Imperial sisters
disease, conflict, and nursing in the British Empire, 1880-1914

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Abstract of a thesis entitled

Imperial Sisters:

Disease, Conflict, and Nursing in the British Empire, 1880-1914

Submitted by

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This thesis is the first scholarly attempt to foreground nurses in the history of the third plague pandemic. While nurses were often praised for their work, they are almost entirely absent from the plague literature, and their experiences have been obscured by male-centric narratives in subsequent plague historiography. The thesis analyses site-specific responses to the plague in two colonial port-cities, Hong Kong and Cape Town, to explore differences and commonalities in colonial nursing regimes. Its chronological focus is principally on the period between 1894, when the first cases of plague were reported in Hong Kong, and 1914, when World War One created new opportunities for overseas employment. However, the thesis also examines the development of nursing from 1880 in order to track shifts in nursing education, professional objectives, and imperial networks. The

thesis addresses a number of questions: To what extent did the plague pandemic function as a catalyst for change, and as a justification for the institutional consolidation and expansion of nursing? How was a nursing ideal constructed and promoted in metropolitan publications? How was this ideal shaped by imperial peripheries? In what ways was this ideal, and the expectations that underpinned it, challenged by frontline plague work?

Chapter One introduces the theoretical framework and identifies key themes of the thesis. It offers a brief proto-history of international nursing, emphasising the importance of biographical "snapshots" in creating an alternative to institutional nursing accounts. It also discusses the unique methodological challenges posed by tracing women's life-stories across the colonial archives. Chapter Two, 'Nursing and the "Terrors" of Plague – Hong Kong, 1894,' begins at the moment when the third plague pandemic drew international attention. It investigates the impact of the crisis on the colony's improvised medical infrastructure and, in particular, evaluates the influence of plague on the evolution of nursing, arguing that the nursing in the crown colony was shaped by unique social, political, and financial concerns. Chapter Three, 'Improvising Measures – Cape Town, 1901,' charts the arrival of plague in South Africa, highlighting the extremity of plague nursing in remote, isolated locations. On the frontline, metropolitan ideals were challenged and nurses were not only vulnerable to infection and death – in addition to other unforeseen dangers that included sexual assault, addition and suicide – they were also liable to moral censuring. Chapter Four, 'London – Making the Ideal Nurse,' considers the changes in metropolitan nursing education that facilitated the recruitment of nurses in the colonies. In this context, the chapter explores the role of a burgeoning nursing literature in the

promotion of the ideal nurse. Chapter Five concludes by summarising the case for why nursing, and the life-stories of nurses, need to be reinstated in plague histories. It also outlines the contribution of the thesis to opening up new avenues for future research in colonial and imperial nursing histories.

An abstract of exactly 465 words

Imperial Sisters:

Disease, Conflict, and Nursing in the British Empire, 1880-1914

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Declaration

I declare that this thesis and the research thereof represents my own work, except where due acknowledgement is made, and that it has not been previously included in a thesis, dissertation or report submitted to this University or to any other institution for a degree, diploma or other qualifications.

Signed 

FLETCHER Angharad

April 2020

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gracious hosts. Your corner of the earth is astonishing, and it is only enhanced by your generosity, curiosity, forbearance, and wit.

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List of Abbreviations

BMJ	*The British Medical Journal*
BNA/RBNA	British Nurses' Association/Royal British Nurses' Association
CMO	Colonial Medical Officer
CO	Colonial Office
CNA/ONA	Colonial Nursing Association/Overseas Nursing Association
GNC	General Nursing Council
INA	Indian Nursing Association
INS/IANS	Indian Nursing Service/Indian Army Nursing Service
KAB	Cape Town Archives Repository
KCH	King's College Hospital
LMA	London Metropolitan Archives
NASA	National Archives of South Africa
PCANR	Princess Christian's Army Nursing Reserve
QAIMNS	Queen Alexandra's Imperial Military Nursing Service
QARNNS	Queen Alexandra's Royal Naval Nursing Service
SATNA	South African Trained Nurses Association
SOAS	School of Oriental and African Studies
UCH	University College Hospital
VOC	Verenigde Oostindische Compagnie (Dutch East India Company)

Chapter One

Introduction – Imperial Nursing

1.1 Introduction

This thesis tracks the development of nursing across three sites of the British empire: Hong Kong, Cape Town, and London. It explores the evolution of professional nursing against the backdrop of the third plague pandemic from the mid-1890s to the eve of World War One, and addresses a number of interrelated questions: To what extent did imperial crises serve as catalysts for institutional changes in nursing? What influences did longer-term socioeconomic forces exert on the transformation of nursing across the empire? How was a nursing ideal constructed and promoted in metropolitan nursing publications and in a new, increasingly standardised nursing curriculum? How was this ideal shaped by imperial peripheries? Lastly, in what ways was this ideal, and the expectations that underpinned it, challenged in the frontline of plague work? By answering these questions this thesis argues that then, as now, nurses were expected to compensate for limitations in underprepared medical infrastructures. Pandemics, as instances of crisis, revealed, and continue to highlight, such inadequacies. Plague work allowed nurses new opportunities in new settings, but also exposed them to new, sometimes distinctly female, dangers. Despite their role as key workers managing inordinately difficult challenges, nurses have been neglected in both historical and contemporary literature, something this thesis seeks to redress.

This chapter is organised in seven sections. Section 2 ('Proto-Nursing in the British Empire') considers the thesis' chronological scope, arguing that shifts in nursing took place at the same time as other institutional changes in the metropole and colonies were reshaping practices of healthcare. It briefly contextualises these changes by examining developments in nursing education and the healthcare systems of countries outside the empire, arguing that while some broad trends can be determined, nursing reforms were often site specific. Section 3 ('Imperial Sites: Hong Kong, Cape Town, London'), offers a rationale for the choice of sites, reiterating the importance of decentralising colonial medical histories, many of which are overly focused on events and organisations in the metropole. Section 4 ('Plague as "Sampling Device"'), traces the connections between nursing and crisis, reflecting on nursing as an exceptional and routine practice. It questions the extent to which nurses were expect to adapt standard training to meet the new challenges of plague and why these women, as key workers, remain absent from male-centric plague narratives. Section 5 ('Colonial Careering') addresses the question of why women embarked on nursing careers overseas, particularly given the dangers and absence of professional support. Section 6 ('Sources, Methods, Approaches') focuses on the archival material that forms the foundation of this thesis, and the specific challenges it presents to the researcher. The engagement of the thesis with the secondary literature is considered and a number of critical research gaps are identified that the thesis aims to address. Section 7 ('Conclusion: Synopses of Chapters') provides synopses of the ensuing chapters and reiterates the central arguments of the thesis. It outlines the contributions that the thesis aims to make to nursing history and to the history of healthcare, as well as to our understanding of British imperial history.

1.2 Proto-Nursing in the British Empire

The decades between 1880 and 1914 witnessed the development of 'scientific nursing' and the expansion of formalised training for nurses in Britain. As part of this process, professionally trained nurses became the focus of a targeted print culture in the form of textbooks, advice literature, and journals. Similar developments occurred several other countries, including the United States, France, Russia and Japan. Katrin Schultheiss, examines concurrent changes in nursing in France, charting its shift from a vocation dominated by the Catholic Church and lay assistants of both genders, to a "feminine profession" that functioned as a microcosm for broader political changes, including the shaping of an idealized "female citizen."[1]

Within the British Empire, developments in metropolitan nursing were mirrored and adapted in the colonies. Many of the nurses trained a generation before became the first matrons of large colonial hospitals. Their experiences helped shape education and specialist print culture in the colonies and back in the metropole. This helped to foster trans-colonial and imperial nursing networks, allowing easier recruitment and support. These networks were reinforced by the circulation of nurses, as those taught at large metropolitan hospitals went to work overseas, and a smaller number of women born in the colonies and other international locations chose to pursue their education in Britain. The importance of informal nursing networks was paramount, given the lack of official networks, particularly in the distant parts of the empire. These circumstances are illustrated by the 1901 correspondence between Georgina Franklin and Florence

[1] Katrin Schultheiss, *Bodies and Souls: Politics and the Professionalization of Nursing in France* (Cambridge, MA: Harvard University Press, 2001), pp.3-8.

Nightingale, described in the second chapter of this thesis. After referencing their brief previous interactions at St Thomas Hospital in London, and detailing the difficult conditions experience by plague nurses at the Government Civil Hospital in Hong Kong, Franklin asked Nightingale to exert her influence, and help her relocate to a position with the Indian Army Service.[2]

At the same time, this period saw the inauguration of indigenous professional nurse training programmes in the colonies.[3] Although there have been handful of excellent, detailed studies of nursing in colonial contexts, much of this writing is site specific, focused on a later period and, unlike this thesis, does not adopt a trans-colonial perspective. Helen Sweet and Anne Digby have produced several thorough reviews of the debates surrounding race, class, gender and labour in the development of South African nursing, but much of this work adopts and entirely domestic view.[4] One notable exception is Catherine Ceniza Choy's *Empire of Care* (2003), which roots the professionalisation of nursing in the Philippines, and the subsequent migration of qualified nurses to the United States to meet labour shortfalls, in the Americanisation of hospital training systems during the early twentieth-century period of colonial rule.[5] However, Choy's work, based to some extent on interview conducted with Filipino nurses in New York, described a predominantly unidirectional movement from the colonial periphery to the metropole for study and work, rather than circulation between different

[2] London Metropolitan Archives (LMA). H01/ST/NC/05/003/046 & H01/ST/NC/18/029/008.
[3] Margaret Jones, 'Heroines of Lonely Outposts or Tools of the Empire? British Nurses in Britain's Model Colony: Ceylon, 1878-1948,' *Nursing Enquiry*, vol.11, no.3 (2004): 148-60.
[4] Helen Sweet and Anne Digby. 'Race, identity and the nursing profession in South Africa, c.1850-1958', in Barbara Mortimer and Susan McGann, eds., *New Directions in the History of Nursing: International Perspectives* (London: Routledge, 2005), pp.109-124.
[5] Catherine Ceniza Choy. *Empire of Care: Nursing and Migration in Filipino American History* (London: Duke University Press, 2003), pp.6-7.

international locations.[6] Margaret Shkimba and Karen Flynn also make good use of oral history when charting similar migrations from the UK and Caribbean to Canada in the post-World War Two era, and the impact this shift had on occupational identity.[7]

The international expansion of nursing at the turn of the nineteenth and twentieth centuries may be viewed in relation to a broader medico-health transition from bedside to hospital to laboratory.[8] The rise of bacteriology and the identification of "germs" as the causal agents of disease from the 1870s led to new practices of prevention with nursing increasingly mobilised as a tool of imperial hygiene.[9] The professionalisation of nursing was also a reflection of increasing state involvement in healthcare—albeit, as we shall see, piecemeal and site-specific.

The third plague pandemic created opportunities to act on longstanding plans to deal with the lack of suitable, sustainable nursing care for European communities overseas. This collective call arose in different parts of the British empire at different times, although some of the most insistent demands originated in Hong Kong in the 1870s, as the second chapter of this thesis will demonstrate. Debates, in medical literature and colonial reports, emphasised the moral and economic consequences of unnecessary suffering and death resulting from

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[6] *Ibid*., p.41.
[7] Margaret Shkimba and Karen Flynn, ''In England we did nursing': Caribbean and British Nurses in Great Britain and Canada, 1950-70', in Barbara Mortimer and Susan McGann, eds., *New Directions in the History of Nursing: International Perspectives* (London: Routledge, 2005), pp.141-57.
[8] Nicholas D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870,' *Sociology*, vol.10, no.2 (1976): 225-244; Andrew Cunningham and Perry Williams, *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992).
[9] Jessica Howell, Anne Marie Rafferty, Rosemary Wall, and Anna Snaith, 'Nursing the Tropics: Nurses as Agents of Imperial Hygiene,' *Journal of Public Health*, vol.35, no.2 (2013): 338-341; on imperial hygiene, more generally, see Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (Basingstoke: Palgrave, 2004).

inadequate nursing. As Jessica Howell has noted, the justifications made for the overseas presence of women as healers overlapped with those made for Britain's imperial presence.[10]

Nursing, as Sheryl Nestle has observed, is "an ambivalent site and one in which power relations flow multi-directionally."[11] Colonial nurses, as "multi-layered" subjects, came to embody many things and, in recent years, nurses have drawn corresponding interest from scholars.[12] As key members of the labour force, they offer unique perspectives on women's travel writing, contributing to the literature of empire and exploration, and shedding light on "anxieties around cultural and physical contact that nurses were meant to counteract through their hygienic influence."[13] Nurses disrupted or reinforced imperial narratives. They were expected to use their idealised femininity and professional skills to reaffirm social and political boundaries in colonial spaces, aims that were promoted (and amplified) through training and textbooks.[14] Nurses carried the domestic to the very edges of empire, playing a vital role in the formation of settler versions of home. The agency demonstrated by their choice to seek employment overseas, often in more than one location, is also a rare example of female colonial careering. Nurses functioned as "tools of empire" and agents of biopower, facilitating the monitoring, control, and containment of indigenous populations. They also helped to improve European survival rates, aiding in the construction of new, racially

[10] Jessica Howell, 'Nursing Empire: Travel Letters from Africa and the Caribbean,' *Studies in Travel Writing*, vol.17, no.1 (2013): 62-77 (70).
[11] Sheryl Nestel, '(Ad)ministering Angels: Colonial Nursing and the Extension of Empire in Africa,' *Journal of Medical Humanities*, vol.19, no.4 (1998): 257-77 (258-9).
[12] Anne Marie Rafferty, 'The Seductions of History and the Nursing Diaspora,' *Health and History*, vol.7, no.2 (2005): 2-16; Helen M. Sweet and Sue Hawkins, eds., *Colonial Caring: A History of Colonial and Post-Colonial Nursing* (Manchester: Manchester University Press, 2015).
[13] Howell, Rafferty, Wall and Snaith, 'Nursing the Tropics.'
[14] Nestel, '(Ad)ministering Angels.'

charged discourses surrounding disease and the native body, and evoking science to justify imperial goals.[15]

The third plague pandemic was the first occasion in which nurses were called upon to help manage an imperial, or trans-colonial crisis. The growth of the large metropolitan nursing schools between the 1860s and 1880s, and the consolidation of a formal nursing education (developments addressed in Chapter 4 of this thesis) meant that there were now trained nurses to meet this new demand.[16]

Initial responses to the demand for overseas nurses—on an individual and organisational level—were slow, sporadic, and limited. The Colonial Nursing Association (CNA) was formed as a result of letter sent to the Colonial Office from Mauritius by Mabel Piggott (1854-1949), wife of the Procureur-General of Mauritius and later Honorary Vice President of the association.[17] Piggott argued that if young men were willing to travel overseas for the good of the empire, any subsequent suffering they might experience for want of qualified nursing—if their health were to become compromised—was inexcusable. Her reasoning mirrored that of others who argued that insufficient numbers of specialist "soldier nurses,"

[15] Roy MacLeod and Milton James Lewis, eds., *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988); Nestel, '(Ad)ministering Angels'; Rafferty, 'Seductions of History,' p.12.
[16] Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996); Brian Abel-Smith, *A History of the Nursing Profession* (London: Heinemann, 1960); Christopher J. Maggs, *The Origins of General Nursing* (London: Croom Helm, 1983); Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century: The Quest for Independence* (London: Routledge, 2010).
[17] Piggott's husband, Francis Taylor Piggott, served as Chief Justice of Hong Kong between 1905 and 1912, when he reached the compulsory age of retirement. As part of this role, in January 1912 he accepted the keys for the new Supreme Court from Governor Sir Fredrick Lugard. After stepping down he practiced in the colony for a further two years as a junior counsel.

particularly in India, were hampering the work of medical officers and decreasing the chances of recovery among patients.[18]

The prevention of gratuitous misery caused by unregulated training, and the need to furnish consistent nursing services across colonial territories, also underpinned arguments made in Hong Kong regarding the importance of trained nurses, as Chapter 2 of this thesis will show. While a general call for nurses came from different parts of the empire, crises—often in the form of wars, epidemics, or natural disasters—were often necessary to galvanise these demands. The cause also required the patronage of influential individuals. While the CNA attracted many illustrious patrons—including Albert Grey, the 4th Earl Grey, Winston Churchill, and numerous other peers and politicians—initial recruitment was slow and impact limited.[19] Between 1896 and 1966, when the CNA was dissolved, over 8,400 nurses were offered overseas contracts, although the vast majority began their work in the post-World War I era.[20]

Several other organisations provided opportunities for nurses seeking work overseas. Those wanting to work in India could join a number of religious, philanthropic, or military organisations, working towards different aims at sites across the country. These associations were often driven by prominent political or medical figures, and created opportunities for British trained nurses to work as instructors. There had been sporadic attempts to provide a trained nursing staff at different hospitals in several major cities since the mid-nineteenth century, and

[18] 'Soldier Nurses,' *BMJ* (21 July 1894), p.144.
[19] 'The Colonial Nursing Association,' *BMJ* (June 1901), p.1365.
[20] Howell, Rafferty, Wall, and Snaith, 'Nursing the Tropics'; Anne Marie Rafferty and Rosemary Wall. 'Nursing and the "Hearts and Minds" Campaign, 1948-1958,' in Patricia D'Antonio, Julie A. Fairman, and Jean C. Whelan, eds., *Routledge Handbook on the Global History of Nursing* (New York, NY: Routledge, 2013), pp.218-236.

by the 1870s this cohort had largely been replaced by trained British nurses. Numerous Anglo-American Protestant missions focused on the training of Indian nurses at specific hospitals, including St Stephen's Hospital in Delhi from 1867, and St Catherine's Hospital in Amritsar in 1872.

Private charitable organisations included the Jamsetji Jeejeebhoy Group of Hospitals and the Indian Nursing Association (INA). The latter was founded by the Vicereine, Lady Minto, in 1906 with the aim of providing nursing care for Europeans of all classes anywhere in the British Raj.[21] Former Vicereine, Lady Dufferin, established the National Association for Supplying Female Medical Aid to the Women of India (the Dufferin Fund) in 1883 at the direct request of Queen Victoria. The fund trained Indian women as nurses from 1885 in Calcutta and from 1886 in Bombay.[22] Lastly, the Indian Nursing Service (INS) was formed in 1888 as a result of recommendations made by the 1863 Report of the Royal Commission on the Sanitary State of the Indian Army. The report, driven by Florence Nightingale, highlighted an urgent need for military nurses in the subcontinent[23]

The INS would be replaced by the Queen Alexandra's Military Nursing Service for India in 1903, and later the empire-wide Queen Alexandra's Imperial Military Nursing Service (QAIMNS). Systematic military nursing was progressively consolidated with the Naval Nursing Service (1884), the Army Nursing Service (which aimed to provide sisters to all hospitals of over 100 beds from 1889), and the Princess Christian's Army Nursing Reserve (PCANR). The

[21] 'Lady Minto's Indian Nursing Association,' *Lancet* (7 March 1908), p.735.
[22] Maneesha Lal, 'The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888,' *Bulletin of the History of Medicine*, vol.68, no.1 (1994): 29-66.
[22] Jharna Gourley, *Florence Nightingale and the Health of the Raj* (London: Routledge, 2017).

martial foundations of these groups meant that most members saw service in South Africa.[24] The disproportionate focus on military nursing in the literature is misleading, since it disregards the continuity and heterogeneity of nursing across the colonies.[25] Many of the colonial nursing organisations operated independently of the government and were self-funded.[26]

World War I had significant implications for nursing recruitment, and so provides a convenient termination point for this thesis. The crisis in the metropole reshaped nursing networks as part of a broader imperial enterprise. Probationer records from the major London hospitals reflect the changing shape of nursing networks. The vast majority of women training in the 1910s who later chose to work overseas did so as part of the QAIMNS.[27] Other records indicate military work of a more or less organised nature, including service with the Queen Alexandra's Royal Naval Nursing Service (QARNNS), the organisation's reserve, the Red Cross or simply "military work" at hospitals in France.[28] Some were killed overseas during their service, including Florence D'Oyly Compton of King's College Hospital (KCH), who joined the QAIMNS after completing her training and then drowned near Basra in December 1917.[29] Nurses wanting to work overseas could

[24] Madeline Healey, '"Regarded, Paid and Housed and Menials": Nursing in Colonial India, 1900-1948,' *South Asian History and Culture*, vol.2, no.1 (2010): 55-75 (57-8).
[25] See, for example, Ian Hay, *One Hundred Years of Army Nursing: The Story of the British Army Nursing Services from the time of Florence Nightingale to the Present Day* (London: Cassell & Co., 1953); Nicola Tyrer, *Sisters in Arms: British Army Nurses Tell Their Story* (London: Weidenfeld & Nicholson, 2008); Alison S. Fell and Christine Hallett, eds., *First World War Nursing: New Perspectives* (London: Routledge, 2013).
[26] 'Lady Minto's Indian Nursing Association,' *Lancet* (7 March 1908), p.735; Rafferty, 'Seductions of History,' p.6.
[27] KH/N/FP5/3-4 King's College Hospital Student Nurses' Register, 1905-36, pp.21, 30, 32, 36, 39, 40, 70, 76, 79, and 134.
[28] KH/N/FP5/4, pp.34, 41, 43-4, 47, 109, 115, and 133. KH/N/FP5/3, p.152, 158, 176-7, 180, 185, and 190.
[29] KH/N/FP5/3, p.187.

now do so more easily, as part of the armed forces. This thesis raises questions about the continued movement of nurses to the colonies in light of the war effort.

1.3 Imperial Sites: Hong Kong, Cape Town, London

The global pathways of plague that meshed colonial port cities from the 1890s, such as Hong Kong and Cape Town, were also circuits for other kinds of flows, including the circulation of nurses. In both Hong Kong and Cape Town, plague became a catalyst for infrastructural reform (albeit implemented slowly and piecemeal) and for coercive interventions triggered by anxieties about contagion, migration, and the potential for subversion by native communities. The reclamation of Taipingshan in Hong Kong, and the establishment of townships in the Cape Colony, are striking examples of the colonial state's aggressive push-back in the face of the plague threat.[30]

Hong Kong and Cape Town were also linked in dozens of small ways, some of which are highly pertinent to this thesis. Hong Kong was a major embarkation point for Chinese indentured labourers. As early as 1652, Jan van Riebeech (1619-1677), founder of what would become Cape Town, was lamenting the availably of Chinese "coolies" to help with his gardening. Numbers of Chinese labourers passing through the Cape, often to work in the Witwatersrand (Rand) gold mines, slowly increased until reaching a peak of 63,695 between 1904 and 1907.[31] After plague had begun to effect other colonies, Cape authorities received regular

[30] Maynard W. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909,' *Journal of African History* vol.18, no.3 (1977): 387-410; Hong Kong Museum of Medical Sciences Society. *Plague, SARS and the Story of Medicine in Hong Kong* (Hong Kong: Hong Kong University Press, 2006).
[31] Rachel K. Bright, *Chinese Labour in South Africa, 1902-10: Race, Violence and Global Spectacle* (Basingstoke: Palgrave Macmillan, 2013).

reports from the governors of Hong Kong, Mauritius and Madagascar, detailing their respective outbreaks and helping the Cape Colony organise its own defences.[32] Once plague had arrived in Cape Town in the early spring of 1901, some suspected Hong Kong as a possible origin.[33]

In Hong Kong and Cape Town nurses became "plague martyrs." They helped to reinforce feminine nursing ideals and retrench boundaries during a period of transition at the edge of empire. At the same time, nurses were compelled to navigate contagious and racial anxieties in both their working and private lives.[34] The extreme conditions of anti-plague work put pressure on metropolitan ideals of nursing, creating a complex moral space for nurses to operate in. Finally, authorities in both port cities struggled to attract, retain, and educate nurses. The early history of nursing in both colonies (as elsewhere) was shaped by racial, socioeconomic, and practical concerns. Both colonies were to rely on overseas nurses until well into the twentieth century.

This thesis argues that imperial nursing needs to be viewed in relation to site-specific histories of healthcare, as well as in relation to the dynamics of a wider imperial world. Thus, despite their many similarities, Hong Kong and Cape Town should be understood as very different colonial sites. The former was a crown colony and by the 1890s, a major entrepot and transhipment hub abutting the Qing Empire. The latter, established by the Dutch in the mid-seventeenth

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[32] Cape Town Archives Repository (hereafter KAB). KAB/CO/7261/32 Correspondence of the Colonial Office: Health Branch, Bubonic Plague: Measures to be Taken to Prevent the Invasion of, vol. 1, folio 32.

[33] Myron J. Echenberg, *Plague Ports: The Global Urban Impact of Bubonic Plague, 1894-1901* (New York, NY: New York University Press, 2007), p.271.

[34] On these colonial anxieties, see the essays collected in Robert Peckham, ed., *Empires of Panic: Epidemics and Colonial Anxieties* (Hong Kong: Hong Kong University Press, 2015) and Harald Fischer-Tiné, ed., *Anxieties, Fear and Panic in Colonial Settings: Empires on the Verge of a Nervous Breakdown* (Basingstoke: Palgrave, 2017).

century, was a self-governing colony with an elected prime minister (from 1872). By the end of the century, the discovery of diamond and gold deposits around Kimberley and in the Transvaal encouraged a policy of aggressive expansion, which led to increasing political instability, and ultimately to war between the British empire and the Boer states (1899-1902). These contexts were to influence the formation of healthcare services in both colonies, and to shape the development of nursing.

Moreover, changes in London were also key to the evolution of colonial nursing. Journals produced in the metropole, and similar titles later published in the colonies, helped to construct and promote ideals of nursing. This took place against the background of institutional transformations, as the nursing curriculum was increasingly standardised (see Chapter 4).

1.4 Plague as "Sampling Device"

To what extent was nursing a crisis occupation? How should we understand the difference between 'war nursing' or 'epidemic nursing' and civil nursing?[35] Between exceptional and routine nursing work?[36] Nurses in Hong Kong and Cape Town experienced the inadequacies of makeshift medico-health infrastructures that exposed them to unwarranted risks and dangers.

An important focus in this thesis is on the kinds of work that plague nurses were expected to perform, and on the degree to which they were called upon to adapt this regimen in the face of local circumstances. The thesis also suggests that the plague crisis, while it represents a "state of exception" in which regular

[35] Patricia D'Antonio, 'Nurses in War,' *Lancet*, vol.360, special issue, S7-S8 (December 1, 2002).
[36] Hawkins, *Nursing and Women's Labour*.

working practices were suspended, or at the least modified, also provides a useful framing device that makes visible obscured social and political processes.[37] In so arguing, the thesis draws on the work of the historian Charles E. Rosenberg, who has suggested that disease can function as a "multidimensional sampling device" to shed light on "the relationship between social thought and social structure."[38] In other words, epidemic episodes offer lenses for exploring processes that are invisible in non-crisis moments.[39] The plague outbreak, as a particular genre of crisis event, provides a "sampling device" that discloses sociocultural and institutional changes.

To date, plague narratives remain exclusively male-centred, despite the fact that the majority of the labour performed in plague cases was undertaken by female nurses. Accounts of the plague by well-known figures such as Dr James Cantlie (1851-1926), Dr William John Ritchie Simpson (1855-1931) are largely silent on the issue of women, as are the voluminous reports written by the many medical and colonial officers discussed in other chapters of this thesis. Women are also conspicuously absent in subsequent plague historiography.[40] In short, gender has been side-lined in the history of plague, while issues of race predominate.[41]

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[37] On states of exception, see Giorgio Agamben, *State of Exception*. Translated by Kevin Attell (Chicago, IL: University of Chicago Press, 2005), and Didier Fassin and Mariella Pandolfi, eds., *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions* (New York, NY: Zone Books, 2010).

[38] Charles E. Rosenberg, 'Introduction: Framing Disease: Illness, Society, History,' in Charles E. Rosenberg and Janet Golden, eds., *Framing Disease: Studies in Cultural* History (New Brunswick, NJ: Rutgers University Press, 1992), xiii-xxvi (xxiii), and *The Cholera Years: The United States in 1832, 1849 and 1866* (Chicago, IL: University of Chicago Press, [1962] 1987), p.4.

[39] On the implications of crises approaches to history, see Janet Roitman's insightful study *Anti-Crisis* (Durham, NC: Duke University Press, 2014).

[40] See, for example, Echenberg, *Plague Ports*, the essays collected in Lukas Engelmann, John Henderson, and Christos Lynteris, eds., *Plague and the City* (London: Routledge, 2018), and Carol Ann Benedict, *Bubonic Plague in Nineteenth-Century China* (Stanford, CA: Stanford University Press, 1996).

[41] The third plague pandemic was the first global disease event to be systematically photographed. The 'Visual Representations of the Third Plague Pandemic' project (2013 to 2018) funded by the European Research Council (ERC) and based at the University of Cambridge and the University of

This thesis provides an important corrective to these male-centred plague histories. It seeks to reinstate women as crucial agents in plague history.

1.5 Colonial Careering

Why did nurses go out to the colonies? As Anne Summers has argued, overseas nursing—in the context of warfare—provided new opportunities for sexual, social, and geographical adventure. Nurses were driven by a desire to free themselves from restrictive domestic environments and working roles. Did they leave for better pay and less onerous working conditions overseas? As we shall see, many nurses still ended up impoverished, receiving inadequate pay and lacking family support.[42]

Did nurses leave to be of service to the empire as their letters and application forms may suggest? Was it a desire to get married?[43] Temporary contracts were rare opportunities to further education, to gather enviable practical experience, to assume new leadership roles, and to attain the patriotic and professional distinction often associated with such posts. There is demonstrable evidence for colonial careering across the empire. As David Lambert and Alan Lester have observed, "the term 'career' is a suggestive one that captures a sense of volition, agency and self-advancement, but also accident, chance encounter and the impact of factors beyond the control of the individual."

St Andrews collected thousands of plague images. Strikingly few of these images, however, feature women.

[42] Anne Summers, *Angels and Citizens: British Women as Military Nurses, 1854-1914* (London: Routledge Kegan & Paul, 1988).

[43] Diana Solano and Anne Marie Rafferty, 'Can Lessons Be Learned from History? The Origins of the British Imperial Nurse Labour Market,' *International Journal of Nursing Studies*, vol.44, no.6 (2007):1055-63.

It is in the context of this sense of "career" and "careering" that this thesis seeks to understand the trajectory of nurses.[44]

Nurses applied for service overseas via letters, testimonials and recommendations, so the reputation of the individual nurse providing the documentation was important. They survived when they reached the colonies through a reliance on nursing networks that provided practical solutions to problems arising when women travelled unsupervised around the empire.

Nurses in the colonies were open to abuse. They had no personal protection. There is evidence of nurses not being paid, forced to work 24-hour shifts, and writing to the Cape government because the hospitals were so bad they felt they could no longer perform their duties. Colonial careering carried mortal dangers, some of which were specifically female. Nurses suffered from illness and exhaustion: some nurses were so debilitated they were incapable of working, or were required to take long periods of leave which left them in financially precarious circumstances. They faced death from infectious disease, natural disaster, or war. There were other risks, as well. The nurses who arrived in Cape Town were shipwrecked off Robben Island. The pressure of work and the lack of support could lead to suicide. Suggestions of impropriety could ruin a nurse's career. Nurses were exposed to the dangers of sexual assault.

1.6 Sources, Methods, Approaches

As key workers in metropolitan and colonial settings, British nurses are by no means absent from the archives, appearing in hospital and military records,

[44] David Lambert and Alan Lester, 'Introduction: Imperial Spaces, Imperial Subjects,' in David Lambert and Alan Lester, eds., *Colonial Lives Across the British Empire: Imperial Careering in the Long Nineteenth Century* (Cambridge: Cambridge University Press, 2006), pp.1- 31 (21-22).

private papers, photographic and print collections, government and colonial reports, newspapers and, from 1921 onwards, as part of a national roll of registered practitioners. However, one reason for the current lack of scholarly enquiry is the inherent difficulty in tracing nursing records, particularly those of individual nurses, from the early history of colonial nursing. At this stage, there remains no collected, digitised or, in some instances, alphabetised record of trained nurses and probationers in Britain before 1921, an issue that the 1919 Nursing Registration Act and the 1920 establishment of the General Nursing Council (GNC) attempted to rectify.[45] Hospital records from before this period, even in relatively centralized bureaucracies like London, remain fragmented.

Where such records do exist, it is often only at the level of the individual hospital. Some institutions, including Guy's Hospital, maintained no register of nurses employed before being legally required to do so, despite the fact that "nurses" of some description appear in salary statements, ledgers, report books, and other administrative minutiae from the mid-eighteenth century onwards.[46] Records from some institutions, including St Mary's Hospital in Paddington and University College Hospital (UCH), are only partially catalogued and somewhat inaccessible. Large sections of the records from other hospitals, including the Royal London, Middlesex, and Westminster, have not survived.[47] The National

[45] Rafferty, *Politics of Nursing*.
[46] London Metropolitan Archives (LMA) H09/GY collection.
[47] *LMA Leaflet 36. History of Nursing* (www.cityoflondon.gov.uk/things-to-do/london-metropolitan-archives/visitor-information/Documents/36-history-of-nursing-at-lma.pdf), pp.7-8, and pp.11-2. For the Westminster Hospital see LMA H02/WH. A few records concerning nursing in the eighteen and nineteenth century survive in this collection, including the Registers of Probationer Nurses 1885-1890 and 1900-1947 (H02/WH/C/01/1-11) and the Registers of Sisters and Nurses 1899-1950 (H02/WH/C/02/1-16). The Royal London Hospital Archives and Museum and St Bartholomew's Hospital Archives and Museum do contain fragments of several relevant nursing collections, including the St Bartholomew's Hospital School of Nursing (SBHB/MO), the London Hospital School of Nursing, later Princess Alexandra School of Nursing and Midwifery and

Archives and Wellcome Library have compiled a database of existing hospital records, giving brief details of what is known to have survived and where that material is located. However, little information is available regarding records still held by individual hospitals.

Archivists Janet Foster and Julia Sheppard have highlighted some of these issues, arguing that before around 1860, most notably prior to the establishment of nurse training schools, there were no specific archives and little documentary evidence of any kind. Beyond the authors' valuable initial overview of existing material and reminder of correct archive practice, improvements in the range, quality and accessibility of material currently available, in addition to the commitment and resourcefulness of archivists working with that material, challenge their claims surrounding the difficulty of locating useful data.[48] This is particularly true of the growing number of digitization ventures, including the hundreds of nursing textbooks and plague treatises, dating from the eighteenth century onwards, that form part of the UK Medical Heritage Library, the Pioneering Nurses project at King's College Archives—which aims to offer as much biographical information as possible about the first thousand members of the British Nurses' Association (BNA)—and the Irish Nursing Journals Collection, added to the online library platform at University College Dublin in 2012.[49]

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also the London Hospital School of Midwifery (RLHLH/NE, RLHLH/N) and the Royal London Hospital League of Nurses, St Bartholomew's Hospital League of Nurses and other nursing societies (RLHLN, SBHLN and others). This material comprises some nurse and probationer records, ephemera, papers relating to prominent individuals like Edith Cavell, photographs, lecture notes and exam results but again, what remains if far from complete (http://www.calmhosting01.com/BartsHealth/CalmView/What.aspx).

[48] Janet Foster and Julia Sheppard, 'Archives and the History of Nursing,' in Celia Davies, ed., *Rewriting Nursing History* (London: Croom Helm, 1982), pp.200-14.

[49] UK Medical Heritage Library (https://archive.org/details/ukmhl). Pioneering Nurses Project (http://www.kingscollections.org/nurses/home); Irish Nursing Journal Collection (https://digital.ucd.ie/view/ivrla:35760).

However, many of these developments, including the introduction of the 1921 national roll of registered nurses, are of little assistance to those researching the careers and experiences of the thousands of British nurses already working across the empire. An individual nurse may appear in a few scribbled lines detailing her training as a probationer at a large metropolitan teaching hospital in London, Glasgow, Edinburgh, or Manchester, before disappearing for a decade and reappearing as a staff nurse or matron in Bulawayo, Hyderabad, or Sydney, her progress marked by little more than shipping manifests and a cursory mention in the local newspaper. The issue is compounded if a specific nurse has no military record, never worked for any humanitarian organisation—for example the CNA, the QAIMNS (from 1902), or Lady Minto's Indian Nursing Service (from 1906)—published no memoir, or left no personal papers in any archive. The paucity of such material, and the disproportionate representation of prominent nurses like Florence Nightingale in whatever material has survived, is noted by a number of nursing scholars.[50] These circumstances are true for the majority of colonial nurses, particularly those employed to meet shortfalls during instances of perceived crisis, including the nurses recruited during the third plague pandemic.

One consequence of these methodological challenges is that the experiences of nurses with prominent military service records have come to dominate nursing historiography, eclipsing the equally valid encounters of those with a less obvious archival presence and leading to studies of nursing with a narrow geographical and chronological focus.[51] The inclusion of a more diverse

[50] Sue Hawkins, *Nursing and Women's Labour*, p.9; Barbara Mortimer, 'Introduction: the history of nursing: yesterday, today and tomorrow,' in Barbara Mortimer and Susan McGann, eds., *New Directions in the History of Nursing: International Perspectives* (London: Routledge, 2005), pp.13-4.
[51] Angharad Fletcher, 'Imperial Sisters in Hong Kong: Disease, Conflict and Nursing in the British Empire, 1880-1914,' in Sweet and Hawkins, eds., *Colonial Caring*, pp.42-3. Examples of this trend

and nuanced range of biographical fragments challenges assumptions surrounding the collective nature of the colonial nursing experience and facilitates a more transnational approach to the history of nursing.

Given that complete nursing records in any location prior to 1921 are rare, some of the most valuable material examined as a basis for this thesis are the King's College Hospital (KCH) School of Nursing Student Nurse Records from the King's College Archives, and the Nightingale Training School Records and Saint John's House Records from St Thomas' Hospital, now held as part of the Nightingale Collection at the London Metropolitan Archives (LMA).[52] The material is comprehensive, varied, and detailed, particularly when compared to other nursing collections from the nineteenth and early twentieth centuries. In addition to information on annual changes to the nursing curriculum, matrons' reports, descriptions of hospital regulations and infringements, extensive records outlining the duties and salaries of various nursing roles from the level of probationer to matron, and some interviews with specific nurses over a significant period of each hospital's history, the material also comprises thorough notes on individual nurses and probationers in a single register. This information includes their social background, exam results, specialist training, hospital career, any

include Ruth Rae, *Veiled Lives: Threading Australian Nursing History into the Fabric of the First World War* (Burwood, NSW: The College of Nursing, 2009); Peter Rees, *The Other Anzacs: Nurses at War 1914-1918* (New South Wales: Allen & Unwin, 2008); Summers, *Angels and Citizens*; Chris Schoeman, *Angels of Mercy: Foreign Women in the Anglo-Boer War* (Cape Town: Zebra Press, 2013); Eric Taylor, *Wartime Nurse: One Hundred Years from the Crimea to Korea, 1854-1954* (London: Robert Hale, 2001); J. C. (Kay) de Villiers, *Healers, Helpers and Hospitals: A History of Military Medicine in the Anglo-Boer War*, Vol. I & II (Pretoria: Protea Book House, 2008); Marianne Baker, *Nightingales in the Mud: The Digger Sisters of the Great War, 1914-1918* (London: Allen & Unwin, 1989); Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (Melbourne: Oxford University Press, 1992); Fell and Hallett, *First World War Nursing*; Christine E. Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009); and Kirsty Harris, *More than Bombs and Bandages: Australian Army Nurses at Work in World War I* (Newport, NSW: Big Sky Publishing, 2011).

[52] KH/N/FP1-19; LMA/H01/ST/NTS/A-Y; and LMA/H01/SJ/A-C.

known subsequent employment, and meticulous, but often deliciously indiscreet, comments on performance and character.[53] This latter aspect is far from frivolous as nursing career paths often depended upon testimonials issued by former instructors and employers, a point explored in detail in the London chapter of this thesis.

