioned more as advocates for the nurses' interests than as disciplinary agents. There was a need to ensure accountability, but equally a need to ensure that nurses were protected against exploitation. The Supervisory Nurse supported her BNs where the practices of the local doctors might adversely affect her workload. One Supervisory Nurse instructed the local doctor to change his practices, but this intervention was not welcomed by the doctor:

By what authority Sister Stammer can 'order' us not to admit so many patients and order me to cease practising so much surgery as she did the last time she was down here. Mr. Petrie was present when she had the temerity to give me these instructions which I treated as an unwarranted impertinence.⁴⁴

³⁹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

⁴⁰ AOT, DPH, 58.28.4, Memo to Sister Widdicombe re her itinerary for inspections, 7 May 1951, (HSD 5).

⁴¹ Details of the Tramway can be found in Branagan, pp. 133–135. Mrs James Smith's travels are described in 'A Lady's Letter from Launceston. Workers for Charity in the North', *Illustrated Tasmanian Mail*, p. 17, 18 March 1931.

⁴² Una Saville, (née Nicholls), Interview, Devonport, 1999.

⁴³ SNs included Sister Daisy Richmond; Sister Clara Alice Stammer MBE; Sister Leila Arnott (Mrs M Read); Sister Olive Green; Sister Joan Clarke (Mrs B Chesterman); Sister Agnes Gartside, Sister Winifred Woolnough; Sister Doris K Noller; Sister Kit J Widdicombe; Sister HM Muir, Sister Winifred Leaver; Sister Dorothy Eleanor Simpson. Sister Winifred Woolnough was trained in the Hobart Public Hospital and registered in Tasmania on 1 April 1931, Registration Number 370. Sister Olive May Green trained at the Public Hospital, Adelaide, and received her training in Child Health at the Karitane Baby Hospital in New Zealand in 1924. Her Tasmanian General Registration was on 21 January 1930, Registration Number 359, and she registered as a Child Welfare Nurse on 22 February 1949. She became a Supervisory Nurse after it was decided that there should be a separate SN for the Northern District. See Kelly, p. 145.

⁴⁴ AOT, DPH 58.17.39, BN Koonya Letter from GMO re Sister Stammer giving him orders, 22 October 1939, (HSD 1/70).

Sometimes the Supervisory Nurse's actions were not welcomed by BNs. Sister Donald protested that the investigation of a complaint against her included a visit, without notice, to her BNC by the Director of the DPH and the Supervisory Nurse while she was out of the area on leave. Sister Donald's advocate argued that:

I am sure that you will understand, that in a mining community a BN who takes upon herself the onerous and responsible duties required by the ill health of people in remote areas such as usually are assumed only by doctors and nurses, needs a just measure of protection against any possible ill founded complaint.⁴⁵

When the DPH became involved with Bush Nursing administration it followed the earlier pattern of supervision and support and appointed Supervisory Nurses with the Department.⁴⁶ Their duties were set out in detail by the Department and included inspection and supervision of centres and hospitals, checking and recording of routine reports of work performed by nurses, investigating proposals for establishment of new centres, initiating new nurses in the work, and keeping of inventories of equipment at BNHs controlled by the Department.⁴⁷ Interestingly advocacy was not listed as one of their functions:

Bush Nursing in those days was a very responsible thing. And we were not really groomed for it. We were never warned about anything, we just finished our training, and if we decided to go bush nursing, we went bush nursing.⁴⁸

Bush Nurses had received training which was more suited to normal hospital work rather than to work as a BN, although there were attempts to increase their skills. Ideally triple-certificated, with training in midwifery, general nursing and child welfare, not all were so trained. While ongoing training was part of the nursing ethos, this tradition was not strong within Bush Nursing:

No, there was nothing like that, nothing at all like that, so we were very much on your own. If there was something that you didn't know you could ask the doctor and he would help you, but you were very much on your own and your training was expected to carry you through most emergencies.⁴⁹

Ongoing training had the potential to reduce BNs' isolation by giving them contact with other BNs, but it was not organised in a way that might achieve this end. While BNs had little ongoing education, the programs they attended were not designed specifically for BNs. There was more attention to the training issue in the later part of the Bush Nursing era, and Sister 'Lexie' Burns remembers leaving Waratah to attend refresher courses in

⁴⁵ AOT, DPH, 58/1942, (HSD 1/86).

⁴⁶ AOT, DPH, 51.1.44, Departmental Staff appointments, resignations, and AOT, DPH, 8 September 1961, Letter to Sister DK Noller from DPH re retirement, (HSD 1/89). One nurse who was central to this role over a long period was Sister Noller, who after 5 years as a BN in Tasmania, became a SN for 16 years, finally retiring in 1961 with ill health.

⁴⁷ AOT, DPH, 51.1.44, Departmental—Staff—appointments, resignations, (HSD 1/89).

⁴⁸ Janice Flora Barnes, (previously Brookes and née Fenton), Interview, Devonport, 1999.

⁴⁹ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

Launceston in her latter years as a BN.⁵⁰ Other nurses saw isolation from mainstream nursing and colleagues as a potential problem as did Sister Pitt who after six years out of general hospital nursing applied for leave to spend six months back at her old training school.⁵¹ Orientation for new nurses in the 1940s included a three-day course in dietetics at the main hospitals, and some training in child welfare and in mothercraft was offered to BNs.⁵² There were incentives offered to undertake such training but later in the Bush Nursing period the majority of nurses did not have the ideal broad-based training. This situation was at least in part a consequence of the reduction in the period of nursing training made in response to shortages of nurses in the 1940s.⁵³ In 1953 it was proposed that BNs be graded into four levels, according to the number and type of the qualifications they held, and that this grading be reflected in remuneration. It was hoped that by encouraging broader-based training BNs would be fitted better to the breadth and complexity of their roles.⁵⁴

The relationship between BN and the medical profession was an important one for the nurse. Nurses were in a subservient relationship to the medical profession. This was ingrained deeply from the start of nursing training where 'at the approach of our betters we kept our hands behind our backs, with eyes meekly lowered, speaking only if spoken to'.⁵⁵ Once trained this deference continued and there was little room for independence of action in their work with patients. The Bush Nursing regulations formalised a continuation of the subservient position of the nurse even as she moved from the hospital into the community. While the BNs interviewed generally spoke of the medical profession in a way which was deferential, there was evidence of subservience only when the doctor visited the area. At all other times the nurse acted with a high level of independence, although occasionally seeking advice from the doctor or referring a patient to a doctor or hospital. At a 1936 meeting of the Northern Tasmanian Branch of the BMA concern was expressed by some doctors that the BNs were not under the control of doctors.⁵⁶ In 1938 *The Examiner* reported 'opposition to nurses'. The Medical Officer of Health at Bothwell stated that the

⁵⁰ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

⁵¹ AOT, DPH, 58.8.39, BN Lilydale, Letter from SN re Sister Pitt taking leave for further training, 10 July 1939, (HSD 1/70).

⁵² *TJ&PP*, 1940 and AOT, DPH, 58.26.40, BN, Summary of Receipts and Expenditure—Centres controlled by Dept, Annual Reports, Returns & Requests to centres including forms issued for compilation, annual meeting—BNA State Conference—Annual Report, (HSD 1/79).

⁵³ AOT, DPH, 51.28.42, Departmental, Review of Activities of Dept—Statement submitted to Premier for ALP Conference, resolutions re: Provision of hostels for women travelling to maternity hospitals and care of young children; Extension of GMS; Maternity treatment in Public Hospitals, (HSD 1/86).

⁵⁴ AOT, DPH, Summing up of Inspecting Sister, re qualifications, and Circular letter to Sisters of BN & School Medical Service, 15 September 1953, (HSD 5).

⁵⁵ C Hamilton, 'Nursing Now and Then: One Woman's Memoir' in *Lilith: A Feminist History Journal*, vol. 6, 1989, pp. 83–93.

⁵⁶ AOT, NS 168/5, Unofficial minutes from Northern Division BMA.

establishment of a BN 'invariably led to friction'. Mrs EA Waterworth, of the Bush Nursing Association Committee, said that she was aware of at least two other municipalities where doctors were opposed to BNs.⁵⁷

While the nurse did contact the nearest doctor on occasion for advice or authorisation, the reality of this contact did little to diminish her independence. The doctor of necessity demonstrated a high level of trust in her judgement. He was able to base his advice solely on the clinical information that the nurse conveyed to him. There was no opportunity for him to check the patient's history, findings, or to assess adequately other environmental details. Only by insisting that all such patients be referred to him could he escape the fact that the nurse controlled information about all aspects of the environment on which he was asked to advise. Doctors valued and trusted most nurses' skills. This relationship of trust, while the norm, was certainly not universal. Where doctors and nurses worked more closely together there was an increased potential for relationship difficulty or breakdown of trust. In 1952 the relationship between the two BNs and the local GMO at St Helens deteriorated so badly that the BNs were transferred to another BNC.⁵⁸

Nurses saw the doctor-nurse relationship usually as one of mutual respect and support. When Sister Hazelwood was based in Adamsfield, the closest doctor was in New Norfolk. While Dr Piscitelli never visited Adamsfield he was seen by her as being very supportive and 'was the only help we had. You could depend on him—always just ring him up and any help or anything he could do'.⁵⁹ He would send her, without delay, any supplies she required and would meet the train when she sent patients out of the area. In contrast, the nurse at Cape Barren Island had the advantage of direct access to the doctor from neighbouring Flinders Island, but this was not a regular service and on occasion he would visit only once every three months. The doctor's physical presence allowed greater interchange and support but the infrequent visits provided no relief from the sole responsibility in urgent cases. Even the regular radio contact was at scheduled times only and not always reliable. Again this provided no help when most needed.

Even for BNCs that were in areas where roads were reasonable doctors' visits were irregular. At Ringarooma the nearest doctor was at Scottsdale and visited the BNC only once a week.⁶⁰ His advertised 'circuit' in 1944 reflects the problems of delivering medical services, and nursing services, to areas in which few people had ready access to transport

⁵⁷ *The Examiner*, 'Opposition to Nurses', 13 July 1938, p. 8.

⁵⁸ AOT, DPH, 58.19.3, Director General Medical Services from SN, 10 April 1952, (HSD 5).

⁵⁹ Thurza Hazelwood, (née Cox), Interview, Prospect, 1998.

⁶⁰ Dawn Coffey, Beauty Point, Interview, 1994.

(Table 5.01). The circuits of the doctor and the BN covered 'overlapping' areas but did not see them work in the same place at the same time.

Table 5.01 **Scottsdale Medical Officer Circuit, 1944.**

MEDICAL OFFICER'S CIRCUIT
MONDAY —Gladstone Circuit, 46 miles round trip, embracing: Derby leaving 2 pm Herrick 2.15 pm Herrick Hotel. Pioneer 2.30 to 3 pm, Pioneer Hotel: South Mount Cameron (only if required by message to be left at Pioneer Surgery prior to 3 pm), Mrs A.T. Harper. Gladstone (only if required by message to be left at Pioneer Surgery prior to 3 pm), Gladstone Hotel.
TUESDAY —Winnaleah Circuit, 20 miles round trip, embracing: Derby leaving 2 pm Winnaleah 2.30 to 3 pm, Winnaleah Hotel. Moorina (if required to ring Derby Surgery prior to 2 pm) Mrs. D. Britton.
WEDNESDAY —Derby.
THURSDAY —Ringarooma Circuit, 26 miles round trip embracing: Derby leaving 1.30 pm Branxholm (and call on return) 1.45 to 2 pm, Imperial Hotel. Legerwood (and call on return 2.15 to 2.30, Legerwood Hotel. Ringarooma 2.45 to 4 pm Ringarooma Hotel.
FRIDAY —Derby
SATURDAY —Derby
SUNDAY —Derby
In the event of a delay exceeding half an hour at any surgery, the next place of call will be notified.

Source: AOT, DPH, 13.1944, Ringarooma, State Medical Services timetable Ringarooma Circuit, *North East Advertiser*, (HSD 3).

Table 5.02 **Gladstone Bush Nurse's Circuit, 1949.**

BUSH NURSE'S CIRCUIT
GLADSTONE —Surgery, 9 am till 11 am on Monday, Wednesday, Thursday and Saturday; Baby Clinic every Wednesday from 2 to 4pm.
SOUTH MOUNT CAMERON —Fortnightly, Tuesdays, 11 am to 12.30 pm
PIONEER —Fortnightly, Tuesdays, 2 pm to 4 pm
HERRICK —Fortnightly, Fridays, 10.30 am to 12.30 pm
MOORINA —Fortnightly, Fridays, 2 pm to 3.30 pm
Special visits to be arranged to families at Boobyalla, G. Groves Estate, Groves Bros., Eddystone Lighthouse, Government Water Race families, and other isolated families.

Source: Bush Nursing Association, Gladstone Centre, AOT, DPH, 58/7/49, (HSD 6/34).

In other areas, such as Lilydale during the 1940s, initially there were regular doctors' visits in the district as well as responding to call-outs, and occasionally conducting weekly surgery but, as presumably their practices grew, they ceased regular visits and came only if sent for—and even then only for emergencies.⁶¹ The closest medical support for Waratah was 80 miles distant from GMOs who visited from Wynyard, Burnie or Penguin. While there were regular visits from the doctors, either fortnightly or monthly, occasionally there were lapses for longer periods when the nurse was the sole practitioner for the community

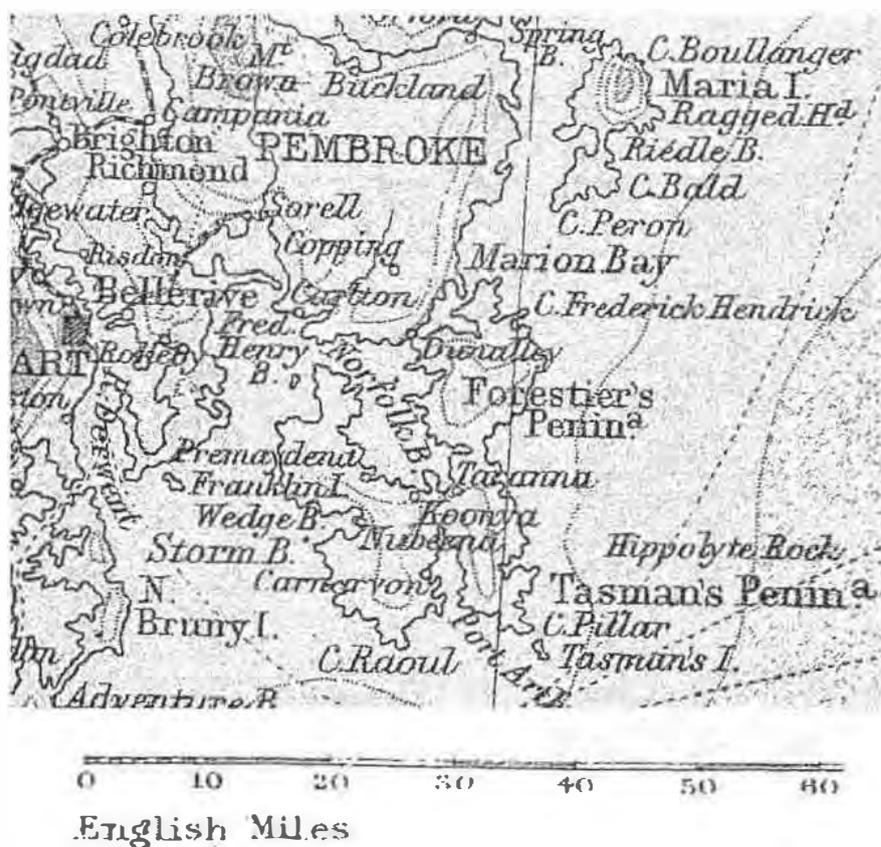
⁶¹ Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

for up to six weeks. Problems with transport and access contributed to gaps in medical services such as experienced on Bruny Island:

Dr Ingram will visit Barnes Bay ... from Alonnah on the first Monday in each month (tide and weather permitting) as long as the road is fit for transport.⁶²

Illness in the GMO and problems with the retention of GMOs also affected medical services on Bruny Island. At Triabunna the GMO would visit from Swansea twice weekly, in addition to visiting when called for emergencies. He also covered a large area, 'as far as Coles Bay', and the work environment was such that maintaining regular visits by private doctors was difficult.⁶³ The unwelcome travel caused retention problems which affected the GMO scheme and, combined with the retention problems in the Bush Nursing scheme, this affected delivery of care and of mutual support.⁶⁴

Map 5.01 Koonya



Koonya Bush Nursing Centre is located near the centre of the Tasman Peninsula in the South Eastern aspect of this map. Sorell lies north west of the peninsula.

Source: John G Bartholomew, 'Victoria and Tasmania' in *Times Survey Atlas of the World*, Edinburgh Geographic Institute, London, The Times, 1922, (From the David Rumsey Institute).

⁶² AOT, DPH, 3.1.39, Kingborough-Bruny District. Request for regular visits by GMO to North Bruny, (HSD 3/3).

⁶³ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

⁶⁴ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

In 1952 the loss of the GMO at Tasman led to the instruction from the DPH that the Koonya BN should deal with emergencies, and the 'Medical Officer at Sorell will provide special services in extreme emergencies'.⁶⁵ This memo appears to require the nurse to exercise a high level of professional independence. It was not only the lack of a doctor which might require the nurse to act independently. Even in areas where a doctor based his practice, access was not necessarily easy. At Oatlands there was a doctor who 'practised there but ... lived out of the area'. He would not see patients who would not pay his bills and the nurse, by default, was required to become the doctor for those people.

The nurse and doctor worked collegially to provide health services, rather than competing or working in a strict hierarchy. The DPH characterised the working relationships in the Montagu Medical Union BNCs at Waratah and Tullah as places where the nurses 'work in conjunction with the doctor, who is resident at Rosebery. He visits Tullah at weekly intervals, and more often if required'.⁶⁶ The nurse not only relied on the doctor for collegial support and advice, but without the nurse's activities the doctor would not have been able to deliver adequate care to the population in the BNC area. Not only was he based out of area and thus could visit at best on a regular rotation, but the workload expected of him when he visited the BNC could be managed only with excellent support from the BN:

Further I am accustomed to impress on them lately that before seeking my help they should ... first see the BN who is paid a salary to attend to them ... [H]er report is likely to be of help to me especially in any new case. I do not grudge my attendance on them ... but some resented my dictum that it was essential that they should if possible see the Nurse especially in chronic cases before appealing to me.⁶⁷

When the doctor was in attendance, the nurse's role was not seen as 'handmaiden' to the doctor. She had a wider role, and must firstly ensure that she met the full range of her professional obligations:

...the BN is not just the Doctor's assistant, & that she has the duty of attending midwifery cases when required, of giving ante-natal advice, & attending to Child Welfare work, & of visiting schools at least once a month. If it can be satisfactorily arranged that this side of Bush Nursing is not neglected it is quite in order to attend the surgery & if visiting with Doctor to stay behind & carry out the nursing treatment ordered by Doctor.⁶⁸

In 1938 at Southport, Sister GA Teasdale was informed by the DPH that:

⁶⁵ AOT, DPH, GMS 4.3.52, Letter from DPH to Council Clerk, Tasman, 23 December 1952, (HSD 3).

⁶⁶ AOT, DPH, 58.17.38, BNC Tullah, Letter to Sister Evans re her interest in relieving at Tullah 23 November 1938, (HSD 1/53).

⁶⁷ AOT, DPH, 5.10.40, Flinders Island District Letter from Dr Ick re visit on Cape Barren Island, 3 June 1940, (HSD 3/4).

⁶⁸ AOT, DPH, 58.23.41, BNC Waratah, Letter from SN re inspection, (HSD 1/80).

on no account must she leave the centre unattended without, in the first instance, obtaining the sanction of the GMO (Dr. Tremayne). Compliance with this direction is essential.⁶⁹

While this is consistent with the Bush Nursing regulations, the directive was unusual, and might have reflected local conditions only in an area where there were some difficulties between the local GMO and the BN. Such a directive, if applied generally, would have made it impossible for BNs to have carried out their role. No such attack upon the autonomous decision-making power of the BN applied at any other centre, nor was this an ongoing directive at that Centre.

Bush Nurses had autonomy in deciding priorities, but their clinical autonomy was limited. They could, and did, initiate treatment on their own account, but were not at liberty to over-ride the treatment of a doctor. The actions of the doctor could create difficulties for the BN and the BNC, particularly if he ordered treatments that created unnecessary nursing workload or adverse cost implications for the centre. In Gladstone the doctor had ordered regular treatment by injection for two patients, rather than opting for oral therapy. This was of concern to the Bush Nursing Committee as it created 'unnecessary' work for the BN and required the BNC to cover the cost of treatment that otherwise would have been a charge against the Pharmaceutical Benefits system. The Department advised that no one had the authority to change the treatment advised or commenced by the doctor. Once the doctor had commenced treatment the BN did not have the clinical autonomy to alter management.⁷⁰

While in some situations the doctor might have authority to dictate nursing practice, in respect of the operation of the BNC or BNH it was the BN who had the ultimate authority to determine if a patient could be admitted to the centre.⁷¹ In-patient beds were primarily for midwifery, and concerns about infection limited their other use. The rule that BNHs be used for maternity and accident cases only was made with the specific purpose of protecting the BN and her patients. It was found that, in a number of hospitals, cases were admitted by the local doctor which were of a chronic and sometimes infectious nature:

Without any definite ruling ... Sister could not successfully protect against the admission of such cases ... unless consent and agreement [of the BN] is obtained, no-one has the power of admitting general cases to a Bush Nursing Hospital.⁷²

⁶⁹ AOT, DPH, 58.14.38, BNC Southport, Memo to Sister GA Teasdale not to leave centre without GMO's sanction 23 November 1938, (HSD 1/53).

⁷⁰ AOT, DPH, 29 November 1950, Letter from Secretary BNA Gladstone re Dr/BN, (HSD 5).

⁷¹ AOT, DPH, 58.1.3, Letter to Council Clerk Alonah from Director General Medical Services re Alonah Hospital admittance, 16 October 1953 and AOT, DPH, 58.2.3, Memo to BNH from Director General Medical Services re Bush Nursing Services, 22 July 1954, (HSD 5).

⁷² AOT, DPH, 58.1.3, (HSD 5) and AOT, DPH, 58.2.3, Memo to BNH from Director General Medical Services re BN Services, 22 July 1954, (HSD 5).

Through this rule the DPH ensured that the BN could protect midwifery care against inappropriate demands from the doctor and cemented the authority of the BN.⁷³ Towards the end of the Bush Nursing era, BNs lost this power as the medical profession exerted more control over the actions of BNs.

In some areas the DPH's sensitivity over nursing competition with medically-run private hospitals also limited the use of BNH.⁷⁴ In 1937 at Cygnet a private doctor, Dr George Wade, had established a private maternity hospital. He expressed concern that the Cygnet BN was antipathic towards him and was in fact a hindrance to him. He believed that the BN and Bush Nursing Committee encouraged home births rather than deliveries at his hospital, a position he argued was to the disadvantage of the patients. His preferred position was that the BN ceased maternity and child welfare work so that he could have the monopoly on the service. In this case this was not acceptable to the DPH.⁷⁵

Doctors in the community were either in private practice or salaried under the GMO Scheme. Where several private doctors worked within a community the nurse needed to be careful that she was not seen to be favouring one doctor over another. The Regulations recognised this problem and set out that the nurse should not attempt to influence the patient's choice of doctor, that the nurse must check with the patient who the doctor 'in charge' was to be, and that she must remain 'in charge' of the case irrespective of any change of doctor. These rules did not prevent nurses referring patients to any doctor or hospital in emergency as they saw fit.⁷⁶ Generally this action was welcomed or accepted although it occasionally had later repercussions:

The patient aged 60 had had an accident a log at mill hitting him in stomach ... Three days later they sent for me again ... This time I found him really ill, all the symptoms of peritonitis, so there was no alternative but to bundle him up & take him to Scottsdale. I knew there would be a terrific row with Dr Keeldeka, the third of this kind ... Dr K raised Hell on telephone, all post office listening.⁷⁷

Personalities often complicate interpersonal relationships. In Scottsdale in 1949 there were two local doctors, a Dr George Arthur Jones and Dr Wilton Whitburne Rail. The BN at Ringarooma observed that:

I find Dr Jones a most difficult man to work with and on the other hand, find Dr Rail, Scottsdale, exceptionally good and helpful. Dr. Jones is admired by about 1/4 of the

⁷³ AOT, DPH, 58.1.3, (HSD 5).

⁷⁴ AOT, DPH, 58.9.37, Letter to Director Public Health from Chief Health Inspector, 21 July 1937, (HSD 1/36).

⁷⁵ AOT, DPH, 58.5.37, BNC Cygnet, 1937, (HSD 1/36)

⁷⁶ Bush Nursing Regulations, Rules 10-12, (HSD 5).

⁷⁷ AOT, DPH, Letter to Sister Nollerre Ringarooma. Dr Keeldeka was at Derby, 11 July 1952, (HSD 5). The name of this Doctor might have been misspelt and could have been Dr Kindelka.

population here and hated intensely by 3/4 of same, I find it very hard suggesting to a patient, will you come and see Dr. Jones? Not on your life!⁷⁸

Her complaint was not without precedence. Others had complained verbally and five nurses had resigned because of this difficult work environment.

The Government Medical Scheme, like the Bush Nursing Scheme, was particularly focussed on rural-health care delivery. It might be expected that GMOs worked in close proximity or in a close relationship with BNs. This was not generally true.⁷⁹ While the GMOs' areas of operation might overlap those of one or more BNCs, generally their contact with BNs was limited:

A GMO visits the district twice weekly, and your nursing work would be performed in close conjunction with this officer. He would also be on call, should an emergency situation arise at any time.⁸⁰

Whether they made regular or irregular visits, the BN still functioned for the most part in isolation. Where doctors visited, the visits were brief and were described as 'never longer than is necessary to fulfil the object of my visit.'⁸¹ Despite this, by 1953 the official position was that:

The GMO becomes, in effect, the Medical Superintendent. He ... should make himself familiar with the instructions at the hospital as soon as possible, and his co-operation is essential to the smooth running of the scheme.⁸²

This ruling was in fact impractical and more often than not the GMO had little day-to-day input.

The formal control of the GMO over BNCs appears seldom to have been exercised, although one GMO was concerned that Sister Margaret Mary Rohr from Flinders Island BNC visited Cape Barren Island and stayed with Sister Gittus without his knowledge.⁸³ The reason why this 'independence of action' should have so distressed Dr Rumbold appears to be related to the 'frosty' relationships between Dr Rumbold's wife (a nurse) and the BNs and BNH. The BNs believed that she interfered in nursing matters at the BNH. Mrs Rumbold desired to take charge of the Flinders Island Hospital. The deterioration of the

⁷⁸ AOT, DPH, Letter to Sister Noller from Nora Fry & postscript from Sister Noller, 11 October 1949, (HSD 5).

⁷⁹ The placement of BNCs and GMOs were both subject to a variety of competing demands and political pressures. At least in one case it appears that there was a greater political value from placing at least some service in a large number of areas than placing BNs and GMOs in the same location. Dr L Bryant, Interview, Bellerive, 1994.

⁸⁰ AOT, DPH, 58.15.39, BN Spring Bay, Letter to NSW Sister wanting details of BN work offer of Triabunna, 30 November 1939, (HSD 1/70).

⁸¹ AOT, DPH, Flinders Island Letter from GMO re complaint about him by school teacher, Cape Barren Island, 5 April 1944, (HSD 1/89).

⁸² AOT, DPH, Circulars Info Relating to & Standing Orders of GMS—re BNCs, 1953, (HSD 3/22).

⁸³ AOT, DPH, Letter to Dr BM Carruthers from Dr Rumbold GMO Flinders Island, 19 September 1947, (HSD 6/10).

relationships between the BNs and the Rumbolds escalated until it eventually led to Dr Rumbold's highly-publicised resignation.⁶⁴ At Rosebery, Dr David Klineberg complained that Sister Isobel Buckley Rushton exhibited:

gross insolence and complete disregard of Medical etiquette and professional conduct ... on numerous occasions [she] has exhibited a total disregard for my instructions. She has frequently left the room without cause when required during examination of Patients and resented all efforts at correction. She always insists that she will not do anything when told to do it.⁶⁵

At Cygnet, Sisters Edith May Luck and Dorothea Henningsen believed that Dr John Aloysius McCluskie mistrusted them.⁶⁶ These examples all point more towards breakdowns in interpersonal relationships rather than conflict based on disagreements about clinical management or control. In other centres the working relationship appears substantially better. At Lilydale the GMO Dr Herbert Spencer Roberts, co-operated with Sister Walsh in caring for the health of residents. Successful arrangements were made for Dr Roberts to see patients in the surgery at the BN's residence.⁶⁷ Facilities were not shared necessarily as was the case on the Furneaux Islands:

I should like to make a few remarks about the position at Cape Barren Island My consulting room is at the Public Hall & the dispensary is a tiny shut off part of the verandah at the school master's house. The centre where the BN will reside is in a third place.⁶⁸

The relationships described were more collegial or parallel than hierarchical. Although under the formal control of GMOs where they existed, there was no significant control of the BN's professional work. Late in the Bush Nursing era there were attempts to formalise aspects of this relationship, particularly in respect to the prescribing of pharmaceuticals, but whether this was to protect the BN or consolidate power is uncertain:

⁶⁴ AOT, DPH, 5.15.47, Flinders Island District re Conflict at Hospital Dr Rumbold/Wife and Sisters, (HSD 3/15).

⁶⁵ AOT, DPH, 58.13.40, BN Rosebery Letter Dr Klineberg complaining of Sister Rushton's conduct, 4 May 1940, (HSD 1/79). Sister Isobel B Rushton was born in Tasmania and trained at the Public Hospital Launceston. She completed her midwifery training at the Queen Alexandra Hospital in Hobart and had 6 months training in Infectious Diseases at Vacluse, Hobart. She was registered in Tasmania on 28 May 1928, Registration Number 74. Her first Bush Nursing post was at Rosebery.

⁶⁶ AOT, DPH, Report to Director General Health Services from Sister Widdicombe re Dr/Nurse conflict Cygnet, 7 January 1953, (HSD 5). Sister Dorothea Henningsen trained at the Royal Adelaide Hospital and was registered in Tasmania on 30 June 1952, Registration Number 3644. Sister Edith May Luck was a migrant nurse and worked as a relieving BN. She gained Tasmanian registration on 8 December 1949.

⁶⁷ QVMAG, Box 10, Lilydale Bush Nursing Report—re Car and Opening of Centre & help from Dr Roberts, 6 November 1947.

⁶⁸ AOT, DPH, Flinders Island Letter from Dr Ick re views on dispensing drugs/treatment at Cape Barren, 5 April 1939, (HSD 1/70). This arrangement as previously noted in Chapter Three was complicated further by the BN sharing her accommodation and work space with the local missionary Miss Ada Hudson, (HSD 3/3).

