



Learning to be a nurse: the culture of training in a regional Queensland Hospital, 1930 – 1950

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Abstract

Young women wishing to train as a nurse during the early part of this century, entered into a hospital environment which taught them not only the skills of nursing, but also skilled them in how to be a nurse. Along with learning how to do a dressing, they learnt obedience, and while learning how to clean the pan room, they learnt about hierarchy and the traditions of nursing. Trainees were required to live and work within the confines of the hospital grounds, and as such, developed a distinct culture that was a compilation of work, moral and traditional elements. This paper will use a combination of oral and documentary sources to examine the development of the nursing culture and the transformation of nursing students within the ward environment of the Rockhampton Hospital between 1930 and 1950. Focusing on a small regional hospital allows one to gain a greater understanding of the nursing culture, and to investigate this culture to a greater depth as it existed in one location. In particular, aspects of reinforcing the nursing culture will be examined, that is the communication channels that had to be followed, delegation of duties and the nursing hierarchy, and the socialisation of trainees by other trainees as part of the informal educational processes.

Key terms: regional hospitals, nursing, institution, power, discipline.

Introduction

Young women wishing to train as a nurse during the early part of this century entered into a hospital environment which taught them not only the skills of nursing, but also skilled them in how to be a nurse. Along with learning how to do a dressing, they learnt obedience, and while learning how to clean the pan room, they learnt about hierarchy and the traditions of nursing. Trainees were required to live and work within the confines of the hospital grounds, and as such, developed a distinct culture that was a compilation of work, moral and traditional elements. This paper will use a combination of oral and documentary sources to examine the development of the nursing culture and the transformation of nursing students within the ward environment of the Rockhampton Hospital between 1930 and 1950. Focusing on a small regional hospital allows one to gain a greater understanding of the nursing culture, and to investigate this culture to a greater depth as it existed in one location. In particular, aspects of reinforcing the nursing culture will be examined, that is the communication channels that had to be followed, delegation of duties and the nursing hierarchy, and the socialisation of trainees by other trainees as part of the informal educational processes.

Melosh identified the importance of a work culture within nursing in her analysis of apprenticeship-style training in the USA, during the 1930 – 1960 era (Melosh 1982: 5). She suggests this culture was generated partly in response to specific working conditions, including the adaptations and resistance to the constraints made by those in authority. Barber has also noted that Australian nurses in the 1930s were informed early in their training of the totality of lifestyle that was involved in nursing (Barber 1995: 1). This was related to the extraordinary hospital conditions and the important role nurses played within hospitals. This type of culture could nurture an intense commitment to the profession and is indicative of the transformation nurses underwent during their training. For example, many former nurses continued to identify themselves as nurses even though they had not worked as such for many years (Melosh 1982: 66). This strong identification was also evident for those women, and they had to be women, who trained as nurses at the Rockhampton Hospital. Although the vocational aspects of nursing and the ideology of caring for people were strong features of this identity, it is apparent that the nature of the work as well as the structures in which the work was performed, contributed to the generation of this work culture.

The Nursing Hierarchy

One of the fundamental structures underpinning the nursing culture was the nursing hierarchy. One cannot underestimate the esteem the trainee nurses had for the sisters, that is trained nurses, and matrons who directed and monitored their work. Former nurses have suggested that the sister was almost revered by the training nurses and was placed 'on a high pedestal' (interview with R. Dalrymple Oct 3 1996). This pedestal was constructed not only on the basis of seniority, experience and knowledge, but also on a tradition of hierarchical customs and rituals. The early part of the twentieth century was an era when nursing training was arduous, with many trainees never completing their training. To join the ranks of the trained nurse was therefore seen as a major achievement in these women's lives. This factor may also have contributed to the strong identity with nursing which these women were to maintain over many years.