While the nursing records from KCH, the Nightingale Training School, and St John's House are far from exhaustive, they allow a more systematic examination of some of the general statistical information and trends offered by Christopher Maggs and Brian Abel-Smith regarding the changing socioeconomic status of nurses from the mid-to-late nineteenth century. Responding in particular to Maggs's call for more exhaustive local studies, Sue Hawkins has approached the nursing records of St George's Hospital between 1850 and 1900 in a similarly prosopographical manner.[55] This highly revealing and nuanced local study of the lives of ordinary nurses charts the impact of extensive reforms, analysing the social mobility and composition of the nursing community, partly through the addition of the pen portraits of six selected individuals. However, the work includes little of what happened after the nurses left St George's, and this thesis is the first attempt to adopt a prosopographical framework on an imperial scale. As some of the oldest, largest, and most selective training schools in the metropole,

[53] Records from 1897, list each nurse or probationer's name, date of entering, date of leaving, years of service, age, marital status, date of birth, place of birth, place of residence, religious denomination, father (or husband's) profession, whether or not their parents were alive, education, previous occupation, the addresses of two referees, examination results, information on special cases encountered, duration and cause of any sick leave taken, examiners, notes detailing manner, character and professional capabilities, any known subsequent employment and information regarding marriage in some cases. KH/N/FP1-7 & KH/N/FP19/1.

[55] Brian Abel-Smith, *A History of the Nursing Profession,* (London: Heinemann Educational Books, 1960); Christopher J. Maggs, *The Origins of General Nursing* (London: Croom Helm, 1983); Hawkins, *Nursing and Women's Labour*.

close study of records reveals that KCH, the Nightingale Training School, and St John's House produced nurses that were much sought after throughout the empire, becoming feeder schools in some locations. More interestingly, nurses trained there also came to rely upon personal and professional links formed during their time in London, particularly away from governmental resources and support networks in colonial settings. Attrition rates, justifications for expulsions, and performance notes indicate some of the physical and occupational dangers nurses faced. Disease, death, and defamation ruined the lives and careers of many nurses.[57]

In addition, hospital records facilitate the creation of a nursing database, allowing the cross-referencing of names that also appear in colonial records or specialist publications. One significant development of particular importance to this thesis and discussed in its final chapter, is that many of the nurses trained in London were either born in the colonies or subsequently worked overseas, demonstrating a prehistory of private and professional colonial nursing networks before organisation like the CNA and Lady Minto's Indian Nursing Service began to officially encourage the circulation of a highly selective type of female migration and labour. These networks are further emphasised when nursing registers are read alongside print material, including hospital gazettes, or medical and nursing journals, allowing the creation of individual and collective biographies of the earliest colonial nurses.

[57] A. M. Rafferty and D. Solano, 'The Rise and Demise of the Colonial Nursing Service: British Nurses in the Colonies, 1896-1966,' *Nursing History Review*, vol.15, no.1 (2007): 147-154.

Assembling similar biographical fragments in a colonial setting is significantly more challenging, partly as a result of a fractured, decentralised medical infrastructure, and a lack of hospital records from the early colonial period. Here, perceived crises like the third plague pandemic are useful, generating increased interest and documentation from disparate witnesses. In Hong Kong, it is necessary to amass details from passing mentions in a wide variety of administrative reports, the most useful of which are the Hong Kong Government Reports, recently digitised as part of the University of Hong Kong's Digital Initiatives. These comprise the Sessional Papers, Hong Kong Hansard, Blue Books, Administrative Reports, and the *Hong Kong Government Gazette*. Of particular interest are specific reports on the 1894 plague outbreak and annual reports by, among others, the Colonial Surgeon and superintendents of several hospitals, but nurses also briefly appear in annual budgets, memoranda, official correspondence, and government notices. In this archive it is possible to discern the names of some of the nurses working in the colony, their salaries and pensions, when they arrived and departed, the duration of their stay, a brief outline of their duties, and usually some explanation for why each nurse chose to leave her post. This information is limited to those drawing a government salary, for example, at the Tung Wah Hospital or the Government Civil Hospital. Any study of those engaged in private nursing would necessarily be extremely challenging. However, as the Hong Kong chapter of this thesis demonstrates, these official documents are occasionally extraordinarily candid, alluding to deficiencies in existing hospital conditions and staff, and pervasive occupational hazards, such as exhaustion, illness, and violence.

Census data, travel writing, and local newspaper reports, including articles and correspondence in the *China Mail* and *Hong Kong Daily Press*, contain useful supplementary contextual data regarding life in the colony and the impact of plague. The same is true of the London Missionary Archives, housed at the School of Oriental and African Studies (SOAS), which include an incomplete set of annual reports from the Nethersole Hospital (1881) and Alice Memorial Hospital (1887), and correspondence from those members of the society working to deliver western medical care for Hong Kong's poor, and western medical training for Chinese practitioners.[58] Frequently cited as the first hospital in the colony to train nurses, despite a lack of specificity regarding nursing roles, these records do offer some insight into the treatment provided for plague patients and the nature of nursing work during the 1894 outbreak. They also contain rare references to some of the few Chinese and Eurasian women working as trained nurses during the early colonial period.

In the case of Cape Town, plague records housed at the Cape Town Archives Repository (KAB) of the National Archives of South Africa (NASA) are voluminous, diverse, and detailed. Surprisingly, they describe everything from the cost of single beds at improvised hospitals to international quarantine legislation. The records consist predominantly of a chronological dialogue between various agencies, including: the Under Colonial Secretary in London, the Medical Officer of Health for the Colony, the Plague Administration Department, the Office of the Plague Board at various impacted locations across the Cape, other local government departments when necessary—for example the Treasury, Bacteriological Institute

[58] Various reports, photographs and correspondence regarding the Nethersole Hospital, Hong Kong, 1853-1912. CWM/LMS/16/06/1/01-047.

and Office of the Harbourmaster—private citizens, and other medical and civil authorities. These records encompass government reports and correspondence, newspaper articles, leaflets, maps, photographs, public notices, and other related ephemera.[59] A significant proportion of this material details plague nursing and records, although often spread over several volumes. They also reveal significant details about the challenges and dangers faced by colonial nurses, including exhaustion, disease, overwork, accusations of impropriety, violence, and destitution, all of which are discussed in the Cape Town chapter of this thesis.

More detailed descriptions of nursing work, both in London and the colonies, come from rare collections of private papers, for example those of Sir James Cantlie, Emma Durham, Edmund Allenby, and Georgina Franklin.[60] These documents offer a more vibrant, nuanced, and often thoroughly subjective glimpse of plague nursing when read against the backdrop of official government reports and statistics designed to present a drier, objective picture of overstretched medical services. Significant details emerge in this material: for example, the poor wages and appalling working conditions at Hong Kong's Government Civil Hospital (as also detailed in Franklin's letters), and the hunger and exhaustion encountered by probationers at London hospitals during the 1880s described in Durham's diaries. Large collections, like those of Florence Nightingale, also

[59] Cape Town Archives Repository (KAB) MOH/1-426 Medical Officer of Health, Plague Records 1901-1905.
[60] Allenby: 1/2/1-1/2/7 Letters Describing Cape Town, Correspondence and Personal Papers of Edmund Allenby, 1st Viscount Allenby, 1899. GB0100 KH/NL/PP10 Private Papers of Emma Durham, 1848-1936. H01/ST/NC/05/003/046 Transcript of 11 Letters from Florence Nightingale to Georgina Franklin. H01/ST/NC/18/029/008 Letter from Georgina Franklin to Florence Nightingale, 1898. WL/MS1483 Fragments from Hong Kong Plague Letters. WL/MS1487 Sir James Cantlie Lecture on the Plague 1897. WL/MS1488 Sir James Cantlie Lecture on Hong Kong 1898. WL/MS1498 Sir James Cantlie Lecture to the Colonial Nursing Association. WL/MS1719 Collected Plague Documents and Statistics.

contain rare mentions of plague or nursing work in Cape Town and Hong Kong, but the volume of available, partially catalogued material is so vast, and discussions of relevant topics so brief, that any exhaustive search is impractical.

Beyond archival collections, partly as a result of the nineteenth-century expansion of the printed word and an ongoing campaign for professional registration, from the 1880s nurses also became the focus of a targeted print culture that included an increasing number of textbooks, journals, memoirs, and hospital publications.[61] The establishment of *The Nursing Record and Hospital World* was part of this trend. Published between 1888 and 1956, but renamed the *British Journal of Nursing* (*BNJ*) in 1902, the periodical contained reports on the latest treatments, equipment, issues within the nursing profession, hospitals, wards, staff, events, patients, and medicines—material that later formed part of a politicised drive for professional registration.[62] In 1893, the journal was acquired by Dr Bedford Fenwick and his wife, the nurse, activist, and founder of the British Nursing Association (BNA), Ethel Gordon Fenwick, who used the publication to facilitate her campaign for professional certification and registration among nurses, becoming the journal's editor in 1903.[63]

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[61] An increasing amount of this material is available via the UK Medical Heritage Library (https://archive.org/details/ukmhl), although the majority of hospital publications, including the *St Thomas Hospital Gazette*, the *Guy's Hospital Gazette*, the *St Mary's Hospital Gazette* and the prospectuses of most large teaching hospitals can only be consulted as hard copies within various archives.

[62] In 2001, the Royal College of Nursing (RCN) archives digitized some of its rarest nursing journals, including every edition of the *BNJ*, with the aid of a Research Resources in Medical History Grant from the Wellcome Trust. It is possible to search or browse the journal for free via the College's website (https://www2.rcn.org.uk/development/library_and_heritage_services/library_collections/rcn_archive/historical_nursing_journals).

[63] For an excellent summary of the debate surrounding registration and the expansion of the nursing profession see Abel-Smith, *History of the Nursing Profession*; Monica E. Baly, *Nursing and Social Change* (London: Routledge, 1995); Rafferty, *Politics and Nursing Knowledge*; Summers, *Angels and Citizens*.

While the journal continued to reflect the views of Bedford Fenwick and other prominent pro-registrationists, as its popularity increased the periodical also featured significant numbers of articles, letters, obituaries, advertisements, and job applications from across Europe, the United States, and the British empire, eventually becoming a vital recruiting tool as matrons and medical authorities struggled to keep hospitals, particularly those outside imperial "hub" cities, staffed with qualified nurses, an issue explored in greater detail as part of the Cape Town chapter of this thesis. This function was especially important when instances like the arrival of the third plague pandemic further strained fractured and makeshift medical infrastructures. A comprehensive examination of the journal reveals that complex professional and personal networks emerged, which not only provided unprecedented career opportunities for individual nurses and helped ensure the provision of qualified staff in colonial hospitals, but also encouraged the development of a nursing identity at a local and transcontinental level. These networks offered protection for women during a period when opportunities for independent international travel were limited. Although these networks were intentionally fostered to a degree by the journal's contributors and editors with the aim of creating a global consensus regarding registration, they nevertheless provide an opportunity to examine the gap between the aspirations of women attempting to forge careers on the edges of empire, and the pragmatic, often dangerous reality of such ambitions. When read alongside specialist publications or some of the few nursing memoirs from this period, an interesting disparity is revealed between aspirational colonial nursing careers, and the dangers and challenges faced by individuals when they actually travelled overseas.

It is necessary to recognise certain caveats when utilising data from the *BNJ*. Nurses, even certified practitioners trained in Britain, displayed little homogeneity and for the most part the *BNJ* expressed a specifically pro-registrationist stance, an issue explored by Christine Hallett in the context of World War I.[64] However, when cross-referenced with archival material and other specialist and non-specialist publications, the *BNJ* makes it possible to track the employment histories of individual nurses moving between different institutions and colonial outposts, illustrating the type of "colonial careering" formerly associated primarily with men, most notably doctors and subalterns.[65] Other specialist publications include the *American Journal of Nursing* (*AJN*), the *BMJ*, *Guy's Hospital Gazette, The Hospital, The Lancet,* the *London Hospital Gazette,* the *National Medical Journal of China,* the *Post-Graduate, St Bartholomew's Hospital Journal, St George's Hospital Gazette*, *St Mary's Hospital Gazette*, *St Thomas' Hospital Gazette,* the *South African Medical Journal,* the *South African Medical Record, The Stethoscope*, and the *Transvaal Medical Journal.* Collectively, this material offers a different and perhaps more objective perspective beyond that of the highly politicised *BJN*, and helps to sharpen the image of a global nursing network. Lastly, nursing textbooks and ancillary volumes, some of which, including *Wellcome's Professional Nurses Diary*, were marketed specifically to nurses working overseas, illustrate the kind of knowledge and skills expected of

[64] Hallett examines the politicised production of nursing knowledge, with particular emphasis on pro-registrationist links between scientific knowledge and nursing registration. Christine E. Hallett, '"Intelligent Interest in their Own Affairs": The First World War, the *British Journal of Nursing* and the Pursuit of Nursing Knowledge,' in D'Antonio, Fairman, and Whelan, eds., *Routledge Handbook on the Global History of Nursing*, pp.95-113.

[65] See Clare Anderson, *Subaltern Lives: Biographies of Colonialism in the Indian Ocean World 1790-1920* (Cambridge: Cambridge University Press, 2012); Anna Crozier, *Practicing Colonial Medicine: The Colonial Medical Services in British East Africa* (London: I. B. Tauris, 2007); Lambert and Lester, *Colonial Lives*.

colonial nurses, information that often had to be rapidly adapted in the context of plague nursing.

The process of tracing separate or collective biographies is further complicated by marriage. While nurses were conventionally required to resign their position before marriage, those working in colonial settings can often be found in the archival records continuing in their current posts or reappearing later in more senior roles.[66] While it is conjecture to postulate as to the pragmatic foundations of this trend, it is clear that many colonial locations remained short of both trained nurses and eligible bachelorettes, creating a tension between the practical need for specialised, experienced nurses and expected social norms generated in the metropole, which then needed to be enacted on an individual basis. Additional complications ensue when some nurses adopt new, devotional forms of address after qualifying as Sisters.[67] Names were recycled in some hospitals and there is often no clear link to previous forms of address, so associations can only be made between individuals if both names are recorded in the same document or publication. In rare cases, like that of Sister Henrietta Stockdale, aliases remain consistent and an individual's achievements result in frequent archival references.[68] However, in the case of less renowned

[66] In many London hospitals, women were required to demonstrate that they were either a spinster or a widow before commencing nurse probationer training. See King's College Hospital Archives KH/N/FR/7/1 Statistics Regarding Student Nurses 1902-1922. KH/N/FR/5/1-15 Student Nurse's Registers, 1885-1960.

[67] During this period the term "Sister" contains some ambiguity and is not necessarily religious in character. Some nurses did receive their training from religious orders but in large training schools and hospitals the term also denoted a nurse of a superior rank whose education had been almost entirely secular.

[68] Sister Henrietta Stockdale (1847-1911) was an associate of Mrs. Bedford Fenwick and an alumna of University College London. Best known for fostering the development of nursing care in South Africa, she used the Cape Colony's Medical and Pharmacy Act of 1891 to create the world's first registered nurses. She is discussed at some length in Chapter 3 of this thesis.

practitioners, connections become more challenging, a tendency aptly illustrated by the case of Miss Boyd Carpenter, who became Sister Christian after finishing her training at St Thomas' Hospital. Carpenter then worked in Hong Kong during the initial 1894 plague outbreak, later marrying and moving to Yokohama because of ill health. The association between the two incarnations of the same nurse is only possible because of a fleeting synopsis of her education and career trajectory recorded in a single issue of the *St Thomas' Hospital Gazette* after she was promoted to the role of matron in Yokohama.

The various challenges associated with attempting to trace nursing biographies across numerous archives are highlighted by the career of Nurse Georgina Franklin, who began her training at St Thomas' Hospital in 1893. While there she came to the attention of Florence Nightingale, who corresponded with her during her time as a plague nurse in India and Hong Kong between 1897 and 1901. Franklin used this interaction to publish "Some Personal Reflections of Miss Florence Nightingale" in 1910 under the pseudonym of "Lamorna." She is next seen in a 1912 issue of the *BNJ* as Mrs Langley, receiving a diamond-encrusted Imperial Eagle brooch from the Emperor of Russia for her work nursing the wounded sailors of the *H. M. Variag* between 1903 and 1904 as part of the Russo-Japanese War.[69] Nurse Franklin is one of hundreds of practitioners who move

[69] LMA H01/ST/NC/05/003/046 Typescript of 11 Letters from Florence Nightingale, South St. to Georgina Franklin. LMA H01/ST/NC/18/029/008 Nurse Georgina Frankin, Govnt. Civil Hospital, Hong Kong to Florence Nightingale; Gérard Vallée, ed., *Florence Nightingale on Social Change in India: The Collected Works of Florence Nightingale, Vol. 10* (Waterloo: Wilfrid *Laurier* University Press, 2007), pp. 791-2; Lynn McDonald, ed., *Florence Nightingale: Extending Nursing: The Collected Works of Florence Nightingale, Vol. 13* (Waterloo: Wilfrid *Laurier* University Press, 2009), p.552; *Nursing Mirror and Midwives' Journal*, vol.3 (1910), pp.347-9; *BJN*, vol.61 (1912), p.142.

spectre-like through the archival record, generating the briefest of brief glimpses of a career that was self-evidently internationally distinguished.

Reading across such an extensive and diverse range of sources forms the foundation of this study and is vital for a number of reasons. As the work aims to recognise nurses as individual agents and add a new, female perspective to the established but currently overwhelmingly male narrative of the third plague pandemic, an inclusive approach to a significant number of archival collections is necessary. As previously stated, while nurses are by no means absent from the records, material generated by their male colleagues in medical, colonial, or military service is usually more accessible and therefore tempting to focus on for historians.[70] A posopographical approach allows for the construction of databases that make it possible to trace improvised nursing networks, illustrating global circulation in a period before organisations like the CNA began to encourage this highly specific form of female migration. A methodology of this nature challenges assumptions that nursing practice was constituted in the metropole before being exported to the colonies, and allows nursing history to transcend the geographical and chronological boundaries imposed by limited studies confined to specific locations and events. Furthermore, the inclusion of biographical fragments

[70] There is substantial bibliography of works devoted to the history of military nursing: see Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (Melbourne: Oxford University Press, 1992); Rupert D. Goodman, *Our War Nurses: The History of the Royal Australian Army Nursing Corps, 1902-1988* (Brisbane: Boolarong Publications, 1988); Kirsty Harris, *More than Bombs and Bandages: Australian Army Nurses at Work in World War I* (Newport: Big Sky Publishing, 2011); Ian Hay, *One Hundred Years of Army Nursing: The Story of the British Army Nursing Services from the time of Florence Nightingale to the Present Day* (London: Cassell & Co., 1953); Catherine McCullagh, *Willingly into the Fray: One Hundred Years of Australian Army Nursing* (Newport: Big Sky Publishing, 2010); Anne Summers, *Angels and Citizens: British Women as Military Nurses, 1854-1914* (London: Routledge & Kegan Paul, 1988); Jacquez Charl (Kay) De Villiers, *Healers, Helpers and Hospitals: A History of Military Medicine in the Anglo-Boer War*, 2 vols. (Pretoria: Protea Book House, 2008).

reveals something about the type of women who chose to make their careers on the edges of empire, demonstrating the challenging and often dangerous nature of nursing in colonial settings.

This thesis engages with and seeks to bring together, for the first time, research from a number of areas within imperial, medical, and health history. It does so by reading across different archives, and by employing an interdisciplinary methodology that bridges biographical, institutional, and social historical approaches. For example, it finds purchase in the work of Sonya Grypma who has emphasized the importance of biographical research in nursing history. The scholarship of Clare Anderson, David Lambert, and Alan Lister has also suggested how biographical histories may be helpful in furthering our understanding imperial history.[71] Anderson had "argued for a biographical centring of men and women in history." She makes use of life-writing "to piece together fragments from the archives" in order to shed light on imperial networks.[72] Lambert and Lister have also stressed the ways in imperial networks "connect different places," and they have shown how colonial places were central to the "reformulation of individual subjectivity."[73]

Nurses are often entirely absent from even the most recent colonial medical histories. Claire E. Edington's detailed and emotive account of institutional psychiatric care in French Indochina makes no mention of nurses of

[71] Sonya Grypma, 'Critical Issues in the Use of Biographic Methods in Nursing History,' *Nursing History Review*, vol.13 (2005): 171- 87.
[72] Anderson, *Subaltern Lives*, p.187.
[73] Lambert and Lester, 'Introduction, pp.13-15; see also David Lambert, 'Reflections on the Concept of Imperial Biographies,' *Geschichte und Gesellschaft*, vol.40, no.1 (2014): 22-41.

either gender, who undoubtedly provided much of the "care" described.[74] In relation to the secondary literature, the thesis builds, firstly, on a growing body of scholarship aimed at recuperating the history of imperial nursing. This includes notable work by Anne Marie Rafferty, Julie Fairman, Christine Hallett, Julia Hallam, and Anne Summers. Secondly, the thesis contributes in important ways to the substantive literature on the third plague pandemic, with notable work by Myron J. Echenberg, Christos Lynteris, Robert Peckham, and others.[75] Thirdly, it adds to scholarship in the history of medicine and health that elucidates the ideological and politico-economical contexts that shape disease identities, health practices, and humanitarian interventions. This includes seminal work by Rosenberg (discussed above), David Arnold, Warwick Anderson, Alison Bashford, Michael Barnett, Pratik Chakraparti, Anna Crozier, Andrew Cunningham, Bridie Andrews, Philip D. Curtin, Mark Harrison, Daniel R. Headrick, Liesbeth Hessenlink, Sarah Hodges, and others.[76] Fifth, the thesis draws on colonial histories of Hong Kong and Cape Town that have demonstrated the extent to which health is entangled with political concerns: Adam Ashforth, Elizabeth Sinn, Anne Digby, Shula Marks, and Elizabeth Van Heyningen.[77] And finally, the thesis draws on innovative work

[74] Claire E. Edington. *Beyond the Asylum: Mental Illness in French Colonial Vietnam* (London: Cornell University Press, 2019).

[75] See, for example, Echenberg, *Plague Ports*; Lukas Englemann, John Henderson, and Christos Lynteris, eds., *Plague and the City* (London and New York: Routledge, 2018); Robert Peckham, 'Hong Kong Junk: Plague and the Economy of Chinese Things,' *Bulletin of the History of Medicine*, vol.90, no.1 (2016): 32-60.

[76] See Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines (*Durham, NC: Duke University Press, 2006); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkley: University of California Press, 1993); Michael Barnett, *Empire of Humanity: A History of Humanitarianism* (Ithaca, NY: Cornell University Press, 2011); Pratik Chakrabarti, *Medicine and Empire, 1600-1960* (London: Palgrave Macmillan, 2013); Crozier, *Practicing Colonial Medicine*; Philip D. Curtin, *Disease and Empire: The Health of European Troops in the Conquest of Africa* (Cambridge: Cambridge University Press, 1998) and *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century* (Cambridge: Cambridge University Press, 1989).

[77] Adam Ashforth, *Witchcraft, Violence and Democracy in South Africa* (Chicago, IL: University of Chicago Press, 2005); Shula Marks, *Divided Sisterhood: Race, Class and Gender in the South African*

on gender, race, and empire. This includes work by Philippa Levine, Clare Midgley, Jessica Howell, Ronald Hyam, Saul Dubow, Catherine Hall, and Jayne O. Ifekwunigwe.[78]

1.7 Conclusion: Synopses of Chapters

Chapter 2, 'Nursing and the "Terrors" of Plague – Hong Kong, 1894,' focuses on the development of nursing in Hong Kong. The first section looks at nursing before the bubonic plague outbreak in 1894. It shows how the development of nursing was influenced by specific colonial concerns that pivoted on issues of race and economics. Nursing, like Hong Kong's broader medical infrastructure, was improvised and fractured. It was undertaken by Chinese and European wardmasters, religious orders, and amateurs of varying levels of skill, education and experience. The designation "nurse" appears very early in the financial records of the colony, although these "nurses" are among the poorest paid staff. Nursing was an extremely onerous and poorly compensated role. There was also little organised determination to train local nurses, despite early efforts at the Nethersole Hospital (1893). The practical challenges of training local nurses (e.g.

Nursing Profession (London: MacMillan, 1994); Elizabeth Sinn, *Power and Charity: A Chinese Merchant Elite in Colonial Hong Kong* (Hong Kong: Hong Kong University Press, 2003); Elizabeth van Heyningen, 'Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910,' *Medical History*, vol.33 (1989): 450-71.

[78] See Philippa Levine, *The British Empire: Sunrise to Sunset* (Harlow: Longman, 2007) and *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire* (London: Routledge, 2003), as well as the edited collection *Gender and Empire* (Oxford: Oxford University Press, 2004); Jayne O. Ifekwunigwe, *Scattered Belongings: Cultural Paradoxes of 'Race,' Nation and Gender* (London: Routledge, 1999).

dearth of skill, facilities, and diversity of cases, racial challenges etc.) are highlighted.

Section 2 examines the arrival of new female nurses in the late 1880s and traces the role of these nurses during the 1894 outbreak. The argument, here, is that while nurses were championed as "heroines" and "martyrs," their contribution was also side-lined. Section 3, shows how nurses constituted part of a new medical and public health infrastructure post 1894. Nursing was linked to the creation of new medical spaces, notably hospitals. The changing status of nurses mirrored other social changes. Despite being a city of transition and a "space of flow," Hong Kong was becoming a location where families might settle.[79] As a result, there was a requirement for more suitable medical facilities, of which nurses were a key component.

Chapter 3, 'Improving Measures – Cape Town, 1901,' follows the life-stories of twenty British nurses recruited to meet staffing shortfalls when plague appears in Cape Town. The chapter addresses a number of questions: Why did South Africa remain so dependent on overseas nursing? How did this dependence shape local nursing education and professional identity? How did this dependence impact the daily reality of plague nursing? What dangers did understaffing expose nurses to? Lacking any formal support structure, particularly in remote locations, how did nurses utilise their own networks to cope with these dangers? And if the situation was so dangerous, why did overseas nurses keep coming?

[79] Elizabeth Sinn, 'Lesson in Openness: Creating a Space of Flow in Hong Kong,' in Helen F. Siu and Agnes S. Ku, eds., *Hong Kong Mobile: Making a Global Population* (Hong Kong: Hong Kong University Press, 2008), pp.13-44.

The chapter begins with an overview of the development of nursing in South Africa. It discusses the early efforts by Sister Henrietta Stockdale in Kimberly and the Order of All Saints/St George at the New Somerset Hospital, noting the strong links maintained with London hospitals. These links were utilised to recruit new nurses, especially for senior or teaching posts. Nursing remained inaccessible to local coloured, African, Indian, and Malay communities, and was disdained by Afrikaans women. Nursing remained a profession fit only for South African ladies of British descent. There were racial, legal, professional, economic, cultural and linguistic concerns surrounding the training of local nurses. As a result, there was chronic understaffing even before plague (e.g. the third largest hospital in the country at Port Elizabeth was run by just nine nurses). This was a constant theme in local professional journals, and one of the reasons why women could "pretend" to be nurses.

The chapter then investigates nursing during the 1901 plague outbreak in Cape Town. It considers how plague arrived in Cape Town and the measures that were taken to contain it. As in Hong Kong, plague revealed longstanding civic tensions and provided a justification for coercive interventions (e.g. relocation populations). Cape Town had a decade to prepare for plague and other large infectious disease outbreaks. Legislation was enacted throughout the 1890s, and this period saw the appointment of new staff (e.g. the first Colonial Medical Officer), the establishment of remote quarantine sites, and the separation of civil from military hospitals. Nursing was one area, however, where the government was underprepared. Attempts to recruit nurses for quarantine hospitals, even on a temporary basis, had proven unsustainable.

The focus of the chapter then shifts onto specific cases, notably the experiences of the Keyser Sisters both of whom die of plague in Cape Town in April 1901. Ella Maria Keyser was considered a plague specialist. She cared for Cape Town's first plague cases and became Matron of the Maitland Plague Hospital. Both sisters were given elaborate headstones and feature in Kipling's poem *Dirge of Dead Sisters* (1902), alongside references to Mary Kingsley (who died of typhoid in Simon's Town in 1900 after volunteering to nurse Boer POWs). As the case of the Keyser Sisters shows, plague nursing was dangerous in a number of ways, and the Maitland Hospital was overstretched for months, despite being the most centralised and well-staffed of all of Cape Town's plague hospitals.

The idealisation of female sacrifice in a colonial context served as a recruiting tool and a reminder of expected nursing standards. Plague Records reinforce this characterisation (e.g. the copious documentation devoted to what headstone should be selected). This celebration of the nurse concealed the realities of exhaustion and understaffing that might contribute to a nurse's death. The chapter considers the case of J. Merry and E. J. Short who resigned from the East London plague camp in March 1905 after over two years of service, citing working and living conditions that made it impossible to discharge their duties. Merry's superiors had been forced to write to the Cape Government in January 1905 requesting additional pay, as Merry had been acting as both day and night sister.

Nursing could lead to despair and suicide. This was the case with Alice Darley, who died after ingesting morphine at the Maitland Plague Hospital in August 1901. Darley was one of the original twenty British nurses to arrive in

South Africa. Her case was referred to the Senior Government Analyst at Cape Town. Blame was deflected from the hospital. The medical team who attempted to resuscitate Darley attributed the cause of death and argued that the nurse could have bought the morphine in London or Cape Town. Interviews with other nurses about Darley's psychological state. A plausible, respectable cause was sought (e.g. the death of her brother).

The chapter compares the official treatment of Darley's death to that of the Keyser sisters. Darley was not commemorated in the hospital cemetery and government reports contain no reference to where the body was eventually interned. No mention is made of her death in the professional press. Official reports rarely use the word suicide, but focus instead on absolving the hospital and its staff from any blame. Rather than being seen as a warning that nurses were overworked and unsupported, Darley is characterised as 'defective,' her death a symptom of her own weakness.

Indeed, the 'defective' nurse is a trope in specialist and general print culture. Examples come from London and the colonies. Letters and articles discuss alcoholism and drug dependence. The nurse is also portrayed as a potential sexual predator. Journals and textbooks address these fears by reiterating the importance of moral precepts and the impeccable character of the ideal nurse. If a nurse is unable to adhere to these high standards, she and her inherent character defects and weaknesses are to blame. Boundaries are reasserted and the troublesome female body is thus contained within the colonial setting.

The remaining cases considered in the chapter focus on the physical perils that nursing involved, including the threat of sexual attack. The rape of Nurse

Lowe in January 1904 provides an illustrative case. Lowe's attack was drawn to the attention of the Colonial Secretary and led to a voluminous correspondence and a detailed investigation. This concentrated on the actions of the nurse and her behaviour, and official reports were apparently designed to absolve colonial and hospital authorities of blame: Was she wearing her uniform? Where was she walking? Was she walking alone? What relationship did she have with the man who had assaulted her? The case of Nurse Lowe's rape reveals underlying fears regarding how nurses were expected to navigate racial as well as sexual norms in their private and working lives. The deepest fears of medical and colonial authorities arose from the interactions between white nurses and non-white supine patients. South African journals feature lengthy discussions about what contact white nurses were expected to have with black patients. The implications are that if a nurse behaves correctly, she should be able to protect herself. Any sexual contact with non-white individuals is depicted as a form of violation. The archives contain a number of cases of nurses accused of sexual improprieties. Such as a nurse accused by her matron of, among other things, being out all night with doctors. In short, despite the lure of adventure and a rewarding social life being used to "sell" different colonial locations, nurses navigated a complex and often challenging moral landscape. Allegations of "incorrect behaviour" could ruin careers as new positions were awarded on the strength of previous testimonies. The dangers were not insubstantial and colonial officials were not innocent of these possibilities. The contracts given to the twenty British nurses recruited to work during the plague state explicitly that Sir David Tennant, Agent General for the Government of the Cape of Good Hope, was to be in no way personally liable for any issue that might arise as a result of the contract. At the same time, nurses

had little practical support to help them navigate the new landscape they found themselves in.

Chapter Four, 'Making the Ideal Nurse – London, 1914,' explores institutional changes in the metropole that encouraged the movement of nurses across the Empire. The chapter considers what kind of person became a nurse and why. At the turn of the century, an increasing percentage of overseas nurses trained in London but returned to their home countries. What training did a colonial nurse receive? What contracts were available subsequently? How did these compare to colonial contracts? The chapter considers the inducements offered to nurses for working overseas. These ranged from adventure to specialist training, the possibility of taking on new roles and responsibilities, independence, marriage, and service to the empire. This section also reflects on the "systems" that existed to help draw nurses overseas, including specialist and general print culture, and personal connections.

Chapter Five, 'Conclusion,' reiterates the central arguments of the thesis. The chapter also points to further areas of research and argues for the need for more sited studies that would furnish an opportunity for a grounded imperial history of nursing.

In an insightful article published in 2007, Diana Solano and Ann Marie Rafferty remarked on "the paucity of prior research into the relationship between nursing and 'empire.'" They noted how this lack of nursing scholarship stood "in marked contrast to the explosion of interest in the role that science and medicine

played in constructing representations of imperialism."[80] This thesis attempts to take up the challenge to offer fresh insights into "the relationship between nursing and 'empire.'" It focuses on a period of profound transition in nursing between 1880 and 1914 to trace the uneven rise of professional nursing across three sites of empire: Hong Kong, Cape Town, and London. It sets the history of nursing within a broader institutional context to show how a programmatic, broadly imperial approach to nursing, which was articulated in textbooks, journals, and newspapers, broke down in the face of local contingencies. In Hong Kong and Cape Town nurses were compelled to adjust expectations about the work a nurse should do and the person a nurse should be. Nursing at the edges of empire involved improvisations; making do with often provisional infrastructure. It also entailed navigating a complex terrain, transgressing boundaries—of class, gender, and race—often with dire consequences.

[80] Solano and Rafferty, 'Rise and Demise of the Colonial Nursing Service,' p.148.

Chapter Two

Nursing and the "Terrors" of Plague – Hong Kong, 1894

> It is most difficult to describe the horrors of the work the Sisters undertook, they had the risk of infection from a disease at that time little known but whose terrors are historical. The majority of their patients on admission being in a state of furious delirium, needing constant attention and causing the most distressing scenes. They had to serve for long consecutive hours in wards where the heat of the atmosphere…was most oppressive, amid odours of the most offensive description from the involuntary exertions of the patients, whom they had to clean. Besides which were the fetid suppurating sores they had to dress, all within the overpowering fumes from chloride of lime, carbolic acid and other disinfectants. This work they did cheerfully during the hottest months of the year, work sufficient to try the nerve and endurance of the strongest men. That danger they ran was a real one had they not been very careful in carrying out their instructions…The devotion of these brave ladies in the performance of their duties has received the recognition of the citizens of the Colony…

Letter from Colonial Surgeon Dr. Philip Bernard Chenery Ayres to the Right Honourable Joseph Chamberlain, Principal Secretary of State for the Colonies, 30th July 1895.[81]

2.1 Introduction

In the aftermath of the 1894 plague outbreak, Dr Philip Ayres, Colonial Surgeon and Inspector of Hospitals in Hong Kong, wrote to Joseph Chamberlain to recommend that the nine nurses working at the Government Civil Hospital be awarded the Order of the Red Cross in recognition of their singular devotion to

[81] See Jerome J. Platt, Maurice E. Jones, and Arleen Kay Platt, *The Whitewash Brigade: The Hong Kong Plague, 1894* (London: Dix Noonan Web, 1998), pp.222-223.

duty. Several of the nurses in question had been recruited via the Crown Agents for the Colonies in 1892 to address longstanding concerns about the quality of nursing at the Government Civil Hospital. During the 1894 epidemic, at great personal risk, the nurses had volunteered to work at the government plague hospitals. In addition to receiving the Red Cross, Ayres suggested that the nurses—Clara Eastmond, Emma Gertrude Ireland, Eliza Francis Higgin, Catherine McIntosh, Gertrude Annie Brookes, Caroline Walker, Evelyn M. Palmer, Sara E. Baker, and Anna Elizabeth Penrudocke—be given a 50 percent supplement to their pay for the three months of the initial plague outbreak.

As Ayres emphasised in his letter, the Hong Kong nurses had played a critical part in the campaign to manage the "terror" of the plague. Given the scientific uncertainty about the origins of the disease and its mystifying pathway of transmission, quarantine and nursing represented cornerstones of the government's response.[82] The nurses had toiled under "oppressive" conditions, sometimes working twelve hour shifts. Plague had jeopardised their health, and the "horror" of their plague work defied description. While the nurses had received local recognition with the award of Hong Kong plague medals, it was time, Ayres argued, for more formal appreciation.[83]

[82] On competing germ theories of the plague, see Mary P. Sutphen, 'Not What but Where: Bubonic Plague and the Reception of Germ Theories in Hong Kong and Calcutta, 1894-1897,' *Journal of the History of Medicine*, vol.52 (1997), pp.81-113.

[83] The medal, paid for by the government of Hong Kong, was awarded to those who had volunteered their services during the plague. It had been given predominantly to members of the King's Shropshire Light Infantry, as well as other military and medical personnel, colonial administrators and police officers. While no comprehensive list of recipients is known to exist, 183 gold medal recipients and 819 silver medal recipients have been traced; see Platt, Jones, and Platt, *The Whitewash Brigade*.

Despite a burgeoning scholarship on the history of public health and medicine in Hong Kong, to date little scholarly attention has been paid to nursing, or to the role of women in the development of the colony's healthcare, more generally.[84] What little scholarship that does exist has focused almost exclusively on military or post-World War II nursing, a period with a more accessible and extensive archive. Moreover, the literature has tended to over-emphasise developments in China and missionary nursing, neglecting the distinctive nature of nursing in the crown colony, and the idiosyncratic factors that shaped its development there.[85]

This chapter seeks to fill the gap. Sections 2 to 4 examine the role of nursing in Hong Kong prior to, during, and after the plague outbreak. While the aim is to gauge the impact of the plague on the evolution of colonial nursing, it also endeavours to draw out larger historiographical issues about the nature and scope of colonial nursing during a period of institutional transformation, when biomedical innovations were transforming health practices. To what extent was Hong Kong exceptional? How did the plague crisis shape the future of nursing there? Under what circumstances did Hong Kong nurses work?

Section 5 ('Nursing and Plague Science') considers the degree to which nurses were marginalised in the plague literature that proliferated from the

[84] Examples of recent works focused on Hong Kong's colonial health, include Ka-che Yip, Yuen-sand Leung, and Man-kong Wong, *Health Policy and Disease in Colonial and Post-colonial Hong Kong, 1841-2003* (London and New York: Routledge, 2016); Faith C. S. Ho, *Western Medicine for Chinese: How the Hong Kong College of Medicine Achieved a Breakthrough* (Hong Kong: Hong Kong University Press, 2017); Moira M. W. Chan-Yeung, *A Medical History of Hong Kong, 1842-1941* (Hong Kong: The Chinese University Press, 2018); and Yip Ka-che, Wong Man-kong, and Leung Yuen-sang, eds., *A Documentary History of Public Health in Hong* (Hong Kong: The Chinese University Press, 2018).

[85] See, however, David Kang, *Missionaries, Women and Health Care: History of Nursing in Colonial Hong Kong, 1887-1942*. Unpublished PhD Thesis: The Chinese University of Hong Kong (2013).

1890s. This is a phenomenon that has persisted. Is mirrored in the majority of plague histories that have tended to concentrate either on the heroic colonial fight against disease, or on the coercive nature of the state's draconian response. In the former case, widely disseminated illustrations of the so-called "whitewash brigade"—troops of the King's Shropshire Light Infantry Regiment—have been central to a male narrative of selfless devotion. Such male-focused public health accounts mirror equally gendered breakthrough narratives, epitomized in the myth of the lone scientist-physician Alexandre Yersin, pictured as a quasi-explorer who struggles alone and at great personal cost to locate the source of the disease.[86]

Female encounters with plague are rarely invoked in plague histories When they are, they are often reshaped by male narrators. The iconography of the commemorative plague medals struck in honour of those who had given service during the epidemic, idealizes the caring work of nurses. The medals depict an attentive nurse dressed in what resemble classical robes, bending over a prostrate Chinese patient, with one arm to his breast. Meanwhile, a British soldier keeps death at bay, pushing back against a skeletal phantom figure who attacks from above with a sharp blade.

