PROFESSIONAL CLOSURE: CONSTRUCTING THE IMAGE OF NEW ZEALAND NURSING 1880 - 1940

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ABSTRACT

The concept of professional closure is a sociological explanation for the way that professions limit their membership. From early in the nineteenth century the medical profession in New Zealand promoted exclusionary closure strategies which ensured their control over the other health-related occupational groups.

This paper examines the way that professional closure has shaped the development of nursing in this country since Nightingale nurses arrived in New Zealand in the 1880s, and how professional closure effectively constructed the image of New Zealand nursing through the discourse of vocationism during the sixty year period 1880 - 1940.

Key words Professional closure. discourse, vocation, profession.

INTRODUCTION

Until relatively recently history as a field of study focused almost exclusively on men. It was often written from a male viewpoint that tended to devalue and trivialise women's work. During the period 1880-1940 the patriarchal socio-political system that prevailed, relegated nursing to a position of subordination relative to the medical profession. The result is that the vast range of nursing's caring practice has been virtually absent from the annals of New Zealand's written history. Nurses seldom received acknowledgment except in cases of scandal, situations where influential family connections led to their recognition, or if they died in the course of their work, especially if they were killed during a war. This tendency for historians to focus only on exceptional women accounts for many of the gaps in our nursing history. Historically, and largely due to the powerful forces of professional closure, nursing within the New Zealand health care system has been rendered almost invisible.

PROFESSIONAL CLOSURE

The concept of professional closure is a sociological explanation for the way in which professions limit their membership.[1] The source of this approach is Max Weber's concept of 'social closure', the process of mobilising power to enhance or defend a group's share of rewards or resources. Access to all resources becomes limited to a restricted circle of 'eligibles'.[2] Raymond Murphy describes two modes of closure - exclusion and usurpation. Exclusionary closure is the exercise of power in a downward direction through a process of subordination whereby one group secures its advantages over another group, restricting opportunities of the subordinate group. The powerful group defines the subordinate group as inferior. Usurpationary closure is the exercise of power in an upward direction as the less advantaged group, having perceived itself as an outsider, attempts to secure the advantages of the more powerful groups. The desire of some

individuals for more than their share of power, prestige and wealth initiates a counter struggle by the excluded group to escape subjection, loss of esteem and dispossession.[3] Usurpation poses a threat to the class structure, requiring the more powerful to adopt strategies to maintain their privileged position.

Women were the main healers and caregivers in colonial New Zealand up to the late 19th century.[4] Until the Medical Practitioners Act of 1868, and the introduction of compulsory registration of doctors, the boundaries between the various health occupations were considerably blurred, with the medical profession no better positioned to monopolise the health care system than other health occupational groups. As health care became a marketable commodity, these groups all sought to enhance their image in the move towards professional status. The New Zealand medical profession mobilised its closure strategies to secure a position of power, control and monopoly over all other health workers within the evolving health economy.[5]

Christopher Maggs, a British nurse historian, provided interesting insights into the emergence of the new scientifically trained nurse in Britain between 1881 and 1914.[6] Maggs' research highlighted the sense of superiority and the elevated status the new system of training engendered in British nurses. He provided reliable evidence to indicate that the British medical profession considered nursing a very real threat to their superior position in the health care system and that they utilised powerful socio-political forces to ensure that the privileged status the doctors were beginning to enjoy, was not usurped by the 'trained nurse'.[7]

In the 1880s 'Lady nurses', products of the Nightingale system, were introduced to New Zealand hospitals, and nurse training commenced in the main centres. The hierarchical, patriarchal health care system thus became firmly established in this country. In light of the experience of the British medical profession in relation to the 'trained nurse', the New Zealand medical profession and political decision makers were prepared.[8] Jan Rodgers' research shows that in New Zealand, as in Britain, rules based on gender, class and state-legitimised credentials effectively shaped nursing's image so that it was consistent with the prevailing public perception of what constituted nursing.[9] Rodgers detailed some of the oppressive strategies that subordinated nursing to medicine at the turn of the century in New Zealand. In the 1890s matrons, without a professional support group, lost control over the selection of staff and the management of nursing services.[10] In the early 1900s hospital authorities, all male, selected probationers and promoted nurses on the basis of family connections rather than to ensure high standards of nursing care.[11]