The new trainee nurse, often referred to as a probationer, began her training confronted with an entirely new world. This world consisted of patients with exotic sounding diseases, and a complex system of seniority. The probationer was expected to learn the rules of this complex hospital system as best she could, picking up what she could from her colleagues (*Rockhampton Evening News* Sept. 2 1930: 2).¹ One of the more significant means of learning not only the skills of nursing, but also the unwritten rules and regulations, was through the informal educational processes. A significant feature of nurse training during the early part of the twentieth century was the expectation that senior student nurses undertake a teaching role and train the more junior nurses with regards to skills and procedures. One of the consequences of this system of education was a strengthening of the socialisation of new nurses into the work culture. Bessant claims that the professional socialisation of nurses in Australia pre-1980 was powerfully interwoven with the general socialisation that enforced certain values, aspirations and subordinate behaviour (Bessant 1992: 156). It is not difficult to imagine senior nurses schooling junior staff on how to do a dressing while at the same time reinforcing the values of the hierarchy or how to best appease the ward sister.

Compulsory residency within the hospital grounds aided this process of learning the rules and expectations. Fletcher noted that living-in reinforced the secondary

socialisation of nurses, whereby institutional norms were internalised (Fletcher 1997: 42). Within the hospital ward, nurses were accorded status that was dependent on how long they had been employed at the hospital. This system was exact to the day, in that if nurse A began her training on Thursday, and nurse B commenced on Friday, nurse A would continue to be senior to nurse B throughout their training. Seniority was viewed with a great deal of importance as certain privileges were inextricably linked to this system. This system could also be used for disciplinary purposes, such that misdemeanours were often rewarded with demotions for extended periods of time.²

On the whole, there were three broad strata of nursing students at the Rockhampton Hospital – the senior nurse, the middle and the junior nurse. There was also a hierarchy among the trained staff. Each ward was assigned a sister, who was responsible for the running of that ward. The sisters also had to take turns to supervise the hospital after hours. The deputy matron was usually a ward sister who supported and acted in the position of matron as required. The matron was responsible for the behaviour of the nursing staff, and the overall running of nursing and domestic services within the hospital.



Senior Staff Rockhampton Hospital c1930³

Dennison Oct 4 1996); writing out reports (interview with N. Windsor Oct. 9 1996); as well as more 'hands-on' duties such as giving injections (interview with K. Austin June 20 1996) and undertaking the more complex dressings (interview with N. Windsor Oct 9 1996). The junior nurse was primarily directed by the more senior staff (interview with M. Baggett Oct 6 1996). Her duties usually incorporated the more menial ward tasks such as cleaning, monitoring equipment and utensils, and carrying out basic patient nursing such as back care. The middle nurse attended those duties which remained, that is, dressings, oral medications, patient hygiene and observations among others. As each shift did not necessarily have distinct senior, middle and junior nurses, the system of seniority came into play. For example, should the above mentioned nurses A and B be on duty with a senior nurse, nurse A would be allocated the middle nurse status, while nurse B would be given the more labour intensive junior duties.

The tasks that were assigned to each nurse were carried out according to an established regime within the hospital. These procedures were usually standard within the hospital, although not necessarily within the state or nation, as revealed by the request for national standardisation of procedures in 1948 by an outspoken Queensland matron (Grant 1948: 166). This call to standardise procedures was part of the scientific management scheme that had captured the imagination of nurses and administrators throughout the world during the early part of this century. McPherson explains scientific management as the process whereby particular tasks

The allocation of duties among the nursing students on the ward was in accordance with seniority. The senior nurse had either completed her final exams, or was about to sit for them. Her task was to run the ward under the supervision of the sister (interview with L. Lowrey Oct. 2 1996), although the sister was not always in attendance. This included training more junior staff (interview with B. West June 4 1996); learning administrative tasks (interview with L. Lowrey Oct. 2 1996); ensuring all nursing work was completed for the shift (interview with I.

were broken down to their component parts and each stage was examined in order to become more efficient (McPherson 1996: 88). The scientific management concept was initially involved in improving factory production efficiency, and although the measures were not easily translated into nursing, McPherson suggests that the concept of standardised procedures allowed nurses to be drilled in techniques (88-92). This allowed a small staff of trained nurses to supervise a large number of trainees and maintain a certain standard of nursing. Just what effect the ideals of scientific management had on ward nursing is unclear at present and requires further investigation; however, it is likely that these concepts worked to legitimise the hierarchical system already in place.