The real and difficult work that nurses performed is abstracted into arguments about hygienic modernity and summoned as evidence of ongoing government efforts to extend the remit of healthcare to the colonized population. Unlike in London (Chapter 4) and, to a lesser extent, Cape Town (Chapter 3),

[86] On Yersin as the heroic explorer, see Robert Peckham, 'Matshed Laboratory: Colonies, Cultures, and Bacteriology,' in Robert Peckham and David M. Pomfret, eds., *Imperial Contagions: Medicine, Hygiene, and Cultures of Planning in Asia* (Hong Kong: Hong Kong University Press, 2013), pp.123-147; and on the iconography of the plague in Hong Kong, see Robert Peckham, 'Plague Views: Epidemics, Photography, and the Ruined City,' in Englemann, Henderson, and Lynteris, eds., *Plague and the City*, pp.91-115.

personal accounts by nurses of their life and work in Hong Kong are rare. It is difficult to gain first hand access to the "distressing scenes" alluded to by Ayres, and to the gruelling experience of tending to sick patients in extreme conditions. With few exceptions, the testimony of nurses is recorded in official contexts. A notable case being Matron Eastmond's interview as part of the 1895 Committee of Inquiry convened after the plague to identify failings in the health system—an episode discussed later in this chapter.

Despite its marginalization in Hong Kong histories, nursing offers a unique opportunity to explore female experiences in – among the non-Chinese community at least – an overwhelmingly male colony, and a means to challenge dominant narratives. As we shall see, nursing may also provide a lens for rethinking interactions between Europeans and Chinese, and for bringing gender to the fore in order to complicate the binary of colonial and colonised. In the 1891 census, the last conducted before the third plague pandemic, out of a total population of 221,441, only 8,545 were identified as "white," a category that accommodated Europeans and American civilians, as well as all Army and Navy personnel. This figure included only 300 adult British women, amounting to 0.13 percent of the total population.[87] Furthermore, an analysis of plague nursing in Hong Kong highlights the disjuncture between "ideal" nursing roles promoted by professional publications in Britain (discussed in detail in the London chapter of this thesis), and the often perilous reality that such overseas opportunities actually presented.

[87] J. H. Stewart Lockhart, 'Census Report 1891 for Hong Kong,' *Hong Kong Sessional Papers* (1891), pp.377 and 380.

Although invariably downplayed in the scholarship, female doctors and nurses were recognised as playing important roles during the plague crisis, as attested by Ayres's efforts on their behalf. The Hong Kong nurses were commended for their dedication and credited with smoothing relations with the Chinese. "The work done by the Sisters during this trying time," Ayres contended, "has done much to overcome the dislike of the Chinese to the Government Civil Hospital…It has now become so popular with the Chinese that it is difficult to find room for the applicant for relied, instead of as heretofore when many beds remained empty." As James Lowson, Acting Superintendent of the Government Hospital, further conceded:

> If ever this Colony has had reason to congratulate itself it was when we were able to procure well-trained British nurses. I think the greatest compliment that I can pay these ladies is to say that had it not been for their presence there could have been no well-run epidemic hospital during last summer When the hospitals were crowded it was often a matter of difficulty for the Medical Officers employed to keep their meals in their stomachs. It would have been much harder if they had had to remain in constant attendance all the time as our Sisters had to.[88]

Lowson's remarks suggest a collaborative ethos in which nurses are able to substitute for doctors, albeit under conditions of urgency. These sentiments were echoed in 1901 by Dr John Bell, Acting Principal Medical (he married a Hong Kong nurse, Anne Penrudocke, in 1899), and used in his annual report to reflect on the significant improvements he had witnessed at the Government Civil Hospital since his arrival in 1887. The institution had gone from a staff consisting of a single

[88] James Lowson, 'The Epidemic of Bubonic Plague in Hongkong, 1894,' *Hong Kong Government Gazette* (13 April 1895), p.396.

Medical Officer, two European wardmasters, and countless nondescript Chinese servants, to one where additional medical officers and "skilled English nurses" no longer oversaw operations performed on the veranda, but presided over a "proper operating theatre." The Government Hospital formed part of a network of hospitals that included the infectious diseases hospital at Kennedy Town and the Lunatic Asylum. Nurses were central to creating "an institution which contrasts very favourably with similar ones in this part of the world." Bell felt that the population, particularly the small European and Indian communities, should be grateful for a hospital where "everyone may be sure of skilled nursing if not treatment, and may end his days, if such be his fate, surrounded by the utmost care and comfort obtainable so far from home."[89]

At the Second Biennial Congress of the Far Eastern Association of Tropical Medicine—held in 1911, the same year as the University of Hong Kong was officially opened—Dr John Mitford Atkinson, then Principal Civil Medical Officer in Hong Kong, used his presidential address to evaluate developments in the field over the preceding quarter century. Atkinson (who married the Matron of the Government Civil Hospital, Clara Eastmond, in 1898) cited developments in colonial nursing as among the most significant, alongside the establishment of designated research funds, the London School of Tropical Medicine (1899), and various other individual research posts across East Asia. Characterizing Hong Kong as "the pioneer of the nursing movement," Atkinson described the nurses' "unselfish work" during "the various outbreaks of Plague and other infectious diseases," in addition to their daily work in the hospital. He cites the deaths of two

[89] John Bell, 'Annual Report of the Medical Department, 1901,' *Hong Kong Government Gazette* (23 March 1901), pp. 685-6.

nurses from plague in 1898, whom he does not name, as examples of this altruism.[90]

Atkinson was keen to claim a strategic role for himself in promoting nursing. In his talk before the Far Eastern Association, for example, he claimed disingenuously to have been "instrumental in obtaining the appointment of the first staff of trained Nurses to a British Colony" after alerting the Government to the need for a nursing staff at the Government Civil Hospital in 1888. Atkinson bolstered these claims by citing the arrival of six nurses in 1890, far in advance of the establishment of Lady Piggott's CNA in 1896. In reality, calls for trained European nurses arose from multiple voices and predated Atkinson's demands by over a decade. However, Atkinson's comments tie the institutional history of tropical medicine firmly to that of nursing and reinforce the image of Hong Kong as a healthy location, with accesses to the innovative, metropolitan medical technologies.

Atkinson was not unique in laying claim to a pivotal role in the development of nursing. Governor Des Voeux remarked in his memoirs that when he had arrived in the colony in 1887 "skilled assistance to the doctors in the care of patients was evidently a serious want." According to his account, he helped to procure nurses from Europe after an attempt to recruit local nurses had failed.[91]

[90] John Mitford Atkinson, 'Presidential Address: The Progress of Tropical Medicine during the Past Twenty-Five Years,' in *Transactions of the Second Biennial Congress of the Far Eastern Association of Tropical Medicine*, Francis Clark, ed. (Hong Kong: Noronha, 1912), pp.16-17.
[91] George William Des Voeux, *My Colonial Service in British Guiana, St. Lucia, Trinidad, Fiji, Australia, Newfoundland, and Hong Kong*, 2 vols. (London: John Murray, 1903), II, pp.201-202.

2.2 Pre-Plague Nursing

Networks of nursing had developed in China through various missionary organisations, with nursing assuming a distinctive character in different parts of the country.[92] Several scholars have argued that nursing was imported to Hong Kong from China by medical missionaries in the 1880s, specifically by women including Elizabeth McKechnie (1845-1939), who arrived in Shanghai from the United States in 1884 and began training local girls to work at the bedside of patients, thus constituting the first attempt at nursing education in China.[93] She became head nurse of the twenty-bed Margaret Williams Hospital, which opened in 1885.

Early nursing in Hong Kong was ad hoc and comprised male and female staff members of various nationalities with disparate levels of training and experience. French Sisters of Mercy were often used to combat shortfalls at the Government Civil Hospital.[94] Nurses of some variety are mentioned numerous times in various colonial reports before 1894. For example, Chinese nurses were affected by a mysterious contagious disease at Victoria Goal in March 1866. A few years later, there was discussion about the need to revaccinate nurses working at the smallpox hospital. In 1869, the Colonial Surgeon commented on the "embarrassing" state of nursing at the Government Civil Hospital:

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[92] G. H. Choa. *'Heal the Sick' was their Motto: The Protestant Medical Missionaries in China* (Hong Kong: Chinese University Press, 1990); Sonya Joy Grypma, *Healing Henan: Canadian Nurses and the North China Mission 1888-1947* (Vancouver: UNC Press, 2008); Xu Guangqui, *American Doctors in Canton: Modernization in China 1835-1935* (New Brunswick, NJ: Transaction, 2011).
[93] Kang, *Missionaries, Women and Health Care*, pp.35-36; Derek Smith and Sa Tang, 'Nursing in China: Historical Development, Current Issues and Future Challenges,' *Japanese Journal of Nursing and Health Sciences*, vol.5 (2004), p.16.
[94] Ayres, 'Colonial Surgeon's Report for 1888,' *Hong Kong Sessional Papers* (1889), p.174.

> The Chinese coolies are altogether unsuited to this employment and are utterly untrustworthy – and the few Europeans who are willing to serve in the capacity of wardmasters are generally men who can obtain nothing better, and are only a degree superior, in many respects, to the Chinese. If it were possible to induce the Sisters of Charity to undertake this duty, the benefit would be incalculable.[95]

The limited room required for nurses in the Government Hospital was mentioned in April 1878; and the lack of accommodation for nurses at the Lock Hospital is underlined in a report of May 1879.[96] Who precisely these nurses were, and what level of training or certification they had obtained, remains unclear. In this period, the kind of European ladies that had worked alongside Nightingale in the Crimea were certainly absent, and it is probable that the nurses mentioned in Hong Kong were men. A report published in April 1881 on the Civil Hospital mentions nurses sleeping on bedrolls beside coolies in stairways and passages after a fire, conditions deemed inappropriate for skilled women of any background.[97]

The projected cost of nursing was a perennial concern. In his 1887 report, the Colonial Surgeon commented on a "scheme for the employment of European Female professional nurses," and concluded: "If on enquiry in England it is found feasible the scheme will undoubtedly be a very great benefit to the Hospital. It is not however without some drawbacks for the nurses will have to reside on the premises and this will require a considerable increase of accommodation in the

[95] 'Colonial Surgeon's Report for the Year 1869.'
[96] *Hong Kong Government Gazette* (12 May 1866), p.191; *Hong Kong Government Gazette* (13 April 1872), p.212; *Hongkong Government Gazette* (6 July 1878), p.326; *Hong Kong Government Gazette* (9 July 1879), p.409.
[97] 'Colonial Surgeon's Report for 1880.'

shape of an additional block of buildings which means considerable expense. As usual it is a question of initial outlay."[98]

Nursing in Hong Kong was a dangerous occupation, even before the arrival of the plague. In his 1889 report from the Civil Hospital, Atkinson made special mention of the "considerable sickness amongst the members of the Nursing Staff." Of the forty-four hospital staff, twenty-nine were admitted to the wards at some point during the year, including Atkinson himself. Fifteen of these cases were malarial, caused in part, Atkinson suspected, by work done on the foundations of the new hospital buildings. Several other nurses were hospitalised for "intermittent fever."[99] In 1888, Lin Ting, a senior Chinese nurse of "exceptionally good character" and twelve years of service in the Government Civil Hospital died from blood poisoning after a week's illness. He had become infected while attending the case of a "well known and much respected Citizen" who spent eight months in hospital, losing his leg in the process.[100] Lin's colleague, Wong Nang, received five weeks of treatment for typhoid fever. Nurses at other hospitals fared no better. Six nurses from the Lock Hospital and Lunatic Asylum were also admitted during the year, one of whom died of "remittent fever."[101]

What constituted nursing work was somewhat nebulous. Indeed, an uncritical definition of what it meant to be a "nurse," particularly before the arrival of trained British nurses, may lead to problematic conclusions regarding the development of "professionalisation" in the colony, most notably with regard to

[98] 'Colonial Surgeon's Report for 1887.'
[99] Atkinson, 'Report from the Superintendent of the Civil Hospital,' *Hong Kong Sessional Paper*s (1889), pp.195-6.
[100] Ayres, 'Colonial Surgeon's Report for 1888'; Atkinson, 'Report from the Superintendent of the Civil Hospital' (1889), pp.175 and 196.
[101] Atkinson, 'Report from the Superintendent of the Civil Hospital' (1889), p.196.

the training of indigenous nurses. So much of the nurses' time was devoted to cleaning that in 1888, Atkinson, in his quest to have hot water supplied to both floors of the hospital, argued that "every contrivance to save labour and cleaning should be employed so that the time and labour of the attendant should be employed in Nursing and not in other duties."[102]

In 1875, the first year in which female nurses of any kind are listed as receiving a government salary, the unnamed principal ward master of the Government Civil Hospital drew an annual income of $100. A further three subordinate ward masters received $195 collectively. In addition to the punishing hours and onerous, confining nature of the work, the principal ward master faced the further ignominy of earning the same salary as a Post Office agent, bailiff, police constable, engine driver with the fire brigade, and first class turnkey at the Victoria Gaol, positions that demanded similar levels of literacy but far less manual labour.[103] This discrepancy did not escape the notice of Ayres, who used his annual report of 1873 to argue that, compared to what men in similar positions might expect in Britain, current wardmaster salaries were insufficient, particularly given the gruelling climate and unpleasant hospital conditions. Using the inspectors of police as his example, particularly as they faced a comparable level of responsibility, Ayres felt, "the European Ward masters are very much worse off in the duties they have to perform…ignorance or carelessness on their parts, means death or injury to patients and therefore they should not be worse paid."[104] The salary was made no more appealing by its equivalence to that collected by many

[102] Atkinson, 'Report from the Superintendent of the Civil Hospital' (1889), p.194.
[103] 'Civil Establishment of Hongkong for the year 1875,' *Blue Book* (1875), pp.74, 84, 90-91, 96, and 100.
[104] *Hong Kong Government Gazette* (4 April 1874), p.157.

white-collar Chinese workers, including the notice server of the Colonial Treasury, an assistant master at the Central School, a police force clerk and interpreter, and a third class clerk working alongside the coroner.[105] Circumstances did not escape the notice of the few European wardmasters, whose time at the hospital was often marked by a welcome arrival and a rapid departure.[106]

In the same year, the single female nurse at the Government Civil Hospital earned just $7.10s, making her the second-poorest paid member of staff –only the nondescript coolie workers received less—with a salary almost half that of the hospital gate keeper or the nightsoil scavenger. At the Lock Hospital, remuneration was slightly better, with the only female nurse earning £20 and the matron, M. Garthwaith, drawing a salary of $75.[107] While the names or ethnicity of most nurses are not recorded in colonial records before 1878, such low wages undoubtedly indicate Chinese staff. For the male staff there was a slight improvement the following year, with the introduction of four classes of wardmaster earning between $40 and $125.[108] Female members of staff would have to wait another year to see any improvement in their pay, however nugatory.[109] Across all government medical centres, wages became incrementally stratified on grounds of race, not skill, or experience.

Chinese staff were least likely to enjoy any increased remuneration, regardless of their expertise or length of service. Ah Lok, a Chinese wardmaster, frequently commended in the Colonial Surgeon's annual reports, retired on a

[105] 'Civil Establishment of Hongkong for the year 1875,' *Blue Book* (1875), pp.66, 86, 92, and 94.
[106] Ayres, 'Colonial Surgeon's Report for 1888,' p. 174.
[107]'Civil Establishment of Hongkong for the year 1875,' *Blue Book* (1875), pp.90-1 and 102.
[108] 'Civil Establishment of Hongkong for the year 1876,' *Blue Book* (1876), pp.94 and 106,
[109] 'Civil Establishment of Hongkong for the year 1877,' *Blue Book* (1877), pp.94, 96, and 108.

pension after twenty-two years' service.[110] Ah had also acted as a post-mortem assistant and interpreter to Chinese patient. He had been anxious to resign for some time, believing himself no longer strong enough for the work, and only remained in his poster after entreaties were made by Ayres and Atkinson, asking Ah to remain in place until the nursing staff was more adequate.[111]

Frugal pay and hard, dangerous work meant that the early nursing staff at the Government Civil Hospital were of variable quality. For the three wardmasters hired during 1888, one was an ex-policeman who left Hong Kong as soon as his term of service with the police expired, another proved unsuitable and was removed after six months, and a third, formerly an assistant turnkey at Victoria Gaol, was appointed only on a temporary basis. Each had to be trained in their duties, "as they were entirely unacquainted with nursing." Despite his experience, and vital presence, Ah earned $420 a year, compared to the $480 offered to the newly appointed assistant turnkey and the $600 paid to the ex-policeman who spent less than a year in his post.[112] These disappointments led Atkinson, then hospital superintendent, to appeal to Britain for a trained wardmaster, preferably one who had served in the Army Medical Staff Corps, believing no suitable men to be present in the colony.[113] Atkinson characterised the more junior nursing staff as a class of servant where "constant watching and supervision are absolutely necessary," whose scant interest in their work was not improved by his brief lecture course on the fundamentals of nursing.[114]

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[110] Ayres, 'Colonial Surgeon's Report for 1888.'
[111] Atkinson, 'Report from the Superintendent of the Civil Hospital,' (1889), p.195.
[112] 'Civil Establishment of Hongkong for the year 1888,' *Blue Book* (1888), pp.56-57.
[113] Atkinson, 'Report from the Superintendent of the Civil Hospital' (1889), p.195.
[114] *Ibid*.

Poor wages, limited career development, and disagreeable working conditions resulted in high attrition rates and regular complaints from the colonial surgeon and hospital superintendents regarding the quality of their staff. John Ivor Murray, then acting superintendent of the Government Civil Hospital, described his male nurses as "low class and not reliable" in his annual report of 1881, something he again attributed to subpar wages, poor working conditions, and ad hoc recruitment. He proposed further reorganisation of salaries based on experience not ethnicity. Ayres endorsed these recommendations, believing they would be "of great benefit to the working of the institution."[115]

In 1888, the two Chinese wardmasters of the Government Civil Hospital were placed under arrest for robbing patients, most reprehensibly the dying. Two European NCOs from the Medical Staff Corps were sent to replace them, but neither they, nor the majority of the untrained Chinese staff, had any real knowledge of the nursing function they were required to perform. In 1889, the medical superintendent wrote to the governor advocating a new system of nursing comprising two European wardmasters and five trained European sisters, one of which would function in the position of head nurse. As noted above, Des Voeux had taken the initiative to promote nursing soon after his arrival in 1887.[116] At the time there was nowhere for these women to live. While a new wing of the hospital had included quarters for medical staff, there were no rooms for either Chinese or European nurses. An interim solution was devised when five French Sisters of Mercy arrived in the colony, although it has been argued that their twelve-month presence was ineffective as they found the work excessively

[115] 'Reports of the Colonial Surgeon and Other Sanitary Papers, 1881.'
[116] Des Voeux, *My Colonial Service*, II, pp.201-202.

arduous and the restrictions of their order prevented them from undertaking many vital tasks.[117]

It has been claimed that in 1890 a new matron and five sisters were appointed around the time a new wing of the hospital was opened, making them responsible for 130 beds over two private and four public wards. Among this batch of nurses was Emma Gertrude Ireland (1857-1898), who had been one of the nurses to care for John "the Elephant Man" Merrick throughout his stay at the Royal London Hospital. Ireland was on duty when Merrick was first admitted in 1886, having begun work there in March of the same year, aged 29. She had formerly worked at the St Pancras Infirmary and was reportedly the last nurse to see Merrick alive on 11 April 1890. Three months later she left the hospital for Hong Kong.

Formal nurse training in Hong Kong began in the early 1890s. In 1893, the Nethersole Hospital was opened and became the first institution in the colony to develop the rudiments of a nurses' training programme aimed at local Chinese women. Two more European sisters ostensibly arrived in Hong Kong in 1892, allowing the hospital to dispense with wardmasters. The initial duties of nurses included administering medication, changing dressings, distributing diets, taking temperatures as well as receiving and admitting patients. Stratton makes the unsubstantiated claim that the European nurses created a more efficient hospital, were of great comfort to patients and could manage the Chinese employees better,

[117] D. Stratton, 'History of Nursing in Government Hospitals,' *Hong Kong Nursing Journal*, vol.14 (1973), p.34.

as demonstrated by a decrease in death rates and an increase in private patients.[118]

Accommodation was improvised. While they awaited the construction of the new government quarters for the medical, European ,and Chinese nursing staff, the existing nursing staff were sent to live in buildings scheduled to become part of the new Lock Hospital.[119] Eventually the nurses were moved to purpose-built quarters on Bonham Road, next to the University and the Government Civil Hospital. It was vital to complete this work before the arrival of the European sisters. The construction of quarters for medical and nursing staff should be viewed alongside more ambitious infrastructural projects initiated from the 1890s through the early twentieth century. These include a new wing of the Government Civil Hospital, a laboratory, a mortuary, separate barracks for Chinese attendants, and the Tai Tam Reservoir scheme. Together, these initiatives reflects a more concerted effort to create new hygienic and medical spaces with designated functions.

2.3 Nursing the Plague

Hong Kong was declared an infected port on 10 May 1894 after the first case of plague had been described by Lowson at the Government Civil Hospital on 8 May. Lowson had just returned for an investigatory trip to Canton, which had convinced him that the city was heavily infested. Given the intense shipping traffic between

[118] *Ibid*., p.35.
[119] Ayres, 'Colonial Surgeon's Report for 1888,' p. 176.

Hong Kong and Canton the likelihood of the plague reaching the colony was high.[120]

The hospital hulk *Hygeia* was moved to West Point to absorb cases from the Tung Wah Hospital, which was believed to be a health hazard even before the plague struck. The *Hygeia* rapidly filled and buildings in Kennedy Town, including a police station, glassworks, and slaughterhouse, were rapidly converted into plague hospitals. What became known as the Glassworks Hospital remained controversial, as it was staffed by doctors from the Tung Wah who employed only Chinese medicine and methods as treatment under the supervision of those trained in western biomedicine. As an understandable result of local preferences, the Glassworks Hospital became rapidly overcrowded, housing twice as many cases as it was originally designed to hold, and was eventually closed on 16 June. A New Glassworks Hospital was eventually opened and staffed by personnel from the Alice Memorial and Nethersole Hospitals.

In 1894, Hong Kong was a global commercial hub, part of an imperial web spanning the globe and bound by new developments in transportation and communications. It was one of the busiest ports in the world handling half of all Chinese imports and a third of exports, comprising 22 million tons of goods—two million more than London—and facilitated by approximately 4,000 European residents working alongside 200,000 Chinese labourers, most of whom were Cantonese immigrants from the Mainland.[121] John Carroll has argued that Hong

[120] For an account of the plague's diffusion across Yunan and Southern China to Hong Kong from the eighteenth century, see Benedict, *Bubonic Plague*.
[121] Echenberg, *Plague Ports*, p.15. However, Frank Welsh argues that the figures for trade passing through Hong Kong might be less impressive than they initially appear as the majority of cargo was comprised of coastal Chinese rather than international trading; see *A History of Hong Kong* (London: Harper Collins Publishers, 1993), p.271. Nevertheless, Hong Kong was still considered to

Kong was a multi-ethnic society comprising Chinese, Europeans, Americans, Armenians, Indians, Portuguese from Macau, Jews from Bombay and Eurasians, who gravitated towards segregated communities yet maintained extensive daily contact.[122] Nineteenth-century commentators emphasised the transient nature of Hong Kong's Chinese population. As Ernest Eitel remarked in 1895, the population constituted a heaving, "incongruous mass."[123] The colony's early population remained transient, young, and overwhelmingly male. This was equally true of the Chinese and non-Chinese communities. Writing in 1912, Francis Clark characterised the population,

> as largely a young adult one and is maintained almost entirely by immigration, both in the case of the Chinese and the Non-Chinese—for the vast majority of the former regard China as their home, and merely visit Hong Kong for the purpose of supplying the demands of the labour market, with the result that between three and four thousand Chinese enter and leave the Colony daily. This explains the reasons way more than 70 per cent of the total Chinese population are males – they are labourers in search of work – and why nearly 60 per cent of them are between the ages of 20 and 45 years.[124]

The situation was similar among the non-Chinese, 66 percent of whom were men. This group was comprised of troops, naval officers, a handful of merchants, and other professionals and government officials who, in Clark's opinion, with "short

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be a vital trading hub heavily influenced by imperial economic concerns when both domestic and international trade later facilitated the spread of plague.

[122] Carroll also notes that the majority of information on the indigenous populace, particularly middle and lower class Chinese, comes from colonial records and as such, even the most nuanced and sensitive local study consequently struggles to maintain a balanced analysis; see *A Concise History of Hong Kong* (Hong Kong: Hong Kong University Press, 2007), p.36.

[123] Ernest John Eitel, *Europe in China: The History of Hongkong from the Beginning to the Year 1882* (Hon Kong: Kelly and Walsh, 195), p.i

[124] Francis Clarke, 'Guide to Hong Kong,' in *Transactions of the Second Biennial Congress of the Far Eastern Association of Tropical Medicine*, Francis Clark, ed. (Hong Kong: Noronha, 1912), pp.x.

intervals of leave to the homeland," would spend between twenty and thirty years in the colony before retiring at the age of fifty-five or sixty. This group "usually hope to leave...and return to their native land" in time to collect a small pension from "a grateful mother country," assuming they had not succeeded in amassing their own funds.[125] Hong Kong's population was also largely Chinese. In 1911, the non-Chinese population, including all other nationalities, was 2.72 percent, or 12,075 out of a total of 444.664.[126]

The nine nursing sisters who arrived from London had originally been engaged by the Secretary of State and had agreed to six-year contracts of service culminating in six months leave, meaning that a return passage Hong Kong was part of their remuneration. Upon arrival, the original group was divided into three shifts of three nurses working from 6am to 2pm, 2pm to 10pm, or 10pm to 6am. Each sister had two amahs to assist her and held authority over any of the hospital's "boys" on the ward. The sisters needed only to defer authority to their Matron or a doctor, although the matron in question, Miss Eastmond, had no authority over wardmasters or any of the other "boys" working in the hospital. She also did not work with the matron of the Lock Hospital, who was herself assisted by an amah. It is likely that their nursing duties were largely confined to the Government Civil Hospital as Lowson had noted his dissatisfaction at the nursing conditions in places like the *Hygeia*, deeming it inappropriate and impractical for the British sisters to offer their services at such locations.[127] This is perhaps to be expected for, as Mark Harrison notes when discussing the validity

[125] Clark, 'Guide to Hong Kong,' pp.x-xi.
[126] *Ibid*., p.x.
[127] 'Medical Committee Report on the Plague' (1895) p.31.

of characterising medicine as a "tool of empire" and a vital part of the relationship between territorial expansion and scientific innovation, the principal concern of colonial medicine was the health and inherent vulnerability of Europeans, particularly troops, in the tropics.[129] In Hong Kong, the best care and most innovative medical protocol—in this case the employment of trained European nurses—was naturally available first at the Government Civil Hospital, an establishment founded to cater primarily to European needs.

Treatment was made more difficult by the fact that institutions, including the Alice Memorial and Nethersole Hospitals, had to be closed due to their proximity to infected areas. Lowson's plague report references Chinese nursing staff and a Eurasian Sister from the Italian Convent who died after incubating the disease for five days.[130] Lowson recorded his regret at her death because, as she passed away at the Alice Memorial Hospital, she was the only member of the European medical staff at a western hospital to die. Her death was blamed on "excessive zeal" as the "dangers of nursing should have been carefully pointed out to her."[131] Recommended hygienic practices for nurses were also detailed, particularly when dealing with scratches on fingers, yet there was evidently no surplus of qualified staff as Lowson notes that it was necessary for the European nursing staff at the Civil Hospital to be reinforced by two police constables.[132] He records a total of nine European sisters as part of the Government Medical Staff, and two unspecified sisters each at the *Hygeia* and Kennedy Town Hospital. The

[129] Mark Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine, 1859-1914* (Cambridge: Cambridge University Press, 1994), p.2.
[130] Lowson, 'Epidemic of Bubonic Plague,' pp.375, 378, and 383.
[131] *Ibid*., p.396.
[132] *Ibid*., pp.371 and 385.

specific details of the nursing staff and their roles were left to the matron, Miss Eastmond, who supervised her team spending alternate weeks at the Civil Hospital, "where the work though as heavy was not as disgusting or depressing," and other hospitals throughout Hong Kong.[133] Although fourteen Chinese boys were recruited to help with nursing aboard the *Hygeia* on 11 May, three days later many of the Chinese staff had fled both the *Hygeia* and the Kennedy Town Hospital, many so desperate to escape the plague that they swam ashore.[134] Lowson was also so unimpressed by nursing standards at the Glassworks Hospital, which the "Chinese had mismanaged," that he offered his expertise but was declined by the Permanent Committee.[135]

Elizabeth Frances Higgin (Sister Frances) and Emma Gertrude Ireland (Sister Ireland) both died of plague in April 1898 after resuming work at the Government Civil Hospital. According to a report in the *Lancet*, Higgin had become infected after a delirious patient had coughed in her face, and Ireland became infected after caring for her colleague. A third nurse, Sister Catherine, had already contracted the plague in 1896 and "was saved as if by a miracle."[136] The following year, a stained-glass window that depicted a scriptural allegory for the care of the sick—was unveiled at St John's Cathedral in Hong Kong, although it was subsequently destroyed during World War II. A silver rose bowl, a wooden chest, and a clock were presented to the remaining nursing staff. The *Nursing Record and Hospital World* marked the occasion by remarking that, while the nurses "have

[133] *Ibid.,* p.396.
[134] *Ibid*., p.393.
[135] *Ibid.,* p.394.
[136] 'Plague in Hong-Kong: The Deaths of Two Nursing Sisters,' *Lancet* (11 June 1898), p.1635.

never been found wanting to risk their lives, or, as was the recent instance, to lay them down in the service of humanity."[137]

A letter written by Georgina Franklin, one of the Hong Kong nurses, is an exceptional female interpretation of the plague experience that gives insight into a nurse's daily work. The letter holds particular significance as Franklin's pleas are framed against the backdrop of a detailed description of the bubonic plague and its impact on Hong Kong. Franklin's letter complements other viewpoints, such as the first clinical description of the plague in Canton provided by the physician Mary West Niles, offering a rare glimpse of the outbreak from the perspective of a female clinician:

> Plague has been, still is, raging here, the returns showing a few weeks ago 1202 cases attacked, 1131 deaths. The percentage of recoveries still only averages 5 or 6 per cent. Europeans have also succumbed. They are now attempting to nurse all cases under Western treatment by sending us down alternately. It interferes rather seriously with the working of the Govt. Civil Hospital and stops all question of the Sisters' leave for which 4 have waited 2, and 1, three years. However, we hope it will soon subside for the exodus of people is becoming noticeable, 70,000 Chinese also having departed, some of them being averse to plague restrictions, others being really afraid of the disease. I suppose Hong Kong eventually, like India, will give up measures which the Chinese, far from supporting, are averse to in every way. It is to be hoped no serious fracas will […] before then but the natives are so taciturn and conservative, that no warning might be forthcoming.[138]

[137] 'Nursing Echoes,' *Nursing Record and Hospital World*, vol.23 (October 1899), p.338.
[138] Lowson, 'Epidemic of Bubonic Plague,' p.396; see also Mary West Niles, 'Plague in Canton,' *China Medical Missionary Journal*, vol.8, no.2 (June 1894), pp.116-119.

2.4 After the Plague

As soon as the initial outbreak was over, an inquiry was held into the handling of the epidemic. Different stakeholder were invited to testify before a committee. Ayres claimed that as the nurses expected contractual leave, and as at least one of the group was always ill in his opinion, unless a local system of support could be devised, the Hong Kong authorities would be required to apply to the Secretary of State for two additional sisters in order to cover the absences of their colleagues. When asked by the committee if any locally trained nurses would attain the same status as Europeans, Ayres replied, "they would be only superior amahs."[139] He proposed that they should be taken from Miss Johnson's school, or similar institutions, and live there while being paid a monthly subsistence allowance of $5 and a uniform. It was also reiterated that these nurses would never be allowed to become part of the nursing staff of Europeans, reside in the same accommodation, or share a mess:

> We consider that the scheme referred to is practicable to this extent, viz., that the young women, whom it is proposed to train, should be trained on the understanding that they can qualify as "nurses" only and can never attain the rank of "sisters" to whom that will and must always remain subordinate. We are of the opinion they cannot be trained locally with a view to ultimately taking the place of the European sisters, and that, even if they could be, it would be obviously undesirable on the grounds of their nationality and origin to accord them such equality. Subject to the above limitations, we are proposed to recommend the scheme as a tentative measure on the grounds of economy.[140]

[139] 'Medical Committee Report' (1895), p.9.
[140] *Ibid*.,p.v.

The committee went on to declare that after the introduction of these ancillary "nurses," the need to obtain new "sisters" from Europe to assume the work of those on leave at any point would be obviated. Optimistically, the report also claimed that with the addition of these new trainees, the needs of private nursing would be gradually met and eventually, if they proved capable nurses and could assume much of the work presently undertaken by European sisters, then those sisters could assume lighter duties and a more supervisory role. Nonetheless, the committee was unwilling to claim that this situation would lead to an eventual reduction in the number of European practitioners required.

When asked if a training system could be developed in Hong Kong aimed at "young ladies in the Colony" who might wish to enter the nursing profession in a similar way to their British counterparts in order to avoid the considerable expense of bringing more European sisters out to replace any that might die, leave or get married, Ayres replied: "The young ladies out here would not care to go through the training these Sisters have undergone at home. These Sisters have washed down wards and done everything from the lowest grade. We could never train them out here."[141] This was a distinct possibility as not only was Hong Kong a famously insalubrious location, but a heavy military and naval presence had also ensured an overwhelmingly male society and a consequent lack of marriageable women. The census of 1872 estimated that among the Chinese there were seven men for every woman and five to one in the European community.[142] European nurses—women already deemed "ladies" before being allowed to commence their

[141] 'Medical Committee Report' (1895), p.10.
[142] Carroll, *A Concise History*, p.56.

training—might prove a tempting prospect if they happened to survive their service.

Clara Eastmond, Matron of the Government Civil hospital and one of the nine European sisters to work during the 1894 outbreak, shared similar views. When asked repeatedly if her current staff was adequate, she replied, "the staff is not sufficient if one is on leave or if anyone knocks up."[143] When questioned about her opinion on Lowson's scheme, she stated, "I approve of it being tried," but again was careful to note the subordinate status of locally trained nurses as their position would ultimately be:

> Nothing; they would have to leave after a time. They could not come on as Sisters. We could not train Sisters sufficiently at the Civil Hospital. We could not train them to become Sisters; they might do private nursing but they could not hold the same position as nurses at home. There is not enough experience here to train Sisters…These girls would cease to become probationers. I do not think they could take the place of Sisters. They would not have the same influence with the patients. They would require to be constantly under the eye of the Sisters.[144]

Despite noting the increasing volume of work at the hospital, Eastmond felt these women would only be of use when a sister was ill and not as permanent editions to her staff. She also considered it a "risky enterprise" to employ them specifically as nurses to wives and children of policemen and other civil servants as part of the Government Civil Hospital's regular staff. When pressed on the issue, Eastmond became somewhat defensive: "Our Sisters are sent out from home; they are

[143] 'Medical Committee Report' (1895), p.11.
[144] *Ibid*.,p.12.

trained in the London Hospitals. We have no difficulty in getting them."[145] When the committee enquired whether the Eurasians, who Eastmond would only ever refer to as "nurses," "probationers," or, in an informal context, "girls," could be trained only to manage conditions common within the tropics, Eastmond was adamant:

> If you want to train a nurse you want here constantly under your eye. I feel I could not possibly train a nurse as they are trained at home. I should not like to say I could; I do not think I could do it properly…I do not think the cases here lend themselves in the same was for training a nurse…In the same way as we could train these Eurasian girls, but not to take the place of the Sisters on the Hospital.[146]

Eastmond's final word on the matter was that, if cost was disregarded, it would be "more satisfactory" to employ another European sister, who would be worth more than two probationers, as quality could therefore be ensured. Similar requests were still being made in 1914 by unofficial European members of the Legislative Council, despite the Government Civil Hospital having more European staff than other institutions of a similar size within the Empire.[147] Perhaps, as a last attempt to preserve revenue, the committee questioned whether any "ladies" of the colony could be employed to relieve the nurses of some of their more menial duties, Eastmond scoffed: "It would be difficult to get a lady here to come in and make eighteen beds of a morning."[148]

[145] *Ibid*., p.13.
[146] *Ibid*., p.13.
[147] Carroll, *A Concise History*, p.113.
[148] Medical 'Committee Report' (1895), p.14.

New nursing initiatives were proposed after 1895, but they seldom materialised. As part of the celebrations put on to mark the Queen's Diamond Jubilee in 1897, for example, it was proposed to establish a nursing institute, along with the Victoria Hospital for Women and Children.[149] But nothing came of the institute and nursing was still marginalised. In 1901, a year in which both Lowson and Atkinson were given a year's leave, three of the nursing staff were only granted two months leave. One of the nurses, Miss Batchelor (Sister Helen), was then loaned to the Naval Authorities at Weihaiwei, and eventually resigned. When asked if the existing medical staff of the colony was sufficient to deal with any further outbreaks, the plague committee was unable to reach a consensus, remarking that,

> When necessity arises, and that the Principal Medical Officer shall have the power of appropriation and allotting such special duties. In the case of great emergency we are unable to recommend any definite course of action, seeing that the proper steps to be taken on such occasions must necessarily depend on the circumstances and the conditions and must be decided accordingly. We, however, venture to suggest that in the event of any grave emergency arising liberal inducement be offered to outside medical practitioners (local or otherwise) to place their services at the disposal of the Government).[150]

After 1894 and the arrival of certified European nurses, the distinction between "nurses" and "sisters" became gradually more concrete, and many of those previously deemed "nurses" became "amahs" or merely "probationers," as restrictions determined by education, experience and ethnicity were

[149] Chan-Yeung, *A Medical History*, p.105.
[150] 'Medical Committee Report '(1895), pp.iii-iv.

implemented. The term "sister" now applied only to trained European practitioners or the members of the French and Italian convents required to intermittently fulfil a nursing function during the preceding decade, although it is worth noting that the only position not linguistically or pragmatically altered was that of "matron" of the Lock Hospital. This change was indicative, not only of the perceived impact the European Sisters had made during the outbreak, it also symbolised a collective recognition of an existing international nursing professional standard which Hong Kong had previously failed to adhere to, allowing the 1894 infestation to act as a lens through which to examine changes in nursing practice within the context of empire, as well as the increasing consolidation and stratification of medical services across the colony.

In 1900, Bell noted that when the nurses' workload becomes "exceptionally heavy," a room at Craigieburn on The Peak, then the governor's summer residence, was placed at their disposal.[151] In 1900, the two matrons of the Government Civil Hospital were paid $900 a year and the remaining seven sisters, including Franklin, earned somewhere between $682 and $847. However, the four probationers at the hospital earned only $220 annually[152]

In 1900, when Atkinson went on leave for a year his replacement, Lowson, was first ill for five weeks and then left on a year's leave as a result of ill health. During the same period, two nurses from the Government Civil Hospital resigned, although only one did so explicitly on the grounds of poor health, and neither probationer engaged to replace them stayed for any appreciable length of time.

[151] John Bell, 'Report of the Acting Principal Medical Officer for the Year 1900,' *Hong Kong Sessional Papers* (1901), p.248.
[152] 'Civil Establishments of Hong Kong for the Year 1900,' *Blue Book* (1900). p.170.