Instructions in writing should be given to Sister, regarding the administration of drugs and treatment which she is required to carry out during the medical officer's absence, and in cases of emergency.⁸⁹

We shall see that, in the late 1940s when similar instructions had been issued, such control was not instituted necessarily, but the above 1952 instruction clearly was constraining the BNs' freedom of action. Generally there was surprisingly little tension in the relationships between BNs and doctors—perhaps because their contacts were limited. Bush Nurses saw doctors as very helpful and supportive. At Gladstone the doctor from Scottsdale visited twice each week:

The doctors were a terrific help to me. If there was anybody very very sick, they'd tell me what to expect and what to do about it. Oh, no, the doctors were the biggest help of the lot.⁹⁰

At King Island the BNs saw the doctor as 'very good, kind and tolerant to all'.⁹¹

The Bush Nurse's Tools of Trade

Before examining the independent management of clinical conditions, the range of equipment and medications which nurses could access in their work will be explored. The 'tools of trade' of BNs give a clue to the range of functions which it was accepted fell within their ambit. They were provided with equipment and medications which would allow them to function well beyond the confines of usual nursing practice. In travelling to Babel Island the nurse was expected to take her 'entire hospital' with her including all furnishings, equipment and drugs.⁹² There are curious omissions from this list with the DPH advising the BN that 'All nursing equipment is supplied ... [but] Nurses generally prefer to take their own hypodermic syringes'⁹³ while the BN, after perusing the list prepared by the DPH, noted that:

Acting under Miss Stammer's instructions I called at the Public Health Office, Launceston, to examine the kit to be used by the bush nurse at Babel Island. The following are, in my opinion, necessary but are not included—Gauze, Lint, Cotton Wool, Iodine, Eusol.⁹⁴

⁸⁹ AOT, DPH, Circular re Bush Nursing Rules and circulation list, 1 December 1952, (HSD 3/22).

⁹⁰ Evelyn Mellish, Interview, Musselroe Bay, 1994.

⁹¹ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

⁹² AOT, DPH, Letter to DPH from Inspector Parker re further equipment needed for nurse at Babel Island, 20 April 1936, (HSD 1/24). AOT, DPH, Letter to DPH from Inspector Clark re equipment being returned from Babel Island, 15 May 1934, (HSD 1/5). AOT, DPH, 1937 List of Nurse's Equipment for Quarters at Babel Is; AOT, DPH, Letter to DPH from Inspector Parker re equipment needed for nurse's quarters Babel Island, 3 March 1937, (HSD 1/36).

⁹³ AOT, DPH, Letter to Sister Foster from SN re kit for Babel Island & supplies, 20 February 1936, (HSD 1/24).

⁹⁴ AOT, DPH, Letter to DPH from Sister Foster re further items needed for kit for Babel Island nurse, 4 March 1936, (HSD 1/24).

The list of equipment was similar at Chappell Island, again a seasonal BNC and one where a doctor was most unlikely to visit.⁹⁵ The list is designed for the needs of a small BNC, one which was not to have in-patient beds. It is clear that wound care including suturing, not unsurprisingly, was a major category of expected work on the Island. The BN would have required some simple equipment for the compounding of medicines. That skills in compounding were required was noted by Dr TJ Ick, the GMO on Flinders Island. He had complained that, before Cape Barren Island had the services of a BN,

owing to the natural ignorance concerning matters medical of the school master I have had more than one unnecessary journey & have had unnecessary trouble in keeping the drug supply sufficient for current needs.⁹⁶

He foresaw with the arrival of the BN that 'A nurse of course will be able to dispense & in an emergency to compound simpler medicines ... her presence should save me many unnecessary journeys'.⁹⁷ The equipment and facilities available to the BN with which to carry out her work generally improved over the era, but varied somewhat between centres. There is no evidence that the Bush Nursing Service developed an agreed list of equipment. Some nurses found that requests for diagnostic equipment were questioned and not supported. Sister Donald at Storys Creek requested the provision of an ophthalmoscope,⁹⁸ an auriscope,⁹⁹ and a sphygmomanometer.¹⁰⁰ Doctor John Lewers Grove was asked by Dr Carruthers, Director of Hospital and Medical Services, to visit Storys Creek to assess whether or not the equipment ordered really was needed.¹⁰¹ His report stated that the BN would have neither the need of, nor competence in using, an ophthalmoscope. Despite the auriscope being a 'simple instrument' he believed that few nurses could gain skills in its use, and therefore would be 'led into a sense of false security'. He further stated that it was dangerous for the nurse to take responsibility for a case of earache. Finally he saw that the

⁹⁵ AOT, DPH, 58.7A.39, BN Chappell Island Mutton Bird, List Nursing Equipment — General Equipment—1 enamel bowl 12"; 2 lbs. Cotton wool; 2 enamel bowls 6"; 1 lb. lint; 2 enamel bowls 3"; 3 yds unsterile gauze; 2 kidney dishes 12" & 8"; 1 pkt. Sterile gauze; 1 scalpel; 1 doz. bandages 3"; 1 pr. scissors (surgical); 1 doz. bandages 2"; 2 prs. artery forceps; 1 snakebite outfit; 2 prs. dressing forceps; 1 tin elastoplast—2 1/2' x 1 yd; 1 needle holder; 2 clinical thermometers; 1 probe; 1 enamel measure 20 ozs.; 1 tongue spatula; 1 medicine measure 2 ozs; 1 enamel funnel; 2 nail brushes; 2 cutting needles (full curved); 2 record syringes (1–5c.c. & 1–1c.c.); 2 cutting needles (half curved); Small quantity sutures, (HSD 1/70).

⁹⁶ AOT, DPH, 5.4.39, Flinders Island Letter from Dr Ick re views on dispensing drugs/treatment at Cape Barren Island, (HSD 3/3).

⁹⁷ AOT, DPH, 5.4.39, (HSD 3/3).

⁹⁸ For looking, under magnification, at and inside the eye.

⁹⁹ For looking, under magnification, in the ear canal, particularly to examine the ear drum.

¹⁰⁰ For checking blood pressure.

¹⁰¹ Dr John Grove Senior made regular visits to Storys Creek to check the miners for mining-related lung disease (pneumoconiosis, asbestosis, tuberculosis) and carried chest X-rays assisted by his 10 year old son who developed the film. Dr John Grove Junior, Personal Communication, 2003.

sphygmomanometer was equipment that probably would 'be the medium of at least psychological damage to the patient'.¹⁰²

This report is damning in its assertion that patient outcomes would suffer if the BN had access to diagnostic equipment. While nurses had not been trained in the use of this type of equipment, the experience of other BNs was that local practitioners encouraged its use. The backing of local doctors meant that some nurses had a wider range of diagnostic equipment and were encouraged to use it. It seems that, in contrast to Dr Grove's opinion, many doctors saw that in supporting the nurses' diagnostic skills they were making things easier for themselves as well as for the nurses. It might be that Dr Grove's report was more a reflection of his concern about the abilities of a particular nurse. Nevertheless, also in 1947, another BN who already possessed an auriscope had a request for replacement batteries for this denied. In arguing for reconsideration of her request she stated that she used it many times a week, and that there 'is no satisfactory substitute'. It is unknown whether her request was met, or whether she decided to supply batteries at her own cost. At Grassy on King Island, a request by the BN for a stethoscope and sphygmomanometer was turned down on the basis that 'this equipment should be carried by the doctor'.¹⁰³

Equipment provision improved over the BN era. Gradually equipment such as oxygen and nitrous oxide-giving sets became available at some BNCs, and in the late 1940s X-ray machines were provided to BNCs as required.¹⁰⁴ Some of the BNs found that X-ray machines were an imposition on them as it was left to the BN to develop the films and to clean up the mess left behind after the doctor had left:

Dr Godfrey Smith is coming to X-ray on Wednesday again, its about the only thing I look forward to with dread. He usually brings 2 other women with him to help—you should see the mess that is left behind to clean up. Takes 2 days for the floor to dry out sometimes. Good job it isn't every week!¹⁰⁵

Other nurses found X-ray to be a useful diagnostic tool.¹⁰⁶

The BN not only needed a properly-equipped BNC, but in order to facilitate her role in the community she required a Bush Nursing kit with a substantial range of drugs, reference material and equipment. No written recommendations exist for such a kit, and no complete kit has been located. The AMA Museum in Hobart contains a Bush Nursing kit

¹⁰² AOT, DPH, Letter to the Director of Hospital & Medical Services from Dr J L Grove, 10 March 1947, (HSD 6/1).

¹⁰³ AOT, DPH, 58.8.48, Letter from Secretary DPH to BN Grassy, 09 November 1948, (HSD 5).

¹⁰⁴ *TJP&P*, 1947.

¹⁰⁵ AOT, DPH, Letter to Sister Noller from Sister Llewellyn, Grassy Centre, 28 October 1952, (HSD 5).

¹⁰⁶ The X-ray machines provided were useful for simple plain film examinations such as X-rays for diagnosis of fractures, and of chest problems such as pneumonia.

from the early 1930s. This appears to be incomplete but provides a flavour of the BN's kit. The kit belonged to Sister Mildred Emma Eiszele who was in the New Norfolk area in the 1930s, the contents of which are listed in *Appendix G*.¹⁰⁷ This kit, when full, would have been quite heavy, and looks slightly larger than the kit carried by BNs walking to patients as shown in Photograph 3.5.

In the early part of the Bush Nursing era, the number of potent and effective pharmaceuticals was limited. The BN's kit was perhaps not very different from that which a doctor might carry. Attitudes of the DPH to, and restrictions on, access to and prescribing of pharmaceuticals tended to change over the history of Bush Nursing, at least in part as a consequence of new drugs, in particular the potent antibacterial medications. Official restrictions (as set out within guidelines or correspondence) on nursing practice also varied in responses to changes in the availability of doctors.

There seems to be no uniformity or clear guidelines as to what medications should be held by the BN, and under what circumstances BNs could prescribe medications without reference to a doctor. For much of the BN era this remained unclear, and was perhaps a source of confusion. In 1937 a letter to the Tasmanian Bush Nursing Association with regard to prescribing shows that, although there was concern about narcotics, other medications were not a perceived problem.¹⁰⁸ In 1940 the DPH still had not formed a clear view about the appropriate access of BNs to medications, and gives an impression of confusion. Sister C M Cooke arrived to take up a position at a BNC, and noted that the drug cupboard contained extensive stocks of narcotic drugs. She was concerned and wrote to her Supervisory Nurse asking for clarification about what she could prescribe. Supervisory Nurse Stammer then passed the request for information to the Director of Public Health for response, and he in turn asked that Sister Cooke consult the nearest doctor for his advice—and that she should act in accordance with this advice.¹⁰⁹ The DPH was unable or unwilling to provide guidance for the BN.

The BNC needed to carry a stock of medications because delivery of ordered medication could take several weeks. In this situation it was unwise for the BN to order only as required for particular patients. Many supplies such as Tiger Snake Antivenin, pain relief, and medications for acute and potentially serious illness could be required at short notice. This appears to be recognised by the DPH in 1939 when it sent three packets of

¹⁰⁷ Sister Mildred Emma Eiszele graduated from the Public Hospital Hobart and was registered in Tasmania on 27 May 1929, Registration Number 212.

¹⁰⁸ AOT, DPH, 58.35.37, Letter to Dr BM Carruthers, Director DPH to TBNA, 9 October 1937, (HSD 1/36).

¹⁰⁹ AOT, DPH, 58.2.40, BN Avoca—correspondence, 1940, (HSD 1/79).

Tiger-snake Antivenin both to Sister Rossiter, for use on Babel Island, and Sister Evans, for use on Chappell Island.¹¹⁰ Despite the logic behind having adequate medication stocks in BNCs, the DPH stated in 1941 that at Flinders Island:

as you have a Govt. Medical Officer, who is authorised to order all drugs required, there is no need for the Bush Nursing Hospital to carry a stock of medicines. Any drug needed for a patient is naturally prescribed and dispensed by the doctor.¹¹¹

This advice conflicts with the evidence demonstrating that not only did BNCs carry a range of medications for use by BNs, but also BNs carried a well-stocked bag of medications with them. It would have been impractical or impossible for BNs to have carried out their work, especially in the days before rapid and accessible transport, without carrying with them their tools of trade and oft-used remedies. The advice from the DPH not only conflicted with reality, but earned the Director of the DPH the ire of Sister LE Green who wrote that:

I am informed that I 'do not need to hold drugs, etc' as 'Dr is the Chemist'. As I believe I can claim to be the Senior Bush Nurse of Australia, being in my 16th year of these duties, there is very little I do not know about it! But I am not accustomed to working with a Doctor!¹¹²

The range of drugs in the BN kit includes much of what a doctor in the 1930s might have been able to prescribe if confronted with the same clinical problems as the BN.¹¹³

A large collection of medication is evident in Sister Eiszele's Bush Nursing kit, and later in this chapter when prescribing behaviour is examined it will be seen that a wider range of medications appeared to be available to the BN on Babel Island. From Babel Island in 1934 unused medication is recorded and a number of additional items can be added to the list of potentially-available medications for the BN.¹¹⁴ Many 'home remedies', such as a range of poultices, were carried by BNCs to be dispensed and used by the nurses.

¹¹⁰ AOT, DPH, 58.7A.39, BN Chappel Island Mutton Bird—re Dr Ick to visit bird Island & sending of antivenin, 16 March 1939, (HSD 1/70).

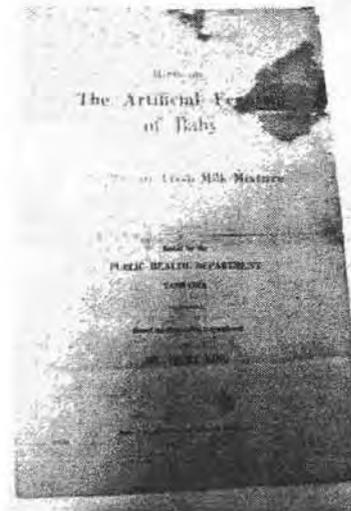
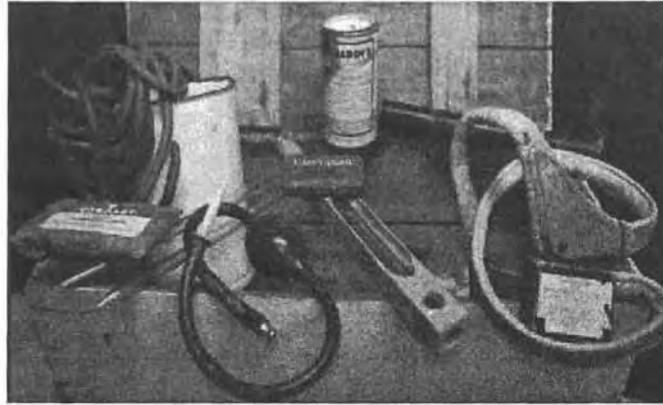
¹¹¹ AOT, DPH, 58.6.41A, BN Flinders Island Equipment, Stores SN to Nurse Green re ordering drugs, 9 October 1941, (HSD 1/79).

¹¹² AOT, DPH, 58.6.41A, BN Flinders Island Equipment, Stores—Nurse Green complaint about Doctor and Drugs, 1 November 1941, (HSD 1/79).

¹¹³ At Chappel Island in 1939 the list of available medications were 1 tube strychnine 1/30 grain; 3 tubes antivenene serum; 4 ozs. sal volatile; 25 tabs. Dovers powders—gr. 5; 1 lb. tinct iodine; 3 lbs. Plastine; 1 lb. picric acid solution; 21 ozs. pot. Permang; 2 qts. Dettol; 4 ozs. zinc ointment; 11 tabs. A.P.C.; 4 lb. boracic ointment; 100 Quinn. sulph.; 8 ozs. glycerine; 50 tabs calomel—gr. 1; 1 tube morphia 1/4 grain; 1/2 lb. mag. Sulph; 2 ozs. adrenalin; 1 bottle 'Three Star' brandy; 8 ozs. tinct. benz. co.; 1/2 lb castor oil. AOT, DPH, 58.7A.39, BN Chappel Island Mutton Bird—List Nursing Equipment, (HSD 1/70).

¹¹⁴ Carbolic Acid; Fairson Phenysol; Hydrogen Peroxide; Mist Alba; Eucalyptus Oil. AOT, DPH, Letter to DPH from Inspector Clark re equipment being returned from Babel Island, 15 May 1934, (HSD 1/5 to 1/6).

Photograph 5.02 Sister Eiszle's Bush Nursing Kit



*The BN kit carries a wide range of medications, syringes for douching, surgical trusses and instruments for dressings. 'Science' is well represented in Dr Truby King's book **The Artificial Feeding of Baby**, and patent nostrums with the **Barry's Trichoperous**.*

Photographer: Alex Thomson, 2003.

Source: Photograph, Marita Bardenhagen, Personal Collection.

Artefacts, AMA Collection, Hobart, Tasmania

In order to circumvent the slow supply of ordered drugs, nurses purchased supplies from travelling salesmen (including the Rawleigh's agent) which the Department did not consider acceptable. Furthermore the practice of nurses purchasing drugs directly from pharmacies was seen as posing a considerable problem particularly in relation to the ordering of narcotics. Thus, in addition to the restriction on prescribing, the DPH developed limits on the supply of drugs to BNs. Drugs ordered were confined to those for which written medical authorisation was obtained and which had to be supplied through a pharmacy. Bush Nurses were not to obtain their drugs from the travelling salesmen.¹¹⁵ Although this was promulgated in 1937, prior to 1938 BNs were authorised to, or at least not censured in, ordering narcotics on their own account:

In reference to your order for ... Tablets containing Morphia, viz ... Under new¹¹⁶ regulations, would you please apply to Dr. Carruthers, Director of Public Health, Hobart, for permission to obtain these tablets. Until we receive this we are unable to supply your order.¹¹⁷

Why there was a change in policy of the drug ordering is not clear as it predates by some time stronger guidelines and tighter restrictions on prescribing by BNs.

Undoubtedly, in respect of narcotic drugs, the DPH was concerned about abuse potential. At one stage the Director of the DPH was concerned that a BN at Ouse might be misusing drugs, and become a 'drug fiend', perhaps as a consequence of the 'place [being] too dull for her'.¹¹⁸ Regulations in respect of recording all prescribing of medication, and in particular of 'Dangerous Drugs' in a special Drug Record Book, were reinforced. Restrictions on the quantity and types of narcotics which could be stored in a BNC came into place in 1953:

None of these drugs shall be held at any hospital or centre with the exception of:- Morphine (one tube), Pethidine (one box of 50--Bush Nursing Hospitals only).¹¹⁹

With the dangers posed by tetanus and diphtheria, anti-toxin also was available in the BNC although nurses were not supposed to immunise.¹²⁰

The types of medications available for treatment of health problems in the early Bush Nursing era were limited in scope but not obviously different for BNs as distinct from doctors. The changes in the restrictions on BN prescribing parallel the development of potent new agents for the BN's work. It will be seen that despite these controls, at least

¹¹⁵ AOT, DPH, 58.35.37, BN Ordering of narcotics to be through doctor, 19 October 1937, (HSD 1/36).

¹¹⁶ My emphasis.

¹¹⁷ AOT, DPH, 58.2.38, BN Avoca, Letter to BN, Avoca re ordering 'Hypo Tabs Morph', (HSD 1/53).

¹¹⁸ AOT, DPH, 58.12.3, Memo to Sister Noller from Director Hospital Medical Services re Ouse centre, 14 June 1951, (HSD 5).

¹¹⁹ AOT, DPH, 58.28.3, Circular to BNHs and BNCs re Narcotic Drugs, 12 August 1953, (HSD 5).

¹²⁰ AOT, DPH, 58.6.41A, BN Flinders Island Equip, Stores Memo to Sister Green re requested supplies ordered, 26 September 1941, (HSD 1/80).

until the late 1940s, without supervision, BNs still provided treatment to patients which was no less than could be provided by doctors. The lack of clarity in guidelines and directives provided to BNs, and obvious lack of action taken over the breaches in guidelines that we shall observe later, suggest that attempts to restrict access by BNs to medication were not because of serious quality-of-care issues.

The Professional Practice of the Bush Nurse

In many rural areas in Canada and New Zealand the majority of rural nursing activity was provided by two types of nurse—District and Public Health Nurses. The District nurses handled maternity and bedside nursing care; and the Public Health Nurses dealt with health education, and disease prevention in mothers and children.¹²¹ The Tasmanian BN fulfilled a role similar to the combined role of these two groups of nurses. The BN's work was not confined necessarily to the three desired areas of certification but these were the major areas of work. Her practice in each of these areas of nursing will be described and analysed in turn as each area had particular features. The professional practice of the nurse can be explored from official correspondence and reports, and from interview data. In addition it is valuable to analyse the written record of her activity. The Bush Nursing regulations state in respect of maintaining a written record:

Sister shall keep a register of patients, in which she shall enter a daily record of work performed. She shall record all midwifery cases [and] ... shall submit a monthly report of work performed to the Public Health Department.¹²²

It can be argued that the requirement to keep such a record demonstrates that the BN was accountable in her own right for the quality of her work.¹²³ Similarly doctors have such a requirement, and it is this record that more often than not forms the basis of any decision about the appropriateness of their practice. Bush Nurses confirm that they kept a record of their daily work. Vi Millington recalled: 'You had to do a report and every day you kept a log of all your patients and things'.¹²⁴ Evelyn Mellish confirmed the practice: 'Oh yes, there was a big book. You wrote in this big book everything you did. What happened'.¹²⁵ These records might not have been complete. The records were for public consumption, so it is possible that they had been edited. Practical issues did reduce the completeness of recording. While in the BNC case histories were maintained, in home visiting it was more difficult to keep the patient history.¹²⁶

¹²¹ Mill, Leipert, Duncan, 'Public Health Nursing in Alberta and BC', pp. 18–23.

¹²² AOT, DPH, List of Principal Duties Required of Bush Nursing Sisters, (HSD 5).

¹²³ Dingwall argues the converse to this, p. 215, 'If a nurse does not commit her plans to paper then she is unlikely to become accountable for them'.

¹²⁴ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

¹²⁵ Evelyn Mellish, Interview, Musselroe Bay, 1994.

¹²⁶ Una Saville, (née Nicholls), Interview, Devonport, 1999.

There are now no extant nursing records with the exception of records in relation to two different Bush Nursing activities in four distinct periods—obstetric records from Marawah (December 1922 to November 1940); the daily log of the BNs who were on Babel Island (in the mutton-bird seasons of 1934 to 1937); the daily log of Bush Nursing activity on Chappell Island (in April 1939); and the daily log of patients treated on Bruny Island (June 1945 to August 1949).¹²⁷ The obstetric records and the daily log provide essentially non-overlapping sets of clinical functions. Information from all these sources will be explored to characterise the professional work of the nurse and, where available, interview data and public records will be integrated with the clinical record data. These records span a critical period in health care from before to after the availability of potent antibacterial medications and provide insight into the impact of these on nursing practice.

Bush Nurses generally did not keep personal diaries—those asked if they had done so described having being too busy.¹²⁸ The clinical notes that were kept, and are still extant, do not contain rich evidence of thought processes, emotions or management. They merely provide a written list of the nature of a clinical problem and its management or, in the case of maternity records, a list of cases with brief descriptive data (such as the time of each stage of labour, baby's weight, and drugs given). These are very clearly part of an official transcript and BNs comment on the circumspection with which they framed their formal communication with others. Despite the limitations of such data, they can be used to provide some details of the work of nurses and to inform an understanding of how nurses saw their role.¹²⁹ The integration of the nurses' written records with other official correspondence, and with personal interviews, enables some of the inherent richness of their work and experiences to be recreated.

Midwifery

Midwifery care, from the first call for BNs in 1910, was to be a core component of the nurses' activity and the area in which practice guidelines formally mandated the greatest independence from doctors. While delivery numbers might not have been high, maternity care was seen as the primary responsibility of the BN. The requirements of midwifery dictated other aspects of their role. Bush Nurses all recount the many deliveries made in the remote BNCs, at homes or on the way to the nearest hospital. Bush Nurses were required to practise only normal midwifery but in many cases this was difficult. Mothers did not want to leave their families and sometimes held off calling for assistance until it

¹²⁷ The Bruny Island records were located in May 2003.

¹²⁸ The exception was Sister Agnes Mackenzie. AC Hearn, Personal Communication 2003.

¹²⁹ Dr John C Morris and Professor Alexander N Thomson provided a medical analysis of these sets of data.

was too late to travel. Where a Bush Nursing delivery was considered inappropriate, prior to the birth of their babies women would have to travel to the city to stay with family or friends, or rent accommodation in either the maternity homes or hospitals. This strategy did not guarantee success for many reasons, including finding someone to care for the children at home, economic hardship and access to transport. At Adamsfield the policy was that no babies were to be delivered in the area so most women would leave when they knew that their time was due. Here the restrictions on delivery were enforced because of the extreme primitive living conditions but also almost certainly because of the difficulty in retaining BNs with midwifery qualifications. Nevertheless in 1927 the first baby born in the area was delivered by Sister Bessell. The girl was named 'Osma' (Lanham) after the rare mineral being mined.¹³⁰ Eric French can remember his aunt sending him off to the mine and on his return there was a baby at the hospital. Another baby was stillborn, but the policy was relatively successful as there were few babies born at Adamsfield.¹³¹

Before BNs provided midwifery services in the bush, mothers relied on the services of untrained midwives.¹³² Sister P Smithurst described that the task of the untrained midwife not only was delivering the baby but also nursing the mother in bed for ten days while at the same time caring for the rest of the family. She recalls that 'often it meant a long walk from their homes with their own children having to be left in the care of an older sister'.¹³³ She notes that in 1920 when the Bush Nursing Service began in Hamilton, BNs also were required to deliver women in their own homes and to care for their family as the

¹³⁰ Barbara Tweedie, Adamsfield, unpublished paper, 83 Lord Street, Sandy Bay, 13 September 1999.

¹³¹ From 1929–1935 there were eight midwifery cases at Adamsfield but it is unclear if they left the field for deliveries. AOT, DPH, Letter to ER Vernon Smith from SN, 20 December 1935, (HSD 1/13).

¹³² There is no evidence that BNs worked with or came into conflict with registered or unregistered midwives. Although there appears to be some overlap shown in the list of registered midwives compared to the area of BNs, this could be explained by married nurses living in the area who kept up their registration but did not practice. The Parliamentary Papers provide lists of Midwives and could provide data for future research. As well there have been several theses about Tasmanian Midwives written which are referred to in Chapter One. Bush Nurses often worked in areas in which unregistered midwives also were active. In particular unregistered Aboriginal midwives worked in tandem with the BN and in between bush nurse appointments to the (Furneaux) islands. Aboriginal women, (and in particular one who had been employed to work for the bush nurses on Cape Barren Island as a young girl) deny there was ever any conflict between the traditional Aboriginal midwives of the period and the BN. Aboriginal midwives on Cape Barren Island were in high demand for both black and white births. The role of a skilled midwife was highly valued regardless of skin colour. One particular Aboriginal midwife known as Julia Burgess, (née Mansell) stands out in the history of the Islands. Julia delivered a number of children on various small islands throughout the Furneaux group and would usually remain with the family for a period after the birth. A notebook belonging to Julia still exists detailing the procedures to follow in childbirth. The notebook, a published version of midwifery procedures, has been handed down to her descendants who continued to use her advice. Interview with her grand daughter VM:1994. See also Sheryl Brennar, 'Island Women 1910–1960', PhD Thesis University of Tasmania, 2002, pp. 198–202.

¹³³ Phyllis Smithurst, *Early Days*, (in house staff publication), Ouse Hospital, 1976. Sister Smithurst was Matron of Ouse Hospital.

mother convalesced. The domestic service provided had the BNs functioning almost as a 'substitute wife'. The primacy of the domestic role for some of her clients can be seen from the letters of complaint which appeared in the pages of the *Mercury*, the local paper, soon after the service started. Complaints included that:

The right sort of nurse is not appointed; they are too highly trained and not used to bush life's makeshifts. What is wanted is someone to take care of things as they come, go into the home, nurse and look after the baby, cook and look after the family. But she has to be waited on, and requires a separate bedroom.

The mother and the father have a right to say what kind of woman is wanted by them. If the home is too poor and small to allow extra help, then a nurse that cannot take charge is useless.¹³⁴

One correspondent disagreed, writing:

I can hardly believe it is the mothers who object to the highly trained nurse, but the families who will not fend for themselves while the mother is laid by.¹³⁵

One nurse denied these accusations of needing to be waited on and pointed out that she even made jam and cooked bread while looking after the family of a recently-delivered mother. After the flood of correspondence the DPH requested that a local Bush Nursing Committee be formed, and desired to see the service move from home to BNC-based deliveries. Initially the community did not want a hospital, but in 1927 a BNC was opened in Ouse and the Bush Nursing Service was moved to Ouse from Hamilton. The BNC provided one room for maternity patients, and babies no longer were to be delivered at home.¹³⁶ This tension between home delivery services and hospital midwifery was to resurface constantly. It was not only when attending home deliveries that BNs had to carry out the domestic duties. While patients were in hospital the BN had to buy the food, and do the cooking, washing and ironing. If she overspent her budget the cost of food would need to come out of her pay, so some nurses added keeping fowls and maintaining a vegetable garden to their range of duties.

Infection was a significant concern, and the nurse's ability to carry out other health tasks was limited when she was involved in maternity care. Puerperal sepsis and perinatal infection were significant sources of maternal morbidity and mortality.¹³⁷ Prevention of infection became a pre-eminent concern of those involved in midwifery and drove clinical

¹³⁴ Smithurst.

¹³⁵ Smithurst.

¹³⁶ Smithurst.

¹³⁷ Puerperal sepsis is related to childbirth. Perinatal means during the period after the birth (up to 28 days after the birth). For further discussion on these issues see McCalman, *Sex and Suffering* and also Philippa Mein Smith, 'Mortality in Childbirth', pp. 137–155 in Barbara Brookes, Charlotte Macdonald and Margaret Tennant (eds), *Women in History: Essays on European Women in New Zealand*, Allen & Unwin, North Sydney, 1986.

behaviour and regulation.¹³⁸ The Regulations governing BNHs prevented their use for infectious cases. Nurses were not allowed to attend infectious cases, except in emergency, without prior medical and District Committee sanction.¹³⁹ This latter rule would seem somewhat impractical, and appears not to have been applied generally. The demands and requirements of midwifery took precedence over other tasks, but in one obstetric record in the Marrawah series the nurse notes that she stopped visiting the mother and baby at day eight because she had started attending a 'paralysis case'.

The workload attributable to midwifery was considerable. In the period 27 December 1922 to 13 November 1940 there are recorded some 93 deliveries in the Marrawah Bush Nursing area. For the most part these records are in sequential 'case number' order and they appear to represent a complete history of midwifery, or at least delivery (intrapartum), care from the date of the opening of the BNC to November 1940.¹⁴⁰ Antenatal care is not recorded, but Annual Reports note the total number of antenatal patients cared for at each Centre. Sixteen of the deliveries are listed as being at the mother's home. There was an average of 5.2 deliveries per year and this case load at Marrawah appears stable over the 18 year period.¹⁴¹ Attendance at each case was in the range 2 to 14 days. At this time it was considered that post-natal care was appropriate for some 10 to 14 days, and the average recorded duration of 11.6 days is consistent with this. Thus, on average, some 60 days of nurse time (excluding ante-natal care) each year was spent in maternity-related care to patients the nurse had delivered, providing mother and baby care in the mother's home or at the BNC. Additional time in midwifery-based activity would have been spent in care of women in the ante-natal period and to women delivered elsewhere (or by doctors).