The credit goes to Florence Nightingale for lifting the popular perception of nursing away from the 'Sairey Gamp and Betsy Prigg' image of the slovenly, gin drinking, illiterate 'lower order' woman immortalised in the writings of Charles Dickens in the early part of the nineteenth century. By introducing the apprenticeship model to nursing training, and by restricting entry so that only educated 'young ladies' were accepted into the training schools, Nightingale effectively created a situation whereby these restrictions became rules of closure that excluded the untrained and the uneducated from the developing profession. With a strong military influence, a legacy from

her Crimean experience, combined with principles borrowed from religious orders, Nightingale successfully altered the public's perception of the trained nurse to that of an almost saint-like woman. The required characteristics of the nurse thus became a combination of 'gender, subservience, vocation, morality and discipline'.[12]

As the twentieth century dawned, the new concept of nursing had evolved, the result of scientific advances in preventative and curative medicine and the effects of new legislation, in particular the Public Health Act of 1900. This Act created a Minister of Public Health, the first to be established in the British Commonwealth, especially acclaimed because this was the first time in the history of Great Britain and the Commonwealth that the welfare of the people had become a government priority. Interestingly, despite this acknowledgment that prevention was better than cure, nursing became increasingly concentrated in hospitals, with nurse training being focused on caring for the sick.

Although nursing education in both Britain and New Zealand developed from the Nightingale system, New Zealand secured registration of nurses eighteen years earlier than Britain. By regulating nursing, the Director-General of Hospitals and Charitable Institutions, Dr Duncan MacGregor and his assistant Grace Neill, a nurse trained under the Nightingale system, intended to raise the standards of nursing practice, increase the status of nurses and protect the public and the medical profession from unsafe, untrained nurse practitioners.[13] Thanks to the political astuteness of Grace Neill in preparing the groundwork carefully, by 1901 the New Zealand trained nurse had a recognised qualification through a system of credentialling comparable to that of doctors, though with a lower status.[14] The campaign by the British Nurses Association to introduce nursing registration and to control nursing education and practice standards was opposed, not only by many politicians and the medical profession in Britain, but by Florence Nightingale herself. Miss Nightingale insisted that examinations could test only knowledge, not character, virtue and morals.[15] The British trained nurse was not afforded the status of a nationally recognised qualification until 1919.

The Nurses Registration Act of 1901 introduced the elements of registration and examinable competence to nursing's professional project. Institutionalised medical care continued to expand and nursing, now with a scientific knowledge base underpinning its practice, was well positioned to assume a role complementary to medicine. However, though the value of the registered nurse was being recognised, without the political influence and lobbying power available to medicine and other male dominated groups, nursing relinquished the right to autonomous practice as it encountered the forces of closure, particularly from the medical profession. This capitulation occurred as the regulation of nurses enabled the nursing leaders to concentrate on improving and developing consistently high standards of nursing practice.

A major difference between nursing in Britain and New Zealand was that in New Zealand the 'trained nurse' was not considered to have a significant role in the management of hospitals. The management component was omitted from the New Zealand nursing curriculum. New Zealand nurses learned antiseptic and aseptic techniques, the conscientious administration of medications and

treatments, anatomy and physiology, dietetics and the crucial values of trustworthiness, obedience and subservience.[16] Administration, management and teaching skills gave the 'first generation' of Nightingale nurses in Britain a strong sense of their own value, and of their ability to reform and transform nursing. The course components related to management, teaching and administration did not surface in the New Zealand nursing curriculum until post graduate studies were offered in 1928. The first nurses to be trained in New Zealand were not of the 'first generation', the subject of Maggs' study, they were the 'second generation', taught by nurses inculcated with the class conscious values of the British Nightingale system.[17]

Nightingale's objective was that nurses trained in the new system, confident and superior, would go forth with missionary-like zeal throughout the world, to train future generations of nurses in the new image, thus developing and enhancing the status and standards of the nursing profession.[18] Maggs quite accurately described this process as occupational imperialism, the idea of bringing progress to underdeveloped or backward areas, teaching the principles of self-development but, as in the New Zealand situation, by removing the management, teaching and administration components from the curriculum, denying the means of self-determination.[19] This process of 'occupational imperialism' effectively socialised New Zealand nurses into the Nightingale ethos.