Nurse Robbins, of the government's private staff went to Japan on sick leave for an unspecified period of time. The hospital also went through five wardmasters. Of these, one resigned, one was dismissed, and one chose army life over that on the wards.[153]

Hospital authorities felt they could spare nurses, loaning them to other British territories and deriving valuable additional income from private nursing. In 1900, Nurse Barr and Nurse Batchelor were sent to the British concession of Weihaiwei in the Shandong Peninsula while back in Hong Kong, their colleague generated an additional $1,886.23 in additional revenue, 5.46 percent of the total received by the hospital.[154] When patients were refused access to the hospital, insufficient accommodation was used as a justification, rather than understaffing.[155]

2.5 Nursing and Plague Science

Although the bacteriologists Alexandre Yersin (1863-1943) and Kitasato Shibasaburō (1853-1931) isolated and described the bacillus responsible for plague during the first outbreak in Hong Kong, little was known about the illness. The disease's vector and transmission pathways were described four years later, after Paul-Louis Simond (1858-1947) published his work from Bombay in 1898. Even following these scientific breakthroughs, quarantine and nursing remained the only real way of helping people survive in a pre-antibiotic era.

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153 Bell, 'Report of the Acting Principle Medical Officer for the Year 1900,' p.247.
154 *Ibid*., pp.247 & 251.
155 This fate usually befell destitute Chinese patients as they comprised the vast majority of those seeking attention, and were the only group elidable for treatment at the Government Civil Hospital exempt from fees; see Bell, 'Report of the Acting Principle Medical Officer for the Year 1900,' p.249.

In the decades following the identification of the plague bacterium, increasing numbers of medical men and colonial officials, often directly engaged in managing the disease in different colonial locations, sought to share their experiences. A substantial plague literature emerged. Specialist books and journal articles comprise much of this advice literature that describes the history, aetiology, symptoms, and treatment of plague. Despite the central role nursing played in containment and patient prognosis, nurses are almost entirely absent from these works. A. L. Gregg's *Tropical Nursing* (1929) is perhaps the only attempt to codify plague nursing and advises that septicaemic and pneumonic plague are always fatal, and even in bubonic plague, "the mildest type, the mortality is high."[156]

In some cases, plague books of several hundred pages that describe clinical aspects of the disease in great detail fail to offer any guidance on how a plague patient might be nursed.[157] In other cases, nurses become faceless victims of the disease they attempted to combat.[158] Often there was an implication that nurses

[156] Gregg, *Tropical Nursing*, p.112.

[157] Anon, *The Bengal Plague Manual* (Calcutta: Bengal Secretariat Press, 1903); B. L. Dhingra, *Plague* (Lahore: The Mufid-i-am Press, 1898); Burnside Foster, *The Bubo Plague in China with a Brief Account of the Great Plague of London* (Chicago, IL: American Medical Association Press, 1894); Prestonjee M. Kanga, *Reflection on Plague and the Methods of Checking it* (Bombay: Bombay Education Society's Press, 1907); Maṣlaḥat al-Ṣiḥḥah al-'Umūmīyah, *Instructions on Procedure in Outbreaks of Plague* (Cairo: Government Press, 1913); William John Ritchie Simpson; 'The Croonian Lecture on Plague,' reprinted from *The Lancet*. Lecture I, 29th June 1907, pp.1757-61. Lecture II, 13th July 1907, pp.74-8. Lecture III, 20th July 1907, pp.142-7. Lecture IV, 27th July 1907, pp.209-12; *Preliminary Memoranda on Plague Prevention in Hong Kong* (Hong Kong: Noronha & Co., Government Press, 1902); *Journal of Hygiene Plague Supplement IV: Ninth Report on Plague Investigations in India* (Cambridge: Cambridge University Press, 1915).

[158] James Cantlie, *Plague: How to Recognise, Prevent and Treat Plague* (London: Cassell and Company, Limited, 1900), p.28; Charles Creighton, *Plague in India* (Washington: Government Printing Office, 1907), p.314; J. Foster Palmer, 'Modern Epidemics: Plague,' *Medical Magazine*, vol.8, no.11 (November 1899), p. 1002; Ernest Hanbury Hankin, *The Bubonic Plague* (Allahabad: The Pioneer Press, 1899), pp. 20, 35, and 56; William Ernest Jennings, *A Manual of Plague* (London: Rebman Limited, 1903) pp.62, 160, and 163;William John Ritchie Simpson, *A Treatise on Plague dealing with Historical, Epidemiological, Clinical, Therapeutic and Preventative aspects of the Disease* (Cambridge: Cambridge University Press, 1905), pp.78, 200, 256, 301-3, and 380.

were at least partly at fault when they became infected.[159] In a few examples, the possibility of contagion is used as a justification for the recruitment of trained nursing staff, since the "careless" mistakes of the unqualified attendant would be avoided by trained nurses.[160] However, texts rarely differentiate between professionally qualified women, family members, and volunteer carers.[161] No other details are specified beyond the circumstances of their infection. Occasionally, the unfortunate nurse is named—something more likely in cases where the casualty was the physician's appropriately certified helpmeet—but in the majority of cases the nurse exists anonymously, her contribution entirely overshadowed.[162]

Nurses are not the intended audience of this canon. While nurses may be infrequently discussed, they are never addressed. When nurses are mentioned they are largely shadowy figures at the margins. Even though there is recognition that they fulfil intense roles, often involving a great deal of hazardous and onerous work, there is little precision about what their role entails.[163] Lieutenant-Colonel Walter Gaven King, Sanitary Commission for Madras, for example, advises that nurses should segregate and burn any material used to absorb fetid, infectious

[159] *Tropical Nursing*, pp.111 and 113.
[160] George Harlow Waters, 'Plague in Bombay, 1896-1900,' Presidential Address to the Anthropological Society of Bombay (1900), p.10.
[161] Simpson, *Treatise on Plague*, p.213.
[162] Thomas Clifford Allbutt, *Plague* (New York: Macmillan, 1906), p.38; B. L. Dhingra. *Plague* (Lahore: The Mufid-i-am Press, 1898), p.13; John Macauley Eager, *The Present Pandemic of Plague* (Washington: Government Printing Office, 1908), p.15; Maximilian Herzog, *The Plague: Bacteriology, Morbid Anatomy, and Histopathology* (Manila: Bureau of Public Printing, 1904), p. 25; R. Nathan. *Plague in India, 1896* (Vol.4) (Shimla: Government Central Printing Office, 1898), pp.105, 113, 115 & 117.
[163] W. G. King, *The Plague Inspector* (Madras: Addison & Co., 1899), pp.50, 54, and 84.

fluids from patients during their daily work. No advice is proffered, however, on how nurses might safeguard themselves while conducting these tasks.[164]

Other authors do nothing more than repeatedly remind nurses to wash their hands and face with abrasive disinfectants, particularly after contact with patients.[165] Dr John William Ritchie Simpson (1855-1905) recommended scrupulous attention to hygiene of both body and home, in addition to prophylactic doses of Haffkine's or Yersin's plague serum. Patients could enjoy six or seven months of immunity after suffering 48 hours of nausea, headaches, fevers, soreness, and malaise.[166] However, the death of the Keyser sisters in Cape Town, and of Elizabeth Francis Higgin and Emma Gertrude Ireland in Hong Kong, testify to the inefficacy of this approach. Later literature revised inoculation guidelines, openly acknowledging that the process was a "somewhat unpleasant experience" that required repletion and offered protection for only three months.[167]

Silences within the sources can be equally revealing of the inherent dangers of plague nursing. Ashutosh Mitra, Chief Medical Officer of Kashmir for much of his life, argued that the nursing of plague patients should preferably be left to close relatives, and that all those not directly involved should remove themselves from the sickroom.[168] Plague was deadly enough for Mitra to advise all others, including physicians, to step back while nurses stepped forward, to be confined with their patients and the illness. Later works give some indication of

[164] King, *Plague Inspector*, pp.52 and 68.
[165] Nathan, *Plague in India*, pp.326, 383, and 416; Simpson, *Treatise on Plague*, p.331.
[166] Simpson, *Treatise on Plague*, p.331.
[167] Gregg, *Tropical Nursing*, p.115.
[168] *Indian Medical Gazette*, vol.62, no.4 (April 1927), p.228; Ashutosh Mitra, *The Bubonic Plague* (Calcutta: Thacker, Spink and Co., 1897), pp.28 and 31.

the intensity of this process. Gregg advises, "None but authorised attendants should be allowed in the same locality as a case of plague, nor may the attendants or contact mix with other people until they have had a quarantine period of ten days."[169] In previous chapters, we have seen how nurses working in Hong Kong and Cape Town alluded to the intensity and loneliness of their work. Read alongside the brief accounts of plague nursing contained in the medical literature, the writings of the nurses themselves (when they do exist) reinforce the impression of women labouring amidst sick "native" bodies in remote colonial settings, often with little official guidance and support.

Plague nurses become no more visible in mid-twentieth-century sources. While L. Fabian Hirst's influential *The Conquest of Plague* (1953) represents the culmination of an entire research career, it contains just three references to nursing. Even at his most expansive, Hirst is willing to conceded that nursing is not without risk because of the likelihood of contact with infectious fluid, and "no disease is more dangerous to nurse" than the pneumonic plague. But he has nothing to say on how this task might be accomplished.[170]

While nurses were marginalised in the plague literature, they remained crucial to disease management. As noted above, some authors recognized that nursing was fundamental to the positive outcome of plague cases. However, they failed to consider how or why this support was efficacious.[171] Simpson's *Treatise on Plague* (1905) recommends nursing of a "skilled kind" as essential, as "any

[169] Gregg, *Tropical Nursing*, p.114.
[170] Hirst only other reference to plague nursing is a brief historical discussion of the pivotal role held by those caring for victims of the Black Death, particularly when assessing whether a patient should be confined to their home. L. Fabian Hirst. *The Conquest of Plague: A Study of the Evolution of Epidemiology* (Oxford: The Clarendon Press, 1953), pp.232, 255, and 410.
[171] Nathan, *Plague in India,* p.92.

organisation against plague is incomplete unless it has skilled nurses, not only for the patients in the plague hospitals, but also for those patients who are permitted to remain at home."[172] While Mitra discusses nursing on just five occasions—one of which is a historical reference to nurses stealing from patients—he remains happy to concede that "skilful nursing is essential and necessary," as "no other disease requires more skilful nursing than the plague, therefore ample nursing staff should be provided."[173] Dr. James Cantlie's *Plague: How to Recognise, Treat and Prevent Plague* (1900), argues that in order to have any hope of successfully curtailing an outbreak, "diagnosis, segregation, isolation, quarantine, cleansing of insanitary localities, transportation of sick, plague hospitals, nursing, inoculation, disposal of the dead, disinfection of houses must have all been arranged beforehand."[174] Cantlie reminds his readers that, as with many other diseases, while there is no cure for plague, with "judicious" and "good" nursing, cases can be brought to a successful conclusion.[175] In his opinion, skilled nursing would have a more profound effect on plague patients than those suffering from any other disease: "Once for all let it be understood that in no disease does one get such immediate results…as a direct outcome of watchful nursing, as in plague."[176]

On the subject of how patients were to be nursed, authors are far less expansive. Mitra offers ample guidance on disease management but provides little insight into who might undertake this work, other than that nursing numbers should be "ample" and their care "skilful." While only "trained men" should be

[172] Simpson, *Treatise on Plague*, p.386
[173] Mitra, *Bubonic Plague*, pp.4, 29, and 34.
[174] Cantlie, *Plague*, p.46.
[175] *Ibid.,* pp. 57-8
[176] *Ibid.*, p.57.

employed in the disinfection process and in running of the hospital, Mitra does not extend these requirements to nursing.[177] Cantlie confines his comments on nursing to two paragraphs, recommending one nurse for every two patients during the first five days of the illness if their efforts were to have the greatest impact. As no nurse should be on duty for more than eight hours, he recommends four-hour watches. As plague was "the most fatal illness known", Cantlie felt that, "A nurse must never let a patient out of sight for a moment, be the patient asleep or awake. She cannot leave the ward or room, without posting a deputy, for any purpose whatever."[178] While the liberal supply of doctors and nurses recommended might seem "outrageous" they were essential to the lives of plague patients, European, and Asian, due to the rapid and unpredictable nature of the illness.[179] Simpson also recommends a drastic increase in the number of nurses available in times of plague, this should be done well in advance, regularly inspected and under the control of the medical service.[180]

Simpson's writing is rare in alluding to the difficulties and dangers of plague nursing. While good nursing was essential in preserving the strength of the patient and aiding recovery:

> The nursing is difficult and at times dangerous on account of the delusions of the patient, who may, accordingly, resist being fed and resent being attended, or who may be constantly attempting to get out of bed and escape. Under certain conditions it is absolutely necessary to employ mechanical restraint to keep the patient from inflicting self-injuries or being dangerous.[181]

[177] Mitra, *Bubonic Plague*, p.29.
[178] Cantlie, *Plague,* p.58.
[179] *Ibid.*
[180] Simpson, *Treatise on Plague*, pp.367-8.
[181] *Ibid*., p.329.

Nurses were also charged with confining patients to their beds as early as possible in the illness, careful feeding and ensuring that a recumbent position was maintained. These measures aimed to preserve the patient's strength, avoid complications, prevent syncope, and was calculated to produce the best possible results, with or without serotherapy.[182] Simpson alludes to the miseries of plague nursing early in the treatise when he includes a lengthy description of the Justinian plague (541-2) from Procopius of Caesarea, as part of a detailed historical discussion of global plague outbreaks. In this account, nurses are to be pitied to the same degree as patients. Their work renders them so fatigued that they become easily infected and die rapidly, while physicians and those entrusted to bury the dead escape,

> they had to put back the sufferers who threw themselves out of bed and rolled upon the floor, or had to drag them back and restrain them by force when they wished to throw themselves out of window, when they found water they burned to throw themselves into it, not from a desire to drink, for men threw themselves into the sea, but moved by their delirium. Nor was the struggle in the matter of food less, they would not take it if they could help it.[183]

Although some authors did identify nursing as central to plague management, a category of specialist "plague nurses" did not emerge. No literature or training focusing specifically on plague emerged, reflecting a wider dearth of support for nurses who elected to work overseas.[184] However, as the London chapter of this

[182] *Ibid.*, p.329.
[183] *Ibid.*, p.8.
[184] Howell, Rafferty, Wall, and Snaith, 'Nursing the Tropics,' pp.338-341.

thesis has demonstrated, nurses engaged in plague work did not exist within a vacuum. They could make use of a range of specialist and general literature, and the ability to improvise was a prized asset among these nurses. Those with suitable professional expertise became desirable additions to medical teams managing outbreaks of plague and other infectious diseases in different locations, as Sister Catherine McIntosh's move from Hong Kong to Poona (Pune) demonstrates.[185] As noted above, Gregg's *Tropical Nursing* was arguably the first attempt to provide detailed instructions specifically for those engaged in plague nursing, produced more than thirty years after the disease was first recorded in Hong Kong. The author recommends techniques similar to those employed when managing severe fevers, with an additional focus on dressing any buboes and bedsores that appear. Patients were to be confined—preferably within a specialist isolation hospital—given a light diet and plenty of water in an environment of absolute cleanliness supplemented with liberal use of antiseptics. Prophylactic measures are paramount, and the work includes detailed descriptions of how plague might be eradicated in homes and rat populations, going as far as to remind nurses that any filled rat traps must be entirely submerged in buckets filled with a strong antiseptic solution for at least thirty minutes before proceeding. The image of a nurse drowning rats and organising domestic fumigation teams is not entirely fanciful. Like the *Wellcome Diaries*, Gregg's work creates the impression that nurses might be expected to manage any number of challenging situations singlehandedly: from operations for elephantiasis, to how to select the correct mosquito net.[186] During her work in Poona, Catherine McIntosh was instrumental

[185] 'A Noble Volunteer,' p.210; 'The Plague at Poona,' p.60; 'Nurses of the London Hospital,' p.46.
[186] Gregg, *Tropical Nursing*, pp.51-5 and 107.

during house-to-house plague inspections, as she was able to enter all-female zenanas and thereby ameliorate some of the tension caused by the searches.[187] Research on the Manchurian plague from 1910 has revealed the increasingly diverse and active role of female nursing in epidemic situations—particularly within the Manchurian Plague Prevention Service established in 1912.

2.6 Conclusion

The plague crisis helped to foreground nursing and its importance in Hong Kong. While a number of medical officers had advocated the need for European nurses long before 1894, the plague served as a catalyst to reignite debate about the indispensability of nursing to a modern colonial health service. A committee was convened to report on the state of the colony's healthcare in the aftermath of the 1894 plague outbreak and highlighted the provision of nursing as a key facet of health infrastructure.

Follow-through however, was minimal and piecemeal. Despite the trumpeting of nursing at the turn of the century, it was to be many decades until nursing became embedded institutionally in Hong Kong. In 1927, the Tung Wah Hospital set up a school for training nurses, as did the Hong Kong Sanatorium and Hospital, initiatives that paralleled the development of nursing in mainland China.[188] However, it was not until 1931 that the Nurses Registration Ordinance

[187] 'The Plague at Poona,' p.60.
[188] Sally Chan and Frances Wong, 'Development of Basic Nursing Education in China and Hong Kong,' *Journal of Advanced Nursing*, vol.29, no.6 (1999), pp.1300-130; E. Poon, 'A Brief History of Nursing in Hong Kong,' *Hong Kong Nursing Journal*, vol.35 (1983), pp.119-123.

formalised nursing in the colony and provided for a Nursing Board to regulate the profession.[189]

Considering the plague from the perspective of nursing provided a means of recuperating female agency in male-centric plague histories. It also shifts the focus of the historiography from the mainly missionary accounts to secular versions of care giving. Not only does nursing reframe the history of healthcare practice within the colony, it also brings into sharp relief the contrast between the professional ideology that was emerging about the professional identity of nursing in the metropole and the gruelling conditions nurses had to endure and operate under in colonial environments. As we shall see, the image of colonial adventure and opportunity remained undented. The harsh realities of colonial nursing were downplayed in the burgeoning trade press and by colonial regimes intent on recruiting aspiring women to their service.

[189] Chan-Yeung, *A Medical History*, p.105.

Chapter Three

Improvising Measures – Cape Town, 1901

3.1 Introduction

In 1901, the year that the bubonic plague broke out in South Africa, *Wellcome's Professional Nurse's Diary* proffered some practical advice to nurses working in the colony on how to ensure they remained "in the front rank" of their profession:

> [The nurse's] success depends upon her power to adapt such means as are at hand (often lamentably imperfect) to the needs of her profession. Unless she is prepared to make the most of the tact, common sense, and general ability with which nature has endowed her, she can never hope to be in the front rank. Practical experience shows that emotional or spasmodic enthusiasm—such as one often sees in the novice—is a most untrustworthy motive-force when it is brought into contact with monotonous daily work.[190]

Published in London, with different editions focusing on specific colonies, the *Diary* was an almanac intended for a readership of British nurses working across the Empire.[191] It comprised a regularly updated collection of edifying articles, recommendations for treatment, reference guides for general nursing, medical advertisements, diseases symptomologies, and guidelines for sanitary

[190] WF/M/PB/20/1-4, 'The General Principles of Nursing,' *Wellcome's Professional Nurses Diary*, South Africa Edition (London: Burroughs Wellcome & Co., 1901), p.39.

[191] Examples of such information include how to send a letter in each of the separate colonies that would later comprise South Africa after federation, how to pack a pannier for visiting patients in remote locations and the legal requirements for making a will, either for yourself or a patient. Separate editions of the *Wellcome's Professional Diaries* were issued for nurses, pharmacists, doctors and other medical professionals from the late 1880s up until World War II. Overseas nurses could select either the Colonial, South African, Australian or Indian editions.

procedures. Each *Diary* was designed to offer instruction to private and district nurses, or to those working in remote regional health centres, as it was assumed that practitioners in large urban hospitals would already have access to sufficient infrastructures offering support and guidance. The use of the word "diary" connoted a particular genre, or format. As we shall see in Chapter 4, like the nurse's letter and testimonial, the diary served as a critical means of "self-positioning."[192]

While functioning primarily as a vehicle for advertising, the *Wellcome Profession Diary* also aimed to inform colonial nurses about what they were expected to know, what roles they were expected to fulfil and, perhaps most significantly, the kind of person they were expected to be. It constituted one of the earliest forms of advice literature to nurses in the tropics, and given the spartan nature of the literature for nursing in the colonies, the series represents one of the few staples for the historian to draw upon.

As the article quoted above underlines, nurses were required to demonstrate professional detachment to an almost mechanical extent. While displaying tact, common sense, and consistency of purpose, the colonial nurse also needed to adapt to local circumstances.[193] As we shall see in Chapter 4 of this thesis, metropolitan nursing journals and the popular press played a crucial role in the construction and promotion of the ideal nurse—an ideal that strove to reconcile apparently irreconcilable qualities. Thus, the colonial nurse was

[192] See Jessica M. Howell, 'Nurse Going Native: Language and Identity in Letters from Africa and the British West Indies,' *Journal of Commonwealth Literature*,vol.51, no.1 (2016): 165-181 (167).
[193] Given that the content of the South African editions of the diary focus heavily on military nursing, it is likely that they were initially aimed at nurses serving in the Second Boer War. However, much of the material references more general district or private nursing, and all editions of the diary contain similar advice concerning the temperament and skills of the ideal nurse.

expected to combine an adherence to a set of rigid principles that pivoted on cleanliness and purity at the same time as prioritizing "adaptability" in the face of local situations.

This chapter explores the 1901 plague outbreak in Cape Town as a "sampling device" (see Introduction to this thesis) that sheds light on key facets of colonial nursing in the South African colony and, in particular, on how issues of gender, race, and class became entangled in nursing practice. Section 2 ('The Cape Colony') sets the scene for the main argument by providing an overview of the social and political situation in the Cape under colonial rule. Section 3 ('Local Limitations and Overseas Dependency: The Development of Nursing in South Africa') sketches a pre-1901 history of nursing in South Africa, emphasizing the difficulties in recruiting suitable local women and discussing the local particularities that shaped the colonial nursing regime there. Section 4 ('Preparing for the Inevitable: Plague Arrives in Cape Town') considers the advent of bubonic plague in the colony. Public health legislation enacted throughout the 1890s allowed Cape Town to be relatively well prepared for the arrival of plague in February 1901. Systematic planning had begun as early as 1898, although initial detection methods were arguably deficient, and provision was only made for a limited number of cases.

Section 5 ('Plague Nursing in the Cape') investigates the recruitment of plague nurses. This section argues that nursing was one area in which the Cape Colony was distinctly underprepared. Early attempts to recruit nurses to work in regional quarantine centres proved unsuccessful. Furthermore, complex legal, social, cultural, and economic issues meant that the local labour pool of potential

nurses was underutilised. The colony would remain dependent on imported overseas nurses for several decades after plague was no longer a major health issue. Despite links with the nursing schools of King's College Hospital (KCL) and University College Hospital (UCH) in London dating back to the 1870s, nursing in South Africa remained a profession fit only for British ladies of sufficient means, largely disdained by the Afrikaans community, and intellectually and financially inaccessible to the "coloured," Malay, Indian, and African populations.[194] After struggling to source reliable candidates locally, the 1901 plague outbreak prompted the Cape government to recruit twenty nurses from the London teaching hospitals in an attempt to ensure quality of care and maintain educational and training standards.

The primary focus of Section 6 ('Moral Boundaries, Colonial Transgressions') is on the experiences of the nurses dispatched to the Cape Colony during the plague epidemic. In particular, this section examines the case of Alice Darley, a nurse who died from a morphine overdose, and Margaret Robb Low, a nurse who was purportedly raped by a "native". These episodes are used to reflect more broadly on how the plague drew attention to the contested nature of colonial nursing and exposed latent tensions within the metropolitan ideal. This section also suggests the extent to which colonial power may be linked to the policing of race and sexuality, and how a crisis episode created conditions in which the integrity of the colonial self was challenged. This intimate connection between

[194] The term "coloured" is used throughout this thesis in a South African context, just as it is in numerous contemporary scholarly works. While the continued use of a label with such complicated historical and cultural meanings is problematic, it is not the aim of this thesis to unpick terminology which, given the focus of this work, is peripheral.

nursing and racial thinking is drawn out to suggest how colonial nursing identities were produced by specific disciplinary regimes.[195]

For the twenty British nurses specifically recruited during the plague outbreak in the Cape Colony, their temporary government contracts offered not only the potential for adventure, but also represented, for some, a calculated move towards individual professional advancement of the kind usually associated with colonial doctors. Appointments like those at the Maitland Plague Hospital represented rare opportunities to further education, gain practical experience, assume leadership roles, and attain the patriotic and professional distinction often associated with such posts. These opportunities were uncommon in peacetime. All of these factors could be utilised to lever increasingly senior positions elsewhere in South Africa, back in Britain or in other colonies, and numerous examples of this strategic colonial careering are included later in this chapter.

In reality, colonial nurses were often held to impossibly high standards and received limited support, even during events, such as disease outbreaks, that strained existing medical infrastructures. Plague nursing in South Africa placed nurses in situations that were physically dangerous and emotionally isolating. Infection and death were among the potential risks confronted by all medical professionals working in plague hospitals. Yet nurses also faced distinctly "female" dangers, including accusations of sexual impropriety and threats of rape, which were enough to ruin reputations, careers, and lives. The experiences of the nurses who worked through the Cape Town plague outbreak evoked the deepest fears of

[195] See, in this context, the arguments made about race, sexuality and the "bourgeois self" in Ann Laura Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (Durham, NC: Duke University Press, 1995).

the medical and colonial authorities surrounding white women working in a colonial setting, often at the very "frontiers" of empire. Many of these fears stemmed from the hypothetical outcomes of prolonged contact between different racial bodies.

3.2 The Cape Colony

Scholars of South Africa agree that the colony was not financially viable before the discovery of diamonds and gold.[196] Initially, the Cape Colony was a slave-owning outpost three months sailing from Britain. It was useful only as an African military base and presented a welcome stop on the long but profitable trade routes between Europe and Asia. Around 25,000 Dutch, German, and French Huguenot settlers occupied over 100,000 square miles of territory. They were dependent on the labour of imported slaves and a sub-class of indigenous workers. When the British annexed the Cape from the Dutch East India Company (*Vereenigde Oost-Indische Compagnie* or VOC) in January 1806, Cape Town had a relatively small population of 16,000. However, the discovery of what are still perhaps the richest deposits of diamonds in the world in 1867, and of gold in 1886, attracted migrants from the African interior, Europe, Australia, Argentina, and Asia. The resulting rush was bolstered by the fact that the country was also rich in copper, iron, chrome, and uranium, and possessed the navigable road, river, and rail networks that would allow for large-scale mining and exportation of such spoils.

[196] Martin Meredith, *Diamonds, Gold and War: The Making of Modern South Africa* (London: Simon & Schuster, 2007), pp.1-3.

A number of historians, including Randall Packard, have argued that the exploitation of the goldfields was a key factor in the expansion of healthcare services in South Africa.[197] Shula Marks has likewise connected the discovery of rich mineral deposits directly with the growth of the nursing service from the 1870s onwards. Changing patterns of disease, she maintains, highlighted the need for the kind of hospital care offered by trained professionals then enjoyed in the United States and Britain.[198] Charlotte Searle, in her efforts to link developments in South African nursing with the legacy of Nightingale, has gone so far as to claim that conditions in the goldfields mirrored those in the Crimea: both presented an attractive prospect for nurses and were vital in fostering a professional self-identity. While such contentions are perhaps debatable, the growth of the South African healthcare service, including institutional nursing, was certainly driven, at least in part, by the economic expansion of the country.

By 1899, the seam of gold near Witwaterstrand was producing nearly 30 percent of the world's gold, contained sixty million pounds of British investment, and employed some 100,000 Africans across the various mining companies.[199] When workers abandoned their posts during disputes over poor pay, illegal searches, and substandard living conditions, some 63,000 Chinese workers were imported, many passing through Canton and Hong Kong on their passage to South Africa. As capital of the Cape Colony, Cape Town still contained only a tiny proportion of the total number of British émigrés, overseas investment, and

[197] Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Healthy and Disease in South Africa* (Berkley: University of California Press, 1989).
[198] Marks, *Divided Sisterhood,* p.16.
[199] Leonard Thompson, *A History of South Africa* (New Haven, CT: Yale University Press, 2014), p.120.

international trade by the time the plague arrived, despite the fecundity of the diamond and gold fields.

Yet empire-building, particularly permanent settlement, was still viewed as an economic and moral necessity. The British chose to retain a regular military presence in the region from 1811 in order to protect economic and strategic interests. They also attempted to protect the eastern frontier and encourage British emigration through economically sponsored migration aimed at reducing the prevalent unemployment and social unrest after the Napoleonic Wars. Parliament voted £50,000 for the process, selecting 4,000 men, women, and children from over 80,000 applications. The "1820 Settlers" as they are known—the first large group of British settlers in the colony—did not prosper, however. A lack of farming experience, poor soil, and harassment on disputed territory drove most back to the villages, or home to Britain within a few years.

Leonard Thompson offers a useful comparison when envisioning the role of Cape Town within Britain's extended overseas networks: in 1870, the United States contained 32 million people of European decent and 53,000 miles of railroad, whereas South Africa held 250,000 white people and 70 miles of railroad.[200] The white population was dependent on imports of basic items, such tea, coffee, and flour. Thompson also notes that imports were only worth £3 million a year and exports, which were comprised largely of wool and ostrich feathers, were worth significantly less. The revenue of the four white states came to £750,000 a year, around 75 percent of which came from the Cape Colony. Cape Town had a population of 50,000; around half of whom were white, and no other

[200] *Ibid.,* p.53.

city was anywhere near comparable in size. However, there were ten times as many Africans in the area now covered by the modern Republic of South Africa, with many of that number living in independent territories surrounding existing "European" states and territories.[201] Thomson describes the Cape Town of 1870 as "an imbroglio of peoples of disparate African, Asian, and European origins and cultures."[202]

This vast yet frequently unwilling labour pool, coupled with the existence of manufacturing industries in the around surrounding Cape Town, allowed the colony to take advantage of the mineral boom fuelled by industrialization. By 1900, Cape Town, the oldest European settlement in southern Africa, also boasted the largest port and most extensive rail links across the wider hinterland. Thus, by the time the plague arrived in Cape Town, the colony—and South Africa in general—had undergone what was perhaps among the most rapid periods of change in its history. Tensions over land and labour, inflamed by differing ideological assumptions and cultural perceptions, had been further exasperated by the discovery and exploitation of large quantities of gold and diamonds from the interior.

The population of Cape Town in 1901was diverse, and included expelled Russian Jews, Argentine *gauchos*, British and other foreign *uitlanders* expelled from Afrikaans provinces at the start of the Second Boer War, coloured Malay Muslims that comprised about 20 percent of the total population, a small number of East Indians, and *skollies*—homeless members of the coloured community.

[201] *Ibid.,* p.108.
[202] *Ibid.,* p.109.

Wealth facilitated segregation, and the *uitlanders* who had previously been mining magnates enjoyed an entirely different lifestyle to that of other émigrés. Despite the recent disturbances of the Second Boer War, Cape Town also contained a significant Afrikaans population, decedents of the seventeenth-century Dutch settlers and inheritors of a unified cultural identity and written language from the late nineteenth century onwards. However, the Afrikaans population remained small, with most continuing to live in the Transvaal and Orange Free State.

One growing sector of the community was that of black Africans, originally from the eastern Cape or Transkei. Some were urban residents, some displaced by war and some were migrant workers, attracted by the potential economic opportunities of the port city. This group, comprising Xhosa, Mfengu, Tembu, and people from other locations, often exhibited strained relations between the different social factions. Despite the fact that the city's commerce was dependent on these itinerant "kaffirs," they resided at the bottom of the social pyramid, living in the worst housing and, as a result, being disproportionately impacted by disease. Kaffirs, mixed farmers whose descendants are now referred to as Africans, were to be distinguished from the no less inelegant terms of "bushmen," hunter-gatherer groups and ancestors of today's San people, and "Hottentots," pastoralists who are now referred to in historical texts as the Khoikhoi. The latter two groups rarely became urban workers and almost never feature in plague records as a result.

Conditions were made worse in similar ways to those observed in Hong Kong, through the unwillingness of landlords to spend any more than necessary on overcrowded dwellings, and the desire of many migrant workers to save as

much money as possible to send home to their families. While a Clean Party did exist in the Municipal Council of Cape Town, advocating British ideas of sanitary practice, the public works they instigated were focused on the central business district (CBD), for example the building of a tramway. Black neighbourhoods remained filthy and maligned. In 1901, District 6, the most populous in the city, contained a third of the city's residents yet garnered just five percent of civic spending.[203]

3.3 Local Limitations and Overseas Dependency: The Development of Nursing in South Africa

Nursing historians and successive senior members of the South African Trained Nurses Association (SATNA), founded in 1914, have been keen to note that South Africa was the first location in the British Empire to demand some form of professional registration and standardization.[204] Nurses were required to be registered in the Cape Colony as early as 1891 (in contrast, as noted in the previous chapter, nurses were not registered in Hong Kong until 1931). However, Cape Town's plague epidemic demonstrates that such markers of professionalization were intermittently implemented and limited in scope.[205] In

[203] Echenberg, *Plague Ports*, p.276.
[204] While few critical histories exist exploring the later development of nurse training in South Africa, see however Anne Digby's *Diversity and Division in Medicine: Health Care in South Africa from the 1800s* (Oxford: Lang, 2006); Marks's *Divided Sisterhood*; and Helen Sweet's '"Wanted: 16 Nurses of the Better Educated Type": Provision of Nurses to South Africa in the Late Nineteenth and Early Twentieth centuries,' *Nursing Enquiry*, vol.11, no.3 (2004): 176-184.
[205] Previously, the only professional associations that South African nurses could belong to were the individual branches of the Royal British Nurses' Association (RBNA) in places like Kimberley and Cape Town, thereby strengthening ties between the colony and the metropole, and helping to ensure that professional self-identity in South Africa was constituted in relation to these links. Examples of the tendency to cite South Africa as the first location to require nursing legislation include Brian Abel-Smith, *A History of the Nursing Profession* (London: Heinemann Educational

1901, professional nursing in South Africa had no roots and little influence outside of urban centres. It struggled to attract suitable regional candidates of sufficient quality, particularly from non-English speaking communities, and was yet to form a local professional self-identity, a situation that was not helped by its dependency on overseas practitioners, particularly for senior, or teaching posts or during events the Cape government perceived as potential crises.

As in Britain, even after the arrival of professional nurses, South African hospitals remained largely the preserve of those who were too poor to afford care in private residences or at the homes of their physicians. Hospitals were often run by a superintendent and a matron, usually a married couple who lived on hospital grounds. Care was undertaken by unskilled attendants who were predominantly male and white, or non-white in equal measure. Convalescent patients were also expected to help care for their sicker counterparts. Crisis episodes, such as the arrival of plague or the outbreak of the Second Boer War, were exceptional influences on the expansion of institutional care that made it necessary to establish temporary quarantines and makeshift hospitals with specific functions and infrastructures in an attempt to manage new and largely unexpected demands.

Although Thompson maintains that midwives in the employ of the Dutch East India Company were among the first women in the colony, and the only female members of staff on the company payroll, these individuals were limited in

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Books, 1960); Linda C. Andrist, Patrice K. Nicholas, and Karen A. Wolf, eds., *A History of Nursing Ideas* (Sudbury, MA: Jones and Bartlett Publishing, 2006); Monica E. Baly, *Nursing and Social Change* (London: Routledge, 1995); Patricia D'Antonio, Julie A. Fairman, and Jean C. Whelan, eds., *Routledge Handbook on the Global History of Nursing* (London: Routledge, 2013); Charlotte Searle, *A History of the Development of Nursing in South Africa, 1652-1960* (Cape Town: Struik, 1965).

number and represented nothing more than the early presence of amateurs with varying levels of skill.[206] As in Hong Kong, the European community was initially dependent on an improvised system of care (at least outside the home) that varied in terms of quality of service. In some areas, it was supported by religious orders, including the Anglican Church in Cape Town and Bloemfontein, and the Roman Catholic Church in Johannesburg.[207]

Marks contends that as in Britain, the history of modern professional nursing in South Africa is strongly identified with a heroic founder. The impact of Sister Henrietta Stockdale (1847-1911), who outlined training standards and a founding charter, and established the first South African nursing school at Kimberley in the 1880s (discussed at some length in Chapter 5 of this thesis) is compared to the influence exerted by Florence Nightingale on British nursing. There was evidently great need for a nursing facility in the frontier town of Kimberly, where annual death rates in the 1880s were over 40 for every 1,000 persons among the white community and 100 for every 1,000 persons among non-whites, largely as a result of intestinal infections or respiratory ailments like pneumonia, miners' phthisis and tuberculosis, in addition to the dangerous nature of mining as an occupation.[208] Stockdale was a pro-imperial Anglican nun who never considered training black women as nurses. Her approaches and beliefs

[206] Thompson, *A History*, p.40.
[207] For a more detailed examination of the impact of religious orders and missionary medicine on South African nursing, see Helen Sweet, 'Mission Nursing in the South African Context: The Spread of Knowledge during the Colonial and Apartheid Periods,' in Ellen Fleischmann, Sonya Grypma, Michael Marten, and Inger Marie Okkenhaug, eds., *Transnational and Historical Perspectives on Global Health, Welfare and Humanitarianism* (Kristiansand: Portal Books, 2013), pp.137-155 and 'Expectations, Encounters and Ecclesiastics: Mission Medicine in Zululand, South Africa,' in Mark Harrison, Margaret Jones, and Helen Sweet, eds., *From Western Medicine to Global Medicine: The Hospital Beyond the West* (Hyderabad: Orient Blackswan, 2009), pp.330-59.
[208] Marks, *Divided Sisterhood,* p.24.

were actually closer to those of the founder of the BNA, Mrs Bedford Fenwick. However, Marks states that the Nightingale analogy has often been useful when mediating change and conflict in South African nursing.[209]

Stockdale's medical knowledge was far from exhaustive but she had received some tuition at Clewer Hospital and Great Ormond Street Hospital in London, and she did supplement this training at UCH when she returned home briefly in 1877 after contracting a fever. In London, she also encountered colleagues training from the Order of All Saints, an organization that had already assumed many of the nursing duties at UCH and the New Somerset Hospital, as well as those who intended to pursue private nursing as a career.

One result of these efforts was that the majority of the probationers at the Kimberley Hospital came from Britain, indicating a degree of affluence which separated these candidates from the average British nurse of the time who, she argues, was far more likely to be drawn from the working classes.[210] A steady stream of British-born nurses and probationers allowed Sister Henrietta in the Eastern Cape to slowly replace the early untrained matrons and hospital helpers. This process was not mirrored in Cape Town itself, where links between UCH, the Order of All Saints, and the Somerset Hospital were strengthened after the arrival of Sister Mary Agatha, a friend and college of Sister Henrietta, and the successor

[209] Marks, *Divided Sisterhood,* pp.14-5. The image of Stockdale as South Africa's Nightingale has been reinforced and strategically employed by other nurses and historians of nursing, most notably by Charlotte Searle, a tendency that often occurs at milestone moments of commemoration for nursing in South Africa; see *A History of the Development of Nursing*; *Ethos of Nursing and Midwifery: A General Perspective* (Durban: Butterworth-Heinemann, 1987); *Selected Aspects of Nursing* (Durban: Butterworth-Heinemann, 1989); *Towards Excellence: The Centenary of State Registration for Nurses and Midwives in South Africa, 1891-1991* (Durban: The South African Nursing Council, 1991); and *Professional Practice: South African Nursing Perspective* (Durban: Butterworth-Heinemann, 1983).
[210] Marks, *Divided* Sisterhood, p.32.

of Sister Bowden, as matron in 1886. Although it was necessary to maintain a supply of trained British nurses, efforts to raise the status of the profession attracted sufficient numbers of locally born probationers. However, as has already been noted, nursing graduates tended to prefer urban placements and were disinclined to undertake challenging work like plague nursing, leaving some locations and nursing specialities understaffed.

By the 1890s, there was a well-established, informal network of nurses moving between Britain, South Africa, and other colonial locations. This network was fortified by connections between individuals and institutions, like those between UCH and the New Somerset Hospital, rendering it more than a little nepotistic in character. The network also allowed institutions to remain dependent on overseas nursing and locally short-handed, yet it also provided a mechanism to meet this shortfall during periods that pressurised existing medical infrastructures, for example during the plague epidemic.