¹³⁸ After the advent of antibiotics the fear of infection appeared to recede. Pressure by doctors to admit patients, previously considered unsuitable, to BNCs was to increase. The eventual loss of the BN's control over admissions to BNCs reflects in part the loss of the BN's autonomy, but also suggests that the DPH was becoming more *laissez faire* about the admission of infectious patients to hospitals that were to conduct deliveries. An additional factor was that BN involvement in intrapartum care was slowly declining under the pressure and influence of the medicalisation of birthing, and thus there was less potential for a BN to manage an infectious case and then be required to conduct a delivery.

¹³⁹ Rule 13: The Nurse may not, except in case of emergency, attend infectious cases, unless the approval of the medical attendant and the sanction of the District Committee.

¹⁴⁰ A graph of delivery numbers over time is approximately linear, giving further confidence in the assumption that the records are a complete set of delivery data. Nevertheless data from workload summaries for this BNC over this period state that there were 103 deliveries—this discrepancy may reflect that the start and finish of workload reporting periods may not correspond with the start and finish of the maternity case series.

¹⁴¹ The workload data submitted in the Annual Reports of the BNCs records 103 maternity cases over the years for which we have detailed obstetric data. Given that the Annual Reports cover a longer period of time (i.e. full years) this may explain the discrepancy, or there may be unrecorded cases (possibly antenatal care only, or missing delivery data). In addition there is no information about the delivery in three of the 93 cases—it is possible that this reflects that these were ante-natal attendances only.

Sister Mackenzie recalls that she might have had two or three midwifery patients under her care at any time:

I remember once having one at Cooee, another at Wivenhoe and a third at Glance Creek. I would sleep at the newest babies' home, rise early, fix up mother and babe, go on to the next home, do for mother and babe and washing, then to the third one doing the same. Stay there until evening, fix them up for the night, back to the second home and return to the first mother and babe that night. I had to visit or stay with them each until the babe was ten days old, then visit again in a week.¹⁴²

At Marrawah a BN described the workload and stress of maternity care in a 1949 letter to the Supervisory Nurse thanking her for a four-day holiday:

[I] would like to say thank you for my recent four days reprieve. I really don't think I could have kept going otherwise as may have noticed by the report June was pretty hectic. My two May, two June and two July mids all came off in twenty two days. Might not have been so bad if they'd all been straight forward, but one had APH¹⁴³ another a very sickly babe, and a third a prem. Still, everything has settled down now and I'm much refreshed after a break.¹⁴⁴

Most BNs recalled caring for large numbers of maternity cases. At Triaburua Sister 'Vi' Thompson remembers approximately 22 maternity cases in one year, and that she averaged 15 a year.¹⁴⁵ Sister Hazel Bird also recalls a high maternity case load:

Oh gee, they came in with the ... cows, as I used to say. The people in the district told me I delivered fifty [in four years]. Oh well, I usually had a baby in most of the time.¹⁴⁶

Recollection of delivery numbers is fraught with difficulty, but Annual Reports show a wide range of delivery numbers each year from the levels seen at Marrawah, with up to over 100 deliveries each year in some centres. The post-war years in particular experienced a baby boom.

The records suggest that the nurse usually functioned without medical advice, supervision or assistance. In analysing the case data we can see that the BN had to cope with a variety of intrapartum and perinatal complications.¹⁴⁷ Of the 93 deliveries at Marrawah noted earlier, the doctor was recorded as being in attendance on three occasions (once for an instrumental delivery, and on two occasions after the delivery to attend to the removal of a retained placenta). The doctor was called for advice on two other occasions.

Many mothers had had many previous deliveries—nine mothers were having their first delivery, and two mothers their tenth—the 'average' mother was in her fourth

¹⁴² Hearn, p. 59.

¹⁴³ Ante partum haemorrhage—bleeding per vagina before the birth of the baby.

¹⁴⁴ AOT, DPH, 58.13.49D, Letter to Sister Noller from Sister Leslie D Meredith, Marrawah, 9 July 1949, (HSD 6/34).

¹⁴⁵ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

¹⁴⁶ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

¹⁴⁷ Intrapartum—during the delivery.

pregnancy. That only ten per cent of mothers were having their first child suggests that most primiparas were referred out of the area for intrapartum care.¹⁴⁸ Sister Bird at Marrawah in the mid-to-late 1930s, states that she 'never took a primipara ... I'd never have a bar of it—she had to go to a doctor'.¹⁴⁹ For Sister Bird the first pregnancy was a 'test' of how the subsequent deliveries might progress:

If they had their first baby and they were ... trouble free, just a normal case, well when they had their second and the third ... they were usually straight forward cases.

They then became suitable for delivery at the BNC. The maternity records show that Sister Bird delivered only one primipara, her second delivery whilst in Marrawah, and that was as a consequence of a premature labour. The outcome was not good, with the baby being in poor condition, and requiring transfer to hospital after discussion with the doctor by telephone. At the Tasman Hospital in 1949 all primiparas were transferred to a base facility.¹⁵⁰

There were special facilities for the delivery of unmarried mothers based away from the rural areas. While considered socially unacceptable, unmarried motherhood was common:

Of course I had single girls pregnant ... in those days, I mean to say you gave them the option, there were a lot of adoptions in those days ... and ... I had a very good liaison with the Queen Alex ... for these single girls going and having their babies ... from Triabunna down ... to Hobart. I'd send them down. See there was the clinic for single girls at the Queen Alex ... I'd send them away, you know to have the babies.¹⁵¹

Sending the unmarried mothers out of area provided a break from community glare and easy access to the adoption services. Some BNs were involved actively in helping with these arrangements. At Ouse the Bush Nursing Committee objected to the admission of a 16-year-old single woman to the BNC for delivery as she was 'terribly ignorant in all ways—and human odour dreadful'.¹⁵² The claim made by the Ouse committee was that no patient would be prepared to come into hospital after she had delivered. Although the case against the patient was not based on medical grounds, the Director of Public Health concurred with the committee that 'the case is not a fit and proper one for admission to your Bush Nursing Hospital'. Arrangements were made for her care in Hobart.¹⁵³ Residents of small communities lacked anonymity, and moral judgements could be harsh. Bush Nurses interviewed were unwilling to talk about unmarried mothers and their care. It was

¹⁴⁸ Woman with no prior deliveries.

¹⁴⁹ Hazel Gaffney, (née Bird), Interview, Prospect, 1999.

¹⁵⁰ AOT, DPH, 58.28.49, SN report Tasman Hospital, (HSD 6/34).

¹⁵¹ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

¹⁵² AOT, DPH, 58.10.38, Letter to Sister Stammer from Ouse Bush Nursing Committee, 23 August 1938, (HSD 1/53).

¹⁵³ AOT, DPH, 58.10.38, Letter to Ouse Bush Nursing Committee from Dr BM Carruthers, 25 August 1938, (HSD 1/53).

a taboo subject, several BNs concerned that by discussing the issue it might allow identification of the women involved as the communities that the nurses served were small. Some BNs saw that their role with these patients was in counselling the mothers and their families about the options available to them.

The mothers in the Marrawah series ranged in age from 19 to 44 years, and it might be that younger women were managed at a base facility. Were there young single women whose pregnancies and deliveries were managed by the BN, rather than the nurse providing merely a counselling service? In four cases, all prior to 1928, the record does not record maternal age. This might merely be oversight or might have been deliberate censoring of the data by the nurses. One has no data at all, merely the case number. One case record is missing from the series entirely. One records a premature delivery and stillbirth in a woman recorded as having had 'two miscarriages and one abortion' previously. It is possible that each might have had 'stigmatised status' on the basis of maternal age or marital status. In the last of these four, a mother is recorded as being in her fourth pregnancy but no delivery data are recorded. She is less likely a candidate for low maternal age. All deliveries where presentation is recorded were vertex (79/93).¹⁵⁴ Of the 14 where presentation was unrecorded, five babies were born before the nurse arrived at the patient's home or the patient arrived at the BNH. Breech presentations are statistically four per cent of births, thus we would expect that at least one mother would be recorded as having a breech presentation.¹⁵⁵ It generally is accepted that breech births are higher risk events and might have been expected to have been referred for management by a doctor, or for a doctor to have been consulted. It is possible that BNs effectively recognised and referred on all mothers with breech presentations, or alternatively that the three or four expected breech births are in the nine where presentation is not recorded. If in fact the BN did deliver one or more breech babies, and this is not recorded, there might have been some deliberate 'sanitising' of the record to ensure that it did not reflect the BN carrying out high-risk work. If this is true, other less obvious omissions might exist within the available data.

There is a record of doctor attendance or advice in only one of these premature deliveries highlighting both the isolation of the BN and her independence of practice. In four cases delivery occurred at or before 28 weeks' gestation—one at 16 weeks died after delivery from prematurity; one at 24 weeks was stillborn, the fetal movements having stopped weeks before the onset of labour; one at 28 weeks' gestation was transferred to

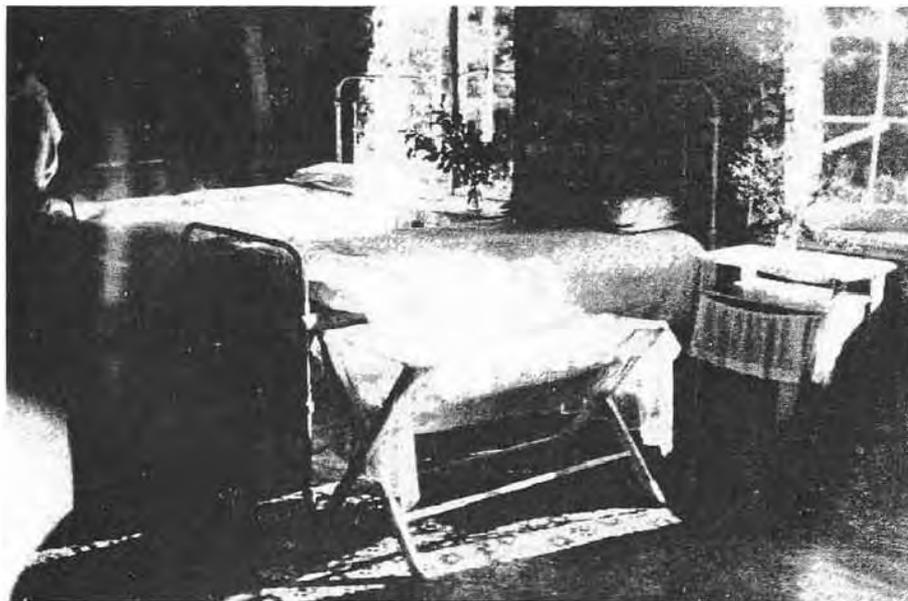
¹⁵⁴In a vertex the baby's head is delivered first. This is safer than a breech, or buttocks first, delivery.

¹⁵⁵This is the 'generally accepted figure' from overall birth statistics. Professor AN Thomson, Personal Communication, 2003.

hospital under medical care in a 'poor condition'; and one was born at home apparently surviving but requiring 20 days of nurse attendance.¹⁵⁶ Delivery complications of a significant nature recorded in the data are outlined in Table 5.02, and again in most of these cases doctors did not attend or were not consulted.¹⁵⁷ Again the BN's isolation resulted in her carrying out deliveries in which significant problems occurred, usually without medical advice or assistance.

The doctor is noted as attending two of Sister Bird's 12 deliveries, once for an ante-partum haemorrhage and once for a retained placenta. Interview data support these records. Hazel Gaffney (née Bird) recalls that she provided the majority of the obstetric care without medical assistance or supervision. Furthermore she was unsupported by other nurses or midwives. She found it difficult to cope single-handed as the women were 'big women ... and very heavy'. With permission from the DPH she trained a local woman as an assistant, to make work much easier. The assistant also proved valuable when a delivery could not be effected as the umbilical cord was wrapped twice around the child's neck. She asked the assistant to telephone the doctor to ask for advice. Fortunately the doctor was sitting by the telephone and provided advice quickly—so quickly that the mother was not aware that a problem had occurred.

Photograph 5.03 Maternity Ward at the Tasman Bush Nursing Centre



A characteristic midwifery ward, usually, as here, a maximum of two beds.
Source: DPH, Bush Nursing Album, NBT.

¹⁵⁶ The 'normal' duration of pregnancy is 40 weeks, and delivery before 36 weeks carries significantly higher risk to the baby. The fetus is the unborn baby.

¹⁵⁷ A number of cases had more than one complication.

Table 5.03 Delivery Complications¹⁵⁸ⁱ

Complication	Number of Deliveries	Doctor Attendance
Ante-partum haemorrhage ¹⁵⁹	1	1
Retained placenta ¹⁶⁰	3	2
Post partum haemorrhage ¹⁶¹	12	1
Premature ruptured membranes ¹⁶²	3	1
Stillbirth ¹⁶³	2	0
Perinatal death ¹⁶⁴	2	0
Neonatal convulsions	3	0
Cyanosis of baby ¹⁶⁵	1	0
'Poor' condition of baby ¹⁶⁶	1	0
Twins ¹⁶⁷	1	0
Shoulder dystocia	1	0
	25	5

Source: Compiled from record: AOT, AA 740 and AA78, Marrawah DNC, Midwife's Record Of Cases visited 27 December 1922–29 January 1930, and Redpa DNC, Midwife's Record of Cases visited 4 September 1929–13 November 1940.

¹⁵⁸ Medical explanations provided by Professor A N Thomson. Ante-partum haemorrhage—vaginal bleeding prior to delivery; retained placenta—the placenta (after-birth) failing to release and deliver as expected after the delivery of the baby; post-partum haemorrhage—significant bleeding after the delivery of the baby; premature ruptured membranes—the rupture of membranes around the baby leading to loss of amniotic fluid before the onset of labour; stillbirth—baby being born dead; perinatal death—death of baby within 1st seven days of life; neonatal convulsions—convulsions in the 1st month of life; cyanosis—lack of oxygen in baby leading to a blueness in skin colour; shoulder dystocia—a situation in which the baby's shoulder obstructs the delivery process.

¹⁵⁹ Dr Henry Hollister Jackson from Smithton attended the delivery—it is uncertain from the records at what stage of the delivery he arrived. This was a full term delivery of a 35-year-old mother having her 9th pregnancy. A nine hour first stage is recorded for the labour, the delivery was instrumental, and a live female baby was produced. There is no indication that there was other maternal or perinatal morbidity.

¹⁶⁰ In the 16 week premature delivery the mother suffered from a retained placenta which is recorded as requiring a manual removal and appears to have been removed by the nurse. In the other two occasions where a retained placenta is recorded the doctor attended to effect a manual removal. In one of these two a post partum haemorrhage is recorded.

¹⁶¹ In June 1930 the first use of an oxytocic agent (a drug designed to stimulate uterine contraction) is recorded and this is in relation to a delivery with a 'slight post-partum haemorrhage'. This is the 51st delivery recorded in this series of 93 cases. Only two cases are recorded in the previous 50 where post-partum haemorrhage occurred (one in the 16 week premature delivery, and one in a post-term [42 week] delivery with a good outcome). Thus in the final 43 deliveries post-partum haemorrhage is recorded some 10 times in contrast with twice in the first 50 deliveries. In all cases an oxytocic agent is recorded as being given.

¹⁶² The doctor attended one case to remove the placenta 4 hours post partum.

¹⁶³ One at 24 and one at 36 weeks gestation.

¹⁶⁴ One at 16 weeks from prematurity, one at 40 weeks from convulsions at 12 hours of age.

¹⁶⁵ Cyanosis at birth, baby was not cyanosed at the time of discharge.

¹⁶⁶ Dr Geoffrey Brutus Packham was telephoned and the baby was transferred to hospital.

¹⁶⁷ The smaller twin died the day after delivery. The doctor was consulted by telephone on the day of delivery.

The BN carried out an 'operative' intervention in several cases, removing at least one retained placenta, and suturing at least two perineal tears. Until 1930, there is no record of administered medication to mother during the labour or delivery. After this date the BN administered medication to the mother in relation to delivery from June 1930 in 23 of the 43 deliveries. In all cases this included an oxytocic agent, other medications being used in a small proportion of cases.¹⁶⁸ In one instance only is there a record of doctor involvement in the immediate decision to use oxytocics. In another case bromide and brandy were prescribed where a baby started convulsing on the fourth day after delivery. The doctor had been contacted for advice thus he might have initiated the treatment. The high level of recorded prescribing in spite of its low level of authorisation might reflect a blanket approval for prescription of in-labour medications which became available at about that time to reduce bleeding.¹⁶⁹ Whilst doctors were seldom in attendance or asked for advice it is noted in one case that: 'Child and mother in good condition on seventh day. Dr Jackson's permission to leave case'. This implies, at least in this case, that a variation from usual care required the seeking of (or perhaps the nurse prudently was advised to seek) a doctor's permission or approval.

Multiple births were uncommon at BNCs, although a case of triplets (the Triffetts) is recorded at Ouse in 1947. The first baby was delivered by the BN, Sister Audrey Brown, before the arrival of Dr Bryant. Sister Brown is noted as resigning the next day. It is unclear whether Sister Brown's resignation was because of the triple birth, Dr Bryant's tardiness, or coincidence. At Ouse from 1951–1952, of 99 maternity patients there were two sets of twins.¹⁷⁰ At Lilydale, a BNC much closer to a base hospital than was Ouse, Sister Walsh is noted in *The Examiner* in 1945 as having delivered two sets of twins.¹⁷¹

¹⁶⁸ Oxytocic agents are designed to increase uterine contraction and in this series of cases are primarily used to reduce the risk of or severity of bleeding after delivery. Reasons for use of oxytocic agents—uterine relaxation in labour 1; end of third stage 7; excess loss 1; post partum haemorrhage 7; post-partum haemorrhage and relaxing uterus 1; delayed placenta 2; not recorded 2; later excess loss 2; Total cases 23.

¹⁶⁹ Professor AN Thomson, Personal Communication, 2003.

¹⁷⁰ AOT, DPH, 58.12.3, Report for Director General Medical Services from Sister DK Noller re Ouse Hospital, 27 October 1953, (HSD 5).

¹⁷¹ *The Examiner*, 15 September 1945, 'Bush Nurses are vital to country centres'.

Photograph 5.04 Bush Nurse Holding Ouse Triplets



*Peter, Kayleen and Michael Triffett, 28 March 1947. The triplets remained at the Ouse Bush Nursing Hospital until they were three months old. Sisters Kathleen Bishop and Leila D'Roseley Wilson, both of Queensland, nursed the infants*¹⁷²
Source: DPH, Bush Nursing Album, NBT.

When practising from a BNC the BN primarily was isolated from other health care support or medical supervision. Even greater isolation was experienced by the BN when carrying out home deliveries. These procedures placed the nurse beyond trained help (when she had it), in a more difficult environment for infection control or coping with emergencies, and often in a situation where she did not have ready access to a telephone for assistance or advice.¹⁷³ Nevertheless, home deliveries were encouraged in different areas within the State at varying times over the Bush Nursing era. In Hamilton, home deliveries ceased in 1927. In 1929, a nurse was supplied by the Tasmanian Bush Nursing Association to Spring Bay where maternity cases were her main work. Home deliveries were the norm and a small charge was made for this assistance.¹⁷⁴ At other times there were rules preventing the BN from attending maternity cases in the home. By the 1920s the medical profession had been active in arguing for hospital-based deliveries with statements such as: 'The public should be taught that it is just as necessary to go to hospital for childbirth as for a surgical operation', but Bush Nursing was slow to follow this advice.¹⁷⁵ In theory, even where deliveries were to be carried out in the BNC, through accident or design, mothers might leave it too late to reach the BNC, and have the baby at home before the BN's arrival. The rule against home deliveries appears to have been applied inconsistently perhaps

¹⁷² AOT DPH, 58.12.3, Letter to BNA from SN, 12 April 1951, (HSD 5)

¹⁷³ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

¹⁷⁴ Lester, p. 180.

¹⁷⁵ Barrington, p. 156.

because of the impracticality of enforcing it, and BNs such as Sister Connors at Ulverstone carried out planned home births. Despite the arguments of the medical profession, the public still wanted a home delivery service. A home delivery was featured in the Mothercraft section of the *Australian Woman's Mirror* in 1934 extolling the value to the mother from the viewpoint of both convenience and cost.¹⁷⁶ Bush Nurses were put under pressure to allow patients who had had previous home deliveries to have their next baby at home. Not all doctors were against home delivery and some pressure for the BN's attendance at home deliveries came from various local doctors.¹⁷⁷ The conditions of practice were difficult. Sister Mackenzie describes delivering most of her babies by candlelight as very few homes had electricity. She:

boiled water in kerosene tins [25 litre cans], also boiled clothes in same, hiked onto an iron hook which was usually hanging halfway up the chimney ... [With] only one basin to wash the dishes, make the bread, wash the family and bathe their father's septic knee in.¹⁷⁸

Another midwife also describes nightmare conditions under which to carry out midwifery care in the patient's home:

My third maternity case this month was a terrible one. Just a one-roomed hut, not a night-gown or basin, or any article to use. The rain and wind were beating in at all angles, and smoke coming down the chimney, blinding myself and patient. In fact, I do not know how the woman lived, the rain was beating in on the baby whilst it was being born.¹⁷⁹

The poor facilities in many patients' homes put mother and baby at risk, and increased the difficulties experienced by BNs. At Koonya in 1949 nurses were advised that approval was not granted to attend confinements in private homes because of the demands of other hospital patients, and the risks posed by the lack of facilities, but home deliveries continued in many BNCs.¹⁸⁰ The BNs carried with them, at times walking to their cases, all the equipment they might need when attending home deliveries. At Lilydale Sister Walsh remembers carrying a little bag with her home-delivery equipment. There was no anaesthetic or morphine. Someone would come and clean up after the delivery and the mothers would look after the babies.¹⁸¹ The isolation experienced when conducting home deliveries is underlined also by a complaint from a GMO who found it difficult to deal with the combination of working without assistance and the lack of preparation of the

¹⁷⁶ *The Australian Woman's Mirror*, 20 February 1934.

¹⁷⁷ AOT, DPH, 58.15.37, BN Swansea Letter to Sister Burchill from Director Public Health re maternity cases & hospital, (HSD 1/36).

¹⁷⁸ Hearn, p. 60.

¹⁷⁹ NAA, Bush Nursing in Tasmania, Series A2487, Item 1922/8480, Extract from BN's letter sent to Earle from Mrs Darling Central Committee, Southern Division, TBNA, 22 May 1922.

¹⁸⁰ The BN would be unable to adequately care for patients in the BNC when she was spending long periods of time, often days, in caring for the maternity patient and her family. Intrapartum care and postpartum care delivered in hospital was seen as both safer and more time efficient. AOT, DPH, 58.26.49, (HSD 5).

¹⁸¹ Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

household to cope with the demands of the delivery.¹⁶² Ambivalence to home deliveries continued at every level with approval for home deliveries being given and rescinded in response to local requests or pressures. At Campbell Town and Avoca the doctor and BN were both from Britain. It was noted by the Fingal Council Clerk that:

It is understood that the policy of Aus. Medical Men is now hospitalisation for all midwifery patents, but the reverse is the case in Britain, & Dr [Trevor Cory] Beard of Campbell Town & Sister Clark of Avoca are both immigrants from England.¹⁶³

He requested the advice of the DPH, and with the background of the BN and doctor there was agreement that home-based midwifery would be accepted. Things did not run smoothly and the DPH rescinded its approval:

Owing to recent happenings and following complaints ... midwifery patients need to make arrangements for confinement at Campbell Town Hospital ... Domiciliary midwifery would be undertaken only in emergency.¹⁶⁴

While conditions were not optimal for home delivery, the conditions under which the BN worked even within the BNC were at times primitive. Electricity was not available during much of the Bush Nursing era, and at Koonya Sister Burnley recalls the consequent difficulties with 'most of the babies ... born by the light of kerosene lamps'.¹⁶⁵ Despite the dangers of infection many BNCs had inadequate facilities for sterilisation. Even in 1951 conditions were not optimal for delivery in some BNCs. At the Brighton Camp BNC:

Apart from an emergency midwifery kit I keep at the Centre there are absolutely no facilities for midwifery at the Hostel. The rooms are about 8x10ft with no water or conveniences & nothing to help resuscitate a baby ... it is most difficult in their small rooms to carry out any degree of asepsis.¹⁶⁶

Patients often came to the BNC prior to the onset of labour as travel times from their homes to the BNC could be too long to allow mothers to reach the BNC before the baby delivered. In locations such as Cape Barren Island, poor weather might delay travel to the BNC for some days. Within the BNC bed numbers were limited, and even though the BN often gave up her own bed for patients, at Whitemark 'an expectant mother had to live for some time at Whitemark [despite the] inclement weather in a tent'.¹⁶⁷ Isolation stretched facilities at times to breaking point. Small centres experienced a greater percentage fluctuation in delivery numbers than is experienced in larger centres and this created bed availability and workload-management difficulties for BNs.

¹⁶² AOT, DPH, 58.35.43, BN Kingborough District, proposed BNC, (HSD 1/87).

¹⁶³ AOT, 58.2.3, Letter to Director Hospital Medical Services from Fingal Council Clerk re change of surgery hours, 20 January 1953, (HSD 5).

¹⁶⁴ AOT, DPH, 58.2.3, Letter to Fingal Council from DPH re maternity cases in private homes, 8 June 1953, (HSD 5).

¹⁶⁵ *Weekender*, 20 July 1985.

¹⁶⁶ AOT, DPH, Letter to DPH from Sister Vera J Josey, Brighton Camp, re midwifery facilities, 13 March 1951, (HSD 5).

¹⁶⁷ AOT, DPH, 58.4.3, Letter to Minister for Health from Flinders Council Clerk request for reopening Cape Barren Hospital, 22 July 1953, (HSD 5).

Sister Walsh delivered approximately 40 babies while at Lilydale and there were no deaths although babies were born in cars, on the floors of bush huts and in private homes. When it was required, transferring mother, or at times baby and mother, to hospital was not always easy. Sister Walsh recalls the details of the birth of one particular baby on a mid-winter's night, 'I wrapped it in cotton wool and put it in a shoe box then went into Launceston to Dr Geraldine Archer'. The baby lived but, unwanted, was adopted out.¹⁸⁸ Transfers of small or premature babies out of the area posed problems as it was believed that the baby ideally should be stable for at least 24 hours before transfer, but most BNCs were not staffed appropriately to care adequately for these babies over that 24 hours.¹⁸⁹ Economic policy also regulated transfer:

Re the premature baby transfer. The 5 lb, 14 day old baby was sent (per Drs orders) by bus, as the mother had no money with which to hire a car or ambulance, & the driver was instructed to leave the mother at the gates of the Mothercraft Home. The baby was in good condition on discharge & was being transferred because there was doubt about the mother's capacity to handle it.¹⁹⁰

It is not surprising therefore that nurses such as Sister Walsh often would drive women or women and babies to the nearest base facility. Sister Walsh sometimes travelled in her pyjamas and dressing gown and, where the woman was in labour, hoped the baby would wait until arrival at the hospital. Deliveries in cars were not usual, but many nurses recall these events. Harvey Bardenhagen drove the only car for hire in Lilydale and occasionally the baby was born in his Pontiac on the way to Launceston. It was useful when the nurse had a driver as in this situation Harvey could assist Sister Walsh with the births. 'If he ever got a new car it would always be christened'.¹⁹¹

Although Lilydale was close to a base hospital, the poor roads isolated this facility. The BN was called on to improvise adequate care in very trying circumstances. Sister Walsh vividly remembered the problems that ensued when a large maternity patient, weighing 20 stone and in labour with twins, was being transported to hospital. The car got stuck in the clay soil and tipped up with the patient in it. Her husband fetched water from the creek, full of 'gum leaves and all sorts', but it was boiled and used to clean the babies and the mother.¹⁹² At Gladstone Sister Mellish occasionally delivered babies on her own while transporting the mother to hospital in a car, and Sister Bird recalls that:

¹⁸⁸ Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

¹⁸⁹ AOT, DPH, 58.2.3, Memo for Bush Nursing Sisters from Director Hospital Medical Services re transfer of patients, 8 June 1955, (HSD 5).

¹⁹⁰ AOT, DPH, Letter to Sister Noller from Sister Davies re baby transfer, 20 November 1953, (HSD 5).

¹⁹¹ Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

¹⁹² Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

... only one [was] delivered in the car. We got it to the hospital OK ... they'd ring up and say their waters had broken and away we'd go ... I just stopped on the side of the road and waited for the baby to deliver itself.¹⁹³

Sister Isyabell Ann Weir has 'never forgotten and never will' forget carrying out a delivery in a car on a cold snowy night in the midlands. Rushing out into the snow in her bare feet and dressed only in a 'wrap' she struggled to deliver a baby in the dark. With the darkness and the panic the patient had neglected to take off her pants and Sister Weir described that she:

... will never forget this great big wet slippery cold baby slipping into these pants and I was trying to extract the baby from the pants. [laughter] And the cord and the pants and the baby [were] all mixed up and it was terrible and it was cold and awful and dark. [There was] elastic in the legs [of the pants] too [laughter] and with the babies feet and cord going into them ... it was tight and the elastic was stretched.

It was difficult in the back of the car, struggling to deliver the baby with no help from those in the car as 'they were the most unhelpful people too and silly as a wheel. And they wouldn't do anything I asked them to do'. Grabbing the baby Sister Weir ran into the BNC to wrap it in towels. The baby becoming 'freezing cold' was warmed with hot water bottles. Despite contracting pneumonia, the infant survived.¹⁹⁴

Bending the rules was necessary for as an isolated health professional the BN provided care to patients 'whatever' their health problem. The BN's roles in midwifery, general nursing and child health could produce conflict and danger. This tension in roles was to persist at all BNCs where only one BN was appointed. The concerns over infection not only restricted placing infectious cases in BNCs, but also the official recommendation was that at least one week should separate work with infectious and midwifery cases. This rule was ignored knowingly to cope with the reality of isolated practice. The isolation of Flinders Island from other hospital accommodation called for some special consideration.¹⁹⁵ By having two nurses at this BNC it was possible for 'doubtful cases' to be attended by one nurse leaving the other free for 'midwifery and clean cases'.¹⁹⁶ This was an idealised situation but BNCs with two nurses were the exception. Even at these BNCs the night duty requirements of such BNCs made the segregating of work unattainable. Where there was only one nurse it would have been impossible to follow the recommendations about work separation. Midwifery was not a predictable activity, and the nurse would have to deal with general emergencies as they arose. Sister Bernadine Ellen Lancaster was dressing the

¹⁹³ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

¹⁹⁴ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

¹⁹⁵ AOT, DPH, 58.6.41H, BN Whitemark, Letter to Council Clerk Flinders Island re infectious cases no treated in hospital 10 September 1941, (HSD 1 / 80).

¹⁹⁶ AOT, DPH, 58.33.37, Williamsford, Letter DPH, from SN re extra sister for Rosebery maternity work 2 November 1937, (HSD 1 / 36).

wound of a patient who had a supra pubic operation at hospital.¹⁹⁷ The DPH was concerned, and knowing that two midwifery patients were booked for that month, stated:

It is essential, in the interests of the health of the latter patients, that Sister Lancaster should discontinue her attendance on the first-mentioned case for at least one week before it is anticipated she will be called to the first of her lying-in cases.¹⁹⁸

In an isolated area with no other available care for her patients, this was unworkable advice. Moreover given her workload new infectious patients would be expected before she had finished the care of these midwifery cases.