APPRENTICESHIP: THE EARLY NURSING CAREER PATHWAY

A significant similarity between British and New Zealand nursing was that both evolved within the structure of the apprenticeship system. As a means of training new members of an occupational group, this was a well established practice in the Nightingale era. Apprenticeship training provided a reliable source of cheap nursing labour for the hospitals, which in their turn, provided young women with their training, board, uniform, a hospital certificate and a small wage. This was acceptable to the public perception regarding appropriate occupational roles for females. Hospitals in Britain and New Zealand were an extension of the patriarchal domestic situation in which traditionally, women negotiated to exchange their labour for room and board.[20]

Apprenticeship training was not designed to provide a liberal or general education, but rather to keep oppressed groups in subordinate positions. It prepared workers who were willing to conform to prevailing customs, traditions and practices. Apprentice nurses learned to be loyal to their hospital, obedient and docile, and to accept draconian conditions and strict discipline.

Linda Hughes described attempts to develop nursing as a profession as an effort to professionalise domesticity. Drawing on the work of Jo Ann Ashley, Hughes made the analogy between the role expectation of women in the home and the role expectation of women in the hospital.[21] The professionalising strategies of New Zealand's early nurse leaders were thwarted by the prevailing socio-political ideology that was patriarchal and paternalistic, a stance reinforced by the exclusivity of the male medical profession.[22] Ashley, in her study of the effects of paternalism on the development of American nursing, discussed how nurses socialised in this manner identified with the system that oppressed them, and contributed to its continuing

existence.[23] Apprenticeship in any occupation is a structured form of oppression, and for New Zealand nurses, apprenticeship training served largely to rationalise the abuse of student labour through the institutionalised emphasis on low wages, long hours, discipline, order and practical skills. These and other strategies of closure in the education and employment of nurses, effectively relegated nursing's contribution to the New Zealand health care system to that of 'handmaiden', in service to the medical profession. Nursing schools throughout New Zealand generally contributed significantly to the oppression of nurses. The socialisation of nursing into a hierarchical system that demanded subservience, obedience, and loyalty, prevented nurses from developing as autonomous, self-directing professionals.

Nurses, in their turn, effected professional closure to exclude other groups from attaining the privileged status of the trained nurse. One outcome of this was the discriminatory and assimilative structure of the nurse training programme, first established in 1898, which made it difficult, if not impossible, for Maori women to successfully complete the nursing course.[24] The nursing profession did not acknowledge the need to allow for cultural concerns, with entry and training requirements bearing no relevance to the future practice of these nurses. The outcome of this endeavour has been documented.[25] At the same time nursing's rules of closure effectively marginalised untrained women's nursing practices.[26] The Nurses Act of 1901 stated that registered nurses must be given preference of employment in public hospitals. Nursing was constructing an image of professionalism that excluded the untrained from its ranks.

From the beginning of the twentieth century social legislation, initiated by the Liberal government, continued to be enacted. Realising that its own citizens were New Zealand's greatest assets, the government moved to implement legislation to improve the health and welfare of the mother and child.[27] Opportunities for registered nurses were expanding at a rapid rate. Grace Neill worked tirelessly, planning and successfully implementing the system of training and registration of midwives. The Midwives Act of 1904 brought all obstetric nurses and midwives under the control of the Health Department.

The Private Hospitals Act of 1906 provided an unprecedented opportunity for New Zealand nurses and midwives to practice independently and autonomously, by enabling them to apply for a licence to manage their own private hospital.[28] Some of the difficulties that were encountered by those courageous nurses and midwives who took up the challenge of being autonomous practitioners and business women have been described.[29] The pressures that were applied, particularly by the medical profession, meant that the endeavour did not succeed beyond the 1930s.

Neill retired in 1906, following the deaths of Duncan MacGregor and the Premier, Richard Seddon, both close friends of hers. Seddon, described as a humanitarian, had been the architect of the liberal social and health reforms.[30] Without him Neill's political influence was considerably diminished.[31] Neill chose Hester Maclean as her successor, an Australian nurse of Scottish parentage.