Despite these shortcomings, by August 1896, the *South African Medical Journal* was celebrating this apparent transition from an ad hoc collective of partially trained amateurs—the majority of whom came from religious orders—to a comprehensive network of systematically trained nurses. This shift was understood to reflect a biomedical revolution in healthcare:

> That of nursing the sick is no longer the monopoly of the ignorant, baneful and sordid, but has passed into the hands of intelligent and trained women, who volunteer for this vocation from all ranks of society but the lowest, is one of the grandest facts which exist at the close of this century of progress…the practice of surgery, with its present perfections and the treatment of disease in all its minute

> details, could not have won their many triumphs if the evolution of the nurse had not kept even pace…[211]

This triumphalist rhetoric, which placed South Africa's nurses on a par with their colleagues anywhere in the world, disregarded the fact that in the decade before plague arrived in Cape Town there were complex legal, cultural, and socio-political reasons why the colony was still dependent on recruiting practitioners from overseas despite a readily available local labour pool.

From 1889, Stockdale began campaigning for the inclusion of nurses and midwives in planned legislation for the reorganization and registration of the medical and pharmaceutical professions.[212] Supported by the medical fraternity and Cape government, these proposed changes would mean that nursing and midwifery would be standardized, at least to a theoretical extent, under the 1891 Medical and Pharmacy Act. The Colonial Medical Council would then control the syllabus, examination and certification of nurses. Consequently, it would retain practical jurisdiction over entry to the profession, as nurses who did not possess this certificate could not be added to the official register. The Act contained no measures to impede those who abused these guidelines, it simply allowed qualifications to be verified via the register.

The 1891 Medical and Pharmacy Act, passed as part of an extensive reorganisation of Cape Town's public health services, was the specific piece of legislation that led generations of SATNA presidents and nursing historians to

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[211] Walter T. Harris, 'Nursing,' *South African Medical Journal* (August 1896), p.95.
[212] Searle argues that Stockdale's campaign was facilitated by her personal connections, not least with Mrs. Bedford Fenwick; see 'South Africa Celebrated 100 years of State Registration of Nurses and Midwives 1891-1991,' *Nursing RSA Verpleging*, vol.6 (1991), p.7.

claim that South Africa was the first place in the world to have standardized, professionally educated, registered nurses.[213] It proceeded through the colony's empty parliament in less than an hour and faced little resistance. The only two members of the Legislative Assembly to disagree were Dutch, although their arguments focused on midwives, as many were concerned that the Act would prevent women from attending their neighbours in rural areas where there had never been enough skilled doctors and nurses. Objections were perhaps so limited because amateur practitioners in these areas lacked the opportunity or resources that would allow them to express their protestations. In Cape Town, the majority of the medical establishment was British and, as they were in the process of acquiring local registration and independently verified professional status themselves, it is likely that they saw trained European nurses as their natural assistants and a necessary step when attempting to raise the overall standard of healthcare in the colony.[214] Support for the Act was unsurprising given that medical men, as part of the Colonial Medical Council, now had complete control over nursing education and registration. Despite recommendations to that effect, no trained nurses sat on the nursing council or examination board, and none were present when the oral and written examinations required for registration were

[213] The first registered nurse in South Africa, and therefore the first registered nurse in the world, was Sister Louisa Jane Barrett, who had been trained at the Kimberley Hospital and was registered in July 1892.

[214] Cape medical practitioners had originally constituted a branch of the British Medical Association but in 1893 they held their first colony-wide congress and launched the *South African Medical Journal*. A South African Medical Association had been proposed in 1892 but it was not actually formed until January 1897.

conducted. This situation would remain unchanged until 1928, when the first nursing and midwifery representative was elected.[215]

The decision to demand nursing registration was reinforced by an 1899 Act of Parliament in the Natal. Collectively, this legislation marked a centralization of the profession, as certificates would no long be awarded by individual schools but by a single examining body that also designed the syllabus. Those trained before the ruling who neglected to then take their diplomas would subsequently find it difficult to gain employment in institutions and private homes around Cape Town, regardless of the amount of training or experience they already possessed. However, there remained no way of preventing or penalising the behaviour of women who claimed to be "trained nurses", nor removing a nurse's name from the register in the event of misconduct. Different registers were also kept in different regions, making cross-referencing difficult if not impossible. The Act also had little influence outside urban centres, where unqualified nurses could find work without difficulty, and shortages of trained practitioners meant that those in rural communities would continue to be largely dependent on unqualified amateurs, partially qualified nurses or home care for decades to come, if they had access to any nursing at all. This forced many medical men, in the words of the *South African Medical Journal*, to employ "Nursing Helps" as "fully tried nurses are impossible to procure."[216] The Act helped to further polarise the standard of nursing care in urban and rural areas, was perhaps one of the many reasons why healthcare in

[215] The South African medical press indicates that it was felt by many that any issues in nursing that might arise could be ably handled by medical and pharmaceutical representatives; Harris, 'Nursing,' p.95.
[216] Harris, 'Nursing,' p.139.

some areas of South Africa remained subpar for so long and contributed to the need to recruit additional British nurses during the plague epidemic.

While the Act ostensibly created equality among practitioners it actually favoured British graduates and made entry requirements prohibitively difficult for the majority of Afrikaans and non-white women, many of whom had not studied English as a first language or could not demonstrate sufficient levels of schooling or literacy. Yet it also penalised British women as another of the initial problems with the Act was that it disqualified nurses from the UK who were already working in the Cape because most had not undertaken two years training at a local school approved by the Council.[217] One British nurse went on record as claiming it was not only detrimental to the healthcare of the colony but also discouraged British women from travelling there to work:

> I could understand if the nurses crowding from Europe were taking work from the colonial trained nurses; but that is not the case; the supply is not equal to the demand, and I must say it is most discouraging to those who bring the experience of years of work to the service of the Colony, to be degraded at once from their position of trained nurse…[218]

[217] The *South African Medical Journal* contains numerous examples of the detrimental impact of the Act in the form of qualified British nurses who were prohibited from working, and unqualified amateurs masquerading as nurses. These included a previously hysterical patient dubbed "J" who then reappeared resplendent in nursing costume after "reading a small book", a partially illiterate cleaner and tea lady from a Natal hospital known as "H" who continued to work as a nurse despite maiming a patient, a woman referred to as "N" who claimed to know more than doctors and represented "a distinct class of amateur nurse, namely, those who think that every woman is qualified to nurse the sick," and "M," a woman who fabricated not only her qualifications but also familial links to eminent medical men as the editor believed it was "characteristic of the *pirate* nurse to possess great powers of romancing." No less disgruntled was the "British Trained Nurse" who submitted a letter to the same issue of the journal who, despite having studied and worked in various locations in the UK and Ireland for fifteen years, was unable to secure work without retaking the exams she had been guiding probationers through for over a decade; Harris, 'Nursing,' pp.139-40.

[218] Harris, 'Nursing,' p.140.

Once these difficulties had become apparent, the *South African Medical Journal* raised an objection to this complication, stating in August 1896 that, "the demand for nurses if very large and by no means met by the supply, and it is equally important that a good nurse shall not be held back from employment by bonds of red tape."[219] The issue was persistent and was again noted and shelved at a regular meeting of the Cape Colony Medical Council in 1907, when Dr Gregory and Dr Darley-Hartley asked for the council to be able to register overseas diplomas, "if obtained by *bona fide* Colonial students."[220] While training places were now limited to a handful of opportunities in a few preapproved schools, the real issue was going to be attracting candidates deemed suitable to fill those places.

However, what the Act actually did was create a veneer of propriety that barred nurses from controlling their own education for decades, penalised potential applicants from almost all backgrounds for various reasons, limited the supply of qualified nurses to such an extent that it would still be an issue in many areas for decades, and failed to achieve its aim of removing unskilled amateurs. This complex entanglement of legal requirements and practical outcomes was again highlighted by the Cape Town plague outbreak, as the Cape government, despite attempting to prepare well in advance of the outbreak, was still required to recruit twenty nurses from Britain in order to meet the local shortfall of appropriately qualified staff. Their short-term contracts, strict terms of service

[219] Harris, 'Nursing,' p.95.
[220] While there is ambiguity in the author's use of the term "colonial" it is perhaps reasonable to assume that, given the context, the committee was referring candidates who had graduated from recognised hospitals in white colonies; see 'Cape Colony Medical Council,' *South African Medical Record*, vol.10 (1907), p.77.

and concerns surrounding the potentially dire consequences of the epidemic meant that the government were forced to exempt these particular nurses from the legal requirements that had, perhaps, initially necessitated their recruitment. Despite the best efforts of Sister Henrietta Stockdale and her colleagues, by the time plague arrived in South Africa the country was left with a fragmented and partially regulated nursing profession that was still required to recruit a significant proportion of its practitioners from overseas.

One alternative to recruiting from overseas was to train sufficient numbers of non-white nurses, a strategy which would, hypothetically, create symbolic sanitary pioneers for their respective communities and relieve white nurses of the burden of caring for black patients, work that, as shall be seen earlier in the chapter, made many members of the colonial and medical establishment distinctly nervous. There was certainly a strong healing tradition among the women of indigenous populations. As in Hong Kong and China, the nursing function was performed by female members of the extended family when necessary. Further therapeutic measures were habitually orchestrated by the *isangoma* (the Zulu term for a divine healer but an adopted term in all South African languages, a person also referred to as an *igqira* in Xhosa), who diagnosed illness usually caused by either a vengeful ancestor or enemy, and the *inyanga* (herbalist), who provided treatment via the knowledge of hundreds of native medicinal plants. Either practitioner could be equally male or female. Europeans regularly viewed such practices with condescension, believing they were enacted out of superstition and ignorance, soon to be abandoned once European science had shown the non-white population the correct curative path. Instead, a process of

adoption and adaption allowed both western biomedicine and traditional healing practices to exist simultaneously and in some cases symbiotically, as they continue to do in many parts of South Africa today.[221]

While proposals for training non-white nurses were being developed, in some circumstances African men and women had already received enough training to allow them to undertake supporting roles, particularly when conditions like the South African War created an increased demand for practitioners, especially in areas where access to institutional care was difficult. However, much like in China, it was missionaries, convinced that medicine was a tool of civilisation and salvation, who trained the first black nurses at the beginning of the twentieth century. In the Eastern Cape, Dr Neil Macvicar (1871-1949) of the Free Church of Scotland recruited the first non-white nurses, believing they would become superior examples of womanhood within their communities, thus helping to combat credulous practices and embody, as nurses were often expected to do around the world, the prominence of European sanitary ideals. For pragmatic reasons any expansion of black healthcare would necessitate both the training of black nurses and the intervention of missionary groups, not least because white ratepayers and the captains of South Africa's fledgling industries were not prepared to meet the cost despite the fact that white business were entirely dependent on the health of their black workers.

[221] For example, in contemporary South Africa, Jonny Steinberg has conducted a revealing study about how communities encounter illness, focusing on the relationship between indigenous healing practices, most notably the role if the *isangoma*, the government and NGOs (specifically Médecins Sans Frontières) in the Eastern Cape during the ongoing AIDS epidemic; Jonny Steinberg, *Three Letter Plague: A Young Man's Journey through a Great Epidemic* (London: Vintage Books, 2008).

Moves to recruit non-white nurses specifically within the Cape Colony began less than two decades after Sister Stockdale's arrival in the country. In December 1897 Walter T. Harris, Resident Surgeon at Port Elizabeth's Provincial Hospital and editor of a monthly column on nursing issues, expressed his hopes in the *South African Medical Journal* that the recent recruitment of a qualified matron at his hospital, as well as the establishment of a new nursing school, would mean that the hospital was now, "capable of preparing many colonial girls, not only for the examination of the Medical Council, but to become really good nurses, alike fit for the duties of their *Alma Mater* and to supply the growing demand for nurses in South Africa."[222] He considered this the "principal need of the Hospital" as previously, "some of the hundreds of well-informed and brought-up women who are constantly volunteering as probationers" remained untrained. The hospital had no need for a matron who could instruct them as the existing nursing staff, who were "perfectly trained and long experienced nurses from some of the finest schools in the world," were as a result, "too conversant with their work to require instruction." However, this situation would have to be rectified if the hospital, which was at that point the third largest in the colony, was ever to expand.[223] Harris' belief that the existing pool of potential female "colonial" labour was underutilised was certainly valid. Once training schools of a sufficient standard had been established in other colonies, nursing proved an extremely popular career choice. When Australian nursing pioneer Julia Ellen "Nellie" Gould became

[222] It must be noted that Harris' use of the term "colonial girls" here is ambiguous and could refer to non-white nurses in South Africa or those of British or Afrikaans families who were born in the country. However, given the relatively liberal views Harris expresses later in this chapter, coupled with the tendency to view even white South Africans as "European" in some circles, it can reasonably be assumed that he was referring to non-white nurses and probationers.
[223] Walter T. Harris, 'Nursing at the Provincial Hospital, Port Elizabeth,' *South African Medical Journal* (December 1897), pp.213-4.

matron and superintendent of the training school at the Sydney Hospital in 1891, around six hundred women applied for just thirty training places.[224]

The first black nurses to pass the Nursing Certificate of the Cape Colonial Medical Council did so in 1907, although it would be many years before notable numbers of non-white colleagues would be able to follow them. Cecelia Makiwane and Mina Colani were handpicked for their candidature by Miss Mary Balmer, matron of the recently reopened Victoria Hospital in Lovedale in the Eastern Cape. Balmer had arrived in February 1903 to assist Macvicar, who had previously had some success training African Christian men as medical attendants and dressers in Malawi. The Victoria Hospital had been created by the Cape government as a treatment centre for black and indigent white patients, although it was this inclusive admissions policy that would eventually undermine schemes to train black nurses. White patients, regardless of their social background, would habitually demand to be seen first and refused attendance by black nurses, many of whom were also sexually propositioned by patients unable to distinguish between qualified professionals and the subjugated positions black women were frequently reduced to in the wider colony. Eventually, after probationers threatened to run away and Matron Balmer considered resignation, white admission was curtailed.

By 1906, the Cape Colonial Secretary recognised the impracticality of running an integrated hospital as even some of the most liberal practitioners were starting to embrace segregationist sentiments as while Medical Officers of Health advocated that black nurses be allowed to care for lower class male patients, or

[224] Schoeman, *Angels of Mercy*, p.24.

white women and children, hospital authorities preferred dividing entire premises. However, as shall be seen later in the chapter, debates surrounding interracial contact between nurses and patients were strongly gendered, rarely straightforward, influenced by the context and setting in which these women were expect to work, and seldom originated from objections raised by the nurses themselves. There were attempts to train black nurses in other areas, for example at the hospital established for Africans on the Berea in Durban, by Dr James McCord of the American Zulu Mission. By 1910 McCord had trained four nurses—Elizabeth Njapa, Nomhlatuzi Bhengu, Julia Magwaza and Dina Mzoneli—although the hospital was only recognised as a training school in 1924. At this point black nurses were perhaps more symbolic of the fact that training non-white nurses was possible, rather than a pragmatic solution to staffing shortages.

Even after the first black candidates had completed their training and gained employment, thus partially smoothing the way for women who might choose to follow them, numbers of black nurses remained low for numerous reasons. Alongside the concerns of poor salaries, long hours, substandard living conditions, difficult training, authoritarian hospital routines and the fact that they were expected to pack study, lecture attendance, eating and sleeping into their limited free time, black nurses also faced narrow promotion prospects and the potential for racism among their predominantly white, English-speaking superiors. Nevertheless, they were held to the same rigorous standards as their

white colleagues, despite the fact that by the 1920s, there was a clear disparity in living conditions for white and non-white probationers and nurses.[225]

Nor was the instruction of black male nurses considered as an alternative. Dr Macvicar's original experience with black orderlies in Malawi had been positive, as it was elsewhere in colonial Africa, and he had intended to train black male nurses and orderlies at the Victoria Hospital. While Macvicar had envisioned a medical course to be taught at the black University College at Fort Hare, he was forced to abandon such notions as even if early black male practitioners remained in a subordinate position to their white colleagues in terms of dispensing, vaccinating and interpreting, district surgeons still feared the competition that could potentially arise if these men established their own clinics, just as many European doctors and nurses had feared the encroachment of partially trained non-white female nurses. Another proposal from the Natal, which would create a separate system for black men and women to work as nurses and midwives under government licence, yet confine them to working only among their own people, was rejected for similar reasons. These early male black practitioners would remain confined to unlicensed orderly work, where their qualifications were disregarded and their wages gradually decreased. However, in the opinion of the *South African Medical Journal*, doctors need not fear a similar situation occurring within the nursing profession because the nurse would always remain subservient to her (male) medical colleague and thus could be protected from

[225] There is a tendency among some historians of nursing in South Africa, most notably Charlotte Searle, to entirely disregard the difficulties faced by non-white nurses, as well as the legal, social and economic issues restricting the early development of the profession, instead preferring to characterize it as immediately successful, always able to meet patient needs and continually expanding and improving. See, for example, Searle, 'South Africa Celebrated 100 years of State Registration of Nurses and Midwives 1891-1991,' *Nursing RSA Verpleging*, vol.6 (1991), pp.6-8.

malpractice and the temptation of unscrupulous competition; "The nursing profession, honourable as it has become, is but an adjunct of the medical and the individual nurse is always a subordinate officer; therefore there is no need for such stringent exactions."[226]

Objections to the training of non-white nurses did not originate entirely from the European community. African families were equally displeased at the prospect of allowing their daughters to study nursing. As they had been during the early development of nursing in Europe, many of the tasks performed by nurses were considered to be improper work for well-bred African ladies, from the cleaning of wards to the washing of patients. In other areas, where men were increasingly forced to leave villages to find work in white industry, the labour of daughters became vital for sustaining agricultural production. There was also a conflict of ideals as marriage was an integral part of intercommunal relations in African society yet nursing required nurses to be, in theory at least, unmarried.

Nor was it any easier to recruit candidates from Afrikaans communities despite a clear need for nurses in these areas. Nursing was initially not considered an appropriate vocation for cultivated Afrikaans women, who were raised with the expectation that they would become housewives. Although some Afrikaans women had trained with Sister Henrietta as early as 1886, it was only in the 1920s that nursing began to be seen as an appropriate profession for unmarried Dutch women (married women would be banned from hospital employment until World War II, although this legislation was not always easily or willingly enforced). Nursing embodied the ideals of self-sacrifice, determination, service and

[226] Harris, 'Nursing,' p.95

compassion, and, as Afrikaans women set out to transform rural healthcare with alacrity, it was also rendered a patriotic vocation. The religious, devotional and moral roots of nursing assisted in its rebranding among the Dutch community. However, the number of Afrikaans nurses, frequently drawn from the tiny Afrikaans middle-class, would remain low as many girls married young and spoke English, which all training was still conducted in, as a second language if they spoke it at all. Families were disinclined to send their daughters far from home alone, limiting the access of many to large training hospitals in urban centres. Reform was unlikely as, once qualified, Afrikaans nurses were often barred from advancement as promotion required further overseas, preferably British, qualifications. This allowed British nurses to dominate the top tiers for the profession, particularly at the large teaching hospitals. It was not until the 1930s that Afrikaans nurses began to enter the profession in any number and tensions would remain between the two groups, with the British characterising the Dutch as primitive and insanitary. These tensions were reinforced by a continuous stream of recruits from Britain, many of whom were encouraged to settle in an attempt to rebalance gender ratios in some areas.

3.4 Preparing for the Inevitable: Plague Arrives in Cape Town

Much like in Hong Kong, responses from local sanitary authorities to plague in Cape Town were influenced by racial prejudices and practical concerns stemming from the wish to manage rapid "native" urbanization and the unrestricted movement of the indigenous labour force. The plague outbreak functioned as an opportunity to enact policies designed to combat longstanding civil concerns.

While these changes may have happened eventually, plague certainly catalysed the process.

The Cape government, accustomed to handling instances of contagious disease, including smallpox epidemics (there had been a major outbreak of smallpox in 1882) had proposed several schemes to help contain the illness. These precautions, and the limited impact of the initial outbreak, meant that the actual scale of the problem was relatively controlled. The historian Elizabeth Van Heyningen has argued that the Cape government dealt with plague far more efficiently than earlier outbreaks because of a realistic appreciation of the situation and the employment of effective, though socially inflammatory, plague-fighting methods developed elsewhere, particularly in India, where many of Cape Town's plague doctors had recently worked.[227]

However, the plague did elicit panic and blame in relation to the insanitary nature of the aboriginal population. At the same time, panic helped to expedite restrictive domestic policies, most notably the creation of "native reservations," the removal of the majority of Cape Town's black population beyond the city's outskirts, and the extension of civic control over the Jewish, coloured, and Malay communities through the enforced cleansing of dwellings and property. There is an extensive literature examining the relationship between race relations, municipal planning, and disease in Cape Town, particularly the work of Maynard Swanson, van Heyningen, Marks, and Neil Andersson.[228] Racial concerns framed

[227] Elizabeth van Heyninge, 'Public Health and Society in Cape Town 1880-1910,' Unpublished PhD thesis, University of Cape Town, 1989.
[228] Maynard W. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909,' *Journal of African History*, vol.18 (1977): 387-410, and "Urban Origins of Separate Development", *Race* 10 (1968) 31-40; van Heyningen, 'Agents of Empire'; Shula Marks and Neil Andersson, 'Issues in the Political Economy of Health in Southern Africa,' *Journal*

the interaction between female European nurses and male indigenous patients. Several authors, most notably Norman Etherington, have explored colonial fears, particularly the spectre of rape, which influenced all interactions between white European females and the non-white male population.[229] However, as discussed later in the chapter, these fears were most apparent at times of political turmoil, particularly following the formation of the Union of South Africa in 1910. When the plague arrived in Cape Town, professionalism and charitable universalism prevailed over segregationist concerns. Nurses were expected to care for patients regardless of gender, race, or economic status.

Even contemporary sources recognized that the impact of bubonic plague on Cape Town was minimal. In 1904, the *BJN* noted that "in no town or district, except, perhaps, Port Elizabeth, has plague assumed any considerable proportions," although its continued presence in both the rat and human populations of Cape Town and Durban created the potential for further widespread outbreaks and remained a cause for concern in the opinion of the author.[230] By the time the initial 1901 outbreak had ended there had been 807 recorded cases and 389 deaths. In the white population there were 204 cases and 69 deaths, in the "coloured" 431 cases and 244 deaths, and among the African population 172 cases and 76 deaths.[231] Even if the very reasonable assumption is made that not all cases of plague were reported, comparisons with mortality rates

of Southern African Studies, vol.13 (1987): 177-86 and 'Epidemics and Social Control in Twentieth-Century South Africa,' *Social Society for the History of Medicine Bulletin*, vol.34 (1984): 32-34.

[229] Norman Etherington, 'Natal's Black Rape Scare of the 1870s,' *Journal of Southern African Studies*, vol.15, no.1 (1988), pp. 36-53; this is a theme that Etherington returns to in 'Colonial Panics Big and Small in the British Empire (1865-1907),' in Fischer-Tiné, ed., *Anxieties, Fear and Panic*, pp.201-224.

[230] *BJN*, vol.32 (2 April 1904), p.263.

[231] KAB Cape Town's *Mayoral Minutes* (1900-1901), pp.169-79.

in years immediately preceding the outbreak help contextualise these figures and indicate how demographically limited the impact of plague was on Cape Town. According to the 1896 Report of the Medical Officer of Health for the Colony, the entire white population of the Cape of Good Hope was 378,285, living alongside 671,737 "coloured" residents.[232] The mortality rate among the white community was 16.54 per 1,000 and 26.40 per 1,000 among the "coloured" community, but there were significant discrepancies between rural and urban mortality rates.[233]

Such figures are perhaps to be expected as the white community tended to succumb to infectious diseases within the urban environment, despite being able to afford better food and accommodation. Greater numbers of non-white people, while facing the same challenges, also worked in rural and inherently more dangerous posts in heavy industry, trade, manufacturing, and mining, increasing the chances of death by accident, injury or crowd diseases like tuberculosis—a situation that was compounded by limited access to healthcare.[234] George Turner, the then Medical Officer of the Colony, also believed insufficient sanitary

[232] Here the use of the term "coloured" as a racial clarification is ambiguous. While the term "coloured" was, and is, applied to a distinctive ethnic group of duel heritage individuals originally from the Cape region, Turner combines figures for white and "coloured" populations to created "totals for all races" in the colony. It is not clear if he uses the term "coloured" here to refer to all non-white residents (an unlikely occurrence as even at the time, "coloured" people were considered a specific ethnic group and the Cape Colony contained significant numbers of Chinese, Malay and Indian individuals, to whom this term would almost never be applied), or he was simply not able to collect and include data from other ethnic groups.

[233] For whites, the urban environment was more dangerous, with 3,451 (23.05/1,000) urban deaths to 2,771 (12.11/1,000) rural deaths. For the "coloured" community similar trends appear but in greater proportions, with 7,465 (46.60/1,000) urban deaths and 10,261 (19.95/1,000) rural deaths. KAB/CCP/4/10/2/3 Cape of Good Hope Public Health Reports 1897-1900, George Turner, 'Report of the Medical Officer of Health for the Colony for the Year 1896,' pp.4-6. Figures from Cape Town's first census, conducted in 1901, are not used here as they do not, unlike the annual reports of the Colonial Medical Officer, offer an overview of mortality trends and public health concerns over several years preceding the arrival of plague, data which allows comparison and contextualisation.

[234] For a more detailed discussion of mortality trends in South Africa see Randall M. Packard. *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkley: The University of California Press, 1989).

standards and practices were at least partially to blame for mortality rates. Much like the colonial medical authorities in Hong Kong, Turner made repeated references to dirty water, improper disposal of household waste and night soil, overcrowding, dirty dwellings, and unsatisfactory reporting of infectious diseases.[235] After documenting the annual mortality rates of all thirty-two "chief towns" of the Cape, data divided by gender and cause of death, Turner asserted that the greatest threats to health in colony were typhoid, leprosy and venereal disease, lengthy discussions of which appeared annually in his reports alongside his regular diatribes on the poor sanitation of the Colony.[236]

However, these figures were made notoriously unreliable by continual economic migration in all communities and the fact that many industries, particularly those based around trade and mining, made residence in the colony necessary for only part of the year. No mortality or population figures were maintained at all, at this point, for the significantly larger African population, nor the rising numbers of Chinese, Malay or Indian people, even though the majority of Cape Town's trade, manufacturing and infrastructure was becoming increasing dependent on their labour.

Many of the plague cases in the white population arose later in the epidemic, when rats carrying infected fleas were driven from the slum districts by cleaning measures. The African population was statistically the least affected in terms of mortality. Civic authorities used these figures to validate their decision to remove the majority of Cape Town's black population to the new improvised

[235] KAB/CCP/4/10/2/3 Cape of Good Hope Public Health Reports 1897-1900, Turner, Report of the Medical Officer of Health for the Colony for the Year 1896, p.2.
[236] *Ibid*., Annexure XII.

settlement (or "township") at Uitvlugt. They were disinclined to consider other influencing factors, including the forced vaccination of the black population with the Haffkine serum, the access many white people enjoyed to better housing, food and medical care. Notwithstanding these factors, the "coloured" population were allowed to remain in substandard accommodation and were increasingly relied upon for dock work, bringing them into close contact with diseased rats and fleas.

Swanson and van Heyningen have convincingly argued that the black population was disproportionately the focus of sanitary policing to the extent that within this discourse of dirt and disease, bubonic plague and "native" became interchangeable, with one category standing in for the other. Issues surrounding public sanitation and urban planning, viewed in terms of class and ethnic differences in industrialised societies, were racialized in a colonial context, creating what Swanson terms a "sanitation syndrome." This shaped governmental policies, allowed illnesses like plague to be used as a justification for apartheid and segregationist ideology, attitudes which they argue originate in the Natal and Transvaal of the 1870s.[237]

However, for the population of the Cape as a whole, the impact of plague was demographically limited and mortality rates were comparable to those of previous years. It is more likely that, as Robert Peckham has suggested of Hong Kong, plague was perceived principally an economic threat, with quarantine measures curtailing vital trade.[238] However, unlike Hong Kong, Cape Town was

[237] Maynard W. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909,' *Journal of African History*, vol.18 (1977): 387-410.
[238] Robert Peckham, 'Infective Economies: Empire, Panic and the Business of Disease,' *Journal of Imperial and Commonwealth History*, vol.41 (2013): 211-37.

not entirely dependent on trade, and concerns about the fact that the illness might influence troop numbers or spread to other key sites for the British Boer War campaign, also had a significant impact on attempts to control the outbreak. There were fears that the mismanagement of the plague epidemic might undermine colonial authority, revealing vital infrastructural weaknesses.[239]

Despite the relatively limited number of plague cases—and public health legislation enacted throughout the 1890s that made the implementation of potentially extreme disease control methods relatively simple—Cape Town was initially unprepared for managing the epidemic. In 1891, a Health Department had been created and the first Colonial Medical Officer was appointed two years later. In 1894, a Births and Death Registration Act was passed, as was a Public Health Act in 1897. That Act had been developed partly in response to an outbreak of smallpox between May 1882 and March 1883 in which 4,000 people had died, mostly from the "coloured" and Malay communities. The Act made the reporting of infectious disease obligatory, which included plague after 1899, and stated that the Cape government was required to bear the cost of all medical emergencies – thereby incentivising the Cape government to manage infectious disease outbreaks competently and with alacrity in order to avoid spiralling costs - and allowed the health authorities to impose control measures they deemed to be appropriate, by force if necessary, including the power to relocate people in circumstances of "urgent necessity."[240] Gregory had also been to the Inter-State

[239] Arguably this is what happened in India, where the plague fuelled an incipient Indian nationalism. Echenberg contends that this was why the plague outbreak in Cape Town received more attention from the British press, both at home and in South Africa, than any other outbreak except perhaps that in India; see *Plague Ports*, p.292.

[240] Consequently, it was the Cape government that paid the salaries of any nurses engaged in plague work, so perhaps it is understandable that the Cape Town Archives Repository is replete

Plague Conference in Pretoria in February 1899, and observed suspected plague cases in the Transvaal and Mozambique. By October 1899, arrangements had been made for the creation and supply of quarantine camps, which aimed to process all cases detected throughout the Cape Colony, at five key sites: the Maitland Plague Hospital—the site closest to Cape Town—Saldanha Bay, Port Elizabeth, Port St. John and East London.[241] These facilities would be tented, but only if the military could spare the tents, and no arrangements for permanent facilities were made at this stage.

The Cape authorities received regular reports from the Governors of Hong Kong, Mauritius and Madagascar, detailing developments in the epidemic at these locations.[242] Furthermore, the Table Bay Harbour Board issued daily reports on bubonic plague, although these only began to appear once Cape Town had officially been declared an infected port and initially only reported lists of suspect cases of absenteeism among dock workers.[243] While health policy was ostensibly dictated from a central authority in Cape Town, archival records indicate that what actually developed was more of a dialogue between the Office of the Colonial Medical Officer, the Harbour Board, the newly founded Plague Board and local authorities expected to enact measures. Much of the correspondence circulating

with correspondence questioning the salaries of plague nurses, often querying payments down to the very day that a contract was terminated.

[241] These sites were established specifically to manage plague cases near to principle docks and never doubled as military hospitals at any point during the Second Boer War. Cape Town already possessed enough facilities to maintain separate networks of hospitals. These included No.1 and No.2 General Hospital at the Wynberg Barracks, No.3 General Hospital at Rondebosch, the Duke of Portland Hospital for private patients, a private convalescent hospital for officers at Claremont, and hospitals at Green Point and Simon's Town for Boer POWs. Using any hospital for both purposes could be potentially disastrous when attempting to control the spread of plague.

[242] KAB/CO/7261/32 Correspondence of the Colonial Office: Health Branch, Bubonic Plague: Measures to be Taken to Prevent the Invasion of, vol.1, folio 32.

[243] KAB/CHB/233/190 Plague Officers' Reports, Correspondence Files, Bubonic Plague 1899-1901, folio 190.

between these offices focused upon insufficient resources and spending, as well as culpability for inadequately enacted plague prevention measures.

Bubonic plague did finally arrive on 5 March 1900 when the *SS Kilburn* docked at Cape Town, carrying unspecified supplies for the British Army. Since leaving its previous port of Rosario in Argentina, the captain had sickened and died of an unknown disease a day before arrival. With three further crewmen sick, a medical officer prevented disembarkation and summoned the Chief Medical Officer of the Cape Colony, Dr John Gregory (1851-1927). After recognising what he believed were the symptoms of plague, Gregory ordered the entire cargo destroyed and the crew transported, under heavy guard, ninety miles north of Cape Town to the quarantine camp at Saldanha Bay on 11 March. Despite two more cases among the crew and the prompt death of a customs officer who had boarded the vessel upon arrival, laboratory tests for the plague bacillus aboard the *SS Kilburn* were inconclusive and the ship was to remain the suspected, but never proven, source of the infection in Cape Town. Given the large volume of commercial, military and pedestrian traffic passing through the city's dockyards, stimulated in part by the ongoing Second Boer War, the illness could just as credibly have arrived aboard a ship from India, Hong Kong or Australia. The South African ports of Durban, Port Elizabeth and East London were equally at risk from infection carried by wartime commerce, refugees from the interior and economic migrants from South Africa, India and beyond. Durban was also threatened by its links with the international gold and diamond industry. Perhaps it was only the increased numbers of people and goods flowing through Cape Town, coupled with

its age and prevalence of slum housing, that meant it was the first location in South Africa to be affected.

The only other recorded warnings came in the autumn of that year when British military officers noted increasing numbers of dead rodents around the South Arm of the Cape Town docks, and a local physician from the small settlement of King Williams Town documented eight cases, including three fatalities, of a plague-like illness among the African population. This small outbreak was likely to have been caused when a worker from the British remount station at Modder River, carrying infected bales of fodder from Cape Town, returned home to the Izeli district of the city in October 1900. Kay de Villiers argues that the reporting of plague might have been prompter if military sanitation officers had been present as they would have recognised the significance of large numbers of dead rats, a development which would eventually be reported to Gregory on 1 February 1901, although such suppositions are impossible to substantiate and perhaps result from de Villiers' exclusive focus on military medicine.[244] The Under Colonial Secretary did write to the Secretary of the Table Bay Harbour Board on 5 February, noting that the Acting Medical Officer of Health had reported "excessive mortality" among the rat population of the docks. He linked these developments with the potential introduction of bubonic plague and recommended the immediate and thorough destruction of all rats.[245] While the Under Colonial Secretary did enquire whether the Board had received this information via other routes, archival documentation records almost

[244] J. C. (Kay) de Villiers, *Healers, Helpers and Hospitals: A History of Military Medicine in the Anglo-Boer War* (Pretoria: Protea Book House 2008), vol.3, p.146.
[245] KAB/CHB/233/190 Plague Officers' Reports, Correspondence Files, Bubonic Plague 1899-1901, folio 190.

concurrent developments, including increasing numbers of suspicious deaths and heavy mortality in the rat population and the confirmation of the first human cases, indicating that bubonic plague had already gained a significant foothold in Cape Town before reports began to emerge from any sources.

The first undisputed plague deaths, those of the white sailmaker J. McCarthy and "coloured" dockworker Jonas Galleo, came in January 1901 along the South Arm of the docks. The first case to be confirmed by laboratory analysis was that of E. A. McCallum, a white clerk at South Arm who was sent to the Rondebosch Country Hospital on 27th January but was later moved by CMO Gregory to the new temporary quarantine facility, which would soon evolve into the Maitland Plague Hospital, five miles from Cape Town near Uitvlugt, on 9 February. At this point the Maitland was still a tented facility but after 3 April the Cape authorities assumed control of the Imperial Yeomanry Hospital, then the most sophisticated British hospital in the colony, particularly in terms of antiseptic technique, from the British Army as the principal site for suspected plague cases in Cape Town. Escape was made difficult by mounted patrols, armed guards and barbed wire fences, but not impossible, and the people of Cape Town were no keener on having their friends and loved ones removed to isolation hospitals than the people of Hong Kong. The Maitland initially very understaffed, with five physicians and medical students, and two night nurses, attended to over 200 patients. By way of comparison, S. W. F Holloway's study of nursing in London cites a figure of one nurse per 4.3 beds at University College Hospital in 1873, one nurse per 5.2 beds at St Georges, 6.3 beds per nurse at St Mary's and one nurse per

6.7 beds at Guy's.[246] Even if not every bed at the Maitland was in continual use, such figures still contradict Echenberg's assertion that when new nursing recruits arrived from Britain they were surplus to requirements and had "very little to do".[247]

It is perhaps unsurprising that the city's Colonial Bacteriological Institute, which had existed since 1891, had been unable to confirm any of the preceding cases. Colonial Office records indicate that the skeleton staff frequently complained of overwork and insufficient salaries, while also managing numerous other projects, including detailed studies of leprosy and the mass synthesis of vaccinations from cattle lymph in order to help combat rinderpest infections in Egypt and the South Sudan. They also had to contend with an absentee bacteriologist loaned to the Egyptian government as part of the same inoculation project.[248]

On 9 August 1901, the Secretary for the Harbour Board wrote to the Office of the Medical Officer for Health with the results of an investigation into anti-plague measures at the Cape Town docks. An inspection carried out by Dr D. C. Rees, a Medical Officer of the Harbour Board, found rats running about on the deck of one ship during his inspection shortly before another ship arrived directly from an infected port in Mauritius. No precautions were taken with this ship and other

[246] S. W. F. Holloway, 'The All Saint's Sisterhood at University College Hospital 1862-99,' *Medical History*, vol.3 (1959), p.150.
[247] Echenberg, *Plague Ports,* p.288.
[248] KAB/CO/7261/31 Correspondence of the Colonial Office: Health Branch, Appointments of Staff in the Government Bacteriological Laboratory 1899-1901, folio 31. For and interesting and detailed study of the Colonial Bacteriological Institute during this period of scientific transition, see Ngqabutho Madida, 'A History of the Colonial Bacteriological Institute 1891-1905,' University of Cape Town, unpublished MA Thesis (2003).

measures were "most inefficiently carried out."[249] This investigation took place after the MOH had assured the Harbour Board Authorities, who were responsible for enacting anti-plague measures, that such measures were in place and sufficiently robust. The Secretary for the Harbour Board replied on 12 July that the measures, particularly the inspection of hawkers' wares and ships' holds, were "carried out in a very perfunctory manner…while in many cases these measures are not carried out at all."[250]

Cape Town implemented the standard forms of plague control by instigating cleansing, isolation, quarantine and vaccination. However, efforts and impacts were not evenly distributed. When cases of plague were finally confirmed, under Section 15 the Public Health Amendment Act of 1897, the Harbour Board was able to enact detailed regulations, focused on the docks as the supposed site of initial infection and aimed at preventing the spread of the illness. The official Plague Regulations, enacted on 5 June 1901, included allowing only those who had been inoculated to work at the docks, or those who were able to produce a medical certificate stating compelling reasons why they should not be inoculated and only then if they were willing to submit to daily examinations by a Medical Officer appointed by the Board. Inoculation of dock workers was repeatedly recorded as ineffective in Harbour Board correspondence. By 26 April, only 1,536 workers had been inoculated, a number so low that the Union-Castle Mail Steamship Company wrote to the Harbour Board on 12th April enquiring as to provisions made for the visual inspection of dock workers who refused to be vaccinated as the author of

[249] KAB/CHB/233/190 Plague Officers' Reports, Correspondence Files, Bubonic Plague Inoculations and Regulations 1900-1901, folio 190.
[250] *Ibid*.

the letter understood that "only a very small proportion of the dock labourers have been inoculated, and that most of them object to undergo the operation."[251]

Those who were not employed at the docks were required to produce a pass, issued by the Board, stating their business. No through passengers were permitted to leave the docks, nor were members of ship's companies, unless they did not plan on rejoining their vessel. Cabs and other forms of public transport were banned from the area, unless the driver could produce a certificate of inoculation and could demonstrate that the vehicle had been disinfected no more than two days beforehand. Those who failed to produce the correct documentation, or who were caught sneaking either into or out of the dock area, were to be handed over to the police. The regulations, implemented on 29 March, gave all dockworkers, including clerks and other office staff, until 15 April to get inoculated or risk losing their jobs.[252]

Africans were also prevented from leaving Cape Town by any means, although those of other ethnicities were allowed to do so after submitting body and belonging to an inspection, and ostensibly agreeing to twelve days of medical surveillance during their voyage. The extent to which this was carried out, particularly among European travellers, is questionable. However, soldiers returning to Britain, Canada and Australia, having passed through the more infectious atmosphere of base camps in Cape Town and up country, were far more rigorously checked. The fear, and very real possibility, was that they would carry the infection to their own ports or others en route. This outcome was narrowly

[251] *Ibid*.
[252] *Ibid*.

avoided in March when the *Roslyn Castle* left Cape Town for Ceylon with 500 Boer POWs aboard. Nearing Durban, a case of plague was suspected among the crew, although sanitary guidelines meant the vessel was not allowed to enter port. After the death and burial of the patient at sea, the ship was ordered back to Cape Town, where the British soldiers were allowed to disembark at Simon's Town but the Boer prisoners were quarantines aboard. When no further cases manifested, the POWs were sent to Ceylon. The case was indicative of the intermittent implementation, on the grounds of race or military standing, of anti-plague measures.