The impossibility of these guidelines is demonstrated easily. A normal delivery can occur between say 36 and 42 week's gestation, and 'ensuring' one week without carrying out dressings on an infected or potentially infected patient would have required her to cease the dressings when her patients were from 35 week's gestation. The BN would carry out very little other work except midwifery under these guidelines. There was then no choice but to ignore knowingly such rules to cope with the demands of work, particularly where there were no 'immediate midwifery bookings'. The following incidents at St Helens BNC illustrate that the DPH also did some of the 'bending':

In view of the fact that St Marys Hospital is becoming very crowded with cases, I think it would be advisable for you to agree to take general cases at your nursing centre in the future. I know this runs contrary to the instruction contained in my recent circular, but this appears to be a special case.¹⁹⁹

Similarly, at Southport, the DPH was unconcerned that a case of encephalitis had been nursed in the BNC as the BN had no immediate midwifery bookings.²⁰⁰ Not only did the concern about infection affect the BN's ability to care for the living, but also there is one case where a BN refused to lay out two patients who had died because she was expecting a midwifery patient. This became the subject of a complaint against the BN, but her actions were upheld by the DPH.²⁰¹

The Bruny Island daily log (1945-1949) provides additional support for the hypothesis that the BN's multifaceted role led to conflict. There is a number of cases recorded where it is obvious that infection-control guidelines had been breached. Nevertheless there is no record of any adverse outcome from such a breakdown. Mrs B was

¹⁹⁷ Sister Bernadine Ellen Lancaster was trained at Yarran Rallied Hospital, Victoria, and registered in Tasmania on 1 March 1934, Registration Number 808.

¹⁹⁸ AOT, DPH, 58.13.37, BN Ringarooma, Letter to Ringarooma committee re Sister's midwifery cases, 5 December 1937, (HSD 1/36).

¹⁹⁹ AOT, DPH, 58.19.3, Letter to St Helens BN from Director Hospital Medical Services re St Marys Hospital, 8 July 1952, (HSD 5).

²⁰⁰ AOT, DPH, 58.18.3, Letter to Director Hospital Medical Services from Sister DK Noller re Southport Hospital, 1 October 1952, (HSD 5).

²⁰¹ AOT, DPH, Glamorgan/Spring Bay. Letter to DPH, from FP Shaw and to Dr Crawford Clelland Marshall (GMO) from Director GMS re laying out dead, 8 March 1952, (HSD 3).

delivered of a son on 24 June 1946, and Mrs W on 25 June 1946. They were to stay in the BNC until the 8 July and 7 July respectively. Four days before the first delivery the BN opened an abscess on the neck of a patient under local anaesthetic. On 1 July she dressed another neck abscess. Given the significance of staphylococcal infection in the perinatal period in the mid-1940s this was a potentially serious breach of the guidelines.²⁰² As the sole nurse for the island the BN appears to have considered that there was no viable alternative to her action. A similar situation occurred when in mid-1947 the relieving BN was dressing an infected hand, which she saw as severe enough to require antibiotics, some five days prior to assisting the doctor with a delivery of a baby who lived but two hours. Later the same month, four days after treating a patient with antibiotics for tonsillitis, the BN delivered a woman of a baby boy. In 1949 on the same day as delivering Mrs D of a girl the BN was managing a patient with a boil on his forehead, and on the day prior to Mrs D's discharge was dressing an infected finger. There is also record of a patient with an infectious condition being admitted to the BNC by the doctor in 1949, again against the standing orders.²⁰³ It was not until 1955 that BNs lost control to the GMOs of BNC admissions, thus the BN, at least in theory, had the power to prevent such an admission.

Although facilities for midwifery within BNCs were not always optimal, as we saw with Brighton Camp even in the 1950s, in general they improved over the Bush Nursing era. Electric light, hot water, and sterilisation equipment slowly reached most BNCs. Pain relief in labour also became possible with the provision of nitrous oxide gas in some centres, usually BNHs by the late 1940s.²⁰⁴ Facilities were improving even as independent midwifery was suffering under the move of intrapartum care to medical.

Midwifery was a central part of the role of the BN, and in this area of practice nurses acted with a high degree of autonomy. The Regulations did not require that normal midwifery be under the direction of a doctor. There was little agreement on what constituted normal midwifery. The Director of Public Health responded to a question from Dr William McLaren Thomson, GMO at Premaydena, that:

It is impossible to define accurately what is a complicated case of midwifery. I state this advisedly and deliberately as a M.R.C.O.G. For practical purposes, the answer is all cases defined as such in any textbook on Obstetrics.

The DPH was not willing to define the limits of normal midwifery, and the test 'is it possible for matters to develop as to put the mother's life in danger?'²⁰⁵ in fact would have

²⁰² Professor AN Thomson, Personal Communication, 2003.

²⁰³ DPH, Hobart, Bush Nursing Service, Alannah Centre, Daily Report Books, June 1945-August 1945 and July 1948-August 1949.

²⁰⁴ AOT, DPH, Reference for Sister E Chapman from SN, 5 December 1949, (HSD 5).

²⁰⁵ AOT, DPH, 4.3.53, Letter from Director DPH to Dr W Thomson, 10 December 1953, (HSD 3).

to be answered in the affirmative in all cases. Despite the lack of definition, there is evidence that BNs attempted to select patients with a proven track record of straightforward obstetrics and referred patients who might be more complex on to doctors. The practicality of this referral at times would have been difficult, particularly before the development of good roads and easy access to transport.

Map 5.02 Bruny Island



Medical support for the Bush Nurse on Bruny Island required the doctor from Snug to visit the island (landing in the north of the island opposite Kettering, or the Bush Nurse to find a boat to get the patient off the island to hospital) on the Tasmanian mainland. Alonnah is located almost opposite Gordon.

Source: John G Bartholomew, 'Victoria and Tasmania' in *Times Survey Atlas of the World*, Edinburgh Geographic Institute, London, The Times, 1922, (From the David Rumsey Institute).

Isolation was the key to the nurses' role in midwifery. The role and impact of isolation is reinforced when one examines the death of a woman following an undiagnosed twin delivery on Bruny Island in 1942. The death was the subject of an inquiry as the G.M.O. at Snug (on mainland Tasmania) had been non-contactable when called by the BN after the

woman's condition had deteriorated. The findings of that inquiry make it clear that the BN became concerned at 6.30 am, and the patient died at 8.10 am. Given that the ferry was out of service, it was claimed that the quickest a doctor could have arrived was 8 am. The death by then could not have been prevented. In fact it took the DPH until 12.30 pm to arrange a doctor's visit, by which time the woman had been dead for many hours.²⁰⁶ It is not surprising that BNs were concerned at times about the lack of backup should a problem arise. Sister Weir comments that her hospital-based midwifery training allowed her to know what might go wrong and thus maternity cases were a 'bit of a worry' to her. Delivering patients in the bush was the nurses' role as:

Doctor's didn't do that. They were too far away [but] fortunately everything went all right with the deliveries and [there were] no complications or complaints.²⁰⁷

Some nurses believed that the medical profession was not in favour of Bush Nursing involvement even in normal midwifery. At Marrawah inaccurate and 'silly rumours' circulated that the BN was not a qualified midwife.²⁰⁸ In 1936 it was said:

There are more babies born to the women in the district than the figures might lead you to believe, but most of them go to Smithton. Personally I would like to see the mothers remain where the Bush Nurse is, provided everything is likely to be normal, but the Doctors have not the same ideas.²⁰⁹

One patient alleged that she was refused accommodation at a boarding-house where she was to await going into labour as she wished to engage a BN. She stated that, 'I think they must be in the swim with the Doctor, who gets his money easy'.²¹⁰ This accusation is unsupported but highlights the suspicion that some mothers held regarding the motives for advice about where they should have their baby and who should deliver it. At that time the midwifery records show an average of 5 deliveries each year at Marrawah while the Annual Reports show some three to seven times this number of antenatal patients were seen at the BNC. If these data are accurate, and these quotations lend credence to their accuracy, it would seem that at least at these centres the majority of deliveries were handled out of the area. This high proportion of out-of-area deliveries could not be explained adequately by differentiation of place of delivery merely on the basis of obstetric risk. Many mothers must have elected, perhaps on medical advice, to have their babies at larger hospitals under medical care. Workload data (Figures 5.01 and 5.02) below demonstrate that BNs' involvement in antenatal care continued to increase rapidly over the

²⁰⁶ AOT, DPH, 3.2.42, Kingsborough-Bruny District, 1942, (HSD 3).

²⁰⁷ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

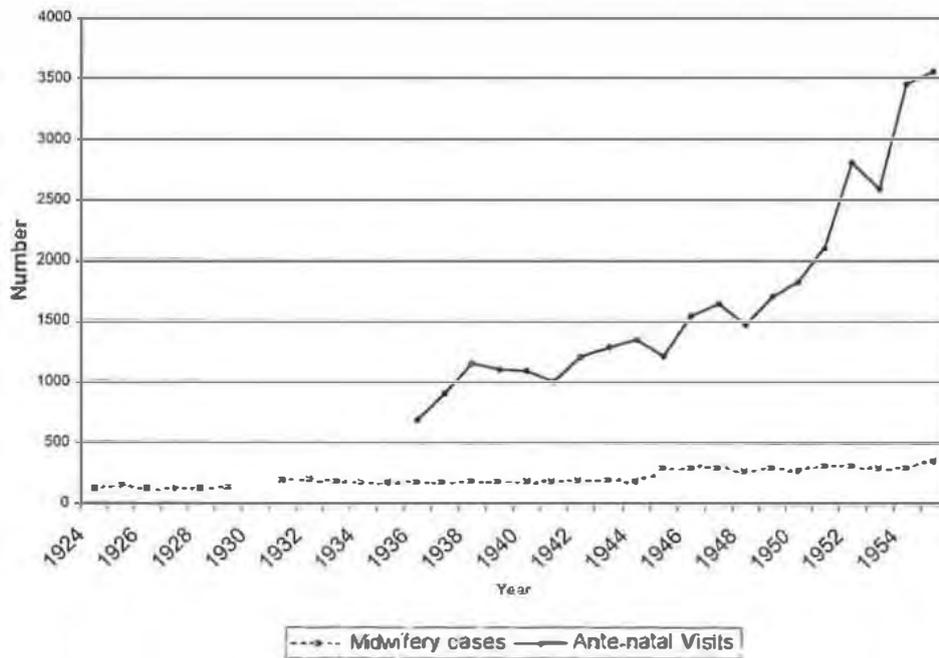
²⁰⁸ QVMAG, Box 10, Newspaper Article, 16 January 1923, Visit of politicians to Marrawah Bush Nursing Home.

²⁰⁹ AOT, DPH, 58.1.36, BN Adamsfield, Letter to Sister Evans from SN, outlining Adamsfield & Marrawah conditions, 20 January 1936, (HSD 1/24).

²¹⁰ NAA, National Archives Series, A457/1—Item L206/15, Report 1922, copy letter to Mrs Darling asking for old coats for children.

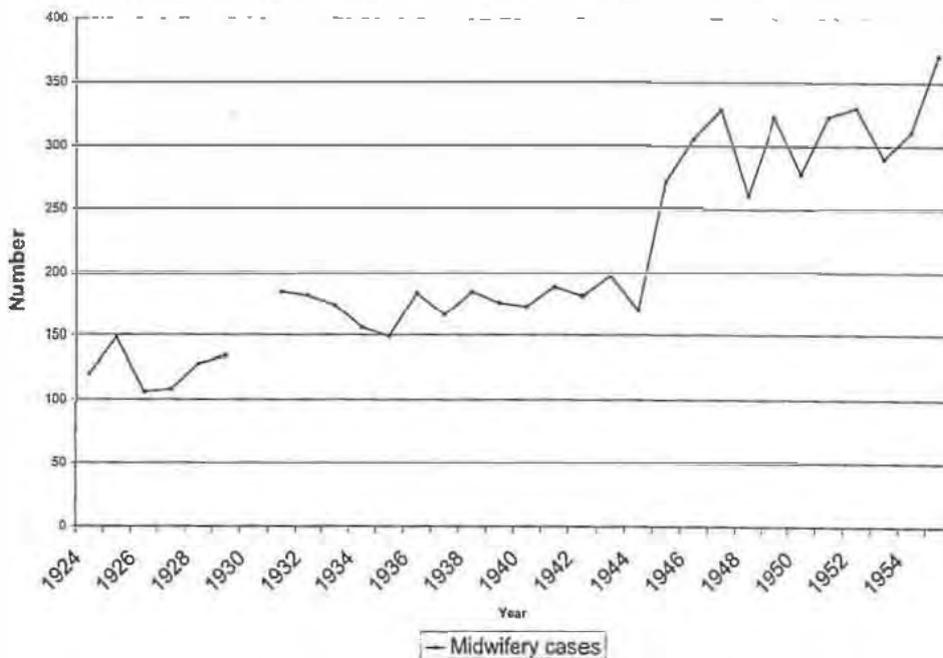
Bush Nursing era, and at a much faster rate than midwifery care.²¹¹ This further supports the hypothesis that case selection by nurse or by patient progressively increased.

Figure 5.01 Bush Nursing Centre Workload—antenatal cases



Source: TJPP&P

Figure 5.02 Bush Nursing Centre Workload—midwifery cases



Source: TJPP&P

²¹¹ AOT, DPH, Annual Reports for BNCs, (HSD5).

Relationships between BNs and doctors in respect of midwifery, despite evidence of competition, generally were mutually-supportive. At Flinders Island, BN and doctor were able to share the doctor's space for conducting maternity care.²¹² BNs, while not seeking medical advice often in regard to their midwifery work, nevertheless generally describe the doctor as supportive. Doctors clearly relied on the BN at least to carry out deliveries in the rural areas that they could not service easily. Financial issues on several occasions led to a less-supportive relationship. Earlier we saw that Dr George Wade, a private practitioner, wanted to 'corner' the entire maternity market at Cygnet. Similarly in 1934 the Board of the Mt Bischoff Provident Fund who funded the BNC at Waratah asked the DPH to instruct the BN to cease maternity work. The doctor whom they employed on salary at that time was allowed by them to do maternity work as a private practitioner. This was an important source of income for him. The DPH would not acquiesce stating that:

It [was] not competent for a Committee or other body controlling the services of a BN to require their official to act contrary to the [BN Association] rules.²¹³

The BN continued to do maternity work. Waratah did not retain the services of a doctor.

Care for patients presenting with pregnancy could require responding to requests for termination of pregnancy. There is no evidence from either interview data or from the official records to suggest that BNs provided such a service. Nevertheless records of the equipment and medications in the nurse's bag suggests that 'bringing on a period' was part of the service provided by some. At least one nurse had to answer a complaint that she had been involved in such an activity, although she was off work from illness at the time of the alleged incident and denied involvement.²¹⁴ In Rossarden, the Supervisory Nurse noted that 'abortions in district have been common' and had advised the BN to 'leave same to Police Department, and avoid becoming involved'.²¹⁵ Sister Laird recalled that induced abortions were not discussed and, even if suspected, were referred to as spontaneous abortions, i.e. miscarriages.²¹⁶

While the Regulations also allowed BNs to work outside 'normal midwifery' without medical direction where 'there is no resident medical practitioner, and where, in the absence of a BN, no skilled aid would be sought', the BN handled a wide range of complex problems with little or no support or advice from a doctor or any other trained health worker. This required midwifery skills at a high level, and appropriate decision-making

²¹² AOT, DPH, 58.6.34, BN Flinders Island, re accommodation for Sister Weeks, 5 December 1949, (HSD 1/5).

²¹³ AOT, DPH, 58.17.34, BN Waratah, 1934, (HSD 1/6).

²¹⁴ Janice Flora Barnes, (previously Brooks and née Fenton), Interview, Devonport, 1999.

²¹⁵ AOT, DPH, Letter to Director General Medical Services from Sister DK Noller re Rossarden Sister, 4 July 1952, (HSD 3).

²¹⁶ 'Lexie' A J Burn, (née Laird), Personal Communication, May 2003.

about management including prescribing and referral. It would have been possible to have increased the contact between midwife and doctor by telephone, and often possible to have had a doctor attend in a timely fashion, but the BN frequently deemed this unnecessary. The evidence demonstrates that she saw her skills as a midwife as appropriate not only to normal midwifery, but also to abnormal or complicated midwifery.

Robert Dingwall and others argue that from the 1920s the independent midwife in the United Kingdom was a fiction.²¹⁷ Innovation started with the doctors and filtered down to others, and the midwife was required to function within the rules defined for her by a doctor. Dingwall sees the midwife as merely 'an extension of the doctor'. It can be argued that a general practitioner obstetrician is in a like position, similarly working within guidelines imposed by the obstetric community. It has not been argued that he is not independent. Everyone works within a framework of acceptable practice. It is the lack of minute-to-minute supervision, the requirement to make her own decisions when faced with new or unexpected problems, and the obligation to record her practice, that all act to make the BN independent.

Furthermore Philippa Mein Smith demonstrates that in New Zealand issues of power, or defining the 'lead carer' in childbirth, have moved backwards and forwards between midwife and doctor over the twentieth century.²¹⁸ Shifts in power also occurred in Australia, as did shifts in belief systems about 'appropriate' childbirth practices. Shifts occurred over time but these were moderated by place, by resources, and by the influence of individuals. In Bush Nursing the gradual moves from home delivery to hospital delivery, and from nursing control to medical control of childbirth, were moderated substantially by the degree of isolation of the BN. Midwifery remained an important part of the Bush Nursing Service at all times in the Bush Nursing era. There is evidence, though, of both case selection by the BN midwife so that 'problematic' cases 'gained the advantage' of medical care at a larger centre, and of patients electing to bypass the local BN to obtain care from doctors. These do not detract from the thesis that the BN functioned as an isolated and independent professional in her midwifery practice.

²¹⁷ Dingwall et al, Chapter 8, 'Midwifery. A State Midwifery Service'.

²¹⁸ Mein Smith, *Maternity in Dispute*, and Mein Smith, *Mothers and King Baby*.

General Nursing

In addition to her role as midwife, the BN was also the primary health care provider in the communities in which she lived and worked. This required her to provide care to people of all ages and with any health problem, referring on only those whom she could not handle within her skills and within the regulations governing her activities. Sister Donald at Rossarden made the point to the DPH that 'a BN ... takes upon herself the onerous and responsible duties required by the ill health of people in remote areas such as usually are assumed only by doctors'.²¹⁹ Her comments reinforce that the nature of this work was significantly different from the BN's midwifery practice in two main ways. Firstly, it was an area of activity which was not related specifically to the health needs of women. Secondly, the role differed markedly from other traditional nursing roles. It provided a service which normally would have been provided by a doctor. Diagnosis and management were key components of the service, and these two activities were traditionally medical roles.²²⁰ The Regulations required that only in cases of emergency and trivial cases could the nurse function without medical direction. By virtue of their isolation it would be expected that BNs worked with greater autonomy than such rules implied. This section of the chapter explores the role of BNs in general health care.

Reference is made to the work of the BN in overall statistics collected by the DPH, but this provides inadequate detail to assess professional practice and independence. Correspondence to and from the Department deals with issues of diagnosis and management, and this provides some clues to their work. This is not comprehensive and provides no picture of the daily life of the BN, but interview detail fills the gaps. While all nurses kept comprehensive diaries of their work, few records of this activity exist today.

There are records of the clinical activities of the BN stationed on Babel Island for the mutton-bird seasons 1934 to 1937, for one month of activity of Chappell Island in April

²¹⁹ AOT, DPH, Letter to Minister for Health from Sister Noller, 3 February 1948, (HSD 5).

²²⁰ Gamarnikow argues that diagnosis cannot be 'rigidly separated from diagnosis and prescription' and that nurses necessarily had to operate in the 'medical diagnostic framework'. As the health system was structured with doctors primarily as 'absent consultants' and nurses as 'ever-present carers', doctors had to rely on 'conditional' rather than 'direct' orders, and this 'locked nurses even more strongly into the functions of diagnosis and prescription'. Eva Gamarnikow, 'Nurse or Woman: gender and professionalism in reformed nursing 1860–1923', pp. 119–120, in P Holden & J Littlewood, (ed), *Anthropology in Nursing*, Routledge, London, 1991. This argument is based in the hospital environment where while nurses' role may well have extended to diagnosis as Gamarnikow argues, but the role was substantially more circumscribed than that of BNs. The Hospital nurse functioned in an environment of conditional orders, the BN in an environment of 'no orders'. While the DPH advised that the BN obtain detailed standing orders which legitimised her actions there is no evidence that such orders existed. Furthermore the BN was actively involved in initiating drug treatment that was maintained without gaining or needing to gain a doctor's imprimatur.

1939, and for Bruny Island from 1945 to 1949.²²¹ Babel and Chappell Islands were isolated islands with primitive facilities, no access to telephone and power, and there were no visits by doctors. No communication with those outside the island was possible, and transporting those who needed hospitalisation off the island was very difficult. There are differences in the ways in which BNs have recorded the encounters with their patients, thus it is not easy to compare the year-by-year workload, but the recording differences have allowed a number of different facets of the work to be highlighted. While Babel Island is in a sense a special case given its high Aboriginal population and the nature of the mutton-bird industry, there are significant similarities between the island and other more remote BNCs. The number of people living on the island under the care of the nurse was not high, but the overall number of visits, and age groups under care, suggest that the data might give a reasonable picture of the type of work and responsibility undertaken by the BN of the 1930s.

Bruny Island, by contrast, while still isolated by sea and lacking often-needed communication technology, was significantly less isolated than the mutton-bird islands. In the period for which data were available Bruny Island was visited regularly by a GMO, weather or other factors permitting. Telephone services were installed so that the BN could contact a doctor outside of normal visits. The island was substantially larger than the mutton-bird islands and roads were reasonable, but access to transport was difficult. The data available for analysis are from a later period than that analysed for Babel and Chappell Islands, and come after the introduction of antibiotic treatment. Also they are after the DPH had tried to restrict the dispensing of medications by BNs. As such the data provide both a check on the 'representativeness' of the Babel Island data and an important window into the changes in Bush Nursing practice over a decade later. These sets of primary source material triangulate the oral histories and DPH correspondence including the published rules and regulations.

On Babel Island there were in total 368 visits to, or visits from, patients recorded over the four mutton-bird seasons from 1934 to 1937. The nurse was stationed on the island between two weeks and one month. Sister Risby was on Babel Island from 31 March to 1 May 1934. In that time she had 76 patient visits, some patients being seen on multiple occasions (up to eight visits). In the first 14 days she spent on the island she was involved with at least two patient visits each day. Over her period on the island she records that she visited all the sheds and huts on the Gulch and the South East at least twice a week and the

²²¹ This is less than 1 per cent of the contacts between Tasmanian BNs and their clients in each of these years, and a lower daily load than some centres. Centres such as Rosebery had over 7 client contacts each day in 1934 compared to Sister Risby's 2.4 per day. Isolated and small centres such as Adamsfield averaged but 1.5 client contacts per day when the mining field was in decline.

remaining sheds and huts on the island at least once a week. This suggests that her contact with patients was at least in part a consequence of her pro-activity, and that she had a significant contact with the populace not recorded as visits to patients. She summarised her work in her report as 'most of the work consisted of minor complaints, the most prevalent being septic wounds, which in most cases were due to the patients' own carelessness. There were not any cases of snake bite'.²²²

The range of work varied from addressing minor health issues to serious complaints. In the absence of a doctor being available for advice, on two occasions, she suggested that the patient seek medical attention off the island. One child in particular was 'very ill with pneumonia', and although the nurse advised that the family seek medical assistance they did not do so. The nurse continued to monitor the child daily until she eventually recovered. Infections comprised the majority of the work, and not surprisingly were on the hands or lower limbs as would be expected from the type of work. Infection sites were skin 12 (includes appendages and eyes), respiratory 9 (pleurisy 1, laryngitis 1, croup 1, pneumonia 1, pleural pain 1, and influenza 4), and gastric 1. There were 4 cases of trauma (2 wounds, 2 sprains), 2 non-infective skin problems (eczema 1, rash 1), and 1 case of epilepsy. Child neglect was suspected by the nurse in one case although there was no sign of external injury. There is clear evidence of the nurse providing a diagnostic label, as opposed to a description of symptoms, in many cases.²²³

Treatments were not described always in sufficient detail to know the full range of treatments used by the nurse. For many conditions the description is merely 'treatment advised', but frequent treatments included 'foment' to areas of inflammation; dressings to wounds and local infections; poultices to the chest wall for respiratory infections such as pneumonia and pleurisy; iodine applications to wounds (such as a scalp wound), the 'pleural cavity' and a sprained wrist; and bathing of inflamed eyes.²²⁴

²²² AOT, DPH, Memorandum from EJ Tudor, 11 March 1935, (HSD 1/13).

²²³ There are many ways in which a diagnostic label might be formulated. Given that the BN arguably was carrying out the role of an independent healthcare professional, one might expect that a diagnostic label would provide some sort of disease basis on which to determine management.' Professor AN Thomson, Personal Communication, 2003.

²²⁴ Foment' are warm wet dressings. Names of all medications given are as recorded by the BN. Abbreviations of treatments given by the BNs have not been expanded because in some cases the abbreviations are ambiguous. For example 'sulph' could be used as an abbreviation for one of a number of different drugs of the sulphur family. On other occasions the nurse's hand writing creates some uncertainty as to the exact nature of a specific treatment and I have attempted to decipher only the writing.

In 1935 Sister Eleanor Burbury travelled to Babel Island, staying there for 39 days.²²⁵ She treated 33 different patients over 101 patient visits of which 55 involved the nurse visiting the patient. One patient with pneumonia was visited by the nurse a total of 28 times. Her workload included issues of women's health (menstruation, menopause, and an 'inquiry re uterus and lump, which appears inside'), oral health (toothache, and mouth ulceration), and a series of infections, inflammations and minor wounds. While Sister Burbury did furnish diagnoses, such as 'pneumonia', for some of her cases, in others she provided merely symptomatic diagnoses. For example diagnoses included labels such as 'swollen forearm', 'discharging area on face', 'pain in chest', 'pain in right side', 'pain in shoulder', and 'indigestion, cough and general weakness'. In each of these cases the nurse has not provided a diagnostic label in the medical tradition.²²⁶ There is evidence that Sister Burbury went beyond a mere label which might cover a range of problems, each of which might require a different therapeutic or management approach. In each case she provided a management of some kind, and these not merely symptomatic managements. Clearly, at times, she had moved from her recorded symptom description to an assessment of cause of the symptoms, and further to the prescribing of a course of treatment designed to deal with the cause of the problem. For example, in the case of Love L with 'indigestion, cough and general weakness' she treated the patient with sodium bicarbonate, boiled water, and Scott's emulsion, and furthermore advised that if there were no improvement that she should visit the doctor.²²⁷

Arguably the nurse had made a clinical decision about the urgency of the problem, the nature of the likely cause, and had put in place a 'safety net' in the event that her diagnosis and prognosis were wrong. In the case of Maud, also with 'indigestion', the management was similar ('sod bic, boiled water') with the addition of 'regulation of bowels and correction of diet'. Once again, while there is no 'true diagnosis' such as might be made by a doctor (although many doctors might simply write the same diagnosis as she), there is clear evidence of a diagnostic process leading to a process of management.²²⁸

In relation to respiratory disease Sister Burbury provided a range of diagnostic labels from 'cold' (Pat), to 'cough and cold' (Phillip) and 'pneumonia' (Ruby). For Pat she managed the 'cold' with advice about 'eucalyptus'; Phillip with 'rest in bed, free fluids'; and Ruby

²²⁵ Sister Eleanor Burbury, aged 97 in 2003, was recently interviewed at Swansea, but could not recall the details of her Bush Nursing experiences. She did vividly recall sleeping with a mosquito net over her bed at Babel Island and awakening one night to see a huge tiger snake draped over the net. Her career was spent mostly in private nursing, and in her latter years nursing at the May Shaw BNH and finally managing a rest home at Swansea where she finally retired in her 80s.

²²⁶ Professor AN Thomson & Dr JC Morris, Personal Communication, 2003.

²²⁷ Despite the time since these records were created, and as it is not possible to obtain consent and some of the patients might still be alive, I have not identified patients by name.

²²⁸ Professor AN Thomson & Dr JC Morris, Personal Communication, 2003.

with 'rest in bed, hot applications to site of pain, sponge, brandy prn, TPR'. This represents a hierarchy of response fitting a hierarchy of seriousness in labelling. Likewise Pat visited the BN twice, the BN visited Phillip twice, but by comparison the BN visited Ruby 28 times. Once again it is evident that the diagnostic process informed the management process. A range of treatments were provided by the BN and it can be seen that she considered a various issues, including lifestyle factors, in her management. For example, for Arthur, with a discharging boil, she advised 'dressings, mag sulph, free fluids, light diet, arm in sling'. For Ben, with toothache, she advised 'iodine to gums, mouth washed, aperient, correction of diet, advice re visit to dentist'. Other treatments used included castor oil, meth spirit, massage, hot saline foot baths, foment, peroxide mouth washes, boroglyceride dressings, and iodine. Once again, thankfully, the nurse had no need for the snake antivenin.

In 1936, and in the following two mutton-bird seasons, Sister Edna Foster was the Babel Island BN. Her records provide us with the age of the patients treated, adding more detail to our understanding of the nurse's work. From 6 April to 20 April 1936 she saw 45 different patients, but has not recorded how often she saw each. As with Sister Burbury she provides diagnoses of variable characteristics—some merely symptomatic, others descriptive of cause and effect. Diagnoses such as 'abscess on face', 'mild attack of influenza', and 'cut with glass on foot' might not vary from the diagnosis offered by a doctor. Douglas, aged 3 years, was visited on two occasions suffering from a 'severe cold in head, inclined to be croupy'. This diagnosis provides an additional level of information about the sick child, an assessment of predisposition to other illness, which would be of value in determining a therapeutic response. Freddie, age unstated, suffered from 'pain in the cardiac region, indigestion'. Here Sister Foster decided to treat with 'sod bic given in warm water'. From the treatments available to the nurse and from the treatment chosen one can conclude that she decided as her initial diagnosis to assume that the cause of the pain in the 'cardiac region' was 'indigestion' rather than angina pectoris.²²⁹ She recorded only one visit for this patient.

There was no easy way to transmit messages to and from the island, and Sister Foster recalls using a novel way of attracting attention when a boy who had poliomyelitis needed to be evacuated from the island. There was a police boat anchored some distance from the

²²⁹ Angina pectoris is restriction of blood flow to the heart muscle leading to chest pain—a potentially life threatening condition. The treatment chosen for Freddie, an antacid was for indigestion. Her bag would have included medications for heart disease. Her lack of follow up to the patient, in contrast with other patients whom she assessed as having serious or potentially serious illness, makes it clear that she was confident in her diagnosis. Professor AN Thomson, Personal Communication, 2003.

shore. She borrowed a gun and fired off shots—the police arrived quickly as the island was supposed to be a gun-free zone and the shots were quite audible on the police boat. The boy subsequently died in hospital. Other serious situations she recalls were related to alcohol and violence.²³⁰ The medical details were not important in the telling of examples of such situations, but the attitude of the BN toward the Aborigines was one of 'they are not responsible'.²³¹ It was also evident from the interviews that the theory of genetic predisposition was accepted commonly amongst the white community, then as now.²³²

The ages of patients, as recorded, demonstrate that the BN was required to have skills in assessing and treating patients of all ages.