The Infant Life Protection Act of 1907 saw nurses appointed to the position of supervising officers, as the State assumed responsibility for the

supervision of 'backward and unwanted' children.[32] It was at this time that Dr Truby King inaugurated the Plunket Society, the object of which was to protect the welfare and health of the women and children of New Zealand. Dr King also established the first Karitane Hospital in Dunedin in 1907.[33] King was a powerful force in influencing policy that strengthened the family unit, emphasising and reinforcing the domestic role of women. This has been described as being 'virtually a cult of motherhood'.[34]

The Public Health Department and the Department of Hospitals and Charitable Institutions merged in 1909, to come under the direction of Dr T.H.A.Valintine.[35] One of Valintine's first moves was to initiate the Backblock District Nursing Service, a service that commenced in 1909 with the appointment of the first district nurse at Uruti, in Taranaki. It could be said that district nurses were independent practitioners, autonomous and accountable for their own practice in the community. However the Hospitals and Charitable Institutions Act of 1909 set very clear parameters for the district nurses, again limiting the nursing responsibility to that of 'handmaiden' to the doctor. The following rules printed in *Kai Tiaki* in 1911 were a reminder to all nurses that the doctor was firmly in control, even without being physically present:

> She shall work under the doctor appointed by the Board, and other doctors practising in her district. . . She shall decide as soon as possible whether or not the services of a medical practitioner are needed, and shall advise the head of the household accordingly. . . .She shall faithfully carry out the instructions of the medical practitioner, and shall from time to time advise him as to the condition of the patient. . . . She may, with the approval of the Board, in remote country districts act as a midwife at confinements, adhering to the "Rules and Guidance of Midwives" in regard with sending for medical aid.[36]

The district nurse, required to live within her district, could not leave it for more than twelve hours at a time without the permission of the Hospital Board. These nurses encountered situations and conditions that the majority of doctors would have considered at best undignified and at worst dangerous.[37] The New Zealand medical profession approved of the nurse trained in the Nightingale method, imbued with the characteristics of obedience, subservience and unquestioning loyalty to her medical 'superiors.'

NURSING RESPONDS TO NATIONAL EMERGENCIES

Jan Rodgers' research shows how World War I catapulted nursing into the arena of public awareness and the powerful influence that professional closure had on the development of the nursing profession during that time.[38] The influenza epidemic of 1918 again raised the profile of nursing when the medical profession throughout New Zealand proved inadequate to meet the demands and expectations of the public. In the wake of the national emergencies, untrained personnel threatened to usurp nursing's hard won exclusive social and economic privileges, but then as the nation recovered, the rules were once more implemented and strengthened through the legislative process.[39] Nursing reaffirmed and applied the forces of closure as the restructured Health Department provided nursing leaders with the means of securing more control over the developing profession. Legislation embodied the 'nurse as a good woman' concept with

the Nurses and Midwives Registration Act of 1925 which introduced the requirement that applicants to the Register of Nurses must be of 'good character and reputation.'[40]

UNIVERSITY EDUCATION

In studying the attempt to introduce university education for nurses at Otago University throughout the 1920s, Beryl Hughes found that not only doctors, but also many nurses vehemently opposed the idea.[41] Nurses were eventually denied the opportunity to acquire a university education. Hughes observed that the failure to establish the five year nursing diploma course at Otago University reflected contemporary New Zealand attitudes to the status of nurses and to the higher education of women in general. In 1928 the Postgraduate School was established in Wellington under the auspices of the Department of Health to provide a six month course of advanced nursing education to nurses in senior positions. Nursing education thus remained firmly under political control.[42]