The extent to which these measures were successful is somewhat questionable. Nevertheless, the correspondence files of the Plague Board do include numerous recorded examples of attempts to prosecute, with varying degrees of success, those who disregarded regulations, usually by entering or leaving the docks without correct documentation.[253] The same folio also contains many examples in letters which the Secretary to the Harbour Board, Frank Robb, refused permission for dock passes, including those requested by numerous female through passengers who wanted to go shopping in town, travellers proposing to take photographs, a crewman's wife, mother and sister who wished to visit another family member living in Cape Town, and a male through passenger who chose not to elaborate on his urgent need to "meet a lady". Exceptions were only made in cases where the alternative would be a European woman remaining unaccompanied at the docks, as in the case of a lieutenant requesting that he be able to escort his mother-in-law or a gentleman who wished to ensure that his

[253] *Ibid*.

wife and children caught their steamer home.[254] The latent fear of unaccompanied European women was evidently greater than the potential threat of contagion.

Although it was undoubtedly the African community who suffered most extensively under new public health legislation, as shall be seen later in this chapter, such documents do demonstrate reasonable attempts, in certain parts of the city, to restrict white movement equally, indicating that plague regulations were not entirely racialised.

However, it is interesting to note that fears surrounding the cleanliness of East Asian races were, in many cases, pathologized to an even greater extent than concerns over the health and habits of the indigenous non-white population. In April 1901, the Union-Castle Mail Steamship Company Limited responded to objections raised by the Harbour Board over Chinese and Malay workers washing their ships when in port, proposing instead that the work be done either on board by their own staff of at another port. The company recognised the "undesirability of any further washing falling into the hands of Chinamen and Malays," the implication being that these workers were either so inherently insanitary, or capable of such substandard work, that it was better to postpone the task, and risk spreading the infection, until the ship had reached another port. Instead, they proposed the work be done by Nannucci Ltd, who were at pains to highlight the diligent sanitary procedures they followed, including seeking independent

[254] *Ibid*.

medical advice and employing predominantly "Italians and Kaffirs" whom they discouraged from every leaving the company accommodation.[255]

Inoculation was to be offered free of charge. In a letter of 16 April 1901 Gregory informed the Colonial Secretary's Office that, while "every effort" was made to inoculate those transported to the contact camps under suspicion of plague a few days before they were allowed to leave in order to ensure that they were no incubating the disease, they had "no powers of compulsion", implying that the screening was unlikely to be effective.[256]

On 13 February, Port Captain and Dock Superintendent W. M. Stephen felt it necessary to circulate a notice reminding those using the docks of existing regulations stating that each vessel was required to have metal shields to prevent rats and a night watchman to guard gangways, presumable to prevent human traffic as much rats.[257] Several factors complicated the ability of authorities to respond rapidly to the threat of plague. Aside from the municipal council, there were fourteen different local councils and various military bodies.

Prime Minister W. P. Schreiner held executive responsibility for the outbreak but in practice he left many of the decisions to Colonial Secretary Sir Thomas L. Graham, who headed a team of approximately twenty experts comprising the newly formed Cape Peninsula Plague Advisory Board. The Board's first meeting took place on 14 February 1899, after CMO Gregory had informed Schreiner and Governor of the Cape Colony Sir Walter Hely-Hutchinson, that

[255] *Ibid*., Letter from the Secretary of the Table Bay Harbour Board to the Union-Castle Mail Steamship Company Ltd., 6 April 1901.
[256] *Ibid*., Letter from CMO John Gregory to the Colonial Secretary's Office, 16 April 1901.
[257] *Ibid*.

plague was present in the city even before the laboratory results of the initial cases had been returned. The Board included various physicians, most of the mayors from the Cape peninsula, the Cape Town chief of police, the general manager of the railways and a liaison officer with the Royal Army Medical Corps. The committee featured only three medical men, Colony CMO Gregory, Alexander Edington and CMO for Cape Town Barnard Fuller. Fuller continued to serve in a part-time capacity, supplementing his income with private practice, as he had initially wanted to resign his post in 1899, but no replacement could be found until October 1901.

While it is certainly true that the majority of the measures aimed at controlling the spread of plague were directed at the "Coloured," Indian and African populations, archival evidence included earlier in this chapter—specifically arguments that all dock workers should be vaccinated regardless of ethnicity, attempts to control pedestrian traffic between docking ships and the city, and attempts to prosecute those who disregarded plague regulations, usually by sneaking into or out of the docks without the correct documentation – demonstrate that responses were not entirely racialised.

Procedure dictated that when a case of plague was identified, the patient was moved to the Maitland and associates they had recently spent time with were taken to the nearby "contact camp." This was done with the help of ambulances displaying yellow crosses and flags. The home of the plague patient was locked, a yellow flag hung over the doorway and their wall marked with a yellow circle and the date that plague was discovered. Then the sanitary squad descended. African properties and possessions were often burned, often to avoid the expensive of

disinfection and compensation claims for property were ignored. In Port Elizabeth, the second largest settlement in the Cape Colony, the city council argued that it had paid all it could afford or was accountable for, but while Europeans and Asians received £47,000, Africans only received £5,000 and African churches £7,000.[258] This is not the case for white business and home owners, and the correspondence files of the Plague Records contain hundreds of cases debating compensation claims from white business owners over the destruction of property or goods where infection was suspected. In the homes of "Coloured" people, floors were removed, walls scraped and everything covered with carbolic acid, coal tar or formalin. In some cases, plasterers, joiners and carpenters were called in to repair the damage, although this costly procedure was only undertaken in around 400 homes. No prevision was made to accommodate evicted homeowners while this procedure was undertaken. The dead and dying were often removed under cover of darkness to avoid panic by uniformed plague officers with smoky lamps. Public harbour traffic was now redirected through Simon's Town, several miles along the coast, and all public vehicles were disinfected on a daily basis.

The removal of the majority of Cape Town's African community began on 12 March, with the city's dockworkers being told to return home from work, only to find their possessions on fire and sanitary squads scrubbing their homes with carbolic acid. The only exceptions were a small number of freeholders, leaseholders, domestic servants and dockworkers. By June, approximately 7,000 Africans, 500 of whom were women, had been moved, predominantly from

[258] Swanson, 'The Sanitation Syndrome,' p.402.

Districts One, Two and Six, via trains and military escorts, to Cape Flats and Uitvlugt. The Cape Colony's Native Reserve Location Act of 1902 converted Uitvlugt, now named Ndabeni, into permanent segregated communities as, many would argue, a precursor to today's townships. Strict regulations were also instigated including a ban on female overnight visitors, the prohibition of the sale and consumption or alcohol, the removal of strangers after twenty-four hours and an 8pm curfew.

The black population of Cape Town, who made up only 15% of the electorate and had never been able to boast an African member of the parliament or cabinet, had little official recourse when rejecting these changes.[259] While there was technically no colour bar to voting rights in South Africa, it was based on property ownership. When the 1892 Franchise and Ballot Act raised the occupational qualification from £25 to £75 and implemented a literacy test, the number of black allowed to vote halves and a further 3,350 coloured voted disappeared from the electoral role.[260] However, the small black "middle-class" bitterly disputed the loss of property rights, legal independence, economic mobility and, in a handful of cases, enfranchisement. Ordinary black people also resisted these changes on numerous occasions. In mid-February, when the plague first appeared, dock workers went on strike when employers attempted to register addresses. On 13 March, around a thousand Africans gathered on the slopes of Table Mountain to plan a more structured resistance but the meeting was broken up by mounted police. Letters appeared in the *Cape Times* objecting to the fact that the black community had been singled out to have their houses and

[259] Thompson, *A History*, p.111.
[260] Meredith, *Diamonds,* p.261.

possession burned while the homes of their coloured neighbours, or the contaminated goods, often belonging to whites, they were required to handle at the docks remained unscathed. Nor were they allowed to avail themselves of the large disinfecting station that had been erected on the foreshore, perhaps in an attempt to save at least some of their possessions.

3.5 Plague Nursing in the Cape

As we saw above, while the Third Plague Pandemic may, in Kay de Villiers's opinion, have "taken the world by surprise," it certainly did not take Cape Town by surprise.[261] South Africa had already closed its boarders with Mozambique to all but limited rail traffic when the disease appeared there in 1899, despite the fact that the outbreak did not, at this point, spread further south than Lourenco Marques, now Maputo. It was around this time that the Cape Medical Board endeavoured to prepare the colony in other ways, including attempting to ensure that sufficient numbers of nurses would be available if the plague did eventually arrive in the region.

In 1899, when proposals for temporary plague hospitals at the outlying ports of Saldanha Bay, Port Elizabeth, Port St. Johns, and East London were being considered, it was also suggested that there should be an attempt to recruit voluntary plague nurses from the local hospitals. At the Somerset Hospital, four nurses volunteered over a period of twelve months from 1 June 1899. The same number was recruited over the same period from 9 May 1899. They were paid a

[261] de Villiers, *Healers*, p.145.

retaining fee of £2 after committing to a one-year period of service, which would rise to £4 a week if they were actually engaged in plague work. It was also expected that, if a nurse left the hospital to work elsewhere, she would recommend a substitute colleague to take her place as a volunteer.

However, this system proved impractical when two of the volunteer nurses from Port Elizabeth withdrew their offers and nobody could be found to take their places. The Civil Commissioner believed that the whole notion of volunteer plague nurses would prove impossible due to the strenuous nature of normal hospital duties, as no nurse in the colony could be expected to make any commitments beyond that which was normally expected of her. One volunteer from the Grey Hospital in King William's Town on the Eastern Cape, reneged on her position as a result of objections raised by her friends and the local Medical Officer believed it would be difficult to get any more plague nurses due to the outbreak of war. Not only might the war prove a more attractive prospect for adventurous service, but those who remained in Port Elizabeth might also be overwhelmed by their duties as increased fighting brought more victims and greater military traffic. By 28 November 1900, the twelve-month period had elapsed and no nurses were being retained. As predictions were made that further recruits would be difficult to find in Port Elizabeth, and a workable system had never been managed in Port St. Johns, although the Magistrate did note the availability of suitable male attendants, it was considered a suitable time to reassess the effectiveness of the approach. Hubert Tucker raised all these issues in a letter to Gregory of 28 November 1900.[262]

[262] KAB/MOH/27/7231.

Echenberg argues that the Cape administrators were forced to recruit additional doctors and nurses from the UK as local practitioners remained unwilling to care for plague patients, not only because of the implicit danger but also because many feared it would impact negatively upon their private practices.[263] By April 1901, after plague cases had already been appearing in Cape Town for two months, Dr Mitchell of the Maitland Hospital was certainly beginning to feel overwhelmed and wrote to Gregory, asking for more nurses and permission to increase the salary of those already working. Gregory's solution was to cable England with a request for twenty new nurses and allow an additional payment of two guineas per week for existing nurses.[264] A detailed file on each of these women exists as part of the Plague Records in the Cape Town archives. These always include a copy of each nurse's original contract of service, and in many cases her letter of application and a thorough account of her time in South Africa, which was more distinguished in some cases than others. Each file also contains a letter listing the full names of all twenty of the British recruits. [265] Collectively, the documents reflect not only a range of backgrounds, levels of experience and motivations for choosing South Africa, that also illustrate the various professional and personal dangers specific to women engaged in colonial careering during the late nineteenth and early twentieth centuries. These women represent a neglected element of the 1901 plague outbreak and a previously ignored aspect of the history of nursing in South Africa, detailed study of this

[263] Echenberg, *Plague Ports,* p.282.
[264] Copy of a letter from Gregory to Mitchell, 20 April 1901.
[265] The nurses in question were: Emily Blake, Louise A. Boret, Alice Darley, Ada Charlotte Day, Victoria Evans, Margaret Gordon, Mary May Coy, Mary Nelson, Lucy Sarah Nottage, Lucy Sophia Price, Sarah Hancock, Catherine M. Hoddell, Alice Clara Holland, Eliza Johnstone, Maggie McCarthie, Ethel Macfie, Mary Middleton, Helen Payne, Margaret Palethorpe and Ada Louise Worman.

specific group illustrates the distinctive nature of plague nursing and the practical experiences of those attempting to combat the illness. This particular group also helps illustrate wider racialised fear surrounding nursing, both in terms of black women training as caregivers, and the implicit tensions that surfaced when European ladies were expected to care for large number of indigenous patients.

The contracts offered to these nurses were no harsher than those required by most hospitals in Britain, and so were unlikely to be viewed as a softer or more financially rewarding option, particularly given the dangerous nature of the work expected. They were always designed to be temporary in nature, running for six months from the date of their embarkation, which was 19 April 1901, but allowed the British or Cape governments the option of extending the agreement at a month's notice. Each nurse was required to "faithfully and diligently employ the whole of her time…as a Nurse of persons afflicted with Plague or other disease as the Government or any Officer or Board duly authorized" at the rate of £4.40 a week, as well as any other expenses she might incur in relation to the performance of her duties. Nurses could expect a free return passage from London to Cape Town, including railway travel between her current location and where she would be expected to work. However, if each nurse at any point refused or neglected to comply with any part of the agreement, fail to perform her duties or was accused of misconduct then she would be suspended, without pay. If allegations, supported by documentary evidence, proved to be correct, then the Government was under no obligation to provide her with a return passage. The wording of the contract also seems to assume that, after the outbreak had abated, each nurse would continue her work elsewhere as the government also agreed to provide a

certificate of good conduct where appropriate. The contract also implicitly acknowledged the dangerous nature of the appointment. The last condition of employment stated that Sir David Tennant, Agent General for the Government of the Cape of Good Hope, would be in no way personally liable for any issue to arise as a result of the contract.[266] Given what would later happen to Alice Darley and Margaret Robb Low this warning represents a genuine possibility rather than a legal precaution.

The nurses, having left Southampton aboard the *SS Tantallon Castle* suffered an unnecessarily dramatic arrival in Cape Town almost three weeks later when the ship ran aground in foggy conditions off Robben Island on 7 May. None of the nurses were hurt, although their vessel was destroyed and the wreck still lies in Table Bay today. The *Nursing Record and Hospital World* was quick to reassure friends of their "personal safety" and also, on a seemingly equal note, that their "personal belongings have been rescued."[267] They were sent to various plague hospitals, including those at Port Elizabeth, Saldanha Bay and East London, as well as the Maitland Hospital, which was their first port of call before being transferred elsewhere. Despite seemingly thorough attempts to prepare in advance for the arrival of plague, nursing remained a somewhat neglected aspect of public health provision for numerous reasons based upon racial, professional, economic, cultural, linguistic concerns that will be explored in more detail later in this chapter, the Cape Colony still remained, even under normal circumstances, dependent upon a steady stream of overseas nurses, predominantly trained in Britain, leaving the potentially productive local labour pool underutilised. Once

[266] Numerous examples of this contract exist in the folios KAB/MOH/27-31.
[267] *Nursing Record and Hospital World*, vol.26 (18 May 1901), p.400.

they had qualified, nurses preferred assignments at large metropolitan centres of care, like those offered by the New Somerset Hospital, creating a clear disparity in standards and availability between urban and rural healthcare. Such disparities were reflected during the plague outbreak when schemes to recruit nurses to care for any potential cases that arose at the satellite quarantine camps proved unpopular, even for a reasonable additional stipend. Understaffing was a frequently cited concern for hospital administrators outside large urban locations even before the outbreak of plague. Walter T. Harris, the Resident Surgeon of the Provincial Hospital in Port Elizabeth, wrote to the *South African Medical Journal* in December 1897, complaining that the third largest hospital in the colony was being run with just nine nurses, a figure which include all children's, staff, charge and junior nurses. These women were expected to care for all patients, except coloured men and alcoholic or venereal whites, before retiring to insufficient quarters where those on night duty were required to sleep above the noisy kitchens.[268] There were plans to alter this situation, which had "frequently been one of hardship", by increasing the staff of nurses to fourteen, plus a matron, in addition to the Sisters of St Peter, who had been helping to care for the children's

[268] It was common practice before World War II to replace nurses on male venereal wards with male orderlies or convalescent patients if possible. It is often noted that this was to "spare" the female nurses, although what they were expected to be spared from is not always clearly articulated. Caring for patients with venereal diseases was certainly intimate and unpleasant, but so were many of the other roles that nurses routinely fulfilled. It is possible that patients on venereal wards, particularly those suffering from the lesions of tertiary syphilis, might have been believed to be particularly difficult, violent or dangerous. However, it is most likely that the protection offered to nurses was entirely moral, as those branded with the stigma of venereal disease were also often characterised as corrupting influences or sexually predatory; see Emily Mayhew, *Wounded: The Long Journey Home from the Great War* (London: Vintage, 2003), p.213.

ward since 1888.[269] Nevertheless, resources in most hospitals remained stretched even under normal circumstances.

Provision for the recruitment of additional nurses at the Saldanha Bay Quarantine Camp had been made as early as April 1899. For the monthly stipend of £2:0.0 these women, whose regular duties kept them at the New Somerset Hospital, were expected to care for local cases of bubonic plague as and when they arose. The ambiguous parameters of their appointment also implied that these nurses might have to travel to Port Elizabeth, East London and Port St John's if needed. This last site was particularly important as it was felt it would not be possible to recruit suitable attendants locally. By 30 May four candidates had been selected, although this would remain an unpopular and eventually unsustainable arrangement.[270] Hospital nurses often struggled with difficult working and living conditions as part of their regular duties, issues that are explored in greater detail later in this chapter, so it is perhaps unsurprising than few were willing to undertake additional work, even if that work was intermittent and reasonably well paid, as long as the number of plague cases remained minimal. No provisions were made, at this stage, for what would happen to the nursing staff if case numbers suddenly became less manageable. It was perhaps hoped that the twenty additional Sisters recruited in Britain would help address this shortfall in the number and quality of nurses, as the majority of this group were transferred to the quarantine stations shortly after arrival.

[269] Walter T. Harris, 'Nursing at the Provincial Hospital, Port Elizabeth,' *South African Medical Journal* (1897), pp.213-4.
[270] KAB/CHB/233/190 Saldanha Bay Quarantine Camp: Nurses from the New Somerset Hospital, Cape Town, Correspondence Files, Bubonic Plague 1899-1901, folio 190.

Archival sources indicate that the quarantine camps in and around Cape Town remained isolated, understaffed to a dangerous extent, unsupported and reliant upon improvised infrastructures, meaning that nurses often felt they were unable to do the job they had been trained to do. Nurse Margaret Harmer, for example, had worked for three years at the Liverpool Infirmary and seven months at the Victoria Institute in Cape Town before being sent, alone, to Mossel Bay, where the Plague Board promptly forgot about her to the point where, many months later, they enquired again if the camp had a nurse and if she was competent. Unsurprisingly, authorities at Mossel Bay found it, "very difficult to obtain staff."[271]

Nurse J. Merry resigned after more than two years of service from the plague camp at East London on 28 March 1905, citing poor conditions as her motivation; "Owing to the existing conditions under which I am expected to nurse at the Plague Camp, I find it utterly impossible to discharge my duties and fail to do justice either to the patients or to myself." Merry's colleague, Nurse E. J. Short also gave her notice, stating that she found it "quite impossible to continue to fulfil conscientiously my duties as nurse under the existing conditions". Nurse Merry's objections were clearly justified as on 27 January 1905, her employers were forced to write to Cape Town asking for overtime to be paid as Merry had worked for eleven days on continual day and night duty because no other nurse could be found to assist her. Dr Anderson, then the Plague Medical Officer at East London, felt that "she thus saved the Government from the serious charge of having the nursing of plague patients neglected", and wrote to the Resident Magistrate to tell

[271] KAB/MOH/7 Medical Officer of Health, Plague Records 1901-1905, folios 25-29.

him as much. In Anderson's opinion, Merry's overtime was well deserved, as she had not only performed her duty beyond expectations, but in doing so had implicitly upheld the standards of medical care in the Cape. Hospital authorities were inclined to agree with Merry's accusations of substandard conditions, particularly as both of the nurses on their staff now refused to work under existing conditions and, as they felt the buildings were no longer suitable for use as a hospital, they advise the CMO in Cape Town to authorise the purchase of the nearby Smallpox lazaretto as more appropriate accommodation.

Nurse Short had encountered difficulties when plague nursing before. In October 1903 she resigned from the plague lazaretto at Port Elizabeth after protracted disputes with the matron. After caring for plague cases all night Short claimed the matron then asked her to weigh and serve groceries for most of the afternoon. Short objected to the "rude and uncivil manner" claiming, "I did not refuse to do the work as the Matron told you I did but I did say I came here to Nurse and not to serve out groceries." Short stated that the principal reason for her resignation was the way the matron had spoken to her; "After the rude way in which she has spoken to me on several occasions to-day – repeatedly calling me a liar I absolutely refuse to work under her and I feel my only course is to ask you to accept the weeks' notice of my resignation." Short's resignation was accepted and her claims investigated.

Once confirmation of the plague had been ascertained, the *BJN* reacted swiftly, publishing comments that implied both the inevitability of the outbreak and the presence of governmental subterfuge. It was argued…, while the medical services were capable of eradicating the illness in the opinion of the author, the

decision of local authorities to have the plague "hushed up" was embarrassing to an almost offensive extent:

> The murder is out at last, and the fact that plague has shown itself in South Africa is acknowledged. We always wonder why these facts should be hushed up - Sooner or later the truth is sure to become known – and one resents being made a fool of, presumably by the all-powerful Censor. The Government has now made an official announcement regarding the nature of the disease, and is establishing hospitals at several inland centres and preparing for every contingency….The persons suspected of plague have been removed to hospital. The cases occurred at Cape Town, Woodstock, and Rondebosch, and in every instance the patient had worked in the military section of the docks, where the disease was first noticed. Plague symptoms were discovered in mice at the docks. Rats have suddenly made their appearance at Greenpoint military camp, having presumably trekked from the docks, where the disease fist broke out. The Harbor Board is offering a reward of 3d. per head for rats.[272]

McCallum was cared for by Ella Maria Keyser, a private nurse and graduate of the Victoria Nurse's Home, an institution with strong links to Sister Henrietta Stockdale and site of Dr Neil Macvicar's ongoing attempts to recruit the colony's first non-white nurses, individuals whose extensive links with the early development of nursing in South Africa will be discussed later in this chapter. Keyser would be appointed Matron of the Maitland Plague Hospital when it opened in March 1901, although it is not clear whether the decision to provide such a senior member of the nursing staff in McCallum's case was a result of his racial background or social and professional connections, Keyser's specialist expertise or the desire of the Cape medical authorities to demonstrate, both locally

[272] *BJN*, vol.26 (16 February 1901), p.133.

and to the international medical community, that the colony was sufficiently equipped to offer care of the highest standards when dealing with a potential outbreak. (Here we have medical theatre. When plague is confirmed the convert a tented military hospital, which has a reputation as one of the most advanced military hospitals in southern Africa, and the find a nurse who is South African trained, but at the best facility in the Cape and by the woman who is, essentially, South Africa's Florence Nightingale (Sister Henrietta).

On 13 February Alexander Edington, bacteriologist for the Cape Colony, confirmed plague in McCallum's case, prompting declarations that Cape Town was an infected port on 15 February, but not before sixteen more cases had developed. By 20th February a total of forty-five cases of plague had been confirmed, although any vague diagnoses of rapidly fatal illnesses, particularly among dock workers or their associates, could also reasonably be supposed to be cases of plague, so actual figures were probably much higher. By this point the entire rat population of the dock area was also believed to be infected. Cases were next spotted in the neighbouring areas of Green Point and Sea Point where a military barracks, POW camp and Breakwater Prison all proved to be comfortable nesting grounds for diseased rats. The authorities did attempt to rectify this situation to some extent when the military barracks at Green Point was moved, but only after 11th May, three months after the outbreak had started.

Keyser received the Haffkine vaccination in late March, shortly after her arrival at the Maitland, but suffered a severe reaction and was incapacitated for several days. By mid-April she had developed plague-like symptoms, including collapsed lungs, which lead to her death from pneumonic plague on 16th April.

Keyser's sister and fellow nurse, Minnie Naomi Keyser, had not been permitted to care for her sister but was a frequent bedside visitor. Both Keyser sisters were already working in South Africa when the first cases of plague were diagnosed, Ellen at the Woodstock Cottage Hospital and Minnie in the more rural settlement of Barberton. Minnie had been working in the hospital since mid-March, when she had also received the Haffkine vaccine, but two days after her sister's death she also began to exhibit symptoms. After three days of treatment she died of heart failure brought on by pneumonic plague. Both sisters received the best treatments, often reserved for European patients, including Pasteur serum (an anti-plague serum developed in 1895 at the Institute Pasteur in Paris by Alexandre Yersin, Émile Roux, Albert Calmette and Amédée Borrel), strychnine, stimulants and oxygen. Even if the Haffkine solution had proven effective in this case, that efficacy general lapsed after about seven months so the inoculation procedure needed to be performed biannually.

The Keyser's were among many "faces of the Sister and the glory in their eyes" commemorated in Rudyard Kipling's *Dirge of Dead Sisters* (1902), a work wrongly assumed, even by the Kipling society, to be only about the nurses killed during the Second Boer War;

> Yet their graves are scattered and their names are clean forgotten,
> Earth shall not remember, but the Waiting Angel knows
> Them that died at Uitvlugt when the plague was on the city—
> Her that fell at Simon's Town in service on our foes.[273]

[273] see www.kiplingsociety.co.uk/poems_dirge.htm

The final line is a reference to Mary Kingsley (1863-1900), the British explorer and writer who died of typhoid while caring for Boer POWs as a volunteer nurse.

Dr Thomas Cameron Dunlop, working alongside the nurses, also died after becoming infected on 23rd March. Having scratched himself while conducting an autopsy on a plague patient, he died six days later. Dunlop and the Keyser sisters were commemorated in the Maitland cemetery and with a plaque that adorned the City Hospital for many years.

3.6 Moral Boundaries, Colonial Transgressions

On the 4 August 1901, Alice Darley, a nurse at the Maitland Hospital, came off night duty at 8am. She had been supervising the male European ward and as such, had been entrusted with the key to a locked cabinet where all the poisons were kept. At 9:30am her colleague from Britain, Emily Blake, was informed by one of the maids, Lizzie Bour, that Darley's breathing was laboured, her face blue, and her skin clammy. Blake ran to fetch the Matron and the Medical Superintendent, Dr Bertwine Goldsmit Roscoe who, with the help of Dr McCulloch, performed artificial respiration and rinsed Darley's stomach, the contents of which were sent to Cape Town for analysis. Despite their efforts, the patient expired at 1pm.[274]

Roscoe postulated that morphia poisoning had been the cause of death but was also careful to deflect blame from the hospital and suggested that nurses could buy such drugs in London or Cape Town. Charles Frederick Juritz, the Senior Government Analyst at Cape Town, found little morphia in the contents of Darley's

[274] KAB/MOH/28 Death of Nurse Darley & Estate of the Late Nurse Alice Darley.

stomach but as the drug is rapidly absorbed it could not be ruled out as a cause of death. It was later alleged at the inquest into her death that she had taken to opportunity to remove two vials of tabloids and a syringe. Blake mentioned that she had been depressed for the preceding few weeks but refused to say why. Matron Bessie Jane Philena Smyth also stated that she had noticed a change in mood as much as six weeks before, although when she confronted Darley about this shift. She received reassurances that there was nothing to worry about. Smyth, part of the first group of nurses employed at the Maitland and matron after the death of Ellen Keyser, believed that Darley's death could be blamed, at least in part, on the death of her brother some months before.[275]

An extensive report on the contents of Darley's stomach was submitted as part of a detailed inquest that also involved an autopsy, interviews with all staff members who had contact with the nurse on the morning of her death, and an inventory of her possessions, a selection of which, along with her savings, were returned to her relatives in Britain. A verdict of death by morphia was pronounced (rather than suicide).[276] The inquest file is silent on the issue of how or why Darley exposed herself to the poison. Unlike the deaths of the Keyser sisters, Darley's death was not commemorated in the hospital cemetery, and the report contains no reference to where her body was eventually interned. The resulting investigation was thorough, particularly when absolving the hospital and its staff of culpability, suicide was only alluded to as a possibility on a handful of occasions, and there was no postulation surrounding why a healthy nurse might have suddenly died of a morphine overdose. The inference was that her actions, if not

[275] *Ibid*.
[276] *Ibid*.

openly shameful, were certainly not appropriate for a representative of the nursing profession or the British empire.

Despite the obvious stress associated with working in difficult and dangerous circumstances, coupled with the somewhat primitive nature of the hospital facilities, the nurses were still expected to uphold the highest of standards and were severely disciplined for any insubordination. When Lucy Sophia Price and Helen Payne, both stationed at the Maitland, disobeyed orders in August 1901, their behaviour was immediately reported to the Cape government. Price had apparently left her post, returned to the Nurses Home, insulted the Matron, and refused to obey instructions. What she had actually done was demand to see Matron Smythe while she, assisted by House Sister Lambe and Nurse Goy, were examining the papers of the recently deceased Nurse Darley, at Dr Roscoe's request. When she was reputedly refused entrance her solution was to peer over the dividing wall of the adjacent cubicle. This may have been the final straw as the Matron did note that her behaviour had been "previously very irregular." Her misdemeanour was forgiven once she had written a letter of apology to Matron Smyth stating that, after her "insubordination" and "rudeness to the Matron" she was "more than sorry that, in my anger, I should have said and done what I did…In future I promise you that my behaviour shall be all that you would wish." Price had apparently infringed regulations by visiting the contact camp but there is no indication that she wrote a similar letter to her colleague.

While both women were warned by Dr Gregory, in an official letter on behalf of the Cape government, that any further transgressions would result in the severest of reprimands, the incidents clearly did not have a significant impact

upon their careers. In January 1902, Price was approved for the post of Assistant Matron and Housekeeper at the New Somerset Hospital in Cape Town. While she was described as "neither the best nor the worst of the twenty nurses which the Government got out from England," Price was one of the nurses selected to remain in the colony after their temporary contracts had expired.[277] She, along with Lucy Sarah Nottage, negotiated a contract extension at the New Somerset Hospital, followed by a return passage to England in May 1902, in addition to a £2 retaining fee similar to that offered to Cape Town's original volunteer nurses. Gregory was happy to consent and ask for "an expression of my thanks" to be conveyed to the women in response to their plague service.[278]

Marks has argued that during the 1900s there is no evidence that white nurses were molested in any way by African patients.[279] If fear of rape and potential interracial sexual transgressions were overstated for, the faintest suggestion of impropriety could nonetheless be enough to seriously damage or potentially end a nurse's career. While rare, the plague records consulted for this thesis did contain an example of sexual violence in the case of Margaret Robb Low. This is a case that has been strangely overlooked by scholars. It may also indicate that sexual encounters, be they voluntary or forced, were underreported in the historical record, perhaps through a desire to protect the individual participants or the reputation of nurses, or white women in general, in difficult frontier environments.

[277] KAB/MOH/30 (Nurse Payne: Charge of Insubordination. Nurses Payne & Price: Insubordination of).
[278] KAB/MOH/30 (Price, Lucy Sophia: Nurse at the Maitland Plague Hospital).
[279] Marks, *Divided Sisterhood*, p.58.

Nurse Low, who had begun working at the East London Plague Lazaretto on 20 January 1904, describes a harrowing attack by someone she refers to only as a "native" in her detailed account. Low was an unmarried woman of twenty-three who was at the time of the incident living in the area of Cambridge. The attack had allegedly taken place when she was on a walk to gather flowers in a neighbouring plantation, half a mile from the Plague Hospital, at around 10:30am. On 24 January, an African man previously unknown to her had assaulted her from behind:

> He made a rush at me, and seized me by the shoulders and hands. Then he caught hold of me by the throat. I struggled and screamed. He threw me down still holding me by the throat and throttling me. He lifted my clothes as I was lying on the ground, unloosened his trousers and pulled them down. The effect of throttling seemed to paralyse me. I felt that I could hardly move. He forced my legs apart and lay on me. He tried to have connection with me but I don't know if he succeeded. After a time he got up. I tried to run up the side of the donga [mobile tin building]. I was screaming. He rushed after me and seized hold of me by the throat again, but he did not throw me down. Before he attempted to throttle me a second time, he caught hold of my apron and tore it off. After the second throttling he took me by the hand and almost pulled me into the bush…he threw me down, took a belt from his waist and said he was going to kill me. He said he would cut my throat. He then loosened my dress, turned me half over, and pulled it off. He kept on slapping me on the mouth every now and then. He took off my petticoat, corset, and combinations. I had only my boots and stockings on….After it was over…At first he would not allow me to go….he led me further into the plantation. When nearly half way through the plantation he left me and said I could go... I don't know what became of him. I found my clothes and put some of them on. I found the buttons torn off my apron, and my combinations were torn…[280]

[280] KAB/MOH/10 Assault on Nurse Low (Affidavit by Nurse Low, 25 January 1904, pp.1-3).

In Low's account, which is even more graphic in places, she also alleges the loss of a silver watch, a rolled gold chain, and money. Later in court she would claim to have challenged him, striking out with her hands before being strangled into submission. She describes her attacker as about twenty-six years old, not very tall, beardless, with a dark scratch on his nose and a similar cut above one of his eyes, although she was unable to say which. The only items of clothing she took any note of were the assailant's checked grey trousers, a light brown jacket, a dirty yellow shirt, and a soft brown felt hat. After her attacker had fled, Low went to the nearby Hood Point Lighthouse, which she believed to be nearer than the hospital, and explained what had happened to the lighthouse keepers, a Mr. and Mrs. Radcliffe.[281] Later in court, George William Radcliffe would assert that this was the first time he had met Low, although he did confirm the extent of her injuries and the site of her apparent attack:

> She appeared greatly excited and distressed. Her clothes were disarranged and her dress was grass and ground stained. The one side of her face was swollen as if she had been struck and there were marks on her neck like finger marks…Miss Low pointed out two spots to me, where I could see by the disturbed ground and grass that a struggle had evidently taken place.[282]

According to Low, Mrs Radcliffe then helped her to wash in her bedroom before Mr. Radcliffe escorted her back to the hospital, while at the same time assisting her in the search for her missing watch, and asking her to identify the sites where she had been attacked. Once back at the hospital, Low was examined

[281] KAB/MOH/10 Assault on Nurse Low (Testimony by Nurse Low in the Court of the Resident Magistrate for the District of East London, 29 January 1904, pp.1-7).
[282] KAB/MOH/10 Assault on Nurse Low (Sworn Statement in front of the Resident Magistrate by George William Radcliffe, 29 January 1904, p.1).

by Dr Cooper in the presence of a nurse from the Frere Hospital. Her clothes were retained at the Head Plague Office in the event that they were needed for the trial, and she was careful to note in her sworn affidavit that she was still "soar and stiff all over," having identified the strangulation injuries on her neck to both the doctor and Mr. Radcliffe. Low was also careful to state that during the attack, she had been dressed as a nurse, although without her uniform bonnet. This point was again made during her testimony in court, before she recounted the rest of the attack.

At 7pm on the evening of her assault, Low identified the site of her attack to P.C. William Henry Anderson, and again to a Detective Sargent Lawrence on the afternoon before the trial after both had come to interview her at the Plague Hospital. According to Anderson, a plain-clothes constable from East London, the Plague Hospital stood about 300 yards from the West Bank Native Location and the site of the attack. They again helped her search for her missing watch and she made her affidavit the following day. Anderson and Lawrence examined the site with Low and the following morning affirmed in court that they had found "signs of a struggle," in the form of a lady's boot marks and flattened grass.[283]

A local man by the name of Sam Mshiywa, also known as Simon, Thomas, Schulpad or "Fish," was apprehended three days after the attack and held without bail on one charge of rape and a second of robbery, despite the fact that Nurse Low herself admitted that she could have just as easily lost the watch and chain in the scuffle. Mshiywa was apprehended when Robert Boon Jackson, a ferry

[283] KAB/MOH/10 Assault on Nurse Low (Sworn Statement in front of the Resident Magistrate by P. C. 36 William Henry Anderson, 29 January 1904, pp.1-3).

superintendent, recognised him from his description aboard the *Clan Graham*, where he was employed as a labourer, and telephoned the police.

Mshiywa was not thought to be a patient at the hospital and no details were given on how he came to be in the area or why he apparently selected Low as a victim. Low identified her attacker in court on 29 January, stating that she had not known him previously. She also stated that her assailant had spoken a mixture of English and Kaffir, and that she had continued to scream, struggle, and attempt to flee throughout the attack, only stopping when threatened with strangulation or throat slashing. She claimed that throughout the attack her assailant had continued to speak both English and Kaffir, and although she was unable to remember what was said, she was confident in the language because she understood "a little Kaffir." Low believed that her violent protestations had not been heard, as the only person in the vicinity was a white boy of fourteen who was out of earshot. She was also, rather mortifyingly, required to justify why there had been no blood on her clothing despite this apparently being her first sexual encounter. She openly postulated in court that this was because she had been naked during the attack. She also stated that she had fallen from a tree several years previously, and incident that she believed had ruptured her hymen. Whether or not those present were convinced of this is questionable but it certainly became a salient point as George Radcliffe was asked during his testimony to produce the towel Low had used that day but was unable to do as they had been washed.

All those who gave evidence declined to be cross-examined in court. Radcliffe also made the point that the attack had occurred on a government plantation, perhaps inferring that this was a location in which a woman might

expect to be safe. Low identified Mshiywa through his clothes, focusing particularly on his trousers and the torn pockets of his jacket, which she claimed he had been wearing on the day of the attack—even going as far as to turn his shirt inside out in order to disguise during the trial. Having picked him out in a line up on the day before the trial, Low was vociferous in her condemnations: "I am positive that you are the man who assaulted me…I have never seen any other man with an eye just like yours." Mshiywa's clothes became central to his apparent identity as the assailant. Snay Qobongavana, a "Kaffir" resident at the same guesthouse as Mshiywa at the West Bank Native Location, stated before the court that he had seen the accused in the dining room of their residence for the first time on Sunday morning, and again the same evening. He was unaware of where Mshiywa had been in the interim, but had recognised him by his clothes, postulating that they were his only set.[284] The accused's sister, Jane Noeka, confirmed this as well as the fact that he had not been at home on Sunday morning. The only time she had been aware of his location was at 3pm that day. She stated that she had not seen him until the police brought him home on Wednesday, and she refuted his claims that he had visited her at home on Sunday night, offered her 6d., and asked where she had been all day.[285] Upon arrest Mshiywa had claimed that he had been all day on Sunday and that his sister could prove it.