Table 5.04 Number and Age of Patients Treated on Babel Island, 1936

Age of patient (years)	Number of patients
<1	2
2-5	3
6-10	3
11-20	5
21-40	10
41-60	5
61-69	0
70	1

Source: AOT, DPH, Babel Island (Mutton-bird Season)

The range of treatments given by Sister Foster provides evidence of additional management options. These include saline and eusol solutions in wound management;²³³ sponging for fever reduction; 'warm oil and eucalyptus' as a rub for respiratory infection; glycerine and warm water swabbing of the mouth for oral thrush in a baby; 'equal parts sod bic and salt' as a gargle for sore throat; APC tablets for pain;²³⁴ 'iodex with methyl salicyl' applied to the face for toothache; warm oil instilled into the ear for 'cold in the head' [possibly the patient had earache]; boric lotion bathing to eyes followed by 'ung applied' for 'cold in eye'; and camphorated oil rubs and spirit rubs for sore chests from infection and a muscle strain respectively.

In 1937 Sister Foster returned to Babel Island in the company of her 10 year old nephew. On this trip she carried out a total of 146 patient visits. A seven-year-old child

²³⁰ Anonymous, Interview, Moonah, 1994.

²³¹ Anonymous, Interview, Moonah, 1994.

²³² See also S Sagers & D Gray, *Aboriginal Health & Society, The Traditional and Contemporary Aboriginal Struggle for Better Health*, Sydney, 1991.

²³³ Edinburgh University Solution of Lime—a solution used in wound treatment until at least the 1980s.

²³⁴ Aspirin, phenacetin and codeine.

with pneumonia evidently caused her the most concern and was visited by her on 22 occasions. In her summary of her time on the island she included the comments:

One case of pneumonia was a source of worry as it was impossible to obtain enough of anything for poulticing. The child improved for a time—then became worse and at present is seriously ill in Launceston Public Hospital.²³⁵

Her case load included the familiar pattern of infections of various types and minor wounds as the predominant part of the workload. She noted that this work was made more difficult by:

the dogs on southeast beach [which] were the same nuisance as during previous years—after Mr Parker [the Health Inspector] left the island. Most of the island was kept reasonably clean except west beach and north point and in both places the odour was putrid owing to offal not being sufficiently covered.²³⁶

On this occasion she has not recorded the age of the patients (with the exception of the child with pneumonia). She has provided information about the balance between visits to the nurse by the patient, and visits by the nurse to the patient. In 1937, 56 visits were by patients to the nurse, whilst the majority required the nurse to visit the patient. Many of the patients she visited, as can be assumed from the diagnoses given, were in fact ambulant and could have attended the nurse. Again it can be seen that the nurse's role was proactive in her provision of health care to an at-risk population and that she functioned autonomously.

Once again a range of new treatments is seen as available to, and used by, the BN: 'mag sulph and glycerine applied' to a boil on an arm; 'argyrol m ii instilled into eye' in a man with a foreign body in his eye; 'vicks vapour rub applied' for 'chest tightness'; 'mist alba given. Kidney pills given'. Barley water ordered for a man with 'constipation, (and) kidney trouble'; castor oil, 'rice water, and boiled water ordered' for a [?] child with diarrhoea; peroxide mouth washes for pyorrhoea; 'four incisions made' in an infected finger as well as 'granulations touched with silver nitrate'; 'vaseline dressings followed by boric ung' to burns from a fall into a fire; 'linseed poultice applied over spread ung' for an 'inflammation of L heel'; and 'Antacid pulv' for 'indigestion'.

In April 1939 Sister May Evans was stationed on Chappell Island and over that month saw eight different individuals of the island population of 70 persons. She states in her correspondence that the population overall was 'very healthy and had no serious illnesses'.²³⁷ Visits to the nurse by patients numbered 16 in total, and patient visits by the

²³⁵ AOT, DPH, 58.7.37, BN Babel Island Mutton Bird Season Sister Foster re pneumonia case and dogs, (HSD 1/36).

²³⁶ AOT, DPH, 58.7.37, (HSD 1/36).

²³⁷ AOT, DPH, BN Chappell Island, BN Report for April 1939, Sister ML Evans, (LSD 51-1).

nurse numbered six. The conditions treated were scabies, boils, burns, jarred hand, headache, backache, fits, and suspected snakebite.

Most of the cases handled on Babel Island were infections and/or minor wounds consistent with work in the mutton-bird industry and the reported hygiene problems of the environment. Nevertheless there were many presenting symptoms, a broad age-range of the client base, and a difficult environment in which to practise. The BN was required to exhibit wide-ranging diagnostic skills in order to cope with the professional and personal isolation of the island. Official archives contain no suggestion that the patients or the authorities were unhappy with the performance of the BNs in this environment. Nurses selected treatments from within the range available to them, and did not fail to use treatments available to them that might have resulted in better patient outcomes. Equally it is doubtful that if they had elected to refer the patient to a doctor treatments would have been significantly different or outcomes any better. The data are short on detail so it is not possible to judge the quality of the health care offered with any degree of certainty.

In summary, the exploration of these written case summaries from Babel and Chappell Islands highlights that most diagnoses are at best symptom descriptions rather than detailed specific diagnoses. The treatments given suggest that 'diagnostic discrimination drove the choice of management'.²³⁸ It is possible that the level of 'precision' in the diagnostic labelling was designed deliberately to stay within the boundaries of acceptable nursing practice and to avoid offending the reader of the records (for example the doctor-dominated DPH). The Regulations required that the BN maintained records and kept these 'for medical inspection'. The records allowed the BN to demonstrate the degree to which she maintained her practice within the boundaries set out by Regulation. Circumspection in recording practice would have been in the nurse's best interest. The Victorian branch of the BMA desired that local doctors sat on the Bush Nursing Committees so that they would have:

access to the nurse's case record book to reassure them that only 'trivial' cases were handled without medical supervision.²³⁹

In Tasmania this did not occur. Most BNs and Bush Nursing Committees were located in areas in which there were no local doctors, so committees did not include doctors on their membership.

²³⁸ Professor AN Thomson & Dr JC Morris, Personal Communication, 2003.

²³⁹ Priestley, p. 81. There is an implication in this quotation that the Bush Nursing Committees had access to the BN's case record book. There is no evidence in the AOT records that such access existed.

Sister Hazel Bird worked at Marrawah in the same period as that for which we have data for Babel Island. During that time she had up to 630 patient contacts each year, but in over four years at the BNC she recalls calling in the doctor on only three occasions. Two doctors, one operating a private hospital, were located at Smithton, the nearest town. The doctors were available for telephone advice 'and if [there was] anything I couldn't cope with I'd ring them up and talk to them ... tell them what I'd done'.²⁴⁰ If things did not go according to plan she would contact the doctor again to inform him of developments. She recalls suturing wounds, applying poultices of linseed to painful regions 'anywhere but the appendix', packing gums after bleeding from dental extractions, and giving injections of morphine for serious pain, and of strychnine. Cough medicines were imported from Melbourne by the gallon. 'Homespun' remedies were offered where appropriate and she recalls advising a man with indigestion, a teetotaler through his faith, to cut the fat off his food and to have three glasses of alcohol a day. This was acceptable advice to him as it was for medicinal purposes ('the locals liked the medicine, a good many of them'), and 'he kept off the fat and he went on the ale and he was cured'.²⁴¹

It is important to note when assessing the range of management options used by the BNs, and when commenting on the specificity of diagnoses, that the daily records of nurse activity outlined above are from a period before the general availability of antibiotic treatments for community-based infections. M&B693 (Sulphapyridine) progressively became available from the late 1930s but would not have been readily available to doctors at this time.²⁴² Penicillin was a later development, and it was not until 1941 that the first human was successfully treated. Before long, penicillin was in full production, primarily for use in the war effort but its community use was not until after the period covered by these data sets.

The Bruny Island daily logs of 1945–1949 contain data similar to that in the logs of daily work on Babel Island.²⁴³ While the age of patients is not recorded, gender is usually evident from the name. As well as recording the nature of the problem, its management, and whether or not a doctor was involved in the care, the BNs have recorded mileage, petrol use, and fees. Significant changes in the potential interventions for infectious diseases had occurred over the previous decade. Antibiotics and immunisations were now generally available, but both were at least in theory restricted to use by doctors. While antibiotic use by BNs might be legitimised by standing orders, telephoned instruction, or

²⁴⁰ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²⁴¹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²⁴² Professor AN Thomson & Dr JC Morris, Personal Communication, 2003.

²⁴³ DPH, Hobart, BNS, Alornah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

post hoc permission, immunisation never was authorised as a nursing procedure. The focus of the analysis of the Bruny Island daily log, in particular, is on the ways in which the BN managed infection given these critical changes.

Routine vaccination for whooping cough is recorded as given many times. In 1946, on one occasion, the administration of ten whooping cough vaccines 'given for doctor' is recorded, and twice within the next month the administration of vaccine to a single patient is recorded. Both mass vaccination and catch-up or routine vaccination outside of a mass vaccination framework thus were considered as normal nursing activity on Bruny Island at that time. In 1947, tetanus antitoxin was given without authorisation by one BN when a patient 'ran a nail 1 inch' into his buttocks, and the following day pertussis bacillus was given to another patient on doctor's orders. She records several other administrations of tetanus antitoxin over the following months as part of wound care. Similarly, in 1948, the use of anti-tetanus serum is recorded as part of the BN's management of lacerations. All these vaccinations and anti-tetanus treatments were carried out without direct medical supervision, and often without specific medical authority.²⁴⁴

Within the first two weeks of the 1945–1949 daily logs it is noted that M&B tablets were given to a woman following a miscarriage, with the doctor being notified.²⁴⁵ The treatment suggests that the 'miscarriage' might have been induced and that the patient had developed a post-abortion infection. The fact that the BN recorded that the doctor was notified demonstrates recognition that antibiotic prescription required medical sanction. Notification of the doctor also might have been in part because of the legal problems posed by an illegal procedure (abortion) which was complicated by a life-threatening infection. Five months later the handwriting in the log shows a different nurse was completing the record. She noted attending a patient with tonsillitis and the patient's child with scarlet fever. Both were given 'M&B'. There is no record of the doctor being advised or seeing the patients, but one of them (presumably the child) was transferred to a hospital in Hobart the following day. Several days later she records giving 'sulph' tablets for tonsillitis to an adult patient whom she visited at his home. A further change of BN appears approximately a month later. After nursing a baby for six days with pneumonia and visiting 4 patients with influenza, all without recorded antibiotic treatment, she records visiting a child and a baby with influenza and prescribing M&B. There is no record of medical consultation, and no clues as to why the latter patients received the antibiotic whilst the former did not. One can speculate that this might have reflected her concern about the severity of the illness in the

²⁴⁴ DPH, Hobart, BNS, Alonnah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

²⁴⁵ Both 'M&B' and 'sulph' refer to antibiotic treatment from the sulphonamide family of medications.

latter cases. Two months later she dispensed M&B760 to a patient with an infected hand, and records advising the Royal Hobart Hospital of her actions. In the following seven months she dispensed antibiotics (sulphathiazole, sulphamerazine, and M&B) on seven occasions, each time without medical authorisation. During this time she had a month's leave and her reliever gave sulphadiazone to a patient with tonsillitis and notes in the record that this was 'ordered from town'.²⁴⁶ Presumably this was authorised by the GMO on the nearest mainland town.

In early 1947 the BN changed again, and once more sulpha drugs are recorded as being given for tonsillitis, although several patients seen on the same day with bronchitis were treated with a 'mixture' only and advised to see the doctor. The notes make it clear that the patient with tonsillitis was unwell and subsequently was admitted to the BNC. On numerous other occasions the BN also prescribed sulpha drugs for infected glands, pneumonia, after removal of fish hooks, vomiting and abdominal pains, diarrhoea, pleurisy, and antrum trouble, all without approval. On occasion she obtained advice from the GMO upon which she prescribed antibiotics for other problems including pyelitis, pleurisy and pneumonia.

In mid-1947 while the BN was on holiday her reliever requested medical authorisation before one antibiotic prescription and retrospectively for another. Her replacement prescribed antibiotics with doctor's authorisation on two occasions, and the subsequent five antibiotic prescriptions appear to have been done without authorisation. It is possible that the doctor had reassured the BN that he had no concerns with her prescription of antibiotics.

Yet another BN was on Bruny Island by mid-1948 and recorded dispensing sulphas to patients with ear ache, influenza, sore throat and pneumonia. It was the last only patient for whom she sought advice, as the man did not improve. The treatment subsequently was changed by the doctor to intramuscular penicillin. After this she again managed a number of patients with pneumonia by dispensing sulpha drugs without seeking authorisation, as well as treating similarly a number of other patients with various infective problems.

In September 1948 the writing in the log changes again as a new BN arrived on Bruny Island. She continued the pattern established by previous BNs with the dispensing of sulpha drugs without seeking authorisation. For a two-month period in late 1948 almost all prescriptions for sulpha drugs carry the added note 'drs case', but by December 1948 the

²⁴⁶ DPH, Hobart, BNS, Alonnah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

BN again was prescribing on her own account. It seems probable that the GMO for some reason, albeit for a short time, had been a regular visitor to Bruny Island, but by year's end had reduced his number of visits. In April and May 1949 the GMO again visited weekly and saw many more patients on each visit than had been customary. Again independent antibiotic prescribing by the BN appears to have reduced although not ceased. A new BN arriving at about this time maintained the pattern of prescribing seen with her predecessors, still independently prescribing between doctor's visits although the doctor continued to have regular well-attended clinics.²⁴⁷

Narcotic prescription by the BN was recorded in a number of cases where there was no record of doctor attendance or consultation. Problems for which this was given included recorded diagnoses such as cholecystitis, malaria, burns, coronary occlusion, ? embolism (as cause of severe headache), gallstones, bladder tumour with urinary obstruction, fractures, and threatened abortion. Other potent medications given without obvious medical authorisation included aminophylline to a patient with a 'heart' problem, atropine for cardiac asthma, adrenalin for facial swelling, ephedrine for asthma, ephedrine for hayfever, phenobarb for 'flu', phenobarb for neurosis, phenobarb for nerves, Q.E.S. tablets for postpartum blood loss, iodine for goitre, and iron for anaemia.²⁴⁸

Over the 50 months of recording the overall breakdown of cases demonstrates that the BNs handled a wide range of trauma. Much was serious such as head injuries, fractures, burns, snake bites, and punctured lungs, while others were of lesser consequence such as lacerations (one of which required 131 catgut sutures.). Infectious diseases were a major part of the workload and included 'exotic' problems such as malaria, some of epidemic importance such as tuberculosis, diphtheria, chicken pox, rubella, impetigo, and scabies, as well as the usual range of respiratory and skin infections. As befits a more settled population than that of islands such as Babel and Chappell, the BN also dealt with a range of chronic diseases such as diabetes and rheumatism, and terminal illnesses such as strokes and serious cardiac disease.²⁴⁹ Again in contrast with the mutton-bird islands, maternity work was another area of important activity. Conditions requiring referral off the island were infrequent but included serious trauma, fractures, and problems such as appendicitis. Procedures undertaken by the BN included suturing of wounds, changing vaginal pessaries, incising boils (occasionally under local anaesthetic), syringing ears,

²⁴⁷ DPH, Hobart, BNS, Alonnah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

²⁴⁸ DPH, Hobart, BNS, Alonnah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

²⁴⁹ Professor AN Thomson & Dr JC Morris, Personal Communication, 2003.

dressing wounds, removing embedded fishhooks, and removing foreign bodies from eyes.²⁵⁰

The work on Bruny Island was in many ways similar to that on Babel and Chappell Islands.²⁵¹ The BN handled a wide variety of problems which was little different from that which would have been handled by a doctor.²⁵² Despite having an ability to consult with a doctor, in the majority of cases the BNs saw no need to do so. As more potent treatments became available to the nurse she availed herself of them, and the treatments given suggest an appropriate match between diagnostic label and treatment. Of course it is not possible to assess the accuracy of that label, except that when patients subsequently were assessed by the GMO there is no evidence of a change in label being given. Perhaps somewhat surprisingly, there appears little difference in recorded details to suggest that those patients who saw the GMO on his regular visits were any more or less unwell than those treated autonomously by the BN.

There is a consistent pattern of apparent independent prescribing by the various BNs who worked on the island, even of antibiotics and narcotics. By the 1940s, the DPH had placed considerable constraints on nursing practice in respect of prescribing, although these were to become yet more stringent in years to come. The records suggest that the majority of BNs on Bruny Island in the period studied had the confidence to prescribe and work beyond the strict confines of the Regulations.²⁵³ There is some suggestion that the GMOs knew of and condoned the BN's prescribing. The GMO would have had access to the BN's daily logs and would have signed the drug requisition forms. There are no records of complaints about the BN's prescribing by the GMOs who visited Bruny Island. The conclusion of this analysis must be that the BN not only worked as an autonomous practitioner but that this was done with the knowledge of, and at least implicit approval of, the GMO.

The lack of ready access to a doctor for advice required special skills of the BN. She needed to have self-confidence, and to be able to improvise as required given the lack of equipment and medications. A further impetus for improvisation was the lack of proven effective treatments. Sister Hazel Bird at Marrawah was called to a very sick baby with

²⁵⁰DPH, Hobart, BNS, Alonnah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

²⁵¹DPH, Hobart, BNS, Alonnah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

²⁵²Professor AN Thomson & Dr JC Morris, Personal Communication, 2003.

²⁵³DPH, Hobart, BNS, Alonnah Centre, Daily Report Books, June 1945–August 1945 and July 1948–August 1949.

gastroenteritis. She was concerned because she could not obtain any medicine for him for over six hours and she:

thought, now what will I do? And I just prayed for a few minutes and it came to me—wash his bowel out. And in those days we used Condey's Crystals ... well I had them in the first aid pack and I had a small enema in that pack ... I sterilised the water, then stood it in a dish of cold water until it came down to the body temperature ... then I started to do the bowel washout ... I would hold his little bottom up and put the enema in and tip a cup full, six ounces of fluid ... and then I'd put him down gently and the mother would lift his head up and the fluid would run out of his little bott. And then I'd give it another go, and another go, and another go—I did that until the wash came back just Condey's, just plain Condey's ... then I got boiled water ... and glucose ... and I gave it to the baby to drink ... by the time the medicine came his temperature was practically normal and he was OK ... He never looked back ... I've never known anybody with gastroenteritis to do a bowel wash out. Well I reckon it's the first thing to do. The bowel's the problem and if you can wash it out, well then you see, your problem, you've got control of it.²⁵⁴

It might be that Sister Bird's treatment was based on the recollection that Condey's crystals were used for vaginal wash-outs for pelvic infections in the late 1800s and early 1900s.²⁵⁵ The treatment was certainly unorthodox but evidently effective. It is likely that such 'innovation' in treatment was possible only because the nurse essentially was isolated and unsupervised. Another, perhaps less surprising, innovation on one occasion was the use of cotton-wool-padded tree bark for splinting a broken leg. Interviews with other BNs confirm that the majority of the problems nurses handled were simple and required only simple remedies. These remedies frequently were improvised:

Often at bush nursing jobs you had to treat insect bites. Bee bites, jackjumper bites, (ants) and spider bites. I was lucky to find some easy remedies for these stings and if possible hot sodium bicarbonate solutions put as quickly as possible and used as compresses. If out in bush I always advised them to get a root or soft stem of a bracken fern and rub firmly on the site of the bite ... Severe cases of bee stings could soon be relieved by bathing the area with a very strong solution of bicarbonate of soda which soon reduced swelling. Brandy, neat, on a cotton wool swab was useful to relieve a tooth ache—one improvised quite often.²⁵⁶

As communities were either farming, mining or timber towns, there were accidents to attend that ranged from goring by an animal, to cut limbs and machine related accidents. Sister McMenamin recalled an accident victim she attended:

I can remember one in particular, late at night. The three men in a car; they had sent one of the men into the hotel to buy some more liquor and he came out and ran over him as he came out! So, of course, they arrived at the hospital with this poor man and, of course, I X-rayed him and so on and I found he had a broken collar bone which I did the first aid for that and told him he must come back and see the doctor. However I can remember the doctor didn't want to see him very much and he sent him off to the Hobart hospital and he arrived at the Hobart hospital and they said,

²⁵⁴ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²⁵⁵ Professor AN Thomson, Personal Communication, 2003 and McCalman, *Sex and Suffering*.

²⁵⁶ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

'Oh, you've had everything done. It's all correct, that's all we can do for you'. So they just sent him home again.²⁵⁷

Once BNs had access to X-ray machines they had an additional useful tool for diagnosis although they were limited to X-rays of limbs and chests. Where treatments did not require surgical intervention there was in fact little that the BN could not and did not do. Bush Nurses frequently engaged in minor surgical work. At Lilydale local accidents often involved sawmilling. There were incidents where trees had crushed and killed men. Others cut their hands with saws and usually were rushed to hospital, accompanied by Sister Walsh. As she arrived for her first day at the Marrawah BNC, Mrs Burnley stitched without anaesthetic a wound in a boy who had been gored in the face by a bull.²⁵⁸ The range and severity of wounds made it 'a terrifying experience ... bush nursing out there'.²⁵⁹ Other significant wounds sutured by the BN included a 'nose bitten off in a brawl',²⁶⁰ and a wound where a young axeman had buried the axe deeply into his foot.²⁶¹

Generally BNs had to manage wounds without anaesthetic and because of this some nurses preferred to use non-surgical techniques for wound management.

I can't stand to see people suffer and put the needle in. So I used to do a lot of strapping work, and that meant of course that they came back for dressings so that you could keep an eye on it ... I got to be an artist at being able to stitch up wounds without putting stitches in it, it was strapping ... I had to stitch one person ... I did not like it because we weren't allowed to give an anaesthetic you see, you could freeze them but they could still feel it.²⁶²

Although Sister Weir comments that BNs were not allowed to give anaesthetic, the data from Bruny Island show that some nurses used local anaesthetic while they were suturing quite extensive wounds. The local freezing of an area with, for example ethyl chloride, was far from effective at reducing pain for significant surgical work. Some nurses had available to them nitrous oxide which they used at times for midwifery. Other BNs took on more responsibility. Bush Nurses who were particularly isolated from doctors, and with difficult access to transport out of the area, tended to take on the greatest levels of responsibility. This could cause controversy. The GMO on Flinders Island wrote to the DPH stating:

I am not happy about the Cape Barren Island situation because physical conditions prevent adequate medical supervision. I happen to know Sister Gittus administered a general anaesthetic herself for a suture job on one occasion.²⁶³

²⁵⁷ Eileen McManus, (née McMenamin), Interview Falmouth, 1994.

²⁵⁸ *Weekender*, 20 July 1985.

²⁵⁹ Thurza Hazelwood, (née Cox), Interview, Prospect, 1999.

²⁶⁰ Thurza Hazelwood in *Sunday Examiner*, 17 June, 1990, p. 18, 'On the Road Again with Eddie Kerfoot and Geoff Willson: "Tale of three sisters! Trip back to Adamsfield"'.
²⁶¹ Thurza Hazelwood, (née Cox), Interview, Prospect, 1999.

²⁶² Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

²⁶³ AOT, DPH, Flinders Island re Dr Rumbold's report on conditions (malnutrition) on Cape Barren Island, 5.15.47, (HSD 3/15).

The DPH's reply was somewhat ambiguous, suggesting that perhaps the administration of an anaesthetic by a BN was an acceptable, though unusual, practice:

Admittedly the residents at Cape Barren Island are unfortunately situated as regards medical attention, but they are very fortunate in having a capable mature nurse in charge of the hospital, who for many years conducted her own private hospital and has had experience in giving anaesthetics.²⁶⁴

The Bush Nursing Regulations were far from specific about what was, or was not, acceptable. While this made it difficult for some nurses who wanted to be certain about the limits imposed upon them, other nurses would work happily to the limits of their perceived competence.

The nursing of general medical patients in their homes brought with it much the same challenges we have seen for home-based midwifery. Many of the patients were poor and the BN needed to transport both her nursing equipment and often even bedding in order to have an appropriate environment for care. These difficulties led to requests for general wards in BNCs.²⁶⁵ Sister Davies on Cape Barren Island had a similar problem with nursing people in their homes and noted:

As for bed patients. With few exceptions I will have to insist that they come into hospital. Quite a number have their beds on the floor and have no regular night attire.²⁶⁶

If they were elderly 'with any sort of decent surroundings' she would attempt to allow them to stay within their respective homes.

Treating infections were a major aspect of the BN's work. Martha Vicinus argues that infection control, a role that could be seen as hygiene-related, was 'women's special field'.²⁶⁷ Infected wounds might lead to tetanus, a particularly dreaded disease. Before the development of potent antibiotics only meticulous wound care could prevent serious infection. Sister Weir tells of a young boy who fell whilst climbing a fence. From a hydrangea stick he sustained a penetrating wound of his hand which she carefully cleaned and dressed. As was her practice she emphasised the importance of returning for further dressings, but the boy did not come back for wound care. He subsequently got tetanus.²⁶⁸ Regular dressings were a critical aspect of wound care and such patients were part of the BN's daily routine. Sister Bird describes treating wounds:

²⁶⁴ AOT, DPH, 5.15.47, (HSD 3/15).

²⁶⁵ AOT, DPH, 58.9.37, Report on Marrawah BN from Nurse M Stirling, 17 May 1937, (HSD 1/36).

²⁶⁶ AOT, DPH, 58.7.40E, BN Cape Barren Island, Letter from Sister Davies, her method re visits to residents homes, 21 September 1940, (HSD 1/79).

²⁶⁷ Martha Vicinus, *Independent Women, work and community for single women 1850–1920*, University of Chicago Press, Chicago, 1985 pp. 85–120.

²⁶⁸ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

with what we called Eusol ... And hot water, they had a kettle and he had to have his hand in this Eusol water for at least half an hour and keep it in as hot as he could possible bear it.²⁶⁹

The advent of anti-tetanus serum became an important part of risk reduction in wound care. Because of its importance it appears from the Bruny Island data that BNs regularly gave such immunisations.

In addition to the dangers of wound infection there was the risk of infectious epidemics. These were always a threat, especially prior to the introduction of immunisations. Epidemics included measles, chicken pox, influenza, whooping cough, diphtheria, polio²⁷⁰ and scarlet fever. There were:

a lot of infectious diseases of course. That'd be rife through the town and they would ask for you or they'd have pneumonia ... and they were nursed at home.²⁷¹

Olga Henwood remembered being treated for whooping cough as a child by the BN on Flinders Island. The treatment was milk laced with garlic. When poliomyelitis struck the Cygnet district, mothers were understandably anxious and would be reluctant to take their children to the Child Welfare Clinic.²⁷² The clinic workload decreased but this was more than replaced with the additional home visiting to those who were ill at home.²⁷³ An added complication of poliomyelitis epidemics was that fear of contracting the disease would see families move from areas of disease outbreak. When a poliomyelitis epidemic occurred in Launceston in 1937 there was 'an influx of adults and children ... to all parts of the Lilydale Municipality'. This increased the work of the BN, and probably imported the infection into the area, with a child 'recently arrived from Launceston' developing the infection.²⁷⁴ Complications of infections such as encephalitis from viral or bacterial infections, heart trouble from diphtheria, and rheumatic fever and kidney disease from streptococcal infections would have preoccupied the mind of the BN as she dealt with her daily rounds of the sick. These all could produce situations in which the BN was likely to ask for medical advice.

As we saw from the BN's daily log books much was to change as 'sulphur drugs and penicillins came into force'. Nurses who were in active practice over that time witnessed substantial changes in the concepts and methods of treatment. Vicinus further argues that

²⁶⁹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²⁷⁰ *North Eastern Advertiser*, 9 November 1919. See also Killalea.

²⁷¹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

²⁷² AOT, DPH, 58.5.38, BN Cygnet, Letter from Nurse Eileen Lade, Cygnet re report sheet and poliomyelitis cases, 1 March 1938, (HSD 1/53).

²⁷³ AOT, DPH, 58.8.38, BN Lilydale, Letter to Sister Pitt from Council in appreciation of hard work during paralysis epidemic, (HSD 1/53).

²⁷⁴ Newspaper File held by D Wilson, *North Eastern Advertiser*, 30 November 1937, Lilydale Infantile Paralysis, no anniversaries.

as medical science progressed in the 1930s the role of hygiene as the nurses' special field was lost.²⁷⁵ The advent of these new treatments, and of immunisation against infection, changed the way BNs had to respond to infectious diseases.

The difficulties in access and communications created isolation from medical help. Not all nurses were unhappy with the isolation. Many thrived on this as it brought with it valued independence, whilst others found the situation stressful. Bush Nurses were challenged by their work. It was rewarding, exciting and at times, terrifying.²⁷⁶ When BNs determined that a patient had a problem that would be best managed within hospital or by a doctor they were careful in the way they handled the communication. While many stated that they never diagnosed, others recognised that they had to make a diagnosis—but that because of the professional hierarchy they saw that:

a nurse normally ... [is] not allowed to diagnose, [but] you do diagnose in your own little head but you refer it to the doctor and he's the one that diagnoses ... its not a nurse's duty to diagnose, that's what I mean.²⁷⁷

Bush Nurses would never state a diagnosis directly to the doctor but they would state the symptoms and 'suggest' the problem. For example, Sister Walsh at Lilydale would tie notes on clothing of referred patients to hospital. Miss Woolley of the Launceston General Hospital recalls that:

she used to send the people in with a note ... give a brief history [and] ... sometimes she would diagnose the case, 'this one I think was appendix'.²⁷⁸

Sister Walsh developed a reputation amongst the resident doctors for her accurate diagnoses, carefully-worded so as not to offend. This care in communication of diagnoses was important as the BN did not want to upset her working relationships with hospitals and visiting doctors. While nurses often recognised that they did the job of a doctor, the doctors were seen as special—the 'top brass'—and could become uncomfortable if someone told them their job:

I got on wonderfully well with my two doctors because I would never say a patient ... had a disease. I'd say he might have it ... because they don't want you to tell them. You see, that's only natural, that they were the specialists, they were the men in, you know, the top brass ... if you turned around and told them what they did have, well they might take a dim view of it.²⁷⁹

Sister Bird's description of the doctors as 'top brass' reflects the view expressed in *Una* in 1905 where nurses were exhorted to see the doctor as the 'commander-in chief' and that

²⁷⁵ Vicinus, p. 120.

²⁷⁶ Thurza Hazelwood, (née Cox), Interview, Prospect, 1999.

²⁷⁷ Una Saville, (née Nicholls), Interview, Devonport, 1999.

²⁷⁸ Joan Woolley, Interview, Longford, 1994.