The system of seniority extended beyond the allocation of tasks. One of the first aspects of nursing to be taught to probationers was the concept of professional etiquette. The lecture notes of the 1930s outline professional etiquette as signifying the conventional rules, acquired through good breeding, that were observed when relating to particular persons in special places (Matron Green Lecture Notes, 1935).⁴ However, in practice, these conventions became a means of yielding power that sometimes became so severe as to obstruct the efficient running of a ward. The conventions included, among others, standing upon entry into the dining room of the matron, sisters or midwifery students (interview with K. Austin June 20 1996), placing one's hands behind the back when addressing anyone more senior (interview with B. West June 4 1996), and never sitting in the presence of a standing senior member (interview with B. Cagney June 3 1996). As one former nurse observed:

You never, ever used Christian names, you never, ever walked in front of a senior nurse, even if she was only a couple of months your senior. A few nurses got pulled back by their belts when they did it (interview with B. Cagney June 3 1996).

The rationale given for professional etiquette was that standing at attention when receiving orders heightened the recipients' understanding of the order and therefore prevented mistakes and facilitated prompt, unquestioning obedience (Matron Green Lecture Notes 1935). This reasoning was strongly based on that of military training, which is not surprising given Florence Nightingale's affiliation with the army throughout the latter part of the nineteenth century. However, this rationale fails to explain the other enforced courtesies prevalent during the 1930s and 1940s, especially the need to carry many of these rules over to off-duty time.

The hierarchical structure was integral to the Nightingale method of nurse training, which became the basis for nurse training in the United Kingdom, Canada, Australia and parts of the United States of America. Abbott outlined the essential elements of this style of training, in which the matron's authority was supreme, although she had to report to a hospital administration board (Abbott 1946: 135). Students lived-in under the supervision of a Home Sister, that is a trained nurse who supervised the nurses' quarters. Theory and practice were an integral part of training and the ward sister occupied a place of great dignity and importance. This system relied on the strict disciplining of students while on and off duty. Foucault's analysis of discipline illustrates the factors necessary to maintain this type of institutional discipline (Foucault 1977: 141-45). He suggests discipline requires enclosure, partition, and rank. These factors were certainly evident in the nursing hierarchy pre-1950 at the Rockhampton Hospital. Nurses had to be inside the nurses quarters by a certain time each night and could only stay out later if granted permission by the matron (interview with B. Cagney June 3 1996). The matron and sisters, who ate at separate tables in the dining room, had white damask tablecloths, denoting their status. The

uniform worn by the nurses also designated their particular level via the number of stripes shown or by the type of veil worn.

Such a system however, would not have succeeded without the acquiescence of the nursing students. One former nurse related that the young women entering nursing had been raised in sheltered societies, never questioning the position of superiors and therefore, readily yielded to this type of training. She observed:

We would never have given cheek to any of our superiors, not only because they had ... so much power over us, but we were raised in a very sheltered kind of society.... We were quite ripe for that kind of training, I think (interview with K. Austin June 20 1996).

While it would appear that most trainees were willing to accept this system of training in order to become trained nurses, it is evident that small pockets of discontent existed at times during the 1930s and 1940s at the Rockhampton Hospital. DeVries has investigated the 1930 Nurses' Inquiry held in Rockhampton in which a small number of trainees at the Rockhampton Hospital gave evidence against the Medical Superintendent before a Police Magistrate (DeVries 1989). In 1947, the trainee nurses put together a petition, known as the Nurses' Charter, complaining about conditions within the Rockhampton Hospital. Most of the issues raised in this petition related to off-duty constraints. This indicates that although the nurses did not overtly object to the working conditions, there was some questioning as to the necessity for the rigidity of regulations outside the ward environment. This questioning of regulations may have been evident in other hospitals as a result of women generally becoming more socially active. However, this aspect is not apparent in the nursing literature.