After the first world war an acute shortage of nurses led to the proliferation of nursing schools. The 1920s saw schools of nursing established in nearly all hospitals throughout the country to provide a cheap and reliable source of labour in the form of trainee nurses.[43] This eventually led to an increase in the number of trained nurses, creating unprecedented unemployment for nurses, a situation that coincided with the economic depression of the 1930s.[44] As the Health Department restructured, private nursing opportunities in the community diminished and the services of many community health nurses and community midwives were discontinued.[45] Private nursing practice ceased to exist with the advent of the Social Security Act of 1938 which heralded the welfare state.[46] The medical profession had, by 1940, successfully established their monopoly over all other health professionals in New Zealand. In a counter action, nursing developed and implemented rules of exclusion and strategies of usurpation to protect and enhance their own emerging professional status. The rules of closure were strengthened to assure nursing's exclusive rights to a monopolistic position as New Zealand trained nurses.[47] However, nursing was content to achieve this in the shadow of the medical profession. Chua and Clegg's contention, that this was possible to achieve without threatening medical control, is indeed relevant to the New Zealand situation.[48] By 1939 when New Zealand entered the second world war, the patriarchal socio-political forces had determined that nursing in New Zealand would not have the right to complete autonomy over its own professional practice and direction.[49]

CONCLUSION

The professional development of nursing in New Zealand has been inimitably shaped by the forces of professional closure. The elements of closure included a continuation of the gender theme, the notion of a vocational calling and educational credentials with examinable competence. The efforts to elevate nursing's status from that of amateur to professional has been a continuous endeavour to discard the image of nursing as a domestic service. This image was perpetuated within the male dominated socio-political environment of New Zealand from the mid-nineteenth century until the late 1930s. However, the effects of professional closure have ensured that nursing in New Zealand was never afforded a higher status than that of a vocation during that period.

End Notes

1 Closure theory attempts to supplant traditional theories of social stratification as a general explanation model for all forms of domination in society.
2 R. Murphy, The structure of closure: A critique and development of the theories of Weber, Collins, and Parkin, *The British Journal of Sociology*, 1984:35:4, p. 548.
3 Ibid., p. 549.
4 J. Rodgers, 'Nursing Education in New Zealand, 1883-1930. The Persistence of the Nightingale Ethos.' MA Thesis in Nursing, Massey University, New Zealand, 1985. passim.
5 M. Belgrave, 'Medicine and the rise of the health professions in New Zealand, 1860-1939', pp. 7-24, in L. Bryder (Ed.), *A Healthy Country*, Wellington, NZ: Bridget WilliamsBooks Ltd, 1991.
6 C. Maggs, *The Origins of General Nursing*, England: Croom Helm Ltd, 1983.
7 Ibid., p. 27.
8 The Nurses Act 1901 established Dr Duncan MacGregor as the Registrar of Nurses.
9 Ibid., p. 139. See also, J. Rodgers, *Nursing Education in New Zealand.*
10 Ibid., p. 16.
11 Ibid., p. 16.
12 W. Chua, & S. Clegg, Professional closure: the case of British nursing, *Theory and Society*, 1990:19. pp. 135-172.
13 Report of the Director-General of Hospitals and Charitable Institutions, Dr Duncan MacGregor, to the Minister of Education, *Appendices to the Journal of the House of Representatives* (*AJHR*), H-22, 1901:4B, p. 4.
14 J.O.C. Neill, *Grace Neill: the Story of a Noblewoman*, Christchurch, NZ: N. Peryer Ltd, 1961.
15 M. Diamond, 'The Nightingale nurse: a study in Victorian values'. Conference Paper presented at Massey University, Palmerston North, NZ., 1980.
16 J. Rodgers, *Nursing Education in New Zealand.* passim.
17 M. Diamond, *Nightingale Nurse*, passim.
18 ibid.
19 C. Maggs, *Origins Nursing*, pp. 26-28.
20 E. Baer, Nurses, in R. Apple (Ed.), *Women, Health and Medicine in America: A Historical Handbook*, New York: Garland Publishing, 1990. p. 462.
21 L. Hughes, Professionalizing domesticity: a synthesis of selected nursing historiography, *Advances in Nursing Science*, 1990:12:4. pp. 25-31. See also, J. A. Ashley, *Hospitals, Paternalism and the Role of the Nurse*, Columbia University, New York: Teachers College Press, 1976.
22 L. Hughes, *Professionalizing Domesticity*, p. 29.
23 J. A. Ashley, *Hospitals, Paternalism*, p. 33
24 M. Holdaway, Where are the Maori nurses who were to become those 'Efficient Preachers of the Gospel of Health?' *Nursing Praxis in New Zealand*, 1993, 8:1, pp. 25-34.
25 R.T. Lange, 'The Revival of a Dying Race: A Study of Maori Health Reform 1900-1918 and its Nineteenth Century Background', MA Thesis, University of Auckland, 1972. P. Woods, Efficient preachers of the gospel of health: The 1898 scheme for educating Maori nurses, *Nursing Praxis in New Zealand*, 1992, 7:1. pp. 12-21; A. McKegg , 'Ministering Angels Government Back Blocks Nursing Service, and the Maori Nursing Service 1900-1939'; MA Thesis, University of Auckland, 1991. See also, M. Holdaway, *Maori Nurses.*
26 Nurses Registration Act, 1901; Nurses Registration Act 1908; Nurses Regulations 1908.