²⁷⁹ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994.

they should do nothing 'to disturb the patients' confidence, but rather strive, by every legitimate means, to impress [their] charge[s] with the value of his services'. It was seen that this task required the nurse to bring 'sympathy and tact' to bear, and that this was the nurse's 'important task'.²⁶⁰ All the BNs interviewed saw such tact as a necessary part of their communication. It was the communication of this diagnostic activity that was more of a problem than the act of diagnosis itself. The division of labour described by Eva Gamarnikow was that 'the doctor diagnosed and prescribed, and the nurses observed and reported'. She claims that the role of doctor and nurse were almost identical.²⁶¹ She quotes from the *Nursing Times* in 1906: 'It is the nurse's business to observe and report symptoms but never her business to give a name to the disease or [to] any set of symptoms'.²⁶²

The BN could not have carried out her work, let alone stayed within the Regulations (for example ensuring that she treated only 'trivial cases'), without using appropriate diagnostic skills. Sister Janice Fenton notes that accurate clinical diagnosis was encouraged by the doctor in her area:

Oh yes. I diagnosed pneumonias and the doctor in Smithton was so interested I had, he gave me a stethoscope ... In those days you couldn't send cases up to Wynyard without being really ill. [So the doctor didn't mind you diagnosing?] No. They encouraged it!²⁶³

Without good diagnostic skills on the part of the BN, patients would be transferred unnecessarily out of the area, or serious problems might be missed. The consequences would have been undesirable not only for the patient, but also for the doctor in affecting his workload adversely. In this context Dr Grove's comments about the BN's access to diagnostic equipment could be seen as having consequences which were difficult for the patient, the nurse and the doctor.

Missed diagnosis could lead to complaint as occurred when Sister M Allen at Tullah failed to recognise a gangrenous appendix. The nurse stated in her defence that as 'there were not any definite symptoms of appendix which were taught me in my training it was a hard case to understand'.²⁶⁴ When the doctor was visiting the area several days later Sister Allen asked him to see the patient:

On November 19th 1942 I arrived for my usual visit in Tullah by 4 pm and was asked by Sister Allen to see Mr Brown, I went straightaway to his place and, I found him suffering from the effects of gangrenous appendix, although he did not show the usual signs of this condition. I am unable to say, how long this condition had existed, but I am convinced, that it would be impossible for a person without special surgical

²⁶⁰ 'The Nurse and the Doctor', editorial, *Una*, April 1905, p. 1. in G Strachan, 'Labour of Love'.

²⁶¹ Gamarnikow, p. 116.

²⁶² Gamarnikow, p. 117.

²⁶³ Janice Flora Barnes, (Previously Brooks and née Fenton), Interview, Devonport, 1999.

²⁶⁴ AOT, DPH, BN Tullah, Re relieving BN—see also file 87.7.43, 58.20.43, (HSD 1/87).

training to recognize the seriousness of this atypical case, consequently no possible blame can be attached to Sister Allen for failing to do so.²⁸⁵

Nurses were trained in a hospital environment in which diagnostic acumen was not seen as within their required competence, but as BNs they were placed in a position where they needed to develop skills in diagnosis under difficult environmental conditions. Whereas these skills needed to be learnt on the job, there was no formal system of support and training to encourage their development.

It was perhaps surprisingly infrequent for there to be a complaint about BNs' diagnoses or management. A missed diagnosis of pneumonia soon after the availability of penicillin led to a 'reminder', by the Minister of Health (a former GMO), that the BN's role was 'to only render first aid, and except in cases of minor complaints [to] obtain medical advice by telephone or otherwise'.²⁸⁶ This advice was perhaps more a retreat behind regulations than a statement that could have been followed by the majority of BNs over the period of the Bush Nursing Service since its inception. Perhaps it was also a reflection of directions to come from Government as improved technology and transport reduced the isolation of the BN, and health-care innovation was appropriated by the medical profession. The local doctor supported the charge that:

Sister Rushton had taken on too much responsibility, and that it was not her place to make a diagnosis, she should have known that a doctor was necessary. He said the only hope was penicillin and sister was not qualified enough to give it.²⁸⁷

He additionally complained that she had treated a '4 inch axe gash into the tibia' and that subsequently the patient required hospital admission for bone infection, operative treatment, and penicillin.²⁸⁸

It is hard to judge quality of practice in retrospect but the records of the BN's work in the area of general medical nursing suggest that she functioned with a high level of professional independence and with the general trust of her medical colleagues. In deciding whether to treat patients at the BNC, in their homes, or to refer them for medical care she had to determine the likely cause of and best treatments for the health problems presented to her. Where it seemed appropriate to transfer the patient to the care of a doctor this transfer was not always easy.

²⁸⁵ AOT, DPH, 87.7.43, 58.20.43, (HSD 1/87).

²⁸⁶ AOT, 58.01.49, Letter to Sister Isobel B Rushton from Minister for Health, RJ Turnbull, 1 February 1949, (HSD 6/34).

²⁸⁷ AOT, 58.01.49, Letter to Council Clerk from Freeman, 5 January 1949, (HSD 6/34).

²⁸⁸ AOT, 58.01.49, Letter from Dr R Webster, Campbell Town, 18 January 1949, (HSD 6/34).

The critical test required of the BN was first and foremost diagnosis. In current nursing practice nurses now talk of 'nursing diagnoses' to differentiate these from the medical diagnosis. This is a new concept and the activity of the BN was more in the model of the 'medical diagnosis'. Many of the BNs interviewed have stated that nurses did not diagnose, whilst others have accepted that they did perform diagnostic functions but were circumspect about it. Diagnosis is an activity which has a categorisation function—the level of diagnosis required and/or demonstrated by the BNs in the main might be lower than that currently exhibited by doctors. This might be a reflection of the need to be circumspect, and the lack of need to be highly specific when management options were more limited than they are for current health-care professionals. Diagnosis leads naturally to the definition and implementation of a plan of management. Once the BN was placed in a position where diagnosis was required it was only a small step to provide the patient with any supportive management within the BN's ability or the availability of materials. The Regulations required that only in cases of emergency and trivial cases should the nurse function without medical direction, except where there was no resident doctor and in the absence of the nurse no skilled aid would be sought. Emergency cases are perhaps non-contentious, but 'trivial cases' can be determined only by accurate diagnosis or in retrospect. Nevertheless medical direction was not sought necessarily for non-trivial cases. The Regulations did not permit the nurse to function independently when no other skilled aid was readily available, only when it would not be sought otherwise. The way this Regulation was framed gives rise to speculation that it was designed to be broken. Certainly there is evidence that, during at least some of the Bush Nursing period, the BN often operated as an independent health professional offering much the same basic diagnosis and management technologies as were available to the medical profession at that time. It might be that the lack of close supervision on occasion led to unorthodox treatments or even to unsafe practice, but this perhaps was a corollary of independent practice.

A critical part of the role of the BN was to separate health problems into two groups—those that she could deal with and those that required referral to, or advice from, a doctor. The low number of recorded complaints suggests that BNs managed this categorisation well although they acknowledge that it was not always easy. Sister Evelyn Mellish at Gladstone recalled some moments of doubt but was generally confident she could care for her patients:

As long as I knew my job and knew what I was doing then did the right thing, that was. There were one or two things that I did wonder whether I did the right thing. I wonder if I should have done something different. But anyway it was too late then.²⁸⁹

²⁸⁹ Evelyn Mellish, Interview, Musselroe Bay, 1994.

As sole practitioners, BNs would need to make quick decisions regarding referring patients on to city or town hospitals especially if the local doctors were unable to advise via the telephone.²⁹⁰ Bush Nurses attended to the majority of cases without outside help or advice. Referrals were the exception. According to her family and past residents of Ringarooma, Sister 'Maisie' Rayner attended the majority of cases alone but did refer some to the Scottsdale hospital or rang the local doctor for advice:

She acted on her own definitely. Oh, she did ring up Irving with grandmother's snake bite, then we took her to Scottsdale in the car.²⁹¹

While at Gladstone, Sister Mellish recalled only ever sending urgent cases on to hospital.²⁹² When nurses felt that a patient should be referred on to the doctor or hospital their judgement was trusted by the doctors. Mr Van Der Hek recalls that if Sister Walsh rang the doctor saying that she had a patient requiring immediate hospitalisation, the doctor would say, 'all right I'll arrange for an ambulance, I won't come out, you know, I'll take your word for it'.²⁹³ Dr John C Morris, the Registrar at the LGH during this period, confirms this opinion and notes that in his experience her judgement was never wrong.²⁹⁴

Nursing training had not prepared BNs for their role as prescriber and compounder of medications. Many new BNs experienced some guilt when first faced with the need to prescribe, and as one BN stated, 'I will admit at times you would have to prescribe without the doctor's authority so you just let him know afterwards' but despite feeling some initial guilt about prescribing 'you soon get over it. You soon get straight into it'.²⁹⁵ There is little evidence that nurses' guilt or insecurity lasted more than the initial period of their BN experience—the feeling of being able to do something when faced with a problem soon would have dispersed this guilt. As Victoria Hobbs notes, in the early years of Bush Nursing there were few treatments that could be acted upon in hospital that the nurse, at least in theory, could not carry out successfully in the patient's home:

... even patients with infectious diseases were successfully isolated, an accepted barrier being a blanket impregnated with carbolic being hung across the door of the sick person's room.²⁹⁶

The treatments that were seen to be effective were not subject necessarily to restricted supply. Bush Nurses did not require medical direction to tell them what range of treatments they should use, and they had a clear idea of what they were trying to achieve.

²⁹⁰ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

²⁹¹ Dawn Coffey, Interview, Beauty Point, 1994.

²⁹² Evelyn Mellish, Interview, Musselroe Bay, 1994.

²⁹³ Art Van Der Hek, Interview, Norwood, 1995. Mr Van Der Hek became Council Clerk in January 1965 and retired in September 1995.

²⁹⁴ Dr JC Morris, Personal Communication, April 2003.

²⁹⁵ Una Saville, (née Nicholls), Interview, Devonport, 1999.

²⁹⁶ Victoria Hobbs, *But Westward Look*, University of Western Australia Press, 1980, p. 56.

While the DPH was unhappy about BNs obtaining medical supplies from outside the official system, there was acceptance of BN prescribing, albeit an acceptance which appears to have varied by both time and location. In general there was less of a problem with the prescription of symptomatic treatments than with the use of more potent treatments such as antibacterials. Even symptomatic treatments were at times discouraged as when the Supervisory Nurse noted that 'Sister [Margaret E] Gill had been in the habit of prescribing cough mixtures etc for patients'.²⁹⁷ Narcotic drugs were subject to the greatest restriction. Injectable medications were less likely to be prescribed by nurses.²⁹⁸ Prescription was seen to require the examination of the patient. There was some community pressure, particularly when antibiotics became available, to dispense on request. In general nurses resisted this pressure and had DPH support for such action:

Some of these people seem to be of the opinion that the Sulpha Drugs are cure alls and to be given out indiscriminately. I of course cannot do this.²⁹⁹

Circumstances could arise where the BN might see this as the only reasonable course of action:

A case in question, Sulphur Drugs were sent out to a mother with three sick children, without Sister having seen the children. This happened because of distances, and pressure of work, preventing Sister from attending at the time transport was available.³⁰⁰

Such an action left the BN in a difficult and unsupported position should the health outcome not be satisfactory. It was recommended that BNs obtain a detailed Standing Order for prescribing, but there is no record in the BN archives that these were developed for any BNC.³⁰¹ With the low level of continuity of GMOs in some areas, and in other areas access to a doctor being infrequent or difficult, this directive would have been hard to implement. Furthermore the DPH accepted that this might be more difficult in areas where the BN's contacts were with private doctors rather than with GMOs.³⁰²

Not only was the BN to take care in her own prescribing but she was responsible also for demonstrating that all stocks of dangerous drugs were accounted for properly. The DPH warned that:

²⁹⁷ AOT, DPH, 58.13.41, BN Ringarooma Letter from SN re stocks of drugs. Sister Gill was Margaret E Gill, (HSD 1/79).

²⁹⁸ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994

²⁹⁹ AOT, DPH, 58.10.2, Letter to Director Medical Services from Sister Good, Mole Creek Centre, 11 September 1952, (HSD 5).

³⁰⁰ AOT, DPH, Memo to PHD from Sister Widdicombe re Sulphur Drugs & more consultation between Drs & Sisters, 23 May 1952, (HSD 5).

³⁰¹ AOT, DPH, 58.27.45, BN Strahan, (HSD 1/91).

³⁰² AOT, DPH, 58.28.3, Letter to Sister N Jean Bryan, Oatlands from Director General Medical Services re circular on drugs, 24 August 1953, (HSD 5).

should any untoward happening eventuate from non-observation of the abovementioned instructions, then the Bush Nursing Sister involved would be held responsible.³⁰³

In at least one area of practice prescribing appears unquestioned, and neither prior nor subsequent written authorisation to prescribe was required. In midwifery cases, nurses gave ergot preparations to patients without permission from a doctor either at the time, or later, yet no record of a 'standing order' has been found. This might be because prescribing of ergot became the norm in maternity practice, and BNs were allowed to conduct normal deliveries without medical supervision. Despite this apparent freedom to prescribe, it was considered necessary for the nurse to have a written order from a doctor when requesting her supplies of ergot.³⁰⁴

There is no clarity in the Bush Nursing records about the limits to prescribing which were enforced, although at most times it was deemed appropriate for any dispensing to be authorised by the doctor, even if in retrospect.³⁰⁵ The health care environment was changing. As Bessant and Bessant note:

Increasingly a patient's survival was dependent on the proper application of a particular treatment, rather than in building up her or his strength over a long period of time, and relying on her or his inherent vitality to ensure survival.³⁰⁶

These changes had been underway since the early 1930s but there was a rapid increase in the speed of change in the 1950s as advances in medical research during the war years became available for application to the civilian population. It is perhaps no coincidence that there was an attempt to clarify or regularise the prescribing by BNs in the 1950s under Standing Order 22 of the Bush Nursing regulations. While in correspondence to nurses about this issue the Department highlighted the dangers relating to chloromycetin and stated that the use of this drug without medical supervision was 'absolutely prohibited', the Department also stated categorically that the nurse would be liable for the consequences of any adverse effect from prescribing any medication. It finished with, in effect, a warning—obtain written authorisation for anything that might be prescribed.

The attention of all Bush Nursing Sisters is drawn to the dangers inherent in their using certain drugs without medical supervision. Often due to local circumstances, such as isolation, difficulty in obtaining the services of a doctor, &c., Bush Nursing Sisters have become accustomed to using drugs without medical reference. In many instances this may be all right, but frequently conditions exist in the patient which are discoverable only by a doctor, and which conditions preclude the use of certain drugs dangerous in such conditions. In other instances, drugs which have become popular

³⁰³ AOT, DPH, 58.28.3, Circular to Bush Nursing Hospitals and Centres re Narcotic Drugs, 12 August 1953, (HSD 5).

³⁰⁴ AOT, DPH, 58.37.41, BN Circular re Ordering of Ergot products, doctor's order to be attached, 23 June 1941, (HSD 1/80).

³⁰⁵ AOT, DPH, 58.23.41, BN Waratah Letter from SN re inspection of Waratah centre, (HSD 1/80).

³⁰⁶ Bessant & Bessant, *The Growth of Profession*.

for various reasons are used in a haphazard manner, although such drugs are powerful and can be dangerous. One which comes to mind is Chlormycetin. This is a very powerful anti-biotic used in quite a number of conditions, both of major and minor nature. Some few months ago the Department saw fit to warn the whole medical profession concerning the dangers in the use of this drug ... Chlormycetin can very easily, and in some cases on normal doses, cause a fatal aplastic anaemia. The use of such a drug by a nursing Sister without medical supervision, in such cases as Whooping Cough and other minor/major ailments is absolutely prohibited. Nursing Sisters should take note that the consequences of their using any drugs without medical supervision will be directly referable to them. Instructions in writing should be obtained by a Sister, regarding the administration of drugs and treatment which she is required to carry out during the Medical Officer's absence, and in the cases of emergency.³⁰⁷

The warning uses the example of an uncommon reaction to a valuable drug—a drug that eventually almost ceased to be administered by the medical profession because of the inherent risks.³⁰⁸ It seems that such an example could be considered somewhat of a 'logical overkill'. It really does not address the risks versus benefits of prescribing safer drugs, and it would appear that the DPH has adopted 'scare mongering' to try to stamp out a relatively safe behaviour. Other than within the context of the changes that were occurring in the availability of new treatments, the motivation for this pronouncement at this time is unclear—but it is in its timing close to the 'demise' of the Bush Nursing Scheme. By now the numbers of doctors had increased, and transport and communications were improved substantially compared with the situation in the early days of Bush Nursing. Perhaps in addition to the changes in medical treatments, the combination of medico-political and legal power and the changes in society had caught up with the professional independence of the BN. The directive offers the nurse an 'acceptable' alternative to case-by-case medical approval—she could prescribe if she held a written standing order from the Medical Officer outlining the circumstances in which she might prescribe.

She might alternatively take the risk of prescribing then seeking a doctor's authorisation in retrospect for the prescription. In the event that permission was unforthcoming she was warned that she faced the full consequences of her actions. This is no different from the responsibility that is carried by the medical profession, but the nurse neither had the legislative backing nor insurance backing to cover such liability. It is uncertain what the outcome of this advice was on nursing practice. That the BN was expected to keep detailed records of her actions is consistent with the view that the BN was responsible for her actions at all stages in the Bush Nursing era. Furthermore these actions clearly included the prescribing of pharmaceuticals—even if this were, at least in theory while certainly not in practice, in exceptional circumstances. No BN was subject to legal

³⁰⁷ *State of Tasmania DPH Bush Nursing Service Information relating to Standing Orders of the Bush Nursing Service August, 1953*, p. 7. (Personal copy of 'Lexie' A] Burns, Waratah).

³⁰⁸ Professor AN Thomson, Personal Communication, 2003.

threat or penalty as a consequence of her actions, either before or after this memorandum. This perhaps reflects a difference in the public climate in respect of litigation as much as it might be seen to reflect ambiguity about the degree to which the BN was legally responsible for her clinical practice and its outcomes. It is hard to escape the conclusion that the BN, at least until 1953, was independent in her clinical judgement and in the implementation of treatment.

The Bush Nurse and Child Health

The third major area of Bush Nursing work was in health services to children. Once again, providing a core health service to isolated individuals, the BN's day-to-day role in child health to a large extent was unsupported by those charged with the coordination of the service. Bush Nurses provided services to children through ante-natal and post-natal care, care for sick children, assistance with immunisation, in school health, and in child health promotion.

By operating Child Welfare Clinics at the BNCs there was a decreased need to conduct as many home-based child welfare visits.³⁰⁹ All BNs recalled that their weekly clinics played a social role. This was the one place where the mothers could meet together to compare notes, chat and dress up.³¹⁰ Transport and communication problems and the scattered nature of the rural populations resulted in all women being isolated. The Child Welfare Clinics provided an ideal opportunity to socialise. The nurse would weigh the babies, generally answer queries, and give advice to mothers:

I had a clinic, quite a big one. They all turned up to see who could dress their babies the best, you know. They took great pride in their families.³¹¹

The clinics were often very informal, operating more as a drop-in social centre rather than as a scheduled clinic, unless there was going to be a visit from the doctor.³¹² Prior to the opening of a BNC there was often no existing Child Welfare Clinic. Once a BNC was established and a Child Welfare Clinic opened often additional clinics were operated in areas distant from the BNC if sufficient local support were forthcoming.³¹³ When telephone

³⁰⁹ *TJPP&P*, 1950.

³¹⁰ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

³¹¹ Viola C Millington (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

³¹² Una Saville, (née Nicholls), Interview, Devonport, 1999.

³¹³ AOT, DPH, 58.18.38, BN Ulverstone, letter from Sister Iles re opening Sprent Child Welfare Clinic, 8 July 1938, (HSD 1/53). 'Last Tuesday, with the assistance of the CWA, I opened a Child Welfare Clinic at Sprent. They have provided the entire equipment, including a set of scales, which I am to be allowed to use throughout the Municipality. They accept the full responsibility of financing and general care of the clinic. Until a more suitable room is obtained the rector is allowing us the free use of the Church vestry with the Church Clubroom as a waiting room where the mothers will be entertained by the CWA to afternoon tea. The Clinic will be open one day each month, the day coinciding with the CWA monthly meeting. This will ensure regular visiting and save a considerable amount of travelling as the homes are very scattered. I have had repeated requests to

services were generally available many mothers would ring the BN for advice.³¹⁴ Post-natal care was becoming an increasing part of the BN's role which meant that often she would make additional home visits to small or new babies:

I used to visit them for six weeks to make sure they knew what they were doing. Especially if they were new mums. Sometimes ... once a week, sometimes twice a week ... if it was their first baby.³¹⁵

Photograph 5.05 Child Welfare Clinic, Flinders Island



Source: Furneaux Island Museum.

Financial hardship within the community was a concern in the 1930s which hampered the delivery of medical care, midwifery, and child health. Child welfare work was regarded highly by the community, the Lilydale Municipality seeing this as being the 'most important' part of her work.³¹⁶ Before the free GMO Scheme started in 1938, Bush Nursing care was more cost effective than medical care for maternal and child health. Through the BN mothers had access to free ante-natal and post-natal care:

Although the local Doctors never refuse to attend such cases it is not fair to ask them to travel long distances and give their time and service knowing the patient will not be able to pay. A high percentage of the midwifery cases which I nurse have no domestic help ... the ones who go home to full responsibility of the home duties on the 10th or 11th day after confinement ... are unable to breast feed their babies. They

open Clinics in other out-back centres, and have had suitable rooms offered free for the purpose, but refuse to do anything without an enthusiastic local committee, who will undertake the responsibility of the care and provision of the necessary equipment.'

³¹⁴ Eileen McManus, (née McMenamin), Falmouth, Interview, 1994.

³¹⁵ Evelyn Mellish, Interview, Musselroe Bay, 1994.

³¹⁶ Newspaper Clipping File held by D Wilson, *The Examiner* 28 September 1937, effect of free Government Medical Service on Bush Nursing, and Newspaper Clipping File held by D Wilson, *North Eastern Advertiser*, 20 November 1936, Annual Report Lilydale BN.

are not able to regain their strength and establish a good breast supply ... This is very marked in mothers who have their children in quick succession, and some of them are not able to afford the necessary medical and surgical care, and continue to suffer. I find that a great majority of the mothers are not aware that they are privileged to free pre and post natal care by the BN, and suffer unnecessarily, accepting their abnormal condition as inevitable³¹⁷

and the nurse would obtain medication for the mothers without the need for the mother to see the doctor thus incurring additional expense:

The local Doctors are very sympathetic ... with all cases whom I ask advice for, and do not hesitate to prescribe on my advice. In some instances they have obtained free Hospital accommodation, and given free care to poor mothers on my recommendation.³¹⁸

The combination of the isolation of rural communities and the frequent poverty enhanced the value of the Bush Nursing Service even in respect of non-urgent care such as child welfare.

By the 1940s there had been an expansion of the Child Welfare Services. In 1942, some 'eighteen child welfare sisters (served) a total of twenty-nine clinics throughout the State'.³¹⁹ In the war years petrol rationing affected the provision of services. In the post-war period new facilities became available for welfare work as War Memorial Halls or centres were constructed.³²⁰ These centres, whether in formal facilities, or based in temporary borrowed space, continued to fill an important need. Without these clinics mothers often were forced to weigh their babies at the local store as they did 'not hav(e) time to visit the hospital ... from outlying districts'.³²¹ Thus in addition to the clinic at Grassy, the BN on King Island proposed to operate clinics or visit children at 'Yamba-coona, Naracoopa, Pearshape, Egg Lagoon, and Manana'.³²²

³¹⁷ AOT, DPH, 58.18.38, BN Ulverstone, Letter from Sister Iles plight of poor mothers unable to convalesce longer, 8 July 1937, (HSD 1/53).

³¹⁸ AOT, DPH, 58.18.38, (HSD 1/53).

³¹⁹ This figure includes the BNs who carried out child welfare work as well as the dedicated Child Welfare Sisters. AOT, DPH, 51.28.42, Departmental, Review of Activities of Dept—Statement submitted to Premier for ALP Conference, resolutions re: Provision of hostels for women travelling to maternity hospitals and care of young children; Extension of GMS; Maternity treatment in Public Hospitals, (HSD 5).

³²⁰ AOT, DPH, Letter from K Widdicombe re King, 30 October 1946, (HSD 1/92).

³²¹ AOT, DPH, (HSD 1/92).

³²² AOT, DPH, (HSD 1/92).

Map 5.03 King Island



King Island is 36 miles from north to south.

Source: King Island Council, <http://www.kingisland.tas.gov.au/map>

The Child Welfare Services were being taken to the clients. Where the nurse was to visit the client she sometimes required innovative strategies for locating the residence. It was not necessarily easy finding the clients:

I got a list of babies' names from the register, but no addresses, so where these babies were located was a mystery to me. This problem was solved by taking my sister along in the car to watch out for nappies on the clothes lines. Having my sister as lookout was a big help in more ways than one. As this was my first car and I was still learning to change gears, I could concentrate on the driving while she watched out for obstacles on the road.³²³

Child welfare work could be quite complex and the conditions of work arduous. Sister Weir, relating stories of incest and physical abuse, tells of supporting a mother unjustly charged with child neglect. Sister Weir was involved in training other nurses in child welfare work. She believed that, as those families most in need would not attend the clinic, they required visiting. The child welfare trainees:

³²³ Hearn, p. 59.

hated going into places where there were bad mothers and they used to write 'savage dog' or they would write 'not at home' so as not to call at the house ... I used to go up to the dogs and let them smell my hand and they would gradually let me in. As for 'not at home' I knew they were pretending not to be at home ... and I would go around the back and soon find them. Sadly there was very little ... power that you had or could do. I would report it and get the Social Security people to come out but they were no good at all. There were filthy houses and the men would say, 'Look out, Sister, don't put your foot in the shit, Sister'. And they would have relieved themselves on the floor!³²⁴

A similar story is related in a contemporaneous newspaper story about Bush Nursing. In this story the BN, working in conjunction with the local Health Inspector during an epidemic of an infectious disease, went to visit a house to take swabs. When they arrived at the house they found it locked up, and it appeared that no one was home. Suspicious, the BN and the Health Inspector decided to use a 'little strategy, and temporarily retired', then crept up to the house on foot. This time the doors were open, and everyone was at home. They were informed that on the first occasion the family had watched them approaching, and had locked up the house. Later that day they had to pursue a small boy into the bush in order to take a throat swab. This was time-consuming work and 'owing to the difficulty experienced in locating a number of people, the nurse could not find time for lunch, but managed to get a cup of tea during the day'.³²⁵ The combination of isolated communities and fear and suspicion together served to make the BN's tasks especially arduous.

Despite the difficulties involved in this type of work, support and training for the nurses appeared less than optimal. Since nutritional problems were of concern to many BNs, the nurses were active in giving advice especially in infancy and childhood. Many BNs felt that they had little training in this area. Some such as Sister JE Fraser, who had never studied child welfare, requested assistance from the Department with leaflets on feeding babies various milk mixtures and food for older babies.³²⁶ In 1953 in a memorandum to the Director of Public Health it was noted that dedicated Child Welfare Sisters visited two areas where the BN did not hold the requisite certificate.³²⁷ In one area, Maydena, the BN was an immigrant, 'not yet familiar with the country' and thus it was not appropriate for her to deliver welfare services. In all BNCs except these three areas BNs provided child health and welfare advice but as:

³²⁴ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1999.

³²⁵ Newspaper Clipping File held by D Wilson, *Mercury*, 11 June 1927, 'Trials of a Bush Nurse'.

³²⁶ AOT, DPH, 58.01.49, Letter to SN Sister Noller from Sister Fraser, Avoca, 26 August 1949, (HSD 6/34).

³²⁷ The memorandum was headed 'MEMORANDUM FOR DIRECTOR-GENERAL OF MEDICAL SERVICES BUSH NURSING SERVICE, Incorporating (a) School Medical Service, (b) Child Welfare Service', the title reflecting the close relationships between Bush Nursing and these activities.

less than one third of the Bush Nursing Staff hold Child Welfare Certificates ... there are noticeable instances of babies not thriving, mothers receiving incorrect advice, and school children receiving inferior tuition.³²⁸

The Director, in reply, endorsed these comments about unsatisfactory advice and outcomes and went on to say that it was of the utmost importance to entrust this work only to those appropriately qualified.³²⁹ He was concerned that the lack of training made it difficult for the DPH to achieve the desired outcome of providing 'all parents with expert child guidance'.³³⁰

With the BN involved in 'well child care' and in advising mothers with children with health problems, often she was the first professional in a position to recognise a significant health problem. Linda Bryder notes the claim that the New Zealand Plunket nurse was at times the first person to see or diagnose an urgent situation.³³¹ The New Zealand Plunket Society, supported by its Plunket Advisory Board, a Board which included two doctors, determined in 1910 that a doctor should be called only 'in cases of serious illness'. The words 'serious illness' were 'not intended to include mere infantile ailments, eg simple diarrhoea, indigestion or colic', and nurses were instructed to delete references to any illness or to deaths in their annual reports.³³² With these simple ailments a major cause of infant mortality, the Plunket Nurses clearly were involved in vital illness-management and were seen to be providing a service rivalling that provided by doctors. It is highly likely from the evidence from interviews and existing data that BNs operated with a similar degree of independence to that exhibited by the Plunket Nurses. There is no evidence that the Tasmanian Bush Nursing organisation provided formal support for such independence or for 'editing' of data relating to critical outcomes. The BN's isolation and often minimal training and supervision left her independent by default. The DPH, the Supervisory Nurses, and the BNs, were all concerned about the impact of this lack of training and support.

In Canada, the Albertan and British Columbian Public Health Nurses were responsible for setting up Child Welfare Clinics throughout rural areas in response to a concern about high maternal and infant mortality at the end of World War I.³³³ In

³²⁸ AOT, DPH, Memo to Director General Medical Services re School Medical & Child Welfare Services, 15 September 1953, (HSD 5).

³²⁹ AOT, DPH, 51.17.2, Memo from Director Public Health re incorporating school medical & child Welfare work for BN, 17 September 1953, (HSD 5).

³³⁰ AOT, DPH, Circular letter to Sisters of Bush Nursing and School Medical Services, 15 September 1953, (HSD 5).

³³¹ L Bryder, 'The Plunket Nurse as a New Zealand Icon', UK Centre for the History of Nursing Seminar Papers, 2000-02, <http://www.qmuc.ac.uk/hn/history/seminars02.htm>.

³³² Bryder, 'The Plunket Nurse as a New Zealand Icon'.

³³³ Mill, Leipert, Duncan, pp. 18-23.

Tasmanian rural areas, as in Canada, it made sense to graft the needed Child Welfare Services onto an existing workforce rather than to try to expand the dedicated Child Welfare Nursing Service into rural areas. Child Welfare Clinics often were set up in conjunction with the start of a BNC and the BN was the identified professional who could take charge of the service.³³⁴ However because Child Welfare Services also were delivered by dedicated Child Welfare Nurses there was potential territorial overlap, and either consequent mutual support or conflict. Neither outcome developed as BNs were engaged in child welfare activity only where there was no dedicated service; Child Welfare Nurses visited few BNs' communities.

Infection was a serious health problem in the early 20th century, which meant that the availability of immunisation was a significant advance in public health, but:

This free service (immunisation) is another of the doctor's important duties, and cannot be delegated to nursing sisters.³³⁵

It was a public health intervention of such importance that the BN on Cape Barren Island recalls that the Minister of Health, Dr Turnbull, visited the island to assist in giving immunisations in the 1950s. His involvement was at a very practical level:

We had a great day. There were all these children screaming and going on and he wanted me to, you know, go straight through ... you know he'd been in the war, years I think, and felt we had to do each one.³³⁶

This reinforces the public health and political importance of immunisation against the serious epidemics of the day. Bush Nursing Standing Orders clearly stated that immunisations were a free service as part of the Government Medical Officer's duties, and were not to be delegated to Nursing sisters.³³⁷ This statement is repeated in numerous official documents.³³⁸ As early as 1939 in Tasmania the DPH had foreshadowed the giving of immunisations by BNs when they stated that:

The enthusiasm of all districts [for the Bush Nursing Service] is great ... The scheme is in its initial stages, and there are many aspects of development that will come up for further consideration as more information comes to hand. It is hoped that later on an extensive campaign of diphtheria immunisation will be undertaken.³³⁹

³³⁴ QVMAG, Box 10, 18 July 1932, Lilydale BN Annual Meeting re Child Welfare Centre.