The mechanisms used by the nursing management to ensure nurses adhered to hierarchical conventions included rigorous monitoring of their activities and through discipline which was normally based on demotion. Monitoring of nurses' activities was carried out by the ward sister, who would check the number of pleats made in the mosquito net, the distance of the quilt from the floor, the number of broken thermometers and so forth. Mostly this monitoring related to ward tidiness and economy. However, the matron was responsible for monitoring of the hospital overall and this was accomplished through a once or twice daily tour of the hospital. Matron's rounds illustrated the importance of the nursing hierarchy within the culture of nursing during the 1930s and 1940s. Prior to the matron making her round, everything had to be cleaned, including the patients, and ward made impeccably tidy. This included having the pillowcases facing away from the door, all the bed wheels in the same direction, and all the bed linen pulled tight, regardless of patient comfort (interviews with N. McKenzie July 31 1996; B. Cagney June 3 1996; N. Windsor Oct 10 1996; M. Chambers July 5 1996; I. Dennison Oct 4 1996). Patient care was manipulated to suit the needs of the ward and the ritual of daily inspection.

The rationale for insisting on military tidiness by a certain time in the day appears to have been related to the importance placed on discipline and obedience during nurse training. Ashdown noted that these two factors were the key to satisfactory and efficient work, and that in order to rule, one first had to learn to obey (Ashdown 1925: 2). Discipline and obedience could be measured by the tidiness of a ward. Discipline and obedience were also the fundamental tenets underlying the cultural transformation that occurred as part of a nurse's training.

Communication Channels

One of the features identified by Melosh as part of the nursing work culture in the USA was the method nurses adopted to address each other (Melosh 1982: 63). Surnames or nicknames were used exclusively, a feature that is normally associated with male arenas. The nurses of the Rockhampton Hospital also addressed each other by nicknames usually associated with their surname (interview with I. Dennison Oct 4 1996). Melosh suggests this practice developed as a consequence of the strict hospital etiquette that required nurses to be addressed by a formal title, for example, 'Nurse Smith', while on the ward (63). This habit extended to off-duty time and even many years after they had finished their training and had married, many of these nurses continued to refer to their former colleagues by their nicknames.

The communication channels that were used during the early twentieth century had many consequences that went beyond nicknames. In many ways the communication channels reinforced the hierarchical structures through the control of information. One of the most obvious methods employed regarding this control of information was the specification that nurses were not to provide any information to the patient about his or her condition. This could only be provided by a sister or doctor (Matron Green Lecture Notes 1945). This may have been a very practical requirement, in that although the nurses were attending to the patient, they were task-orientated and therefore may not have been aware of all the contributing factors. This was further confounded in that although patients' charts were available on the ward, nurses did not often get the chance to read them (interview with J. Kidd Sept 12 1996), and gain a more comprehensive understanding of the patient and his or her condition. Therefore, there may have been a risk of nurses giving the wrong information to patients. However, by neither encouraging nurses to seek a broader understanding of a patient's condition nor allowing the nurses to convey any information to the patient, the nurse's status was not only maintained, but reinforced. In addition, the use of technical language contributed to the hierarchical distinction as it took some time and experience before trainee nurses became familiar with the meanings associated with the 'new' language (Fletcher 1997: 48).