[27] M. Lambie, A wealth of information: facts relating to our nursing history which every nurse should know', *KT*, July 1960, pp. 8-17.
[28] Private Hospitals Act, 1906, No. 18.
[29] K. Wilson, A nurse challenges the patriarchy, *KT*, September 1995. See also, C. De Vore, Midwives as business women: 1900 to 1938. *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*. N. Chick & J. Rodgers (Eds), 1997.
[30] D. Hamer, Centralisation and nationalism 1891-1912, in Keith Sinclair (Ed.), *The Oxford Illustrated History of New Zealand*, Auckland: Oxford University Press, 1990, pp. 125-152, passim.
[31] J.O.C. Neill, *Grace Neill*, pp. 58-60.
[32] M. Lambie, *Facts Nursing*.
[33] Ibid. Karitane Hospitals were for healthy babies with feeding problems.
[34] D. Hamer, *Oxford Illustrated History of New Zealand*, p. 150.
[35] R.E. Wright-St Clair, *A History of General Practice and the Royal N.Z. College of General Practitioners*, Upper Hutt, NZ: Wright and Carman Ltd, 1989. p. 30.
[36] H Maclean, Rules relating to the appointment of District Nurses, *KT*, July, 1911, pp. 130-131.
[37] *KT*, 1912 - 1914, ran regular features on the Backblock District Nursing Scheme.
[38] J.A. Rodgers, '"A Paradox of Power and Marginality" : New Zealand Nurses' Professional Campaign During War, 1900 - 1920.' PhD Thesis, Massey University. Palmerston North. 1994. See also, Nurses Regulations 1914 and 1916.
[39] Nurses Registration Amendment Act 1920 [11 Geo. V, No 55]; Nurses and Midwives Regulations, 1922.
[40] Nurses Registration Act, 1908. No. 134. See also, A. Kennedy, Educating our nurses: Nelson College for Girls 1892 - 1910, in N. Chick & J. Rodgers, *Looking Back, Moving Forward, 1997*.
[41] B. Hughes, Nursing education: The collapse of the Diploma of Nursing at the University of Otago, 1925 - 1926. *New Zealand Journal of History, 12*, 17 - 33.
[42] Ibid.
[43] Nurses Registration Amendment Act 1920 [11 Geo. V, No 55]; Nurses and Midwives Regulations, 1922; May, 1924; September 1924; Nurses Registration Act 1925 [16 Geo. V, No 10]; Nurses and Midwives Regulations, 1928.
[44] M.I. Lambie, *My Story; Memoirs of a New Zealand Nurse*, Christchurch, NZ: N.M. Peryer Ltd, 1956. pp. 73-74.
[45] Ibid.
[46] Social Security Act, 1938.
[47] Nurses Registration Amendment Act 1920 Nurses and Midwives Regulations, 1922; May, 1924; September 1924; Nurses Registration Act 1925; Nurses and Midwives Regulations, 1928.
[48] W. Chua, & S. Clegg, *Professional Closure*, p. 138. See also M. Belgrave's essay: *Healthy Country*, p. 24. Belgrave argued that the success of health professional groups within the emerging NZ health market depended as much on class and gender and the ability to align with 'medical science' as on the nature of the treatment provided, even at the cost of being subordinated to medicine.
[49] For a study of the socio-political influences on New Zealand nursing from 1939 to 1950 see K. Wilson, Nursing on the home front during World War II: An essential service in New Zealand, *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*. N. Chick & J. Rodgers (Eds).

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