³³⁵ AOT, DPH, 1.15.53, Circulars Info Relating to & Standing Orders of GMS re BNCs, (HSD 3/22).

³³⁶ Una Saville, (née Nicholls), Interview, Devonport, 1999.

³³⁷ State of Tasmania DPH Bush Nursing Service Information relating to Standing Orders of the Bush Nursing Service August 1953. In contrast with the situation in Tasmania, during the 1920s District Nurses in Alberta administered immunisations independently, but this activity did not become part of the Public Health Nurse's role in British Columbia until the 1940s when doctor numbers reduced as a consequence of war service. Mill, Leipert, Duncan, pp. 18–23. Monica Green claims that Public Health Nurses were the first nurse immunisers in Canada. Green, p. 66.

³³⁸ AOT, DPH, 58.11.7, Letter to Sister Perrett Oatlands from Sister Noller re Diphtheria Immunisation, 28 August 1950, (HSD 5) and AOT, DPH, 58.11.7, Letter to Mrs Sattler Parattah from Director Hospital Medical Services re Immunisation, 27 September 1950, (HSD 5).

³³⁹ AOT, DPH, Miscellaneous General, Government Medical Services in Country Districts, 1 January 1939, (HSD 3/2).

Diphtheria immunisation commenced in the early 1940s.³⁴⁰ Poliomyelitis immunisation was available from 1956 (initially the injectable Salk vaccine, and from 1966 oral Sabin vaccine).³⁴¹ Perhaps consistent with the DPH's earlier statement, most of the interviewed BNs remember assisting doctors to administer vaccinations, but also many recall having given immunisations independently with the support of the local municipalities. These recollections support the Bruny Island daily log records.

There were good practical reasons for allowing nurses to give immunisations. At Derby, Dr Jones, the GMO, had been giving the BN vaccine for her use, presumably because he was not making regular visits to Gladstone.³⁴² The Director of Hospital and Medical Services was not happy with the service provided. The Director asked Dr Jones to ensure that he visited once weekly to provide support to the BN, and reminded him that immunisations should be carried out by the doctor. In the Director's view the nurse was in attendance only to sterilise instruments and to prepare skin. Further the Director stated that 'the Minister desires this'.³⁴³ At Ringarooma also the BN had been deputised by Dr Jones to give all the diphtheria injections. With the local community living on scattered farms they found it difficult to attend the BNC for doctor's visits. The Department intervened, stopping the BN from obtaining the vaccine, leaving the BN unhappy with this action and its impact on the community's access to vaccination.³⁴⁴ The infrequent and relatively fleeting visits of the GMO would have made immunisation delivery more convenient if given by the BN. There was the potential that not only might such a hiccough in vaccine supply reduce the vaccine up-take but that also the BN would have to cope with a number of clients who had been 'put out' by the bureaucratic response. This situation was to change and by 1957 Public Health Reports specifically noted that, in many centres, sisters have assisted doctors with the immunisation of children against poliomyelitis, diphtheria, tetanus and whooping cough 'to a greater extent than in previous years'.³⁴⁵ Successful immunisation programmes depended on flexible delivery of immunisation, and the BN's role as sole health practitioner in many communities was again important to the public health.

³⁴⁰ QVMAG Box 10, Newspaper Article, 9 April 1940, re old Lilydale school site for BNC & diphtheria immunisation.

³⁴¹ Killalea refers to Statistics of Tasmania, Commonwealth Bureau of Statistics, Tas Branch, Hobart, 1909–10, 1929–1930 and 1934.

³⁴² AOT, DPH, 13.2.50, Letter from Director of Hospital and Medical Services to Dr Jones, 20 July 1950, (HSD 3).

³⁴³ AOT, Letter from Director Hospital and Medical Services to Dr Jones, 9 August 1950, (HSD 3).

³⁴⁴ AOT, DPH, Letter to Sister Noller re Ringarooma, 11 July 1952, (HSD 5).

³⁴⁵ TJPP&P, 1957.

The Bush Nurse's Myriad Roles and Workload

The role of certifying the death of patients was another function which was usually the domain of the doctor. Bush Nurses were required to perform this function in the doctor's absence. Usually she would be the first called when a death occurred in the community, even before the police were notified. Even with these deaths, 'Of course and you'd have to go and lay out'.³⁴⁶ On most occasions she would perform this duty alone, but Sister Connor recalled that after a tragic accident in Burnie late one night, where two men were killed, the police officer insisted on accompanying her to the mortuary.³⁴⁷ Sudden unexpected deaths included suicides, but most nurses would stress that they were rare. According to at least one nurse, these were as a rule 'mentally disturbed patients'. Taboos surrounding suicide were evident with most of the nurses interviewed, were distressing to them, and an area that BNs preferred not to remember or at least not to discuss openly. These were the:

worst things. Yes, when those people shot themselves. That was the worst thing. In the case of [suicide] ... they called me. I rang the police ... doctor.³⁴⁸

At Lilydale Sister Walsh always accompanied police when they attended suicide cases. At Bruny Island in 1937, Sister Jane Finn made a difficult descent down a cliff to provide aid to a man who fell off rocks while fishing, only to find he was dead. She secured the body so that it could be retrieved safely the next day. The visiting doctor to the island had no desire to descend the same cliff, and accepted the BN's declaration of death. She thus was allowed to sign and submit the death certificate to the Coroner, a task normally reserved in legislation for doctors.³⁴⁹

Bush Nurses were not required to 'lay out' those who had died but were 'placed in an intolerable position if they accept(ed) their privilege of refusing to lay out bodies in the district'.³⁵⁰ Refusing such a task, one few other community members were likely to feel comfortable with, potentially would have jeopardised her place within the community. The situation on Cape Barren Island in the 1950s was unique. The BN and her schoolteacher husband orchestrated the whole ceremony surrounding death from the certification, to the laying out and to the burying. While in hospital training she had learnt how to lay out a body, but attendants then took over and transported the body. Now she had to organise this as well. There was no local undertaker, so from that point her husband took over

³⁴⁶ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

³⁴⁷ Family notes from interview with T Connors, 1990, Private Collection.

³⁴⁸ Evelyn Mellish, Interview, Musselroe Bay, 1994.

³⁴⁹ Cape Bruny Lighthouse.

<http://www.lighthouse.net.au/lights/TAS/Cape%20Bruny/Cape%20Bruny.htm>.

³⁵⁰ AOT, DPH, GMO, Dr RG Mair in letter to Director of Public Health, 17 July 1951, (HSD 3).

combining his duties as a Special Constable with that of undertaker.³⁵¹ He might have signed the death certificates, given that a doctor visited infrequently, or the bodies might have been held until a doctor's visit could be arranged.³⁵² He even would have to make up the coffins and organise someone to dig the grave, and finally to conduct the funeral service:

Our hearse was a spring dray. The coffin didn't fit very well in it. It had the old draught horse ... yet [the mourners] would hop up on this dray ... and off we would traipse to the cemetery.³⁵³

Like the BN's many faceted role, her husband saw himself as 'a Jack-of-all-trades but you seemed to take it in your stride. There was just nobody else, I say nobody'.³⁵⁴

Lack of facilities for handling the dead was the usual rule. Where a 'morgue' existed it was merely a shed, like the small unlined shed beside the BNH on Bruny Island. Here a body would wait until the doctor could visit, then the BN would have to assist with autopsies as required. Often no such morgue existed. Sister Llewellyn at Storys Creek found herself in a difficult position in connection with a death on Christmas Day because of the lack of a morgue. The St Marys police were contacted and, as there was no means of conveying the body to the nearest morgue at Avoca, the police directed that the body remain in the house. When the householder returned, he demanded that the body be moved to the BNC. The BN was not able to assist in this regard as the only potential space in the BNC was used for treating patients.³⁵⁵ At Adamsfield there was no morgue and the doctor did not visit. In this location the deceased would be carried out of the area so that death could be certified.

The BN's isolation, and her central role and prominent position in the community, led to her being asked, and often accepting, a wide range of other health-related roles and functions in her community. Some of these roles were a consequence of bureaucratic attempts to fill gaps in the health services. Other roles resulted from requests from within the community made of their valued nurse.

As with child welfare, there was a dedicated school health service but the isolation of rural communities in Tasmania meant that no School Health Nurses were stationed within many of these rural Tasmanian locations. As early as 1927 the Education Department reached agreement with the Bush Nursing Service for BNs to visit districts not able to be

³⁵¹ This role also included Coroner.

³⁵² That was the usual situation in other BNCs.

³⁵³ Charles Saville, Interview, Devonport, 1999.

³⁵⁴ Charles Saville, Interview, Devonport, 1999.

³⁵⁵ AOT, DPH, 58.20.49, letters to and from Sister Llewellyn Storys Creek, (HSD 6/34).

covered by the School Nurse. In that year alone there were 99 visits to schools throughout the state by BNs.³⁵⁶ Many BNs regularly attended the schools to check ears, throats, eyes and teeth, and to carry out inspections for head lice, and skin infections such as scabies and ringworm. The role was agreeable for some BNs: 'I did the school children examining. Not all [BNs] did do it, but ... I was interested in doing it'.³⁵⁷ Others were unhappy to take on School Health work believing that it was inappropriate for BNs even to do interval visits to address ongoing problems such as head lice particularly where a dedicated School Nurse could visit at least on occasion.³⁵⁸ It was to become part of the BN's many roles to attend schools at times in the company of the GMO, and at times on her own account, to provide health checks for children.³⁵⁹ There were simple treatments for the main complaints, sore throats and head lice, but Sister Walsh recalls it was difficult to persuade the mothers to cooperate. Of concern to the BNs was evidence of child neglect and overwork where children laboured for long hours on farms.³⁶⁰

In 1938 the DPH believed that the BN should visit each school regularly, in addition to visiting with the GMO, and advised that:

A lot of the work will, of necessity, devolve upon you and your co-operation with the Doctor in this direction will be much appreciated.³⁶¹

An important part of the school visits was the provision of health education for the children. The BNs incorporated 'Mothercraft for School Girls' and lectured the senior girls on child care, some setting exams for them and awarding prizes. This activity bore fruit and Sister Isyabell Williams recalls that:

Years later when I went back there again ... they were the best mothers I had and they were doing all the things ... they had learnt to do and it was most rewarding.³⁶²

There was a belief that by educating the children it might be possible that future generations might not have the problems of the day.³⁶³

³⁵⁶ *TJPP&P*, 1928–9.

³⁵⁷ Viola C Millington (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

³⁵⁸ E Mellish, Interview, Musselroe Bay, 1994.

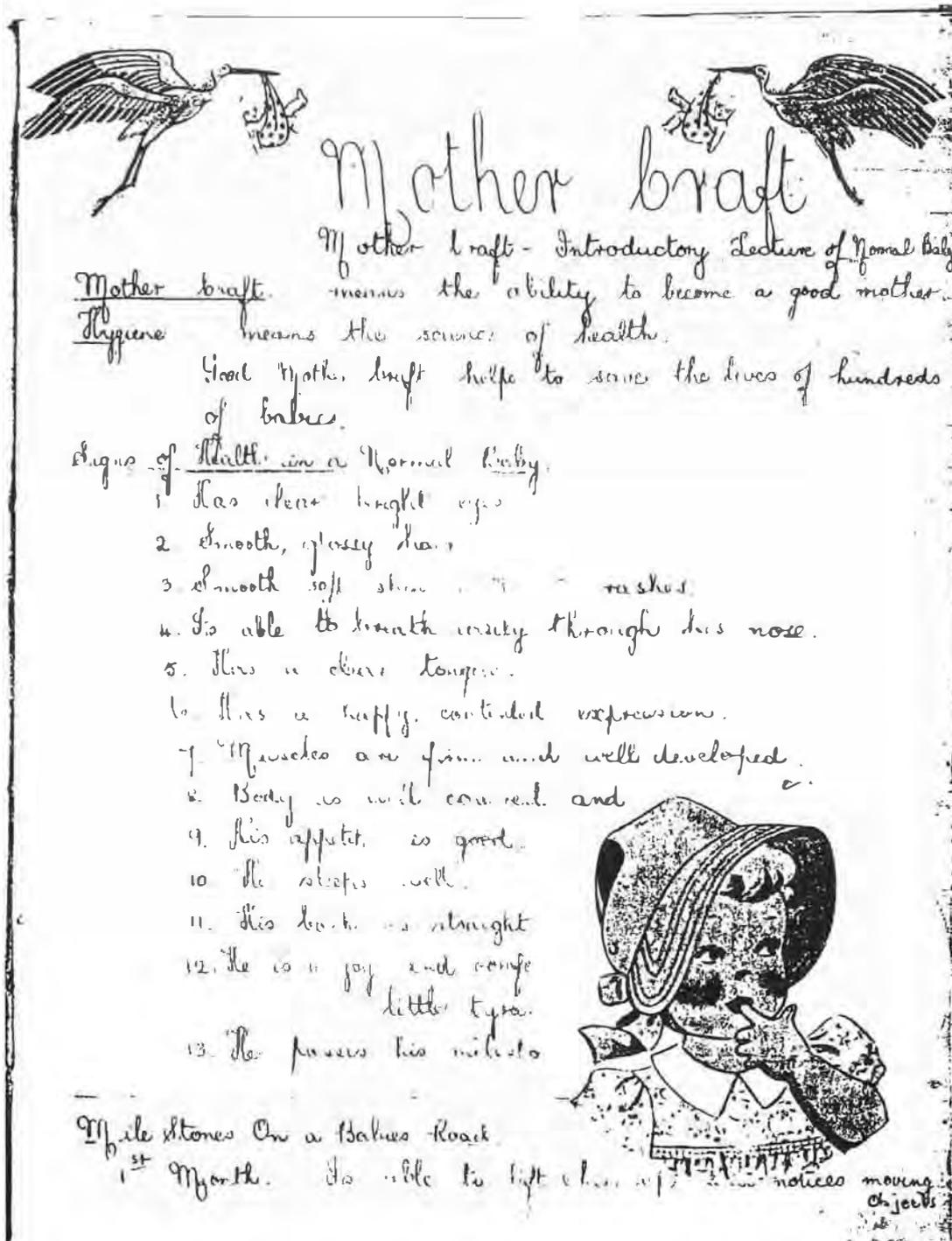
³⁵⁹ Usually for immunisation programs.

³⁶⁰ Mary Walsh, Oral History Tape, Interviewer—Dr Philip Mahnken, South Australia.

³⁶¹ AOT, DPH, 58.15.38, BN Swansea, Dr/Nurse—Letter to Sister Noller re school inspection & co-operate with Dr, (HSD 1/53).

³⁶² Isyabell Ann Weir, (née Williams). Interview, 1999.

³⁶³ AOT, DPH, 4.9.38, Tasman District Request by CWA for medical inspection of school children, 7 August 1938, (HSD 3/1). Community organisations such as the CWA encouraged the development of School Health programs.



Lecture notes for mothercraft education in School—the 4th line reads 'Hygiene means the science of health'
Source: Bruny Island History Collection, Bruny Island Museum.

Bashford suggests that 'enthusiastic engagement with domestic science discourse was one way in which nurses reconceptualized their work as modern and scientific, while at the same time firmly retain[ing] its basis in the feminine world of domesticity'.³⁶⁴ In seven BNCs the workload of the BN was such that the additional burden imposed by school

³⁶⁴ Bashford, p. 130.

health was unable to be accepted.³⁶⁵ Some centres, such as Sorell and Lilydale, were sufficiently close to the cities to mean that a dedicated School Health Nurse could fill the need by making trips into the country to those schools (although Sister Pitt visited 11 schools on a regular basis when she was the BN at Lilydale).³⁶⁶ With the obvious workload-stresses on the nurses, overlap of activity was to be avoided.³⁶⁷

Success in avoiding overlap, and the impact of high workloads and isolation, are suggested by Sister Harvey's recall that in her six or eight years as a School Nurse in rural Tasmania she did not come into contact with BNs.³⁶⁸ The Bush Nursing Service, School Health and child welfare remained closely allied services, but it was only the BNs who had the capacity and willingness to take on all three roles as the DPH acknowledged in 1953.³⁶⁹

One of the BN's central roles was that of public health educator. She encouraged and taught the community the benefits of diet, exercise and hygiene. Perhaps her greatest impact was made through her contact with new mothers, but her daily contact with families added to opportunities for education. In schools she attempted to influence the young, and education and support of the elderly was also part of her concern. Care of the elderly was a significant part of the daily work of BNs and of their visits within the community. When they became ill, isolated elderly people stayed in the BNH until they were well and able to cope fully at home as the BN could not visit them readily in their homes. This was particularly true when transport was developed poorly.³⁷⁰ Dietary advice and vision testing were important to maintain the health and independence of the elderly.³⁷¹ It was:

... just a normal part of the nursing just to check up on their diet ... especially with old people who tended to deteriorate rapidly if ... they didn't look after themselves properly, especially if they were living alone.³⁷²

Regular exercise and hygiene were advised also but BNs interviewed saw that the advice they gave was quite different from current thinking.³⁷³ Much of the visiting to the aged was more related to social needs than to particular health problems.³⁷⁴

³⁶⁵ AOT, DPH, Memo to Director General Medical Services re School Medical & Child Welfare Services, 15 September 1953, (HSD 5).

³⁶⁶ AOT, DPH, 15 September 1953, (HSD 5). AOT, DPH, 58.8.38, BN Lilydale, Letter from Lilydale Council re BN school inspections & one 'crippled' pupil, 24 June 1938, (HSD 1/53).

³⁶⁷ AOT, DPH, Memo for Sisters Noller and Widdicombe from Director General Medical Services, 26 June 1952, (HSD 5).

³⁶⁸ Mrs Betty White, née Harvey, Personal Communication, April 2003.

³⁶⁹ AOT, DPH, Summing up of Inspecting Sister re qualifications, 15 September 1953, (HSD 5).

³⁷⁰ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

³⁷¹ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

³⁷² Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

³⁷³ Eileen McManus, (née McMenamin), Interview, Falmouth, 1994.

³⁷⁴ AOT, DPH, Bush Nursing Annual Report 1946-1947 Northern Centres, (HSD 6/56).

Bush Nurses became respected mediators within their communities. They were involved in marriage counselling, and counselling in cases of domestic violence and suicide. Bush Nurses were required to be good listeners with interpersonal skills to cope with this social work role:

Well, you just did that, you know, and people came to you with their problems and worries and things, but you see it was small town ... you just sort of quite enjoyed doing [this work].³⁷⁵

Often social problems would be identified indirectly, from the concerns expressed by neighbours, as some were reluctant to discuss openly issues such as domestic violence for fear that legal action might ensue.³⁷⁶ Alcohol and drug abuse posed difficulties in some communities and BNs were at times grateful for the assistance of the police if they felt threatened by drug requests.³⁷⁷ Where alcohol abuse was a problem BNs might be threatened with violence as happened to Sister Janice Barnes (née Fenton) when she visited a house where a drunk miner had 'barricaded' his wife in the house:

... so I was sent for and he had a bottle of beer coming down at my head. He must have changed his mind because he took it away.³⁷⁸

Sister Barnes believed that the BN was called to such problems as the police did not like attending domestic disputes.

Bush Nurses also functioned as the central focus for aid work. During the Depression donated items of clothing and food would be sent to the BN at Adamsfield to distribute amongst the miners and their families. Many mining families were finding it hard to make a living during this time and 'some had hardly enough clothes to keep them warm'.³⁷⁹ The BN's role at Adamsfield was complex—not only did she assist families through her nursing work and her involvement with clothing aid, she also helped organise entertainment. There was no resident policeman at Adamsfield and so a Vigilance Committee, comprising six or seven men, was appointed by the police to keep law and order.³⁸⁰ The Vigilance Committee turned a blind eye to the 'grog' shop and the bookmaker—in this case the BN was the bookmaker. One could argue that in this respect her 'encouragement' of gambling might have helped to entrench poverty. In 1938 the Bush Nursing Association appointed a Bush Nursing Almoner, Sister Gill. This initiative was heralded as 'an outstanding feature of bush nursing for the year' and underscored the mission of Bush Nursing as a social service and the impact of the Depression on Tasmanian communities.³⁸¹

³⁷⁵ Viola C Millington, (previously Thompson and née Liersch), Interview, Sandy Bay, 1994.

³⁷⁶ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1995.

³⁷⁷ Isyabell Ann Weir, (née Williams), Interview, Westbury, 1995.

³⁷⁸ Janice Flora Barnes, (Previously Brooks and née Fenton), Interview, Devonport, 1995.

³⁷⁹ Thurza Hazelwood, (née Cox), Interview, Prospect 1999.

³⁸⁰ Thurza Hazelwood, (née Cox), Interview, Prospect 1999.

³⁸¹ *The Examiner*, 'Bush Nursing Association', 13 July 1938, p. 8.

A direct result of operating within isolated BNCs was that BNs did not have the support infrastructure to which they had been accustomed in their earlier roles within larger hospitals. Again without prior training for such a role, and without infrastructure support, they had responsibilities in managing the BNC, reporting to the DPH, assisting with fund-raising, training and supervising staff, and promoting Bush Nursing. Bush Nurses were required to relate to a range of groups and individuals and to have good skills in personal and business management. It was not easy fulfilling all these obligations as the BN at Ringarooma stated in a letter to Supervisory Nurse Noller:

I have never yet been able to sit down & do this monthly account without interruptions, especially careful adding so have asked Mr Webster of the Bank to help with books in future & check additions.³⁸²

Community support for the BN was critical for the smooth running of the BNC as well as easing her isolation.

Not only did the BN have a diverse nursing-based role but her work occasionally expanded to take on the role of dentist, veterinarian, and health inspector. According to Jennifer Cramer, nurses today still face the same problems that were faced by the BN:

Nurses assume responsibility for all activities necessary to the functioning of the remote community health facility.

She notes that Ann Kreger 'recorded a considerable load of non-nursing functions which were performed by the remote-area nurse'.³⁸³ In the Bush Nursing era Tasmanian BNs performed a wide variety of roles. These were aggregated by former patients and family members of BNs: 'Yes. She was everything'.³⁸⁴ 'She was the works'.³⁸⁵ This role-diversity led Peninsula residents to describe Sister Barnicoat, the BN at Koonya in 1917, as 'nursing sister, midwife, doctor and friend'.³⁸⁶

Dentists were not regular visitors to isolated rural areas and many centres received only one visit per year. This would result in a concentrated few days assisting the dentist or coping with the consequences of his work after he had left the area.

Oh, a dentist landed round about once a year and he'd pull teeth all day ... we only had one or two that bled ... [I'd] pack that right down ... and leave it there for a few days and it would either come out or they'd come back and let me take it out.³⁸⁷

³⁸² AOT, DPH, Letter to Sister Noller re Ringarooma, 11 July 1952, (HSD 5).

³⁸³ J Cramer, 'Dilemmas of remote area practice', p. 137. See also Ann Kreger, *Remote Area Nursing Practice – a question of education*, Council of Remote-Area Nurses of Australia, Perth, 1991.

³⁸⁴ Dawn Coffey, Interview, Beauty Point, 1994.

³⁸⁵ Margaret Spark, Interview, Beauty Point, 1994.

³⁸⁶ Margaret Scott, p. 59.

³⁸⁷ Hazel Gaffney, (née Bird), Interview, Ulverstone, 1994

Some dentists worked from the BNC when arriving in the area for their monthly visits and there is some evidence that BNs might have assisted the dentist by administering 'gas and oxygen' anaesthetics.³⁸⁸ Other dentists took their dental surgery with them.

Bush Nurses also acted as advocates for dental health. Sister Iles at Ulverstone was 'dismayed' about the poor state of children's dentition 'especially in the poorer, out-back centres, where the children are not so well nourished, and have less chance of regular dental care'.³⁸⁹ She persuaded the Parents & Friends Association of the Nietta School to pay for Mr Piercey, a local dental surgeon, to visit the school and extract the worst of the teeth for the children. While there was a free Government Dental Scheme it had been two years since the area last had been visited by the Government Dentist. Dental decay was a significant problem with only three of 19 children examined by Sister Iles at the South Nietta School being free of dental cavities, and some of the children appeared malnourished.³⁹⁰

Occasionally BNs found themselves attending non-human patients. All BNs recall cases where animals were the patients. 'What have I had? Horses, dogs, cats, goats'.³⁹¹ Some nurses were called only to domestic animals, for example animals which had splinters or had been caught in traps. Sister Connors remembered splinting a heifer's leg.³⁹² It was in the Sprent district and upon arriving at the home discovered the family in turmoil as their one milking cow which was their only source of milk, butter and cream had been injured. Although she explained that they should call the vet, she was pressed to assist and eventually complied with their request to rescue the animal.³⁹³ On another occasion she remembered easing the pain of a large draught horse.³⁹⁴ The veterinary work was just seen as an extension of BNs' nursing knowledge and 'commonsense'.

Not only did BNs work closely at times with Health Inspectors, one became Health Inspector as well as BN. On Babel Island in 1936 Sister Foster travelled to the Island with the Health Inspector. He stayed only the day, and after that she acted as the Health Inspector for the remainder of the mutton-bird season. This was an official appointment made by the DPH.³⁹⁵ Her role was to inspect the sheds and the general hygiene used in the

³⁸⁸ AOT, DPH, Report from Sister Noller re Oatlands Hospital, 16 March 1950, (HSD 5).

³⁸⁹ AOT, DPH, 58.18.38, BN Ulverstone, Dental Work Letter from Sister Iles re poor teeth etc of school children, 8 July 1938, (HSD 1/53).

³⁹⁰ AOT, DPH, 58.18.38, (HSD 1/53).

³⁹¹ Evelyn Mellish Interview, Musselroe Bay, 1994.

³⁹² *Advocate*, clipping, nd, Private Collection.

³⁹³ *Advocate*, Reporter's notes, nd, Private Collection.

³⁹⁴ Family notes from interview with T Connors, 1990, Private Collection.

³⁹⁵ AOT, DPH, BN Babel Island re authorisation for sanitary inspection by Sister Foster, 2 March 1936, (HSD 1/24) and (LSD 51).

processing of the birds.³⁹⁶ In one report she complained of the putrid smell caused by the offal of the mutton birds not being covered adequately.³⁹⁷ The dogs also were reported as being a nuisance. Despite the problems, she admitted in her report that 'being caught in a weak moment I again promised them, subject to your approval, [to] ... go back to them next season'.³⁹⁸

Industrial advocacy was a role adopted by some nurses in response to the at times dangerous conditions in industries such as mining. The BN at Storys Creek refused to allow one man to return to work in the mine until the mine had been made safer. She saw this role as important and her actions as something that she had to do as there was no one else in a position to act on the miner's behalf.³⁹⁹

With her complex multifaceted role and the large district she covered, the BN was generally busy. Bush Nurses clearly were dedicated to their work and to their communities. Working in a small community resulted in levels of personal involvement and emotional investment which were higher than those experienced by health-care workers operating in groups within larger areas or facilities. There was for the BN substantial danger as she worked in her isolation—danger from what we now would describe as 'burnout':

There are many temptations in small communities to render superlative service and to do so at a strain resulting eventually in resignation, and at the same time leaving behind a tradition which will be a strain on successors.⁴⁰⁰

The hours of work of isolated BNs were often long and associated with the stress of isolation, decision-making, and travel. One case could involve the BN in much work. Travelling into the countryside to see a child, Sister Walsh diagnosed scarlet fever. She escorted the child to the base hospital and then travelled back to the child's home to disinfect the house. While starting in the morning, it was night before she arrived home.⁴⁰¹ BNs could be called out every night for weeks on end, and then still have to cope with their daily duties.⁴⁰² Even when they eventually arrived back to the BNC after 'finishing' their

³⁹⁶ The Health Inspector was later appointed to remain for the duration of the season. Irynej Joseph Skira, 'Tasmanian Aborigines and Muttonbirding: an historical examination', (PhD Thesis), Department of Geography, University of Tasmania, 1993, p. 203.

³⁹⁷ AOT, DPH Records, Report 11 March 1937, (HSD 1/24) and (LSD 51).

³⁹⁸ AOT, DPH Records, Report 10 May 1937, (HSD 1/24) and (LSD 51).

³⁹⁹ Janice Flora Barnes, (previously Brooks and née Fenton), Interview, Devonport, 1995.

⁴⁰⁰ AOT, GMO Dr R Mair to Director of Public Health, 17 July 1951, (HSD 3).

⁴⁰¹ QVMAG, Box 10, Memo 21 May 1949 from Mr Wilson re time off for Sister Walsh due to heavy weekend work.

⁴⁰² QVMAG, Box 10, Annual Report Bush Nursing Committee, 31 October 1946, and QVMAG Box 10, Newspaper Article, 12 August 1938, re monthly report of BN, night time call outs etc. and AOT, DPH, 58.6.41H, BN Whitemark, Letter from SN re inspection of Flinders Island BNC, 16 December 1941, (HSD 1/79).

day they would 'have to do the cooking for the sick patients who had no one else to look after them'.⁴⁰³

In some BNCs workloads were light but even then the nurse was on-call continuously unless on holiday leave. 'I was on duty seven days a week and on-call twenty four hours a day' and holiday leave was not easily arranged.⁴⁰⁴ Some BNCs gained a reputation for poor conditions of work, more often related to personality conflicts than to actual workload, although the ways in which community expectations were managed contributed to nursing stress. At Ringarooma the conditions and expectations of the local committee were considered unacceptable by all the nurses who worked there, leading to a rapid turnover of nurses.⁴⁰⁵ As the conditions 'gained publicity amongst the nurses' it was extremely difficult to obtain any staffing.⁴⁰⁶ While nurses were to be on-call at all times for emergencies, the locals at Ringarooma expected the nurse to be available even for non-emergency problems at all hours, seven days a week. At this BNC the nurses were not 'assisted or encouraged' in social activity, rather it was condemned.⁴⁰⁷

In 1941, in response to a complaint from a doctor about the unavailability of a BN to assist in nursing a patient, the DPH supported the nurse. Although the Regulations were quoted, it was noted that the BN should not work more than 12 consecutive hours.⁴⁰⁸ This advice generally seems not to have been followed. In Rossarden, Sister Donald was the subject of complaint, part of which alleged that she had failed to respond to urgent cases, but in reply she argued:

What is an urgent case? My record shows that I have never turned anyone away—103 is a large number of 'urgent cases' in nine months in a place where the population can not exceed 300 persons.⁴⁰⁹

Clearly, community expectations of the nurse appear excessive.

In 1947 at Storys Creek the nurse objected to a suggestion that she should stay up until midnight each night in case the miners 'want[ed] something', and that she should never leave the house in the evening for the same reason. She commented that 'if a person is never to have a day nor an hour away from the surgery I think you will realize what the

⁴⁰³ *Weekender*, 20 July 1985.

⁴⁰⁴ Hearn, p. 59.

⁴⁰⁵ AOT, DPH, 58.14.49, BNC, Ringarooma, (HSD 6/34).