In many ways the nurses, especially the more junior nurses, were completely bypassed with regards to information. Data gathered by the nurses was channelled up via senior nurses to the sister who would distribute as necessary, either to the doctor or to the matron. How effective this method was for channelling information back to the nurses is not clear. A number of comments made by former nurses would suggest that information often did not reach the more junior staff. For example, after a doctor's round, the sister would write up the orders in a day book which the nurses were supposed to check, although 'only the senior nurse and the next nurse [did], the junior one only did what she was told, and looked after the pan room' (interview with M. Baggett June 6 1996). Another former nurse recalled that nurses were expected to read the day book when coming on duty in the afternoon, and that if something had been overlooked, this was highlighted in large red writing by the sister (interview with I. Dennison Oct 4 1996). It would seem then that the day book became a significant source of information for the nurses, and the only other source aside from word of mouth instructions, most of which was done 'on the run' (interview with K. Austin June 20 1996).

One of the difficulties associated with this channelling of information via the hierarchical tree was inefficiency, which in some cases was life threatening. If a nurse answered a phone which required a message to be relayed to a doctor on the ward, she would have to tell her senior nurse, who would tell the sister, who would

tell the doctor (interview with I. Dennison Oct 4 1996). This was regardless of how urgent the message may have been. Those who broke rank and spoke directly to a doctor had to be reprimanded, again, regardless of the urgency of the situation. As one former nurse recalled:

It was very stratified, you didn't speak to, if you could help it, for instructions or anything, you could speak to the sister, but you rarely did. You spoke to the next person up, who relayed your message, and it was probably a mortal sin to speak to a doctor. In kid's ward once, there was a tonsillectomy kid I looked over and saw he was bleeding like a fountain, and the surgeon was still in the ward talking to the sister, and I went up and acquainted him of the fact... but I had to report to sister and then I had to report to Matron, and I also had to report to ... the medical superintendent because I'd broken rank, and of course, they knew I had done the right thing, ... but it had to be documented that I had broken rank. That I had been reprimanded and that I was truly sorry (interview with K. Austin June 20 1996).

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

Conclusion

During the first part of the twentieth century, women entered into the nursing profession for a number of reasons, many of which were based on ideals of philanthropy and Christian service (Bessant 1992). As they progressed through their nurse training, the rules and regulations that they were obliged to follow gradually moulded them. These constraints were related to how they could behave, who they could speak to and what work they were permitted to undertake. They learnt the behaviours expected of them through the informal and formal processes of their education, the ward environment and through living with each other in the nurses' quarters. Hence they became a part of the nursing culture of their hospital and the wider profession.

Although it is apparent there were some differences in specific work practices and nursing procedures between various hospitals in Queensland and, indeed, within the Western world, there was a surprising level of conformity regarding the culture of nursing. Throughout most of this century, professional development within nursing has been attributed to Nightingale, although Baly has more recently questioned the extent of Nightingale's influence (Baly 1986: 16-18). Through investigating the work practices and culture of nursing students within a small regional hospital in Queensland during the 1930s and 1940s, this paper has suggested that the fundamental elements of the nursing culture found at the Rockhampton Hospital were essentially those of other training hospitals. In addition, this culture appears to have been an intrinsic part of learning to be a nurse during the earlier part of the twentieth century. It is therefore, pertinent for nurse educators to understand these historical roots of the nursing culture as they prepare students for the wards of the twenty-first century. By not ignoring the important role culture has played in the development of nursing students in the past, and the profession as a whole, educators can enhance the transition of contemporary students to becoming nurses.

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Endnotes

¹ Nurse McDonald, giving evidence at the Rockhampton Hospital Inquiry, as reported in the *Rockhampton Evening News* Sept 2 1930.

² An example of this was given by Nurse Sinclair during the Rockhampton Hospital Inquiry, when she described how as a third year nurse she had been assigned to locker duty, a task normally undertaken by junior nurses (*Rockhampton Evening News* Sept 26 1930: 16).

³This photograph was provided by the Rockhampton Hospital Museum.

⁴These notes are a student's original hand written copy held in the Rockhampton Hospital Museum.

Notes on the Author: Wendy is a lecturer within the School of Nursing and Health Studies, where she teaches undergraduate nursing students on the Bundaberg

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