An extensive file on Nurse Lowe's case is stored among the Ministry of Health records of the plague outbreak and housed in the Cape Town Archives Repository. These folios are bound in a rough chronological order and so

[284] KAB/MOH/10 Assault on Nurse Low (Sworn Statement in front of the Resident Magistrate by Snay Qobongavana, 29th January 1904, p.1).
[285] KAB/MOH/10 Assault on Nurse Low (Sworn Statement in front of the Resident Magistrate by Jane Noeka, 29 January 1904, pp.1-2).

documents included in the same folio and not pertinent to the case, nor is it reference at any other point in these records. The file came to be included here when, in March 1904, John Gregory, in his role as Medical Officer of Health for the Colony, forwarded the material at the request of the Colonial Secretary. Gregory was also asked to provide assurance that, after consulting with the local magistrate, that sufficient precautions had been taken to protect female staff at the hospital in East London. [286] The magistrate who provided this assurance was Arthur Henry Garcia, the man who had presided over the trial of Mshiywa.

Low's testimony in court is slightly more sensational than the one presented in her affidavit. On this occasion her assault was comprised of multiple attacks of considerable violence involving beatings, ripped clothes and snapped watch chains by a man who left "his person exposed" for much of the confrontation. Low even claimed that the prisoner had threatened to thrash her with the belt he was wearing during his court appearance. She was also careful to repeatedly state how hard she struggled, how loud she screamed and the fact that she was unsure if her attacker, despite his efforts, had "made connection."

Low was apparently not the only woman Mshiywa had attacked. Sophia Mtyulubo, a married woman from the East Bank Native Location, was brought before the court to tell another extraordinary story. On Wednesday 20th at 1pm she had been walking alone with her baby on her back when Mshiywa approached her and asked to pay her for sex. She refused and began collecting wood when he attacked her:

[286] KAB/MOH/10 (Appointment of Nurse Low on the Plague Staff, East London. Assault on Nurse Low).

> The prisoner rushed at me from behind and caught hold of me by the neck. I faced him and we had a struggle. I screamed. The prisoner threw me down. I fell on my back on my baby, aged three months. The prisoner held me down by the throat and tried to throttle me. I asked the prisoner, while he was holding me down on the ground, to allow me to remove my baby. The prisoner made no reply but he took hold of me by the collar of my jacket and held me there while I sat up and took off my baby. I placed the child to the right of me.[287]

For Norman Etherington and Marks, fears of rape were more prominent at times of conflict, for example during the South African War and after the formation of the Union, and so were also indicative of the wider potential for sexual subversion and "mirrored apprehensions of political disintegration and loss of property and led to a redefining of racial and gender boundaries."[288] While black unskilled labourers working in white female wards were rarely contested, the image of white nurses in intimate contact with black male bodies evoked powerful fears surrounding the vulnerability of white women when exposed to the unrestrained and bestial nature of black male sexuality, particularly at the colonial frontier. However, nursing as a vocation still carried religious connotations, which meant that its practitioners, particularly those who had been trained by religious orders, were expected to be celibate.

In the Low case discussed above, the native body is transformed from victim to menace; from a recipient of care to a perpetrator of violence. Such transgressive episodes show how the danger posed by the plague was bound up with complex issues of perceived "racial danger, difference, and subordination."

[287] *Ibid*., (Sworn Statement by Sophia Mtyulubo).
[288] Marks, *Divided Sisterhood,* p.58.

Indeed, as Nayan Shah has argued in his discussion of epidemics and race in nineteenth and twentieth-century San Francisco, "The meanings of race gathered webs of prevailing gender, sex, class, national, and religious relations and forged new systems of social identities and political divisions."[289]

3.7 Conclusion

Colonial nursing was a key component of public health, which, as Shah has shown "served as one of the most agile and expansive regulatory mechanisms" in the nineteenth century.[290] This chapter has explored the development of nursing in the Cape Colony, with a particular focus on the 1901 plague outbreak. Despite legislation that allowed the Cape government to prepare well in advance, and the resultant limited demographic impact of the disease, the arrival of plague revealed inherent deficiencies in nursing infrastructures in the Cape and across South Africa.

On the colonial frontline, plague nurses were inevitably exposed to contagion. As Mary Douglas long ago noted, notions of cleanliness and hygiene are freighted cultural terms that are defined in relation to their opposites: pathogenicity, contamination, and defilement. In Douglas's well-known formulation "dirt is matter out of place" and "implies two conditions: a set of ordered relations and a contravention of that order."[291] The anxiety expressed in

[289] Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley, CA: University of California Press, 2001), p.5.
[290] *Ibid*., p.3.
[291] Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (London: Routledge, [1966] 1991), p.35.

colonial reports about the fate of nurses in frontline situations where professional and hygienic boundaries came under stress, reflects a broader preoccupation with the vulnerability of "ordered relations" and the ever-present spectre of their transgression.

Metropolitan nursing ideals were tested during the plague crisis in the Cape Colony. Working in often remote hospitals, plague nurses were exposed to conditions that challenged the code of working practices propagated in the nursing literature and in the progressively standardized nursing curriculum in Britain (see Chapter 4 for further discussion of this). Publications such as the *Wellcome's Professional Nurse's Diary*, called upon nurses to cultivate flexibility as part of their repertoire. The ability to adapt was considered crucial when "monotonous daily work" was disrupted by unforeseen circumstances.[292] Adaptability, however, brought with it attendant risks. It could jeopardise the borders that delineated the colonial order from the subjugated native body, opening up an ambiguous moral space. And implicitly, in moving away for their prescribed role, an abstracted institutional agency was reassigned to the person of the individual nurse. In this sense, borders may be conceptualized "not only as spatial or geographic phenomena that demarcate the sovereign territories of states but also a social, political or economic expressions either of belonging or of exclusion."[293] In improvising measures to deal with the plague crisis, nurses demonstrated their ability to adapt, which was a quality lauded in the nursing

[292] WF/M/PB/20/1-4, 'The General Principles of Nursing,' *Wellcome's Professional Nurses Diary*, South Africa Edition (London: Burroughs Wellcome & Co., 1901), p.39.
[293] Anssi Paasi, 'A *Border Theory*: An Unattainable Dream or a Realistic Aim for Border Scholars,' in Doris Wastl-Walter, ed., *The Routledge Research Companion to Border Studies* (London and New York: Routledge, [2011] 2016), pp.1-31.

manuals. At the same time, this adaptability destabilized the rigid moral borders that defined the metropolitan nursing ideal.

Chapter Four

Making the Ideal Nurse – London, 1880

4.1 Introduction

This chapter extends the arguments presented in Chapters 2 and 3, by examining the evolving culture of nursing education in the metropole from the 1880s to the early twentieth century. The aim of the chapter is to place the experiences of colonial nurses discussed in the previous two chapters within the context of broader institutional developments in Britain. The chapter is organized in six sections. Section 2 ('Professional Boundaries') examines nursing debates that pivot on the maintenance of personal and professional boundaries. In so doing, the section elaborates on earlier discussions in the thesis, particularly in Chapter 3 about the consequences of a nurse's moral transgressions. How did a nurse's training prepare her for the management of the complex "moral boundaries" in colonial settings where white women laboured, often in extreme conditions, amongst "native" populations? As we saw in relation to both Hong Kong and Cape Town, issues of gender, class, and race were fundamentally entangled.

Section 3 ('"Intelligent Obedience": Nursing Education') provides an overview of the professional nursing literature at the turn of the nineteenth and twentieth centuries in order to shed light on the construction of the ideal nurse. The promotion of this ideal, and the often contradictory assumptions it embodied, epitomized in the notion of "intelligent obedience," a form of dependent responsibility within discretionary authority —was critical to the problematic

policing of moral boundaries, particularly in the colonies. The ideal of the virtuous nurse inevitably implied its opposite: the fallen, or deviant nurse. In the popular press, the deviant nurse was a subversive and persistent danger, a sexualized, corrupting, disobedient, vulgar social climber that haunted the sickroom, particularly in private residences.[294] Close study of professional and popular publications indicates that characterizations of a nurse's ideal qualities were often ambiguous, even irreconcilable. However, there was a consensus in late nineteenth-century writing that if a nurse could not meet these seemingly impossible standards, she alone was at fault.

Section 4 ('Becoming a Colonial Nurse') considers the ways in which British nursing graduates could be recruited to work in the colonies. An analysis of professional publications, most notably the *BJN* and journals published by the various London teaching hospitals, demonstrates that these sources functioned as recruiting tools for hospitals across the Empire. At the same time, recruitment often involved leveraging individual and institutional networks. This section considers these various mechanisms of informal and formal recruitment, including the role of the personal testimony.

Section 5 ('Henrietta Stockdale: A Nursing Life Abroad') focuses on the life and writings of Henrietta Stockdale (1847-1911), a nursing "pioneer" in South Africa, to shed further light on the process of colonial recruitment; it grounds and amplifies the argument presented in the previous section. Stockdale's papers and published articles offer invaluable insights into the professional and social

[294] On popular representations of nurses in Victorian literature from the 1850s, see See Arlene Young, *From Spinster to Career Woman: Middle-Class Women and Work in Victorian England* (Montreal: McGill-Queen's University Press, 2019).

backgrounds of the women who worked as nurses during the early years of the Third Plague Pandemic. It also allows for a more critical assessment of the claims made by medical and social historians about the motivation for these women working overseas. By way of a conclusion, the final section recaps on the key themes and suggests further lines of research.

4.2 Professional Boundaries

In a letter to *The Nursing Record and Hospital World*, published in September 1894, one correspondent wrote to praise the quality of nursing across the Empire. The writer objected to criticisms made in earlier issues of the journal about the shortcomings of colonial nursing. Drawing on personal experience working overseas—predominantly in Sydney and Melbourne—the correspondent cited many examples of quality care, successful training, and up-to-date hospitals.

While defending colonial nurses and their work, however, the letter also gave voice to the complex moral nexus within which nurses worked; their ambivalent professional role and motivations for working abroad:

> The truth is that young Nurses, as well as young members of other employments and professions in this country, form high hopes and sanguine expectations…of the advantages of colonial occupations to those, with home education and experience, who determine to try their fortunes elsewhere; and on arrival in the Colonies are disappointed to find that the rivalries of life are not less keen there than in their native land. Some breast themselves to their work in a good spirit, courageously overcome their difficulties, and, ultimately, succeed; but others…who perhaps have little claim to superiority in their professions, or who are wholly

> incapable of maintaining their places in the competition of life, take a jaundiced view of their surroundings…[295]

As we see from the above quote the onus for success lay very much with the individual nurse who was obliged to operate within an environment in which she often held responsibility without the necessary authority to discharge that responsibility. Nurses who had trained in the best London hospitals were encouraged to consider the financial and social prospects presented by colonial work. While many professional publications functioned as recruiting devices for overseas nursing (see Section 3)—often implying that life and labour was easier in the colonies—there was also a suggestion that nurses who sought "to try their fortunes elsewhere" were opportunistic, lacking the necessary stamina to succeed at home. When a nurse failed to adapt to a challenging colonial environment, often as a result of unanticipated dangers and difficulties, she was entirely at fault. As the correspondent to *The Nursing Record and Hospital World* put it, a nurse's unrealistically "high hopes and sanguine expectations" were in part responsible for her subjection to "the rivalries of life." In such circumstances, a nurse was found professionally wanting, a victim of her own moral weakness.

At home and in the colonies, nurses were expected to circumnavigate complex social and moral worlds. As Jessica Howell has observed, working conditions for nurses abroad "varied drastically according to location. Some might be sent to fully equipped governmental hospitals, whilst others would find themselves the only European nursing sister in a makeshift clinic, perhaps

[295] F. Larkworthy, 'Nursing in the Colonies: Letters to the Editor,' *Nursing Record and Hospital World*, vol.13 (15 September 1894), p.179.

affiliated with a private mining concern or on the outskirts of a plantation village."[296] Professional nursing publications frequently invoked the characteristics of the virtuous, ideal nurse that would enable her to overcome any challenge in the field. However, little practical guidance was offered on how to deal with the moral and professional quagmire that a colonial posting could represent. The mere fact of being a white woman in a taxing colonial setting made working life there problematic. The pressure of work, particularly during disease outbreaks or military conflict, served only to compound these intrinsic difficulties.[297]

One message, however, was clear. If nurses did transgress the rigid boundaries of propriety, often as victims of distinctly colonial dangers in remote and unsupported locations, they alone were to blame. As Anne Marie Rafferty has argued, "virtue" became a vital aspect of nursing education that was progressively codified in the nineteenth century. However, the occupational culture of nursing, as an essentially moral metier, undermined attempts by nurses to gain access to prestigious institutions and centres of learning.[298] Rafferty's perceptive analysis focuses exclusively on developments in Britain and the United States, leaving colonial settings unexplored. In Britain's far-flung imperial dominions, the thorny practicalities of nursing meant that the moral boundaries imposed by a "virtue"-centred nursing education and work culture over the preceding half century needed to be redrawn.

[296] Howell, 'Nurse Going Native,' p.167.
[297] On the harsh environment experienced by colonial nurses, see Schoeman's discussion of nurses during the Anglo-Boer War in *Angels of Mercy*.
[298] Rafferty, *Politics of Nursing Knowledge*, p.1.

To date, little research has been conducted into how individual nurses negotiated this challenging colonial terrain and attempted to balance a metropolitan nursing ethos with the exigencies of the colonial sickroom. The aim of this thesis has been to address this lacuna by exploring what happened to those nurses who, in the midst of an epidemic crisis, did transgress these boundaries in some manner. The thesis has also sought to analyse the "culture of blame" that developed around events in which, as examples from the Hong Kong and Cape Town chapters have shown, nurses could not reasonably be considered culpable.

In doing so, the aim has been to complicate the picture of a medical establishment resentful of the independent and unsupervised nature of nursing, particularly in a domestic setting. Hospital training and standardized textbooks were used to engender discipline and obedience, while simultaneously defusing conflicts of authority between doctors and nurses.[299] Yet overseas nursing offered something of a paradox for those trained in Britain. Textbooks and reference guides—examples of which feature in the Section 3 below—prized intelligence and independence above all other qualities. Those with specialist training were rewarded with promotions, and doctors frequently acknowledged that plague outbreaks could only be successfully managed through the deployment of skilled nurses.

[299] Rafferty, *Politics of Nursing Knowledge*, pp.10-11.

4.3 "Intelligent Obedience": Nursing Education

In a study of nursing at UCH, published in 1959, S. W. F. Holloway anticipated other scholars of nursing history by arguing that between 1862 and 1899 nursing ceased to be a trade and became a profession. This was a process, according to Holloway, aided by several factors, including the widespread influence of Florence Nightingale's ideas, a general movement towards the emancipation of women, the educational developments enacted by the Forster's Education Act of 1870 (which established a framework of schooling for children between the ages of five and thirteen in England and Wales), and the improved living standards of the working and middle classes. Collectively, these four converging factors facilitated the supply of trained nurses.[300]

Historians such as Brian Abel-Smith have further argued that the influence of the High Church Movement, demographic factors like later marriage, low marriage rates, and migration for employment opportunities, also helped to create a suitable pool of potential nursing labour (although he fails to offer detailed statistics or illustrations of these developments to back his contention). The progressive removal of the religious orders from hospital nursing was accompanied by an oft-repeated desire to raise the standards of the profession by ensuring that predominantly middle and upper-class women undertook training.[301]

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[300] S. W. F. Holloway, 'The All Saint's Sisterhood at University College Hospital, 1862-99,' *Medical History*, vol.3 (1959), p. 153.
[301] See Young, *From Spinster to Career Woman*, who considers nursing disputes over hospital reform (pp.39-102).

Notwithstanding this secularizing drive, it is important to note that until 1889 all the nurses employed at UCH were expected to be members of the Church of England. Moreover, many of the London hospitals, until the beginning of the twentieth century, were still dependent on the nurses provided by charitable orders. The Sisters of the Poor, part of the Anglican Society of All Saints, undertook most of the nursing at UCH between 1862 and 1899. Nursing at KCH had fallen to the Anglican Order of St. John even earlier in 1856, although this is perhaps unsurprising as St. John had been created, to a large extent, by R. B. Todd, William Bowman, and Lionel Beale, all members of the KCH's medical staff.

While remaining still more of a "calling" than a career—one still characterized by a heavily devotional rhetoric—nurses were expected to be suitably educated and could thus demand, at least according to professional publications, appropriate wages, working conditions, and respect. Ladies' journals from the period depict nursing as a desirable profession for the increasing number of unmarried, educated women of respectable social backgrounds, allowing them to respond to feminine charitable and nurturing urges, while also implying that reasonable pay and accommodation outside the family home would allow for a degree of autonomy and adventure and an important part of the 'hidden curriculum'.

Articles reinforced gendered boundaries in the sickroom by dissuading women interested in healing from becoming doctors. Perhaps as a result of the potentially dangerous consequences of allowing women to care for prostrate males—particularly in the unsupervised context of the private sickroom—textbooks created as part of the new nursing syllabus relentlessly promoted the

inherent qualities nurses were expected to possess. These textbooks functioned as an amalgamation of moral guide and scientific disquisition.

Professional journals reiterated these expectations on a monthly basis, reinforcing the boundaries between what was permissible and what was not. They promoted nursing norms and set expectations. What was required, were women who manifested the idealized attributes of a nurse, regardless of upbringing. A nurse was expected to be clean, notwithstanding her environment, devoted to duty, friendly but never familiar, intelligent but unfailingly obedient, discrete yet always in command of the sickroom.

The insistent reinforcement of this nursing ideal in professional and popular publications, however, reveals latent concerns surrounding feminine morality in the workplace, and the potential for nurses to succumb to temptation. Understanding the fears that underlie attempts to control potentially ungovernable, unpredictable, and subversive female behaviour is an essential part of understanding the reactions to the transgressive actions of nurses in colonial locations such as Hong Kong and Cape Town—reactions that became increasingly forceful the further removed nurses were from imperial hubs.

Late-nineteenth-century commentators were convinced that given the right inducements, attracting candidates to the profession from appropriate backgrounds would not prove difficult. A variety of economic, social, and humanitarian incentives were evoked. This mixed- bag of enticements, however, could have countervailing effects. In an article entitled 'Nurses à la Mode,' written for *The Nineteenth Century* in 1897, Lady Eliza Priestly observes:

> No doubt many daughters of rich fathers seek hospital nursing as a relief from the idleness of home life, and in the *bona-fide* hope of doing something to help suffering humanity in various ways, but there are others who rush in for it in a pure spirit of adventure, and have no small difficulty in bearing the strain and restraints of the compulsory three or even four years' hospital training. Others, again, are honestly impelled to it by necessity, and if not choked off by the scenes they witness, and the awful glimpses of life unveiled before them, they bear the burden well, and taking matters seriously, turn out the most profitable nurses for the institution, and the most valuable to the world at large. The pity is that whatever the intellectual calibre, the motive, the temper, and the temperament of the woman, the certificate for all is the same, and she stands before the world after the prescribed three or four years training pronounced competent to attend the sick in all the various and verifying circumstances of life, in every kind of home.[302]

In another article for *The Saint Pauls Magazine*, published several decades earlier, Charlotte Haddon adopts a decidedly mercenary approach when advocating nursing as a suitable profession for the "right kind" of "gentlewoman." Her emphasis on economic status contradicts Abel-Smith's assertion that if a Victorian woman hoped to escape "the boredom of family life, it could not be from any commercial motives."[303] According to Haddon, a nurse might be expected to expend between half and a full guinea a week as a boarder at a nursing school, around £200 in total over the duration of a two or three year training course, thus barring those who did not initially possess reasonable means of support. The demand for educated nurses from cultivated backgrounds, however, was

[302] Eliza Priestley, 'Nurses à la Mode,' *The Nineteenth Century*, vol.41 (January 1897), p.30. The *Nineteenth Century* was a monthly British literary magazine published from 1877 with the aim of circulating debate by the leading intellectuals of the day. The daughter of the well-known publisher Robert Chambers, she was married to the physician William Priestley, a relative of the scientist Joseph Priestley.

[303] Charlotte Haddon, 'Nursing as a Profession for Ladies,' *The Saint Pauls Magazine*, vol.8 (August 1871), pp.458-61.

apparently so great that nurses, unlike lady doctors, "would very soon meet with employment" and the best could expect to earn between two and three guineas a day.[304]

While seemingly conservative in tone, the emphasis on the financial benefits of a career in nursing implies that nursing could lead to potential independence from the familial home. A woman need not feel ashamed of her financial motivations, for, as Haddon points out, lady doctors accepted fees and the rich could be expected to pay for superior care. Gentlewomen should embrace capitalist principles if they wanted to succeed. As Haddon notes, "ladies must make their services valuable before they can have the right to command their own terms."

Registering on a suitable training programme offered a clear route to creating this added value, and Haddon recommends the Children's Hospital in Great Ormond Street, the Middlesex Hospital, the BNA in Paddington, and Miss Merryweather's Training School for Nurses in Liverpool for this purpose—institutions that were sure to expand in order to meet predicted demand. Enrolment on a correct programme of training would also protect ladies from menial labour requirements, for despite attempts by Haddon to refute the argument that "lady-nurses would not be willing to do all that is required in a sickroom," a nurse should never be "overtired" and so it would be "undesirable for her to expend her valuable strength" on work that could be entrusted to servants.

[304] Priestley cites a figure of between two and five guineas a week in the best houses in 1897; see 'Nurses à la Mode,' p.30. The second ever issue of the *BJN* also repeatedly acknowledged the increasing demand for qualified private nurses, not least because of the superior comfort these women could offer and the more prevalent use of scientific methods and equipment in the domestic sickroom, yet declined to mention the fees such a practitioner might command; see also Miss Catherine Jane Wood, 'Private Nursing,' *The Nursing Record*, vol.1 (12 April 1888), pp.14-15.

Nor would a family, according to the author, be foolish enough to employ the expensive services of a qualified nurse for anything but the most severe medical cases.

Like others, Haddon was convinced that the professionalization of nursing (at least among the right classes) would solve several issues. First, an appropriate remunerative occupation would be created for gentlewomen, allowing them to attain a superior status to teachers or governesses, while also supporting themselves in a way lady doctors, initially at least, could not. Second, the overall standard of care would be raised as it would no longer be the preserve of charitable amateurs, although the author did not wish to disparage, "those noble and compassionate women who have proved that love can dignify and consecrate the most repulsive tasks." Third, it would preserve the health of other women who would otherwise feel obliged to care for ailing relatives and mean that those lying ill at home would have a better chance of survival:

> We are often hearing of ladies who have ruined their health by trying, untrained, to nurse their friends. Many a wife and mother has continued night and day to watch by the sick-bed, who would gladly have taken proper rest had seen been able to tryst the nurse; and yet with all her care, she has not succeeded in her conflict with disease as a more experienced person might have done.[305]

Such writing advocates nursing as a profession for gentlewomen by employing ambiguous tropes that would become an established feature of nursing literature for the next century. Changes and professionalization were "very much desired by

[305] Haddon, 'Nursing as a Profession,' p.460.

medical men," and while women were to be allowed entry into the sickroom, it would be because "a sphere of action would be preferable in which she would not have to compete with him [the doctor], but in which her own particular endowments would give her special advantage." While Haddon's article is not directly critical of lady doctors—even going to far as to use them as a justification for why trained nurses should now be paid—comments like this, and arguments that the benefits of nursing would deter gentlewomen from following "unsuitable occupations," were more likely to reinforce gendered stereotypes than unsettle them. Indeed, there was a consensus among late-nineteenth-century commentators that nursing would preserve gender roles rather than challenge them. Mutual assistance in the sickroom was preferred, because while the space had been hitherto "monopolised by the stronger sex," rivalry was unbecoming and would "lower both the quality and the remuneration of the work done."[306]

In Priestley's opinion, training better nurses was in no way a stepping stone towards an "army of medical illegals" or "a world overrun with *medical women* [italics in the original], legal and semi-legal." Not only would a nurse prefer the busy atmosphere at the hospital, she would also have little respect for the authority of her female colleague from the medical school for, "the only complaint we hear on the part of the lady doctors is the difficulty they find in getting modern trained nurses to act under them at all!"[307] If upper class and highly educated nurses had a tendency to disregard the advice of male doctors, female doctors had

[306] Haddon, 'Nursing as a Profession,' p.461.
[307] Priestley, 'Nurses à la Mode,' p.35.

little hope, in Priestley's view, of commanding the authority necessary to work effectively.

Initially, Haddon's article might appear to argue that nursing was a method through which Victorian gentlewomen would gain a more influential and independent role by offering them a status, a defined place in the public sphere, a selective and challenging profession, and autonomous spending power. However, as with many aspects of nursing, her article is ambiguous. While it calls for the mobilization of large numbers of women to the sickroom and advocates the improvement of conditions for those already working there, it simultaneously reinforces gendered boundaries—boundaries that are best preserved by women of an appropriate background.

The implicit, and sometimes explicit, motivation for encouraging a better class of women to become nurses was that these women were inherently better equipped to preserve the social and professional boundaries of the sick room, thus negating many existing problems. The most frequently cited of these included theft, laziness, slovenly conduct, drunkenness, and lascivious behaviour. Training nurses who came from the same backgrounds as their patients could create problems, including promoting nurses who would likely disobey doctors out of a conviction that their knowledge and experience was superior. Nurses might also exploit their position as a way of pursuing advantageous marriages. If a nursing education honed idealized feminine characteristics, as a career nursing might also provide preparation for suitable wives. Indeed, the ideal medical partnership was imagined in quasi-conjugal terms, as a unique physical and emotional partnership:

> Where does the character of the "help-meet" come out so strikingly as in the sick-room, where the quick eye, the soft hand, the light step and the ready ear, second the wisdom of the physician, and execute his behests better than he himself could have imagined.[308]

It is conventional for nursing reference guides and textbooks of the late nineteenth and early twentieth century to begin with an overview of the position and function of the nurse, before systematically outlining her duties, and identifying the inherent characteristics a successful nurse was expected to possess. Designed to be comprehensive, these nursing textbooks often comprise treatment and symptomology guides, pharmacopeia, contagion and other technical theory, anatomy revision, and inclusive referencing. They also incorporate a range of miscellaneous material, including meditations on patient temperament and medicinal cooking in an intriguing admixture of the scientific and the domestic.

According to *The Nursing Record* in 1888, any nurse should be neat, clean, strong, of appropriate age and experience, with certifications from good institutions. Ideal nurses were those who were more than happy when "sacrificing themselves to one of the most glorious of martyrdoms and yearning for – not merely yielding to – a duty which is almost divine." Only when she possessed the requisite knowledge and was inculcated with a calmness of mind, would the nurse be able to overcome her natural sympathy and manage the case with the

[308] Haddon, 'Nursing as a Profession,' p.461.

appropriate level of professionalism, thereby ensuring the most beneficial outcome for the patient, as well as gaining the confidence of those around her.[309]

As "agents of imperial hygiene," nurses were required to be paragons of cleanliness.[310] Textbooks strove to inculcate in nurses an appreciation of personal hygiene that extended from the scrubbing of hands to the purging of the "dirty mind." Indeed, the nurse embodied a hygienic continuum that ranged from mind, person, to environment:

> Is there anything more calculated to demoralise a ward than a dirty slattern of a nurse, whose cuffs and never clean, whose apron is always crumpled and stained, whose hands look as if they never made the proper acquaintance of soap and water, whose beds are never spotless, and whose window ledges are never properly dusted? A naturally clean-minded woman is clean in her person, her nursing, and in all her work, for she cannot respect herself if she is careless about the purity of her person and her surroundings. It is the lax and slovenly habit of mind that finds its expression in a lax and slovenly habit of body.[311]

The Nursing Record regularly reminded nurses of the expectations that accompanied their position and it is difficult to find an edition of the journal that did not, in some way, remind readers of what was permissible (and/or unacceptable). The winner of the publication's first ever essay prize was a Miss C. M. Loch with a submission bluntly entitled 'What Constitutes an Efficient Nurse?' The author considered it vital to restate the expectations set by Nightingale in

[309] 'Practical Nursing: Chapter 1 – A Suitable Nurse,' *The Nursing Record*, vol.1 (12 April 1888), p.19.
[310] Howell, Rafferty, Snaith, and Wall, 'Nursing the Tropics.'
[311] Loch, 'What Constitutes and Efficient Nurse?,' pp.54-5.

order to help the nurse "stand all the criticism that she is sure to get" during "this time when many critical eyes are upon her, only ready to condemn her."[312]

In an article published a few months later simply entitled 'Honour,' Wilhelmina Mollett, Matron of the Chelsea Infirmary, argued that "honour" was the foundation stone of medicine and that female practitioners were expected to act accordingly:

> Nursing is the woman's share of medical work, and it is a profession that no one who has not the keenest sense of honour should ever undertake. A nurse's honour consists essentially in always acting with entire truthfulness and rectitude, at all times to do the best work of which she is capable, to bring to bear upon that work in all its details all her best energies, her highest faculties and fullest powers; so alone will she be worthy of the responsibility that rests in her hands. No-one but the nurse herself can ever know whether she has really done her best in her work – the best of which she is personally capable.[313]

Self-awareness here is identified as a critical attribute of the successful nurse: the ability to know oneself and recognize the moral basis of one's own actions. Mollett seems to find the suggestion almost offensive that any woman might, as a result of her gender, act upon baser motives. Moreover, Mollett's emphasis on self-reliance implies that ultimately there can be no external guidance on these matters. If a nurse fails in her duty, regardless of the circumstances, she has only herself to blame.

In Mollett's opinion, the preservation of a nurse's sense of honour should be sufficient reward. Failure to rise to standards ("the practical ideal of

[312] *Ibid*., pp.64-7.
[313] Miss Mollett, 'Honour,' *Nursing Record*, vol.1 (26 April 1888), p.40.

humanity")—manifested by slovenly work—resulted from a deficit of honour, which was a characteristic to be prized above intelligence and aptitude. Indeed, honour which was closely associated with purity, made a nurse more attractive, since it added "dignity to the most homely and unpretending character."[314]

Percy G. Lewis's influential textbook *Nursing, Its Theory and Practice: Being a Complete Text-Book of Medical, Surgical and Monthly Nursing*, published in 1897, claimed in its preface to be the first reference book aimed at the qualified nurse. It was allegedly written on demand, in response to nurses who sought clarification on medical issues, including how to deal with unfamiliar conditions. Lewis argued that, despite common supposition, the "born nurse" did not in fact exist. Nursing was a profession and nursing skills, rather than being innate, were acquired through dedicated training. As he remarked, it "is very much a matter of brains, hard work and common-sense."[315]

Lewis was willing to concede, however, that certain inherent characteristics could make learning how to be a nurse easier. These included; decisiveness, the ability to introspect, and consideration for the sick. Indeed, Lewis frequently contradicts his pronouncements, declaring for example that nurses required "ability at least above the average" and that while they were expected to be "obedient," this was not a "blind," unthinking obedience but rather an "intelligent obedience":

> Nurses should remember that she is the kind of woman doctors require as nurses. It must be understood that nursing is not a pleasant pastime, to be taken up merely as

[314] *Ibid*., pp.40-1. On purity and nursing, see Miss Mollett, 'Purity,' *Nursing Record*, vol.1 (3 May 1888), p.54.
[315] Percy G. Lewis, *Nursing, Its Theory and Practice: Being a Complete Text-Book of Medical, Surgical and Monthly Nursing* (London: The Scientific Press Limited, 1897), pp.2-3.

> something to do, but that it is a profession involving hard work and immense responsibility, and possession of ability at least above the average. Obedience is one of the things which most often goes against the grain with those commencing their nursing career. Yet it is most essential, especially in relation to the doctor's orders, in which nurses cannot often possibly follow the reasoning which led to them. In speaking of obedience, it must be pointed out that is it not blind, but intelligent, obedience which is required…Let those who take up nursing think well before entering on it.[316]

A nurse must report on what she sees but never offer an opinion or attempt to diagnose, a point repeated at several intervals during the book.[317]

The fine line between acquiescence and independence preoccupied many commentators. In her *Practical Points in Nursing, for Nurses in Private Practice* (1896), a book which saw many reprints, Emily A. M. Stoney sought to outline in detail what was expected of a private nurse. Stoney reminds her nurse-readers to recognize their limitations and never to assume in the hospital the autonomy required in private practice, for "there would be no possible excuse for the nurse to act on her own responsibilities in the hospital, as there is always a doctor within calling distance."[318]

Professional journals stressed the imperative for a nurse to show deference to the physician she worked alongside. As one author asserted in *The Nursing Record* in 1888, "we do not for one moment place ourselves on the platform of the medical profession, yet we do claim to be their assistants; we do

[316] Lewis, *Nursing,* pp.2-3.
[317] *Ibid*., p.10.
[318] Emily A. M. Stoney, *Practical Points in Nursing, for Nurses in Private Practice* (London: The Scientific Press Limited, 1896), p.17.

claim a dignity and importance for our work second only to theirs." The nurse's subordination is emphasized, and the author concludes: "With the doctor the nurse stands on a different footing. To a certain extent she shares his professional standing, and is there as his representative and assistant, *but* his subordinate."[319]

4.4 Becoming a Colonial Nurse

Scholars of nursing history have identified a number of factors to explain the imperial pull, including a desire for adventure, romantic or otherwise, the possibility of domestic and professional freedom, and the promise of better economic or working conditions in the colonies. As noted in the Introduction to this thesis, the notion that work and life were somehow "easier" in the colonies, is a theme taken up by many nursing historians who also suggest, somewhat vaguely, that boundaries were more "fluid" in colonial locations. While professional publications may have implied as much, and necessity did perhaps give rise to greater flexibility in relation to professional boundaries—demonstrable by increasingly rapid promotion prospects—reactions to those women who somehow fell short of a nursing ideal would indicate that moral boundaries were just as rigid. By comparing nursing ideals in the metropole with colonial "realities," it may be possible to form a better understanding of the complex moral terrain that nurses were obliged to navigate, and to assess the extent to which nurses were able to acquire a more active, autonomous agency.

[319] Miss C. J. Wood, 'Private Nursing,' *Nursing Record*, vol.1 (12 April 1888), pp.15-16.

Methods of recruitment ranged from the publicizing of available opportunities overseas, contained within job adverts and descriptions of the type of person who might thrive in a colonial environment, to more oblique approaches, for example mentions of hospital alumni who had forged similar career paths, lists of books which might comprise the library of a colonial practitioner, accommodation available for single women in different locations, and articles concerning aspects of tropical medicine.[320] Recruitment aimed to meet shortfalls in nursing staff, particularly at large hospitals or in more remote locations, or in areas where attempts to train nurses in specific locations had been lacklustre. It also sought to strengthen existing international links between individuals, hospitals, and nursing schools.

Notwithstanding the cautionary asides that pervade many of the articles on colonial work (warning of the dangers abroad), the presiding tone in this writing about the Empire is on the whole favourable and reassuring. Articles reassert the quality of nursing facilities in the colonies and depict the hospitals there as desirable places to work, the perfect balance between comfort and adventure. Hospitals competed for the best candidates from the limited pool of women trained each year in the finest British nursing schools, preferably with suitable social background, character, and professional experience, who were willing to work overseas.

[320] The mention of new nursing appointments and the charting of their preceding career paths was intentional. In April 1888, *The Nursing Record* requested that sisters and matrons who had gained a new appointment write to the journal, taking care to note where they had trained and any previous positions held. The editor promised a specific column devoted principally to the promoting information; see 'Nursing Echoes,' *Nursing Record*, vol.1 (19 April 1888), p.20.

Inspection of this material reveals a distinctive form of female colonial careering of the kind Anna Crozier notes among colonial doctors in East Africa.[321] Individuals appear across the decades in the pages of the *BJN,* and other related publications, moving around the world and up the career ladder, using desirable colonial or military nursing experience to attain more senior roles at home or in the colonies. Outside of military service, colonial nursing contracts represented rare opportunities to further education, gather exotic and enviable practical experience, assume new leadership roles, and attain the patriotic and professional distinction often associated with such posts.

Rather than representing merely another form of unspecified colonial "circulation," the movement of these women falls into three distinct categories: those with comparably brief colonial service who tended to return home, those moving between relatively interconnected colonial "hubs," and those choosing to take appointments in increasingly remote locations. However, when the representations of colonial nursing from the metropolitan publications are compared with archival material from the Hong Kong and Cape Town chapters of this thesis, clear discrepancies are revealed. Many women who went overseas discovered that colonial nursing was significantly more challenging and dangerous that they had been led to believe.

The argument that colonial nursing offered superior working conditions to those in Britain is particularly misleading. As noted in Chapter 2 of this thesis, the nurses contracted to work in Cape Town were no better paid than those at home, and the conditions in which they were employment were generally worse. For

[321] Crozier, *Practising Colonial Medicine*.

many of these nurses, the opportunity to work in the colonies arose at moments of crisis: during outbreaks of epidemic disease or at times of military conflict. These circumstances resulting in difficult, challenging work that cannot reasonably be considered a "softer option." Moreover, contracts for colonial and military nursing were often situational and temporary, requiring nurses to move between numerous roles, locations, and hospitals, even during relatively short overseas stints.

At the same time, the movement of nurses overseas cannot be regarded as part of a concerted governmental effort to encourage the circulation of "appropriate" forms of female labour within the empire. Neither were nurses intended to solve the gender imbalance, which was prevalent in colonies like Hong Kong (Chapter 1), by creating regulated opportunities for colonial men to find British wives. There was no joined up policy that sought to connect the need to solve the problems created by a surfeit of unmarried men in the colonies with the need to equip the colonies with appropriately qualified and reliable nursing staff.

By the 1890s, professional nursing predominantly involved a three-year training programme at a large metropolitan teaching hospital. Women with further postgraduate specialties, such as fever nursing, which was in particularly high demand in the colonies, often found it easier to get jobs overseas because they could provide a wider range of testimonials, experience, and expertise. While the *BJN*, and several of the in-house publications from the London hospitals, do contain examples of nurses marrying overseas, they were far scarcer than nurses marrying at home because, in both cases and despite a few exceptions, nurses usually had to leave the profession once they were married. Encouraging nurses

to meet the shortages in understaffed colonial hospitals might have provided marriageable women, but it would also have left hospitals understaffed.

The Nursing Record first proposed that British nurses be sent to establish training schools overseas in April 1888. The sites chosen were Egypt, specifically Cairo and later Alexandria if all progressed satisfactorily, and India, where it was believed that a better class of local would appreciate good nursing. The stated intention was to develop nursing among the indigenous populations, rather than perpetually transplant British nurses when required: "It is proposed that English nurses should be sent out there to educate female natives in the art and science of nursing." The first candidates were given £25 for the passage, paid £84 a year, and received free board, lodgings, uniforms and expenses.[322]

Despite the numerous mentions of the benefits of overseas nursing from 1888 onwards, *The Nursing Record* was careful to remind potential employees that they should only consider emigration through sanctioned channels. In May 1888, in response to claims made by several emigration societies, particularly in reference to work in Canada, the publication entreated nurses not "to trust too much in current high-coloured statements respecting fields for nursing abroad," and to use only reputable agents from each colony working in London. They were also urged to make sure they had secured a job before they left Britain.[323] Such precautions were intended to protect individual nurses, while ensuring the quality of British nurses working overseas. They were also a means of underscoring the distinctions between trained professionals and local amateurs.

[322] 'Nursing Echoes,' *Nursing Record*, vol.1 (19 April 1888), pp.19-20.
[323] *Ibid*., (3 May 1888), p.57.

While British nurses moved to work overseas, other women came to Britain for training. The records of all the large teaching hospitals in London indicate that nurses were arriving from abroad to study as early as the 1870s and 1880s.[324] Many of these women were born in the colonies or received some part of their education in a different country, usually on the continent.