⁴⁰⁶ AOT, DPH, 58.42, (HSD 1/87 and 1/89).

⁴⁰⁷ AOT, DPH, 58.42, (HSD 1/87 and 1/89).

⁴⁰⁸ 'The Nurse shall proceed to any part of the district in which, in the opinion of a medical practitioner, her presence is desirable.' AOT, DPH, 58.13.41, BN Ringarooma, Letter to Sister Gill re ruling on doctor giving orders, 10 October 1941, (HSD 1/80).

⁴⁰⁹ AOT, DPH, Letter to Minister for Health from Sister Noller, 3 February 1948, (HSD 5).

ultimate outcome will be'.⁴¹⁰ She requested that the Department advise their expectations of nurses' hours. They did so soon after and stated that the award was for 44 hours per week and that 'evening calls should only be made in cases of extreme urgency or emergency'.⁴¹¹ The DPH sent a circular warning that, unless out-of-hours calls were controlled, BNCs would neither be able to retain staff nor to compete for nurses in an environment in which the usual nurse's working week was 40 hours.⁴¹² In contrast with this advice, some years earlier the DPH had cautioned a BN that:

it is a common practice, in almost every bush nursing centre, for a nurse to work excessive hours on various occasions ... this is unavoidable, and as a rule, the nurses ... accept their responsibilities without protest.

She was asked to reconsider her objection about long hours and to 'conform to recognised practice'.⁴¹³ Despite the DPH now advising a 44-hour week, night calls remained arduous. They were generated by the expectations of patients, the expectations of the local doctors, and the often unsociable hours associated with midwifery practice. Also in 1947 the DPH requested of Dr Jones at Derby that he eliminate 'all excessive duties of the BN' after they received a complaint that the hours of the BN at Ringarooma were 'too strenuous owing to the number of night calls that she receives'.⁴¹⁴ The Doctor was not convinced that the conditions were inappropriate and rejoined that while the BN might complain about being asked to do out-of-hours work, 'she not infrequently rings me late at night for advice or to visit a patient'.⁴¹⁵

A number of strategies were employed to reduce workloads. Primarily these were based around financial disincentives to call the BN 'out of hours'. Such disincentives were introduced first in 1948. Some Medical Unions did not charge patient fees over and above the subscriptions. One of the Medical Unions required patients to pay the Sister directly for 'out of hours' calls and then to receive reimbursement later from the Union. It was claimed that 'this method appears to have a psychological effect and reduces the number of calls and claims'.⁴¹⁶ The DPH remained concerned about the number of such calls.⁴¹⁷ In 1950 the BN at Brighton received an average of six calls every Sunday. The DPH recommended that

⁴¹⁰ AOT, DPH, Letter from Sister Greta Llewellyn to the Secretary, 19 November 1947, (HSD 5).

⁴¹¹ AOT, DPH, Letter to the Sec Rossarden and also the Storeys Creek Medical Unions from the Secretary for Public Health, 3 December 1947, (HSD 5).

⁴¹² AOT, DPH, Letter to Dr BM Carruthers from DFK Noller, re out of hour calls, 18 September 1950, (HSD 5).

⁴¹³ AOT, DPH, 58.20.39, BN Waratah Letter to Sister LE Tollner, sometimes necessary to work excessive hours, (HSD 7/10).

⁴¹⁴ AOT, DPH, 5.3.47, Letter to Dr GA Jones Derby from Dr BM Carruthers, Director of Hospital and Medical Services, (HSD 16/10).

⁴¹⁵ AOT, DPH, 20.3.47, (HSD 16/3).

⁴¹⁶ AOT, DPH, 58.8.3, Report for Director General Medical Services from Sister Widdicombe re Grassy BNC, 3 September 1952, (HSD 5).

⁴¹⁷ AOT, DPH, Letter to Medical Union Grassy from Director General Medical Services re out of hours calls at Grassy Centre, 20 February 1952, (HSD 5).

a five shilling fee be charged for calls outside the hours of 9 am to 6 pm weekdays, and 9 am to 12 pm Saturday. It was hoped that calls would reduce to emergency calls only, but it was not until 1952 that this ruling was adopted uniformly.

Where a BNC employed two or more nurses workloads were at least in theory more manageable, but in practice this was not straightforward. Infection control issues required job differentiation and thus reduced time off. Where more than one nurse was employed there were always in-patient beds, and thus shifts of 24 hours or more on continuous duty were not unusual. In 1949 a BN's concerned mother wrote to her Member of Parliament requesting his intervention because while the BNC was staffed by two Sisters both were on call 24-hours a day. Usually they did a 'tour of duty' of 12-hours each per day, seven days a week. When a delivery occurred both sisters were on duty and thus frequently worked more than 84-hours a week. She was concerned lest the sister become 'the patient through broken health'.⁴¹⁸ Even in such centres personality issues, whether between the nurses themselves, or between nurses and others (such as community committees, doctors), created working conditions which were stressful and often unacceptable.⁴¹⁹

Where BNs had families of their own this created even more stress for the nurses as they struggled to provide adequate care for both patients and family (normally without help from their husbands as they resided elsewhere, and also usually were working). Sister B Blair struggled with midwifery work, with the care of her own baby, and with the demands of washing hospital linen—much of the time without access to a washing machine.⁴²⁰ Mrs McDowitt was covering the Bush Nursing duties at Grassy but found the workload prevented her from attending to her own family's needs.⁴²¹

The long hours and the work stresses often led to resignations. In 1950 Sister Murphy at Tasman reported that she was 'unable to continue' as she was 'tired out from nights without sleep and insufficient rest'.⁴²² Long hours not only hampered the BN's ability to have a social life but also could affect patient safety. Sister LF Hurnall's resignation in 1951

⁴¹⁸ AOT, DPH, Letter to JJ Dwyer, Minister for Agriculture from GA Thorp Cygnet, 8 November 1949, (HSD 5).

⁴¹⁹ AOT, DPH, Letter to Miss Noller from BN, Rosebery, 15 May 1947, (HSD 6/3).

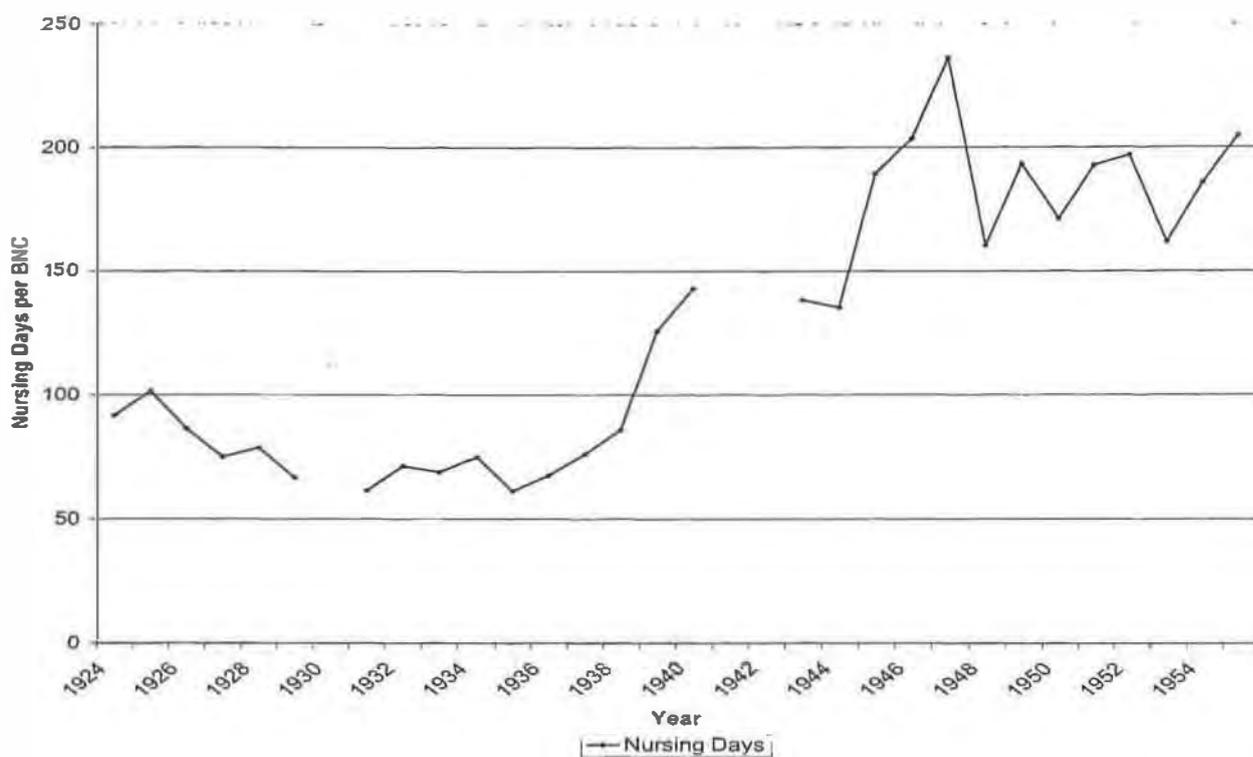
⁴²⁰ AOT, DPH, Letter to Mr Driscoll from Sister B Blair, Koonya child welfare re overwork, 23 May 1952, (HSD 5).

⁴²¹ AOT, DPH, 58.45.45, BN, Grassy (King Is) Proposed Centre, (HSD 1/91).

⁴²² AOT, DPH, Memo to Dr BM Carruthers from Sister DK Noller re over work of Sister at Tasman Hospital, 16 June 1950, (HSD 5).

as BN at Waratah was in part because she was concerned that her long working hours did not allow her to give patients the attention they needed.⁴²³

Figure 5.03 Bush Nursing Centre Workloads—nursing days per Bush Nursing Centre



Source: Collated from the *Tasmanian Journal of Parliamentary Papers and Proceedings* and Tasmanian Bush Nursing Records.

The changing nature of the health-care system also led to changes in the ways in which BNCs and BNHs were used. The 1950s saw the expanded use of BNHs for the admission of 'general, chronic and psychiatric patients'. Increased in-patient work had a consequent disruption of BNs' nights when otherwise they might have expected to be able to rest.⁴²⁴ The significant increase in nursing care related to patients admitted to the BNC is demonstrated in Figure 5.03. By the late 1940s the number of 'nursing days' for each BNC had almost doubled from that seen in the 1920s and 1930s.⁴²⁵

⁴²³ This issue was not a consideration for the DPH at the time but is receiving increasing attention in current health care debates. AOT, DPH, Letter to SN from Sister LF Humall re resignation from Waratah, 10 July 1951, (HSD 5).

⁴²⁴ AOT, DPH, 58.23.7, Report re Tasman BNH, 7 August 1950, (HSD 5).

⁴²⁵ A nursing day is defined as one patient being in a bed in the BNC for one day.

CONCLUSION

Bush Nursing was a unique response to the Australian need for health delivery to the bush. Canada and New Zealand, as dominions of the British Empire and as frontier 'white-settler' societies, developed rural nursing schemes tailored to their own national circumstances. British District Nursing was the model from which each country borrowed as its nurses pushed out into remote areas to provide health care. While their 'labels' were different, the women who worked in frontier Canada, and in the New Zealand backblocks, were of the same calibre as Bush Nurses—they were required to be strong, capable women with missionary zeal, full of initiative and able to act independently. The focus of Bush Nursing was on the needs of women and children particularly, although the Bush Nurse provided a comprehensive primary health care service. Thus the history of Bush Nursing encompasses rural, women's and nursing history and is embedded within rural isolation. Tasmania's rural dwellers truly lived an isolated existence, at least until the development of transport and communications infrastructure, and increased affluence, allowed easy contact with the outside world.

Bush Nursing developed as a women's movement, promoted by women of prominence, such as the wife of the Governor-General, and strongly supported by middle-class women and women's organisations. The movement was placed against the background of the Progressive movement, the development of the Tasmanian Department of Public Health, and ideologies of 'scientific motherhood'. 'The management of (families by) middle class experts' became translated into Federal government initiatives, but it was the Bush Nurse, as the intervening expert, who was a crucial agent of change at grass-roots level and who implemented progressive ideas and policies. While Bush Nursing was a women's activity, and the organisation developed from women's concerns and advocacy, men figured prominently in policy development and organisational control. This thesis is not the story of these men, but is the history of the foot soldiers in the battle between the new science and the ills of society—its 'decadence' requiring social change through the application of knowledge.

The thesis has focussed on the minutiae of the everyday life of Bush Nurses. Work practice, working spaces and the mundane routines of life have been reconstructed, using evidence garnered from the triangulation of interviews, documents and photographs, to provide a sophisticated multi-layered, or 'thick description', of the lived experiences of Bush Nurses. This synthesis and its interpretation, have provided an insight into their lives and ways of living. The oral recollections and written sources have both challenged and

validated each other. The intricacies of the public versus the private, in both personal and professional lives, are highlighted. Finally the pictorial evidence challenges our perceptions as it portrays the changed 'meaning' of words, e.g. roads and uniforms and provides a sense of isolation that can be lost or undermined by mere description.

'Bush Nursing' is seen to be a dynamic concept. The boundaries of professional practice for Bush Nurses were contested and in a state of continual flux. They varied over time and place, based on individuals, the environment and changes in technology. The period of study was one of significant change with world wars, a depression, revolutions in transport and communication, changing roles for women and substantial changes in health care. Bush Nursing evolved, and operated, during this period of great change. Furthermore, Bush Nurses were sent to serve contrasting environments, widely dispersed across the Tasmanian landscape. Despite the diversity of locations, which included islands, mining, forestry and farming communities, and the changing external socio-political environment, Bush Nursing possessed two core attributes—*isolation and independence*.

Bush Nurses developed as, arguably, members of the first professional group of nurses with an expanded role. They were the pioneers of independent nurse professionals. The collegial relationship, and mutual dependency, between Government Medical Officers and Bush Nurses is exposed against the usual historiography of medical and nursing conflict. This thesis shows that, in these rural environments, doctors and nurses, in the main, developed working relationships of trust and support. Contrasting this view of a collegial environment is the evidence of medical opposition and desire for medical control. From the inception of Bush Nursing, this is demonstrated through occasional vignettes of doctor-nurse conflict, and in the slow encroachment on nursing practice by the medical profession, which gained in momentum in the latter years of Bush Nursing.

Initial opposition to nurse independence was allayed by reassurance that the nurse, only in exceptional circumstances, would act independently, but all Bush Nursing environments 'were exceptional'. The Bush Nursing Regulations institutionalised the medical control of Bush Nurses, except in normal maternity work and in exceptional situations. It was clear to Bush Nursing's founders that, despite the assurance and the Regulations, such control could not be, and would not be, realised. Bush Nurses were placed in areas without doctors and without the means for them, or their patients, to gain access to medical advice or treatment easily. Later, conflict was at times ostensibly based on grounds of 'quality of care' or the nurse's 'exceeding her brief', but little evidence has been deduced which supports specific instances of such transgression, let alone that the Bush Nurse was generally in breach of appropriate professional guidelines. In fact, even in later

years when medical-professional control of Bush Nursing was tightened, there is compelling evidence that doctors supported Bush Nurses' practices even beyond official guidelines.

By 1939 the Tasmanian Government, in response to concerns about the cost of medical care, developed the Free Government Medical Scheme. This scheme reduced the isolation of at least some Bush Nurses and, in many cases, provided a nominated doctor to whom the Bush Nurse was responsible. Nevertheless, most Bush Nurses still worked in isolation and autonomously, and even in the mid-1940s there was little that a doctor might do that Bush Nurses did not do without supervision or control. Conflict was, at other times, clearly related to tensions based on financial rather than clinical grounds—the area of maternity care being a particular battleground where some doctors' motives for complaint against Bush Nurses reflected their concern about loss of potential income.

The story of independence is thus complex, but it is seen that the conditions under which Bush Nurses worked were unlike those of their hospital counterparts and facilitated their unique autonomy. It was the failure of the medical profession, through unwillingness or inability, to provide health care to many, if not most, rural dwellers that allowed Bush Nursing to flourish. Most Bush Nurses did not work in close proximity to doctors. While some Bush Nursing Centres, or their communities, were visited by doctors on a regular basis, others were never visited. Furthermore, the medical profession could not exert day-to-day control over the action of Bush Nurses while communication technology was rudimentary. Even as telecommunications advanced, access to telephones or radios was limited. Communities often had but a single telephone or radio, and it was not possible for the Bush Nurse to gain timely access to medical advice while on her rounds, or even while involved in midwifery care within the Bush Nursing Centre.

It was not until the advent of potent, medical-profession controlled, pharmaceuticals that Bush Nurses were more limited than medical practitioners in therapeutic endeavour. Early Bush Nursing kits contained a broad range of contemporary remedies, and health outcome was more often a result of quality nursing care than the chemical remedies selected. It was the ability of the medical profession to gain legal control over the dispensing of antibacterials and narcotics that more clearly defined the differences between the (mandated) treatments of doctors and nurses. Even then Bush Nurses grasped the possibilities offered by the new antibacterials and, with the certain knowledge of many doctors, dispensed these to patients without asking for or receiving medical approval. In parallel with the development of antibacterial therapy came the logical extension of scientific motherhood—the concept of birthing requiring medical intervention within

centralised hospital environments. Antenatal care was increasing in accepted importance, and Bush Nurses were to become more antenatal care providers than providers of intrapartum care. The medical profession was highly successful in changing the culture of childbirth. Many patients travelled out of their area for childbirth, but others were sceptical of the rationale for medical-controlled delivery.

It is clear that from the latter 1930s there was an agenda for change within the Department of Public Health with a view to constraining the work of the Bush Nurse. This agenda could be advanced but slowly as the Department of Public Health grappled with financial and workforce constraints brought on by the twin insults of the Great Depression and World War II. Local communities faced financial hardship also and this, compounded by the adverse impact of the Government Medical Scheme on Bush Nursing finances, saw an increase in the control the Department of Public Health gained over Bush Nursing Centres. The Bush Nurse was to be relabelled progressively from 'Bush Nurse', to 'Sister—Bush Nursing Service', and finally to 'Sister—District Nursing Service'. The Department of Public Health determined to take away from the Bush Nurse her identification with the triumphs or successes of the early days of Bush Nursing. Bush Nursing ownership of that history, and its resulting kudos, would reduce the Department of Public Health's potential to restructure Bush Nurses' work. Furthermore the term 'Bush' was seen to conjure up a 'misleading picture of her work ... in isolated wild areas with no conveniences or amenities'.⁴²⁶ As the walls of isolation came tumbling down, particularly after World War II with increased affluence and access to transport, the 'bush' was now extracted from Bush Nursing in a practical and political sense. The Bush Nurse was not to be seen as isolated and, by extension, as independent. Through the nomenclature change forced on Bush Nurses, the Department of Public Health aimed to reduce their independence and power through a gradual process of blurring of professional identity and demythologisation. The name change placed Bush Nursing and Bush Nurses more within the mainstream of nursing.

The perceived need to isolate the Bush Nursing Centre from the demands of non-maternity work, a need based on the fear of infection, also disappeared with the infection-free, or infection-controlled, world introduced by the new antibacterials. Puerperal sepsis was no longer as feared. The physical and temporal barriers placed between nursing general, or infectious, cases and maternity cases were being eroded. This erosion had a critical outcome—finally, in 1955, Bush Nurses lost control of Bush Nursing Centre admissions to the Government Medical Officers. This was perhaps the end of autonomy. By

⁴²⁶ 'History of Bush Nursing in Tasmania—1910–1956'.

the time Bush Nursing officially ceased in 1957 the role of the Bush Nurse was different substantially from that of the first Bush Nurse of 1911.

Professional and personal isolation had many contributing factors over the forty-five year time span of Bush Nursing. The voices of the Bush Nurses often show despair and loneliness, and to continue working in these conditions took considerable courage. The level of actual or perceived collegial support and supervision from, and interaction with, other health care workers such as doctors were central to the Bush Nurses' sense of professional isolation. Their personal living arrangements, a consequence of the physical isolation and frontier nature of many of the communities, provided environments markedly different from the hospital environments that the nurses had hitherto experienced. The conditions were indisputably harsh, and these became reflected in isolation bonuses. But money could not assuage their loneliness, frustration and feeling of powerlessness. High rainfall, mountain climates, and heavy snow made access to patients difficult. This was compounded by the winding bush tracks, often impassable roads, flooded rivers, and treacherous sea passages. Walking, riding horses, or using vehicular traffic with frequent mechanical breakdowns tested their mettle. Not only did the Bush Nurse have to endure these conditions to access her patients, but transferring those that could not be nursed at home to the Bush Nursing Centre, or to an out-of-area facility, was at times even more fraught with difficulty.

This thesis has highlighted not only transport hardships but also has identified a little known history of women's use of transport. Access to transport was a privilege, and in many ways a necessity, for Bush Nurses. For single women to have not only the opportunity to travel unaccompanied but also the chance to master the skills of driving was uncommon during this period. Such experiences were male domains and, in having this unique independence, Bush Nurses were pioneers.

As pioneers, this uncommon freedom at times brought them into conflict with the community. Community concern was phrased in terms of excessive mileage, inappropriate personal use of vehicles, poor driving skills, personal safety, security of vehicles, and costs of transport. When the majority of people within the community did not own cars, and women were not usually seen in such high profile and independent roles, this conflict was inevitable.

Gender-based divisions in role within rural communities, not only in the area of transport but also in access to communication technology have been revealed in this thesis. Communication between the Bush Nurse and her supports outside the community was

initially minimal. Postal services provided communication with substantial delay between sending a message and getting a reply, the delay reducing as technologies such as telegram, pedal wireless, and telephone were introduced. After-hours access to communication technology was more usual for the policeman than the Bush Nurse but, even when available, the equipment provided was not always reliable.

Gender issues were also examined through the social and professional activities of single nurses, and through marriage and the Bush Nurse. As single women, Bush Nurses had considerable independence compared to other rural women, but needed to take care in the types of social contacts they pursued. Male visitors were not acceptable in the Bush Nursing Centre and Bush Nurse's primary social activities were group based. Marriage reduced the hazards of single life, but usually required the loss of status as a permanent or paid Bush Nurse. Married Bush Nurses were allowed to act as unpaid relievers, or were tolerated only in the most extremely isolated of areas. The conflicts between the role of mother or wife and Bush Nurse were a challenge for the nurse, a challenge made more difficult by the Department of Public Health's intolerance of the nurse's combining these roles. Married nurses were not afforded the same status, nor provided with the same degree of support, as single nurses since they 'had husbands to support them'. Nevertheless married nurses were an invaluable resource for the Department of Public Health as they provided with them with a casual relief-force of workers. They were the reserve army of Bush Nurses, and became a critical resource in **World War II**. The introduction of Man Power at this time saw the conditions for married women improve and this led the way in social change and opportunities for married women. Many conservative rural communities had previously not approved of married women in the workforce.

Marriage did not always reduce the Bush Nurse's isolation. New problems were raised resulting from marriage per se, and from family life, in remote rural communities. It was not easy for the nurse to synchronise her holidays with those of her husband. Usually the husband had to live apart from the Bush Nurse. This created, for the nurse, the difficulty of what to do with the children when working, particularly when called out after hours. The Bush Nurse gained the additional workload of mother/wife, and the challenges involved in having to send her children to boarding schools. There was community conflict arising from status of 'working mother'. Community, and Department of Public Health, concerns were raised about the possibility that Bush Nursing facilities would be destroyed by the nurse's children, and that her children increased the potential for infection transmission. Perhaps finally, and most importantly, Bush Nurses were traditionally seen as married to their profession, untouchable 'virgins on the hill', and were often described in terms, borrowed from religious discourse, which saw them as part of a 'monastic order'.

Married nurses challenged the very basis of nursing sacrifice and the role of women in rural communities.

The Bush Nurse's integration into her community was crucial to her success as a nurse and in combating her sense of isolation. Community support was, particularly in the early years of Bush Nursing, the key to the establishment and survival of the Bush Nursing Centre. Such support was eroded by the loss of local control over Bush Nursing Centres, but remained a critical factor in recruitment and retention of nurses within the community.

Throughout the state, the Bush Nurse's workplace was characterised by lack of uniformity. Makeshift premises included slab huts, tents and garages. Later purpose-built centres were provided but many Bush Nursing Centres remained in 'temporary' buildings or renovated cottages. These buildings were usually ill-equipped. The Bush Nursing Centres were a focal point for their rural and remote communities and evolved through the initiatives of the community and the nurse. The history of the buildings and their architecture together speak of the endeavours of the community and the personal and professional life of the nurse. These buildings are under threat and merit consideration for preservation as exemplars of rural cultural values.

Boundaries between home and the Bush Nursing Centre were blurred. The physical design of the facilities, and often, primitive conditions, created problems for autonomy and privacy. The combination of home and work in the same building, and the continuous on-call status of the nurses, resulted in lack of privacy, leisure and freedom. A lack of bed space required some Bush Nurses to give up their own beds for patients. In addition to nursing, the Bush Nurse was often cook and cleaner, coping with no electricity, inadequate septic or sewage facilities, and unreliable food supply. Not only were living conditions often primitive, basic medical equipment varied from centre to centre and was often inadequate. The Department of Public Health was never able to develop an agreed standard of equipment for the Bush Nurse, and at times the lack of support for items of equipment hampered the work of the nurse. In some centres, by contrast, Bush Nurses had good access to a much wider range of equipment with the support and encouragement of local medical practitioners, but in general there was no theatre, no equipment, no anaesthetics and in many cases Bush Nurses were required to provide their own instruments. Medications were also often in short supply and many nurses resorted to purchasing supplies from travelling salesmen, to the wrath of the Department of Public Health. By the late 1940s and early 1950s x-ray machines and dark rooms, anaesthetic machines, and infant resuscitators were beginning to be provided.

Bush Nurses were alienated from the community by virtue of being placed on pedestals within the community. It became important to try to delineate the boundary between public and personal persona, and the Bush Nurse used her uniform as a tool to achieve such separation. Her uniform provided a visible badge of professional identity, and through defining her role and status helped evoke community trust and confidence in her skills. The uniform additionally provided protection for the nurse as a single woman including creating a barrier to sexual intimacy. In contrast to the hospital-based nurse where the uniform provided anonymity as well as class definition, for the Bush Nurse anonymity was not possible. Furthermore boundary definition was incomplete as the Bush Nurse could not leave her place of work and escape to her home—these were usually the same building.

The special status of the Bush Nurse as a single independent women married to her profession allowed the nurse a privileged position with access to families' private lives. She had a multi-functional responsibility which included roles as the 'unofficial Medical Officer', as well as midwife, general nurse, school nurse, and child health nurse. She was first on the scene of accidents, acted as ambulance driver, undertaker, attended emergencies with police, became after-hours telephone operator and even became the vet. Her expanded role (both official and unofficial) resulted in a broadened perspective of what it was to be a nurse in the community but acted to increase her visibility. Her behaviour had to be constrained to meet these expectations. This decreased personal freedom and privacy, and enhanced her apartness from the community. As educated women and salary earners in usually male environment Bush Nurses developed substantial independence, but isolation and independence had a human cost.

Bush Nurses had a separate professional identity and status within nursing. Although they were individuals working alone, they identified as a specific group with peculiar skills and identity. Nevertheless, as a group they were not able to, and never attempted, to become politically active. They did not meet together as a group, but merely in ones or twos as they met one another whilst undertaking further education or while relieving for holidays.

The Bush Nurse's role within the community included being the focal point for fund raising for the Bush Nursing Centre, an activity which not only supported the centre but also served to strengthen the rural community. Her relationships as a nurse also created social opportunity and helped integrate her into the community. It was perhaps through religious observance that many nurses felt that they had the greatest personal support as a member of a community rather than in other situations where they found it impossible to

set aside their professional personae. With a lack of nursing support, other than a brief contact with a reliever or with the Supervisory Nurse, other working relationships in the community took on some importance. These working relationships were few but included collegial support from teachers, police and the local council. The employment of domestic aides usually allowed the nurse to form an additional working relationship. While the majority of aides were young girls with whom the Bush Nurse had little in common, some were older women and with these some strong friendships were evident.

The independence of professional practice of Bush Nurses was demonstrated by examining the work of Bush Nurses, particularly the analysis of their work as midwives and general nurses. Bush Nurses practiced a broad range of health care activity without recourse to immediate supervision, and most often without readily available collegial support. Even when working in close relationships with doctors, in many cases they were still working independently in respect of their nursing practice. Bush Nurses diagnosed and instituted treatment including the dispensing of drugs, performed minor surgical procedures, referred to hospitals, ascertained (and in one case certified) deaths, and practiced simple and complicated intra-partum care all without the prior or subsequent authorisation of a doctor. Their work relationships with other nurses were limited, even in Bush Nursing Centres with more than one nurse, and nursing supervision was limited to occasional visits from the Supervisory Nurse. Medical supervision was limited by the lack of availability of doctors, and in part by the role of the Bush Nurse as in-charge of her Bush Nursing Centre. This latter role placed her in control of the doctor's admitting or patient care behaviour, until her authority was rescinded late in the Bush Nursing period. While the official position was that the Bush Nurse was under the guidance or authority of the local medical officer except in emergency, it is clear from the official correspondence, from oral history, and from case records, that the Bush Nurse acted in the main with as much independence as she was prepared to accept. Furthermore, while the Bush Nurses' clinical records were potentially liable for audit by the Department of Public Health and its medical officers, there is no evidence that any routine oversight was exercised over Bush Nurse's activities (except belatedly over the prescription of narcotic drugs and occasionally over immunisation). This independence was necessary if Bush Nursing was to deliver health care to rural communities. A Bush Nurse in an isolated Bush Nursing Centre was unable to contact a doctor within hours or days, thus she had to act independently. Professional isolation shaped her role and her status. It was expected that Bush Nurses would use their initiative, improvise with basic equipment and refer patients to urban doctors or hospitals when necessary and appropriate. It is clear that official rules were not always practical and not always able to be followed. Even when able to seek medical approval for actions, Bush Nurses frequently did not consider it necessary to do. Not only did doctors tacitly, or

explicitly, encourage Bush Nurses to go beyond their official role, but also it is clear that the Department of Public Health usually refrained from documenting disagreement with the independent actions of its nurses—at least until the latter days of Bush Nursing.

It is indisputable that Bush Nurses, as women who worked and survived in extraordinary circumstances, were special. By reconstructing the work patterns and lives of Tasmanian Bush Nurses, the dual themes of isolation and independence emerged and became interwoven inextricably. Bush Nurses were considered heroines of rural and outback Australia and feature in the folklore of rural Tasmania. These women were an integral part of isolated communities and provided health care, and more, from womb to tomb. This thesis goes further than celebrating their lives by placing these women in context as it examines their clinical work and collective lived experiences. By weaving their stories with the documents of the past, this analysis provides insights into the history of everyday lives of Tasmanian rural women. Like many things female, and many things rural, this history has, until now, been invisible. This thesis addresses the paucity of recorded lived experiences of Bush Nurses and in doing so underlines the achievements of one group of rural and isolated women in the first half of the twentieth century. The stories of Bush Nurses in Tasmania, and their isolation and autonomy, can now be compared with their counterparts elsewhere. As a social history of rural Tasmanian women grounded in people's experiences, the thesis provides an understanding of what life was like in outback Tasmania during this period of great change and challenges and fills a gap in the history of health provision in non-urban Tasmania.