The majority of nurses recruited by hospitals were hired through recommendations. In order to document their educational and employment history, many—particularly more experienced nurses, those who had held senior positions, or those who had trained in various specialties—carried packets of testimonials in support. The *BJN* considered the use of testimonials to be so significant—a matter of "life and death," and of great influence on the prospects of the patient—that it used a significant portion of its second issue to advise the judicious checking of testimonials when selecting private nurses:

> A professional nurse should be made to answer for herself, to give an account of her claim to assume the title. She should not be taken at her own valuation but be asked to show proofs of her training and skill. Surely this is no hardship on a nurse, if she has the honour of her profession at heart?[325]

While some nurses chose to belong to professional organizations like the RBNA or the SATNA, this was by no means a prerequisite, as noted elsewhere in this thesis, so checking lists or registered nurses offered by these institutions was not a reliable method for ensuring a candidate's suitability. Testimonials were usually

[324] KH/N/FP5/1-4 Student Nurses' Registers, 1885-1936. SM/NR 2/1/1-2 St Marys' Hospital Nursing Records: Register of Probationers, 1876-1904.
[325] Miss C. J. Wood, 'Private Nursing,' *Nursing Record*, vol.1 (12 April 1888), p.14.

letters of support and introduction written by a senior staff member familiar with a nurse's work, for example a matron, medical superintendent, or supervising physician. These documents allowed new employers to familiarize themselves with the duration of a nurse's placement, the type of work she was capable of undertaking, and the standard to which she executed those tasks. They also provided a contact person at former posts and, while all major teaching hospitals also kept records of its nurses and probationers, often with detailed comments on performance, testimonials were usually the easiest way to verify a nurse's background.

Most nurses carried their testimonials between employers, so finding collections of these documents in archives is rare. However, the "Plague Records" of Cape Town do contain numerous examples, as copies, or as originals. An example is the letter written by a doctor in support of a Miss A. Courtney Clarke:

> I have the greatest pleasure in recording my high opinions of Miss A. Courtney Clarke…She is a lady of high professional character and she has always had an influence for good over those who have worked under her. She is a thoroughly well trained and skilful nurse and likewise an experienced and economical housekeeper. I have always found her very pleasant to work with, and most careful and contentious in carrying out Medical directions, and she has always kept good discipline in the Hospital, at the same time treating those under her with consideration and kindness. These attainments, together with her single-minded devotion to her work, have rendered her a most efficient Matron.

As the letter progresses, the testimonial becomes increasingly effusive and someone, perhaps Clarke herself, had chosen to highlight his remarks about her consideration and kindness.

As noted in the Introduction of this thesis, several historians of nursing have argued that colonial nursing, like military nursing, offered British nursing a wider range of opportunities than they might find at home. Summers has argued that despite the domestic, maternal and wifely connotations of nineteenth-century nurses, prompting nurses to work for "love, a roof over their heads and a rather small amount of spending money," war nursing provided one of the more romantic and exciting potential escapes from the confines of accepted feminine roles. This was a perception of the profession reinforced by representations that characterized nurses as heroines able to transgress the restrictions of the home or training institution.[326] Summers also notes that private and colonial nursing could afford the same opportunities. Marks has made similar points, commenting: "For those with a sense of adventure, nursing in the colonies via the sisterhoods provided one solution to the constraints of Victorian society and women's lack of employment at home—the means of combining excitement and the experience of new people and places while at the same time fulfilling women's sacred duty: self-sacrifice for others."[327] However, despite these frequently cited arguments, there has been little study of the women who considered overseas nursing opportunities, the process by which this was encouraged, and the experiences of those who chose this employment.

The experiences of some of these women have been explored in the Hong Kong and Cape Town chapters of this thesis. The aim of this section is to look more closely at how women might have been encouraged to work overseas outside of formal recruitment campaigns, for example as part of the Colonial Nursing

[326] Anne Summers, 'Images of the Nineteenth-Century Nurse,' *History Today*, vol.34 (1984), p.41.
[327] Marks, *Divided Sisterhood*, p.22.

Association, or the Queen Alexandra's Royal Army Nursing Corps during the Boer Wars.

Given the CNA was not founded until 1896, and the numbers of nurses joining this Association remain minimal for the first few years since its inception, there was no one system or method a British nurse might use to gain a post at an overseas hospital during the period covered by this thesis. To be sure, the CNA was established with the express purpose of providing trained nurses to the colonies. Winston Churchill was an early supporter, proposing a ball to raise funds for those who became incapacitated during their work for the Association and needed to rely on temporary sick pay. For the first five years, P&O and other steamship companies, offered nurses going to work overseas a small concession on their passage.[328] Yet, as Howell reminds us, while the CNA "supported the goals of both the Colonial Office and Colonial Medical Service, the CNA was not under the auspices of either, nor could it change colonial policy or medical services directly."[329]

Rafferty has argued that members of the CNA were "multi-layered subjects operating with complex motives in pursuit of multiple agendas," who had very real expectations of a better life overseas. Incentives ranged from practical concerns, including contracts that provided accommodation, reasonable pay and pensions if candidates were to remain in place long enough, to more abstract desires for autonomy, independence, adventure and memories that would last a lifetime.

[328] 'The Colonial Nursing Association,' *BMJ* (1 June 1901), p.1365.
[329] Howell, 'Nurse Going Native,' p.167.

Nurses considering a post in Cape Town might be swayed by what they read in the *BJN*. A regular featured dubbed "Our Foreign Letter" extolled the virtues of institutions and individuals working overseas. As Howell notes, the letter, as a genre of testimony, "also created an opportunity for the Association [CNA] to mould nurses' behaviour from afar, so that each woman would reflect well on her profession and on her employer."[330] The "Foreign Letter" feature in the BJN usually described the medical facilities of locations within the empire, although occasionally notices on Europe or the United States as the RBNA sought to maintain links with professional associations there.

On 30 April 1898, the New Somerset Hospital became the focus of praise. The writer had been "so charmed" by a recent visit that her first impulse was to inform the journal about the facilities. The "beautiful hospital" was "the first building one notices on entering the harbour…it reminds one forcibly of some time-honoured ancestral English home." It was also surrounded by "stately trees and lovely gardens, with the sea washing up fresh and musical to within a few yards of the door." The author was also careful to commend the out of town locations which ensured that the hospital was removed from the "noise and other disadvantages" of a more central location yet convenient enough to be reached in ten minutes by electric tram at a cost of only threepence. The wards were "beautifully lofty and airy," each equipped with a veranda featuring a view of Table Bay and the Blandberg Hills. The operating theatre was also "justly a source of pride," with marble flooring and fittings, tiled walls and electric lights, allowing the facility to be used around the clock. Perhaps of greater interest to potential

[330] Howell, 'Nurse Going Native,' p.168; see also Howell, 'Nursing Empire.'

nurse recruits were the "charmingly arranged" nurses' quarters, which contained "airy and nicely furnished" cubicles and a spaciously and cool sitting room.[331] The commentator was equally complimentary of the matron, Sister Lucy Alicia of the Order of All Saints, in a manner that suggested the type of nurse likely to thrive at the New Somerset:

> …one was a little surprised to find so broad-minded and public spirited a woman garbed in the religious habit, and yet half an hour's intercourse convinced me that here was to be found the ideal nurse and woman – a very worthy disciple of St Bartholomew's tradition.

For the secular nurse, or the nurse who perhaps needed to be more fiscally-minded, the article was followed by a description of Cape Town's Victoria Nurses Institute, founded to provide professional nurses for the public at a more reasonable cost, enabling them to "procure that scientific nursing which is so essential in cases of sickness, and which often means the difference between life and death."[332] The Institute aimed to raise the standards of nursing in the colony, foster an "*esprit de corps"* among these women, and extoll the benefits of nursing "amongst every class of the community." Here, nurses could use the cooperative structure of the organization to earn a competitive salary doing nothing but private work but still paying reasonable rates for food and accommodation at an organization which allowed a single woman to travel to and work in the city, alongside experienced colleagues, without any suggestion of impropriety and with some system of support. This was vital for a nurse who was not affiliated with any

[331] *Nursing Record and Hospital World*, vol.20 (30 April 1898), pp.362-4.
[332] *Nursing Record and Hospital World*, vol.20 (30 April 1898), p.364.

of the large hospitals or religious orders. For the community, the institute had a philanthropic function as it offered subsidised nurses on a temporary basis for even the poorest districts, while also helping to maintain the thin veneer of white respectability among those with limited means. Similar examples of this type of article are quoted at length in the Cape Town chapter of this thesis, one of which opened with the exclamation: "I am told there are sure to be some good openings for nurses in South Africa soon."[333]

4.5 Henrietta Stockdale: A Nursing Life Abroad

Sister Henrietta Stockdale, pioneer of professional nursing in South Africa, whose efforts are detailed in the Cape Town chapter of this thesis, submitted a paper to the *Nursing Record* in August 1892. As Matron of the Kimberley Hospital, Stockdale described working conditions and the lifestyle enjoyed by overseas nurses, while also making careful note of the type of woman such an appointment might suit. Her paper was then read before the RBNA, who believed it "should be read by all Nurses desirous of emigrating to that quarter of the globe."

When describing the conditions at the Robben Island leper colony, Stockdale vividly captures the difficult work and conditions, yet at the same time, idealizes the qualities of potential British recruits hoping to emigrate to the Cape:

> It should be, it must be, echoed by every true-hearted Nurse who works there; and the greatest care, the closest observation, the most scrupulous obedience to orders, should second the ceaseless efforts of the doctors there to find some remedy or some amelioration for this terrible disease. But how great must be the patience, and how firm

[333] *Nursing Record and Hospital World*, vol.25 (3 November 1900), p.361.

> the faith to work on day after day amidst scenes so dreadful, in such loneliness and isolation, coping with dull depression and the irritable distorted minds of the lepers; with the mountains and towers of Capetown [sic] continually in sight and continually out of reach – with no 'good cause' to cheer one's heart, no 'convalescent patients' to comfort one's mind; the waves of the sea before one, 'waves of sand forlornly multiplied' behind…No English Nurse should think of leper work until she has tried and patiently endured for some years the dullest work, the greatest monotony, and the dirtiest patients that England can afford.[334]

The article serves several functions, legitimizing South Africa's healthcare facilities and indicating that they were comparable with any in Britain or in other colonies, locations that competed to tempt qualified nurses considering overseas employment. The "good work" of overseas postings is mentioned, as is the "thoroughly good administration," implying the existence of a hospital hierarchy that insisted upon high standards, correct management and clear roles. A system that ambitious nurses might make use of if they had an interest in advancing their careers. However, these comments also indicated a level of support that, as the experiences of the nurses recorded in Cape Town as part of this dissertation demonstrate, was not always available, particularly in rural areas where jobs were more plentiful and where newly arrived nurses were often sent to meet shortfalls.

The gist of the paper is contradictory as it repeatedly mentions the emotional and physical difficultly of the work, yet also implies that the colonial nurse would not suffer material deprivation.[335] When examined in its entirety,

[334] Sister Henrietta Stockdale, 'Nursing in the Colonies,' *Nursing Record*, vol.8 (25 August 1892), p.696.
[335] Stockdale, 'Nursing in the Colonies,' p.696.

Stockdale's paper functions as an advertisement, designed to attract potential employees for South Africa's hospitals while also championing the quality and professionalism of the local medical infrastructure. It warns of difficult working conditions, thus serving to attract the right candidates with the right qualities and hopefully minimising the number of nurse who found Cape life unsuitable and returned to Britain, leaving vacant positions that were difficult to fill. This was a particular issue at the time because, as the Cape Town chapter of this thesis notes, appropriate local candidates were scarce and South African nursing remained dependent on its close ties with London. In achieving her aim Stockdale chooses to make the New Somerset Hospital, then the largest centre of acute medicine in southern Africa, sound like a convalescent home that skilfully blended modernism and gentility:

> Stately New Somerset, so handsome and cheerful, with its balconies seeming almost to overhang the blue waters of Table Bay, with every convenience and comfort, with electric light everywhere, with much of ornament and decoration, with thoroughly good administration and good work – any provincial town in England might be proud to possess it. But as you stand on the broad grass path between the hospital and the sea, on clear days you can see far away to your left what looks like the funnel of a steamer, but is really the tall lighthouse of Robben Island, the Isle of Lepers…The Nurses, whoever they may be, who go there should have plenty of courage and plenty of hope.[336]

Stockdale made references to equally resplendent medical and municipal facilities at Durban, evoking parallel desires among potential employees for civility and

[336] Stockdale, 'Nursing in the Colonies,' p.696.

exoticism, as among the town's "many fine buildings...Zulus carry huge branches of bananas."

However, Stockdale chooses to end her discussion with a sober reminder of the type of woman best suited to an overseas posting. Some might interpret this as one of numerous attempts to attract the "right kind" of woman to South Africa, particularly the right kind of British women, which remained a governmental priority reemphasised here at the close of the Second Boer War. However, it is more likely an attempt to attract the right kind of nurse, as in South Africa, and in many locations, nurses who chose to marry and settle were forced to renounce their professional role, a situation that would remain relatively unchanged until World War II. Women hunting husbands, no matter how accomplished in nursing education, were of little use to Sister Henrietta, a busy matron and head of a nursing school with strong religious foundations.

Articles like those of Sister Henrietta are not advertisements for marriage or attempts to encourage emigration; they aim to recruit qualified employees who would embrace the challenges of the colonial environment. In reinforcing her aim, she again references qualities desirable and often expected in a professional nurse:

> One word more, of the kind of Nurse who should come out to the colonies, the type of woman most likely to be a success. It should never be forgotten that an entire change of the mode of life and of country and companions removes for a time all secondary motives. On the other hand, the English Nurse is exposed to sharp criticism in her new home, and here comes in the narrowness of my subject. The Nurse faithful, devoted, unselfish, healthy, straightforward, and honest-hearted, who would be a success in the colonies, would be a good success anywhere. But to those who advise Nurses to go here or stay at home I would say a word.

Stockdale was not afraid of using professional journals and other outlets to legitimise South African nursing, but here is one of several examples of her using a professional journal directly as a recruiting tools.

Another nurse who worked overseas and has left extensive recollections of her training is Emma Durham, who trained at King's College Hospital (KCH) between 1872 and 1875. At that time, the hospital was based in Lincoln's Inn Fields and much of the nursing work was carried out by the St. John's House Sisterhood. According to Durham, nurses were usually expected to be at least twenty-five years-old before they began their training, although she admits to being slightly younger. Probationers were expected to be up at 6:30am, dressed, having stripped their beds, and completed their prayers. They were given a twenty-minute lunch break, although food was apparently so bad that "country eggs" were often cooked and smuggled in pockets for tea or speedy snacks. Staff were seated in order of seniority and service, so being a probationer mean the "last of everything." The hours between 2pm and 4pm were ostensibly for rest, although Durham claims that the probationers at KCH were deemed to be so pale that they were forced to spend a significant proportion of this time walking outdoors or pay a sixpence fine. She herself spent much of that time hiding in a park to the rear of the Savoy.

Work was difficult and both blisters and "little creatures" were ubiquitous among the nurses. Hygienic shortfalls were frequently and ruefully noted in Durham's recollections for example her first experience of chloroform was when administering to allow the removal of a four-pound tumour from a forty-eight-

year-old woman who had never had a bath. When qualified and working at the hospital conditions and food, supplemented with beer, were a little better, although a nurse could expect to be on duty between 8am and 10pm.

Durham went on to join the Universities Mission to Central Africa, working in Zanzibar where she helped establish the first hospital there for indigenous patients. She also worked as a Red Cross nurse in that Natal (as part of the 1879 Zulu War), Egypt, France, Germany, Italy, Belgium, Switzerland, Russia, and the United States, before dying in 1936, again at KCH, although by this point the hospital had relocated to Denmark Hill.[337] As she asserts in her memoirs:

> No woman should think of taking up a nurse's life unless she is capable of some self-sacrifices. The cry for some years has been, give us a better class of women, more refined, better educated. Are these women prepared to give up the fleshpots of Egypt, to be content with plainly cooked food, to be, in fact, a help to the suffering poor, to forget self in their work? Only such women should be accepted in any hospital; only such women are worthy of the name of nurse.

Here, Durham chooses to express herself within the established nursing tropes of altruism and dedication. However, much like Sister Henrietta's warnings about working on Robben Island, Durham leaves candidates under no illusions about expected standards and sacrifices.

[337] 'The Passing Bells: Sister Emma Durham RRC,' *BJN,* vol.84 (November 1936), p.300. Durham had also apparently worked as a private nurse for Alfred Lord Tennyson for the last two years of his life, during which time he wrote "Crossing the Bar."

4.6 Conclusion

This chapter has explored the role of metropolitan nursing journals and textbooks in the construction and promotion of a nursing ideal and how this ideal was projected to create an image of an imagined colonial community and healthcare environment. The aim has been to provide a broader context to the discussions in Chapters 2 and 3 about the challenges posed to nurses who sought employment in the colonies. Working under difficult conditions, often in makeshift hospitals, nurses ran the risk of undermining these enculturated nursing ideals.

The metropolitan nursing literature that has been examined in this chapter is riven with contradictions about the scope of nursing work, and the qualities that were required for the nursing vocation. These contradictions became more pronounced overseas, and in the midst of crisis situations, such as the Third Plague Pandemic, where the policing of boundaries broke down and nurses were compelled to extemporize.

The chapter has also considered the role played by nurses themselves in what Howell calls "self-positioning." Articles, letters, and testimonials provided a means for nurses to project an image of themselves as representative of the "colonial nurse" in ways that could be strategic for recruitment. In this sense, (auto)biographical sketches, or "biographical snapshots," functioned as rhetorical devices for conveying authenticity.[338] They created an emotive affinity between

[338] Howell, 'Going Native Nurse,' p.168, who cites the work of Amanda Gilroy and W. M. Verhoeven, *Epistolary Histories: Letters, Fiction, Culture*. Charlottesville: University Press of Virginia, 2000), p.1.

colony and metropole, producing a stage for the metropolitan nurse to imagine a possible colonial future.

There was a strong performative dimension to this vision of nursing as a vocation and profession, accentuated by the many references to fiction and theatre in the nursing literature. An author in *The Nursing Record*, for example, recommended that nurses not begin their training before the age of twenty-three, to allow her to develop a love of music, art and poetry.[339] As Stoney remarked:

> A nurse should improve her mind be reading the best books at her command, by going out and visiting friends, and by attending the theatre twice a month: this will keep her in touch with outside affairs, and she will be able to converse intelligently with her patients. Her manner towards her patients and towards all with whom she comes into contact should be kind, pleasant, courteous and cheerful—repressing all attempts at familiarity. It should be remembered that while we cannot dictate the manner of other people towards us, yet we can to a certain extent have it what we would like it to be; and we can always control our bearing towards them. The nurse should cultivate a contented mind and a cheerful face, avoid affection and all temptation to air her knowledge – a mistake that many nurses are prone to make – and learn to control her emotions. The patients should be made to feel that they are her first thought, and they will learn to have faith and trust her.[340]

Here, the injunction to visit the theatre is part of a broader prescription for the nurse to overcome the confines of a narrower institutional life and gain "control" over her behaviour so as to foster "faith and trust" in the patient. In effect, the nurse is called upon to perform. Indeed, Stoney's book, like other nursing

[339] Loch, 'What Constitutes and Efficient Nurse?, p.64.
[340] Stoney, *Practical Points in Nursing*, pp.17-8.

textbooks of the period, can themselves be read as a means of performing a nursing subjectivity.[341]

Nurses could serve as "agents of imperial hygiene," since their work was often recruited to the cause of the colonial state.[342] As Nestel has argued in her analysis of colonial nursing and native reproductive practices, "while nursing work may have improved native health in colonized regions, it also contributed significantly to the establishment and stabilization of the racialized order of colonial rule."[343] Yet, as we have seen, nurses also held the power to destabilize this order, even posing a threat to colonial authority itself. This thesis demonstrates the nurse as a skilled interpreter and navigator of boundaries, distal from their point of origin yet able to articulate a shared vision of the ideal through networks of communication, her dress, demeanor and leadership behavior. The figure of the nurse is far from a dull monochrome category. Rather, in the colonial setting she becomes a dazzling, yet fugitive figure, one difficult to hunt and pin down. Yet her very presence disrupts the dominant male narrative of empire, complicating her agency and allegiance not only to empire but the nascent professional empire that was emerging in the period considered within this thesis.

[341] For an elaboration of nineteenth-century literature and narrative strategies "used to perform English subjectivity during the time of the British Empire," see Angelina Poon, *Enacting Englishness in the Victorian Period: Colonialism and the Politics of Performance* (London and New York: Routledge, 2008).
[342] Howell, Rafferty, Snaith, and Wall, 'Nursing the Tropics.'
[343] Nestel, '(Ad)ministering Angels,' pp.271-2.

Chapter Five
Conclusion

5.1 Introduction

This thesis has argued that the third plague pandemic offers an invaluable "sampling device" for gauging the development of institutional nursing across the British empire.[344] Focusing on three sites—Hong Kong, Cape Town, and London—it has shown how plague could serve as a catalyst for change, although when it did occur, change was invariably slow and piecemeal. The timeframe that forms the central focus of the argument—roughly from the 1880s to the eve of World War I—bridges the period between an unregulated and often improvised species of nursing and an institutionally grounded nursing underpinned by standardized training that reflected new hygienic practices.[345]

Port cities were often amongst the first affected by plague, and consequently became cornerstones of epidemic response.[346] Hong Kong and Cape Town were spaces of substantial disquietude, situated at the edge of vast, complex landmasses, and governed by a small European community living amongst a far larger indigenous population frequently characterized as inherently unhygienic, prone to crowd-living, and socially disruptive.[347] Bound by trade, transportation,

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[344] Rosenberg, 'Framing Disease.'
[345] For a classic account of this new "hygienic modernity" that underpinned colonial regimes in East Asia, see Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley: University of California Press, 2004).
[346] Echenberg, *Plague Ports*.
[347] On the countermeasures that these assumed native proclivities necessitated, see Arnold, *Colonizing the Body*.

and technology, these cities relied on links to other colonies and the metropole. While these connections made each location vulnerable to disease, they also facilitated the development of countermeasures in the form of information, expertise, and manpower.

In Hong Kong, the absence of nursing was noted by various colonial surgeons, officials, and governors through the 1860s and 1870s. In the 1880s, a new emphasis on hygiene and sanitary infrastructure (water, sewage, and housing) coincided with calls to develop the colony's health institutions. The 1880s saw the creation of a new Sanitary Board (1883), the establishment of the Hong Kong College of Medicine for Chinese, and the Alice Memorial Hospital (1887). Nursing was identified as a crucial but absent service that would complement and extend these other developments. At the end of the decade, the first Western-trained nurses disembarked in Hong Kong from London. The arrival of plague in the late spring of 1894, and the crisis it triggered, however, was to refocus attention on the nursing question and on the shortcomings of the improvised system that had arisen to meet demand. Not only did Hong Kong lack sufficient numbers of qualified nurses, it also lacked the material infrastructure required to support any permanent nursing staff.

The Cape Colony was also left relatively unprepared for the arrival of plague in 1901, despite efforts to monitor the disease internationally and establish local containment solutions. The problem of shortfalls in the numbers of available nurses was compounded by impoverished opportunities for training, significant challenges to recruitment, and the drain on nursing numbers and resources created by the Second Boer War (1899-1902). Plague highlighted the extremity of

nursing in the Cape. Those recruited from Britain to help manage the disease were required to work in multiple and often remote locations, including in the quarantine hospitals at Saldanha Bay, Port Elizabeth, Port St John and East London, hundreds of kilometres from Cape Town.

In the course of their efforts to manage successive plague outbreaks, nurses were repeatedly commended. They were acknowledged as an essential component of disease planning and response. The gravity of their work, and the attention it received, created opportunities for further recruitment to address longstanding needs, and fostered discussion about how nursing education might be expanded. However, these discussions were locally inflected. They were shaped by specific political, cultural, and economic concerns that varied from site to site. Impediments to the growth of nursing education, and to the maintenance of a permanent nursing staff, were negotiated differently, although numerous colonies continued to recruit heavily from Britain for decades. Distinctive circumstances in each colony prompted distinctive solutions to nursing shortfalls, challenging suggestions of homogeneity in the "imperial nursing" of the late nineteenth and early twentieth centuries. To this extent, tracing local histories of nursing may shed light on the formation of colonial societies in relation to broader trans-colonial and imperial relations.

With the exception of India, demand for qualified nurses predates the formation of most religious, philanthropic, military, and overseas nursing organizations, including the CNA in 1896.[351] Discussions that placed nurses and

[351] Solano and Rafferty, 'The Rise and Demise of the Colonial Nursing Service.' Sporadic early attempts to bring qualified nurses to India and establish training programmes are discussed in the introduction of this thesis. These include attempts to recruit indigenous probationers at various

nursing at the centre of crisis management—like those of Ayres, Cantlie, and Simpson—were rare outside of warfare. Colonial records, print culture, and plague literature regularly analogized efforts to combat disease with military operations, particularly when describing nursing work as part of a concerted colonial campaign to restore authority on the front.[352] This metaphoric framing of anti-disease intervention as a form of belligerent intercession has persisted.

5.2 Nursing and Colonial Anxiety

Particularly in Cape Town, the necessary intimacy involved in nursing gave rise to a host of anxieties that were exacerbated in "the contact zone," where issues of gender, race, and class were intensified.[353] As Anne McClintock has remarked, "the transmission of white, male power through control of colonized women" constitutes one of "the governing themes of Western imperialism."[354] White female nurses working in the colonial sickroom troubled the symmetry of this racial politics.

The lack of direct government support and supervision in the oftentimes isolated hospitals where nurses were sent had profound consequences for the

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independent hospitals, established the National Association for Supplying Medical Aid by Women to the Women of India (the Dufferin Fund) in 1883, and the Indian Nursing Service in 1888. See Healey, '"Regarded, Paid and Housed and Menials"; Jones, 'Heroines of Lonely Outposts'; Lal, 'The Politics of Gender.'

[352] Gregg argues at the first sign of plague, "the most determined war should be declared upon the rats"; see *Tropical Nursing*, p.113. Simpson frequently describes measures to "combat" the disease, see *A Treatise on Plague*, pp.174, 316, 376, 381, and 384.

[353] Mary Louise Pratt, *Imperial Eyes: Travel Writing and Transculturation* (London: Routledge, 1992), pp.4-7. On the concept of "colonial anxiety," see Peckham, 'Introduction: Panic—Reading the Signs'; and Harald Fischer-Tiné and Christine Whyte, 'Empires and Emotions,' in Fischer-Tiné and Whyte, eds., *Anxieties, Fear and Panic*, pp.1-24.

[354] Anne McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest* (New York and London: Routledge, 1995), pp.2-3.

women involved, leaving them exhausted and exposing them to potential infection, violence, and death. Living and working in these awkward spaces at the edge of empire was beset with danger.[355] As discussed at some length in Chapter 3, nurses also faced accusations of impropriety. Perceived moral transgressions could lead to official admonition that ruined reputations and indeed, as discussed in Chapter 3, drove some women to suicide. A nurse's social capital was vulnerable and limited. Careers could be abruptly cut short by barbed rumours and innuendos that sparked moral panic among colonial officialdom and sometimes the wider colonial community. As Stanley Cohen has observed in his classic study, the term "moral panic" describes a moment when "a condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests."[356] The colonial ward could provide such a condition with nurses identified as a weak link in the colonial armamentarium.

Cases of rape and suicide in these colonial sites jarred with a metropolitan ideal of nursing embodied in the plague photographs that do exist, for example those showing white-uniformed nurses in plague hospitals in Bombay. Indeed, as we saw in Hong Kong in Chapter 2, there was a discrepancy between the rhetorical celebration of nursing as a vocation that was projected in idealized terms, and the grim realities of nursing in practice. Newspapers and government reports

[355] On the "awkward" geography of empire and the limits of imperial sovereignty, see Lauren Benton, *A Search for Sovereignty: Law and Geography in European Empires, 1400-1900* (Cambridge: Cambridge University Press, 2010).
[356] Stanley Cohen, *Folk Devils and Moral Panics: The Creation of the Mods and Rockers* (London: Paladin, 1972), p.9. On rumors in colonial Africa, see classically, Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley, CA: University of California Press, 2000).

celebrated the work of nurses, even as nurses remained poorly paid, overworked, and institutionally marginalized.[357]

5.3 Plague and Colonial Careering

A key argument of this thesis has been that the plague crisis furnishes a means of recovering life-stories and biographies that are too often obscured in expansive imperial histories that emphasize state interventions, prioritizing process over people.[358] Plague nursing remains surprisingly neglected. In contrast, there is a burgeoning literature on colonial and missionary nursing.[359] Histories of military nursing are also plentiful, giving a somewhat distorted impression of how the growth of institutional nursing was shaped and influenced. The impulse to write institutional histories of nursing is understandable, not least because professional bodies often create extensive archives which help address some of the methodological concerns associated with subject visibility discussed in the introduction of this thesis. However, such histories only provide a partial account of the early history of nursing in the British Empire. One of the goals of this thesis has been to push back against institutional histories in order to recuperate the often side-lined agency of female nurses who operated outside of formal institutional frameworks. In so doing, the thesis contributes to a growing

[357] On the question of "what constitutes 'true' marginality—or 'subalterity,' see Anderson, *Subaltern Lives*, p.7.
[358] On the use of the "biographical snapshot" in colonial history, see Anderson, *Subaltern Lives*, pp.12-15.
[359] See, for example, Iris Boroway, ed., *Uneasy Encounters: The Politics of Medicine and Health in China, 1900-1937* (Frankfurt: Peter Lang, 2009); Kaiyi Chen, 'Missionaries and the Early Development of Nursing in China,' *Nursing History Review*, vol.4, no.1 (1996): 129-49; Gerald Hugh Choa, *"Heal the Sick" was Their Motto: The Protestant Medical Missionaries in China* (Hong Kong: Chinese University Press, 1990); Grypma, *Healing Henan*; and Sweet and Hawkin, *Colonial Caring.*

scholarship that explores "the ways that individual people made the British empire, and some of the ways that the empire made them."[361] While plague created new opportunities for nurses to travel, this mobility made nurses visible in new ways. At the same time, new institutional arrangements and mass publications in the metropole encouraged an imperial careering. The Third Plague Pandemic underscored the glaring shortcomings in nursing care across the Empire. But it also highlighted the importance of the women dispatched to address these institutional defects: nurses who moved between colonies and metropole in the decades before the formal constitution of international nursing organizations.

5.4 Nursing and Communication

Examining events in Hong Kong and the Cape Colony alongside developments in nursing education in London, and studying the origins and experiences of those later engaged in colonial plague nursing, demonstrates how critically underprepared many of these women were for their task. In the 1890s, as discussed in Chapter 4, nursing education was undergoing a period of transformation. Attrition rates in the large metropolitan teaching hospitals were high, the numbers of nurses produced small, and nursing shortages chronic, both at home and overseas. In order to ensure the provision of qualified nurses, different colonies competed for recruits relying, as part of this process, on informal connections between nurses, and using the pages of a growing

[361] David Lambert and Alan Lester, 'Imperial Spaces, Imperial Subjects,' in Lambert and Lester, eds., *Colonial Lives*, p.1).

professional press to showcase seductive visions of empire.[362] Improvised nursing networks offered a degree of support for nurses who found themselves in isolated colonial locations without the assistance of established syndicates.

The politics of communication has been a major theme in the thesis: the forging of personal networks and their convergence with—and separation from—formal institutional circuits; the development of mass print culture—in the form of newspapers and journals—that disseminated news and ideas about what nursing was or ought to be; and the fragile lines of communication within nascent health infrastructures at moments of crisis, when competing interests often lead to breakdown and violence.[363] Also crucial to any life-writing approach is the fragmentary evidence left by the nurses themselves in letters and diaries, or gleaned from official reports and legal testimonies.

5.5 Global History, Local Nursing

In focusing on grounded, site-specific histories, this thesis endeavours to qualify a generalized imperial approach to nursing that elides differences to focus on interconnections. Studies that posit the rise of an "imperial nursing" are often concerned exclusively with institutional advancements—training facilities and hospitals, for example, which are invariably taken as indicators of change. In so doing, these works often fail to account for how changes were actualized and negotiated by individual actors on the ground, often under trying conditions in the

[362] Rafferty, 'Seductions of History.'
[363] On the development of a global communication infrastructure during this period, see Dwayne R. Winseck and Robert M. Pike, *Communication and Empire: Media, Markets, and Globalization, 1860-1930* (Durham, NC: Duke University Press, 2007).

fractious environment of the sickroom. As the Hong Kong and Cape Town chapters of this thesis have demonstrated, day-to-day mediations were fraught with danger.

In focusing on these local struggles, the thesis offers an implicit critique of a certain trend in global history to focus on unimpeded circulations, which are conceived as "flows."[364] To reformulate Clare Anderson's argument in *Subaltern Lives*, nursing may serve as a means of "interrogating colonialism."[365] Sarah Hodges has cautioned against the uncritical acceptance of the "global" in histories of medicine. The "global," she argues is too easily reified, posing a "menace" to understanding grounded specificities.[366] Warwick Anderson has also questioned the assumptions that inform these metaphoric constructions of flow: "In imagining the 'global' as the product of unprecedented flows and circulations, do we tend to ignore its uneven terrain, heterogeneity, and contestation?" This thesis is an attempt, following Anderson, to "resist the hydraulic turn and instead to articulate critical histories of 'global' health."[367] In emphasizing the uneven terrain and heterogeneity of imperial nursing, the purpose has been to open up new avenues of comparative research.

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[364] For examples of "networked" histories, see Tony Ballantyne, *Webs of Empire: Locating New Zealand's Colonial Past* (Wellington: Bridget Williams Books, 2012); Mark Harrison, *Contagion: How Commerce has Spread Disease* (New Haven, CT: Yale University Press, 2012); Alan Lester, *Imperial Networks: Creating Identities in Nineteenth Century South Africa and Britain* (London: Routledge, 2001); Deborah Joy Neill, *Networks in Tropical Medicine: Internationalism, Colonialism, and the Rise of a Medical Specialty, 1890-1930* (Stanford, CA: Stanford University Press, 2012); Kerry Ward, *Networks of Empire: Forced Migration in the Dutch East India Company* (Cambridge: Cambridge University Press, 2009).

[365] Anderson, *Subaltern Lives*, p.1

[366] Sarah Hodges, 'The Global Menace,' *Social History of Medicine*, vol.25, no.3 (2011): 719-728.

[367] Warwick Anderson, 'Making Global Health History: The Postcolonial Worldliness of Biomedicine,' *Social History of Medicine*, vol.27, no.2 (2014), p.372.

5.6 Future Research

This thesis makes no claim to extrapolate a general history of imperial nursing from the evidence of three colonial sites. On the contrary, it has argued that the very notion of "imperial nursing" requires critiquing as a catchall all category that describes (and inevitably reduces) the complexity of formal and informal networks that constituted "nursing" during this period. The thesis has argued that while empire—and specifically epidemic threats to empire—opened up new pathways for nurses to move globally, historians need to be much more attentive to the local circumstances that prevailed in different "host" colonial settings. Put simply, nursing regimes evolved differently in different places. Moreover, these differences were critical to the push and pull dynamics that drove imperial nursing.

The purpose of the thesis has thus been to open up a new research space for fresh comparative work in the history of nursing. Building on the arguments of this thesis, for example, there is now a need to bridge histories of Hong Kong, Cape Town, and other colonial sites, with developments of nursing in India from the late 1890s. Indeed, my aim in future work will be to trace the life stories of those experienced plague nurses who were recruited to work in India after 1896.[368] In short, this thesis is offered as a preliminary attempt to reinstate nurses into narratives of the plague (and of the Third Plague Pandemic in particular) that have for too long been male-centred and shaped by the assumptions of institutional history.

[368] Nathan, *Plague in India*, pp.117-8.

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H01/ST/SJ/C/05	Staff Records: Register of Assistant Nurses, 1883-4
H01/ST/SJ/C/06	Staff Records: Register of Nurses, 1882-1912
H01/ST/SJ/C/07	Staff Records: Register of Midwives and Monthly Nurses, 1886-92
H01/ST/SJ/C/08	Staff Records: Nurses' Fees, 1913-9
H01/ST/SJ/C/011	Staff Records: Information for Applicants, 188?
H01/ST/SJ/C/012	Staff Records: Dossiers for Nursing Staff, 1885-1953
H09/GY/GHTNI/A/03	Administration: Annual Reports, 1909-14
H09/GY/GHTNI/A/05	Agreements for Employment of Lady Superintendent and Terms for Probationers, 1893-1913
H09/GY/GHTNI/C/01	Staff Records, 1893-1921

iii: Special Collections, School of Oriental and African Studies, London (SOAS)

CWM/LMS/15/10/1/012	Photographs, Ho Miu Ling Hospital, Hong Kong, c.1895-c.1917
CWM/LMS/15/10/3/052	Hong Kong Hospital Staff, c.1900-1938
CWM/LMS/16/02/01/041	Letters from Dr William Lockheart, Hospital in Hong Kong, 1843
CWM/LMS/16/02/01/060	Letters from Dr J R Carmichael, Hospital Work in Hong Kong, 1862
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CWM/LMS/16/06	South China Reports, Box 1-4, 1866-1912
CWM/LMS/16/06/1/033/02	Robert Gibson, Report on the Nethersole Hospital, Hong Kong, 1898
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CWM/LMS/04/14/024	Standard Railway Map of South Africa 1939
CWM/LMS/04/14/025	Junta's Map of South Africa from the Cape to the Zambezi 1891
CWM/LMS/04/14/049	Map of the Colony of the Cape of Good Hope and Neighbouring Territories 1895
CWM/LMS/15/10/3/052	Photographs of Various Hong Kong Hospitals and Staff, c.1900-1938

iv: St Mary's Hospital Archives, London

SM/NR2/1/1	St Mary's Nursing Records: Register of Probationers, 1876-1895
SM/NR2/1/2	St Mary's Nursing Records: Register of Probationers, 1895-1904

v: Wellcome Library, London (WL)

MS1483	Fragments from Hong Kong Plague Letters
MS1487	Sir James Cantlie Lecture on the Plague 1897
MS1488	Sir James Cantlie Lecture on Hong Kong 1898
MS1498	Sir James Cantlie Lecture to the Colonial Nursing Association
MS1719	Collected Plague Documents and Statistics
MS6935	Assorted Printed Papers on Bubonic Plague 1886-1911

SA/QNI/U.1/1	Historical Colonial Associations Re Federation to the Queen's Nurses from Queensland, Cape Town and Tanzania 1896-1901
SA/QNI/Z.1/7	Rosalind Paget: Demand for and Supply of Queen's Nurses
WF/M/PB/18/1	*Wellcome's Professional Nurses Diary,* Colonial Edition 1898
WF/M/PB/18/2	*Wellcome's Professional Nurses Diary,* Colonial Edition 1899
WF/M/PB/20/1	*Wellcome's Professional Nurses Diary,* South Africa Edition 1901
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WF/M/PB/20/3	*Wellcome's Professional Nurses Diary,* South Africa Edition 1915-16
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vi: National Archives of South Africa, Cape Town Archives Repository (KAB)

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CCP/4/10/2/3	Cape of Good Hope Public Health Reports 1897-1900
CHB/233/190	Correspondence Files, Bubonic Plague 1899-1901, Folio 190
CO/7261	Colonial Office, Health Branch 1899-1904, Folios 29-32
CO/7266	Colonial Office, Health Branch 1899-1904, Folios 32a-32c
J16	Doctors and patients. Maybe vaccinating against smallpox or inoculating against bubonic plague, 1901
J17	Doctors and patients. Maybe vaccinating against smallpox or inoculating against bubonic plague, 1901
J18	Doctors and patients. Maybe vaccinating against smallpox or inoculating against bubonic plague, 1901
J5158	Plague Camp: Ward. 1900. Cape Town
J5160	Plague Camp, Cape Town: Staff
MOH/6	Medical Officer of Health, Plague Records 1901-1905, Folio 17-24
MOH/7	Medical Officer of Health, Plague Records 1901-1905, Folio 25-29
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MOH/15	Medical Officer of Health, Plague Records 1901-1905, Folio 53-59
MOH/16	Medical Officer of Health, Plague Records 1901-1905, Folio 64
MOH/18	Medical Officer of Health, Plague Records 1901-1905, Folio 70-73
MOH/19	Medical Officer of Health, Plague Records 1901-1905, Folio 75-84
MOH/20	Medical Officer of Health, Plague Records 1901-1905, Folio 89-91
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MOH/28	Medical Officer of Health, Plague Records 1901-1905, Folio 231, Part II
MOH/29	Medical Officer of Health, Plague Records 1901-1905, Folio 231, Part III
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MOH/31	Medical Officer of Health, Plague Records 1901-1905, Folio 252-258
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